universal interventions is engendering a culture of "mistrust" in response to risk management, which in turn affects interactions and relationships between staff and patients. Policies such as these should be reviewed by the team.

Specific issues, highlighted by case note review, include the review team feeling that there should be increased clarity of the pathway between risk assessment and a pro-active management plan, including placing the patient on CAT RED. The review team feel a more formal process review should occur after significant incidents. Documented care plans do not appear to be updated during the adolescents stay in response to risk assessment outcomes. . The requirement to have a multidisciplinary care plan does not disallow a nursing care plan, or a behavioural management plan being written and updated on a regular basis.

If programmed responses such as the A1-7 and Cat Red processes to risk taking behaviour are to continue, the review team are of the opinion BAC staff need to:
(1) review current programs and update them in relation to current patients,
(2) Document patient compliance and responses to the program,
(3) Monitor usefulness overall of such programs in modifying behaviour and
(4) Give consideration to a process whereby the adolescent and staff member sit down together to discuss and agree on logical consequences following risk taking behaviours. Age and developmental maturity may influence the outcomes.

6.5 BAC Management issues relating to critical incidents

BAC staff need to establish a process whereby incidents considered to have potentially major consequences are investigated. Park needs to consider updating incident forms to include risk assessment of the incident looking at the actual and potential outcomes rather than as primarily a reporting tool. Simple categories could include; What happened, Why and how did it happen, What opportunities are there to prevent a further occurrence?

EXHIBIT 75

WMS.9000.0003.00450

A broad BAC response would include better communication about risk and risk management, more focused training, consideration of fatigue and rostering issues, environment and equipment needs, reviewing relevant rules/policies/procedures and other barriers that become evident. This process needs to become the basis for changes in practice. For example a review of the 'chair through the window' incident would have inevitably led to the urgent need to ensure that BAC glass is replaced or in some other way the clients are protected. A failure to look at potential risk management issues resulting from serious incidents could be seen as negligent.

6.6 Training, Education and Orientation for all staff

Many staff stated there was no regular inservice program or training days programmed at the BAC or for BAC staff. The review team feel that regular and ongoing training for BAC staff, in risk management and other issues should be mandatory. Such training should be consistent with the severity of problems that BAC patients present and the issues around intense medium to long term admissions for adolescents. A special focus should be training and education for new staff on adolescent issues. This currently appears to be ad hoc, with some staff reporting they were not offered any training opportunities related to working with adolescents or developing their understanding of adolescence. It was clear that opportunities for personal clinical supervision should also be explored and incorporated into the BAC processes.

Example of potential risk management training would be regular participation in a program of local critical incident response training, which would include:

(1) Fire evacuation,
(2) Managing aggression,
(3) Managing a medical emergency (eg an adolescent who looses a significant amount of blood after cutting themselves; or where an adolescent is found unconscious, with several empty pill packets next to them)
(4) Secluding a patient.
(5) CPR

EXHIBIT 75

WMS.9000.0003.00452

Orientation: the review team feel the orientation process and documentation should be improved, specifically:

(1) The manual needs to be updated, and several copies need to exist.

(2) All new staff need to be orientated including casual staff. Consideration be given to developing a competency based orientation programme, where staff need to be able to demonstrate skills and understanding of processes, developmental issues and therapies.

(3) Consider making up a 'cheat sheet' orientation for casual staff with the absolutely essential information to manage for a shift on it.

EXHIBIT 75

WMS.9000.0003.00454

7. LONG TERM ISSUES THE CONTINUING ROLE OF THE BAC

This report has focused on critical incidents and risk management at the BAC. However, a pervasive theme amongst staff, and in the review teams opinion a significant barrier to change at the BAC is the uncertainty of the unit.

The review team encourage The Park and BAC management to activity pursue clarity of this issue. In doing so the review team note contemporary themes, not necessarily core to mental health but clearly related to adolescent mental health, that are reasons why the BAC offers a unique opportunity to severely troubled youth. Firstly most BAC clients have been serially suspended or excluded from the education system. Cessation of schooling confers a further and serious impairment to this client group. The BAC provides a unique educational opportunity for this group, with good evidence of major academic gains being made by clients during their BAC stay.

Secondly, youth homelessness is unacceptably high and the BAC clients are at the severe end of the spectrum of risk factors that lead to homelessness. Without the BAC many of this client group will become homeless and denied a place of safety, therapy and education. In brief without the BAC many of this group will still need accommodation somewhere, but alternative accommodation could not provide the possibility of restoration and rehabilitation which the BAC staff work so hard to provide to a very disenfranchised group of adolescents.

All services should change over time, and the BAC has this challenge. Precipitous action such as closure of the unit without a process of re-orientation with other SE Queensland service units could remove a part of the continuum of care that is extremely difficult to replace and simply transfers the burden to other areas of the wider system.

EXHIBIT 75

WMS.9000.0003.00456

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EXHIBIT 75

WMS.9000.0003.00462

Appendix I: Information provided by the BAC

Figure A1: Summary of Critical Incident by Incident Month.

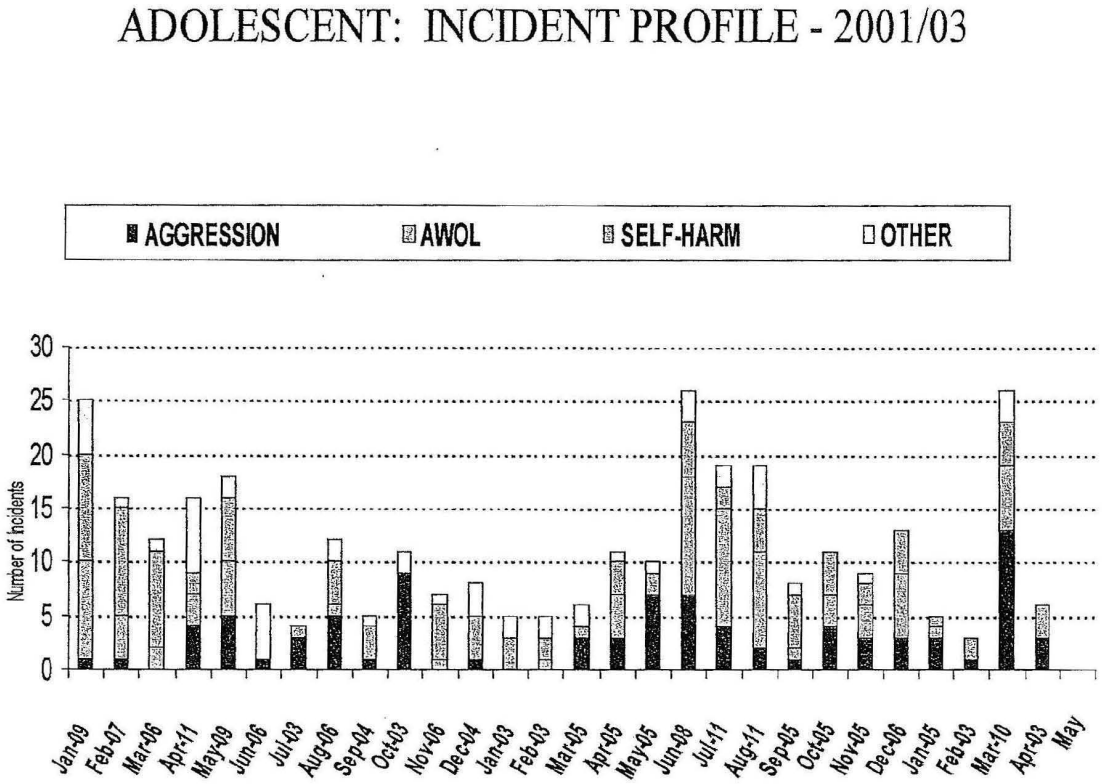


EXHIBIT 75

WMS.9000.0003.00464

ADMISSION CRITERIA TO THE BARETT ADOLESCENT CENTRE

The need to review our admission criteria comes from two sources:

1. The McDermott et al report "CONSULTATION on AGGRESSION and VIOLENCE at the BAC"
2. A meeting on September 11th at the Mental Health Unit to consider the admission criteria for inpatient units.

The McDermott et al report

The report recorded the range of diagnostic groups at BAC *as "psychosis, depressive disorders, avoidant anxious disorders, OCD, Tourettes syndrome, eating disorders, traumatic stress disorders, Aspergers syndrome"*

"From this presentation it was noted that the BAC accepted a wide range of individuals with a wide range of presentations and would generally give many individuals a go to see whether they could use the therapy offered at the BAC. This philosophy was stated by most senior clinicians, and they were clear that the admission criteria were quite open, ie. from 13 to 17 years of age with a psychiatric illness, and suitable to be on an open unit and with evidence of client and family commitment. Individuals with substance abuse, with a diagnosis of only conduct disorder ort who had moderate or severe intellectual handicap were excluded from the BAC."

There was a clear perception from all levels of clinical and management staff that the type of client seen at BAC had changed over recent years. Many clinical staff noted there was a mismatch of recently referred adolescents with the original treatment philosophy at the unit, mainly manifest by an increase in the amount of disturbed behaviour including increased client histories of aggression and social problems. Some clinicians felt there were more patients with co-morbid drug and alcohol problems or adolescents from geographically remote locations, including Darwin. Some clinicians noted that the recent occurrence of finding several patients in possession of weapons was very unusual in the long history of the BAC. Lastly, many staff felt that the unit was under increasing pressure from external stakeholders to accept children whose presentations did not meet the admission criteria for the unit, and who in fact would previously have been excluded from those presentations. Examples included adolescents on remand from the Brisbane Youth Detention Centre."

The first of there recommendations was more clear admission criteria. *"The review team felt the BAC should undertake a purposeful process to determine which patients are most likely to receive benefits from the BAC program, and how this fits with the current continuum of client care across SE Queensland. The review team were surprised by the role of potential diagnoses of individuals at the BAC and the oft stated ethos by all levels of staff of "having a go" with most types of presenting problems. A review of the target groups need not only be diagnosis driven. For example a role for individuals with severe, persisting self-harm (therefore problem based) may be equally as valuable.*

In their executive summary they said *"However the review team recommend further work in the delineation of the BAC in the continuum of care of adolescent mental health services in SE Queensland. Tasks include the current evidence base for adolescent inpatient care and whether the current broad admission brief should not be changed to focus on a more limited diagnostic range or alternatively to focus on particular challenging behaviours such as individuals with internalising conditions and mild externalising behaviour or individuals with sever and ongoing suicidality and self harm.*

Mental Health Unit and Zonal Initiatives

Attached is a file which contains a document *"Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units"* It's pretty unsatisfactory when it comes to BAC. They actually ignore some relevant principles.

Before this came out, I had given a presentation to a zonal meeting about our admission criteria, trying to get across the interaction between the diagnosis (actually diagnoses multiple in most case), the loss of function in many tasks of adolescent development, and the difficulties in the home environments, to give people an idea of what we do that the acute units do not. Some services still find the concept difficult to comprehend, so I thought it may be worthwhile to provide some more concrete guidelines eg Admission to BAC should be considered when:

- An adolescent with an eating disorder has been admitted three times in six months or has spent a total of five of the last twelve months in hospital without evidence of significant stabilisation of weight.
- An adolescent has self harmed to the point of requiring medical intervention, or with serious suicidal intent three times or more in the last three months with no stabilisation of suicidal ideation
- An adolescent, due to serious affective disorder (depression or anxiety), having lost their social and educational network for three months or more, shows no improvement in affect or participation in therapy after three months of intervention.
- An adolescent has a severe psychotic disorder requiring hospitalisation for three months or more
- An adolescent with severe OCD or Tourettes Disorder with significant functional impairment either in the family, socially or educationally has not responded to at least four months of adequate pharmacotherapy and appropriate psychological interventions.

Child and Youth Mental Health Services

Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units

Queensland Government

CONTENTS

1. Introduction

These guiding principles are concerned with access to and provision of treatment for children and adolescents (0-18 years) who require admission to a Queensland Health child and youth mental health acute inpatient unit. The admission criteria and priorities, referral and admission processes and pathways, minimum standards and transfer processes are intended to assist clinician, consumer and carer decisions in acute and emergency mental health situations. The guidelines are not designed to replace clinical judgement, but to provide principles and minimum standards to enhance service delivery and assist practitioners in their decision-making, with an emphasis on promoting best practice and improving consumer outcomes.

As outlined in the *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)*, an underlying principle of child and youth inpatient treatment is to keep periods of hospitalisation to a minimum. In general, community-based care is the primary aim, and inpatient care is reserved for those who either fail to respond to community approaches or require more intensive forms of care and additional benefits of the inpatient setting.

Implicit in this document is the recognition that hospital-based treatment is just one component of an overall package of acute care in child and youth mental health service delivery; hence every admission will have specific indications and aims. Child and Youth Mental Health Services (CYMHS) function as an integrated whole, with maximum flexibility for children and adolescents to move between acute inpatient and community-based treatment according to need at different phases and stages of mental health problems. As with all other aspects of mental health care in Queensland, partnership and collaboration with the consumer's carer and/or family, the referring agent and any other service providers involved is emphasised in all decision making.

This document emphasises the need to fully articulate the reasons for considering admission to hospital, and describes how priorities will be determined, in order to lead to more purposeful interventions and optimal use of limited inpatient resources.

2. Scope and purpose

This document aims to assist in the safe and effective assessment and treatment of children and adolescents who require child and youth mental health acute inpatient care by defining:

- the process for making a referral for admission
- the process of determining acceptance for admission
- the safe transport of patients between health facilities
- clear admission criteria and priorities
- admission processes
- contingency plans for bed management at times of peak demand.

This document applies to all Queensland Health (QH) child and youth mental health acute inpatient units in Queensland, and will provide guidelines for mental health clinicians, general practitioners, private psychiatrists and other referrers. The guidelines take into account:

- the needs of people of Aboriginal or Torres Strait Islander background
- the needs of people from non-English speaking backgrounds
- issues of gender, physical and intellectual disability and age
- consumer and carer values and participation
- rural and regional issues
- the recovery model of mental health service provision.

2.1. Clinical Services Capability Framework

The Clinical Services Capability Framework (CSCF) outlines the minimum standards around workforce, quality and safety, support services and other requirements required in both public and licensed private health services to ensure safe and appropriately supported clinical services. The CSCF defines child and youth inpatient services from levels 2 to 6. The CSCF is available on the Planning and Coordination Branch web page on QHEPS.

The CSCF recognises that children and adolescents will at times receive inpatient treatment in settings that are not specialist child or adolescent inpatient beds because of ease of access, urgency, or in the interests of keeping the child or adolescent close to the home community. As suggested in the CSCF, services at levels 2, 3 and 4 should have service level agreements with a specified level 5 service, and this would include criteria and processes for transfer of children and young people who cannot be treated appropriately in their local area.

2.2. National Standards for Mental Health Services

These guidelines have been informed by the *National Standards for Mental Health Services (2010)* with particular reference to the following criterion:

1.9 The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.

2.11 The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.

4.1 The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.

6.16 The right of consumer to have visitors and maintain close relationships with family and friends is recognised and respected by the MHS.

9.3 The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.

10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.

10.1.2 The MHS treats consumers and carers with respect and dignity.

10.3.3 The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment.

2.3. Adolescent Extended Treatment and Rehabilitation Centre

The Adolescent Extended Treatment and Rehabilitation Centre (AETRC), formally Barrett Adolescent Centre, provides extended (up to 12 months) specialist assessment and treatment and rehabilitation to young people between 13-17 years of age with severe

persistent mental illness/es. As the AETRC has its own admission processes, the scope of this document does not include admission to the AETRC. At times the transfer of young people between the AETRC and acute inpatient units will be required. A current review of the AETRC will clearly articulate referral processes, at which time this document will be updated to reflect these changes. In the interim, discussions regarding referrals to the AETRC should be made between the referring service to the AETRC Clinical Liaison, Clinical Nurse.

3. Admission criteria

As outlined in the *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996),* a child and youth acute inpatient unit provides assessment and short-term intensive treatment, as part of the continuum of care, for children and adolescents experiencing acute episodes of mental illness who cannot be treated more appropriately in community settings. Inpatient units provide 24 hours a day, seven days a week, treatment during an acute episode of mental illness, in a structured environment, as part of a longer-term treatment plan. Admissions occur when the presenting behaviour cannot be safely managed in the community, or when treatment cannot be provided at a less intensive level. Access to inpatient beds will only be available following assessment by a child and youth mental health clinician. This may occur as a planned admission or following a crisis assessment in an emergency department or community setting. The decision to admit a child or young person should be a clinical judgement which integrates the following five elements:

1. Clinical criteria
2. Vulnerability criteria
3. Admission priorities
4. Risks associated with admission
5. Other (non-clinical) considerations.

3.1. Clinical criteria

A child or adolescent is admitted to a child and youth mental health acute inpatient unit for the following clinical reasons:

- recognised or probable psychiatric illness or disorder and reasonable likelihood that inpatient care will result in substantial benefit

  AND at least one of the following:

- previous unsuccessful trial of intervention in a less restrictive setting, or circumstances do not allow such a trial to be considered
- high level of vulnerability to harm (as defined by the vulnerability criteria stated below)
- the presence of a significant co-existing medical condition which would complicate or increase the risk to the consumer or others if treatment of the psychiatric illness is provided in a less restrictive setting
- significant impairment of self-care skills and social functioning at home and at school, as a result of a mental illness or disorder, where the disorder cannot be adequately treated in a community setting
- there is a requirement for specialised psychiatric treatment such as the provision of intensive psychotherapeutic interventions or the introduction of medication that is not able to be safely delivered in a less restrictive setting
- the diagnostic or systemic complexity of the case requires a range of assessments which cannot be done in a less restrictive setting.

3.2. Vulnerability criteria

A high level of vulnerability to harm will be evidenced by one or more of the following:

Danger to self:

- significant recent life threatening attempt at self-harm with confirmed imminent risk
- specific suicidal intentions with high lethality and availability of means
- risk of suicide or serious self-harm that cannot safely be managed in a less restrictive setting
- a level of impulsiveness and impaired judgement which places the child or adolescent at significant risk of being harmed by others.

Danger to others:

- significant recent violent acts and continued imminent risk
- specific threats of violence with high lethality and available means
- behaviour that poses a significant risk of social, financial or psychological harm to others
- level of dangerousness to others that cannot be managed in a less restrictive setting.

Access to appropriate care and services:

- where community-based CYMHS cannot provide the necessary range or intensity of services to meet the child's or young person's needs in terms of risk management or effective treatment
- where the child's or young person's parents, family or carers are unable to meet their needs or provide adequate care and safety during a period of mental illness/instability.

3.3. Admission Priorities

On occasions the need for child and youth acute inpatient beds may exceed availability. Consequently it is important that there is statewide consistency in determining the clinical need for inpatient resources and that access to these resources is equitable across Queensland. When one bed is available but there are two or more eligible referrals, then the inpatient unit will use these guidelines to determine admission priority. The **level of risk** is always the primary consideration, with the secondary consideration being the **safety** and **suitability** of current care arrangements.

Level of risk:

- priority one - there is an immediate risk of death or serious physical harm, either to the child or adolescent, or to others
- priority two - there is a clear risk of suicide, self harm or violence, but without immediate intentions or access to the means
- priority three – there are distressing and incapacitating symptoms, or progressive deterioration and loss of function with regard to self-care and social functioning
- priority four - the child or adolescent requires complex multi-disciplinary assessment in an inpatient setting.

Level of current care:

- priority one - the child/adolescent is at home or in another community setting
- priority two - the child/adolescent is in a setting that can provide a level of safety but can offer only very short-term care, e.g. an emergency department
- priority three - the setting can provide a level of safety but cannot provide adequate mental health treatment, e.g. a paediatric or medical ward, or a youth detention centre
- priority four - the child/adolescent is in an adult mental health unit.

3.4. Risks associated with admission

The benefits of admission should always be weighed against the potential risks associated with admission. Potential risks to consider include:

- Some children and adolescents experience a negative clinical reaction to the environment and peer group of a child or adolescent inpatient unit. This can take the form of regression, acting-out behaviour and increased self-harm or aggression.
- Separation from family, friends, school, and other ecological support systems can hinder or negate some essential elements of the recovery process, and undermine the ability of consumers and carers to cope with the mental illness in a 'real world' setting.
- Separation from family, friends and community can be very distressing for the child or adolescent, particularly for those of Aboriginal or Torres Strait Islander, and those of culturally and linguistically diverse (CALD) backgrounds.
- When a child or adolescent is admitted to a unit which is a significant geographical distance from their home, it can be difficult to deliver effective treatment because of the impossibility of providing effective family therapy and other systemic interventions.
- In some instances, outcomes of previous inpatient admissions may have demonstrated that further admissions are likely to be unhelpful or counterproductive for the child or adolescent.
- Adolescents with autism and intellectual impairment (without comorbid mental illness) often do not benefit from admission because the change of environment may be unsettling and distressing. In addition, the positive behavioural changes achieved in an inpatient setting are often not generalised to the home environment. Adolescents with autism and intellectual impairment who are referred for acute inpatient admissions should only be admitted as part of an interagency process involving the Department of Communities (Disability and Community Care Services). In general, admission of such consumers to an adolescent acute inpatient unit is not advisable and careful consideration of the risks and benefits of admission is required.

Taking these potential risks into account, the referrer may be advised to consider alternatives such as intensive community support, or admission to a less specialised unit (CSCF level 2, 3 or 4) in the consumer's local area. In these cases, the child or adolescent inpatient unit has a responsibility to give advice on alternative units or services, and to liaise with these units.

3.5. Other considerations

In addition to clinical factors, there are other considerations which should be taken into account when deciding whether or not to admit a child or adolescent including:

- the needs and choices of the consumer, carer and/or family according to geographical proximity to place of usual residence
- the expectations of the referring agent, and whether these can be met by the inpatient unit
- whether admitting a particular consumer may create difficulties regarding confidentiality or the specific management of another child/adolescent
- when the child or adolescent or family member has an outstanding serious complaint regarding the particular mental health service where the inpatient unit is located.

4. Referral and admission processes

4.1. Referral

Referral to a child or adolescent acute inpatient unit should ideally be made by a CYMHS clinician in consultation with the treating CYMHS psychiatrist. In an emergency situation, for example when the child or adolescent has been seen in an emergency department, the referral may be made by a general adult mental health psychiatrist or psychiatric registrar.

In rural areas where CYMHS clinicians or psychiatrists are not available, a referral may be made by a hospital medical officer or a general practitioner (GP). If the referral is made by a medical officer or a GP, then the referrer should discuss the referral directly with the intake officer of the relevant child and youth mental health acute inpatient unit (refer to Appendix A) who, if necessary, will discuss with the consultant psychiatrist on call for the inpatient unit. If there is no local CYMHS worker involved in the referral, then the admitting unit should alert the local hub CYMHS service or E-CYMHS.

The referral may be initiated at any time, 24 hours a day, seven days a week, by means of a telephone call to the intake officer (or equivalent) at the relevant child or adolescent inpatient unit. The referrer must also provide the intake officer with a comprehensive written clinical assessment, either by fax, or electronically through the Consumer Integrated Mental Health Application (CIMHA). The clinical assessment will include:

- a mental state examination
- diagnosis / provisional diagnosis / formulation
- physical status / medical clearance if indicated

- *Mental Health Act (2000)* status
- medication history
- risk assessment and risk management plan
- accommodation / support details
- referrer's goals for admission of the child or adolescent.

Prior to making a referral, the referrer is encouraged to seek expert advice which is available 24 hours/day, seven days a week through the on-call services at the Mater Children's Hospital, the Child and Family Therapy Unit at the Royal Children's Hospital (RCH), and the Adolescent Unit at the Royal Brisbane and Women's Hospital (RBWH). Referrers from the South Brisbane and South Queensland areas should contact the Mater Children's Hospital, and referrers from North Brisbane, Central Queensland or North Queensland should contact the RCH or RBWH.

NB. Prior to any transport for the young person being arranged, a destination bed must be negotiated with the receiving inpatient unit.

4.2. Decision to accept the referral

The intake officer will consider the admission based on the criteria and priorities outlined in this document; the current capacity of the inpatient unit; and the distance from the referring service. The intake officer will only accept the admission after consultation with the accepting inpatient team and after comprehensive written clinical information, including a **Transport Risk Management Plan** (p.13) has been provided.

Local referrals

Where the child or adolescent is being referred within metropolitan south-east Queensland or within a regional district with a child and youth mental health acute inpatient unit, the following should apply:

- If the child or adolescent meets the criteria and the inpatient unit has capacity, then they should be admitted as soon as possible.
- If the inpatient unit does not have the beds or capacity to admit the child or adolescent, the intake officer should advise the referrer on which other child or adolescent inpatient unit may have beds or advise on alternative crisis management strategies.

Regional, rural or remote referrals

Where the child or adolescent is being referred from a district without a child and youth mental health acute inpatient unit, the following should apply:

- If the child or adolescent meets the criteria and the inpatient unit has capacity, then the referrer and the admitting unit should reach mutual agreement regarding the time of their transfer and arrival at the unit.
- As a general rule, the transfer should be planned, so that the child or adolescent arrives within daylight hours with adequate time for the receiving unit to carry out the admission process.
- If this cannot be achieved, then the referrer may be advised to arrange for the child or adolescent to be admitted to a local level 2, 3 or 4 service overnight or as otherwise agreed with the admitting unit.
- If the child/adolescent is admitted to a local level 2, 3 or 4 service, it is good practice for them to be reassessed by a CYMHS clinician before being referred for admission to a child or adolescent acute inpatient unit. If a CYMHS clinician is not available then the child/adolescent should be reassessed by a mental health clinician or medical officer. If the level of risk has reduced, it may be that admission to a child or adolescent acute inpatient unit is no longer indicated

4.3. Transport

Transport Risk Management Plan

All consumers will have a written Transport Risk Management Plan completed by the referring clinician, which should address the following:

- the possible risks during the transport process (such as absconding, violence, self harm, suicide, and undue patient distress)
- plans to minimise these risks such as the *Mental Health Act (2000)* status, the nature of the escort, level of observation, the mode of transport, medication prior to departure, Pro re nata (PRN) medication during transport, contingency plans and contact people in the event of a crisis.

If the child or adolescent cannot be transported safely, then they should be stabilised at the current location and not transferred.

Mode of transport

Transport options include:

- private vehicle
- public transport: taxi, bus, rail or aircraft
- QH vehicle
- Queensland Ambulance Service (QAS) vehicle
- Queensland Police Service (QPS) vehicle

- Air retrieval as coordinated through Retrieval Services Queensland.

Escort options include:

- family member
- QH staff
- QAS staff
- QPS staff
- air retrieval service provider staff.

The appropriate mode of transport, escort and crew mix will be agreed on by the referring clinician, the inpatient unit intake officer, the child's or adolescent's carers, and if appropriate the QAS Transport Centre, the QPS, or the Queensland Emergency Medical System Coordination Centres (for emergency and/or air transport). The mode of transport will depend on clinical factors as well as distance: as a general rule air transport is used for journeys of more than 2.5 hours by road. Where a private vehicle, public transport, or a QH vehicle is to be used, it is the responsibility of the referring service to coordinate transport arrangements. Where a QAS or QPS vehicle or aircraft is used, it is the responsibility of the inpatient unit to coordinate the arrangements with the relevant communications centre.

Communication

The referrer should make telephone contact with the inpatient unit at the time of the child's or adolescent's departure to update the inpatient unit on their status and travel arrangements.

Aircraft transport

The referrer should be aware of the relevant air retrieval service provider's policies for risk assessment and risk management, such as the possibility that physical restraint and general anaesthetic may be required during air transportation. The level of possible distress, the *Mental Health Act (2000)* requirements, and the need for safe extubation of an anaesthetised child or adolescent at the receiving hospital should be considered. The Director of the receiving unit should be involved in the planning of all admissions where transport by aircraft will be required.

Police Assistance

Police assistance may be requested for the transport of a child or adolescent who is subject to the *Mental Health Act (2000)*; however the QPS are not regarded as a primary

transport provider. Health service staff will accompany any child or adolescent being transferred by police vehicle.

Sedation for purposes of transfer

On occasion it may be necessary to offer the use of sedation before or during the transport process. The sedation plan should be discussed between the referrer and the intake officer (or equivalent), and should be in keeping with the CYMHS Acute Sedation Guidelines (when developed), which can be provided to the referrer if necessary. In the case of a child or adolescent being transported by aircraft, the sedation plan will be in keeping with the relevant air retrieval service provider's guidelines. A list of all medication prescribed before and during transfer should accompany the consumer and the escort to the inpatient unit, and the escort should record the time and dose of all PRN medications administered on the journey. Depending on the level of sedation, it may be necessary for the consumer to be taken to the emergency department for assessment prior to admission to the inpatient unit. This decision should be made in consultation with the on-call psychiatrist at the receiving service prior to the consumer being transferred.

4.4. Admission process

Intakes that result in admission during the hours of 0800 – 1600 will:

- present directly to the ward at an agreed time which has been negotiated with the intake officer / shift coordinator / psychiatric registrar / principal house officer or resident medical officer, who will be required to review the patient when they arrive on the ward
- require the admitting inpatient unit to make contact with the consumer's local CYMHS upon admission or as soon as possible afterwards (if this had not already occurred).

Intakes that result in admission after 1600 hours OR result in an admission during 0800 – 1600 hours when there is no psychiatric registrar / principal house officer on the ward will:

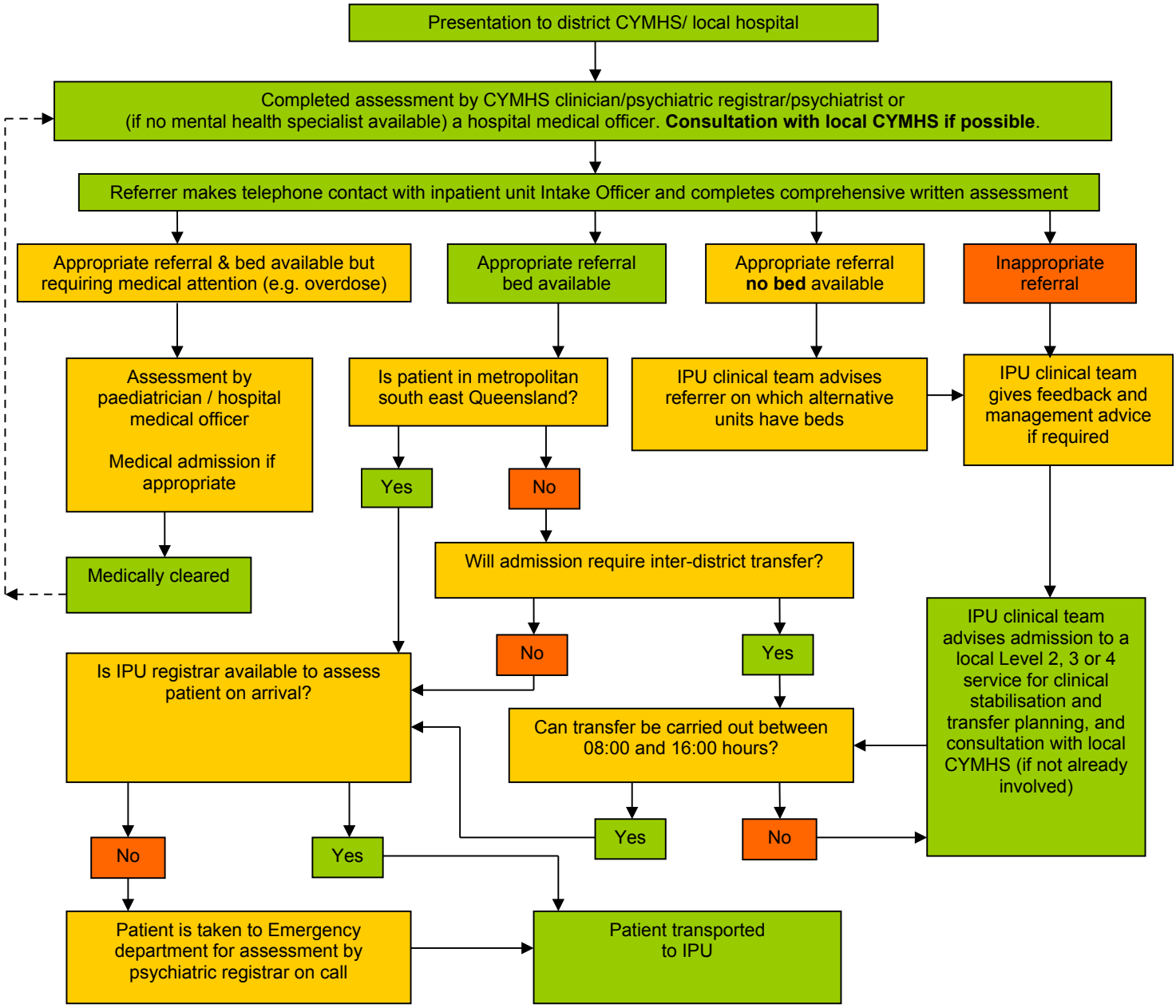
- be discussed between the intake officer / shift coordinator and the psychiatric registrar on call
- require an assessment by a psychiatric registrar and be medically cleared at the emergency department, prior to acceptance for admission

- require a review by the psychiatric registrar of the intake assessments and document a treatment plan in the emergency department when the patient arrives, ensuring that physical examination has been completed prior to acceptance to the ward.

  N.B. Original *Mental Health Act (2000)* paperwork should accompany the patient when admitted to the unit.

5. Referral and Admission Pathways

5.1. Flowchart



NB: A written Transport Risk Management Plan must be completed by the referring clinician and provided to the IPU prior to transportation.

Flow Chart Key: IPU = Inpatient Unit CYMHS = Child and Youth Mental Health Service

5.2. Children and adolescents under the care of Department of Communities (Child Safety Services)

When a child or adolescent is admitted from a foster care or residential care placement, it is to be expected that:

- prior to admission, there is an identified child safety officer (CSO) for purposes of liaison, supporting the young person, and care planning
- Child Safety Services can identify a discharge residential address before the child or adolescent is accepted for admission (exceptions to this rule can only be authorised by the Director of the inpatient unit or the after-hours on-call consultant psychiatrist)
- Child Safety Services will engage with both the inpatient unit and the community CYMHS in relation to care planning for a child or adolescent who is subject to ongoing Child Safety Services interventions
- Child Safety Services will prescribe, in writing, the visiting arrangements for parents/carers visiting the inpatient unit and provide supervision of these visits if required
- Child Safety Services will ensure that adequate support is provided to the child or adolescent such as planned visits from a carer, non government organisation (NGO), service provider or CSO
- the Interim Memorandum of Understanding between CYMHS and the Department of Communities is referred to by both departments to assist in the discharge planning process.

5.3. Aboriginal and Torres Strait Islander children and adolescents

When the referred child/adolescent identifies as Aboriginal and/or Torres Strait Islander, the inpatient unit should consider the impact of separating them from their community and family, and admitting them to an inpatient environment where they may feel isolated and distressed. As a minimum, the local Indigenous Mental Health Worker or Aboriginal and Torres Straight Islander Hospital Liaison Officer should be informed of the planned admission before the child/adolescent is admitted. It is strongly recommended that if available, an Indigenous Mental Health Worker is involved in the admission process, to consult with the referrer, advise on treatment needs, provide cultural advocacy, and if necessary advise and support the child's/adolescent's family and be present when they are admitted. It is important to also consider specific cultural and linguistic needs of parents/carers of this consumer group. Parents/carers may also require communication with an Indigenous Mental Health Worker for cultural safety reasons or translation assistance. For example, information about the diagnosis, treatment plan and medications should be explained in easily understood terms, or translated into the appropriate language as required.

Differences between Aboriginal and Torres Strait Islander cultures should be recognised.

5.4. Culturally and linguistically diverse (CALD) children and adolescents

The inpatient unit should plan for the specific needs of children and adolescents from a CALD background, including Aboriginal and Torres Strait Islander backgrounds where traditional languages are the first spoken language. The unit should ensure that written information is available to the child/adolescent and their family in the appropriate language (as far as possible), that a suitable interpreter is available at the time of admission (and as required during the inpatient stay), and that their dietary and other cultural needs will be catered for on the unit.

5.5. Children and adolescents with disabilities

Before accepting for admission a child or adolescent who has a significant physical disability, the unit management should consider whether the unit's design (i.e. disabled access features) will meet their needs, or whether an alternative unit may be more suitable. However these concerns should not impede the child's/adolescent's access to appropriate mental health care. In the case of Deaf consumers, an interpreter should be available at the time of admission and as required during their stay.

6. Alternatives to admission

These guidelines have noted that inpatient beds are a limited resource and have indicated the clinical situations which are prioritised for admission, and the safety considerations and other constraints which might place delays on the admission process.

Inpatient beds will not always be available when they are needed and requested by referrers. However, it is recognised that child and adolescent inpatient units are not only a resource for admissions but can also be a source of consultation and expert advice. When admission is not possible or not appropriate, the inpatient unit consultant psychiatrist (or other appropriate staff) should provide the referrer with useful advice on the following:

- other inpatient services which might be able to admit the child/adolescent
- when the child/adolescent is already in an inpatient service (such as a general medical, paediatric or adult mental health unit), advice on measures which will assist with short term treatment, crisis management and crisis resolution
- short term measures to ensure the child's/adolescent's safety in a community setting.

6.1. Admissions to out of area child and youth mental health acute inpatient units

When urgent admission is required to a child or adolescent inpatient unit but there is no bed available, the unit should advise the referrer on which other unit(s) to contact. This advice may be derived from the intake officer's knowledge of the bed status of other units, or may be derived from standing arrangements for service provision according to the consumer's location (see appendix A, p.23).

If there are no available beds in the local child or adolescent inpatient unit then a referral should be made to an alternative unit (as per the table in appendix A). The alternative unit should take responsibility for the child or adolescent treatment until the reason for admission has been resolved or they can be transferred safely back to the local unit or community mental health services. If the child/adolescent is a past or existing consumer of the local area inpatient unit then the alternative unit should liaise with the local inpatient unit about the child's/adolescent's treatment needs and discharge arrangements.

6.2. Adult Mental Health or Paediatric Units

In keeping with the CSCF (refer to section 2.1, p. 5), it may be considered appropriate for temporary care and stabilisation of a child up to 14 years to be provided in a paediatric inpatient unit until their physical or mental state is such that they can be transferred to an available child and youth mental health inpatient bed. Similarly it may be considered appropriate for temporary care and stabilisation of a adolescent 16 years or older to be provided in a adult mental health acute inpatient unit until their mental state is such that they can be managed in the community or transferred to an available child and youth mental health inpatient bed. In some cases where an adolescent 14-16 years has physical and emotional maturity, or where there is no alternative, it would be acceptable for the consumer to be admitted to an adult mental health unit, with the provision of adequate measures to maintain the adolescent's safety. In these situations a safety plan must be completed prior to admission.

If the admission is appropriate and no beds are available, the receiving adolescent unit will recontact the current treating team when a bed becomes available. The current treating team is also expected to maintain communication with the receiving inpatient unit to update the unit's intake officer on the consumer's clinical status.

6.3. Short term management in a community setting

When appropriate, the inpatient unit staff (usually the consultant psychiatrist or another senior clinician) may advise the referrer on strategies to manage the crisis until a bed is available, or until a bed is no longer required. However the inpatient unit should take into account the clinical capabilities of the community-based service and if possible assist in identifying local resources.

- The referrer should reach an agreement with the consumer and carer and/or family about the length of time for which the current situation can be managed, and about strategies to relieve distress and manage risk.
- The referrer should have a collaborative discussion with the consumer and carer and/or family in relation to alternative admission options (adult mental health or paediatric units as outlined above) or alternative accommodation arrangements (respite or emergency residential care).
- The referrer should explore the range of crisis intervention measures available locally to ensure safety and follow-up (for instance, use of extended hours service, Emergency Department, linkage with Adult Mental Health, follow up by inpatient unit staff, community CYMHS intensive follow up etc).

7. References

1. *National Standards for Mental Health Services (2010).*
2. *Clinical Services Capability Framework Version 3 (2009) Section 1.2.*
3. *Queensland Medical Transport System. Transport of people with a mental illness from rural, remote and regional Queensland. Standard Operating Procedures (2006).*
4. *Queensland Mental Health Patient Safety Plan 2008–2013.*
5. *Queensland Mental Health Services Guidelines for inter-district transfers of consumers.*
6. *Interim Memorandum of Understanding between Queensland Health Child and Youth Mental Health Services and Department of Communities Child Safety, Youth and Families 2010–2013.*
7. *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement, 1996.*
8. *Mental Health Act (2000).*

Appendix A:

Child and Youth Mental Health Acute Inpatient Units

Admission priority

The following table outlines the order of priority that services should attempt to use when seeking a child/adolescent inpatient admission. If primary and secondary facilities are not able to admit then other facilities will need to be sourced.

Referring Area	Adolescent Primary Access	Adolescent Secondary Access	Child Primary Access	Child Secondary Access
Bayside	Logan	Mater	Mater	Gold Coast
Gold Coast	Gold Coast	Logan	Gold Coast	Mater
Logan	Logan	Gold Coast	Mater	Gold Coast
Mater	Mater	Logan	Mater	Gold Coast
Toowoomba	Mater	Logan	Mater	Gold Coast
West Moreton / South Burnett	Logan	Gold Coast	Mater	Gold Coast
Southern Qld Rural Districts	Mater	Logan	Mater	Gold Coast
For all areas North of the Brisbane River [c]	RBWH [a]	Mater	CFTU-RCH [b]	Mater

[a] Royal Brisbane and Women's Hospital. [b] Child and Family Therapy Unit, Royal Children's Hospital. [C] Includes North Brisbane (RCH & Redcliffe/Caboolture), Sunshine Coast, Wide Bay, Central Queensland, Central West, Mackay, Townsville, Mt Isa, Cairns and Hinterland, Cape York, Torres Strait and Northern Peninsula.

THE PARK – CENTRE FOR MENTAL HEALTH
OPERATIONAL PLAN
BARRETT ADOLESCENT CENTRE BUSINESS UNIT

July 2003 – June 2004

Strategy	Activity	Target	Milestone	Responsibility
Objective 1: Model of Service Delivery Principles				
1.1 Projects identified for the Business Unit	· Implement the recommendations of the McDermott Report in relation to risk management · Barrett Adolescent Unit will conduct a seminar on recovery for treatment resistant adolescents with severe and complex needs	Implement appropriate recommendations by June 2004 One seminar by June 2004	22 of 30 recommendations implemented Key speakers contacted about program	Business Unit Management Committee Trevor Sadler
1.2 Clinical Steering Committee Projects	· Cultural Plan · Clinical Risk Management · Dietary Reference Group · Drug and Alcohol	Reports six monthly from June2004	Clinical risk Management Plan revised	Business Unit Management Committee
1.3 Benchmarking	Establish protocol for benchmarking in association with acute adolescent inpatient units using HoNOSCA and CGAS	Benchmarking issues raised at regular meetings of staff of adolescent inpatient units	Meetings of NUM, Directors established, and item on agenda	Peter Howard Trevor Sadler

Strategy	Activity	Target	Milestone	Responsibility
Objective 1: Model of Service Delivery Principles (Contd)				
1.3 Benchmarking		Benchmarks identified for consumer outcomes and reported to the Clinical Steering Committee include: · HoNOSCA · CGAS · Criticial Incidents · Consumer Satisfaction · ACHS Accreditation retained	HoNOSCA, CGAS, Critical Incident data collected Consumer Satisfaction Survey being reviewed with other adolescent units to meet Mental Health Unit requirements for uniform consumer satisfaction surveys	Business Unit Management Committee Trevor Sadler
1.4 Multidisiciplinary team functioning	· Activities to be identified · Consider more effective method for assessing team functioning	95% on all SLATE scales Current deficits in SLATE scales identified	Currently 91% av, some areas of deficits addressed	Business Unit Management Committee
1.5 Care Planning	Increased percentage of plans where feedback is incorporated from adolescents and parents	100% care planning packages in place according to agreed framework	Current estimate for past month is 80% up from 50%	Business Unit Management Committee
1.6 Research cells established and research identified	· Research capacity will be established · Research priority identified · Evidence applied to practice	· June 2004 · September 2004 · December 2004	No current activity	Business Unit Management Committee

Strategy	Activity	Target	Milestone	Responsibility
Objective 2				
2.1 Budget	Maintain balanced budget	June 2004	Budget targets on track	Business Unit Management Committee
2.2 Review staffing profile and priorities	Fill all staff positions	June 2004	Vacancies in nursing staff being filled, in allied health staff being advertised	Business Unit Management Committee
2.3 Cost effective ways to meet needs and manage budget drivers	Review areas of excess budget expenditure, and identify processes for savings in areas of over run	June 2004	Two areas of budget overrun identified – one rectified, the other being addressed	Business Unit Management Committee
2.5 Leadership and Management	· Determine ways to make information more user friendly for staff	Staff satisfaction meets industry benchmarks	Staff identify being resistant to any further questionnaires and memoranda. Prefer verbal interaction	Business Unit Management Committee
	· Business Unit Management Committee will ensure operational plan milestones and targets are met	All milestones are met by July 2004	More than 70% of milestones met or are being met	Business Unit Management Committee

Strategy	Activity	Target	Milestone	Responsibility
Objective 2 (Contd)				
2.6 Workforce, Morale and Productivity	Maintain the currency of Individual Professional Development Plans	All 2004 Individual Professional Development Plans are completed by June		Business Unit Management Committee
2.7 Skills and training for applying principles to practice	Opportunities will be identified, in collaboration with the School of Mental Health to develop and implement training for staff across the Child and Youth Mental Health Services	Two meetings per calendar year with School of Mental Health and University of Queensland to assist development of programs.	No action taken to date in 2004	Business Unit Management Committee

Strategy	Activity	Target	Milestone	Responsibility
Objective 3				
3.1 Consumer Satisfaction	Review and implement the adolescent consumer satisfaction tool	· Satisfaction meets benchmarks · Report four monthly to Service Improvement Council .	Tool being reviewed in association with other inpatient units	Business Unit Management Committee
3.2 Consumers and Carers develop participation skills	· Continue to support the involvement of parents in Barrett Adolescent Unit · Employ consumer advocate to work with adolescents in promoting participation	Monthly parent support group Train consumer advocate	Monthly meetings in 2003, beginning again in February 2004 Completed December 2003	Clinical Liaison Person Business Unit Management Committee
3.3 Consumers in paid roles on the Business Unit Management Committee	Maintain consumers in paid roles on Management Committee	Employ Consumer advocate 10 hours/month for participation in Management Committee, Administration meeting	Currently attending meetings with adolescents, identified meetings six hours per month	Business Unit Management Committee

Strategy	Activity	Target	Milestone	Responsibility
Objective 3 (Contd)				
3.4 Mental Health Network	· Increase the involvement of referring agents in care planning · Finalise admission criteria for acute and long term residential unit in conjunction with Child and Youth Mental Health Service networks	80% of referring agents attend Intensive Care Plan Work ups Accept admission criteria at Southern and Central Zonal CYMHS meetings in March	Current rate about 60%. Factors to improve attendance identified Admission criteria tabled for March 4 meeting	Business Unit Management Committee Trevor Sadler
3.5 Development of new models	Adopt a pro active approach to resolving the future of Barrett Adolescent Unit	Liaise with Mental Health Unit	Negotiations with senior staff in Southern Zone, Mental Health Unit to identify appropriate recovery framework for children and adolescents	Trevor Sadler
3.6 Staff placements and exchange	· Identify useful placement locations · Adopt proactive approach, including use of Individual Professional Development Plans	One staff member per year on rotation from other areas of The Park, or from other adolescent inpatient units	Current Clinical Liaison Position being filled by staff rotation	Business Unit Management Committee

Strategy	Activity	Target	Milestone	Responsibility
Objective 3 (Contd)				
3.7 Partnership	· Increase the level of involvement of University of Queensland in seminar, research and student placements	Monthly meetings with Professor Graham Martin. Joint research paper with Dr Paul Harnett Seminar in Adolescence with UQ.	Arranged Paper awaiting final review Key speakers identified	Trevor Sadler Trevor Sadler Trevor Sadler
	· Conduct joint research project with the Mater Child and Youth Mental Health Service	Develop the Youth Violence at Home Research Project	Draft of questionnaire completed	Trevor Sadler
3.8 Future of the decommissioned site	Work with the Executive Director to address Barrett Adolescent Unit interests in future site decisions	Discuss options for use of site with Department of Natural Resources	Information obtained from Executive Officer re current developments	Trevor Sadler

EXHIBIT 75

The Park- Centre for Mental Health

Operational Plan 2006-2009
Business Unit 7 (BAU)

Barrett Adolescent Unit **A**

Priority Area/ Strategy	Activity	Target	Milestones	Delegate
Objective 1: work with consumers and carers for best possible outcomes				
Recovery				
Develop and implement projects supporting the Recovery approach. - ***Safety*** - ***Privacy*** - ***Use of seclusion*** - ***Alcohol/drugs*** - ***Gender/cultural issues***	Safe environment with recovery focused programs. Investigate enhanced vehicular/escort capacity. Consumer awareness of privacy rights. Address issues of privacy and traumatisation during seclusion. Smoking guidelines and health promotion/aid.	Safe and therapeutic infrastructure/programs with recovery focus enhance consumer strengths toward normalised daily living. Community and vocational access for consumers. Increased consumer awareness. Clear guidelines for changing female consumers into seclusion attire. Clear guidelines for smoking consumers. Health promotion and supports available.	Quiet room modified. Developed multi-sensory and sand play therapy rooms. Supervision/ training provided for latter (art therapy planned). Hanging points removed. Asbestos precautions taken with renovations. Sandwich day. Procurement of second vehicle being explored. Provision of 'Respecting your Privacy' brochure to adolescent on admission. Work practice guideline completed. Work practice guideline completed. Information on smoking health hazards and 'Quit Smoking' aids provided.	Treating Team. BUM Committee. CNCL. NUM. NUM/ Treating team.
Develop programs to support carer and family involvement with consumers.	Recovery Model utilised in formulation of Individual Treatment Plans.	Problem identification and treatment goals directly linked to developmentally specific Recovery Model. Continue Parent Support Group (PSG) on a needs basis. Establish P&C Association.	Engagement of parents/family members in family therapy. Invitation to parents to participate in PSG and BAC School P&C Association.	Treating Team/BACS.
Consumer Participation				
Increased participation of consumers in care planning process.	Consumers are encouraged to attend case meetings.	Consumer input into treatment planning and review.	Consumers attend case meetings as per choice. Treatment care outcomes are relayed back to consumer and parents by Case Coordinators.	Treating Tm. CCs.
Research				
Undertake benchmarking activity that informs service delivery.	Survey staff attitudes re work environment.	Establish baseline qualitative data. To be completed by August 08.	Completion of staff questionnaires.	SERU.
Research cells undertake clinical issues that apply research to practice.	Increased percentage of SDQ's completed by consumers and carers.	Completion of SDQ's at regular intervals of care.	OIS History presented at ICWs to review progress and reflect care planning.	Nursing Staff.
Linkages				

Operational Plan 2006-2009
Business Unit 7 (BAU)

Barrett Adolescent Unit **A**

Priority Area/ Strategy	Activity	Target	Milestones	Delegate
Develop and maintain linkages with the community.	Consumers will be assisted to develop and maintain linkages with the community, which assist in their recovery process.	Consumer ITP's to contain specific strategies to maintain linkages.	Community linkages actively pursued in treatment collaboration/planning.	Treating Team.
	Provide adolescents with vocational / educational opportunities in the community.	Incorporate specific strategies in ITP's for individual consumers.	Vocational program developed for post-compulsory school consumers. Gradual transition into community school/TAFE options.	OT / CC / BAC School.
Working with Risk				
Risk assessment and management info applied to 100% of care plans.	Continue to work within the recommendations of the 2004 External Review (McDermott Report) with regard to : 1) Orientation and information booklets for carers and consumers are kept up to date. 2) Continue to seek advocacy from past consumers and carers for the retention and redevelopment of BAC.	 Booklets regularly reviewed and updated. Continue Parent Support Group (PSG) on a needs basis. Establish BAC School P&C Association. Participation in 3-year strategic planning 2006.	 Quarterly review. PSGs on hold following poor participation. Reinitiated in April 2008 Parent Teacher night with good response. 2nd Monthly meetings to be organised. Establishment of committee. Staff, consumer (past and present) and carer surveys conducted. Findings and planned initiatives presented to stakeholders in 2006.	 CNCL. CNCL. School Principal. Treating team and BACS.
Objective 2: Ensure organisational capacity to deliver effective services now and into the future				
Recovery				
Support recovery-oriented BU projects with recovery training.	Information on the Recovery Model specific to adolescent development will be provided to all new staff during orientation.	All staff to be aware of Recovery Model principles and their application. 100% compliance in mandatory training.	Recovery model principals reviewed at ICW. Mandatory training as provided by Facility.	Dr Sadler & NUM. NUM

Operational Plan 2006-2009
Business Unit 7 (BAU)

Barrett Adolescent Unit **A**

Priority Area/ Strategy	Activity	Target	Milestones	Delegate
Clinical supervision program in place.	Clinical supervisor appointed.	Clinical Supervisor to offer Clinical Supervision to all BAC clinical staff. New staff to receive preceptorship.	Clinical supervisor appointed April 2007. Each new nursing staff member receives a preceptor.	Linda Asprey. NUM.
Consumer Participation				
Contribute to systematic approach to identify & address consumer needs.	Utilisation of 2nd Monthly Intensive Case Workups and weekly Case Conferences.	Appointment and rostering of CC's to attend team meetings.	CCs attend ICWs. CCs to attend Case Conferences or team to refer to case notes in their absence.	NUM. CCs/NUM.
	Scheduling of ICW's.	All consumers to be reviewed at least 3rd Monthly.	Regular scheduled ICWs.	CNCL.
Research				
Contribute to initiatives that identify capacity issues (i.e. leadership & management).	Continued monitoring of staffing requirements for Continuous Observation and escorts.	Monthly Continuous Obs totals maintained. Retrospective analysis of escort hours.	Monthly indicators reviewed and reported back to BUMC.	NUM/SERU/ BUMC.
Linkages				
Improved communication and inclusive decision making.	Maintain scheduled meetings.	Maximum possible participation.	Distribution of minutes to relevant stakeholders.	Treating team.
Working with Risk				
Improve organisation's ability to support and promote safe environment.	Use of Root Cause Analysis following critical incidents.	Implementation of recommendations.	RCA's conducted in April, August and November 2006 following 4 critical incidents.	Dr Sadler.
Continue to work within the guidelines of the 2004 External Review regarding: Risk Assessments.	Risk assessments on new referrals presented with the Assessment interview.	Maximum compliance.	Risk profiles recorded in assessment interview reports.	CNCL.
Continued advocacy for the retention of BAC and it's redevelopment as a purpose built facility which meets service delivery needs and supports safe practice and environment.	District Management to work with BAC Executive team to pursue the unit's redevelopment at The Park.	Service model and project plan to be developed.	Provision of final BAC re-development plan.	BAC and District Executive Management

Operational Plan 2006-2009
Business Unit 7 (BAU)

Priority Area/ Strategy	Activity	Target	Milestones	Delegate
Ensure protocols related to Child Protection are implemented and maintained.	Continued monitoring of Child Safety Legislation training and currency / renewal of Blue Card.	100% compliance with Blue Card and mandatory training requirements.	Stage 3 Mandatory Child Safety training completed by all nursing staff at BAC.	NUM.
Priority Area/ Strategy	**Activity**	**Target**	**Milestones**	**Delegate**
Objective 3: Provide a service that is understood and valued by internal and external communities				
Recovery				
Identify consumers for discharge to appropriate alternative community-based options.	Completion of housing/alternative accommodation survey.	100% completion.	Completed.	CNCL.
Work with regarding consumer needs for housing & accommodation.	Identify alternative accommodation options as part of care planning process.	Options identified where available.	Alternative avenues explored where service gaps existed. Consumers supported with transition to independent living. Attendance at Accom. Forum.	Treating team. CNCL.
Consumer Participation				
Contribute to increased opportunities for internal and external consumer involvement.	Consumers and carers in paid consultancy roles.	Maintain one past consumer and one present carer in paid position to attend Business Unit Administration and Housekeeping Meeting.	Consumer representative paid consultancy position. Carer position waiting to be filled.	BUM Committee.
Research				
Help identify models that will meet the needs current and emerging populations.	Participate with partners to unmet needs of target groups and host Child and Youth Mental Health (CYMHS) forums.	Participate in planning for District CYMH services. Enhanced staff awareness. Collaborate with partners to develop programs (including school refusal).	2 day forum as part of consultation process for development of a CYMH specific 5-year plan. Regular representation at quarterly SEQ CYMHS Group Meeting. Adolescent recovery care model booklet done. Plans for 5-day forum for CYMHS networks in August 2008. Monthly attendance at Southern Area MH network and Council of Australian Govts.	Dr Sadler. NUM. Dr Sadler. Dr Sadler. Dr Sadler.
Identify local projects that can contribute to organisation's major research showcases.	Conduct retrospective analysis on CNCL reports to establish Waiting List database.	Waiting list database to analyse referral trends.	SERU developed database. CNCL to input data.	CNCL/SERU
Linkages				

Operational Plan 2006-2009
Business Unit 7 (BAU)

Priority Area/ Strategy	Activity	Target	Milestones	Delegate
Develop shared care models.	Improved continuity of care with referring agencies.	80% of referring agencies to attend ICW.	External agencies invited to attend ICWs.	CNCL.
Ensure adequate handover of clinical information.	Discharge summaries.	100% completion of discharge summaries.	Compliance.	Project officer/Dr Sadler.
Working with Risk				
Communication activities that promote The Park's role.	Development of Webpage for use by prospective consumers, carers and mental health staff.	Service webpage to be developed by Dec 2009.	QEd webpage completed end-2007. QHealth webpage workgroup to be commenced by October 2008. BAC Health Staff to be assigned to receive training for webpage maintenance.	BAC School. BAC Exec. BAC Exec.

Terms of Reference

External Investigation

Review of Consumer Incidents – Barrett Adolescent Centre

As the Commissioning Authority for Darling Downs – West Moreton Health Service District I authorise the appointment of an external investigating team to conduct a review of consumer incidents within the Barrett Adolescent Centre.

I authorise the following investigators to undertake the investigation:

- Dr Garry Walter – Psychiatrist
- Martin Baker – Psychologist
- Michele George- Nurse

The appointment of the investigating team pursuant to Part 6 of the *Health Services Act 1991* provides authority to the investigating team to gain access to confidential Queensland Health documents and records for the purpose of the investigation only. In particular, the investigating team are entitled to obtain and examine directly any relevant patient records necessary to determine the facts within the review. The investigating team are to preserve the confidentiality of patient records at all times.

The authorised investigation team shall:

1. Examine and make recommendations regarding the safe care of consumers of the Barrett Adolescent Centre including:

- Suggesting appropriate measures to manage the mix and acuity of the consumers attending the Centre
- Measures to ensure that arrangements for transferring care are timely and safe
- Measures to enhance capacity of the Centre to safely manage high levels of behavioural disturbance
- Measures to review the progress, appropriateness and models of care.

2. Review the PRIME Incident Reports provided and suggest appropriate interventions including:

- Strategies to reduce the risk of contagion
- Strategies to ensure the appropriate handover of care including to and from other medical services.

Pam Lane
Chief Executive Officer
Darling Downs – West Moreton Health Service District

Date: 27. 1. 09

TES2029

2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

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BACKGROUND

For a considerable period of time, concern has been expressed about the role, function and capacity of the Barrett Adolescent Centre (BAC) to provide an appropriate, effective and safe service for its client group. Most recently, the ACHS indicated concerns about the capacity of BAC to provide safe care. The local governing body has decided that environmental changes (including relocation) are necessary. These have been agreed to and are underway.

The present review has been commissioned in the knowledge that the proposed environmental/geographical shift will take place. The reviewers were asked to focus upon the philosophy and clinical practices of the unit, with a view to assessing whether the unit is safely meeting the needs of the consumer group, and to make recommendations for change and improvement.

PREVIOUS REVIEWS AND REPORTS

ACHS Review

In a recent accreditation survey by the ACHS, BAC received a "High Priority Recommendation" from the ACHS to ensure that immediate modifications are made to improve patient and staff safety. In making this and other recommendations, the ACHS observed:

- Patients admitted to BAC have severe and complex clinical pictures;
- BAC has limited choice over which patients it accepts;
- In the Park Hospital redevelopment, BAC has lost access to facilities;
- There are aspects of BAC's configuration and related building issues that are dangerous;

- There has been an increase in critical incidents;
- There has been an increased use of "Continuous Observation".

The ACHS made a number of other recommendations around staffing and infrastructure needs.

DOH Brief

A brief to the Director General of Health in Queensland noted that the profile of consumers treated in BAC had changed since the opening of the new Acute Child and Youth Mental Health Beds in Queensland and that BAC was now treating more complex and impaired cases. Apparently, the Acute Units are now referring to the BAC if there are no obvious community placement options. This has resulted in more complex cases in BAC and even less "referral out" options. In support of this contention is the fact that Average Length of Stay in BAC has risen from four months in 1994 to ten months in 2006.

McDermott Review

This review considered: the impact of critical incidents on BAC; current risks at BAC; BAC management practices, staff, environment and systemic issues; and, BAC responses to critical incidents. The recommendations included:

- Admission criteria and a more clearly defined target group;
- Better Risk Assessment in the admission process;
- Improvement of the risk monitoring process, especially the "Risk Assessment Tool";
- Improving the relationship with other parts of Park Hospital;
- Providing more certainty about the future of BAC.

Also included were recommendations about staff training, whether the unit is open or locked, the material fabric of the Unit, and the role of BAC within Queensland Mental Health Planning.

Community Visitors Report

This report noted that:

- BAC was over Census;
- BAC had clients in it who were over age;
- "The Unit is not of a standard to safely house medium to long term residents";
- "Not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis".

Queensland Nurses Union

The Union had written a letter of concern, specifically around the injuries sustained by a nurse trying to apprehend a client who had run away.

CRITICAL INCIDENTS

In addition to the above reports, the present reviewers were provided with three incidents to consider. The local governing body believed these to be emblematic of the difficult issues BAC faces and expressed a desire for the reviewers to examine these incidents within the broad purpose of the review. These reports related to three young women who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

- All the patients were female;
- All were near or over the age of 18 years;
- All exhibited severe and complex self-harming behaviours;
- All had been given diagnoses that did not seem to adequately reflect the chronicity, severity and complexity of the behaviours;

- Referral on to Adult Mental Health Services or other more appropriate services did not appear to be an option that had been realistically considered for any of the patients.

The reviewers conducted an incident and file review of the cases and have incorporated considerations around the incidents into the broader observations and recommendations of the report.

On the basis of the above materials, meetings with stakeholders and key staff on 26 and 27 February 2009, and attendance at a staff/stakeholder ongoing education meeting, we offer the following observations and recommendations:

OBSERVATIONS AND *RECOMMENDATIONS*

Governance

In terms of both corporate and clinical governance, a number of the usual mechanisms, processes and systems for ensuring proper governance did not appear to be in place at BAC. Specifically, there did ***not*** appear to be:

1. Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;
2. Clear local policies that are integrated with wider policies aimed at managing risks;
3. Procedures for all professional groups to identify and remedy poor performance;
4. Much in the way of Quality Improvement activities. A comprehensive approach would include consideration and use of
    - Clinical guidelines/Evidence-based practice;
    - Continuing Professional Development;
    - Clinical Audits;
    - The effective monitoring of clinical care deficiencies;

- Research and development;
- "Caldicott principles" to manage the collection and use of patient information;

To elaborate, the role of BAC in the hospital and State plan remains unclear. BAC does not feature in the hospital organisational charts, nor is its role articulated in a State-wide plan for child and adolescent mental health services. While patient safety was certainly a priority at BAC, there was a focus on physical environmental issues and less emphasis on a systematic approach that included formal reporting and documenting in the medical record for all incidents, including "near misses", and a process for reviewing incidents to inform staff and to effect change in client management to improve patient safety.

To support the above process and address other clinical documentation issues, regular reviews of medical records (file audits) are often used in other centres; this did not seem to be the practice at BAC.

Policies and procedures sighted had been in place a long time with little evidence of a review of their continued appropriateness.

There did not appear to be a system in place to manage, respond to or analyse complaints either from within the client population in the unit or from the broader community.

While we did not specifically ask about this issue, it is feasible that Performance Reviews are not a regular part of professional practice at BAC and, if they are, they do not appear to be targeted at assisting clinicians to maintain best practice and improve patient care.

BAC does not appear to have a framework which aligns with State legislation, Queensland Health policy directives, and local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working in the unit. In the absence of this framework, aspects of

recruitment, the capacity to adopt particular clinical models and a coherent approach to professional development and clinical supervision are all compromised. For example, it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.

Communication around continuity of care of clients in the unit, but particularly between nursing staff on each shift and between shifts, is poor and poorly documented.

Recommendations:

1. *That generally accepted mechanisms of clinical and corporate governance are introduced or enhanced within BAC. These would include:*
2. *The State and hospital should give a clear determination of the role and function of BAC.*
3. *This information (about role and function) needs to be disseminated in written form to all stakeholders.*
4. *The role and function should be operationalized and a reporting framework developed such that the unit is shown to be fulfilling its function.*
5. *That a procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.*
6. *That an integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.*
7. *All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.*
8. *Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.*

9. *All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.*
10. *That a system for managing, responding to and analysing complaints be introduced to improve community and client satisfaction with BAC.*
11. *That Performance Review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.*
12. *That audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.*
13. *Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.*

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit.

The reviewers had a number of interventions described to them; however, Milieu Therapy and Adventure Therapy were the two overriding interventions highlighted as encapsulating the clinical approach of the programme.

Typically, **Milieu Therapy** is a form of psychotherapy that involves the use of therapeutic communities. It has been used as a viable treatment modality for children for over fifty years in residential and inpatient settings. Milieu Therapy is potentially a powerful therapeutic tool when individual dynamics and the social system can be combined in a planned and meaningful way to manage and change behaviour and relationships in settings such as BAC.

There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence. Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

Adventure Therapy is the creation of opportunities to explore the unknown in a safe environment through team based adventure activities. This therapeutic approach has the capacity to engage adolescents and young people. There is a small body of literature about the intervention and, while the data about effectiveness from that literature is equivocal, its use at BAC is not contraindicated. Its drawbacks, however, are that it is not an activity that can be intensively introduced into the day to day running of the unit and that as a stand-alone intervention its outcomes are poor.

It is noted that the loss (as reported in early reviews) of positions and facilities will have compromised the capacity of BAC to successfully implement structured out of hours activity and the Adventure Therapy Programme.

The A1-A7 programs are behaviour management programs employed to manage difficult and challenging behaviours. It has been previously noted that they have been used for many years without documented evidence that they are effective or that they have been systematically reviewed.

A previous review conducted in 2003 recommended the BAC close the programs for several days each year to invest time in program review, management, procedural and training issues. There is no evidence that this recommendation has been acted upon.

The recommendation made previously (2003) to close the program for several days to undertake review and development activities is considered to remain integral to the successful functioning of BAC.

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

Time and effort could be directed at identifying interventions, other than continuous observation, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance. Pursuing the idea of a high dependency unit may prove to be the most judicious use of human and financial resources.

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities. The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

It is worth emphasising that while it may be argued that the various types or aspects of treatment – Milieu Therapy, Adventure Therapy - described above have a role, these should not be the cornerstone of a contemporary treatment program, nor the optimal "model of care". For example, patients with eating disorders may benefit from using the "Maudsley Eating Disorders Model", those with challenging personalities may warrant Dialectical Behaviour Therapy (DBT), etc.

Finally a previous review noted that "not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

Recommendations:

1. *A model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service.*
2. *The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.*
3. *That the increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.*
4. *If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate training and supervision for staff provided.*
5. *That Adventure Therapy may continue but, if so, this should be seen as a component part of an overall therapeutic approach.*
6. *That interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.*
7. *The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.*
8. *Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.*
9. *Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.*

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to

reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

During the visit, some nursing staff identified that it was particularly stressful being allocated to escort duty, during which time the nurse is required to be a continuous escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

Recommendations:

1. *Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation & Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).*

   [Patient allocation sees an individual nurse allocated to a group of patients and undertaking total patient care for that group. It has the advantages of providing personalised and holistic care while increasing the sense of autonomy and accountability and allowing more opportunities for communication with other health professionals. Team nursing involves dividing work between a group of nurses who are allocated to care for a number of patients. The Team Nursing Model strengths are identified as improving collaboration, flexibility and time efficiency as well as having a supportive/teaching function. The Combination Patient Allocation & Team Model combines the strengths of team nursing with patient allocation.]