Section 4 Statewide and Other Targeted Services

Subsection 4.2 - Child and Youth Forensic Service

Child and Youth Forensic Service	Level 3
Service description	☐ capable of providing short- to long-term or intermittent ambulatory mental health care to high-risk/complexity voluntary and involuntary mental health consumers involved in, or at risk of involvement in, the juvenile justice system. ☐ also provide consultation-liaison to range of government and non-government agencies, with aim of facilitating collaborative multiagency model of care. ☐ functions as part of integrated service that provides mental health care for target population within Youth Detention Centres, court liaison services and community forensic outreach services. ☐ accessible during business hours. ☐ delivered predominantly by multidisciplinary team of child and youth mental health professionals with qualifications and or/ experience in forensic mental health. ☐ service provision typically includes: multidisciplinary assessment such as forensic and risk assessments; medico-legal reporting; targeted clinical interventions by mental health professionals; care coordination/case management; consumer and carer education and information; documented frequent case review; primary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate. **Note:** Lower level services for child and youth forensic mental health consumers are delivered as part of core business associated with ambulatory, acute inpatient and non-acute inpatient services for children and adolescents, as defined in Child and Youth Mental Health Services section of this module.
Service requirements	As per module overview, plus: ☐ identification, ongoing assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance). ☐ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. ☐ targeted clinical programs for individuals and/or groups. ☐ forward referrals for assessment / diagnosis / intervention as required. ☐ development of comprehensive individual mental health recovery plan within 1 week of assessment where appropriate. ☐ extensive clinical detail collected to inform assessment / diagnosis / intervention / recovery. ☐ assertive outreach to the service and target population. ☐ access to psychoeducation for consumers, families/carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ☐ specialist mental health assessments and interventions conducted by child and youth mental health clinicians and health workers of this service. ☐ documented processes and collaborative partnerships established with key stakeholders associated with criminal justice system—Department of Justice and Attorney General, Youth Detention Centres, Child Safety Services, and other stakeholders, including Department of Education, Training and Employment. ☐ working partnerships established with child and youth mental health and children's health services, Queensland Police Service, Queensland Corrective Services, and Department of Justice and Attorney-General. ☐ specialist consultation-liaison to other health and non-health services/agencies for target population. ☐ authorised mental health service under *Mental Health Act 2000*. ☐ may provide range of additional clinical programs and services such as outreach and telehealth services, extended treatment program.

Child and Youth Forensic Service	Level 5
Workforce requirements	As per module overview, plus: Medical ☐ access—during business hours—to registered medical specialist with credentials in psychiatry, a certificate in child and adolescent psychiatry (or equivalent), and relevant specialist qualifications and/or experience in forensic assessment, case management and review. ☐ access—during business hours—to registered medical specialist with credentials in paediatrics for medical consultation-liaison (may be via telehealth). ☐ access—24 hours—to registered medical specialist with credentials in psychiatry. Nursing ☐ access—during business hours—to registered nurse with qualifications in mental health and/or extensive mental health experience who has qualifications and/or experience in child and youth mental health and/or forensic mental health. Allied health ☐ access—during business hours—to multidisciplinary team of allied health professionals with child and youth mental health and/or forensic mental health qualifications and/or experience. ☐ access to psychology, social work, occupational therapy, speech pathology, dietetic and dedicated pharmacy services for mental health. Other ☐ access to Indigenous Health Workers (where appropriate). ☐ access to range of local health / mental health specialties (may be on a visiting basis or by outreach services).
Specific risk considerations	☐ Nil

Support service requirements for child and youth forensic mental health services	Level 5	
	On-site	Accessible
Medical imaging		2
Medication		2
Pathology		2

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.3 - Deafness and Mental Health Service

Deafness and Mental Health Service	Level 5
Service description	☐ highly specialised integrated service providing short term or intermittent mental health care to low-, moderate- and high-risk/complexity voluntary and involuntary adult mental health consumers via statewide consultation-liaison service. ☐ delivered to targeted adult population diagnosed with mental illness and who are deaf or have hearing loss, and some of whom have special care needs. ☐ delivered from range of sites across the state; however, statewide coordination of these services is centralised, with service accessible during business hours. ☐ service delivered by highly specialised team of mental health professionals with specialist qualifications and experience in deafness and mental health. ☐ service components consist of: – statewide consultation-liaison with Queensland Health and non-Queensland Health service providers – acute psychiatric assessments of mental health consumers (face-to-face and/or via telehealth facilities) – educational modules for skills transfer to service providers – specialised consultation-liaison services for special needs groups (e.g. Aboriginal and Torres Strait Islander people who are deaf). ☐ service provision typically includes, assessment and targeted interventions by mental health professionals; consumer and carer education and information; primary and secondary prevention programs; consultation-liaison with other service providers; and referral, where appropriate.
Service requirements	As per module overview, plus: ☐ identification, ongoing assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance). ☐ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. ☐ targeted clinical programs for individuals / groups / families. ☐ forward referrals for assessment, diagnosis and intervention as required. ☐ input into development of comprehensive and individual mental health recovery plan within 1 week of assessment. ☐ extensive clinical detail collected to inform assessment, diagnosis, intervention, recovery and broader service delivery in all service levels. ☐ facilitation of access to range of primary and secondary prevention services. ☐ assertive outreach applicable to service and target population. ☐ statewide clinical forums to assist dissemination of clinical expertise. ☐ psychoeducation for consumers, families / carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ☐ separate clinical services for families / carers, if required. ☐ as consultation service primary clinical responsibility and decision-making for consumer remains with referring service. ☐ statewide specialist consultation-liaison to other health and non-health services / agencies for people who are deaf or hard of hearing. ☐ mental health assessments and interventions conducted in accordance with Queensland Health guidelines for working with consumers who are deaf or hard of hearing. ☐ assistance, support and resources provided to referring mental health service to ensure appropriate recovery plan is prepared and reviewed for each consumer. ☐ authorised service under *Mental Health Act 2000*.

Deafness and Mental Health Service	Level 6
Workforce requirements	As per module overview, plus: Medical □ access—during business hours—to registered medical specialist with credentials in psychiatry for assessment, case management and review. Nursing □ access—during business hours—to registered nurse with qualifications in mental health and/or extensive mental health experience. Allied health □ access—during business hours—to allied health professionals with qualifications and experience in mental health. Other □ consultation available from range of specialist services, particularly related to people who are deaf and as such identify as a cultural and linguistic minority as well as to those with marked hearing loss
Specific risk considerations	□ Nil

Support service requirements for deafness and mental health services	Level 6	
	On-site	Accessible
Medication		2
Medical imaging		3
Pathology		3

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.4 - Eating Disorders Service

Eating Disorders Service	Level 3
Service description	▫ provides specialist resources and support enabling mental health ambulatory and acute inpatient care services 24/7.[3, 4] ▫ integrated service delivered to targeted adult population diagnosed with (or at high risk of developing) serious and/or complex eating disorders. ▫ provides acute ambulatory and inpatient mental health care to voluntary and involuntary adult mental health consumers with an eating disorder who present with problems ranging from low to highest risk/complexity, and may have special care needs. ▫ adolescent consumers older than 14 years may access this service, where clinically and developmentally appropriate, and in line with policy and procedural documentation of the eating disorders service. ▫ services may be delivered from a range of sites across the state; however, this service is centrally coordinated. ▫ ambulatory service components may include statewide consultation-liaison service, outpatient assessment and treatment recognition services, specialist outpatient therapy and/or intensive outpatient program (consumers referred to ambulatory service components present with problems ranging from low to highest risk/complexity, some of whom may demonstrate most extreme comorbidities and/or indicators of treatment resistance). ▫ acute inpatient service components at this level are co-located with a Level 5 or 6 adult acute inpatient mental health service (consumers meeting admission criteria for acute inpatient component present with problems defined as highest risk/complexity and these consumers are unable to be adequately or safely cared for within their local acute inpatient mental health service). ▫ service provision includes: comprehensive multidisciplinary assessment; targeted specialist interventions by mental health and medical health professionals, care coordination; consumers and carer education; documented frequent case review; targeted group programs, all levels of prevention programs / services; consultation-liaison with lower level mental health services; and referral, where appropriate. ▫ lower level services for mental health consumers with an eating disorder are delivered as part of core business associated with ambulatory, acute inpatient and non-acute inpatient services—these service areas are defined in the Child and Youth Services, Adult Services and Older Persons Services sections of this module.
Service requirements	As per module overview, plus: ▫ authorised service under *Mental Health Act 2000*. ▫ identification, ongoing assessment, monitoring and interventions of complex mental health problems (that may be associated with most complex comorbidities and/or indicators of treatment resistance). ▫ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. ▫ targeted clinical programs for individuals / groups / families / carers. ▫ medication management. ▫ forward referrals for assessment / diagnosis / intervention as required. ▫ development of comprehensive individual mental health recovery plan within 1 week of assessment. ▫ referral to community mental health clinicians on hospital discharge, as appropriate. ▫ extensive range of primary (e.g. stress management), secondary (e.g. re-feeding syndrome) and tertiary (e.g. treatment maintenance) prevention services. ▫ psychoeducation for consumers, families/carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ▫ separate clinical services for families / carers, if required. ▫ specialist mental health assessments / interventions conducted by clinicians of this service. ▫ specialist consultation-liaison to other health and non-health services / agencies for target population. ▫ current policy and procedure documentation informs the processes of consultation-liaison with lower level services who provide an eating disorders mental health service. ▫ documented processes and collaborative partnerships with key stakeholders associated with eating disorder treatment, research and education (e.g. Eating Disorders Association). ▫ clinicians providing mental health services participate in clinical practice supervision with clinicians qualified and experienced in eating disorders and mental health. ▫ may provide extensive range of additional clinical programs and service components, such as an outreach service, telehealth services or a day program. ▫ as clinically indicated, ECT services may be facilitated and/or provided by mental health service authorised to provide ECT under *Mental*

Eating Disorders Service	Level 6
	Health Act 2000. □ statewide clinical forums to assist dissemination of clinical expertise. □ extensive clinical detail collected to inform assessment / diagnosis / intervention / recovery and broader service delivery in all levels of service.
Workforce requirements	As per module overview, plus. □ delivered by multidisciplinary team of highly specialised clinicians / mental health professionals. A Level 6 ***ambulatory service*** requires: Medical □ access—during business hours—to registered medical specialist with credentials in psychiatry and specialist qualifications and experience in eating disorders assessment, case management and review. Nursing □ access—during business hours—to registered nurses (with qualifications in mental health and/or extensive mental health experience) relevant to the service being provided. Allied health □ access—during business hours—to multidisciplinary team of allied health professionals with qualifications and experience in eating disorders and mental health. □ access to dedicated pharmacy services for mental health. Other □ access to an extensive range of visiting or local health / mental health specialties.
	A Level 6 ***inpatient service*** requires: Medical □ consumer admitted by / under registered medical specialist with credentials in psychiatry. □ access—24 hours—to registered medical specialist with credentials in psychiatry and specialist qualification and experience in eating disorders assessment, treatment, case management and review. □ access—24 hours—to registered medical practitioner (psychiatry registrar / principal house officer / senior medical officer / career medical officer) with credentials relevant to the discipline. □ medical services provided on-site or in close enough proximity to provide rapid response at all times. Nursing □ suitably qualified and experienced nurse in charge (however titled) of unit. □ registered nurse in charge of each shift with qualifications in mental health and/or extensive mental health experience. □ nursing staff on each shift, two or more of whom have qualifications in mental health and/or extensive mental health experience. Allied health □ access to multidisciplinary team of allied health professionals with qualifications and experience in eating disorders and mental health (postgraduate training desirable). □ access after-hours to generalist psychology, social work and dietetic services. □ access to dedicated pharmacy services for mental health. Other □ access to extensive range of visiting or local health / mental health specialties.
Specific risk considerations	□ Nil

Support service requirements for eating disorders services	Level 6	
	On-site	Accessible
Anaesthetic*	3	
Medical imaging		2
Medication		4
Pathology		3
Perioperative (relevant section/s)*	3	

*Required only in services where ECT performed

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.5 - Emergency Service

Emergency Service	Level 4	Level 5
Service description	▫ capable of providing 24 hours a day short-term emergency mental health treatment and care for low- to high-risk/complexity voluntary, and if authorised to do so, involuntary mental health consumers (across age spectrum) who present to emergency service and are triaged as having mental health problem / disorder associated with their current presentation. ▫ service provided predominantly by general health clinicians within general hospital. ▫ local mental health service (may be community- or hospital-based) provides consultation-liaison service to emergency department as required. ▫ service provision typically includes: assessment and brief treatment of acute mental health problems and illnesses, and stabilisation of emergencies before onward referral or retrieval by medical practitioners and/or other qualified staff.	▫ delivered on-site with Level 5 or Level 6 acute inpatient mental health service and provides initial triage, treatment and definitive care for majority of emergency presentations before retrieval by medical practitioners and/or other qualified staff. ▫ provided predominantly by mental health professionals within general hospital. ▫ triage conducted by general health clinicians of emergency department and further mental health assessments / interventions then conducted by mental health clinicians assigned to emergency department. ▫ mental health clinicians stationed within emergency department at least during business hours (one example of service model delivered at this level of service is Psychiatric Emergency Centre —or equivalent).
Service requirements	As per module overview, plus: ▫ identification, initial acute assessment, brief intervention, monitoring and stabilisation of mental health problems. ▫ medication review and management. ▫ forward referrals for expert assessment, diagnosis and intervention as required. ▫ basic clinical detail collected to inform assessment, diagnosis, intervention and recovery. ▫ limited psychoeducation (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ▫ level of consumer observation informed by triage category and individual risk assessment. ▫ mental health assessments, interventions and monitoring conducted by team of general and mental health (as required) professionals reflecting triage rating. ▫ mental health assessments and interventions conducted in consultation with mental health clinician where clinically indicated, and associated with documented review process. ▫ clinical staff providing mental health care have access—during business hours—to experienced mental health clinician who is authorised mental health practitioner and can provide advice, support and direction for care. ▫ consultation-liaison mental health service from on-site and/or community-based mental health service as required. ▫ additional mental health assessments and interventions may be directly provided by mental health clinicians using telehealth facilities, visiting and/or community-based workforce. ▫ may provide short-stay inpatient unit/area; however, there are no designated mental health beds or mental health clinicians associated with this short-stay unit / area. ▫ may be authorised service under *Mental Health Act 2000*.	As per Level 4, plus: ▫ assessment and brief treatment of acute mental health problems and illnesses, and stabilisation of emergencies before onward referral or retrieval by medical practitioners and/or other qualified staff. ▫ integrated approach to identification, assessment and preliminary intervention of any co-occurring substance-use disorders. ▫ psychoeducation (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ▫ mental health assessments, interventions and monitoring conducted by multidisciplinary team of mental health professionals assigned to emergency department (at least on during business hours). ▫ one mental health clinician (assigned to emergency department per shift) is authorised mental health practitioner. ▫ mental health Acute Care Team and/or consultation-liaison service provides extended-hours service and has documented processes and collaborative partnership with emergency department. ▫ documented processes with Level 5 or 6 acute inpatient mental health service. ▫ current policy and procedure informs documented processes and collaborative partnerships between this service and all other mental health services within same HHS or service area. ▫ documented processes and collaborative partnerships established between emergency department and integrated mental health service, as evidenced by regular minuted meetings—copy of minutes should be forwarded to emergency department and lead clinician/s responsible for governance of Emergency Mental Health. ▫ designated mental health area within emergency department, but this does not necessarily have designated mental health beds. ▫ if clinically indicated, consumers younger than 18 years reviewed by registered medical specialist with credentials in psychiatry and certificate in child and adolescent psychiatry (or equivalent) or their delegated registered medical practitioner in psychiatry under supervision (e.g.

Emergency Service	Level 4	Level 5
		psychiatric registrar) within 48 hours of initial psychiatric assessment. ▫ registered medical specialist with credentials in psychiatry reviews health records of all mental health consumer separations within 24 hours. ▫ is authorised mental health service under *Mental Health Act 2000*. ▫ may be delivered by emergency department-based Acute Care Teams (or their equivalent). ▫ may provide short-stay medical inpatient beds and mental health clinicians may provide direct care of mental health consumers admitted to these beds (as required/negotiated).
Workforce requirements	As per module overview, plus: Medical ▫ access to registered medical practitioner ▫ medical services provided on-site or in close enough proximity to provide rapid response at all times. Nursing ▫ registered nurses. Allied health ▫ access—during business hours—to community- or hospital-based allied health professionals with mental health qualifications and/or experience.	As per Level 4, plus: Medical ▫ extended-hours access to registered medical specialist with credentials in psychiatry for assessment, treatment, case management and case review. ▫ access—24 hours—to registered medical practitioner. Nursing ▫ extended-hours access to registered nurses, majority with qualifications in mental health and/or extensive mental health experience. Allied health ▫ extended-hours access to community- or hospital-based allied health professionals with qualifications and/or experience in mental health care. Other ▫ access to a range of visiting or local health / mental health specialties.
Specific risk considerations	▫ Nil	▫ Nil

Support service requirements for emergency mental health services	Level 4		Level 5	
	On-site	Accessible	On-site	Accessible
Emergency	4		5	
Medical imaging		3		3
Medication	5		5	
Pathology		3		3

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.6 - Evolve Therapeutic Service

Evolve Therapeutic Service	Level 4	Level 5
Service description	▫ capable of providing medium- to long-term ambulatory mental health care for targeted population of voluntary and involuntary mental health consumers (up to age of 18 years) presenting with high-risk/complexity psychological and behavioural support and special care needs and/or indicators of treatment resistance. ▫ all referrals are of those children and young people in care of Department of Communities (Child Safety Services). ▫ service provided in partnership with Department of Communities—(Child Safety Services) and (Disability Services), and Department of Education Training and Employment with service accessible during business hours. ▫ service delivered by one or more child and youth mental health professionals (nurses, allied health) who provide specialised mental health care services, and who work in consultation with Level 5 Evolve Therapeutic Service which acts as central base for activity and plays support and coordination role to satellite services. ▫ service provision typically includes: assessment; therapeutic and systemic intervention; care coordination / case management; consumer and carer education and information; documented frequent case review; primary and secondary prevention programs; consultation-liaison with lower and higher level mental health services, and Level 5 Evolve Therapeutic Service; and referral, where appropriate.	▫ capable of providing medium- to long-term mental health care for targeted population of voluntary and involuntary mental health consumers (up to age of 18 years) presenting with highest risk/complexity psychological and behavioural support and special care needs, demonstrating most severe comorbidities and/or indicators of treatment resistance. ▫ all referrals are of those children and young people in care of Department of Communities (Child Safety Services). ▫ service provided in partnership with Department of Communities—(Child Safety Services) and (Disability Services), and Department of Education, Training and Employment. ▫ service delivered by multidisciplinary team of mental health professionals with qualifications and/or experience in child and youth mental health. ▫ service provision typically includes: assessment; therapeutic and systemic intervention, care coordination / case management; consumer and carer education and information; documented frequent case review; all levels of prevention programs; consultation-liaison with lower and higher level mental health services, and lower level Evolve Therapeutic Services, and referral, where appropriate.
Service requirements	As per module overview, plus: ▫ identification, ongoing assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with comorbidities and/or indicators of treatment resistance). ▫ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. ▫ some targeted clinical programs for individuals / groups / families / carers. ▫ forward referrals for assessment / diagnosis / intervention as required. ▫ development of comprehensive individual mental health recovery plan within 1 week of completed assessment report. ▫ clinical detail collected to inform assessment / diagnosis / intervention / recovery ▫ range of primary, secondary and tertiary prevention services, as clinically indicated. ▫ specialist consultation-liaison with other health and non-health services / agencies for the target population. ▫ assertive outreach applicable to service and target population. ▫ psychoeducation for consumers, families/carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ▫ separate clinical services for families/carers, if required. ▫ mental health assessments / interventions conducted by child and youth mental health clinicians of this service. ▫ mental health assessments / interventions demonstrate multiple theoretical underpinnings.	As per Level 4, plus: ▫ targeted clinical programs for individuals / groups / families / carers. ▫ clinical detail collected to inform assessment / diagnosis / intervention / recovery, and broader service delivery in all levels of service. ▫ extensive range of primary, secondary and tertiary prevention services, as clinically indicated. ▫ mental health assessment / intervention conducted by comprehensive multidisciplinary team of mental health clinicians. ▫ current policy and procedure documentation informs processes of consultation-liaison with lower level Evolve services. ▫ may be an authorised mental health service under *Mental Health Act 2000*.

Evolve Therapeutic Service	Level 4	Level 5
	▫ this service works in partnership with local/nearest child and youth mental health service. ▫ weekly consultation-liaison session between staff of spoke site and credentialed child and adolescent psychiatrist from hub site (may be via telehealth) as appropriate. ▫ effective corporate and clinical governance structures and communication strategies promoting and supporting integration between hub and spoke sites. ▫ documented processes and collaborative partnerships established with Department of Communities and Department of Education, Training and Employment. ▫ authorised service under *Mental Health Act 2000*.	
Workforce requirements	As per module overview, plus: Medical ▫ registered medical specialist with credentials in psychiatry and a certificate in child and adolescent psychiatry (or equivalent) conducts clinical / case supervision with service clinicians (this may be via telehealth facilities) as appropriate. ▫ registered medical specialist with credentials in psychiatry and certificate in child and adolescent psychiatry (or equivalent) attends / consults on all clinical review meetings on regular basis (this may be via videoconference) as appropriate. ▫ access to registered medical specialist with credentials in psychiatry and certificate in child and adolescent psychiatry (or equivalent) for assessment, case management and review (this may be via telehealth facilities) as appropriate. Nursing ▫ access—during business hours—to at least one registered nurse with relevant specialist child and youth mental health qualifications and/or experience (postgraduate training desirable). Allied health ▫ access—during business hours—to an allied health professional with relevant specialist child and youth mental health qualifications and/or experience (where registered nurse not accessible). Other ▫ access to Aboriginal and Torres Strait Islander mental health worker / senior health worker, service and evaluation research coordinator, and professional development coordinator	As per Level 4, plus: Medical ▫ access to registered medical practitioner with credentials in psychiatry (psychiatry registrar). Nursing ▫ access—during business hours—to registered nurses with qualifications in mental health and/or extensive mental health experience and/or qualifications and experience in child and youth mental health. Allied health ▫ access to multidisciplinary team of allied health professionals with child and youth mental health qualifications and/or experience. ▫ some of these clinicians have: – specialist qualifications and/or experience in specific intervention areas relevant to service being provided – postgraduate qualifications. Other ▫ access to range of visiting or local health / mental health specialties.
Specific risk considerations	▫ Nil	▫ Nil

Support service requirements for evolve therapeutic services	Level 4		Level 5	
	On-site	Accessible	On-site	Accessible
Medical imaging		2		2
Medication		3		3
Pathology		2		3

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers. *Accessible* means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.7 - Homeless Health Outreach Service

Homeless Health Outreach Service	Level 5
Service description	☐ capable of providing short- to long-term or intermittent non-admitted mental health care to low-, moderate- and high-risk/complexity voluntary and involuntary mental health consumers across age spectrum who have been displaced or are homeless, and who have difficulty in accessing other services. ☐ extended-hours weekday service and/or limited-hours weekend mental health care service. ☐ delivered predominantly by multidisciplinary team of general, mental health, and drug and alcohol professionals (psychiatry, medical, nursing, allied health and other health workers) on assertive outreach basis, either at dedicated homeless services or on the streets ('in place') to homeless people who are experiencing mental illness and/or drug and alcohol problems. ☐ services provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; care coordination / case management; consumer and carer education and information; documented frequent case review; primary and secondary prevention programs; consultation-liaison with lower and higher level mental health services; and referral, where appropriate.
Service requirements	As per module overview, plus: ☐ care to low-, moderate- and high-risk/complexity voluntary and involuntary mental health consumers across age spectrum who have been displaced or are homeless, and who have difficulty in accessing other services. ☐ identification, ongoing assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance). ☐ integrated approach to the identification, assessment and intervention of any co-occurring substance-use disorders. ☐ forward referrals for assessment / diagnosis / intervention as required. ☐ development of comprehensive individual mental health recovery plan within 1 week of assessment. ☐ extensive clinical detail collected to inform assessment / diagnosis / intervention / recovery. ☐ extensive range of primary (e.g. stress management) and secondary (e.g. weight management) prevention services. ☐ assertive outreach applicable to service and target population. ☐ psychoeducation for consumers, families / carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ☐ authorised mental health service under *Mental Health Act 2000*. ☐ Assessments / interventions conducted by multidisciplinary team of general, mental health, and drug and alcohol professionals. ☐ service provision takes place in consumer's own environment or at other sites (e.g. hospital, recreational venues) ensuring all safety concerns are taken into account. ☐ consultation-liaison services to local health services as required. ☐ service works in partnership with mental health services and non-government specialist providers. ☐ documented processes and collaborative partnerships with key stakeholders relevant to homeless health (e.g. Department of Communities and non-government organisations providing shelter / refuge / food).
Workforce requirements	As per module overview, plus multidisciplinary team of general, mental health, and drug and alcohol professionals, including: ☐ drug and alcohol clinicians may be part of the integrated team. ☐ access to experienced and qualified age-appropriate clinical staff. **Medical** ☐ access—during business hours—to registered medical specialist with credentials in psychiatry for assessment, case management and review. **Nursing** ☐ access—during business hours and some extended-hours—to registered nurse with qualifications in mental health and/or extensive mental health experience. **Allied health** ☐ access—during business hours and some extended hours—to multidisciplinary team of allied health professionals with qualifications and/or experience in mental health.

Homeless health Outreach Service	Level 5
	Other □ each team has minimum of two Aboriginal and Torres Strait Islander health workers, male and female, to ensure appropriate gender-specific and cultural requirements are met. □ access to extensive range of visiting or local health / mental health specialties.
Specific risk considerations	□ Nil

Support service requirements for homeless health outreach services	Level 5	
	On-site	Accessible
Medication		2
Medical imaging		1
Pathology		1

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.8 - Perinatal and Infant Service

Perinatal and Infant Service	Level 3	Level 4	Level 5	Level 6
Service description	☐ capable of providing short- to long-term or intermittent ambulatory mental health care for voluntary and involuntary mental health consumers (and their infants) presenting with low-, moderate- and some high-risk/complexity perinatal- and/or infant-related mental health problems. ☐ accessible during business hours with some capacity for extended-hours service. ☐ timeframe for ambulatory perinatal mental health service delivery ranges from preconception to child's second birthday (24 months)—women in perinatal period experiencing moderate to severe mental health difficulties requiring mental health assessment may access range of mental health perinatal services, as can women who have had miscarriage, stillbirth, neonatal death or termination. ☐ expected majority of consumers are female; however, some fathers may access range of perinatal mental health services. ☐ timeframe for ambulatory infant mental health service delivery ranges from preconception to child's third birthday (36 months)—infants with severe and complex needs presenting with social, emotional and behavioural difficulties and developmental delays, often in context of trauma or compromised parent–infant relationships, may access range of infant mental health services.	☐ capable of providing short-term acute inpatient mental health care for voluntary and involuntary mental health consumers (and their infants) presenting with low risk/complexity perinatal- and/or infant-related mental health problems. ☐ may be provided for mothers and their infants when admission to nominated adult acute inpatient unit is most clinically appropriate and safe service for the individual case, and when transfer to higher level perinatal and infant mental health inpatient service is not feasible or clinically necessary. ☐ provide inpatient mental health care for mothers and their infants (from third trimester of pregnancy until infant becomes mobile) where mother exhibits signs and/or symptoms of serious mental illness that have not responded adequately to less intensive interventions in the community, and/or safety and treatment needs of dyad/family warrant admission. ☐ infants will only be admitted if it can be clearly determined during assessment mother is capable of caring independently (with support of staff as required) for the infant in a safe manner. ☐ delivered predominantly by multidisciplinary team of mental health professionals 24 hours a day in an adult acute inpatient mental health service without allocated mother–infant beds. ☐ service may operate on demand and is delivered via a hospital that incorporates an acute inpatient mental health	☐ capable of providing short- to medium-term or intermittent acute inpatient mental health care for voluntary and involuntary mental health consumers (and their infants) presenting with low-, moderate- and high-risk/complexity perinatal- and/or infant-related mental health problems. ☐ service delivered as one component of Level 5 or Level 6 adult acute inpatient mental health unit that comprises limited number of designated mother–infant beds and provides mental health care 24 hours a day. ☐ delivered predominantly by multidisciplinary team of mental health professionals providing acute inpatient mental health service. ☐ delivered via a hospital that incorporates an acute inpatient mental health unit or via purpose-designed and built mental health facility. ☐ service provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; care coordination / case management, consumer and carer education and information; documented frequent case review; group programs, primary and secondary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate. **Note:** Lower level services for inpatients presenting with perinatal and/or infant-related mental health problems delivered as part of core	☐ capable of providing short- to medium-term and intermittent inpatient perinatal and/or infant mental health care to voluntary and involuntary mental health consumers (and their infants) presenting with highest level of risk and complexity, and special care needs (consumers presenting with low to moderate risk and/or complexity can be admitted to this level of service as is clinically appropriate and relevant to individual consumer needs). ☐ provides care 24 hours a day. ☐ highly specialised statewide inpatient service delivered via dedicated mother–infant mental health unit co-located with Level 5 or 6 acute inpatient mental health unit. ☐ provides inpatient care to parents and their infants (from preconception to 36 months—upper age limit will depend on physical environment of the service) where mother exhibits signs and/or symptoms of serious mental illness at severe end of spectrum that have not responded adequately to less intensive interventions in the community, and/or safety and treatment needs of dyad/family warrant admission. ☐ on occasion, mother may be admitted in third trimester of pregnancy. ☐ father may rarely be admitted in his own right, along with his infant. ☐ offers assessment and intervention for range of perinatal and infant mental health disorders and relationship disturbances at highest level of risk and

Perinatal and Infant Service	Level 3	Level 4	Level 5	Level 6
	▫ delivered predominantly by multidisciplinary team of mental health professionals who provide local, community mental health care service specifically for target population. ▫ most commonly delivered via hospital-based outpatient clinic, community mental health clinic or home-based care. ▫ service provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; care coordination / case management; consumer and carer education and information; documented regular case review; some group programs; primary and secondary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate. ▫ where members of this population of mental health consumers are pregnant or within birth and early postnatal period, consultation and liaison must occur with maternity health professionals (e.g. registered nurses with credentials in midwifery and registered medical specialists with credentials in obstetrics, children's and/or neonatology). Note: Lower level services for ambulatory consumers presenting with perinatal and/or infant mental health problems are delivered as part of core business associated with ambulatory mental health services, as defined in the *Child and Youth Services* and *Adult Services* sections of this module.	unit or via purpose-designed and built mental health facility. ▫ service provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; care coordination / case management, consumer and carer education and information; documented frequent case review; primary and some secondary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate. **Note:** Lower level services for inpatients presenting with perinatal and/or infant-related mental health problems delivered as part of core business associated with acute inpatient mental health services, as defined in the *Child and Youth Services* and *Adult Services* sections of this module. For an adult acute inpatient unit to admit infants with their mothers, service is required to meet criteria stipulated in this section, Subsection 4.3, Perinatal and Infant Services (Level 4 or higher).	business associated with acute inpatient mental health services, as defined in the *Child and Youth Services* and *Adult Services* sections of this module.	complexity, especially those that require admission of several family members. ▫ may include most complex cases where there is combination of mental illness, personality disorder, substance abuse, infant distress or disorder, and child safety concerns. ▫ service demonstrates specialist expertise in delivery of perinatal and infant mental health services to targeted population and is delivered by multidisciplinary team of mental health professionals with expertise in perinatal and/or infant mental health. ▫ service provision includes: multidisciplinary assessment and specialised interventions by mental health professionals; consumer and carer education; documented daily case review; targeted group programs, all levels of prevention programs/services; consultation-liaison with: lower level mental health services; and referral, where appropriate. ▫ if physical environment permits, this service can operate as parent–infant inpatient service with physical layout designed to safely meet needs of older infants and their families, including family rooms and outdoor play spaces (allowing for admission of infants up to age of 36 months as well as sibling groups where all are younger than 36 months at time of admission).

Perinatal and infant Service	Level 3	Level 4	Level 5	Level 6
Service requirements	As per module overview, plus: □ identification, ongoing assessment, monitoring and interventions of mental health problems (that may be associated with comorbidities and/or indicators of treatment resistance). □ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. □ forward referrals for assessment, diagnosis and/or intervention as required. □ clinical detail collected to inform assessment, diagnosis, intervention and recovery. □ development of comprehensive individual mental health recovery plan within 1 week of assessment. □ range of primary (e.g. stress management) and secondary (e.g. mother–infant therapy) prevention services. □ psychoeducation for consumers and family/carer (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). □ may be authorised mental health service under *Mental Health Act 2000*. □ policy—supporting multidisciplinary approach to pregnancy, birth and early postnatal care—is in place for women who are planning pregnancy or who are pregnant, outlining communication channels between mental health and maternity teams. □ policy outlining communication channels between mental health and maternity carers is in place where pregnant women are receiving care at	As per Level 3, plus: □ wide range of primary (e.g. stress management) and some secondary (e.g. mother infant therapy) prevention services. If infant admitted with mother, following requirements are to be met: □ consultation-liaison initiated immediately and maintained with higher level perinatal and infant mental health service throughout the admission □ mother and infant provided with single, ensuite room that must have clear observation paths for nursing staff at all times and is within close proximity to nursing station (room should be able to be locked from outside and be key accessible only by nursing staff) □ infant monitors, either connected to nurses' station or able to transmit while mobile, in use at all times in order for infant's wellbeing to be monitored.	As per Level 4, plus: □ identification, ongoing assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance). □ medication management. □ targeted clinical programs for individuals / groups / families. □ extensive clinical detail collected to inform assessment, diagnosis, intervention and recovery. □ extensive range of primary (e.g. stress management) and secondary (e.g. mother infant therapy) prevention services. □ assertive outreach applicable to service and target population. □ psychoeducation for consumers, families/carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). □ separate clinical services for families/carers, if required. □ consultation-liaison services to local health services as required. □ clinicians providing mental health services participate in clinical practice supervision with clinician/s qualified and/or experienced in perinatal and infant mental health. □ mental health assessments and interventions conducted by multidisciplinary team of mental health professionals. □ authorised mental health service under *Mental Health Act 2000* □ as clinically indicated, ECT services may be facilitated and/or provided to an adult by mental health service authorised to provide ECT	As per Level 5, plus: □ identification, ongoing assessment, monitoring and interventions of complex mental health problems (that may be associated with most complex comorbidities and/or indicators of treatment resistance). □ extensive clinical detail collected to inform assessment, diagnosis, intervention and recovery, and broader service delivery in all levels of service. extensive range of primary (e.g. stress management), secondary (e.g. mother infant therapy) and tertiary (e.g. psychosis treatment maintenance) prevention services. □ statewide clinical forums to assist dissemination of clinical expertise. □ specialist mental health assessments and interventions conducted by multidisciplinary team of mental health professionals with specialist qualifications and experience in perinatal and/or infant mental health. □ specialist consultation-liaison to other health and non-health services / agencies for target population.

Perinatal and Infant Service	Level 3	Level 4	Level 5	Level 6
	this service level. □ where appropriate, documentation of care is contained within pregnancy handheld record to promote communication and information between the woman and mental health and maternity care teams. □ documented processes with Level 5 or 6 acute .npatient mental health service (child and youth, adult and/or perinatal and infant) capable of perinatal and infant mental health care. □ service based within HHS or part of service network that also includes Level 5 or 6 acute inpatient mental health unit (child and youth, adult and/or perinatal and infant) capable of perinatal and infant mental health care. □ mental health assessments and interventions conducted by mental health clinicians of this service.		under *Mental Health Act 2000*.	

Perinatal and Infant Service	Level 3	Level 4	Level 5	Level 6
Workforce requirements	As per module overview, plus: Medical □ access to registered medical specialist with credentials in psychiatry (with training / experience in perinatal and/or infant mental health) for assessment, case management and review. Nursing □ access—during business hours—to registered nurse who has qualifications in mental health and/or extensive mental health experience, in addition to training and/or experience in perinatal and/or infant mental health. Allied health □ access—during business hours—to multidisciplinary team of allied health professionals with training / experience in perinatal and/or infant mental health. Other □ consultation may be available from visiting specialties in mental health, maternity and child health and other areas of health.	As per Level 3, plus: Medical □ consumer admitted by / under registered medical specialist with credentials in psychiatry. □ access—24 hours—to medical practitioner. □ access to registered medical specialist with credentials in paediatrics for medical consultation-liaison (may be via telehealth). Nursing □ suitably qualified and experience registered nurse (however titled) in charge of unit. □ registered nurse in charge of each shift suitably qualified and has extensive mental health experience. □ unit nursing staff, two or more of whom each shift are registered nurses and have qualifications in mental health and/or extensive mental health experience. □ if inpatient unit occupancy is low, only one nurse per shift need have qualifications in mental health and/or extensive mental health experience. □ enrolled nurses may complement nursing team. □ if infant admitted with mother, registered nurse with qualifications in mental health and/or extensive mental health experience provides 24-hour care and observation for mother and infant throughout admission. Allied health □ access to psychology, social work, occupational therapy, speech pathology and dietetic services (postgraduate training desirable). □ access to dedicated pharmacy services for mental health. Other □ AINs or equivalent may complement clinical team at	As per Level 4, plus: Nursing □ at least one registered nurse per shift with qualifications and experience in child health and/or perinatal/infant mental health. Other □ access to extensive range of on-site and/or visiting specialties in health / mental health / maternity / child health.	As per Level 5, plus: Medical □ access—24 hours—to registered medical specialist with credentials in psychiatry and qualifications and experience in perinatal and/or infant mental health. Nursing □ registered nurses, majority of whom have qualifications in mental health and/or extensive mental health experience or qualifications and/or extensive experience in perinatal and/or infant mental health. Allied health □ extended-hours access to community- or hospital-based allied health professionals with relevant specialist mental health qualifications and experience.

Perinatal and Infant Service	Level 3	Level 4	Level 5	Level 6
		discretion of nurse in charge. □ Bachelor of Nursing students (second or third year undergraduate) may complement clinical team at discretion of nurse in charge and under registered nurse supervision. □ access to range of on-site and/or visiting specialties in health / mental health / maternity / child health		
Specific risk considerations	□ Nil	□ Nil	□ Nil	□ Nil

Support service requirements for perinatal and infant mental health services	Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic*					3		3	
Medical imaging		1		2		3		3
Medication		2	3		4		5	
Pathology		2		2		3		3
Perioperative (relevant section/s)*					3		3	

*Required only in services where ECT performed

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4 Statewide and Other Targeted Services

Subsection 4.9 - Transcultural Service

Transcultural Service	Level 6
Service description	☐ capable of providing short-term or intermittent mental health care to low-, moderate- and high-risk/complexity voluntary and involuntary mental health consumers via statewide consultation-liaison and/or outreach mental health service. ☐ integrated service delivered to targeted population across all ages from culturally and linguistically diverse backgrounds, diagnosed with mental illness or present with mental health problems and who may show evidence of range of complexities relating to cultural barriers, migration and settlement issues, some consumers presenting with special care needs. ☐ accessible during business hours with some service components operating on extended-hours basis. ☐ service components consist of: – transcultural clinical consultation service providing intake, triage and consultation – range of programs / strategies for promotion, prevention and early intervention of mental illness in target population – cultural consultation service that provides cultural clarification, advice and support (including socio-cultural assessments) and is coordinated by clinicians of Transcultural Mental Health Service with input from range of bicultural / bilingual cultural consultants. ☐ service provision typically includes: multidisciplinary assessment, diagnosis clarification, triage and targeted interventions by transcultural mental health professionals; assistance with care planning / care coordination; consumer and carer education and information; primary and secondary promotion, prevention and early intervention programs; consultation-liaison with other service providers; and referral, where appropriate. ☐ delivered by highly specialised, multidisciplinary team of mental health professionals (psychiatrists, nurses, allied health professionals, cultural consultants and other health workers) with qualifications and experience in transcultural mental health.
Service requirements	As per module overview, plus: ☐ care to low-, moderate- and high-risk/complexity voluntary and involuntary mental health consumers via statewide consultation-liaison and/or outreach mental health service. ☐ identification, assessment, monitoring and interventions of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance). ☐ integrated approach to identification, assessment and intervention of any co-occurring substance-use disorders. ☐ input into targeted clinical programs for individuals / groups / families (transcultural content for group programs delivered by mental health services). ☐ forward referrals for assessment / diagnosis / intervention as required. ☐ timely contribution to development of comprehensive and culturally appropriate mental health recovery plan. ☐ extensive clinical detail collected to inform assessment / diagnosis / intervention / recovery, and broader service delivery in all levels of service. ☐ access to range of primary (e.g. transcultural stress management resources) and secondary (e.g. culturally tailored programs for mental health literacy and recovery programs) prevention services. ☐ assertive outreach applicable to service and target population. ☐ psychoeducation for consumers, families / carers and groups (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services). ☐ separate clinical services for families/carers, if required. ☐ specialist mental health assessments and interventions are conducted by clinicians and health workers of this service, reflecting cultural appropriateness. ☐ as consultation service, primary clinical responsibility and decision-making for consumer remains with referring service. ☐ where appropriate, facilitates access for presenting individuals to their local mental health service or other relevant services, including general practitioners and multicultural support services. ☐ statewide specialist consultation-liaison to other health and non-health services / agencies for target population. ☐ Mental Health Promotion Prevention and Early Intervention (MHPPEI) activities coordinated and delivered by project officers and/or group facilitators who are suitably qualified and experienced in program topic area and cross cultural work, and are supervised by qualified allied health staff.

Transcultural Service	Level 6
	▢ works in partnership with mental health services and non-government specialist providers. ▢ provides assistance, support and resources to referring mental health service to ensure a culturally appropriate recovery plan is prepared and reviewed for each consumer. ▢ current policy and procedure documentation maintained for MHPPEI and cultural consultation programs, and integrated into staff induction training. ▢ documented processes and collaborative partnerships with multicultural services sector (e.g. Department of Immigration and non-government multicultural services, such as refugee services, cultural groups and organisations). ▢ co-located with authorised service under *Mental Health Act 2000*.
Workforce requirements	As per module overview, plus multidisciplinary team of mental health professionals with qualifications and experience in transcultural mental health, including: Medical ▢ access—during business hours—to registered medical specialist with credentials in psychiatry and relevant specialist qualifications and experience in transcultural mental health in relation to assessment, management and review of culturally and linguistically diverse consumers. ▢ where consumers of clinical consultation service are also consumers of their local mental health service, their ongoing care is coordinated by registered medical specialist with credentials in psychiatry for assessment, treatment, case management and case review. Nursing ▢ access—during business hours—to registered nurse with cross-cultural qualifications and experience relevant to service being provided. Allied health ▢ access—during business hours—to multidisciplinary team of allied health professionals with relevant specialist mental health and cross-cultural qualifications and experience. ▢ additional allied health support provided to cultural consultation service by registered clinicians with qualifications and experience in delivering transcultural mental health care. ▢ access to senior allied health staff member of the service (in an on-call capacity) for bilingual mental health clinicians who deliver services outside regular business hours. Other ▢ access to bilingual consultants. ▢ access to range of visiting or local health / mental health specialties. ▢ clinical and cultural consultation services provided face-to-face, via telehealth facilities or on visiting basis.
Specific risk considerations	▢ Nil

Support service requirements for transcultural mental health services	Level 6	
	On-site	Accessible
Medication		2
Medical imaging		3
Pathology		3

Table note: *On-site* means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Legislation, regulations and legislative standards

In addition to what is outlined in the *Fundamentals of the Framework*, mental health services must comply with the following:

- *Mental Health Act 2000* Resource Guide - http://www.health.qld.gov.au/mha2000/resource_guide.asp
- National Standards for Mental Health Services 2010
- Patients Absent Without Permission Flipchart - http://qheps.health.qld.gov.au/mentalhealth/mha/policy.htm
- *Queensland Criminal Code Act 1899* www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CriminCode.pdf

Non-mandatory standards, guidelines, benchmarks, policies and frameworks (not exhaustive & hyperlinks current at date of release of CSCF v3.2)

In addition to what is outlined in the *Fundamentals of the Framework*, the following are relevant to mental health services:

- A national framework for recovery-oriented mental health services, AHMAC, Commonwealth of Australia, 2013 - http://www.ahmac.gov.au/cms_documents/National%20Mental%20Health%20Recovery%20Framework%202013 Guide-practitioners&providers.PDF
- Australian and New Zealand College of Anaesthetists Professional Standard PS55: Recommendations of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations. ANZCA; 2008. www.anzca.edu.au/resources/professional-documents/
- Australian Government Department of Health and Ageing. National Practice Standards for the Mental Health Workforce. 2013 State of Victoria, Department of Health 2013f. http://www.health.gov.au/internet/main/publishing.nsf/Content/5D7909E82304E6D2CA257C430004E877/$File/wkstd13.pdf
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- Australian Mental Health Outcomes and Classification Network. Reporting Framework for the National Outcomes and Casemix Collection. www.amhocn.org/
- Guidelines for determining benefits for private health insurance purposes for private mental health care, Private Mental Health Alliance. (as updated from time to time)
  http://www.pmha.com.au/Portals/4/PublicDocuments/GuidelinesForDeterminingBenefitsForHealthInsuranceBenefitsPurposesForPrivateMentalHealthCare/Guidelines%20for%20Determining%20Benefits%202012%20Edition.pdf
- Guideline for Mental Health Service Responsiveness for Aboriginal and Torres Strait Islander People. http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-365-4-1.pdf
- Guideline for the use of the cultural information gathering tool (best practice for the provision of Aboriginal and Torres Strait Islander culturally appropriate mental health care). Mental Health, Alcohol and Other Drugs Branch.
  http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-365-3.pdf
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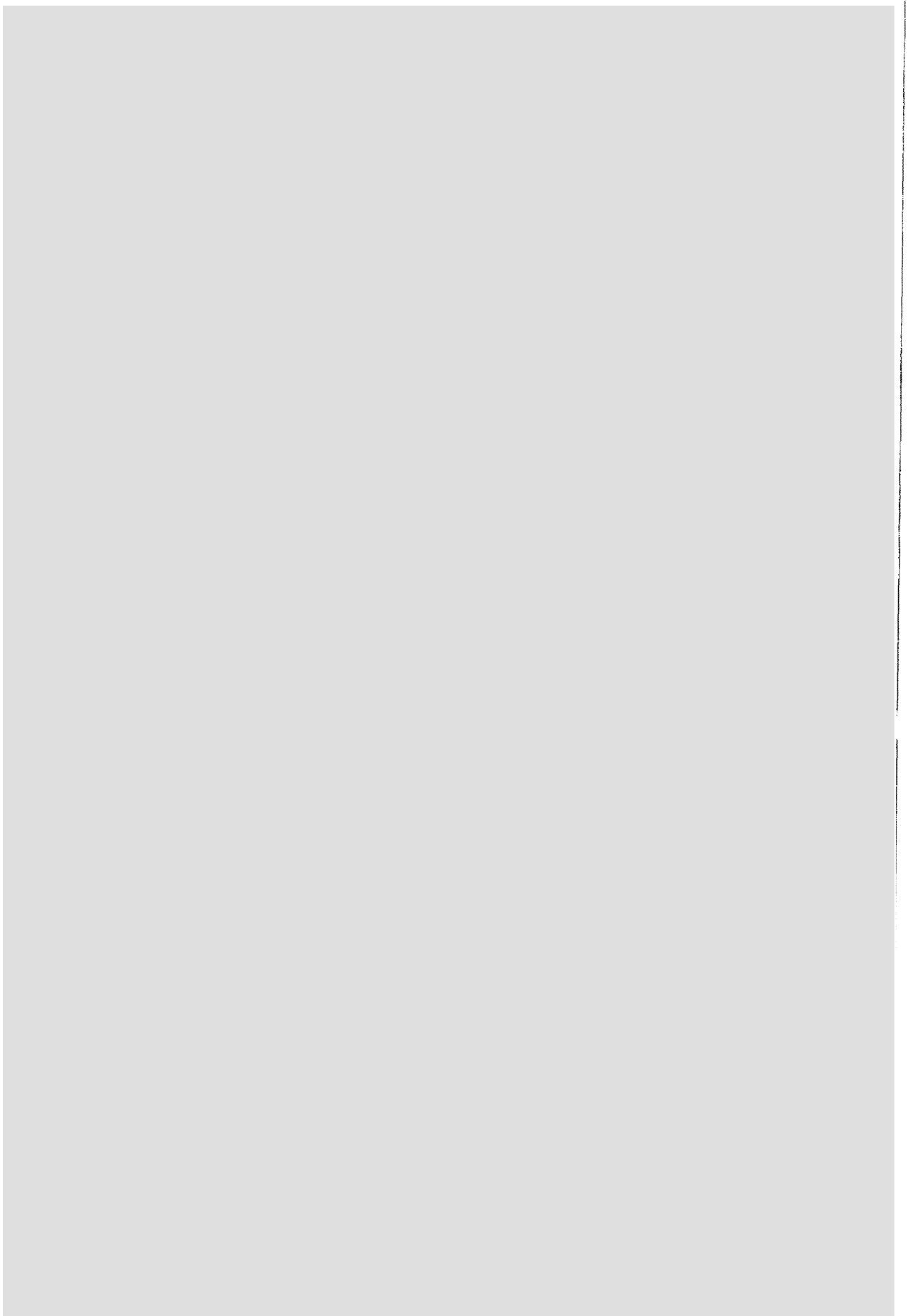

Acute Care Teams

ADOLESCENT INTEGRATED TREATMENT AND REHABILITATION RECOVERY CENTRE

MODEL OF SERVICE GUIDELINE

Comment: What is meant by this term here? Consider name to reflect where the centre sits in the CYMHS continuum of care

* a/mHS Adolescent Extended Rf Servic

1. What does the Service intend to achieve?

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

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The key functions of the AITRC are to:

- perform a comprehensive assessment of the adolescent that is informed by obtaining a thorough treatment history from service providers and carers
- provide evidence based treatment interventions to alleviate or treat distressing symptoms and promote recovery
- provide evidenced based interventions to assist progression in developmental tasks which are arrested secondary to the mental illness
- provide a 3-6 month staged treatment program that will ultimately assist recovery and reintegration back into the community

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Treatment programs undertaken by the AITRC will include an extensive range of evidence based therapeutic interventions and comprehensive activities to assist in the development and recovery of the consumer. Programs will include:

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- programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 3-6 month therapeutic interventions delivered by a multi disciplinary team
- a range of generic and when appropriate specific therapeutic interventions that are delivered by appropriately trained staff
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family
- multiple interventions that are integrated and reinforced across settings and across periods of time.

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

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

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2. Who is the Service for?

The AITRC is available for Queensland adolescents:

- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have failed to respond to previous treatment delivered by other child and adolescent mental health services including CYMHS Community Clinics, Evolve and Acute Inpatient Child and Youth Mental Health Services,
- likely to benefit from a range of clinical interventions of varying intensity
- who may have co-morbid mental illness and intellectual impairment

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

- the AITRC director
- referring specialist
- other key stakeholders identified by the AITRC director

In making a decision the panel will consider the:

- likelihood of the adolescent to experience a positive therapeutic outcome
- potential for treatment at AITRC to assist with developmental progression
- potential adverse impacts on the adolescent of being admitted to the unit
- potential adverse impacts on other adolescents if they were to be admitted
-

A comprehensive recovery and discharge management plan that includes community reintegration will in place prior to admission for all adolescents.

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

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

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

- Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid social anxiety disorder.
- Adolescents who have been unable to attend school for prolonged periods in spite of active community interventions. These may have a range of disorders including Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder.
- Adolescents with persistent depression, usually in the context of childhood abuse. They frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.

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<#>maintain strong operational and strategic links to the CYMHS network¶
<#>establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services¶
<#>provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder.¶ ... [1]
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Acute Care Teams

- Adolescents with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour that is usually secondary to complex post traumatic stress disorder.

Developmental delays and family difficulties are not uncommon.

Deleted: Adolescents with persistent, severe psychoses.¶

3. What does the Service do?

The key components of AITRC will be defined here.

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

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Comment: No reference to pre admission assessment in previous column. Need to discuss further the assessment process.

Comment: Is this pre assessment?

Key Component	Key Elements	Comments
	Clinical Nurse will liaise with the referrer until the adolescent is admitted.	the need for admission to help determine priorities for admissions. • The Clinical Liaison Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
Referral, Access And Triage (cont'd)	• Priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral.	
Developing Networks with Other Services	• The AITRC will develop and maintain partnerships with other relevant Health Services.	• This includes formal arrangements with medical services for treating medical conditions which may arise. • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders
	• The AITRC will develop and maintain partnerships with other relevant agencies who interact with adolescents with severe and complex mental illness	• This includes but is not limited to The Department of Communities (Child Safety), The Department of Communities (Disability Services) and The Department of Communities (Housing & Homelessness)
ASSESSMENTS		
Assessments of Mental Health/Illness	• The AITRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	• These assessments begin with collection of information from referrers, the assessment interview and throughout admission.
	• The AITRC will obtain a detailed history of the interventions to date for the mental illness	• This is obtained by the time of admission
Assessments of Family/Carers	• The AITRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care.	• This process begins with the referral and continues throughout the admission
	• Parents/carers will have their needs assessed as indicated or requested	• Parents or carers will be involved in the mental health care of the adolescent as

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Education Qld
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Comment: When possible

? parental mental health issues
- identified MH needs / linkages to ATODS/MH
- parenting deficits parent effectiveness work.

Key Component	Key Elements	Comments
		much as possible. Significant effort should be made to support this involvement.
Developmental Assessments	• The AITRC will obtain a comprehensive understanding of developmental disorders and their current impact	• This process begins with available information on referral and during the admission.
	• The AITRC will obtain information on schooling as it is available	• This occurs upon admission
Assessments of Function	• The AITRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• This assessment occurs throughout the admission
Assessments of Physical Health	• Routine physical examination will occur on admission	•
	• Physical health is to be monitored throughout the admission	•
	• Appropriate physical investigations should be informed as necessary	•
	• Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings	
Assessments of Risk	• Risk assessments will initially be conducted on admission and be reviewed on a daily basis	• All risk assessments will be recorded in the electronic clinical record.
	• Documentation of all past history of deliberate self harm will be included in assessment of current risk.	• Risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation.
	• will include a formalised suicide risk assessment and include,	
	•	•
General Aspects of Assessment	• All assessment processes will be documented and integrated into the care plan.	•
	• Routine assessments will be prompt and timely.	• All of the initial assessments of mental health, development and family are to be completed within two weeks of admission.
	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioners.	•
	• The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents).	•
	• Assessments of alcohol and drug use will be conducted with the	•

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* Risk (A) function panel cross — Risk —

(what panel does)

Risk management
— Clinical Indicators
? Standards.
— Effect regulation
sign
— Staff development
—

Key Component	Key Elements	Comments
	adolescent on admission and routinely throughout ongoing contact with the service.	
CLINICAL INTERVENTIONS		
Psychotherapeutic Interventions	• Individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• Therapists will receive recognised, specific training in the mode of therapy. • The Therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • The therapist will have access to regular supervision • Specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships) • Supportive therapies will be integrated into the overall therapeutic approaches to the adolescent.
Psychotherapeutic Interventions (cont'd)	• Individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	• As above
	• Individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	• Used at times when the adolescent is distressed or to generalise strategies to the day to day environment. • Staff undertaking such supportive interventions should receive training in the limited use of specific modalities of therapy. • Staff offering supportive therapy will have access to clinical supervision. • Supportive therapies will be integrated into the overall therapeutic approaches to the adolescent.
	• Psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• As for individual verbal interventions

Key Component	Key Elements	Comments
Behavioural Interventions	• Individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• Behavioural program constructed under appropriate supervision • Monitor evidence for effectiveness of intervention.
	• Individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• Review effectiveness of behavioural program at individual and Centre level
	• Group general or specific behavioural interventions	• Monitor evidence for effectiveness of intervention
Psycho-education Interventions	• Includes general specific or general psycho-education on mental illness	•
Family Interventions	• Supportive family interventions to support the family while adolescent is in the Centre, develop conditions of leave etc.	• Supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent. • Includes psycho-education for parents/carers
Family Interventions (cont'd)	• Family therapy as appropriate	• Therapist will have recognised training and supervision in family therapy • Therapists will have access to continuing supervision • Review evidence for effectiveness of the intervention • Family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• Monitoring mental health of parent/carer	• Support for parent/carer to access appropriate mental health care
	• Monitor risk of abuse or neglect	• Fulfil statutory obligations if child protection conerns are identified.
	• Promote qualities of care which enable reflection of qualities of home	• Review of interactions with staff • Support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• Milieu based interventions to promote appropriate development	•
	• School based interventions to promote learning, educational or vocational goals and life skills	•
	• Individual based interventions to promote an aspect of adolescent development	•
	• Group based interventions to	• Individualised according to

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Comment: ? definition is treatment communities of 9-18 months

Comment: Is this too vague?

Key Component	Key Elements	Comments
	promote aspects of adolescent development	adolescents in the group • Goals to be defined • Under the clinical direction of a nominated clinician
Pharmacological Interventions	• Administration of psychotropic medications under the direction of the consultant psychiatrist	• Education given to the adolescent and parent(s)/carer about medication and potential adverse effects • Regular administration and supervision of psychotropic medications • Regular monitoring for efficacy and adverse effects of psychotropic medications.
	• Administration of non-psychotropic medications under medical supervision.	• Includes medications for general physical health
Other Interventions	• ~~Multi-sensory room~~ Sensory modulation	• Utilised under the supervision of trained staff
	• Electroconvulsive Therapy	• Monitor evidence of effects • Administered in accord with the *Mental Health Act 2000*
CLINICAL CARE COORDINATION AND REVIEW		
Care Coordination	• Prior to admission a Care Coordinator will be appointed to each adolescent.	• The Care Coordinator can be a member of the treating team and is appointed by the AITRC director
	The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • Monitoring the adolescents mental state and level of function in developmental tasks • assisting the adolescent to identify and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	• An orientation information pack will be available to adolescents and their parent(s)/carer(s) • [ ] • [ ] • [ ] •
Care Monitoring	• providing a detailed report of the adolescent's progress for the care planning meeting	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and

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Deleted: The Care Coordinator will monitor mental state and level of function in developmental tasks

Comment: Something about tools used in here?

Deleted: The Care Coordinator will help the adolescent to identify goals for the care plan and subsequently implement them during their admission.

Comment: How do they assist/strategies.

Deleted: The Care Coordinator will be the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process.

Comment: Information sharing protocols?

Deleted: The Care Coordinator will assist the adolescent in implementing strategies from individual and group interventions in daily living

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– interventions to promote
– Structured programs –

Sensory modulation
under other Principles inpatient units
– safe, contained, relaxating environment

Key Component	Key Elements	Comments
		group interventions and observations.
	• adolescents at high risk and require higher levels of observations will be reviewed daily.	• This includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist.
	* diversified workforce.	•
Case Review	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• The Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed.
	Child/Adolescent-specific staff.	• The adolescent, referring agencies and other key stakeholders are invited to participate in the Case Review process.
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions.
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include consumers and carers, • appropriate structured assessments will be utilised, • the process will include objective measures, • annual audits will ensure that reviews are being conducted.
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent, interventions that have occurred, and to review progress within the context of the case plan.	• A consultant psychiatrist should be in attendance at every multidisciplinary team meeting.
	• risk assessments will be updated as necessary in the case conference	• The frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • Risk will be reviewed at a minimum of ?
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record.	• progress notes will be consecutive within the clinical record according to date

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Key Component	Key Elements	Comments
	• clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes	• personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date.
	• There will be a single written clinical record for each adolescent	• the written record will align with any electronic record
	• all case reviews will be documented in the adolescent's clinical record	• actions will be agreed to and changes in treatment discussed by the whole team and recorded
CONTINUITY OF CARE AND DISCHARGE PLANNING		
Continuity of Care	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings. • The Care Coordinator will liaise more frequently with others as necessary.
	• specifically defined joint therapeutic interventions between the AITRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave	• Joint interventions can only occur if clear communication between the AITRC and external clinician can be established
	• responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• this will be negotiated between the AITRC and the local CYMHS
Discharge Planning (cont'd)	• Discharge planning can begin where an adolescent's therapeutic and developmental progress give clear indication of future directions	• The adolescent is actively involved in discharge planning. • Discharge planning may begin at an earlier stage if there are probably significant obstacles e.g. accommodation, engagement with another Mental Health Service
	• Discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• The AITRC School will be primarily responsible for and support school reintegration
	• Discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge.	• The Registrar and Care Coordinator will prepare this letter. • It should identify relapse patterns and risk assessment/ management information. • Follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter.

Key Component	Key Elements	Comments
	• A further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AITRC	• This will be prepared by the clinicians involved in direct interventions
	• If events necessitate an unplanned discharge, the AITRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessements. In the event of discharge the AITRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	•
TEAM APPROACH		
	• A multidisciplinary team approach will be provided utilising the specific skills of each discipline	• The majority of clinical cases will be known to the majority of team members.
	• Clear clinical and corporate leadership will be provided for the team.	•
	• Case loads should be managed to ensure effective use of resources and to support staff.	•
	• Staff employed by the Department of Education and Training will be regarded as part of the team	•

4. Service and operational procedures

The AITRC will function best when:

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

Comment: ? what do they mean by integrated here.

Caseload

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

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

Comment: I would prefer to discuss this with Trevor before changing it.

Staffing

Comment: Are there not specific staffing requirements for the centre? i.e. Ratios/no.s

Acute Care Teams

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

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Comment: Do they always have this mix or should we say ideally.

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

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

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Hours of Operation

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

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Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

Consumers and carers will be involved in the delivery of staff training where appropriate.

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Staff from the AITRC will both engage in and deliver training to other components of the CYMHS where appropriate.

Training will include:

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- Queensland Health Mandatory Training requirements (fire safety, etc)
- AITRC orientation training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.);
- medication management;
- use of the *MHA 2000*;
- engaging and interacting with other service providers; and
- risk and suicide risk assessment and management.

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Comment: I think we need more specific skills here.

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

5. Clinical and corporate governance

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

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

The centre will be directly responsible to the corporate governance of the Queensland Children's Health Service District. Operationalisation of this corporate governance will occur through the AITRC director reporting directly to the Blah blah!!!

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

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

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

7. How do Services relate to each other?

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

8. How do consumers and carers improve our Service?

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

9. What ensures a safe, high quality Service?

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

Comment: Do we need to spell out how often.

Comment: Need your help here Judi!

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¶
At a local level, the Centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate a Parent Representative and the School Principal and an. They will meet regularly in meetings chaired by the Consultant Psychiatrist.¶
¶
The Centre will be responsible to the Corporate Governance of the Health District to which it belongs. If the primary Mental Health Service administering Mental Health Services in this Health District is an Adult Mental Health Service, they must at all times consult with the Child and Youth Mental Health Services of the Queensland Children's Health Service District regarding administrative and governance issues as this is a Level 6 Service for Young People.¶

Comment: Suggest we remove this.

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

10. Key resources and further reading

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

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In addition the AITRC seeks to:
maintain strong operational and strategic links to the CYMHS network
establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services
provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
develop the capacity for research into effective interventions for young people with severe and complex disorder

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have reasonable trials of intervention at local

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private child and adolescent psychiatrists or psychologists or Headspace services.

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who may have behavioural problems, use substances only if these are secondary to their mental illness

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Various processes of assessment (initial referral to the Clinical Liaison Clinical Nurse – CLCN, intake meeting, assessment interview) determine the

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Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

Model of Service

Comment: Level 6 CFCS?

1. What does the Service intend to achieve?

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

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

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

The key functions of the AETRC are to:

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

Comment: Judi

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

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Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff
- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family
- transition to the community facilitated by partial hospitalisation with outpatient follow up available if appropriate
- assertive discharge planning to integrate the adolescent back into their community and local treatment services

Length of Admission

- admissions will be for a maximum of 6 months
- in some specific cases an admission beyond 6 months or a ~~second admission~~ may be ~~considered~~ clinically indicated
- where the length of stay exceeds 6 months or ~~a second admission~~ is required the case must first be reviewed by the panel

Settings for assessments and interventions may include inpatient, therapeutic residential, step down and day patient and vary in the level of care provided.

Level of Care

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

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

Comment: Judi ?

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

Severe and complex mental illness in adolescents occurs in a ~~number~~ range of disorders. AETRC typically treats adolescent that can be characterised ~~into four broad groups~~ as outlined below:

1. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Community treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AITRC. Previous hospital admissions for treatment of the eating disorder may have occurred. Any admission to AETRC of an adolescent with an eating disorder will be linked into the Queensland Children's Hospital (QCH) for specialist medical treatment. Adolescents requiring nutritional resuscitation will be referred to QCH.

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

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

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

Table 2. Adolescent Extended Treatment Centre, Diagnostic Profile[1]

	Percentage	ICD-10 Category Code
Social Anxiety Disorders	51.8%	F20 – F29
OCD and Anxiety Disorders	23.5%	
Eating Disorders	27.1%	
Depression and Dysthymic Disorders	62.4%	
Post Traumatic Symptoms	24.7%	
Schizophrenia	5.9%	
Pervasive Developmental Disorders	20%	
Receptive-Expressive Language Disorders	52.9%	

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

	Percentage	ICD-10 Category Code
Other Developmental Disorders	51.8%	
Oppositional Defiant Disorder	50.6%	
Substance Abuse	9.4%	
Disorders with an Organic Origin	3.5%	
Parent child relational disorders	83.5%	

Data source: Chart Review of Patients

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

- the AETRC director
- referring specialist and/or Team Leader
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders

In making a decision the panel will consider the:

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

A comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents.

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

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

Admission Risks

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

- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder

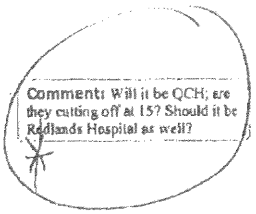
3. What does the Service do?

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

Comment: Judi re Jackie's comment

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
WORKING WITH OTHER SERVICE PROVIDERS	• the AETRC will develop and maintain strong partnerships with other CYMHS • shared-care with the referrer and the community CYMHS will be maintained • the AETRC panel will develop and maintain partnerships with other relevant health services	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network • in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC • this includes formal agreements with QCH to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; Surgical management of severe lacerations or burns from self injury • adult mental health links • this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders
REFFERAL, ACCESS AND TRIAGE	• Statewide referrals are accepted for planned admissions • responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	• this supports continuity of care for the adolescent
	• mandatory child protection reporting of suspected abuse or harm	• AETRC staff will comply with Queensland health (QH) policy regarding mandatory reporting of suspected abuse or harm
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there



Comment: Judi

Key Component	Key Elements	Comments
Referral, Access And Triage (cont'd)		is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
	• if there is a waiting period prior to admission, the Clinical Liaison Clinical Nurse will liaise with the referrer until the adolescent is admitted	• this process monitors changes in acuity and indeed, the need for admission to help determine priorities for admissions • the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	
	• the AITRC will develop and maintain partnerships with other relevant agencies who interact with adolescents with severe and complex mental illness	• this includes but is not limited to The Department of Communities (Child Safety), The Department of Communities (Disability Services) and The Department of Communities (Housing & Homelessness), Education Queensland

Comment: Refer to cfcs

Key Component	Key Elements	Comments
ASSESSMENTS	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	• assessments begin with collection of information from referrers, the assessment interview and throughout admission
Assessments of Mental Health/Illness	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Assessments of Family/Carers	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care	• this process begins with the referral and continues throughout the admission
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible. Significant effort should be made to support this involvement
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	
Developmental Assessments	• the AITRC will obtain a comprehensive understanding of developmental disorders and their current impact	• this process begins with available information on referral and during the admission
	• the AITRC will obtain information on schooling as it is available	• this occurs upon admission
Assessments of Function	• the AITRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• this assessment occurs throughout the admission
Assessments of Physical Health	• routine physical examination will occur on admission	•
	• physical health is to be monitored throughout the admission	•
	• appropriate physical investigations should be informed as necessary	•
• Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings.		
Assessments of Risk	• a key function of the panel will be to assess risk prior to admission	• all risk assessments will be recorded in the electronic clinical record
	• risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team	
	• documentation of all past history of deliberate self harm will be included in assessment of current risk	• risk assessment will be in accordance with the risk assessment contained in the state-wide standardised clinical documentation
	• will include a formalised suicide risk assessment and include	

Key Component	Key Elements	Comments
General Aspects of Assessment	• all assessment processes will be documented and integrated into the care plan	•
	• routine assessments will be prompt and timely	• all of the initial assessments of mental health, development and family are to be completed within two weeks of admission
	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioners	•
	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)	•
	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service	•
RECOVERY PLANNING	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent.

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Key Component	Key Elements	Comments
CLINICAL INTERVENTIONS **Psychotherapeutic Interventions**	• Individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the Therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships) • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
Psychotherapeutic Interventions (cont'd)	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	• as above
	• Individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	• used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking such supportive interventions should receive training in the limited use of specific modalities of therapy • staff offering supportive therapy will have access to clinical supervision • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• as for individual verbal interventions

Key Component	Key Elements	Comments
Behavioural Interventions	• individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• behavioural program constructed under appropriate supervision • monitor evidence for effectiveness of intervention
	• individual general behavioural interventions to reduce specific behaviours (e.g. self harm) • group general or specific behavioural interventions	• review effectiveness of behavioural program at individual and Centre level • Monitor evidence for effectiveness of intervention
Psycho-education Interventions	• includes general specific or general psycho-education on mental illness	
Family Interventions	• supportive family interventions to support the family while adolescent is in the Centre, develop conditions of leave etc	• supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent • Includes psycho-education for parents/carers
	• family therapy as appropriate	• therapist will have recognised training and supervision in family therapy • therapists will have access to continuing supervision • review evidence for effectiveness of the intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer	• support for parent/carer to access appropriate mental health care
	• monitor risk of abuse or neglect	• fulfil statutory obligations if child protection concerns are identified
	• promote qualities of care which enable reflection of qualities of home	• review of Interactions with staff • support staff in reviewing interactions with and attitudes to adolescent

Key Component	Key Elements	Comments
Interventions to Facilitate Tasks of Adolescent Development	• interventions to promote appropriate development in a safe and validating environment	
	• school based interventions to promote learning, educational or vocational goals and life skills	
	• individual based interventions to promote an aspect of adolescent development	
	• group based interventions to promote aspects of adolescent development	• individualised according to adolescents in the group • goals to be defined • under the clinical direction of a nominated clinician
	• adventure based and recreational activities	
Pharmacological Interventions	• administration of psychotropic medications under the direction of the consultant psychiatrist	• education given to the adolescent and parent(s)/carer about medication and potential adverse effects • regular administration and supervision of psychotropic medications • regular monitoring for efficacy and adverse effects of psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff • monitor evidence of effects
	• electroconvulsive therapy	• a rarely used intervention, subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*

	• there will be a single written clinical record for each adolescent • all case reviews will be documented in the adolescent's clinical record	• the written record will align with any electronic record • actions will be agreed to and changes in treatment discussed by the whole team and recorded
DISCHARGE PLANNING	• discharge planning can begin where an adolescent's therapeutic and developmental progress give clear indication of future directions	• the adolescent is actively involved in discharge planning • discharge planning may begin at an earlier stage if there are probably significant obstacles e.g. accommodation, engagement with another Mental Health Service
	• discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• the AITRC School will be primarily responsible for and support school reintegration
	• discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge	• the Registrar and Care Coordinator will prepare this letter • it should identify relapse patterns and risk assessment/ management information • follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter
	• a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AITRC • if events necessitate an unplanned discharge, the AITRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments • in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	• this will be prepared by the clinicians involved in direct interventions
TRANSFER	•	•
CONTINUITY OF CARE	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings • the Care Coordinator will liaise more frequently with others as necessary

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

4. Service and operational procedures

The AETRC will function best when:

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

Caseload

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

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

Staffing

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

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

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

Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

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

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

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs. AETRC staff should not assume their service mirrors other CYMHS
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Comment: Judi?

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

5. Clinical and corporate governance

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

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

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

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

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

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

7. How do Services relate to each other?

- formalised partnerships
- MOU
- guidelines
- statewide model of CYMHS
- The AETRC is part of the CYMHS network of services in Queensland as described in Section 3

Comment: Local agreements with QCH???

Comment: Dept. child safety, others?

Comment: Suggest we remove this.

8. How do consumers and carers improve our Service?

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

- consumer and carer participation in collaborative treatment planning

- consumer and carer feedback tools (e.g. surveys, suggestion boxes)
- consumer and carer's will inform staff training

Comment: added

Consumer and carer involvement will be compliant with the National Mental Health Standards.
*General statements re this issue (e.g. service planning, service development, service evaluation, input into own clinical care etc) will be made in Intro / overview of the MOS Framework.
*Any specific to ACT?

9. What ensures a safe, high quality service?

- the service capability of the AETRC is defined in the Child and Youth Non-Acute Inpatient sub module of the *Clinical Services Capability Framework (CSCF) - Mental Health Services Module*(v 3, 2010) as Level 6
- adherence to the Australian Council of Health Care Standards (ACHS), current accreditation standards and National Standards for Mental Health Services
- appropriate clinical governance structures
- Skilled and appropriately qualified staff
- professional supervision and education available for staff
- evidence based treatment modalities
- staff professional development
- clear policy and procedures
- clinical practice guidelines, including safe medication practices

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

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

Legislative Framework:

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

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10. Key resources and further reading

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

Based on the principles of Recovery, as outlined in the ***Sharing Responsibility for Recovery: creating and sustaining recovery orientated systems of care for mental health*** document, mental health services operate on the premise that most consumers can and do recover[2] from mental illness. Services are directed at helping the consumer (and

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

their family/carers) manage their illness and enhance their capacity for recovery. Importantly, the AETRC team considers how the concept of Recovery applies to adolescents and their families/carers. This includes acknowledgement that Recovery should take into account developmental processes, that the concepts of Recovery may also be applied to parents, carers and entire families, and that the mental health field for this consumer group is broader than that for adults (i.e. including prevention and early intervention; a wider range of challenges and disorders, not all of which are mental illnesses; and that the focus should be on promoting the positive potential of all children and adolescents).

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

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

Model of Service

1. What does the Service intend to achieve?

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

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

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

The key functions of the AETRC are to:

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

A simple questions

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

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

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

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Programs will include:

- phased, treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 3 month treatment as above incorporating a range of therapeutic interventions delivered by appropriately trained staff
- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family,
- the multiple interventions are integrated and reinforced across settings and across periods of time. (This is a key component of what must happen, and what makes it different to other CYMHS settings.)
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services

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Length of Admission:

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

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Level of Care:

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

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

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

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

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

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

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

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

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

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

- Senior staff of the AETRC,

- referring specialist and/or Team Leader
- representative from the QCH CYMHS (Interim arrangements may exist). This could be a designated QCH CYMHS Liaison Person, so that they don't at a question from the unit and so has away with no idea of the unit and whether or not adolescents will benefit.
- AITRC School Principal or their designate
- other identified key stakeholders

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In making a decision the panel will consider the:

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

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

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

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

Admission Risks

Some young people may pose considerable risk to others. Admission to AETRC **will** be decided on an individual case basis by a multidisciplinary review panel.

Admission risks include but are not restricted to:

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

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3. What does the Service do?

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

The key components of AETRC are defined below:

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Key Component	Key Elements	Comments

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

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Key Component	Key Elements	Comments
		appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
Referral, Access and Triage		• this process monitors changes in acuity and the need for admission to help determine priorities for admissions
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	
Key Component	**Key Elements**	**Comments**
Assessments **Mental Health Assessments**	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Family/Carers Assessments	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the	• this process begins with the referral and continues throughout the admission

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

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Key Component	Key Elements	Comments
Assessment		prompt and timely • initial assessments of mental health, development and family are to be completed within two weeks of admission
	• Communication	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	• Care Plans	• all assessment processes will be documented and integrated into the care plan
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service
• **Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings**		
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies
Clinical Interventions		

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

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

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

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

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

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

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

4. Service and operational procedures

The AETRC will function best when:

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

Caseload

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

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

Staffing

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

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

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

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Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

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

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

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

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

Training will include:

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

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

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

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

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

Where specific therapies are being delivered staff will be trained in the particular modality of the therapy e.g. family therapy, cognitive therapies, (All staff should understand the principles of behaviour programs including exposure, desensitisation, reinforcement and

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Education: However cognitive therapy has a number of strengths of the way which is developing all the time

5. Clinical and corporate governance

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

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

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

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

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

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

7. How do Services relate to each other?

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

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8. How do adolescents and carers improve our Service?

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

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

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

9. What ensures a safe, high quality Service?

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

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

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007. http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.
- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html
- Guidelines for the administration of electroconvulsive therapy (ECT): http://gheps.health.qld.gov au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health gov au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars0?-03-799_528.htm/$H LE/799_528a pdf.

Legislative Framework:

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

10. Key resources and further reading

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

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Information from Trina Sadler & Clin Director etc

OBSERVATIONS ABOUT ADOLESCENTS WITH SEVERE AND COMPLEX MENTAL ILLNESS: DIFFICULTIES AND PROCESSES OF CHANGE

Presumably all adolescents admitted to the AITRC will have had an extensive range of evidenced based treatments in the 12 - 36 months they have been in CYMH services prior to admission. Questions on the MOSD review panel's minds will naturally be:

- $ why haven't they responded to date to evidenced based treatments?
- $ what does an AITRC offer to bring about change? (Do they have access to other evidenced based therapies that other CYMHS don't?)
- $ what do they observe about the processes of change?

The previous paper outlined the lack of guidance from research about interventions for adolescents with mental illness at the most severe and complex end of the spectrum. This necessitates going back to first scientific principles - good observations about individual phenomena and behaviours, observing trends, developing hypotheses and testing hypotheses.

This first section outlines my observations from the last 23 years. (I don't have any strong preferences for treatment approaches - we draw from a number of evidenced based therapies. I don't think these observations are selective to fit into any theoretical frameworks. In fact some were confusing at first, not fitting in with dominant theories.) In some disorders, we are simply continuing to make observations, in others observing trends and in some making hypotheses. That's the state of our science to date.

The facts

- $ that adolescents have disorders which persist in spite of evidenced base treatments,
- $ we find change only after multiple interventions, often with several interventions in a week or even in a day and
- $ change only occurs over time

suggest that the relationships between interventions are likely to be complex to describe. Any notion of further, easily described interventions for a particular condition is naive.

Observations of lack of responses to previous evidenced based treatments and on processes of change

- $ As described in the previous paper, most adolescents with any disorder have profound difficulties in recognising, understanding, differentiating and expressing emotions. We observe that progress in therapy commences when this skill develops.
- $ The few who have an adequate capacity for emotional understanding gave invariably been in a chaotic environment which has never validated legitimate emotions.
- $ Many adolescents with severe anxiety have great difficulty in acknowledging their anxiety.
- $ All adolescents with school refusal, severe social anxiety and have a specific learning difficulty have major difficulties acknowledging their learning difficult, because it is another area in which they can be judged. They can be strongly avoidant of some or all school work for months. Prior to admission, this has been a significant factor perpetuating their school refusal.
- $ Cognitive based approaches to manage anxiety cannot proceed until they can acknowledge their anxiety.
- $ Non-verbal interventions (in our case art, sand play and adventure therapy) often facilitate emotional expression.

- We observe that a treatment only approach for a disorder does not necessarily reult in decreased impairment.
- We observe that impaired functioning in development tasks limits treatment interventions.
- We observe that as adolescents with anorexia face a challenge in a developmental task or in expressing some emotion their eating behaviours become more resistant to change at that point. Conversely, mastering a developmental challenge lessens the rigidity in their eating disordered behaviours. Consequently I conclude that developmental difficulties and difficulties expressing particular emotions are expressed in eating disordered behaviours and this perpetuate the disorder.
- Conversely we observe that progressing in a development task (the rehabilitation component) in which they had difficulty can facilitate progress in treatment again. This differs from physical medicine (e.g. a fractured hip) where treatment (surgical stabilisation) is followed by rehabilitation.
- We do not observe a one to one correlation between disorder or behaviour and therapy. We observe that a prescribed approach for a particular disorder or behaviour is not supported by the literature nor is it reflected in our experience. What is necessary for adolescents with persistent disorder is a thorough assessment of an individual to map out potential therapeutic interventions, but being flexible to modify as various issues for that adolescent arise. This is entirely consistent with the literature.
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- Anyone familiar with the literature on self harm will be aware that there is neither a consensus approach to treatment or even assessment or how to conceptualise the range of presentations in adolescents with self harm.

For the purpose of explaining the next point

- $ Psychologists (in particular) are trained in a range of cognitive therapies - motivational interviewing, acceptance-commitment therapy, DBT, stress inoculation as well as more generic CBT approaches. They and other staff have attended specialised workshops on CBT-E etc.
- $ Many cognitive therapies are what I would term "linear" or therapist directed. That is, therapy progresses in some sort of line - they have a beginning and work through a series of steps to examine and modify cognitions. The more manualised versions are highly "linear" (therapist directed), whereas some are "modifiably linear" therapist directed but modified in collaboration with the adolescent.
- $ Psychologists, occupational therapists, nursing staff and medical staff have basic to advanced training in behaviour therapies. These are primarily utilised in behaviour modification and graded in vivo exposure. Good behaviour therapy requires an individualised approach, but along a proposed hierarchy - this I would term "individualised linear" therapy - that is the therapist makes an individual assessment, directs the course of the action, but continually individualises the approach according to the adolescent repsonse.
- $ Currently we do not have anyone formally trained in psychodynamic therapy. There are many insights from these schools of therapy which are invaluable in therapeutic work with adolescents at the severe end of the spectrum, and in particular, those who have been abused. These insights include the profound interactions between parent and adolescent and adolescent's conflicts about their parenting; issues of dependency, individuation etc.; concepts of defences against various emotions; and emotional interactions between therapists (including not only the prime individual therapist, but on a long term inpatient unit a number of staff significant ot the adolescent) and the adolescent. CBT based therapies often do not acknowledge these issues (I am not sure about CAT). I would term psychodyamic therapy "non-linear" or "adolescent directed".
- $ Family therapy has provided insights particularly in how systems interact. While we have a social worker trained in family therapy, and utilise it where possible, I do not attempt to clssify it in terms of its linearity.

Back to observations

- $ We observe that therapeutic progress is rarely linear i.e., that therapy for a particular disorder begins and progresses until recovery. It begins, progresses to a certain stage (with respect to individual therapy) and then there is a moratorium on that issue. Often this will not progress further until they have developed mastery in an area of impairment, or addressed and issue in family therapy and/or individual therapy will need to explore another area of concern for the adolescent.
- $ In this way treatment at the AITRC is far more likely to be non-linear akin to psychodynamic treatments, even with a primary individual therapy utilising a cognitve approach. I observe that therapists who are highly structured without being sensitive to the issues important to an adolescent and being flexible in their approach rarely facilitate change. On the other hand, adolescents who have difficulties with verbal (and in particular emotional) expression find non-directive psychotherapies difficult. They prefer some structure, but one that is very sensitive to them, and which facilitates expression.
- $ Similar co-morbidities often interact differently in different adolescents. Strong co-

morbidities between anorexia nervosa and social anxiety disorder were previously noted. Add to this the perfectionism found in a number of adolescents with anorexia and what Chris Fairbairn called "core low self esteem". We observe that these interact in different ways in different adolescents to maintain each other. We observe that parallel therapy aimed at each (the eating disorder, the social anxiety disorder, the core low self esteem and the perfectionism) is overwhelming to an adolescent. We do not observe that therapy proceeds in a sequential order - first treat one disorder, then another etc. Therapy progresses by treating one to a certain stage, then it becomes apparent another must be addressed for further progress to be made. Therapy on the first disorder may resume, or it may go to a third. There is no order of sequence. The therapist and team must be flexible to provide adolescent centred therapy. The interactions of components in therapy are very poorly described in the literature. Descriptions of evidenced based treatments for co-morbid conditions are almost absent.

$ Behavioural interventions are offered at various times and in various situations. One example is a community access group. This may be a simple outing to the movies, catching public transport. An adolescent with social anxiety may have difficulties asking for tickets, food etc, sitting with people, eating in front of other people. In effect this is a form of graded exposure for various aspects of their social anxiety. Some may do the entire activity simply to be part of the group, some may be able to perform only some of the activities, which is part of grading their exposure, while others may need some preparatory exercises. Simply being out with others and not doing any of these activities will the most basic elements of the exposure. Thus a group activity, with careful assessment and monitoring of the individuals within the group provides a recognised therapeutic intervention for anxiety. This occurs throughout treatment - it is not specific to any stage. As well as addressing anxiety, it may facilitate a number of developmental tasks (e.g. competencies for independence, acquiring different leisure skills). This may then facilitate individual work in another area. There are multiple interventions similar to this.

$ A behavioural intervention at one time may have a different impact on an adolescent at a later stage, when they are cognitively and emotionally able to assimilate more. Thus groups may be repeated at later stages.

$ A number of non-verbal interventions (e.g. music, art, sand play) are used in CYMHS. The evidence base for these is not strong, but clinicians find them useful. I have noted our observations about their utility in facilitating emotional expression. We have observed that adolescents do not utilise them as the sole means of expression (i.e., the whole of therapy is not art or sand play or whatever). Rather verbal therapy can be enhanced when they have the capacity to utilise art or sand play for a period either as part of therapy with the prime therapist, or with a specialist in the area. I regard their role as facilitative therapies. Research methodology into interventions which facilitate other therapies is underdeveloped.

$ Adventure therapy (problem solving, high ropes, etc) is another form of non-verbal therapy. We note a variety of effects. For some it facilitates problem solving to be able to be utilised in cognitive therapy. For others who do not recognise anxiety, it is a tangible form which then helps them to recognise it in others. A third group learn specific strategies for anxiety reduction in these tangible activities which they can then apply to other, less tangible areas. Adolescents who have been abused from the avoidant disorder of childhood group find the sensory experiences facilitate working through abuse. Others dins a sense of mastery in some activities which decreases anxiety in other areas. This is a generic activity which is non-specifically applied (as

long as the adolescent has the basic competencies) whic has a number of different effects. This can be measured on A-B-A methodology for individuals, but may be lost on a group effect. Again this is facilitative rather than a primary intervention.

- $ Adolescents who have been multiply abused have difficulties with DBT. They do not like relaxation, nor sensory awareness. They are prone to somaesthetic hallucinations. Their bodies have experienced horrific sensory overload. This is consistent with some of the research from van der Kelk and others. They regain somatic mastery through a number of physically based interventions - sports and exercise, drumming, high ropes, multi-sensory room etc.
- $ Impairments are addressed through exposure (where anxiety is the major issues), a range of opportunities (for those from impoverished environments) and education (e.g. cooking groups, learner's licence preparation).
- $ We observe some adolescents simply wish to continue formal schooling, and have the capacity to do so. For others, simply being in the routine of initially sitting in a classroom and doing some work provokes anxiety. The school needs to be involved in graded exposure of school work.
- $ Relationships with staff obviously have an impact on an adolescent when they are in the unit for months. Adolescents recognise staff as individuals. If they have experienced "good enough" parenting, they will regard staff hopefully as decent adults who are there to help them work through their issues. Adolescents who have been abandoned, abused or neglected by their parents after several months of observing and interacting with staff begin to reflect on their own parents, and work through issues. This is an important in helping them work through their trauma issues.

BAC Interventions

I observe that the particular features of the BAC program which add on to what adolescents may have received in community or acute adolescent inpatient CYMHS are:

- $ a range of both specific, individualised and generic interventions
- $ interventions which occur throughout the day
- $ interventions which facilitate primary interventions
- $ interventions which help to generalise and reinforce primary interventions
- $ interventions which address impairment
- $ interventions which help to generalise the impacts of hospitalisation into integration into the community.

These interventions are more wide-ranging and more intensive than in a community CYMHS These interventions are more treatment orientated that in an acute adolescent inpatient CYMHS (particularly with respect to treatments that require longer terms of intervention. These interventions are more independent of family structure and effects than either a community or day patient CYMHS. This is important for those adolescents who cannot return to their families.

1. Assessments

A comprehensive assessment, while the initial phase continues throughout the admission. Assessments are from multiple sources:

- $ obtaining as much collatarel information that is avialable including information from CYMHS, school reports, Child Safety (where relevant).

$ formal assessments e.g. psychological assessments of both general and disorder specific factors, language and problem solving assessments, occupational therapy assessments of both living skills and sensorimotor skills, educational assessments
$ assessments of various aspects of function within the unit e.g. interactions with peers, self care skills, mood changes etc. These usually occur over several weeks to understand what is trait, and what was due to the impacts of admission.

2. Specific treatments for disorders

2.1 School refusal

I have noted previously that there is not a one to one correspondence between treatment and this behaviour, even if a specific disorder, e.g. social anxiety disorder is present. This is in part due to the extent of the disorder, the adolescent's degree of defensiveness about or acknowledgement of it, the interaction of the disorder with other disorders e.g. Asperger's or other anxiety disorders, whether a learning disorder is present, the interaction of the disorder with parenting factors, and whether the disorder was an extension of a long term pattern of behavioural inhibition (likely to evolve into avoidant personality disorder) or whether there was a fairly clear onset in late puberty or early adolescence.

Given those caveats the treatment for this behaviour or of social anxiety disorder (which predominates in school refusal) are:
$ behavioural interventions for graded exposure in various areas of anxiety
$ cognitive therapies for anxiety
$ general pscyhotherapy for related emotional factors
$ educational involvement and remediation where possible and necessary
$ graded exposure to community involvement (e.g. outside schools)
$ family therapy both with respect to roles, communication, practical issues on leave as well as tasks with re-integration to school.

2.2 Anorexia nervosa

Typically the management of anorexia nervosa has several components:
$ Weight restoration - this is preferably through a behavioural program which is as least restrictive as possible. (This is not the strict operant behavioural program for the 70's and 80's, but seeks to implement the principles without the punitive aspects. I was interested that an almost identical approach is used at the Pine lodge unit in Chester - a leading disorder for eating disorders in the UK.) Naso-gastric re-feeding is only used as an extreme resort. (Again similar to Pine Lodge.) This program is devised in conjunction with the psychologist, the dietitian and the care co-ordinator and myself. As with all behavioural programs the effects are continually monitored.
$ Nutritional stabilisation and normalising eating. This is an individual collaboration between the dietitian and the adolescent. This includes three meals and three snscks a day, with liquid supplements only if necessary to reduce anxiety.
$ Nursing staff with experience in anorexia provide epert supervision at meal times.
$ Cognitive therapies including motivational change for eating disorders, general therapy at examing eating cognitions, acceptance commitment therapy as well as therapy for reducing specific anxiety, therapy for exploring issues with parents (many of the parents have significant pscyhopathology, and are difficult to engage)
$ Behavioural interventions to provide graded exposure for various aspects of social

anxiety. This includes a food challenges group which helps adolescents with anorexia and social phobia begin to eat out in public.

$ Psychotherapy to facilitate exploration of various issues of trauma where this is a significant factor.

$ Family therapy is rarely of the Maudsley type because adolescents tend to be older, and other aspects of the program encourage the adolescent to actively take on the responsibility of managing their own eating. The aim of the family therapy is to explore general family communication, roles etc. Our social worker has a background in a number of schools of family therapy, and utilises whatever is the most applicable for a family.

The minutes of the first MOSD recorded a comment that we did not have the experience to treat anorexia. This statement puzzled me as to what evidence this is based on.

We certainly do not have experience in treating anorexia in its most complicated phases. I have treated adolescents with severe and persistent anorexia for the past 23 years. Two dietitians over the past five years provide a minimum of a day a week time to adolescents with anorexia. A psychologist of eight years experience at the severe end provides most of the individual treatment. We can undoubtedly aquire further skills, but this is a very solid basis on which to build further expertise.

In the UK, a service for those with severe and persistent anorexia is provided only in the private sector. Units such as Pine Lodge at Chester refer some of the 12% of their adolescents with persistent anorexia to them. I will visit some of these specilaist units for adolescents with the most persistent disorders over the next fortnight. Certainly, from what I saw at Pine Lodge, there is strong similarity in the specific elements of treatment for eating disorders. I believe it is likely the non-specific elements or our program contribute to significant improvement in at least 50% of this difficult group.

2.3 Symptoms and behaviours associated with abuse

$ Self harm is reduced through a combination of behavioural programs to reduce at self harm, individual therapy to understand causes of distress, recognise early warning signs and utilise alternate coping mechanisms. Adolescents seldom utilise DBT principles as first line interventions. They often appreciate and begin to assimilate them after a period of psychotherapy. This is in line with what my UK colleagues observe.

$ General psychotherapy facilitates exploration of parenting issues; interactions with peers both in the present on the unit and peer interactions in the past; emotional responses and boundaries in the current environment (very important in adolescents with the avoidant disorder of childhood who have internalised emotions). Often this can be facilitated by non-verbal therapies at various points.

$ Specific management for PTSD symptoms including dissociation, exploration of hallucinoses, flashbacks nightmares etc. Strong therapeutic relationships with a number of staff and certainty of safety and capacity for staff to contain distressing emotions are important preludes to this process. Nursing staff with skills in this area are critical to this process as these symptoms are more prevalent in the evening.

$ EMDR is available but seldom utilised by adolescents

$ Where an adolescent will accept stress innoculation therapy is offered prior to specific trauma exposure therapy.

$ Trauma exposure therapy occurs towards the end of treatment. The process has been outlined before to the adolescent. The adolescent requests therapy before it is commenced. This is sometimes after a period after discharge, and they will return to the unit for the therapy for a matter of weeks because it is so emotionally difficult.

Individual therapy for specific disorders typically occurs once or twice a week, although in the phase of exposure to abuse, it may be up to three times a week in the most acute phase.

3. "Generic" elements

I term these as "generic" because they are interventions for a number of adolescents irrespective of disorder. They are not applied generically, but individualised to an adolescent or for a group of adolescents.

$ education program. This program is very flexible, providing for continuing education (primarily english, maths, science, history, geography, cimputer) for adolescents who continue to have links with their own schools; remedial education; graded exposure to doing schoolwork for adolescents who have anxious avoidance of school; non-academic subjects physical education, music, home economics, TAFE modules; guidance officer support with subjects, educational and vocational options for school return and finally are integral to the process of integration into school.

$ Groups may be tailored in their content for the whole group of adolescents who are not selacted for the group. The DBT group is an example. We find that adolescents of this severity and complexity often lack the cognitive and emotional awareness to benefit from a formal DBT approach. It has been modified and adapted, and the skills elements delivered in a group format over about 32 sessions. All adolescents are expected to attend, although their involvement and utilisation of the skills is highly variable some understand principles after six months. Adolescents who have experienced abuse find issues of awareness of themselves difficult because an important coping mechanism has been to block out awareness of sensations. They benefit the least until they are ready to work through some of their abuse issues. (The relationship issue which I believe is a significant component of DBT is not an issue in a long term unit.) Staff are made aware of the particular focus of the group for a week, and the skills generalised where possible in day to day settings throughout the week.

$ Other groups are tailored for a specific sub-group with particular needs e.g. the community access group. Adolescents are selected because of lack in a number of competencies in accessing community events for adolescent appropriate activities. Their individual difficulties are assessed. The group becomes a group format for desensitisation, although activities for each adolescent are individualised for that activity.

$ Some groups are verbal - e.g. a "boys to men" group for adolescents who have had poor experiences of fathering to help understand some of the issues they are facing about growing up to be a man, sexuality etc.

$ Other groups have high activity components e.g. the various components of the adventure therapy program. Skills for this were described earlier. The principles learned are enunciated in debriefing sessions, and then generalised in the day to day program.

$ Physical activities and interventions are an important part of the program. Some of these are active exercise for building health and fitness into daily routines or learning