Acute Adolescent Inpatient Unit Model of Service

March 2015

Queensland Public Mental Health Services

Acute adolescent inpatient unit – model of service

1. What does the service intend to achieve?

AAI Units provide 24 hour acute mental health assessment and care to adolescents, in a safe, structured, highly supervised and supportive environment during an acute episode of mental illness. Admissions occur when an adolescent (the consumer) presents with mental illness, serious mental health problems with associated co-morbidities, or is at risk of developing such, and who cannot be adequately supported in the community. AAI Units operate on the premise that inpatient treatment is only one phase of the treatment process that assists consumers, families and/or carers recover their health, well being and developmental potential. Child and youth mental health services ensure that young people are treated in the least restrictive environment possible. This recognises the need for safety and cultural sensitivity, with the minimum possible disruption to their family and educational, social and community networks.

The focus of care is on the stabilisation of acute symptoms, the provision of diagnostic formulation, and a range of recovery focussed treatments within a developmental framework. Recommendations regarding interventions are also facilitated in collaboration with a range of community service providers. The engagement of consumers, families and/or carers' in collaborative recovery focussed treatment planning is paramount. This enables the consumer to build on their strengths, enhance their self esteem, build on opportunities for social inclusion and promote recovery focused outcomes upon discharge.

AAI Units are gazetted as authorised mental health services (AMHS) in accordance with Section 495 of the *Mental Health Act 2000*. Other inpatient and specialist health units are also gazetted to enable access to other health services whilst an inpatient. AAIU exist within the spectrum of integrated mental health services and other health services.

The key functions of AAI Units are to:

- deliver acute mental health care and crisis intervention to consumers in a safe and therapeutic setting
- provide inpatient multidisciplinary care , diagnostic assessment, treatment and evidence informed clinical interventions, including recovery and discharge planning for consumers generally aged between 13 and 17 years
- arrange, coordinate and support access to a range of services for consumers, their families and/or carers to ensure seamless service provision
- provide a therapeutic milieu with an emphasis on positive communication, interactions and healthy relationships
- provide a range of evidence informed therapies within a neurobiological developmental framework.

AAI Unit functions contribute to:

- providing a safe environment for consumers, staff and visitors
- supporting consumers to maintain hope, progress in their recovery and promote resilience
- enhancing interpersonal skills and improvements in family and peer relationships
- supporting consumers, families and/or carers across the broad continuum of care including facilitating smooth transition to other appropriate services
- providing high quality, recovery-oriented care to consumers, families and/or carers
- facilitating post discharge support and follow up

AAI Units will be able to:

- manage psychiatric emergency situations safely and effectively
- provide evidence informed assessment and treatment services
- provide appropriate levels of observation, supervision and individual support
- provide education, information, and support to consumers, families and/or carers
- establish linkages with local services to facilitate the referral and support of consumers, families and/or carers after discharge
- formulate care plans with the consumer, family and/or carer, and community supports, that address their needs upon being discharged from hospital
- involve consumers, and where appropriate, family and/or carers in all phases of care and support them in their navigation of the mental health system
- discharge consumers in a timely manner and enable a safe return to a community-based setting.

2. Who is the service for?

AAI Units are provided for consumers, generally aged 13 to 17 years, who are acutely psychiatrically unwell and require 24 hour clinical support and containment in a safe and structured environment. The service is intended for consumers with complex and severe mental illness, usually associated with complex psychological or social factors. Consumers who are at risk of suicide or self harm, or pose a risk to others, and cannot be adequately managed in the community setting are admitted to AAIU.

3. What does the service do?

AAI Units are delivered as part of an integrated mental health service system that includes community mental health services, non-acute inpatient services, consultation-liaison psychiatry, and a range of specialist positions, teams and state-wide services. The key components of an AAI Unit are defined here at table 1. These components are essential for the effective operation of an AAI Unit.

Table 1:

Key component	Key elements	Comments
3.1.0 Working with other service providers	**3.1.1** Strong partnerships are developed with other local health and mental health service providers, education services, the Department of Communities, Child Safety and Disability Services, Department of Housing and Public Works, the Department of Justice and Attorney General and NGO's,	• The AAIU will work in close collaboration with other service providers to meet the individual needs of the consumer, and their family and or/carers. • Formal agreements will be developed where possible. • Clear, regular contact and communication processes are maintained for all phases of care. • Advice, education and support on mental health issues are provided to other services. • The AAI Unit will work with Service Integration Coordinators (SIC) to establish efficient, collaborative partnerships with local service providers and key clinical and non-clinical support services, including housing/accommodation, vocational,

Key component	Key elements	Comments
		financial and social supports. • When more than one service provider is involved in service delivery, AAIU will initiate and participate in discussions around which service will adopt the role of lead agency Hyperlink: • Community Visitors Program
	3.1.2 There is active engagement with primary health care providers to meet the general health care needs of the consumer.	• Shared care arrangements with General Practitioners (GPs), mental health nurses working in GP practices, private psychologists and counsellors are encouraged. • All efforts will be made to record a nominated GP in CIMHA for 100 percent of consumers.
	3.1.3 When consumers have specific needs (e.g. sensory impairment, Aboriginal and Torres Strait Islander populations, Culturally and Linguistically Diverse [CALD] Backgrounds, dual disability), AAIU will engage the assistance of appropriate services to ensure that communication and cultural issues are addressed.	Hyperlinks: • Interpreter services • Hearing impaired/deafness • Transcultural mental health • Indigenous mental health • Multicultural mental health • Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 • Department of Communities - Disability and Community Care Services
3.2.0 **Referral, access and triage**	**3.2.1** Admissions to the AAIU can occur from a range of referral sources including Community Child and Youth Mental Health Services (CCYMHS), Evolve Therapeutic Services, Acute Care Teams, Emergency Departments (ED), other mental health inpatient units, other wards, and private psychiatrists.	• Referrals to the AAIU will occur through a single point of entry. An intake officer or case manager can arrange direct admission to the AAIU. • Clear information regarding referral and access processes will be available to referrers. • Information on referral pathways, and admission criteria is available in the following: Hyperlink: • Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units, 2010 • All referrals will be communicated verbally and in writing, using standardised clinical documentation. • The referrer will provide an assessment that includes: – a mental state examination – risk assessment

Key component	Key elements	Comments
		– presenting problem – substance use – medication history – physical status, and medical clearance if indicated – formulation – provisional diagnosis – *Mental Health Act 2000* status – goals for admission – accommodation and support details • Wherever possible copies of completed assessment tools will accompany referrals, and be scanned or recorded in CIMHA. • All referral information will be recorded and/or scanned into CIMHA on admission.
	3.2.2 Consumers can be admitted directly from the Mental Health Court, a watch-house or correctional facility pursuant to the *Mental Health Act 2000*, or after assessment and referral by prison mental health services, court liaison services or an Acute Care Team service.	Hyperlinks: • *Mental Health Act 2000*. • *Mental Health Act 2000 Resource Guide* • *Mental Health Act 2000* Forensic Provisions • Mental Health Review Tribunal • Mental Health Court
	3.2.3 The decision to admit to an AAI Unit is made by a consultant psychiatrist or an appropriately trained medical delegate who is under the supervision of a consultant psychiatrist.	• The decision to admit will take into account the: – nature of the problem – acuity and severity of the disturbance and associated risks – complexity of the condition (including co-morbidity) – extent of functional impairment – risk assessment – benefits and risks associated with admission – geographical proximity and referrer's goals of admission – safe transfer from rural and remote sites – the time of day of the referral – availability of other appropriate services. • If the decision is not to admit, alternatives to admission will be provided to referrers, by the intake officer after consultation with the consultant psychiatrist. Hyperlink:

Key component	Key elements	Comments
		◦ Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units, 2010
	3.2.4 All referrals are triaged when received and admissions are prioritised according to clinical need.	• Urgent classification will be given to young people who are suicidal, psychotic, severely disturbed and traumatised and considered to be at significant risk of harm to themselves, others, or the community Hyperlink: • Child and Youth Mental Health Services Consumer Intake form
	3.2.5 Admission usually occurs following a range of less restrictive interventions such as: – CCYMHS assessment and treatment – enrolment in a day program – for rural and remote areas, admission to the nearest hospital, with mental health care provided by adult mental health or paediatric staff. This can be in consultation with local child and youth services (Clinical Service Capability Framework (CSCF) level 2, 3, and 4 services) or consultation with CSCF level 5 or 6 facilities.	• Where possible, admissions are conducted as part of a collaborative assessment and treatment plan between AAIU, CCYMHS, ED and consultation liaison psychiatry services provided to general hospital wards. Hyperlink: • Clinical Service Capability Framework
	3.2.6 A general information and orientation pack will be provided and explained to all consumers, families, and/or carers on admission.	• The pack will include information on: – treatment and support options – the multidisciplinary team role and function outline – assessments, family meetings and treatment planning – ward and school programs – contact phone numbers – visiting hours schedule – general ward information, including policies on smoking, mobile phone use, property, consent, ancillary services – *Mental Health Act 2000* statement of rights and responsibilities for involuntary patients – consumer, families, and/or carer information sheets on the use of seclusion and restraint – mechanisms for providing feedback – National Outcomes Casemix

Key component	Key elements	Comments
		Collection activities – community support services – culturally diverse orientation material specific to the unique populace of the local service. Hyperlink: National Standards for Mental Health Services
3.3.0 Assessment		
	3.3.1 On admission, a comprehensive clinical assessment will be undertaken including: • the presenting problems • past interventions • developmental history • relationships • attachment and history of trauma • mental state examination • medical history • alcohol and other drug use • cultural factors • legal issues including custody and guardianship • family history • consideration of whether the consumer may be a parent with care responsibilities for infants and children.	• A formulation of the presenting problems will be developed and contribute to a diagnosis and discussion of recovery goals. The formulation will be holistic and include: – symptoms – relationships – attachments – family dynamics and functioning – school performance – developmental trajectory – co-morbidities – protective factors. • Assessment will specifically assess the ability of the young person and available supports (including formal and informal carers) to maintain function and prevent relapse. • Assessment and care planning is a continuous process throughout the admission period. Hyperlinks: • Child and Youth Mental Health Services Consumer Assessment form • Child and Youth Mental Health Services Drug Assessment Problem List
	3.3.2 Every effort will be made to limit the repetitive nature of the information gathering process for the consumer.	
	3.3.3 Assessment will involve input from family, and/or carers and key service providers as appropriate. The family and/or carer assessment will include: • the history of the presenting complaint • developmental history	• Consent to disclose information and to involve key stakeholders, and family and/or carers in the consumer's care will be sought in every case. • Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. Hyperlinks: • Suite of clinical documents

Key component	Key elements	Comments
	• the family and/or carers perspectives of the issues • transitions and life cycle changes in the family • relationships • attachment and history of trauma • parenting styles • limit setting • roles and responsibilities within the family • emotional climate of the family • legal issues.	• Queensland Health Child and Youth Mental Health Services State-wide Standardised Suite of Clinical Documentation User Guide • *Hospital and Health Boards Act 2011* – Part 7 Confidentiality • Right to Information and Information Privacy • Information sharing between mental health workers, consumers, carers, family and significant others. • *Mental Health Act 2000* • *Mental Health Act 2000 Resource Guide* • *Mental Health Act 2000* Forensic Provisions • Mental Health Review Tribunal • Mental Health Court • Forensic Patient Management Policy and Procedures • Policy and Practice Guidelines for the Care of Disability Forensic Patients
	3.3.4 Engagement will occur with an Aboriginal and Torres Strait Islander Mental Health Worker or Hospital Liaison Worker to support and assist with the facilitation of information for a comprehensive assessment of Aboriginal and Torres Strait Islander consumers.	• Where an Aboriginal and Torres Strait Islander mental health worker is not available, identification of an appropriate and recognised Aboriginal and/or Torres Strait Islander person is integral in addressing the cultural needs of the consumer. Hyperlinks: • *Guideline for Mental Health Service Responsiveness for Aboriginal and Torres Strait Islander People*
	3.3.5 The Cultural Information Gathering Tool will collect cultural information relevant to the individual and that may impact on the consumer's presentation, diagnosis, treatment and recovery.	• Aboriginal and Torres Strait Islander Cultural Information Gathering Tool • User Guide for the Aboriginal and Torres Strait Islander Cultural Information Gathering Tool.
	3.3.6 Risk assessments will occur: • on admission as part of the comprehensive clinical assessment • prior to transfer to any other unit/facility • prior to and following periods of leave • prior to discharge	• Comprehensive risk assessments will include: – harm to self – vulnerability – risks of physical or emotional deterioration – triggers to symptoms and/or behavioural disturbance – absconding – non-adherence to treatment

Key component	Key elements	Comments
	• where clinically indicated due to change in presentation or every three months.	– harm to others – child protection issues. • Specific areas of risk may be evaluated more frequently as outlined in the consumer's treatment plan. • Risk assessments will be recorded in the clinical record, using the clinical risk screening tool. • The discharge risk assessment will be recorded on the discharge summary in CIMHA. • Risk management protocols will be consistent with Queensland Health policy. Hyperlinks: • Child and Youth Mental Health Services Risk Screening Tool • Guidelines for Suicide Risk Assessment and Management
	3.3.7 Child safety concerns will be identified through risk assessment and addressed in accordance with mandatory requirements.	Hyperlinks: • *Child Protection Act 1999* • Mental health child protection form • Information sharing between mental health workers, consumers, carers, family and significant others.
	3.3.8 A physical examination by a medical officer will be completed on all consumers within 8 hours of admission. This includes consumers admitted via the Emergency Department, directly from community clinics, or from other hospitals.	• For those consumers admitted via the Emergency Department, essential physical health and diagnostic interventions will be undertaken in the Emergency Department prior to admission to an AAI Unit. The outcome of these investigations will be documented in the consumer's clinical record. • Documented evidence of a complete physical health assessment will be included in the consumer's clinical record. Hyperlink: • Child and Youth Mental Health Services Physical Examination and Investigation form • Clinical alerts (e.g. medication allergies, blood-borne viruses) will be recorded in the clinical file and in CIMHA. • Potential physical or oral health problems will be identified and discussed with the consumer, their family and or/carer, the GP, dentist and other relevant primary health care providers. • The consumer, family and/or carers

Key component	Key elements	Comments
		will be actively supported to access primary health care and health improvement. • All efforts will be made to record a nominated GP in CIMHA for 100 percent of consumers.
	3.3.9 Drug and alcohol use will be routinely screened, assessed and documented. Information and advice to address alcohol and drug use, if relevant, will be routinely provided. For some consumers alternative or additional support is required.	• Harm minimisation interventions and motivational interviewing will be available. • Co-occurring alcohol and drug problems will be included in recovery planning. Hyperlinks: • Child and Youth Mental Health Services Drug Assessment Problem List • Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines • Queensland Health Dual Diagnosis Clinical Guidelines • Queensland Health Dual Diagnosis Clinician Toolkit
	3.3.10 Specialised diagnostic assessments may occur to ascertain specific mental health problems and identify evidence informed therapeutic interventions.	• A range of diagnostic assessments will be undertaken in hospital if clinically indicated for treatment and formulation of cases (e.g. CT scan, EEG, Bone mineral density, Psychometric assessments, Endocrinology review). • If not completed during the admission, recommendations regarding further assessments will be provided to community follow up service providers through documentation on the discharge summary and recorded in CIMHA. Hyperlink : • Mental Health Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary • Case Management Policy Framework
	3.3.11 The outcome of assessments will be promptly communicated to the consumer, family and/or carer and other stakeholders (with consent).	• A family meeting will be organised as soon as practicable after admission to communicate the outcome of assessments. Hyperlinks: • *Hospital and Health Boards Act 2011* – Part 7 Confidentiality • Right to information and information privacy • Information sharing between mental

Key component	Key elements	Comments
		health workers, consumers, carers, family and significant others.
3.4.0 Recovery planning and relapse prevention	**3.4.1** An individual recovery plan will be developed with all consumers, and their families and/or carers. Review of progress and planning of future goals will be integrated into the recovery plan.	• Recovery plans are developed on the premise that consumers can and do recover from mental illness. • Children and young people with mental illness may have disrupted developmental trajectories. Recovery plans also need to address their developmental needs. • Recovery plans identify: – available supports – crisis management strategies – therapeutic goals – intervention processes – psycho-educational needs – relapse prevention strategies. • Recovery plans may also include strategies for improving: – family functioning – pro-social and developmentally appropriate interests and hobbies – peer functioning – quality of life (such as time to experience developmentally relevant play and fun) – achievement at school / vocational goals – mastery over the tasks of adolescence. • Recovery plans will be updated at a frequency determined by change in presentation or need, but will be formally reviewed at least three monthly (to review routine outcome measures, treatment progress and to address any change in needs). • All changes to the recovery plan will be discussed at the Multidisciplinary Team (MDT) Review. Hyperlinks: • Child and Youth Mental Health Services Recovery Plan • A National Framework for Recovery Oriented Mental Health Services: Guide for Practitioners and Providers
	3.4.2 The consumer, family and/ or carer are strongly encouraged to have ownership of, and sign, their recovery plans.	• Changes to the recovery plan will be discussed with the consumer, family and /or carer, and relevant service providers.

Key component	Key elements	Comments
	3.4.3 The relationship between the consumer and their family and/or carer and their resilience is important to recovery.	• Whilst adolescents 13 – 17 years gain further independence and mastery to separate from their family and/or carer, evidence suggests that adolescents with mental health problems require support in re-connecting with their parents.
	3.4.4 Every effort will be made to ensure that treatment planning focuses on the consumer's own goals.	• Where conflicting goals exist (e.g. for consumers receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the consumer, and the family and /or carer's goals and values.
3.5.0 Clinical interventions	**3.5.1** All aspects of service will reflect the development of collaborative relationships between consumers, families and /or carers and staff.	• The focus will be on strengths, connectedness, personal involvement, personal choice, empowerment and increasing confidence in accessing the system. • Treatment will be provided in the least restrictive setting that properly balances the consumer's autonomy with their need for observation and treatment in a safe environment. • Teleconference and videoconference facilities will be available for those families and/or carers unable to access the AAI Unit in person.
	3.5.2 Clinical interventions are guided by assessment, formulation and diagnostic processes, using a bio-psychosocial developmental framework.	• Clinical interventions will be evidence informed, sensitive to the consumer, their family and/or carer's needs. • Treatment planning will consider and build on the strengths, resilience and protective factors within the individual, their family, culture and community.
	3.5.3 A range of integrated therapeutic, rehabilitation and recovery-focused interventions will be utilised to reduce the severity of symptoms, and increase resilience to cope with mental health issues. Interventions will be evidence-informed. Efficacy of treatment and progress will be reviewed throughout the inpatient phase of care.	• Interventions may be individualised, group based or generic programs. • **Individualised interventions** may include but are not limited to: – psychological interventions o verbal o non-verbal therapies [e.g. play, adventure, art, yoga and music] o psycho-education. – short term family interventions and psycho-education – individualised behavioural programs – pharmacotherapy – other biological interventions (including electroconvulsive therapy)

Key component	Key elements	Comments
		– referral to community follow up family therapy if indicated. Hyperlinks: • Guidelines for the Administration of Electroconvulsive Therapy • **Group interventions** may include but are not limited to: – a range of tailored group activities, predominantly activity based, targeting areas of psychological and developmental need. • A structured group and educational timetable will be available to consumers, families and/or carers. • **Generic interventions** may include but are not limited to: – maintaining a milieu with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and management of the consumer group to maximise each consumers care – forming appropriate therapeutic alliances – programmes and forums in the community – providing opportunities for activities of daily living, leisure, social interaction and personal privacy.
	3.5.4 The ongoing educational or vocational needs of the consumer are considered in tandem with their clinical and care needs.	• All efforts are made to ensure the least disruption to consumers' schooling or work training. • The AAI Unit school teacher (with consent) will liaise with the home school representative to determine whether the consumer's mental health issues impact on their school performance. • Consultation and planning will occur with the home school teacher/supervisor to facilitate the educational /vocational program during the admission and support reintegration into class/work environment upon discharge. • If a consumer is not currently enrolled in an education/vocational program every effort should be made to facilitate this where appropriate.

Key component	Key elements	Comments
	3.5.5 Carers are integral to the mental health care process. Family members and carers are provided with emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and well being.	• Interventions to promote recovery are as much focussed on engaging with the family and carer as the consumer. • Recovery may include family work and parent-child work. • Time to provide emotional support to the consumer, family and/or carers will be given adequate priority. Hyperlinks: • Carers matter webpage • The consumer, carer and family participation framework
3.6.0 Pharmacotherapy	**3.6.1** Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision making processes between the treating team, the consumer, family and/or carers, and the ward pharmacist.	• The medication goals of the consumer, family and/or carer will be integrated with evidence based clinical treatment guidelines. • Medication compliance is enhanced when rationales for pharmacological intervention are provided to consumers and carers. Hyperlink: • Framework for reducing adverse medication events in mental health services.
	3.6.2 Across all treatment settings, prescribing, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards.	• Medication is reviewed by the AAI Unit medical practitioners at regular intervals, but wherever possible, the consumer, family and/or carer are encouraged to agree to a joint monitoring program with their local Community CYMHS, private service provider or GP. • Monitoring of the consumer for evidence of appropriate and sufficient response to medication will be routinely conducted. • Monitoring of medication side-effects will be routinely conducted with an emphasis on metabolic complications of psychopharmacological treatment. • Strategies focussing on medication adherence will be in place.
	3.6.3 The AAI Unit will ensure that prescribed medication is available on discharge and that the consumer, family and/or carer are advised how to obtain ongoing supplies.	• Supply of prescribed medication for leave or discharge will be coordinated by the AAI Unit and the pharmacy department. • Mental health pharmacists or an appropriate delegate will provide medication counselling to consumers, families and/or carers prior to discharge. • Information providing accurate details

Key component	Key elements	Comments
		of discharge medications will be provided to all healthcare providers involved in the care of the consumer (e.g. GP, Community CYMHS, private psychiatrist, and community pharmacy). Hyperlinks to : • National Inpatient Medication Chart • medication liaison on discharge • safe medication practice unit • therapeutic guidelines-psychotropic • Psychotropic Medication Information Leaflets • Guidelines for the safe use of antipsychotics in Schizophrenia. • Mental Health Services Metabolic Monitoring form • Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary
3.7.0 Crisis management	**3.7.1** There are instances where increased levels of intervention are necessary for the management of symptoms and/or behaviours that increase the risk of harm to the consumer or others.	• All staff will be familiar with specific policy and practice guidelines relating to the management of acute behavioural disturbance within the AAI Unit. • Link state-wide procedure – management of acute behavioural disturbance in children and adolescents (soon to be available). • A specific management plan will address consumer distress and any associated behavioural disturbance. The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every consumer whose risk assessment identifies actual or potential aggression as an issue. The plan will list preventative strategies and de-escalation strategies, and must also be supported by the availability of appropriately prescribed medication. Intervention strategies will include: – increased visual observation – de-escalation techniques – development of a management plan – targeting the specific behaviour or symptom – use of medication to relieve agitation/aggression

Key component	Key elements	Comments
		– utilisation of Non-violent Crisis Intervention/ABM techniques. • Where all other interventions have not had a therapeutic effect, restraint and/or seclusion will be utilised. These interventions are delivered by qualified staff following a comprehensive risk assessment. • All staff working in the AAI Unit will have attended ABM training at the level deemed appropriate to their particular work area. • Families and /or carers are immediately informed of changes in a consumer's behavioural presentation. • In high risk situations it may be clinically indicated for a consumer to be transferred to an acute observation area in an adult mental health unit to ensure the safety of other consumers on the AAI Unit. Hyperlinks to : • *Mental Health Act 2000* Resource Guide • Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services • Policy on seclusion in authorised mental health services [http //qheps health qld gov.au/mhalu/ documents/policies/secl_policy pdf] • Policy on mechanical restraint in authorised mental health services] http://qheps health qld.gov.au/mhalu/ documents/policies/mech_rest_policy .pdf • Mental health visual observations • Guidelines for Operation of Mental Health High Dependency Units in Queensland • occupational violence prevention training [http://qheps.health qld.gov.au/safety/ safety_topics/wpd/ohsms_2_60_38.pd f]. • Searches in authorised mental health services: Clinical practice guidelines

Key component	Key elements	Comments
3.8.0 Clinical review	**3.8.1** All cases will be discussed at a Multidisciplinary Team (MDT) Review at least weekly.	• A consultant psychiatrist or appropriate medical delegate will participate in all MDT Reviews (this may be via telehealth). • All MDT Reviews will be documented in the consumer's clinical record, the consumer care review summary, and in CIMHA. • Where consumers are part of, or are being referred to, another part of the mental health service, MDT Reviews should include an appropriate representative from that treating team. Hyperlinks to : • Child and Youth Mental Health Services Consumer Care Review Summary form • CIMHA business rule
	3.8.2 In addition to the weekly MDT Review, ad hoc clinical review meetings will be scheduled when required (e.g. to discuss cases with complex clinical issues, following a critical event or in preparation for discharge).	• Critical events will be reviewed utilising the clinical incident management implementation standard. Hyperlink to: • clinical incident management implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf].
	3.8.3 The consumer's recovery plan will inform discussion at the MDT Review Any significant changes in intervention will be incorporated into the individual care/treatment plan.	• The viewpoint of the consumer, family and/or carer and their community based supports such as teachers and community mental health case managers will be considered during the reviews. • Outcomes of clinical reviews will be discussed with consumers, families and/or carers. • Any changes to the recovery plan will be made in collaboration with the consumer, family and/or carer. • Structured risk and review processes will be utilised.
	3.8.4 Each consumer's progress will be routinely monitored and evaluated including the use of outcome measures.	• The National Outcomes and Casemix Collection (NOCC) will be used, and other measures will be used, based on each consumer's individual requirements. Hyperlink to : • Mental Health Outcomes Collection Protocol • Outcome and Casemix measures for mental health services
3.9.0	**3.9.1**	• The consumer, family and/or carer will

Key component	Key elements	Comments
Team approach	A multidisciplinary team approach will be provided.	be informed of the multidisciplinary model. • Recognition of the need for Aboriginal and Torres Strait Islander mental health workers within the MDT is integral for consumers, carers and families that identify as Aboriginal and/or Torres Strait Islander descent. • Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. • Clinical, discipline and peer supervision will be available to all staff.
	3.9.2 Clear clinical and operational leadership will be provided for staff and for the team.	• There will be a well defined and clearly documented local process for escalation of discipline specific clinical issues.
	3.9.3 Case loads will be monitored by the nurse unit manager (and other staff as appropriate) to ensure effective use of resources and to support staff to respond to crises in a timely, effective manner.	
3.10.0 Continuity and coordination of care	**3.10.1** Clearly documented mental health service contact information (covering access 24 hours, 7 days per week) is provided to consumers, families, and /or carers, referral sources and other relevant supports.	• Provision of this information will be documented in the clinical record, including the recovery plan and the discharge summary. • Relevant information documents detailing specific service response information will be readily available.
	3.10.2 Every consumer will have a designated treating consultant psychiatrist.	• Recorded in the CIMHA as the internal contact, treating consultant psychiatrist.
	3.10.3 Every consumer will be assigned a principal service provider (PSP).	• Recorded in the CIMHA as the internal contact, PSP. • The PSP is responsible for co-ordinating appropriate assessment, care and review, and completing referral and ongoing care processes. • In the event a consumer identifies as Indigenous, an Indigenous mental health worker or an Indigenous health worker will be assigned to the consumer to participate in ongoing service provision.
	3.10.4 Each consumer will be allocated a	• Consumers will be aware of who their focal nurse is.

Key component	Key elements	Comments
	focal nurse for each shift.	
	3.10.5 The AAI Unit will actively engage with other treating teams in coordination of care across inpatient (acute and non acute) and community settings.	
	3.10.6 Where applicable, the consumer's treating team will be identified in the clinical record, MDT Review documentation and communication will be maintained with the tre3ating team throughout the inpatient phase of care.	• The PSP from Community CYMHS or other treating team will be recorded in CIMHA and remain constant during an inpatient admission.
	3.10.7 Community based supports are included in recovery planning and discharge planning wherever possible.	• NGO service providers who have established (or are establishing) support links with consumers, families, and/or carers will be given access to AAI Units as appropriate. • All community based supports will be co-ordinated prior to discharge. • The process for sharing information will be explicitly documented for each case, taking existing privacy and confidentiality considerations into account. Hyperlink to: • *Hospital and Health Boards Act 2011 – Part 7 Confidentiality* • Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary
3.11.0 **Transfer/ internal transition of care**	**3.11.1** A written handover will be provided on every transfer/discharge occasion.	• Guidelines for internal transfers will be clearly written, and receiving teams will be contacted before transfer is concluded. • A verbal handover will be provided on the day of transfer. • During the transition phase there will be an appropriate plan to ensure smooth transfer of care which includes the early engagement of all service providers in ongoing care. Hyperlink to: • Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary

Key component	Key elements	Comments
	3.11.2 Disengagement with the AAI Unit will only occur after the receiving team and the family and/or carers have been contacted regarding follow up care arrangements.	• Consumers admitted to an AAI Unit outside of the HHS that they reside in will be treated in that AAI Unit, and any decisions regarding a transfer back to their area, either to inpatient or community care, will be based on the clinical needs of the consumer. • Policies and procedures for internal transfers will be clearly written, and receiving teams will make strenuous efforts to establish contact within a reasonable time period. • AAI Unit and Community CYMHS staff will negotiate which service will contact the family and/or carer regarding follow up appointment times, depending on individual receiving team's processes around intake. • A feedback mechanism is in place so that the referral agency informs the referee if the consumer fails to attend arranged follow up. The referral agency will follow internal processes when patients do not attend follow up appointments.
	3.11.3 Local protocols for out of area transfers will be mutually agreed and documented.	• Hyperlink to Inter-District Transfer policy when available • Information on inter-HHS transfers between CYMHS is available in the below document. Hyperlink to : • Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units, 2010
	3.11.4 Where possible, consumers will not be transferred to another HHS during crisis.	• Where transfer is unavoidable, both services need to make direct contact and ensure safe transfer (service capability will be considered). • Appropriate crisis plans will be prepared with the consumer, family and/or carers.
	3.11.5 Consumers, family and/or carers will be informed of transfer procedures.	
	3.11.6 Consumers being transferred under an Involuntary Treatment Order will remain the responsibility of the transferring service until the first medical assessment is completed.	• Clear arrangements for contact with consumers by the receiving AMHS should be established where a consumer is being transferred from an inpatient facility or from one community facility to another.

Key component	Key elements	Comments
3.12.0 Discharge/ external transition of care	**3.12.1** Planning for discharge from an AAI Unit will commence at the time of admission. Consumers will be discharged promptly, as clinically indicated and in accordance with their individual recovery plan.	• Consumers, their families and/or carers, the referrer and other key stakeholders will be actively engaged in discharge planning from the time of admission. • Discharge planning will be a routine component of each clinical review process. • Consumer, their family, and/ or carer will be asked to sign their discharge plan. • It is highly recommended that the involvement of Aboriginal and Torres Strait Islander mental health workers is prioritised for transfer/discharge of consumers of Aboriginal and Torres Strait Islander descent. • HHS mental health services will give priority to consumers transferring back to their HHS from the AAI Unit. This ensures that the consumer does not remain in the AAI Unit longer than is deemed clinically necessary. • Discharge planning should also consider accommodation and support needs for consumers who are homeless or at risk of homelessness.
	3.12.2 Discharge planning will include a recovery plan, and incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.	Hyperlink to: • Child and Youth Mental Health Services Recovery Plan form • The recovery, relapse prevention and crisis management plans will be provided to the consumer, family and/ or carer, GP and relevant support agencies.
	3.12.3 Where consumers are absent without leave, there will be documented evidence of attempts to contact consumer, family and /or carers and other service providers (e.g. QPS), before discharge.	
	3.12.4 Where the consumer is subject to provisions of the *Mental Health Act 2000* there will be documented evidence that all statutory requirements have been met.	• *Mental Health Act 2000*

Key component	Key elements	Comments
	3.12.5 Discharge will occur when the consumer no longer requires acute inpatient care and has supports in place to manage in the community.	• The decision to discharge is at the discretion of the consultant psychiatrist in consultation with AAI Unit staff. • Consideration is given to the maintenance of benefits gained from treatment interventions (e.g. involvement in a day program may be encouraged to assist the transition and facilitate rehabilitation and recovery goals). Hyperlink to: • Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary
	3.12.6 Comprehensive liaison and handover will occur with all service providers who will contribute to ongoing care post-discharge.	• All clinicians are responsible for confirming that a follow up appointment has been made prior to discharge (where the consumer/family have refused follow up, this will be documented in the clinical record). • All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within 48 hours. • Discharge summaries need to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral. • Relapse patterns and risk management information will be clearly outlined. • A follow-up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the discharge letter was received. Hyperlinks to: • Queensland Health Child and Youth Mental Health Services State-wide Standardised Suite of Clinical Documentation User Guide • Suite of Clinical Documents • The PSP will contact the follow up service provider to ensure they accept the referral for ongoing provision of care (this will be noted in the consumer clinical record). • All consumers referred to a Community CYMHS team will be contacted by the Community CYMHS team within 24 hours of discharge. • Consumers discharged from the AAI Unit will be seen by the receiving

Key component	Key elements	Comments
		team in a timely manner.
	3.12.7 • The consumer, family and or/carer will be supported to make a follow up appointment with their GP, or other suitable follow up service provider, prior to discharge.	
3.13.0 Collection of data, record keeping and documentation	**3.13.1** The AAI Unit will enter and review all required information in CIMHA, in accordance with approved state-wide and HHS business rules.	Hyperlink to: • CIMHA business rule
	3.13.2 The AAI Unit will utilise routine outcome measures as part of assessment, recovery planning and service development. These will include those mandated through the National Outcomes and Casemix Collection (NOCC): - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) - Strengths and Difficulties Questionnaire (SDQ) - Children's Global Assessment Scale (CGAS) - Factors Influencing Health Status (FIHS).	• Outcomes data is presented at all formal case reviews and will be an item on the relevant meeting agendas. • Results of outcomes are routinely discussed with consumers and their families and or carers. • Outcomes data is used with consumers to: a. record details of symptoms and functioning b. monitor changes c. review progress and plan future goals in the recovery plan. Hyperlink to : • Mental Health Outcomes Collection Protocol • Outcome and Casemix measures for mental health services
	3.13.3 All contacts, clinical processes, recovery and relapse prevention planning will be documented in the consumer's clinical record.	• Progress notes will be consecutive (according to date of event) within all hard copy consumer clinical records. Hyperlinks to: • Queensland Health Child and Youth Mental Health Services Statewide Standardised Suite of Clinical Documentation User Guide • Suite of clinical documents • Aboriginal and Torres Strait Islander Cultural Information Gathering Tool Guide .
	3.13.4 Clinical records will be kept in accordance with legislative and local policy requirements.	• Personal and demographic details of the consumer, family, and/or carers and other health service providers will be reviewed regularly and kept up to date. • Mobile or tablet technology will support any increasing application of electronic record keeping.

Key component	Key elements	Comments
		Hyperlink to • Clinical records management policy • Retention and disposal of clinical records protocol • Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines
	3.13.5 Local and statewide audit processes will monitor the quality of record keeping and documentation (including external communications), and support the relevant skill development.	
3.14.0 Working with families, carers and friends	**3.14.1** The involvement of families and carers is integral to successful outcomes and therefore their engagement is incorporated into every component of service provision.	• Consumer/Guardian consent to disclose information and to involve family and/or carers in care will be sought in every case. Hyperlinks to: • *Guardianship and Administration Act 2000* • Carers matter • The consumer, carer and family participation framework • *Hospital and Health Boards Act 2011* – Part 7 Confidentiality • Right to information and information privacy • Information sharing between mental health workers, consumers, carers, family and significant others
	3.14.2 Education and information will be provided to the consumer, family and/or carers at all stages of contact with the service.	• This will include a range of components such as: – Education and information about the mental illness or mental health issues – the journey within the service – mental health care options – pharmacotherapy – support services – recovery pathways – contact information for the mental health service and relevant external service providers. • Education and information provided will be documented in the clinical file.
	3.14.3 The needs of families and carers must be routinely addressed.	• Identification of carers and their needs is part of the assessment process and is included in care planning.

Key component	Key elements	Comments
	3.14.4 Support services will be offered to families and carers regardless of whether consent is given for their involvement in the consumer's care. **3.14.5** Consumers who are children of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided. If a consumer of AAI Unit is pregnant or a parent with primary care responsibilities, their infants/ children will be routinely considered as part of all assessments. Interventions will be provided/ facilitated if needed.	• Support may be provided by a member of the mental health service organisation or another organisation. Hyperlinks to: • *Child Protection Act 1999* • Mental health child protection form • Family support form • Children of parents with a mental illness (COPMI) website
3.15.0 Mental health peer support services	**3.15.1** All consumers, families and/or carers will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Consumer and carer consultants are accessible via the local HHS mental health service.

4. Related services

Child and youth mental health services (CYMHS) operate in a complex, multi-system environment including crucial interactions with other areas of Queensland Health (e.g. Alcohol Tobacco and Other Drug Services and Community Health), other Queensland Government departments (e.g. the Department of Education and Training, Department of Communities, Child Safety and Disability Services and the Department of Housing and Public Works), , General Practitioners, private providers and non-government organisations.

The AAI Unit should be integrated and coordinated, with specialist mental health services and other services for young people. This ensures continuity of care across the service system and through the consumer's developmental transitions, joint planning, and development and coordination of services. Family members and carers are to be provided with emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and well being.

AAI Units work collaboratively with Education Queensland to enable a comprehensive and tailored educational program within AAI Units.

5. Caseload

AAI Units provide a 24 hour service, which requires nursing staff to be continuous shift workers. The model of nursing care will be a combination of case management and patient allocation. The skill mix and patient complexity is taken into consideration when allocating nursing staff. The patient will be informed of their focal nurse for each shift.

6. Workforce

The staffing profile for AAIU is comprised of a multidisciplinary mix of clinical and non clinical staff. Treatment and care is provided by clinical mental health workers including doctors, nurses and allied health staff, music and art therapists, as well as a range of non-clinical staff including Indigenous mental health workers, diversional, leisure, yoga and recreational therapists and allied health assistants and staff from the Department of Education, Training and Employment. Involvement of, and access to consumer and carer consultants and recovery support workers should be facilitated within the integrated mental health service. Additionally, the multidisciplinary team is supported by administrative officers, catering, security and hygiene staff who assist with the day to day operations of the unit.

The effectiveness of AAI Units is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The complexity of consumers accessing the service suggests the need to provide staff with continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. AAI Units undertake evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, encouraging rotations through the unit for staff from other areas of the integrated mental health service, and supporting education and research opportunities.

7. Team clinical governance

AAI Units operate under the direction of a Clinical Director and a Nurse Unit Manager/Team Leader. Clear reporting roles ensure effective management and the efficiency of service delivery. Multidisciplinary team work is essential. Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

All AAI Units will identify a single point of clinical accountability for every consumer.

Multidisciplinary team work is essential as consumers receive treatment and care from a range of specialist medical, nursing, allied health, therapy and pharmacy staff with appropriate qualifications, skills and experience.

All admitted consumers' will be discussed at a clinical review meeting within 24 hours of presentation and at MDT reviews at least weekly. A consultant psychiatrist will participate in the MDT Review. A consultant psychiatrist or appropriate delegate will participate in daily clinical review meetings. This may be direct participation or via telehealth.

AAI Units exist within the spectrum of integrated mental health services and other health services. Services are provided in partnership with the consumer, their family and carers as well as a range of other government and non-government organisations (NGOs).

8. Hours of operation

24 hours a day, 7 days a week.

9. Staff training

Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure that they are clinically competent. Staff are encouraged and supported in working towards the attainment of specialised mental health

qualifications. All training will be based on best practice principles and evidence-based treatment guidelines, and underpinned by the *National framework for recovery oriented mental health services.*

All clinical staff must be engaged in relevant professional development to ensure contemporary and evidence based intervention and treatment is provided to consumers, their carers and family. The clinical acuity and complexity of consumers accessing inpatient services is on the rise. There is a high proportion of the population accessing inpatient units that have experienced significant abuse, trauma and/or neglect. The current literature outlines the limitations of verbal treatments with traumatised adolescents, with a paradigm shift away from these traditional therapies. There is growing focus on the integrated approach to managing these traumatised consumers both in the community and within inpatient settings. Specialist skills are required to manage escalating behaviours as a result of trauma, including attachment issues and affect deregulation. All clinicians are to be adequately trained in these specialist skills to provide effective evidenced informed interventions.

Involvement in research activities is also highly desirable. This is also a requirement for annual registration with the governing bodies of most disciplines.

Training should be based on best practice principles and will be underpinned by the recovery framework. Teams are encouraged to make the relevant components of their training available to their service partners (e.g. NGOs, GPs).

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

- orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- promotion, prevention and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for, children and adolescents and their families and /or carers
- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention
- *Mental Health Act 2000*
- National Standards for Mental Health Services 2010
- evidenced informed practice in service delivery
- consumer focused recovery planning
- routine outcome measurement training
- a range of treatment modalities including individual, group and family-based therapy
- an understanding of the impact of complex trauma and disrupted attachment
- child safety services training
- perinatal and infant mental health training
- knowledge of mental health diagnostic classification systems
- medication management
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- cultural capability training
- alcohol and drug assessment and interventions
- family therapy.

10. Acute adolescent inpatient units function best when:

- consumers, family and/or carers, and other service provider's are engaged and involved in all aspects of care planning and delivery
- there is an explicit attitude that consumers can and do recover from mental illness
- there is an adequate skill mix, with senior level clinical expertise and knowledge being demonstrated by the majority of staff across all shifts
- there are clear and strong clinical and operational leadership roles which recognise each others strengths and work to form a collaborative relationship
- senior staff, including medical staff, take an active role in fostering the development of clinical skills for less experienced staff
- staff are provided with adequate professional support and training
- staff are provided with peer supervision/clinical supervision, including reflective practice
- service delivery is integrated, with established procedures that support continuity of care across settings and between services
- there is unit integration with local mental health services, specifically community child and youth mental health services, acute hospital services, emergency departments, and primary care supports
- there is adherence to evidence informed care, treatments, interventions and processes
- a range of performance, quality and safety indicators are actively utilised to inform service planning and provision
- there is a culture of openness and responsiveness to service user feedback.
- clinical governance is intrinsically embedded throughout all processes and practices within the service.