new skills or participating in a new range of activities to increase their range of potential leisure activities. These are under the direction of both occupational therapists (who conduct physical skills assessments in consultation with a physiotherapist) and a part time phyical education teacher. Some of these are passive e.g the multi-sensory room for which there are multiple uses e.g. self control in reducing anger, practical supplementation in the early stages of relaxation techniques in the highly anxious adolescent to help them grasp the principles to regaining somatic sensory control in the abused adolescent. These are often delivered in association with nursing staff under the supervision of an occupational therapist.

$ General psychotherapy differs from disorder specific psychotherapy in that it deals more with emotions and behaviours in the day to day settings, relationships with parents and other issues which may arise. It may be exploratory, supportive or general cognitive. It is characteristic of psychotherapy with adolescents with severe and complex disorders that disorder specific psychotherapy will proceed for a time, and then interpersonal, family or other issues will need to be explored for a time to allow the disorder specific psychotherapy to occur.

$ Behavioural analyses were mentioned in the previous paper. This is obviously relevant to analyses of disturbed behaviour - self harm, aggression, absconding, but also occurs with other behaviours e.g. extreme passivity, extreme compliance etc. Good analysis of behaviours is critical to understanding a number of issues for the adolescents with poor verbal ability in terms of emotions they have difficulty expressing, care eliciting behaviours vs behaviours exploring care issues, whether the illness serves a function for the adolescent etc. It is important to analyse the context of both single behaviours, and patterns of behaviour.

$ Behaviour modification beyond modification of disorder specific behavoirus and anxiety reduction often facilitates insights into necessities to adopt different strategies for both emotional expression and interpersonal functioning.

$ Finally the day to day program of life on the ward is important. For example, there are constant opportunities for peer interactions. Some of it will be positive, some negative. Reflections on the day to day interactions with peers are important to enable the socially anxious adolescent to develop and practice skills. (The evidence is that with support this can be generalised into their contact with peers in community settings.) Adolescents who internalise blame for interpersonal relationships with significant people can have alternate emotions validated by clinicians who have observed a negative interaction occurring to the adolescent. This is the most powerful intervention I know of in altering their schemas about attributions for events. Another example is the necessity to practice self care and organisational skills. This is not an issue for some, but an important intervention for change for others. There are multiple such activities in day to day routine which support change in various areas.

These last three interventions are built into the day to day program.

4. Integration of assessments and interventions into a coherent framework.

We observe that therapeutic work with adolescents necessitates:

$ synthesising and integrating information from the variety of assessments with both disorder specific and generic interventions

$ integrating the discipline specific and generic inputs of a multidisciplinary team into a cohesive team framework.

$ having a conceptual framework for both treatment and rehabilitation.

- $ observing moratoriums in one area of progress while therapeutic or rehabilitative work in another area continues
- $ it is useful to work utilising the adolescent's strengths as well as working on their deficits.
- $ although there is no clear evidenced based treatments for this group, it is vital that throughout there is evidenced based practice to guide interventions.

This requires development of a cohesive framework in which:

- $ interventions, both therapeutic and rehabilitative can be understood, planned for an implemented
- $ difficulties in progress can be examined and alternate strategies developed
- $ absolute limitations in function which are not likely to respond to further interventions can be accepted and alternate strategies planned.
- $ discharge can be be planned.

Over the years we have developed an integrated framework which utilises a component familiar to all CYMHS clinicians with two components which are familiar to some clinicians, but not to all. The first is probably the least recognised - an evidenced based knowledge of adolescent development. The second is a knowledge of parenting functions - this is more familiar to many clinicians, although many myths abound.

The first component familiar to all CYMHS clinicians.

- $ The DSM-IV-R or ICD-10 diagnoses. The former is not highly reliable in adolescents. The latter is perhaps too non-specific for use. As outlined above, one to one correspondence and a particular therapy is problematic.
- $ Behaviours consequent on this diagnosis, e.g. anorexia is often accompanied by food restriction, excess solitary exercise, sometimes purging, soemtimes laxative use, sometimes preoccupation with food etc. All diagnoses are associated with a particular range of behaviours. These behaviours have an impact on the adolescent's development and family or carers. It is important to catalogue behaviours to enable intensive interventions to be performed, and programs to be individualised. (For example, there is no point in a program to restrict excessive exercise in an adolescent for whom this is not an issue.)
- $ Understanding the family and school environments through which they have passed including the functioning of the adolescent as a child over the years, and the impact of the environment on the adolescent. Basic to all child and adolescent mental health.
- $ Understanding biological factors contributing to the development of the adolescent. These include temperament, levels of impulsivity/attention, sociability, language and learning deficits. These will interact with development, life events and mental illness in a variety of ways which is often ignored by treatment protocols.
- $ Family therapy is sometimes important, but often parents have abused and colluded in the abuse or abandoned and neglected their adolescent.

The major headings for the second component (developmental tasks of adolescents) are:

- $ adjust to physical changes (including sexual characteristics)
- $ negotiate schooling
- $ negotiate cognitive maturity
- $ negotiate emotional maturity
- $ negotiate peer relationships
- $ negotiate boundaries

- $ negotiate moral maturity
- $ develop self care skills
- $ develop leisure skills
- $ develop competencies for independence
- $ negotiate individuation within the family
- $ develop identity
- $ develop life schemas
- $ plan for the future

Within each of these are numerous sub-headings.

The **basis** for these is

- $ direct observation of various components of adolescent development in clinical and non-clinical populations and from literature on adolescent development from across cultures and centuries
- $ an extensive search of the literature on adolescent development both from short term cross sectional studies, and also from large longitudinal studies of non-clinical populations of adolescents across several countries including Australia.

There is a fairly substantial base for this. In general, new research validates existing literature rather than changing it substantially.

The **purposes** for this analysis of tasks of adolescent development are

- $ to provide an evidence-based framework for adolescent development. Mythology about this is not uncommon within CYMHS and outside of it.
- $ to provide for an analysis of an adolescent's strengths. Unless this is formally documented, strengths may be overlooked. The general literature on rehabilitation emphasises using strengths as a springboard where possible for rehabilitation.
- $ to provide a framework for analysis of impairments. The purpose of this is to gain an insight into those which may be suitable for rehabilitation and those which cannot be changed to enable either acceptance of the issue or some way of ameliorating its effects. Currently there is no framework for rehabilitation in adolescent mental health. The seems a reasonable start to develop a model for rehabilitation, because it is built on substantial evidence of the impact of these tasks.
- $ to develop a framework for rehabilitation.

The major headings of the third component (the tasks of parenting) are:

- $ commitment to the adolescent
- $ bonding style
- $ adequacy of nurturance
- $ meet appropriate dependency needs
- $ meet appropriate protection needs
- $ establishment of boundaries
- $ capacity to supervise, monitor
- $ style of correction
- $ communication of values, schemas
- $ capacity to contain emotions
- $ capacity to facilitate transitions
- $ capacity to understand

The **basis** for these is similar to that for adolescent development:

- $ direct observation of various components of parenting in non-clinical populations and from literature on adolescent development from across cultures and centuries
- $ an extensive search of the literature on parenting both from short term cross sectional studies, and also from large longitudinal studies of non-clinical populations of adolescents across several countries including Australia.

A substantial literature has been reviewed to develop this. Again, as with the tasks of adolescent development, new research on parenting validates existing literature rather than changing it substantially.

The **purposes** for this analysis of tasks of parenting are:

- $ to provide an evidence-based framework for parenting. Mythology about parenting is rife both within CYMHS and outside of it.
- $ to provide for an analysis of an parent function. There have often been substantial family interventions over the years prior to admission. This provides a framework as to what has and has not changed (indeed, may be incapable of change).
- $ to understand the strengths of the family for the adolescent, and what the adolescent may have to accept in the family, including moving outside of home.
- $ to provide a more evidence based understanding of transference behaviours that arise in some adolescents, and minimise speculation.

These three components form the basis for a problem solving matrix in which to analyse interventions, rehabilitation, treatment, moratoriums, challenges, and the path towards discharge.

Research and Training

Although BAC has had clinicians with a strong interest and track record in research, clinical demands have rarely afforded opportunities for research to be developed. Although we are currently in an institution with a strong research component, research collaborations have not resulted in spite of our strong approaches. Research requires a strong infrastructure which we do not currently have.

There are multiple issues for training from this document. A psychologist, for instance, would need to be trained in multiple approaches to anorexia, not just one framework. The same is true for other training. Numerous specific areas can be identified for nursing staff. I do not have time to analyse this, in order to get it off in time.

REFERRAL SOURCES

The decision to take referrals only from CYMHS raise grave concerns on a number of areas.

- $ The AITRC would be the only Level 6 child and adolescent unit to admit on the basis of referral source as well as severity of the illness and need for specialised treatment.
- $ Some Queensland adolescents would be ineligible for the most intensive levels of intervention of simply on the basis that they chose private treatment rather than public treatment. Currently all the service is available to all Queensland adolescents who require it.
- $ Some families we have seen at the Mater initially go to a CYMHS, and then opt for private treatment, steadfastly refusing to return to the original CYMHS. They are thus ineligible for the service because fo this decision.
- $ Under current Medicare arrangements, private child and adolescent psychiatrists have the option of working closely with other professionals - psychologists, social workers, dietitians, nurses. I know some have taken up this option, essentially replicates the function of a multidisciiplinary team. Yet they would not be eligible to refer to a service.
- $ If a competent child psychiatrist feels that admission to the AITRC is indicated, they would have no option bit to refer to the local CYMHS. There is a fair chance that this will be difficult for the adolescent to establish relationships with a new therapist, and may not add anything in treatment, but simply prolong the time until admission.
- $ We regularly involve CYMHS clinicians in the management of ongoing management of their adolescents. I observe that many CYMHS clinicians are the sole case manager, with little involvement of other clinicians in the team. This concurs with observations when I have provided cover for community CYMHS. Rather than being true multidisciplinary teams with discipline specific functions and utilising discipline specific strengths, some CYMHS are essentially multiple solo practitioners from a range of disciplines. Multidisciplinary input is largely limited to comments at case reviews, case conference. This comment is often more generic than discipline specific. Yet these solo practitioners have access to the AITRC, whereas a private child psychiatrist does not.
- $ CYMHS teams operate with considerable differences in levels of expertise and experience. Because clinicians often perform generic roles, some will perform functions outside of that for which their undergraduate training has prepared them. With time their knowledge and experience will develop. A CYMHS team with a significant proportion new graduates, or clinicians new to CYMHS will have the right to refer to the AITRC. A private child and adolescent psychiatrist with at least six years of supervised clinical training does not. They would need to refer to the CYMHS.
- $ Private child psychiatrists are able to admit to adolescent acute inpatient units

A well functioning multidisciplinary team is undoubtedly the ideal. It may not be the rule. A competent child psychiatrist may make an equally valid referral as a CYMHS clinician in a poorly functioning team.

Input from Director Seidler C/Director BAC

FOUR ISSUES WITH THE BAC MOS

1. **The use of the word "consumers".**

Currently this version uses the term "consumer", "adolescent" and "young person".

I avoided the use of the term "consumer" deliberately for three reasons except when it refers to "consumer participation".

- The adolescents detest being referred to as "consumers". They say it makes them feel like greedy takers and users. They invariably refer to themselves as "patients" (in spite of the fact that staff never use that term), "adolescents" or "the kids" -- never "consumers". I suggest that if we are "consumer focussed" we should respect their wishes and not refer to them as such wherever possible. This should be sufficient argument in itself.
- It totally belies the nature of the relationship the adolescent has with the service and alien to the notion of recovery. We are partners and collaborators with them in reducing the impact of their mental illness or indeed, helping them move from a state of mental illness to one of mental health. There is nothing in the term "consumer" which reflects this relationship. It is a term describing the disappearance of a passive object caused by an active one. It comes from the Latin *consumere* to destroy (*con* with, *sumere* to take).
- It is a dehumanising term. We talk about a bushfire "consuming" fuel in the forest, of people consuming food or goods, about the fuel consumption of a car. An inanimate object which is consumed by either another inanimate or an animate thing or being. It is the language of economics, not of sociology. I refer to "adolescents", because that is common language used by all of society. It does not separate them out from the rest of their peers, it regards them as they are -- essentially young people.

How health ever was beguiled into accepting such a gross term is beyond me. But mental health should lead the revolution against it. We are in the fortunate position of having a term in common usage which is not cumbersome to use which instantly conveys the sense of who we are talking about.

2. **Deletion of reference to "Therapeutic Residential" and "Step Down" unit**

First of all this is not some sort of hostel out in the community when adolescents are discharged.

It is problematic, because they don't currently exist. But they are solidly endorsed by the Mental Health Branch and the State Wide Child and Youth Mental Health Network as an essential component of the new service.

This was described:

- and first raised at the May 2006 forum to discuss CYMHS inpatient and day patient facilities.
- at the SWCYMHN meeting in late 2007 early 2008 as part of the redevelopment of BAC (and endorsed by that group)
- at a special meeting of CYMHS and MHB people to discuss the MOSD for BAC in March 2008

- at subsequent reference group meetings in June/July held between CYMHS representatives, the Mental Health Branch and representatives from the then Zones and Health Services which were to be potential sites. It was again strongly endorsed at this level as being a necessary component.
- at the presentation of the site options to the SWCYMHN by the MHB in late 2008. It was again accepted as part of that plan.

"Therapeutic Residential" refers to more home like accommodation with a carer where adolescents of lower acuity (e.g. those with severe school refusal secondary to severe social anxiety) can stay at nights but fully participate in all aspects of the program.

I have tried to present the notion that we have accommodation which reflects more appropriately varying levels of acuity. We readily accept the notion that there may need to be high dependency beds for those of higher acuity, but apparently baulk at the notion of low dependency beds. In a state as decentralised as Queensland, it is not viable to develop day patient units in more than about 8 centres. Some will need that service, but only from associated appropriate accommodation. That is not the only reason. We recently had [redacted] who, even when they get their unit, would be referred to us for certain reasons. They would have been far better off in a Therapeutic Residential.

It offers two advantages:

- from the adolescent's point of view, less exposure to distressing high acuity behaviours of others
- from the economists point of view, more adolescents being treated for a similar expenditure.

Win/win.

We are also exploring the concept of a Therapeutic Residential for young people in the care of the Department, principally those in Evolve services. This has received support from Evolve clinicians, the Mental Health Branch and the Department is open to examining the concept.

"Step Down Unit" refers to what is essentially a two bedroom flat on the grounds for adolescents who

- will need to live independently on discharge
- have acuity needs that are reduced sufficiently not to need an inpatient unit
- need to acquire life skills or the confidence that they can live independently.

Time after time I have seen an adolescent with severe mental illness and a home situation which is unviable come to a point in their treatment where they really understand what they can work in to get better, but face the horrible prospect of being homeless or facing some unknown "youth accommodation" which may never materialise. They are well enough (and often old enough) that the ward with its acuity is in itself a source of distress. For most of them, their solution is often to either abscond or return prematurely into an abusive home environment. Having a unit on site with less intensity and which supports semi-independent living would enable these adolescents to develop a sense of control over the future. The move to Redlands offers the opportunity to partner with two NGO's to provide further transitional accommodation, so that these adolescents have a clear idea of a pathway for the

future. The current nebulous arrangements of youth accommodation in an unknown community are too vague for comfort. They just see no pathway, and deteriorate.

We feel so strongly that this should be an essential part of the unit, that I would argue we should not waste money on rebuilding a new unit if it does not include a step down facility.

3. Target population

The wording of the final draft (from this week) is "Consumers engaged with the centre will present with a range of mental health problems and/or disorders, but predominantly, they will have complicated diagnoses associated with mood and anxiety disorders, developmental disorders, language disorders and oppositional defiant disorders. A majority will be diagnosed with parent-child relational problems. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2."

This appears to be a random version which differs from the preceding drafts of last week. "Consumers engaged with the centre will present with a range of mental health problems and/or disorders, but predominantly, they will have complicated diagnoses associated with eating disorders, mood and anxiety disorders, and trauma experiences. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2."

No mention of eating disorders or trauma in the new version.

I can understand where this latest version came from – the data in the table of diagnoses. But this is a classical example where data used on its own loses considerable information.

Basically there are 4 main groups of adolescents admitted to the unit and one non-group.

- Those with severe, persistent eating disorder
- Those with severe, recurrent self harm
- Those with severe school refusal (mainly social anxiety)
- Those with severe persistent psychosis
- And a small group of assorted – organic, the occasional young person with Aspergers and a difficult family etc.

Those with severe, persistent eating disorder invariably have severe social anxiety, many have other anxiety disorders e.g OCD, generalised anxiety, two thirds are depressed, a few have PTSD, and some (a minority) are oppositional.

Those with severe, recurrent self harm are usually the victims of multiple abuse, always have a mood disorder, some have anxiety disorder, most but not all have PTSD (but have trauma related symptoms which cannot be classified). Some are really compliant, some are extremely oppositional to the point of some actually being called a conduct disorder.

Those with severe school refusal (mainly social anxiety) almost invariably have ODD as a secondary issue, other anxiety disorders and sometimes a mood disorder.

No one is admitted because they have an Oppositional Defiant Disorder. But recognising that this is a secondary disorder for half the adolescents conveys some sense of the potential for behavioural disturbance on the unit.

An associated observation is that those with severe school refusal and Oppositional Defiant Disorder often stay for shorter periods than those with severe eating disorders and severe self harm. Thus the numbers of those admitted with ODD will be higher for this reason, but at any one time, the clinical interventions on the unit for those with severe eating disorders and severe self harm/depression/PTSD secondary to trauma will be more intense than those with severe social anxiety/school refusal and ODD.

I still believe my original description captures the intensity of what we see. "The primary diagnostic profiles of young people admitted to the Adolescent Extended Treatment Centre are adolescents with persistent eating disorders, complex illness and behaviours associated with trauma and severe anxiety and mood disorders, often with associated delays in particular developmental areas." Numerous phrases have been dropped form the original draft, and I believe that some of what differentiates us from an acute inpatient unit has consequently been lost.

Last week's wording is better, probably adequate, but this week's wording is off the mark.

4. Performance, Quality and Safety Indicators.

I agree that a necessary change needed to be made in the following paragraph. "Adolescents, family members, carers, (and) referring service providers and the local community of the adolescent are involved in the planning, development, implementation and evaluation of the mental health service" to include local service providers. I must admit that by this part of the document my attention flagged in reading.

However, I believe it is a little unwieldy in practice. If it read by inserting the blue "and" and deleted the phrase in red, it would reflect reality. There is no way any but the immediate local community is going to want to get involved in the planning, development etc. of this unit they know nothing about.

From: David Crompton
To: Judi Krause
Date: 9/02/2010 7:58 am
Subject: Re: MOSD BAU

Dear Judi
I spoke with Shirley yesterday. Officially Pam Lane has not released the document yet so staff have not seen it. She has asked if you could summarise key points but not include recommendations.
I would suggest do a summary of issues and then let Shirley review. Just include me in the loop.
Shirley is otherwise happy with process.
Thanks
David

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District

>>> Judi Krause 8/02/2010 3:11 pm >>>
Hi David
I have arranged a meeting for CYMHS stakeholders for Wednesday to discuss the MOSD for BAU as requested. I was wondering if it was appropriate to circulate the 2009 review of the centre at this meeting or would you prefer we (Brett and I who have been privy to the report) just integrate some of the suggestions into the discussion?

If it is appropriate to circulate this report (to a limited group who would be asked to maintain confidentiality and not circulate further) then please send me through an electronic version.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

From: Judi Krause
To: Shirley Wigan
CC: David Crompton
Date: 10/02/2010 7:53 am
Subject: Outline of meeting to discuss MOSD BAU
Attachments: Summary of Issues to consider when reviewing the.doc

Hi Shirley
As discussed at the Mental Health Capital Works Program meeting last week I have arranged for a meeting with key CYMHS stakeholders to review the Barrett Adolescent Unit Model of Service Delivery.

The expected outcome of this meeting would be to begin to clearly articulate the continuum of care including referral pathways, admission criteria, defined target group, diagnostic groupings, evidence based treatment modalities, staff skill mix, discharge planning and program evaluation/ outcomes. A further consideration would be the resource impact on Redlands Hospital to provide appropriate support to BAU.

I had planned to give a summary of the 2009 Review of BAU outlining only key points to consider in the revised model, rather than any discussion around direct recommendations from the report. I am mindful that this report has not been released to relevant staff at this stage. I have included my summary of this report for your perusal. I felt it was important for all group members to be cognizant of the issues that will guide the review of the MOSD. Please advise me if you feel the summary is too inclusive. I was not intending to give copies to the group.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

From: "McDermott, Brett"
To: "Judi Krause" "James Scott"
CC: "FionaT Cameron"
Date: 11/02/2010 11:55 am
Subject: BAC-AITRC Model of Service Delivery doc- thoughts

Hi Judi,
see below some thoughts from me about the AITRC MSD doc.

Feedback on the AITRC model of service guideline document:

Firstly I concur with some of our senior adult colleagues that the model of service document has some areas which appear ambiguous and hard to follow and there is a general flavour that the documented practices do not appear to be very contemporary.

My overarching philosophical concern is that there is very little evidence in the document that the future AITRC service will be integrated within a CYMHS continuum of care or indeed the state-wide CYMHS model of service. The document says in several places that they are seeking integration and collaboration, however, there is no structural process specified around this. The danger is that Barrett will be perceived as an isolated stand alone and unintegrated service. It will also be in danger of not benefiting from a continuous reform process and we may remain in the unfortunate situation of having serial 3 - 5 year reviews of perceived problems in the AITRC unit.

The solution is clear to me and that is the AITRC service should become part of a larger CYMHS service entity and in fact be line managed by that service. Given AITRC is a state-wide and quaternary service it is my opinion that the ultimate line management should be to the Queensland Children's health district and the Queensland Children's Hospital through Child and Youth Mental Health at the Queensland Children's Hospital. Rather than wait for three years for this to happen it is my advice that the interim solution is that the AITRC service become part of the Mater CYMHS continuum of service. Mater CYMHS already has state-wide services such as the Adolescent drug and alcohol withdrawal service (ADAWS) and so there would be no change in the AITRC state-wide service delivery it would just be managed and integrated with Mater CYMHS. This also makes geographic sense given that it currently resides in the Southern sector and there are strong professional links between some Mater and Barrett staff.

Clinical governance

My other overarching philosophical issue is the document does not easily afford understanding of the patient's journey through their time at the AITRC service. Different interventions are well enunciated and tabulated, however, this does not give an idea of what actually happens to the client. Normally care in such a unit is phased. The first phase is one of developing rapport, a therapeutic alliance, developing shared treatment goals and a greater understanding of risk. At this stage risk management interventions occur. During phase two of treatment there are less concerns about safety and at this stage of treatment specific therapies such as DBT, IPT, trauma focused CBT can be undertaken within an overarching milieu and systemically informed practice. Phase 3 is a phase of relentless move towards community integration and/or transition back to the referring service or on to adult mental health services. I would like to see the model of service reformulated with this in mind.

Some specific issues from the document:

* Under key functions of AITRC I note it says that they will perform a comprehensive assessment of the adolescent I think that

should be more orientated towards building upon the substantial understanding of the adolescent that already exists in referring CAMHS and other services.

* Under the second paragraph and series of dot points this is where I think we can start talking about phases of care.
* Under the two dot points of the bottom of the first page I think this should be rewritten to enshrine line management to CYMHS.
* I think another intervention that will help ongoing integration with CYMHS is that, not dissimilar to the Evolve process, entry to AITRC should be via a complex case meeting process which involves the referring specialists, AITRC team and key senior members of the AITRC service. There might be coopted members who are senior Child Psychiatry or Allied Health practitioners who sit on this panel. This will immediately increase integration and allow some degree of uniformity and consistency of accepted patients with a model of care.
* On page 2 first series of dot points dot point number 3 we need a more comprehensive definition of severe and complex mental illness
* Under dot point 5 I would remove the possibility of referrals by private child and adolescent psychiatrists or psychologists and headspace services. Again this is an exponsive quaternary service and there must be the demonstration, though the complex case process, of a purposeful and prolonged period of multidisciplinary care prior to the individual being accepted in the AITRC service. In my view multidisciplinary care is not the combination of a private psychiatrist and psychologist rather it's the application of a dedicated team approach. It may be that the complex case process advises referral to a day program or some other service prior to referral to AITRC.
* At the start of the paragraph 'Various processes of Assessment' the word various should be deleted, it should be a unitary assessment process that involves a complex case discussion.
* Under the heading adolescents may continue beyond their 18th birthday we should include the words 'this is a case by case decision and requires the direct involvement of the Director. In all cases of treatment beyond the 18th birthday there must be an active plan for integration or transition to other services.
* In the bottom of page 2 the dot points about the characteristics of those who go to the unit I would remove the final dot point about psychosis I would include a dot point that says 'adolescents with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour that is usually secondary to complex post traumatic stress disorder'.
* On page 3 under developing networks with CYMHS again I would reword this to enshrine line management to CYMHS.
* Under page 4 when we talk about assessment of mental illness,s assessments of family and carers and developmental services I would reword to emphasise that the onus is on the referring agency to prepare comprehensive information that will be presented at the complex case intake discussion group (this needs clearly a better name) i.e. the onus is on the referring team to actually provide very detailed family development forensic drug and alcohol and other histories.
* Under page 5 under assessment of risk given that these individuals are often at the extreme end of challenging behaviour this section should be more comprehensive, for instance rather than just risk assessments should be conducted on admission and then be routine we should spell out that the referring team needs to provide not only a risk assessment but documentation of all past history of deliberate self harm and the consequence of this behaviour such as therapeutic endeavours related to this, inpatient admissions and the like. I feel that also there should be some distinction between cumulative risk and acute risk where cumulative risk are individuals who have prejudicial histories of child sexual and physical abuse domestic violence or

chronic neglect and are already on a complex PTSD trajectory. This is important because those with significant cumulative risk are more likely to act on acute events.

* On page 7 the "voice" should be reviewed throughout the whole document so for instance it says dot point top of page 7 therapists "should" have recognised training and supervision in family therapy this clearly should read therapists will have recognised training, again the therapist will have continuing supervision later on the therapist will be integrated I think the would should allows an unacceptable amount of leeway.
* Under page 8 there is a series of detailed dot points about care coordination and later in the document it says that the nursing staff are most responsible for care coordination. I think this section needs to be reviewed with a view to the recent recommendations from the Barrett Adolescent Centre review. I think also that there should be thought around more contemporary methods of dealing with individuals presenting with psychosocial complexity we may need the guidance of inpatient NUM's and Directors for this. For instance around some complex cases a mini team is preferable to a case coordination model.
* Page 10 the notes on discharge planning should now be reviewed. Somewhere else in the document it needs to be made clear that we will be advising a maximum episode of care lasting for 6 months at the new AITRC service. This clearly changes the dynamic between the referring service and AITRC in the knowledge that they will be having the patient back sooner rather than later and that discharge and transition planning should occur earlier in the admission and be clearly very comprehensive this section needs to be reviewed with this in mind.
* Page 11 the third series of dot points the dot point team members are fully integrated does not make any sense and two lines down you should remove the words under normal circumstances and start that sentence with care coordination there are no circumstances where a student should coordinate a AITRC patient.
* On Page 12 the dot point at the top I firmly believe that the consultant psychiatrist of AITRC should not be rostered on call and accessible 24 hours 7 day per week. This is extremely worrying in terms of the ability of the consultant to continue this kind of on call roster, the possibility of ever recruiting a successor to undertake this type of roster and ongoing lack of input from other senior psychiatrists in Brisbane. When AITRC is integrated into another CYMHS service clearly the Psychiatrist on that after hours roster would then be those who were on call to AITRC.
* Further down the page staff training needs significant expansion.
* The last paragraph of page 12 is now redundant in that we are advising that AITRC be integrated with another CYMHS Service further a model of care cannot direct it's parent service in the way that this paragraph is written for instance it cannot tell a district adult mental health service that it must consult a child mental health service. Again the solution to this is integrated into CYMHS.

I hope these comments have been of some help, Brett.

From: David Crompton
To: Judi Krause
Date: 17/02/2010 10:05 am
Subject: Re: MOSD BAC

Judi I think it is best that we use what fits the groups needs, that in the long term will make it easier for your group.

David
A/Professor David Crompton
Executive Director Mental Health Metro South
Telephone 0733394626
-----Original Message-----
From: Judi Krause
To: David Crompton

Sent: 17/02/2010 09:55:23
Subject: MOSD BAC

Hi David
we are about to have our second meeting for the review of the MOSD BAC. I just wanted to clarify how you want our recommendations to be delivered. We can document a list of recommendations and forward these to you. Alternatively we can actually make changes to the MOSD draft document using track changes. We felt the second method whilst time consuming may be more beneficial in the long term. Please advise me which method you would prefer.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

From: Trevor Sadler
To:
CC: FionaT Cameron
Date: 22/02/2010 9:16 am
Subject: Re: Document for meeting tomorrow

Dear Colleagues,

I had some software problems, and have only just been able to access my Queensland Health emails.

I just read the minutes of the first meeting. I agree with a number of the comments, including coming under the Mater.

However some of the comments and recommendations were incredibly naive, particularly around treatment issues, clinical issues, comparisons with other units etc. They are simply not supported in the research.

I have spent hours on what is supposed to be an overseas holiday going through my literature searches, getting on to CKN etc. to prepare a paper for what we do. I won't get it finished tonight, but I'll do my best to get it to you as soon as possible. I will try to connect with the next meeting, if my schedule the next day permits me to do so.

The draft MOSD is currently rubbish.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

>>> Judi Krause 18/02/2010 5:53 pm >>>
Hi there
this is the MOSD draft which Fiona has started to amend with suggestions from the first meeting. This is not completed. We would suggest that you have a copy with you for the meeting tomorrow and we can discuss further.

Please do not make changes directly onto the model we **will** try to do this in the meeting tomorrow.
Talk to you then.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)

From: Trevor Sadler
To: Brett McDermott; Erica Lee; James Scott; Judi Krause; Michael Daubne...
Date: 22/02/2010 10:57 am
Subject: BAC MOSD
Attachments: BAC MOSD.rtf

Dear Colleagues,

This is part 1 of the comments on our MOSD -developing reference points.

This includes descriptions of the patients, literature reviews on various topics and observations from other inpatient units.

I haven't provided references for the literature reviews. I am on holidays. I ask that you trust my integrity to provide honest accounts from my surveys of the literature. Over the past 10 years I have spent hundreds of hours searching the literature for answers to the problems we face. I have most of these searches on my lap top, so was able to access them easily. Some I needed to update via CKN and my UQ library rights.

What got me rlled when I began to read the MOSD were references to evidenced based treatments. This paper explains why I think the concept is naive in the population we see, and why we need to develop an alternate approach. My next paper will outline our observations and approach more thoroughly.

I must point out that our MOSD was the **first draft** of the first CYMHS MOSD in the new format, done just before Christmas. Leanne resigned without providing feedback. It is natural that there were deficiencies. There are no CYMHS MOSD reference points or any feedback to develop it further.

I will comment on other issues in the minutes as I get internet access. I don't think the place we are staying tomorrow night for 6 nights is reliable.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

From: Denisse Best
To: FionaT Cameron
CC: Krause, Judi
Date: 1/03/2010 9:05 am
Subject: Re: Fwd: BAC latest version Fiona FYI

** Proprietary **
Judi sent me the version for comment - here it is as I note Judi is away for a few days

>>> Denisse Best 1/03/2010 7:54 am >>>
Hi judi I have read not quite all
but 2 things stand out

in the pateints to be treated
there is no mention of those with psychosis - and i would think that they would get a priority if it is persistent and needing longer time to treat

and 2 "adventure based" therapy - this can only be provided with an adequately qualified and certified staffing - but I guess this will come out in the wash I guess I might be tempted to say "recreational and adventure based activites subject to the availability of properly certified staff"

From: Judi Krause
To: FionaT Cameron
Date: 4/03/2010 11:21 am
Subject: Psychosis

Hi there
I have just spoken to DB and she had some points to make about the model (unfortunately belatedly!!).
1. psychosis - she felt we had to put something in about young people with treatment resistant psychosis (under who accesses the unit) this is imperative she feels as we would look foolish to adult psychiatrists without this inclusion.
2. she also felt that we should look at that list (of which groups use the unit) and put them in priority of highest users to lower users. She felt it read like eating disorders was a priority area. She also felt we should predicate the diagnostic tables with 'this data reflects past admission profiles' implying that these may change over time with the new MOSD.
3. She could not give clarity re: who would be responsible for managing young people with medical needs i.e. eating disorders but felt that if they were a MH client then QCH would most probably service them
4. She felt it needed strengthening around 'transition' to adult services and integrating rehabilitation. She felt the document was weak in these areas.
5. She felt we needed to articulate a range of evidence based treatments that would be part of the standardised suite of treatments that would then be customised to suit the individuals presentation. She thought this was important in relation to linking these with the groups of diagnoses we had identified in the client profile.
6. She also gave me information to add in my letter - which I am going back to **now**!!
Breathe.
I will send you through the letter once I have finished!
talk soon
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: "McDermott, Brett"
To: "Judi Krause"
CC: "Denisse Best", "FionaT Cameron"
Date: 4/03/2010 1:54 pm
Subject: RE: Covering letter for MOSD BAU

Hi Judi,
some brief points:
its AITRC (I = integrated)
small point I'm an Executive Director not a clinical Director
big point - I think we should head off some Trevor criticism by talking to it. I would add a second last line of last para (see XXXX) "The group note that Dr Sadler is critical of the 6 month treatment time frame suggesting there is no evidence for this period of care. The group note that there is equally no evidence for a 1-3 year admission and these lengthier periods of care are more costly, block beds and appear developmentally inconsistent with generalising change to the patient's local setting."

cheers,
Brett.

From: Judi Krause
Sent: Thursday, 4 March 2010 1:06 PM
To: McDermott, Brett
Cc: Denisse Best; FionaT Cameron
Subject: Covering letter for MOSD BAU

HI everyone
apologies for the delay in getting this out I have had multiple interruptions this morning. If you have any feedback I need it asap as I have to send this to David/Shirley by 2pm. I am then leaving to attend the Facility Planning meeting at Redlands where I will no doubt have the opportunity to discuss further with David and Shirley. This letter is just in email form at present to make it easier to send around. I will format it appropriately on letterhead.
Regards
Judi

Dear David and Shirley
please find enclosed the draft model of service delivery for the Adolescent Extended Treatment and Rehabilitation Centre (AETRC) formerly known as Barrett Adolescent Unit. As requested by yourselves at the Redland Facility Project Team Meeting on 4th February this document has been reviewed by a working group of the Statewide Mental Health Network Child and Youth Sub Group. This group comprised of Erica Lee, Manager Mater CYMHS, Dr. Brett McDermott, Clinical Director Mater CYMHS, Dr. Penny Brassey, Clinical Director, Townsville CYMHS, Dr. Michael Daubney, Clinical Director, Metro South CYMHS, Dr. James Scott, Child Psychiatrist, RCH CYMHS, Fiona Cameron, A/Statewide Principal Project Officer, CYMHS, Dr. Trevor Sadler, Clinical Director, AETRC (who provided input via email as he is currently overseas) and myself. Recommendations have been further reviewed by Denisse Best, Allied Health Leader, Queensland Children's Services.

The group acknowledged that reviewing the MOSD was a complex task which was not conducive to the four week timeframe. The group were able to meet on three occasions with email communication in between sessions.

The emphasis has been on addressing clinical governance issues, positioning AETRC in the integrated CYMHS continuum of care and refining referral, treatment and discharge processes. The group recommended clinical governance of AETRC be incorporated within the QCH (the Mater in the interim period) as this would address some of the key themes identified in the recent reviews. It would facilitate the establishment of clear reporting relationships, address risk management and patient safety issues and enable multidisciplinary staff to link into existing frameworks of clinical supervision, staff development and clinical education and peer support networks. It would also ensure that the national mental health reform agenda is embedded into the operational management of AETRC.

There are a range of recommendations relating to the continuum of care including referrals being reviewed by a multidisciplinary intake panel consisting of key stakeholders, treatment being defined to a six month period in most cases, a suite of evidence based treatments being available which will be tailored to suit the individual's needs and more assertive discharge planning processes being adopted.

In relation to resources required from Redland Hospital it would be envisaged that they would support acute medical emergencies and other medical issues that can be managed locally. AETRC as an integrated component of the Mater/ QCH would have access to a range of specialists who could provide support.

In relation to the proposed building design of AETRC when it is relocated to Redlands it is recommended that this be revised in lieu of the changes to the MOSD. The cottage style of accommodation may not be conducive to the proposed six month treatment model.

While some significant changes have been made to the original draft MOSD the group would like to emphasise that this document should not be viewed as the final version of the MOSD for AETRC. Further work is required to finalise this document and encapsulate the detail of the above recommendations. The group view it as imperative that we continue to work on this document and are consulted with in relation to any changes that are proposed. The group would further like to be involved in any building re-design.

As you were aware Dr. Trevor Sadler, Clinical Director of AETRC, was unable to participate in these group discussions. He has sent us a range of email information in relation to the current treatment programs at AETRC and his observations from visiting other adolescent units overseas. It should be noted that there was not group consensus on all issues. Trevor felt strongly that model proposed above did not encapsulate the complexity of the AETRC cohort and was simplistic in nature. XXXX For your information I have enclosed the information that Trevor forwarded to the group.

Please do not hesitate to contact myself (or any member of the group) in relation to the above information if further clarity or discussion is required.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)

From: Judi Krause
To: David Crompton
CC: Aaron Groves; [redacted] Shirley Wigan
Date: 5/03/2010 8:33 am
Subject: MOSD for Adolescent Extended Treatment and Rehabilitation Centre
Attachments: OBSERVATIONS OF ADOLESCENTS WITH SEVERE AND COMPLEX MENTA ILLNESS.doc; REFE RRAL SOURCESTO THE AITRC.doc; Covering Letter to D.Crompton.doc; AETRC Draf t MOSD 4.3.10.doc

Hi David
please find enclosed the modified draft MOSD for Adolescent Extended Treatment and Rehabilitation Centre. I have enclosed a covering letter to add context to the MOSD changes. I have also enclosed some information Trevor Sadler sent to the group whilst overseas.

I had taken hard copies of this information with me yesterday to the Facility Project Team Meeting at Redlands as I had anticipated that you and Shirley would be there and that we could discuss this further.

The facility project team were keen to hear about the changes to the MOSD in relation to the building design. I mentioned some of the proposed changes but stated that it would be hard to comment on design implications without knowing firstly what current design has been confirmed, now the site has been chosen (most of the CYMHS group were unsure of the status of the current design) and secondly if the MOSD changes would be endorsed and when/how this would occur. We were unclear what the process would be now the CYMHS group have forwarded the recommendations to you.

Katie Eckersley suggested that before decisions could be made about design changes further discussion would need to occur to address the abovementioned issues. This will be reflected in the minutes of the meeting and I am sure Katie will be in touch with you in relation to this.

I would envisage that the next step is for myself and Brett McDermott (as representatives of the broader group) to meet with you to discuss the draft MOSD and further discuss the design and operational implications.

Please do not hesitate to contact me (or any of our working group members) if you require further clarity in relation to any of the enclosed information.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services
[redacted]

From: David Crompton
To: Judi Krause
CC: Aaron Groves; [redacted] ED_MHSMetroSouth; Katie E...
Date: 8/03/2010 6:47 pm
Subject: Re: MOSD for Adolescent Extended Treatment and Rehabilitation Centre

Dear Judi
Many thanks for the report. Appreciate the work of those involved and I will write to each person to thank them for the time they gave to this body of work.
Sorry I was unable to attend last week but the District wanted me at another meeting for the day.
I will ask Miranda to set up a meeting to discuss the documents.
We are in the process of developing a PD for a Clinical Director of CYMHS for Metro South MHS that will have responsibility for ensuring the KPIs are delivered.
It is evident this position will need strong links with the broader CYMHS community to ensure monitoring of standards etc.
Regards
David

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District
Telephone [redacted]

>>> Judi Krause 5/03/2010 8:33 am >>>
Hi David
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I would envisage that the next step is for myself and Brett McDermott (as representatives of the broader group) to meet with you to discuss the draft MOSD and further discuss the design and operational implications.

Please do not hesitate to contact me (or any of our working group members) if you require further clarity in relation to any of the enclosed information.
Kind Regards

From: Judi Krause
To: Trevor Sadler
Date: 29/04/2010 8:39 am
Subject: Re: "Cottages" in the new AITRC

Hi Trevor
thanks for your email I will give you some background to that comment. The working group of the CYMHS sub group that reviewed the MOSD did not have an opportunity to review the plans of BAU. At the Redlands Facility Project team meeting following the review (which neither Shirley or David attended) the project planning team were keen to hear how changes to the MOSD had impacted upon design. I advised them that we had not been able to consider this and that we would be happy to do so, but needed to know what the MOSD would look like to do this. As David Crompton and Metro South have the final say re: MOSD (and we stated that it was not a completed document and needed further work) it was decided to have a further meeting between the original group that met in January (David, Brett, Erica, myself, you and John Quinn and ?Aaron Groves). David was arranging this. The first meeting date proposed was cancelled and has yet to be re-scheduled.

In the interim period John Quinn has given me a copy of the plans and Brett, Erica and I have briefly looked at them. There were questions raised around the HDU area (? need for this) and the configuration of the beds (? safety concerns re: capacity for staff to supervise, especially on night duty). We felt it was hard to have the discussion without you or BAU reps there as we did not have the history (some of which you had provided today) of the design. I had indicated to the facility project team that there were unlikely to be any changes to the school plans or the gym.

So we are waiting for David Crompton to advise us of when we will all meet to discuss this further. There has been no further progress from the last facility project team meeting. I am not sure where this places us for todays meeting. All further progress seems to be reliant upon the MOSD and I am surprised that David hasn't prioritised this meeting as we were initially given such a tight timeframe to review the MOSD as you would be aware. It is somewhat frustrating for us all.

I am not able to attend the meeting today in person but hope to phone in. If you want to discuss further don't hesitate to contact me my work mobile is
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

>>> Trevor Sadler 28/04/2010 11:54 pm >>>
Hello Judi,

In your covering letter to David et al regarding the revised MOSD (which still needs discussion) for the AITRC, you mentioned it may have implications for the "cottage" configuration.

I am not sure exactly what you had in mind here, but I thought I'd explain our thinking.

The word "cottage" is a bit of a misnomer, I believe, and one used by the architects. Basically they are collections of bedrooms with either shared or single en suites. Originally the architects envisaged a small area where they could sit - I think that is worth thinking about, but space may be an issue.

Basically bedrooms can be configured in any way - in a big arc all facing the nursing station, or in a long corridor, or two corridors as we now have, or the configuration we are proposing. Length of stay

for the proposed configuration is largely irrelevant for any length of stay beyond a month.

I visited a dozen units overseas. Skye House in Glasgow, built within the last 12 months, and with an average length of stay less than 6 months had a similar configuration.

The advantages that we see it is that
the entry to each four room cluster is visible from the nursing station. This is more difficult in a long corridor configuration (8 overseas units had this, and reported this difficulty)
each cluster will be single sex. Modules of four allow for some flexibility when there is an imbalance of sexes. Currently we have an 8 bed and a 10 bed wing. There were times we had 10 girls, could have taken more, and only 2 boys. A four bed module could have allowed for a 12 and 2 split.
Separating sexes is imperative - it is easier to identify no-go boundaries beyond which the opposite sex cannot go as opposed to a single corridor.
Even for a length of stay of 3-4 months, adolescents identify it is important to have some sense of personal space to which they can retreat. This configuration offers a sense of what is their area, albeit shared with 3 others, but not the whole group.
Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

Barrett Adolescent Unit (BAU)- MOSD impact on building design

Jaimee Keating [redacted] Sent: Monday, May 24, 2010 11:12 AM

Required: [redacted]

When: Thursday, May 27, 2010 9:00 AM-10:00 AM.

Location: Room 30 CYMHS Spring Hill (Teleconf details below)

Show time as: Busy

Meeting Status: Accepted

Importance: High

Categories: Urgent

Attachments: Plans.pdf (211 KB) ; Plans 2.pdf (148 KB)

Description:
Hi everyone
As discussed in recent Statewide Mental Health Network, CYMHS sub network meetings the MOSD for Barrett Adolescent Unit has undergone some changes. Many of you were actively involved in this process. As you would also be aware BAU is being relocated to Redlands in the future. The facility project team is requesting a review of the current site plans for the redeveloped BAU to ensure these remain conducive to the MOSD changes. There is mounting pressure to provide this information asap as building plans have been put on hold awaiting direction in relation to this matter.

I have enclosed copies of the plans as they currently stand. Trevor has kindly provided these and many of you will be familiar with them. He has added some comments as outlined below:

I am not keen on the amount of space between bedrooms and nursing office. However, I do like the basic configuration of bedrooms - just with the NO closer.

As Trevor has recently been overseas and reviewed adolescent extended treatment facilities he will be able to give further feedback about international examples.

Teleconference Details
Participants Dial: [redacted]
Pin # [redacted]

Regards

Jaimee Keating
Executive Support Officer to
Executive Director
Child and Youth Mental Health Service
Children's Health Services

Cnr Rogers & Water St,
Spring Hill, QLD, 4000
Postal Address: PO BOX 1507, Fortitude Valley 4006
[redacted]

From: Trevor Sadler
To: Judi Krause
Date: 25/06/2010 11:47 am
Subject: BAC MOSD

Hello Judi,

I tried to ring earlier, but you were in a meeting. I'm about to go off on leave to NZ. I'll try to have a holiday this time, but I'm sure there will be some matters I need to attend to.

Would Thursday 15/7/2010 be OK for a meeting? I can make sure any documentation is sent off.

All of this is consistent, I think, with best practice. The notion of just supplying beds is archaic.

I have never sought to be an empire builder. Indeed, I advocated strongly for day programs and acute inpatient units in local areas to the Mental health branch in the 1990's. We are in an anomalous situation with our school where it is relatively well resourced. Ed Qld knows that it is, but is happy for that to continue. If they reduced our resources, it will not be to redistribute it to other CYMHS day programs - they will be lost to our system. I am just trying to make our clinical and educational resources available to as many adolescents as possible. If they are there, they should be used to capacity.

My concerns are these:
The MOSD for day programs is much more similar to the AITRC than to acute inpatient units.
There is no mention in the 2007 - 2017 of an acute inpatient unit at Redlands.
There is no mention in the 2007 - 2017 of an day program at Redlands. These are therefore decisions within the Directorate without consultation with the CYMHS network. They have only be made within the past 12 months.
The day program MOSD says that the day program at Logan will cover Redlands. However, because of the logistics of transport, this is not feasible (as example is one of many to illustrate this). Mater works well because it is at a public transport hub, although even then there are limitations.
Ed Qld is unlikely to resource a day program at Redlands by more than one part time teacher, particularly when the AITRC is in the same area.
We would need to duplicate the rehabilitation expertise already at the AITRC for a separate local day program. This is likely to lead to a poorly resourced local day program, when we could add to the breadth of existing service.
These are issues I would like to canvas on 15/7.

Kind regards,

Trevor

Dr Trevor Sadler

Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

From: Judi Krause
To: Erica Lee
CC:
Date: 25/06/2010 6:34 pm
Subject: Monday's catch up

Hi Erica
unfortunately I am unable to attend our catch up meeting next week on Monday afternoon. I need to attend an urgent meeting re: a client in CFTU and that is the only time that suited everyone. I am mindful that we need to catch up re: the allied health showcase on 9th July, among other things. My diary is pretty ugly I have only three weeks left before I go on leave.

I have some time on **Monday 5th July from 2 - 4** if you would like to catch up then. We could firm up the presentation for the 9th. In the interim period I can jot down some ideas on the template and send it to you for your input.

Another issue is the Barrett Adolescent Unit Model of Service Delivery. David Crompton (via the Barrett Facility Project Team Meeting yesterday, which I telephone linked into) has indicated that this model needs to be progressed asap. The 'day program' component which David has indicated there is no funding for and needs to be 'dropped' from the facility planning. David has also indicated that there is no additional funds for the 'step down' or parent accommodation that Trevor has referred to previously.
The MOSD needs to be reviewed in lieu of how clients are going to be managed if there is no day component and if there is no capacity for 'step down'.

David is going to contact us all by letter requesting urgent attention to this. Trevor is now on leave in NZ for two weeks. He has suggested that we meet on Thursday July 15th at 10am here at Spring Hill. If this time and date suits you and Brett I will organise for Jaimee to arrange a room and teleconferencing facilities so Michael Daubney and others can be involved. I will also forward an email that Trevor has sent with some of his thoughts around what the Model needs to outline.
The other person we need to meet with is Kevin who I will try to pin down again for some time in the week before I go. He has been very difficult to catch up with. I will keep you posted, talk soon
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: Judi Krause
To: [redacted] Erica Lee; Ian Williams; James Scott; ...
CC: Janet Martin; Trevor Sadler
Date: 8/07/2010 10:52 am
Subject: Model of Service Delivery Barrett Adolescent Unit

Dear colleagues
We have been requested by Dr. David Crompton, Director, Metro South Mental Health to continue to progress work to refine the Model of Service Delivery for Barrett Adolescent Unit. Most of you were involved in the initial stages of this project earlier this year.

Trevor is currently overseas on leave but will be back next week. He is confident that we can address the outstanding issues in the MOSD in a timely manner. At the recent Redlands Facility Project Team meeting we were advised that the current funding for BAU is for a 15 bed unit, there is no additional funding for the proposed parents retreat and a day therapy program. It was reiterated that the governance model would be under Metro South Health Service District not QCH as our original document proposed. The Planning team are asking that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

A meeting is scheduled for **Thursday July 15th, 10am at Spring Hill CYMHS in Room 30**.

Teleconference facilities will be available details below.
Participants Dial: [redacted]
Enter Pin # [redacted]

I look forward to seeing you there, if you are unable to attend on the day, the post meeting revised MOSD will be disseminated via email and we would really appreciate your timely feedback. Thank you all for your ongoing enthusiasm and commitment to ensuring our extended treatment facility for CYMHS is conducive to meeting the needs of the young people within our communities.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services
[redacted]

RE: Model of Service Delivery Barrett Adolescent Unit

Lee, Erica

Sent: Tuesday, August 10, 2010 6:31 PM

To:

Cc:

Attachments: AETRC Draft MOSD 15.07.10.doc (261 KB)

Hello everyone

I am following up on the Model of Service for the Barrett Adolescent Unit.

Those of you who attended the meeting on Thursday 15th July at Spring Hill will recall that the MOS document for Barreett was revised on that day in the light of the information received from the Facility Project Team (see email below from Judi) and in particular the Planning team asked that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

I have attached the revised document for your review if you were at the meeting on 15th July.
Could you please check that the revisions made do accurately reflect the discussions that we had on that day and the agreement that we reached about key points.

Essentially the document is now finished and will be tabled at the next Statewide child and youth advisory group for endorsement on 26th August 2010.

I would be grateful if you could respond as soon as possible if you have any comments about accuracy of the document.

Thanks
Kind regards
Erica

Erica Lee
Executive Manager
Mater Child and Youth Mental Health Service
L2 Potter Building|| Annerley Rd|| South Brisbane|| Qld 4101

Mater's 2008 Annual Review: 2008.mater.org.au

-----Original Message-----
From: Judi Krause
Sent: Thursday, 8 July 2010 10:52 AM
To: Ian Williams; James Scott; Janelle Bowra; Jennifer Sands; Nigel Collings; Penny Brassey; McDermott, Brett; Lee, Erica
Cc: Janet Martin; Trevor Sadler
Subject: Model of Service Delivery Barrett Adolescent Unit

Dear colleagues
We have been requested by Dr. David Crompton, Director, Metro South Mental Health to continue to progress work to refine the Model of Service Delivery for Barrett Adolescent Unit. Most of you were involved in the initial stages of this project earlier this year.

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proposed parents retreat and a day therapy program. It was reiterated that the governance model would be under Metro South Health Service District not QCH as our original document proposed. The Planning team are asking that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

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Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS) Children's Health Services

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 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 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 that will ultimately assist recovery and reintegration back into the community

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.

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.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

Length of Admission:
- admissions will be individually planned
- in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission.

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
- 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 developmental delay 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.

4. Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.

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. 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. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility.

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

- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

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 AETRC

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
- ongoing significant substance abuse

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.

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 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
	• 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 Metro South facilities (paediatric and adult health services) and/or 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 • 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
Working with other service providers		

Key Component	Key Elements	Comments
		Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of a reasonable suspicion of child abuse and neglect	• AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect
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 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 following consultation with the treating

Key Component	Key Elements	Comments
		team
	• 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 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 will 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	• the AETRC will obtain assessments	• this assessment occurs

Key Component	Key Elements	Comments
Function	on an adolescent's function in tasks appropriate to their stage of development	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 and updated at case review • documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA) • risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of Assessment	• assessment timeframes	• routine assessments will be 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 and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact

Key Component	Key Elements	Comments
		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 Case 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 Psychotherapeutic	• Interventions will be individualised according to the adolescent's treatment needs • individual verbal therapeutic interventions utilising a predominant 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	◦ individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.) • individual supportive verbal or non-	• used at times when the

Key Component	Key Elements	Comments
	verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	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 behavioural interventions	• monitor evidence for 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

Key Component	Key Elements	Comments
		intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer • monitor risk of abuse or neglect • promote qualities of care which enable reflection of qualities of home	• support for parent/carer to access appropriate mental health care • fulfil statutory obligations if child protection concerns are identified • 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 • 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 which may include adventure based and recreational activities	• 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,

Key Component	Key Elements	Comments
		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 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	• 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)
Care Monitoring	• providing a detailed report of the adolescent's progress for the care planning meeting • adolescents at high risk and require higher levels of observations will be reviewed daily	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations • 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

Key Component	Key Elements	Comments
	• 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 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	• actions will be agreed to and

Key Component	Key Elements	Comments
	in the adolescent's clinical record	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
	• 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 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	

Key Component	Key Elements	Comments
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 either when the adolescent is attending the Centre or on periods of extended leave	• joint interventions can only occur if clear communication between the AETRC 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 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 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 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
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

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 Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. 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

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

Consumer 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://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*.

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

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RE: Model of Service Delivery Barrett Adolescent Unit

Trevor Sadler

Sent: Friday, August 13, 2010 11:35 AM

To:

Cc:

Attachments: AETRC Draft MOSD 15.07.10.doc (317 KB)

Dear Colleagues,

I mentioned at the end of the meeting that there were a few finer points I wanted to add in. I emailed Janet about these. They are in red in the attached document.

1. Include in the section about adolescents who may not benefit "adolescents who may be at risk of recurrent absconding". In our experience they do not do at all well, and we are more open than acute inpatient units.
2. In staffing, include "dietetics". This is essential for those with a range of problems including persistent eating disorders. It would be a pity if we did not have ready access to a dietitian. UK units have dietitians listed in their staffing profiles.
3. I have expanded the section on staff training. I would like the MOS to give teeth to the training needs. This is part of our training needs to align with the CSCF.
4. I would like to revisit the CSCF to see that it aligns with it. I can't locate my copy. Does anyone have one?

Kind regards,

Trevor

>>> "Lee, Erica" 10/08/2010 6:31 pm >>>
Hello everyone

I am following up on the Model of Service for the Barrett Adolescent Unit.

Those of you who attended the meeting on Thursday 15th July at Spring Hill will recall that the MOS document for Barrett was revised on that day in the light of the information received from the Facility Project Team (see email below from Judi) and in particular the Planning team asked that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

I have attached the revised document for your review if you were at the meeting on 15th July.
Could you please check that the revisions made do accurately reflect the discussions that we had on that day and the agreement that we reached about key points.

Essentially the document is now finished and will be tabled at the next Statewide child and youth advisory group for endorsement on 26th August 2010.

I would be grateful if you could respond as soon as possible if you have any comments about accuracy of the document.

Thanks
Kind regards
Erica

Erica Lee

Executive Manager
Mater Child and Youth Mental Health Service
L2 Potter Building|| Annerley Rd|| South Brisbane|| Qld 4101

Mater's 2008 Annual Review: 2008.mater.org.au

-----Original Message-----
From: Judi Krause
Sent: Thursday, 8 July 2010 10:52 AM
To: Ian Williams; James Scott; Janelle Bowra; Jennifer Sands; Nigel Collings; Penny Brassey; McDermott, Brett; Lee, Erica
Cc: Janet Martin; Trevor Sadler
Subject: Model of Service Delivery Barrett Adolescent Unit

Dear colleagues
We have been requested by Dr. David Crompton, Director, Metro South Mental Health to continue to progress work to refine the Model of Service Delivery for Barrett Adolescent Unit. Most of you were involved in the initial stages of this project earlier this year.

Trevor is currently overseas on leave but will be back next week. He is confident that we can address the outstanding issues in the MOSD in a timely manner. At the recent Redlands Facility Project Team meeting we were advised that the current funding for BAU is for a 15 bed unit, there is no additional funding for the proposed parents retreat and a day therapy program. It was reiterated that the governance model would be under Metro South Health Service District not QCH as our original document proposed. The Planning team are asking that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

A meeting is scheduled for Thursday July 15th, 10am at Spring Hill CYMHS in Room 30.

Teleconference facilities will be available details below.
Participants Dial:
Enter Pin #

I look forward to seeing you there, if you are unable to attend on the day, the post meeting revised MOSD will be disseminated via email and we would really appreciate your timely feedback. Thank you all for your ongoing enthusiasm and commitment to ensuring our extended treatment facility for CYMHS is conducive to meeting the needs of the young people within our communities.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS) Children's Health Services

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 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 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 that will ultimately assist recovery and reintegration back into the community

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.

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.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

Length of Admission:
- admissions will be individually planned
- in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission.

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
- 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 developmental delay 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.

4. Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.

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. 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. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility.

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

- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

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 AETRC

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
- ongoing significant substance abuse
- adolescents who have a history of recurrent absconding

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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 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:

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
	• 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 Metro South facilities (paediatric and adult health services) and/or 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 • 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),
Working with other service providers		

Key Component	Key Elements	Comments
		the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of a reasonable suspicion of child abuse and neglect	• AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect
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 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 following

Key Component	Key Elements	Comments
		consultation with the treating team
	• 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 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 will 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

Key Component	Key Elements	Comments
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 and updated at case review • documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA) • risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of Assessment	• assessment timeframes	• routine assessments will be 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 and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely

Key Component	Key Elements	Comments
		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 Case 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 Psychotherapeutic	• Interventions will be individualised according to the adolescent's treatment needs • individual verbal therapeutic interventions utilising a predominant 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	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	

Key Component	Key Elements	Comments
	• 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 behavioural interventions	• monitor evidence for 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

Key Component	Key Elements	Comments
		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 • 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 which may include adventure based and recreational activities	• 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

Key Component	Key Elements	Comments
	• 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 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	• 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)
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

Key Component	Key Elements	Comments
		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 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

Key Component	Key Elements	Comments
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
	• 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 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	

Key Component	Key Elements	Comments
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 either when the adolescent is attending the Centre or on periods of extended leave	• joint interventions can only occur if clear communication between the AETRC 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 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.

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 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
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

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

Staff Training

Mandatory training

- Fire
- Safety
- Resuscitation
- Aggression Management
- Understanding and use of the *MHA 2000*
- CIMHA
- risk and suicide risk assessment and management.

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Generic CYMHS training

- CYMHS Key Skills training
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- principles of the service (including cultural awareness and training, safety, etc.)
- Child Protection

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Training specific to the AETRC.

- AETRC orientation training
- Formal knowledge of aetiology, symptoms and a range of relevant conditions in child and adolescent mental health
- Knowledge of child and adolescent development, family functioning, attachment and adult-adolescent interactions.
- Working with young people with learning disabilities, intellectual disabilities, substance use, visual impairment, hearing problems, physical disability and physical illness alongside mental health problems
- Understanding principles of team roles (shared and specific), team development and functioning

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- The nature and development of the therapeutic environment for children and young people including opportunities for developmental enhancement and understanding interactions within the unit.
- Managing relationships and boundaries between young people and staff, including appropriate touch
- Principles of care coordination
- Systematised behavioural observations, behavioural analysis and developing behavioural management plans
- Essentials and implementations of evidenced based practice
- Medication management
- Specialised treatment interventions for family therapy, cognitive therapies and focal psychodynamic therapies
- 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.
- Audit skills
- Research skills
- Supervision is included in the job description of every member of the Multidisciplinary Team
- Centre managers have had further training in management and team leadership

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 Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. 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 Waco! (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

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

Consumer 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://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.*

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

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Fwd: Re: MOSD Barrett

Judi Krause [redacted]

Sent: Thursday, September 30, 2010 3:02 PM

To: [redacted]

Attachments: AETRC MOS final Draft.doc (256 KB)

Hi David and Shirley
I am enclosing a copy of the Model of Service Delivery for Barrett. The working party of the Statewide Mental Health Network Child and Youth Advisory group completed this whilst I was on leave overseas and it was tabled at the August meeting.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services
[redacted]

>>> Jackie Bartlett 30/09/2010 12:34 pm >>>
Hi Judi,

please find attached. Tabled at the August SWMHN C&YAG meeting.

regards

Jackie Bartlett
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[redacted]

>>> Judi Krause 30/09/2010 11:04 am >>>
Hi Jackie
can you send me the final version of this document. I don't seem to have it on file here
thanks, I will then forward to David Crompton as we discussed to ensure he has formally got this via the CYMHS advisory group.
Kind Regards
Judi

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 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 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 that will ultimately assist recovery and reintegration back into the community

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.

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