Dr Radovini is a consultant Psychiatrist with over 25 years clinical experience in Mental Health in the private and public sectors, metropolitan and rural settings and child, adolescent, youth and adult psychiatry.

Dr Radovini is the Director of Mindful – the Victorian state-wide teaching and training unit hosting postgraduate courses, professional forums, workshops, short courses for clinicians working in Child and Adolescent Health Services (CAMHS) as well as clinicians working in other sectors e.g. education, welfare, private practice.

In November 2011, Dr Radovini was appointed as the inaugural Clinical Director of **headspace** – National Youth Mental Health Foundation, a Commonwealth Government initiative designed to provide early access to mental health services for youth aged 12-25 years via **headspace** centres, e-headspace and school support programs.

From 2009 – 2011, Dr Radovini was the inaugural Chief Child Psychiatrist with the Victorian Government Department of Health. This position was created by the Minister for Mental Health as part of the Victorian Mental Health Reform Strategy to focus on the needs of children, young people and their families.

Dr Radovini was also the Consultant Child & Adolescent Psychiatrist with the Orygen Youth Health Intensive Mobile Youth Outreach Service (IMYOS) team for nine years. The IMYOS team works with high risk young people with multiple and complex needs and develops innovative ways of working with vulnerable young people and their families and carers. Dr Radovini has co-authored several papers describing the IMYOS model of care.

RSVPs for Sandra Radovini Parent and Carer Information Session Wednesday 10 December 2013

Name	Parent/Carer

Apologies:

Other attendees:
Dr Anne Brennan
Sharon Kelly
Leanne Geppert
Ingrid Adamson
Stephen Stathis

RSVPs for Sandra Radovini Staff Session Tuesday 10 December 2013

Name	Title	Service	Dietary Requirements
Megan Hayes	Occupational Therapist		
Carol Hughes	Social Worker		
Matthew Beswick	Clinical Nurse		
Mara Kochardy	Nurse		
Anne Brennan	A/Clinical Director		

RSVPs for Sandra Radovini Dinner Tuesday 10 December 2013

Name	Title	Service	Dietary Requirements
Meenakshi Sundaram Shanmugam	Consultant Psychiatrist	Pine Rivers CYMHS	
Anne Brennan	A/Clinical Director	BAC	
Sue Wilson	Child and Adolescent Psychiatrist	Private	
Leanne Geppert	A/Director of Strategy,	West Moreton	
Lesley Dwyer	Chief Executive	West Moreton	
Judi Krause	Executive Director, CYMHS	CHQ	
Bernice Holland	Project Support Officer MH&SS	West Moreton	
Ingrid Adamson	Project Manager	CHQ	
Laura Johnson	Project Manager	West Moreton	
Peter Parry	Child and Adolescent Psychiatrist	Nundah CYMHS, CHQ	Gluten Free

Barrett Adolescent Parent Session

11 December 2013

Today…

1. Overview of the Transitional Service Options
2. Update from Children's Health Queensland on elements of the proposed future service options
3. Presentation – Dr Sandra Radovini (Victoria)

Goals…

- Update on progression of work around future service options
- Opportunity to ask questions and provide input
- Hear about Victorian service models and their experience in caring for young people with complex mental health needs

WM HHS Transitional Service Options - an interim plan

Recovery oriented treatment and rehabilitation for young people (aged 16 – 21 years) with severe and persistent mental health problems

Key Issues:

- Imperative at all levels to ensure no gap to service delivery for BAC consumers and other young people in Qld
- Partnership service model – WM HHS, CHQ, Aftercare, Department of Health
- The interim options will be a pilot for the future service options
- Need to focus on individual, recovery–orientated packages of care, that reintegrate and reconnect young people to their communities, family, school/vocation and local mental health services
- Clinical safety and risk mitigation are key priorities
- Interface between QH and DETE is high priority – Alignment between QH and DETE model of service delivery

WM HHS Transitional Service Options - 3 Phases

Phase 1

Activity Based Holiday Program

Site – The Park
16 December 2013 – 24 January 2014

Target population
Current BAC inpatients and day patients (as clinically safe and indicated)
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity

Referral Process
BAC Assessment and Referral

Overview of service / treatment
Activity and socialisation focus
Monday to Thursday school hours + parent session on Fridays

Staffing Required
Core staff:– Aftercare team (clinical and other) + BAC staff

Length of Program Delivery
Up to length of Christmas School Holidays 2013/14

Governance
WM HHS and Aftercare

Phase 2

West Moreton Transitional Service:
- **Assertive Community Outreach Service**
- **Day Program**
- **Supported Accommodation**
- **Pursuing option for sub-acute inpatient beds**

Site – To be confirmed (pursuing Greenslopes option)
February 2014 commencement

Target population
Current BAC inpatients and day patients 16y-21y
New patients meeting criteria from other HHSs – previously eligible for referral to BAC
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity

Referral Process
CYMHS Assessment and Referral
State-wide Clinical Referral Panel

Overview of service / treatment
Assertive Community Outreach Service: 5 days / extended hours
Delivered in least restrictive environment and utilising a recovery model – range of flexible outreach services for engagement, treatment & rehabilitation to assist young people to meet their developmental tasks in the context of recovery from mental health presentations
Day Program: Monday to Thursday school hours and school terms
Delivered in a therapeutic milieu – range of facilities in community
Individual, family and group therapeutic & rehabilitation programs
In-reach educational tutors + ongoing access to local school/vocation
Supported Accommodation: 7 days
Delivered in a therapeutic milieu – domestic style facility
In-reach CYMHS clinical team

Staffing Required
Core staff:– Aftercare team (clinical and other) + identified CYMHS clinician/s

Length of Program Delivery
ACOS & Day Program: Up to 12 months, Supported Accomm: Up to 6 months

Governance
Joint – CHQ, WMHHS, Aftercare

Phase 3

Transition to State-wide Adolescent Extended Treatment and Rehabilitation Services*

***Details to be defined via the Statewide AETR Strategy, under leadership of CHQ HHS**

Target population
As per State-wide Adolescent Extended Treatment and Rehabilitation Strategy

Governance
CHQ HHS

Native File (Non-image file)...Printing skipped

Children's Health Queensland Hospital and Health Service

Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care

Assoc. Prof. Stephen Stathis
Clinical Director, CYMHS
Children's Health Queensland, Hospital & Health Service

Great State. Great Opportunity

Queensland Government

Background

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

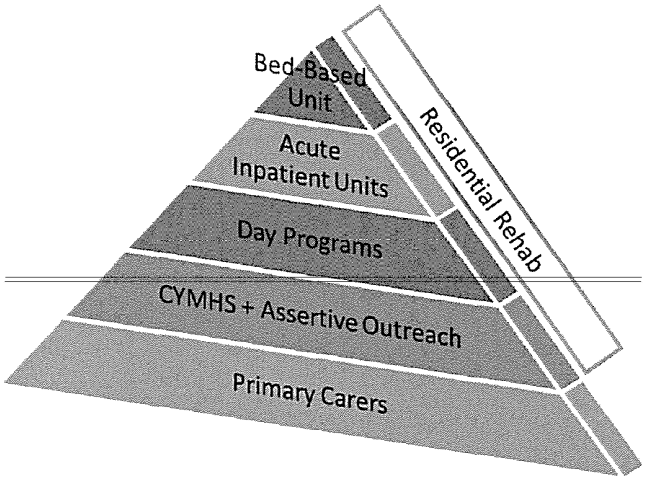
Our Consultation Process

- Expert Clinical Reference Group
- Mental health experts and care providers across QLD and Australia
- Site Visits:
  - Victoria – Intensive Mobile Youth Outreach Services; Y-PARC; Youth Residential Units
  - NSW – Walker Unit and Rivendell – Concorde Hospital
  - QLD – Mobile Intensive Team (Adult); ADAWS; TOHI
- Consumer / Carer Engagement on Working Groups and Steering Committee
- Regular communication with families, carers, and young people currently using services

ECRG Recommendations

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

Proposed Model of Care Options*



* Please note that the number and location of services, proposed in the Model of Care above, is subject to the availability of skilled workforce and funding.

Proposed Assertive Community Treatment Service (Tier 2a)

This service provides ongoing care and treatment through intensive mobile interventions in a community or residential setting.

For adolescents who may have...

- A need for intensive supportive care out of hours
- No fixed address or are transient
- A high risk of disengagement from treatment services
- No bed-based or Day Program options in their local community

Proposed Day Program (Tier 2a)

This service provides a range of intensive therapy, extended treatment, and rehabilitation through individual and group therapy.

For adolescents who ...

- Have a history of school exclusion or refusal
- Have social difficulties requiring group-based work
- Have a supportive home environment that ensures safety and/or access to CYMHS
- Live within proximity to the Day Program
- Don't require inpatient care

Proposed Step Up / Step Down Unit (Tier 2b)

This service provides short-term residential treatment, in partnership with NGOs, with services provided by specialist-trained mental health staff.

For adolescents who ...

- Require an increase in intensity of treatment to prevent admission into an acute inpatient unit (Step Up)
- Enables early discharge from a subacute/acute inpatient unit (Step Down)

Proposed Residential Rehabilitation Unit (Tier 2b)

This service provides long-term accommodation and recovery-oriented treatment, in partnership with NGOs, with inreach services from specialist-trained mental health staff.

For adolescents who ...

- Are 16 to 21 years old and able to consent to treatment
- May be unable to return home
- Require additional support to develop independent living skills
- Don't require inpatient care

Proposed Subacute Bed-Based Unit (Tier 3)

This service provides medium-term, intensive, hospital-based treatment and rehabilitation services in a secure, safe, structured environment.

For adolescents who ...

- Have a level of acuity or risk that requires inpatient admission
- Are unlikely to improve in the short term (i.e. weeks or months)
- Require a therapeutic environment not provided by an acute inpatient unit

Timeframes

Model of Care

Nearing completion, with work being undertaken to finalise the details of all options.

Implementation

Needs to consider:

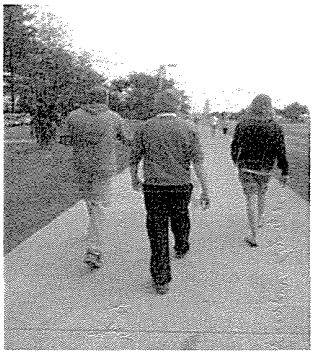
- Areas of community need
- Availability of skilled resources and funding

Some service options will be available earlier than others

For more information…

More information about the model of care, and its implementation, will be made available at:

http://www.health.qld.gov.au/rch/families/cymhs-extendedtreat.asp



In the meantime, if you have any questions about our plans, please contact:

CHQ_Adolescent_MH@health.qld.gov.au

Terms of Reference

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee

1. Purpose and Functions

The purpose of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee (Steering Committee) is to:

- Monitor and oversee the implementation of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Project Plan (Project Plan) to ensure that project milestones and key deliverables are met in the required timeframes, and that all accountabilities are fulfilled.
- Review and submit any proposed amendments of the Project Plan to the Chief Executive (CE) and Department of Health (DoH) Oversight Committee for approval.
- Establish, monitor and oversee the three Working Groups and their associated processes and outputs.
- Provide a decision-making, guidance and leadership role with respect to mental health service planning, models of care, staffing transition, financial management and consumer transition associated with the project.
- Provide governance of the project risk management process and associated mitigation strategies, and escalate in a timely manner to the CE and DoH Oversight Committee.
- Identify roles and responsibilities within the key stakeholder groups regarding information collection and reporting, transition of consumers, re-allocation of funding, including the identification of overlap and related roles.
- Prepare a communication plan for endorsement by the CE and DoH Oversight Committee.
- To facilitate expert discussion from key clinician and consumer stakeholder groups around planning and implementation activity associated with the Project Plan.
- Preparation and provision of update reports to the Executive Management Team, and Hospital and Health Service Board as required.
- To oversee the management of strategic risks.
- To monitor overall budget and financial management associated with the Project Plan.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the Project Plan.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Authority

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

The Committee will endorse all deliverables for approval by the Chief Executive and Department of Health (CE DoH) Oversight Committee.

Decision Making:

- Recommendations made by the Steering Committee, to the CE DoH Oversight Committee, will be by majority.
- If there is no group consensus in relation to critical matters the Chair has the right to decide
- Decisions (and required actions) will be recorded in the minutes of the meeting.

4. Frequency of meetings

Meetings will be held fortnightly on a Monday at 0830 am for 1.5 hours in duration unless otherwise advised.

In addition, the Chair may call additional meetings as necessary to address any matters referred to the committee or in respect of matters the committee wishes to pursue within its Term of Reference.

Attendance can be in-person, or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of the **project SW AETR options**. The Chair will advise the Committee members approximately one month prior to the dissolution of the Steering Committee once the service is mainstreamed.

5. Membership

Divisional Director	CYMHS, CHQ HHS	Co Chair
Clinical Director	CYMHS, CHQ HHS	Co Chair
Director of Strategy	MHSS, West Moreton HHS	Member
Director	Planning and Partnership Unit, MHAOD Branch	Member
Senior Representative	Queensland Alliance	Member
Senior Representative	*headspace*	Member
Senior Representative	Mental Health, Northern Clinical Cluster (or equivalent)	Member
Senior Representative	Mental Health, Central Clinical Cluster (or equivalent)	Member
Senior Representative	Mental Health, Southern Clinical Cluster (or equivalent)	Member
Consumer Representative		Member
Carer Representative		Member
Clinical Director	BAC, MHSS, West Moreton HHS	Member
Senior Representative	Metro South HHS	Member
Executive Director	Office of Strategy Management CHQ HHS	Member

Membership will take into account issues associated with confidentiality and conflicts of interest (including contestability).

Chair:
The Steering Committee will be co chaired by the Divisional Director of CYMHS CHQ and the Clinical Director of CYMHS CHQ, or his/her delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
The Secretariat will be provided by CHQ, who will facilitate the provision of the:

- Venue
- Agenda
- Minutes of previous meetings
- Briefs for any agenda items that require endorsement by the Chair five (5) working days prior to the meeting.

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

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

6. Quorum

The quorum will be half the number of official committee members plus one.

7. Reporting

The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee provides the following:

- Monthly Project Status Reports will be provided by the Steering Committee to the CE and DoH Oversight Committee, Queensland Mental Health Commissioner, Department of Education Training and Employment, and HHS Boards as identified by the CE and DoH Oversight Committee.
- Fortnightly written updates will be provided by each of the Working Groups to the Steering Committee seven (7) days prior to each Committee meeting for discussion as a standing agenda item.

8. Performance and Reporting

Performance will be determined by objectives of the Project Plan being met within the required time-frames.

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

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

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

9. Risk Management

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

The Committee will:

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

Risks will be identified and documented in the project plan and new risks identified will be escalated to the Steering Committee and reviewed as a standing agenda item.

A Risk Register will be established and reviewed at the Steering Committee meetings.

Document history

Version	Date	Author	Nature of amendment
1.0	26/08/13	Divisional Director CYMHS CHQ HHS	Initial Draft
1.1	03/09/13	A/Senior Project Officer OSM CHQ HHS	Incorporate CHQ HHS feedback
2.0		A/Director of Strategy, MHSS	Additional comments
2.1	09/09/13	A/Director of Strategy, MHSS	Incorporate SC feedback
3.0	19/09/13	Project Manager, SW AETRS	Edit Authority Section
FINAL	23/09/13	Project Manager, SW AETRS	Endorsed by SW AETR Steering Committee

Previous versions should be recorded and available for audit.

West Moreton Hospital and Health Service

Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel

Reporting Period: October 2013

Overview: BAC Patients (Inpatient, Outpatients and Day patients) and Waitlist

Current Inpatient	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Date (Transition Plan developed)	Proposed discharge date
1				30.10.2013	
2				15.10.2013	
3				22.10.2013	
4				29.10.2013	
5				22.10.2013	
6				29.10.2013	
7				22.10.2013	
8				30.10.2013	
9				15.10.2013	
10				TBA	
11				16.10.2013	

Current Day Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				6.11.2013	
2				6.11.2013	
3				30.10.2013	

Current Out Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				29.10.2013	
2				6.11.2013	
3				15.10.2013	

Waitlist	Age	Health District/ CYMHS/Home Town	Panel Date (Transition Plan developed)
1			14.11.2013
2			20.11.2013
3			13.11.2013
4			20.11.2013
5			13.11.2013
6			26.11.2013
7			26.11.2013
8			14.11.2013

Queensland Government

West Moreton Hospital and Health Service

Update:

- The Clinical Care Transition Panel was convened for the first time on 15 October 2013 and since then has met three times.
- At present the Panel has reviewed [redacted] at BAC. Transition plans are under development for these consumers including the preparation of clinical documentation (eg. CIMHA) for handover to identified service providers.
- The Panel has identified [redacted] who have more complex presentations and finding appropriate services and support is anticipated to be more challenging. Work has commenced on identifying strategies and solutions for these patients.

Issues:

- The Panel has identified a number of challenges associated with the transition planning for the young people at BAC. This includes access to appropriate supported accommodation and mental health trained support workers. One strategy that has been identified to assist with this would be to provide strategic communication on what is happening at BAC to upper management of key organisations and government departments. Another strategy identified is to invite the key NGO stakeholders to BAC to discuss what services they could potentially provide to the target group. This meeting has been scheduled for Monday 28 October 2013.

Risks:

- The Panel has identified significant clinical risks for [redacted] The Panel is currently mitigating this by seeking expert opinion from statewide senior mental health clinicians. It should be noted that there may be some delays in the transition process for some of the more complex cases.

Prepared by:
Laura Johnson, Project Officer, West Moreton Hospital and Health Service.

Endorsed by:
Dr Anne Brennan, A/Clinical Director, West Moreton Hospital and Health Service.

Queensland Government

Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel

Reporting Period: November 2013

Overview: BAC Patients (Inpatient, Outpatients and Day patients) and Waitlist

Current Inpatient	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Date (Transition Plan developed)	Proposed discharge date
1				30.10.2013	
2				15.10.2013	
3				22.10.2013	
4				29.10.2013	
5				22.10.2013	
6				29.10.2013	
7				22.10.2013	
8				30.10.2013	
9				15.10.2013	
10				5.11.2013	
11				16.10.2013	

Current Day Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				6.11.2013	
2				6.11.2013	
3				30.10.2013	

Current Out Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				29.10.2013	
2				15.10.2013	

Waitlist and Assessment List
The Panel is currently following up with the referring CYMHS of all young people on the BAC Waitlist and Assessment List to ascertain a status update.

Queensland Government

West Moreton Hospital and Health Service

Update:

- The Clinical Care Transition Panel was convened for the first time on 15 October 2013 and since then has met eight times.
- At present the Panel has reviewed all of [redacted] at BAC. Transition plans are under development for all of the consumers including the preparation of clinical documentation (eg. CIMHA) for handover to identified service providers.
- [redacted]
- The Panel continues to work finding solutions for the more complex cases including working alongside with other hospital and health services, government departments and non-government organisations.

Issues:

- Ongoing - the Panel has identified a number of challenges associated with the transition planning for the young people at BAC. This includes access to appropriate supported accommodation and mental health trained support workers. One strategy that has been identified to assist with this would be to provide strategic communication on what is happening at BAC to upper management of key organisations and government departments. Another strategy identified was to invite the key NGO stakeholders to BAC to discuss what services they could potentially provide to the target group. This meeting was held on Monday 28 October 2013.

Risks:

- Please note this risk is unchanged - the Panel has identified significant clinical risks for [redacted] at BAC. The Panel is currently mitigating this by seeking expert opinion from statewide senior mental health clinicians. It should be noted that there may be some delays in the transition process for some of the more complex cases.

Prepared by:
Laura Johnson, Project Officer, West Moreton Hospital and Health Service.

Endorsed by:
Dr Anne Brennan, A/Clinical Director, West Moreton Hospital and Health Service.

Queensland Government

Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel

Reporting Period: December 2013

Overview: BAC Patients (Inpatient, Outpatients and Day patients) and Waitlist

Current Inpatient	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Date (Transition Plan developed)	Proposed discharge date
1				30.10.2013	
2				15.10.2013	
3				22.10.2013	
4				29.10.2013	
5				22.10.2013	
6				29.10.2013	
7				22.10.2013	
8				30.10.2013	
9				15.10.2013	
10				5.11.2013	
11				16.10.2013	

Current Day Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				6.11.2013	
2				6.11.2013	
3				30.10.2013	

Current Out Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				29.10.2013	
2				15.10.2013	

Queensland Government

West Moreton Hospital and Health Service

Waitlist and Assessment List
The Panel is finalising follow up with the referring CYMHS of all young people on the BAC Waitlist and Assessment List.

Update:
- The Clinical Care Transition Panel was convened for the first time on 15 October 2013 and since then has met eight times.
- At present the Panel has reviewed all of [redacted] at BAC. The transition plans for all day and out patients has been finalised including the preparation of clinical documentation (eg. CIMHA) for handover to identified service providers.
- Work is still ongoing to finalise the transition plans for the inpatients as there have been a number of barriers particularly around sourcing appropriate accommodation for these patients. The Panel has escalated these issues and continues to seek appropriate solutions for these patients.
- [redacted]
- The [redacted] will all be discharged by 24 January 2014.
- The Panel continues to work finding solutions for the more complex cases including working alongside with other hospital and health services, government departments and non-government organisations.

Issues:
- Ongoing - the Panel has identified a number of challenges associated with the transition planning for the young people at BAC. This includes access to appropriate supported accommodation and mental health trained support workers. One strategy that has been identified to assist with this would be to provide strategic communication on what is happening at BAC to upper management of key organisations and government departments including meetings at the Director-General level. Another strategy identified was to invite the key NGO stakeholders to BAC to discuss what services they could potentially provide to the target group. This meeting was held on Monday 28 October 2013.

Risks:
- Please note this risk is unchanged - the Panel has identified significant clinical risks for [redacted] at BAC. The Panel is currently mitigating this by seeking expert opinion from statewide senior mental health clinicians. It should be noted that there may be some delays in the transition process for some of the more complex cases.

Prepared by:
Laura Johnson, Project Officer, West Moreton Hospital and Health Service.

Endorsed by:
Dr Anne Brennan, A/Clinical Director, West Moreton Hospital and Health Service.

Queensland Government

West Moreton Hospital and Health Service

Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel

Reporting Period: January 2014

Overview: BAC Patients (Inpatient, Outpatients and Day patients) and Waitlist

Current Inpatient	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Date (Transition Plan developed)	Proposed discharge date
1				30.10.2013	
2				15.10.2013	
3				22.10.2013	
4				29.10.2013	
5				22.10.2013	
6				29.10.2013	
7				22.10.2013	
8				30.10.2013	
9				15.10.2013	
10				5.11.2013	
11				16.10.2013	

Current Day Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				6.11.2013	
2				6.11.2013	
3				30.10.2013	

Queensland Government

West Moreton Hospital and Health Service

Current Out Patients	Age	Admission Date	Health District/ CYMHS/Home Town	Panel Convened and Transition Plan developed	Proposed discharge date
1				29.10.2013	
2				15.10.2013	

Waitlist and Assessment List
The BAC Waitlist and Assessment List has been updated. A review of ongoing care needs has been made. A meeting has been arranged between WM HHS and CHQ HHS to handover.

Update:
- The Clinical Care Transition Panel was convened for the first time on 15 October 2013 and since then has met eight times.
- At present the Panel has reviewed all of the 16 patients at BAC. The transition plans for all patients has been finalised including the preparation of clinical documentation (eg. CIMHA) for handover to identified service providers.
- Work is still ongoing to finalise the transition plans for the inpatients as there have been a number of barriers particularly around sourcing appropriate accommodation for these patients. The Panel has escalated these issues and continues to seek appropriate solutions for these patients.
- As of 28 January 2014 all patients (inpatients, day patients and outpatients) have been discharged to appropriate care options.
- Extensive consultation and liaison occurred to ensure the Panel found appropriate solutions for the more complex cases including working alongside with other hospital and health services, government departments and non-government organisations.

Issues:
- The Panel identified a number of challenges associated with the transition planning for the young people at BAC. This included access to appropriate supported accommodation and mental health trained support workers. One strategy that was identified included providing strategic communication on what is happening at BAC to upper management of key organisations and government departments including meetings at the Director-General level. Another strategy identified was to invite the key NGO stakeholders to BAC to discuss what services they could potentially provide to the target group. This meeting was held on Monday 28 October 2013.

Risks:
- At present there are nil risks, although follow up will need to occur with all patients transitioned from BAC.

Prepared by:
Laura Johnson, Project Officer, West Moreton Hospital and Health Service.

Endorsed by:
Dr Anne Brennan, A/Clinical Director, West Moreton Hospital and Health Service.

Queensland Government

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Service Options Implementation Working Group

1. Purpose

The purpose of the SW AETR Service Options Implementation Working Group is to develop and implement contemporary service options, within a statewide model of service for adolescent mental health extended treatment and rehabilitation.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the SW AETR Service Options Implementation Working Group include:

- Develop new and/or adapt service options across the continuum of care to meet the needs of adolescents requiring extended treatment and rehabilitation and produce a Service Options Paper.
- In liaison with the SW AETR Financial and Workforce Planning Working Group, identify financial and human resources for new service options.
- Develop a Statewide Model of Service for adolescent mental health extended treatment and rehabilitation.
- Develop an Options Paper for the Governance Model for SW AETR services under CHQ HHS.
- Develop an Implementation Plan for the statewide model of service, including staffing, contract management, where appropriate, and other resources.
- Facilitate expert discussion from clinician and consumer stakeholders around planning, developing, and implementing activities associated with SW AETR service options.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Manage risks associated with the development and implementation of SW AETR service options, and escalate where resolution is required to successfully implement SW AETR service options.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

5. Frequency of meetings

Meetings will be held on a fortnightly basis, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Working Group, or in respect of matters the Working Group wishes to pursue within the Terms of Reference.

Attendance can be in-person or via teleconference mediums.

The Working Group is life-limited for the duration of development and implementation of SW AETR service options and their transition to CHQ HHS. The Chair will advise Working Group members approximately one month prior to the dissolution of the Working Group.

6. Membership

Manager, Clinical Governance Office of the Chief Psychiatrist MHAODB (Chair)
Clinical Director, CYMHS CHQ HHS
Director of Strategy, MHSS West Moreton HHS
Project Manager, SW AETRS, Children's Health Qld HHS (as Secretariat)
Project Officer, SW AETRS, West Moreton HHS
HHS Northern Representative
HHS Central Representative
HHS Southern Representative
Mater Hospital Representative
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The Working Group will be chaired by the Manager, Clinical Governance Office of the Chief Psychiatrist MHAODB, or their delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

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

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

Other Participants:
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7. Quorum

As this is not a decision making group, a quorum is not applicable.

8. Performance and Reporting

The Secretariat is to circulate an Action Register to Working Group members within three business days of each Working Group meeting. Chair will determine the resolution of outstanding action items as they arise.

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

- Identify risks and mitigation strategies associated with the development and implementation of SW AETR service options; and
- Implement processes to enable the Working Group to identify, monitor, manage, and escalate critical risks as they relate to the functions of the Working Group.

Document history

Version	Date	Author	Nature of amendment
1.0	18/09/13	Ingrid Adamson	First draft
1.0	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
FINAL	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee

Previous versions should be recorded and available for audit.

From: Laura Johnson
Sent: 27 Sep 2013 15:17:07 +1000
To: Clayworth, Vanessa
Cc: Adamson, Ingrid
Subject: Fwd: Statewide Adolescent Extended Treatment and Rehabilitation Implementation - Service Options Working Group
Attachments: SW AETR Working Group_Service Options_TOR FINAL.doc
Importance: High

Hi Vanessa,

You have been nominated to attend the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Service Options Forum on Tuesday 1 October 2013 from 10.30 until 3. The forum will be held at Training Room 1, Ground Floor, 15 Butterfield Street.

Please see the email below for more information.

Can you please advise if you are able to attend and whether you have any dietary requirements or need a car park as soon as possible. Apologies for the short notice.

Agenda will be sent out on Monday.

Kind regards
Laura

Laura Johnson
Project Officer - Redevelopment
Mental Health & Specialised Services

West Moreton Hospital and Health Service
T:
E:

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
Locked Bag 500, Sumner Park BC, QLD 4074

www.health.qld.gov.au

>>> On 9/25/2013 at 2:27 pm, wrote:
Good Afternoon,

I am writing with regard to the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, which is to identify a new range of contemporary service options for the delivery of statewide adolescent mental health services. Three Working Groups have also been established to deliver on various aspects of this initiative, and you have been nominated as your Mental Health Cluster Representative for Working Group 1 - Service Options Implementation. This Working Group has been charted to develop preferred service options for adolescent mental health extended treatment and rehabilitation services, together with an implementation plan.

Given our commitment to finalise the implementation strategy in a timely manner, we are moving quickly to progress this initiative. As such, we would like to convene a half day Workshop with all nominated representatives next **Tuesday 1st October 2013 from 10.30am until 3pm**. We have scheduled a 10.30am start to allow representatives from outside of Brisbane to make the workshop, and we will be arranging car parking for those driving in. Due to the importance of this work, the Children's Health Queensland HHS will also meet the costs of flying representatives from the North Qld Clusters down to Brisbane, so that they can attend this workshop in person.

It would be greatly appreciated if you could **please advise of your availability for this workshop at your earliest convenience** and if you will require a car park or flight arrangements.

In the meantime, the Project Team is finalising the agenda for this workshop, which we hope to have to you by the end of this week. The workshop will be held at Herston, Brisbane and the venue details will be included with the agenda. I have also attached a copy of the Terms of Reference for the Working Group, for your information.

Should you have any questions or would like any other information, please feel free to contact me.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETRS
Office of Strategy Management

Children's Health Queensland
Hospital and Health Service
E:
Royal Children's Hospital
HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Service Options Implementation Working Group

1. Purpose

The purpose of the SW AETR Service Options Implementation Working Group is to develop and implement contemporary service options, within a statewide model of service for adolescent mental health extended treatment and rehabilitation, within the timeframes defined by ????.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the SW AETR Service Options Implementation Working Group include:

- Develop new and/or adapt service options across the continuum of care to meet the needs of adolescents requiring extended treatment and rehabilitation and produce a Service Options Paper.
- In liaison with the SW AETR Financial and Workforce Planning Working Group, identify financial and human resources for new service options.
- Develop a Statewide Model of Service for adolescent mental health extended treatment and rehabilitation.
- Develop an Options Paper for the Governance Model for SW AETR services under CHQ HHS.
- Develop an Implementation Plan for the statewide model of service, including staffing, contract management, where appropriate, and other resources.
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1.0	18/09/13	Ingrid Adamson	First draft
1.0	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
FINAL	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee

Previous versions should be recorded and available for audit.

Meeting Agenda

Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group

Comment [J]: Are we calling this forum?

Date:	Tuesday 1st October
Time:	10.30am to 3.00pm
Venue:	~~Mental Health Branch,~~ Training Room 1, Ground Floor, Butterfield Street, Herston

Chair:	Leanne Geppert Deborah Miller	Director Strategy, Mental Health and Specialised Services, West Moreton, HHS A/Executive Director, Office of Strategy Management, CHQ HHS
Secretariat:	Ingrid Adamson	Project Manager SW AETRS, Office of Strategy Management, CHQ HHS
Attendees:	Dr Naysun Saeedi	Staff Consultant, Mental Health, Cairns HHS
	Dr Ian Williams	Director of Adolescent Psychiatry, Adolescent Psychiatry Mental Health, RB&WH
	Emma Hart	Team Leader, Adolescent Inpatient Unit And Day Service, Townsville HHS
	Michelle Fryer	Child Psychiatrist, CYMHS, Gold Coast HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Janelle Bowra	Nursing Unit Manager, Metro South HHS
	Amelia Callaghan	State Manager, Headspace
	Erica Lee	CYMHS, Service Manager, Mater Hospital ~~Representative~~
		Consumer Carer Representative
	Jackie Bartlett (proxy for Janet Martin)	Principal Project Officer, Clinical Governance, Office of the Chief Psychiatrist
	Vanessa Clayworth	A/Nurse Unit Manager, Barrett Adolescent Centre
	Laura Johnson	SW AETRS Project Officer ~~SW AETR~~, MHSS West Moreton HHS
	Bernice Holland	Administration Officer, MHSS WM HHS
Apologies:	Kimberly Curr	A/Manager, CYMHS Toowoomba HHA
	Shannon March	Consultant, CYMHS Toowoomba HHS
	Janet Martin	Manager, Clinical Governance Office of the Chief Psychiatrist, MHAODB
	Stephen Stathis	Clinical Director, CYMHS CHQ HHS
	Sean Hatherill	Child Psychiatrist, CYMHS Metro South HHS

The purpose of this Workshop is to explore the current and future service options for adolescent extended treatment and rehabilitation.

The aim of this platform of services is to provide medium term, recovery oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development

The target group:

- 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.
- Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.
- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.

Workshop Agenda

Time	Item	Action Officer
10.30am	Morning Tea and Welcome	LG/IA
10.45am	Introductions and Apologies Statement of Conflict/Interest	LG
10:55am	Session 1 – Current Service Options, including: • Geography • Exclusion criteria • Referral Source • Pathways in and out • Length of Stay • Treatment Modalities • Skills required • Environment of delivery Exploring the current strengths and weaknesses of the service options, and any gaps in the referral interface between service options.	LG DM IA LJ
12:15pm	Lunch	
12:45pm	Session 2 – Future Service Options, including: • What could be included to provide a more comprehensive model of service to adolescents? • What evidence-based, best practices should we consider or research? • What are our counterparts in other states and countries doing? • What are appropriate service standards and benchmarks?	LG DM IA LJ
2:15pm	Afternoon Tea, where we will be joined by: • Dr Peter Steer, Health Service Chief Executive, CHQ HHS • Lesley Dwyer, Health Service Chief Executive, West Moreton HHS • Sharon Kelly, Executive Director, Mental Health and& Specialised Services, West Moreton HHS • Bill Kingswell, Executive Director, Mental Health Alcohol and& Other Drugs ~~Directorate~~Branch	

Workshop Agenda		
Time	**Item**	**Action Officer**
2:30pm	Workshop Debrief • Review of service options – current and future • Where to from here? • Next meeting	 All IA IA
3.00pm	Workshop Conclusion	

From: Ingrid Adamson
Sent: 30 Sep 2013 15:39:32 +1000
To: Gerard Howe; ;Deborah Miller;Emma Hart;Gerard Howe;Ian Williams;Jackie Bartlett;Janelle Bowra;Janet Martin;Kimberly Curr;Laura Johnson;Leanne Geppert;Michelle Fryer;Naysun Saeedi;Raymond Ho;Sean Hatherill;Shannon March;Stephen Stathis;Vanessa Clayworth;Erica Lee; Mary-Anne Morgan;
Cc: Bernice Holland;Bill Kingswell;Lesley Dwyer;Peter Steer;Sharon Kelly
Subject: Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum
Attachments: 20131001 Workshop Agenda.doc, Attach 1_Expert Clinical Reference Group Recommendations July 2013.pdf, Attach 2_WMHHS-CHQ BAC Media Statement 130805.pdf, Attach 3_FAQ BAC.pdf, SW AETR Working Group_Service Options_TOR FINAL.doc
Importance: High

Good afternoon and thank you for your patience as we finalised the agenda for tomorrow's forum (attached).

We currently have 16 attendees (and 7 apologies) and I'd like to thank each of you for your participation at such short notice. For those of you who are unable to attend tomorrow, we will circulate the notes taken from the forum to you for review and further comment.

I have also attached the recommendations from the Expert Clinical Reference Group (ECRG). This ECRG was established to ensure broad and extensive consultation in regard to service model elements. Their recommendations have been accepted and are attached (Attachment 1) for your review prior to the forum.

I have also attached a Media Statement (Attachment 2) and a Frequently Asked Questions sheet (Attachment 3) for further background information. You will also find a copy of the Working Group's Terms of Reference for those of you who may have not seen these as yet.

For those of you who have requested car parking, Bernice Holland will be in touch with regard to the parking bay number allocated to you.

In the meantime, if you have any questions, please feel free to contact me on

I look forward to meeting those of you who will be attending tomorrow.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

Children's Health Queensland Hospital and Health Service
E:
Level 1, North Tower
Royal Children's Hospital
HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

Meeting Agenda

Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum

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	Erica Lee	CYMHS, Service Manager, Mater Hospital
	Gerry Howe	Team Leader, CYMHS, Fraser Coast Integrated Mental Health, Wide Bay HHS
	Ian Williams	Director of Adolescent Psychiatry, Adolescent Psychiatry Mental Health, RB&WH
	Jackie Bartlett (proxy for Janet Martin)	Principal Project Officer, Clinical Governance, Office of the Chief Psychiatrist, MHOADB
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	Mary-Anne Morgan	Partnerships Manager, Mental Illness Fellowship Queensland
	Michelle Fryer	Child Psychiatrist, CYMHS, Gold Coast HHS
	Naysun Saeedi	Staff Consultant, Mental Health, Cairns HHS
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2:30pm	Workshop Debrief • Review of service options – current and future • Where to from here? • Next meeting	All IA IA
3.00pm	Workshop Conclusion	

West Moreton Hospital and Health Service

Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Queensland Government

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

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

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

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

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

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

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

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

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

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

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept with the following consideration.** Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

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

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	**Accept.**
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	**Accept.**

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West Moreton Hospital and Health Service
Children's Health Queensland Hospital and Health Service

Media Statement

Queensland Government

6 August 2013

Statewide focus on adolescent mental health

Statewide governance around mental health extended treatment and rehabilitation for adolescents will be moving to Children's Health Queensland.

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs.

She said West Moreton Hospital and Health Service had heard the voices of staff, consumers and their families, and engaged an expert clinical reference group over the past eight months.

"After taking into consideration the recommendations of the expert clinical reference group and a range of other key issues in national and state mental health service delivery, the West Moreton Hospital and Health Board determined that the Barrett Adolescent Centre is no longer an appropriate model of care for these young people," Ms Dwyer said.

"The board also determined that a number of alternative models will be explored over the coming months under the leadership of Children's Health Queensland.

"It is important to put the safety and individual mental health needs of these adolescents first by providing the most contemporary care options available to us in the most suitable environment.

"It is time for a new statewide model of care. We are also striving to provide services closer to home for these young people, so they can be nearer to their families and social networks," Ms Dwyer said.

Dr Steer said as part of its statewide role to provide healthcare for Queensland's children, Children's Health Queensland would provide the governance for any new model of care.

"This means that we will work closely with West Moreton HHS as well as other hospital and health services and non-government agencies to ensure there are new service options in place by early 2014," Dr Steer said.

"This model of care may include both inpatient and community care components.

"Understanding what options are needed has already begun with the work of the expert clinical reference group, and now we can progress this further and implement the best options for these young people," he said.

"This is a positive step forward for adolescent mental health care in this state," Dr Steer said.

To view the expert clinical reference group recommendations visit http://www.health.qld.gov.au/westmoreton/html/bac/

ENDS

Media contact:

West Moreton Hospital and Health Service -
Children's Health Queensland -

West Moreton Hospital and Health Service
Children's Health Queensland Hospital and Health Service

Queensland Government

What is the Barrett Adolescent Centre (BAC)?
Barrett Adolescent Centre is a 15-bed inpatient service for adolescents requiring longer term mental health treatment. It is currently located within The Park – Centre for Mental Health campus. The Park will be a secure forensic adult mental health facility that provides acute and rehabilitation services by December 2013.

This ongoing redevelopment at The Park means this is no longer a suitable place for adolescents with complex mental health needs.

What is happening to BAC?
Barrett Adolescent Centre will continue to provide care to young people until suitable service options have been determined. We anticipate adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

An expert clinical reference group has determined that adolescents require specialised and appropriate care options where they can be as close as possible to their community, families and support systems. West Moreton Hospital and Health Service will work closely with hospital and health services across the state, as well as other mental health care providers to ensure appropriate care plans are in place for all adolescents who require care.

We will also work together with the community and mental health consumers to ensure their needs are met.

Who was in the expert clinical reference group?
Members of the expert clinical reference group comprised adolescent mental health experts from Queensland and interstate, a former BAC consumer and the parent of a current BAC consumer.

What will happen to the consumers currently being treated at BAC?
West Moreton Hospital and Health Service is committed to ensuring no adolescent goes without the expert mental health care they require. The goal is to ensure our youth are cared for in an environment that is best suited for them. It is in the best interests of young people that they are not cared for in the same environment as adult mental health consumers who require high secure care.

Care coordinators and clinicians will work closely with the consumers, families and services to ensure that the appropriate care and support is provided for them.

What happens if there are not enough spaces for young people in other services?
The implementation group will consider all the available services and any extra services that might be required to support this particular group of adolescents.

What will happen to the young people currently waiting for a place in BAC?
Each individual adolescent that has been referred to the BAC and is currently on the waiting list for care will be considered on an individual basis. Clinicians will work with local and statewide services to determine how their needs can be best met in a timely manner.

How can the Queensland Government know this is the best option for the young people of the state?

This decision has been carefully considered and the recommendations made by an expert clinical reference group. The expert clinical reference group considered a range of options and recommended a number of strategies to better support the adolescent needs. These strategies will include both inpatient and community based services.

What is the process, and how long will it take, to transfer the existing consumers to other services or facilities?
The governance of the adolescent mental health service has been handed to the Children's Health Queensland Hospital and Health Service and an implementation group will progress the next step. This group will use the expert clinical reference group recommendations, and broader consultation, to identify and develop the service options.

We anticipate that some of those options will be available by early 2014.

Is this a cost cutting exercise?
No, this is about the safety and wellbeing of young Queenslanders in need of mental health support services and treatment. The Queensland Government has committed a further $2 million dollars to support the new models of care and services.

What happens to the funding previously allocated to BAC?
Funding that would have been allocated to BAC will be dispersed appropriately to the organisations providing the new services or treatment as part of the implementation group decision making.

Will jobs be lost?
West Moreton Hospital and Health Service will work closely with each individual staff member who is affected to identify options available to them. The hospital and health service is committed to following appropriate human resource processes.

What about the education services?
The Department of Education, Training and Employment is committed to continuing education plans for all BAC consumers.

How can I contribute to the implementation process?
The implementation group will include on their membership a range of stakeholders inclusive of families, carers and consumers. As the strategies are developed ongoing consultation will occur to ensure the best possible care for our adolescents in the most appropriate setting.

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Service Options Implementation Working Group

1. Purpose

The purpose of the SW AETR Service Options Implementation Working Group is to develop and implement contemporary service options, within a statewide model of service for adolescent mental health extended treatment and rehabilitation.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the SW AETR Service Options Implementation Working Group include:

- Develop new and/or adapt service options across the continuum of care to meet the needs of adolescents requiring extended treatment and rehabilitation and produce a Service Options Paper.
- In liaison with the SW AETR Financial and Workforce Planning Working Group, identify financial and human resources for new service options.
- Develop a Statewide Model of Service for adolescent mental health extended treatment and rehabilitation.
- Develop an Options Paper for the Governance Model for SW AETR services under CHQ HHS.
- Develop an Implementation Plan for the statewide model of service, including staffing, contract management, where appropriate, and other resources.
- Facilitate expert discussion from clinician and consumer stakeholders around planning, developing, and implementing activities associated with SW AETR service options.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Manage risks associated with the development and implementation of SW AETR service options, and escalate where resolution is required to successfully implement SW AETR service options.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

5. Frequency of meetings

Meetings will be held on a fortnightly basis, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Working Group, or in respect of matters the Working Group wishes to pursue within the Terms of Reference.

Attendance can be in-person or via teleconference mediums.

The Working Group is life-limited for the duration of development and implementation of SW AETR service options and their transition to CHQ HHS. The Chair will advise Working Group members approximately one month prior to the dissolution of the Working Group.

6. Membership

Manager, Clinical Governance Office of the Chief Psychiatrist MHAODB (Chair)
Clinical Director, CYMHS CHQ HHS
Director of Strategy, MHSS West Moreton HHS
Project Manager, SW AETRS, Children's Health Qld HHS (as Secretariat)
Project Officer, SW AETRS, West Moreton HHS
HHS Northern Representative
HHS Central Representative
HHS Southern Representative
Mater Hospital Representative
NGO Representative
Consumer Carer Representative

Chair:
The Working Group will be chaired by the Manager, Clinical Governance Office of the Chief Psychiatrist MHAODB, or their delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

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

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

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

7. Quorum

As this is not a decision making group, a quorum is not applicable.

8. Performance and Reporting

The Secretariat is to circulate an Action Register to Working Group members within three business days of each Working Group meeting. Chair will determine the resolution of outstanding action items as they arise.

The Secretariat will coordinate the endorsement of fortnightly status reports, and other related advice to be provided as required, to the SW AETR Steering Committee.

Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

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

10. Risk Management

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

- Identify risks and mitigation strategies associated with the development and implementation of SW AETR service options; and
- Implement processes to enable the Working Group to identify, monitor, manage, and escalate critical risks as they relate to the functions of the Working Group.

Document history

Version	Date	Author	Nature of amendment
1.0	18/09/13	Ingrid Adamson	First draft
1.0	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
FINAL	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee

Previous versions should be recorded and available for audit.

From: Ingrid Adamson
Sent: 2 Oct 2013 09:14:12 +1000
To: Naysun Saeedi; Emma Hart;Ian Williams;Jackie Bartlett;Janelle Bowra;Michelle Fryer;Raymond Ho;Vanessa Clayworth;Erica Lee; ;Alison_Jansen_
Cc: Bernice Holland;Laura Johnson;Leanne Geppert
Subject: Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum
Attachments: 20131001 Forum Evaluation.doc

Good Morning,

On behalf of the SW AETR Project Team, we would like to thank you again for your time yesterday. It was extremely valuable to get your input and we are so pleased with the information we have been able to collate through your collective knowledge. So thank you.

As Leanne mentioned, the next steps from here will be to bring all of this information together into a format for your review. In the meantime, you may have other thoughts or ideas which come to mind, so please feel free to forward any additional ideas to me for inclusion.

At the same time, we were hoping you might be able to give us a few more minutes of your time to provide us with some feedback on the session yesterday. I have attached an evaluation form which should only take a few minutes to complete. As we will be looking to hold other forums in the future, it would really useful to have your feedback on what worked well and what we could do differently next time.

Again, thank you for your time and I will be in touch again soon.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

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Royal Children's Hospital
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>>> Ingrid Adamson 30/09/2013 3:39 pm >>>
Good afternoon and thank you for your patience as we finalised the agenda for tomorrow's forum (attached).

We currently have 16 attendees (and 7 apologies) and I'd like to thank each of you for your participation at such short notice. For those of you who are unable to attend tomorrow, we will circulate the notes taken from the forum to you for review and further comment.

I have also attached the recommendations from the Expert Clinical Reference Group (ECRG). This ECRG was established to ensure broad and extensive consultation in regard to service

model elements. Their recommendations have been accepted and are attached (Attachment 1) for your review prior to the forum.

I have also attached a Media Statement (Attachment 2) and a Frequently Asked Questions sheet (Attachment 3) for further background information. You will also find a copy of the Working Group's Terms of Reference for those of you who may have not seen these as yet.

For those of you who have requested car parking, Bernice Holland will be in touch with regard to the parking bay number allocated to you.

In the meantime, if you have any questions, please feel free to contact me on

I look forward to meeting those of you who will be attending tomorrow.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

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Forum Evaluation

SW AETR Service Options Implementation Working Group

Forum: Tuesday 1st October 2013

Please check (X) the most appropriate box:

	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
I found the Service Options Forum valuable					
I will leave the Forum with new ideas and knowledge					
The forum provided opportunity to share ideas and learn from other coordinators					
The Forum was well organised					
My contributions to the Forum were valued					
The Forum sessions were relevant and useful					

Please provide a response to the following questions:

What was the most valuable part of the Forum?

What was the least valuable part of the Forum?

Other comments:

THANK YOU!

From: Ingrid Adamson
Sent: 16 Oct 2013 17:30:12 +1000
To: Gerard Howe;Mikaela Moore; Deborah Miller;Emma Hart;Ian Williams;Jackie Bartlett;Janelle Bowra;Janet Martin;Judi Krause;Kimberly Curr;Laura Johnson;Leanne Geppert;Michelle Fryer;Naysun Saeedi;Raymond Ho;Sean Hatherill;Shannon March;Vanessa Clayworth;Erica Lee;H ;Mary-Anne Morgan
Cc: Bernice Holland;Stephen Stathis
Subject: Service Options Working Group - Statewide Adolescent Extended Treatment and Rehabilitation (AETR) Strategy
Attachments: AETR Service Options Data_Final.doc

Good Afternoon,

Thank you once again for your time at the Service Options Forum on the 1st October. We have now consolidated all of your 'post it note' contributions into the attached document and again would like to thank you for your energy and participation in that exercise.

We have subsequently distilled your contributions into the following key dot points, which we believe will greatly assist us in shaping the future AETR service options:

- More efficient utilisation of existing mental health (MH) services and resources
- Greater education and awareness regarding the MH services available, especially for primary care providers, carer representatives, and families
- Greater family support and involvement in MH care plans and interventions
- Inclusion of dual-diagnosis services for co-morbid alcohol and other drug problems
- Stronger linkages to adult MH services in so far as to ensure smooth transition from adolescent MH services
- Redirection of current resources (e.g. BAC operational funding) into future service enhancements
- More assertive outreach and mobile service options over extended hours
- Need for a multi-disciplinary clinical care review team to assess consumer needs and refer to the most appropriate service options to meet those needs

One issue identified during the forum was the need for services for 18 to 25 year olds with mental health problems not deemed appropriate for adult MH services, however, this is unfortunately out of scope of this initiative.

Now that we have this information, we would like to test this against four scenarios to better understand how these would be managed currently within your HHS. We are also interested in hearing about the strategies you would implement to provide improved clinical care for these scenarios into the future. This could include better use of current resources or the use of additional resources you believe could be supported within your local area. These scenarios will be sent to you in a separate email.

In the meantime, if you have any questions or further feedback, please feel free to contact me.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
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Adolescent Mental Health Extended Treatment and Rehabilitation Service Options

Target Population
Provide recovery-oriented treatment and rehabilitation for young people aged 13-17 years with severe and persistent mental health that may include co-morbid alcohol and other drug (AOD) problems, which significantly interfere with social, emotional, behavioural, and psychological functioning and development. (Flexibility in upper age limit, depending on presenting issue and developmental age, as opposed to chronological age).

Expert Clinical Reference Group Principles:

A key principle for child and youth mental health services is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social, and community networks.

- Develop/maintain stable networks
- Promote wellness and help young people and their families in a youth oriented environment
- Provide services either in, or as close to, the young person's local community
- Collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing
- Collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease
- Integrate with child and youth mental health services (CYMHS), and as required, adult mental health services
- Recognise that young people need help with a variety of issues and not just illness
- Utilise and access community-based supports and services where they exist, rather than re-create all supports and services within the mental health setting
- Treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff
- Provide flexible and targeted programs that can be delivered across a range of contexts and environments
- Have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment and keep the family engaged with the young person and the problems they are facing.
- Have capacity to offer intensive family therapy and family support
- Have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down
- Acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person
- Engage with a range of educational or vocational support services appropriate to the needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections.

Service Options **where the adolescent, their family and the community are central to its success:**

Identified for all levels (future):

- AOD and dual diagnosis services for adolescents with capacity for family as well as individual intervention across all tiers/need levels
- Family support and intervention including but not limited to family therapy across all levels
- CYMHS intake specialist assessment and collaborative determination (with family) for best service options along the continuum to meet needs
- Need service for 18 - 25 year olds with borderline personality and other disorders not deemed serious enough for Adult Services
- Seamless service across AOD+MH, Adult to Child, primary care to tertiary care
- Ensure consistent use of single consumer clinical record for all organisations to access (CIMHA)
- Care coordination – MDTR – multi-disciplinary team review
- Special consideration for ATSI, culturally and linguistically diverse (CALD), rural and remote, homeless

Acute Inpatient Care	Current	Future
Providers	CYMHS/HHS Acute Beds: Royal Children's Hospital 10 beds 0-14yo Royal Women's Hospital 12 beds 14-17yo Mater South Brisbane 12 beds 0-17yo Logan Hospital 10 beds 13-17yo Robina Hospital 8 beds 0-17yo Toowoomba 8 beds 14-17yo Townsville (new) 8 beds 14-17yo Paediatric Beds	Statewide bed management service IPU in Cairns
Environment of Delivery	Hospital setting Access to high dependency units and other medical specialties Co-located with day program units Safe, predictable environment away from stressors Availability of a seclusion room Access to school	24 hour admission Department of Emergency Medicine (DEM) to cover extended hours and weekends Reduce stigma in DEM Peer support for DEM Specialist CYMHS in DEM Access to after-hours adolescent MH clinicians to assess and refer (a lot of presentations to DEM between 10pm and 1am) Greater collaboration with Paediatric beds Utilise vacant beds when on leave Cease admission to adults Quiet spaces (for out of control autistic children) and privacy More High Dependency Units Young adult inpatient services for 17-25 y.o.
Diagnoses	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to engage and comply with treatment Actively using illegal substances Unable to be managed in the community	
Exclusion Criteria	Purely accommodation issues Medically compromised (need a medical bed) No or low risk of harm to self and others – safe to be in the community No identified mental illness Long term MH issues not amenable to acute care Conduct Dx with no co-morbid MH issues	Gap with NGOs due to age criteria
Referral In	Limited planned admissions Family and Peers headspace CYMHS NGOs Filtered through MHS Paediatrics Adult AMHU (regional) Schools Emergency Department Hospital inpatients Day Programs Units Private clinicians - GPs, psychs * No need to go through DEM although after hour admissions are only available through DEM	Acute inpatient sits alongside other levels of care - goals are diagnosis, stabilisation, and risk management Entry must be through MH assessment

Acute Inpatient Care	Current	Future
Treatment	Defusing - aggression management Speech and language Psychometric assessments Sensory modulation CBT, ACT, IPT, wellness Expressive therapy (art, music, play, exercise) Individual and family therapy Structure program for sleep and hygiene Mentalisation Continuous and close observation Attachment and development Overnight leave Acute withdrawal AOD	Specialist CYMHS in DEM Information packs from NGOs Family-centred care for parents and siblings Flexibility to meet the needs of patients and families Communicate more effectively and honestly with parents/carers when consumers present in DEM - contain their fears Specialist assessment and planning Validate ACT expertise in risk assessment and immediate management and support with C&A expertise Treatment planning to include emergency admissions - consider prioritise for acute and not refer out to AMHU Recognise need for leave in IPU treatment plans Drug and alcohol - dual diagnosis
kills	Risk assessment Discharge planning Child and youth training/experience Case Management Organise investigations Medication Milieu therapy Individual and family therapy Trauma knowledge Child safety legislation knowledge	
Length of Stay	KPI is 14 days Ranges from 1 day to 6 months (rare) - ave is 10 to 14 days Ranges from 1 day to 150 days - Logan is 8 days Longer stays with eating disorder patients	14 days
Step Up / Down / Out	Non-acute inpatient Day Program Adult MH headspace DOCs NGOs Private providers PHaMs	
Further Research		ACT model of care May 2013
Staffing		
Funding	Individual HHSs	Individual HHSs
Governance	Individual HHSs	Individual HHSs

Non-Acute Inpatient	Current	Future
Providers	Barrett Adolescent Centre (15 beds)	1 or 2 units in Qld – SE Qld and North Qld
Environment of Delivery	24 x 7 delivery Access for state-wide consumers Old, dated and unnatural Provides space and green Secure and lockable Not purpose built Near forensic service site at Wacol Near train line	Small units of 2-5 beds - 10 beds maximum Not an institution An alternative to hospital beds Mobile therapeutic team for extended care Use foster placement or residential facilities Family / Carer accommodation Need a secure model if in on ITO Purpose built Provide respite care Good links to hospital
Diagnoses	Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development. Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment. Mental illness is persistent and the consumer is a risk to themselves and/or others. Medium to high level of acuity requiring extended treatment and rehabilitation. Includes: persistent depression, concomitant symptoms, social anxiety disorder, PTSD, self-harm, suicidal persistent psychosis, persistent eating disorder, etc.	Include AOD in the model Psychosis Mood disorders Personality disorders
Exclusion Criteria	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to or difficult to engage and comply with treatment Actively using illegal substances Younger adolescents Involuntary/Unwilling (except ITO) Predominantly social (e.g. child protection) Conduct disorder Needing crisis care	What about eating disorders? What about emerging BPD and dysregulation?
Referral In	Narrow and Limited Tertiary MHS and CYMHS Acute units Day Program Private psychologists and psychiatrists, GPs, Guidance Officers, Families Problem: referrers disengage / close the case once referred	Only referred in when all other options have been exhausted, e.g. in the community, CYMHS, inpatient, and day programs CYMHS Assessment Statewide Clinical Referral Panel (representation from multidisciplinary MH clinicians and community sector)
Treatment	Current care has worked well with severely disabled, complex psychotic and severe complex chronic suicidal and violent Fragmentation of treatment plan between BAC and community Sustained therapeutic relationships Rehabilitation Developmentally appropriate Institutional care impact on certain clusters of	In-patient therapeutic milieu Integrated care with local CYMHS Individual, family and group Therapeutic and Rehabilitation Programs – 7 days per week On-site education and vocational support with option to attend local school Capacity for family/carer admissions (family room)

Non-Acute Inpatient	Current	Future
	patients Pre-vocational TAFE Schooling essential Sensory modulation CBT, ACT, IPT, wellness Expressive therapy (art, music, play, exercise) Individual and family therapy Case management by nursing staff Milieu Social skills group Dietician / meal therapy Dialectical Behaviour Therapy (DBT) Life skills group Adventure based learning Continuous and close observation	Maintains family engagement with the adolescent Well-staffed day program Care coordination - with parents, foster family, etc. and next stage of care Underpinned by stable residential environment with high supervision Support transition back to the community Wrap around services on exit Community Liaison Social inclusiveness - build social supports for young people dislocated from education Build partnerships in the community, e.g. TAFE, gyms, recreational services, employment agencies, etc.
Skills	MDT Experienced clinicians with tertiary level specialist care areas and disciplines – risk assessment, assess mental state, manager emotional dysregulation, manage behaviours and impaired medical states, provide therapeutic interventions Understand trauma and attachment Maintains boundaries Psycho-pharm Medical care / education Nurses Allied health Dietician Family Therapy Maudsley Program for Eating Disorders Education	Specialised Mental Health staff Staff need higher skill level than inpatient and day program staff CNC Nursing Allied health Support workers AO Consultant registrar
Length of Stay	1 to 2 years 6 to 18 months Too long away from carers and community	Medium term admissions up to 3mths 3 to 6 months Individually assessed - include flexibility Short as possible time to achieve clinical outcome and then return to community
Step Up / Down / Out	CYMHS Adult MHS Child Safety Housing	Need central team to support regional team when consumer returns to the community Clarify exit criteria Clarify point of discharge and step down to MH provider, parents or community Need effective discharge planning
Further Research		ACME house transition model VIC Spectrum Program (adult personality disorders) Modified therapeutic communities' model / framework from AOD / Dual Diagnosis Y-PARC
Staffing		Multidisciplinary and clinical DETE
Funding	To be determined – nil capital funding allocated Potential site not identified at this time	Based on 10 beds in Victoria Model • $3.5m capital • $1.8m operating
Governance	WM HHS	

Residential Service	(Not currently available) Future
Providers	None currently NB: TOHI in Cairns for over 18yo
Environment of delivery	24 x 7 availability Toowoomba, Sunshine Coast, Gold Coast, Rockhampton, Townsville, Cairns Co-locate with Day Program Services Bed-based residential and respite service for after hours and weekend care Potential for family rooms to accommodate family members AOD residential rehab for under 18 year olds Similar to current provision by NGO but with higher levels of expertise and skill Supported accommodation to transition to independent living Need young adult community services - 17-25 year olds Youth camps like Booya, youth justice/NGOs for up to 6 weeks Could be a stand-alone service with specific target cohort and own FTE with skill base Option to residential is recruit foster carers
Diagnoses	Psychosis Mood disorders Personality disorders Accommodation needs of family due to geographic distance Capacity to live in a group setting
Exclusion Criteria	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to engage and comply with treatment Actively using illegal substances
Referral In	CYMHS Assessment ADAWS Other AOD Programs Court headspace Inpatient units with reduced acuity Private practitioners and Community Clinics IPU persistent
Treatment	Provides accommodation but not the intervention Day program attendance Outreach and out-of-hours services for patients In-reach CYMHS support In-reach education and vocational support with option to attend local school Integrate with local acute inpatient, day program, and public community MH teams Group Program Case Manager +/- initial referrer Social Skills Daily living skills Family work Develop strengths for parents / carers (so not dependent on day program)
Skills Required	Community support staff (community-based provider) or skilled MH clinician onsite for 24x7 operations Training and in-reach by CYMHS Basic medical skills, e.g. first aid, CPR Family-centred care Allied health - OT, dietician, psych, nurses Drugs and alcohol AOD intervention skills Therapeutic carer skills Clinical liaison to coordinate care Child safety assessment / input
Length of Stay	Up to 6 months Up to 12 months Case-by-case basis

Residential Service	(Not currently available) Future
Step Up / Down / Out	Inpatient units with increased acuity Day programs CYMHS Adult MHS Child Safety Housing Private providers
Further Research	QLD Community of Care Unit (for >18 years old) ADAWS residential model Child Safety Accommodation Programs - Therapeutic Residential (Placement) Services (TRS) – 12-15yo, for up to 18 months (DoC) – Cairns, Townsville, Morayfield, Goodna Ted Noffs in NSW Resi model + day program in Vic USAS in Vic WA has NGO resi with State MH Day Program
Staffing	Multidisciplinary and clinical Staffing from community sector DETE
unding	To be confirmed
Governance	Residential accommodation in partnership with community-based provider and CHQ

Day Programs	Current	Future
Providers	CYMHS Mater Barrett Adolescent Centre	New day programs
Environment of Delivery	• South Brisbane • Toowoomba • Townsville 12 to 15 places per day program Monday to Friday Business Hours Attached to CYMHS or hospitals - linked with an acute facility or bed unit Access to education Mater - Purpose built Barrett - not purpose built, forensic setting, distant from homes Need to have good family support	• Royal Children's Hospital Catchment • Prince Charles Hospital • Gold Coast • Sunshine Coast • Townsville • Rockhampton 12 to 15 places per day program Local - near home and family Increase the number of programs to cater for increased number of patients Young adult community services - 17-25 year olds Outreach and out of hours services for patients Need to have good family support
Diagnoses	Anxiety School refusal May require admission into an Inpatient Unit (acute or other) and attend day program during business hours	
Exclusion Criteria	Outside of region Tried community CYMHS or Private Therapy and will benefit from program Medium to long term high acuity, risk to self or others, severe and persistent problems, conduct disorder	
Referral In	Private practitioners and Community Clinics ADAWS Other AOD Programs Court headspace Acute and non-acute inpatient units with reduced acuity CYMHS IPU persistent	CYMHS Assessment - overarching MH intake process for all referrals
Treatment	Group Program Case Manager +/- initial referrer Delivered in a therapeutic milieu (including day program, family home, school setting, etc.) Family-centred care Sensory modulation CBT, ACT, IPT, wellness Expressive therapy (art, music, play, exercise) Individual and family therapy Rehabilitation Programs Social Skills Daily living skills Family work Art therapy Parent Group DBT Education Program onsite and vocational services where required (DETE)	Care coordination Modularised Guidance officers in day programs Child safety assessment / input Focus on functional recovery and life skills Utilise NGO sector to delivery components of the day program to encourage links to the community Modified therapeutic communities (refer AOD framework) Flexibility to meet individual developmental need Step down - ACT model of care May 2013 4-4-4 Home visits when needed Pet therapy Music, dance, and art therapy Develop strengths for parents / carers Program is designed and delivered in collaboration between CYMHS, day program, NGOs, families, consumer, etc.

Day Programs	Current	Future
		Education/Vocational component with option to attend local school Needs parent / carer engagement
Skills	Peer work Basic medical skills, e.g. first aid, CPR Allied health - OT, dietician, psych, nurses Drugs and alcohol Sand play and art therapy Systematic desensitisation Daily living activities Recreational activities	AOD intervention skills Dual diagnosis Therapeutic carer skills Clinical liaison to coordinate care Multidisciplinary Clinical Staff from community sector DETE
Length of Stay	Attendance up to 5 days Monday to Friday Mater - 6 to 12 months maximum Barrett - ave 12 months 6 to 8 months - with some longer stays	Attendance up to 5 days Monday to Friday Up to 12 months – case-by-case basis
Step Up / Down / Out	To inpatient unit when increase in acuity Adult MHS Child Safety Housing CYMHS Outreach	
Further Research		WA has NGO resi with State MH Day Program
Staffing		Multidisciplinary and clinical Staffing from community sector DETE
Funding	To be determined	To be determined
Governance	Mater, HHSs	CHQ HHS

Outreach and Outpatient	Current	Future
Providers	CYMHS and e-CYMHS Statewide eating disorder CYMHS service MHAODB Child and Youth Forensic Outreach Service HHSs Evolve Therapeutic Services Wuchapperan Cains ATSI Mental Health EPPIC TOHI Logan CYFOS	Amalgamate Evolve and CYMHS
Environment of Delivery	Existing locations around the state Colocation of services Mobile (only a few) e-CYMHS rural & remote (provides GP liaison) 15 MITT case managers travel to HHSs in consultation with eCYMHS Business Hours Monday to Friday	Integrated with adults? Youth Acute Care Teams Mobile intensive outreach to community, homes, & DEMs in and out of hours Home-based service delivery Frequent contact More outreach services Increase accessibility in remote areas Stay near community
Diagnoses	Beyond mild to moderate MH issues	
Exclusion Criteria	Severe and complex mental health issues Evolve = top 17% of children in child protection	
Referral In	Family or peers Primary carer: GPs, psychs, school, Paeds, EDIs, counsellors Consumer advocates ATAPS YETI in Cairns Centacare Mission Australia MI Networks MIFQ Child Safety HOF - Helping Out Families Vocational Services - INSTEP Seasons for change Drug & Alcohol - ADOURES Hot House Guidance Officers Schools - exclude troubled children School mental health nurses and counsellors Ed links Emergency department Support agencies Dual diagnosis coordinators headspace post ?? suicide	CNAP - Complex Needs Assessment Panel (multi-sector involvement)
Treatment	Ambulatory care Shared-care options with community-based providers Family-inclusive practice Evidence-based therapy Telehealth Brief intervention Specific youth transitional education programs	Need disability service Management of eating disorders Effective inter-agency (Govt/NGO) collaboration Consistency across HHSs Greater utilisation of private practitioners Need to reach Centrelink, Social Workers, UTLAHA Assist in education / upselling others in the life of

Outreach and Outpatient	Current	Future
	(MIFQ) Shared decision making Service integration coordinators (only 16yrs above & severe mental illness) Consultation and delivery In collaboration with Child Safety	a young person, e.g. parents, carers, teachers, school nurse, youth justice, child safety Programs in partnership with Qld Health & NGO (e.g. DBT programs in Cairns) Timely access to specialised expertise Telemedicine Bridge gap between EI and some CYMHS thresholds Youth and family participation Wrap around service - collaboration and coordination to fit individuals and carers
Skills	Peer workers Awareness of community services (training, financially sustainable, etc.) Risk assessment MH Assessment AOD Assessment Assessing Gillick competency Medication appropriateness Self-reflection Inter-agency liaison Technology - web-based information and interventions CYMHS core competency framework	More trained youth-specific peer workers Culturally sensitive (better access to translation services, etc.) Youth engagement skills Medical based therapy (MBT) Individual, Group and Family Therapy Dual diagnosis Substance abuse interventions Increase knowledge of what is available in NGOs
Length of Stay		Increase flexibility Base on clinical needs
Step Up / Down / Out	Day program Inpatient Acute Adult MH GPs or private practitioners, e.g. psychs, OTs, physios, etc.	
Further Research		IMYOS Sth Melbourne - enhanced CYMHS model (AOD, personality, d/o emerging) WA has NGO resi with State MH Day Program
Staffing		
Funding		To be determined
Governance	CYMHS – CHQ Child Safety HHSs	CHQ HHS Child Safety

Primary Care	Current	Future
Providers	General Practitioners Psychiatrists Psychologists Medicare Locals (ATAPS) headspace NGOs Youth Hub Community health services Some youth friendly housing, instep Mind Matters School Church Groups Schools Child development unit Community child health clinics	
Environment of delivery	ATAPS MFQ - PHaMs, Youth Hub headspace: Nundah, Inala, Ipswich, Gold Coast, Sunshine Coast, Mackay, Cairns, Townsville e-Headspace - Australia wide Business hours Monday to Friday	GP access to C&Y psychiatrists to support management at a local level Youth Link - unable/unwilling to engage with MH service - caters for 13-24 y.o. with serious MH and/or complex social issues Integrated care coordination with other tiers headspace coming to Brisbane CBD, Mt Isa, Redcliffe, Rockhampton, Logan, Indooroopilly
Diagnoses		
Exclusion Criteria	Severe and complex mental health issues - too acute / high risk / complex Most headspaces won't accept court referrals Mental Health Care Plan eligibility ATAPS eligibility MHNI Referred from 1 degree care to CYMHS Relationship issues	MHNI - unfreeze the incentive Missed/cancelled appointments - review the process
Referral In	Self-referral Carers Family members Peers MI Networks Consumer advocates Guidance Officers Schools - exclude troubled children School mental health nurses and counsellors Ed links	
Treatment	Consultation and delivery Family support and intervention Family-inclusive practice Shared decision making Partnership Model with Qld Health Telehealth	CNAP - Complex Needs Assessment Panel (multi-sector involvement) Identification of support services Greater utilisation of private practitioners Need to reach Centrelink, Social Workers, UTLAHA Youth MHFA courses - need to be utilised Programs in partnership with Qld Health & NGO (e.g. DBT programs in Cairns) Timely access to specialised expertise Telemedicine Youth and family participation Wrap around service - collaboration and

Primary Care	Current	Future
		coordination to fit individuals and carers Stay near community
Skills Required	Private Practitioner competencies Inter-agency liaison Awareness of community services (training, financially sustainable, web-based information, etc.) Medication appropriateness	More trained youth-specific peer workers Culturally sensitive (better access to translation services, etc.) More school-based youth health nurses and counsellors Youth engagement skills Medical based therapy (MBT) Increased knowledge of what is available in NGOs Increased knowledge of CYMHS
Length of Stay	ATAPS - 6+6+6 NGOs vary with state funding GPs - ongoing (some items capped) MBS - 6+4 sessions	Increased flexibility Based on clinical needs
Step Up / Out	Outreach/outpatient Day program Inpatient Acute Adult MH	
Further research		WA - 3 pilot Youth Reach sites Milwaukee Wrap Around partnerships
Staffing		
Funding	Private Federal	Private Federal
Governance	Privately owned and managed Federal	Privately owned and managed Federal

From: Ingrid Adamson
Sent: 5 Nov 2013 10:18:09 +1000
To: Sean Hatherill;Mikaela Moore; Deborah Miller;Emma Hart;Gerard Howe;Ian Williams;Jackie Bartlett;Janelle Bowra;Janet Martin;Judi Krause;Kimberly Curr;Laura Johnson;Leanne Geppert;Michelle Fryer;Naysun Saeedi;Raymond Ho;Shannon March;Stephen Stathis;Vanessa Clayworth;Erica Lee; ;Mary-Anne Morgan
Cc: Bernice Holland
Subject: SW AETRS Case Scenario Responses
Attachments: AETR Case Scenarios_Consumer_Carer Consolidated.doc, AETR Case Scenarios_Clinician Consolidated.doc

Good morning and thank you to those who responded to the Case Scenarios.

Attached are the consolidated responses, the first from the consumer/carer perspective and the second from the clinician perspective. This information has also been presented to the SW AETRS Steering Committee for their information.

The next steps from here are:

- Collate population data and supporting evidence to confirm service options and their location.
- Refine service options into an AETR Service Model for endorsement by end November 2013 (including governance, financial and workforce requirements).

In the meantime, if you have any questions or would like any other information, please let me know.

Thanks again for your participation and contributions.

Warm regards,
Ingrid

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Case Scenarios

SW AETR Service Options Implementation Working Group Consolidated Responses from Clinicians

Case Scenario 1 - Ritchie

- Male aged 17years 1month
- Living in rental home with single mother and sister who is 10 years old
- Presenting problem: self harm, moderate to severe depression, severe generalised anxiety, limited social system, daily marijuana use, no school attendance for the last 2 years
- Significant life events: long term parental domestic violence, father left family 3 years ago and limited ongoing contact with children
- Two brief acute adolescent inpatient admissions over last 4 years – partial but short-term symptom resolution post discharge; difficulty reintegrating to home following acute admissions
- Sporadic Child and Youth Mental Health community outpatient treatment episodes of care – now refusing to attend

Response 1:
Current Resources:

- Individual counselling - Youth counselling services e.g. YFS, InSync, BABI
- Possibly ATAP with private service provider
- If not resist CYMHS, CYMHS can offer individual psychotherapy
- Family Therapy (from CYMHS service) on resolving trauma and re-establish family connection
- Independent living transition – Youth Accommodation Services.
- Employment support services –ACCESS
- ADAWS – drop in and outreach services

Top 3 resources

- Day Treatment Program – crucial components include evidence informed group and individual work for the client and families/carers (i.e. DBT, MBT, CBT), educational and vocational support, multidisciplinary review, linkages with NGO's
- Mobile family intensive treatment team - crucial components include small case load, ability to work with the family within the home, systemic approach
- Transitional residential service with independent living training support – run by an NGO

Possible outcome:

- On-going therapy support from counselling service – NGO or Private practitioners
- Living independently; employed and with on-going independent support.

Response 2:

- Potential for CCYMHS to close him from service due to not engaging in treatment and or Not Attending appointments
- Potential referral to the Adolescent Day Program – Probably accept him if he was able to be engaged in the program with goals to address social anxiety and meet tasks of adolescence.
- Look at linking in with Youth ATODS? Or do work ourselves around drug misuse.
- Plan to engage in Education/Vocational option

Additional resources

- Education, housing, extended hours CYMHS response.

Outcome
- This young person may improve in functioning while in the day program however would potentially not be able to access adult services and therefore may not be sustained

Response 3:
Current resources:
17 year old meets criteria for severe and persistent mental illness with marked impairment of functioning, psycho-social perpetuating factors and poor prognosis with likelihood of long health and disability costs if untreated. With local resources, management would include:
- Engagement and collaboration with parent, attempt to work as a team providing support and education for her. Also assessment of impact on sibling and consideration of resources sibling might need for support (may be through case manager, as open service episode or alternative service provider depending on need of sibling, what is available and mother's capacity to attend).
- Attempts to engage young person through home visiting
- Likely acute admission to try and reinstitute treatment, with clear plan for discharge giving history of difficulty reintegrating home
- Consider role and applicability MHA
- During admission, regular visits with case manager and other support people (e.g. youth worker see below) to engage and try and develop alliance.
- Medication
- Consider referral to CNAP and possible role of youth worker in engagement and assistance with developing ADL
- Consider other community agencies e.g. Ohana, that provides alternative education / vocation in medium term
- Consider out of home accommodation but options very limited and patient unlikely to be able to utilise available options given level of impairment.
- Would be considered appropriate for referral to BAC
- Prognosis poor.

Top three resources:
- Skilled, psychologically informed outreach workers who can home visit regularly with view to engagement in community
- Step-down rehabilitation service – longer stay than acute, better access to education and especially vocationally training
- Possibly day unit but issue of non-compliance with attendance is biggest barrier here
- Access to centralised rehabilitation beds.

Response 4:
Current resources
- Encourage attendance at Hot House
- Referral to Youth At Risk Initiative and Youth Support Coordinator Initiative
- Encourage attendance at PCYC and Brisbane Youth Service
- Refer to Big Brother Program/ PhAMS
- Interagency Communication Plan

Top three resources
- Continuing Care Team
- Consider Transition to Adult Mental Health (timeline)

Outcome
- Overall restrictions due to funding cuts throughout services
- Closure of services (BAC)

Response 5:
Difficult to treat due to poor engagement however treatment available from CYMHS currently in conjunction with NGOs if can engage. Consider use of Mental a health Act if meets criteria to facilitate initiation of treatment and alliance. There may be role for initiation of management in Acute Unit. Engage

Mother. Home visit for purposes of initial assessment Link with youth and family support services in local area need mobile service. Explore other family supports extended family etc. Head space may be a useful service to engage and link with psychiatrist, vocational pathway etc role for Alcohol and drug service Hot House our area. Link to program to assist work readiness once engaged and functioning improved.

Gaps:

- Mobile CYMHS treatment service with sound links to youth and family support service, alcohol and drugs services, educational and vocational pathway
- Likely to need transport option
- Day facility with various programs therapeutic, social, access to education/ traineeship supported work integration, alcohol and drug services individual counselling.

Response 6:

Current resources

- We would try case management at CYMHS through a mixture of clinic-based and home-visit appointments. This is likely to be of limited effect given the situation.

Top three resources

- More staff to have an assertive outreach team to provide intensive home-based/outreach service.
- A day program

Outcome

- We would try to work with the patient, and try to bring in NGO services to support as well.

Case Scenario 2 - Lucy

- Female aged 15years 6months
- Living in family home with older parents from a high socioeconomic background. Older sister (19years old) and brother (22years old) left home
- Presenting problem: repeated suicidal attempts and ongoing self harm, depression and anxiety, eating disorder not otherwise specified (of anorexia/restrictive type), very poor social system, being home schooled but Lucy is not engaging
- Significant life events: sexual abuse by extended family member from age of 7y to 10y, expelled from 3 schools
- Limited response to several inpatient admissions following suicide attempts
- Reasonable attendance at CYMHS outpatient, but limited improvement in presenting problems
- Some history of attendance at headspace
- Currently on an anti-depressant and compliance is good

Response 1:
Current Resources:

- Individual trauma based counselling - CYMHS
- Centre-ed (Alternative school)
- Possibly HOF referral
- Family therapy on family re-structuring and healing
- Youth service support to provide youth mentoring
- Refer to Logan Interagency Forum as a complex case management discussion

Top 3 resources

- Day Treatment Program – MBT-A, MBT-F, DBT-A
- Mobile family intensive treatment team - crucial components include small case load, ability to work with the family within the home, systemic approach
- 24 hour Child Psychiatrist Cover

Possible outcome:

- On-going therapy support from counselling service – NGO or Private practitioners
- Back to some kind of schooling or vocational training
- Potential for multiple crisis presentations to ED – a crisis plan would need to be developed clearly articulating the limited gains of inpatient treatment and alternatives to admission.

Response 2:
CYMHS would refer to the Adolescent Day Program, with a focus on Family Therapy, Integrating back into the school environment, ACT therapeutic groups, Social skill development.

Resources – To run the Day Program with these complex clients we need to have adequate multidisciplinary staffing numbers, highly trained staff, and well supervised staff.

Potential Outcome – Would expect engagement in the Day program to improve global functioning and embed appropriate health seeking behaviours. This case would be intensive and take up hours of staff time so potential impact on ability to accept other intensive clients into the program at the same time with current staffing profile.

Response 3:
Current resources:

- Re-assess for as yet unidentified perpetuating factors

- Review engagement and therapeutic alliance with parents; ensure shared understanding and agreement of aetiology and management plan.
- Review therapy provided to date and appropriateness and effectiveness of same
- Likely problems will be chronic (given CSA history) and slow to ameliorate, ensure realistic expectations of progress on all sides (scenario doesn't say how long patient has been in treatment for).
- Brief inpatient admissions in acute unit for risk management but prolonged admission avoided
- Continue regular out-patient psychological intervention with
- Consider alternative supported education programs as above
- Also explore additional supports for parents

Response 4:
Current resources

- Referral to EDOS- CBT E
- Interagency Communication Plan
- Crisis Intervention Plan
- Mentor
- Encourage to attend Brisbane Youth Service
- Consider Expressive Therapies
- DBT Program
- Private Therapist
- Day Program

Top three resources

- Continuing Care Team/ Adolescent MITT team
- Day Program
- Youth Mental Health Trained Support Worker

Outcome

- Overall restrictions due to funding cuts throughout services
- Closure of services (BAC)

Response 5:
CYMHS complex case review as engaging. But limited progress what are the reasons? Family assessment and therapy. Social skills group. Management plan involving community after hours CYMHS /DEM/ inpatient team

Explore NGO options to improve social connection, activities out of home, flexi school
Possible private outpatient adolescent group program at Newfarm DBT/MBT group

Gaps:

- Mentalisation-based group and individual program (or other evidence based treatment program for this group) with lead clinician and integrated community/ inpatient management plan for community and crisis management Need processes for case review and supervision and an Acute Care team after hours service linked after hours management plan
- Social skills group
- Specialised educational/ vocational pathway
- These could be offered by different services however there would need to be strong working relationships, an allocated clinician coordinating, meetings of agencies involved to discuss adolescent & family progress and provide supervision & training.

Response 6:
Current resources

- We would try intensive (we can afford only weekly) sessions: individual therapy sessions (along DBT lines) and family/parent sessions, with a detailed crisis plan and emergency department presentation plan.

Top three resources

- More staff to be able to service the above, and perhaps see patient twice a week when needed.
- A day program.

Outcome

- We will be able to put in place the above (1), but it will be very taxing of resources, and there is good chance that the intervention will not be enough and her symptoms continue and possible worsen with time.

Case Scenario 3 - Paul

- Male aged 14years 6months
- Living with father, no siblings
- Presenting problem: aggression towards others, self harm, moderate depression, history of severe bullying at school, sporadic attendance at school in last 2 years, request by both Paul and father to help find 'alternative accommodation' as they cannot live together any longer
- Significant life events: mother died of cancer 5 years ago, father mostly absent due to work commitments, close relationship with grandmother who died 3 years ago
- No inpatient admissions
- Poor engagement in outpatient CYMHS – trouble with transport and parental support to attend
- Has recently begun experimenting with alcohol and marijuana
- Has been charged with shoplifting and two other minor offences over the last 6 months

Response1:
Current Resources:

- Individual psychotherapy (grief & loss, trauma & attachment based)
- Drug & alcohol support from youth service
- Possible HOF
- Family therapy on father-son relationship building and family grief issues.
- Alternative school – Centre-Ed
- Child Safety Notification – father unwilling and unable +/- EVOLVE referral if CSS become custodians

Top 3 resources

- Day Treatment Program
- Mobile family intensive treatment team
- Use respite/foster placement or therapeutic residential within the Child Safety Services System
- EVOLVE therapeutic with expanded scope to include early intervention for families at risk of relinquishing care

Possible outcome:

- Repair father-son relationship
- Living back home
- Attendance school regularly
- Child safety Notification – CSS legal custodian
- Possible forensic involvement down the track if no intervention

Response 2:
Potential child safety notification if Father does not want him to live there anymore.
Potential discharge from CCYMHS if not attending appointments

Resources – extended treatment service, better resourced CCYMHS with models that support outreach, home based services.

Potential Outcome – services would not meet his needs and become a reactive response when behaviour around D & A and forensic issues escalate.

Response 3:
Current resources:

- Liaison with Child safety given patients age and parent's struggle to care

- Look at NGO programs that provide in home support to families and programs providing outreach support to young people (including around ADLs, schooling, drug and alcohol use).
- Work with school if possible to facilitate return
- Attempt to improve engagement with CYMHS, can sometimes access youth workers to bring young person to appointment or by seeing YP in school
- Work towards developing therapeutic alliance where issues of grief and loss can be addressed

Response 4:
Current resources

- Mentor/PhAMS; Big Brother Program (provide transport to appointments)
- Referral to Support Accommodation Service that assists with Life Skills and Developmental Tasks
- Youth Justice Program; BABI
- Supported Accommodation Service; would have to assess developmental tasks, social skills, risk assessments; mixed genders or male only
- Referral to Respite/ Support Services for both Adolescent and Father
- Encourage to attend Hot House
- Referral to Youth Support Coordinator Initiative
- Referral to CYFOS

Top three resources

- CYMHS Outreach Service
- Day program
- Youth trained mental health Support Worker; community access

Outcome

- Overall restrictions due to funding cuts throughout services
- Closure of services (BAC)
- Support services accepting; criteria dependant on Health Catchment

Response 5:
Planned admission to inpatient unit to assess, engage and commence management and community management planning. Parent sessions. Liaise with DOCS for support to maintain placement or alternative care. Assessment of learning. Reintegrate with school expected to be very difficult but not necessarily impossible. Community CYMHS on discharge from unit, perhaps evolve. Parent child therapy.
Father may need own therapy, otherwise support via NGO (often difficult to refer parents to therapeutic services due to acceptance criteria)
Explore options to assist with parental support, respite and transport. (Likely to be difficult unless meets criteria for DSQ/DOCS)

Gaps:

- Day program linked to school offering group and individual therapy skills building. Would have to have a transport service to be viable for many families and program links to other NGO and support services.
- Including Parent child (Family) therapy
- Ready access to Parent individual therapy and group (for education training support)
- Links to mainstream school /vocational training pathway/supported employment.
- 24 hour specialised supported residential link with staff training and supervision to assist with consistent management of behaviours in youth with emotional dysregulation, trauma histories etc. (Youth accommodation services as they currently exist are not resourced to manage self harming and this behaviour and or admission to hospital typically results in loss of accommodation and thereby supportive relationships which can replicate past losses and impair recovery)

Response 6:

Current resources

- We would try to see the patient and dad (home visit or at clinic), use medications as necessary, and try to get service Act for Kids to support Paul and dad. We will involve DChS to discuss with dad residence and care options. If Youth Justice become involved, we will work with them.

Top three resources

- More staff to have an assertive outreach team to provide intensive home-based/outreach service.
- Access to Youth workers or mentors to support Paul.

Outcome

- Our intervention might make things a little better or slow worsening, but realistically things are likely to get worse for Paul.

Case Scenario 4 - Mary

- Female aged 16years 7months
- Living with parents and 3 siblings (one older and two younger), low average socioeconomic background
- Presenting problem: aggression towards parents and others, self harm, severe depression, reasonable social system, some psychotic symptoms evident, sporadic attendance at school in last 2 years
- History of poly-substance misuse (marijuana, alcohol, and speed); pre-contemplative about changing
- Significant life events: moved house frequently as a child, history of physical and emotional abuse within family towards all children, father lost job and unemployed since last year
- 1 recent admission to an adult acute inpatient unit for 2 days observation
- Poor engagement in outpatient CYMHS
- Trials of anti-depressants and anti-psychotics have failed mainly due to poor compliance
- Parents are reluctant to have her continue to live at home, and are especially worried about her violent outbursts

Response 1:
Current Resources:

- Possibly HOF
- Individual psychotherapy on self-reflective ability, and self-soothing
- Family therapy to assist on family's experience & trauma.
- Alternative schooling - Centre-Ed
- ADAWS
- Early Psychosis Team
- Inpatient admission for diagnostic clarification +/- treatment
- If psychotic – may need to utilise the MHA for compliance +/- depot medication

Top 3 resources

- Day Treatment Program
- Mobile family intensive treatment team (which includes an Early Psychosis case manager)
- Adolescent Inpatient Unit to step down care – either one of the above

Possible outcome:

- Living at home with on-going family support from NGO
- On-going individual psychotherapy
- Child safety Notification – CSS legal custodian

Response 2:
? supported accommodation with Child Safety
Referral to adolescent day program
Referral to EPI team

Resources – Extended / flexible model for community based care, education. Supported accommodation

Potential Outcome – potentially do well in the day program and improve functioning and reengage with school.

Response 3:
Current resources:

- Attempt to engage with parents and develop collaborative alliance with them, explore and see if alternative parenting younger sibling can be achieved.
- Ongoing attempts to engage YP
- Offer family therapy to try and improve home situation, probably with a focus on individuation and launching
- Encourage and support parents and YP to explore alternative living arrangements if living at home untenable, note local options very limited often with long waiting lists
- Consider child safety if younger sibling at risk from ongoing parental abuse
- Engage our NGO partners as above in providing support around education and drug and alcohol use
- Motivational interviewing, potential for ADAWS.
- Prognosis poor.

Outcome

- Increased resources for in-reach to home
- Day program to provide more intensive intervention along with educational / vocational interventions with medium term rehabilitation focus.
- Increased supported accommodation for young people that has the expertise to manage psychological issues and mental illness. Current provision is very limited and often lacks the necessary expertise and skills to manage such young people therapeutically and therefore effectively.

Response 4:
Current resources

- Referral to YSCI
- Encourage to attend Hot House appointment
- Referral to Youth and Family Service (Logan)
- Blister pack
- Discuss respite services to support adolescents and parents
- Consider Supported Accommodation Services

Top three resources

- Continuing Care Team/ CYMHS Outreach Service
- Tier 2b Service
- Specialised Adolescent Mental Health Assessment Team- Emergency Department; after hours (see link from program; Victoria included in email: http://www.nwmh.mh.org.au/youth-mental-health/w1/i1001219/

Outcome

- Overall restrictions due to funding cuts throughout services
- Closure of services (BAC)

Response 5:
If severe depression and Psychotic symptoms then would warrant inpatient adolescent unit admission for assessment and treatment (under MHA if required) at least initially. JEO or EEO may be required to facilitate. Family involvement. Refer family to family support services if agreeable and available locally. Thorough assessment. Engagement and careful transition planning. Inpatient Hot House appointment and outpatient support if willing. Commence medication(if indicated while inpatient and await a clinical response) may be role for depot voluntary of involuntary under MHA depending on assessment and meeting MHA criteria (e.g. psychotic illness) manage by least restrictive means. Outpatient CYMHS engagement CYMHS- case manager to visit on unit to build alliance and transition care. Therapy in community. Will rely on therapist and establishment of therapeutic alliance. May require alternative youth supported accommodation on discharge. DOCs unlikely to accept referral due to age. Transport or home visits may be necessary to assist progress with therapy and access to educational/ vocational training.

Other option may be ADAWS program and CL CYMHS mental health involvement if agreeable and engagement by this pathway with community services as above.

Gaps:

- Day facility as discussed above with link to residential facility and youth worker support.
- Alternatively longer term 3-6 months residential MH and ATODS program
- Mobile specialised MH service for youth with capacity to address and manage complex co-morbidity and well linked with NGOs specialised accommodation service

Response 6:

Current resources

- We would attempt intensive case management, with mix of clinic-based and home visits. Parent and family supports will be included. We would discuss with DChS re residence and parental difficulties to care for Mary.

Top three resources

- A day program
- More staff to have an assertive outreach team to provide intensive home-based/outreach service.

Outcome

- Likelihood is that her symptoms will fluctuate, but will continue till she is 18, at which point we would try to hand over to the MIRT team to provide intensive rehab/support.

Additional Comments:

While these scenarios are representative of some of the adolescent presentations that we find difficult to engage and manage with our current service models and resources they are not truly representative of a significant group of patients that I have been involved with which have required BAC admission.

It is difficult to capture the full spectrum of illness and disability that we deal with in 3 case scenarios and with limited time to respond.

Out of home accommodation including rehabilitation and supported accommodation for young people on the Gold Coast very limited in amount and capacity to deal with psychiatric illness and disability.

Further points that came to mind:

- Need for Complex Care Panels
- Adolescent MITT Team
- Continuing Care Team/ CYMHS Outreach
- After hours/Emergency Child and Adolescent Mental Health Assessment Team
- Accessible database for CYMHS; Tiers, Support Services, Accommodation, Community Links (e.g. Access Point for adults)
- Need to be less exclusion criteria for services and more inclusion criteria.
- http://www.nwmh.mh.org.au/youth-mental-health/w1/i1001219/ If you have the chance: models

Case Scenarios

SW AETR Service Options Implementation Working Group Consolidated Responses from Consumers and Carers

Case Scenario 1 - Ritchie

- Male aged 17years 1month
- Living in rental home with single mother and sister who is 10 years old
- Presenting problem: self harm, moderate to severe depression, severe generalised anxiety, limited social system, daily marijuana use, no school attendance for the last 2 years
- Significant life events: long term parental domestic violence, father left family 3 years ago and limited ongoing contact with children
- Two brief acute adolescent inpatient admissions over last 4 years – partial but short-term symptom resolution post discharge; difficulty reintegrating to home following acute admissions
- Sporadic Child and Youth Mental Health community outpatient treatment episodes of care – now refusing to attend

Response 1:

How you would like to be treated?

- As the mum I would really want someone to understand how tough my life has been and how worried I am about my son. I would probably be worried about my daughter and what influence her brother might be having. I have obviously tried to get help in the past but it hasn't worked because of numerous other stresses and now the problem seems entrenched. I want someone to work with the family and offer my son some hope for his future. I probably don't have transport or money to be spending on extra petrol so services need to be locally available or capable of coming to me. I don't want a lot of strangers in my life!!

What continuum of service do you believe is necessary?

- I really feel he needs some intervention promptly but he isn't going to want it. Therefore I think he needs a worker with experience, commitment and a degree of perseverance ready for the long journey and not a quick fix. I think the lad should be invited to set his own goals and priorities of what he thinks will benefit him. Start small and build some successes.
- Respite options and Counselling for mum/Support through COPMI for the daughter/
- Male role modelling for the lad as well as some education around drugs
- Relationships Australia could have a role
- Carers Queensland for mum/ ARAFMI run some good courses workshops but getting there may be difficult
- Centre link check to see all options are being delivered to the family
- Counselling for depression maybe a GP to work with who bulk bills
- Future discussion round TAFE options/employment pathways

What type of follow up would you prefer?

- At first some home visiting to meet the family and set some goals driven by them. Then move towards meeting the lad away from home and engaging in some activity while talking about the problem.
- Exploring vocational options/certificate courses/ Attend TAFE with him to make inquiries
- Ask for a disability support person to assist with study at TAFE

What type of information would you want to receive during treatment?

- Treatment plan signed off with joint goals and options
- Education about self -harm for mum and daughter and how best to respond

- Medication information if needed/Diary for lad to record medication to encourage some independence
- Names of people and organisations clearly recorded who are involved in this case
- Contact details for emergencies/crisis
- Social contacts investigated e.g. interests/hobbies/sport/music/ Volunteering
- Keep mum informed about progress and set backs and how to cope

Response 2:

How would you like to be treated?

- As a carer, the significant challenge is to ensure that his sister, aged 10 years, is able to develop socially and educationally in an environment where her brother has disengaged from education and has effectively removed himself from available health care.
- The challenge with regard to Ritchie himself is that time is running out to some extent as Ritchie is less than one year away from being an adult after which time possible influence on his conduct and activities will severely diminish.
- The number and seriousness of Ritchie's presenting problems possibly overwhelm the carer. There would be an enormous temptation for the carer to resign herself to it all "being too hard" and merely wait for Ritchie to become an adult when, to a certain extent, he becomes responsible for his own problems. However Ritchie needs care now and the carer requires support.
- As it is relatively clear that Ritchie has disengaged himself from the health services with regard to his treatment, the support needed is to assist Ritchie in accessing treatment on a regular basis.
- Being a single mother in a rental home it is possible that finances in the household may be stretched for the carer. In this sense actually getting Ritchie to attend outpatient services may be a challenge and the carer could do with the support of volunteer organisations that might be able to arrange travel for Ritchie to his appointments.

What continuum of service do you believe is necessary?

- The immediate service that Ritchie requires is to re-engage with outpatient treatment. If he is refusing to attend, then there may be the possibility for a social worker to come and collect Ritchie for the appointments or for the social worker to organise the volunteer organisation to provide transport as noted above.
- Further inpatient admissions would appear to be unlikely to have any long-term benefit in that there has previously been only short-term resolution of symptoms post-discharge. This may be due to many reasons including perhaps the difficulty in reintegrating him into the home following the acute admissions.

What type of follow up would you prefer?

- It should be evident to the health service that Ritchie is not attending scheduled outpatient appointments. As his mother, the carer is possibly having less and less influence on Ritchie's day-to-day behaviour and no amount of encouragement by her would possibly be successful in getting Ritchie to resume his outpatient appointments.
- In this environment the follow-up required would be for a representative of the health service to contact Ritchie directly with a view to attempting to encourage him to recommence his outpatient appointments.

What type of information would you want to receive during treatment?

- Ritchie's presenting problems are so significant that any improvement in one area may possibly go unnoticed. Should Ritchie recommence outpatient appointments, it would be beneficial for the treating professional each time to attempt to gauge whether or not Ritchie's symptoms are improving in any respect. Follow-up could involve reporting on any such improvement which might create a more positive environment within the family unit to encourage Ritchie to continue his treatment.

Case Scenario 2 - Lucy

- Female aged 15years 6months
- Living in family home with older parents from a high socioeconomic background. Older sister (19years old) and brother (22years old) left home
- Presenting problem: repeated suicidal attempts and ongoing self harm, depression and anxiety, eating disorder not otherwise specified (of anorexia/restrictive type), very poor social system, being home schooled but Lucy is not engaging
- Significant life events: sexual abuse by extended family member from age of 7y to 10y, expelled from 3 schools
- Limited response to several inpatient admissions following suicide attempts
- Reasonable attendance at CYMHS outpatient, but limited improvement in presenting problems
- Some history of attendance at headspace
- Currently on an anti-depressant and compliance is good

Response 1:

How you would like to be treated?

- I am sure Lucy might be feeling quite isolated in her family unit so it would be important to boost her self-confidence and recognise her as an individual. Her parents might be giving up hope as progress has been very slow. It will be important to keep them involved but at the same time respect Lucy's growing need for independence.

What continuum of service do you believe is necessary?

- Get on top of the physical problems of anorexia
- Work with Lucy on coping strategies for stress and anxiety and how to manage her self harming.
- Review medication
- Educate parents about what is going on and why Lucy is responding this way.
- Family meetings with a view to family therapy if needed
- Attempt to move into attending school rather than isolation of home schooling.
- Work on goal setting round social activities

What type of follow up would you prefer?

- Perhaps the family would be happy to work with a private therapist competent in the Maudsley Family method.
- Sexual abuse support Zig Zag??
- Headspace connection might work for Lucy

What type of information would you want to receive during treatment?

- As a parent I would want to know what treatment plan would help my daughter to recover.
- I would also want to know why she was acting the way she was.
- I would need someone who understood my stress to be there for me and give me advice and keep me informed of how she was travelling.
- I would hope my husband would be included and supported too.

Response 2:

How would you like to be treated?

- Lucy's reasonable attendance as an outpatients at CYMHS and a fairly good compliance with medication suggest that, perhaps, she would benefit from more regular contact with outpatient services and the ideal would be for an encouraging and supportive working relationship with, say, a case worker / manager as a familiar point of reference that would lead to not only trust being formed but, hopefully, be a catalyst in building self-esteem and a desire to want to be personally involved in her own health management and future.
- For this to work, Lucy's parents, being her carers, need to be involved in the delivery of the service. Then maybe any residual distrust by Lucy towards her parents concerning the sexual abuse by an

extended family member in her past might be addressed. Any future improved engagement by her parents in Lucy's life may well require exploration of any residual damage from this experience.

What continuum of service do you believe is necessary?

- Due to positive factors such as the patient taking medication regularly / compliantly and there being a reasonable attendance at CYMHS outpatient – this needs to be encouraged as much as possible and recognised. When patients receive positive feedback and acknowledgement of their own efforts it can be an enormous sense of self-pride and a desire to continue doing the right thing.
- The challenge is to ensure that, once removed from the medical services be they as an inpatient or as an outpatient, the contact within the system remains. If the continuum of service is there and maintained there are hopefully fewer admissions to acute wards and, most importantly, the constant awareness of their health and having someone, somewhere to identify with as a positive in this area may ultimately prevent despair that often can result in attempts of suicide.

What type of follow up would you prefer?

- Although perhaps not cost effective, for those less inclined to want to attend outpatients on a regular basis and for those still particularly unwell and in need of support, where necessary home visits may help. Many carers and consumers are so exhausted both pre and post admission that if it is not human contact, be it in person or at least by telephone, used as a follow up then there is not much point in written communication.
- For example, some carers and consumers are not inclined to complete surveys. These are more often than not discarded as being too impersonal and many carers have completed endless surveys in their lives about their child's behaviour and condition.
- The preferred follow up is that of a weekly or fortnightly appointment over a set period of time in order to keep the momentum going. Failing this, a follow-up series of telephone calls would be helpful. These are significant positives for the consumer and carers as they "are not forgotten" once they walk out of the service.
- Many consumers and their support network "fall through the cracks" when they leave intensive support environments and then are left to their own methods of problem-solving. This is the loneliest time for many patients and their families as they struggle to cope alone. This isolation can be a precursor to another possible incident occurring or a general feeling of insecurity.
- Although these services all come at a cost, they may reduce the need for attendance at the Emergency Departments for those desperate for assistance.

What type of information would you want to receive during treatment?

- Information received during all treatments is crucial for both consumers and carers, particularly when consideration is being given for post admission. The information received should encompass:
  (a) likely mood swings or general feeling of well-being
  (b) knowledge of the symptoms to watch for and be able to identify if the patient feels unwell
  (c) what, if any, medication changes have occurred and likely side-effects if applicable. Although a most obvious crucial point for discussion – this is often only spoken about with the consumer and not their support base (e.g. carers)
- In summary, respect and recognition of families as important people providing support to the patient and also as a conduit between the younger consumers and their treating teams is imperative. Good working relationships can impact significantly on patients' care and outcomes.

Response 3:

- Strengthening therapeutic relationship with CYMHS clinician, allowing for clinician to be in best possible position to encourage Lucy to engage with certain services and help her to make other important decisions. If headspace is benefitting Lucy, but she is attending only sporadically, CYMHS clinician attend headspace on 1 or 2 occasions with Lucy to help link her in with support there.
- Due to high socio economic background, possibly be provided with information about private healthcare services which may be able to offer additional support in conjunction with CYMHS and NGO support already being provided.
- Education options discussed with Lucy, however not pushed too hard, as treatment and recovery are incredibly important at this point and too much additional pressure may be counterproductive.

Possibly exploring the option of attending a school or flexible learning centre more for social connection with friends etc than to focus entirely on academic side.

- CYMHS clinician actively involved in Lucy's medication monitoring. I.e. attending psychiatrist appointments with Lucy (assuming it is a CYMHS psych she is seeing) and discussing options with her after psych appointments as she may not feel comfortable discussing directly and openly with psych.

- Lucy to be given clear message that least restrictive method of treatment will always be preferred, however, as she is aware (having been hospitalised after suicide attempts) there is a duty of care, and certain behaviours will result in further action being taken and will be done so against her will if necessary. Talking Lucy through behaviours that she is at risk of, that could lead to involuntary treatment. (This one is very tricky – it MUST be done by a clinician that she feels connected to, and care needs to be taken that it is not done in a threatening manner i.e. – if you do this we are going to put you on an ITO etc. etc. but more of a conversation with her so that she feels she can understand rationale behind actions that have been taken in the past, and that may be taken in the future if/when certain behaviours escalate.) Also giving her alternatives to this happening, i.e. letting her know that she could potentially come into hospital herself if she is feeling like she is suicidal or going to self harm BEFORE she acts, and has the option of a less restrictive, voluntary, short admission to keep her safe. And also if/when she does SI or make a suicide attempt, that she can also have a less restrictive admission if she voluntarily accepts treatment.

Case Scenario 3 - Paul

- Male aged 14years 6months
- Living with father, no siblings
- Presenting problem: aggression towards others, self harm, moderate depression, history of severe bullying at school, sporadic attendance at school in last 2 years, request by both Paul and father to help find 'alternative accommodation' as they cannot live together any longer
- Significant life events: mother died of cancer 5 years ago, father mostly absent due to work commitments, close relationship with grandmother who died 3 years ago
- No inpatient admissions
- Poor engagement in outpatient CYMHS – trouble with transport and parental support to attend
- Has recently begun experimenting with alcohol and marijuana
- Has been charged with shoplifting and two other minor offences over the last 6 months

Response 1:
How you would like to be treated?

- As a father I would want someone to understand how hard it has been and to be nonjudgmental about my parenting. I probably need some support but in a more helpful way. I might then be more open to having my son live with me.

What continuum of service do you believe is necessary?

- Parenting skills for dad
- Conflict resolution for son and dad
- Social connection that they could do together eg hobbies/sport/fishing/bmx
- Psycho education about drugs and alcohol for both parties
- Grief work

What type of follow up would you prefer?

- Someone to do some home visits at first to build a good working relationship and to make it easier to get
- some help
- Educational assistance to reengage son in schooling/ Look at vocational options
- Too young to move out unless totally no hope of improvement in dad son relationship

What type of information would you want to receive during treatment?

- Parenting tasks
- Advice on development and adolescent behaviour
- Role modelling other than dad for son
- Alcohol and drug education
- Strategies to stay calm and in control
- Legal rights for son

Response 2:
How would you like to be treated?

- The presenting problems have so overwhelmed the carer that the apparent only solution is to find alternative accommodation as the father and son can no longer live together. As this is a request by both the father and the son, it would appear that the relationship between them has broken down to perhaps an irretrievable extent.
- However Paul is relatively young at 14 years and 6 months and the father's role in Paul's life needs to be addressed as there is still over three years before Paul becomes an adult. In this time it would be beneficial to have his father's influence in his life and so the challenge for the health service for the father is to ensure that, after Paul is found accommodation elsewhere, the father is still encouraged to play an important role in Paul's developing adolescent years particularly in circumstances where Paul does not have a mother figure in his life.

What continuum of service do you believe is necessary?

- Because of no inpatient admissions recorded in spite of significant life events, along with reported poor engagement in outpatient services, an extended rehabilitation service would be preferable to provide medical and psychological support. Accommodation in an environment that provided this support while teaching the patient both personal and social responsibility would provide security through informative years. Because of his age, housing in care is important.

What type of follow up would you prefer?

- In this scenario, there would be a preference for constant care. With follow-up after discharge being some years away, a strong rehabilitation programme and support network would be off benefit.

What type of information would want to receive during treatment?

- How each of these areas of aggression, self harm, alcohol and marijuana use are being addressed, long term diagnosis, medications prescribed and how to deal with incidents such as self harm etc.

Case Scenario 4 - Mary

- Female aged 16years 7months
- Living with parents and 3 siblings (one older and two younger), low average socioeconomic background
- Presenting problem: aggression towards parents and others, self harm, severe depression, reasonable social system, some psychotic symptoms evident, sporadic attendance at school in last 2 years
- History of poly-substance misuse (marijuana, alcohol, and speed); pre-contemplative about changing
- Significant life events: moved house frequently as a child, history of physical and emotional abuse within family towards all children, father lost job and unemployed since last year
- 1 recent admission to an adult acute inpatient unit for 2 days observation
- Poor engagement in outpatient CYMHS
- Trials of anti-depressants and anti-psychotics have failed mainly due to poor compliance
- Parents are reluctant to have her continue to live at home, and are especially worried about her violent outbursts

Response 1:

How you would like to be treated?

- Acknowledge the difficulties Mary has had to cope with but also respect parent's concerns about her worrying behaviour
- Non blaming environment needs to be fostered but also work on building relationships and conflict management.
- Goal setting with Mary about her future and what her interests are and how she sees her life unfolding
- Check in with Centre link re entitlements but support the interview accompany parents etc if they would like someone to

What continuum of service do you believe is necessary?

- Get medication reviewed and establish some responsibility in Mary to be compliant
- Document her own medication and side effects experienced…involve her more in decision making but keep parents informed as well
- Work on change management program if ready
- Investigate headspace
- Parenting and family work in a non-judgemental way
- Once goals are set work with education options eg TAFE/ senior certificate/ certificates for pre work

What type of follow up would you prefer?

- Mary I think needs to develop some control over her life and be more independent of her parents in a positive mature way.
- Help getting employment or engaging in educational pathway…prepare CV etc
- Parents need some support with parenting tasks build on the family's strengths which have got them this far
- Family work for other siblings

What type of information would you want to receive during treatment?

- Medication information
- Benefits from centre link
- Educational pathways

Response 2:

How would you like to be treated?

- The significant challenge for the carer, assumed to be both father and mother in this instance, is to address the psychotic symptoms evident in Mary's behaviour. Given that medical intervention has failed mainly due to poor compliance, the immediate strategy must revolve around access for Mary to her medication and improving her compliance with taking it.
- Mary is in a situation with a very large number of presenting problems the weight of which perhaps intimidates her carers. The fact that her parents are reluctant to have her continue to live at home is a reasoned response to the fear they may well have of the consequences of a psychotic episode involving the two younger siblings. As there is no short term "fix", the carers in this instance need some idea of what the longer term holds in store for Mary. They may be concerned that, as Mary is only a little over a year away from being an adult, a positive plan for the future is required.
- The carers perhaps would like the health service to engage with them in developing the medium term strategy for Mary's treatment.

What continuum of service do you believe is necessary?

- Mary's poor engagement in outpatient care possibly raises the possibility of a longer admission to an acute inpatient unit in the first instance prior to a rehabilitative phase being commenced. The previous admission was to an adult unit and such may have been inappropriate even though at 16 years and 7 months, Mary is rapidly approaching adulthood. However an inpatient admission to CYMHS would appear to be a viable treatment suggestion.
- Given the history of physical and emotional abuse within the family towards all children, continued care within the family environment is unlikely to assist in improving Mary's symptoms.
- As Mary's home life is significantly challenging and shows little potential for improvement in the short term, Mary particularly requires residential inpatient rehabilitative care. It is not surprising that there is little engagement in outpatient care as it would be obvious to all, especially Mary, that the real problem is not being addressed.

What type of follow up would you prefer?

- The poor engagement in outpatient treatment is the starting point for follow-up in Mary's case. Whatever can be done to firstly encourage Mary to attend and secondly to assist her physical attendance would appear to be strategies worthwhile attempting.
- However with the appropriate care likely to be a residential inpatient rehabilitative facility for Mary, the appropriate follow-up with the carer would be to advise on the possibilities of such and to develop a strategy by which Mary would become eligible for such a facility.

What type of information would you want to receive during treatment?

- The immediate requirement for information during treatment would also involve the steps that are being taken to attempt to have Mary admitted to a residential inpatient rehabilitative facility. If there is some "light at the end of the tunnel" in this respect, Mary's response in other areas such as compliance with her medication and attendance at interim outpatient services might improve.

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Chief Executive
Telephone:
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Our Ref: CEC20130658

Dear Parents and Carers

The statewide project for the Adolescent Extended Treatment and Rehabilitation (SW AETR) Implementation Strategy has commenced under the governance of Children's Health Queensland. As part of the statewide project there is an overarching Steering Committee that has met three times since 26 August 2013 and working with the steering committee are two Working Groups and a Clinical Panel.

One working Group is focusing on the Service Options, building on the work that was completed by the Expert Clinical Reference Group earlier this year. The second working Group will focus on financial and staffing requirements for any future service models. Finally, the Clinical Panel will consist of a team of clinicians led by Dr Anne Brennan (A/Clinical Director of the Barrett Adolescent Centre) that focuses on identifying and supporting the ongoing care needs of and future options for the adolescents currently at Barrett or on the waiting list.

The SW AETR Service Options Implementation Working Group will be meeting for the first time tomorrow, 1 October 2013, when a forum will be held. A second forum is planned in a month's time. This Working Group comprises a range of multi-disciplinary clinicians and service leaders from statewide Child and Youth Mental Health Services (CYMHS), consumer and carer representation, and non government organisation representation.

I would like to invite you to (or you may wish to collectively as a group) prepare a written submission for the consideration of the Service Options Working group. Our aim is to ensure you have an opportunity to contribute to the development of the new service options moving forward. The key questions that we would appreciate you addressing in your submission are:

1. What components of the current services available in Queensland best meet the care requirements of adolescents with complex mental health needs?
2. What are the gaps that you see with the current mental health service options available in Queensland?
3. What opportunities are there for new and/or enhanced services for these adolescents in Queensland?
4. Are there any other comments you wish to make to the working group for their consideration?

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This feedback will be valuable in providing insight into the planning of future service options for adolescent mental health extended treatment and rehabilitation. Please send your submission to Laura Johnson, Project Officer, Mental Health and Specialised Services, West Moreton Hospital and Health Service via [redacted] by Friday 18 October 2013. Your de-identified submission will be utilised by the SW AETR Service Options Implementation Working Group in their second Forum.

Yours sincerely

[redacted]

Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service
30 September 2013

Parent Submission to Service Options Implementation Working Group, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Laura Johnson - Project Officer

Mental Health and Specialised Services

West Moreton Hospital and Health Services

"The aim of youth services should therefore be to reduce the need for transition into adult services." (McGorry, Bates, Birchwood, 2013)

"Estimates suggest that between one-quarter to one-half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence. " (Kim-Cohen et al, 2003)

Introduction

The combined factors of geography, vast distances and population distribution in Queensland mean that no matter where services are located, some young people with severe and complex mental health problems will still need to travel to gain access to appropriate services and/or the services will need to travel to the young people. This means consistent, frequent and regular availability of services will still be difficult to provide. To say that young people shouldn't have to travel to get the kind of treatment and rehabilitation Barrett is idealistic and doesn't reflect reality or practicality. As people travel to access other specialist health services like specialist cardiac or cancer treatment, some young people will have to travel and maybe stay away from home to access the type and intensity of service required to meet their particular mental health needs. There simply aren't the amounts of experienced staff to service young people with complex needs right across the state and the comparatively small percentages of young people with the most complex needs makes multiple extended treatment and rehabilitation services not economically viable. Although parents would prefer their children close to home, and young people may not wish to leave their community, if it comes to a question of keeping your child alive, as it does for many parents, then there is no choice to make – you send your child wherever you need to, to save their life, and help them reclaim their life.

The hope is that with a greater emphasis on promotion, prevention and early intervention, is that young people receive appropriate care that prevents them from progressing to the point where there situation is severe and complex. Queensland spent only **1.7% of the $983.3 million** on Promotion, Prevention and Early Intervention, Action Area 1 of the COAG National Action Plan on Mental Health 2006-2011 funding allocations, a smaller portion of this would have been allocated to youth mental health. Other states spent three and four times this amount in this action area. Unless this situation drastically improves, it will take many years before promotion, prevention and early intervention strategies will have significant impacts on

reducing the numbers of young people with severe and complex needs. Even with a widespread system of well-funded, well-staffed, well-coordinated services for these young people existed state-wide, there will always be some young people who will fall through the gaps. Lack of staff, lack of funding, geographic isolation, unsupportive home environment, abuse, young person's avoidance of help, complexity of young person's mental illness (dual diagnosis) – many reasons will cause the young person to progress to a point where they will need the treatment and rehabilitation of a centre like Barrett. No system or model of care will be perfect and be able to catch every young person that needs help or treatment at the time they most need it. However these young people should be provided with the very best and most comprehensive treatment and rehabilitation available. They are the most vulnerable of all young people and the reality is not all of them will survive. There must be extended treatment and rehabilitation services with onsite schooling for young people with severe and complex mental health problems.

1. Components of the current services available in Queensland that best meet the care requirements of adolescents with complex mental health needs.

(i) Education: Onsite Schooling.

It would be very easy to consider the Barrett School a separate entity, especially being operated by a separate government department. However the School is anything but separate. It delivers much more than merely maintaining access to an academic curriculum. To have a seamless integration between education and treatment, being onsite, has enormous positive benefits for recovery outcomes.

The education programme at Barrett is crucial to the effective treatment and recovery plan for each young person, helping them explore vocational options, develop life-skills, develop self-esteem and re-engage with education. It is uniquely integrated with each young person's individual treatment plan. The access to on-site schooling is a vital factor, in not just transitioning the young people back to a world from which they have long withdrawn, but in preparing them to live independent adult lives. And though it is referred to as 'on-site schooling', it's important to note that the learning experiences don't just take place in the classroom but in the extended community as well. Beyond the group activities where specialised teachers have developed ingenious methods to incorporate learning into therapy and social/personal development activities, the young people engage in a wide range of activities, go on excursions such as career expos, visit workplaces, visit community organisations, do community work, to provide them with broader community experiences. They do work experience in the community facilitated by teachers, and where appropriate for individual students, provide educational support for those attending school and further education such as TAFE off-site.

The School recognises the importance of physical activity in mental health and education of the young people and incorporates Physical Education in their school program as well as providing other physical activity opportunities when possible. The large grounds around the school are therefore an essential component of the onsite schooling, and would need to be catered for at any location to which the facility was relocated.

In addition, the school encourages the adjustment to a more 'normalised' daily routine. 'Patients' become 'students' away from the ward in an environment that leaves any medical/hospital atmosphere aside and allows interaction and the development of peer relationships – a key element of life but quite often something that young sufferers of severe mental illness have never experienced or not in some time. Inpatients live with, attend school and socialise with their peers. In a safe and supportive environment where their peers are often going through similar issues, many young people experience friendship with people their own age (who have not been able to 'fit' in socially) for the first time in their lives. Onsite schooling allows them to interact with their peers in the education environment, offering them the opportunity to learn and practice different ways of engaging and communicating in a different environment, with different expectations, but with the flexibility of being able to withdraw to the ward if they need to or for treatment needs. If the school was off-site this would be much more problematic. In some cases, young people early in their admission are reluctant to attend the school environment – or leave their room even. However with the school onsite, it is much easier to move between the two environments than if the school was off-site.This is particularly crucial for some if not most young people, particularly early in their admission.

The School, as with any organisation, is only as good as its people. All of the staff are highly experienced working with young people with complex mental health problems and the issues that creates for their education. They are extremely knowledgeable, committed and dedicated and know and understand the environment in the ward. This is further highlighted by current teaching staff volunteering their time to run the holiday program for inpatients – an important part of their rehabilitation – because WMHHS staff weren't provided to run the program, as they normally do. It is another of the reasons the Education department wishes to retain the school staff as a team as it recognises the value of the group as a whole, and why the onsite schooling is such an advantage to the overall program of care. The education staff are very connected and engaged with treatment staff. Onsite schooling facilitates the easy exchange of information, because both WMH and Education staff can easily move between the two environments when required. The full wrap around service model can really only be effective if the domains of treatment and care are working in partnership. Unfortunately this occurring in reality outside what has been the Barrett Centre is not evident.

Educators in this team are in a perfect position to be able to document practices and strategies, recognising the value of this information. For example some have commenced an action research project on *Pedagogy for adolescents with psychiatric disorders* and presented at a conference in Amsterdam. The research done ensures ever improving standards of specialised schooling and the opportunity to use this information throughout the broader education system. This capacity for research and consultation is definitely enhanced by the onsite location of the school which allows for easy collaboration and communication with clinical and therapeutic staff. **This further highlights that this model has been a leader in the field of education for adolescents with complex mental illness.**

The current education team are committed to remaining as a group to continue to offer their services as an integral part of the full treatment and rehabilitation program. This is supported by the Education Department. It is ironic that the recognition for the important work done by the onsite education stream of Barrett is recognised and valued by that Department as an essential part of the treatment and rehabilitation component of Barrett, as

identified by the ECRG, yet the Planning Group within the Health Departemnt did not acknowledge the need for the schooling to be onsite. Importantly, the school is well-placed onsite for future opportunities to examine the effect of mental health on their education, and conversely the influence re-engagement in education has on young people's recovery: the reciprocal benefits.

Rivendell is a jointly administered School (NSW Department of Health and Department of Education & Communities - www.rivendell-s.schools.nsw.edu.au) in Concorde West New South Wales. It offers inpatient and day-patient programs with an onsite school and "clinical and education staff work collaboratively on educational programs." Education staff also provide teaching to other offsite hospital inpatient services. Whilst inpatient times are shorter than Barrett, it provides an excellent demonstration of the benefits and capacities of a treatment facility with onsite schooling.

Finally, the incidence of withdrawal and disengagement by adolescents from school and other educational environments is a very common occurrence. It is identified as one of the most significant factors used in mental health assessments and further supports the need for on-site and highly specialised and accessible educational programs.

The close collaboration of Barrett treatment and rehabilitation and Barrett schooling would be a perfect example of what the Government is trying to achieve via Mental Health Commission's whole-of-government strategic mental health plan – the integration and collaboration between departments for better outcomes and coordination of services.

(ii) Services away from home:

Whilst the general thrust of contemporary mental health service provision is to locate services in or close to the communities where people live, the geography of Queensland – the distances - and the population distribution makes it difficult, if not impossible to do. As an example, it easier, faster and cheaper to get from Cairns to Brisbane, than it is to go from Cairns to Townsville. It is not ideal, however this is not always a negative. Barrett patients have cited that there can actually be advantages to a NON-localised facility i.e. it can act as a circuit breaker for the young person to put an end to the cycle they have been stuck in – one of moving from acute facility to home back to acute facility, especially where there are limited other services. In some circumstances, in an all too familiar environment, a young person is destined to repeat destructive or stagnating patterns of behaviour. So moving to a totally new environment can not only give them a more conducive setting for understanding their condition and addressing their problems, but it can be a conscious trigger for them to acknowledge that they have NOT progressed in their previous situations and need to now apply themselves as fully as they can because their illness has reached a level that has warranted such a significant change. This is particularly relevant when a person comes from a regional area where the social and service systems are small. A current inpatient recounted this as her experience. Being recognized in their home community because of the scars from self-harm or being bullied or ridiculed because of the stigma of mental illness and the public knowledge that the young person has been admitted to an acute ward can seriously exacerbate a young person's mental health issues. In addition, in circumstances where abuse or neglect in the home environment has actually been a significant factor in the mental health issue that young person is suffering, being away from unsupportive or, in some cases, an abusive home environment is clearly a positive step and one that is vital if any progress is to be made at all.

The benefits of leaving the home environment are also apparent for young people in the same location as the service. Becoming an inpatient provides the same circuit-breaker for destructive habits and behaviours, an opportunity to escape an unsupportive or abusive environment, a chance to re-engage with schooling and peers, develop social and community connections and access the level of clinical and therapeutic support they require.

(iii) Combined Inpatient/Day-patient capacity:

Not all inpatients will remain in Barrett to become day patients. But for those patients for whom returning to their home is not an option or young people who live locally who are not ready for discharge, the capacity to attend as a day-patient as they progress in their treatment and recovery is an advantage. The young person is able to begin gradually, starting with one day a week if needed. This allows them to maintain the connection with staff, school and treatment and try out their independence and self-management. The sense of belonging and support is maintained but progress is tested and consolidated as young people reconnect with home and community.

Staff can observe the effects of treatment and the associated changes that take place in adolescents who transition from full-time inpatient to day-patient. Barrett can continue to monitor the progress of day patients and adjust treatment level and type accordingly. The young person can be supported to further build on home and community links until full day-patient status. Likewise as a full day-patient, the treatment team can facilitate further reduction of day attendance, at the same time expanding the young person's engagement with other education or vocational options and service providers (including residential if required) as determined by their treatment plan. This allows for a seamless transition back into the community.

(iv) Community:

There is a risk of viewing Barrett as a one-dimensional facility – inpatient - and seeing it just as a collection of components – Psychiatrists, Psychologists, Doctor, associated Therapists, Mental Health Nurses, Educators, Support staff, residential facilities, other support services. A tick and flick list of these items would indicate that the young people have access to all the essential ingredients to help them move towards recovery. Just having all of these components in the one place does not mean that young people will recover, no matter how many years of experience the people have or how modern and purpose-designed the building is.

There is something at Barrett that isn't listed on anyone's job description, or activity or feature of the Centre, but is a function of the combination of all of these things in an environment and atmosphere of commitment, dedication, experience and passion to help these young people. It would be difficult to measure – difficult to qualify and quantify. It is probably defined best as 'the whole is greater than the sum of its parts'. It is the sense of **community** it provides to the young people. This helps them to overcome their social isolation, develop confidence in their interactions, feel acceptance and build relationships – make progress towards recovery: feel part of something.

Just like any community, there are rules, different environments, different people, different activities, different expectations etc., just on a smaller scale. There is safety, stability, consistency, reassurance, security and trust, even if the young person doesn't feel these things on admission, the structure, routines and relationships will allow them to develop. Not every aspect of this community will be positive or pleasant for the young person – as in the

the wider community, but they experience these things with the support, guidance and under the observation of staff – 24 hours a day. This will help build resilience and skills that can be used in the wider community.

The relationships formed in this 'micro-community' between staff (school, clinical, therapy) and adolescents are vital to their participation and engagement in – and effectiveness of – treatment, therapy and schooling – and are an extremely powerful component of the 'community'. Such relationships can take much longer to develop in the general community as contact with clinicians and other workers would be more brief, less frequent, and more variable. The young person's inclination to engage in treatment and school could be severely reduced without these substantial relationships.

Many of the aspects of life that have either eluded these young people, or they have actively disconnected from due to their mental illness is available to them within this community, and with treatment, rehabilitation and time, will enable them to return to their own communities to lead fulfilling lives.

2. Gaps within the current mental health service options available in Queensland.

(i) No/insufficient service available:

This is self-explanatory. Either the service doesn't exist, which is often the case in rural and regional services or the service does not have sufficient resources to provide the service: insufficient inpatient beds; lack/unavailability of staff; staff with lack of experience; demand for service creating waiting lists/long waiting times for appointments. This results in no access to services, inadequate services or the extreme outcome of young people being placed in adult facilities, which can result in further trauma to the young person and an exacerbation of their condition.

Inconsistency in staff and their training/expertise in the area of Adolescent Mental Health has been the biggest problem identified by parents and their young person. The variation in quality of service delivery needs to be minimal for young people to develop faith in the service they are receiving.

(ii) Lack of recognition of developmental theory:

The fact that young people with complex needs are required to access adult services either due to lack of services (as described above) or after the age of 18 shows a complete lack of recognition for latest research on adolescence. Patrick McGorry states "Emerging adulthood is now a more prolonged and unstable developmental stage" (2013). For youth with complex needs this if often magnified because they can be socially, mentally and emotionally developmentally delayed to varying degrees due to their social isolation and subsequent loss of contact with peers and associated social engagement. So even at 18 they may not be at a level of maturity equivalent to their same-age peers. This will particularly depend on the amount and quality of treatment and rehabilitation they have had access to, how long they have been accessing it, and how successful it has been. There must be alternatives for these young people besides adult facitilies, even after they turn 18.

(iii) Failure to access service:

In this case the service is available but not able to be accessed. It was recently stated at a Mental Health Commission forum that <50% of young people that present to the CYMHS do not get past intake. Investigations would need to be undertaken as to whether this was due to the service being full, or the young person was not assessed as needing the service. Whether the assessment is accurate would depend on the level of experience of staff and/ the preparedness of the staff to listen to the parent/carer presenting with the young person. . If young people are being turned away from CYMH services, how does this demonstrate early intervention/prevention? There are many examples of these instances – just talk to parents.

(iv) Lack of networking and collaboration between services:

In some communities/areas, there is a distinct lack of cooperation between services. Parents have reported incidents where CYMHS have not wanted to refer to other community-based services or recommended against using them. Reasons for this vary from being possessive of the patient and not wanting to relinquish control of treatment; resistance to referring patient on because of fear of scrutiny of treatment already provided; service and staff available but not experienced enough to handle young person with complex needs. At a recent mental health forum, comments were made about the almost 'competition' type atmosphere between services (competing for funding, payments for placements) that hinders the collaboration between services. This is a major objective of the Mental Heatlh Commission – to develop a whole-of-government strategic mental health plan that will facilitate (hopefully) the collaboration and better integration of associated government departments (health, education, justice, housing) and community mental health services. Unfortunately, and unbelievably, the development of a new model and the Minister's intention to set up 'residential' type or other services – his descritpions have never been specific - will not be part of this process.

(v) Lack of recognition of genuine family support

The experience of many families is that they have been 'demonised' by the existing service system. Many talk of feeling as though they are blamed for their child's condition or judged when their child presents with instances of self-harm in hospitals. While it is acknowledged that some incidents of trauma or abuse may have occurred in the home, it is also a very uncommon cause for most adolescents. There does not seem to be much recognition for experience/knowledge of the parent/carer and conversely in some cases, if the parent demonstrated any professional knowledge, they were expected to become the sole service provider for their child.

Family support is a fundamental part of supporting any person in need. Building up the capacity of families will continue to be the most effective way to support young people by providing training/mentoring/counselling/support pathways. Rather than become defensive when families and parents ask questions – the approach could be inclusive and respectful. Sadly, this is not the experience of many parents.

The family is who an adolescent is discharged home to after an admission in any hospital. Often this occurs without a discharge plan or timely/effective service responses post admission. There are limited referral options and CYMH services have been unable to

provide the range of services needed. This has left families desperate, worried and ill-equipped to keep their children safe or be working towards a recovery. When families keep asking for help, they are ignored or not believed leading to a growing lack of faith and belief in the system or the government stations over seeing it. In addition, the lack of consultation with families further embeds the lack of genuine family involvement and consideration.

3. Opportunities for new and/or enhanced services for adolescents with complex mental health needs.

(i) E-health/E-Therapy:

Barrett could develop models for interaction with young people via this medium. This could be integrated into the full range of treatment and therapy programmes for young people who are on leave from the centre, follow-up of recently discharged patients, even to commence contact with young people on the waitlist and their clinicians/therapists/family/supports. Offering the facility for family contact would enable to young people to have a more meaningful interaction with their families, especially when they are a long way from home. E-health modes could be used to facilitate contact/consultation with rural/regional clinicians who request or require consultation with the specialist team at Barrett, even so far as establishing case conferencing for young people on the waitlist or for consideration for referral.(Refer to attachment 1)

(ii) Family Units:

Family units could be attached to an extended treatment and rehabilitation service for families/carers of those who live outside the metropolitan area, to better facilitate the involvement and support of parents in their child's treatment, such as is available for parents of children with other health problems. (Refer to attachment 1)

(iii) Mobile Services

"There is a lack of appropriate and urgently-responsive mobile community-based services that would support children, young people and their families in the least restrictive place of intervention. Such services would reduce the likelihood of hospital admission, reduce the demands on hospital emergency departments, and support earlier discharge from hospital, thereby reducing the demands on inpatient beds." (Extract from Issues Paper submitted to Mental Heatlh Commission 'Quality, integrated, responsive and recovery-focussed child and youth mental health services across Queensland' Prepared and submitted by:Queensland Children's Health Hospital and Health Service CYMHS in collaboration with partners)

(iv) Clinical Case Management Advisory Teams:

There needs to be communication between the services that work with and refer young people with severe and complex needs and a specialist facility like Barrett to minimise the risk of these young people being lost by being referred somewhere that can't help or being on a referral round-about or with just no service available at all. If you consider that the number of young people with the most severe and complex mental health problems could be around 1% (estimate), it is only logic to realise that clinicians may go through their career without ever having contact with this cohort of young people (depending on where they work) or at least see very few. A centre like Barrett should have a clinician who is available to consult with other clinicians and services around the state – especially regional services

where staff may not be experienced or have limited experience with severe and complex mental health cases. This would not be a casual arrangement relying on local clinicians' decisions to consult, but a formalised process with indicators that would trigger a consultation with an expert clinician. E-health and teleconferencing would easily enable this (refer question 3 (i)). There should be a team that meets – like Child Protection teams that operate in connections with hospitals (SCAN teams? or they used to be called that) that monitor the young people that are identified as at risk of deteriorating into a severe and complex condition so they don't get lost in the system. Again this would be a formalised process with protocols based on indicators to trigger referrals to the team to minimise the likelihood of these young people fall through the gaps and fail to access the appropriate clinical care. This would also increase the likelihood that young people could remain in their community if it was combined with direct clinical and therapeutic consultations with Barrett staff. This team would Case-manage a statewide caseload of the most at risk or most severely ill young people. Lack of local experienced clinicians would be much less of an issue and that clinician would meet regularly with the team to discuss the care and progress of young people on the caselist. That way, the expertise of Barrett is valued and used to inform the care/case management of these kids before they get worse. This team would have a state-wide caseload. The Health Minister stated in a radio interview in July, how eager he was to utilise the potential and benefits of E-consultations so this might be something he would support.

(iv) Establish Barrett (Tier 3 Service) with onsite schooling with a Research and Advisory Function

Refer to attachment

(v) How did they get here?

When a young person presents to an acute facility or is admitted to Barrett, the question should be asked – **HOW DID THEY GET HERE?** And in one way, it probably is, through the gathering of patient information on admission to get a case history, but not in order to work out which part of the system failed – what are the gaps that allowed this young person to deteriorate into this state? **And not so something can be done about it.** This information needs to be gathered and analysed to work out where the gaps are and why young people end up in this situation, in most case, despite desperate efforts by their parents/carers. Was it inexperienced staff, lack of service – all of the above issues recorded in question two. However there is a problem with this. Parents/carers tell clinicians, therapists, support services, doctors. And if you are lucky, you will get an understanding one who will really **hear** you and view you as their most important resource – someone who knows their patient better than anyone else. But in so many cases – as you would find if you asked parents/carers – they have to fight, advocate, push, pester. This is exhausting and heartbreaking.

Imaging your child having attempted suicide several times and then the only way you can get your child into the specialist care they so obviously need is by advocating to your federal MP to pressure the Health Minister to do something so your child doesn't die. Imagine being a parent who has told specialists over and over again what they see their child do, how they see their child behave, how their child won't leave the house – won't get off their bed because of the anxiety that they will vomit: and then being looked at as a though you are 'helicopter parent'; a 'Munchausen by Proxy' candidate; a neurotic, deluded possibly menopausal woman with her own mental health problems who is misunderstanding

adolescent behaviour. Parents/carers fight. They get tired: exhausted. They will dissolve into tears when they tell you about their children – not because they are coming unhinged – but because they love them and it devastates them to see their child spiral into despair; because they've sat beside a hospital bed after a suicide attempt and wondered if their child would live; because they listen to their child banging their head on the metal bed frame out of frustration because they can't understand why they can't be 'normal' and they don't understand why they feel the way they do. You would cry too. There is a huge push to end the stigma surrounding Mental Illness, but there should also be a campaign to end the judgement, blame, preconceptions, against parents/carers. Obviously there are parents that don't care, abuse and neglect and fail to support their children. But don't demonise all parents and automatically assume the worst. There is an enormous and devastating impact on the parents/carers and families of young people with severe and complex mental health problems. They need support, understanding, and they know their children.

Imagine if you finally found somewhere that could help your child after months, sometimes years of trying. Imagine if they were admitted and you started seeing changes that gave you hope. Imagine then, that you were told it was closing down.

4. Other comments for consideration.

(i) Barrett/Tier 3 and other services shouldn't be created/adjusted as the Minister is trying to do before the Mental Health Commission is finished with their process. In fact there should be a unique commission process specifically for youth mental health services, and how they might then integrate with adult services that should run parallel to the Commission's main process – it is too big to do in one group. Youth services will get lost again without a specific plan and process of their own. Especially if the government is emphasizing prevention and early intervention. In Western Australia, the WA Commission for Children and Young People commissioned an Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia. The subsequent report (2011) specified that "The Inquiry has recommended that the **Mental Health Commission** become the lead coordinating body for the improvement of service delivery for children and young people's mental health – by developing a comprehensive and strategic plan for the mental health and wellbeing of children and young people and leading a whole-of-government implementation process:

Recommendation 10

"A whole-of-government collaboration to improve the mental health and wellbeing of children and young people across the State be led by the Mental Health Commission. (Page 63)". Queenslanders see this as an appropriate process, and singling out a specific service for closure WITHOUT such a thorough procedure is in complete contradiction to best practice.

On a National level, the National Mental Health Service Planning Framework (NMHSPF) Project, an initiative of the Fourth National Mental Health Plan, will provided its finalised Care Packages and Service Mapping on 30 September 2013. This is one part of a much larger process to develop national modelling for mental health services – involving consumers and community in the process – which will have implications for models of delivery and funding. The NMHSPF project is joint-led by the NSW Ministry of Health and Queensland Health. What implications, if any, does this National process have for the whole-of-government plan to be developed by QMHC, and if a Care Package describing service models for 12-17 year olds

has been designed, should Queensland wait to see what models are proposed before undertaking significant changes to youth mental health services, especially since funding will be tied to these models based on population demand for each service?

(ii) Health needs of any type become complex when they are neglected. If you leave any condition without treatment or inadequate treatment, eventually it will become chronic, acute and serious. In many cases, it will become life threatening. While there is significant recognition of this in much of the health sector (eg all forms of cancer, diabetes, heart conditions) with extensive methods and availability of 'early detection', low grade intervention and preventative treatments, this is still not a priority in adolescent mental health.

As with many human services, it is more appropriate and cost efficient to provide services in the community setting through localised community based organisations and agencies. These rely on funding from all three levels of government. Services such as CYMHS could be developed into portal services that are much better resourced and become a trusted first point if a young person shows any sign of an emerging mental health need.

The focus needs to be on genuine and fool proof intake and assessment and then coordination of a referral plan to the most suited treatment/program/specialised services for each individual need. This will require those services to exist. This requires reliable and ongoing funding and a reversal in the funding cuts that have been implemented in the last 18 months. If the aim is to diminish the need for complex care, then the action must be on the preventative and early response services.

Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK Patrick McGorry, Tony Bates and Max Birchwood. (British Journal of Psychiatry 2013)

Kim-Cohen, J. et al 2003, cited in Department of Health, Mental Health Division (England) 2010, New horizons: confident communities, brighter futures: a framework for developing wellbeing, England, p. 26.

Well meant or well spent? Accountability for the $8 billion of mental health reform, Rosenberg et al. 2012

http://www.ccyp.wa.gov.au/files/MentalWellbeingInquiry/CCYP%20Mental%20Health%20Inquiry%20-%20Report%20to%20Parliament.pdf

Utilising the Barrett Centre for Research and Specialist Advisory Centre ... an added benefit of sustaining/expanding the Barrett model

The Fourth National National Mental Health Plan states that *"services should be informed by the available evidence and look to innovative models as examples of service improvement."* Therefore, with 30 years of data and information that could be utilised for retrospective studies, Barrett is in a unique position to study a range of aspects of adolescent mental health and mental illness. It is therefore consistent with National mental health objectives. With its move to governance by Children's Health Queensland, the research and education function of Barrett would fit well within Children's Health Queensland Strategic Plan, under Strategic Direction 6 i.e. *"excellence in paediatric health care through innovation, research, education and the application of evidence-based practice across daily processes and systems. We will embrace invention and innovation to continually improve the value of our service."*

Study areas could include self-harming, social anxiety (in particular its role in social isolation and exclusion) and benefits to recovery of the 'community' environment created at Barrett. Barrett could link with other institutions/research facilities to become part of larger studies or focus on research in the unique environment – where adolescents engage in a range of activities and environments (including Education) always supervised and observed by staff.

Information gathered from Barrett could be used to inform practice and treatment in many other areas. With such an emphasis on prevention and early intervention in National and State mental healthcare objectives, Barrett could make a valuable contribution by analysing the circumstances under which adolescents find themselves admitted to Barrett and use this information to develop strategies and processes for prevention, early intervention and even identification of risk factors. I acknowledge that an extended treatment facility is an expensive model to fund, however the capacity for research within such a facility to inform practice and structure of models for earlier intervention could prove invaluable – and provide savings in the long term, particularly if this could result in the reduction of young people requiring extended treatment. That research could improve the effectiveness of earlier intervention, improving outcomes and recovery for adolescents at an earlier stage. That would both reduce the cost of service provision and reduce waiting lists for services offering more intensive/inpatient care – and importantly save young people from progressing further through the mental health system than they would otherwise do.

Barrett is also in the unique position of being able to observe the effects of treatment on and the associated changes that take place in adolescents who transition from full-time inpatient to day patient. Barrett can continue to monitor the progress of day patients and adjust treatment level and type accordingly. Follow-up studies on young people after discharge could identify successes and reasons why others may need to return to other forms of care. Observations and knowledge gained from these observations is quite unique and could be applied to a range of treatment settings.

There is opportunity to build on and improve the treatment program:, family units, for those who live outside the metropolitan area, could be attached to Barrett to better facilitate the involvement in and support of parents in their child's treatment, such as is available for parents of children with other health problems (Ronald McDonald House). Barrett could develop models for interaction with young people via this E-Health/E-Therapy. This could be integrated into the full range of treatment and therapy programmes for young people who are on leave from the centre, follow-up of recently discharged patients, even to commence contact with young people on the waitlist and their clinicians, therapists and family/supports. Group therapy and professional development could be

delivered to rural and regional areas, facilitated by local staff. Offering the facility for family contact would enable to young people to have a more meaningful interaction with their families, especially when they are a long way from home. E-health modes could be used to facilitate contact/consultation with rural/regional clinicians who request or require consultation with the specialist team at Barrett, even so far as establishing case conferencing for young people on the waitlist or for consideration for referral.

Introducing promotion and early intervention strategies into schools and training school staff in the identification of students at risk of mental health problems is an avenue for reducing the stigma of mental health issues and increasing the opportunity for early intervention. In Priority Area 2 of the Fourth National Mental HealthWork one of the actions is to " work with schools..to deliver programs to improve mental health literacy and enhance resilience." One of the "indicators for monitoring change is the proportion of primary and secondary schools with mental health literacy component included in curriculum." The Barrett School could provide training opportunities for education students, such as the treatment side of Barrett does now for a range of clinical and therapeutic students. The Education staff working in the Barrett School possess many years of experience working with adolescents in an education environment. One of the great tragedies, should Barrett close, is that the collective knowledge and experience of the team will be lost. With mental health issues so prevalent in adolescence, this expert education team are in a position to be able to document practices and strategies and share this information throughout the state education system – a valuable opportunity that should not be lost. The educators at Barrett recognise this and have commenced an action research project on *Pedagogy for adolescents with psychiatric disorders* and presented at a conference in Amsterdam. In addition, the teaching group could link with other organisations to participate in studies and/or contribute to the community knowledge base of mental health issues in schools.

The Queensland Health Minister, during interviews at the time he announced the closure of Barrett Adolescent Centre, repeatedly claimed Barrett had done a good job over the years. *Why then, close it?* The wealth of knowledge and expertise at Barrett is extremely valuable and it has been a successful facility. Why not build on the important role it has played in treating a unique and specific group of adolescents, whose needs will not be adequately met by community-based models. It is intended that the Mental Health Commission will "*promote greater use of research and evaluation in service development and delivery.*" It is to develop a whole-of-government strategic plan that in part "*drives innovation and best practice through knowledge sharing, research and evidence-based policy and practice.*" Barrett *with a research function* could certainly aspire those QMHC objectives. Surely there is scope even for Barrett to link with University of Queensland and/or other Tertiary institutions and the Queensland Centre for Mental Health Research? Orygen Youth Health in Victoria very successfully combines a research function with a youth mental health service model and it attracts significant funding – another $18 million from the new Federal Government for its research into youth mental health issues and service delivery. There is no reason that the Barrett Research facility could not be in the same position.

There is a considerable and increasing amount of research into community based/collaborative models of care and but little research on Tier 3 service provision for severe levels of mental illness other than acute care – certainly no research on a unique facility such as Barrett that combines treatment and rehabilitation and education with community connection, from a 'recovery platform'. If Barrett is being closed because of a lack of evidence in contrast to that existing to support community based models of care, that is, in essence, a false premise, as there is a general lack of any research and any evidence, supportive or otherwise. Can the government guarantee that the recovery and social inclusion for this cohort of youth with severe mental illness will be better under

new models of care – what measures did they use? Does the government know what the rates for re-engagement in education, training, employment and socially are for these young people – how did they measure those? Is the government certain that readmissions and relapses will be reduced under the new model – if so, how did they arrive at these figures? These questions and many others could be answered if the Barrett model could incorporate with a research facility. The argument for a new model to replace Barrett must be based on more than just being 'contemporary'. There must be some justification based on outcomes. There is significant justification for the existence of Barrett model within the National Mental Health Framework and the Fourth National Mental Health Plan. Rather than close in favour of new options, the government should be valuing the unique resource and knowledge base of Barrett and building on its significant foundations and looking at ways to utilise this valuable knowledge.

We urge those undertaking the future planning for mental healthcare across Queensland to consider the opportunities that retention of the Barrett Centre affords – not simply in providing the ongoing successful treatment of young sufferers of severe mental illness (there is no doubt that that is ample reason for the centre's existence), but as a vital tool in the research that could define future models beyond Queensland and even Australia. To neglect this valuable resource and the role it could play in the future not only ignores the needs of current adolescent sufferers of mental illness, but those in the generations to come.

Meeting Agenda

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Date:	4 November 2013
Time:	9am – 10.30am
Venue:	Seminar Room, CYMHS, Cnr Roger and Water Streets Spring Hill *(parking via Roger St entrance)*
Video/ Teleconference Details:	Details will be provided on request ***** Please advise secretariat if you want to dial in*****

Chair:	Judi Krause	Divisional Director CYMHS CHQ HHS
	Stephen Stathis	Clinical Director CYMHS CHQ HHS
Secretariat:	Ingrid Adamson	SW AETR Project Manager
Attendees:	Amelia Callaghan	State Manager Headspace
T/C (not video)	Cara McCormack	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
	Deborah Miller	A/Executive Director Office of Strategy Management, CHQ HHS
	Elisabeth Hoehn	A/Clinical Director CYMHS CHQ HHS
	Josie Sorban	Director of Psychology, CHQ HHS
	Laura Johnson	Project Officer, SW AETR, WM HHS
	Leanne Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
	Marie Kelly	A/Director Planning and Partnership Unit, MHAODB
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
T/C		Carer Representative
		Consumer Representative
Apologies:	Amanda Tilse	Operational Manager Alcohol, other Drugs & Campus, Mater Hospital
Observers / Guests:		Current , representing Submission Current , representing Submission Current , representing Submission

* Attachments accompany this item; papers to be tabled if available

1.	**Presentations**	
Item no	**Item**	**Action Officer**
1.0	**Parents' Submission** (9.30am to 10am)	Chair

2.	Meeting Opening	
Item no	**Item**	**Action Officer**
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous meeting *(attached)*	Chair
2.4	Statement of achievements	Chair

3.	Business Arising from previous minutes	
Item no	**Item**	**Action Officer**
3.1	• Nil	

4.	Matters for Decision	
Item no	**Item**	**Action Officer**
4.1	• Nil	

5.	Matters for Discussion	
Item no	**Item**	**Action Officer**
5.1	Visit to NSW Walker and Rivendell Units	SS / JK
5.2	Project staffing allocation post January 2014	Chair

6.	Standard Agenda Items	
Item no	**Item**	**Action Officer**
6.1	**Service Options Working Group Update** • Status Update • Case Scenario Summary	SS
6.2	**Clinical Care Transition Panels Update** • Status Update	LG
6.3	**Financial and Workforce Planning Working group Update** • Status Update	LG / IA
6.4	**Risk Management** • Nil changes to the Risk Register	IA
6.5	**Progress of key milestones and deliverables** • Monthly Status Report	IA
6.6	**Other business**	

7.	Matters for Noting	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence** • ABC – World Today Interview	SS

8.	For Information (papers only)	
Item no	**Item**	**Action Officer**
8.1	Following discussions with Sandra Radovini, from Victoria, her visit is being scheduled for early December. An agenda for her visit is under development.	LG

Next Meeting

Date: Monday 18th November 2013

Time: 9am – 10.30am

Venue: Seminar Room, CYMHS Cnr Roger & Water Streets Spring Hill

Children's Health Queensland Hospital and Health Service
Statewide Adolescent Extended Treatment & Rehabilitation Implementation
Steering Committee Action Item Register
(Status Indicators: Red = Significant delay, Amber = Slight delay, Green = On Track and Blue = Completed)

Meeting Date	Action Item #	Previous Meeting Reference	Action Item	Action Officer	Due Date	Status Update	Status
09/09/13	3.3	Working Group Membership	Contact each working group to establish membership and convene meetings	Leanne Geppert	23/09/13	First meeting 22/10/13 - CE Oversight Committee direction required	
09/09/13	4.2	Committee Action Plan	Finalise Project Plan; and develop Risk Register and Comms Plan	Ingrid Adamson	21/10/13	Project Plan endorsed and Risk Register developed; Comms Plan still under development	
09/10/13	3.1	Working Group Update	Email consumer scenarios to WG1 representatives for input	Leanne Geppert Stephen Stathis	21/10/13	Completed	
09/10/13	3.1	Working Group Update	Present to the Child and Youth Statewide Advisory Group at the end of the month	Stephen Stathis	31/10/13		
09/10/13	3.1	Working Group Update	Establish web page for SW AETR Initiative - part of CHQ Communications Strategy	Ingrid Adamson	31/10/13		
09/10/13	3.4	Correspondence	CHQ to finalise communications strategy	Ingrid Adamson	21/10/13	Underway	
09/10/13	5.1	Victorian Visit	Confirm travel dates with Sandra Radovini	Leanne Geppert	31/10/13	Underway	
21/10/13	5.1	Parent Submission	Circulate Parent Submission to Committee Members	Ingrid Adamson	30/10/13	Completed	
21/10/13	5.1	Parent Submission	Circulate consumer engagement framework/Committee guidelines	Ingrid Adamson	30/10/13	Completed	
21/10/13	6.1	Service Options Working Group	Present findings from Case Scenario responses	Stephen Stathis	04/11/13	Underway	
21/10/13	6.2	Clinical Care Panel	Provide status update for monthly report	Laura Johnston	31/10/13	Completed	
21/10/13	6.5	Project Milestones	Present completed Gantt Chart	Ingrid Adamson	04/11/13	Underway	

Minutes

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Date:	04/11/2013	Time:	09:00am	Venue:	Rm 30 CYMHS Cnr Rogers & Water Streets, Spring Hill

Chair:	Divisional Director CYMHS CHQ HHS (JK) Clinical Director CYMHS CHQ HHS (SS)
Secretariat:	SW AETR Project Manager (IA)
Attendees Teleconferenced	A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG) SW AETR Project Officer (LJ) A/Executive Director Office of Strategy Management, CHQ (DM) Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) A/Clinical Director CYMHS (EH) Director of Psychology, CHQ HHS (JS) [redacted] A/Director Planning & Partnership Unit MHAODB (MK) State Manager Headspace (AC)
Apologies	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (CM) Operational Manager Alcohol, other Drugs & Campus, Mater (AT)
Observers/ Guests:	[redacted]

Item No	Topic	Action	Committee member	Due date
1.	**Presentations**			
	Parent Presentation • [redacted] and [redacted] presented to the Committee. They also distributed some handouts for the Committee's Information • After the parents left, LG advised care planning is underway and that there is no imperative to have children out by 13th December. This date is the end of the school term. LG advised that, if at the end of January, they still have consumers then they will keep the BAC doors open to care for them.	Distribute handouts provided by parents	IA	8/11
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	LG, EH	
2.4	Statement of achievements • LG wanted to acknowledge that the two districts are working well together as issues arise and appreciates the collaboration.	Covered below	Chair	

Item No	Topic	Action	Committee member	Due date
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	Nil			
4.	**Matters for Decision**			
4.1	Nil			
5.	**Matters for Discussion**			
5.1	• JK has had communication with Lesley van Schoubroeck and she advised that she is receiving questions regarding BAC and asked if it would be ok to distribute the BAC Fact Sheets to her. LG agreed to add her to the distribution list so she receives the latest fact sheets as they are produced.	Add Lesley to distribution list	LG	8/11
	Visit to NSW Walker and Rivendell Units • JK shared information regarding the recent site visit to NSW.			
	• A site visit report will be circulated to the steering committee.	Distribute site visit report	IA	18/11
	• RH raised the question: what are the resource differences for NSW families compared with QLD? JK stated further information could be collected on this.	Seek further information regarding NSW services	JK/SS	18/11
	• EH noted that the discharge experience at BAC has been challenging – not in so far as families not engaging but rather getting them involved in the ongoing management of their child post discharge. • It was noted that education is a critical element in this and we need to look at how this is done. For example, Mater and RCH schools are identified as leaders nationally – need to look at what they are doing well. Also need to look at how Education complements the mental health service.	Explore education elements as part of service model	SS	Ongoing
	Project Staffing Allocation • Due to time constraints this item was not discussed.			
6.	**Standard Agenda Items**			
6.1	**Service Options WG Update** • Due to time constraints this item, and the Case Scenario Responses, were not discussed			
6.2	**Clinical Care Transition Panels Update** • LJ briefly covered the Panel Status Report provided to the Committee			
6.3	**Financial and Workforce Planning WG Update** • Noted that agreement was not reached between WM HHS and CHQ HHS regarding the purpose and ToR for the WG. • DM noted both HHSs needed to work together to collate current financial information and to inform workforce and financial requirements for future service options. • Direction is now sought from the Steering	Distribute Terms of Reference with comments and WG Minutes to Steering Committee for review	IA	8/11

Item No	Topic	Action	Committee member	Due date
	Committee			
6.4	**Risk Management** • Nil risks to note			
6.5	**Progress of key milestones and deliverables** • An update on progress will be provided through the Project Gantt Chart at future meetings – still under development			
6.6	**Other Business** • Nil			
7.	**Matters for Noting**			
7.1	**Major correspondence** • Noted that several interviews have been held with ABC-World Today, including two with parents, one with SS on Wednesday 30th and one with Sharon Kelly on Friday 1st			
8.	**For Information**			
8.1	• It was noted that Sandra Radovini's visit will now take place in mid-December.			
Next meeting: Monday 18th November 2013, 9am – 11am, CYMHS Spring Hill.				

ENDORSED BY:

Signature: **Date:** /09/13

Name:
Position: