As well there may be indications for an in-depth nutrition assessment

- Medical and psychosocial history - medications known to have drug-nutrient interactions, depression or dysthymia, diagnosed eating disorder (AN, BN, EDNOS), at risk of re-feeding syndrome, disordered/fussy eating, ASD, developmental delay, chronic disease i.e. diabetes
- Growth and development - underweight, overweight, at-risk of overweight, short stature
- Dietary intake and physical activity - history of food insecurity, meal skipping, inadequate micronutrient intake, excessive intake of total or saturated fat, food allergy or intolerance, vegetarian diet, dieting, fasting, alcohol consumption, minimal/excessive sport/physical activity
- Physical observations and biochemistry – hypertension, hyperlipidaemia, iron deficiency anaemia

SECTION 2: INTERVENTIONS

Clinicians providing interventions at the time of the Review were contacted and asked to provide a list of:

- The range of interventions they provided at the time of the Review
- The evidence base for these interventions (including any reviews since the Review)

These interventions are listed in three categories

- Interventions Specific to a Disorder
- Treatment Interventions across Disorders
- Rehabilitation Interventions to Address Impairments across Disorders

1. Interventions Specific to a Disorder

School Refusal/Social Anxiety Disorder and Co-morbid Anxiety Disorders

- Behavioural Interventions – exposure individually or via groups

  Evidence Base

  Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*

  Borgeat F, Stankovic M, Khazaal Y, Rouget BW, Baumann MC, Riquier F, O'Connor K, Jermann F, Zullino D, Bondolfi G, (2009) Does the form or the amount of exposure make a difference in the cognitive-behavioral therapy treatment of social phobia? *Journal of Nervous and Mental Disease. 197:507-13,*

  Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*

  Storch EA, Larson M, Adkins J, Geffken GR, Murphy TK, Goodman WK. (2008). Evidence-based treatment of pediatric obsessive-compulsive disorder. In: Handbook of evidence-based therapies for children and adolescents: Bridging science and practice. *Steele RG. (Ed.); Elkin TD (Ed.), Roberts MC. (Ed.); New York, NY, US: Springer Science + Business Media, 2008. pp. 103-120.*

- Social Skills Enhancement

  Evidence Base

  Beidel DC, Turner SM, Young BJ. (2006) Social effectiveness therapy for children: five years later. *Behavior Therapy 37:416-25*

  Cook CR. Gresham FM, Kern L, Barreras RB, Thornton S, Crews SD, (2008). Social skills training for secondary students with emotional and/or behavioral disorders: A review and

analysis of the meta-analytic literature. *Journal of Emotional and Behavioral Disorders 16:131-144.*
Herbert JD, Gaudiano BA, Rheingold AA, Myers VH, Dalrymple K Nolan, E M. (2005) Social Skills Training Augments the Effectiveness of Cognitive Behavioral Group Therapy for Social Anxiety Disorder. *Behavior Therapy. 36:125-138.*
Spence SH, Donovan C, Brechman-Toussaint M (2000) The treatment of childhood social phobia: The effectiveness of a SST-based cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry 41:713-726*

- Cognitive Therapies

  Evidence Base

King NJ, Heyne D, Ollendick TH (2005) Cognitive-behavioral treatments for anxiety and phobic disorders in children and adolescents: A review. *Behavioral Disorders. 30:241-257.*
Layne AE. Bernstein GA. Egan EA. Kushner MG. (2003) Predictors of treatment response in anxious-depressed adolescents with school refusal. *Journal of the American Academy of Child & Adolescent Psychiatry 42:319-26*

- Family Therapy

  Evidence Base

Kendall PC. Hudson JL. Gosch E. Flannery-Schroeder E. Suveg C (2008) Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. *Journal of Consulting & Clinical Psychology. 76:282-97*
Siqueland L, Rynn M, Diamond GS. (2005) Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders. 19:361-81*

Depression, Dissociation and PTSD

- Trauma Focussed Cognitive Behaviour Therapy and Stress Inoculation Therapy

  Evidence Base

Forbes D, Creamer M, Phelps A, Bryant R, McFarlane A, Devilly GJ, Matthews L, Raphael B, Doran C, Merlin T, Newton S. (2007) Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder *Australian & New Zealand Journal of Psychiatry* 41:637-648
Cohen JA, Deblinger E, Mannarino AP, Steer R. (2004) A multisite, randomized controlled trial for children with sexual abuse related PTSD symptoms. *Journal of the American Academy of Child Adolescent Psychiatry. 43:393-402*
Foa EB, Chrestman KR, Gilboa-Schechtman E, (2009). Prolonged exposure therapy for adolescents with PTSD: Emotional processing of traumatic experiences: Therapist guide.; *New York, NY, US: Oxford University Press, 2009. xii, 206 pp*
Hembree EA, Foa EB (2003) Interventions for trauma-related emotional disturbances in adult victims of crime *Journal of Traumatic Stress 16:187-199.*
Hembree EA, Foa EB Dorfan NM, Street GP, Kowalski J, Tu X (2003) Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress. 16: 555-562*
Jonsson PV (2009) Complex trauma, impact on development and possible solutions on an adolescent intensive care unit *Clinical Child Psychology & Psychiatry. 14:437-54*
King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH (2000). Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial. *Journal of the American Academy of Child Adolescent Psychiatry. 39: 1347-1355.*
Lewis C, Simons A, Silva S, Rohde P, Small D, Murakami J, High R, March J. 2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology. 77:422-428.*
Rauch SA, Cahill SP (2003) Treatment and Prevention of Posttraumatic Stress Disorder. Primary Psychiatry. 10:60-65.
Trowell J, Kolvin I, Weeranamthri T, Sadoski H, Berelowitz M, Glasser D Leitch I (2002) Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry160:234-247.*

Saunders BE, Berliner L, Hanson RF, eds. *Child Physical and Sexual Abuse: Guidelines for Treatment.* Revised Report: April 26, 2004. National Crime Victims Research and Treatment Center.
Spermon D, Gibney P, Darlington Y. (2009) Complex trauma, dissociation, and the use of symbolism in therapy. *Journal of Trauma & Dissociation. 10:436-50*
Weber S (2009) Treatment of trauma- and abuse-related dissociative symptom disorders in children and adolescents *Journal of Child & Adolescent Psychiatric Nursing. 22:2-6*
In addition, expressive therapies (art, sandplay) facilitate the expression of emotions and expression of traumatic events related to trauma focussed therapy.

Eating Disorders

- Integrated Management Program
  Evidence Base
  Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*
  National Collaborating Centre for Mental Health (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders *National Institute for Clinical Excellence Clinical Guideline*
- Dietetic Management
  Evidence Base
  Dietetic Management of Adolescents with Eating Disorders is based on existing guidelines and current literature. Including but not limited to:
  Golden HN. (2003)et al Eating disorders in adolescents: position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health. 33:496-503.*
  Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults http://www.daa.asn.au/index.asp?pageID=2145872887
  American Dietetic Association (2006) Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Anorexia Nervosa, Bulimia Nervosa, and Other Eating Disorders. *Journal of the American Dietetic Association. 106: 2073-2082.*
  ANZAED The Role of Nutritional Management in the Treatment of Eating Disorders Position Paper. (2008) http://www.anzead.org.au/files/nutrition_position_paper.pdf
  Yager J, Devlin MJ, Halmi KA, Herzog DB, Mitchell JE, Powers P, Zerbe KJ, (2006) Practice guideline for the treatment of patients with eating disorders (3rd edition) Arlington *American Psychiatric Association.*
  Eating Disorder Toolkit - a practice-based guide to the inpatient management of adolescents with eating disorders, with special reference to regional and rural areas (2008) *MH-Kids Centre for Eating Disorders*
  Dietetic Association of Australia. Guidelines for paediatric nutrition support in health care facilities. (2001)
  Dietetic Association of Australia. Enteral Feeding Manual for Adults in Health Care Facilities. (2007)
  The Dietetic Association of Australia Eating Disorders Interest Group acknowledges that there is a gap literature regarding practice guidelines for the management of Anorexia Nervosa in Children and Adolescents. This is currently being addressed.
- Psychotherapies (including Motivational Enhancement and CBT-E) and Family Therapies. (Numerous articles up to the present outline[24,25,26] the poor

[24] Gowers S, Bryant-Waugh R. (2004) Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry 2004; 45: 63–83.*
[25] Hay PPJ, Bacaltchuk J, Byrnes RT, Claudino AM, Ekmejian AA, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD003909.*
[26] Treasure J, Claudino AM, Zucker N (2010) Eating disorders *The Lancet 375:583-593*

Evidence Base for therapeutic interventions for anorexia nervosa, although the strongest to date is for the Maudsley Intervention. Where this is not suitable – e.g failure of the intervention already, or the adolescent is in unstable foster care, interventions are planned on a range of interventions described in the literature. These are listed below.)

Bowers W. (2002). Cognitive therapy for anorexia nervosa. *Cognitive and Behavioral Practice. 9:247-253.*

Bowers WA, Ansher LS (2008) The effectiveness of cognitive behavioural therapy on changing eating disorder symptoms and psychopathology of 32 anorexia nervosa patients at hospital discharge and one year follow up. *Annals of Clinical Psychiatry 20:79-86*

Eisler I, Simic, M, Russell GF Dare C (2007) A randomised control trial of two forms of family therapy in adolescent anorexia nervosa: a five year follow up *Journal of Child Psychology and Psychiatry and Allied Disciplines 49:552-60*

Fairburn CG, Cooper Z, Shafran R. (2003) Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. Behavior *Research and Therapy 2003; 41: 509–28.*

Keel PK, Haedt A. Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child Adolescent Psychology 2008; 37: 39–61.*

Pearson, K., (2009). Cognitive behavior therapy and eating disorders. *British Journal of Psychology. 100:804-806.*

Robin AL, Siegel PT, Move AW, Gilroy M, Dennis AB, Sikand A (1999) A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa *Journal of the American Academy of Child and Adolescent Psychiatry 38:1482 – 1489*

Tierney S, Fox JR (2009) Chronic anorexia nervosa: a Delphi study to explore practitioners' views *International Journal of Eating Disorders 42:62-67*

Townsend E. Hawton K. Altman DG. Arensman E. Gunnell D. Hazell P. House A. Van Heeringen K. (2001) The efficacy of problem-solving treatments after deliberate self-harm: meta-analysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine. 31:979-88*

2. Treatment Interventions across Disorders

Individual Therapies

Evidence base

Young JF, Mufson L, Davies M (2006) 'Impact of Comorbid Anxiety in an Effectiveness Study of Interpersonal Psychotherapy for Depressed Adolescents', *Journal of the American Academy for Child and Adolescent Psychiatry 45:904-912.*

Castonguay LG, Beutler LE. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology,:631–638.*

Kaslow NJ, Thompson MP (1998) Applying criteria for empirically supported treatments to studies of psychosocial interventions for children and adolescents depression. *Journal of Clinical Child and Adolescent Psychology 27:146-155*

King, R. (1998) Evidence-based practice: where is the evidence? The case of cognitive behaviour therapy and depression. *Australian Psychologist*, 33, 83-88.

Family Therapies

Evidence base

Carr, A. (2009) 'The effectiveness of family therapy and systemic interventions for child-focused problems', *Journal of Family Therapy*, (31) 3-45.

Hayes AM, Laurenceau JP, Feldman G, Strauss JL, Cardaciotto (2007) Change is not always linear: the study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review27:715-723*

Larner, G. (2009) 'Integrating family therapy in adolescent depression: an ethical stance', *Journal of Family Therapy 31: 213-232.*

The following group interventions are adaptations of interventions described in the literature. Each group is described briefly.

Groups – Dialectical Behaviour Therapy

DBT is a therapy approach, with skills that can be used for any individual who has difficulty tolerating distress, regulating emotions and relating effectively with others. Four core skills learned in DBT: mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness. It has been found that DBT is most successfully incorporated into the treatment program by a weekly group of one hour for all adolescent patients at BAC. One DBT skill is addressed each term. Outcomes are measured by evaluation of checklists of attendance, behaviour, participation and progress has generally shown a gradual improvement in group performance over each term. Changes in the cohort tend to alter group dynamics. Increased participation coincides with anonymous group participation and collective group activities.

Evidence base

Dimeff LA, Koerner K (2007). Dialectical behavior therapy in clinical practice: Applications across disorders and settings. *New York, NY, US: Guilford Press, 363 pp.*

James AC, Taylor A, Winmill L, Alfoadari K (2008). A preliminary community study of dialectical behavior therapy (DBT) with adolescent females demonstrating persistent, deliberate self-harm (DSH). *Child and Adolescent Mental Health 13:148-152.*

Bogels SM. Sijbers GFVM. Voncken M (2006) Mindfulness and task concentration training for social phobia: A pilot study *Journal of Cognitive Psychotherapy. 20:33-44.*

Nelson-Gray RO, Keane SP, Hurst RM, Mitchell JT, Warburton JB, Chok JT, Cobb AR. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behaviour Research and Therapy 44:1811-1820.*

Salbach-Andrae H, Bohnekamp I, Pfeiffer E, Lehmkuhl U, Miller AL. (2008). Dialectical behavior therapy of anorexia and bulimia nervosa among adolescents: A case series. *Cognitive and Behavioral Practice 15:415-425.*

Groups – Social Skills and Community Access Groups

Social Skills training - this group has been run in many formats, depending on staffing, consumer and resourcing capabilities. It is focused on developing key verbal and non-verbal communication skills, and interpersonal skills (for example negotiation, problem-solving, assertiveness.

Community Access - to develop skills enabling independence in the community e.g. Public Transport, accessing community facilities, purchasing and consuming meals in public planning leisure-based outings; to encourage development of organisational and planning skills; to improve social skills through participation in group processes; to provide exposure to reduce anxiety around food, socialising, talking to shop assistants and promoting safety whilst in public spaces; to be able to work well within a group setting.

These groups have both treatment and rehabilitation components.

Evidence Base

Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*

Davies S (2004) A group-work approach to addressing friendship issues in the treatment of adolescents with eating disorders *Clinical Child Psychology and Psychiatry 94:519-531*

Dirks MA, Treat TA, Weersing VR (2007) Integrating theoretical, measurement, and intervention models of youth social competence. *Clinical Psychology Review 27:327-347*

LaGreca AM, Santogrossi DA (1980) Social Skills Training with elementary school students: a behavioral group approach. *Journal of Consulting and Clinical Psychology 48:220-227*

Losel F, Beelman A (2003) Effects of child skills training in preventing antisocial behavior: A systematic review of randomized evaluations. *The Annals of the American Academy of Political and Social Science 587: 84-109*

Rao PA, Beidel DC, Murray MJ (2008) Social skills interventions for children and adolescents with Asperger's Syndrome or High-functioning autism: A review and recommendations. *Journal of Autism and Developmental Disorders 38:535-361*

Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*
Spence SH (2003) Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health 8:84-96*
Webster-Stratton C, Reid J, Hammond M. (2001) Social skills and problem-solving training for children with early-onset conduct problems: Who benefits? *Journal of Child Psychology and Psychiatry 42:943-952*

Groups – Adventure Therapy

Adventure therapy creates an environment of experiential learning where adolescents face challenges which enable them to learn to problem solve to overcome challenges; learn to identify emotions and cognitions associated with challenging situations and implement strategies to moderate. Adventure activities can facilitates experiential learning by providing a tool to enable adolescents to reflect, generalise and apply what they have learnt from an adventure based experience. It utilises communication skills and skills in group participation. The main components are problem solving activities, challenging activities and camping. Observation suggests that individual A-B-A research designs may be more valid than group evaluations because of the heterogeneity of the group and variations.

Evidence Base

Carlson KP, Cook M (2007) Challenge by choice: adventure-based counselling for seriously ill adolescents *Child and Adolescent Psychiatric Clinics of North America 16:909-919*
Cook EC (2008) Residential wilderness programs: the role of social support in influencing seld-evaluations of male adolescents *Adolescence 43:751-774*
Gillan MC, Balkin RS (2006) Adventure counselling as an adjunct to group counselling in hospital and clinical settings *Journal for Specialists in Group Work 31:153-164*
Jelalian E, Mehlenbeck R, Lloyd-Richardson EE, Birmaher V, Wing RR (2006) 'Adventure therapy' combined with cognitive-behavioral treatment for overweight adolescents *International Journal of Obesity 30:31-39*
Kelly VA (2006) Women of courage: a personal account of a wilderness based experiential group for survivors of abuse *Journal for Specialists in Group Work 31:99-111*

3. Rehabilitation Interventions to Address Impairments across Disorders

A range of group and individual interventions are aimed at improving function in adolescents with a range of developmental impairments.

There is a dearth of research into rehabilitation interventions for adolescents with severe and complex mental illness. This suggests either that adolescents with severe and complex mental illness

- do not suffer impairments in function secondary to severe and complex mental illness or
- that any functional impairments resolve on treatment of the disorders or
- that impairments in function are commonly overlooked by clinicians or
- that rehabilitation interventions to address functional impairments are not as easy to address in common research paradigms

The first two possibilities are not supported by clinical observation.

Groups – psycho-education

Psycho-education – delivered in a group process to foster acceptance and tolerance within the ward environment – reducing stigmatisation and bullying. The group enables adolescents to understand differences between people.

Groups – fitness and physical activity

Sporting group, gym group, bike riding group, walking group run in 8- 10 week programs. Most adolescents including those with anorexia nervosa and social anxiety engage in solitary leisure pursuits prior to admission and either solitary or no exercise. Engaging in leisure accounts for 50-57% of most young people's time. Leisure enhances competencies, self efficacy and self worth. Adolescents that feel less competent are more likely to choose solitary activities and use these opportunities to ruminate on their problems. Conversely there is evidence to support non-specific psychological effects of exercise

Evidence Base

Bracegirdle, H. (2002). Developing physical fitness to promote mental health. In J. Creek (Ed.), *Occupational Therapy in Mental health* (3rd ed.). (pp. 209-225). Sydney: Churchill Livingstone.

Davies, S. Parekh K, Etalapaa K, Wood, D, Jaffa T (2008) The inpatient management of physical activity in young people with anorexia nervosa *European Eating Disorders Review 16:334-340*

Henley R, Schweitzer I, De Gara F, Vetter S (2008) How psychosocial and sports programs help youth manage adversity: a review of what we know and what we should research *International Journal of Psychotherapy 12:53-61*

Tokumura M, Yoshiba S, Tanaka T, Nanri S, Watanabe H (2003) Prescribed exercise training improves exercise capacity of convalescent children and adolescents with anorexia nervosa *European Journal of Pediatrics 162:430-431*

Szabo CP, Green K (2002) Hospitalized anorexics and resistance training: impact on body composition and psychological well-being. A preliminary study *Eating and Weight Disorders 7:293 - 297*

Groups – cooking

Cooking groups involve planning balanced and varied meals, growing or purchasing food to preparation, developing simple to complex cooking skills, trialling new foods, and when consuming the meal, learning meal etiquette and socialising during meal time and learning the basics of eating out.

Evidence Base

Hinojosa, J., & Blount, M.L. (2004). *The texture of life; Purposeful activities in occupational therapy* (2nd ed.). Bethesda: AJOT

Zielinski-Grimm, E., Meus, J. S., Brown, C., Exley, M., & Manner, T. (2009). *OTJR: Occupation, Participation and Health.* Meal Preparation: Comparing Treatment Approaches to Increase Acquisition of Skills for Adults With Schizophrenic Disorders. 29:04.

Individual treatment and rehabilitation interventions – healthy eating (Dietitian + Nursing Staff)

The Dietitian meets with adolescents directly to identify priority areas for behaviour change. Graded dietary changes are developed with supportive meal therapy and Motivation Interviewing techniques where change is necessary. Meal plan developed for adolescents with eating disorders and for adolescents with specific dietary requirements that require support from staff for effective implementation. Special dietary requirements can be met by hospital foodservices.

Individual rehabilitation interventions - self care (Occupational Therapist + Nursing Staff)

- Personal care – showering, dressing, sleep patterns, basic first aid etc,
- Community management – road safety, public transport, budgeting etc.

- Vocational readiness – work interests and goals, motivation to find and work, job search resumes, time management etc.
- House management – chores and home duties, planning meals cooking and preparing simple and complex meal etc.
- School – attending school, addressing difficulties, managing work load, time
- Individualised dietary planning

Evidence base

Kopelowicz, A. & Liberman, R. P. (2003). Integration of Care: Integrating Treatment with Rehabilitation for Persons With Major Mental Illness. *Psychiatric Services 54, 1491-1498.*
Lloyd C, Waghorn G (2007) The importance of vocation in recovery for young people with psychiatric disabilities *British Journal of Occupational Therapy 70:50-59*
Loyd, C., Waghorn, G. (2010). The Importance of Vocation in Recovery for Young People with Mental Illness. In Loyd, C. *Vocational Rehabilitation and Mental Health* (pp. 115-151). United Kingdom: Wiley-Blackwell

Individual rehabilitation interventions - leisure activities (Occupational Therapist + Nursing Staff)

- Quiet relaxation – identifying and participating in interests, hobbies etc.
- Active relaxation – sports, outings, travel, exercise, fitness and health
- Socialisation – keeping in touch with family, friends, social participation etc.

Individual rehabilitation interventions – improved communication skills (Speech Pathologist + Nursing Staff)

- individual skills training for social interactions;
- development of self talk for self regulation;
- development and use of language underlying emotional literacy;
- development and use of language underlying for problem solving;
- development and acquisition of vocabulary and sentence construction skills to assist functional communication

APPENDIX 3 – RESEARCH PRESENTATIONS

All of the publications, presentations, current research projects and academic links are based on research conducted at BAC

Publications

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

Clarke A, Soady D (2006) Social skills impairment impacts on behaviour in the school setting, Talkabout, Volume 19, 2006 (with Deborah Soady, Logan-Beaudesert CYMHS)

Clarke A (2008) Tourette's Syndrome: A comprehensive review of diagnosis, course, aetiology, assessment and treatment" *Talkabout 21*

Ward, D. (2009) Five messages every adolescent needs to hear, *Psychotherapy in Australia 15:48-54*

Presentations:

Harnett P, Sadler T (2003) Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA) in an adolescent inpatient centre *Queensland Health Mental Health Research Conference, Brisbane*

Sadler T (2004) Borderline Personality Disorder in Adolescence *Bi-National Grand Rounds, CYMHS Training Centre, Brisbane*

Sadler T (2005) Models of Care in Grief and Trauma *Child and Adolescent Psychiatry Grand Rounds, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *Speech Pathology Australia National Conference, Fremantle*

Clarke A (2006) Communication Profiling and masking Behaviours *Department of Child Psychiatry, University of Queensland/Royal Brisbane and Women's Hospital, State-wide Grand Rounds*

Clarke A (2006) Prevalence of Communication Disorders in Mental Health *Queensland Health and Medical Research Conference, Brisbane*

Corbett D, Clarke A (2006) Community Access and Socialisation Group *Australian Allied Health Conference, Hobart*

Sadler T (2006) Adolescent Trauma *Seminar: Trauma in Childhood and Adolescence, Toowoomba*

Clarke A (2006) Communication Profiling and masking Behaviours *Education Queensland, Training and Development Seminar (TADS), Brisbane*

Sadler T (2006) The role of attachment in professional interactions with traumatised adolescents *Brisbane North Interagency Forum, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *17th World congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals. Melbourne*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *Mater Kids in Mind Conference, Brisbane*

Clarke A (2007) Communication and Mental Health *Mater Kids in Mind Conference, Brisbane*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Corbett D, Bruce K (2008) "Food Challenges" Community Access group for Adolescents with Eating Disorders. *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Sadler T (2008) Reflections on two decades of adolescent school refusal *Child and Adolescent Psychiatry Grand Rounds, Brisbane*
Corbett D, Ward D (2009) The BAC Community Access and Socialisation Group *Protecting Children Today Conference, Brisbane*
Hayes M, Clarke A (2009) The role of Occupational Therapy and Speech Pathology in managing children with complex trauma *Zonal Directors Statewide Meeting, Department of Child Safety, Brisbane*
Hoang K (2009) Benefits of adventure therapy in a mental health setting. *Victorian Outdoor Education Conference, Melbourne*

Current Research Projects:
Case review study, (first commenced in 2005 and continuing), compares communication disorders and psychiatric diagnoses. Results found common communication profile amongst eating disordered (anorexic) patients; identified the prevalence of communication impairment in the self-harming population. This project is currently being considered by the University of Queensland, Division of Speech Pathology and Audiology, for inclusion in the next round of Honour's and Master's students.
A proposal is currently before RCH Ethics Committee entitled: Communicate: an examination of the interface between self harming populations and communication impaired populations in child and youth mental health services.
Design, trial and evaluation of *BAC Adolescent Developmental Tasks Questionnaire* – a measure of the key adolescent developmental milestones to assess an adolescent's strengths and difficulties to assist care planning in a rehabilitation environment.

Academic Links:
Clarke A, (2005 – 2009) Invited lecturer: Communication profiles in mental health, engagement with adolescents, Specific diagnoses – ADHD, Aspergers, OCD, anxiety, depression *University of Queensland Division of Speech Pathology, School of Rehabilitation Sciences*
Corbett D (2006 – 2009) Invited lecturer: Clinical skills in adolescence *Masters and Doctorate of Clinical Psychology Postgraduate Program, Psychology Department, The University of Queensland*
Corbett D (2006 – 2009) Invited lecturer: The scientist practitioner model in action *Postgraduate Honours Psychology Program, Psychology Department, The University of Queensland*
Sadler T (1993 – 2010) Managing adolescents with severe and complex mental illness (4 sessions per year) *Queensland Advanced Trainee Registrar Program, RANZCP*

West Moreton Hospital and Health Service
TERMS OF REFERENCE

Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy					
Date:	30.11.12	Review Date:	N/A	Version:	Final

1. Purpose:

1.1 The purpose of the Expert Clinical Reference Group is to:
Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.

2. Scope and functions:

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland
- will be evidenced based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models.
- will take into account the Clinical Services Capability Framework (for Mental Health) and
- will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.

3. Membership (position held only):

3.1 Members:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace
- Ms Emma Hart, NUM, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School
- consumer representative
- carer representative

. Carer Consultant will provide support to the consumer and representative will on the Expert Clinical Reference Group.

The Chair on behalf of the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide additional input into the development of a contemporary evidence based model of care.

3.2 Proxies:
Due to the time limited nature of this reference group, it is unlikely that the use of proxies will be effective.

4. Chairperson

4.1 Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch (MHAODB)

5. Secretariat (position held only):

5.1 MHAODB will provide the secretariat to the Expert Clinical Reference Group.

6. Reporting relationships:

6.1 The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy.

7. Sub Committees:

7.1 Nil.

8. Frequency of meetings:

8.1 Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet on at least a fortnightly basis (in person or tele/videoconference) until a recommended model of care is developed. It may reconvene on an as needs basis to examine plans regarding the implementation of an endorsed model of care.

9. Quorum:

9.1 The quorum for Expert Clinical Reference Group meetings will be half of membership plus one.

10. Authorisation:

These Terms of Reference may be altered following committee consultation and endorsement by the Chief Executive West Moreton HHS and A/Executive Director MHAODB on the recommendation of the Expert Clinical Reference Group.

Chairperson: Dr Leanne Geppert, Director Planning and Partnerships Unit, MHAODB

Date: Signature:

Terms of Reference

Chief Executive and Department of Health Oversight Committee

1. Purpose

The purpose of the Chief Executive and Department of Health Oversight Committee (CE DoH OC) is to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.

2. Guiding principles

- *Hospital and Health Boards Act 2011*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the Oversight Committee include:

- Provision of executive leadership, strategic advice and advocacy in the implementation of Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) service options.
- To identify the priorities and objectives associated with the development and implementation of SW AETR services, and to endorse plans and actions to achieve these objectives.
- To oversight the development of a contemporary model of care for SW AETR services within the allocated budget.
- To provide a strategic forum to drive a focus on outcomes and achievement of the transition of SW AETR services to CHQ HHS.
- To facilitate expert discussion from key executive around planning, development, and implementation of SW AETR services.
- To oversee the management of strategic risks.
- To monitor overall financial management of the transition of AETR services from West Moreton HHS to CHQ HHS.
- Provision of guidance and oversight for communication and stakeholder planning.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the SW AETR services.

4. Authority

Members are individually accountable for their delegated responsibility and collectively responsible to contribute to advice provided by the Committee to the Chair in the interests of a whole-of-service position.

Decision Making:

- Decisions made by the Steering Committee will be by majority.
- Where group consensus cannot be reached in relation to critical decisions, the Chair takes the final position

5. Frequency of meetings

Meetings will be held monthly, following the Chief Executive Forums, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Committee or in respect of matters the Committee wishes to pursue within the Term of Reference.

Attendance can be in-person or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of transition to CHQ HHS. The Chair will advise the Committee members approximately one month prior to the dissolution of the Oversight Committee.

6. Membership

Dr Peter Steer (Chair)	Health Service Chief Executive, CHQ HHS
Dr Michael Cleary	Deputy Director General, Health Service and Clinical Innovation Division
Mrs Lesley Dwyer	Health Service Chief Executive, West Moreton HHS
Dr Richard Ashby	Health Service Chief Executive, Metro South HHS
Mrs Julia Squire	Health Service Chief Executive, Townsville HHS
Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
Ms Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
Ms Ingrid Adamson (Secretariat)	Project Manager, SW AETRS, CHQ HHS

Chair:
The Steering Committee will be chaired by the Health Service Chief Executive, CHQ, or his delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Manager, SW AETRS or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Oversight Committee, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the committee. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

A quorum will comprise half of the voting members, including the Chair, plus one.

8. Performance and Reporting

The Secretariat is to circulate an action register to Committee members within three business days of each Committee meeting.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided, as required, to the Children's Health Queensland Hospital and Health Service Board. Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

10. Risk Management

A proactive approach to risk management will underpin the business of this Committee. The Committee will:

- Identify risks and mitigation strategies associated with the implementation of the SW AETR services; and
- Implement processes to enable the Committee to identify, monitor and manage critical risks as they relate to the functions of the Committee.