Barrett Adolescent Centre Commission of Inquiry

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

STATEMENT OF TREVOR BRUCE SADLER

Name of Witness:	Trevor Bruce Sadler
Date of birth:	
Current address:	
Occupation:	Psychiatrist
Contact details (phone/email):	
Date and place of statement:	17 February 2016 and Brisbane
Statement taken by:	K & L Gates

I **Trevor Bruce Sadler** make oath and state as follows:

1. This statement is supplementary to my statements sworn 11 December 2015 and 12 February 2016.

Planning Group and ECRG

2. I was a member of both the ECRG and the Planning Group.

3. Although I was a member of the Planning Group, I only attended a few possibly 4 meetings. I was not invited to any Planning Group meetings after 15 May 2013. I linked into the meeting on 15 May 2013 from Townsville while delivering a workshop. I recall disagreeing with Dr Kingswell as to the need for a Tier 3 service. We disagreed as to the recommendation to be made in respect of a Tier 3 service which resulted in the sending of my email to Dr Kingswell dated 21 May 2013 which was exhibit N to my statement sworn 11 December 2015.

BAC Model of Service and BAC Rehabilitation Model

4. Although the Barrett Adolescent Centre (**BAC**) did not have a formal and endorsed model of service there were draft models of service that were developed in associated with the State-wide CYMHS advisory group. For example, Denisse Best, who was the

Trevor Sadler .... ~~Justice of the Peace / Commissioner for Declarations /~~ Lawyer

Barrett Adolescent Centre Commission of Inquiry

chair of the State-wide CYMHS provided comments in relation to the BAC draft model of service.

5. Attached and marked "**A**" are the following copies of the various models of service:

   (a) Draft BAC MOSD dated 1 August 2008;

   (b) Draft BAC MOSD_1 dated 12 February 2009;

   (c) BAC MOS dated 28 June 2009;

   (d) BAC MOS edited dated 30 June 2009;

   (e) BAC MOS 2 Denisse comments dated 21 July 2009;

   (f) BAC MOS suggested revisions dated 21 August 2009;

   (g) BAC MOS 2 final draft dated 26 August 2009;

   (h) AITRC MOSD dated 22 December 2009;

   (i) AETRC Draft MOSD 4.3.10 dated 6 May 2010;

   (j) AETRC MOSD final draft dated 15 March 2011;

   (k) AETRC Draft MOSD as a template for DP dated 4 May 2012; and

   (l) AETRC Draft MOSD final draft 20052012.

6. Further to paragraph 168 of my statement sworn 12 February 2016, I note that, in respect of rehabilitation models of mental health, which are separate to a model of service, there is no comprehensive model described in the literature. I have described in my earlier statements how the contributions of symptoms and behaviours associated with mental illness, together with any inherent biological factors impacted on adolescent tasks of development, resulting in impairment. Delays in tasks of adolescent development exacerbated in some instances the symptoms and behaviours of the adolescent which in turn reinforced and extended the impairments in developmental tasks. Addressing these impairments formed the core of the rehabilitation model at BAC. Attached and marked "**B**" is a document that maps the components of the BAC model against the relevant domains in the International Classification of Function Disability and Health (**ICFDH**).

Standing Down and Transition Arrangements

7. The Commission has stated that the alleged incident which resulted in my suspension from duty as Clinical Director of BAC, and how that suspension was handled, is relevant to the allegation that there were shortcomings in the clinical governance of the BAC.

....

Trevor Sadler | **~~Justice of the Peace / Commissioner for Declarations~~ / Lawyer**

8. I understand that an Investigation Report and some correspondence from the West Moreton Hospital and Health Service (**WMHHS**) to my solicitors, K&L Gates in respect of my suspension and other relevant correspondence has already been provided to the Commission.

9. The following correspondence regarding my suspension is attached and marked "**C**":

    a. Letter from WMHHS to Dr Sadler dated 11 December 2013;

    b. Email from K&L Gates to WMHHS enclosing response show cause dated 17 January 2014;

    c. Email from WMHHS to Dr Sadler dated 17 February 2014;

    d. Letter to WMHHS to Dr Sadler dated 28 February 2014;

    e. Letter from WMHHS to Dr Sadler dated 20 March 2014; and

    f. Letter from WMHHS to Dr Sadler dated 12 May 2014.

This is a supplementary statement provided at the request of the Commission.

***OATHS ACT* 1867 (DECLARATION)**

I Trevor Bruce Sadler do solemnly and sincerely declare that:

(1) This written statement by me dated 17 February 2016 and contained in pages numbered 1 to 4 is true to the best of my knowledge and belief: and

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

..Signature

Taken and declared before me at ....Brisbane.............. this 17th day of February 2016.

Trevor Sadler

~~Justice of the Peace / Commissioner for Declarations /~~ Lawyer

Taken By ....

~~Justice of the Peace / Commissioner for Declarations /~~ Lawyer

....

Trevor Sadler **~~Justice of the Peace / Commissioner for Declarations /~~ Lawyer**

MODEL OF SERVICE

Barrett Adolescent Centre

Service Description and Function:

The Barrett Adolescent Centre provides interventions in a manner consistent with the principles articulated in the *Queensland Plan for Mental Health 2007-2017.* Services ensure the active involvement of adolescents, families or carers in all aspects of care in a system which is structured to promote resilience and recovery.

The Barrett Adolescent Centre is a State wide service which is integrated with other parts of the Child and Youth Mental Health Services for referral, liaison and engagement and with Education Queensland in the provision of services. It also collaborates with other Government Departments and community organisations to maximise opportunities for recovery. Mental health services are delivered recognising the critical necessity for intensive evidence based interventions for adolescents with severe and complex illness to promote recovery and mental health and to reduce ongoing mental health problems as they move into adult life.

The Barrett Adolescent Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. Many experience chronic family dysfunction which exacerbates the severity and persistence of the disorder. Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at Barrett Adolescent Centre rather than transfer to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors.

Integrated treatment and rehabilitation is provided in the least restrictive setting consistent with the health and safety of the adolescent, the quality of their family life and the capacity to access the service. Currently the options are limited to admission as an inpatient, or attendance as a day patient. A range of intensive interventions for most adolescents are provided during the day on week days. Interventions of varying intensity occur outside these hours for those requiring care in the structured inpatient environment. Care in this environment continues 24 hours a day.

The Barrett Adolescent Centre is located in the South East of Queensland, the centre of the greatest population. The low incidence of those requiring referral from any one Health District, and the decentralised demography of Queensland mean that some adolescents will be separated from their families and communities. Most adolescents are isolated from peers and communities for months prior to admission, but special consideration is needed in reintegrating them into their community as discharge approaches. Adolescents and families can be assisted in maintaining contact through the Patient Transit Assistance Scheme, but on site accommodation for families was lost at the turn of the century.

While most adolescents will return to their families or carers, 36% will be unable to return, and alternate accommodation and support found. Severe family dysfunction impacts on the mental illness of a further 27% of adolescents and requires intensive interventions, and greater levels of recovery to cope with an adverse family situation.

Average length of stay (to be filled in)

The Barrett Adolescent Centre facilitates an adolescent's recovery from mental illness by a multidisciplinary team approach to identifying strengths, providing evidence based treatments, care of the standard of good quality parenting, facilitating developmental tasks, supporting families or working through losses associated with the absence of family and integrating the adolescent into family, good quality care, educational or vocational environments and a peer group in a local community. The individually tailored programs provide opportunities that maximise a person's strengths and potential, thus enhancing their quality of life. Many adolescents on admission are in the pre-contemplative stage of treatment, and require considerable therapeutic and developmental engagement before they will contemplate change.

The *Clinical Services Capability Framework for Mental Health* categorises the Barrett Adolescent Centre as a level six inpatient service. Detailed information relating the Barrett Adolescent Centre's service capability can be accessed through the *CSCF MH Module.*

Target population and service planning guidelines:

The Barrett Adolescent Centre provides services to adolescents who have symptoms or signs of serious mental illness and persistent impairment that have not responded adequately to less intensive interventions. All presented with co-morbid disorders or behaviours. The incidence of significant disorders of adolescents admitted 2002 - 2006 is provided in Table 1. The numbers are greater than !00% because of co-morbidity.

Table 1. Diagnostic profile of admitted adolescents (18 – 64years) in 2006 -07

Diagnosis	Percentage	ICD-10 Category Code
OCD and Anxiety Disorders	32.9%	F20 - F29
Eating Disorders		
Depression		
Post Traumatic Symptoms		
Schizophrenia		
Pervasive Developmental Disorders		
Receptive-Expressive Language Disorders		
Other Developmental Disorders		
Abuse by Official agency		
Seeking Interventions known to be harmful		
Parent child conflict		

Planning

Currently BAC does not feature in the Glossy version of the *Queensland Plan for Mental Health 2007 – 2017.*

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

Mental Health Act 2000 (MHA 2000)
Currently the Barrett Adolescent Centre is a part of The Park – Centre for Mental Health which is gazetted as *authorised mental health services* in accordance with Section 495 of the *Mental Health Act 2000.* Voluntary and involuntary adolescents are assessed and treated within this setting.

Service delivery pathway:

The Barrett Adolescent Centre accepts referrals from other CYMHS facilities (community clinics, acute inpatient or day patient units, or a private child and adolescent psychologist or psychiatrist. A comprehensive clinical assessment occurs prior to the decision to admit to assess the adolescent's suitability for admission, potential interactions with other adolescents and to orientate the adolescent and their family or carer to the unit.

Based on available clinical information from the referred and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually 2 or 6 weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to advise of progress towards admission, and assess the levels of acuity. Timing of admission is determined by the length of time on the waiting list, the relative acuity and the current mix of adolescents within the unit.

An initial Care Plan is developed in consultation with the adolescent and their family or carer on admission. During admission, adolescents have a range of least restrictive, evidenced based therapeutic interventions and access to a range of developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Plan goals occurs through regular reviews led by their treating team. Adolescents and the referrers are invited to participate in these reviews. These plans reflect phases of an adolescent's admission – to incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Core Service provision:

1. Clinical Interventions

A range of integrated therapeutic, rehabilitation and recovery focused interventions are delivered or coordinated by the multidisciplinary mental health team and education through the Barrett Adolescent School. Interventions are either individualised, group or generic.

Individualised evidenced based interventions include:

- Psychological interventions (verbal and non-verbal therapies and education)
- Pharmacotherapy (including acute sedation where necessary)
- Family therapy and education

- Individualised behavioural programs. These may include seclusion and restraint.
- Maintaining adolescent safety and wellbeing with a range of interventions consistent with least restrictive practice. This may include a range of levels of visual observation. High dependency care consists of contiuous observations within limited spaces according to levels of risk..
- Other biological interventions (e.g. ECT, psychosurgery)

Interventions delivered in groups include

- Individual education plans delivered by the Barrett School (staff emploiyed by DETA)
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include

- Maintaining a milieu with professional staff reflecting qualities consistent with longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances with the majority of staff
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy

2. Collaborative care systems and service linkages

The Barrett Adolescent Centre is part of the broader Child and Youth Mental Health Services located throughout Queensland. The service is provided in partnership with the adolescent, their family or carer, the Department of Education, Training and Welfare and where appropriate the Department of Child Safety.

3. BAC Discharge Planning

All adolescents requiring extended inpatient or day patient integrated treatment and rehabilitation have a severe persistent level of mental illness and severe impairment manifest as moratorium of many of their tasks of adolescent development for many months or sometimes years prior to admission. For most extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period. Some have not required further mental health treatment when they are well into their third decade of life.

For this reason inpatient care is likely to be extended if they are thought to be suitable for an open admission. Depending on the primary mental illness for which they have been admitted, and associated co-morbid mental illness, progress typically proceeds in a number of stages which can be broadly identified. For the most part the length of time within any one stage is limited by factors within the adolescent, or by ongoing interactions with their family or carer.

Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular

variables associated with progress have been assessed. Nevertheless potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

Discharge planning typically involves

- Continued engagement of the parent or carer is sought throughout the admission, and potential care enhanced with both family therapy and psycho-education..
- The capacity of parents or carers to provide safe, appropriate care is assessed. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Discharge planning includes extended periods of leave, transition to partial hospitalisation or day program if appropriate.
- A clear educational or vocational plan is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Discharge planning includes linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the admission. Follow up will be arranged by negotiation with this team and the adolescent and their family with either the referrer, another specialist service or if appropriate, with the limited outpatient service at Barrett Adolescent Centre.
- Linkages with Disability Services Queensland and support providers are made where appropriate.

4. Expected Clinical Outcomes

Child and Youth Mentla Health Services utilise ar range of outcome measures including The Health of the Nations Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale, and the FSHe evaluate the severity of illness, the impact on functioning, the impact of family functioning and the impact of previous adverse experiences on both illness and function.

Over the length of a period of extended integrated treatment and rehabilitation an adolescent may show fluctuations in their HoNOSCA and CGAS scores depending on variables within the adolescent, their illness(es) and their family or carer. By the end of the period of care their scores will improve on a number of the items measured by the HoNOSCA, and CGAS scores will rise. However global HoNOSCA and CGAS scores are likely to continue improving by six months post discharge, as the adolescent consolidates therapeutic gains and becomes integrated into the community.

The chart below gives blah blah blah

Staffing structure and composition:

Structure and Resources:

Barrett Adolescent Centre operates with a Medical Director and Nurse Unit Manager who have final point accountability in designated areas. Multidisciplinary team work is essential to both developing the directions and programs of the service and for provision of therapeutic service. Key performance indicators are monitored within the Centre to ensure drive quality of service in producing the best outcome for adolescents and make recommendations to enhance efficiency.

Adolescents receive specific, group and generic therapeutic interventions from a range of specialist medical, nursing, health professionals, and education staff with appropriate qualifications, skills and experience. All clinical staff must be engaged in relevant professional development to ensure contemporary and evidence based intervention and treatment is provided to adolescents, their family or carers. Involvement in research activities is developing and will become integral to the unit as a Level 6 facility under the Clinical Services Capability Framework. Good administration is necessary to support staff function.

The role of the Consultant Psychiatrist, Registrars and Medical Officers includes but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidsicplinary team.
- Engaging with other professionals in the multi-disciplinary team to ensure that programs are directed towards treatment, rehabilitation and recovery for adolescents.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Developing individual treatment/care/recovery plans in consultation with the other members of the treating team, the adolescent, the family or carers
- Administering the *MHA 2000* as required under legislation
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice

The role of the Nursing staff includes but is not limited to:

- Providing appropriate levels of observation, supervision and care required in response to this assessment
- Developing individual treatment/care/recovery plans in consultation with the other members of the treating team, the adolescent, the family or carers
- Monitoring mental state, risk to self and others and physical health

- Assisting adolscents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate
- Implementing interventions as outlined in the Recovery Plan, eg. psychological and developmental interventions, administering medication.
- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual care plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs
- Providing nursing care for general medical conditions in consultation with appropriate medical teams
- Communicating with community support services to ensure that adolescents have access to the supports they require
- Undertaking relevant supervision and professional development and to ensure contemporary and evidence based practice.

The role of Health Professional staff includes but is not limited to:
(Acute Inpatient)

- Providing psychosocial screening and specialised assessment in the areas of personal strengths, coping skills, social supports, community support, accommodation needs and goals, activities of daily living, vocational and educational goals, and financial status
- Providing specialised psychosocial, psychometric, functional, cognitive, sensory assessment in the areas of social work, occupational therapy, dietician and psychology as required
- Facilitation and provision of individual and group psychoeducation and therapeutic interventions to minimise the negative impact of mental illness and assist adolescents, carers and their family to achieve recovery
- Communicating with community support services to ensure that people have access to supports they require
- Facilitation and provision of therapeutic and diversional programs in partnership with nursing staff to reduce boredom and increase social and physical activity
- Undertaking relevant supervision, and professional development to ensure contemporary and evidence based practice.

(Community Care Unit)

- Providing psychosocial screening and specialised assessment in the areas of personal strengths, coping skills, social supports, community support, accommodation needs and goals, activities of daily living, vocational and educational goals, and financial status
- Providing specialised psychosocial and or psychometric assessment in the areas of social work, occupational therapy, dietetics and psychology as required

DRAFT

- Facilitating a range of rehabilitation programs in partnership with nursing staff and other service providers for adolescents, their family or carers to assist recovery
- Communicating with community support services to ensure that people have access to supports they require
- Engaging adolescents in activities of daily living and providing options to increase social and physical activity and reduce boredom in conjunction with other staff and service providers
- Undertaking relevant supervision, and professional development to ensure contemporary and evidence based practice.

Performance Quality and Safety Indicators:

Queensland Health is committed to continuous improvement of mental health services and quality of life for people living with mental health problems and mental illness. Quality services are crucial to a comprehensive, safe and effective mental health system and to recovery. A culture of routine evaluation is supported in which information is used to drive the quality of clinical practice, service delivery, and planning and policy development.

The *Queensland's Mental Health Patient Safety Plan (2008- 2013)* supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. Strategies required to make a safer service, will deliver better consumer outcomes, and a better mental health service for the state overall. The following guiding principles and standards are embraced by all mental health services to ensure safe and effective service provision:

- Service delivery is focused on adolescents and the achievement of positive outcomes
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness
- Practice is improved through a strategic framework of assessment, monitoring, planning, evaluation and follow up
- Comprehensive, coordinated and individualised care that considers all aspects of the sdolescent's recovery is provided
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible
- Adolescents, family members, carers and the local community are involved in the planning, development, implementation and evaluation of the mental health service
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in care planning, and staff work with them to develop their own supports in their community
- Strategies such as incident reporting, Root Cause Analysis (RCA) and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements

- Participation in professional development activities and demonstration of learning in daily practices

These principles are consistent with and should be read in conjunction with the following standards:

- *Australian Council of Health Care Standards (Improving Performance, Safe Environment)*
- *National Mental Health Standards (Standard 1, 2, 3, 5, 7, 8, 10. 11, 11.3, 11.4, 11.4C, 11.4E)*

District mental health services in Queensland are accredited against the National Mental Health Standards and all services participate in the routine accreditation survey as defined by the Australian Council of Health Care Standards.

This document will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017.*

Key resources:

- The Queensland Plan for Mental Health 2007 – 2017
- Clinical Services Capability Framework for Mental Health
- Royal Australian and New Zealand College of Psychiatrists – Guidelines for Inpatient Care
- Queensland's Mental Health Patient Safety Plan (2008- 2013)
- Mental Health Act 2000
- Mental Health Visual Observation Policy and Clinical Practice Guidelines

MODEL OF SERVICE

Barrett Adolescent Centre

Service Description and Function:

The Barrett Adolescent Centre provides interventions in a manner consistent with the principles articulated in the *Queensland Plan for Mental Health 2007-2017*. Services ensure the active involvement of adolescents, families or carers in all aspects of care in a system which is structured to promote resilience and recovery.

The Barrett Adolescent Centre is a State wide service which is integrated with other parts of the Child and Youth Mental Health Services for referral, liaison and engagement and with Education Queensland in the provision of services. It also collaborates with other Government Departments and community organisations to maximise opportunities for recovery. Mental health services are delivered recognising the critical necessity for intensive evidence based interventions for adolescents with severe and complex illness to promote recovery and mental health and to reduce ongoing mental health problems as they move into adult life.

The Barrett Adolescent Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. Many experience chronic family dysfunction which exacerbates the severity and persistence of the disorder. Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at Barrett Adolescent Centre rather than transfer to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors.

Integrated treatment and rehabilitation is provided in the least restrictive setting consistent with the health and safety of the adolescent, the quality of their family life and the capacity to access the service. Currently the options are limited to admission as an inpatient, or attendance as a day patient. A range of intensive interventions for most adolescents are provided during the day on week days. Interventions of varying intensity occur outside these hours for those requiring care in the structured inpatient environment. Care in this environment continues 24 hours a day.

The Barrett Adolescent Centre is located in the South East of Queensland, the centre of the greatest population. The low incidence of those requiring referral from any one Health District, and the decentralised demography of Queensland mean that some adolescents will be separated from their families and communities. Most adolescents are isolated from peers and communities for months prior to admission, but special consideration is needed in reintegrating them into their community as discharge approaches. Adolescents and families can be assisted in maintaining contact through the Patient Transit Assistance Scheme, but on site accommodation for families was lost at the turn of the century.

While most adolescents will return to their families or carers, 36% will be unable to return, and alternate accommodation and support found. Severe family dysfunction impacts on the mental illness of a further 27% of adolescents and requires intensive interventions, and greater levels of recovery to cope with an adverse family situation.

Average length of stay (to be filled in)

The Barrett Adolescent Centre facilitates an adolescent's recovery from mental illness by a multidisciplinary team approach to identifying strengths, providing evidence based treatments, care of the standard of good quality parenting, facilitating developmental tasks, supporting families or working through losses associated with the absence of family and integrating the adolescent into family, good quality care, educational or vocational environments and a peer group in a local community. The individually tailored programs provide opportunities that maximise a person's strengths and potential, thus enhancing their quality of life. Many adolescents on admission are in the pre-contemplative stage of treatment, and require considerable therapeutic and developmental engagement before they will contemplate change.

The *Clinical Services Capability Framework for Mental Health* categorises the Barrett Adolescent Centre as a level six inpatient service. Detailed information relating the Barrett Adolescent Centre's service capability can be accessed through the *CSCF MH Module.*

Target population and service planning guidelines:

The Barrett Adolescent Centre provides services to adolescents who have symptoms or signs of serious mental illness and persistent impairment that have not responded adequately to less intensive interventions. All presented with co-morbid disorders or behaviours. The incidence of significant disorders of adolescents admitted 2002 - 2006 is provided in Table 1. The numbers are greater than !00% because of co-morbidity.

Table 1. Diagnostic profile of admitted adolescents (18 – 64years) in 2006 -07

Diagnosis	Percentage	ICD-10 Category Code
OCD and Anxiety Disorders	32.9%	F20 - F29
Eating Disorders		
Depression		
Post Traumatic Symptoms		
Schizophrenia		
Pervasive Developmental Disorders		
Receptive-Expressive Language Disorders		
Other Developmental Disorders		
Abuse by Official agency		
Seeking Interventions known to be harmful		
Parent child conflict		

Planning

Currently BAC does not feature in the Glossy version of the *Queensland Plan for Mental Health 2007 – 2017.*

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

Mental Health Act 2000 (MHA 2000)
Currently the Barrett Adolescent Centre is a part of The Park – Centre for Mental Health which is gazetted as *authorised mental health services* in accordance with Section 495 of the *Mental Health Act 2000.* Voluntary and involuntary adolescents are assessed and treated within this setting.

Service delivery pathway:

The Barrett Adolescent Centre accepts referrals from other CYMHS facilities (community clinics, acute inpatient or day patient units, or a private child and adolescent psychologist or psychiatrist. A comprehensive clinical assessment occurs prior to the decision to admit to assess the adolescent's suitability for admission, potential interactions with other adolescents and to orientate the adolescent and their family or carer to the unit.

Based on available clinical information from the referred and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually 2 or 6 weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to advise of progress towards admission, and assess the levels of acuity. Timing of admission is determined by the length of time on the waiting list, the relative acuity and the current mix of adolescents within the unit.

An initial Care Plan is developed in consultation with the adolescent and their family or carer on admission. During admission, adolescents have a range of least restrictive, evidenced based therapeutic interventions and access to a range of developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Plan goals occurs through regular reviews led by their treating team. Adolescents and the referrers are invited to participate in these reviews. These plans reflect phases of an adolescent's admission – to incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Core Service provision:

1. Clinical Interventions

A range of integrated therapeutic, rehabilitation and recovery focused interventions are delivered or coordinated by the multidisciplinary mental health team and education through the Barrett Adolescent School. Interventions are either individualised, group or generic.

Individualised evidenced based interventions include:

- Psychological interventions (verbal and non-verbal therapies and education)
- Pharmacotherapy (including acute sedation where necessary)
- Family therapy and education

- Individualised behavioural programs. These may include seclusion and restraint.
- Maintaining adolescent safety and wellbeing with a range of interventions consistent with least restrictive practice. This may include a range of levels of visual observation. High dependency care consists of contiuous observations within limited spaces according to levels of risk..
- Other biological interventions (e.g. ECT, psychosurgery)

Interventions delivered in groups include

- Individual education plans delivered by the Barrett School (staff emploiyed by DETA)
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include

- Maintaining a milieu with professional staff reflecting qualities consistent with longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances with the majority of staff
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy

2. Collaborative care systems and service linkages

The Barrett Adolescent Centre is part of the broader Child and Youth Mental Health Services located throughout Queensland. The service is provided in partnership with the adolescent, their family or carer, the Department of Education, Training and Welfare and where appropriate the Department of Child Safety.

3. BAC Discharge Planning

All adolescents requiring extended inpatient or day patient integrated treatment and rehabilitation have a severe persistent level of mental illness and severe impairment manifest as moratorium of many of their tasks of adolescent development for many months or sometimes years prior to admission. For most extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period. Some have not required further mental health treatment when they are well into their third decade of life.

For this reason inpatient care is likely to be extended if they are thought to be suitable for an open admission. Depending on the primary mental illness for which they have been admitted, and associated co-morbid mental illness, progress typically proceeds in a number of stages which can be broadly identified. For the most part the length of time within any one stage is limited by factors within the adolescent, or by ongoing interactions with their family or carer.

Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular

variables associated with progress have been assessed. Nevertheless potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

Discharge planning typically involves

- Continued engagement of the parent or carer is sought throughout the admission, and potential care enhanced with both family therapy and psycho-education..
- The capacity of parents or carers to provide safe, appropriate care is assessed. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Discharge planning includes extended periods of leave, transition to partial hospitalisation or day program if appropriate.
- A clear educational or vocational plan is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Discharge planning includes linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the admission. Follow up will be arranged by negotiation with this team and the adolescent and their family with either the referrer, another specialist service or if appropriate, with the limited outpatient service at Barrett Adolescent Centre.
- Linkages with Disability Services Queensland and support providers are made where appropriate.

4. *Expected Clinical Outcomes*

Child and Youth Mentla Health Services utilise ar range of outcome measures including The Health of the Nations Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale, and the FSHe evaluate the severity of illness, the impact on functioning, the impact of family functioning and the impact of previous adverse experiences on both illness and function.

Over the length of a period of extended integrated treatment and rehabilitation an adolescent may show fluctuations in their HoNOSCA and CGAS scores depending on variables within the adolescent, their illness(es) and their family or carer. By the end of the period of care their scores will improve on a number of the items measured by the HoNOSCA, and CGAS scores will rise. However global HoNOSCA and CGAS scores are likely to continue improving by six months post discharge, as the adolescent consolidates therapeutic gains and becomes integrated into the community.

The chart below gives blah blah blah

Staffing structure and composition:

Structure and Resources:

Barrett Adolescent Centre operates with a Medical Director and Nurse Unit Manager who have final point accountability in designated areas. Multidisciplinary team work is essential to both developing the directions and programs of the service and for provision of therapeutic service. Key performance indicators are monitored within the Centre to ensure drive quality of service in producing the best outcome for adolescents and make recommendations to enhance efficiency.

Adolescents receive specific, group and generic therapeutic interventions from a range of specialist medical, nursing, health professionals, and education staff with appropriate qualifications, skills and experience. All clinical staff must be engaged in relevant professional development to ensure contemporary and evidence based intervention and treatment is provided to adolescents, their family or carers. Involvement in research activities is developing and will become integral to the unit as a Level 6 facility under the Clinical Services Capability Framework. Good administration is necessary to support staff function.

The role of the Consultant Psychiatrist, Registrars and Medical Officers includes but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidsicplinary team.
- Engaging with other professionals in the multi-disciplinary team to ensure that programs are directed towards treatment, rehabilitation and recovery for adolescents.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Developing individual treatment/care/recovery plans in consultation with the other members of the treating team, the adolescent, the family or carers
- Administering the *MHA 2000* as required under legislation
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice

The role of the Nursing staff includes but is not limited to:

- Providing appropriate levels of observation, supervision and care required in response to this assessment
- Developing individual treatment/care/recovery plans in consultation with the other members of the treating team, the adolescent, the family or carers
- Monitoring mental state, risk to self and others and physical health

- Assisting adolscents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate
- Implementing interventions as outlined in the Recovery Plan, eg. psychological and developmental interventions, administering medication.
- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual care plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs
- Providing nursing care for general medical conditions in consultation with appropriate medical teams
- Communicating with community support services to ensure that adolescents have access to the supports they require
- Undertaking relevant supervision and professional development and to ensure contemporary and evidence based practice.

The role of Health Professional staff includes but is not limited to:
(Acute Inpatient)

- Providing psychosocial screening and specialised assessment in the areas of personal strengths, coping skills, social supports, community support, accommodation needs and goals, activities of daily living, vocational and educational goals, and financial status
- Providing specialised psychosocial, psychometric, functional, cognitive, sensory assessment in the areas of social work, occupational therapy, dietician and psychology as required
- Facilitation and provision of individual and group psychoeducation and therapeutic interventions to minimise the negative impact of mental illness and assist adolescents, carers and their family to achieve recovery
- Communicating with community support services to ensure that people have access to supports they require
- Facilitation and provision of therapeutic and diversional programs in partnership with nursing staff to reduce boredom and increase social and physical activity
- Undertaking relevant supervision, and professional development to ensure contemporary and evidence based practice.

(Community Care Unit)

- Providing psychosocial screening and specialised assessment in the areas of personal strengths, coping skills, social supports, community support, accommodation needs and goals, activities of daily living, vocational and educational goals, and financial status
- Providing specialised psychosocial and or psychometric assessment in the areas of social work, occupational therapy, dietetics and psychology as required

- Facilitating a range of rehabilitation programs in partnership with nursing staff and other service providers for adolescents, their family or carers to assist recovery
- Communicating with community support services to ensure that people have access to supports they require
- Engaging adolescents in activities of daily living and providing options to increase social and physical activity and reduce boredom in conjunction with other staff and service providers
- Undertaking relevant supervision, and professional development to ensure contemporary and evidence based practice.

Performance Quality and Safety Indicators:

Queensland Health is committed to continuous improvement of mental health services and quality of life for people living with mental health problems and mental illness. Quality services are crucial to a comprehensive, safe and effective mental health system and to recovery. A culture of routine evaluation is supported in which information is used to drive the quality of clinical practice, service delivery, and planning and policy development.

The *Queensland's Mental Health Patient Safety Plan (2008- 2013)* supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. Strategies required to make a safer service, will deliver better consumer outcomes, and a better mental health service for the state overall. The following guiding principles and standards are embraced by all mental health services to ensure safe and effective service provision:

- Service delivery is focused on adolescents and the achievement of positive outcomes
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness
- Practice is improved through a strategic framework of assessment, monitoring, planning, evaluation and follow up
- Comprehensive, coordinated and individualised care that considers all aspects of the sdolescent's recovery is provided
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible
- Adolescents, family members, carers and the local community are involved in the planning, development, implementation and evaluation of the mental health service
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in care planning, and staff work with them to develop their own supports in their community
- Strategies such as incident reporting, Root Cause Analysis (RCA) and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements

- Participation in professional development activities and demonstration of learning in daily practices

These principles are consistent with and should be read in conjunction with the following standards:

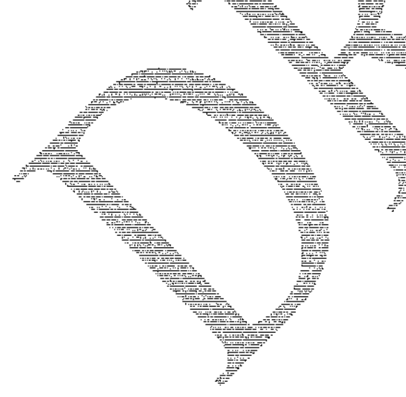
- *Australian Council of Health Care Standards (Improving Performance, Safe Environment)*
- *National Mental Health Standards (Standard 1, 2, 3, 5, 7, 8, 10. 11, 11.3, 11.4, 11.4C, 11.4E)*

District mental health services in Queensland are accredited against the National Mental Health Standards and all services participate in the routine accreditation survey as defined by the Australian Council of Health Care Standards.

This document will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017.*

Key resources:

- The Queensland Plan for Mental Health 2007 – 2017
- Clinical Services Capability Framework for Mental Health
- Royal Australian and New Zealand College of Psychiatrists – Guidelines for Inpatient Care
- Queensland's Mental Health Patient Safety Plan (2008- 2013)
- Mental Health Act 2000
- Mental Health Visual Observation Policy and Clinical Practice Guidelines



Model of Service for Mental Health in Queensland

Service Guideline for the ADOLSCENT EXTENDED TREATMENT CENTRE

Service Description and Function:

The Adolescent Extended Treatment Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to Queensland adolescents between 13 and 17 years of age with severe psychosocial impairment resulting from severe, persistent mental illness(es) often complicated by developmental co-morbidities. Many experience chronic family dysfunction which exacerbates the severity and persistence of the disorder and the disability. Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at Adolescent Extended Treatment Centre rather than transfer to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors.

It offers various levels of care from 24 hour care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to more independent care in therapeutic or step down residential settings. partial hospitalisation or day program for those whose behaviours associated with severe mental illness are not life threatening.. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions to young people and planning for their discharge.

Care focuses on the treatment or stabilisation of the symptoms of severe mental illness and developing tailored rehabilitation interventions (psychosocial, educational and vocational programs) to promote progress in developmental tasks towards a level of recovery appropriate to the adolescent and their illness. Discharge planning is facilitated in collaboration with a range of service providers to enable the young person to build on their strengths and maintain and enhance recovery focused outcomes upon discharge.

The primary diagnostic profiles of young people admitted to the Adolescent Extended Treatment Centre are adolescents with persistent eating disorders, complex illness and behaviours associated with trauma and severe anxiety and mood disorders, often with associated delays in particular developmental areas.. The average length of stay for an adolescent admitted to the Adolescent Extended Treatment Centre is 9.3 months with a median of 8 months.

The service capability of the Adolescent Extended Treatment Centre is defined within the *Clinical Services Capability Framework - Mental Health Module* which can be found on the CSCF or the Mental Health Branch website once endorsement and implementation is complete in 2009.

Target population and service planning guidelines:

Target population:
The Adolescent Extended Treatment Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. All present with co-morbid disorders or developmental delays

For Endorsement - 26 March 2009

The incidence of significant disorders of adolescents admitted 2002 -2006 is provided in Table 1. The numbers are greater than !00% because of co-morbidity.

Table 1. Young person Demographics, 2007/2008

Young person Demographics	Adolescent aged 14 to less than 18 years
Mean Age	16.2 years (range 13.9 – 18.0)
Gender	44.9% of young persons were male and 55.1% female
Aboriginal and or Torres Strait Islander Background	• 95.5% were neither Aboriginal nor Torres Strait Islander • 4.5% were from an Aboriginal and/or Torres Strait Islander background
Mental Health Legal Status	39.3% of young persons were involuntary at some point during their period of care
Average length of stay	41 weeks
Median length of stay	32 weeks

Data source: Queensland Health Admitted Patient Data Collection and Outcomes Information System

(a) Age is calculated based upon first contact with mental health services within the reference period.

26 March 2009

Based on the activity data collected in 2008, it is anticipated that the proportion of young people admitted to Acute Adolescent Units will have the following primary diagnosis according to the figures in Table 2.

Table 2. Diagnostic profile of admitted adolescents (18 – 64years) in 2006 -07

Diagnosis	Percentage	ICD-10 Category Code
OCD and Anxiety Disorders	32.9%	F20 - F29
Eating Disorders		
Depression		
Post Traumatic Symptoms		
Schizophrenia		
Pervasive Developmental Disorders		
Receptive-Expressive Language Disorders		
Other Developmental Disorders		
Abuse by Official agency		
Seeking Interventions known to be harmful		
Parent child conflict		

Data source: Outcomes Information System

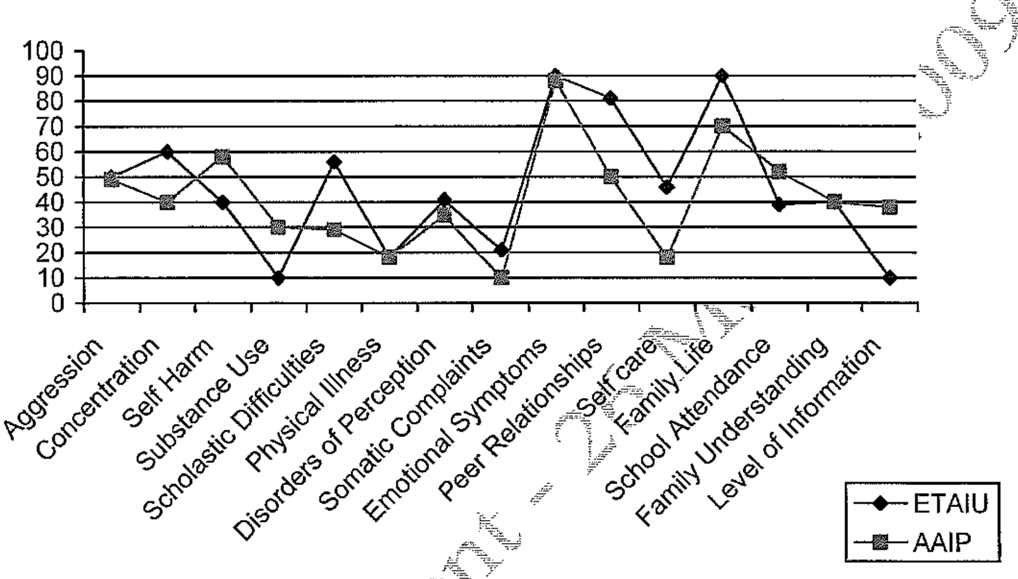
NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Diagnosis is that recorded in the Outcomes Information System at the end of episode (movement to other mental health setting and to no further care).

Child and Youth Mental Health Services utilise a range of outcome measures including The Health of the Nations Outcomes Scale for Children and Adolescents (HoNOSCA) to evaluate the severity of illness, the impact on the young person and the family's functioning and the impact of previous adverse experiences on both the illness and level of functioning. Young people admitted to the Barrett Adolescent Centre typically present with clinically significant HoNOSCA scores as indicated in the following table.

Table 3. HoNOSCA Clinically Significant Items on admission for adolescents aged 14 to less than 18 years admitted to an Adolescent Extended Treatment Centre(ETAIU) vs an Acute Adolescent Inpatient Unit



Data source: Outcomes Information System

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Percentage is calculated for each individual item, but only when the scores are between 0 and 4. Measures with a 7 or 9 are excluded from this analysis on an item by item basis, therefore the denominator may change between items.

(c) *n* refers to the number of collections with a score between 0 and 4.

Planning guidelines:

The *Queensland Plan for Mental Health 2007 – 2017* does not refer to the equivalent of the Adolescent Extended Treatment Centre, nor is it mentioned in *Future Directions for Child and Youth Mental Health Services in Queensland.* In spite of this the Centre is proposed to be rebuilt with a bed capacity which neither meets clinical need nor population demand.

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

For Endorsement - 25 May 09

Legislative Framework:

The Adolescent Extended Treatment Centre is currently a unit within The Park – Centre for Mental Health which is gazetted as an *authorised mental health services* in accordance with Section 495 of the *Mental Health Act 2000.*

Service delivery pathway:

The Adolescent Extended Treatment Centre accepts referrals from other CYMHS facilities in Queensland (community clinics, acute inpatient or day patient units), or a private child and adolescent psychologist or psychiatrist. A comprehensive clinical assessment occurs prior to the decision to admit to assess the adolescent's suitability for admission, potential interactions with other adolescents and to orientate the adolescent and their family or carer to the unit.

Based on available clinical information from the referred and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually 2 or 6 weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to assess the levels of acuity and advise of progress towards admission. Timing of admission is determined by the length of time on the waiting list, the relative acuity and the current mix of adolescents within the unit.

An initial Care Plan is developed in consultation with the adolescent and their family or carer on admission. During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Care planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent. These plans reflect phases of an adolescent's admission. They incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Treatment is provided in the least restrictive, most appropriate facility for the re4quired level of care that balances the young person's autonomy with their need for observation and treatment in a safe environment.

Planning for discharge from the Adolescent Extended Treatment Centrecommences once there is a clear assessment of the adolescent, stages of change, stability of family and care systems and capacity to work towards different stages of recovery. The referring district mental health service and families or carers (with the consent of an adolescent over the age of 16 years), are included in all aspects of discharge planning.

Core Service provision:

1. Clinical Interventions

A multidisciplinary mental health team in conjunction with the Adolescent Extended Treatment Centre School delivers and coordinates a range of integrated therapeutic, rehabilitation and recovery focused interventions. These interventions focus not only on the symptoms and behaviours associated with severe, persistent mental illness, but

also on the reciprocal interactions between these symptoms and behaviours on delays and moratoriums in developmental tasks and specific developmental impairments.

Interventions may be individual, group or generic.

Individualised interventions determined by evidenced based practice include:

- Psychological interventions (verbal and non-verbal therapies and education)
- Pharmacotherapy (including acute sedation where necessary)
- Family therapy and education
- Individualised behavioural programs.
- Other biological interventions (e.g. ECT, psychosurgery)

Interventions delivered in groups include

- Individual education plans delivered by the Extended Treatment Adolescent Inpatient School (staff employed by Education Queensland)
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include

- Maintaining a milieu with professional staff so that young people experience an environment consistent with the qualities identified in longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances with the majority of staff
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy
- Encouraging peer support opportunities, where available, for young people and/or families to appropriately engage with past young persons/carers for peer support;

The Adolescent Extended Treatment Centre School addresses delays and moratoriums on a number of developmental tasks including education and vocational preparation. Appropriate educational plans are developed after an assessment of the adolescent's educational strengths and difficulties. If a young person is not currently enrolled in an education program, a decision will be made whether to simply engage an adolescent in a school readiness program, develop a formal educational program with links to external curricula or develop educational strengths to enhance vocational readiness. The school develops a transitional program towards continuing education or workforce participation as part of the Unit's comprehensive discharge planning.

Increased levels of intervention are sometimes necessary for the management of clinical presentations associated with an acute exacerbation of mental illness and behavioural difficulties that increase the risk to themselves or others. These increased levels of interventions are delivered by qualified staff following a comprehensive risk assessment. They may take a number of forms ranging from specific behavioural, activity based or sensorimotor interventions through to increased *visual observation* and the use of a *designated high dependency area* through to the potential use of *restraint and seclusion.* The use of an increased level of intervention is based on the clinical need to ensure the safety of the young person as well as the safety of others. The maintenance of basic human rights, such as privacy, dignity, cultural background and confidentiality are recognised, respected and promoted in all clinical

interventions. All staff should be familiar with the specific policy and practice guidelines which have been developed by the Mental Health Branch.

2. *Collaborative care systems and service linkages*

Child and Youth Mental Health services operate in a complex, multi-system environment including crucial interactions with Education Queensland, Department of Child Safety, Child Health Services, Juvenile Justice, Disability Services Queensland, Department of Communities, Alcohol Tobacco and Other Drug Services, private providers, non-government organisations disability support providers and others.

Services should be integrated and coordinated, with partnerships and linkages with other agencies for young people and with specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing and coordinating services should be developed.

3. *Adolescent Extended Treatment Centre Discharge Planning*

Discharge planning is a component of each young person's Recovery Plan. Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular variables associated with progress have been assessed. Nevertheless potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

Young people are usually discharged from the Adolescent Extended Treatment Centre back to their home environment or independent living. Adolescents may transition between the various components of the program to assist the transition and facilitate rehabilitation and recovery goals. Considerable support will still be required on discharge for the young person and their family and/or carers.

Adolescent Extended Treatment Centre discharge planning and support for young people includes but is not limited to:

- Continued engagement of the parent or carer throughout the admission where possible and appropriate with the potential for enhanced care on discharge.
- Assessing the capacity of parents or carers to provide safe, appropriate care. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Facilitating extended periods of leave, and transition to partial hospitalisation, step down facility or day program if appropriate.
- Developing a clear educational or vocational plan which is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Developing linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the admission. Follow up will be arranged by negotiation with this team and the adolescent

and their family with either the referrer, another specialist service or if appropriate, with the limited outpatient service at the Extended Treatment Adolescent Unit.

- Maintaining collaborative relationships with a wide range of service providers including education providers, extended family and carers, general practitioners, general community health services and/or adult mental health services to meet the needs of the young person and enhance their capacity to effectively manage their mental health care needs in a less intensive environment and continue recovery.

4. Expected Clinical Outcomes

All adolescents requiring extended inpatient or day patient integrated treatment and rehabilitation have a severe persistent level of mental illness and severe impairment manifest as moratorium of many of their tasks of adolescent development for many months or sometimes years prior to admission. For most extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period. Some have not required further mental health treatment when they are well into their third decade of life.

Staffing structure and composition:

The Adolescent Extended Treatment Centre is staffed by a multidisciplinary team of clinical and non clinical staff. Treatment and rehabilitation is provided by clinical mental health workers including doctors, nurses and health professionals including occupational therapists, psychologists, social workers and speech pathologists with access to a regular dietitian and exercise physiologist. Additionally, the multidisciplinary team are supported by administrative officers, catering and security staff who assist with the day to day operations of the unit. Young person and carer consultants and peer support workers should be engaged by the service. *(CSCF Workforce hyperlink)*

The Adolescent Extended Treatment Centre and Education Queensland work collaboratively to ensure the effective provision of resources to enable a comprehensive and tailored educational program as an essential strategy of rehabilitation.

The effectiveness of the Adolescent Extended Treatment Centre is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The complexity of adolescents mandates the need to provide staff with continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. The Adolescent Extended Treatment Centreprovides clinical placements for undergraduate students, encouraging rotations through the unit from staff from other areas of the mental health services and supporting education and research opportunities.

A number of roles and duties are generic to all Adolescent Extended Treatment Centre Clinical staff, These roles include but are not limited to:

- Monitoring mental state during activities, monitoring risk and participating in the development of appropriate risk management plans
- Generalising the gains from a range of individual and group based interventions to assist recovery;
- Engaging and promoting activities which facilitate progress in developmental tasks in conjunction with other staff and service providers;
- Developing individual care plans in consultation with the other members of the treating team, the adolescent, the family or carers
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice.
- Evaluate the evidence for individual and group interventions to develop a continuum of evidence based practice

The role of the Consultant Psychiatrist, Registrars and Medical Officers includes but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidisciplinary team.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Administering the *MHA 2000* as required under legislation

The role of the Nursing staff includes but is not limited to:

- Providing high quality levels observations of symptom and behavioural changes, risk of harm to self or others, progress in developmental tasks, responses to care, counselling and group interventions, and interactions with parents/carers to formulate appropriate levels of supervision, individual support, medication adjustments, counselling interventions and behavioural management plans
- Assisting adolescents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate
- Implementing and evaluating the effectiveness of nursing interventions as outlined in the Recovery Plan.
- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual care plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.

- Developing areas of individual expertise to contribute to the range of recovery oriented programs
- Providing nursing care for general medical conditions in consultation with appropriate medical teams
- Communicating with community support services to ensure that adolescents have access to the supports they require

The role of Allied Health staff includes but is not limited to:

- Providing discipline specific individual assessment of the young person's development, progress in developmental tasks and symptoms and behaviours of mental illness;
- Develop discipline specific, cross discipline and generic interventions towards treatment and rehabilitation of the mental illness in the context of impairments in developmental tasks associated with both the mental illness and developmental delays.
- Implementing a range of individual and group based adolescent, parent/carer and family therapy utilising verbal, non-verbal and activity based therapies.

The role of Young person and Carer Consultants includes but is not limited to:

- Effectively engaging young people and carers through appropriate consultation methods, to inform recruitment and selection process, through making effective use of individual's skills, experience and availability. This may include, but is not limited to young persons and carers serving as members of recruitment and selection panels
- Effectively engage with adolescents to meaningfully participate in the planning, delivery and evaluation of the services provided by the Adolescent Extended Treatment Centre and identifying areas for improvement;
- Working collaboratively with clinicians to foster a recovery focused service; to enhance a positive outcome for the adolescents;

Performance, Quality and Safety Indicators:

The Adolescent Extended Treatment Centre has not been benchmarked on Key Performance Indicators because of the lack of comparable facilities. The following indicators are adapted from the *Queensland's Mental Health Patient Safety Plan (2008- 2013)* which supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. The following guiding principles are proposed as indicators of performance accountability and quality.

- Service delivery is focused on adolescents and the achievement of positive outcomes
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness
- Practice is improved through a strategic framework of assessment, monitoring, planning, evaluation and follow up
- Comprehensive, coordinated and individualised care that considers all aspects of the sdolescent's recovery is provided
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible

- Adolescents, family members, carers and the local community are involved in the planning, development, implementation and evaluation of the mental health service
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in care planning, and staff work with them to develop their own supports in their community
- Strategies such as incident reporting, Root Cause Analysis (RCA) and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements
- Participation in professional development activities and demonstration of learning in daily practices

This document will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017*. The Strategic Policy Unit of the Mental Health Branch is charged with ensuring that the policies and procedures remain relevant and updated.

Key resources:

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

Draft 3 March 09

For Endorsement - 26 March 2009

Model of Service for Mental Health in Queensland

Service Guideline for the ADOLSCENT EXTENDED TREATMENT CENTRE

Service Description and Function:

The Adolescent Extended Treatment Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to Queensland adolescents between 13 and 17 years of age with severe psychosocial impairment resulting from severe, persistent mental illness(es) often complicated by developmental co-morbidities. Many experience chronic family dysfunction which exacerbates the severity and persistence of the disorder and the disability. Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at Adolescent Extended Treatment Centre rather than transfer to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors.

It offers various levels of care from 24 hour care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to more independent care in therapeutic or step down residential settings, partial hospitalisation or day program for those whose behaviours associated with severe mental illness are not life threatening. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions to young people and planning for their discharge.

Care focuses on the treatment or stabilisation of the symptoms of severe mental illness and developing tailored rehabilitation interventions (psychosocial, educational and vocational programs) to promote progress in developmental tasks towards a level of recovery appropriate to the adolescent and their illness. Discharge planning is facilitated in collaboration with a range of service providers to enable the young person to build on their strengths and maintain and enhance recovery focused outcomes upon discharge.

The primary diagnostic profiles of young people admitted to the Adolescent Extended Treatment Centre are adolescents with persistent eating disorders, complex illness and behaviours associated with trauma and severe anxiety and mood disorders, often with associated delays in particular developmental areas. The average length of stay for an adolescent admitted to the Adolescent Extended Treatment Centre is 9.5 months with a median of 7.5 months.

The service capability of the Adolescent Extended Treatment Centre is defined in the Child and Youth Non-Acute Inpatient sub module of the *Clinical Services Capability Framework (CSCF) - Mental Health Services Module*, which can be found on either the *CSCF* or Mental Health Branch website once endorsement and implementation is complete in early 2010.

Target population and service planning guidelines:

Target population:

The Adolescent Extended Treatment Centre provides multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. All present with co-morbid disorders or developmental delays.

The incidence of significant disorders of adolescents admitted 2004 -2009 is provided in Table 1.

Table 1. Young person demographics, 2004-2009

Young person Demographics	**Adolescent aged 14 to less than 18 years**
Mean Age	15.62 years (range 13 – 18)
Gender	44.9% of young persons were male and 55.1% female
Aboriginal and or Torres Strait Islander Background	• 95.5% were neither Aboriginal nor Torres Strait Islander • 4.5% were from an Aboriginal and/or Torres Strait Islander background
Mental Health Legal Status	39.3% of young persons were involuntary at some point during their period of care

Data source: HBISCUS audit of Barrett Adolescent Centre patients

(a) Age is calculated based upon first contact with mental health services within the reference period.

Based on the activity data collected in 2004-2009, it is anticipated that the proportion of young people admitted to Adolescent Extended Treatment Centre will have the following primary diagnosis according to the figures in Table 2.

Table 1. Diagnostic profile of admitted adolescents (13 – 18 years) in 2004 -09

Social Anxiety Disorders	51.8%	F20 – F29
OCD and Anxiety Disorders	23.5%	
Eating Disorders	27.1%	
Depression and Dysthymic Disorders	62.4%	
Post Traumatic Symptoms	24.7%	
Schizophrenia	5.9%	
Pervasive Developmental Disorders	20%	
Receptive-Expressive Language Disorders	52.9%	
Other Developmental Disorders	51.8%	
Oppositional Defiant Disorder	50.6%	
Substance Abuse	9.4%	
Disorders with an Organic Origin	3.5%	
Parent child relational disorders	83.5%	

Data source: Chart Review of Patients

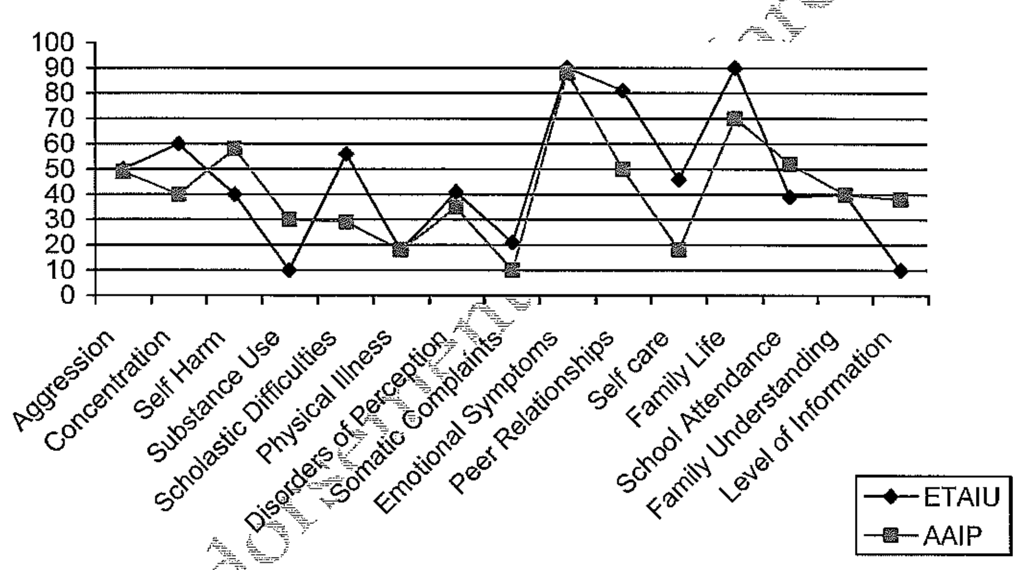
NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Diagnosis is that recorded in the Outcomes Information System at the end of episode (movement to other mental health setting and to no further care).

Child and Youth Mental Health Services utilise a range of outcome measures including The Health of the Nations Outcomes Scale for Children and Adolescents (HoNOSCA) to evaluate the severity of illness, the impact on the young person and the family's functioning, and the impact of previous adverse experiences on both the illness and level of functioning. Young people admitted to the Adolescent Extended Treatment Centre typically present with clinically significant HoNOSCA scores as indicated in the following table.

Table 3. HoNOSCA Clinically Significant Items on admission for adolescents aged 14 to less than 18 years admitted to an Adolescent Extended Treatment Centre(ETAIU) vs an Acute Adolescent Inpatient Unit



Data source: Outcomes Information System

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Percentage is calculated for each individual item, but only when the scores are between 0 and 4. Measures with a 7 or 9 are excluded from this analysis on an item by item basis, therefore the denominator may change between items.

(c) *n* refers to the number of collections with a score between 0 and 4.

Planning guidelines:

The *Queensland Plan for Mental Health 2007 – 2017* does not refer to the equivalent of the Adolescent Extended Treatment Centre, nor is it mentioned in *Future Directions for Child and Youth Mental Health Services in Queensland.* In spite of

this the Centre is proposed to be rebuilt with a bed capacity which neither meets clinical need nor population demand.

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

The Adolescent Extended Treatment Centre is currently a unit within The Park – Centre for Mental Health which is gazetted as an *authorised mental health service* in accordance with Section 495 of the *Mental Health Act 2000.*

Service delivery pathway:

The Adolescent Extended Treatment Centre accepts referrals from other CYMHS facilities in Queensland (community clinics, acute inpatient or day patient units), or a private child/adolescent psychologist or psychiatrist. A comprehensive clinical assessment occurs prior to the decision to admit to assess the adolescent's suitability for admission, potential interactions with other adolescents and to orientate the adolescent and their family or carer to the unit.

Based on available clinical information from the referrer and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually two or six weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to assess the levels of acuity and advise of progress towards admission. Timing of admission is determined by the length of time on the waiting list, the relative acuity and the current mix of adolescents within the unit.

An initial Recovery Plan is developed in consultation with the adolescent and their family or carer on admission. During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent. These plans reflect phases of an adolescent's admission. They incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Treatment is provided in the least restrictive, most appropriate facility for the required level of care that balances the young person's autonomy with their need for observation and treatment in a safe environment.

Discharge planning commences upon admission to the Centre. Readiness for discharge depends on a range of factors, including a series of comprehensive assessments of the adolescent, stages of change, stability of family and care systems and the capacity to work towards different stages of recovery. I reworded this Trevor – does it sound ok? I could not in all honesty pretend to say it begins upon admission. There are just too many intervening variables for this to be meaningful. I know it's what is supposed to happen, but it can't and never will. The referring district mental health service and families or carers (with the consent of an adolescent over the age of 16 years) are included in all aspects of discharge planning.

For Comment March 2009

Core Service provision:

1. Clinical Interventions

A multidisciplinary mental health team in conjunction with the Adolescent Extended Treatment Centre School delivers and coordinates a range of integrated therapeutic, rehabilitation and recovery focused interventions. These interventions focus not only on the symptoms and behaviours associated with severe, persistent mental illness, but also on the reciprocal interactions between these symptoms and behaviours on delays and moratoriums in developmental tasks and specific developmental impairments.

Interventions may be individual, group or generic.

Individualised interventions determined by evidenced based practice include:
- Psychological interventions (verbal and non-verbal therapies and education).
- Pharmacotherapy (including acute sedation where necessary).
- Family therapy and education.
- Individualised behavioural programs.
- Other biological interventions (e.g. Electro Convulsive Therapy [ECT], psychosurgery).

Interventions delivered in groups include:
- Individual education plans delivered by the Extended Treatment Adolescent Inpatient School (staff employed by Education Queensland).
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include:
- Maintaining a milieu with professional staff so that young people experience an environment consistent with the qualities identified in longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances with the majority of staff
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy
- Encouraging peer support opportunities, where available, for young people and/or families to appropriately engage with past young persons/carers for peer support;

Draft 2 March 2009

The Adolescent Extended Treatment Centre School addresses delays and moratoriums on a number of developmental tasks including education and vocational preparation. Appropriate educational plans are developed after an assessment of the adolescent's educational strengths and difficulties. If a young person is not currently enrolled in an education program, a decision will be made whether to simply engage an adolescent in a school readiness program, develop a formal educational program with links to external curricula or develop educational strengths to enhance vocational readiness. The school develops a transitional program towards continuing education or workforce participation as part of the Centre's comprehensive discharge planning.

Increased levels of intervention are sometimes necessary for the management of clinical presentations associated with an acute exacerbation of mental illness and behavioural difficulties that increase the risk to themselves or others. These increased

levels of interventions are delivered by qualified staff following a comprehensive risk assessment. They may take a number of forms ranging from specific behavioural, activity based or sensorimotor interventions through to increased visual observation and the use of a designated high dependency area through to the potential use of restraint and seclusion. The use of an increased level of intervention is based on the clinical need to ensure the safety of the young person as well as the safety of others. The maintenance of basic human rights such as privacy, dignity, cultural background and confidentiality are recognised, respected and promoted in all clinical interventions. All staff should be familiar with the specific policy and practice guidelines which have been developed by the Mental Health Branch.

2. *Collaborative care systems and service linkages*

Child and Youth Mental Health services operate in a complex, multi-system environment including crucial interactions with Education Queensland, Department of Child Safety, Child Health Services, Juvenile Justice, Disability Services Queensland, Department of Communities, Alcohol Tobacco and Other Drug Services, private providers, non-government organisations disability support providers and others.

Services should be integrated and coordinated, with partnerships and linkages with other agencies for young people and with specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing and coordinating services should be developed.

3. *Adolescent Extended Treatment Centre Discharge Planning*

Discharge planning is a component of each young person's Recovery Plan. Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular variables associated with progress have been assessed. Nevertheless, potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

Young people are usually discharged from the Adolescent Extended Treatment Centre back to their home environment or independent living. Adolescents may transition between the various components of the program to assist the transition and facilitate rehabilitation and recovery goals. Considerable support will still be required on discharge for the young person and their family and/or carers.

Adolescent Extended Treatment Centre discharge planning and support for young people includes but is not limited to:

- Continued engagement of the parent or carer throughout the admission where possible and appropriate with the potential for enhanced care on discharge.
- Assessing the capacity of parents or carers to provide safe, appropriate care. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Facilitating extended periods of leave, and transition to partial hospitalisation, step down facility or day program if appropriate.

- Developing a clear educational or vocational plan which is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Developing linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the admission. Follow up will be arranged by negotiation with this team and the adolescent and their family with either the referrer, another specialist service or if appropriate, with the limited outpatient service at the Extended Treatment Adolescent Unit.
- Maintaining collaborative relationships with a wide range of service providers including education providers, extended family and carers, general practitioners, general community health services and/or adult mental health services to meet the needs of the young person and enhance their capacity to effectively manage their mental health care needs in a less intensive environment and continue recovery.

4. *Expected Clinical Outcomes*

All adolescents requiring extended treatment and rehabilitation have severe persistent mental illness resulting in severe impairment. This is manifest as a moratorium of many of their tasks of adolescent development for considerable periods prior to admission. Think the previous sentence needs rewording. For most, extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period. Some have not required further mental health treatment when they are well into their third decade of life. Is there a reference to put here? Anecdotal only – we have met several of them this year.

Staffing structure and composition:

The Adolescent Extended Treatment Centre is staffed by a multidisciplinary team of clinical and non clinical staff. Treatment and rehabilitation is provided by clinical mental health workers including doctors, nurses and health professionals including occupational therapists, psychologists, social workers and speech pathologists with regular access to a dietitian and exercise physiologist. Additionally, the multidisciplinary team are supported by administrative officers, catering and security staff who assist with the day to day operations of the unit. Young person and carer consultants and peer support workers should be engaged by the service. *(CSCF Workforce hyperlink)*

The Adolescent Extended Treatment Centre and Education Queensland work collaboratively to ensure the effective provision of resources to enable a comprehensive and tailored educational program as an essential strategy of rehabilitation.

The effectiveness of the Adolescent Extended Treatment Centre is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The

Draft only March

complexity of adolescence mandates the need to provide staff with continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. The Adolescent Extended Treatment Centre provides clinical placements for undergraduate students, encouraging rotations through the unit from staff from other areas of the mental health services and supporting education and research opportunities.

A number of roles and duties are generic to all Adolescent Extended Treatment Centre Clinical staff. These roles include but are not limited to:

- Monitoring mental state during activities, monitoring risk and participating in the development of appropriate risk management plans.
- Generalising the gains from a range of individual and group based interventions to assist recovery.
- Engaging and promoting activities which facilitate progress in developmental tasks in conjunction with other staff and service providers.
- Developing individual Recovery Plans in consultation with the other members of the treating team, the adolescent, and the family or carers.
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice.
- Evaluate the evidence for individual and group interventions to develop a continuum of evidence based practice.

The role of the Consultant Psychiatrist, Registrars and Medical Officers includes but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidisciplinary team.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Administering the *MHA 2000* as required under legislation.

The role of Nursing staff includes but is not limited to:

- Providing high quality levels observations of symptom and behavioural changes, risk of harm to self or others, progress in developmental tasks, responses to care, counselling and group interventions, and interactions with parents/carers to formulate appropriate levels of supervision, individual support, medication adjustments, counselling interventions and behavioural management plans.
- Assisting adolescents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety.
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate.

For Comment 26 March 2009

- Implementing and evaluating the effectiveness of nursing interventions as outlined in the Recovery Plan.
- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual Recovery Plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs.
- Providing nursing care for general medical conditions in consultation with appropriate medical teams.
- Communicating with community support services to ensure that adolescents have access to the supports they require.

The role of Allied Health staff includes but is not limited to:

- Providing discipline specific individual assessment of the young person's development, progress in developmental tasks and symptoms and behaviours of mental illness.
- Develop discipline specific, cross discipline and generic interventions towards treatment and rehabilitation of the mental illness in the context of impairments in developmental tasks associated with both the mental illness and developmental delays.
- Implementing a range of individual and group based adolescent, parent/carer and family therapy utilising verbal, non-verbal and activity based therapies.

The role of Young person and Carer Consultants includes but is not limited to:

- Effectively engage young people and carers through appropriate consultation methods, to inform recruitment and selection process, through making effective use of individual's skills, experience and availability. This may include, but is not limited to, young persons and carers serving as members of recruitment and selection panels.
- Effectively engage with adolescents to meaningfully participate in the planning, delivery and evaluation of the services provided by the Adolescent Extended Treatment Centre and identifying areas for improvement.
- Working collaboratively with clinicians to foster a recovery focused service to enhance a positive outcome for the adolescents.

Performance, Quality and Safety Indicators:

The Adolescent Extended Treatment Centre has not been benchmarked on Key Performance Indicators because of the lack of comparable facilities. The following indicators are adapted from the *Queensland's Mental Health Patient Safety Plan (2008- 2013)* which supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. The following guiding principles are proposed as indicators of performance accountability and quality.

- Service delivery is focused on adolescents and the achievement of positive outcomes.
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness.

For comment 26 March 2009

- Practice is improved through a strategic framework of assessment, monitoring, planning, evaluation and follow up.
- Comprehensive, coordinated and individualised care that considers all aspects of the adolescent's recovery is provided.
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible.
- Adolescents, family members, carers and the local community are involved in the planning, development, implementation and evaluation of the mental health service.
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in Recovery Planning, and staff work with them to develop their own supports in their community.
- Strategies such as incident reporting, Root Cause Analysis and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements.
- Participation in professional development activities and demonstration of learning in daily practices.

This document will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017.* The Strategic Policy Unit of the Mental Health Branch is charged with ensuring that the policies and procedures remain relevant and updated.

Key resources:

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

- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project

For Endorsement - 26 March 2009

Model of Service for Mental Health in Queensland
Service Guideline for the ADOLESCENT EXTENDED TREATMENT CENTRE

Service Description and Function:

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

The centre offers various levels of care from 24-hour care for adolescents with high acuity in a safe, structured, highly supervised and supportive inpatient environment to more independent care in therapeutic or step down residential settings, partial hospitalisation or day program for those whose behaviours associated with severe mental illness are not life threatening. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions, and discharge planning to young people and their family/carers.

Care focuses on the treatment or stabilisation of the symptoms of severe mental illness and aims to develop tailored rehabilitation interventions (psychosocial, educational and vocational programs) to promote progress in developmental tasks appropriate to the adolescent and their illness. The care and discharge planning delivered by the service is facilitated in collaboration with the consumer, their family/carers and a range of key stakeholders and service providers, so as to enable the young person to build on their strengths and maintain and enhance recovery focused outcomes upon discharge.

The primary diagnostic profiles of young people admitted to the Adolescent Extended Treatment Centre are adolescents with persistent eating disorders, complex illness and behaviours associated with trauma and severe anxiety and mood disorders, often with associated delays in particular developmental areas. The average length of stay for an adolescent admitted to the Adolescent Extended Treatment Centre is 9.5 months with a median of 7.5 months.

The service capability of the Adolescent Extended Treatment Centre is defined in the Child and Youth Non-Acute Inpatient sub module of the *Clinical Services Capability Framework (CSCF) - Mental Health Services Module*, which can be found on either the *CSCF* or Mental Health Branch website once endorsement and implementation is complete in early 2010.

Target Population:

The Adolescent Extended Treatment Centre provides specialist multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. All consumers present with co-morbid disorders or developmental delays.

Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at the Adolescent Extended Treatment Centre rather than transferring to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors.

The incidence of significant disorders of adolescents admitted 2004 -2009 is provided in Table 1.

Table 1. Adolescent Extended Treatment Centre, Consumer Demographics, 2004-2009

Consumer Demographics[1]	
Mean Age	15.62 years (range 13 – 18).
Gender	44.9% of young persons were male and 55.1% female.
Indigenous Australian	• 95.5% were neither Aboriginal nor Torres Strait Islander • 4.5% were from an Aboriginal and/or Torres Strait Islander background
Mental Health Legal Status	39.3% of young persons were involuntary at some point during their period of care.

Data source: HBISCUS audit of Barrett Adolescent Centre patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

Consumers engaged with the centre will present with a range of mental health problems and/or disorders, but predominantly, they will have complicated diagnoses associated with eating disorders, mood and anxiety disorders, and trauma experiences. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2.

[1] Adolescents aged 14 years to less than 18 years.

Table 2. Adolescent Extended Treatment Centre, Diagnostic Profile[2]

	Percentage	ICD-10 Category Code
Social Anxiety Disorders	51.8%	F20 – F29
OCD and Anxiety Disorders	23.5%	
Eating Disorders	27.1%	
Depression and Dysthymic Disorders	62.4%	
Post Traumatic Symptoms	24.7%	
Schizophrenia	5.9%	
Pervasive Developmental Disorders	20%	
Receptive-Expressive Language Disorders	52.9%	
Other Developmental Disorders	51.8%	
Oppositional Defiant Disorder	50.6%	
Substance Abuse	9.4%	
Disorders with an Organic Origin	3.5%	
Parent child relational disorders	83.5%	

Data source: Chart Review of Patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Diagnosis is that recorded in the Outcomes Information System at the end of episode (movement to other mental health setting and to no further care).

For Comment - 26 March 2009

Service Planning Guidelines:

Key stakeholders associated with the *Queensland Plan for Mental Health 2007 – 2017,* in conjunction with service providers and consumers and carers, are leading the redesign and strategic service planning of the Adolescent Extended Treatment Centre.

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

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

Service Delivery Pathway:

Referral

The Adolescent Extended Treatment Centre accepts and prioritises referrals from other Child and Youth Mental Health Service (CYMHS) facilities from across Queensland (community clinics, acute inpatient or day patient units). Under some circumstances, referrals may be accepted from private mental health practitioners. A comprehensive clinical assessment occurs prior to the decision to admit in order to assess the adolescent's suitability for admission, their potential interactions with other adolescents, and to orientate the adolescent and their family/carers to the service.

[2] Admitted adolescents (aged 13 – 18 years) in 2004 – 09.

Treatment Overview
Based on available clinical information from the referrer and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually two to six weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to assess the levels of acuity and will advise of progress towards admission. Timing of admission is determined by the length of time on the waiting list, the relative acuity of the individual case, and the current mix of adolescents within the unit.

Based on the principles of Recovery, as outlined in the ***Sharing Responsibility for Recovery: creating and sustaining recovery orientated systems of care for mental health*** document, mental health services operate on the premise that most consumers can and do recover[3] from mental illness. Services are directed at helping the consumer (and their family/carers) manage their illness and enhance their capacity for recovery. Importantly, the Adolescent Extended Treatment Centre team considers how the concept of Recovery applies to adolescents and their families/carers. This includes acknowledgement that Recovery should take into account developmental processes, that the concepts of Recovery may also be applied to parents, carers and entire families, and that the mental health field for this consumer group is broader than that for adults (i.e. including prevention and early intervention; a wider range of challenges and disorders, not all of which are mental illnesses; and that the focus should be on promoting the positive potential of all children and adolescents).

An initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission. During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent. These plans reflect phases of an adolescent's admission. They incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Treatment is provided in the least restrictive, most appropriate facility for the required level of care that balances the young person's autonomy with their need for observation and treatment in a safe environment.

Core Service Provision:

1. Clinical Interventions
A multidisciplinary mental health team in conjunction with the Adolescent Extended Treatment Centre School delivers and coordinates a range of

[3] It is important to note that some disorders (such as intellectual and developmental disorders) may not be associated with the definition of a 'true' recovery, however, mental health services may still have a role in helping these young people to achieve an optimal level of personal functioning and social participation.

integrated therapeutic, rehabilitation and recovery focused interventions. These interventions focus not only on the symptoms and behaviours associated with severe, persistent mental illness, but also on the reciprocal interactions between these symptoms and behaviours on delays and moratoriums in developmental tasks and specific developmental impairments.

Interventions may be individual, group or generic.

Individualised interventions determined by evidenced based practice include:

- Psychological interventions (verbal and non-verbal therapies and education).
- Pharmacotherapy.
- Family therapy and education.
- Individualised behavioural programs.
- Other biological interventions (e.g. Electro Convulsive Therapy [ECT], psychosurgery).

Interventions delivered in groups include:

- Individual education plans delivered by the Extended Treatment Adolescent Inpatient School (staff employed by Education Queensland).
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include:

- Maintaining a milieu with professional staff so that young people experience an environment consistent with the qualities identified in longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances between staff, consumers and families/carers.
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy
- Encouraging peer support opportunities, where available, for young people and/or families to appropriately engage with past young persons/carers for peer support.

The Adolescent Extended Treatment Centre School addresses delays and moratoriums on a number of developmental tasks including education and vocational preparation. Appropriate educational plans are developed after an assessment of the adolescent's educational strengths and difficulties. If a young person is not currently enrolled in an education program, a decision will be made whether to ~~simply~~ engage an adolescent in a school readiness program, develop a formal educational program with links to external curricula or develop educational strengths to enhance vocational readiness. The school develops a transitional program towards continuing education or workforce participation as part of the Centre's comprehensive discharge planning.

Increased levels of intervention are sometimes necessary for the management of clinical presentations associated with an acute exacerbation of mental illness and behavioural difficulties that increase the risk to

themselves or others. These increased levels of interventions are delivered by qualified staff following a comprehensive risk assessment. They may take a number of forms ranging from specific behavioural, activity based or sensorimotor interventions through to increased visual observation and the use of a designated high dependency area through to the potential use of restraint and seclusion. The use of an increased level of intervention is based on clinical need, in order to ensure the safety of the young person as well as the safety of others. The maintenance of basic human rights such as privacy, dignity, cultural background and confidentiality are recognised, respected and promoted in all clinical interventions. ~~All staff should be familiar with the specific policy and practice guidelines which have been developed by the Mental Health Branch.~~

~~2.~~Discharge Planning

Discharge planning is a component of each young person's Recovery Plan. Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular variables associated with progress have been assessed. Nevertheless, potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

- Young people are most commonly discharged from the Adolescent Extended Treatment Centre back to their home environment or independent living. Adolescents may transition between the various components of the program to assist the transition and facilitate rehabilitation and recovery goals. Considerable support will still be required on discharge for the young person and their family and/or carers.
-

Adolescent Extended Treatment Centre discharge planning and support for young people includes, but is not limited to:

- Continued engagement of the parent or carer throughout the admission where possible and appropriate with the potential for enhanced care on discharge.
- Assessing the capacity of parents or carers to provide safe, appropriate care. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Facilitating extended periods of leave, and transition to partial hospitalisation, step down facility or day program if appropriate.
- Developing a clear educational or vocational plan which is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Developing linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the admission. Follow up will be arranged by negotiation with the adolescent and their family/carers, in addition to the referrer, another

For Comment 20 March 2009

specialist service or if appropriate, with the limited outpatient service at the Extended Treatment Adolescent Unit.

- Maintaining collaborative relationships with a wide range of service providers including education providers, extended family and carers, general practitioners, general community health services and/or adult mental health services to meet the needs of the young person and enhance their capacity to effectively manage their mental health care needs in a less intensive environment and continue recovery.

3. Expected Clinical Outcomes

All adolescents requiring extended treatment and rehabilitation have severe persistent mental illness, resulting in severe impairment. ~~This manifests as a moratorium of adolescent developmental tasks.~~ For most, extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period of time.

Mental health services utilise the *Health of the Nation Outcome Scale for Children and Adolescents* (HoNOSCA) to measure the severity of symptoms and health status of the consumer across 15 broad items. Each item is rated from 0 ("no problem") to 4 ("severe to very severe problem"). These scores can be summed to provide five sub-scales (behaviour problems, impairment, symptomatic problem, social problems and information). Clinicians use this data to record both the complexity of a consumer's episode of illness and to monitor changes in their symptoms and functioning over the period of care. As indicated in Figure 1, CYCMHS consumers will typically present with clinically significant scores in XXX of the sub scales – XXX, XXX, XXX, with an average total score of XXX on admission and XXX on discharge.

.

Figure 1. Adolescent Extended Treatment Centre, Average HoNOSCA Subscale Scores, 2007/2008

Data source: Outcomes Information System

NEED TO ADD THIS TABLE.

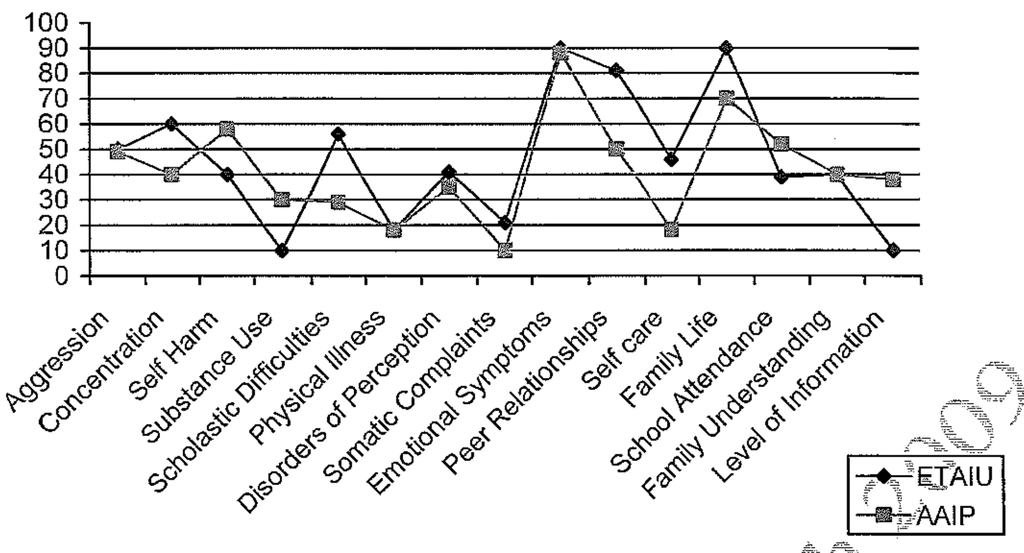
NOTES:

(a) Where an item is scored 7 or 9, for the purpose of this analysis, the score is converted to a zero. However, measures with more than two items, of the first 13 items, rated 7 or 9 are excluded from this analysis. *n* refers to the number of 'valid' collections (that is, measures that have two or less items scored 7 or 9).

~~(a)~~(b) 'Max' refers to the maximum possible score for each of the subscales. Caution is required with any graphical representation as the subscales have different denominators and are therefore not strictly comparable.

Turning now to Figure 2 below, a representation of HoNOSCA scores is provided on the 15 items at admission (new collection), review and end (no further care). Consumers of the Adolescent Extended Treatment Centre will present with clinically significant scores on the majority of items.

Figure 2. Clinically Significant HoNOSCA Items (?date) on Admission.[4]



Data source: Outcomes Information System

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

~~(a)~~(b) Percentage is calculated for each individual item, but only when the scores are between 0 and 4. Measures with a 7 or 9 are excluded from this analysis on an item by item basis, therefore the denominator may change between items.

~~(a)~~(c) *n* refers to the number of collections with a score between 0 and 4.

Applicable to ALL HoNOSCA Data (in addition to the specifics listed under each item)

- New Collections is a combination of New Referral and Referral from other mental health services.
- Review Collections is a combination of Standard Review and Ad Hoc Reviews.
- End of Episode due to *no further care* refers to consumers who are discharged from the community service for whom no further treatment or care is planned by the mental health network. Consumers who move to a different health service setting in a different mental health network (for example, a consumer of ambulatory services in Metro South admitted to an inpatient unit in the Gold Coast) are included in the *no further care* analysis.
- Community episodes which end due to *movement to another health service setting* refers to consumers who are admitted to acute or extended treatment service in the mental health network.
- All reasons for ending an episode, other than those listed above are excluded from the analysis.

4. Collaborative Care Systems and Service Linkages

Child and Youth Mental Health services operate in a complex, multi-system environment including crucial interactions with Education Queensland,

4 Adolescents aged 14 to less than 18 years admitted to an Adolescent Extended Treatment Centre (ETAIU) vs an Acute Adolescent Inpatient Unit.

Exhibit 17 March 2009

Department of Child Safety, Child Health Services, Juvenile Justice, Disability Services Queensland, Department of Communities, Alcohol Tobacco and Other Drug Services, private providers, non-government organisations disability support providers and others.

Services should be integrated and coordinated, with partnerships and linkages with other agencies for young people and with specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing and coordinating services should be developed.

The Adolescent Extended Treatment Centre will develop service linkages with:

- Acute and ambulatory child and youth mental health services
- Adult mental health services
- Specialist health clinics for the target population e.g. diabetes clinic for children
- Community pharmacies
- Educational providers/schools and Guidance Officers
- GPs and other relevant health service providers
- Private mental health service providers
- Child health and developmental services
- Primary health care providers (including those for Indigenous health)
- Department of Communities (Child Safety Services, Youth Justice and Disability Services)
- Government and non-government community-based youth and family counselling and parent support services

Staffing Structure and Composition:

The Adolescent Extended Treatment Centre is staffed by a multidisciplinary team of clinical and non clinical staff. Treatment and rehabilitation is provided by clinical mental health workers including doctors, nurses and health professionals including occupational therapists, psychologists, social workers and speech pathologists with regular access to a dietitian and exercise physiologist. Additionally, the multidisciplinary team are supported by administrative officers, and catering and security staff who assist with the day to day operations of the unit. Young person and carer consultants and peer support workers should be engaged by the service. *(CSCF Workforce hyperlink).*

The Adolescent Extended Treatment Centre and Education Queensland work collaboratively to ensure the effective provision of resources, enabling a comprehensive and tailored educational program as an essential strategy of rehabilitation.

The effectiveness of the Adolescent Extended Treatment Centre is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The complexity of adolescence mandates the need to provide staff with the opportunity to access continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. The Adolescent Extended Treatment Centre provides clinical placements for

undergraduate students, encouraging rotations through the unit from staff from other areas of the mental health services and supporting education and research opportunities.

A number of roles and duties are generic to all Adolescent Extended Treatment Centre clinical staff. These roles include, but are not limited to:

- Monitoring mental state during activities, monitoring risk and participating in the development of appropriate risk management plans.
- Generalising the gains from a range of individual and group based interventions to assist recovery.
- Engaging and promoting activities which facilitate progress in developmental tasks in conjunction with other staff and service providers.
- Developing individual Recovery Plans in consultation with the other members of the treating team, the adolescent, and the family or carers.
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice.
- Evaluating the evidence for individual and group interventions to develop a continuum of evidence based practice.

The role of the consultant psychiatrist, registrars, and medical officers includes, but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidisciplinary team.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Administering the *MHA 2000* as required under legislation.

The role of nursing staff includes, but is not limited to:

- Providing high quality levels observations of symptom and behavioural changes, risk of harm to self or others, progress in developmental tasks, responses to care, counselling and group interventions, and interactions with parents/carers to formulate appropriate levels of supervision, individual support, medication adjustments, counselling interventions and behavioural management plans.
- Assisting adolescents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety.
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate.
- Implementing and evaluating the effectiveness of nursing interventions as outlined in the Recovery Plan.

- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual Recovery Plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs.
- Providing nursing care for general medical conditions in consultation with appropriate medical teams.
- Communicating with community support services to ensure that adolescents have access to the supports they require.

The role of allied health staff includes, but is not limited to:

- Providing discipline specific individual assessment of the young person's development, progress in developmental tasks and symptoms and behaviours of mental illness.
- Develop discipline specific, cross discipline and generic interventions towards treatment and rehabilitation of the mental illness in the context of impairments in developmental tasks associated with both the mental illness and developmental delays.
- Implementing a range of individual and group based adolescent, parent/carer and family therapy utilising verbal, non-verbal and activity based therapies.

The role of consumer and carer workers includes, but is not limited to:

- Effectively engage young people and carers through appropriate consultation methods, to inform recruitment and selection process, through making effective use of individual's skills, experience and availability. This may include, but is not limited to, young persons and carers serving as members of recruitment and selection panels.
- Effectively engage with adolescents to meaningfully participate in the planning, delivery and evaluation of the services provided by the Adolescent Extended Treatment Centre and identifying areas for improvement.
- Working collaboratively with clinicians to foster a recovery focused service to enhance a positive outcome for the adolescents.

FOI Document 26 March 2009

Performance, Quality and Safety Indicators:

The Adolescent Extended Treatment Centre has not been benchmarked on Key Performance Indicators because of the lack of comparable facilities. The following indicators are adapted from the *Queensland's Mental Health Patient Safety Plan (2008- 2013)* which supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. The following guiding principles are proposed as indicators of performance accountability and quality.

- Service delivery is focused on adolescents and the achievement of positive outcomes.

- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness.
- Practice is improved through a ~~strategic~~ framework of assessment, monitoring, planning, evaluation and follow up.
- Comprehensive, coordinated and individualised care that considers all aspects of the adolescent's recovery is provided.
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible.
- Adolescents, family members, carers and the local community are involved in the planning, development, implementation and evaluation of the mental health service.
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in Recovery Planning, and staff work with them to develop their own supports in their community.
- Strategies such as incident reporting, Root Cause Analysis and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements.
- Participation in professional development activities and demonstration of learning in daily practices.

This service guideline will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017*. The Strategic Policy Unit of the Mental Health Branch is charged with ensuring that the policies and procedures remain relevant and updated.

Key resources:

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*
- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008

- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

For Endorsement - 26 March 2009

Current Description

Consumers engaged with the centre will present with a range of mental health problems and/or disorders, but predominantly, they will have complicated diagnoses associated with mood and anxiety disorders, developmental disorders, language disorders and oppositional defiant disorders. A majority will be diagnosed with parent-child relational problems. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2.

Proposed Description

I'm not sure if this first sentence is necessary. (Adolescents engaged with the Centre will present with a range of mental health problems and/or disorders.) Reasons for admission will include severe and persistent eating disorders, social anxiety disorder, persistent severe recurrent self harm with associated depression, anxiety and PTSD and persistent psychotic disorder. There are usually multiple co-morbidities associated with the primary diagnosis including a range of anxiety disorder, oppositional defiant disorder and developmental disorders including language disorders. A majority will be diagnosed with parent-child relational problems. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2.

Current Description

The centre offers various levels of care from 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to more independent care via a partial hospitalisation or day program, or an outpatient program. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions, and discharge planning to young people and their family/carers.

Proposed Description

The centre currently offers various levels of care from 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program. Transition to the community is facilitated by partial hospitalisation with outpatient follow up available if appropriate. The proposed redevelopment of the Centre will include therapeutic residential and step down accommodation and a family stay unit. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions, and discharge planning to young people and their family/carers.

Model of Service for Mental Health in Queensland

Service Guideline for the ADOLESCENT EXTENDED TREATMENT CENTRE

Service Description and Function:

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

The centre currently offers various levels of care from 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program. Transition to the community is facilitated by partial hospitalisation with outpatient follow up available if appropriate. The proposed redevelopment of the Centre will include therapeutic residential and step down accommodation and a family stay unit. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions, and discharge planning to young people and their family/carers.

Care focuses on the treatment or stabilisation of the symptoms of severe mental illness and aims to develop tailored rehabilitation interventions (psychosocial, educational and vocational programs) to promote progress in developmental tasks appropriate to the adolescent and their illness. The care and discharge planning delivered by the service is facilitated in collaboration with the consumer, their family/carers and a range of key stakeholders and service providers, so as to enable the young person to build on their strengths and maintain and enhance recovery focused outcomes upon discharge.

The service capability of the Adolescent Extended Treatment Centre is defined in the Child and Youth Non-Acute Inpatient sub module of the *Clinical Services Capability Framework (CSCF) - Mental Health Services Module*, which can be found on either the *CSCF* or Mental Health Branch website once endorsement and implementation is complete in early 2010.

Target Population:

The Adolescent Extended Treatment Centre provides specialist multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. All present with co-morbid disorders or developmental delays.

Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at the Adolescent Extended Treatment Centre rather than transferring to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors. Transition to an adult mental health service should involve extensive clinical planning and include the consumer, their family/carers, and all service providers.

The incidence of significant disorders of adolescents admitted 2004 -2009 is provided in Table 1.

Table 1. Adolescent Extended Treatment Centre, Consumer Demographics, 2004-2009

Consumer Demographics[1]	
Mean Age	15.62 years (range 13 – 18).
Gender	44.9% of young persons were male and 55.1% female.
Indigenous Australian	• 95.5% were neither Aboriginal nor Torres Strait Islander • 4.5% were from an Aboriginal and/or Torres Strait Islander background
Mental Health Legal Status	39.3% of young persons were involuntary at some point during their period of care.

Data source: HBISCUS audit of Barrett Adolescent Centre patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

The average length of stay for an adolescent admitted to the Adolescent Extended Treatment Centre is 9.5 months with a median of 7.5 months.

Reasons for admission will include severe and persistent eating disorders, social anxiety disorder, persistent severe recurrent self harm with associated depression, anxiety and PTSD and persistent psychotic disorder. There are usually multiple co-morbidities associated with the primary diagnosis including a range of anxiety disorder, oppositional defiant disorder and developmental disorders including language disorders. A majority will be diagnosed with parent-child relational problems. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2.

Endorsed 16 March 2009

[1] Adolescents aged 14 years to less than 18 years.

Table 2. Adolescent Extended Treatment Centre, Diagnostic Profile[2]

	Percentage	ICD-10 Category Code
Social Anxiety Disorders	51.8%	F20 – F29
OCD and Anxiety Disorders	23.5%	
Eating Disorders	27.1%	
Depression and Dysthymic Disorders	62.4%	
Post Traumatic Symptoms	24.7%	
Schizophrenia	5.9%	
Pervasive Developmental Disorders	20%	
Receptive-Expressive Language Disorders	52.9%	
Other Developmental Disorders	51.8%	
Oppositional Defiant Disorder	50.6%	
Substance Abuse	9.4%	
Disorders with an Organic Origin	3.5%	
Parent child relational disorders	83.5%	

Data source: Chart Review of Patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Diagnosis is that recorded in the Outcomes Information System at the end of episode (movement to other mental health setting and to no further care).

Service Planning Guidelines:

Key stakeholders associated with the *Queensland Plan for Mental Health 2007 – 2017,* in conjunction with service providers and consumers and carers, are leading the redesign and strategic service planning of the Adolescent Extended Treatment Centre.

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

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

Service Delivery Pathway:

Referral

The Adolescent Extended Treatment Centre accepts and prioritises referrals from other Child and Youth Mental Health Service (CYMHS) facilities from across Queensland (community clinics, acute inpatient or day patient units). Under some circumstances, referrals may be accepted from private mental health practitioners. A comprehensive clinical assessment occurs prior to the

[2] Admitted adolescents (aged 13 – 18 years) in 2004 – 09.

decision to admit in order to assess the adolescent's suitability for admission, their potential interactions with other adolescents, and to orientate the adolescent and their family/carers to the service.

Treatment Overview
Based on available clinical information from the referrer and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually two to six weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to assess the levels of acuity and will advise of progress towards admission. Timing of admission is determined by the length of time on the waiting list, the relative acuity of the individual case, and the current mix of adolescents within the unit.

Based on the principles of Recovery, as outlined in the ***Sharing Responsibility for Recovery: creating and sustaining recovery orientated systems of care for mental health*** document, mental health services operate on the premise that most consumers can and do recover[3] from mental illness. Services are directed at helping the consumer (and their family/carers) manage their illness and enhance their capacity for recovery. Importantly, the Adolescent Extended Treatment Centre team considers how the concept of Recovery applies to adolescents and their families/carers. This includes acknowledgement that Recovery should take into account developmental processes, that the concepts of Recovery may also be applied to parents, carers and entire families, and that the mental health field for this consumer group is broader than that for adults (i.e. including prevention and early intervention; a wider range of challenges and disorders, not all of which are mental illnesses; and that the focus should be on promoting the positive potential of all children and adolescents).

An initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission. During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent. These plans reflect phases of an adolescent's admission. They incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Treatment is provided in the least restrictive, most appropriate facility for the required level of care that balances the young person's autonomy with their need for observation and treatment in a safe environment.

[3] It is important to note that some disorders (such as intellectual and developmental disorders) may not be associated with the definition of a 'true' recovery, however, mental health services may still have a role in helping these young people to achieve an optimal level of personal functioning and social participation.

Core Service Provision:

1. Clinical Interventions

A multidisciplinary mental health team in conjunction with the Adolescent Extended Treatment Centre School delivers and coordinates a range of integrated therapeutic, rehabilitation and recovery focused interventions. These interventions focus not only on the symptoms and behaviours associated with severe, persistent mental illness, but also on the reciprocal interactions between these symptoms and behaviours on delays and moratoriums in developmental tasks and specific developmental impairments.

Interventions may be individual, group or generic.

Individualised interventions determined by evidenced based practice include:

- Psychological interventions (verbal and non-verbal therapies and education).
- Pharmacotherapy.
- Family therapy and education.
- Individualised behavioural programs.
- Other biological interventions (e.g. Electro Convulsive Therapy [ECT], psychosurgery).

Interventions delivered in groups include:

- Individual education plans delivered by the Extended Treatment Adolescent Inpatient School (staff employed by Education Queensland).
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include:

- Maintaining a milieu with professional staff so that young people experience an environment consistent with the qualities identified in longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances between staff, consumers and families/carers.
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy
- Encouraging peer support opportunities, where available, for young people and/or families to appropriately engage with past young persons/carers for peer support.

For Endorsement 26 March 2009

The Adolescent Extended Treatment Centre School addresses delays and moratoriums on a number of developmental tasks including education and vocational preparation. Appropriate educational plans are developed after an assessment of the adolescent's educational strengths and difficulties. If a young person is not currently enrolled in an education program, a decision will be made whether to engage an adolescent in a school readiness program, develop a formal educational program with links to external curricula or develop educational strengths to enhance vocational readiness. The school develops a transitional program towards continuing education or workforce participation as part of the Centre's comprehensive discharge planning.

Increased levels of intervention are sometimes necessary for the management of clinical presentations associated with an acute exacerbation of mental illness and behavioural difficulties that increase the risk to themselves or others. These increased levels of interventions are delivered by qualified staff following a comprehensive risk assessment. They may take a number of forms ranging from specific behavioural, activity based or sensorimotor interventions through to increased visual observation and the use of a designated high dependency area through to the potential use of restraint and seclusion. The use of an increased level of intervention is based on clinical need, in order to ensure the safety of the young person as well as the safety of others. The maintenance of basic human rights such as privacy, dignity, cultural background and confidentiality are recognised, respected and promoted in all clinical interventions.

2. Discharge Planning

Discharge planning is a component of each young person's Recovery Plan. Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular variables associated with progress have been assessed. Nevertheless, potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

- Young people are most commonly discharged from the Adolescent Extended Treatment Centre back to their home environment or independent living. Adolescents may transition between the various components of the program to assist the transition and facilitate rehabilitation and recovery goals. Considerable support will still be required on discharge for the young person and their family and/or carers.
-

Adolescent Extended Treatment Centre discharge planning and support for young people includes, but is not limited to:

- Continued engagement of the parent or carer throughout the admission where possible and appropriate with the potential for enhanced care on discharge.
- Assessing the capacity of parents or carers to provide safe, appropriate care. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Facilitating extended periods of leave, and transition to partial hospitalisation, step down facility or day program if appropriate.
- Developing a clear educational or vocational plan which is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Developing linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the

admission. Follow up will be arranged by negotiation with the adolescent and their family/carers, in addition to the referrer, another specialist service or if appropriate, with the limited outpatient service at the Extended Treatment Adolescent Unit.

- Maintaining collaborative relationships with a wide range of service providers including education providers, extended family and carers, general practitioners, general community health services and/or adult mental health services to meet the needs of the young person and enhance their capacity to effectively manage their mental health care needs in a less intensive environment and continue recovery.

3. Expected Clinical Outcomes

All adolescents requiring extended treatment and rehabilitation have severe persistent mental illness, resulting in severe impairment. For most, extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period of time.

Mental health services utilise the *Health of the Nation Outcome Scale for Children and Adolescents* (HoNOSCA) to measure the severity of symptoms and health status of the consumer across 15 broad items. Each item is rated from 0 ("no problem") to 4 ("severe to very severe problem"). These scores can be summed to provide five sub-scales (behaviour problems, impairment, symptomatic problem, social problems and information). Clinicians use this data to record both the complexity of a consumer's episode of illness and to monitor changes in their symptoms and functioning over the period of care. As indicated in Figure 1, CYCMHS consumers will typically present with clinically significant scores in XXX of the sub scales – XXX, XXX, XXX, with an average total score of XXX on admission and XXX on discharge.

.

Figure 1. Adolescent Extended Treatment Centre, Average HoNOSCA Subscale Scores, 2007/2008

Data source: Outcomes Information System

NEED TO ADD THIS TABLE.

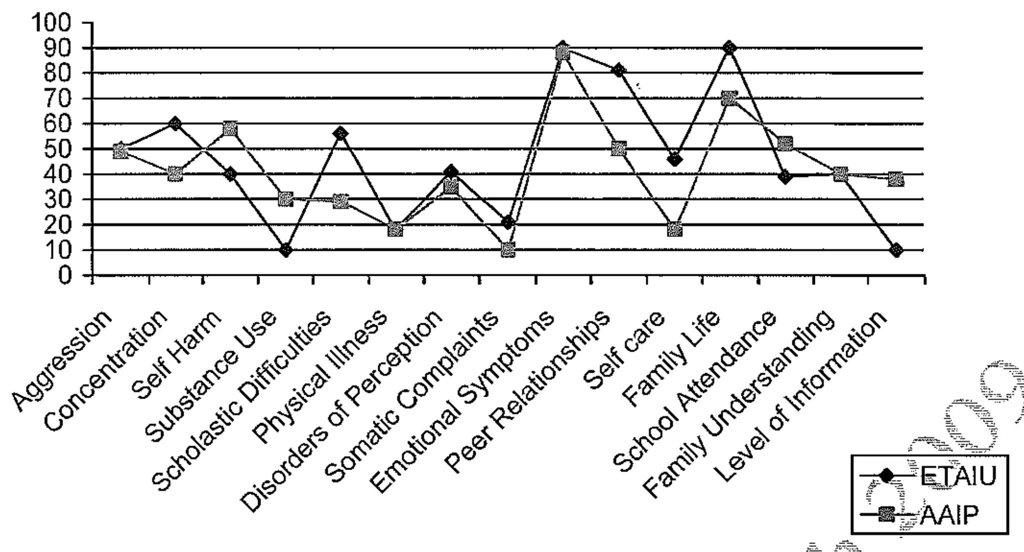
NOTES:

(a) Where an item is scored 7 or 9, for the purpose of this analysis, the score is converted to a zero. However, measures with more than two items, of the first 13 items, rated 7 or 9 are excluded from this analysis. *n* refers to the number of 'valid' collections (that is, measures that have two or less items scored 7 or 9).

(b) 'Max' refers to the maximum possible score for each of the subscales. Caution is required with any graphical representation as the subscales have different denominators and are therefore not strictly comparable.

Turning now to Figure 2 below, a representation of HoNOSCA scores is provided on the 15 items at admission (new collection), review and end (no further care). Consumers of the Adolescent Extended Treatment Centre will present with clinically significant scores on the majority of items.

Figure 2. Clinically Significant HoNOSCA Items (?date) on Admission.[4]



Data source: Outcomes Information System

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Percentage is calculated for each individual item, but only when the scores are between 0 and 4. Measures with a 7 or 9 are excluded from this analysis on an item by item basis, therefore the denominator may change between items.

(c) *n* refers to the number of collections with a score between 0 and 4.

Applicable to ALL HoNOSCA Data (in addition to the specifics listed under each item)

- New Collections is a combination of New Referral and Referral from other mental health services.
- Review Collections is a combination of Standard Review and Ad Hoc Reviews.
- End of Episode due to *no further care* refers to consumers who are discharged from the community service for whom no further treatment or care is planned by the mental health network. Consumers who move to a different health service setting in a different mental health network (for example, a consumer of ambulatory services in Metro South admitted to an inpatient unit in the Gold Coast) are included in the *no further care* analysis.
- Community episodes which end due to *movement to another health service setting* refers to consumers who are admitted to acute or extended treatment service in the mental health network.
- All reasons for ending an episode, other than those listed above are excluded from the analysis.

4. Collaborative Care Systems and Service Linkages

Child and Youth Mental Health services operate in a complex, multi-system environment including crucial interactions with Education Queensland,

[4] Adolescents aged 14 to less than 18 years admitted to an Adolescent Extended Treatment Centre (ETAIU) vs an Acute Adolescent Inpatient Unit.

For Consent ... March 2009

Department of Child Safety, Child Health Services, Juvenile Justice, Disability Services Queensland, Department of Communities, Alcohol Tobacco and Other Drug Services, private providers, non-government organisations disability support providers and others.

Services should be integrated and coordinated, with partnerships and linkages with other agencies for young people and with specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing and coordinating services should be developed.

The Adolescent Extended Treatment Centre will develop service linkages with:

- Acute and ambulatory child and youth mental health services
- Adult mental health services
- Specialist health clinics for the target population e.g. diabetes clinic for children
- Community pharmacies
- Educational providers/schools and Guidance Officers
- GPs and other relevant health service providers
- Private mental health service providers
- Child health and developmental services
- Primary health care providers (including those for Indigenous health)
- Department of Communities (Child Safety Services, Youth Justice and Disability Services)
- Government and non-government community-based youth and family counselling and parent support services

Staffing Structure and Composition:

The Adolescent Extended Treatment Centre is staffed by a multidisciplinary team of clinical and non clinical staff. Treatment and rehabilitation is provided by clinical mental health workers including doctors, nurses and health professionals including occupational therapists, psychologists, social workers and speech pathologists with regular access to a dietitian and exercise physiologist. Additionally, the multidisciplinary team are supported by administrative officers, and catering and security staff who assist with the day to day operations of the unit. Young person and carer consultants and peer support workers should be engaged by the service. *(CSCF Workforce hyperlink).*

The Adolescent Extended Treatment Centre and Education Queensland work collaboratively to ensure the effective provision of resources, enabling a comprehensive and tailored educational program as an essential strategy of rehabilitation.

The effectiveness of the Adolescent Extended Treatment Centre is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The complexity of adolescence mandates the need to provide staff with the opportunity to access continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. The Adolescent Extended Treatment Centre provides clinical placements for

undergraduate students, encouraging rotations through the unit from staff from other areas of the mental health services and supporting education and research opportunities.

A number of roles and duties are generic to all Adolescent Extended Treatment Centre clinical staff. These roles include, but are not limited to:

- Monitoring mental state during activities, monitoring risk and participating in the development of appropriate risk management plans.
- Generalising the gains from a range of individual and group based interventions to assist recovery.
- Engaging and promoting activities which facilitate progress in developmental tasks in conjunction with other staff and service providers.
- Developing individual Recovery Plans in consultation with the other members of the treating team, the adolescent, and the family or carers.
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice.
- Evaluating the evidence for individual and group interventions to develop a continuum of evidence based practice.

The role of the consultant psychiatrist, registrars and medical officers includes, but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidisciplinary team.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Administering the *MHA 2000* as required under legislation.

The role of nursing staff includes, but is not limited to:

- Providing high quality levels observations of symptom and behavioural changes, risk of harm to self or others, progress in developmental tasks, responses to care, counselling and group interventions, and interactions with parents/carers to formulate appropriate levels of supervision, individual support, medication adjustments, counselling interventions and behavioural management plans.
- Assisting adolescents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety.
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate.
- Implementing and evaluating the effectiveness of nursing interventions as outlined in the Recovery Plan.

For Comment 25 March 2009

- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual Recovery Plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs.
- Providing nursing care for general medical conditions in consultation with appropriate medical teams.
- Communicating with community support services to ensure that adolescents have access to the supports they require.

The role of allied health staff includes, but is not limited to:

- Providing discipline specific individual assessment of the young person's development, progress in developmental tasks and symptoms and behaviours of mental illness.
- Develop discipline specific, cross discipline and generic interventions towards treatment and rehabilitation of the mental illness in the context of impairments in developmental tasks associated with both the mental illness and developmental delays.
- Implementing a range of individual and group based adolescent, parent/carer and family therapy utilising verbal, non-verbal and activity based therapies.

The role of consumer and carer workers includes, but is not limited to:

- Effectively engage young people and carers (through appropriate consultation methods) to inform recruitment and selection processes. This may include, but is not limited to, young persons and carers serving as members of recruitment and selection panels or by being involved in staff training where stories of recovery and the consumer/carer lived experience is highlighted.
- Effectively engage with young people and carers to meaningfully participate in the planning, delivery and evaluation of the services provided by the Adolescent Extended Treatment Centre. This should include identifying areas for improvement and what is working well.
- Working collaboratively with clinicians to foster a recovery focused service to enhance a positive outcome for young people and their family/carers.

Performance, Quality and Safety Indicators:

The Adolescent Extended Treatment Centre has not been benchmarked on Key Performance Indicators because of the lack of comparable facilities. The following indicators are adapted from the *Queensland's Mental Health Patient Safety Plan (2008- 2013)* which supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. The following guiding principles are proposed as indicators of performance accountability and quality.

- Service delivery is focused on adolescents and the achievement of positive outcomes.
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness.
- Practice is improved through a framework of assessment, monitoring, planning, evaluation and follow up.
- Comprehensive, coordinated and individualised care that considers all aspects of the adolescent's recovery is provided.
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible.
- Adolescents, family members, carers, referring service providers and the local community of the adolescent are involved in the planning, development, implementation and evaluation of the mental health service.
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in Recovery Planning, and staff work with them to develop their own supports in their community.
- Strategies such as incident reporting, Root Cause Analysis and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements.
- Participation in professional development activities and demonstration of learning in daily practices.

This service guideline will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017.* The Strategic Policy Unit of the Mental Health Branch is charged with ensuring that the policies and procedures remain relevant and updated.

Key resources:

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*

- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

For Endorsement - 26 March 2009

ADOLESCENT INTEGRATED TREATMENT AND REHABILITATION CENTRE
MODEL OF SERVICE GUIDELINE

1. What does the Service intend to achieve?

Mental disorders are the most prevalent illnesses in adolescence. They have the potential to carry the greatest burden of illness into adult life. The Adolescent Integrated Treatment and Rehabilitation Centre (AITRC) is part of the Statewide CYMHS network of Community Teams, Evolve Therapeutic Services, Consultation-Liaison Services and Acute Adolescent Inpatient units.

The key functions of the AITRC are to:

- perform a comprehensive assessment of the adolescent – their strengths, their development to date and previous developmental trajectories, the mental illness and their family or care systems
- provide treatment interventions to alleviate or treat distressing symptoms
- validate strengths and assist progression in developmental tasks which are arrested secondary to the mental illness
- assist the adolescent's reintegration back into the community.

The AITRC offers an extensive range of therapeutic interventions and comprehensive activities to promote development which:

- are developed in partnership with adolescents and where appropriate their parents or carers.
- utilise predominantly specific but also generic multidisciplinary skills
- based on multiple therapeutic approaches which are adapted to longer term interventions
- delivered in a range of contexts including individual, school, community, group and family
- the multiple interventions are integrated and reinforced across settings and across periods of time.

Settings for assessments and interventions vary in the level of care provided. They include inpatient, therapeutic residential, step down and day patient. The level of care is determined by:

- providing care in the least restrictive environment appropriate to an adolescent
- acuity of behaviours associated with the mental illness with respect to safety to self and others
- the ability to care for oneself.
- care systems available for transition to the community
- access to the Centre

In addition the AITRC seeks to:

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services

DRAFT

- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder

2. Who is the Service for?

The AITRC is available for Queensland adolescents

- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- with impaired development secondary to their mental illness
- who have reasonable trials of intervention at local Community, Evolve or Acute Inpatient Child and Youth Mental Health Services, private child and adolescent psychiatrists or psychologists or Headspace services.
- who will benefit from a range of clinical interventions of varying intensity
- who may have behavioural problems, use substances only if these are secondary to their mental illness
- who may have co-morbid mental illness and intellectual impairment

Various processes of assessment (initial referral to the Clinical Liaison Clinical Nurse – CLCN, intake meeting, assessment interview) determine the suitability of admission of the adolescent with respect to the likelihood of

- positive therapeutic outcome and/or
- potential to assist with developmental progression and/or
- potential adverse impacts on the adolescent of being admitted to the unit
- potential adverse impacts on other adolescents if they were to be admitted

Adolescents may continue beyond their 18th birthday if

- continued admission is likely to produce the greatest clinical outcome in terms or symptom reduction and developmental progression
- there is no risk to the safety of other adolescents

Persistent mental illness with severe impairment in adolescents occurs with a number of disorders. Characteristically those referred fall into four broad groups:

- 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
- adolescents who have been unable to attend school for prolonged periods in spite of active community interventions. These may have a range of disorders including Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder.
- Adolescents with persistent depression, usually in the context of childhood abuse. They frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.
- Adolescents with persistent, severe psychoses.

Developmental delays and family difficulties are not uncommon.

DRAFT

3. What does the Service do?

The key components of ACT will be defined here. These components are essential for the effective operation of an ACT service.

Key Component	Key Elements	Comments
WORKING WITH OTHER SERVICE PROVIDERS		
Developing Networks with CYMHS	• The AITRC will develop and maintain strong partnerships with other CYMHS..	• At an organisational level, this includes participation in the Statewide Child and Youth Mental Health Network • In the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AITRC.
Referral, Access And Triage	• Referrals are accepted for planned admissions. Responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the Centre,	• This supports continuity of care for the adolescent.
	• All referrals are made to the Clinical Liaison Clinical Nurse..	• A single point of referral intake ensures consistent collection of adequate referral data, immediate feedback on appropriateness, It expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted.
	• The adolescent is assessed after referral either in person or via videoconference.	• The pre-admission assessment enables adolescent to meet some staff and negotiate their expectations of admission • This assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity.
	• 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 indeed, the need for admission to help determine priorities for admissions. • The Clinical Liaison Clinical Nurse can also advise the referrer regarding the

Key Component	Key Elements	Comments
Referral, Access And Triage (cont'd)		management of adolescents with severe and complex mental illness
	• Priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral.	
Developing Networks with Other Services	• The AITRC will develop and maintain partnerships with other Child and Youth Health Services.	• This includes formal arrangements with medical services for treating medical conditions which may arise • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders
	• The AITRC will develop and maintain partnerships with other agencies who interact with adolescents with severe and complex mental illness	• This includes Child Safety Services, Community Services and Disabilities Queensland.
ASSESSMENTS **Assessments of Mental Health/Illness**	• The AITRC 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	• These assessments begin with collection of information from referrers, the assessment interview and throughout admission.
	• The AITRC will obtain a detailed history of the interventions to date for the mental illness	• This is obtained by the time of admission
Assessments of Family/Carers	• The AITRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care.	• This process begins with the referral and continues throughout the admission
	• Parents/carers should have their needs assessed as indicated or requested	• Parents or carers should be involved in the mental health care as much as possible. Significant effort should be made to support this involvement.
Developmental Assessments	• The AITRC will obtain a comprehensive understanding of developmental disorders and their current impact	• This process begins with available information on referral and during the admission.
	• The AITRC will obtain information on schooling as it is available	• This occurs upon admission

Key Component	Key Elements	Comments
Assessments of Function	• The AITRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• This assessment occurs throughout the admission
Assessments of Physical Health	• Routine physical examination should occur on admission	•
	• Physical health should be monitored throughout the admission	•
	• Appropriate physical investigations should be informed as necessary	•
• Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings		
Assessments of Risk	• Risk assessments should be conducted on admission and then be routine	• All risk assessments should be recorded in the clinical record.
	• Risk assessments should include a formalised suicide risk assessment.	•
General Aspects of Assessment	• All assessment processes should be documented and integrated into the care plan.	•
	• Routine assessments will be prompt and timely.	• All of the initial assessments of mental health, development and family are to be completed within two weeks of admission.
	• *Mental Health Act 2000* assessments should be conducted by Authorised Mental Health Practitioners.	•
	• The outcome of assessments should be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents).	•
	• Assessments of alcohol and drug use should be conducted with the adolescent on admission and routinely throughout ongoing contact with the service.	•
CLINICAL INTERVENTIONS		
Psychotherapeutic Interventions	• Individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• Therapists should receive recognised, specific training in the mode of therapy. • The Therapy is modified according to the capacity fo the adolescent to utilise the therapy, developmental considerations and stage of change in the illness

Key Component	Key Elements	Comments
Psychotherapeutic Interventions (cont'd)		• The therapist should have access to regular supervision • Specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships) • Supportive therapies must be integrated into the overall therapeutic approaches to the adolescent.
	• Individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	• As above
	• Individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	• Used at times when the adolescent is distressed or to generalise strategies to the day to day environment. • Staff undertaking such supportive interventions should receive training in the limited use of specific modalities of therapy. • Staff offering supportive therapy must have access to clinical supervision. • Supportive therapies must be integrated into the overall therapeutic approaches to the adolescent.
	• Psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• As for individual verbal interventions
Behavioural interventions	• Individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• Behavioural program constructed under appropriate supervision • Monitor evidence for effectiveness of intervention.
	• Individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• Review effectiveness of behavioural program at individual and Centre level
	• Group general or specific behavioural interventions	• Monitor evidence for effectiveness of intervention
Psycho-education Interventions	• Includes general specific or general psycho-education on mental illness	•
Family Interventions	• Supportive family interventions to	• Supportive family interventions

Key Component	Key Elements	Comments
Family Interventions (cont'd)	support the family while adolescent is in the Centre, develop conditions of leave etc.	must be integrated into the overall therapeutic approaches to the adolescent. • Includes psycho-education for parents/carers
	• Family therapy as appropriate	• Therapist should have recognised training and supervision in family therapy • Therapist should have access to continuing supervision • Review evidence for effectiveness of the intervention • Family therapy must be integrated into the overall therapeutic approaches to the adolescent
	• Monitoring mental health of parent/carer	• Support for parent/carer to access appropriate mental health care
	• Monitor risk of abuse or neglect	• Fulfil statutory obligations if abuse or neglect detected
	• Promote qualities of care which enable reflection of qualities of home	• Review of interactions with staff • Support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• Milieu based interventions to promote appropriate development	•
	• School based interventions to promote learning, educational or vocational goals and life skills	•
	• Individual based interventions to promote an aspect of adolescent development	•
	• Group based interventions to promote aspects of adolescent development	• Individualised according to adolescents in the group • Goals to be defined • Under the clinical direction of a nominated clinician
Pharmacological Interventions	• Administration of psychotropic medications under the direction of the consultant psychiatrist	• Education given to the adolescent and parent(s)/carer about medication and potential adverse effects • Regular administration and supervision of psychotropic medications • Regular monitoring for efficacy and adverse effects of psychotropic medications.
	• Administration of non-psychotropic	• Includes medications for

Key Component	Key Elements	Comments
	medications under medical supervision.	general physical health
Other Interventions	• Multi-sensory Room	• Utilised under the supervision of trained staff • Monitor evidence of effects
	• Electroconvulsive Therapy	• Administered in accord with the *Mental Health Act 2000*
CLINICAL CARE COORDINATION AND REVIEW		
Care Coordination	• A Care Coordinator will be appointed prior to admission so that the adolescent and their parent(s)/carer can be orientated to the Centre on admission.	•
	• The Care Coordinator will monitor mental state and level of function in developmental tasks	•
	• The Care Coordinator will help the adolescent to identify goals for the care plan and subsequently implement them during their admission.	•
	• The Care Coordinator will be the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process.	•
	• The Care Coordinator will assist the adolescent in implementing strategies from individual and group interventions in daily living	•
	• The Care Coordinator will provide a detailed report of the adolescent's progress for the Care Planning meeting.	•
Care Monitoring	• The adolescent should be monitored regularly during the week by the Registrar and Care Coordinator with respect to mental state, progress and levels of care and supervision required.	• The frequency of monitoring will depend on the levels of acuity • This monitoring must integrate information from individual and group interventions and observations.
	• Adolescents at high risk and require higher levels of observations will be reviewed daily.	• This includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist.
Case Review	• The Case Review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• The Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed. • The adolescent, referring

Key Component	Key Elements	Comments
		agencies and other stakeholders are invited to participate in the Case Review process.
	• All members of the Clinical Team who provide interventions for the adolescent will have input into the Case Review	• The consultant psychiatrist will chair the Case Review meeting. • Documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions.
	• Ad hoc case review meetings may be held at other times if clinically indicated	• These will be initiated after discussion at the Case Conference or at the request of the adolescent
	• Progress and outcomes will be monitored at the Case Review meeting	• This should include consumers and carers where possible. • Appropriate structured assessments should be utilised. Some components of the process should include objective measures. • Annual audits should ensure that reviews are being conducted.
Case Conference	• A weekly Case Conference will be held to integrate information from and about the adolescent and the range of interventions that have occurred, and to review progress within the context of the Care Plan.	• A consultant psychiatrist should be in attendance at every multidisciplinary team meeting.
	• Risk assessments will be updated as necessary in the Case Conference	• The frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed
Record Keeping	• All contacts, clinical processes and care planning should be documented in the adolescent's clinical record.	• Progress notes should be consecutive within the clinical record according to date
	• Clinical records should be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes.	• Personal and demographic details of the adolescent, their parent/carer(s) and other health service providers should be up to date.
	• There should be a single written clinical record for each adolescent.	• The written record should align with any electronic record.
	• All case reviews should be documented in the adolescent's clinical record.	• Actions should be agreed to and changes in treatment discussed by the whole team

Key Component	Key Elements	Comments
		and recorded.
CONTINUITY OF CARE AND DISCHARGE PLANNING		
Continuity of Care	• Referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• Referrers and significant stake holders are invited to participate in the Case Review meetings. • The Care Coordinator will liaise more frequently with others as necessary.
	• Specifically defined joint therapeutic interventions between the AITRC 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 AITRC and external clinician can be established
	• Responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• This will be negotiated between the AITRC and the local CYMHS.
Discharge Planning (cont'd)	• Discharge planning can begin where an adolescent's therapeutic and developmental progress give clear indication of future directions	• The adolescent is actively involved in discharge planning. • Discharge planning may begin at an earlier stage if there are probably significant obstacles e.g. accommodation, engagement with another Mental Health Service
	• Discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• The AITRC School will be primarily responsible for and support school reintegration
	• Discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge.	• The Registrar and Care Coordinator will prepare this letter. • It should identify relapse patterns and risk assessment/ management information. • Follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter.
	• A further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AITRC	• This will be prepared by the clinicians involved in direct Interventions
	• If events necessitate an unplanned discharge, the AITRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord	•

Key Component	Key Elements	Comments
	with their risk assessments. In the event of discharge the AITRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	
TEAM APPROACH	• A multidisciplinary team approach will be provided utilising the specific skills of each discipline • Clear clinical and corporate leadership will be provided for the team. • Case loads should be managed to ensure effective use of resources and to support staff. • Staff employed by the Department of Education and Training will be regarded as part of the team	• The majority of clinical cases will be known to the majority of team members. • • •

4. Service and operational procedures

The AITRC will function best when:

- There is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff.
- Strong internal and external partnerships are established and maintained.
- Clear and strong clinical and operational leadership roles are provided.
- Team members are fully integrated.

Caseload

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

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

Staffing

The staffing establishment will incorporate the skills of psychiatry, nursing, psychology, social work, occupational therapy, and speech pathology. 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 AITRC.

All permanently appointed medical and senior nursing staff be appointed (or working towards becoming) Authorised Mental Health Practitioners.

DRAFT

Hours of Operation

- Access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
- Nursing staff are rostered to cover shifts 24 hours, 7 days a week.
- The consultant psychiatrist is rostered on-call and accessible 24 hours, 7 days per week.
- Crisis support to adolescents on leave is available 24 hours, 7 days a week. A mobile response will not be available.
- Routine assessments and interventions will be scheduled during business hours 7 days.

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

Written, up to date policies should outline procedures for managing different levels of risk (e.g. joint visiting). Staff safety should be explicitly outlined.

Staff Training

Consumers and carers should be involved in the delivery of staff training.

Training should include:

- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.);
- medication management;
- use of the *MHA 2000*;
- engaging and interacting with other service providers; and
- risk and suicide assessment and associated planning.

5. Clinical and corporate governance

The consultant psychiatrist has the final point of clinical decision making and clinical accountability.

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 and an. They will meet regularly in meetings chaired by the Consultant Psychiatrist.

The Centre will be responsible to the Corporate Governance of the Health District to which it belongs. If the primary Mental Health Service administering Mental Health Services in this Health District is an Adult Mental Health Service, they must at all times consult with the Child and Youth Mental Health Services of the Queensland Children's Health Service District regarding administrative and governance issues as this is a Level 6 Service for Young People.

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

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

7. How do Services relate to each other?

The AITRC is part of the CYMHS network of services in Queensland as described in Section 3

8. How do consumers and carers improve our Service?

*General statements re this issue (e.g. service planning, service development, service evaluation, input into own clinical care etc) will be made in Intro / overview of the MOS Framework.
*Any specific to ACT?

9. What ensures a safe, high quality Service?

*General statements re this issue (e.g. regular audits, participation in clinical and consumer outcomes) will be made in Intro / overview of the MOS Framework.
*Any specific to ACT?

The AITRC is mapped within the Clinical Services Capability Framework (v 3, 2010) as Level 6

10. Key resources and further reading

*General – MHA 2000, etc.
*Any specific to ACT?

DRAFT

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

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

Model of Service

1. What does the Service intend to achieve?

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

The Child and Youth Mental Health Service (CYMHS) Adolescent Extended Treatment and rehabilitation Centre (AETRC) is a statewide service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of 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.

The key functions of the AETRC are to:

- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- provide individually tailored evidence based treatment interventions This phrase persists in spite of the fact that evidence based treatment interventions for the disorders we see are scant. An alternate phrase is "provide multiple individually tailored reocgnised therapeutic approaches which are adapted to longer term interventions according to evidence based practice." to alleviate or treat distressing symptoms and promote recovery
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide a 6 month targeted and phased treatment program

4 simple questions.

1. What currently prevents adolescents in being discharged in under 6 months?
2. Are services ready to cope with an early discharge?
3. What will be the impact on an adolescent?
4. What resources are necessary to make this happen? that will ultimately assist recovery and reintegration back into the community

- provide day programs that will provide adolescents with skills to reintegrate back into their community

Treatment programs undertaken by the AETRC will include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery Is recovery an appropriate term in adolescence? 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.

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 6 month treatment As above incorporating a range of therapeutic interventions delivered by appropriately trained staff
- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family
- the multiple interventions are integrated and reinforced across settings and across periods of time. (This is a key component of what must happen, and what makes it different to other CYMHS settings.)
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services

Length of Admission:

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

Level of Care:

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- who have impaired development secondary to their mental illness

- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including mental illness and intellectual impairment

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

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

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

3. Adolescents diagnosed with complex post traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system. This appears to overlap considerably with 1.

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

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Community treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AITRC. What if the adolescent lives in a rural area, and thas been managed between a community CYMHS without specialist eating disorder experience Previous hospital admissions for treatment of the eating disorder may why may? I cannot think of any who have not had extensive periods of hospitalisation totalling 9 – 12 months or more prior to admission 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. Is this always necessary? Adolescents requiring nutritional resuscitation will be referred to QCH. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility. (Comment: Depending on clinical governance arrangements yet to be determined and negotiations with QCH in regard to medical management of adolescent mental health clients)

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

- Senior staff of the AETRC

- referring specialist and/or Team Leader
- representative from the QCH CYMHS (interim arrangements may exist) This must be a designated QCH CYMHS Liaison Person, so that they don't sit in isolation from the unit some 20 kms away with no idea of the unit and whether or not adolescents will benefit.
- AETRC School Principal or their designatge
- other identified key stakeholders

In making a decision the panel will consider the:

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

A comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents. Should a statement be included for those adolescents whose trajectory once admitted does not fit the comprehensive recovery and discharge plan?

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

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

Admission Risks

Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.
Admission risks include but are not restricted to:

- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder
- adolescents with severe and persistent substance use

3. What does the Service do?

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

The key components of AETRC are defined below:

Key Component	Key Elements	Comments

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
Working with other service providers	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with QCH and relevant adult health services to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; Surgical management of severe lacerations or burns from self injury • this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • this includes but is not limited to The Department of Communities (Child Safety), The Department of Communities (Disability Services) and The Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of suspected abuse or harm	• AETRC staff will comply with Queensland health (QH) policy regarding mandatory reporting of suspected abuse or harm
Referral, Access and Triage	• Statewide referrals are accepted for planned admissions	• this supports continuity of care for the adolescent
	• responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on

Key Component	Key Elements	Comments
		appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
Referral, Access and Triage		• this process monitors changes in acuity and the need for admission to help determine priorities for admissions
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	

Key Component	Key Elements	Comments
Assessments **Mental Health Assessments**	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Family/Carers Assessments	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the	• this process begins with the referral and continues throughout the admission

Key Component	Key Elements	Comments
	adolescent is in care	
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible • significant effort should be made to support the involvement of parents/carers
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	
Developmental Assessments	• the AETRC will obtain a comprehensive understanding of developmental disorders and their current impact	• this process begins with available information on referral and during the admission
	• the AETRC will obtain information on schooling as it is available	• this occurs upon admission
Assessments of Function	• the AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• this assessment occurs throughout the admission
Physical Health Assessments	• routine physical examination will occur on admission • physical health is to be monitored throughout the admission • appropriate physical investigations should be informed as necessary	
Risk Assessments	• a key function of the panel will be to assess risk prior to admission • risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA)
	• documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of	• assessment timeframes	• routine assessments will be

Key Component	Key Elements	Comments
Assessment		prompt and timely • initial assessments of mental health, development and family are to be completed within two weeks of admission
	• Communication	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	• Care Plans	• all assessment processes will be documented and integrated into the care plan
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service

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

Key Component	Key Elements	Comments
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies

Clinical

Key Component	Key Elements	Comments
Interventions		
Psychotherapeutic	• individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships)
Psychotherapeutic	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	• supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	• used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• as for individual verbal interventions
Behavioural interventions	• individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• behavioural program constructed under appropriate supervision • monitor evidence for effectiveness of intervention
	• individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• review effectiveness of behavioural program at individual and Centre level
	• group general or specific	• monitor evidence for

Key Component	Key Elements	Comments
	behavioural interventions	effectiveness of intervention
Psycho-education Interventions	• includes general specific or general psycho-education on mental illness	• available to adolescents and their parents/carers
Family Interventions	• family interventions to support the family/carer while the adolescent is in the AETRC	• supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent • includes psycho-education for parents/carers
Family Interventions	• family therapy as appropriate	• therapist will have recognised training in family therapytherapists will have access to continuing supervision • review evidence for effectiveness of the intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer	• support for parent/carer to access appropriate mental health care
	• monitor risk of abuse or neglect	• fulfil statutory obligations if child protection concerns are identified
	• promote qualities of care which enable reflection of qualities of home	• review of interactions with staff • support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• interventions to promote appropriate development in a safe and validating environment	• This includes attention to all aspects of the environment, routines and programs in which the adolescent spends their time
	• school based interventions to promote learning, educational or vocational goals and life skills • individual based interventions to promote an aspect of adolescent development	

Key Component	Key Elements	Comments
	• group based interventions to promote aspects of adolescent development which may include adventure based and recreational activities, I am not sure why these particular group programs are singled out above any others. I did not include them originally for that reason – they are some of a suite of group programs to promote aspects of adolescent development	• individualised according to adolescents in the group • goals to be defined • under the clinical direction of a nominated clinician
Pharmacological Interventions	• administration of psychotropic medications under the direction of the consultant psychiatrist	• education given to the adolescent and parent(s)/carer about medication and potential adverse effects • regular administration and supervision of psychotropic medications • regular monitoring for efficacy and adverse effects of psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff • monitor evidence of effects
	• electroconvulsive therapy	• a rarely used intervention, subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*
Care Coordination **Clinical care coordination and review**	• prior to admission a Care Coordinator will be appointed to each adolescent The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • monitoring the adolescent's mental state and level of function in developmental tasks • assisting the adolescent to identify	• the Care Coordinator can be a member of the treating team and is appointed by the AITRC director • an orientation information pack will be available to adolescents and their parent(s)/carer(s)

Key Component	Key Elements	Comments
	and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	
Care Monitoring	• providing a detailed report of the adolescent's progress for the care planning meeting	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations
	• adolescents at high risk and require higher levels of observations will be reviewed daily	• this includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist
Case Review	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed • the adolescent, referring agencies and other key stakeholders will participate in the Case Review process
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include adolescents and carers • appropriate structured assessments will be utilised • the process will include objective measures • annual audits will ensure that

Key Component	Key Elements	Comments
		reviews are being conducted
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan	• a consultant psychiatrist should be in attendance at every case conference
	• risk assessments will be updated as necessary in the case conference	• the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • risk will be reviewed weekly or more frequently if required
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record	• progress notes will be consecutive within the clinical record according to date
	• clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes	• personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date
	• there will be a single written clinical record for each adolescent	• the written record will align with any electronic record
Record Keeping	• all case reviews will be documented in the adolescent's clinical record	• actions will be agreed to and changes in treatment discussed by the whole team and recorded
Discharge Planning	• discharge planning should begin at time of admission with key stakeholders being actively involved.	• the adolescent and key stakeholders are actively involved in discharge planning • discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service
	• discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• the AETRC School will be primarily responsible for and support school reintegration

Key Component	Key Elements	Comments
	• discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge	• the Registrar and Care Coordinator will prepare this letter • it should identify relapse patterns and risk assessment/ management information • follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter
	• a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AETRC	• this will be prepared by the clinicians involved in direct Interventions
	• if events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments	
	• in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	
Transfer	• depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit • transfer to an adult inpatient unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs	
Continuity of Care	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings • the Care Coordinator will liaise more frequently with others as necessary
Team Approach	• specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated	• joint interventions can only occur if clear communication between the AETRC and

Key Component	Key Elements	Comments
	either when the adolescent is attending the Centre or on periods of extended leave	external clinician can be established
	• responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• this will be negotiated between the AETRC and the local CYMHS
	• case loads should be managed to ensure effective use of resources and to support staff	
	• staff employed by the Department of Education and Training will be regarded as part of the team	

4. Service and operational procedures

The AETRC will function best when:

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

Caseload

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

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

Staffing

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

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

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

Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

This section requires further thought and development, since there is a lead in of 18 – 24 months. I would divide training into 3 broad areas.

- Mandatory training (fire, ABM, resus etc)
- Generic CYMHS training
- Training specific to the AETRC. This is a Level 6 facility requiring a range of specialist expertise. I have introduced components of the training Section from QNIC standards which are relevant to this. In addition, there are specific skills which I believe we need to have.

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

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

Training will include:

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)

- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Below are criteria from the QNIC standards for Staffing and Training. There are overlaps with one or two of the above, but still sufficiently different to be left as separate items for discussion.

- Formal knowledge of aetiology, symptoms and a range of relevant conditions
- The nature and development of the therapeutic environment for children and young people *including opportunities for developmental enhancement and understanding interactions within the unit. (The latter phrases are italicised because they are my paraphrase.*)
- Managing relationships and boundaries between young people and staff, including appropriate touch
- The role of other services and the range of local services and activities
- Members of the nursing team including all newly appointed senior nurse managers, have undertaken further training in child and adolescent mental health
- Working with young people with learning disabilities visual impairment, hearing problems, physical disability and physical illness alongside mental health problems
- Working with young people with co-morbid substance abuse and mental health problems
- Audit skills
- Research skills
- Unit managers have had further training in management and team leadership
- All staff, including temporary staff, have a comprehensive induction which covers key aspects of care (e.g. observation, child protection) before they can have unsupervised access to the young people
- Supervision is included in the job description of every member of the MDT
- Units have a dedicated Human Resources contact who understands the nature of the service
- Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year

In addition to these, there are core skills which I believe it is essential for staff to possess. Generic skills (for all staff) – making systematic observations, principles of behaviour therapies, components of evidence based practice, implementing evidence based practice. Specialty skills (for core groups of staff) – motivational enhancement in eating disorders, dietetics with eating disorders, working through dissociative episodes, using expressive therapies (eg art, sand play) in times of distress, multisensory room interventions, adventure therapy and recreational enhancement. These specialty skills should be listed out with the sentence below. Listing specialty needs/specific therapies in detail is necessary to develop the necessary expertise to provide effective interventions for adolescents with severe and complex mental illness who require a Level 6 facility.
Where specific therapies are being delivered staff will be trained in the particular modality of the therapy e.g. family therapy, cognitive therapies. (All staff should understand the principles of behaviour programs including exposure, desensitisation, reinforcement and

extinction. However cognitive therapy now encompasses a broad range of therapy which is developing all the time

5. Clinical and corporate governance

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

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

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

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

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

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

7. How do Services relate to each other?

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

8. How do adolescents and carers improve our Service?

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

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

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

9. What ensures a safe, high quality Service?

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

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

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

Legislative Framework:

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

10. Key resources and further reading

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

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

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

Model of Service

1. What does the Service intend to achieve?

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

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

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

The key functions of the AETRC are to:

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

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

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff

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

Length of Admission:

- admissions will be individually planned
- in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission.

Level of Care:

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

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

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

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

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

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

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. 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 Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- 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

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

3. What does the Service do?

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

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
Working with other service providers	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with Metro South 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, • Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition,

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

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

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

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

Key Component	Key Elements	Comments
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service

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

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

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

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

Key Component	Key Elements	Comments
		psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff • monitor evidence of effects
	• electroconvulsive therapy	• a rarely used intervention, subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*
Care Coordination **<u>Clinical care coordination and review</u>**	• prior to admission a Care Coordinator will be appointed to each adolescent The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • monitoring the adolescent's mental state and level of function in developmental tasks • assisting the adolescent to identify and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	• the Care Coordinator can be a member of the treating team and is appointed by the AITRC director • an orientation information pack will be available to adolescents and their parent(s)/carer(s)
<u>Care Monitoring</u>	• providing a detailed report of the adolescent's progress for the care planning meeting	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations
	• adolescents at high risk and require higher levels of observations will be reviewed daily	• this includes daily reviews by the registrar, and twice weekly reviews by the consultant

Key Component	Key Elements	Comments
		psychiatrist
Case Review	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed • the adolescent, referring agencies and other key stakeholders will participate in the Case Review process
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include consumers and carers • appropriate structured assessments will be utilised • the process will include objective measures • annual audits will ensure that reviews are being conducted
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan	• a consultant psychiatrist should be in attendance at every case conference
	• risk assessments will be updated as necessary in the case conference	• the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • risk will be reviewed weekly or more frequently if required
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record	• progress notes will be consecutive within the clinical record according to date
	• clinical records will be kept legible and up to date, with clearly	• personal and demographic details of the adolescent, their

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

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

4. Service and operational procedures

The AETRC will function best when:

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

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

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

Staffing

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

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

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

Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

- written, up to date policies will outline procedures for managing different levels of risk (e.g. joint visiting)
- staff safety will be explicitly outlined in risk assessment policy

- risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team

Staff Training

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

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

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

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

5. Clinical and corporate governance

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

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

The Centre will be directly responsible to the corporate governance of the Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. Interim line management arrangements may be required.

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services

- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC.

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

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

7. How do Services relate to each other?

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

8. How do consumers and carers improve our Service?

Consumers and carers will contribute to continued practice improvement through the following mechanisms:

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

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

9. What ensures a safe, high quality Service?

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

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

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

Legislative Framework:

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

10. Key resources and further reading

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

- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

C:\Users\lewisem\AppData\Local\Temp\2\ttwntikw\AETRC MOSD final draft.doc

Adolescent Extended Treatment & Rehabilitation Centre Model of Service

DRAFT

Queensland Public Mental Health Services

Draft Model of Service
Author: C & Y Sub Network – BAC Review Work Group
Additional questions for Trevor Sadler by Bernice Lendich
17/02/2016

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

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.

The key functions of an AETRC are:

- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care.
- Individually planned admissions.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- provide individually tailored evidence based treatment interventions to alleviate or treat distressing symptoms and promote recovery
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide a 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community

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 AETRC functions contribute to:

- targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff (in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission).
- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

The AETRC will be able to:

- provide care in the least restrictive environment appropriate to the adolescent's developmental stage
- provide varying levels of care on the basis of acuity of mental illness associated behaviours; 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
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including 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 the QCH CYMHS (interim arrangements may exist)
- 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.

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

The 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. • Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc. • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	3.1.4 AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect.	• Mandatory child protection reporting of a reasonable suspicion of child abuse and neglect. Hyperlink to: • 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]. child safety policy

Key component	Key elements	Comments
		[http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf]
	3.1.5 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. Hyperlinks to: • interpreter services [http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp] • hearing impaired/deafness [http://www.health.qld.gov.au/pahospital/mentalhealth/docs/damh_con_info.pdf] • transcultural mental health [http://www.health.qld.gov.au/pahospital/qtmhc/default.asp] • Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 [http://qheps.health.qld.gov.au/atsihb/docs/atsiccf.pdf] • Indigenous mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/indigenous.asp] • multicultural mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/multicultural.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	• A single point of referral intake ensures consistent collection of

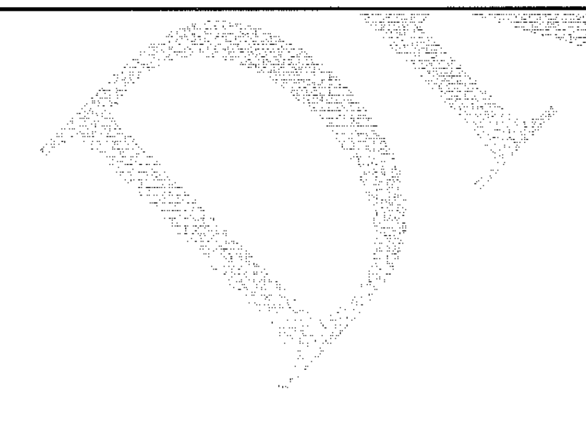
Key component	Key elements	Comments
	Liaison, Clinical Nurse and processed through the intake panel.	adequate referral data and immediate feedback on appropriateness.
	3.2.4 The adolescent is assessed after referral either in person or via videoconference.	• The pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission. • 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. • 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. • 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 **Assessment**	**3.3.1** Assessments will be prompt and timely.	• Initial assessments of mental health, development and family are to be completed within two weeks of admission. Hyperlink to: • mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm] • All assessment processes will be documented and integrated into the care plan. Hyperlink to:

Key component	Key elements	Comments
		• child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf] • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian, and other stakeholders (with consent of the adolescent) Hyperlink to: • *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • carers matter [http://www.health.qld.gov.au/mhcarer/].
	3.3.2 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 Mental Health Assessment	**3.4.1** 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. • mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm] • adolescent assessment form child and youth [http:qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_conass.pdf].
	3.4.2 The AETRC intake panel 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 *Mental Health Act 2000* assessments will be conducted by	Hyperlink to: • *Mental Health Act 2000* [http://www.legislation.qld.gov.au/

Key component	Key elements	Comments
	Authorised Mental Health Practitioner and/or authorised doctor.	LEGISLTN/CURRENT/M/MentalHealA00.pdf].
3.5.0 Family/Carers Assessment	**3.5.1** 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 Developmental Assessment	**3.6.1** 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 The AETRC will obtain information on schooling as it is available.	• This occurs upon admission.
3.7.0 Functional Assessment	**3.7.1** 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 Physical and Oral Health Assessments	**3.8.1** Routine physical examination will occur on admission.	• Appropriate physical investigations should be informed as necessary. Hyperlink to: • physical examination and investigations form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_physical.pdf]. Link to: metabolic monitoring form
	3.8.2 Physical and oral health will be routinely assesses and monitored throughout the admission. Additional resources, education and training to improve the physical and oral health management of adolescents with mental illness is available at: Hyperlink to: • activate: mind & body [http://www.activatemindandbody.com.au/]	• Documented evidence of the physical and oral health assessment will be included in the adolescent clinical record. • Outcomes of physical health assessments will be incorporated in recovery planning. • All efforts will be made to ensure 100% of adolescents have a nominated GP. • Potential physical and oral health problems will be identified and discussed with the GP and/or other primary health care provider
3.9.0	**3.9.1**	• All risk assessments will be

Key component	Key elements	Comments
Risk Assessments	A key function of the panel will be to assess risk prior to admission. **3.9.2** 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.	recorded in the patient charts and electronic clinical record (CIMHA). • Risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation. • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents) Hyperlink to: • CYMHS Risk Screening Tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf] • Documentation of all past history of deliberate self harm will be included in assessment of current risk. • Will include a formalised suicide risk assessment. • 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 **Alcohol and Other Drug**	**3.10.1** Assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service.	Hyperlink to: • Drug Assessment Problem List [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_drug.pdf] • dual diagnosis policy 2008 [http://www.health.qld.gov.au/mh/docs/ddpolicy_final.pdf]. • Interventions range from evidenced for substance use disorders to treatment of primary mental illness 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. • Continual monitoring and review of the adolescent's progress

Key component	Key elements	Comments
		towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies. • recovery plan [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_recplan.pdf]. • 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. • The therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness. • The therapist will have access to regular supervision.

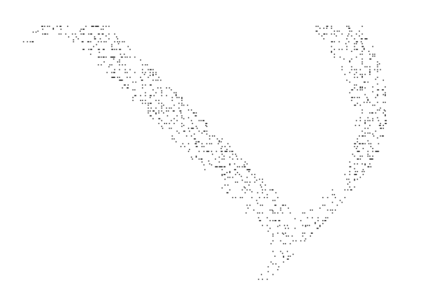


Key component	Key elements	Comments
3.13.0 Psychotherapeutic Interventions	**3.13.1** Psychotherapeutic Interventions can include: • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy) • individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.) • 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) • 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). • Supportive therapies will be integrated into the overall therapeutic approaches to the adolescent. • Can be used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision
3.14.0 Behavioural Interventions	**3.14.1** Behavioural Interventions can include: • individual specific behavioural intervention (e.g. desensitisation program for anxiety) • individual general behavioural interventions to reduce specific behaviours (e.g. self harm) group general or specific behavioural interventions	• Behavioural programs are constructed under appropriate supervision. • Evidence for effectiveness of intervention will be monitored. • Effectiveness of behavioural program at individual and Centre level will be reviewed.
3.15.0 Psycho-education interventions	**3.15.1** Psychoeducation includes general specific or general psycho-education on mental illness.	• Available to adolescents and their parents/carers
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: - psycho education for parents/carers - monitoring of mental health of parents/carers and supporting access to appropriate mental health care as needed - monitoring the risk of abuse or neglect, and fulfilling statutory obligations if child protection concerns are identified - promoting qualities of care which

Key component	Key elements	Comments
		enable reflection of qualities of home - support clinicians in reviewing interactions with and attitudes towards adolescents. • 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. • 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. • Interventions are provided under the clinical direction of a nominated clinician and have defined goals.
3.18.0 **Pharmacological Interventions**	**3.18.1** Medication will be administered, prescribed and monitored as indicated by clinical need, and will involve shared decision making processed between the treating team and the adolescent and their family/carers. - Administration of psychotropic medications will occur under the direction of the consultant psychiatrist. - Administration of non-psychotropic medications (including medications for general health) will occur under medical supervision	• Across all treatment settings all prescriptions, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards. Hyperlink to: • National Inpatient Medication Chart [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/D0DABD9912D44A14CA257516000FDABB/$File/20795.pdf]. • clinical guidelines [http://qheps.health.qld.gov.au/mentalhealth/guidelines.htm]. • medication liaison on discharge [http://qheps.health.qld.gov.au/medicines/documents/general_policies/medic_liaison_discrg.pdf]. • safe medication practice unit

Key component	Key elements	Comments
		[http://qheps.health.qld.gov.au/medicines/]. • therapeutic guidelines-psychotropic [https://online-tg-org-au.cknservices.dotsec.com/ip/]. • Queensland Health Medication Management Plan [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/0AAD5CC37045BF99CA257751001C2543/$File/medicationsafetyplan.PDF] • Education is given to the adolescent and parent(s)/carer about medication and potential adverse effects. • The medication goals of the adolescent/guardian will be integrated with evidence based clinical treatment guidelines. • Where needed, strategies focussed on medication adherence will be in place. • Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment. • Regular administration and supervision of psychotropic medications occurs.
3.19.0 **Other Interventions**	**3.19.1** 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. **3.19.2** 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. • Effectiveness of the approach is monitored. • ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000* *Hyperlink to:* • electroconvulsive therapy guidelines [http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf].
3.20.0	**3.20.1**	• The Care Coordinator can be a

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



Key component	Key elements	Comments
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. • 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. • Outcome measures and the adolescent's progress will be reviewed. • The summation should include attendees, clinical issues raised, treatment care plan, requirements for additional collateral and those responsible for actions. • The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed • The adolescent, referring agencies and other key stakeholders will participate in the Clinical Review process. • All members of the clinical team who provide interventions for the adolescent will have input into the case review. • The consultant psychiatrist will chair the case review meeting and take responsibility for ensuring that assessments and management plans are adequate, and for decisions taken during formal case reviews. • 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. Hyperlink to: • Clinical Incident management

Key component	Key elements	Comments
		implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf]. • child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf] • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • 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. **3.23.2** All clinical record keeping will comply with legislative and local policy requirements	Hyperlink to: • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • progress notes will be consecutive within the clinical record according to date • personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date • clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes • all contacts, clinical processes and care planning, including case review, will be documented in the adolescent's clinical record • there will be a single clinical record for each adolescent which will align with any electronic record Hyperlink to: • retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf].

Key component	Key elements	Comments
		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 • Results of routine outcomes data will be discussed with adolescents and their family/carers to consider and monitor changes in symptoms and functioning • 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 at time of admission 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. • 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	• The AETRC School will be primarily responsible for and support school reintegration.
	3.24.3 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 and Care Coordinator 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. • Follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure discharge information was received. • Discharge summary should identify relapse patterns and risk assessment/ management information. • this will be prepared by the

Key component	Key elements	Comments
		clinicians involved in direct Interventions
	3.24.4 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** 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. • 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. • The AETRC will ensure adolescents have appropriate accommodation to be discharge to, and that external services will follow up in a timely fashion.
	3.25.2 Depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit.	• Transfer procedures will be discussed with adolescents, their family and carers. • Processes for admission into an adolescent acute inpatient unit will be followed, with written and verbal handover provided.
	3.25.3 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.	• Transfer procedures will be discussed with adolescents, their family and carers. • 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** 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 • The Care Coordinator will liaise more frequently with others as necessary
	Responsibility for emergency contact will be clearly defined when	• This will be negotiated between the AETRC and the local CYMHS

Key component	Key elements	Comments
	an adolescent is on extended leave.	
	3.27.2 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 • An example would include the referrer providing parent support while the adolescent is in the AETRC
3.27.0 **Team Approach**	**3.27.1** A multidisciplinary team approach to care is provided.	• Adolescents and family/carers will be informed of the multidisciplinary approach to mental health care on admission to AETRC. • The discipline specific skills of the multidisciplinary team will be utilised as appropriate in all aspects of service provision.
	3.27.4 Staff employed by the Department of Education and Training will be regarded as part of the team.	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** Adolescents and carers will contribute to continued practice improvement of the service.	• This will occur via: -consume and carer participation in collaborative treatment planning - adolescent and carer feedback tools - adolescent and carers will inform staff training.
	3.28.2 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. • 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. • Adolescent/guardian consent to disclose information to and to involve the family/carers in the care will be sought in every case. Hyperlink to: • <u>*Health Services Act 1991*: Confidentiality Guidelines</u> [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_gui

Key component	Key elements	Comments
		delines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf]. • Decision making for children and young people [http://www.childsafety.qld.gov.au/right-to-information/publications/viewpublication.aspx?publication=94].
	3.28.3 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. Hyperlink to: • carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp
	3.28.4 Support services will be offered to families and carers.	• Adolescent consent is not required to offer family/carers education and support. • Support may be provided by a member of the MHS or another organisation.
	3.28.5 Adolescents of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided/facilitated if needed.	Hyperlink to: • *Child Protection Act 1999* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf]. • child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • 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]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_pro

Key component	Key elements	Comments
		t.pdf]. • Family Support Form http://qheps.health.qld.gov.au/patientsafety/mh/documents/family_supp.pdf • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].
3.29.0 Mental Health Peer Support Services	**3.29.1** 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)
- Specialist child and youth mental health services (e.g. forensic services and Evolve, Early Psychosis)
- Acute inpatient mental health teams (child and youth, adolescent, adult)
- Adult mental health services
- Acute Care Teams
- Community Care Units

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
-

Key external (district) relationships include:

- Department of Communities
- The Adult Guardian
- Queensland Public Trustee
- Primary Care Providers
- Department of Education (in particular AETRC School)

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.

DRAFT

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.

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

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 AETRC functions 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 AETRC will be able 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
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including 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 the QCH CYMHS (interim arrangements may exist)
- 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.

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

The 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. • Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc. • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	3.1.4 AETRC staff will comply with Queensland Health (QH) policy	• Mandatory child protection reporting of a reasonable suspicion of child abuse and

Key component	Key elements	Comments
	regarding mandatory reporting of a reasonable suspicion of child abuse and neglect.	neglect. •
	3.1.5 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.
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. • 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. • 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. • This expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted.

Key component	Key elements	Comments
	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 **Assessment**	**3.3.1** Assessments will be prompt and timely.	• Initial assessments of mental health, development and family are to be completed within two weeks of admission. • All assessment processes will be documented and integrated into the care plan. • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian, and other stakeholders (with consent of the adolescent)
	3.3.2 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 **Mental Health Assessment**	**3.4.1** 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.
	3.4.2 The Consultation Liaison Clinical Nurse AETRC intake panel 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 *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor.	
3.5.0 **Family/Carers Assessment**	**3.5.1** AETRC will obtain a detailed history of family structure and dynamics, or	• This process begins with the referral and continues throughout the admission.

Key component	Key elements	Comments
	history of care if the adolescent is in care.	
3.6.0 Developmental Assessment	**3.6.1** 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 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 Functional Assessment	**3.7.1** 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 Physical and Oral Health Assessments	**3.8.1** Routine physical examination will occur on admission.	• Appropriate physical investigations should be informed as necessary.
	3.8.2 Physical and oral health will be routinely assesses and monitored throughout the admission. Additional resources, education and training to improve the physical and oral health management of adolescents with mental illness is available at:	• Documented evidence of the physical and oral health assessment will be included in the adolescent clinical record. • Outcomes of physical health assessments will be incorporated in recovery planning. • All efforts will be made to ensure 100% of adolescents have a nominated GP. • Potential physical and oral health problems will be identified and discussed with the GP and/or other primary health care provider
3.9.0 Risk Assessments	**3.9.1** 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). • Risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation. • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	3.9.2 Risk assessments will be initially conducted on admission and	• Documentation of all past history of deliberate self harm will be included in assessment of current risk.

Key component	Key elements	Comments
	ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review.	• Will include a formalised suicide risk assessment. • 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 **Alcohol and Other Drug**	**3.10.1** Assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service.	• Interventions range from evidenced for substance use disorders to treatment of primary mental illness 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. • 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.
	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. • The therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness. • The therapist will have access to regular supervision.

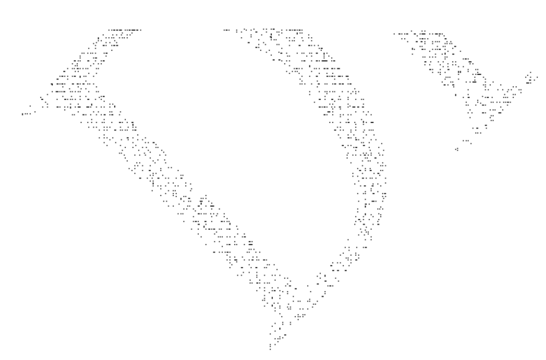
Key component	Key elements	Comments
3.13.0 Psychotherapeutic Interventions	**3.13.1** Psychotherapeutic Interventions can include: • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy) • individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.) • 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) • 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). • Supportive therapies will be integrated into the overall therapeutic approaches to the adolescent. • Can be used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision
3.14.0 Behavioural Interventions	**3.14.1** Behavioural Interventions can include: • individual tailored behavioural intervention for a specific clinical problem (e.g. desensitisation program for anxiety) • group tailored behavioural interventions for a group of adolescents manifesting a common problem • individual general behavioural interventions to reduce specific behaviours (e.g. absconding). These general behavioural interventions will be tailored to individual circumstances • general or specific behavioural interventions to modify the behaviours of a number of adolescents involved in group behaviours **3.14.2** Behavioural interventions for self harm behaviours include: • using questionnaires to determine the reasons for the incident of self	• Behavioural programs are constructed under appropriate supervision. • Evidence for effectiveness of intervention will be monitored. • Effectiveness of behavioural program at individual and Centre level will be reviewed. • Group based interventions are individualised according to adolescents in the group with common issues and may include adventure based and community based activities • All staff should be familiar with specific policy and practice guidelines related to the management of acute behavioural disturbance within the AETRC. • 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 • increased visual observations • restricting access to areas of the ward where an adolescent can be observed • 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 • use of medication if indicated 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. **3.14.3** Behavioural interventions for behaviours which cause harm to others include: • verbal de-escalation • use of outside environment where safe • use of safe forms of reducing aggression e.g. sensory room, punching bag • 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 • use of medication if indicated • review of precipitants to aggression 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: • increased visual observation • de-escalation techniques • development of a management plan targeting the specific behaviour/symptom • service provision in a designated de-escalation area with the capacity for high dependency and seclusion • use of medication to relieve agitation/aggression • 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** 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: - psycho education for parents/carers - monitoring of mental health of parents/carers and supporting access to appropriate mental health care as needed - monitoring the risk of abuse or neglect, and fulfilling statutory obligations if child protection concerns are identified - promoting qualities of care which enable reflection of qualities of home - support clinicians in reviewing interactions with and attitudes towards adolescents. • 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. • 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. • Interventions are provided under the clinical direction of a nominated clinician and have defined goals. • Schooling is individualised according to an adolescent's current school curriculum, academic capacities and mental state. • 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. - Administration of psychotropic medications will occur under the direction of the consultant psychiatrist. - Administration of non-psychotropic medications (including medications for general health) will occur under medical supervision	comply with Queensland Health policies, guidelines and standards. • Education is given to the adolescent and parent(s)/carer about medication and potential adverse effects. • The medication goals of the adolescent/guardian will be integrated with evidence based clinical treatment guidelines. • Where needed, strategies focussed on medication adherence will be in place. • Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment. • Regular administration and supervision of psychotropic medications occurs.
3.19.0 **Other Interventions**	**3.19.1** 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. **3.19.2** 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. • Effectiveness of the approach is monitored. • ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000*
		• All staff will have ABM training at the level deemed appropriate within AETRC 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 7 Parents/carers are immediately informed of changes in a child↕s behavioural presentation.
3.20.0 **Care Coordination**	**3.20.1** Prior to admission, a Care Coordinator will be appointed for	• The Care Coordinator can be a member of the AETRC treating team and is appointed by the

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



Key component	Key elements	Comments
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. • 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. • Outcome measures and the adolescent's progress will be reviewed. • The summation should include attendees, clinical issues raised, treatment care plan, requirements for additional collateral and those responsible for actions. • The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed • The adolescent, referring agencies and other key stakeholders will participate in the Clinical Review process. • All members of the clinical team who provide interventions for the adolescent will have input into the case review. • The consultant psychiatrist will chair the case review meeting and take responsibility for ensuring that assessments and management plans are adequate, and for decisions taken during formal case reviews. • 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. Hyperlink to: • Clinical Incident management

Key component	Key elements	Comments
		implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf]. • child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf] • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • 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. **3.23.2** All clinical record keeping will comply with legislative and local policy requirements	Hyperlink to: • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • progress notes will be consecutive within the clinical record according to date • personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date • clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes • all contacts, clinical processes and care planning, including case review, will be documented in the adolescent's clinical record • there will be a single clinical record for each adolescent which will align with any electronic record Hyperlink to: • retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf].

Key component	Key elements	Comments
		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 • Results of routine outcomes data will be discussed with adolescents and their family/carers to consider and monitor changes in symptoms and functioning • 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 at time of admission 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. • 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	• The AETRC School will be primarily responsible for and support school reintegration.
	3.24.3 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 and Care Coordinator 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. • Follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure discharge information was received. • Discharge summary should identify relapse patterns and risk assessment/ management information. • this will be prepared by the

Key component	Key elements	Comments
		clinicians involved in direct Interventions
	3.24.4 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** 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. • 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. • The AETRC will ensure adolescents have appropriate accommodation to be discharge to, and that external services will follow up in a timely fashion.
	3.25.2 Depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit.	• Transfer procedures will be discussed with adolescents, their family and carers. • Processes for admission into an adolescent acute inpatient unit will be followed, with written and verbal handover provided.
	3.25.3 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.	• Transfer procedures will be discussed with adolescents, their family and carers. • 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** 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 • The Care Coordinator will liaise more frequently with others as necessary
	Responsibility for emergency contact will be clearly defined when	• This will be negotiated between the AETRC and the local CYMHS

Key component	Key elements	Comments
	an adolescent is on extended leave.	
	3.27.2 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 • An example would include the referrer providing parent support while the adolescent is in the AETRC
3.27.0 **Team Approach**	**3.27.1** A multidisciplinary team approach to care is provided.	• Adolescents and family/carers will be informed of the multidisciplinary approach to mental health care on admission to AETRC. • The discipline specific skills of the multidisciplinary team will be utilised as appropriate in all aspects of service provision.
	3.27.4 Staff employed by the Department of Education and Training will be regarded as part of the team.	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** Adolescents and carers will contribute to continued practice improvement of the service.	• This will occur via: -consume and carer participation in collaborative treatment planning - adolescent and carer feedback tools - adolescent and carers will inform staff training.
	3.28.2 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. • 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. • Adolescent/guardian consent to disclose information to and to involve the family/carers in the care will be sought in every case. Hyperlink to: • *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_gui

Key component	Key elements	Comments
		delines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf]. • Decision making for children and young people [http://www.childsafety.qld.gov.au/right-to-information/publications/viewpublication.aspx?publication=94].
	3.28.3 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. Hyperlink to: • carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp
	3.28.4 Support services will be offered to families and carers.	• Adolescent consent is not required to offer family/carers education and support. • Support may be provided by a member of the MHS or another organisation.
	3.28.5 Adolescents of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided/facilitated if needed.	Hyperlink to: • *Child Protection Act 1999* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf]. • child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • 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]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_pro

Key component	Key elements	Comments
		t.pdf]. • Family Support Form http://qheps.health.qld.gov.au/patientsafety/mh/documents/family_supp.pdf • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].
3.29.0 Mental Health Peer Support Services	**3.29.1** 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)
- Specialist child and youth mental health services (e.g. forensic services and Evolve, Early Psychosis)
- Acute inpatient mental health teams (child and youth, adolescent, adult)
- Adult mental health services
- Acute Care Teams
- Community Care Units

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
-

Key external (district) relationships include:

- Department of Communities
- The Adult Guardian
- Queensland Public Trustee
- Primary Care Providers
- Department of Education (in particular AETRC School)

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.

DRAFT

Adolescent Extended Treatment & Rehabilitation Centre Model of Service

Queensland Public Mental Health Services

DRAFT

Draft Model of Service
Author: C & Y Sub Network – BAC Review Work Group
Additional questions for Trevor Sadler by Bernice Lendich
17/02/2016

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

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. 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. Their 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. This continuum of care ensures that adolescents are treated in the least restrictive environment possible, which recognises the need for safety, with the minimum possible disruption to their family, educational, social and community networks.

The AETRC operates on the premise that adolescents can and do recover from mental illness. A range of treatment and recovery focused rehabilitation, psychosocial, educational and vocational programs tailored to the adolescent's assessed clinical and rehabilitation needs is facilitated in collaboration with a range of service providers. This enables the adolescents to build on their strengths, progress in their development and promote recovery focused outcomes upon discharge. Education programs provided by the dedicated school (an integral part of the AETRC) provide essential components of rehabilitation programs and restoration of developmental tasks.

AETRC are gazetted as authorised mental health services in accordance with Section 495 of the Mental Health Act 2000 [http://www.health.qld.gov.au/mha2000].

The key functions of an AETRC are:

- 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.
- Providing multidisciplinary and collaborative consultation, diagnostic assessment, treatment and evidence informed clinical interventions and rehabilitation including recovery and discharge planning for adolescents to facilitate reintegration back to community based treatment.
- Providing flexible, and targeted programs that can be delivered in a range of contexts including, school, community, group and family
- Provide individually tailored, targeted, phased, evidence informed 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.

- To provide family centred support and clinical interventions for families and carers to optimise adolescent functioning within their home environment.
- Provide intensive support to enable successful transition back to the community through arranging, coordinating and supporting access to a range of services for adolescents, to ensure seamless service provision. 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.

AETRC functions go towards:

- providing high quality care in the least restrictive environment to adolescents and their families/carers with a focus on building resilience, fostering individual and family wellbeing, and assisting in the recovery of an appropriate developmental trajectory
- assisting adolescents and their families/carers to maintain hope and progress in their recovery, and to live with mental health problems where such problems persist in the long term
- provide varying levels of care on the basis of acuity of behaviours associated with mental illness; with consideration to providing a safe and therapeutic environment for adolescents, staff and visitors
- assist with establishment of care systems for transition to the community

The AETRC will be able to:

- Appropriately involve adolescents, their families and/or carers in all phases of care and support them in their navigation of the mental health system.
- Convey hope, optimism and a belief in recovery either from mental illness or to living optimally with a mental illness for adolescents, families and /or carers.
- Provide evidence informed assessment and treatment services.
- Provide treatment and rehabilitation within an appropriate timeframe. (In specific cases when the admission exceeds 6 months the adolescent must be reviewed with the referring team to ascertain the potential clinical gains of continued inpatient admission or community treatment.)
- Provide appropriate levels of observation, supervision and individual support.
- Provide information, advice and support to families and/or carers.
- Establish a detailed understanding of local resources for the support of adolescents with mental health problems.
- Promote and advocate for improved access to general health and care services for adolescents.
- Manage psychiatric emergency situations safely and effectively.
- Ensure a timely discharge and a return to community-based services.
- Support adolescents, and their families/carers cross the broad continuum of care, including facilitating smooth transition to other appropriate services and post discharge support and follow up

Following involvement within the AETRC, it is expected that adolescents will have:

- remission of or optimal improvement in the symptoms of their mental illness through intensive treatment;
- stabilisation of behavioural and emotion regulation patterns impacting on their function;
- improved functioning in key areas of development that had been impacted by their mental illness including educational or vocational programs, involvement in social networks, leisure and recreational pursuits;
- improved functioning in areas which have been impacted by developmental co-morbidities;
- a recovery plan which ranges in concepts from recovery from mental illness to recovery which necessitates adjustment to mental illness;

- a management plan to identify potential precipitants to and warning signs of a relapse of mental illness;
- supported, intensive re-integration into the community through implementation of a comprehensive discharge plan negotiated with the adolescent and their family or carers.

2. Who is the service for?

The AETRC is available to Queensland adolescents who are aged 13 – 17 years with severe and complex mental illness:

- have had a range of less restrictive interventions with specialist services in adolescent mental health, but still have persisting symptoms of their mental illness and consequent functional and developmental impairments; and
- who will benefit from a range of clinical interventions and
- require extended and intensive clinical intervention ranging from day admission to an inpatient admission.

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. This is often 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 Personality Disorder and Separation Anxiety 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 AETRC. 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 the AETRC School

In making a decision the panel will consider the:

- adequacy and availability of community treatment based on a thorough treatment history from service providers and carers with a view to assessing the likelihood of therapeutic gains by attending AETRC
- 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)
- potential adverse impacts posed by the adolescent to other inpatients and staff. (e.g. the risks posed by substantiated forensic history of offences of a violent nature or evidence of inappropriate sexualised behaviour)
- potential adverse interactions with other adolescents at a particular time
- possible safety issues

A comprehensive recovery and preliminary 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

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.

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?

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. • Dietetic services to liaise with and advise on the management of eating disorders, adequate

Key component	Key elements	Comments
		nutrition, obesity, interactions with psychotropic medications etc. • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	3.1.4 AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect.	• Mandatory child protection reporting of a reasonable suspicion of child abuse and neglect. Hyperlink to: • 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]. child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf]
	3.1.5 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. Hyperlinks to: • interpreter services [http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp] • hearing impaired/deafness [http://www.health.qld.gov.au/pahospital/mentalhealth/docs/damh_con_info.pdf] • transcultural mental health

Key component	Key elements	Comments
		[http://www.health.qld.gov.au/pahospital/qtmhc/default.asp] • Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 [http://qheps.health.qld.gov.au/atsihb/docs/atsiccf.pdf] • Indigenous mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/indigenous.asp] • multicultural mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/multicultural.asp]
	3.1.6 Provision of appropriate educational services	• The AETRC School is a dedicated facility provided by the Department of Education, Training and Employment. It is regarded as an integral part of the AETRC.
3.2.0 **Referral, access and triage**	**3.2.1** Referrals to the AETRC are made by Queensland services providing specialist adolescent mental health treatment.	• All new service referrals will be to the Clinical Liaison Clinical Nurse as a single point of entry. • Clear information regarding referral pathways to AETRC, including service entry criteria, will be available to referrers. • Referral agencies are supported to remain actively involved during AETRC admission and continue their role as a major service provider following discharge (unless another appropriate referral is made).
	3.2.2 An initial decision is made at intake whether or not to accept an adolescent for assessment for provision of service.	• This initial decision will take into account - The age of the adolescent referred - Level of risk - Clinical criteria - Ability/willingness to engage in the AETRC Program • This decision is made by the Consultation Liaison Person and the intake panel.
	3.2.3 Prior to admission, an assessment interview is arranged. This assessment involves the	• This assessment interview helps to clarify suitability for admission and potential interactions within a particular mix of adolescents on

Key component	Key elements	Comments
	adolescent, their parent(s) or carers and significant others where appropriate.	the AETRC. • This assessment interview is an opportunity to orientate the adolescent to the AETRC. • A general information pack will be available on first presentation for all adolescents and families/carers. Hyperlinks to: • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].
	3.2.4 The initial assessment interview will extend the information available from the referrer to obtain a detailed assessment of the nature of mental illness, its behavioural manifestations, impact on function and development and the course of the mental illness Hyperlinks to: • consumer assessment form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_conass.pdf]. • risk screening tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf].	• The assessment interview allows the clinician to gauge how the adolescent and their families/ carer talks about current symptoms and their level of understanding of the mental illness • It provides opportunity to understand development over several years, and how development has been impacted by the mental disorder if this is not available in the referring information • It provides opportunity to gather specific information which may be relevant to rehabilitation and recovery.
	3.2.5 Potential treatment, rehabilitation and recovery goals will be explored with the adolescent and their families and/ or carers.	• Although prior to developing a formulation, these goals are indicative to the adolescent and their families/carers of what the AETRC may be able to provide. • Discussion of goals at this stage allows some assessment of the understanding and commitment of the adolescent and their families/carer to the process of attending and being involved with the AETRC

	3.2.6
	Suitability for entry to the CAPD will be undertaken by a multidisciplinary team (MDT) intake panel that will consist of CADP:
	• Consultant psychiatrist
		• MDT intake panel meetings will occur weekly.
		• This decision will take into account
		  o Level of risk
		  o Clinical criteria
		  o Admission Priorities

Key component	Key elements	Comments
	• Clinical Liaison Clinical Nurse • NUM • Allied health representative • Principal AETRC school	○ Diagnostic Mix ○ Ability/willingness to engage in the AETRC.
	3.2.7 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.	• Where possible, admissions are conducted as part of a collaborative assessment and treatment plan between the AETRC and the specialist adolescent mental health service referring the adolescent.
	3.2.8 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. • 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. • This expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted.
3.3.0 **Mental Health Assessment**	**3.3.1** Prior to admission the Consultation Liaison Clinical Nurse will obtain a detailed history of the mental health assessments and interventions to date for the adolescent and their family	• The preliminary assessment helps to avoid unnecessary duplication of assessments. • Information from the preliminary assessment is integrated into subsequent assessments Hyperlinks to: • mental health clinical documentation [http://qheps.health.qld.gov.au/mentalhealth/clinical_docs.htm]. • statewide standardised clinical documentation CYMHS user guide [http://qheps.health.qld.gov.au/mentalhealth/docs/cyms_user.pdf].
	3.3.2 From the referral information and the interview arranged on referral, a preliminary formulation is developed	• The formulation is reviewed and refined at case review meetings

Key component	Key elements	Comments
	and presented to the team to plan further targeted assessments and develop an initial treatment and rehabilitation plan	
	3.3.3 Targeted assessments will be prompt and timely.	• Targeted assessments include formal psychological, occupational therapy, speech and language assessments. • These assessments may assist in diagnostic clarification, assessment of symptom severity, developmental variables and functional assessments • The outcome of assessments will be promptly communicated to the adolescent, the families and/or carers, and other stakeholders (with consent of the adolescent)
	3.3.4 Risk assessments will be conducted on admission in to the AETRC and be routine thereafter. A risk assessment will be documented prior to transfer or discharge. Risk assessments will include: • a formalised suicide risk assessment, assessment of risk to others and absconding risk • a component of standardised measurement processes.	• All risk assessments will be recorded in the clinical record, and will be used to formulate a risk management plan. In the initial assessment the risk assessment will be conducted as one component of a comprehensive mental health assessment. • Risk management protocols will be consistent with Queensland Health policy. Hyperlinks to: • integrated risk management policy [http://qheps.health.qld.gov.ay/audit/IRM_Stream/RM_Policy/13355_08_2.0.pdf]. • risk screening tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf]. • child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf].
	3.3.5 Child safety concerns will be addressed in accordance with mandatory requirements. Hyperlink to: • child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_pr	Hyperlink to: • child abuse and neglect [http://qheps.health.qld.gov.au/csu/childabuseneglect.htm]. • meeting the needs of children for whom a person with a mental illness has care responsibilities [http://qheps.health.qld.gov.au/me

Key component	Key elements	Comments
	otect.pdf].	ntalhealth/html/careofchild.htm.
	3.3.6 Assessments of alcohol and drug use will be conducted on entry to the Program and routinely throughout ongoing contact with the service.	
	3.3.7 Physical and oral health will be routinely assessed, managed and documented. Hyperlink to: • physical examination and investigations form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_physical.pdf].	• Documented evidence of physical and oral health assessments or referral will be in the clinical record and included in the consumer integrated mental health application (CIMHA) database. • Clinical alerts (e.g. medication allergies and blood-borne viruses) must be documented. • 100 percent of adolescents have a nominated GP. • Adolescents and their families/ carers will be actively supported to access primary health care services and health improvement activities. • Any potential health problems identified will be discussed with the adolescent and family/carers, and where appropriate with the GP or other primary health care provider. Hyperlink to: • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • General Practice Queensland - A Manual of Mental Health Care in General Practice [http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mangp].
	3.3.8 The outcome of assessments will be communicated to the adolescent, family/carer and other stakeholders as appropriate, in a timely manner.	
	3.3.9 Educational history and attainments will be assessed from admission to the AETRC and throughout the admission	• The education provider for the AETRC will ascertain schools attended, history of attendance, educational attainments and history of educational support where appropriate • The education provider will

Key component	Key elements	Comments
		assess current levels of attainment in different subjects • The education provider will assess progress in subjects
	3.3.10 Assessment of family structure and dynamics will continue during the course of admission to the AETRC	• This process begins with the assessment interview and continues throughout the admission.
	3.3.11 The AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• This assessment occurs throughout the admission.
	3.3.12 *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor.	Hyperlink to: • *Mental Health Act 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf].
3.4.0 **Clinical review**	**3.4.1** All adolescents will be discussed at a multidisciplinary team review (MDTR) at least weekly to integrate information from and about the adolescent, interventions that have occurred, and to review progress within the context of the case plan	• A consultant psychiatrist or appropriate medical delegate will participate in all MDTRs. • All MDTRs will be documented in the adolescent clinical record, the consumer care review summary, and in CIMHA. Hyperlink to : • Child and Youth Mental Health Services Consumer Care Review Summary form [http://qheps.health.qld.gov.au/mentalhealth/docs/cy_cc_review_sum.pdf] • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • Individual care/treatment plans (ICTP) [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_recplan.pdf].
	3.4.2 In addition to the weekly MDTR, ad hoc clinical review meetings will be scheduled when required (e.g. to discuss cases with complex clinical issues, following a critical event or in preparation for discharge).	• Critical events will be reviewed utilising the clinical incident management implementation standard. Hyperlink to: • clinical incident management implementation standard

Key component	Key elements	Comments
		[http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf].
	3.4.3 Continual monitoring of the adolescent's progress towards their recovery plan goals will occur through a process of structured clinical reviews involving the adolescent and their parents or carers, the AETRC multi-disciplinary team (including the AETRC School) and relevant external community agencies including the referring specialist adolescent mental health service provider and potential discharge provider if these may differ.	• Care Plans are formally reviewed and updated at intervals ideally of two months, but not more than three months. • The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed • The viewpoint of the adolescent, family and/or carer and their community based supports such as teachers and community mental health case managers will be considered during the reviews. • 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. • Outcomes of clinical reviews will be discussed with adolescent and family and/or carer. • Any changes to the recovery plan will be made in collaboration with the adolescent, family and/or carer. • Structured risk and review processes will be utilised.
	3.4.4 Each adolescent's progress will be routinely monitored and evaluated including the use of outcome measures.	• National Outcomes and Casemix Collection, and others based on each adolescent's individual requirements. Hyperlink to
3.5.0 **Recovery planning and Relapse Prevention**	**3.5.1** Recovery plans are developed in way that assists adolescents and their families/carers to maintain hope and progress in their recovery, and to live with mental health problems where such problems	• Services are based on the principles of recovery which in relation to adolescent's includes developmental processes and may also be applied to parents, carers and entire families. Hyperlink to:

Key component	Key elements	Comments
	persist in the long term.	• Child and Youth Mental Health Services Recovery Plan (http://qheps.health.qld.gov.au/mentalhealth/docs/cy_recovery_plan.pdf.) • Sharing responsibility for recovery: creating and sustaining recovery oriented systems of care for mental health (http://qheps.health.qld.gov.au/mental health/docs/recovery.pdf.)
	3.5.2 An individual recovery plan will be developed with all adolescents and their families and/or carers. Review of progress and planning of future goals will be integrated into the recovery plan.	• Recovery plans identify: - available supports - crisis management strategies - therapeutic goals intervention processes - psycho-educational needs - relapse prevention strategies. • Recovery plans may also include strategies for improving: - family functioning - pro-social and developmentally appropriate interests and hobbies, - peer functioning - quality of life (such as time to experience developmentally relevant play and fun) - achievement at school/ vocational goals, and mastery over the tasks of adolescence. • Recovery plans will be updated at a frequency determined by change or need, but will be formally reviewed at least three monthly (to review routine outcome measures, treatment progress and any change in needs).
	3.5.3 Recovery and relapse prevention planning is discussed in partnership with every adolescent, their family and/or carers, and in collaboration with other service providers.	• Adolescent's, their families and/or carer's are strongly encouraged to have ownership of, and sign, their recovery plans. • Changes to the recovery plan will be discussed with the adolescent, family/carer, and relevant service providers. • All changes to the recovery plan will be discussed with the MDTR.

Key component	Key elements	Comments
	3.5.4 Recovery planning is almost always partially or fully reliant on the relationship between the adolescent, family and/or carer, their resilience and their individual circumstances.	• Whilst adolescents 13-17 years gain further independence and mastery to separate from their family and/or carer, evidence suggests that adolescents with mental health problems require support in re-connecting with their parents.
	3.5.5 Every effort will be made to ensure that recovery planning focuses on the adolescent's own goals.	• Where conflicting goals exist (e.g. for adolescents receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the adolescent and the family/carer goals values.
3.6.0 **Clinical interventions**	**3.6.1** All aspects of service delivery will reflect the development of collaborative relationships between adolescents and staff.	• AETRC will demonstrate a focus on strengths, connectedness, personal involvement, personal choice and empowerment and increasing confidence in accessing the system.
	3.6.2 Adolescents will be supported to access a range of biopsychosocial interventions and rehabilitation services which meet their individual needs. All interventions must demonstrate attention to developmental frameworks and will be evidence informed	• Clinical interventions will demonstrate evidence informed practice. • Interventions will be based on recovery principles. • Multidisciplinary input will be provided to optimise adolescent recovery. • Interventions will include relapse prevention programs and/or techniques. • Basic human rights, such as privacy, dignity, choice, anti-discrimination and confidentiality are recognised, respected and maintained to the highest degree possible in all clinical interventions.
	3.6.3 Clinical interventions are guided by assessment, formulation and diagnostic processes, using a developmentally appropriate, biopsychosocial approach.	• This will take into consideration the strengths and resilience within the individual, their family and their community. • The consent of the adolescent or parent/guardian to disclose information, and (where needed) to involve family/carers in recovery planning and delivery, will be sought in every case. • Information sharing will occur in every case unless a significant

Key component	Key elements	Comments
		barrier arises, such as inability to gain appropriate lawful consent • Informed consent is documented in the clinical record, detailing that the adolescent/guardian understands the recovery plan. • In most case it is necessary that the guardian agrees to support the provision of ongoing care to the adolescent in the community. Where an adolescent is admitted without adequate involvement of a guardian, alternate supports in the community will be developed • Education and information will be provided to the adolescent, family/carers and significant others at all stages of contact with the service. • A shared understanding will be fostered for all aspects of treatment, including risk management, with explicit, documented evidence of the shared understanding in the clinical file. Hyperlinks to: • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf]. • carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp].
	3.6.4 Clinical care and the development of	

Key component	Key elements	Comments
	both prevention and treatment services should derive from the best available evidence and recognise the frequently complex and multi-factorial nature of mental disorders in adolescents.	
	3.6.5 During service provision, adolescents and their families/carers will have access to and be supported to engage in a range of evidence-informed therapeutic interventions to optimise their rehabilitation, resilience, recovery and relapse prevention.	• Treatment will be provided in the least restrictive setting that properly balances the adolescent's autonomy with their need for observation and treatment in a safe environment.
	3.6.6 A range of flexible and integrated therapeutic, resilience, rehabilitation and recovery focussed interventions are delivered and/or coordinated by the multidisciplinary team.	• Interventions may be individualised, group based or generic programs.
	3.6.7 Individualised evidence-informed interventions include: • Psychological interventions (verbal and non-verbal therapies and education); • Pharmacotherapy • Family therapy and education; • Individualised behavioural programs. • Individualised life skills programs • Individual sensory modulation • Biological treatments e.g. Electroconvulsive Therapy	• Interventions may include art therapy, music therapy, sand play therapy. • ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000* *Hyperlink to:* • electroconvulsive therapy guidelines • [http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf]
	3.6.8 Interventions delivered in groups include: • Individual educational or vocational plans; and • A range of information and skills building groups which are adapted to the needs of a group of adolescents • A range of predominantly activity-based groups which are tailored to meet the	• Examples of information and skills building groups include social skills, dialectical behaviour therapy groups • Examples of activity based groups include community access, adventure therapy groups

Key component	Key elements	Comments
	needs of a particular group of adolescents and aimed at intervening in areas of psychological and developmental need.	
	3.6.9 Generic interventions include: • Maintaining a milieu with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and management of the adolescent group to maximise each adolescent's care; • Encouraging peer support opportunities, where available, for adolescents and/or families to appropriately engage with past consumers/carers for peer support; • Forming appropriate therapeutic alliance; • Providing opportunities for activities of daily living, leisure, social interaction and personal privacy; and • Supporting healthy lifestyle decisions.	• Building and maintaining a therapeutic alliance with the adolescent and their family/carers is at the heart of almost all clinical interventions with young people. • A range of mediums may be used for intervention as adolescent may choose to express their thoughts and feelings through the medium of play and other forms of expressive therapy such as art and music.
	3.6.10 Individualised educational or vocational programs will be developed for each adolescents and are integrated with their clinical state	• The AETRC School will develop individual educational goals with the adolescent taking into account academic capacities and mental state • Curriculum will be provided by external education providers including an adolescent's current school curriculum,. • The school program is determined by the School Principal after continuing consultations with clinicians. • The AETRC School will contribute to life skills programs to prepare the adolescent for work skills or transition to the community

Key component	Key elements	Comments
	3.6.11 Carers are integral to the mental health care process Family members are provided with emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and well being.	• Adolescents under 18 years of age are a child at law1 and are developmentally dependent on adult guidance and support, which reduces from infancy to adulthood at a rate that ideally promotes achievement of the appropriate developmental tasks and developmentally appropriate family relationship. • Consequently, interventions to promote recovery are as much focussed on engaging with the carer as the adolescent and are frequently based around family work and parent-adolescent work. Hyperlink to: • carers matter [http://www.health.qld.gov.au/mhcarer/].
	3.6.12 Mental health services implement a range of multidisciplinary strategies to manage psychiatric emergencies to ensure the safety of the adolescent and others within the immediate environment	Interventions for self harm behaviours include: • using questionnaires to determine the reasons for the incident of self harm • increased visual observations • restricting access to areas of the ward where an adolescent can be observed • 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 • use of medication if indicated • 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.
	3.6.13 Staff will utilise a range of de-escalation behavioural interventions for behaviours which may be a threat to the safety of others.	• Parents/carers are immediately informed of changes in a adolescent's behavioural presentation Behavioural interventions for behaviours which cause harm to others include:

[1] CYCMHS (like all health services for children and adolescents) must be cognisant of the implications of this legal status.

Key component	Key elements	Comments
		• verbal de-escalation • use of outside environment where safe • use of safe forms of reducing aggression e.g. sensory room, punching bag • 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 • use of medication if indicated • review of precipitants to aggression • 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.
	3.6.14 Medication will be prescribed, administered, and monitored as indicated by clinical need and will involve shared decision making processes between the treating team and the adolescent. All pharmacological interventions including prescriptions, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards	• Antipsychotics and other psychotropic medication will be prescribed in accordance with Queensland Health clinical practice guidelines. • Strategies to improve compliance with medication regime must be in place. • Monitoring of medication side-effect will be routinely conducted. • The metabolic monitoring form will be used for all adolescents on antipsychotic or mood stabiliser medication. • Adolescent's personal goals for medication will be incorporated with staff's clinical knowledge. • The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards. Hyperlinks to: • Metabolic monitoring form [http://qheps.health.qld.gov.au/mentalhealth/docs/metabolic_mon_form.pdf] • clinical guidelines [http://qheps.health.qld.gov.au/mentalhealth/guidelines.htm]. • medication liaison on discharge

Key component	Key elements	Comments
		[http://qheps.health.qld.gov.au/medicines/documents/general_policies/medic_liaison_discrg.pdf]. • National Health and Medical Research Council (NH&MRC) Guidelines for Management of Depression (when available) • acute sedation guidelines for children and young people (under development) • therapeutic guidelines-psychotropic [https://online-tg-org-au.cknservices.dotsec.com/ip/].
	3.6.15 Management of physical health of adolescents will be in association with a primary health care provider.	• All adolescents will receive information about physical health issues. • Adolescents will be supported to access primary health care and health improvement services..
	3.6.16 Time to provide emotional support to the adolescent and carer/s will be given adequate priority.	• This type of support will assist with engagement, concordance with treatment regime, etc
	3.6.17 Education and information will be provided at all stages of contact with the service.	• This will include a range of components such as education, information about the mental health disorder/s or problem/s, progression through the service, mental health care options, medications (benefit, usage, potential side effects and potential effects of missing doses/stopping), support services, recovery pathways, etc
3.7.0 **Team approach**	**3.7.1** A multidisciplinary team approach will be provided. The AETRC School is an integral part of the team.	• The adolescent, family and/or carer will be informed of the multidisciplinary model. • Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. • Clinical, discipline and peer supervision will be available to individual staff and the team.
	3.7.2 Clear clinical and operational leadership will be provided staff and for the team	• There will be a well defined and clearly documented local process for escalation of discipline specific clinical issues.
	3.7.3 Case management processes will	Hyperlink to: • case management policy

Key component	Key elements	Comments
	be managed to ensure effective use of resources and to support staff to respond to crises in an effective manner.	[http://qheps.health.qld.gov.a/mentalhealth/docs/casemanage_polstate.pdf].
3.8.0 Continuity of care and care co-ordination	**3.8.1** Clear documented 24 hours, 7 days per week, mental health service contact information is provided to adolescents, families, carers referral sources and other relevant supports.	• Provision of this information will be documented in the clinical record, including the recovery plan and the discharge summary. • Relevant information documents detailing specific service response information will be readily available.
	3.8.2 Every adolescent will have a designated treating consultant psychiatrist.	• This will be recorded in the CIMHA as the internal contact, treating consultant psychiatrist.
	3.8.3 Prior to admission, a Care Coordinator will be appointed for each adolescent will be noted on CIMHA as principal service provider	• The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parents/carers • assisting the adolescent to identify, develop and implement goals for their recovery and crisis management plans in partnership with the family/carer where appropriate. • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living • providing a detailed report of the adolescent's progress for the care planning meeting..
	3.8.4 AETRC will actively engage with other treating teams in coordination of care across inpatient (acute and non acute) and community settings. In particular, responsibility for emergency contact will be clearly defined when an adolescent is on extended leave.	• Referring services providing specialist and adolescent mental health treatment to maintain clinical/professional contact with the PSP via case reviews, email, tele-links, video – links, telephone and face to face contact. • Open communication between the AETRC and the local ACT team is essential for after hours crisis care for the adolescent and their

Key component	Key elements	Comments
		family/carers.
	3.8.5 The adolescent's treating team will be identified in the clinical record, MDTR documentation and communication will be maintained throughout the phase of care.	• The PSP and other service providers [redacted] will be recorded in the CIMHA and remain constant during the phase of care.
	3.8.6 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 • An example would include the referrer providing parent support while the adolescent is in the AETRC
	3.8.7 Community based supports are included in recovery planning and discharge planning wherever possible.	• Non-government organisation service providers who have established (or are establishing) support links with the adolescent, families and/or carers will be given access to AETRC as appropriate. • All community based supports will be co-ordinated prior to discharge. • The process for sharing information will be explicitly documented for each case taking existing privacy and confidentiality considerations into account. Hyperlink to: • Health Services Act 1991 part 7 Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/confguidelines.pdf].
3.9.0 Transfer/transition of care	**3.9.1** Disengagement with AETRC will not occur before the receiving team has made contact, scheduled a first appointment and confirmed attendance at the scheduled appointment.	• Guidelines for internal transfers will be clearly written, and receiving teams will make assertive efforts to establish contact within a reasonable time period. • The time period will be individually determined at a local level between AETRC and the receiving team/s. • A feedback mechanism is in place so that the receiving team informs the referring team if the adolescent fails to attend or if significant problems occur or recur.

Key component	Key elements	Comments
	3.9.2 Clearly documented provisions will be outlined between the AETRC, community services and acute inpatient units for adolescents who may experience crisis during the transition phase.	• Where transfer is inevitable, all services need to make direct contact and ensure safe transfer (service capability will be considered).
	3.9.3 A timely written handover will be provided on every transfer occasion. Hyperlink to: • consumer end of episode/discharge summary [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_consumer.pdf]	• Both a written and verbal handover will be provided to the receiving team within a week of day of transfer.
	3.9.4 Adolescents and their families/carers will be informed of transfer procedures.	• Families/carers will be informed of the transfer in a timely manner as consent will be required for the transfer. • Families/carers will be provided with relevant information concerning reasons for transfer and expected outcomes. Hyperlinks to: • *Health Services Act 1991*: Confidentiality Guidelines [http://www.health.qld.gov.au/foi/docs/conf_guidelines.pdf] • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp] • Information sharing between mental health workers, consumers, carers, family and significant others. [http://www.health.qld.gov.au/mentalhealth/docs/info_sharing.pdf].
	3.9.5 Adolescents transferred under an involuntary treatment order will remain the responsibility of the transferring service until the first medical assessment is completed.	Hyperlinks to: • Mental Health Act 2000 [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf] • MHA2000 Resource Guide [http://qheps.health.qld.gov.au/mhalu/resource_guide.htm]
3.10.0 **Discharge/external transition of care**	**3.10.1** Planning for discharge from AETRC will commence at the time of	• The referring specialist adolescent mental health service providers and families/carers will be

Key component	Key elements	Comments
	referral.	included in all aspects of discharge planning. • DMHS will give priority to adolescents transferring back to their district from AETRC. • The decision to discharge is at the discretion of the consultant psychiatrist in consultation with the MDT.
	3.10.2 Discharge planning is a component of each adolescent's Recovery and Relapse Prevention Plan.	• It is anticipated that support may be required on discharge for the adolescent and their family and/or carers. Hyperlink to: • recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf].
	3.10.3 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 • 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 • Discharge planning recognises the needs at times that re-admission may be necessary where risk of relapse is high.
	3.10.4 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 care arrangements do not exist, safe supervised accommodation with adequate supports will be sought.	• Where the family home or usual care arrangements are appropriate and supportive, every endeavour will be made to encourage the adolescent to return • The adolescent will be integral to all planning for accommodation on discharge • Parents providing a safe and supportive environment will always be involved in planning for accommodation on discharge. • 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?

Key component	Key elements	Comments
		• 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 • 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 • The adolescent will be equipped to live independently in preparation for discharge outside of home • 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
	3.10.5 AETRC discharge planning and support for adolescents includes: • Facilitating contact between the adolescent, their family or carers and their community case manager (PSP) as well as relevant other support services; and • Maintaining collaborative relationships with a wide range of service providers including general practitioners, education providers, extended family and carers, general community health services and/or adult mental health services to meet the needs of the adolescent and enhance their capacity to effectively manage in a less intensive environment and enable recovery.	•

Key component	Key elements	Comments
	3.10.6 The discharge plan will include a relapse prevention plan, crisis management plan, and service re-entry plan.	Hyperlink to: • crisis intervention plan [http://qheps.health.qld.gov.au/patientsafety/mh/documents/mh_cip.pdf]
	3.10.7 Comprehensive liaison and handover will occur with all other service providers who will contribute to ongoing care.	• All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) same day as discharge. • Relapse patterns and risk assessment/management information will be provided where available. • A follow-up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the discharge letter was received. • Discharge summaries will be comprehensive and indicate relevant information including diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral. • Compliance with the mental health clinical documentation is the minimum requirement for documentation. Hyperlink to: • mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm].
	3.10.8 Adolescents will be encouraged to actively contribute to (and countersign) their discharge plan.	• Family/carers will also be directly involved in discharge planning. • Where adolescents are lost to follow-up, there will be documented evidence of attempts to contact adolescents, family/carers and other service providers before discharge.
	3.10.9 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.	• Every attempt to engage with specialist mental health service providers will be made on discharge and the adolescent supported to attend
	3.10.10	• Transfer procedures will be

Key component	Key elements	Comments
	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. • Processes for admission into an adult acute mental health inpatient unit will be followed, with written and verbal handover provided.
3.11.0 Collection of data, record keeping and documentation	**3.11.1** AETRC will enter and review all required information into the CIMHA in accordance with approved statewide and district business rules.	Hyperlink to: • CIMHA business rules [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm].
	3.11.2 AETRC will utilise routine outcome measures as part of assessment, recovery planning and service development. These will include those mandated through the National Outcomes and Case mix Collection (NOCC): - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) - Strengths and Difficulties Questionnaire (SDQ) - Children's Global Assessment Scale (CGAS) - Factors Influencing Health Status (FIHS).	• Outcomes data is presented at all formal case reviews and will be an item agenda on the relevant meeting agendas. • Results of outcomes are routinely discussed with the adolescent and their family and/or carers. • Outcomes data is used with the adolescent to: a. record details of symptoms and functioning b. monitor changes c. review progress and plan future goals in the recovery plan. Hyperlink to : • NOCC collection protocol: http://qheps.health.qld.gov.au/mhinfo/documents/collprotv1.6.pdf
	3.11.3 All contacts, clinical processes, recovery and relapse prevention planning will be documented in the adolescent's clinical record.	• Progress notes will be consecutive (according to date of event) within all hard copy consumer clinical records. Hyperlinks to: • Queensland Health Child and Youth Mental Health Services Statewide Standardised Suite of Clinical Documentation User Guide [http://qheps.health.qld.gov.au/mentalhealth/docs/cyms_user.pdf] • Clinical Documentation [http://qheps.health.qld.gov.au/mentalhealth/clinical_docs.htm]
	3.11.4 Clinical records will be kept in accordance with legislative and local policy requirements.	• Personal and demographic details of the adolescent, their family/carer and other health service providers will be kept up to

Key component	Key elements	Comments
	Hyperlink to: • retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf].	date. • Mobile or tablet technology will support increasing application of electronic record keeping.
	3.11.5 Local and statewide audit processes will monitor the quality of record keeping and documentation (including external communications), and support the relevant skill development.	
3.12.0 **Mental health peer support services**	**3.12.1** All adolescents and families/carers will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Consumer consultants are accessible via a local MHS.

4. Related services

The Adolescent Extended Treatment and Rehabilitation Centre operates in a complex, multi-system environment involving crucial interactions with a range of state and commonwealth government agencies including but not limited to education providers, the Department of Communities, Child Safety and Disability Services, Queensland Police Services, child health services, alcohol, tobacco and other drug services, youth justice, private providers, NGOs, disability support providers and others. The AETRC School, under the Department of Education, Training and Employment is an integral part of the Centre.

Services are integrated and co-ordinated with partnerships and linkages with other agencies for children and adolescents and with specialist mental health services, to ensure continuity of care across the service system and through adolescent developmental transitions. Mechanisms for joint planning, developing and co-ordinating services are developed and maintained.

The AETRC will develop service linkages with services, including but not limited to:

- specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services);
- Child and Youth mental health services;
- acute and non-acute child and youth mental health inpatient services;
- adult mental health services;
- private mental health service providers;
- alcohol, tobacco and other drug services;
- specialist health clinics for the target population e.g. sexual health clinics
- community pharmacies;
- local educational providers/schools, guidance officers and Ed-LinQ co-ordinators;
- primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health) and local GPs;
- child and family health and developmental services;
- Department of Communities, Child Safety and Disability Services;
- Youth justice services;

- government and non-government community-based youth and family counselling and parent support services;
- housing and welfare services;
- transcultural and Aboriginal and Torres Strait Islander services.

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. 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.

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

Staffing will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology, other specialist CYMHS staff (including music and art therapists) and access to a dietitian. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

A range of non-clinical staff (including indigenous mental health workers, diversional and recreational therapists, and allied health assistants) may assist in providing services. Involvement of and access to consumer and carer consultants and peer support workers should be facilitated within the integrated mental health service. Additionally, the multidisciplinary team will be supported by administrative officers, catering and hygiene staff who will assist with the day-to-day operations of the AETRC. Hyperlink to Clinical Service Capability Framework Mental Health Services Module.

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

The effectiveness of the AETRC is dependent upon an adequate number of appropriately trained staff. The complexity of the mental health needs of adolescents necessitates the provision of continuing education and professional development programs, clinical supervision, mentoring and other appropriate staff support mechanisms. AETRC will undertake evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, encouraging rotations through the unit of staff from other areas of the integrated mental health service and supporting education and research opportunities.

7. Team clinical governance

Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

Clinical decision making, clinical accountability and allocation of clinical case loads will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director.

The NUM is accountable for the direct management of nursing staff. This includes:

- operational management of nursing staff(including day to day clinical support, resource and administrative management)
- systems maintenance
- staff operational/administrative supervision including performance management
- and through the Consultation Liaison Clinical Nurse, liaison with other mental health services, external organisations and community groups.

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.

Strong and enduring relationships will be evident with the designated acute and community child and youth mental health services.

Clinical supervision and ongoing professional development are necessary components of maintaining a skilled mental health workforce within the AETRC. The discipline senior and/or practice supervisor provides/facilitates discipline specific and/or intervention specific opportunities for the clinician to develop identified professional skills and reflect on elements of practice. Clinicians are supported to maintain their own health and wellbeing, avoid burnout, and to access career development guidance.

The AETRC will incorporate the National Standards for Mental Health and Australian Council on Healthcare Standards into all workplace instructions, quality activities and procedures. All measures of outcomes, data and reports will be acted upon and corrective action taken if necessary. Programs and procedures will be reviewed as per workplace instructions.

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 education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure clinical competence. All training will be based on best practice principles and evidence informed treatment guidelines, and underpinned by the Queensland Government Recovery Framework. Teams will be encouraged to make the relevant components of their training available to their service partners (e.g. GPs, NGOs). Consumers and carers will be involved in staff training and development.

AETRC will have dedicated time and resources for clinical education and clinical supervision, in addition to adequate clinical staffing numbers.

Education and training will include a focus on strategies and mechanisms to foster meaningful participation of adolescents, and families/carers across all levels of service delivery, implementation and evaluation. Adolescents and their families/carers will be involved in the development and delivery of training to staff.

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

- Queensland Health mandatory training requirements (fire safety, aggressive behaviour management, cultural awareness and training etc.)
- AETRC orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service;
- promotion, prevention and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for adolescents and their families and /or carers;
- knowledge of adolescent and family development and psychopathology
- training in the principles of the service (including models of recovery and rehabilitation and staff adolescent interactions and boundaries etc.)
- developmentally appropriate assessment and treatment;
- risk assessment and management, and associated planning and intervention;
- *Mental Health Act 2000;*
- National Standards for Mental Health Services;
- evidenced informed practice in service delivery;
- consumer focused recovery planning;
- routine outcome measurement training;
- a range of treatment modalities including individual, group and family-based therapy;
- child safety services training;
- knowledge of mental health diagnostic classification systems;
- medication management;
- communication and interpersonal processes;
- provisions for the maintenance of discipline-specific core competencies;
- supervision skills;
- Cultural capability training;
- Family therapy.
- team work
- principles and practice of other CYMHS facilities - community clinics, inpatient and day programs, alcohol and drug services and forensic outreach services

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

10. The AETRC functions best when:

- Adolescents, their families and /or carers and other service providers are involved in all aspects of recovery planning and delivery;
- There is an explicit attitude that adolescents and their families/carers will progress in their recovery by maintaining hope and assisting to live with mental health problems where such problems persist in the long term;
- There is an adequate skill mix within the team, with senior level clinical expertise and knowledge regarding necessary interventions being demonstrated by the majority of staff;
- Teams are well integrated with other local mental health service components and primary care supports;
- Teams have a good general knowledge of local resources;

- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service
- Clear and strong clinical and operational leadership roles are provided, and work collaboratively;
- There is clear and explicit responsibility for a local population and clear links to specified organisations;
- Clear pathways exist for onward-referral as clinically required;
- Where collaborative care arrangements are in place across different service providers, shared recovery plans and relapse prevention plans are utilised;
- Senior staff take an active role in fostering the development of clinical skills in less experienced staff;
- Strong internal and external partnerships are established and maintained;
- Caseloads are regularly reviewed and assertively managed;
- All staff are provided with professional support, clinical supervision and training.
- Service evaluation and research are prioritised appropriately

DRAFT

ALIGNMENT OF BAC REHABILITATION MODEL AND ACTIVITIES WITH WHO INTERNATIONAL CLASSIFICATION OF FUNCTION DISABILITY AND HEALTH (ICFDH)

Notes:

1. The first column lists the ICFDH domain together with the code for reference.

2. The second column lists factors in the BAC model which map against a particular domain.
   a. "Behaviours" refers to behaviours or symptoms of the illness relevant to the domain. These are usually described in the third column.
   b. "Sub" refers to inherent biological factors in the substrate. Factors identified are those in EXHIBIT of the submission of 12 February 2016.
   c. "DTA" refers to Developmental Tasks of Adolescence". Tasks listed are those identified (with relevant sub-components) in EXHIBIT of the submission of 12 February 2016.

3. The third column has four types of comments.
   a. Comments in normal type about the symptoms or behaviours associated with a mental illness, or inborn biological substrate factors which are relevant to this ICFDH domain, sometimes with an explanation of how they may impact a Task of Adolescent Development.
   b. Treatment approaches relevant to addressing that domain are in *italics*
   c. Rehabilitation approaches relevant to addressing that domain are in **bold.**
   d. My observations of how interventions were either enhanced or made difficult by being in the BAC community (either as inpatient or day patient) are underlined.

4. "Habilitation" (to equip) is a more appropriate term in adolescents who in normal circumstances are acquiring skills in many of these functional domains. It is a preferred term among a number of clinicians, but has not gained wide acceptance. The term "rehabilitation" is taken to also incorporate habilitation activities.

5. Adolescents were assessed individually. Not all ICFDH domains applied to all adolescents.

6. Programs in effect targeted multiple ICFDH domains. There was not a separate program for each ICFDH domain.

7. An adolescent who was not impaired in an ICFDH domain being addressed in that activity, may depending on the activity and their stage of transition participate in the activity at their own pace or at a higher level; participate in the activity and assist others or participate in an alternate activity.

8. This table illustrates the range of activities, and the integration of treatment and rehabilitation approaches for adolescents spending at least part of the day in the BAC community.

WHO ICFDH domain	BAC domain	Comments about effects of illness, Treatment, Rehabilitation activities and any effects of being in the BAC community.
B BODY FUNCTIONS – CHAPTER 1 MENTAL FUNCTIONS		
b126 Temperament and personality functions – Extraversion, Agreeableness, Conscientiousness, Psychic stability, Openness to experience, Optimism, Confidence, Trustworthiness	Sub – temperament	Some examples "Perfectionism/conscientiousness" can be so extreme that adolescents do not submit assignments. Can be associated with anxiety and depression because of fear of failure, impacts identity. *Treatment: Individual therapy – explore role of perfectionism in schemas, cognitions, identity.* **Rehabilitation – school assisted with approaches to challenge perfectionism, individual program enables the adolescent to progress in spite of perfectionism, while providing positive feedback on completed work at less than "perfect" standard. Shifts occur over months.** "Agreeableness" may be to such an extreme an adolescent cannot set boundaries on others. They become overwhelmed trying to meet demands and expectations of others. *Treatment: Individual therapy – examine cognitions around setting boundaries. Family therapy – examine boundaries within family. Setting boundaries with others explored in individual therapy and with care coordinators in new interactions in transition to the community.* **Rehabilitation – nursing staff assisted with modelling boundaries, reflected on day to day interactions with peer demands in the ward, legitimised boundaries.** Utilised the community setting by in vivo practice of setting boundaries with peers, others.
b130 Energy and drive functions - Energy level, Motivation, Appetite, Craving, Impulse control	Behaviours; Sub – temperament, impulsivity issues, perceptuo-sensory sensitivities; DTA – negotiate school, self care, develop a sense of the future	Multiple issues present. Depression directly impacts energy, motivation, appetite. Motivation is decreased for an activity that is avoided due to anxiety. Anorexia negates appetite. ADHD may affect impulse control. Outside of disorder variations in motivation, energy and satiety levels can be functions of temperament. Adolescents range from very self-driven and motivated to very passive. Mental illness (affecting the developmental tasks) was imposed on any inherent level of energy and drive. Other factors. Some have high sensory thresholds and are sensory seeking affecting craving. Obesity due to sedentary lifestyle in social anxiety + cravings and lack of satiety feedbacks then impacts on identity, self image which reinforces social anxiety. *Treatment – multiple interventions (psychological, behavioural, pharmacological) to treat depression, anxiety, eating disorders.* **Rehabilitation: Resuming some schooling, peer interactions can prevent further impairment in the depression, maintain some level of motivation. Can contribute to a sense of hopefulness for**

		the future. Exposure to activities in the community not only a treatment for those with anxiety, but can motivate to explore further activities. Exposure to new activities (e.g. cooking groups, adventure therapy) provides a sense of mastery for some which then generalised into other areas. A variety of fitness activities enhance energy levels in the previously sedentary. Those with no inherent satiety mechanisms, or with limited range of appetite can explore cooking, meal portions etc. Sleep patterns and behaviours on leave monitored to enable generalisation to the community. The BAC community setting enabled observations of impacts in multiple domains, distinguished low motivation and energy due to mental illness from that due to inherent passivity.
b134 Sleep functions – Amount, onset, maintenance, quality of sleep; Functions involving the sleep cycle	Behaviours; DTA – care for the self	Depression, anxiety can both impact on sleep. Sleep reversal not uncommon prior to admission. Sleep may be impacted by PTSD symptoms. Some adolescents have sleep initiation insomnia not associated with a disorder. *Treatment – in vivo sleep hygiene practices implemented, pharmacotherapy sometimes effective. Utilising night staff to contain, explore emotions aroused by PTSD symptoms.* Nursing staff provided accurate monitoring of sleep patterns. For those with sleep reversal secondary to school refusal, the BAC community setting was a strong factor in normalising sleep patterns.
b140 Attention functions – Sustaining, shifting, dividing, maintaining attention	Behaviours; Sub – attention delays, perceptuo-sensory sensitivities	Symptoms of depression – poor concentration; of generalised anxiety – hyperarousal with shifting attention, difficulty sustaining attention; of PTSD – hyperousal, excessive shifting of attention. Adolescent may have undiagnosed ADHD. Some adolescents with complex PTSD have excessive concentration problems secondary to the effects of stress hormones in the brain. Perceptuo-sensory difficulties may produce difficulties with attention in certain environments where an adolescent is sensory sensitive. *Treatment for ADHD – pharmacotherapy, CBT; attention functions improved with treatment of anxiety, depression.* In the BAC community, nursing staff apply grounding techniques during flashbacks, dissociation. **Rehabilitation: small school classes (usually 5 – 6); shorter school periods with 15 minute breaks between periods; classes requiring greater concentration scheduled for morning; commence with morning walk; flexible so that those with serious sleep issues may miss first lesson; flexibility within lesson activities to cater for a range of concentration levels. Review of strategies to cope with poor concentration in transition to the community.**
b144 Memory functions - Short-term, Long-term, Retrieval of	Behaviours; Sub – learning delays	Included in this category are the intrusive memories of complex PTSD. *Treatment – grounding, sensory room, trauma-focussed CBT.* **Rehabilitation: Occasionally**

memory		**impaired memory persisted into transition. OTs worked to develop functional aides – check lists and more lately phone reminders.**
b152 Emotional functions, Appropriateness of emotion, Regulation of emotion, Range of emotion, Emotional functions – other, specified	DTA – Develop emotional maturity	Many adolescents do not have an emotional vocabulary (alexithymia). Some have a predominant emotion e.g. anger or depression for a range of emotions. Changes in these can take six months or more. *Treatment – individual therapy; social skills group; DBT group; non-verbal expressive therapies; supportive in vivo counselling by nursing staff on the ward in times of distress; family therapy to discuss emotions in home; in vivo monitoring of emotion (anxiety) in exposure exercises; experiential learning about emotions (e.g. adventure therapy).* BAC community contribution to learning – staff know of incidents about peers and family, can monitor and enable processing of emotional reactions at the time of the event or soon after. Administer "Reasons to self harm scale" to explore complexity of emotions around self harm proximal to the event.
b156 Perceptual functions - Auditory Visual, Olfactory, Tactile, Visuospatial perception	Behaviours; Sub - perceptuo-sensory	Trigger stimuli in PTSD identified (e.g. smells). Some adolescents sensory sensitive and become overwhelmed. *Treatment: " Grounding" to reduce dissociation when trigger stimuli occur, psychological therapies to decouple stimuli from dissociative response, utilise sensory room.* The BAC environment provided n vivo application of "grounding" and use of sensory room integral to improvement for adolescents with complex PTSD. Adolescents could become so dysregulated they were unable to apply techniques without expert assistance from staff they trusted. **Rehabilitation: OTs interpreted results from sensory profile into effects on real life situations, worked with adolescent to develop strategies to cope with potentially overwhelming stimuli e.g. shopping centres (excess sight, sound, movement).**
b160 Thought functions - Content of thought, control of thought	Behaviours	Content and control of thought difficult in severe anxiety disorders. *Treatment: CBT in individual therapy, DBT group.* **Rehabilitation: OT's worked with adolescents in rehabilitation activities involving exposure to enable adolescent to monitor thoughts and utilise strategies to control.**
b164Higher-level cognitive functions - Abstraction, Organization and planning, Time management, Cognitive flexibility, Insight, Judgement, Problem-solving	Behaviours; DTA – develop cognitive maturity, planning for the future	The difficulties in these areas are predominantly inherent and developmental. Adolescents lacking in these skills are less psychologically minded, take longer to benefit from psychological therapies (unless behaviourally based). Anxiety impairs cognitive flexibility, problem solving when confronted with anxiety provoking stimuli. *Treatment: CBT in individual treatment, elements of DBT group, problem solving a component of adventure therapy activities.* **Rehabilitation: school identified organisation, planning, time management, problem solving issues and assisted the adolescent to develop strategies to improve these areas. Teachers**

		had the skills to recognise emotional, temperament factors which may exacerbate these issues, and took account of these in approaches to strategies. OT's assessed for organisational skills, worked with adolescent to develop strategies. They worked with the adolescent to extend these strategies as the transitioned into the community. In the BAC environment, nursing staff enabled the adolescent to implement these strategies in day to day living.
b167 Mental functions of language - Reception of language, Reception of spoken language, Reception of written language, Reception of sign language, Expression of language, Expression of spoken language, Expression of written language, Integrative language functions	Sub – language delays, learning delays	Speech and language pathologist (SLP) identified difficulties in these areas, informed all staff on implications on the ward. *Treatment: SLP worked to reduce deficits, but this was often difficult, particularly in receptive areas.* **Rehabilitation: SLP worked with adolescents to develop insight into the difficulties, develop strategies to overcome these and overcome reticence to seek help, particularly in those with social anxiety. School considered strategies to optimise learning styles, provided guidance with respect to future educational implications.** Ideally stable ward staff could understand these difficulties and assist adolescent when observations on ward indicated it affected interactions with peers, staff.
b172 Calculation functions – Simple, complex calculation	Sub – learning delays; DTA – negotiate school, develop competencies to become independent.	Some adolescents had profound primary dyscalculia (maths equivalent of dyslexia), others had difficulties, but anxiety about these difficulties caused a block in this area. **Rehabilitation: School provided remedial help to progress from assessed (rather than expected level of function), worked on strategies to reduce anxiety about maths by structured exposure activities. Profound dyscalculia has significant implications for life skills – suitable employment goals, purchasing goods. OTs, school developed strategies around this. Nursing staff assisted with generalising strategies on outings.**
b176 Mental function of sequencing complex movements	Behaviours; Sub – motor delays, DTA – care for the self, developing competencies to become independent	Uncommon to be impaired, but for some with cerebral assault e.g. cerebral palsy, perinatal stroke, the limitations of physical movement augmented mental health issues in functional impairment. **Rehabilitation: OT's assessed function, obtained aides to function to optimise participation in activities of daily living.**
b180 Experience of self and time functions – Experience of self, Body image, Experience of time	Behaviours; DTA – coping with physical changes, identity	Distortions of experience of self evident in complex PTSD (derealisation, depersonalisation), as were distortions in time. Some adolescents have an inherently poor sense of time affecting organisational skills. Body image is an issue in anorexia, but obesity can be an exacerbating factor in social anxiety. *Treatment: "Grounding techniques" in individual therapy and supportive counselling by nursing staff, generalisation of DBT techniques, use of sensory room.* Comments as above in b156 apply. *In anorexia, impacts of body image on identity explored in individual therapy.* **Rehabilitation: A number of obese adolescents lost >30 kg through the various**

		fitness programs, with positive impacts on identity, motivation etc. Adolescents with anorexia assisted with negotiating tasks of adolescent development which had stalled (e.g. peer relationships, leisure) to lessen preoccupation with body image. Also benefitted from physical exercise to increase lean muscle mass in the process of gaining weight.
b BODY FUNCTIONS – CHAPTER 7 NEUROMUSCULOSKELETAL AND MOVEMENT-RELATED FUNCTIONS		
b710-b729 Functions of the joints and bones – Mobility and stability of joint functions, Muscle power, tone, endurance functions, Control of voluntary and involuntary movement functions, Gait pattern	Sub – motor delays	Many adolescents had inherent coordination difficulties or low muscle tone. This affected activities ranging from writing to catching a ball. Those with social anxiety disorder were sensitive to these physical differences from their peers. It exacerbated the social anxiety disorder. Conversely, some withdrew from activities because of social anxiety, with lack of participation in skills and subsequent stalling of skills development. Some sedentary adolescents struggled to walk 200 metres on admission. **Rehabilitation: After assessments by OTs, and sometimes the physiotherapist from The Park, interventions ranged from individualised programs to build core tone, improve pencil grip or writing skills to group activities (morning walk, physical education, targeted exercise programs in the school), external gym, swimming, adventure therapy with the OTs to use of trampoline on the ward, recreation activities in the afternoons and evenings organised by nursing staff. At times, the school and OTs facilitated use of technologies rather than writing for learning programs. The range of fitness programs improved endurance.** I consider the combination of individual and group programs run within the BAC community with which they were becoming familiar, essential to engaging an adolescent with social anxiety, further motivating them to explore new challenges. There would be more resistance to engaging on either an individual basis or in combination with group activity with a group they were not familiar.
d ACTIVITIES AND PARTICIPATION -d1 CHAPTER 1 LEARNING AND APPLYING KNOWLEDGE		
d110-d129 Purposeful sensory experiences – Watching, Listening, Other purposeful sensing	Behaviours; Sub – perceptuo-sensory sensitivities,	Sensory intrusions in PTSD noted previously. Some adolescents have a very high threshold for sensory activity, causing them to miss cues. *Treatment: DBT and applications of "mindfulness" with generalisation by nursing staff to particular situations.*
d130-d159 Basic learning – Copying, Rehearsing, Learning to read, Learning to write, Learning to calculate, Acquiring skills, Basic	Sub – learning delays, language delays; DTA – negotiate school	Only recently has literature emerged on the potential contribution of learning difficulties to school refusal and social anxiety. Learning issues in adolescents with complex PTSD or anorexia contributed to issues with identity. **Rehabilitation: From initial assessments, the school identified the issues. Teachers spend**

learning,		**considerable time desensitising some students to the school environment (learning environment, peers, academic challenges) and progressively engaged them in education. They provided remedial help to adolescents whose attainments were at mid-primary school level.** For those with anxiety, the BAC community effects of small classes, a familiar group of peers with whom they became comfortable, and teachers with an understanding of anxiety was essential to engagement.
d160-d179 Applying knowledge - Focusing attention, Thinking, Reading, Writing, Calculating, Solving problems, Making decisions, Applying knowledge, other specified	Behaviours; Sub – attention delays, learning delays, language delays; DTA – develop cognitive maturity, negotiate school	Lack of attendance at school was an issue for most in maintaining knowledge and skills. Some experienced the effects of specific mental illnesses on cognitive functioning (chronic psychosis, complex PTSD and sometimes anorexia nervosa. **Rehabilitation: Maintaining existing skills, or at least some engagement in learning was important to identity for those with cognitive deficits secondary to severe illness. Small class room size, teachers who understood the impacts who could develop strategies how to support in some continued engagement and then being able to assist with developing alternate educational pathways was important. Teachers had to cope with a complex environment – students in a range of years, with different learning capabilities with different impacts of mental illness. This was the application of knowledge within the classroom. Outside the classroom, both teachers and OTs enabled adolescents to apply this knowledge in a range of activities – cooking groups (reading recipes, estimating quantities, shopping for ingredients), cafe days (taking orders, money), going to the Brisbane markets to fill orders etc. In these activities they assisted the skill of each individual in deciding on tasks, and facilitated their gaining further skills.**
d ACTIVITIES AND PARTICIPATION - d2 CHAPTER 2 GENERAL TASKS AND DEMANDS		
d210 Undertaking single tasks (d210) or multiple tasks (d220) - Undertaking a simple task, a complex task, Undertaking single or multiple tasks independently, Undertaking single or multiple tasks in a group	Behaviours; Sub – learning delays, motor delays, sociability; DTA – develop cognitive maturity, develop competencies to become independent	Adolescents often participated in a narrow range of activities because of the limitations of the mental illness. Many only participated in basic self care and accessing social media, computer games. They did not participate in chores at home. **Rehabilitation: Involvement in group activities – maintaining the school garden, participating in landscaping projects (measuring building), planning for holiday program activities, meal preparation groups, adventure therapy activities. Flexibility to do it one on one with teachers, OT, nursing staff or in a group.** I considered the range of programs, the size and familiarity of the group in the BAC community, opportunities for both peer learning, teaching and support and tangible outcomes which developed mastery and competencies to be important elements which worked in combination. They would be hard to replicate individually.

d240 Handling stress and other psychological demands - Handling responsibilities, Handling stress, Handling crisis	Behaviours; Sub – temperament; DTA – develop cognitive maturity, develop emotional maturity, establish boundaries, develop competencies to become independent, develop life schemas,	Various mental illness predisposed to difficulties in handling stress. In addition, there were individual variations in the capacity to handle stress and offer support. *Treatment: Individual psychological therapies assisted recognising stress, approaches to stress. Elements of DBT group discussed strategies to handle stress. Nursing staff assisted in vivo generalisation from these to enable adolescents to manage stressful situations either on the ward or in transition. The excessively prosocial adolescent was encouraged at times to limit support in others distress so that they did not become overwhelmed. Others learned to problem solve.* **Rehabilitation: Some in vivo modelling of strategies to handle stress, crisis and responsibilities in the adventure therapy group. Transition involved a new set of stresses. Staffed assisted the adolescents to implement these strategies into the community.** I considered the group process in the BAC community helped to generalise the approaches to deal with stress, enabled development of peer support as well as modelling from peers in more emotionally neutral situations (e.g. adventure therapy).
d ACTIVITIES AND PARTICIPATION - d3 CHAPTER 3 COMMUNICATION		
d310-d329 Communicating – receiving - spoken messages - nonverbal messages, body gestures, general signs and symbols, drawings and photographs, formal sign language messages, written messages d330-d349 Communicating - producing - Speaking, Producing nonverbal messages, Producing body language, Producing signs and symbols, Producing drawings and photographs, Producing messages in formal sign language, Writing messages d350-d369 Conversation and use of communication devices and techniques - Starting a conversation, Sustaining a conversation, Ending a conversation, Conversing with one person, Conversing with many people Discussion with one person, Discussion with many people	Behaviours; Sub – sociability, language; DTA – negotiate peer relationships, develop life schemas	Difficulties with communication strategies can be a contributing factor to social anxiety, which exacerbates the difficulties of perceiving judgment of others. Adolescents with Asperger's have difficulties with communication, but others have deficits in social skills without meeting the criteria for Asperger's. The deficits described can be core deficits in Expressive – Receptive Language Disorder. **Rehabilitation: Core social skills and communication skills addressed in the Social Skills group run by SLP and psychologist. Some elements of DBT group applicable to this area. Regular nursing staff mixing in ward environment with adolescents both modelled conversational skills, and enabled adolescents to generalise skills from the group to the ward conversations. Teachers promoted structured activities to enhance discourse, listening and discussion skills.** The integration of these various activities within the stable community of BAC peers and core staff was essential to developing conversational skills. *Treatment: Generalisation of skills to the family in family therapy. Discussion in individual therapy about conversational difficulties in outside settings – e.g. application of these skills in transition to an external school, TAFE.*
d ACTIVITIES AND PARTICIPATION - d4 CHAPTER 4 MOBILITY		
d430-d449 Carrying, moving and handling objects - Fine hand use,	Sub – motor delays; DTA – occupy leisure time. Identity	Leisure often became very constricted, and skills became dormant. Many adolescents had not had opportunities to explore any range of activities. At times difficulties in

Hand and arm use, Reaching, Throwing, Catching		these areas impacted on identity. **Rehabilitation: Individual assessment of motor function, individual coordination exercises with OT, school fitness and physical activity programs provided exposure in a safe environment to a number of sports. Alternative strategies developed (e.g. use of technology, aides) if physical limitations caused significant impairment.** Learning in a group environment fostered participation, motivation to push through limits.
d450-d469 Walking and moving - Walking short distances, Walking long distances, Climbing, Running, Jumping, Swimming,	Behaviours; Sub – motor delays; DTA –occupy leisure time, identity	Some with chronic school refusal were extremely unfit on admission. They did not participate in any physical activity. Some with complex PTSD had very restricted activity because of prolonged hospitalisation. Those with a severe eating disorder typically participated in a narrow range of activities in social isolation. Some came from developmentally impoverished environments. As for above comments with respect to occupy leisure time and impacts on identity. **Rehabilitation: School – morning walk, group exercises, physical education program, gardening program. OTs – programs at external gyms and swimming pools, holiday program activities, adventure therapies. Nursing staff provided opportunities for impromptu participation in physical activities. Importantly, OTs and care coordinators assisted an adolescent in engaging in activities in the outside communities once the adolescent was confident with some degree of mastery.** These activities performed initially with other members of the BAC community provided a safe environment to extend oneself, develop new skills which could then be generalised to the outside community.
d470-d489 Moving around using transportation - Using human-powered vehicles, Using private motorized transportation, Using public motorized transportation, Driving	Behaviours; Sub – motor delays; DTA –occupy leisure time; develop competencies to become independent, identity	Adolescents with severe social anxiety typically avoided public transport. This could be exacerbated by learning deficits. Those with complex PTSD and severe psychosis were often uncomfortable on public transport in proximity to strangers. **Rehabilitation: School organised bike riding around The Park in lieu of the morning walk to engage adolescents in bike riding as an activity. OTs and some teachers had a longer bike riding group. Various individual and group outings in the BAC car, but often by public transport. OT worked with adolescents to look up timetables, plan trip. Assessed skills and enabled buying a GoCard, identifying trains, buses, stops. Worked with care coordinator to desensitise to crowds, develop safety strategies on public transport etc. Trained staff (nursing, OT) were able to use these exercises in progressive exposure, being sensitive to the adolescent's levels of anxiety, and grading the activity accordingly. Adolescents were either assisted with or encouraged to use public transport to access leave to generalise this skill into the community. OTs facilitated access to**

		online practice sessions for the Learner's Permit, and once obtained, helped arrange driving lessons.
d ACTIVITIES AND PARTICIPATION - d5 CHAPTER 5 SELF-CARE		
d510 Washing oneself, d520 Caring for body parts – skin, teeth, hair d530 Toileting - Regulating urination, Regulating defaecation, Menstrual care	Behaviours; Sub – motor delays; DTA - care for the self Behaviours; Sub – motor delays; DTA - care for the self	Self care deteriorated in some adolescents with severe school refusal. They were frequently oppositional when asked to do basic self care. Some adolescents continued to have primary enuresis (bed wetting), or much less frequently encopresis (faecal incontinence). Some adolescents with complex PTSD had re-experiencing phenomena in the shower, with resultant avoidance of bathing. *Treatment: A preliminary treatment protocol was implemented for enuresis, including reviewing medication, waking to go to toilet etc. This may be done under the advice of an enuresis clinic. Adolescents with complex trauma were desensitised to the bathroom if possible, or assisted with "grounding" strategies otherwise.* **Rehabilitation: establishing daily routines on the ward, assessment of skills. Sometimes aides for using the shower, eating utensils etc for those with a physical disability were provided. Nursing staff monitored evidence for actual washing if it became apparent the adolescent went to he shower, turned the water on but had not washed. They worked through reasons and strategies. Adolescents were encouraged to maintain self care on leave.** The BAC community environment facilitated peer group acceptance of routines. Motivation to fit in with the peer group was a strong motivating factor to establish and maintain self care routines.
d540 Dressing - Choosing appropriate clothing, Eating, Drinking, Looking after one's health, Ensuring one's physical comfort, Managing diet and fitness, Maintaining one's health	Behaviours; Sub – motor delays; DTA – coping with physical changes, care for the self, identity	Choosing appropriate clothing was more of an issue with some of the girls than the boys. At times this was related to identity, particularly for some with complex PTSD. At other times it was evidence of a slightly "manic" phase. Often it was an awareness of emerging sexuality in the context of coping with physical changes. There were times when adolescents with extensive scarring needed to be sensitive to their choice of clothes in consideration of the impact on others e.g. when applying for a job, serving customers. Looking after health and managing diet and fitness were issues for those who were sedentary secondary to social withdrawal, and those with an eating disorder (anorexia or bulimia). *Treatment: Predominantly and issue in those with an eating disorder. Work through eating disordered cognitions. Provided dietary advice, support and meal plans in association with dietitian. Where trauma contributed to the disorder, treatment of trauma resulted in improvements in health and diet. For those with complex PTSD, working through impacts of trauma on identity, helped resolve some of the clothing issues. Adolescents in a "manic phase" usually responded to limit setting. It was rarely a full blown bipolar disorder.*

		Rehabilitation: Strong relationships with staff to accept limits with inappropriate clothing. Active fitness programs run by both the school and OTs. Healthy eating program (including produce from the kitchen garden) run by school and OT. Generalisation into the community – healthy eating on leave, participation in local fitness activities – e.g. enrolment in gym when transition begun.
d ACTIVITIES AND PARTICIPATION - d6 CHAPTER 6 DOMESTIC LIFE		
d610-d629 Acquisition of necessities - Acquiring a place to live, Renting a place to live, Furnishing a place to live, Acquisition of goods and services – Shopping, Gathering daily necessities	Sub – learning delays; DTA – develop cognitive maturity, develop competencies to become independent, develop life schemas, develop a sense of the future	This was particularly relevant for adolescents who were unable to return home. Learning delays (dyslexia, dyscalculia) could have a significant impact, as could an inherent lack of organisational skills. **Rehabilitation: OT, social worker, care coordinator helped the adolescent to look for supported accommodation, or on occasions rent a flat. They ascertained with the adolescent what was required to set up in that accommodation, and then shop for the necessities, budgeting as necessary. Strategies to overcome impacts of learning delays developed.**
d630 Preparing meals - Preparing simple meals, Preparing complex meals d640 Doing housework - Washing and drying clothes and garments, Cleaning cooking area and utensils, Cleaning living area, Using household appliances, Storing daily necessities, Disposing of garbage	DTA – develop cognitive maturity, care for the self, develop competencies to become independent, develop identity	**Rehabilitation: Individually and in the group, both through the school and OTs, adolescents were enabled to plan meals, shop for the ingredients, cook the meal and clean up afterwards. Preferably adolescents would be self sufficient in regularly organising their own breakfast and lunch. Opportunities for this were limited. Adolescents were encouraged to cook meals at home on leave. Adolescents were encouraged to use the washing machine on the unit, and hang out their clothes, using the dryer only as a second option.**
d650-d669 Caring for household objects - Maintaining dwelling and furnishings, Taking care of plants, indoors and outdoors	DTA – develop cognitive maturity, care for the self, develop competencies to become independent, develop identity	Often there were not opportunities for this. Because of a lack of cleaning time by the cleaners in the last few months, adolescents took on the responsibility of cleaning their own area. This would be desirable consistent with work place health and safety. **Rehabilitation: Adolescents cared for school garden.**
d660 Assisting others - Assisting others with self-care, in communication, in interpersonal relations, in nutrition, in health maintenance	Sub – temperament, sociability; DTA – establish boundaries, negotiate peer relationships, develop identity, develop life schemas	Some adolescents were always willing to offer support to others to the detriment of their own physical health. Other adolescents were always disparaging of others. There were times it was inappropriate to offer assistance. We discouraged adolescents from talking with others about their issues, but instead direct it to staff. **Rehabilitation: If an adolescent was well enough, and had the competencies, they were encouraged to help others in group activities, e.g. provide help with measurements in cooking group, offer encouragement to peers in their activities, practical assistance to peers in the adventure program etc. The highly prosocial**

		adolescent was encouraged to direct others who wanted to talk about their problems instead to staff. Social skills groups examined a perspective on others. Assistance with generalising into the community (e.g. relationships at a transition school) were processed in individual therapy, with the staff who picked them up from school (if they required transport) or their care coordinator.
d ACTIVITIES AND PARTICIPATION - d7 CHAPTER 7 INTERPERSONAL INTERACTIONS AND RELATIONSHIPS		
d710-d729 General interpersonal interactions - Basic interpersonal interactions - Respect and warmth in relationships, Appreciation in relationships, Tolerance in relationships, Criticism in relationships, Social cues in relationships, Physical contact in relationships; Complex interpersonal interactions - Forming relationships, Terminating relationships, Regulating behaviours within interactions, Interacting according to social rules, Maintaining social space, Complex interpersonal interactions, other specified	Behaviours; Sub – temperament, sociability, language delays; DTA – develop emotional maturity; establish boundaries, negotiate peer relationships, develop moral maturity, develop identity, develop life schemas	This was an area of great difficulty for many adolescents, and contributed to maintaining both symptoms and impairment. Adolescents with Asperger's had difficulties in interpreting social cues and basic interpersonal interactions. The adolescent with severe social anxiety withdrew because they had difficulties in tolerating criticism. The small closed BAC community had negative and positive effects on these. Adolescents had a small cohort of peers with whom to make friendships. Often there were a number of factors which were likely to make peer relationships more difficult. Many of these may not be in their friendship group even if both were well. The adolescent could suffer considerably if adversely impacted by peers. On the other hand, the closed group offered opportunities for exposure to peers, close supervision of adverse interactions and formal and informal opportunities to examine the nature and dynamics of peer relationships. *Treatment: Individual therapy offered opportunities to examine the dynamics and contexts of relationships, emotions arising out of difficult relationships, setting boundaries, challenging cognitions of perceived criticisms etc.* **Rehabilitation: The Social Skills group and elements of the DBT group specifically addressed aspects of interpersonal relationships. Activity groups (cooking groups, bike riding, adventure therapy) offered opportunities to develop assistance for others, tolerance of other's limitations, communicating clearly, receiving help. The morning meeting (chaired by an adolescent) provided a forum for feedback on certain behaviours. Staff assisted with behavioural regulation in interpersonal relationships. There were opportunities for teaching and nursing staff to provide reflection on social relationships in day to day activities.**
d730-d779 Particular interpersonal relationships - Relating with strangers	Behaviours; Sub – temperament, sociability, language delays; DTA – develop emotional maturity; develop moral maturity, establish boundaries, develop	Adolescents with social anxiety had to moderate cognitions, withdrawal behaviours and physical symptoms around strangers. Some with complex PTSD experienced perceptual disturbances around strangers reminding them of the abuser. Others tended to interact inappropriately with strangers. Some had behavioural inhibition since childhood. Adolescents with Asperger's varied from those who withdrew to those who approached in an inappropriate manner. *Treatment: Individual psychological*

	identity, develop life schemas	*treatments for Social Anxiety and issues arising out of complex PTSD, including treatment of symptoms, exploration of identity etc. Individual treatment with adolescents with Asperger's focussed on understanding nature of social relationships and developing life schemas.* **Rehabilitation: Staff monitored and assisted with interactions with strangers on community outings – included being served in shops, supervision of inappropriate comments, discussing any adverse comments from strangers and providing the opportunity to reflect on feedback. In vivo feedback by staff of protective behaviours, setting boundaries. These activities were a part of ad hoc interventions on community outings, or reflections after an adolescent went on leave.** The BAC environment was enhanced by close interactions with adolescents, knowledge of patterns of interactions of the adolescent from multiple direct observations in various settings.
Formal relationships - Relating with persons in authority, Relating with equals, Formal relationships, other specified	Behaviours; Sub – temperament, sociability, DTA – develop life schemas, establish boundaries, develop moral maturity,	These relationships are aspects of going to a new external school or commencing employment. Inherent sociability and approach factors, social anxiety and perceptions of others (life schemas) all impact on the adolescent. **Rehabilitation: Provide rehearsal strategies prior to an interview, support during and feedback post interview.** *Treatment: In individual therapy, review with adolescents relationships in school and work place after placement*
d730-d779 Particular interpersonal relationships - Informal social relationships - Informal relationships with friends, with neighbours, with acquaintances, with co-inhabitants, with peers, Informal social relationships, other specified	Behaviours; Sub – temperament, sociability, language delays; DTA – develop emotional maturity; establish boundaries, negotiate peer relationships, develop moral maturity, develop identity, develop life schemas	Avoidant behaviours of social anxiety; dimensions of agreeableness/disagreeableness in temperament, inherent social skills all affected the capacity of some adolescents to manage informal social relationships appropriately to a particular relationship. The primary external peer group for some adolescents was peers they met in acute inpatient units. The comments in d710 – 729 apply in this section. *Treatment: Social skills group examined aspects of different relationships. Elements of DBT group provided skills in dealing with relationships. Individual therapy examined relating to others on the unit, relationships with peers external to the unit, setting boundaries, re-evaluating friendships as they formed a new identity, dealing with antisocial influences. Supportive counselling from nursing staff also helped adolescents to process these issues after leave, phone calls from others.* **Rehabilitation: Provide feedback on interactions during and after unit based activities.**
d760 Family relationships - Parent-child relationships, Child-parent relationships, Sibling relationships, Extended family relationships, Family relationships, other specified	Behaviours; Sub – temperament; DTA – develop cognitive maturity, care for the self, develop moral maturity, develop emotional maturity,	Whatever the family dynamic, adolescents prior to admission had come to some degree of functional standstill. Negative emotions were expression at high levels, whether on by parents or by adolescents or the interaction of both. Role changes were almost inevitable, with parents having to take on a greater carer role than expected, or being unable to do this. *Treatment: Family therapy was a key intervention to explore*

	establish boundaries, develop competencies to become independent, develop identity, individuate, develop life schemas	*communication styles, roles, expression of emotion, interactions between family members. In addition, individual therapy enabled an adolescent to explore their emotions, perceptions of themselves within the family, and how this could change, individuation. Both processes – family and individual therapy focusing on family interactions were important.* **Rehabilitation: General rehabilitation approaches described in previous sections – from greater participation in self care, assuming greater responsibilities for self, resuming educational or vocational pathways enabled the adolescent to assume a different role within the family.** When adolescents experienced good quality care in the family, they should have experienced a continuation of care within the unit. Staffing instability had an enormous impact on the care they experienced from some staff. For adolescents who experienced sub-optimal care in the home environment, the care they experienced in BAC from the stable staff often was a dilemma. They told us later their dilemmas could be whether to trust staff, why staff cared for them, why parents had not cared or could parents care enough if the adolescent tried to please them more. Trust issues were resolved by observing key staff over time. *Treatment: In these cases, individual therapy enabled them to grieve over the parent who "should have been"; explore emotions of self worth as to why they were not worthy of care; develop schemas of life in planning for the future where they had to assume care at an earlier stage than they wished.* One of the issues was to provide clear boundaries on the care BAC was able to provide, and what it could never make up for a failure of parenting. **Rehabilitation activities enabled the adolescent to be equipped to assume self care, and provide support through ongoing contact to mature into that self care.**
d770 Intimate relationships - Romantic relationships, Sexual relationships, Intimate relationships, other specified	Behaviours; Sub – temperament, sociability, impulsivity issues; DTA – negotiate peer relationships, establish boundaries, develop moral maturity, develop identity	Romantic relationships presented significant challenges when they occurred. They were discouraged because of the impacts on the adolescents involved, on their peers and the moratorium on therapeutic progress for the individual adolescents in the romantic relationship. At times, an adolescent was discharged if the impacts were significant, and it was safe to do so. Where possible, we attempted to head off relationships by rules about pairing off in the very early stages, about physical proximity. I am aware of opposite sex intimate relationships occurring on only two occasions while at The Park. The layout of the ward, supervision of staff, monitoring ground leave made this possible. Possibly in the last seven years of BAC, same sex intimate relationships between girls occurred on occasions in the four bed rooms. When staff became aware, the involved parties were separated into different sleeping areas, and some degree of shower supervision was implemented. There was one case

		of same sex assault which resulted in criminal charges. Sexualised behaviours between boys (but not intimate relationships) occurred on occasions. All cases were assessed as to the impact on the adolescent. The opportunity to lay charges was afforded. On occasions, adolescents entered into romantic relationships with peers external to the unit. If this was within the age of consent (as it was in all cases I recall), the family were encouraged to provide the primary guidance. **Rehabilitation: Relationships were discussed in various groups during the course of admission, so that the adolescent had some guidance beforehand to consider relationships. Adolescent love proceeded regardless.** *Treatment: At times, an adolescent discussed relationship difficulties in individual therapy. These were usually well in the transition phase.*
ACTIVITIES AND PARTICIPATION - d8 CHAPTER 8 MAJOR LIFE AREAS		
d810-d839 Education - Informal education, School education, Vocational training, Higher education, Education, other specified and unspecified	DTA – negotiate school, negotiate peer relationships, develop life schemas	**Rehabilitation: Measures to engage adolescents in education was described in sections b167, 172 and d160 - 179. The school had the capacity to provide education from a remedial level to doing OP level subjects through enrolment in the School of Distance Education. A number of Certificate level courses were available through the school through collaboration with TAFE. Considerable effort was made to engage adolescents with external education providers – mainstream schooling, alternate schooling, TAFE, private RTOs. Adolescents were taken to Career Expos and (if relevant) Uni Expos. The school provided guidance about suitable career choices, subject choices, based on abilities. At times adolescents required support in adjusting their educational and career goals either because of the impacts of the mental illness or because of their abilities. This took months at times if there was considerable emotional investment in the goal.** **Very anxious adolescents often required a form of graduated exposure to an external school, TAFE or other facility. Considerable support was provided in the initial phases –the adolescent was transported to the facility, staff waited at the facility for the negotiated lessons, then brought them back to BAC. Support was withdrawn in stages until the adolescent attended independently. OTs facilitated enrolment in specific training courses – e.g. barista courses.**
d840-d859 Work and employment - Apprenticeship (work preparation), Acquiring, keeping and terminating a job, Seeking employment,	Sub – learning, language delays; DTA – develop cognitive maturity, develop competencies to become	**Rehabilitation: BAC school arranged work experience for a number of adolescents. The school was able to arrange traineeships on occasions. Both the school and OTs assisted adolescents with drawing up resumes. OTs and care coordinators assisted adolescents with handing out resumes and job applications.**

Maintaining a job, Terminating a job, Remunerative employment, Part-time employment, Full-time employment, Non-remunerative employment	independent, establish boundaries, develop life schemas	**OTs and care coordinators provided support in attending interviews, spoke to employers. Some adolescents engaged in part time work prior to leaving the unit.** *Treatment: Any difficulties in employment could be discussed in individual therapy, or with the OTs or care coordinators. Sometimes resolution was required, at other times, adolescents were assisted in negotiating resolution of workplace bullying.*
d860-d879 Economic life - Basic economic transactions, Complex economic transactions, Economic self-sufficiency, Personal economic resources, Public economic entitlements Economic self-sufficiency, other specified	Sub – learning, language delays, impulsivity issues; DTA – develop cognitive maturity, develop competencies to become independent,	**Rehabilitation: The social worker or OTs facilitated application for Centrelink benefits for eligible adolescents. OTs assisted adolescents to open a bank account if they did not have one. OTs spent time enabling adolescents to develop budgets. Where parental support was provided, parents were asked to provide a certain allowance. Nursing staff assisted adolescents to budget within this allowance. School trips to the markets provided adolescents experience in judging value. OTs and nursing staff provided opportunities for adolescents with independent incomes to shop in store and online while learning to live within a budget. Holiday program activities provided opportunities for more limited decisions about expenditure within a budget.**
d ACTIVITIES AND PARTICIPATION - d9 CHAPTER 9 COMMUNITY, SOCIAL AND CIVIC LIFE		
d910 Community life - Informal associations, Formal associations	DTA – develop life schemas	**Rehabilitation: Exposure to community agencies (e.g. volunteering at an animal welfare facility) was arranged by the school. OTs explored opportunities for community engagement e.g. scouts, State Emergency Service, St John's.**
d920 Recreation and leisure – Play, Sports, Arts and culture, Crafts, Hobbies, Socialising, Recreation and leisure, other specified	Sub – motor delays; DTA – negotiate peer relationships, occupy leisure time, develop cognitive maturity, develop identity	**Rehabilitation: School, OTs and nursing staff provided adolescents with exposure to a range of leisure activities – indoor and outdoor sports, ice skating, craft and woodworking shows, theatre, concerts, beach activities and fishing etc. Endeavours were made to keep an adolescent from regional areas who played a sport previously to link with a local team and play on weekends. Staff assisted adolescents with linking with local recreational facilities when on leave, as part of the transition process.**
d930 Religion and spirituality - Human rights, Political life and citizenship, Community, social and civic life, other specified	DTA – develop life schemas, develop identity, negotiate peer relationships	**Rehabilitation: Adolescents were supported in exploring spirituality and participate in organised religion. Usually the latter was involvement in a youth group relevant to the faith the wished to explore. They were actively supported in attending from the unit if they were unable to access leave. School provided education and exposure to the political process. Those exploring issues of sexuality were linked to an appropriate organisation providing peer support.**
e ENVIRONMENTAL FACTORS – e1 CHAPTER 1 PRODUCTS AND TECHNOLOGY, e3 CHAPTER 3 SUPPORT AND RELATIONSHIPS, e4 CHAPTER 4 ATTITUDES		
e125 Products and technology for	Behaviours, DTA – negotiate	Social interactions with peers for a number of adolescents with severe social anxiety

use in personal communication	peer relationships, develop emotional maturity	were often limited to online contacts. *Treatment: Examine use of social media for expressing emotions (some sites such as Tumblr) – explore what was posted, what should be private; explore coping with cyber-bullying in individual therapy (including limiting accounts). Explore online contact with peers vs face to face interactions in social skills groups.* **Rehabilitation: Provide support for and monitoring of accessing websites, online buying and communication.**
e125 Products and technology for use in education	DTA – negotiate school	**Develop competencies in the use of technology in schools. Provide support for online education which can be transferred to outside settings.**
e310 Support and e410 Individual attitudes of Immediate family, e315 Support and e415 Individual attitudes of extended family members	Sub – temperament; DTA – care for the self, develop moral maturity, develop emotional maturity, establish boundaries, develop competencies to become independent, develop identity, individuate, develop life schemas	Levels of support in families varied greatly. Some parents provided excellent support to a very unwell adolescent, at expense to their own health, career, finances etc. Other parents struggled to provide continuing support in the face of continued unwellness, while other's lack of support was a significant factor in deterioration for the adolescent. *Treatment: Family therapy ascertained levels of support within the family, and sought to improve communication and understanding of emotions to enhance levels of family support. Individual therapy assisted the adolescent to reflect on support they required of the family – what was realistic, situations in which they needed support, unrealistic demands, their participation as emerging adults in the family. Also assisted some adolescents who found little support in family relationships to work through the emotions that this engendered. Provided an evaluation of supports from extended family members. Extended family engaged where necessary.* For some families, the opportunity to consider issues while family members were apart, and tensions were lower, enabled them to implement strategies which were difficult in the community.
e320 – e 345 Support and e420 – e445 Individual attitudes of friends, Acquaintances, peers, colleagues, neighbours and community members, People in positions of authority, Strangers	Behaviours; Sub – temperament; DTA –care for the self, develop moral maturity, develop emotional maturity, establish boundaries, develop competencies to become independent, develop identity, individuate, develop life schemas	Adolescents varied in capacity to obtain support from others – some with complex PTSD were wary of others; those with persisting social anxiety had a limited group whom they could trust would not be judgmental; those with Asperger's sometimes lacked the approach skills to gain support; the overly prosocial adolescent preferred to help others rather than recognise their own need for support. *Treatment: Social skills, elements of DBT groups enabled adolescents to reflect on the mutual nature of support in the community. Individual therapy provided opportunities for reflection nature of supports, setting boundaries in some cases on the demands of others for support, recognising grooming behaviours vs genuine support from others. Care coordinators and the individual therapist help adolescents in transition process a new set of support networks and attitudes of others.* **Rehabilitation: Various group activities (e.g. adventure therapy enable adolescents to receive and give support).**

		Living in the BAC community, adolescents learn to live with and process a variety of attitudes to strangers with whom they become better acquainted.
e355 Support and e450 Individual attitudes of health professionals, and of health-related professionals	DTA – develop cognitive skills, develop competencies to become independent	*Careful transition of therapies to clinicians in the community. Sometimes link to a new GP.*

West Moreton Hospital and Health Service

Enquiries to: Workplace Relations
Telephone:
Facsimile:
Our Ref:

Dr Trevor Sadler

Dear Dr Sadler

Complaint made in relation to

I refer to your employment as a Clinical Director with the Barrett Adolescent Centre (**BAC**)

As you are aware an external investigator was appointed to conduct an investigation into the allegations and you were provided with an opportunity to be interviewed as part of the investigation process on 4 November 2013.

The investigator has now finalised the investigation and the investigation report has been provided to me as the decision maker (the **Investigation Report**).

The investigation found that a number of allegations were substantiated, as outlined in the Investigation Report.

On consideration of the Investigation Report I have decided to put the following allegations to you for response.

BACKGROUND

(a) At all times relevant to these allegations you were employed as Clinical Director, BAC, West Moreton Hospital and Health Service.

(b) At all times relevant to the allegations you were responsible for the management of BAC.

Office
Queensland Health

Postal

Phone

Fax

Possible grounds for discipline

I have considered the information currently available to me in respect of Allegation Four and consider there may be grounds for you to be disciplined pursuant to the *Public Service Act 2008*, sections:

1. Section 187 (a), that you may have performed your duties carelessly, incompetently and/or inefficiently. If the allegation that you failed to ensure that you and employees at BAC accurately recorded incidents and correspondence with the Complainants in the clinical notes, it may be found that you performed your duties carelessly, incompetently and/or inefficiently.

CRIME AND MISCONDUCT COMMISSION

The concerns raised by the Complainants were referred to the Crime and Misconduct Commission on 10 October 2013 and were referred back to West Moreton Hospital and Health Service for investigation.

POSSIBLE DISCIPLINARY ACTION

In accordance with the principles of natural justice, no determination has been made or will be made until you have had the opportunity to respond.

Should a determination be made that there are grounds for you to be disciplined pursuant to the *Public Service Act 2008* the disciplinary action that may be taken includes, but is not limited to, one or more of the following:

(a) termination of employment
(b) reduction in classification level and consequential change of duties
(c) transfer or redeployment to other public service employment
(d) forfeiture or deferral of a remuneration increment or increase
(e) reduction in remuneration
(f) imposition of a monetary penalty
(g) direction that a penalty imposed be deducted from periodic remuneration payments
(h) a reprimand.

Lewis, Erin

From:	Robert King
Sent:	Friday, 17 January 2014 5:00 PM
To:	Tali Gibson
Subject:	Response to Show Cause - Dr T Sadler
Attachments:	Response to Show Cause by Dr T Sadler.pdf

We attach a copy of the response by Dr T Sadler to the letter to him of 11 December 2013, requiring him to show cause in relation to 4 allegations. The allegations concern matters at the Barrett Adolescent Centre.

The hard copy will be forward by express post.

If you have any questions, please contact us.

Robert King
Special Counsel
K&L Gates
Level 16, Central Plaza Two, 66 Eagle Street
Brisbane QLD 4000, Australia
Phone:
Fax:
Mobile:

www.klgates.com

Background

Your letter notes "at all times relevant to these allegations you were employed as Clinical Director, BAC, West Moreton Hospital and Health Service. At all times are relevant to the allegations you were responsible for the management of BAC."

My role as the Clinical Director is complex. The functions, authorities and responsibilities need to be clarified and understood to give context to and to understand my response to a number of the allegations. Accordingly, as part of this background section, I will describe:

- the changes in my role;
- my role in clinical leadership (as Clinical Director);
- my leadership role within the BAC Management Committee;
- line management responsibilities; and
- the limitations on my capacity and responsibility for the management at BAC.

Changes in my role

1989 - 1991	I was appointed Visiting Medical Officer (psychiatrist) with the Division of Youth Welfare and Guidance. My services were to be provided (initially) to the Barrett Adolescent Centre **(BAC)**. If however, the permanent psychiatrist already in the VMO role returned to BAC, I was to be transferred to a community Child Guidance Clinic (the precursors of CYMHS). In my VMO role, I was also Acting Medical Director. From 1989 – 1991 the Medical Director at BAC - Dr C Breakey - was the Acting Senior Medical Director of the Division of Youth Welfare and Guidance. The organisational chart relevant to this time denotes the psychiatry registrar and medical officer as reporting to the Medical Director who in turn reported to both the Senior Medical Director of the Division of Youth Welfare and Guidance and also to the Medical Superintendent of the Wolston Park Hospital. In accordance with the organisation chart, the child guidance therapists reported to the Senior Child Guidance Therapist of the Division of Youth Welfare and Guidance. The psychologist, social worker and occupational therapist were seconded from the Division of Youth Welfare and Guidance and reported to their discipline seniors in both the Division and Wolston Park Hospital. Nursing staff were seconded from the Wolston Park Hospital. They reported to the Nursing Supervisor who reported to the Matron of the hospital. Department of Education staff reported solely to the hierarchy of the Department of Education. Because there were complex lines of reporting (no one person or discipline had over all management responsibility, but each relevant

	discipline had responsibility for their own staff) the overall management of BAC was undertaken by a BAC Management Committee (**Committee**). The Committee comprised: ◦ the Medical Director; ◦ the Nursing Supervisor; ◦ the School Principal; and ◦ an Allied Health representative (usually the Psychologist).
1991 - 1994	From 1991 the Division of Youth Welfare and Guidance was abolished. BAC became a unit within the Wolston Park Hospital (**Hospital**) and the Hospital reported to the West Moreton Health Services Region. I informed both the Executive Director and Medical Superintendent of the hospital that I was in an acting capacity as Medical Director only and I invited them to consider advertising for the position permanently. I would then resign as psychiatrist. They declined to do this. In January 1991 the Hospital Executive produced a document Mission Statement, Goals, Target Populations, Treatment Programs and Internal Organisation. Significantly, this document provides: *"...the Hospital is managed by an Executive Committee made up of the Medical Superintendent, the Director of Nursing, the Hospital Manager and be as Senior Paramedical Officer. The Medical Superintendent is responsible for the supervision and direction of all clinical staff other than nursing. The Director of Nursing is responsible for the administration, control, and direction of nursing staff and provision of nursing services in the hospital.* *Each unit has a management committee with representatives of each of medical, nursing, and Allied health staff. The management committee is responsible for the development, co-ordination and monitoring of clinical programs in that particular unit."* In 1992 the Hospital Manager was replaced by an Executive Director who was a single point of accountability within the management structure of the Hospital. This was the only change to the internal organisation of the Hospital.
1995 - 2003	I was designated as Business Unit Director of the BAC Business Unit as a default position because there was no other psychiatrist within BAC. (Each Business Unit Director was the most senior psychiatrist within the Business Unit.) The Business Unit Management Orientation Book reads – *"Basically, the units are intended to operate autonomously within the complex. Initially they have limited control over their budget and expenditure within each cost centre.* *It should be noted that the anticipated HRM delegation appointed to the Business Unit director does not override that of the ADON and Nurse Manager's current delegation authority. If it is seen that the Unit and/or cost centre could exceed their budget, then the Management Committee as a whole is required to discuss the issues, reach a resolution and act on it. If an agreement cannot be reached or further*

	clarification is required, the Business Unit Management Committee is to advise the Executive of the problems and the suggested means of resolving it. *It should be emphasised that the Executive see the Business Unit Director of the one point of accountability for each Business Unit. Therefore, the final direction of each Unit will depend on the decisions made by the Business Unit Director in consultation with be Business Unit Management Committee."* The Business Unit Director was also a member of the Hospital Executive. It was clear from: ∘ the caveat above; ∘ the context of the whole document; ∘ the "Guidelines of Best Practice Implementations Strategies and Initiatives" of July 1996 (which among other things delineated the particular responsibilities of the Business Unit Manager and Business Unit Team); and ∘ the Human Resource Management Manual of November 1998, that the single point of accountability only applied to the financial management of BAC. It did not and does not apply to the management of staff from individual disciplines. An organisational chart from this time is clear that line management responsibility was maintained along the lines of individual disciplines, with: ∘ psychiatrists reporting to the Director of Clinical Services; ∘ nurses reporting through the organisational structure to the Director of Nursing; and ∘ Allied Health reporting to their respective discipline seniors. I did, though have considerable input into obtaining the best mix of Allied Health skills to suit the needs of BAC. An important development at this time was the discussion about Leadership versus Management at the Executive Committee meetings. It was recognised that the Business Unit Director did not have management responsibility for a significant proportion of staff. The discussion about leadership focused on ways of stimulating and supporting those members of the Committee who did have management authority and responsibility in the areas that were most likely to affect budgetary outcomes.
2003 - 2007	The development of the Corporate Governance and Model of Service Delivery in October 2003 was the next significant development. The role of the Hospital Executive was redefined and with this redefinition, a modification of the role of the Business Unit Director. The roles and responsibilities of the Clinical Business Unit Management Committees were also re-defined. These are outlined in Appendix A. The role of the Business Unit Director in the Facility Executive aligned to leadership rather than management. Management responsibilities of BAC continued to the shared between members of the BAC Clinical

	Business Unit Management Committee (**CBUMC**). The Business Unit Director chaired the CBUMC, but the Business Unit Director role (until May 2012) related solely to the conduct of the CBUMC meeting. It was not a management role nor was it responsible for line management authority. Professional reporting lines remained unchanged from previous organisational charts.
2007 – 2012	In about 2007 all mental health services in the West Moreton Health Service District came under the leadership of a single Executive Director. With this appointment, a West Moreton Mental Health Services Executive [Team] was established comprising a representative from each mental health service in the District. This had some impact on the role and function of The Park Facility Executive (TPFE). Minutes of the meetings of the latter TPFE record that it implemented decisions from the District Executive and received reports from a number of Committees within the Hospital. From 2003, there was a significant expansion of the number of committees that reported to the TPFE. Many committees concerned nursing responsibilities and as a result, the BAC Nurse Unit Manager (NUM) replaced me on the TPFE. This apparently was of no concern within the structure of the Executive. Also, at some time, the psychiatrist leader within the Clinical Business Unit was referred to as the Clinical Director and ceased to be known as the Business Unit Director. I am not aware that the role of Clinical Director was ever defined and how this role differed from the Business Unit Director. The Business Planning Framework was introduced in 2010 as a means of formalising the structure of the Clinical Business Units. Inherent within the documents from the different Clinical Business Units were significant changes to the role of the Nursing Director (ND) and the NUM. The role of the Clinical Director was not defined in these documents, although some defined the role of the psychiatrist. By September 2011, the TPFE minutes noted: *"Corporate Governance and Model of Service Delivery 2003". A/Service Improvement Co-ordinator (A/SIC) advised that a considerable amount of work needs to be done to update this document. Each unit that is referred in the 2003 document need to take the responsibility to update their Procedures and Work Instructions. A/SIC advised that as of now there are no policies within The Park, only Corporate Office has policies. Corporate Office has requested that facilities remove all policies and replace them with Procedures (facility wide) and Work Instructions (Units). It is going to be a big workload for those concerned."* No further work was done on this until at least April 2012 when the (A/SIC) undertook to look at the documents again. It is clear that there was significant evolution away from the 2003 organisational structures of management processes and roles. In my submission, a fog descended on the role of the Clinical Director. The change in roles is further evidenced in the position description

	(APPENDIX C) of the Nurse Unit Manager of 2012. This role description places a significant responsibility for management of BAC on to both the NUM and the Nursing Director, although the role description of the Clinical Nurse places some limitations on the extent of that responsibility.
2012 - 2013	This period was a time considerable change in the formation of the structure of the West Moreton Mental Health and Specialised Services (WMMHSS) and the composition of the Executive structure. The functioning of the CBUMC continued to attend to day to day operational management. During this period - while there were clear lines of management responsibility – within the various clinical disciplines – Nursing, Medical, Allied Health – there was little recognition of the interactions between the disciplines in decisions that were made at more senior levels of management. As I describe later; this resulted in the Clinical Director role solely providing leadership on clinical matters. Indeed, I raised with each of the Acting Nurse Unit Managers (A/NUM) the issue of the Nursing Director (ND) attending the CBUMC meeting. Not only were the position and organisational descriptions indicative that this person was an integral part of the CBUMC, but we needed them to understand the issues we confronted and those issues being raised by the consumer representatives so that they could more effectively be taken to the Executive. Unfortunately there was no response from the ND, who did have a greatly expanded role within the Facility.

My Clinical Leadership role

The matters over which I had leadership and management are set out below.

I had the responsibility to make the final decide on if and when an adolescent was admitted into the program. I did this however, after extensive consultation with the NUM and the Clinical Nurse Liaison Peron (CLCP), considering the data we obtained from the referrer, the assessment interview (in the context of the severity and impairment they faced), the level of acuity, the impact on and the impact of a particular mix of adolescents and the stability and experience of staffing.

I undertook the regular reviews of the adolescents (either in primary consultation or in secondary consultation with the psychiatric registrar) taking into account their mental state, their developmental needs, their experience of being at BAC, their relationship with their family and their progress in therapy.

I synthesised my observations of the adolescent with the observations of a multidisciplinary team (MDT) who saw the adolescent in various contexts. The observations occurred in informal settings in conversations with staff to help staff conceptualise the processes going on within the adolescent and in their role in helping the adolescent to progress in rehabilitation and treatment.

More importantly, I chaired the weekly Case Conference and three monthly Care Planning Reviews for synthesising observations and developing clinical directions for future treatment and rehabilitation. I took responsibility for approving a range of appropriate interventions (and the timing of the interventions) to be provided by the MDT and for review in subsequent meetings if those interventions had occurred.

The responsibility for the quality of the clinical intervention lay with the professional who was providing it. I was not and am not responsible for staff actions and decisions made outside the framework determined in these two key multidisciplinary team meetings. To ensure consistent application of decisions from the Case Conference and the Care Planning Reviews, I remained permanently on call for consultations with staff.

As well as assuming responsibility for clinical decision making, I endeavoured to provide leadership to the MDT by providing a framework in which the multiple interactions and interventions between adolescents and staff and between adolescents could be examined, understood and used in the development of treatment plants. (APPENDIX D) (This framework has been incorporated into the therapeutic programs in the Day Programs in Townsville and Toowoomba, as well as some centres in the UK, Canada and Switzerland after visits by clinicians from overseas units.)

I had sole responsibility for determining the types and dose of medication, although changes were usually implemented by the registrar. Only a very senior advanced trainee could initiate a change in medication without consulting with me first.

I am responsible for the decision to discharge an adolescent, after consultation with the MDT regarding clinical progress, suitability of support in the community and adequate transition planning. I was responsible for whether it was necessary to discharge an adolescent because it was not a suitable therapeutic environment for them, or they were having an adverse effect on other adolescents or staff. Again, this was always after extensive consultation with the MDT.

My role in leadership within the BAC Management Committee

As outlined in the first section the Committee comprised leadership from:

- Health – Nursing, Allied Health and Medical; and
- Education.

A review of the Committee minutes shows that each member made valuable contributions to leadership. Nursing staff played a particularly valuable role in leadership in operational and environmental matters. Allied Health provided leadership in program development in treatment and rehabilitation interventions. The Principal provided leadership in educational and vocational programs. All members played a leadership role in the development of a positive culture within BAC. . This leadership was translated into practice through the respective management responsibilities of each member of the management team.

Among my leadership roles over the years I have contributed to the development of strategic plans, ensuring national standards were incorporated into clinical decision-making and practice, linking with key external Child and Youth Mental Health Service leaders, developing key documents for Corporate planning such as the Model of Service Delivery and developing a clear conceptual framework for BAC. I believe this partnership of leaders provided genuine direction for BAC in what were often difficult and challenging circumstances. To ensure that BAC provided the best quality care available I maintained and up to date literature search on adolescent inpatient units, was an e-mail correspondent of the Quality Network Inpatient CAMHS (QNIC), Royal College of Psychiatrists and visited several overseas inpatient units in 2010 and 2011.

At all times it is assumed that individual members have defined responsibilities within their area of expertise, contributing to the management of BAC. No single member is considered to have overall responsibility for management of BAC.

Line management responsibilities

As set out above, all the organisational charts over the past 25 years show the lines of responsibility for individual disciplines along the current lines. The only exception has been with Allied Health who reported (only at times) through their discipline seniors to the Director of Clinical Services. All performance reviews and management authority and responsibilities were always along these discipline lines.

At all times the only people over whom I have line management responsibility are the psychiatric registrar and the medical officer (when one was appointed). While I had significant input in developing the position descriptions of several Allied Health positions and sat on the interview panels for all of our current staff, I do not direct their day to day activities. Allied Health staff report to the Clinical Director on operational matters and to their discipline seniors on professional matters. Nursing staff report to their relevant senior and do not report to the Clinical Director.

There are only two occasions in recent years that I have been invited on to the interview panel for nursing staff.

At times I have had disagreed with some of the decisions made by senior nursing management above the level of the NUM or A/NUM. These decisions contacted on at capacity to provide best practice clinical services. I have always respected the position of the NUM and asked if they would take up these issues themselves or whether they would like me to approach senior nursing management directly.

The limits on my responsibilities and management of BAC

The discussion below illustrates both:

- that I am not responsible for the management of BAC in practice; and
- gives context to allow an informed consideration of the confirmed allegations, given my responsibility for management of staff of other members of the leadership team.

Having a stable staffing contingent is crucial to providing quality treatment and rehabilitation in an adolescent inpatient unit. The BAC was established on the principle of a closed roster for nursing staff. This is consistent with accepted good practice in inpatient units in the UK. The extract below is taken from the QNIC Standards 2011.

2.1.5 1	The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need.
Guidance:	A CAMHS inpatient unit is likely to have a problem with over-use of agency nurses if more than 15% of staff are agency staff during a week or if more than one member of staff on a shift are from an agency. Agency staff should not be used for more than two shifts in a day.
Ref 8, pg 19:	'Service user feedback reinforces the importance of a regular and stable workforce which enables the development of therapeutic relationship and trust in providing support at distressing times. The National Audit of Violence (HC 2005) found that lack of leadership, inexperienced ward staff combined with an over reliance on bank and agency staff can have a negative effect upon the continuity of care and overall safety of the acute inpatient ward.'
2.1.6 2	Where bank and agency staff are used, they are familiar with the service and experienced in working with young people with mental health problems"

I was so concerned by nursing instability that I began to note the number of nursing staff working on the Unit from information from the Staff Lists. The regular complement of nursing staff from July 2012 – 2013 were 20 regular staff and 3 staff in training on a 3 month rotation. During the last quarter of 2012, 61 different nursing staff worked on the ward. Essentially there were 38 strangers during that quarter who did not know the adolescents. In the first quarter of 2013 there were 55. I could not break down the numbers below fortnightly numbers. However, the percentage of non-regular nursing staff in a fortnight ranged from 19% to 39% - well above the QNIC recommendations. At times there were up to four non-regular nurses on a shift, which again is well above QNIC recommendations.

Failure to provide stable/consistent staffing results in inconsistent management of adolescent's behaviours, lack of opportunity to provide effective clinical interventions when needed, inappropriate interventions. For example, for advice, increased use of seclusion, increased use of medication, neglect of adolescent's needs, lack of awareness of protocols, use of interventions more appropriate to adults and poor quality of observations.

Casual or temporary staff are less familiar (or unfamiliar) with patient needs and cannot be relied on to provide the necessary qualities of staff outlined in APPENDIX D.

This reduced capacity to provide an effective clinical program had a consequential impact on clinical decision-making. In all, this has impaired the capacity of permanent staff to perform their duties by limiting the time they spend in their role as Care Co-ordinators (CC). Permanent staff must supervise and orientate short term staff instead of interacting with the adolescents. This limits the time permanent staff have to provide therapeutic interventions on a shift and increases the demands adolescents placed on an individual permanent staff for therapeutic interventions (because they do not want to approach non-permanent staff). This resulted in adolescents storing up emotional issues with the potential for an increase in self harm and aggression.

Inconsistencies in staffing began in 2003 and was exacerbated by the proposed redevelopment of BAC in 2008. This has been a major concern to the various people who undertook the NUM role during that period, and was a regular item on the agenda of the CBUMC. It has become more critical since 2010 with changed (less stabile) leadership at the level of Clinical Nurse (CN), short term contracts offered to staff and higher levels of acuity resulting in harm (Child Protection Act 1999) because of a range of decisions made by either the District or the Health and Hospital Service.

Inconsistent staffing affected both the clinical management and the management of BAC as a whole. The NUM and I identified inconsistent staffing as a problem and from time to time. I offered my support in approaching higher levels of Nursing Management on the issue. I did this on several occasions, but it was clear that the Director of Nursing was constrained in the decisions he could make by a higher level of Management.

In 2012 and 2013 there were several decisions made at higher levels of Management which had an impact on the management of BAC. I can recall being informed of only one of these by the Director of Clinical Services. On all other occasions these decisions were communicated to the NUM who then informed me. That I was not informed of these higher management directives is consistent with my not being responsible for the management of BAC.

One of these decisions was the subject of a complaint by M and F. They complained that S was not able to attend school when he was on continuous observations. This directive however, was from a higher level of Management to the NUM and was given in about mid-August. It was not part of BAC's policy on continuous observations and it caused distress to S, and harm (Child Protection Act 1999) to at least one other adolescent. It impacted on clinical care and was in fact a decision pertaining to clinical management. I contended the directive with the nurses but they were obliged to follow the directive because it had come down through their line Management.

This illustrates that I was not responsible or had authority for the overall management of BAC.

Early in 2013 and despite that fact that BAC was with (even under) its budget, it became necessary to reduce staffing levels. I proposed changes to staffing in Allied Health by reviewing the classification level of the Social Worker and reducing it to a 0.5 position. I maintained that there was an absolute clinical need for other positions to remain to ensure the best service to adolescents until BAC closed or was relocated. This was supported by recommendations of the Expert Clinical Reference Group and accepted by the Planning Group. I communicated my position to both the Executive Director of the WMMHSS (ED WMMHSS) and the Acting Director of Allied Health A/DoAH. Significant changes to positions were made which were not communicated to me directly but I only found out through the affected staff. I also wrote to the Director of Nursing as well as the ED WMMHSS and the A/DoAH when I became aware of these changes as they impacted on the roles of nursing staff which were to undergo a concomitant reduction. These staffing reductions and changes continue without my being informed of them directly.

Again, This is consistent with me not being responsible for the overall management of BAC.

APPENDIX A – 2003 Role of Business Unit Director

Extracts from the **2003** ***"Corporate Governance and Model of Service Delivery".***

Executive Management Committee

Purpose

This committee brings together the senior leaders in the organisation to work with the Executive Director to deliver the strategic objectives for the organisation.

Membership includes the Directors of the Business Units, whose particular role is to ensure that the priority issues of the Business Units are represented at the Executive Management Committee, and that the organisation wide goals are implemented at the Business Unit level.

Responsibilities of the Executive Management Committee include:

- Determining the organisation's strategic directions
- Development of the strategic plan
- Coordinating the development of operational plans
- Monitoring the achievement of the strategic plan
- Providing high level organisational leadership
- Reviewing and evaluating human resource management strategies
- Ensuring effective and appropriate management of organisational resources

Clinical Steering Committee

Purpose

The Clinical Steering Committee provides clinical leadership and coordination of clinical practices across the organisation. It is a multidisciplinary forum for the discussion of clinical policies and procedures and monitoring of clinical projects and outcomes. The committee reports to the Executive Management Committee through the Director of Clinical Services and to Business Unit Management Committees through business unit representatives.

This committee is also responsible for:

- Coordinating implementation of the model of service delivery
- Defining and prioritising clinical project areas
- Providing leadership and support for clinical projects

Clinical Business Unit Management Committees

Purpose

The five clinical programs outlined in the Model of Service Delivery have been grouped into three Business Units; the Extended Treatment Business Unit which includes Extended Treatment and Rehabilitation, Dual Diagnosis and Medium Secure; the High Secure Business Unit, and the Barrett Adolescent Unit. Each of these business units has a Business Unit Management Committee, which provides multidisciplinary leadership to ensure high quality of care for consumers, and support for their carers and families. The committees are responsible for:

- Develop, implement and monitor the Business Unit operational plan
- Provide leadership to ensure the achievement of the operational goals
- Providing multidisciplinary and clinical leadership
- The cost effective management of resource allocations
- Developing and maintaining strong links with client districts or referring agencies
- Developing partnerships with consumers, carers and community support networks
- Initiating and driving service improvement
- Ensuring effective communication with all staff throughout the Business Unit
- Forming partnerships with key stakeholders, for example district mental health services, Department of Corrections, Disability Services Queensland, Queensland Police

The role of the Business Unit Committees varies according to core business requirements.

For instance the High Security Business Unit is a key component of the Integrated Forensic Mental Health Service. The Barrett Adolescent Service is a part of a statewide network of Child and Youth Mental Health Services and has a vital partnership with Education Queensland.

The Business Unit Directors chair the committees and membership varies but includes Assistant Directors of Nursing, Nurse Practice Coordinators Clinical Nurse Consultants, Rehabilitation Program Coordinators, Allied Health Seniors, Consumer representatives and Finance and Administration officers.

APPENDIX B – Changes in Business Unit Management 2010

Business Planning Framework BAC Working Document 2010

Leadership and Management

All nursing staff employed by AETRC are accountable to the Nurse Unit Manger (Business Unit 7), in which the Nurse Unit Manager is accountable to the Director of Nursing of Business Unit 2 and Business Unit 7.

All AETRC staffing matters that are of a clinical nature are accountable to the Director of AETRC. With regards to professional matters for Allied Health Staff they are accountable to their Discipline Seniors at The Park.

The Nurse Unit Manager and the Director of Nursing (Business Units 2 and 7) attend Executive Meeting in which they disseminate information to and from AETRC via formal minutes on G: drive, email, verbally at Nurses meetings.

Business Planning Framework ET&R 2010 - 11

Leadership and Management

The facility has an established management structure which is representative of all disciplines and streams (Medical, Nursing, Allied Health and Corporate administration and operational support services).

Within ET&R, there are established reporting relationships and accountabilities for all disciplines. The Nursing Director (**ND**) assumes the role of Business Unit (BU) Director in addition to providing professional Leadership to and Management of to the nursing stream specifically.

There are formal mechanisms at facility level and unit level to ensure discipline specific issues can be raised and discussed as well as individual sessions where senior nurses can meet one on one with the ND for management supervision and support.

APPENDIX C – Position Descriptions

Position Description for NUM (from at least January 2012)

Job ad reference:	H13WM0336
Role title:	Nurse Unit Manager
Status:	Temporary Full Time *(up to 9 months)*
Unit/Branch:	Barrett Adolescent Unit

Purpose

Provide an evidence based and contemporary clinical nursing service within a designated unit via operational management, leadership and the coordination of knowledge, skills and resources.

The Nurse Unit Manager is a Registered Nurse who is an expert practitioner in a specific area of practice. The Nurse Unit Manager is accountable for the planning, coordination, implementation and evaluation of high standards of consumer care in the ward/unit.

The Nurse Unit Manager in collaboration with the Nursing Director manages the delivery of safe, high quality, cost effective care. *(emphasis mine)*

Your key responsibilities

- Fulfil the responsibilities of this role in accordance with Queensland Health's core values, as outlined above.
- Staffing and budget responsibilities:
  - This position supervises: Clinical Nurses, Registered Nurses, Enrolled Nurses, nursing undergraduates, visiting nurses and other delegated nursing staff within the Barrett Adolescent Centre
  - Financial accountability for the nursing stream within the unit including the management of all nursing rosters for the unit
  - Operational and administrative staff liaise with the Nurse Unit Manager on daily operational issues
  - The Nurse Unit Manager reports to the Nursing Director.

Job ad reference for Clinical Nurse as of January 2012

Role title:	Clinical Nurse
Status:	Permanent full time position
Unit/Branch:	The Park - Centre for Mental Health Treatment, Research and Education
Division/District:	Division of Mental Health West Moreton Health Service District
Location:	Wacol
Classification level:	Nurse Grade 6

Purpose of role

- The Clinical Nurse is responsible for delivering quality nursing care at an advanced level that requires a broad developing knowledge in professional issues within a specified field of practice.
- The Clinical Nurse provides direction and support to other nursing staff while promoting professional standards of practice and conduct, and is responsible for achievement of unit goals and standards.

Staffing responsibilities

- The position reports to the Nurse Unit Manager of the relevant Unit.
- EN, EEN, ENAP, Student and Graduate Nurses and Registered Nurses report to this position

Key accountabilities

- Fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined above.
- Improving consumer outcomes through application of advanced knowledge and skills in adolescent mental health nursing.
- Provide clinical leadership to promote a learning environment that encourages clinicians to value education, research and evidence based practices.
- Provide care coordination for complex clients
- **The Clinical Nurse has accountability and responsibility for own actions and acts to rectify unsafe nursing practice and/or unprofessional conduct.** *(emphasis mine)*
- Co-ordinate staff and manage resources as delegated, including reprioritizing of departmental needs and supporting day-to-day changes

APPENDIX D – Conceptual model for treatment and rehabilitation at BAC

Adolescents with severe, complex and persistent mental illness which results in severe impairment experience difficulties in a number of domains. They often have vulnerabilities and life experiences which have predisposed them to having more severe forms of mental illness.

The first domain is that of the interactions between various inherent developmental vulnerabilities (if present), the mental illness and the developmental tasks of adolescence (listed below).

Cope with physical changes

Develop cognitive maturity

Negotiate school

Negotiate peer relationships

Develop emotional maturity

Care for the self

Develop moral maturity

Occupy leisure time

Establish boundaries

Develop competencies to become independent

Develop identity

Individuate

Develop life schemas

Develop a sense of future

Impairments in developmental tasks due to either mental illness or developmental vulnerabilities (if present) perpetuate the mental illness in adolescents referred to BAC. Our task is to gain a comprehensive understanding of any underlying developmental vulnerabilities, treat and manage where necessary, and treat the mental illness in conjunction with providing rehabilitation for the impairments of the developmental tasks.

At the same time, the adolescent has experienced family life. Their parents or carers will have fulfilled to varying degree the tasks of parenting (listed below).

Level of commitment

Adequacy of nurturance

Attachment/bonding styles

Met dependency needs

Met protection needs

Levels of consistency, supervision, monitoring

Correction styles

Communication of schemas, values

Adequate boundaries

Emotional containment

Capacity to facilitate transitions

Capacity to understand

Adolescents who presented to the unit whose parents have fulfilled most of these developmental tasks will expect similar qualities in staff at BAC. Staff can never be surrogate parents to the adolescents. However they are experience is that when the above qualities are manifest to a large degree in staff it facilitates the progress of the adolescents in treatment. Adolescents who have experienced parenting or care where many of these qualities are absent find it a positive therapeutic experience to be in an environment where staff are manifest these qualities.

The parent's understanding of the mental illness, their understanding of developmental vulnerabilities (if present), the adolescent's experience of the degree of fulfilment of the tasks of parenting and the interactions between adolescents and their parent or carer can in turn have a significant impact on both the mental illness and the developmental tasks of adolescents. Ideally the staff should have the capacity to analyse these interactions in providing therapeutic interventions at BAC and develop appropriate behavioural programs.

Queensland
Government

West Moreton Hospital and Health Service

Enquiries to: Workplace Relations
Telephone:
Facsimile:
Our Ref:

Dr Trevor Sadler
C/o K&L Gates

By Email:

Dear Dr Sadler

I refer to my letter dated 11 December 2013 in which I asked you to provide a response to the allegations made against you.

I am in receipt of the response provided on your behalf by K&L Gates dated 17 January 2014.

My decision in relation to the allegations

I have carefully considered all of the information available to me, including your response, however all the information may not be specifically mentioned in my decision.

Background to your response

You provided some general background regarding your role as Clinical Director and the impact of casual/temporary staff at Barrett Adolescent Centre in your response, including that:

(a) *'[You are] not aware that the role of Clinical Director was ever defined and how this role differed from the Business Unit Director.'*

(b) *'No single member is considered to have overall responsibility for management of BAC.'*

(c) *'Allied health staff report to the Clinical Director on operational matters and to their discipline seniors on professional matters. Nursing staff report to their relevant senior and do not report to the Clinical Director.'*

(d) *'[You are] not responsible for the management of BAC in practice.'*

(e) *'Failure to provide stable/consistent staffing results in inconsistent management of adolescent's behaviours, lack of opportunity to provide effective clinical interventions when needed, inappropriate interventions.'*

(f) *'Casual or temporary staff are less familiar (or unfamiliar) with patient needs and cannot be relied on to provide the necessary qualities of staff...'*

(g) *'In 2012 and 2013 there were several decisions made at higher levels with Management which had an impact on the management of BAC... That I was not informed of these higher management directives is consistent with my not being responsible for the management of BAC.'*

(h) *'Significant changes to positions were made which were not communicated to me directly but I only found out through the affected staff.'*

I accept that you are not responsible for the day to day management of the nurses at BAC. However, you are responsible for the clinical management for all clients at BAC and are on call 24/7 to manage clinical issues regarding clients. Therefore I cannot accept that you do not have any responsibility for the management of BAC.

In relation to your assertion regarding the impact of casual/temporary nursing staff on the service provided by BAC, I am of the understanding that the casual/temporary nurses are experienced in mental health and therefore I do not believe that your opinion regarding these nurses is accurate.

EXHIBIT 189