In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Dr Scott Harden of c/- Crown Law, Medical Director, Forensic Adolescent Mental Health Alcohol And Other Drug Programs, Child and Youth Mental Health Services, Children's Health Queensland states on oath:

1. I have been provided with a Requirement to Give Information in a Written Statement dated 2 February 2016. **Exhibit A** to this affidavit is a copy of this notice and the attachments to the notice.

Background and experience

2. I am a psychiatrist registered to practice in Australia. I have additional subspecialty training in child and adolescent psychiatry in Australia and New Zealand and am a member of the faculty of child and adolescent psychiatry of the Royal Australian and New Zealand College of Psychiatrists. I have undertaken significant post fellowship training and experience in forensic psychiatry and am a member of the Forensic Psychiatric Faculty of the Royal Australian and New Zealand College of Psychiatrists.

3. I did a training rotation at the Barrett Adolescent Centre as a psychiatric registrar in 1996 for six months.

Deponent A J.P., C.Ded., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
TEL:
Email:

4. I have worked for Queensland Health in one or another capacity since 1989. I have been a senior medical staff member in Child and Youth Mental Health Services since 2000. I was Medical Director of the Child Inpatient Unit (CFTU) at the Royal Children's Hospital 2001 – 2003. I have undertaken a number of overseas and interstate visits to other mental health services including numerous adolescent inpatient units in New South Wales, Victoria, Finland and the United Kingdom.

5. I have been extensively involved in the Royal Australian and New Zealand College of Psychiatrists with a particular interest in governance and child and adolescent mental health services. I am currently the chair of the Queensland branch of the Forensic Faculty of the Royal Australian and New Zealand College of Psychiatrists and Chair of the Binational Section of Child and Adolescent Forensic Psychiatry of the same college.

6. My current clinical public sector appointment is Medical Director, Forensic Adolescent Mental Health Alcohol And Other Drug Programs, Child and Youth Mental Health Services, Children's Health Queensland.

7. I also hold appointments as, Assisting Psychiatrist Mental Health Court and Tribunal Member General Medical Assessment Tribunal – Psychiatric Workers Compensation Regulator.

8. In addition I have a private clinical and medico-legal psychiatric practice.

9. **Exhibit B** to this affidavit is my current curriculum vitae.

Responses to questions in notice

10. With regard to the email I sent to Dr Kingswell dated 9 November 2012 (and marked with document number QHD.012.002.1149):

(a) As best I recall, the briefing of Dr Kingswell referred to was an outline of the process of the closure of the Barrett Adolescent Centre and some discussion of replacement services. I do not remember the detail of this discussion.

(b) "The branch" referred to is the committee of the Queensland branch of the Royal Australian and New Zealand College of psychiatrists.

(c) My diary identifies this meeting as occurring on Tuesday, 13 November 2012.

(d) My general recollection is that the briefing was that the Barrett Adolescent Centre (**BAC**) was to close and be replaced by other services. I do not recall details more specific than that.

11. With regard to the email from Dr Brennan dated 1 November 2013 (and marked DAB.001.001.0503) in regard to a patient at BAC .

(a) The appointment took place.

(b) The appointment occurred at BAC.

(c) My service (the Child and Youth Forensic Outreach Service) prepared a report authored by Ms Tasneem Hasan, forensic psychologist and myself with regard to the specific question of the risk the young person might pose to others. **Exhibit C** to this affidavit is a copy of the report and clinical notes .

(d) The oral advice was that our opinion was the young person was at low risk of harming others. The written advice is contained within our report.

12. With regard to the email from myself to Dr Stathis dated 30 January 2014 (and marked QHD.012.001.7691, the email regarding Tier 3 medical structures was actually to do with the proposed and implemented medical hierarchy within the new organisation Children's Health Queensland. It was not in any way associated with BAC. The reason

that the original proposal was unhelpful was that appointments of medical directors to the various hospital areas would not have come into effect until just prior to the district amalgamation and new hospital opening. This did not occur anyway and the positions were appointed six months prior to that.

13. With regard to the email from myself to Ms Julie Kinross dated 26 July 2014 (and marked QHD.012.001.5822):

(a) The group I was referring to were adolescents in the 13 to 18 year age range who were severely psychiatrically unwell to the extent that they were unable to be safely managed in non-secure adolescent mental health wards. As a result they were frequently transferred to high dependency areas of adult mental health facilities for prolonged periods and this was clinically and developmentally inappropriate and unhelpful. This occurred because there were no secure (secure in terms of level of physical and staff security of the facilities) adolescent beds in Queensland.

(b) This group are not forensic patients, that is they have not come in contact with the criminal justice system in a formal way, and therefore are not able to be managed in adult "secure" facilities anyway. If they are transferred to either adult high dependency units or "secure" facilities these facilities are not developmentally appropriate, lack educational input, expose young people to a mix of older, more unwell and aggressive patients and the units do not have developmentally trained staff accustomed to dealing with young people.

(c) There has been no change since my email. As I have noted these young people are generally transferred to adult high dependency mental health beds until they can be safely managed in less intensive and physically secure settings. If

they are on a forensic order or similar they are transferred to adult secure mental health facilities.

14. With regard to the same document and my views regarding a secure mental health facility for young people:

(a) The age range for such a facility should be approximately 13 to 18 years with some flexibility based on clinical grounds.

(b) The location of the facility would not be critical. It could be located on "the park" complex however there are no other child and adolescent mental health services in that location. Ideally such a facility should be co-located with an existing critical mass of child and adolescent mental health services to assist with clinical and staffing issues or co-located with a youth detention facility or similar where there could be some sharing of security infrastructure or similar. Any such facility should be part of a seamless continuum of care for young people requiring such services and have strong links with other services caring for these young people.

(c) This facility is the same as discussed at the teleconference on 7 May 2015 as recorded in document number HD.006.005.1043. The possibility of it being placed within a precinct of young people's facilities is one approach attempting to take advantage of possible synergies within different services. Such a precinct could have secure adolescent mental health beds in one facility, secure developmental adolescent beds in another part and day and partial hospitalisation as well as other outreach services. Co-location is potentially helpful from the point of view of a range of planning issues including everything from physical plant through to specialist staff recruitment and support and hotel services.

(d) There is in my view no clinical reason why such a facility would necessarily need to be separate from other planning taking part regarding extended adolescent mental health services.

15. In my opinion, there are a small number of severely disabled young people with treatment resistant mental health problems who may require extended treatment and rehabilitation. They generally have a poor long-term prognosis. Clearly they require treatment services.

16. In my view the BAC model of care and treatment was an appropriate one when that unit was opened. It had ceased being consistent with best practice approaches to such treatment probably two decades ago. It was a stand-alone unit in an isolated area with no associated child and youth mental health services. It provided predominantly an inpatient model of care with some day hospital type care. Because of its geographic location and model of care it required young people to be dislocated from their communities of origin, often for prolonged periods of time. It did not have natural links with the rest of the specialist child and youth mental health care services (in my view).

17. The group of young people who require treatment by such a service are likely to require a prolonged, predominantly rehabilitative and recovery oriented approach to treatment. This is a strongly psychosocial set of interventions although clearly medical treatments are often critical in combination with these approaches. If it is possible, it is most important that these treatments, often requiring some years of intervention, are undertaken as close as possible to the young person's community of origin or their community that will support them into the future.

18. Dislocating young people from their environment for prolonged admissions is extremely detrimental to their normal developmental progress and causes them to lose contact with many of the forces that encourage growth and development such as

engagement with their usual peer group and family and links to educational and cultural affiliations.

19. This approach of chronic long-term admissions for treatment of mental health problems becomes conflated with issues around child protection, families and accommodation stability in an unhelpful way. Just because a young person might require out-of-home care in association with treatment of their mental health problems, does not mean that their needs are best met with a long-term inpatient mental health unit stay. It may be that supported accommodation plus outreach mental health services in the community will produce a substantially better outcome and less potential psychosocial damage.

20. In my opinion, a comprehensive, developmentally sensitive and best practice approach will not be "bed oriented", that is the idea of a "facility" focused predominantly around inpatient or residential care. Instead a flexible range of interventions should be targeted at the needs of the young people. Conflation of different kinds of needs i.e. mental health, accommodation, education, vocational training, substance rehabilitation, social support, peer engagement etc. should not occur. If there are clear synergies from meeting more than one need with one intervention that is useful, however an inflexible approach where all needs are thought to be met by one intervention such as prolonged inpatient care is as I have previously described unhelpful, outdated and often damaging.

21. Any ideal model should undergo ongoing review and modification as required to meet the needs of the population and to take into account changes in medical knowledge that might affect interventions.

22. The model of service developed by Queensland Health in about August 2010 seems an appropriate level of response to the group I have described.

23. In my view the model developed by Queensland Health in May or December 2012 is a more sophisticated version of the previous model and also seems an appropriate and comprehensive set of responses to the group I have described.

24. The model of service developed by the Rivendell Unit in December 2012 is in my opinion a much more limited approach without as wide a range of options for approaches to intervention. This limitation is inherent upon the predominantly admission base approach to intervention. Otherwise it seems an appropriate suite of interventions that links to other community-based services and interventions.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

Sworn by Dr Scott Harden on 10 February 2016 at Brisbane in the presence of:)

A Justice of the Peace, C\Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to the Affidavit of Dr Scott Harden sworn on 10 February 2016.

[redacted]

Dep[redacted]

[redacted]

A J.P., C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Scott Harden

Of: c/- Crown Law, by email to:

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to *Commissions of Inquiry Order (No. 4) 2015* to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **4:00 pm, Thursday 11 February 2016**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 2nd day of February 2016

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

1. Look at document number QHD.012.002.1149 (attached) being an email from you to Dr Kingswell dated 9 November 2012. In that document you refer to Dr Kingswell's "*briefing to the branch*". Please explain:

   a. Dr Kingswell's "*briefing*" – what was said by Dr Kingswell?

   b. "*the branch*" to which Dr Kingswell gave the briefing;

   c. the date or approximate date of that briefing;

   d. what Dr Kingswell said, in that briefing, concerning the Barrett Adolescent Centre (**BAC**).

2. Look at document number DAB.001.001.0503 (attached) being an email from Dr Brennan to you dated 1 November 2013. In that document Dr Anne Brennan refers to a proposed appointment you were to have with a patient at BAC.

   a. Did that appointment take place?

   b. Did it take place at the BAC?

   c. Did you prepare a clinical note of that appointment and, if so, please identify that note and supply a copy?

   d. Did you make any clinical notes, or recommendations, in relation to the transition of from BAC and, if so, identify those notes or recommendations and provide a copy of any such notes or recommendations (in so far as they are written) and provide the details of any oral recommendations.

3. Look at document number QHD.012.001.7691 (attached) being an email from you to Dr Stathis dated 30 January 2014. In that document your email to Dr Stathis says that:

"I note that this (i.e. the email below) *says it* (i.e. a Tier 3 Medical Structure – Lady Cilento Children's Hospital Consultation) *doesn't start until Nov 2014 – that is not very helpful"*.

Please explain that email. In particular, were you concerned that the proposed Tier 3 facility was not going to be in place until November 2014 in circumstances where BAC was closing, or was to be closed in or about January 2014?

4. Look at document number QHD.012.001.5822 (attached) being an email from you to Ms Julie Kinross dated 26 July 2014. In the third paragraph of that email by you to Julie Kinross you say there is a group that Ms Kinross' services do not see who are *"not adequately and appropriately managed within an adult secure mental health setting"*. Please explain:

   a. the 'group' you were referring to, including age and diagnosis (or diagnosis category);

   b. why that group is not adequately managed in an adult secure mental health setting;

   c. where such a group was managed before your email, and where such a group has been managed since your email.

5. In that same document you refer (in the sixth paragraph) to the need for a more secure adolescent mental health facility for <u>both</u>:

   a. *"the appropriate treatment of very ill young people in detention who require hospital treatment"*; and

   b. *"the appropriate treatment of very ill unwell young people in 'ordinary' adolescent mental health unit settings who have significant behavioural disturbance and are currently being transferred to adult settings with in my observation often significant detrimental effects on their mental health and management"*.

As to your view that there is a need for such an adolescent mental health facility, please express your opinion on the following:

c. what age group/s should be catered for by such a facility;

d. whether such a facility could or should be located at "The Park" (and why); if "no", at what other location or type of location it should be located;

e. whether such a facility is the same, or similar to, or different (and, if different, how it is different) to the *"young persons' secure care precinct at Wacol"* discussed in a teleconference on 7 May 2015 as recorded in document number QHD.006.005.1043 (attached) being a file/meeting note dated 7 May 2015; whether it should be part of such a precinct, and why;

f. whether such a facility should be separate from *"any planning taking place regarding extended adolescent services under the Queensland Government election commitments"* as referred to in document number QHD.006.005.1051 (attached) being a meeting note dated 21 July 2015, and if so why.

6. In your opinion is there a need for an adolescent mental health facility (not being a forensic facility) which caters for young people:

a. with severe and complex mental health problems; and/or

b. who need extended treatment and rehabilitation.

If "yes":

a. should the model of care for such a facility be the same as, or substantially the same as, or should it differ from the model of care and treatment offered by the BAC? In so far as it should differ, please explain how it should differ.

b. should the model of care for such a facility be the same as, or substantially the same as, or should it differ from the model of service developed by Queensland Health (**QH**) in or about August 2010 as shown in document number

QHD.006.003.2982 (attached)? In so far as it should differ, please explain how it should differ.

c. should the model of care for such a facility be the same as, or substantially the same as, or should it differ from the model of service developed by QH in May or December 2012 as shown in document number DBK.001.001.0214 (attached)? In so far as it should differ, please explain how it should differ.

d. should the model of care for such a facility be the same as, or substantially the same as, or should it differ from the Rivendell Unit Model of Service developed by the Sydney Local Health District in May or December 2012 as shown in the attached document? In so far as it should differ, please explain how it should differ.

7. Explain any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Terms of Reference.

8. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

BAC

From: Scott Harden <[redacted]>
To: Bill Kingswell <[redacted]>
Bcc: Stephen Stathis <[redacted]>
Date: Fri, 09 Nov 2012 10:02:06 +1000

Hi Bill,

As you are now probably aware there have been a large number of emails sent by some senior child psychiatrists to all or almost all child psychiatrists in Qld regarding possible Barrett Adolescent Centre closure, this started last Friday evening with the BAC director but I gather the Mater director spoke to the media yesterday at the Carmody Inquiry. I had been ignoring them but in retrospect wonder if I should have given you a heads up.

I hasten to add I had not shared your briefing to the branch with any of these people.

There seems to be a rather hysterical tone to some of this material and injudicious language but a high degree of support (unthinking support in my opinion).

Thought I would pass this on. Was hoping there would be a more reasoned systemic discussion and may yet be.

Happy to give more details on who is who if you wanted but perhaps on the phone. Stephen Stathis has just gone on a week's holiday today (after he met with Leanne yesterday). As you are aware I have a long term interest in Child and Youth Services but am a mere VMO at RCH forensic CYMHS (although Judi Krause the ED and Stephen Stathis know I am in contact with you about this stuff)

Feel free to ring [redacted]

Very aware that this is only one small issue on your radar.

Best wishes

Scott Harden

From: Anne Brennan
Subject: BAC client Friday 1/11/13
Date: 1 November 2013 12:55 am
To: Scott Harden

[redacted]

I apologise for the brevity of this information and for not being present. I will try and get there as soon as I can.
Thank you very much for committing so much of your time to coming out to BAC to do this.
Anne

FW: Tier 3 Medical Structure - Lady Cilento Children's Hospital Consultation

From: Scott Harden <
To: Stephen Stathis <
Date: Thu, 30 Jan 2014 19:38:35 +1000
Attachments: CHQ02691 to all SMOs re Tier 3 Medical Structure Consultation.pdf (110.5 kB); Feedback to Medical Staff on Tier 3.pdf (1.51 MB)

I note that this says it doesn't start until Nov 2014 – that is not very helpful

S

From: CHQ_EDMS
Sent: Thursday, 30 January 2014 6:22 PM
To: Aaron Donaldson; Alan Isles; Alan Sive; Alexandra Donaldson; Alison Harris; Alison Harris; ALISON ING; Andrew Blanch; Andrew Hallahan; Andrew Moore; Anita Cairns; Anja Kriegeskotten; Anne B Chang; Anne Kynaston; Anthony Herbert; Anthony Slater; Anubhav Sarikwal; Ben Whitehead; Ben Zugai; Bhavesh Patel; Brent Masters; Brett Chaseling; Catherine Skellern; Chris Fraser; Claire Wainwright; Craig McBride; Daniel Boyd; David Coman; Elisabeth Hoehn; Emma McIntyre; Frances Connor; Frances Ware; Geoff Donald; Geoffrey Withers; Gert Tollesson; Gillian Long; Glen Gole; Helen Buntain; Helen Irving; Ian Williams; Irene Skiathitis; James Scott; Jane Peake; Jason Acworth; Jason Schoutrop; Jean Kelly; Jennifer Batch; Jeremy Robertson; Jim McGill; Julia Clark; Julie McEniery; Juliet Clayton; Karen Liddle; Kate Sinclair; Kathleen Cooke; Katie Tinning; Katina Breeze; Keith Grimwood; Kerri-Lyn Webb; Kevin Plumpton; ; Kieran Frawley; Kim McLennan; Kristina McLennan; Leisha Callaghan; Liane Lockwood; Lisa Copeland; Looi Ee; Louise Conwell; Louise Butler; Louise Marsh; Lyndall Patterson; Lynne McKinlay; Maree Crawford; Margaret Little; Margot Bosanquet; Marion Thomas; Mark Coulthard; Meenakshi Sundaram Shanmugam; Melissa Jessop; Mellissa Naidoo; Michael Nissen; Michael Guandalini; Michael O'Keeffe; Michelle Phillips; Michelle Thompson; Monique Dade; Morag Whyte; Mui Khoon Chang; Natalie Deuble; Natalie Phillips; Neil Paterson; Nicola Previtera; Nigel Dore; Nitin Kapur; Otilie Tork; Owen Gillies; Patricia Connor; Paul Lee-Archer; Peter Borzi; Peter Lewindon; Peter Sly; Peter Trnka; Peter Parry; Priya Edwards; Rhyanon Murray; Robert Black; Robert Elliott; Romi Das Gupta; Ross Pinkerton; Ross Walker; Roy Kimble; Salvatore Catania; Sarah Martin; Sarah McMahon; Sasaka Bandaranayake; Sheanna Maine; Sheanna Maine; Simon Brown; Sonia Singh; Sophie Calvert; Stephen Malone; Stephen Stathis; Steven McTaggart; Susan Thornton; Tavey Dorofaeff; Theresa Carroll; Tim Hassall; Trevor Gervais; Uyen Tran; Vanessa Rich; Wayne Nicholls; ; Andrew Lomas; Andrew Broadhurst; Andrew Lomas; Barry Appleton; Benjamin Rogers; Brian Wilson-Boyd; Bruce Black; Bruce McPhee; Cameron Hastie; Christopher Beem; Christopher Burke; Daphne Wilcox; David Anderson; David Bell-Allen; David Ho; David Winkle; David Hill; Elizabeth Boge; Geoff Cleghorn; Hannah Burns; Ivan Astori; James Earnshaw; Jan Wuth; John Burke; John Tuffley; John Letidschke; John Varghese; Julie Agnew; Justine McCarthy; Kelvin Choo; Linda Wells; Maria Hanger; Marie Cox; Marion Thomas; Martin Wood; Martina Meyer-Witting; Mary Jessop; Navid Adib; Nicola Acworth; Patrick See; Paul Canty; Paul Pincus; Peter DeBuse; Peter Rowan; Peter Steadman; Peter Waterhouse; Philip Richardson; Raymond Goh; Richard Theile; Robert Labrom; Sarah Goetz; Scott Harden; Sonia Yuen; Stuart Bade; Susan O'Mahony; Terence Casey; Tim Sullivan
Cc: ; Julie McEniery; Stephen Stathis; Steven McTaggart; Ross Walker; Peter Steer; Deborah Miller; Carmel Perrett; Sue McKee; Loretta Seamer; Shelley Nowlan; ; John Wakefield; Lily Erazo; Greg Coonan
Subject: Tier 3 Medical Structure - Lady Cilento Children's Hospital Consultation

Please find attached a memo from Dr John Wakefield, Executive Director, Medical Services regarding the above.

Dr Connors/Dr Hubbard – can you please arrange circulation amongst the Senior Doctors at Mater Children's Hospital.

Regards.

Kerry Short
Executive Support Officer

to
Executive Director Medical Services
Royal Children's Hospital

Children's Health Queensland Hospital and Health Service Queensland Health
T:
E:
Level 1, North Tower, RCH, Herston Road, Herston QLD 4029
www.health.qld.gov.au/childrenshealth/

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Queensland Government

Department of Health

File/Meeting Note

Mental Health Alcohol and Other Drugs Branch

Date/Location	Teleconference on 7 May 2015, commencing 8.30am
Attendees	Children's Health Queensland (CHQ) HHS: Judi Kraus, Stephen Stathis, Scott Harden, Paul Letters Mental Health Alcohol and Other Drugs Branch (MHAODB): Marie Kelly, Bruce Ferriday

Reason for Note	This is a record of the meeting relating to Queensland Health plans for secure mental health care for young people in response to inquiries from Youth Justice. An email from Julie Kinross to Bill Kingswell outlined the plan to submit an infrastructure plan to Cabinet and identified one issue as the rising number of young people with significant and uncontrolled clinical mental health issues in detention. Mainstream detention is not seen an appropriate environment for these young people. Youth Justice is interested in discussing the idea of a young persons' secure care precinct at Wacol.
Business Arising	Not applicable
First Meeting Discussion	1. The preliminary meeting involving CHQ and MHAODB outlined some initial thinking for a secure mental health care facility for young people based on and informed by UK service provision. • The UK with approximately ten times the adolescent population has 90 secure beds for young people (age range 14-18 years) including disability forensic. Considering the population, a preliminary estimation for a 10 to 12 bed facility in Queensland would appear appropriate. • Stephen Stathis described a number of distinct cohorts that would utilise this type of facility. – From Youth Justice: ▪ Severe and persistent mental illness, psychiatrically unwell ▪ Cognitively impaired , repeat offender, aggressive ▪ Severe and persistent mental illness, aggressive , disruptive – From mental health services ▪ Severe and persistent mental illness, unwell, long term treatment – Not in scope is forensic disability 2. There was further discussion about considerations for a facility of this type.

	• Based on the cohorts, bed size and considering economies of scale a gazetted 12-bed unit with 2 x 6-bed wings with provision for swing beds to accommodate smaller cohorts and male/female, would initially appear to be suitable. • The suggested location of a facility at Wacol was noted. • In the Queensland youth justice system offenders 17+ years older move to the adult system. Currently there are 60 in Queensland. 3. The model of service was discussed in relation to service provider. • In the UK the secure care for young people is commissioned through the NHS. Health takes the lead relating to service provision. One facility is sub-contracted to private providers. • Stephen Stathis advised of some preliminary thinking about a partnership model for the operation of a facility: – Department of Health to provide clinical governance – the Department of Justice to provide security and infrastructure governance • Marie Kelly advised about discussions with Youth Justice expressing an interest in an allocation of the Townsville Youth Resi beds. • Overall it was noted there are multiple agendas and careful consideration is required in relation to the model of care and in particular, exit pathways, in the establishment of any facility.

Second meeting discussion	4. At this point in the teleconference representatives from Youth Justice including Julie Kinross joined the meeting at approximately 9.00am. 5. Stephen Stathis provided a description of UK mental health secure care services for young people and outlined the cohorts that may use this type of service. 6. Julie Kinross advised that Youth Justice is seeking to engage with partners to discuss a possible service model for Queensland. The needs and the cohorts described by Stephen Stathis were supported as accurately representing Youth Justice clients. 7. Julie Kinross also advised of consideration for other cohorts: • Young people on ice with an underlying mental health issue, which is estimated as 1 in 10 of the youth justice clients. 90 per cent of Youth Justice clients has substance issues and ten percent of the 90 percent are using ice. Youth Justice are seeking consideration of a model of service for this group that includes: – shared care – better mental health assessment – accommodation options – better ways to manage care with Department of Health input/in-reach • Foetal Alcohol Syndrome children are described as a cohort requiring better support. Data is not available for numbers of this cohort, however numbers in the Youth Justice system, is believed to be

	consistent with literature which is 20 per cent (check this). 8. There was some further discussion about the Youth Justice System and other cohorts that may be considered. • 30 per cent of children in detention lack capacity. Youth Justice is considering how to better support this group as an alternative to criminalising these children. • Two secure care facilities operating in north and south Brisbane that provide child safety care were outlined. The child safety cohort was described as youth out of control. Data is showing a tripling of females in the last three years requiring for child safety care. 9. Options for resources and the type of facilities to meet the needs of these groups were discussed further. • Julie Kinross described a community based model with partnership arrangements and building of facilities that permits accommodation of smaller populations with similar care needs. • The availability of a greenfield site belonging to the Department of Communities, Child Safety and Disability Services (DCCSSDS) has been identified, however use is dependent on NDIS outcomes. • Land behind the Women's Prison has been identified. • The difficulty of locating a non-secure facility at Wacol was noted. • The growth area of the corridor between Brisbane and the Gold Coast has been identified including parcels of land available at Redlands and Beaudesert. Stephen Stathis advised of the difficulty in attracting staff to work at Beaudesert. • Julie Kinross advised that land in Cairns is also being considered to accommodate Youth Justice needs. It has been estimated that a facility the size of Brisbane Youth Detention will be required in Cairns by 2030. • Julie Kinross identified that if social policy agencies support a Child Safety proposal for a facility, it is more difficult for the Government to sell parcels of undeveloped land. 10. Julie Kinross provided some background to the interest by Youth Justice in the Townsville Resi. • A Government commitment for the Minister for Justice relates to the development of an infrastructure plan for youth justice. There was an intervention in Cabinet for consideration of youth justice in the establishment of the Townsville Youth Resi.
Summary of Actions	While no meeting actions were determined, there was agreement from departments represented, to further explore the idea of mental health secure care facilities for young people.

Prepared by: Bruce Ferriday

Unit: Planning and Partnerships Unit

Date: 7 May 2015

Filename: FN_Youth Justice_Teleconference_20150507

Queensland Government

Meeting note

Mental Health Alcohol and Other Drugs Branch

Secure mental health options for young people	
Date/Location	21 July 2015
Attendees:	Stephen Stathis (CHQ), Scott Harden (CHQ), Sandra Eyre (MHAODB), Anna Davis (MHAODB), Karen Rockett (MHAODB)

Discussion:	• There are three identified groups of young people that require secure mental health care: 1. Young people with psychotic illness and mental health problems in youth detention 2. Young people who are cognitively impaired in youth detention 3. Young people in adolescents units who are very unwell and need a higher level of security due to their level of agitation. • We need a service that provides care to both civil and justice system cohorts. • The UK system is closest to ours. UK has 80 to 90 secure adolescent beds which translates to about 8 beds for the Queensland population. • Current youth forensic mental health service system is under strain. Numbers of young people in detention are increasing without commensurate increase in mental health staffing. Service at Brisbane Youth Detention Centre undertakes more of a triage service rather than full service. • Julie Kinross is developing an infrastructure plan for youth justice services. The plan includes a possible youth precinct at Wacol. • Discussion with Julie Kinross centred around those young people unwell and in detention or out in the community under probation. • Dr Stathis and Dr Harden agreed that a built secure mental health facility (for both civil and justice system cohorts) is a good solution. A separate wing would be required for those young people with cognitive impairment. • It was agreed the secure facility would need to be based in the South –East corner. • Could be co-located with BYDC or at the new Wacol precinct outlined by Julie Kinross. • Facility should be separate from any planning taking place regarding extended adolescent services under the Queensland Government election commitments.
Actions to be taken:	• Finalise service mapping document regarding system needs. • Contact Julie Kinross and advise that we are interested in exploring the youth precinct idea further. • Contact Shellee Valentine, Department of the Premier and Cabinet and arrange for them to participate in a meeting with all relevant agencies, including communities, child Safety and youth justice.

Prepared by: Karen Rockett **Cleared by:** Anna Davis

RE: Planning for detention

From: Scott Harden <
To: Julie Kinross <
Cc: David Herbert <, Candace Wakeham <, Stephen Stathis <, Ed Heffernan <, Jillian Spencer <, Paul Letters <, Judi Krause <
Date: Sat, 26 Jul 2014 11:19:48 +1000

Hi Julie

In Townville yesterday so had not logged on to the health email until today.

We are making similar comments and have for some years and we have been beginning to get some traction in recent times in my view.

There is also a group your services don't see who require higher levles of developmentally appropriate containment and treatment for their mental health condition who have not been involved with your services but are not adequately and appropriately managed within an adult secure mental health setting.

The Barrett Adolescent Centre never appropriately managed this group and were in my view in general not involved in the management of this group previously to any significant extent. The replacements for Barrett will not necessarily have a strong forensic element although there may be some crossover in the clients that they are involved with.

Adult prison mental health services also have difficulties in the optimal management of unwell people but have medium and high security mental health facilities that are appropriate to the needs of adults that can be accessed although as always these resources are limited.

It has been my expressed view for at least 8 years that we need a more secure adolescent mental health facility both for the appropriate treatment of very ill young people in detention who require hospital treatment and also the appropriate treatment of very ill unwell young people in "ordinary" adolescent mental health unit settings who have significant behavioural distrubance and are currently being transferred to adult settings with in my observation often significant detrimental effects on their mental health and management.

If we compare such facilities on a per capita basis in the 10 to 18 year population with the United Kingdom (England and Wales actually) we should have 8 to 9 such beds.

It may be that such a facility would need to also have consideration to the forensic disability group as you describe it. In the United Kingdom approximately 20% of such beds are utilised by clients predominantly with a disability focus as well as their behavioural difficulties. In my view this however occurs on a much better developed disability support system in the United Kingdom than we have here.

I have copied into this email Dr Ed Heffernan director of forensic mental health Queensland with whom we have a strong relationship and Dr Steven Stathis who you have met who is medical director for child and youth mental health services for children's health Queensland and Judi Krause the divisional Director for Child and Youth Mental Health Services at Children's Health Queensland. Dr Heffernan, Dr Stathis and I as well as Paul letters and the relevant psychiatrists have been discussing the need for such a service in more detail in recent months and a decision had been made to engage in increased lobbying from the beginning of 2015 once Children's Health Queensland had fully established with the opening of the new Children's Hospital.

We would see it as very strategic and appropriate to begin having such discussions. It is less clear who to engage with in the forensic disability team as the clinical lead for that service Prof O'Brien who you may have met, has recently passed away and I am not sure who the best people to engage with in that area are at this moment.

I would suggest at the very least that Paul letters, myself and Ed Heffernan as well is any of the others have been copied in are engaged in a preliminary discussion of this with regard to how it might be progressed by all relevant agencies and departments. The problem will only continue to become more

difficult and the current clinical situation even less satisfactory as time goes by and we have population increase.

Thank you once again for your most timely email on this matter that has been concerning me much more in the last 6 months.

Yours

Dr Scott Harden
Child and Adolescent Forensic Psychiatrist
Medical Director
Forensic Adolescent Mental Health and Other Drugs Programs
Child and Youth Mental Health Service
Children's Health Queensland HHS

Best Email:
Best Phone:

From: Julie Kinross
Sent: Thursday, 24 July 2014 12:32 PM
To: Scott Harden
Cc: David Herbert; Candace Wakeham
Subject: Planning for detention

Hi Scott

We mentioned to you that we are looking at how to develop the detention centre estate over the next 10-20 years.

Up until last year, we have had young people in detention with significant mental health issues that have been challenging to manage within the detention centres. This number has risen suddenly in the last 12 months to 5-6 and has become a pressing management for us. We wish to develop a plan about how these children should best be treated and detained.

We would like to set up a meeting with the relevant people to ensure that this cohort does not fall between the gaps and that their needs are appropriately reflected in strategic plans for forensic mental health/forensic disability. An option may well be that a separate unit needs to be considered in any plan to build a new Tier 3 facility to replace the Barrett Centre or included in Communities plans for the forensic disability estate.

Could you advise me as to the best people you think we should discuss this with from Children's Health Qld/ Forensic Disability or elsewhere? I am thinking it would be the best use of time, for an initial meeting of the relevant people.

Your advice would be most appreciated.

Julie Kinross | Executive Director
Youth Justice | Department of Justice and Attorney General
T:

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
	• 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,
Working with other service providers		• 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	• 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 Assessments	• 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**		
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 **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 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)
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