Oaths Act 1867

Statutory Declaration

I, **LESLEY DWYER** of care of Corrs Chambers Westgarth, by email to [redacted] in the State of Queensland do solemnly and sincerely declare that:

Background and Experience

1 The Commission understands that from approximately December 2012:

(a) the services then provided by the Barrett Adolescent Centre (the BAC) were under review and that alternative models of service were to be developed to replace the services then provided by BAC; and

(b) the opening of the Extended Forensic Treatment and Rehabilitation Unit (the EFTRU) was proposed for early 2013.

Please state whether that is correct and, if not, why not. If that is correct then state:

1.1 In relation to the statement in paragraph 1(a), it is not correct that from approximately December 2012 the services then provided by the BAC were under review. In that regard:

(a) The decision to close the BAC had been made some years prior to December 2012. The closure was to occur when mental health extended treatment and rehabilitation services to adolescents was transferred to a new facility to be constructed at Redlands.

(b) As stated in paragraph 5.3 of my statutory declaration dated 6 November 2015 (my first statutory declaration), on 29 August 2012 I received confirmation via a memorandum from Glenn Rashleigh of Queensland Health's Health Infrastructure Office that the Redlands project had been cancelled.

(c) As stated in paragraph 5.12 of my first statutory declaration, the cancellation of

the Redlands project did not alter the intention to close BAC but made it necessary to consider alternative models of care including where services would be provided. It was not that the services then provided at BAC were under review.

1.2 The process of considering alternative models of service to be developed to replace the services then provided by BAC commenced with the preparation of the Barrett Adolescent Strategy Plan in about December 2012 and included:

(a) The work and recommendations of the ECRG and the Planning Group as outlined in paragraph 8.4 of my first statutory declaration.

(b) The work of the State Wide Adolescent Treatment and Rehabilitation Implementation Strategy Steering Committee as outlined in paragraph 15.8 of my first statutory declaration.

1.3 I recall that EFTRU was anticipated to open in 2013 but I cannot now recall when in 2013 and, as the anticipated opening date for EFTRU did change due to delays in commissioning the service, I am unable to say with certainty what was the position as at December 2012 or the specifics of when the anticipated date of opening changed.

(c) whether any person/s within Queensland Health (QH), West Moreton Hospital and Health Service (WMHHS) and/or West Moreton Hospital and Health Board (WMHHB) were responsible for coordinating the replacement of the BAC and the opening of EFTRU and, if so, identify those persons and the reports they produced or details of their work;

(d) whether any person/s within QH, WMHHS or WMHHB was responsible for identifying and/or managing the risks associated with the opening of EFTRU and, if so, identify those persons and the reports they produced or details of their work;

(e) whether any person/s within QH, WMHHS or WMHHB was responsible for identifying and/or managing the risks associated with the opening of EFTRU in the vicinity of BAC and, if so, identify those persons and the reports they produced or details of their work.

1.4 The EFTRU service was at an advanced planning stage when I commenced my position with WMHHS on 30 July 2012.

1.5 It is my understanding that:

(a) The EFTRU was a component of the redevelopment plan for The Park as outlined in paragraph 6.6 of my first statutory declaration.

(b) The decision to establish an EFTRU and responsibility for aspects such as approving a model of care for EFTRU would have been matters within the role and responsibility of the MHAODB.

(c) Clinical governance for the establishment of EFTRU would have rested with the High Secure Service at The Park. Dr Terry Stedman and Dr Darren Neillie would have had lead roles in that respect.

1.6 I cannot now recall the names of individuals who may have held particular responsibility with respect to identification or management of risks associated with EFTRU.

1.7 In relation to the identification and management of risks associated with the opening of EFTRU in the vicinity of BAC, a Board Paper presented to the WMHHB for the Board meeting on 23 August 2013 reflects that this risk had been specifically identified and considered. It also notes the risk mitigation steps taken to address that risk. Attached and marked **LD-1** is a copy of that Board Paper.

1.8 It is my understanding that it was well recognised and accepted that there were risks of co-locating EFTRU and the adolescent cohort of BAC on a single site. That risk was identified at least as early as 2008. In that regard, the Site Options Paper for the Redevelopment of the Barrett Adolescent Centre dated October 2008, which led to the selection of the Redlands site for the development of the new adolescent service stated in relation to the possibility of developing the new service at the existing site:

> *.. the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in*

close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.

Attached and marked **LD-2** is a copy of the Site Options Paper.

2 Look at the document entitled *'Queensland Government Funded Services For Young People'* (attached and marked QHD.006.002.8602).

(a) state whether this document was ever submitted on behalf of the Department of Health (and if so, on what date, by whom and to whom);

2.1 I have no recollection of having seen this document prior to receiving it from the Commission attached to the Notice to provide this witness statement.

(b) with respect to BAC and EFTRU services referred to in that document, state whether as at June 2013:

(i) the services then provided by the BAC were under review, and the date when alternative models of service were to be developed to replace the services then provided by BAC; and

2.2 As at June 2013, the services at the BAC were not under review. As at that time:

(a) The WMHHB had approved the development of a communication and implementation plan to support the closure of BAC.

(b) WMHHS was in the process of liaison with the office of the Director-General of Health and the office of the Minister for Health in respect of approval to close BAC.

2.3 As at June 2013, the date when alternative models of service were to be developed (which were not to 'replace' the services then provided at BAC, rather the process was to identify and where necessary develop services across the continuum of mental health care which were required and appropriate to the care of adolescents requiring mental health extended treatment services), was not fixed. That process was ongoing.

(ii) the opening of the Extended Forensic Treatment and Rehabilitation Unit (the EFTRU) was proposed for June, July or August 2013.

2.4 I cannot now recall whether, as at June 2013, the opening of EFTRU was proposed for June, July or August 2013.

Please state whether that is correct and, if not, why not. If that is correct then state

(c) whether any person/s within QH, WMHHS or WMHHB was responsible for coordinating the replacement of the BAC and the opening of EFTRU and, if so, identify those persons and the reports they produced or details of their work;

2.5 I am not aware whether any person/s within QH, WMHHS or WMHHB was responsible for coordinating the replacement of the BAC and the opening of EFTRU.

2.6 I am not aware of, nor do I have access to, any reports or other work undertaken in this respect.

(d) whether any person/s within QH, WMHHS or WMHHB was responsible for identifying and/or managing the risks associated with the opening of EFTRU and, if so, identify those persons and the reports they produced or details of their work;

2.7 Direct responsibility for identifying and managing the risks associated with the opening of EFTRU lay with the High Secure Service within WMHHS, which had clinical governance of the EFTRU.

2.8 I am not aware of, nor do I have access to, any reports or other work undertaken in this respect.

(e) whether any person/s within QH, WMHHS or WMHHB was responsible for identifying and/or managing the risks associated with the opening of EFTRU in the vicinity of BAC and, if so, identify those persons and the reports they produced or details of their work.

2.9 The risks associated with the opening of EFTRU in the vicinity of BAC was a matter under the active consideration of the executive team of the WMHHS Mental Health and Specialised Services team. It was one of the reasons that indefinite delay in closing BAC was not considered a viable option.

2.10 Risk management steps were taken and those steps were reported to the WMHHB. I refer to exhibit LD-1.

2.11 I am not aware of, nor do I have access to, any reports or other work undertaken in this respect.

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

3.1 All documents referred to in my witness statement are exhibited.

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

Taken and declared before me by)
LESLEY DWYER at Brisbane in the)
State of Queensland this)
day of)
Before me:)

....
Signature of authorised witness Signature of declarant

A Justice of the Peace/
Commissioner for Declarations

STATUTORY DECLARATION OF LESLEY DWYER

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LD-1	Board Meeting Agenda Paper for Board meeting on 23 August 2013	WMB.1000.0001.00112-3	1 - 2
LD-2	Report of the site evaluation subgroup Site Options Paper for the redevelopment of the Barrett Adolescent Centre	WMS.5000.0031.00190	3 - 36

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LESLEY DWYER

.....
Witness

West Moreton Hospital and Health Board

BOARD MEETING AGENDA PAPER

Committee:	Board		
Meeting Date:	23 August 2013	**Agenda Item Number:**	7.1
Agenda Subject:	Barratt Adolescent Strategy		
Action required:	☐ For Recommendation	☐ For Discussion	☒ For Noting
Author: Sharon Kelly	**Position:** ED, Mental Health and Specialised Services		**Date:** 14 August 2013

☒ Recommendation/s are consistent with Strategic Plan
☒ Funding impacts are included within approved budget
☒ Risks are identified and mitigation/management strategies included
☒ Implications for patient and/or staff care and well-being have been identified

Proposal

That the West Moreton Hospital and Health Board:

Note current actions in relation to the implementation of the Barrett Adolescent Strategy

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Background

1. Investigations into contemporary model of care for Adolescents requiring extended treatment and rehabilitation mental health care were commenced in November 2012 utilising a range of strategies
2. The Board supported in principle the recommendations of the Expert Clinical Reference Group at its May 2013 meeting with some further high level communication and risk mitigation strategies prior to progressing to announcement and implementation.
3. Progress presented to The Board July meeting and community announcement occurred by The Minister for Health, Mr Lawrence Springborg on Tuesday 6 August.

Key Issues or Risks

4. Communication Strategy
    a. in depth communication plan developed for announcement with endorsement by strategic partners and Minister office.
    b. All steps in plan adhered to and undertaken within 3 days of announcement
    c. Key notes :-
        i. Staff were advised prior to announcement by ED MH&SS and Chief Executive WMHHS. Included in the meeting were the Department of Education Director and HR staff.
        ii. All current consumers and their carers were individually spoken to prior to announcement publically with positive responses.
        iii. Key themes were the positive response to the statewide governance changes to Children Health Queensland; the commitment to ensure current and future consumers will be supported into contemporary models.
        iv. Media has been underwhelming in negativity and all concerns raised by individuals are being attended to as a priority.
5. Patient discharge strategy
    a. all current consumers have an up to date discharge plan
    b. a number of consumers were identified for discharge over the next four months
    c. the treating team have already commenced discussions with each of the family carer's to identify what resources or care may be required by the consumer post December 2013.
    d. Consumers on the wait list have been identified and correspondence provided outlining the process to occur.
    e. Receiving HHS services are engaged in each of these consumers as well to identify what care or alternate services may be required post closure of the BAC facility.
    f. Current negotiations are occurring with the Clinical Director regarding the appropriateness or requirement for short term admissions for some on the wait list.
6. Risk management of service whilst EFTRU has opened and adolescents remain on campus
    a. Extended Forensic Treatment and Rehabilitation Unit opened to first consumers 29 July 2013.

b. First tranche of consumers was direct transfer from the Extended Treatment Rehabilitation unit, already locate on the premises. (aim to test facility etc and staff learning prior to a more significant secure cohort being admitted)
c. Planning for each month a further increase in consumers transferred from the High Secure unit will occur depending on their acuity and consequent full capacity anticipated by January 2014.
d. Each consumer is risk assessed as to their ability to manage in the new environment.
e. As a risk mitigation strategy adolescent consumers are not allowed ground access without escort during this transition phase.

7. Transition of governance
   a. Initial meetings have been had with the Children's Health Queensland and MHAOD branch
   b. A field trip to Victoria to consider alternate models in action is occurring over the 14 August to 16 August by senior clinicians CHQ and representatives of WMHHS.
   c. Implementation plan and progression by CHQ for the first meeting of the implementation group under way.
   d. The implementation group will report to an oversight group which is Chaired by Deputy Director General Dr Michael Cleary and will have representation from the appropriate HHSs who provide adolescent services.

Consultation

8. Significant consultation has occurred during the process with internal and eternal stakeholders.

Financial and Other Implications

9. Budgets attached to the BAC will be removed once the full transition has occurred in early 2014.
10. Ongoing political and reputational implications should any significant incident or adverse media occur during this transition phase.

Strategic and Operational Alignment

11. The closure of BAC and removal of adolescent services from The Park forensic site aligns with both the strategic direction of the HHS and the Queensland Plan for Mental Health 2007-17.

Recommendation

That the West Moreton Hospital and Health Board:

Note current actions in relation to the implementation of the Barrett Adolescent Strategy

Attachments

Nil

Queensland Government
Queensland Health

Mental Health Plan Implementation Team
Mental Health Branch
Division of the Chief Health Officer
12th Floor, Forestry House
160 Mary St,
Brisbane Qld 4000

Report of the site evaluation subgroup

Site Options Paper for the redevelopment of the Barrett Adolescent Centre

October 2008

TABLE OF CONTENTS

Executive Summary

The Queensland Plan for Mental Health 2007-2017 provides significant funding to support mental health service improvement and reform. The plan includes investment in new and upgraded inpatient services.

This report of the Site Evaluation Subgroup includes an appraisal of the options explored for the redevelopment of the Barrett Adolescent Centre (BAC).

At the request of the Area General Managers of the former Southern and Central Area Health Services, the following sites were considered as options for the redevelopment of the BAC:

- Rogers Street Spring Hill;
- CAFTU- RBH;
- Land adjacent to Redland Hospital;
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St); and
- The Park Centre for Mental Health (3 site options on campus considered).

The report finds Redland and The Park as the only architecturally viable options if the service is to be redeveloped as currently envisaged.

It identifies redevelopment at Redland as the preferred option.

The report identifies the need for further consultation on this option with the current Barrett service providers, consumers, carers and the broader Child and Youth Mental Health Sector to inform a final decision.

The Barrett School is a critical component of the service and must be included in the redevelopment of the service at any site. Therefore, negotiation with the Department of Education, Training and the Arts is required in the process of deciding the preferred option.

A final decision for the service location will be made by the District CEOs of Metro South and Darling Downs West Moreton Health Service Districts. It is recommended that the District CEOs provide the Site Evaluation subgroup with the authority to consult these relevant stakeholders on the preferred option. Subject to approval consultation could consider the following identified issues:

- Review of transport options, including duration and cost of journeys. A comparison of the accessibility of the sites particularly for consumers accessing the day program and for consumers and carers travelling from rural, regional and remote areas who require the service.
- Consideration of the impact of the surrounding built environment at Redland. This should take account of the surrounding bushland and include some consideration of risk management strategies associated with bushfires, wildlife and proximity to other infrastructure including the sewage treatment plant.
- Further analysis of the impact of the built environment at The Park and associated risk management strategies. This may include consideration of the implications of having vacant buildings on the site. It could further identify the challenges and opportunities associated with the proximity of the service to the new Police Academy site.
- Further consideration of the cost and time implications should a staged redevelopment at the existing site be pursued.
- Consultation with police to establish whether Redland site may subject the unit to risk from 'undesirable persons' and consideration about how such a risk might be managed.
- Consideration of the implications of the implementation of the Clinical Services Capability Framework (CSCF) and the assignment of a level to the service. In particular, this may further clarify the specialised requirements of the unit including the need for specialist human resources and the advantages of being co-located with 24 hour medical care.

- Further clarification of plans for service expansion in the second half of the plan to provide 5 additional beds for the adolescent unit in the development of step down units and further consideration of accommodation options for family and carers.
- Clarifying the governance arrangements should the unit be located at Redland. In particular the service's reporting relationships to Metro South and/or the Queensland Children's Hospital.
- Further examination of the potential advantages of co-locating the service near the Brisbane Youth Detention Centre at Wacol, Child and Youth Forensic Outreach Service (CYFOS), Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS) given the overlap of demographics and some characteristics of clients seen by each of these services. This requires some consultation with MHATODS and CYFOS to determine whether co-location of this kind is consistent with the service development intentions of these services.

It is proposed that the Site Evaluation Subgroup report on the outcome of this consultation to the District CEOs to support a final decision concerning the site for redevelopment of the Centre.

Dr Aaron Groves
Senior Director, Mental Health Branch
28/10/2008

Introduction

The purpose of this paper is to support decision making associated with the selection of a site for the replacement of the Barrett Adolescent Centre (BAC).

It considers the sites below, which were identified by Area Health Services as potentially suitable for replacement of the centre:

- Rogers Street Spring Hill
- CAFTU- RBH
- Redland Hospital
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)
- The Park Centre for Mental Health (3 site options on campus considered)

The report includes:

- a brief description of the project;
- a summary of the model of service for BAC;
- a description of site requirements and;
- a site appraisal of the two architecturally viable sites- prepared by Project Services.

Appendix One includes the rationale for finding two of the three site options at The Park, CAFTU and Rogers Street to be architecturally unviable. Advice from Southside Health Service District subsequent to the site options tour indicated the option at Logan was no longer available or viable; therefore an appraisal of this site has not been undertaken.

Appendix Two is a collection of 'Site Tour Notes' providing a summary of some of the key issues considered by Site Evaluation subgroup during site visits by the subgroup on 5 August 2008.

The report identifies the need for further elaboration of some of the challenges and opportunities of the two architecturally viable sites to support a final decision concerning the redevelopment of the unit.

The report concludes that Redland appears to be the preferred option for the redevelopment of the service subject to further consultation with the sector.

1. Project Description

Replace Barrett Adolescent Centre with a new 15 bed adolescent extended treatment unit.

Background:

- Decision concerning the location for the redevelopment of the Adolescent unit is contentious
- Redevelopment at The Park is problematic because of the expansion of forensic services being undertaken on the site
- This expansion includes the development of a further 40 extended treatment forensic beds over the next 10 years
- Advantage of the current site is the existing service with highly skilled staff.
- No optimal location for the unit identified by Child and Youth clinicians
- "Site Evaluation Sub Group" established to assist in determining an appropriate site for the unit at the direction of the Area General Managers (participants identified below)
- Subgroup reviewed the site selection criteria and accommodation schedule produced by Project Services in collaboration with BAC staff
- Ranking of site selection criteria reviewed
- Scope for reducing footprint identified in accommodation schedule
- Alternate sites identified in discussion with Area Health Services
- Sub Group visited the following sites on 5 August 2008:

Rogers Street Spring Hill

CAFTU- RBH

Redland Hospital

Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)

The Park Centre for Mental Health (3 site options on campus considered)

- Sub Group agreed to consider the site options on the basis that they may:
  - serve the clinical objectives of the service
  - satisfy the criteria nominated in the 'Site Selection Criteria'
  - meet the design requirements identified in the accommodation schedule

Participants:

Ms Denisse Best	Executive Director	Child & Youth Mental Health Service, Royal Children's Hospital & Health Services Districts, Chair Child & Youth Sub Group
Mr Kevin Fjeldsoe	Director	Mental Health Plan Implementation Team
Dr Trevor Sadler	Clinical Director	Barrett Adolescent Centre
Dr Brett McDermott	Director	Mater Child & Youth Mental Health Service
Ms Linda Ryan	Principal Project Officer	Southern Area Health Service
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Ms Erica Lee	Manager	Child and Youth Mental Health Service
Mr Paul Clare	Principal Project Officer	Mental Health Plan Implementation Team
Mr John Quinn	Manager	Mental Health Plan Implementation Team
Ms Jenny Stone	Assistant Director	(Southern) Program Coordination Unit LWAMB
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area

Additional invitees to site options tour:

Dr Terry Carter	Project Manager,	Mental Health Capital Works Program
Mr David Pagendam	Senior Architect	Project Services
Ms Karen Reidy	Architect	Project Services

Apologies for the site tour:

Dr Bill Kingswell	Director	Mental Health Services - Logan
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area
Mr David Pagendam	Senior Architect	Project Services

2. Brief Summary of the Adolescent Extended Treatment Model of Service

Service integration

The Adolescent Extended Treatment and Rehabilitation Service is an integral part of Child and Youth Mental Health network of services in Queensland. Child and Youth Mental Health Services (CYMHS) include:

- community clinics throughout Queensland
- specialised therapeutic services to children and adolescents in the care of the Department of Child Safety (Evolve teams)
- acute inpatient services in Metro South, Metro North, Mater and Gold Coast Health Districts
- a day program at the Mater Children's Hospital, with proposals to develop further day programs at Townsville and the Sunshine Coast.
- a Child and Youth Forensic Outreach Service (CYFOS)
- a visiting service to the Brisbane Youth Detention Centre

An adolescent of high school age is referred to the Adolescent Extended Treatment and Rehabilitation Service if severe mental illness and impairment persist after extended treatments in one or more of these other settings. It is both a tertiary and quaternary referral service, depending on the severity and complexity of illness and range of settings for intervention prior to referral. Referrals are accepted from throughout Queensland. On occasions it is appropriate to accept referrals from northern New South Wales and the Northern Territory. Referrals may also be made by private child and adolescent psychiatrists or psychologists.

Adolescents usually will be placed on the waiting list, and managed by the referring service until admission is possible. Throughout the admission, ongoing linkages with the referrer will occur via videoconference and case management.

It is proposed that the Adolescent Extended Treatment and Rehabilitation Service be a Level 6 service in the Clinical Services Capability Framework being developed by the Mental Health Branch.

Target population:

Adolescents accepted for referral have severe, persistent, co-morbid mental illnesses associated with a range of impairments. Mental illnesses most commonly diagnosed include:

- depression
- eating disorders
- social and other anxiety disorders
- obsessive compulsive disorder
- dissociative disorders

- post traumatic stress disorder
- psychotic disorders
- organic disorders
- co-morbid disorders of development

The Health of the Nations Outcome Scale for Children and Adolescents (HoNOSCA) is an assessment tool used by mental health services across Australia to assess levels of symptom severity, impairment and family function. Compared with the national average of those admitted to acute adolescent inpatient units, those admitted to the Adolescent Extended Treatment and Rehabilitation Service show similarly high levels of symptoms and acuity (e.g. emotional distress, self harm, perceptual disturbances), but significantly higher levels of impairment (e.g. schooling, self care, peer relationships, impaired concentration) and family dysfunction.

Treatment of many disorders requires the active participation of the adolescent. Frequently they are not contemplating change, but continue with an illness seriously affecting health and their functioning. Both symptom severity and impairment are likely to persist for decades into adult life without adequate intervention.

Service description:

The core of the service is the provision of a wide range of intensive interventions for integrated treatment and rehabilitation. (Unlike many areas of physical medicine in which there is a definitive treatment followed by rehabilitation, effective outcomes in adolescent mental health require an integrated approach to treatment and rehabilitation over months.)

Core approaches to treatment and rehabilitation include:

- utilising standard biological mental health treatments (medication, ECT), although the effectiveness of these is limited
- utilising a wide range of psychological interventions for adolescents with often limited verbal skills and limited understanding of psychological issues
- utilising a wide range of life skill and activity based interventions to address developmental tasks in both treatment and rehabilitation
- providing of a range of comprehensive education and pre-vocational activities through the Department of Education, Training and the Arts
- continuing support of, liaison with and therapy for the family
- maintaining strong community linkages
- safely managing a range of life threatening behaviours
- effectively managing a range of dysfunctional behaviours
- maintaining a ward environment which promotes therapeutic interactions

Depending on levels of acuity and impairment, adolescents access this program at a number of levels:

- as inpatients (full or partial hospitalisation) for those with high to extreme levels of acuity and severe impairment. Up to 15 beds are available for this purpose.
- as day patients for those with severe impairment but lower acuity for those who can access the service.

A comprehensive extended treatment and rehabilitation program for a Statewide service would also include:

- a therapeutic residential unit for those who have severe levels of impairment, low to medium levels of acuity and cannot access the service as a day patient
- a transitional residential facility (step-down) service for those who have moved from high to lower levels of acuity, continue to have moderate to severe impairment, and cannot return to their family home.

- a family stay residential facility to provide intensive family interventions or family interventions with adolescents with extreme acuity.

Legislative framework and Policy Directions:

In common with other Mental Health Services in Queensland,

- adolescents are admitted either as voluntary patients or under the Mental Health Act.
- consumer, and where possible, carer participation is essential to providing service.
- a Recovery framework is clearly articulated, although it differs in concept to adult mental health services.
- adolescents are managed in the least restrictive manner appropriate to safety. (This creates challenges on an open unit.)
- minimising seclusion and restraint is associated with better outcomes, but requires more intensive staffing.
- outcomes are routinely measured utilising a nationally standard suite of scales - the HoNOSCA, Children's Global Assessment Scale (CGAS) and Factors Influencing Health Scale (FIHS).

Pathways of service delivery once admitted

Transfer

- acute medical management at local general hospital occurs at regular intervals.
- rarely acute psychiatric care at referring acute unit may be required.

Discharge

- intensive discharge planning requires considerable integration with the local community of origin (including local schools)
- the adolescent often transitions from full inpatient admission to periods of partial hospitalisation prior to discharge.
- the lack of appropriately supervised accommodation in the NGO sector is a problem for adolescents who cannot return to their family of origin.
- remoteness of referring services makes follow up referral linkage sometimes difficult to sustain
- occasionally it is difficult to access support in adult mental health services if the adolescent requires further long term treatment.

Managing risk

Managing self harm, suicide attempts, absconding and aggression are major risk issues in patient safety in both adolescent and adult sectors. However, there are particular issues in the genesis and management of these risks in adolescents.

- adolescents do not often possess good verbal skills and their distress is manifest instead in a range of behaviours
- adolescents generally are fitter and have fewer problems with mobility (whether secondary to the type of illness or medications). This enables them to abscond.
- adolescents are more likely to encourage a peer to join them in absconding or to copy another with self harm – the so called "contagion effect".
- adolescents are more sensitive to adverse changes in the family environment. Although distant, this may be a potent effect on behaviours within the unit.
- adolescents are often more impulsive, especially in relation to negative life events to which they are more sensitive.
- adolescents have less experience at assessing safety in the community

- adolescents are more likely to react negatively to a perceived closed environment than an open one. There is a complex interaction between built environment and safety which will be described in the next section

Staffing structure and composition:

- Intensive levels of staffing required for intensive interventions and high levels of acuity
- Staff must have training and/or substantial experience in child and adolescent mental health
- Specialist skill sets in a range of psychological, activity based and life skills interventions required
- Clinical and educational multidisciplinary bio psycho social approach
- Maintenance of ongoing professional development and supervision of staff required
- Range of resources to support the necessary range of interventions

Performance, quality and safety:

- consumer and carer satisfaction
- ongoing workplace health and safety monitoring due to nature of service
- outcomes monitoring

3. Site Requirements

THE IMPACT OF BUILT ENVIRONMENT AND EXTENDED ADOLESCENT TREATMENT

1. The Rationale to Develop Guiding Principles for the Built Environment

Adolescents admitted to the Extended Treatment and Rehabilitation unit are likely to spend up to twelve months or more in hospital. (Hospital is acknowledged to be the most restrictive setting in mental health.) About half will at some stage be on an Involuntary Treatment Order. Initially most adolescents do not contemplate the need for change. Many adolescents believe they should be independent and exercising freedoms they see in their peers, These factors have the potential to actively work against the fact that most treatments require the active participation of the adolescent. There is considerable potential for adolescents them to react strongly against treatment, the staff and hospitalisation. This is manifest in two of the risk factors associated with the unit – absconding and aggression.

Clearly identifiable factors can minimise these tensions and their attendant risk factors. Broadly they can be divided into staff attitudes/skills and the impact of built environment. Guiding Principles 1 – 3 below have been extracted from surveys of adolescents who have been asked about the impact of the change of environment from the constricted environment of an acute inpatient setting to the more open environment of the extended treatment unit has had on their attitudes to being in treatment.

Built environment also has numerous other impacts:

- Adolescents on admission range widely in their fitness levels, co-ordination abilities and participation in physical activity. Providing for a range of physical activity addresses a number of impaired tasks of adolescent development. (Principles 2 and 3).
- Adolescents interact intensively with a limited range of peers over a long period. Adequate external and internal spaces achieve a balance between privacy and a range of peer interactions. (Principles 2,3 and 6)
- Adolescents can utilise external spaces to help them regulate emotional distress and aggressive impulses. (Principles 1 and 2)
- Many adolescents have had very limited interactions with peers or areas outside their home prior to admission. Time in acute inpatient units is in enclosed environments. It is initially helpful to spend time outside without the feeling of being on view to the public. (Principles 2 and 3)
- A number of adolescents often talk in therapy in an activity in the grounds. They are uncomfortable in a room with the expectation they should talk. (Principle 2)

The built environment must also be considered within the broader context of the neighbourhood in which it is located.

- An open unit offers more chances to abscond. Adolescents are at risk then of mishap from nefarious persons, or from themselves by accessing of heights or other means to attempt suicide. (Principles 4,5)
- It is essential for rehabilitation that community public transport, sporting, community and recreational facilities are available within reasonable distance to prepare an adolescent for integration into their own communities. (Principle 6)
- Either sufficient recreational space and facilities are located within the grounds of the unit, or within close proximity (less than 1 minute) to afford opportunities for acutely unwell adolescents to access these in safety, or for staff return to attend to crises on the unit. (Principle 1, 2 and 6)

2. Guiding Principles

Six Principles can be derived from the above observations to guide the location and design of the Centre.

Principle 1.
Minimising visual restrictions in the environment enable adolescents to cope better with legislative and behavioural restrictions and the restrictions their illness imposes on them.

Principle 2.
The grounds surrounding the building must have sufficient room for multiple purpose activities – recreation, fitness, socialisation, private areas, areas for emotional regulation and areas to enhance therapies to be undertaken safely.

Principle 3.
Adolescents should not feel they are on display to the public, nor should the public have cause to stigmatise the unit.

Principle 4.
The chances of absconding successfully can be reduced by consideration of factors in the immediate neighbourhood of the Unit.

Principle 5.
The chances of an adverse event following an absconding can be reduced by attention to the immediate neighbourhood of the Unit.

Principle 6.
The neighbourhood in which the unit is located should afford opportunities to practice skills for rehabilitation and community integration which can be generalised to the community in which the adolescent lives.

3. Application of the Principals to Design

3.a Characteristics of the Site

3.a.i external views – desirable:

- Sky, trees, distant objects, grass, landscape, sports ovals. (Principles 1,2)
- Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. (Principle 1,2)
- Water views a bonus. (Principle 2)

3.a.ii External views – undesirable

- Anything that is too busy or intrusive; buildings. (Principles 1,2 and 5)

3.a.iii Access to natural environment

- Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature. (Principles 1,2)

3.a.iv Access to outdoor activities

- Safe place for walking and riding (not on main roads), playing outdoor games and sports, and just "getting away". (Principles 2, 6)

3.a.v External buffer space and boundaries

- At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). (Principle 3)
- There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. (Principles 1,4)
- Good buffer spaces can reduce the need for fences. (Principles 1,4)

3.a.vi Topography

- An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonable level. (Principles 1,2)
- Slopes can be used to hide fences. (Principles 1,4)

3.a.vii Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.

3.a.viii Privacy

- Privacy for the adolescent consumers is important, but the facility should not be too isolated. (Principles 3,6)
- It is desirable for consumers to have opportunities to see people outside, but adolescents should not be "on display". (Principle 3)
- Contact with the public and families needs to be controlled. (Principles 2,3,4 and 5)
- It is important that public thoroughfares do not happen through the facility site. (Principle 3)

3.a.ix Total site area

- 2 Ha preferred area. (Principles 1,2 and 3)
- 1.5 Ha minimum.

3.b. Characteristics of the Immediate Neighbourhood

3.b.i Surrounding built environment

Avoid:-

- High rise and high density buildings. (Principles 1,2 and 5)
- Sites that other buildings look down on. (Principle 3)
- Main roads, railways, and other noisy busy areas. (Principles 3,4 and 5)
- Intimidating or industrial general environment (Principles 2, 3)

3.b.ii Physical hazards

- Avoid bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines. (Principles 4,5)

3.b.iii Absconding

- A buffer of open space around the facility is important to keep sight of an absconder (Principles 4,5)
- A buffer of 500m to public transport to deter rapid absconding. (Principles 4,5)
- Avoid potential hiding places. (Principle 4)

3.b.iv Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.
- It is a Band-7 school (special education) but not all consumers attend this school, therefore access to other schools (particularly high schools) is necessary. (Principle 6)