BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

STATEMENT OF PROFESSOR PHILIP HAZELL

Name of Witness:	Professor Philip Louis Hazell
Date of birth:	[redacted]
Current address:	c/- Thomas Walker Hospital (Rivendell), Hospital Road, Concord West, New South Wales 2138
Occupation:	Psychiatrist
Contact details (phone/email):	[redacted]
Date and place of statement:	Rivendell, Thomas Walker Hospital, Hospital Rd, Concord West, NSW 2138
Statement taken by:	Rachel Cornes and Louise Norman

I **PROFESSOR PHILIP LOUIS HAZELL** make oath and state as follows:

1. I am currently the holder of the following positions:

   (a) Director, Child and Adolescent Mental Health Services, Sydney Local Health District (since July 2014);

   (b) Conjoint Professor of Child and Adolescent Psychiatry, University of Sydney (Concord Clinical School) (since February 2007); and

   (c) Director, Thomas Walker Hospital (Rivendell) Child, Adolescent and Family Mental Health Services (since July 2006).

2. My curriculum vitae is attached and marked '**Attachment PLH-1**'.

3. As Director of Thomas Walker Hospital (Rivendell) Child Adolescent and Family Mental Health Services, I am responsible for the leadership and clinical management of Area Child and Adolescent Mental Health Services, which includes Rivendell Child and Adolescent and Family Service.

4. My Position Description is attached and marked '**Attachment PLH-2**'.

[redacted] .....
Witness Signature:

[redacted] .....
Justice of the Peace / Commissioner for Declarations / Lawyer

NSW Child and Adolescent Mental Health Services

5. I have been asked by the Commission to set out my understanding of child and adolescent mental health services across New South Wales (**NSW**). In broad terms, my understanding is as follows:

   (a) The Mental Health and Drug and Alcohol Office (**MHDAO**), which sits within the NSW Ministry of Health, is responsible for developing, managing and coordinating policy, strategy and program funding relating to mental health;

   (b) The Ministry, in turn, is advised by a Child and Youth Mental Health Statewide Subcommittee, which includes representation from the Local Health Districts, and stakeholders such as consumer representatives, headspace and Child Health;

   (c) Within the MHDAO sits the MH–Children and Young People (**MH–CYP**) unit. The MH-CYP unit provides leadership and support for mental health programs for children and young people;

   (d) NSW Child and Adolescent Mental Health Services (**CAMHS**) sit within the Mental Health Service for each Local Health District and are responsible for providing mental health services for young people aged 0–17 years inclusive. In 2000, a benchmarking process was undertaken by MHDAO for the purposes of identifying the level of need in NSW across the spectrum from community-based services, other outpatient services and inpatient services. The document was revised in 2010. That benchmarking process ultimately informed the policy direction for CAMHS. There has been a major investment in CAMHS over recent years, so that by 2013 the target for acute inpatient beds had been reached. In contrast, community CAMHS are working with around one third of the services recommended in the benchmarking process. Attached and marked '**Attachment PLH-3**' is a document summarizing the benchmarking process as at 23 September 2010;

   (e) The day-to-day operations of CAMHS are the responsibility of 17 Local Health Districts (**LHD**), which each typically serve around 700–800,000 residents, although some are smaller. Each LHD is expected to provide generic community-based multi-disciplinary CAMHS, however some LHDs do also offer more specialised services. Some districts, but not many, have assertive community outreach teams. Nine districts have acute CAMHS inpatient units. These acute units are expected to admit young people from neighbouring districts where no acute unit is available;

   (f) There are 83 CAMHS beds across NSW, which is consistent with the benchmarking undertaken in around 2000 and revised in 2010 (which I discussed above). Despite this large number of beds, CAMHS manages less than half of all child and adolescent inpatient admissions for mental health conditions. Of the inpatient admissions for children and adolescents:

      (i) around 40% are in designated CAMHS services;

(ii) around 40% are admitted to adult facilities; and

(iii) the remaining 20% are admitted to standard paediatric beds.

(g) Additional specialised services within NSW for mental health care, include:

(i) the Justice Health and Forensic Mental Health Network; and

(ii) the Sydney Children's Hospital Network (which comprises the Sydney Children's Hospital at Randwick, and the Children's Hospital at Westmead).

(h) In addition, there are several state-wide specialist mental health services in NSW, namely:

(i) the Rivendell unit (which I discuss further below);

(ii) the Walker Adolescent Unit (**the Walker unit**) (which I also discuss further below); and

(iii) Redbank House, which is located on the Westmead Hospital Campus in Western Sydney. Initially, Redbank House provided services similar to the Rivendell unit (which I discuss below), however it has recently shifted to a more structured admission of around four weeks (a formulaic service). The expectation is that patients of Redbank House will not stay longer than four weeks. Redbank House also has an acute capacity.

(i) There is no dedicated acute mental health inpatient unit in NSW for children. However, some adolescent acute units will admit children under 12 years of age.

6. New South Wales uses the UK four-tier model to describe mental health services, namely:

(a) Tier 1 - primary care, delivered by non-specialists;

(b) Tier 2 – services that would be delivered by solo practitioners. There are no public CAMHS services in this tier;

(c) Tier 3 - services that are general CAMHS community and outpatient services; and

(d) Tier 4 - services that are specialist CAMHS inpatient and intensive community services.

7. Applying this framework, I consider both the Rivendell and Walker units to be Tier 4 services.

The Walker and Rivendell units

8. The Walker and Rivendell units are part of the Concord Centre for Mental Health. The Walker unit is located on the grounds of the Concord Hospital, whilst the Rivendell unit is

located on land adjacent to the hospital. The two units are linked operationally but are administratively separate.

9. As Director of Thomas Walker Hospital (Rivendell) Child Adolescent and Family Mental Health Services, I have overall responsibility for the clinical management and leadership of the Rivendell unit. In addition I have responsibility for financial, facility and human resource management.

10. Because the Walker unit is part of the Concord Hospital, responsibility for human resource management and financial management resides with the hospital. My role and responsibilities with respect to the Walker unit are to provide clinical and strategic leadership.

11. Notwithstanding the administrative separation, the range of clinical interventions for patients is common to both the Rivendell and Walker units (which I discuss below), differing only in intensity.

12. I have been asked by the Commission to outline my understanding as to the operation and management of the Rivendell and Walker units. My knowledge of each unit is as follows.

The Rivendell unit

13. The Rivendell unit is a state-wide tertiary referral service that opened in 1978. The Rivendell unit is not a declared mental health facility as defined by s109 of the *Mental Health Act 2007* (NSW) (**MHA**). As such, all young persons are admitted voluntarily, with the exception of those who might attend as part of the conditions of a Community Treatment Order (in accordance with s 51 of the MHA).

14. The unit provides specialist multidisciplinary assessment and subacute integrated treatment and rehabilitation to young people between 12 and 18 years with persistent mental illness/es that lead to significant impairment.

15. Admission to the Rivendell unit typically does not exceed six months (two school terms).

16. In most instances, admission to the Rivendell unit is a step up from less intensive community treatment, while for a minority it is a step down from more intensive treatment in another inpatient setting (such as, for example, the Walker unit).

17. The focus of the Rivendell unit is on rehabilitation, reinstituting young people into an educational program (schooling) and integrating them back into their families.

18. The Rivendell unit operates Monday to Friday during school terms. The level of admission ranges from day admission to partial hospitalisation (four nights per week). Partially hospitalised patients go home every weekend. An on-call consultant child and adolescent psychiatrist is available 24 hours, 7 days a week.

19. Rivendell patients typically have been unable to attend school for a prolonged period despite active community interventions.

20. The on-site Rivendell School provides education programs which are essential components of rehabilitation and the restoration of developmental tasks.

Rivendell Model of Care

21. The Rivendell unit model of care is recorded in the document attached and marked '**Attachment PLH-4**'.

22. In essence, the model of care provides for a range of evidence-based clinical interventions, which include psychotherapeutic, behavioural, psycho-education and pharmacological interventions. Other interventions employed at the Rivendell unit target and promote physical health and progression in developmental tasks.

23. The model of care also provides for interventions for family and carers, including family therapy. Family meetings generally occur at the Rivendell unit at least fortnightly.

24. The Rivendell unit model of care outlines a number of exclusion criteria for Rivendell admission. These include:

    (a) homelessness (a patient in a stable out of home care placement is not excluded from Rivendell);
    (b) risk of suicide and /or self-injury greater than can be managed safely at Rivendell (this requires consideration of acute ward referral);
    (c) excessive risk to others, whether through violence, sexual offending, fire-setting or drug dealing;
    (d) primary diagnosis of oppositional defiant disorder or conduct disorder (admission confers no benefit to outcome over outpatient therapy);
    (e) primary diagnosis of eating disorder (re-feeding requires management in a supervised medical setting);
    (f) patient/family/guardian unwilling or unable to provide consent.

The Walker unit

25. The Walker unit is essentially a scaled-up Rivendell model. The Walker unit has the capacity to provide involuntary treatment for patients under the MHA.

26. Since its opening on 4 May 2009, the Walker unit has operated as a 12-bed state-wide inpatient long stay unit for young people between 12 and 18 years experiencing severe and unremitting mental illness.

27. Unlike the Rivendell unit, the Walker unit does not have a day program. If a young person is considered well enough to attend a day program, then they are generally transitioned to the Rivendell unit (or elsewhere).

28. I was personally involved in the planning and establishment of the Walker unit. Specifically:

    (a) during the design and build of the new Concord Campus in around 2005, a ward was designated for an adolescent mental health facility, but it was subsequently earmarked for another clinical purpose;

    (b) during the 2007 state election campaign, a candidate for the local electorate announced that that an adolescent mental health inpatient unit would be developed and, as a result, I was urgently tasked with developing a model of care for this proposed facility,

    (c) in developing the model of care for the Walker unit, I understood the expectation of the local candidate was that the new unit would be an acute unit, located in the Concord Campus. However, my concerns with this included that the Concord Campus is a long way from paediatric expertise; an acute unit at Concord did not fit with the state-wide bed planning; and I considered that there were better ways to augment existing acute adolescent mental health services.

    (d) Given these concerns, I proceeded to develop a model of care for a unit located in the Concord campus which was targeted at young people having severe and persistent mental illness. My goal in developing the model of care for this new unit was twofold, namely to:

        (i) alleviate the pressure on the acute units who were at that time each managing 2–3 young patients with severe and persistent mental illness. By freeing up these beds, the model of care aimed to alleviate the bed block for the acute units and help the units to run more efficiently and effectively; and

        (ii) better suit young patients with severe and persistent mental illness who were not responding to treatment in other settings. I recognised that such patients were not well suited to treatment in an acute setting and were not being well served in acute units. The focus of acute units is necessarily on stabilising new admissions, which requires a lot of clinical time. As a result, those patients with 'slow burning' disorders were not receiving the attention that they needed in the acute setting.

29. In terms of physical attributes, the Walker unit is unusually large for a CAMHS inpatient unit. There are two distinct main living areas. Sometimes there will be an incident requiring intervention and staff can deal with that incident in one living area, while the remaining patients use the other living area. There is also generous outdoor space, including a volleyball area.

Walker unit model of care

30. There is not currently any documented model of care for the Walker unit (unlike the Rivendell unit), although one is being developed. A patient and family information brochure, and a Walker unit referral form do however provide some guidance, and are attached and marked '**Attachment PLH-5**' and '**Attachment PLH-6**'.

31. The Walker unit model of care has never been evaluated or formally reviewed outside of the standard accreditation process. Both the Rivendell and Walker units utilise the range of routine outcome measures mandated by the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Children's Global Assessment Scale (CGAS), and the Strengths and Difficulties Questionnaire (SDQ). The CGAS is utilised as a means of reporting/tracking over time.

32. The Walker unit does not track the clinical progress of discharged patients over the medium to long term. Instead, like other inpatient units, the unit tracks the 28-day readmission rate post-discharge. The Walker unit's 28-day readmission rate is currently zero. This compares to a 28-day readmission rate of around 20% for the acute adolescent units. NSW state-wide data indicates that a shorter length of stay is associated with a higher readmission rate.

33. The Rivendell School (which is part of the Rivendell unit) provides educational programs on-site, over the standard school year, to those patients in the Walker unit. Following a request from patients, the Walker unit now also has a summer school program.

34. Family therapy is essential to the Walker (and Rivendell) model of care. Family meetings are held at least fortnightly, and sometimes weekly. In my experience, geographic distance of family is only a barrier to such processes if the family allows it to be — those families who are motivated to be involved will find a way to get to the unit for family meetings. Alternatively, it is sometimes possible to conduct family meetings by teleconference or video conference, although that does somewhat change the dynamic of the meeting.

Referrals and admissions to the Walker unit

35. The admission criteria for the Walker unit include the presence of severe mental illness, with evidence of significant functional impairment and demonstrated treatment resistance. In particular, all patients are required to have previously had treatment at a secondary health care service. Most patients admitted to the Walker unit:

    (a) have had a substantial period of treatment in an acute inpatient setting;

    (b) have significant level of risk (the unit is configured to manage high risk patients); and

(c) are characterised by being atypical (or exceptions), that is they have features or complexities to their situation which are not commonly encountered in routine CAMHS inpatient work.

36. Patients who are admitted to the Walker unit fall into four main groups. Namely, those with:

(a) unremitting psychosis;

(b) unremitting mood disorder — generally bipolar, rather than unipolar depression;

(c) neurodevelopmental disorders such as autism, usually complicated by intercurrent psychosis or mood disorder; or

(d) unremitting/unrelenting suicidality arising from any cause.

37. Typically, at any one time, two of the 12 patients of the Walker unit have an emerging borderline personality disorder. Staff try to cap the number of such admissions at two. This is because a higher number of such patients has been shown to create problems in terms of managing the ward milieu.

38. There are two 'excluded' groups who are not accepted into the Walker unit:

(a) adolescents who are homeless — a patient must have a stable care situation, which may be an out of home care placement; and

(b) adolescents who the assessment team believes can be treated in a less restrictive setting. The assessment team rejects, on average, around one quarter of referrals on this basis.

39. Admissions to the Walker unit are required to involve the input of a child/adolescent psychiatrist and come via a referring agency. As part of this process, the referring agency is required to provide a narrative description of the patient's difficulties as well as the referrer's expectations of treatment in the Walker unit.

40. In the event a patient's referral is accepted, the referring agency is required to then participate in the treatment process, before, during and after the admission. As a result of these requirements, the quality of referrals to the Walker unit is generally very high.

41. Referrers are considered significant stakeholders for both the Rivendell and Walker units and steps are taken to ensure the maintenance of strong operational and strategic links to other CAMHS services. The extent of participation of the referrer during admission differs between the Rivendell and Walker models. This reflects the fact that Rivendell patients return home at least every weekend, and for day patients, overnight.

42. The assessment process for referrals into the Walker unit also involves the input of a multidisciplinary team who visit the patient in their current treatment setting, and meet

with the referring team and the family. Observation of the patient in their community and family environments is considered to be an extremely informative tool and provides a much better understanding of family dynamics. This information, in turn, assists the assessment and development of a treatment plan for the patient. The value of this type of assessment process is reflected (and motivated by) my knowledge of the operations of a forensic service in the United Kingdom run by Professor Dame Sue Bailey (a child and adolescent forensic psychiatrist and a past President of the Royal College of Psychiatrists).

43. The waiting list for the Walker unit is surprisingly short. There are usually only one or two people waiting for admission, and they are generally admitted within one month. I believe there are two main reasons for this, namely:

    (a) the Walker unit deliberately does not put people on an endless waiting list. The assessment team will not do an assessment unless (and until) the unit is in a position to admit a patient within a reasonable period; and

    (b) the demand for the services of the Walker unit has been lower than expected. Colleagues in the acute units throughout NSW have adopted a practice of managing patients in those units, knowing that the Walker unit is there as a safety net if needed. I think acute unit staff enjoy the challenge of treating some of the more complex patients.

Length of stay and discharge from the Walker unit

44. Although it has an admission cap of aged 18, the Walker unit does not arbitrarily discharge patients from the Walker unit simply because they turn 18. There is some discretion. As a matter of practice, staff of the Walker unit continually assess whether a patient is improving within the unit, and admission will continue until the Walker team and the referrer each agree that discharge is appropriate.

45. As stated above, it is a requirement of admission that the relevant referring agency for a patient of the Walker unit has had ongoing participation in the treatment process during and after the admission. As a result, the referrer, which is often the local CAMHS, is kept appraised of the patient's progress and ongoing level of risk in case they need to deal with a crisis situation while the patient is away from Rivendell. For both Rivendell and Walker patients, local CAMHS and the referring agency (if different) are engaged in discharge planning.

46. There are a range of transition options available for patients from the Walker unit. Generally, a patient is discharged back to the care of a local CAMHS. To date, only one patient has sought discharge and transition to adult services.

47. The oldest patient at the Walker unit was 20 years of age, however this was an unusual exception. Recent data show a range of 13-17 years, average age 15.3 years.

48. The length of stay for patients of the Walker unit has crept up over time. Initially the typical length of stay was around 6 months. The most recent figure for average length of stay in the Walker unit is 159 days, but there have been several admissions lasting for over a year.

49. It is unusual for patients to stay longer than six months, however there have been a couple of 'outliers'. The longest length of stay was almost two years. Reasons for unusually long stays are varied. One young person who stayed for over a year had unremitting suicidality and an evolving psychotic disorder. Another patient had neurodevelopmental problems and intercurrent psychosis. In general, patients with psychotic disorders have longer stays than patients with other conditions.

50. At the same time, the seclusion rate within the unit has decreased. In December 2104 the Walker Unit received a Star Performer's Award from NSW Health for reduction in seclusion and restraint.

A 'typical day' at the Walker unit

51. The Commission has asked what a 'typical day' might look like for a Walker unit patient. I would describe a typical day as follows:

    (a) It is 'all hands on deck' in the mornings to get the patients moving, showered and ready for the day. Many of the patients have sleep difficulties and so will be sluggish in the mornings. All of the patients share breakfast together;

    (b) On a school day, the patients will then move to the school program. The space within the unit used as the school room has grown over time because the school program is so integral and important to the overall treatment program. During the school day, the patients are the primary responsibility of the teaching staff, but there are always nursing staff on hand. Sometimes nursing staff sit in with particular patients to help them. Sometimes a patient will be too distressed or impaired to function in the school room, and so they will be allowed to work elsewhere (such as in their room) under supervision by the nursing staff;

    (c) Art therapy and music therapy generally happen within school hours, as part of the schooling program;

    (d) Out of school hours there is a lot of attention on physical fitness, which is particularly important for those patients struggling with their weight. The Living Skills cook teaches the patients about healthy eating and preparing meals;

    (e) In the evenings, there is a combination of structured and unstructured activities which are needed in order to keep structure and lower levels of aggression. There may also be supervised walks or other activities if appropriate, subject to a risk assessment for each patient;

(f) Most family therapy occurs out of school hours, and so after 3pm there will often be family meetings; and

(g) Later in a patient's progress they may be permitted to have family leave. This may be for several hours during the day, or overnight.

Future of the Walker unit

52. Since it's opening in 2009, there have been overtures from time to time to adapt the operations of the Walker unit in some way.

53. For example, there have previously been moves to try and have the Walker unit accept a mix of acute and longer stay patients. There has also previously been a suggestion to include patients with (solely) eating disorders. Either of these changes would be bad clinical practice, and I was involved in successfully resisting both.

54. I am a strong advocate for the continuation and need for the Walker unit. I discuss the basis of my position further below, under the heading 'Opinion'.

The Barrett Adolescent Centre

55. Prior to my involvement with the Expert Clinical Reference Group (**ECRG**), which I discuss further below, I had only a general awareness of the existence of the Barrett Adolescent Centre (**BAC**) in Wacol, Queensland.

56. When I established the Walker unit in 2009, I did not have any cause to examine or have regard to the BAC model of care (despite their similarities).

57. At no time have I ever seen any formal documented model of care for the BAC. Instead, through my involvement with the ECRG, I did once see a draft model of care, which I understood had been prepared for a proposed replacement unit for the BAC, at Redlands. Attached and marked '**Attachment PLH-7**' is a copy of the draft model of care for the replacement unit, which I saw as a member of the ECRG.

58. I assumed that this draft model of care was reflective of the model of care which was being delivered at the BAC. Based on this draft model of care, and other information gleaned through my involvement with the ECRG, I consider the BAC to have been most aligned with the Walker unit model of care, rather than that of the Rivendell unit.

59. The key similarities between the BAC and the Walker unit were that both centres were longer stay units for adolescent mental health patients, and had a focus on rehabilitation.

60. The key difference was that the patient group of the Walker unit appeared to be a step-up from that of the BAC, in terms of the severity of the mental health issues being managed. For example, the Walker unit had a much higher proportion of patients with psychosis, as compared to the BAC.

61. I have previously visited the Wacol campus where the BAC is located, however it was for an unrelated purpose and I did not go inside the BAC.

62. On or about 23 October 2013, I recall receiving a visit from Dr Stephen Stathis (Clinical Director of Child and Youth Mental Health Services) and Ms Judi Krause (Divisional Director, Child and Youth Mental Health Services).

63. From speaking with Dr Stathis and Ms Kraus, I understood each to be visiting in the capacity of members of an Extended Adolescent Treatment and Rehabilitation Strategy Committee, which had been set up in Queensland to review alternative models of adolescent rehabilitation and make recommendations.

64. In the course of this visit, Dr Stathis and Ms Kraus looked at the facilities and met with myself, as well as with key staff of both the Rivendell and Walker units.

The Expert Clinical Reference Group

65. On 28 November 2012, I received an email from Dr Michelle Fryer, who I knew to be Chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry (the Faculty) of the Royal Australian and New Zealand College of Psychiatrists.

66. Dr Fryer advised me that an ECRG had been set up in Queensland to provide advice in relation to the operations of the BAC. Dr Fryer informed me that she was already a member of the ECRG and that the Faculty had been invited to nominate another person to join. Dr Fryer explained that the Queensland Branch had indicated that they wished to nominate a person external to Queensland, and asked whether I would consider accepting the appointment (which I did). Attached and marked '**Attachment PLH-8**' is a copy of this email, which I received from Dr Fryer on 28 November 2012, and my response of the same date.

67. I was a member of the ECRG from around December 2012 until late March/early April 2013. I did not receive any formal Letter of Appointment. Instead, attached and marked '**Attachment PLH-9** is an email which I received on 5 December 2012 from Ms Vaoita Turner (Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch), confirming my membership of the ECRG.

68. In addition to myself, the members of the ECRG included:

    (a) Dr Leanne Geppert (as Chair);

    (b) Dr Michelle Fryer – (Chair of the Queensland Branch of Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists);

    (c) Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS;

    (d) Dr David Hartman (Clinical Director, Community Youth Mental Health Service (CYMHS), Townsville Hospital and Health Service);

(e) Dr Trevor Sadler (Clinical Director, BAC);

(f) Dr Ray Cash (Visiting Medical Officer);

(g) Ms Josie Sorban (Director Psychology, CYMHS, Children's Health Qld Hospital and Health Service);

(h) Ms Amanda Tilse (Operational Manager, Alcohol Other Drugs and Campus Mental Health Services (ATODS), Mater Children's Hospital);

(i) Ms Amelia Callaghan (State Manager Qld NT and WA, Headspace);

(j) Ms Emma Hart (Nurse unit Manager, Adolescent Inpatient Unit and Day Service, Townsville HHS); and

(k) Mr Kevin Rodgers (Principal, Barrett School).

69. In or around January 2013 - approximately one month after the commencement of the ECRG - Ms Cheryl-Anne Wilson also joined as a member of the ECRG. The ECRG had recommended the involvement of a carer's representative, and Ms Wilson joined the ECRG in that capacity.

Role of the ECRG, and my role as a member of the ECRG

70. The Terms of Reference for the ECRG essentially required that the ECRG provide expert opinion to an overarching Planning Group, as to the means of promoting the development of contemporary models of care in Queensland for adolescent mental health. A copy of the Terms of Reference for the ECRG is attached and marked '**Attachment PLH-10**'.

71. I understand the reference in the Terms of Reference to 'contemporary models of care' to mean the most current evidence-based and accepted approach to care. The key difficulty with this Term of Reference was (and remains) that the body of evidence to support models of mental health care for children and adolescents at the severe end of the spectrum is extremely limited. Currently, practice is necessarily largely informed by clinical experience and benchmarking against other services.

72. I would describe the ECRG as being an impressive and efficient process given the size and complexity of the task. The process allowed for frank discussions and disagreement. A lot of work was undertaken by members outside of committee meetings.

73. Throughout January, February and March 2013, the ECRG met regularly (at times, weekly). I recall that there was a sense of pressure which was driven by the Planning Group, who the ECRG reported to. I did not have any direct contact with the Planning Group and am unaware who its members were.

74. Although I was not directly involved in the process, I am aware that during the life of the ECRG, the Chair of the ECRG (Dr Geppert) was responsible for reporting, at intervals, to

the Planning Group and receiving responses back. I cannot recall the specifics of any of the responses given by the Planning Group to the ECRG, however I recall Dr Geppert advising that the responses were along the lines of, 'Yes, that model of care will be considered' or 'No, that type of model might not be considered'.

75. I do not recall receiving any feedback from the Planning Group with respect to the inclusion of a Tier 3 service as one of the ECRG's recommendations.

76. I had two main responsibilities during my time as a member of the ECRG. The first of these was to supply other members of the ECRG with evidence concerning the models of care for Rivendell and Walker units (which I did). The second was to review draft versions of the ECRG report, prior to its finalisation in around March/April 2013.

Recommendations of the ECRG

77. One of the recommendations of the ECRG was that 'Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component'. I remain supportive of this.

78. For a state the size of Queensland, I consider that a lack of a Tier 3 service for adolescents will create difficulties and put pressure on the other levels of service, including 'bed block' for acute inpatient units.

79. From my experience working in adolescent mental health, I am aware that staffing and resourcing shortages in acute units mean that adolescent patients, who are placed in those units, do not receive the type and intensity of care which they need in order to be rehabilitated and transition back into the community. I discuss this further below in my statement, beneath the heading 'Opinion'.

80. Another recommendation of the ECRG was that 'Interim service provision if BAC closes and Tier 3 is not available is associated with risk'. I remain comfortable with this recommendation, also.

81. The primary risks which I identified in this scenario included discontinuity of care, suboptimal care and loss of staff and their skills. From my involvement on the ECRG, I became broadly aware that staff were leaving the BAC as a consequence of the uncertainty surrounding the continuation of its operations (and hence their employment). These staff were leaving and finding employment elsewhere.

The Planning Group

82. I have been told by Commission staff that following the release of the ECRG report, the Planning Group issued its own report which passed comment in respect of each of the recommendations made by the ECRG. I have never read nor been provided with a copy of any such document.

83. I have been told by Commission staff that in this document, the Planning Group made the following comment in respect of ECRG recommendation two (that a tier 3 service be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental health illness):

> Accept with the following considerations.
>
> Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirements of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

84. With respect to this statement by the Planning Group, I consider that there has been a misreading of the values of the National Mental Health Plan and the role of the Y-PARC services in Victoria.

85. The National Mental Health Planning framework is driven by the early intervention model. It is a very robust model but does not manage patients who progress in acuity and intensity and therefore have different needs to those at the early intervention stage. It is not appropriate for the Planning Group to use the absence of consideration of services for young people with severe and persistent mental health disorders in the National Mental Health Plan, as justification for closing BAC.

86. The second reason why I do not consider this comment by the Planning Group to be particularly helpful or relevant is because the Y-PARC model of care is not the same as that in place at facilities such as the BAC and the Walker unit. An effective system of care needs varying levels of intensity, and each level has its own validity. Whilst it is not the role of Y-PARC to manage the 'top end' of severity, this is the role of a facility such as the BAC.

Opinion

87. As I have stated above, I consider there to exist a vacuum in terms of evidence-based literature on what is the 'best model of care'. I am not aware of any literature that supports the proposition that longer-stay units, such as the Walker unit and the BAC, are the best model of care for adolescents with severe, complex and persistent mental disorders.

88. However, equally, I am not aware of any literature that supports the proposition that longer-stay units are harmful or are not the best treatment model for adolescents with severe and complex mental illness.

89. It is clinical folk-lore to assert that it is not a good idea to hospitalise certain adolescent mental health patients. I appreciate the basis for such statements is driven by a concern that, in a hospital setting, there is contagion owing to difficult interpersonal relationships, a

tendency to get into conflict with staff, and consequently an increase in self-harm. I am not aware of any evidence on which to base this belief.

90. The risk of any intensive long-term care is that an adolescent patient may become dependent on the unit, making transition out of the unit more difficult. However, one of the tasks of the admission process for the Walker and Rivendell units is to assess risk of dependency, and to develop a strategy to manage the risk.

91. Importantly, intensive long-term care, such as that provided in the Walker unit or at the BAC, is appropriate only in circumstances where all other options have already been deemed unhelpful. It is consequently a trade-off: risk versus benefit. In appropriate circumstances, the benefit will outweigh the risk.

What is the 'best model of care'?

92. Based on my experience managing the Walker unit, I consider facilities such as the Walker unit and the BAC to be most useful for those adolescents with severe psychosis and mood disorders, or a person who has ongoing suicidal ideations that are assessed as critical and dangerous. For example, adolescents who are being rescued on a regular basis and, without admission, will die either by intent or misadventure.

93. It is my professional opinion that any person with a milder condition (including self-harming or suicidal ideation with ambiguous intent) which is responsive to community care, should not be placed in a long stay unit. It is also my opinion that long-stay inpatient units are not useful for adolescents with a primary diagnosis of either conduct disorder (primarily delinquency) or an eating disorder. There are effective models for the community management of people with conduct disorder. Patients with restrictive eating disorders need access to specialised medical care and are therefore better managed in general hospital beds or combined mental health/medical units.

94. Facilities such as the Walker unit and the BAC are important in any statewide mental health service, in order to take away the demands from the acute units.

95. Based on my experience working in the area, I am aware that adolescent patients with chronic mental health needs are not well catered for in acute wards. This is because staff will necessarily focus most of their attention on new admissions who require a lot of the clinician's time. In addition, the patients with persistent severe conditions are at risk of becoming destabilised each time a new acutely unwell and distressed patient is introduced to the unit

96. By placing adolescents with chronic mental health needs in specialised services, there is a benefit for both the acute services (in terms of allowing staff to run the acute facilities more efficiently and effectively) as well as for the patients concerned (in terms of ensuring that they receive the specialised care that they require in order to rehabilitate).

97. Based on my clinical experience working with adolescent patients in the mental health area, I consider that it is important to have a model of care and system of care for adolescents which:

(a) has a continuum of services at differing levels (one of which is a facility such as the BAC or the Walker unit);

(b) allows patients to move seamlessly in and out of services along the continuum;

(c) is mindful of the developmental stages of an adolescent patient, as well as the severity and phase of their illness;

(d) builds in components that ensure the maintenance of patient physical and dental health and optimises education; and

(e) maintains contact between the patient and their supports (family/carer).

98. It is not possible to be any more specific beyond this. This is because models and systems of care in different jurisdictions have evolved in different ways, driven predominantly by different funding models, rather than clinical imperatives. I am aware of the existence of a number of intensive community-based models of care, which are cited as alternatives for the treatment of young people with severe and complex mental illness. My views in respect of some of these alternatives, are as follows:

(a) *Assertive community treatment/outreach*: I consider these programs to have a place in the continuum of care, however they do not play a role with respect to adolescents with persistent/treatment-resistant mental health illnesses. The reason for this is that such programs are crisis oriented and have a brief and focused intent. They are not helpful for a patient whose mental health illness is chronic, because it pushes the problem into an acute arena, whereas the aim is to avoid crises.

(b) *Day programs*: Day programs play an important step up/step down role, such as between Rivendell and the Walker unit. These programs help patients, for example, return to education or vocational training. However, in order to be of use, a patient must first have a stable base. For this reason, they are not helpful for patient's whose mental health issues are severe.

(c) *Residential treatment units (non-hospital)*: I was at variance with the ECRG in relation to the appropriateness of residential treatment units for adolescents with severe and persistent mental health issues. I would not have recommended the option of a residential treatment unit and do not see them as a viable option. The basis for my position is that care is not being provided by clinical staff. I consider it important that clinical staff be involved in the provision of care, which necessarily includes monitoring of medication and counselling.

(d) *Wraparound services or other types of intensive care management*: I consider these care models to be effective, however not for the group of patients whose mental health issues are severe and persistent. Instead, I consider this care model to be most appropriate for adolescents with conduct disorders, substance abuse or trauma.

(e) *Family preservation/intensive home treatment*: I consider this care model to be effective, however not for the group of patients whose mental health issues are severe and persistent.

OATHS ACT 1867 (DECLARATION)

I PROFESSOR PHILIP LOUIS HAZELL do solemnly and sincerely declare that:

(1) This written statement by me dated 5/11/15 **and contained in pages numbered 1 to 18 is true to the best of my knowledge and belief: and**

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

..... [redacted] .....**Signature**

Taken and declared before me at Concord West **this** fifth **day of** November **2015.**

Taken By ... [redacted] ..... Heather O'Brien
Justice of the Peace / Commissioner for Declarations / Lawyer JP NSW 188577

[redacted] .....
Witness Signature:

..... [redacted] .....
Justice of the Peace / Commissioner for Declarations / Lawyer

CURRICULUM VITAE

PHILIP LOUIS HAZELL

October, 2015

PERSONAL DETAILS

Postal Address:
Thomas Walker Hospital (Rivendell)
Hospital Rd
Concord West, NSW 2138
Australia

Date of Birth:

Place of Birth: Erith, England

Citizenship: Australia, United Kingdom, New Zealand

QUALIFICATIONS

B Med Sc, 1978, Otago University
MB ChB, 1980, Otago University
Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP), 1988
Certificate of Accreditation in Child Psychiatry (RANZCP), 1989
PhD (Medicine), University of Newcastle, 1997

CURRENT APPOINTMENTS

Director, Thomas Walker Hospital (Rivendell) Child, Adolescent and Family Mental Health Services.
Appointed July 2006

Director, Child and Adolescent Mental Health Service, Sydney Local Health District.
Appointed July 2014

Conjoint Professor of Child and Adolescent Psychiatry, University of Sydney (Concord Clinical School)
Appointed February 2007

PREVIOUS APPOINTMENTS

Dec 2011-Dec 2014
Discipline Head, Psychiatry, University of Sydney

March 1998 – Dec 2014
Conjoint Professor of Child and Adolescent Psychiatry, University of Newcastle

Sept 2006 – June 2014
Director, Infant, Child and Adolescent Mental Health Services, Sydney South West Area Health Service.

March 1998-July 2006
Director of Child and Youth Mental Health, Hunter New England Mental Health Service.

Jan 1993-March 1998
Senior Lecturer in Psychiatry, Faculty of Medicine, University of Newcastle.

May 1997-March 1998
Head of Discipline of Psychiatry, Faculty of Medicine, University of Newcastle.

April 1989-Dec 1992
Lecturer in Psychiatry, Faculty of Medicine, University of Newcastle.

Dec 1989-March 1998
Visiting Medical Officer (Academic) to the Department of Psychiatry, Mater Misericordiae Hospital, Waratah.

Oct 1989-March 1998
Visiting Medical Officer (Academic) to the University Psychiatry Unit, Lingard Hospital, Merewether.

July 1995-March 1998
Clinical Director, Behaviour Problems Clinic, and Visiting Medical Officer (Academic) to the Child Psychiatry Service, Wallsend Hospital Campus.

Aug 1995-May 1996
Acting Head, Discipline of Psychiatry, Faculty of Medicine and Health Sciences, University of Newcastle

Feb 1991-Feb 1995
Director of Child and Adolescent Psychiatry, Department Paediatrics, John Hunter Hospital, Newcastle, NSW.

Feb 1989-April 1989
Staff Specialist in Child Psychiatry, Child & Adolescent Mental Health Service, Flinders Medical Centre, Adelaide, South Australia.

Feb 1987-Feb 1989
Fellow in Child Psychiatry with the Child & Adolescent Mental Health Service, Flinders Medical Centre, Adelaide, South Australia.

Feb 1983-Feb 1987
Registrar in Psychiatry with the Child, Adolescent and Family Health Service, Psychiatric Services (affiliated with Flinders Medical Centre), Adelaide, South Australia.

Dec 1980-Dec 1982
House Officer with the Wellington Hospital Board, Wellington, New Zealand. Clinical rotations included general surgery, general medicine, general hospital psychiatry, psychiatric hospital, accident and emergency, and neurosurgery.

MEMBERSHIP OF PROFESSIONAL BODIES

Royal Australian & New Zealand College of Psychiatrists
Faculty of Child and Adolescent Psychiatry (RANZCP)
Biological Psychiatry Section (RANZCP)
Australian Society for Psychiatric Research
American Academy of Child and Adolescent Psychiatry
Association for Child Psychology and Psychiatry (UK)
Cochrane Collaboration

PUBLICATIONS

Books and monographs

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Invited book chapters

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2. Hazell PL. "Family therapy 1: General Considerations". In RJ Kosky, HS Eshkevari, VJ Carr (Eds.) Mental Health and Illness: A text book for Health Science Students. Sydney; Butterworth-Heinemann 1991, pp 408-411.

3. Hazell PL. Attention Deficit Hyperactivity Disorder. In Theory and Practice in Psychological Medicine: A Companion to the Management of Mental Disorders Eds Beaumont P, Andrews G, Boyce P, Carr V. Sydney; WHO Collaborating Centre 1997 pp 62-65.

4. Carr V, Hazell P, Carter G. Self Assessment Case Studies. In Theory and Practice in Psychological Medicine: A Companion to the Management of Mental Disorders. Eds Beaumont P, Andrews G, Boyce P, Carr V. Sydney, WHO Collaborating Centre 1997 pp 307-369.

5. Hazell P. Tricyclic antidepresssants in children: Is there a rationale for use. In: "Disease Management Review – Depression." Adis International, Auckland 1998: II: pp 93-99. ISBN 0-86471-043-7. Reprinted in: "Controversies in Depression Management." Ed Palmer KJ. Auckland; Adis International 2000 pp 65-72.

6. Martin, G., Kuller, N. and Hazell, P., 1999. The effect on adolescents of the completed suicide of another student. In E. Barrington Thomas (Ed.), What Every Principal Needs to Know About Student Health and Welfare. The Professional Reading Guide for Educational Administrators, Point Lonsdale, Victoria.

7. Hazell P. Treatment strategies for adolescent suicide attempters. In: "The International Handbook of Suicide and Attempted Suicide." Eds Hawton K, van Heeringen K. Bognor Regis; Wiley 2000 pp 539-554.

8. Hazell P. Depressive disorders in children and adolescents. In : "Clinical Evidence. A Compendium of the Best Available Evidence for Effective Health Care". 3rd Edn. Ed Godlee F. London; BMJ Publishing 2000 pp 448-454.

9. Hazell P. Depression in children and adolescents. In : "Clinical Evidence. A Compendium of the Best Available Evidence for Effective Health Care". 4th Edn. Ed Barton S. London; BMJ Publishing, 2000 pp 536-542.

10. Rey JM, Hazell P, Patton G, Tonge B. Child and adolescent psychiatry. In: "Foundations of Clinical Psychiatry". 2nd Edn. Eds Bloch S ,Singh BS. Melbourne; Melbourne University Press 2001 pp 359-392.

11. Hazell P. Depression in children and adolescents. In : "Clinical Evidence. A Compendium of the Best Available Evidence for Effective Health Care". 5th Edn. Ed Barton S. London, BMJ Publishing, 2001 pp 246-252.

12. Hazell P. Depression in children and adolescents. In : "Clinical Evidence. A Compendium of the Best Available Evidence for Effective Health Care". 6th Edn. Ed Barton S. London, BMJ Publishing 2001 pp 278-284.

13. Hazell P. Depression in children and adolescents. In : "Clinical Evidence. A Compendium of the Best Available Evidence for Effective Health Care". 7th Edn. Ed Barton S. London; BMJ Publishing 2002 pp 307-313.

14. Hazell P. An evidence based approach. In "The Clinician's Guide to Psychotropic Prescribing in Children and Adolescents" Eds Nunn K, Dey C. Newcastle; Child and Adolescent Mental Health Statewide Network 2003 pp 2-7.

15. Hutchins P, Hazell P, Nunn K. Attention deficit hyperactivity disorder (ADHD). In "The Clinician's Guide to Psychotropic Prescribing in Children and Adolescents" Eds Nunn K, Dey C. Newcastle; Child and Adolescent Mental Health Statewide Network 2003 pp 162-171

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17. Hazell P. Depression in adolescents. In "Mood Disorders. Recognition and treatment. Eds Joyce PR and Mitchell PB. Sydney; University of New South Wales Press 2004, pp 358-367

18. Hazell P. Child and adolescent mental health services in Australia and New Zealand: policy and development. In: "Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation" Eds Williams R, Kerfoot M. Oxford; Oxford University Press 2005, pp 353-361

19. Rey J, Hazell P, Walter G. Child and adolescent psychiatry. In "Foundations of Clinical Psychiatry" 3rd Edn. Bloch S, Singh B (eds). Melbourne; Melbourne University Press 2007, pp 387-419

20. Hazell P. Pediatric Bipolar Disorder: From the perspective of Australia and New Zealand. In: " Pediatric Bipolar Disorder: A Global Perspective." Diler RS (ed). New York; Nova Science Publishers 2007, pp 33-56

21. Rey JM, Hazell PL. Depression in Children and Adolescents. In: "Treating Child and Adolescent Depression." Rey JM, Birmaher B (eds). Philadelphia; Wolters Kluver/Lippincott Williams & Wilkins 2009, pp 3-16

22. Hazell P. ADHD. In Physical as Anything: Supporting Students with Medical, Developmental and Psychological Conditions. Eds Stevens MM, Halls K, Lovelace K, Proft K, Rayner J, Tenny T, Turnell R. www.physicalasanything.com.au 2013

23. Hazell P. Suicide and self-harm. In "A Clinical Handbook of Adolescent Medicine". Steinbeck K, Kohn M (eds). Singapore; World Scientific 2013, pp 373-382

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1. Hazell P. Peterson DW. Laverty R. Brief communication. Inability of hexamethonium to block the discriminative stimulus (SD) property of nicotine. Pharmacology, Biochemistry & Behavior. 1978; 9:137-140.

2. Hazell PL. Postvention after teenage suicide: An Australian experience. Journal of Adolescence 1991; 14:335-342.

3. Hazell PL and Lewin TJ. Friends of adolescent suicide attempters and completers. Journal of the American Academy of Child and Adolescent Psychiatry 1993; 32: 76-81.

4. Hazell PL and Lewin TJ. An evaluation of postvention counselling following teenage suicide. Suicide and Life-Threatening Behavior 1993; 23: 101-109.

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6. Barnsley L, Cameron R, Engel CE, Feletti GI, Hazell PL et al. Ratings of performance of graduates from traditional and non-traditional medical schools. Teaching and Learning in Medicine 1994; 6:179-184.

7. Rolfe I, Pearson SA, Smith AJ, Barnsley L, Hazell PL et al. Communication skills of interns in New South Wales. Medical Journal of Australia 1994; 161:667-670.

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9. Carr VJ, Lewin TJ, Webster RA, Hazell PL, Kenardy J, Carter GL. Psychosocial sequelae of the Newcastle earthquake I: Community disaster experiences and psychological morbidity six months post-disaster. Psychological Medicine 1995; 25:539-556.

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13. Buckley NA, Dawson AH, Whyte IM, Hazell PL, Meza A, Britt H. An analysis of age and gender influences on the relative risk for suicide and psychotropic drug self-poisoning. Acta Psychiatrica Scandinavica 1996; 93:168-171.

14. Hazell P*. Tricyclic antidepressants in children: is there a rationale for use? CNS Drugs 1996; 5:233-239.

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38. Hazell P* Editorial: Depression in children. British Medical Journal 2002;325:229-230.

39. Hazell P.* Kid in the Corner (in A symposium on Attention Deficit Hyperactivity Disorder (ADHD)). Australian and New Zealand Journal of Psychiatry 2002;36:475-477.

40. Chan RTW, Rey JM, Hazell PL. Clinical Practice Guidelines for depression in young people: Are the treatment recommendations outdated? Medical Journal of Australia 2002;177:448-451.

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43. Hazell P. Depression in children and adolescents. Evidence-Based Mental Health 2003; 6:103-4

44. Hazell P, Carr V, Lewin T, Sly K. Manic symptoms in young males with ADHD predict functioning but not diagnosis after six years. Journal of the American Academy of Child and Adolescent Psychiatry 2003; 42;552-560.

45. Hazell P, Stuart J. A randomized controlled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. Journal of the American Academy of Child and Adolescent Psychiatry 2003; 42:886-894.

46. Tarren-Sweeney, M., Hazell, P., & Carr, V. Are foster parents reliable informants of children's behaviour problems? Child: Care, Health and Development 2004;30:167-175

47. Buitelaar J, Danckaerts M, Gillberg C, Zuddas A, Becker K, Bouvard M, Fagan J, Gadoros J, Harpin V, Hazell P, Johnson M, Lerman-Sagie T, Soutullo C, Wolanczyk T, Zeiner P, Fouche D, Krikke-Workel J, Zhang S, Michelson D, for the Atomoxetine International Study Group: A Prosepective, Multi-Center, Open-Label Assessment of Atomoxetine in Non-North-American Children and Adolescents with ADHD. European Child and Adolescent Psychiatry 2004;13:249-257

48. Hazell P. A review of the newer compounds available in Australia for the treatment of attention-deficit/hyperactivity disorder. Australasian Psychiatry 2004;12: 369-375

49. Burns J, Dudley M, Hazell P, Patton G. The clinical management of deliberate self-harm in young people: the need for evidence based approaches to reduce repetition. Australian and New Zealand Journal of Psychiatry 2005; 39:121-128.

50. Hazell P, Lewin T, Sly K. What is a clinically important level of improvement in symptoms of attention-deficit/hyperactivity disorder? Australian and New Zealand Journal of Psychiatry 2005;39:354-358

51. Tarren-Sweeney M, Hazell P. The mental health and socialization of siblings in care. Children and Youth Services Review 2005;27: 821-843

52. Hazell P. Prescribing psychotropic medications to children in general practice. Australian Prescriber 2005;28: 116-118

53. *Hazell P. Do adrenergically active drugs have a role in the first-line treatment of attention-deficit/hyperactivity disorder? Expert Opinion on Pharmacotherapy 2005;6: 1991-1998

54. Tarren-Sweeney M. Hazell P. Mental health of children in foster and kinship care in New South Wales, Australia. Journal of Paediatrics and Child Health 2006;42: 89-97.

55. Hazell P, Zhang S, Wolanczyk T, Barton J, Johnson M, Zuddas A, Danckaerts M, Ladikos A, Benn D, Yoran-Hegesh R, Zeiner P, Michelson D. Comorbid oppositional defiant disorder and the risk of relapse during 9 months of atomoxetine treatment for attention-deficit/hyperactivity disorder. European Child and Adolescent Psychiatry 2006;15: 105-110.

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58. *Hazell P. Pharmacological management of Attention-Deficit Hyperactivity Disorder in adolescents: special considerations. CNS Drugs 2007:21: 37-45.

59. Hazell P. Does the treatment of mental disorders in childhood lead to a healthier adulthood? Current Opinion in Psychiatry 2007;20:315-318.

60. Cahill C, Hanstock T, Jairam J, Hazell P, Walter G, Mahli G. A comparison of diagnostic guidelines for juvenile bipolar disorder. Australian & New Zealand Journal of Psychiatry 2007;41:479-484.

61. Clayton EH, Hanstock TL, Garg ML, Hazell PL. Long-chain Omega-3 Polyunsaturated Fatty Acids in the treatment of psychiatric illnesses in children and adolescents. Acta Neuropsychiatrica 2007; 19:92-103.

62. *Hazell P. When should I worry about the sad or anxious adolescent patient? Medicine Today 2007;8;63-65

63. *Hazell P. Editorial: Depression in adolescents. British Medical Journal 2007;335:106-107

64. Bangs ME, Hazell P, Danckaerts M, Hoare P, Coghill DR, Wehmeier P, Williams DW, Moore RF, Levine L. Atomoxetine for the treatment of attention-deficit/hyperactivity disorder and oppositional defiant disorder. Pediatrics 2008;121:314-320

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*Invited paper

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Conference Information: 24th CINP Congress, JUN 20-24, 2004 Paris, FRANCE
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Conference Information: 3rd Biennial Conference of the International-Society-for-Bipolar-Disorders, JAN 27-30, 2008 New Delhi, INDIA
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1. Hazell PL. "Why brain research?". Editorial for the Joint Medical Newsletter special edition for Medical Research Week 1990: Decade of the Brain. August 1990, pp 3-5.

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3. Hazell P. The school's response to suicide. Education Australia 1993; 21:17-18.

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2. Hazell P, Anderson J, Kowalenko N, Lonie C, Dowling D, Foce T et al. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand. The Royal Australian and New Zealand College of Psychiatrists, Faculty of Child and Adolescent Psychiatry Melbourne, 2010

CONFERENCE PRESENTATIONS

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1. Hazell PL. "Children's perceptions of their psychiatrically ill parents" presented to the inaugural Faculty of Child Psychiatry, RANZCP Annual General Meeting, Adelaide, September, 1988.

2. Hazell PL. "Early intervention in secondary schools following the suicide of a student". Presented to the Annual Meeting of the Faculty of Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Lorne, Victoria, September 1990.

3. Hazell PL*. Workshop: "The effect of peer suicide on adolescents". Presented to the National Association for Loss and Grief Annual Conference. Theme: "Children: the forgotten mourners". Newcastle, June 1991.

4. Hazell PL*. Workshop: "Mental Health Consultation to Schools". Presented to the 5th Annual Youth Conference, University of New South Wales, July 1991.

5. Hazell PL and Lewin TJ. "An evaluation of postvention following adolescent suicide". Faculty of Child Psychiatry, RANZCP, Annual General Meeting, Fremantle, October, 1991.

6. Hazell PL and Lewin TJ. "Friends of adolescent suicide attempters and completers". Australian Society of Psychiatric Research Annual Meeting, Prince Henry Hospital, Sydney, November, 1991.

7. Hazell PL, Levy F, Dossettor D. Workshop: "An update on child and adolescent psychopharmacology". Presented to Faculty of Child Psychiatry, RANZCP Annual Meeting, Leura, April 1992.

8. Hazell PL and Williamson M. " Childhood trauma and personality development". Presented to the Lingard Symposium: The spectrum of traumatic stress, Kirkton Park, Pokolbin, Nov 27, 1992.

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11. Hazell PL*. Workshop: "A broad perspective on suicide prevention and postvention in schools". Presented with Assoc Prof Ronald Dyck from Edmonton Canada to the National Youth Foundation Conference "Turning the Tide... Suicide Prevention", Darling Harbour, Sydney, Nov 10, 1993.

12. Hazell PL, O'Connell D, Heathcote D, Robertson J, Henry D. "A meta-analysis of the efficacy of tricyclics in the treatment of child and adolescent depression". Presented to the Australian Society for Psychiatric Research, Sydney, Dec 2, 1993.

13. Deveson A, Wicks W, Hazell P*, Smith M. "Media responsibilities in suicide." Workshop presented to the Public Health Association Conference, Canberra Feb 28, 1994.

14. Hazell PL. "Teaching postvention principles by role play." Workshop presented to the Public Health Association Conference, Canberra March 1, 1994.

15. Hazell PL*. "An overview of suicide research in NSW." Conference: Early Detection and Intervention with Adolescent Suicidal Behaviours. Adelaide, Oct 6, 1994.

16. Martin G, Hazell P, Sandercock K, Giannakoureas A. "The Brief Adolescent Risk Taking Scale (Bart S): Preliminary validation studies." RANZCP Faculty of Child and Adolescent Psychiatry Meeting, Adelaide, Oct 6-9, 1994.

17. Hazell PL. "An Area response to Attention Deficit Hyperactivity Disorder." RANZCP Faculty of Child and Adolescent Psychiatry Meeting, Adelaide, Oct 6-9, 1994.

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21. Hazell P*. "ADHD. The Australian Scene." Presented to the Russell Barkley Workshop on ADHD, University of New South Wales, August 11, 1995

22. Hazell P, McDowell M, Walton J. An audit of psychostimulant prescribing to children in the Hunter region of New South Wales@. Annual meeting, Faculty of Child and Adolescent Psychiatry, RANZCP. Christchurch, New Zealand Sept 8, 1995.

23. Hazell PL, O'Connell D, Heathcote D, Robertson J, Henry D. Handling multiple outcome measures@. Poster presented at the 3rd Cochrane Colloquium, Oslo, Norway Oct 5-8, 1995.

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29. Tarren-Sweeney M, Hazell P, Carr V. AConstruction of research clinical ranges for the Child Behaviour Checklist.@ Poster presented to the Australian Society for Psychiatric Research Annual Scientific Meeting, Newcastle 27-29 November, 1996.

30. Hazell P, Lewin T, Carter N. AFriends of adolescent suicide attempters: A detailed pilot study@. International Association for Suicide Prevention 19th annual meeting, Adelaide 24-27 March, 1997.

31. Hazell P*, Lewin T, Carter N. AWhy we should be interested in the friendship networks of suicide attempters and completers.@ Annual Congress of the Royal Australian and New Zealand College of Psychiatrists, Sydney 5-8 May, 1997.

32. Hazell P, McDowell M, Lewin T, Walton J. AFactors influencing medium term response to psychostimulant medication.@ Annual Congress of the Royal Australian and New Zealand College of Psychiatrists, Sydney 5-8 May, 1997.

33. Hazell P, McDowell M, Lewin T, Walton J. AFactors influencing medium term response to psychostimulant medication.@ Annual Meeting of the Faculty of Child and Adolescent Psychiatry (RANCZP) held in collaboration with the ASEAN Child Psychiatry Association, Nusa Dua (Bali, Indonesia) 17-21 September, 1997.

34. Hazell P. AWhat works and what is safe? Levels of evidence to support clinical decision making in child and adolescent psychiatry.@ Workshop presented to the Annual Meeting of the Faculty of Child and Adolescent Psychiatry (RANCZP) held in collaboration with the ASEAN Child Psychiatry Association, Nusa Dua (Bali, Indonesia) 17-21 September, 1997.

35. Hazell P, Lewin T. ALearning problems are common in children with emotional disorders too@ (poster). Annual Meeting of the Faculty of Child and Adolescent Psychiatry (RANCZP) held in collaboration with the ASEAN Child Psychiatry Association, Nusa Dua (Bali, Indonesia) 17-21 September, 1997.

36. Henry DA, Hill S, Sly K, Nikolajevic-Sarunac J, O=Connell D, Hazell P. AInformation framing: Effects on health professionals= practices@ (poster). Cochrane Colloquium, Amsterdam 8-12 October, 1997.

37. Hazell P*, Cockburn J. Information gathering and information giving skills for the future doctor. Australian and New Zealand College of Anaesthetists and Faculty of Intensive Care Annual Scientific Meeting , Newcastle, May 2-6, 1998.

38. Hazell PL*, O'Connell D, Heathcote D, Robertson J, Henry D. Antidepressants in young people. In Werry J, Hazell P, Mrazek D. Symposium: Medication use in young people. Presented to the Third National Conference on Child and Adolescent Mental Health, Sydney, July 23-25, 1998.

39. Hazell P, McDowell M, Lewin T, Walton J. Factors influencing medium term response to psychostimulant medication. Presented to the Third National Conference on Child and Adolescent Mental Health, Sydney, July 23-25, 1998.

40. Hazell P. CBCL clinical scales discriminate juvenile mania from ADHD. Other rating scales do not. Presented to the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists 11th Annual Meeting, Sydney, 22-25 October, 1998.

41. Hazell P, Heim C, Bisits A, Hackworthy C, Webber M. Melancholia in Music. Presented to the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists 11th Annual Meeting, Sydney, 22-25 October, 1998.

42. Nunn K, Hazell P. Strategies in psychopharmacological intervention. Workshop presented to the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists 11th Annual Meeting, Sydney, 22-25 October, 1998.

43. Hazell P*. Evidence based pharmacotherapy for child and adolescent depression. Presented to the "Out of the Blues" conference on youth depression, Adelaide, 6-7 November, 1998.

44. Hazell P, Lewin T, Carr V. Preliminary evidence that Mania+ADHD is a meaningful clinical subtype (poster). Annual meeting of the Australasian Society for Psychiatric Research, Brisbane, 3-4 December, 1998.

45. Hazell P, Sly K. The efficacy of treatments for preschool aged children with ADHD: A systematic review. Annual meeting of the Australasian Society for Psychiatric Research, Sydney, 2-3 December, 1999.

46. Sly K, Hazell P, Lewin T, Carr V, Kable C. Methods of follow-up: A prospective study of adolescent males with ADHD in the Hunter region (poster). Annual meeting of the Australasian Society for Psychiatric Research, Sydney, 2-3 December, 1999.

47. Hazell P, Heim C, Bisits A, Hackworthy C, Webber M. Melancholia in Music. Presented to the Annual Meeting of the Royal Australian and New Zealand College of Psychiatrists Adelaide, 27-30 April 2000.

48. Hazell P, Sly K. The efficacy of treatments for preschool aged children with ADHD: A systematic review. Joint meeting of the Faculty of Child and Adolescent Psychiatry and the New Zealand Child and Adolescent Mental Health Association, Auckland, New Zealand, 29 June – 1 July, 2000.

49. Tarren-Sweeney M, Hazell P, Keatinge D, Vimpani G, Callan K. The priority of needs of families of children manifesting disruptive behaviours. Joint meeting of the Faculty of Child and Adolescent Psychiatry and the New Zealand Child and Adolescent Mental Health Association, Auckland, New Zealand, 29 June – 1 July, 2000.

50. Hazell P, Lewin T, Sly K. What do parents expect of psychostimulant medication? Joint meeting of the Faculty of Child and Adolescent Psychiatry and the New Zealand Child and Adolescent Mental Health Association, Auckland, New Zealand, 29 June – 1 July, 2000.

51. Hazell P*. Still going...Hyperactivity enters its second century. Irlen International Conference, Maroochydore, Queensland, 7 July, 2000.

52. Hazell P, Lewin T, Sly K. What do parents expect of psychostimulant medication? Annual meeting of the Australasian Society for Psychiatric Research, Adelaide, 6-8 Dec, 2000.

53. Hazell P, Stuart J. An RCT of clonidine augmentation of psychostimulants for ADHD and comorbid conduct problems: A mid-term report. Annual meeting of the Australasian Society for Psychiatric Research, Adelaide, 6-8 Dec, 2000.

54. Hazell P, Lewin T, Sly K. What do parents expect of psychostimulant medication? 6th Children's Hospital Education and Research Institute Conference: 'ADHD in the Third Millenium', Westmead, 16-18 March, 2001.

55. Hazell P, Stuart J. An RCT of clonidine augmentation of psychostimulants for ADHD and comorbid conduct problems: A mid-term report. 6th Children's Hospital Education and Research Institute Conference: 'ADHD in the Third Millenium', Westmead, 16-18 March, 2001.

56. Hazell P. The priority of needs of families of children manifesting disruptive behaviours. 4th National Conference Infant Child Adolescent and Family Mental Health, Brisbane, 28-31 March, 2001.

57. Martin G, Hazell P, Sanders M, Kowalenko N. Clinical approaches to child and adolescent mental health. 4th National Conference Infant Child Adolescent and Family Mental Health, Brisbane, 28-31 March, 2001.

58. Karayanidis, F., Jenkins, L., Fox, L., & Hazell, P. Task switching: A. Behavioural and event-related potential indices in adults. 24th Annual Brain Impairment Conference, , Magnetic Island, Queensland, Australia. 17-20 May 2001.

59. Jenkins, L., Karayanidis, F., Fox, L., & Hazell, P. Task switching: B. Behavioural and event-related potential indices in children. 24th Annual Brain Impairment Conference, , Magnetic Island, Queensland, Australia. 17-20 May, 2001.

60. Karayanidis, F., Jenkins, L., Fox, L. & Hazell, P. Attentional control in children: Behavioural and ERP measures of task switching. 13th Conference on Event-Related Potentials of the Brain (EPIC), Paris, France, 9-14 July 2001.

61. Sawyer M, Whaites L, Rey J, Hazell P, Graetz B, Baghurst P. The quality of life of children and adolescents with mental disorders (poster). 48th Annual Meeting of the American Academy of Child and Adolescent Psychiatry in conjunction with the 14th Meeting of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists. Honolulu, Oct 2001

62. Hazell P, Sawyer M, Graetz B, Whaites L, Rey J, Baghurst P. The impact on family function of comorbid versus single disorders (poster). 48th Annual Meeting of the American Academy of Child and Adolescent Psychiatry in conjunction with the 14th Meeting of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists. Honolulu, Oct 2001

63. Hazell P, Carr V, Lewin T, Sly K. Manic symptoms by age 9-13 years predict later functioning but not diagnosis in ADHD males (poster). Pediatric Bipolar Meeting, Boston, 9 March 2002.

64. Hazell P*. ADHD in Oz. Keynote address to the 'Steps to Success' conference on ADHD. Sydney, 9 August 2002

65. Hazell P, Stuart J. A randomised controlled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. Faculty of Child and Adolescent Psychiatry (RANZCP) 2002 National Conference, Barossa Valley South Australia, 4-6 October 2002

66. Hazell P. Becoming a clinical investigator in a drug company trial. Faculty of Child and Adolescent Psychiatry (RANZCP) 2002 National Conference, Barossa Valley South Australia, 4-6 October 2002

67. Hazell P, Stuart J. A randomized controled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. International Congress of Child and Adolescent Psychiatry and Allied Professions, New Delhi, 29 Oct – 2 Nov, 2002.

68. Hazell P, Carr V, Lewin T, Sly K. Manic symptoms by age 9-13 years predict functioning but not diagnosis in ADHD males. International Congress of Child and Adolescent Psychiatry and Allied Professions, New Delhi, 29 Oct – 2 Nov, 2002.

69. Hazell P. The influence of policy on child and adolescent mental health services in Australai and New Zealand. In Rey J, Hazell P, Sawyer M. Workshop: Child & adolescent psychiatry in the antipodes: marrying research findings with policy in service development and training Presented to the xth meeting of the European Society for Child and Adolescent Psychiatry, Paris, 29 Sept – 3 Oct 2003

70. Hazell P, Danckaerts M, Zeiner P, Barton J, Johnsson M, Zhang S, Michelson D. effect on opposiitonal defiant disorder on risk of ADHD relapse during treatment with atomoxetine. Poster presented to the xth meeting of the European Society for Child and Adolescent Psychiatry, Paris, 29 Sept – 3 Oct 2003

71. Tarren-Sweeney, M., Hazell P. The mental health of children in long-term foster and kinship care in NSW (The Children in Care Study). Oral presentation at the Annual Scientific Meeting of the Australasian Society for Psychiatric Research (ASPR) Christchurch, New Zealand, 4th - 5th December 2003.

72. Tarren-Sweeney, M., Hazell P. Development of the Assessment Checklist for Children (ACC): A psychiatric rating scale for children in care. Poster presented at the Annual Scientific Meeting of the Australasian Society for Psychiatric Research (ASPR) Christchurch, New Zealand, 4th - 5th December 2003.

73. Becker K, Buitelaar J, Danckaerts M et al. Does Atomoxetine treatment improve psychosocial and family functioning in ADHD children and adolescents? (poster) 12th European Symposium on Determinants and Consequences of Psychiatric Illness, Mannheim, Germany 23-24 June, 2004

74. Hazell P; Danckaerts M; Zeiner P; Barton J; Johnson M; Zhang S; Michelson D EFFECT OF OPPOSITIONAL DEFIANT DISORDER ON RISK OF ADHD RELAPSE DURING TREATMENT WITH ATOMOXETINE (poster). 39th Congress of the Royal Australian and New Zealand College of Psychiatrists, Christchurch, New Zealand 9-13 May, 2004.

75. Kelsey D, Hazell P, Sumner C, Sutton V, Schuh K, Allen A, Michelson D ONCE-DAILY ATOMOXETINE IN CHILDHOOD ADHD: CONTINUOUS SYMPTOM RELIEF (poster). 39th Congress of the Royal Australian and New Zealand College of Psychiatrists, Christchurch, New Zealand 9-13 May, 2004.

76. Hazell P, Faries D, Perwien A, Kelsey D, Sumner C, Allen A, and Michelson D. EFFECTS OF ATOMOXETINE ON THE QUALITY OF LIFE OF CHILDREN WITH ADHD (poster). 39th Congress of the Royal Australian and New Zealand College of Psychiatrists, Christchurch, New Zealand 9-13 May, 2004.

77. Hazell P, Carr V, Lewin T. RETROSPECTIVE REPORTING OF CHILDHOOD SYMPTOMS OF ADHD. 39th Congress of the Royal Australian and New Zealand College of Psychiatrists, Christchurch, New Zealand 9-13 May, 2004.

78. Hazell P. THE APPROVAL AND FUNDING OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN. RANZCP Faculty of Child and Adolescent Psychiatry Meeting, Darwin, 8-11 July, 2004

79. Hazell P*. A randomized controled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. American Academy of Child and Adolescent Psychiatry 51st Annual Meeting, Washington DC, USA, 19-24 Oct, 2004

80. Hazell P*. The lifetime impact of ADHD. Philippines Psychiatric Association Annual Meeting, Tagaytay, Philippines, 26 Jan, 2005.

81. Hazell P*. The Adolescent with ADHD: Managing Transition. 40th Congress of the Royal Australian and New Zealand College of Psychiatrists, Sydney 22-26 May 2005

82. Hazell P*. Treatment of the inattentive and hyperactive/impulsive subtypes of ADHD. 40th Congress of the Royal Australian and New Zealand College of Psychiatrists, Sydney 22-26 May 2005

83. Hazell P, Zeiner P, Barton J, Johnson M, Wolaÿczyk T, Zhang S, Danckaerts D, Michelson D. Effect of Oppositional Defiant Disorder on Risk of ADHD Relapse During Treatment with Atomoxetine Polish Psychiatric Association Congress Child and Adolescents Section 29 Sept - 1 Oct 2005; Lódz, Poland

84. Hazell P*. Pharmacotherapy of autism with prominent hyperactive-impulsive symptoms. Annual meeting of the New Zealand Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Turangi, 30 Nov-2 December, 2005

85. Hazell P*. The controversy surrounding SSRIs for children and adolescents. Annual meeting of the New Zealand Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Turangi, 30 Nov-2 December, 2005

86. Hazell P*. The development of integrated child health and mental health programs. Annual meeting of the New Zealand Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Turangi, 30 Nov-2 December, 2005

87. Hazell P*. Mood disorder in children and adolescents who are disruptive. Treating Mood Disorders in Youth in an Era of Uncertainty Sydney, 8 Sept, 2006. Satellite conference to the 17th IACAPAP World Congress Conference,

88. Hazell P*. The management of comorbidity associated with ADHD. Lilly Symposium, 17th IACAPAP World Congress Conference, Melbourne 12 Sept, 2006.

89. Hazell P. Atomoxetine for the Treatment of Attention-Deficit/Hyperactivity Disorder and Oppositional Defiant Disorder. 17th IACAPAP World Congress Conference, Melbourne 13 Sept, 2006.

90. Hazell P. Does juvenile bipolar disorder persist into adulthood? Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Hobart 12 Oct, 2007

91. Hazell P. What responsibility does child and adolescent psychiatry have to children and young people with Conduct Disorder? Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Hobart 12 Oct, 2007

92. *Hazell P. The safety and efficacy of antidepressant medication for children and adolescents. Society of Hospital pharmacists of Australia 28th Federal Conference, Sydney 9 Nov, 2007

93. *Hazell P, Gaskin C. Pathways from ADHD to Delinquency. Sponsored satellite symposium to the RACP Congress, Adelaide 11 May, 2008

94. Russell J, Abraham S, Hilderscheid E, Anderson R, Redwin R, Hazell P. Eating and weight disorders in a residential psychiatric unit for adolescents (poster). World Psychiatric Association 14th World Congress, Prague 20-25 Sept, 2008

95. *Hazell P. Developmental trajectories. 5th Asia Pacific Forum on ADHD, Seoul, 27 Sept, 2008

96. Hazell P. The use of clinical global outcome measures in coal face research. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Port Douglas, 13 Oct, 2008

97. Lonie C, Hazell P, Anderson J, Kowalenko K. Planning integrated early intervention systems for infants, children and adolescents. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Port Douglas, 13 Oct, 2008

98. Martin G, Hazell P, Kay T, McGill K. MOSH ('Moving on from Self-Harm'): Replication of a randomised controlled trial of group therapy for self-injury in adolescents. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Port Douglas, 13 Oct, 2008

99. *Hazell P. The long-term consequences of ADHD. 6th Asia Pacific Forum on ADHD, Shanghai, 4 July, 2009

100. *Hazell P. Management of disruptive behaviour disorders comorbid with mood disorder. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Queenstown NZ, 7 Sept, 2009

101. Lonie C, Hazell P, Anderson J, Kowalenko K. Planning integrated early intervention systems for infants, children and adolescents. Update. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Queenstown NZ, 7 Sept, 2009

102. Hazell P, Martin G, McGill K. Is preventing repetition or hastening attenuation the more appropriate treatment goal for young people who repeatedly self-harm? (poster) Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Queenstown NZ, 9 Sept, 2009

103. *Hazell P. Julian Katz Oration. I look ahead: Equipping trainees for future practice in child and adolescent psychiatry. Faculty of Child and Adolescent Psychiatry, RANZCP Annual Meeting, Queenstown NZ, 9 Sept, 2009

104. *Hazell P. Forensic Child and Adolescent Psychiatry. Training Issues. Inaugural Forensic Child and Adolescent Psychiatry Conference, RANZCP, Sydney, 2 Oct 2009

105. *Hazell P, Martin G, McGill K. Is preventing repetition or hastening attenuation the more appropriate treatment goal for young people who repeatedly self-harm? American Academy of Child and Adolescent Psychiatry Annual Meeting, Honolulu, 27 Oct, 2009

106. *Hazell P. The Challenges to Demonstrating the Long-Term Effects of Treatment for ADHD. Asia-Pacific ADHD Forum, Beijing, 1 June, 2010

107. Hazell P. Transitioning from Childhood to Adolescence: Tailoring ADHD Management. 19th Meeting of the International Association for Child and Adolescent Psychiatry and Allied Professionals, Bejing, 4 June, 2010

108. Hazell P. Broad versus Narrow Phenotype Bipolar Disorder in Youth. Australasian Society for Bipolar and Depressive Disorders 3rd Annual Meeting, Sydney, 21 Oct 2011

109. *Hazell P. Self Injury. Excellence in Child Mental Health/Excellence in Paediatrics, Istanbul, 30 Nov-3 Dec 2011

110. Hazell P. Side effects and safety issues. Symposium on Paediatric Psychopharmacology, Annual Meeting of the Faculty of Child and Adolescent Psychiatry, RANZCP, Manly 3-5 Oct, 2012

111. Hazell P*. Self-harm in adolescents. 3rd Vietnam Australia Mental Health Conference, Hanoi, 16-17 Oct, 2012

112. Hazell P*. Child and adolescent psychopharmacology: Side effects and safety issues. 3rd Vietnam Australia Mental Health Conference, Hanoi, 16-17 Oct, 2012

113. Hazell P*. Pharmacotherapy of Autism Spectrum Disorders. Clinical and Practice Expo, Pharmaceutical Society of Australia. Sydney 31 May, 2013

114. Hazell P. The relationship between SMS mood monitoring and serial measures of depression in young people aged 10-12 years. Annual Meeting of the Faculty of Child and Adolescent Psychiatry, RANZCP Melbourne 9-12 Oct, 2013

115. Hazell P*. Pharmacotherapy of Autism Spectrum Disorders. Annual Meeting of the Faculty of Child and Adolescent Psychiatry, RANZCP Melbourne 9-12 Oct, 2013

116. Bowden M, Hazell P. On the Roller-Coaster: Parent Stress in Infant Liver Disease (poster). World Association of Infant Mental Health Conference, Edinburgh, June 18, 2014

117. Witt K, Hawton K, Arensman E, Gunnell D, Hazell P, Salisbury T, Townsend E, van Heeringen K. Effectiveness of psychological and pharmacological treatments for self-harm patients: An ongoing Cochrane systematic review and meta-analysis. European Symposium on Suicide & Suicidal Behaviour,Tallinn, 29th August 2014.

118. Hazell P, Sprague, Sharpe J, Feilds K. How opening specialist CAMHS inpatient units affected the flow of juvenile admissions to adult psychiatric and paediatric medical units in New South Wales, Australia (poster). European Psychiatric Association Meeting, Vienna, Austria, 28-31 March 2015

119. Sciberras E, Nicholson J, Anderson V, Hazell P, Jongeling B, Silk T, Bisset M, Ukoumunne O, Efron D. Do outcomes for children with subthreshold ADHD differ from children with ADHD and non-ADHD controls? A community-based study. Symposium presentation accepted 16th *International ESCAP congress*, Madrid, Spain 20-24 June 2015.

120. Bowden M, Hazell P. Family adjustment when an infant has a serious illness: putting research into practice. Free paper accepted 16th *International ESCAP congress*, Madrid, Spain 20-24 June 2015.

121. Green J, Rinehart N, Anderson V, Efron D, Nicholson J, Hazell P, Sciberras E. Autism spectrum disorder symptoms in children with ADHD: association with parent, couple and family functioning. Poster presentation accepted 16th International European Society for Child and Adolescent Psychiatry Congress, Madrid, Spain 20-24 June 2015

122. Hazell P, Sprague, Sharpe J, Feilds K. How opening specialist CAMHS inpatient units affected the flow of juvenile admissions to adult psychiatric and paediatric medical units in New South Wales, Australia. RANZCP Faculty of Child and Adolescent Psychiatry Meeting, Port Vila, Vanuatu 2 October, 2015

*Invited speaker

State and local conferences

1. Hazell PL. "The referral process and its influence on subsequent case management". Presented to the Child Psychiatry Interest Group half day seminar, Newcastle, December 1989.

2. Hazell PL*. "Adolescents in the 90s". Presented to the Annual Meeting of the Paediatric Nurses Association (New South Wales) Hunter Region Zone, Maitland, August 1990.

3. Hazell PL*. "Children of psychiatrically ill parents". Presented to Prince of Wales Children's Hospital Child Psychiatry Conference, Prince of Wales Children's Hospital, Sydney, October 1991.

4. Hazell PL*. "Towards an effort theory of attention deficit disorder". Presented to workshop "Research approaches to attention deficit disorder". Prince of Wales Children's Hospital, Randwick, October, 1991. Discussant: Dr Rachel Gittelman-Klein, Columbia University, New York.

5. Hazell PL*. "Trauma debriefing". NSW Guidance and Counselling Association. "Trauma debriefing. After the headlines fade .... keeping trauma workers alive." University of Western Sydney, Westmead Campus, November, 1991.

6. Armstrong D, Clarke W, Callan K, Hazell PL*. Workshop: "Multidisciplinary approach to behavioural disorders". Presented to 4th Annual NSW Community Child and Family Health Conference, Newcastle, January, 1992.

7. Hazell PL*. "Adolescents exposed to peer attempted and completed suicide - pathogenic effects, interventions". Presented to "Critical Incidents and Psychic Trauma in the Young - Sequelae and Management". Child Adolescent and Family Conference, Redbank House, Westmead Hospital, March 1992.

8. Hazell PL*. "What to expect following the traumatic death of a student". Presented to Prince of Wales Department of Child and Adolescent Psychiatry Conference "Traumatic death and suicide in adolescence: the school's response". Prince of Wales Children's Hospital, Sydney, March 13 and April 2, 1992.

9. Hazell PL*. "Postvention: What can and should be done". Presented to Prince of Wales Department of Child and Adolescent Psychiatry Conference "Traumatic death and suicide in adolescence: the school's response". Prince of Wales Children's Hospital, Sydney, March 13 and April 2, 1992.

10. Hazell PL*. "Attention deficit disorders". Presented to the Hunter Paediatric Society Paediatric Update, Kirkton Park, Pokolbin, August 8, 1992.

11. Hazell PL*. Workshop: "Inattention and disruptive behaviour in children". Presented to the Lake Macquarie South Education Cluster Development Day, Wangi Wangi, August 12, 1992.

12. Hazell PL*. Understanding dysfunctional families. Presented to the Hunter Institute of Mental Health seminar: Pastoral care and recognising mental illness, Newcastle, Oct 14, 1992.

13. Hazell PL*. The child who doesn't sleep. Presented to the Hunter Postgraduate Medical Institute Update Series III: "I'm not sleeping well", Newcastle, April 3, 1993.

14. Hazell PL*. "Attention Deficit Hyperactivity Disorder". Presented to the Rural Doctors Association Meeting, Pokolbin, July 24, 1993.

15. Hazell PL*. Workshop: "Youth suicide in rural Australia". Presented to the Rural Doctors Association Meeting, Pokolbin, July 25, 1993.

16. Hazell PL*. "An update on Attention Deficit Hyperactivity Disorder". Presented to the Annual Meeting of the Hunter Paediatric Society, Maitland Sept 24, 1993.

17. Hazell PL*. "The relevance of comorbidity to child and adolescent psychiatry." NSW Branch of the Faculty of Child and Adolescent Psychiatry, RANZCP. NSW Institute of Psychiatry, May 10, 1994.

18. Hazell PL*. "ADHD. A clinical overview." Workshop presented to the Hunter Association of Behaviour Intervention Teachers Conference, Newcastle July 12, 1994.

19. Hazell PL*. Attention Deficit Hyperactivity Disorder. Presentation to the Macquarie Hastings Division of General Practice Mental Health Education Day, Port Macquarie, July 26, 1997.

20. Hazell PL*. ASuicide Prevention in Young Males@. Presentation to the Macquarie Hastings Division of General Practice Mental Health Education Day, Port Macquarie, July 26, 1997.

21. Hazell PL*. APharmacological treatment of ADD/ADHD.@ Paper delivered to the Hunter Institute of Mental Health Symposium on ADD/ADHD, Newcastle, August 8-9, 1997.

22. Hazell P*, Heim C, Bisits A, Hackworthy C, Webber M. AMelancholia in Music@. Paper presented to the 5th Lingard Symposium ADepression: How Sharp is the Cutting Edge?@. Newcastle, NSW, Nov 21-22, 1997.

23. Hazell P*. The overlap of Mania with ADHD. NSW Branch, Faculty of Child and Adolescent Psychiatry, RANZCP, Sydney, May 12, 1998.

24. Hazell P*. The scope for early intervention in bipolar affective disorder. Presented to the Australian Early Intervention Network Symposium, Newcastle, July 21, 1998.

25. Hazell P*. Children's experience of parents with mental illness. Presented to Hunter Institute of Mental Health/Children of Parents Sufering Mental Ilness Conference. "Meeting the Challenge. Maximising Resilience in Children, Newcastle, 27 November, 1998.

26. Hazell P*. My depressed young patient is not getting better. What should I do? Presented to the 1999 Rivendell Conference "Sweet medicine or a bitter pill? Psychiatric medication in young people". Concord Hospital, Sydney, 30 March, 1999.

27. Hazell P*. Evidence based child psychiatry. Presented to the Annual Scientific Day of the NSW Faculty of Child and Adolescent Psychiatry, RANZCP, Sydney, 4 June, 1999.

28. Hazell P, Sly K. The effectiveness of treatments for preschool aged children with ADHD: A systematic review. Presented to Hippocrates and Socrates V (Children's Hospital Education Research Institute Conference). Positive Solutions for Challenging Behaviours, University of Sydney, Sydney, 2-3 June, 2000.

29. Hazell P, Devir H, Goh D, Peacock G, Smith L. A specialized clinic directed to prepubertal children presenting with challenging behaviours. Presented to Hippocrates and Socrates V (Children's Hospital Education Research Institute Conference). Positive Solutions for Challenging Behaviours, University of Sydney, Sydney, 2-3 June, 2000.

30. Hazell P. The relationship between Attention Deficit Hyperactivity Disorder and Mood Disorders. Presented to Hippocrates and Socrates V (Children's Hospital Education Research Institute Conference). Positive Solutions for Challenging Behaviours, University of Sydney, Sydney, 2-3 June, 2000.

31. Tarren-Sweeney M, Vimpani G, Hazell P, Keatinge D, Callan K. A study of the perceived service needs of Hunter region families who have children with disruptive behaviour problems. Presented to Hippocrates and Socrates V (Children's Hospital Education Research Institute Conference). Positive Solutions for Challenging Behaviours, University of Sydney, Sydney, 2-3 June, 2000.

32. Hazell P*. Use of stimulants in preschoolers. Paediatric Psychopharmacology Conference, Sydney, 16 Feb, 2001.

33. Hazell P*. Management of complex comorbid symptoms in young people with ADHD. Redbank Youth Conference 2001: Dislocation and transormation in the lives of young people. Westmead, 10 August, 2001.

34. Hazell P*. Attention Deficit/Hyperactivity Disorder and Tourette Syndrome. Tourette Syndrome Association of Australia Symposium on Tourette Syndrome and Associated Disorders, Newcastle, 4 May, 2002

35. Hazell P*. Why I am chaotically attracted to fish. Aetiological theories for bipolar disorder. Symposium on Biological Causes for Psychiatric Illness, Newcastle, 9 August, 2003

36. Hazell P*. The school's response to suicide. Youth Suicide Postvention Forum, Westmead, 6 November, 2003

37. Hazell P*. Rating scales for ADHD. Achenbach Conference, North Sydney Education Centre, North Ryde, 26 July, 2004.

38. Hazell P*. A collaborative service model. One Child Joint Paediatric and Child Psychiatry Meeting, Gold Coast, 15-17 July, 2005.

39. Hazell P*. Should adolescent self-harmers and suicide ideators be hospitalised? One Child Joint Paediatric and Child Psychiatry Meeting, Gold Coast, 15-17 July, 2005.

40. Hazell P*. Fidgety Phil. Presented to Hippocrates and Socrates X (Children's Hospital at Westmead Education Research Institute 10th Annual Conference)- Learning About Learning Difficulties. Westmead, 1-2 September, 2005
41. Hazell P* Pharmacotherapy of autism with ADHD. Association of Doctors in Developmental Disability Annual Clinical Conference, Newcastle, 4 Nov, 2005
42. Hazell P*. Tailoring management of ADHD to the needs of the adolescent patient. Putting Evidence Into Practice to Reach and Teach ADHD, Children's Hospital at Westmead Education Research Institute Conference, Westmead, 6 September, 2007
43. Hazell P* The effectiveness and risks of antipsychotic drugs in paediatric bipolar disorder. Black Dog Institute Symposium on Paediatric Bipolar Disorder, Sydney, 8 Oct, 2009

46. Hazell P*. Self-harm and suicide in young Australians. RESEARCH TO PRACTICE SEMINAR: ADOLESCENT SELF HARM AND SUICIDE. Sydney, 25 Sept, 2014

47. Hazell P*. Are We Medicalizing Naughtiness? Paper delivered to the Myths and Dogma Symposium, Concord Research Week, Concord RGH, 26 August, 2014

*Invited speaker

Conference Convenor

1. Continuities and Discontinuities in Youth Mental Health. Sydney 10 Nov, 2007
2. Youth Mental Health Symposium. Managing Transitions in Youth Mental Health Care (Better) Sydney 14-16 November 2008
3. Youth Mental Health Symposium. Impacts on the Developing Brain. Melbourne 8&9 August 2009
4. Youth Mental Health Symposium. Regulation and Dysregulation. Brisbane 7 &8 August 2010
5. Youth Mental Health Symposium. Clinical Reason in Complex Cases, Melbourne, 6-7 August, 2011
6. Clinical Insights Symposium ADHD Sydney 17-18 March, 2012
7. Annual Meeting of the Faculty of Child and Adolescent Psychiatry, RANZCP, Manly, 3-5 Oct, 2012

Thesis

1. Discriminative stimulus properties of drugs. Submitted for the degree Bachelor of Medical Science, University of Otago, 1978.

2. Effortful and automatic mental processes in Attention Deficit Hyperactivity Disorder and related disorders. Submitted for the degree of PhD, University of Newcastle, 1997.

Dissertations

1. Children's perceptions of their psychiatrically ill parents. Submitted to fulfil requirements of Part II examination for Fellowship of the Royal Australian and New Zealand College of Psychiatrists, 1988.

2. The referral process and its influence on case management. Submitted to fulfil requirements for Certificate of Accreditation in Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists, 1989.

RESEARCH GRANTS

1. University of Newcastle Research Management Committee Grant No 158462. "Are there unique deficits in Attention Deficit Hyperactivity Disorder? 1991. $7,000.

2. NH&MRC Primary Grant No 920385. "The role of mental effort in Attention Deficit Hyperactivity Disorder" 1992-1994. Approx. $100,000. Associate investigator: Prof V Carr.

3. Hazell and Lewin. University of Newcastle Research Management Committee Grant "Friends of Adolescent Suicide Attempters". 1994. $10, 000

4. Hazell and McDowell. NSW Health Outcomes Project. Monitoring of outcomes of children with Attention deficit Hyperactivity disorder and related conditions treated with stimulant medication.1994/1995. $25,600.

5. Carter, Carr, Dawson, Hazell, Henry, Lewin and Whyte. NSW Health Outcomes Project. Self poisoning patients: Assessment, management, prevention and clinical outcomes. $30,000. 1994/1995.

6. Vimpani and Hazell. NSW Dept of Health Special Grant. Rural Adolescent Self Harm Project. $25,000. 1994-

7. Hazell, Henry and Cotton. A systematic review of the efficacy of behaviour therapy in the treatment of Attention Deficit Hyperactivity Disorder. University of Newcastle Research Management Committee Grant. $5,500. 1996

8. Henry, Hazell, Buckley, O=Connell, Hill and Robertson. University of Newcastle Infrastructure Grant. Systematic Review Group. $135,000. 1996-1997.

9. Waring T, Hazell P, Holbrook P. Evaluation of the National Mental Health in Schools Program. Commonwealth Department of Health and Family Services. $150,000. 1998-1999.

10. Hazell P. Guidelines for early intervention in Attention Deficit Hyperactivity Disorder. Australian Early Intervention Network (AusEinet). $12,300. 1998-1999.

11. Hazell P, Lewin T, Carr V. A prospective study of manic symptoms in ADHD males. NH&MRC Primary Grant No. 990132. $100,000. 1999-2000.

12. Hazell P, Stuart J. Randomized double blind placebo control trial of clonidine augmentation of psychostimulant treatment for children aged 6-14 years with comorbid ADHD and Oppositional Defiant Disorder/Conduct Disorder. Australian Rotary Health Research Fund. $60,000. 2000-2001.

13. Karayinidis F, Hazell P. Switching attention between tasks in attention-deficit hyperactivity disorder (ADHD) and control children: A behavioural and electrophysiological study. Australian Research Council Small Grant. $10,200. 2000.

14. Karayinidis F, Hazell P. Switching attention between tasks in attention-deficit hyperactivity disorder (ADHD) and control children: A behavioural and electrophysiological study. John Hunter Children's Hospital Research Foundation $8000. 2000.

15. Hazell P, Martin G. Developmental group psychotherapy for deliberate self-harm. American Foundation for Suicide Prevention $125000 2004-2006

16. Martin G, Hazell P, Harrison J, Taylor A, Swannell S. Australian National Epidemiological Study of Self Injury (ANESSI). Commonwealth Department of Health and Aging $494,016 2007-2008

17. Hazell P, Hirneth S, Hanstock T. Juvenile Bipolar Disorder: Evaluation of Symptom Profiles, Treatment Outcomes, and Predictors of Treatment Effectiveness for Clients from a Community Mental Health Clinic. Australian Rotary Health Research Fund, $51,800 2009

18. Eapen V, Hazell P, Ward P, Barton G, Faure-Brac G. Evaluation of health promotion and preventive lifestyle intervention for young patients receiving antipsychotic medication: Impact on weight gain and quality of life. Australian Rotary Health Research Fund, $50,000 2009

19. Hazell P, Chow CM, Steinbeck K, Hawke C. Sleep, puberty and depression. Australian Rotary Health Research Fund, $18,000 2010

20. Reddihough D, Marraffa C, Hazell P, Lee K, Kohn M, Wray J. Multi-site randomised controlled trial of fluoxetine in children and adolescents with autism. NH&MRC Project Grant No. 607332. $481,825. 2010-2012.

21. Nicholson J, Efron D, Sciberras E, Hazell P, Anderson V, Okoumunne O. The Childrens' Attention Project: A community-based longitudinal study of children with ADHD and non-ADHD controls. NH&MRC Project Grant No. 1008522. $846441. 2011-2015.

22. Steinbeck K, Hawke C, Hazell P, Skinner R, Ivers R, Booy R, Cumming R, Fulcher R. The Archer Study- Puberty and Adolescence NH&MRC Project Grant No. 1003312.$975651. 2011-2014

23. Hanstock T, Clayton E, Hazell P. Omega-3 supplementation for children and adolescents with bipolar disorder. Behavioural, Cognitive & Social Sciences-Psychology-UNE Seeding Grant Scheme.$7000 2011

24. Silk T, Anderson V, Scibberra E, Nicholson J, Efron D, Hazell P. Trajectories in brain structure and function for children with and without ADHD: Associations with academic, cognitive, social, and mental health outcomes NHMRC Project Grant Application: APP1065895 $1,174,958.30 2014-2018

Teaching grants

1. Waring T, Hazell P. National Youth Suicide Strategy. Inclusion of youth suicide prevention in relevant university educational programmes. Commonwealth Department of Health and Family Services. $300,000. 1997-1998.

AWARDS

1. Anthony Eden Cup for Public Speaking, New Zealand secondary schools 1974

2. University Junior Scholarship (New Zealand) 1975-1979

3. Medical Research Council of New Zealand Student Scholarship 1978

4. Elaine Schlosser Lewis Award for Research in Attention Deficit Disorder, American Academy of Child and Adolescent Psychiatry 2004.

5. Hunter Children's Research Foundation Community Award for Research Excellence-Achievement in Research, 2004

6. Hunter Children's Research Foundation Research Mentor of the Year, 2005

OTHER ACADEMIC ACTIVITIES

Journal Reviewer

1. Australian and New Zealand Journal of Psychiatry 1992-
2. CNS Drugs 1997-
3. Australian Psychologist 1998-
4. Journal of Paediatrics and Child Health 1998-
5. Journal of Traumatic Stress 1999-
6. Journal of Child Psychology and Psychiatry 2000-
7. Medical Journal of Australia 2000-
8. British Medical Journal and affiliated publications 2000-
9. Clinical Child Psychology and Psychiatry 2000-
10. Biological Psychiatry 2002-
11. Archives of General Psychiatry 2003-
12. Bipolar Disorders 2004-
13. Acta Paediatrica 2005-
14. Pediatrics 2005-
15. Public Library of Science- Medicine 2005-
16. Journal of the American Academy of Child and Adolescent Psychiatry 2006-
17. American Journal of Psychiatry 2006-
18. Pediatric Drugs 2007-

19. International Journal of Mental Health Systems 2007-
20. Expert Review of Neurotherapeutics 2008-
21. Progress in Neuro-Psychopharmacology & Biological Psychiatry 2008-
22. Expert Opinion on Pharmacotherapy 2008-
23. Journal of Affective Disorders
24. British Journal of Clinical Pharmacology 2009-
25. Asia-Pacific Psychiatry 2009-
26. Australian and New Zealand Journal of Public Health 2009-
27. Suicide and Life-Threatening Behavior 2009-
28. Journal of Clinical Psychopharmacology 2010-
29. British Journal of Psychiatry 2010-
30. Children and Youth Services Review 2011-
31. Early Intervention in Psychiatry 2011-
32. Current Medical Research and Opinion 2011-
33. Neuropsychiatric Disease and Treatment 2012-
34. Review of General Psychology 2012-
35. Advances in Mental Health 2012-
36. Neuropsychiatry 2013-
37. Australian Family Physician 2013-
38. Psychology Research and Behavior Management 2013-
39. Asian Journal of Psychiatry 2014-
40. Neuropsychology 2014-
41. European Child and Adolescent Psychiatry 2014-
42. Australian Medical Student Journal 2014-
43. The Scientific World Journal 2014-
44. Epidemiology and Psychiatric Services 2014-
45. Neurology Research International 2015-
46. Psychopharmacology 2015-
47. Disability and Rehabilitation 2015-

Grant Reviews

1. ARC 1989-
2. Research Management Committee (University of Newcastle) 1989-
3. NH&MRC 1994-
4. Channel 7 Children's Research Foundation (SA) 1995-
5. Wellcome Institute (UK) 1995-
6. New Zealand Medical Research Council 1996-
7. Victorian Mental Health Foundation 1998-
8. Children's Research Foundation 1999-
9. The Hospital for Sick Children Foundation (Toronto Canada) 2000-
10. New Zealand Neurological Research Foundation 2000-
11. Canadian Institutes of Health Research 2001-
12. German Federal Ministry for Research and Education and the German Research Foundation 2007-
13. Israel Science Foundation 2011-
14. Dutch health care research proposal 2015-

Other Reviews

1. RTI-UNC Evidence-based Practice Centre (USA) 2004-
2. National Health Service (UK) Health Technology Assessment Programme 2005-
3. Australian Medicines Handbook 2005-

Editorial Panels

1. Bulletin of the Faculty of Child and Adolescent Psychiatry, RANZCP 1995-2000
2. Depression, Anxiety and Neurosis Systematic Review Group, Cochrane Collaboration 1995-
3. Developmental, Psychosocial and Learning Problems Review Group, Cochrane Collaboration 2002-
4. The Clinician 2003-
5. Current Opinion in Psychiatry- Guest Special Section Editor 2006-21012
6. Member, editorial board, Current Opinion in Psychiatry 2013-

Examiner

1. RANZCP Year 1 exams 1993-2002.

2. Theses for Bachelor of Medical Science, Diploma in Clinical Epidemiology, Master of Educational Studies, Master of Public Health, Doctor of Philosophy, Doctor of Medicine

3. Member for the RANZCP Committee for Examinations Oct 2000- Oct 2006

Consultancy

1. Witness to the NSW Parliamentary Subcommittee on Social Issues Inquiry into Rural Suicide, August 30, 1994.
2. Member of the Expert Clinical Reference Group (ECRG) of the Barrett Adolescent Strategy.Queensland, 2013
3. Expert adviser to the National Children's Commissioner examination into intentional self harm in children, May 13, 2014

Conference Organising activities

1. Member, Scientific Committee, Faculty of Child and Adolescent Psychiatry RANZCP Annual Meeting, Sydney 1998
2. Chair, Scientific Committee, Youth Mental Health symposium (funded by Janssen) 2007-2011
3. Member, Scientific Committee, Excellence in Child and Adolescent Psychiatry, Istanbul, 2011
4. Chair Scientific Committee, Clinical Insights (funded by Shire) 2012-2013
5. Chair, Scientific Committee, Faculty of Child and Adolescent Psychiatry RANZCP Annual Meeting, Sydney 2012
6. Member, Advisory Board to the 7th Congress of the Asian Society for Child and Adolescent Psychiatry and Allied Professions New Delhi 2013

ADMINISTRATIVE RESPONSIBILITIES

Academic

1. Member of the Research Committee. Faculty of Medicine, University of Newcastle March, 1990-Jan 1998.

4. Member of the Program Evaluation Committee, Faculty of Medicine, University of Newcastle February, 1991- March 1998.

5. Joint Coordinator of the neuropsychiatry term, Year 2 medical undergraduates University of Newcastle 1989-1998.

2. Coordinator of the Year 1 medical interview skills program University of Newcastle 1991-1998.

3. Coordinator of the Bachelor of Medical Science program, University of Newcastle Jan 93-Jan 98

4. Research Officer (acting) for the Hunter Institute of Mental Health Aug 93- Aug 94.

5. Member of the Admissions Committee, Faculty of Medicine, University of Newcastle April 93-Feb 98

6. Member of the interim Financial Management Committee for the Faculty of Medicine and Health Sciences, University of Newcastle,1996.

7. Acting Head of Discipline of Psychiatry, University of Newcastle, August 1995 to May 1996. During this period prepared submission to the CUDA Review of the Faculty of Medicine and Health Sciences, participated in the Heads of Discipline Committee responding to the CUDA

Review, and participated in the Faculty review process in general. Also successfully recruited psychiatrist to the senior lecturer position vacant from Jan 95, position filled July 1996.

8. Head, Discipline of Psychiatry, University of Newcastle May 1997-March 1998.
9. Member of the Research Committee, NSW Institute of Psychiatry, Dec 1998 – June 2001.
10. Member of the Academic Advisory Board, NSW Institute of Psychiatry Nov 2000-Oct 2003
11. Head, Discipline of Psychiatry, University of Sydney, Jan 2012-Dec 2014
12. Coordinator, child and adolescent psychiatry teaching, Sydney Medical School, 2014-

Clinical

1. Director of the Child and Adolescent Psychiatry Unit within the Department of Paediatrics, John Hunter Hospital, February 1991- February 1995 .
2. Member of the management group for the Department of Paediatrics, John Hunter Hospital February 1991- February 1995.
3. Member of the Paediatric Service Development Group, Hunter Area Health Service October 1992-2006.
4. Deputy Superintendent, Nexus Child and Adolescent Psychiatric Inpatient Unit, Feb 2003-August 2004
5. Director, Rivendell Child Adolescent and Family Mental Health Services 2006-
6. Director, SSWAHS Infant Child and Adolescent Mental Health Services 2006-2014
7. Member, Statewide (NSW) CYMHS Subcommittee 2006-
8. Director, SLHD Child and Adolescent Mental Health Service 2014-

Professional

1. Member and Public Officer of the Postgraduate Training Committee in Psychiatry for the Newcastle and Central Coast Psychiatry Training Scheme 1989-2006.
2. Past member of the Standing Committee for Child Psychiatry, NSW Institute of Psychiatry.
3. Past member of the Child Psychiatry Advisory Committee to the NSW Department of Health.
4. Member Committee for Examinations RANZCP Oct 2000-Oct 2006
5. Chair, Observed Clinical Interview Subcommittee, RANZCP Committee for Examinations, Oct 2002-Oct 2006
6. Chair of the Subcommittee for Advanced Training in Child and Adolescent Psychiatry, RANZCP and member, Committee for Training and Dual Fellowship Training Committee, RANZCP Feb 2007-May 2013
7. Treasurer, NSW Branch Faculty of Child and Adolescent Psychiatry, RANZCP 2010-
8. Member, RANZCP Clinical Practice Guideline Subcommittee on Self Harm

Community

1. Member of the Kotara SSP (emotionally disturbed) school council June 93-June 95.
2. Member, NSW Paediatric Clinical Trials Working Party, reporting to the Ministry for Science and Medical Research 2005-2006
3. Member, Mental Health Research Advisory Group to the Dept Of Health NSW 2006
4. Member, NSW Child Death Review Team, June 2015-

EXTRACURRICULAR

1. Leader, 2nd violins, Strathfield Symphony Orchestra
2. Member (violin 2) Strathfield String Quartet
3. Deputy Leader, 2nd violins, NSW Doctors Orchestra

Sydney South West Area Health Service
Area Mental Health Service

JOB DESCRIPTION

IDENTIFICATION

POSITION TITLE:	Director Child & Adolescent Mental Health Services, Thomas Walker Hospital (Rivendell) & Associated Services. Eligible for conjoint position with the University of Sydney
QUALIFICATIONS:	▫ Medical degree registrable in NSW ▫ FRANZCP or equivalent recognised specialist psychiatrist qualification ▫ Certificate of Advanced Training in Child & Adolescent Psychiatry (RANZCP) or recognised equivalent.
CONDITIONS:	Director role subject to four year term and eligible for reappointment Substantive Post: Senior Medical Practitioner In accordance with the Salaried Medical Practitioners (State) Award.
SUMMARY OF ROLE:	Leadership and clinical management of Area Child & Adolescent Mental Health Services, which includes Rivendell Child and Adolescent and Family Service.
ORGANISATIONAL ENVIRONMENT:	The Director of Child and Adolescent Services will have responsibility for Child & Adolescent Mental Health Services in the North East cluster of Sydney South West Area Health Service. These responsibilities will include responsibility for clinical and service development, strategy, quality improvement and resource management. This position includes direct responsibility for the Rivendell Child, Adolescent and Family Service. The position reports to and is under the direction of the Area Director of Mental Health Services.

SYDNEY SOUTH WEST AREA MENTAL HEALTH SERVICES

DIRECTOR, CHILD AND ADOLESCENT MENTAL HEALTH

STATEMENT OF DUTIES

POSITION TITLE:	Director Child & Adolescent Mental Health Services, Thomas Walker Hospital (Rivendell) & Associated Services. Eligible for conjoint position with the University of Sydney
AWARD CLASSIFICATION:	In accordance with Salaried Medical Practitioners (State) Award.
RESPONSIBLE TO:	SSWAHS Area Clinical Director Mental Health in all matters to do with the Area Health Service and to the Associate Dean of the Central Clinical School of the University of Sydney on University matters.

Summary of Position:

- Oversee the management of Child & Adolescent Mental Health Services within the North East cluster of Sydney South West Area Health Service which addresses both a population focused approach to Area residents and a tertiary service within New South Wales.
- Facilitate the development of a comprehensive mental health program for children and young people.
- Facilitate the implementation of effective strategic planning process.
- Facilitate the development of a balanced range of services, maintaining a consistent and uniform approach to policy development and service provision.
- Oversee the clinical management resources allocated to Child and Adolescent Mental Health in the area within a framework of quality and accountability, in partnership with the Director of Nursing, Area Mental Health Service.

Responsibilities:

Working in consultation with the Area Director Mental Health and Area Mental Health Executive the Director has the following responsibilities:

1. Strategic Tasks

- Contribute to the development and implementation of strategies to set the direction of a comprehensive Child and Adolescent Mental Health Services.
- Ensure the strategies are consistent with National and State Mental Health policies and plans.
- Review these strategies in consultation with staff, consumers, carers, other appropriate service providers and the defined community.
- Provide expert advice on Child and Adolescent Mental Health Service needs and service priorities.
- Identify and support the professional development of staff working in Child and Adolescent Mental Health Services.
- Advise on the co-ordination and implementation of data systems, including those, which identify severity, and patterns of mental health problems and mental disorders.
- Advise on inter-sectoral issues and strategies to develop effective working relationships between mental health services, other government departments and other relevant service providers.
- Advise on a framework across the Area which provides service evaluation, outcome measurement, research and continuous quality improvement.
- Other relevant duties as required.

2. Clinical & Management Tasks:

- Be responsible for the management of multidisciplinary clinical staff of the Child & Adolescent Mental Health Service.
- Be responsible for all treatment programs in the service.
- Maintain a clinical caseload and be responsible for the assessment, therapeutic management and inter-agency liaison of these cases.
- Ensure appropriate communication and collaboration between different professional groups, including teaching staff in the provision of an integrated multi-modal care of children and families.
- Liaise and collaborate with the Principal of the Rivendell education program regarding the delivery of special education services to the young people attending classes in the Service. Liaise with Department of Education and Training staff on the provision of local and regional Mental Health Services.
- Maintain close collaborative links with the Child and Adolescent Teams managed by the Division of Population Health. In particular ensure comprehensive consultative services are provided to these teams.
- Establish links with referring agents within Sydney South West Area Health Service and across the state.
- Develop and maintain an up to date Policy and Procedures Manual and produce an Annual Report.
- Ensure regular appraisals of all Health staff and appropriate follow up where there are concerns.

- Attend a yearly appraisal of a professional performance with the Area Director Mental Health.

3. Teaching & training Tasks

- Provide clinical supervision to registrars in training in accordance with RANZCP guidelines.
- Provide tutorials and clinical experience to medical students of the University of Sydney.
- Organise teaching of medical students from the University of Sydney.
- Develop links with the University of Sydney Department of Psychological Medicine and with other universities as appropriate and promote research within the Area Child and Adolescent Mental Health Service.
- Maintain conjoint appointment functions with the University of Sydney based on level of appointment.

GENERAL ACCOUNTABILITIES

I Quality Improvement

- To implement quality activities to guide service delivery and continued improvement.
- To facilitate work practice reviews to ensure current standards are maintained and technological changes are incorporated to reflect corporate objectives.
- To implement recommendations for improvement which may emanate from work practice reviews.
- To ensure compliance with the standards contained within the Australian Council on Health Care Standards Guidelines for Accreditation.

II Training

- To attend Induction.
- To ensure employees are provided access to appropriate training and development to assist them in personal development.
- To attend annual training in the following:

Fire Safety	
Infection Control	*
Cardio Pulmonary Resuscitation	*
Manual Handling	*
Management of Aggression	*

and any other training courses specified by management which will enhance personal development and productivity requirements.

* as appropriate to the position of the employee and the facility.

III Corruption Prevention

- To report any suspected fraud in the workplace.
- To minimise the incidence of corruption and fraud within the workplace.
- To instigate investigations into any suspected incidences of fraud and corruption.

IV Policies and Procedures

- To ensure familiarity with, and adherence to, relevant NSW Health Department, SSWAHS and Facility / Services policies and procedures that are relevant to the performance of the duties specified in this Job Description.
- A commitment to reduce waste generation and segregate general, clinical and recyclable waste for safe disposal. Participate in waste reduction strategies which avoid, reduce recycle and re-use waste.
- Comply with Privacy legislation and corresponding SSWAHS Policies and procedures.
- To ensure staff have access to, and adhere to, policies and procedures required for the performance of their duties.

V Code of Conduct

- To abide by the SSWAHS Code of Conduct.

VI Occupational Health and Safety Responsibilities

- To ensure compliance with the following:
  Occupational Health and Safety Act (2000) and amendments
  Workers Compensation Act 1987 and amendments
  Workplace Injury Management and Workers Compensation Act 1998 and amendments
  NSW Health Department Guidelines Australian Standards
- To ensure all accidents and incidents are reported, recorded, investigated and analysed and short and long term corrective action is taken and its effectiveness evaluated.
- To participate in the Workplace Rehabilitation Programme.
- To notify the Rehabilitation Coordinator of all injuries and ensure effective rehabilitation of injured workers.
- To ensure regular workplace inspections are conducted and recorded and all reported risks are assessed and appropriate action taken to manage risks and evaluate its effectiveness.
- To ensure staff are familiar with emergency procedures by

organising attendance at appropriate training (for example: Fire Safety Training).

VII Smoke Free Environment

- To abide by the SSWAHS Smoke Free Environment Policy.

VIII EEO and Affirmative Action

- To abide by EEO principles, policies and procedures.
- To promote, implement and evaluate EEO and Affirmative Action policies and strategies.

IX Performance Management

- To participate in the SSWAHS Performance Management Programme.

X Child Protection Guidelines

- To facilitate staff awareness of the NSW Health, SSWAHS and local service child protection policies and procedures, including reporting requirements
- To facilitate staff attendance at appropriate training programs for Child Protection.
- To facilitate provision of appropriate supervision/support to staff who are involved in critical incidents/child protection issues.

The above is a brief statement of the duties of the position as at : / /

As occupant of this position, I have noted this Statement of Duties.

NSW Health Mental Health Program Council

MHPC 10-05 COUNCIL PAPER

Ref No: MHPC 10-05 Agenda **Item No**.5.3 **Tab** 10

Authors: G Stewart, S Hailstone
J Burgess

Date: 23 Sept 2010

MENTAL HEALTH - CLINICAL CARE AND PREVENTION SERVICE PLANNING MODEL (MH-CCP)

RECOMMENDATION:

THAT the Mental Health Program Council:

1. **APPROVE/ENDORSE** the content of the NSW MH-CCP model i.e. the care packages, and the specifications shown in the Excel Spreadsheets.

2. **NOTE** that if the NSW MH-CCP model as presented is approved, then the final document to accompany NSW MH-CCP 2010 will be prepared.

BACKGROUND:

NSW MH-CCP

Since the *MH-CCP discussion document* was sent out in 2009, MHDAO has consulted with AHSs and revised the model in consultation with the relevant sub-committees of the MHPC and the MH-CCP Expert Advisory Group.

The MH-CCP Project Team has completed cross checking final information to be included in the model. The care package specifications for each of the six age groups are shown at Attachment 1-6. The Excel spreadsheets for each of the six age groups are shown at Attachments 7-12.

A comparison of MH-CCP 2000 vs. MH CCP 2010 is provided at Attachment 13, which also includes projections through to 2021. Some key points from this comparison are:

1) The estimated cost of implementing the new model would be 24% higher than that of the old model. This varies between age groups, with a much larger increase for older people (53%) and children and adolescents (34%) than for adults 18-64 (17%).

2) The increase for older people largely reflects the inclusion of services for the Behavioural and Psychological Symptoms of Dementia (BPSD)

3) Within the child/ adolescent group, the increases for infants aged 0-1 (110%) and teenagers aged 12-17 (50%) are much larger than those for toddlers 2-4 (30%) and for primary schoolers aged 5-11 (0%).

4) The increase for infants reflects the fact that the older model used a very conservative estimate – those at extreme risk only. The increase for teenagers reflects more intensive Early Psychosis services and non-acute inpatient care.

The agreed finalisation procedure was that the MH-CCP EAG and the MH Program Council members will be able to review the basic spreadsheets and care packages and in the light of a summary of their consequences make comments before the final documentation is prepared.

RISK ANALYSIS:

- In general there has been an increase in the intensity of clinical care in the modelling to date, which will significantly increase the predicted costs for all age groups.

ABORIGINAL IMPACT:

- There is no specific modelling of Aboriginal Mental Health Services.

CALD IMPACT:

- There is no specific modelling of CALD Mental Health Services.

RURAL SERVICES IMPACT:

- There is some specific modelling of rural versions of Care Packages where the relevant sub-committees identified a need to have different packages.

ATTACHMENTS:

1) MH-CCP 2010 care package specifications age group 0-1
2) MH-CCP 2010 care package specifications age group 2-4
3) MH-CCP 2010 care package specifications age group 5-11
4) MH-CCP 2010 care package specifications age group 12-17
5) MH-CCP 2010 care package specifications age group 18-64
6) MH-CCP 2010 care package specifications age group 65+
7) MH-CCP 2010 Excel spreadsheet age group 0-1
8) MH-CCP 2010 Excel spreadsheet age group 2-4
9) MH-CCP 2010 Excel spreadsheet age group 5-11
10) MH-CCP 2010 Excel spreadsheet age group 12-17
11) MH-CCP 2010 Excel spreadsheet age group 18-64
12) MH-CCP 2010 Excel spreadsheet age group 65+
13) MH-CCP 2010 vs. MH- CCP 2000: an indicative comparison

MH-CCP 2010 vs. MH-CCP 2000: a comparison

OVERALL COMPARISONS

For the purposes of comparing MH-CCP version 1.11 (MH-CCP 2000) with Version 2010, we have applied two updates to the older model. These are:

- The calculations in the previous model have been re-based to the standard NSW population of 2006 rather than 1996. This has only a small effect.
- The inpatient staffing ratios (clinical FTE per bed) have also been re-based from the 1997 Queensland Health "Optimal Staffing profiles" to the current NSW staffing ratios used in MH-CCP 2010. The modelled ratios were close to NSW practice in 1998, but are now out of date because of the impact of the Reasonable Nursing Workloads provisions in the Award negotiated in 2003. The impact of this change is considerable, but it is not an optional change. To indicate that this comparison is with a version of MH-CCP 2000 that has been updated to 2006, we refer to it as MH-CCP 2006.

Table 1 – Overall Cost Summary, MH-CCP v2006 and v2010

MENTAL HEALTH CLINICAL CARE AND PREVENTION MODEL PARAMETERS									
NSW by Age Group	0 to 1		2 to 4		5 to 11		12 to 17		0 to 17
POPULATION									
Standard populations	100,000		100,000		100,000		100,000		100,000
NSW pop 2006	177,800		258,400		621,900		552,200		1,610,300
% by agegrp	2.6%		3.8%		9.1%		8.1%		23.6%
	V2010	V2006	V2010	V2006	V2010	V2006	V2010	V2006	V2010 V2006
APPROX MULTIPLIER FROM VER 1.11 TO VER 2	2.1		1.3		1.0		1.5		1.34

MENTAL HEALTH CLINICAL CARE AND PREVENTION MODEL PARAMETERS								
NSW by Age Group	0 to 17		18 to 64		65+		Total	
POPULATION								
Standard populations	100,000		100,000		100,000		100,000	
NSW pop 2006	1,610,300		4,285,000		920,700		6,816,000	
% by agegrp	23.6%		62.9%		13.5%		100%	
	V2010	V2006	V2010	V2006	V2010	V2006	V2010	V2006
APPROX MULTIPLIER FROM VER 1.11 TO VER 2	1.34		1.17		1.53		1.24	

The main points of the comparison are:

- The estimated cost of implementing the new model would be 24% higher than that of the old model. This varies between age groups, with a much larger increase for older people (53%) and children and adolescents (34%) than for adults 18-64 (17%).
- The increase for older people largely reflects the inclusion of services for the Behavioural and Psychological Symptoms of Dementia (BPSD)
- Within the child/ adolescent group, the increases for infants aged 0-1 (110%) and teenagers aged 12-17 (50%) are much larger than those for toddlers 2-4 (30%) and for primary schoolers aged 5-11 (0%).
- The increase for infants reflects the fact that the older model used a very conservative estimate – those at extreme risk only. The increase for teenagers reflects more intensive Early Psychosis services and non-acute inpatient care.

SUMMARY OF RESOURCE PREDICTIONS

Employed Clinical Staff

MENTAL HEALTH CLINICAL CARE AND PREVENTION MODEL PARAMETERS								
NSW by Age Group	0 to 17		18 to 64		65+		Total	
POPULATION								
Standard populations	100,000		100,000		100,000		100,000	
NSW pop 2006	1,610,300		4,285,000		920,700		6,816,000	
% by agegrp	24%		63%		14%		100%	
WORKFORCE (Clinical FTE staff) required								
	V2010	V2006	V2010	V2006	V2010	V2006	V2010	V2006
Ambulatory Care (per 100K age-specific population)	86.1	66.0	80.9	58.3	63.1	48.4	79.7	57.8
Inpatient care staff	16.7	11.5	88.8	108.3	95.6	98.5	72.7	84.1
Place Based care staff	0.8	0.0	2.9	5.5	61.7	3.2	10.3	3.9
TOTAL STAFF NUMBERS REQUIRED FOR NSW 2006	1,669	1,248	7,395	7,376	2,029	1,383	11,093	10,006
Check	140,000	140,000	140,000	140,000	140,000	140,000	140,000	140,000
WORKFORCE (Clinical FTE staff) Current (2006-07) as % of requirements, V2 versus V1								
Ambulatory Care (per 100K age-specific population)	27.8		47.3		21.3		39.2	
Inpatient care staff	13.6		70.5		55.3		55.0	
Residential care staff	0.2		2.1		1.3		1.6	
TOTAL STAFF NUMBERS REQUIRED FOR NSW 2006	670		5,141		717		6,528	
RATIO	40%	54%	70%	70%	35%	52%	59%	65%

Note 1: This comparison is based only on the workforce employed by NSW Health. It does not take into account the large increase in HBOS and HASI services that appear only as costs because they are contracted with other providers. This has a major impact on the comparisons for Ages 18-64.

Note 2: The 2006-07 "actual" data reported here comes from the latest version of the Mental Health Establishments Database provided to the Strategic Planning and Evaluation (SPE) team in the Mental Health and Drug and Alcohol Office, which is dated May 2009.

The general results shown here are consistent with the cost increase data already discussed, as would be expected since the costs are (largely) derived from staff numbers. The overall increase in employed staff is only about 10%, and the increase in employed staff is almost entirely confined to the age groups 0-17 and 65+, with the middle group remaining unchanged overall. Within that, however, there is a substantial shift of staff from inpatient care to ambulatory care, reflecting the much lower estimate of need for non-acute inpatient care (in particular), and the increased emphasis on ambulatory care. In addition, the 17% increase in costs for the Adult age group is in contracted HASI and related care that generates no increase in employed staff.

Note that the staff-based indexes of need met for the oldest and youngest age groups were just above 50% on the old model, and are substantially below 50% on the new one, while the adult 18-64 index remains unchanged at 70%. It is not a new result for NSW that services are more concentrated on the adult group here than in other jurisdictions.

BEDS AND PROGRAM PLACES

MENTAL HEALTH CLINICAL CARE AND PREVENTION MODEL PARAMETERS								
NSW by Age Group	0 to 17		18 to 64		65+		Total	
POPULATION								
Standard populations	100,000		100,000		100,000		100,000	
NSW pop 2006	1,610,300		4,285,000		920,700		6,816,000	
% by agegrp	23.6%		62.9%		13.5%		100%	
BEDS (per 100k, age-specific)								
	V2010	V2006	V2010	V2006	V2010	V2006	V2010	V2006
ALL HOSPITAL BEDS	9.9	4.5	49.7	62.2	56.7	60.7	41.3	48.3
Acute	5.4	4.5	30.9	31.8	29.3	26.5	24.7	24.6
Non-Acute (but not VLS)	4.5	0.0	5.4	18.8	15.3	9.1	6.5	13.0
VLS	0.0	0.0	13.4	11.6	12.1	25.0	10.1	10.7
PROGRAM PLACES (per 100k, age-specific)								
PROGRAM PLACES	0.8	0.0	386.6	5.0	224.6	10.7	273.6	4.6
Various age-specific CAMHS	0.8	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Supported Living in the Community (HBOS & L-HASI)	0.0	0.0	358.7	0.0	0.0	0.0	225.5	0.0
Supported Living in the Community (M-HASI & above or equiv.)	0.0	0.0	27.8	5.0	19.0	0.0	20.1	3.1
RACF Partnership (65+)	0.0	0.0	0.0	0.0	205.7	10.7	27.8	1.4

The main changes in hospital bed requirements between the models are as follows:

- The requirement for hospital beds is doubled (from 4.5 to 9.9 per 100,000 aged 0-17), most of which is the addition of Non-Acute beds for ages 12-17.
- There is no material change in the Acute bed requirements for ages 18-64. This is partly the result of savings achieved by expansion of HASI.
- There is a large reduction in Non Acute requirements for Ages 18-64, from 18.8 per 100,000 to 5.4 per 100,000). This is mainly the result of analysing NSW length of stay distributions to identify the proportion that are accommodated within an ALOS of 14 days as modelled for Acute. This is explained in detail in TAB B.
- There is a small increase in the requirements for very long Stay (VLS) beds
- There is a small increase in the Acute bed requirements for people aged 65+. Note that a third of these beds are now modelled as being located in Acute units for adults 18-64 (14 day ALOS), while the others are SMHSOP units (35 day ALOS).
- The increase from 9.1 to 15.3 Non-Acute beds per 100,000 people aged 65+ reflects two opposed factors. The requirements for Non-Acute beds for those with primary mental illnesses have decreased from 9.1 to 3.1 (for the same reasons as for Adults 18-64), but this is outweighed by the new requirement for 12.7 beds in TBASIS units for those with BPSD.
- There is a large reduction in the estimated demand for VLS beds for those aged 65+, reflecting the development of partnership models with residential aged Care facilities (see below).

The previous model did not represent "places" in programs of care other than hospital beds or 24 hour supported community residential units. These places tend to be age-specific, and quite different in cost, so that totals are not very meaningful. The main changes are the HASI and related services for adults ages 18-64, which are now a major feature of the model, and the MH-RACF partnerships for people aged 65+. Both of these have the effect of reducing demand on hospital beds.

SUMMARY BY AGE GROUP

The draft "calculator" for MH-CCP 2010 produced the following results for NSW when applied to the projected populations from 2006 through 2021. The "All Age" summary, which is not particularly meaningful as rates per 100,000 total population, but similar tables for each age group follow.

OVERALL PREDICTIONS, ALL AGES

Persons All Ages (Rates are calculated for on 2006 numbers only) Population	MH-CCP 23-Aug-10 100,000	2006 6,816,087	2011 7,207,641	2016 7,603,502	2021 8,008,299
CLINICAL STAFF (FTE)	**162.71**	**11,090**	**11,778**	**12,480**	**13,207**
Check	162.71	-	-	-	-
NON -INPATIENT CLINICAL STAFF	**79.68**	**5,431**	**5,724**	**6,003**	**6,302**
Ambulatory Care only (+/- HBOS, +/-Aged Care)	**56.30**	**3,837**	**4,030**	**4,207**	**4,400**
Prevention and promotion	6.38	435	455	474	495
Ambulatory MILD	5.86	399	421	442	464
Ambulatory MODERATE	15.25	1,039	1,102	1,165	1,230
Ambulatory SEVERE (except as below)	28.82	1,964	2,053	2,126	2,212
Ambulatory Care around Inpatient episodes	**19.60**	**1,336**	**1,411**	**1,479**	**1,551**
C/L to ED attenders (including non-admitted PECC)	1.60	109	117	125	133
C/L to Patients in general beds	2.17	148	156	164	173
Patients in MH Beds	15.84	1,079	1,138	1,190	1,244
Ambulatory Support for Program Places	**1.71**	**117**	**124**	**130**	**137**
Supported Living in the Community (HASI and equivalent)	1.70	116	123	130	136
Other	0.01	1	1	1	1
RACF Partnerships	**2.07**	**141**	**160**	**187**	**214**
INPATIENT CLINICAL STAFF	**72.69**	**4,955**	**5,267**	**5,576**	**5,889**
Acute	45.85	3,125	3,319	3,508	3,698
Non-Acute	10.66	740	790	846	906
VLS	15.98	1,089	1,158	1,222	1,285
PLACE-BASED CLINICAL STAFF	**10.33**	**704**	**786**	**900**	**1,017**
Various age-specific	10.33	704	786	900	1,017
BEDS & PROGRAM PLACES	**314.97**	**21,469**	**22,757**	**23,934**	**25,072**
HOSPITAL BEDS	**41.26**	**2,812**	**2,992**	**3,170**	**3,351**
Acute IP Beds	**24.68**	**1,682**	**1,787**	**1,887**	**1,989**
EIP (12-17, 18-24)	3.08	210	219	226	234
Other Acute (remainder of Acute beds)	21.61	1,473	17,636	18,275	18,865
Non-Acute IP Beds	**6.50**	**443**	**475**	**510**	**549**
EIP (12-17) (use of HILS beds)	0.56	38	39	39	41
TBASIS (65+)	1.64	112	127	148	170
Other Non-Acute (remainder of Non-Acute beds)	4.30	293	309	323	338
VLS beds	**10.07**	**687**	**730**	**772**	**813**
PROGRAM PLACES	**273.71**	**18,657**	**19,765**	**20,764**	**21,720**
Various age-specific CAMHS	0.19	13	13	14	15
Supported Living in the Community (HBOS & L-HASI)	225.67	15,382	16,155	16,714	17,225
Supported Living in the Community (M-HASI & above or equiv.)	20.07	1,368	1,451	1,528	1,602
RACF Partnership (65+)	27.78	1,893	2,145	2,507	2,879
Non-MH Resources	***0.00***	-	-	-	-
		-	-	-	-
Special School Places	*0.19*	*13*	*14*	*14*	*15*
Residents with primary MI in RACFs (MI C/L only)	*131.69*	*8,976*	*10,169*	*11,887*	*13,648*
Private Hospital Beds	*2.71*	*185*	*197*	*210*	*222*
General Hospital Beds	*5.64*	*384*	*421*	*458*	*497*

PREDICTED RESOURCE REQUIREMENTS FOR AGES 0 and 1

Persons Age 0-1 Population	MH-CCP 23-Aug-10 100,000	2006 174,472	2011 190,774	2016 198,414	2021 206,348
CLINICAL STAFF (FTE)	**82.09**	**143**	**157**	**163**	**169**
Check	-	-	-	-	-
NON -INPATIENT CLINICAL STAFF	**82.09**	**143**	**157**	**163**	**169**
Ambulatory Care only (+/- HBOS)	**79.53**	139	152	158	164
Prevention and promotion	13.80	24	26	27	28
Ambulatory MILD	7.63	13	15	15	16
Ambulatory MODERATE	7.97	14	15	16	16
Ambulatory SEVERE (except as below)	50.13	87	96	99	103
Ambulatory Care around Inpatient episodes	**2.56**	**4**	**5**	**5**	**5**
C/L to ED attenders (including non-admitted PECC)	0.05	0	0	0	0
Patients in general beds	2.51	4	5	5	5
MH Acute RCFU	-	-	-	-	-
Ambulatory Support for Program Places	**0.00**	-	-	-	-
	-	-	-	-	-
INPATIENT CLINICAL STAFF	**0.00**	-	-	-	-
MH Acute RCFU	-	-	-	-	-
Other Non-Acute	-	-	-	-	-
PLACE-BASED CLINICAL STAFF	**0.00**	-	-	-	-
ECU Intensive Outpatient stay	-	-	-	-	-
BEDS & PROGRAM PLACES	**0.00**	**0**	**1**	**1**	**1**
HOSPITAL BEDS	**0.00**	**0**	**1**	**1**	**1**
Acute IP Beds	**0.00**	0	1	1	1
MH Acute RCFU	-	0	1	1	1
Non-Acute IP Beds	**0.00**	-	-	-	-
Other Non-Acute	-	-	-	-	-
PROGRAM PLACES	**0.00**	-	-	-	-
	-	-	-	-	-
Non-MH Resources		-	-	-	-
Special School Places	-	-	-	-	-
Private Hospital Beds	-	-	-	-	-
General Hospital Beds	*1.59*	*3*	*9*	*9*	*9*

PREDICTED RESOURCE REQUIREMENTS FOR AGES 2 – 4

Persons Age 2-4 Population	MH-CCP 23-Aug-10 100,000		2006 261,709	2011 286,162	2016 297,620	2021 309,522
CLINICAL STAFF (FTE)	**59.11**		**155**	**169**	**176**	**183**
Check		-	-	-	-	-
NON -INPATIENT CLINICAL STAFF	**58.73**		**154**	**168**	**175**	**182**
Ambulatory Care only (+/- HBOS)	**58.08**		152	166	173	180
Prevention and promotion		12.28	32	35	37	38
Ambulatory MILD		6.81	18	19	20	21
Ambulatory MODERATE		7.38	19	21	22	23
Ambulatory SEVERE (except as below)		31.60	83	90	94	98
Ambulatory Care around Inpatient episodes	**0.59**		**2**	**2**	**2**	**2**
C/L to ED attenders (including non-admitted PECC)		0.04	0	0	0	0
Patients in general beds or residential CFU		0.39	1	1	1	1
MH Acute RCFU		0.16	0	0	0	0
Ambulatory Support for Program Places	**0.07**		**0**	**0**	**0**	**0**
Family Care Clinic stay		0.04	0	0	0	0
ECU Intensive Outpatient stay + Special School		0.02	0	0	0	0
INPATIENT CLINICAL STAFF	**0.17**		**0**	**0**	**1**	**1**
MH Acute RCFU		0.17	0	0	1	1
Other Non-Acute		-	-	-	-	-
PLACE-BASED CLINICAL STAFF	**0.21**		**1**	**1**	**1**	**1**
ECU Intensive Outpatient stay		0.21	1	1	1	1
BEDS & PROGRAM PLACES	**0.87**		**2**	**2**	**3**	**3**
HOSPITAL BEDS	**0.09**		**0**	**0**	**0**	**0**
Acute IP Beds	**0.09**		**0**	**0**	**0**	**0**
MH Acute RCFU		0.09	0	0	0	0
Non-Acute IP Beds	**0.00**		-	-	-	-
Other Non-Acute		-	-	-	-	-
PROGRAM PLACES	**0.77**		**2**	**2**	**2**	**2**
ECU Intensive Outpatient stay + Special School		0.77	2	2	2	2
Non-MH Resources			-	-	-	-
Special School Places		*0.84*	*2*	*2*	*3*	*3*
Private Hospital Beds		*0.02*	*0*	*0*	*0*	*0*
General Hospital Beds		*0.27*	*1*	*1*	*1*	*1*

PREDICTED RESOURCE REQUIREMENTS FOR AGES 5 - 11

Persons Age 5-11 Population	MH-CCP 23-Aug-10 100,000		2006 623,631	2011 627,698	2016 669,528	2021 704,208
CLINICAL STAFF (FTE)	**63.86**		**398**	**401**	**428**	**450**
Check	-		-	-	-	-
NON -INPATIENT CLINICAL STAFF	**59.51**		**371**	**374**	**398**	**419**
Ambulatory Care only (+/- HBOS)	56.85		355	357	381	400
Prevention and promotion		12.28	77	77	82	87
Ambulatory MILD		6.80	42	43	45	48
Ambulatory MODERATE		9.60	60	60	64	68
Ambulatory SEVERE (except as below)		28.17	176	177	189	198
Ambulatory Care around Inpatient episodes	2.58		16	16	17	18
C/L to ED attenders (including non-admitted PECC)		0.12	1	1	1	1
C/L to Patients in general beds		0.33	2	2	2	2
Other Acute		2.13	13	13	14	15
Other Non- Acute		-	-	-	-	-
Ambulatory Support for Program Places	0.08		0	0	1	1
Day program + Special School		0.08	0	0	1	1
INPATIENT CLINICAL STAFF	**2.34**		**15**	**15**	**16**	**16**
Other Acute		2.34	15	15	16	16
Other Non-Acute		-	-	-	-	-
PLACE-BASED CLINICAL STAFF	**2.01**		**13**	**13**	**13**	**14**
Day program + Special School		2.01	13	13	13	14
BEDS & PROGRAM PLACES	**2.88**		**18**	**18**	**19**	**20**
HOSPITAL BEDS	**1.12**		**7**	**7**	**7**	**8**
Acute IP Beds	1.12		7	7	7	8
Other Acute (remainder of Acute beds)		1.12	7	7	7	8
Non-Acute IP Beds	0.00		-	-	-	-
Other Non-Acute		-	-	-	-	-
PROGRAM PLACES	**1.77**		**11**	**11**	**12**	**12**
Day program + Special School		1.77	11	11	12	12
Non-MH Resources			-	-	-	-
Special School Places		*1.77*	*11*	*11*	*12*	*12*
Private Hospital Beds		*0.06*	*0*	*0*	*0*	*0*
General Hospital Beds		*0.73*	*5*	*5*	*5*	*5*

PREDICTED RESOURCE REQUIREMENTS FOR AGES 12 - 17

Persons Age 12-17 Population	MH-CCP 23-Aug-10 100,000		2006 547,991	2011 556,740	2016 559,833	2021 587,153
CLINICAL STAFF (FTE)	**176.31**		**966**	**982**	**987**	**1,035**
Check	-		-	-	-	-
NON -INPATIENT CLINICAL STAFF	**130.25**		**714**	**725**	**729**	**765**
Ambulatory Care only (+/- HBOS)	**104.73**		**574**	**583**	**586**	**615**
Prevention and promotion		12.28	67	68	69	72
Ambulatory MILD		6.62	36	37	37	39
Ambulatory MODERATE		11.22	62	62	63	66
Ambulatory SEVERE (except as below)		74.60	409	415	418	438
Ambulatory Care around Inpatient episodes	**25.52**		**140**	**142**	**143**	**150**
C/L to ED attenders (including non-admitted PECC)		1.16	6	6	7	7
C/L to Patients in general beds		7.12	39	40	40	42
EIP (12-17) Acute		3.50	19	19	20	21
Other Acute		9.70	53	54	54	57
EIP (12-17) HILS		2.15	12	12	12	13
Other Non- Acute		1.90	10	11	11	11
Ambulatory Support for Program Places	**0.00**		**-**	**-**	**-**	**-**
	-		-	-	-	-
INPATIENT CLINICAL STAFF	**46.06**		**252**	**256**	**258**	**270**
EIP (12-17) Acute		7.17	39	40	40	42
Other Acute		16.71	92	93	94	98
EIP (12-17) HILS		11.75	64	65	66	69
Other Non-Acute		10.42	57	58	58	61
PLACE-BASED CLINICAL STAFF	**0.00**		**-**	**-**	**-**	**-**
	-		-	-	-	-
BEDS & PROGRAM PLACES	**27.57**		**151**	**154**	**154**	**162**
HOSPITAL BEDS	**27.57**		**151**	**154**	**154**	**162**
Acute IP Beds	**14.41**		**79**	**80**	**81**	**85**
EIP (12-17) (use of Acute beds)		5.02	28	28	28	29
Other Acute (remainder of Acute beds)		9.39	51	52	53	55
All other Acute		-	-	-	-	-
Non-Acute IP Beds	**13.16**		**72**	**73**	**74**	**77**
EIP (12-17) (use of HILS beds)		6.98	38	39	39	41
Other Non-Acute (remainder of HILS beds)		6.19	34	34	35	36
PROGRAM PLACES	**0.00**		**-**	**-**	**-**	**-**
	-		-	-	-	-
Non-MH Resources			**-**	**-**	**-**	**-**
Special School Places		-	-	-	-	-
Private Hospital Beds		*0.96*	*5*	*5*	*5*	*6*
General Hospital Beds		*6.63*	*36*	*37*	*37*	*39*

SUMMARY RESOURCE REQUIREMENTS FOR AGES 0 - 17

Persons Age 0-17 (Rates are calculated on 2006 numbers only) Population	MH-CCP 23-Aug-10 100,000	2006 1,607,803	2011 1,661,374	2016 1,725,395	2021 1,807,230
CLINICAL STAFF (FTE)	**103.39**	**1,662**	**1,708**	**1,753**	**1,837**
Check	103.39	-	-	-	-
NON -INPATIENT CLINICAL STAFF	**85.94**	**1,382**	**1,423**	**1,465**	**1,535**
Ambulatory Care only (+/- HBOS)	**75.83**	**1,219**	**1,258**	**1,298**	**1,359**
Prevention and promotion	12.45	200	207	215	225
Ambulatory MILD	6.83	110	114	118	124
Ambulatory MODERATE	9.62	155	159	165	173
Ambulatory SEVERE (except as below)	46.94	755	778	800	838
Ambulatory Care around Inpatient episodes	**10.07**	**162**	**165**	**167**	**175**
C/L to ED attenders (including non-admitted PECC)	0.45	7	7	8	8
C/L to Patients in general beds	2.89	46	48	48	50
Patients in MH Beds	6.73	108	110	111	117
Ambulatory Support for Program Places	**0.04**	**1**	**1**	**1**	**1**
	0.04	0.65	1	1	1
INPATIENT CLINICAL STAFF	**16.64**	**267**	**272**	**274**	**287**
Acute	9.08	146	148	150	157
Non-Acute	7.56	122	123	124	130
PLACE-BASED CLINICAL STAFF	**0.82**	**13**	**13**	**14**	**15**
Various age-specific	0.82	13	13	14	15
BEDS & PROGRAM PLACES	**10.62**	**172**	**175**	**177**	**185**
HOSPITAL BEDS	**9.81**	**158**	**161**	**163**	**171**
Acute IP Beds	**5.33**	**86**	**88**	**89**	**93**
EIP (12-17) (use of Acute beds)	1.19	19	19	20	21
Other Acute (remainder of Acute beds)	4.13	66	68	69	72
Non-Acute IP Beds	**4.49**	**72**	**73**	**74**	**77**
EIP (12-17) (use of HILS beds)	2.38	38	39	39	41
Other Non-Acute (remainder of HILS beds)	2.11	34	34	35	36
PROGRAM PLACES	**0.81**	**13**	**13**	**14**	**15**
Various age-specific	0.81	13	13	14	15
Non-MH Resources	*0.00*	-	-	-	-
		-	-	-	-
Special School Places	*0.82*	*13*	*14*	*14*	*15*
Private Hospital Beds	*0.35*	*6*	*6*	*6*	*6*
General Hospital Beds	*2.76*	*44*	*51*	*52*	*54*

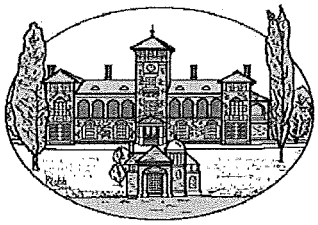
PREDICTED RESOURCE REQUIREMENTS FOR AGES 18 – 64

Persons Age 18-64 Population	MH-CCP 23-Aug-10 100,000		2006 4,287,672	2011 4,503,295	2016 4,658,946	2021 4,801,318
CLINICAL STAFF (FTE)	**172.57**		**7,399**	**7,772**	**8,040**	**8,286**
Check	-		-	-	-	-
NON -INPATIENT CLINICAL STAFF	**80.90**		**3,469**	**3,643**	**3,769**	**3,884**
Ambulatory Care only (+/- HBOS)	54.69		2,345	2,463	2,548	2,626
Prevention and promotion		5.04	216	227	235	242
Ambulatory MILD		5.80	249	261	270	279
Ambulatory MODERATE		16.76	719	755	781	805
Ambulatory SEVERE (except as below)		27.09	1,161	1,220	1,262	1,301
Ambulatory Care around Inpatient episodes	23.83		1,022	1,073	1,110	1,144
C/L to ED attenders (including non-admitted PECC)		1.70	73	77	79	82
C/L to Patients in general beds		1.81	78	82	84	87
EIP (18-24)		1.65	71	74	77	79
Other Acute		17.87	766	805	832	858
Non- Acute		0.75	32	34	35	36
VLS (Partnership time only)		0.05	2	2	2	2
Ambulatory Support for Program Places	2.37		102	107	111	114
SCL-Low (1.5 - 2.5 hrs/wk)		0.66	28	30	31	32
HBOS (Nil specific - HBOS applies to any clinical package)		-	-	-	-	-
L-HASI and eq SLC		0.66	28	30	31	32
SLC-High (8 - 12 hrs/wk)		1.40	60	63	65	67
M-HASI and eq SLC		0.19	8	9	9	9
H-HASI and eq SLC		1.21	52	54	56	58
SLC-Very High (16 - 35 hrs/wk)		0.31	13	14	14	15
V-HASI and eq SLC		0.29	12	13	14	14
X-HASI and eq SLC (Partnership time only)		0.02	1	1	1	1
INPATIENT CLINICAL STAFF	**88.80**		**3,808**	**3,999**	**4,137**	**4,264**
Acute IP Clinical Staff	57.57		2,469	2,593	2,682	2,764
EIP (18-24)		7.78	333	350	362	373
PND		0.73	31	33	34	35
Acute (90%)		43.30	1,856	1,950	2,017	2,079
Acute - Intensive (10%)		5.77	248	260	269	277
All other Acute		-	-	-	-	-
Non-Acute IP Clinical Staff	9.62		412	433	448	462
Very Long Stay (VLS) Clinical staff	21.61		927	973	1,007	1,038
VLS IP Beds-Rehabilitation		9.82	421	442	458	472
VLS IP Beds-Extended Care		11.79	505	531	549	566
PLACE-BASED CLINICAL STAFF	**2.88**		**123**	**129**	**134**	**138**
X-HASI and eq SLC		2.88	123	129	134	138
BEDS & PROGRAM PLACES	**436.30**		**18,707**	**19,648**	**20,327**	**20,948**
HOSPITAL BEDS	**49.72**		**2,132**	**2,239**	**2,317**	**2,387**
Acute IP Beds	30.94		1,326	1,393	1,441	1,485
EIP (18-24)		4.25	182	191	198	204
PND		0.40	17	18	19	19
Acute (90%)		23.66	1,014	1,065	1,102	1,136
Acute - Intensive (10%)		2.63	113	118	122	126
All other Acute		-	-	-	-	-
Non-Acute IP Beds	5.37		230	242	250	258
Very Long Stay (VLS)	13.42		575	604	625	644
VLS IP Beds-Rehabilitation		5.37	230	242	250	258
VLS IP Beds-Extended Care		8.05	345	363	375	387
PROGRAM PLACES	**386.58**		**16,575**	**17,409**	**18,011**	**18,561**
SLC-Low (1.5 - 2.5 hrs/wk)	358.75		15,382	16,155	16,714	17,225
HBOS		328.27	14,075	14,783	15,294	15,761
L-HASI and eq SLC		30.48	1,307	1,373	1,420	1,463
SLC-High (8 - 12 hrs/wk)	20.33		872	915	947	976
M-HASI and eq SLC		4.88	209	220	227	234
H-HASI and eq SLC		15.45	662	696	720	742
SLC-Very High (16 - 35 hrs/wk)	7.51		322	338	350	360
V-HASI and eq SLC		2.50	107	112	116	120
X-HASI and eq SLC		5.01	215	226	233	241
Non-MH Resources			-	-	-	-
Nursing Home Beds		*0.00*	-	-	-	-
Private Hospital Beds		*3.25*	*139*	*146*	*152*	*156*
General Hospital Beds		*4.31*	*185*	*194*	*201*	*207*

PREDICTED RESOURCE REQUIREMENTS FOR AGES 65+

Persons Age 65+ Population	MH-CCP 23-Aug-10 100,000	2006 920,612	2011 1,042,973	2016 1,219,160	2021 1,399,751
CLINICAL STAFF (FTE)	**220.33**	**2,028**	**2,298**	**2,686**	**3,084**
Check	-	-	-	-	-
NON -INPATIENT CLINICAL STAFF	**63.08**	**581**	**658**	**769**	**883**
Ambulatory Care only (+/- Age care packages)	**29.66**	**273**	**309**	**362**	**415**
Prevention and promotion	2.00	18	21	24	28
Ambulatory MILD	4.40	41	46	54	62
Ambulatory MODERATE	18.02	166	188	220	252
Ambulatory SEVERE (except as below)	5.24	48	55	64	73
Ambulatory Care around Inpatient episodes	**16.54**	**152**	**173**	**202**	**232**
C/L to ED attenders (including non-admitted PECC)	3.11	29	32	38	44
C/L to Patients in general beds	2.55	23	27	31	36
Acute in general adult unit	4.21	39	44	51	59
Acute in SMHSOP unit	5.15	47	54	63	72
Non-Acute (MI)	0.39	4	4	5	5
TBASIS (BPSD)	1.13	10	12	14	16
VLS	-	-	-	-	-
Ambulatory Support for Program Places	**1.56**	**14**	**16**	**19**	**22**
SLC-Low (1.5 - 2.5 hrs/wk)	-	-	-	-	-
HBOS (Nil specific - HBOS applies to any clinical package)	-	-	-	-	-
L-HASI and eq SLC	-	-	-	-	-
SLC-High (8 - 12 hrs/wk)	-	-	-	-	-
M-HASI and eq SLC	-	-	-	-	-
H-HASI and eq SLC	-	-	-	-	-
SLC-Very High (16 - 35 hrs/wk)	1.56	14	16	19	22
OP-HASI (eq V-HASI)and eq SLC	1.56	14	16	19	22
X-HASI and eq SLC	-	-	-	-	-
RACF stays	**15.32**	**141**	**160**	**187**	**214**
C/L to residents with primary MI in RACFs (MI only)	6.87	63	72	84	96
MH-RACF partnership (MI and BPSD)	8.45	78	88	103	118
INPATIENT CLINICAL STAFF	**95.55**	**880**	**997**	**1,165**	**1,337**
Acute IP Clinical Staff	**55.45**	**510**	**578**	**676**	**776**
Acute in general adult unit	17.87	165	186	218	250
Acute in SMHSOP unit	37.57	346	392	458	526
Non-Acute IP Clinical Staff	**22.42**	**206**	**234**	**273**	**314**
Non-Acute (MI)	4.60	42	48	56	64
TBASIS (BPSD)	17.82	164	186	217	249
Very Long Stay (VLS) Clinical staff	**17.69**	**163**	**184**	**216**	**248**
PLACE-BASED CLINICAL STAFF	**61.70**	**568**	**644**	**752**	**864**
RACF Partnerships	**61.70**	**568**	**644**	**752**	**864**
MH-RACF partnership (MI and BPSD)	61.70	568	644	752	864
X-HASI and eq SLC (DoH operated CR24 units)	-	-	-	-	-
BEDS & PROGRAM PLACES	**281.33**	**2,590**	**2,934**	**3,430**	**3,938**
HOSPITAL BEDS	**56.68**	**522**	**591**	**691**	**793**
Acute IP Beds	**29.29**	**270**	**305**	**357**	**410**
Acute in general adult unit	7.49	69	78	91	105
Acute in general adult unit - Intensive (10% in MI, 30% in BPSD)	1.90	17	20	23	27
Acute in SMHSOP unit	16.74	154	175	204	234
Acute in SMHSOP unit - Intensive (10% in MI, 30% in BPSD)	3.16	29	33	39	44
Non-Acute IP Beds	**15.31**	**141**	**160**	**187**	**214**
Non-Acute (MI)	3.14	29	33	38	44
TBASIS (BPSD)	12.17	112	127	148	170
Very Long Stay (VLS)	**12.08**	**111**	**126**	**147**	**169**
PROGRAM PLACES (Supported Living in the Communi	**224.65**	**2,068**	**2,343**	**2,739**	**3,144**
SLC-Low (1.5 - 2.5 hrs/wk)	-	-	-	-	-
HBOS	-	-	-	-	-
L-HASI and eq SLC	-	-	-	-	-
SLC-High (8 - 12 hrs/wk)	-	-	-	-	-
M-HASI and eq SLC	-	-	-	-	-
H-HASI and eq SLC	-	-	-	-	-
SLC-Very High (16 - 35 hrs/wk)	**18.98**	**175**	**198**	**231**	**266**
OP-HASI (eq V-HASI) and eq SLC	18.98	175	198	231	266
RACF Partnerships	**205.67**	**1,893**	**2,145**	**2,507**	**2,879**
MH-RACF partnership (MI and BPSD)	205.67	1,893	2,145	2,507	2,879
Non-MH Resources		-	-	-	-
Residents with primary MI in RACFs (MI C/L only)	*975.00*	*8,976*	*10,169*	*11,887*	*13,648*
Private Hospital beds (MI only)	*4.29*	*40*	*45*	*52*	*60*

Health
Sydney
Local Health District



Rivendell Child Adolescent &Mental Health Service
Thomas Walker Hospital
Hospital Road
Concord West, NSW 2138

Rivendell Unit
Model of Service

1. *What does the service* intend to achieve?

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

The Rivendell Unit is a State-wide tertiary referral service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to young people between 12 and 18 years of age with persistent mental illness/es that lead to significant impairment. A history of school non-attendance or school dysfunction is a feature common to most young people attending the program. Many also experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

The Rivendell Unit is part of the State-wide CAMHS continuum of care that includes centre based and mobile community based treatment teams, residential and day programs, acute adolescent mental health inpatient units, a longer stay high severity unit, a young person's forensic unit and a rehabilitation and sub-acute unit. The Rivendell Unit also interfaces with other mental health providers including general adult psychiatric services, specialized early psychosis teams, youth mental health services, private practitioners, and Headspace. In most circumstances admission to the Rivendell Unit is a step up from less intensive community treatment, while for a minority it is a step down from more intensive treatment in an acute inpatient setting.

Treatment undertaken by the Rivendell Unit will include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery of the young person. The program will follow structured phases incorporating assessment, establishing a therapeutic alliance and developing realistic therapeutic goals, treatment and rehabilitation, and transfer of care planning to facilitate reintegration back to community based treatment. Education programs provided by the Rivendell School (an integral part of the Rivendell Unit) provide essential components of rehabilitation and restoration of developmental tasks.

The key functions of the Rivendell Unit are to:

- plan an admission to accommodate the individual characteristics of the young person;
- ensure a level of admission consistent with least restrictive care and capacity to access the service. Level of admission will range from day admission to partial hospitalisation (four nights per week);
- build upon existing comprehensive assessment of the young person (obtaining a thorough treatment history from service providers and carers);

- provide flexible and targeted programmes that can be delivered in a range of contexts associated with the Rivendell Unit including individual, the designated school, community, group and family;
- provide individually tailored, targeted, phased, evidence based treatment interventions to alleviate or treat symptoms that will ultimately assist recovery and restoration of educational and social functioning;
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness;
- provide intensive support to enable successful transition to an educational or vocational pathway;
- provide intensive intervention to address family issues that may be impeding recovery;
- provide assertive transfer of care planning to integrate the young person back into their family, educational pathway, community and appropriate local treatment services.

The principles underlying these functions of the Rivendell Unit are to:

- provide care in the least restrictive environment appropriate to the young person's development stage;
- develop treatment and rehabilitation programs in partnership with young people and their parents or carers;
- provide treatment and rehabilitation within an appropriate timeframe (when the admission exceeds 6 months the young person's ongoing treatment must be negotiated with the referring team to ascertain the potential clinical gains and risks of continued treatment;
- provide varying levels of care on the basis of acuity of behaviours associated with mental illness with consideration for the safety of self and others and after consideration of the young person's capacity to undertake daily self care activities;
- assist with establishment of care systems for transition to community treatment.

2. Who is the service for?

The Rivendell Unit is available for NSW and ACT young people:

- who are aged 12 – 18 years;
- who are 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 child and adolescent psychiatrists, CAMHS community clinics, private mental health clinicians, acute inpatient child and adolescent mental health services and Headspace;
- who will benefit from a range of clinical interventions;
- who have the capacity to manage voluntary treatment.

The Lawson Program treats young people with severe and complex mental illness with primary diagnoses of depressive disorders, anxiety disorder (separation anxiety, generalised anxiety disorder, social anxiety disorder) and obsessive compulsive disorder. They typically have been unable to attend school for a prolonged period despite active community interventions.

The Yaralla Program treats young people with severe and complex mental illness with primary diagnoses of psychotic disorders, bipolar affective disorder and the comorbidities of autistic spectrum disorders. They typically have been unable to attend school for a prolonged period despite active community interventions.

Exclusion criteria for Rivendell admission include:

- homelessness (a client in a stable out of home care placement is not excluded from Rivendell);
- risk of suicide and /or self-injury greater than can be managed safely at Rivendell (this requires consideration of acute ward referral);
- excessive risk to others, whether through violence, sexual offending, fire-setting or drug dealing;
- primary diagnosis of oppositional defiant disorder or conduct disorder (admission confers no benefit to outcome over outpatient therapy);
- primary diagnosis of eating disorder (re-feeding requires management in a supervised medical setting);
- client/family/guardian unwilling or unable to provide consent.

The Rivendell Unit is not a declared mental health facility as defined by Section 109 of the NSW Mental Health Act, 2007. As such all young persons are voluntary with the exception of those who might attend as part of the conditions of a Community Treatment Order (in accordance with Secion 51 of the NSW Mental Health Act, 2007).

3. What does the service do?

The key components of the Rivendell Unit are defined here. These components are essential for the effective operation of the Rivendell Unit. Treatments provided by the Rivendell Unit will be based on evidence based practices tailored to meet the individual's mental health needs.

Given below are key components and elements our service.

Key Components	Key Elements	Comments
3.1.0 **Working with other service providers**	3.1.1 The Rivendell Unit will develop and maintain strong partner-ships with other components of the CAMHS network.	At an organisational level, this includes participation in the State-wide Child & Adolescent Mental Health Subcommittee.
	3.1.2 Shared-care with the referrer will be maintained	In the provision of service this includes processes for regular communication with referrers in all phases of care of the young person in the Rivendell Unit.
	3.1.3 The Rivendell Unit will develop and maintain partnerships with other relevant health and non-health services that interact with young people with severe and complex mental illness.	This includes formal agreements with Concord Hospital to provide emergency medical services, and CAMHS and adult acute mental health facilities to provide services should a Rivendell patient require more restrictive care. Dietetic services to liaise with and advise on the manage-ment of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc.

		This includes but is not limited to Family and Community Services, Disability and Aged Services, Housing, Education and Police. Non-government agencies such as Burnside, Life Without Barriers, Families First, NGO Specialised Schools, Rosemount Youth Service, WAYS.
	3.1.4 Rivendell Unit staff will comply with NSW Health policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect.	Mandatory child protection reporting of a reasonable suspicion of significant child abuse and neglect.
	3.1.5 When young people have specific needs (e.g.sensory impairment, transcultural) to ensure effective communication, Rivendell Unit will engage the assistance of appropriate services.	Certain population groups require specific consideration and collaborative support. This includes people from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people.
	3.1.6 Provision of appropriate educational services.	The Rivendell Unit School is a dedicated facility provided by the Department of Education and Training. It is regarded as an integral part of the Rivendell Unit.
Key Components	Key Elements	Comments
3.2.0 **Referral, access and triage**	3.2.1 State-wide referrals from treating mental health professionals are accepted for planned admissions.	
	3.2.2. All referrals are made to a rostered intake worker. All non-accepted referrals are reviewed at a weekly allocation meeting	A single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness.
Key Components	Key Elements	Comments
3. 3.0 **Initial Assessment**	3.3.1 Assessments will be prompt and timely	This assessment enables further determination of the

		potential for therapeutic benefit from the admission, the impact on or of being with other young people and some assessment of acuity.
	3.3.2 The young person and their family are assessed at Rivendell by two clinicians. Consideration can be given for video conference in unusual circumstances	The formulation is reviewed and refined at weekly case review meetings.
	3.3.3 The assessment is to determine diagnosis, formulation, treatment targets and modalities, stage of readiness for change and the capacity to work with the Rivendell programme. This includes assessment of risk in the Rivendell environment. A comprehensive clinical formulation is developed from the assessment, which is refined and updated secondary to ongoing assessment process.	Assessment begins with the referral and continues throughout the admission.
	3.3.4 **Mental Health Assessment**: The Rivendell Unit will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of mental illness.	This process begins with the referral and continues throughout the admission.
	3.3.5 **Family/Carers Assessment**: The Rivendell Unit will obtain detailed history of family structure and dynamic, or history of care if the young person is in care.	This process begins with available information on referral and during the admission.
	3.3.6 **Development Assessment**: The Rivendell Unit will obtain a comprehensive understanding of developmental disorders and their current impact.	

	3.3.7 **Educational Assessment**: Educational assessments are an essential component of assessment.	The Rivendell School will assess schools attended, previous educational attainments, current educational strengths and difficulties. These will be integrated into the formulation.
	3.3.8 **Functional Assessment**: The Rivendell Unit will obtain assessments on an young person's function in tasks appropriate to their stage of development.	This assessment commences with the initial assessment and continues throughout the admission.
	3.3.9 **Alcohol and Other Drug Assessment**: Assessments of alcohol and drug use will be conducted with the young person on admission and routinely throughout ongoing contact with the service.	Evidence-based treatment interventions may be incorporated in their care plan.
	3.3.10 **Physical Health Assessment**: Physical health status will be assessed at initial assessment.	Appropriate physical investigations should be performed as necessary.
	Physical examination will occur within 24 hours of admission.	Documented evidence of the physical health assessment will be included in the young person's clinical record.
	Physical health will be routinely assessed and monitored throughout the admission.	Outcomes of physical health assessments will be incorporated in recovery planning.
	Additional resources, education and training to improve the physical health management of young people with mental illness is available.	All efforts will be made to ensure 100% of young people have a nominated GP. Potential physical health problems will be identified and discussed with the GP and/or other primary health care provider. Metabolic health will be systematically monitored in any patient prescribed antipsychotic or mood stabilizing medication.

Key Components	Key Elements	Comments
3.4.0 **Admission Decision**	3.4.1 The decision to offer admission is made at the multi-disciplinary Admissions Meeting. The immediate management plan (ie need for further information and planning for the admission, which usually includes DET) is made.	This promotes reflection on likely success of treatment, risk management and therapeutic planning with input from senior clinicians. In making a decision to admit to the Unit, the Admissions Team will consider the: (i)Adequacy and availability of community treatment based on a thorough treatment history from service providers and carers with a view to assessing the likelihood of therapeutic gains by attending the Rivendell Unit and the likelihood of the young person to experience a positive therapeutic outcome. (ii)Potential for treatment at Rivendell Unit to assist with developmental progression (iii)Potential adverse impacts on the young person of being admitted to the unit (e.g. isolation from existing supports and/or cultural connection). (iii)Potential adverse impacts posed by the young person to other inpatients and staff. (e.g. the risks posed by aggression to self and others, inappropriate sexualised behaviour, substance misuse). (iv)Other possible safety issues.
	3.4.2 The Inpatient Director adds the young person's name to the Inpatient List on the 'G' drive.	
	3.4.3 Responsibility for the clinical care of the young person remains with the referring service until the young person is admitted to the Rivendell	This process monitors changes in acuity and the need for admission to help determine priorities for admissions. The assessing clinicians can

	Unit . If there is a waiting period prior to admission, the assessing clinicians will liaise with the referrer until the adolescent is admitted. 3.4.4. Priorities for admission are determined on the basis of educational stage. Year 12 students, for whom school non-attendance would be most detrimental to educational progress, are given highest priority. 3.4.5. Rural referrals – young people from rural and regional NSW are offered residential treatment. In considering the adequacy of outpatient treatment prior to admission, the team will recognise that some rural areas have limited resources. Young people from metropolitan Sydney may be offered residential day or a combination of residential and day treatment. 3.4.6 Youth and their families are given the Rivendell Admission Information Booklet, which includes written information on the programs, expectations and rules	also advise the referrer regarding the management of young people with severe and complex mental illness. Information regarding local accommodation options will be available for families. Information regarding subsidised travel for rural families may be sought through the Rivendell SSP School.
Key Components	Key Elements	Comments
3.5.0 **Pre- Admission Meeting**	3.5.1 A pre-admission meeting will be organised when an inpatient place becomes available. 3.5.2 The preadmission meeting is	The pre-admission meeting enables the young person and the family to meet some staff and negotiate their expectations of admission.

	used to negotiate the: • goals of admission • rights and responsibilities • informed written consent for admission • risk assessment and risk management plan • proposed length of stay and proposed transfer of care plan • young person's and family's understanding of mini-team member roles and contact details • day or residential or combination of both	
Key Components	Key Elements	Comments
3.6.0 **Risk Assessments**	3.6.1 A key function of the intake and assessment process will be to assess risk prior to admission. 3.6.2 Risk assessments will be initially conducted on admission and a risk management plan will be formulated. Ongoing risk assessments will occur and the management plan will be reviewed according to need.	All risk assessments will be recorded in the patient charts Risk assessment will be in accordance with the risk assessment contained in the State-wide standardised clinical documentation. The outcome of assessments will be promptly communicated to the young person, the parent or guardian and other stakeholders (if the young person consents). Documentation of all past history of deliberate self harm will be included in assessment of current risk. Will include a formalised suicide risk assessment. The frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed, with a minimum of weekly reviews to occur.
Key Components	Key Elements	Comments
3.7.0 **Care Plan**	3.7.1 An Initial Care Plan is	During admission, young

	developed in consultation with the young person and their family/carers on admission.	people have access to a range of least restrictive, therapeutic interventions determined by evidence based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the young person's progress towards recovery is made in collaboration with the treating team, young person, the referrer, the family and other relevant agencies. Where conflicting goals exist they will be clearly outlined and addressed in a way that is most consistent with the young person's own goals and values
Key Components	Key Elements	Comments
3.8.0 **Clinical Interventions**	3.8.1. Clinical interventions will be individualised according to the young person's treatment needs. All interventions must demonstrate attention to developmental frameworks and will be evidence based.	Therapists will receive recognised, specific training in the mode of therapy identified. The therapy is modified according to the capacity of the young person to utilise the therapy, developmental considerations and stage of change in the illness. The therapist will have access to regular supervision.
Key Components	Key Elements	Comments
3.9.0 **Psycho therapeutic Interventions**	3.9.1 Psychotherapeutic interventions may include : • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy). • individual non-verbal therapeutic interventions within established therapeutic framework (e.g. art, music therapies etc.) • individual supportive verbal	Specific therapies may use integrations from a range of psychological frameworks. i.e supportive therapies will be integrated into the overall therapeutic approaches to the young person. Staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision Throughout the day and in the

	or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy). • psychotherapeutic group interventions (e.g. Mindfulness Based Cognitive Therapy, CBT, DBT).	evenings, the nurses will use real-time opportunities to help the young person practice skills learned in individual therapy
Key Components	Key Elements	Comments
3.10.0 **Behavioural Interventions**	3.10.1 Behavioural interventions are utilised to enhance adaptive behaviours and reduce unhelpful behaviours and may include: • behavioural activation; • activity scheduling; • relocation; • systematic desensitisation; • positive reinforcement; • pleasant event scheduling; • logical consequences; • distress tolerance activities; • use of level system; • use of sensory room. These maybe implemented individually and/or in groups. 3.10.2 Patients who engage in self-harm while on or off the unit not requiring acute medical care will typically be placed on reflection leave for 24 to 48 hours. On return the incident will be reviewed with the young person and carer and treating team Strategies for harmful	Behavioural programs are constructed under appropriate supervision. Evidence for effectiveness of intervention will be monitored. Effectiveness of behavioural program at individual and program level will be reviewed. Group based interventions are individualised according to adolescents in the group with common issues and may include adventure based and community based activities All staff should be familiar with specific policy and practice guidelines related to the management of acute behavioural disturbance within the Rivendell Unit. Temporary separation from the program reduces the likelihood of contagion amongst other patients. A specific management plan will address the young person's distress and any associated behavioural disturbance. The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every adolescent whose risk assessment identifies actual or potential

	behaviours to others include: • verbal de-escalation • use of outside environment where safe. • increased visual observation; • de-escalation techniques • development of a management plan targeting the specific behaviour/symptom • use of medication to relieve agitation/aggression	aggression as an issue. The plan will list preventative strategies and de-escalation strategies.
Key Components	Key Elements	Comments
3.11.0 **Psycho-education Interventions**	3.11.1 Psycho-education includes specific or general psycho-education on mental illness and normal development in young people.	Available to young people and their parents/carers. This includes the sexual safety group and the protective behaviours group.
Key Components	Key Elements	Comments
3.12.0 **Family & Carer Interventions**	Family and carer interventions are offered to support the family/carer while the young person is in the Rivendell Unit. Family interventions are integrated with other therapeutic approaches. Specific family therapy interventions can take the form of supportive family therapy specific parenting programs (Tuning into Teens) and Parent Support Group.	This will include family meetings occurring at a frequency of no less than once per fortnight throughout the admission and allows for: - psycho education for parents/carers - monitoring of mental health of parents/carers and supporting access to appropriate mental health care as needed - monitoring the risk of abuse or neglect, and fulfilling statutory obligations if child protection concerns are identified - promoting qualities of care which enable reflection of qualities of home Evidence for effectiveness of the intervention and interactions with staff will be reviewed. Therapists will have recognised training in family

		therapy and access to continuing supervision.
Key Components	Key Elements	Comments
3.13.0 **Interventions to Facilitate Tasks of Young Person Development**	3.13.1 Interventions are provided to promote appropriate development in a safe and validating environment. 3.13.2 Individualised educational programs will be developed	Individual based interventions are provided to promote development in young people. Group based interventions recognise the developmental stage of the participants. Interventions are provided under the clinical direction of a nominated clinician and have defined goals. The Rivendell School will develop individual educational goals with the young person taking into account academic capacities and mental state. Curriculum will be provided by external education providers including the young person's current school curriculum. The school program is determined by the School Principal after continuing consultations with clinicians. The Rivendell School will contribute to life skills programs to prepare the young person for work skills or transition to the community.
Key Components	Key Elements	Comments
3.14.0 **Pharmacological Interventions**	3.14.1 Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision making between the treating team and the adolescent and their family/carers. Administration of medications will occur under the direction of a consultant psychiatrist.	Across all treatment settings all prescriptions, dispensing and administration of medicines will comply with NSW Health policies, guidelines and standards. Education is given to the young person and parent(s)/carer about medication, potential benefits and potential adverse effects.

		The medication management will be informed wherever possible by evidence based medication guidelines. Where needed, strategies focussed on medication adherence will be in place. Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment.
Key Components	Key Elements	Comments
3.15.0 **Other Interventions**	3.15.1 Sensory modulation is an approach aimed at teaching clients to learn to use their sensory systems to modulate their responses, in order to improve participation in meaningful life activities. 3.15.2 Electroconvulsive therapy (ECT) will be available where indicated and will be provided according to NSW Health guidelines. This will be administered at the ECT suite, Concord Centre for Mental Health, by a suitably credentialed clinician.	ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2007*
Key Components	Key Elements	Comments
3.16.0 **Physical Health Interventions**	Sports psychology will be available for young people. Fitness regimes will be guided by sports psychologist and implemented by nursing staff. Healthy eating will be promoted by availablilty of health food options. Afternoon physical activity groups will be held. Dietitian consultation will be available	Dietitian attends the Unit weekly for individual consultation and treatment planning.

Key Components	Key Elements	Comments
3.17.0 **Care Coordination**	3.17.1 Prior to admission, each young person is assigned a clinical care team, comprising a consultant psychiatrist, as case manager, a primary nurse and a teacher.	The Case Manager can be a member of the Rivendell Unit treating team and is appointed by the Rivendell Unit Inpatient Director
	3.17.2 The Team will be responsible for:	
	• providing centre orientation to the young person and their parent(s)/carer(s)	• An orientation information pack will be available to young people and their parent(s)/carer(s).
	• monitoring the adolescent's mental state and level of function in developmental tasks	• The frequency of monitoring will depend on the levels of acuity.
	• assisting the adolescent to identify and implement goals for their care plan	• Adolescents at high risk and require higher levels of observations will be reviewed daily
	• acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process	• Monitoring will integrate information from individual and group interventions and observations. This includes weekly reviews by the consultant psychiatrist
	• assisting the adolescent in implementing strategies from individual and group interventions in daily living providing a detailed report of the adolescent's progress at the weekly team meeting	
Key Components	Key Elements	Comments
13.18.0 **Clinical Review**	3.18.1 Continual monitoring of the young person's progress towards their recovery plan goals will occur through a process of structured clinical reviews involving the Rivendell Unit multi-disciplinary team (including the Rivendell School) and relevant external	• Weekly clinical reviews are documented on Care Review Forms. • Care Plans are formally reviewed and updated at intervals ideally of two weekly, but not more than monthly.

	community agencies.	• There will be an established agenda for discussion of cases, with concise documentation of the content of the discussion and the ongoing plan of care recorded on the Care Plan • Outcome measures and the young person's progress will be reviewed in accordance with State-wide policy concerning standardized mental health outcome measures. • The summation should include attendees, clinical issues raised, treatment care plan, requirements for additional collateral and responsible for actions.
	3.18.2 Weekly Team Meeting: A weekly team meeting will be held to integrate information from and about the young person, interventions that have occurred, and to review progress within the context of the case plan.	• All members of the clinical team and a representative of the Rivendell School who provide interventions for the adolescent will have input into the case review. • A consultant psychiatrist will chair the case review meeting and take responsibility for ensuring that assessments and management plans are adequate, and for decisions taken during formal case reviews. Audits will ensure that reviews are being conducted.
	3.18.3 Ad hoc case review meetings (mini team 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, or may be required to address complex clinical issues and following a critical event.

Key Components	Key Elements	Comments
3.19.0 **Collection of data, record keeping and documentation**	3.19.1 Rivendell Unit staff will enter and review all required information into CERNER in accordance with approved State-wide and district business rules.	
	3.19.2 All clinical record keeping will comply with legislative and local policy requirements	• progress notes will be consecutive within the clinical record according to date • personal and demographic details of the young person, their parent/carer(s) and other health service providers will be up 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 • all contacts, clinical processes and care planning, educational progress, and case review, will be documented in the young person's clinical record • there will be a single clinical record for each young person which will align with any electronic record.
	3.19.2 Rivendell Unit utilise the range of routine outcome measures mandated through the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ).	• Routine outcomes data is utilised at all formal case reviews • Results of routine outcomes data will be discussed with adolescents and their family/carers to consider and monitor changes in symptoms and functioning • Outcomes data is used in developing and reviewing recovery plans.
Key Components	Key Elements	Comments
3.20.0 **Discharge Planning**	3.20.1 Planning for discharge from Rivendell Unit should commence when the	Discharge planning should address potential significant obstacles e.g. accommodation, engagement with another

	assessment phase has been completed. This should involve key stakeholders including the young person, parents and carers.	mental health service. The decision to discharge is at the discretion of the consultant psychiatrist in consultation with the multidisciplinary team.
	3.20.2 Discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• Discharge planning will occur in close collaboration with the young person and their family • Discharge planning will consider the young person's potential for optimal functioning and determine the level of care required to support that functioning as an inpatient, partial inpatient, day admission or in the community. • Discharge planning recognises the needs at times that re-admission may be necessary where risk of relapse is high.
	3.20.3 Discharge planning will require the ascertainment that the potential accommodation is safe and appropriate. In most cases, this will be the family home, or established care arrangements. Where the family home is unsafe, unable to provide the necessary support or where care arrangements do not exist, safe supervised accommodation with adequate supports will be sought	• Where the family home or usual care arrangements are appropriate and supportive, every endeavour will be made to encourage the adolescent to return • The adolescent will be integral to all planning for accommodation on discharge • Parents providing a safe and supportive environment will always be involved in planning for accommodation on discharge. • Any decision to not return the young person to the home of origin will be made in collaboration with the young person and their parents/guardians if they are under the age of 18
	3.20.4 Discharge summaries need to be comprehensive and indicate diagnosis, treatment and Interventions provided, progress of care, recommendation for ongoing	• The Registrar, Case Coordinator and key clinicians will prepare this letter and the Consultant Psychiatrist is responsible

	care and procedures for re-referral. 3.20.5 Discharge summaries need to be comprehensive and indicate diagnosis, treatment and interventions provided, progress of care, recommendation for ongoing care and procedures for re-referral. 3.20.6 If events necessitate an unplanned discharge, the Rivendell Unit will ensure the young person's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments.	for ensuring that discharge summaries are sent to key health providers (e.g. GP) on the day of discharge. • Follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure discharge information was received. • Discharge summary should identify relapse patterns and risk assessment/ management information. This will be prepared by the clinicians involved in direct interventions.
Key Components	Key Elements	Comments
3.21.0. **Transfer/Transition of Care**	3.21.1 All appropriate community based support will be co-ordinated prior to discharge. The young person's community treating team will be identified in the clinical record and communication will be maintained during the transition period	• Guidelines for internal transfers will be clearly written, and receiving teams will make contact before transfer is concluded. A written and verbal handover will be provided with every transfer/discharge process. • During the transition phase there will be an appropriate plan to ensure smooth transition of care. This will support continuity of care for the young person and ensure the early engagement of all service providers in ongoing care.

	3.21.2 Depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit	The Rivendell School will be primarily responsible for and support school reintegration. Transfer procedures will be discussed with adolescents, their family and carers. Processes for admission into a young persons acute inpatient unit will be followed, with written and verbal handover provided
Key Components	Key Elements	Comments
3.22.0 **Continuity of Care**	3.22.1 Referrers and significant stake holders in the young person's life will be included in the development of Care Planning throughout the admission. Local CAMHS may remain as other service providers. 3.22.2 Responsibility for emergency contact will be clearly defined when a young person is on extended leave 3.22.3 Specifically defined joint therapeutic interventions between the Rivendell Unit and the referrer can be negotiated either when the young person is attending the Service or on periods of extended leave	Referrers and significant stake holders are invited to participate in the Case Review meetings The Case Coordinator will liaise more frequently with others as necessary Responsibility for emergency contact will be clearly defined when a young person is on extended leave Joint interventions can only occur if clear communication between the Rivendell Unit and external clinician can be established An example would include the referrer providing parent support while the young person is in the Rivendell Unit.

Key Components	Key Elements	Comments
3.23.0 **Team Approach**	3.23.1 A multidisciplinary team approach to care is provided.	• Young people and family/carers will be informed of the multidisciplinary approach to mental health care on admission to Rivendell Unit. The discipline specific skills of the multidisciplinary team will be utilised as appropriate in all aspects of service provision.
	3.23.2 Staff employed by the Department of Education and Training will be regarded as part of the team.	Department of Education and Training supports the Rivendell Unit in providing teaching and resource staff for the school.
Key Components	**Key elements**	**Comments**
3.24.0 Working with families, carers and friends	3.24.1 Adolescents and carers will contribute to continued practice improvement of the service.	• This will occur via: -consumer and carer participation in collaborative treatment planning - young person and carer feedback tools - young person and carer feedback will inform staff training and service development.
	3.24.2 We will work collaboratively with families and carers.	• Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. • The family/carer is identified in the young person's clinical record and where relevant, it is clearly identified that they understand the treatment plan and agree to support the provision of ongoing care to the young person in the Rivendell Unit. Young person/guardian consent to disclose information to and to involve the family/carers in the care will be sought in every case.

	3.24.3 Parents/carers will have their needs assessed as indicated or requested. If parent/carer mental health needs are identified the Rivendell Unit will attempt to meet these needs and if necessary refer to an adult mental health service. 3.24.4 Support services will be offered to families and carers. e.g. ARFMI, SANE, Inner West Support Services and Helpline.	• Identification of family/carers and their need is part of the assessment process and is included in care planning. • Adolescent consent is not required to offer family/carers education and support. • Support may be provided by a member of the Mental Health Service or another organisation.
Key Components	Key Elements	Comments
3.25.0 Peer Support Services	3.25.1 All young people will be offered information and assistance to access local peer support services e.g. Reach Out, Twenty 10, Black Dog.	Peer support services may be provided by internal or external services.

4. Related services

The Rivendell Unit is part of the CAMHS network of services in NSW and as such maintains strong operational and strategic links to other CAMHS services.

5. 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, case coordination will not be provided by students or staff appointed less than 0.4 FTE. Typically Case Coordinators are allied health or junior medical staff.

6. Workforce

Clinical staffing will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, clinical psychology, neuro-psychology, sports psychology, social work, other specialist CAMHS staff and access to a dietitian. While there is a typical staff establishment, this may be altered according to need.

Administrative support is essential for the efficient operation of the Rivendell Unit.

7. Team clinical governance

Clinical decision making and clinical accountability will be the ultimate responsibility of the Consultant Psychiatrist, who reports to the Inpatient Director, who reports in turn to the Director of Rivendell Child Adolescent and Family Mental Health Services. At a local level, the service is managed by a core team including the Nurse Unit Manager, Senior Allied Health Professionals, Consultant Psychiatrists, an Adolescent Advocate, and the School Principal. This team will meet regularly in management meetings chaired by the Director of Rivendell Child Adolescent and Family Mental Health Services.

The Rivendell Unit will be directly responsible to Corporate Governance of SLHD. The Management Committee reports to the Director who is a member of the cross-district Executive.

Performance management of non-nursing staff lies with senior discipline staff in collaboration with the Unit Director.

Nursing staff performance management is the responsibility of the NUM who is in turn performance managed by the Nurse Manager.

8. Hours of operation

The Rivendell Unit operates Monday – Friday during school terms.

An on-call consultant child and adolescent psychiatrist is available 24 hours, 7 days per week.

Access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff.
Routine assessments and interventions will be scheduled during business hours.

During holidays Rivendell hosts day and residential programs for a number of organisations including SLASA, STARTS, ALIV, SICRYS, COPMI. The operation of these programmes is not covered in the MOS document.

9. Staff training

Staff will be provided with continuing clinical education opportunities, mandatory training, clinical supervision, and other support mechanisms to ensure that they are clinically competent. All training and education will be based on best practice principles and evidence-based treatment guidelines, and will be underpinned by the NSW Health CAMHS workforce development strategy.

Education and training will include a focus on strategies and mechanisms to foster meaningful adolescent and carer participation across all levels of service delivery, implementation and evaluation.

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

- NSW Health mandatory training requirements (fire safety, aggressive behaviour management, cultural awareness and training etc.)
- Rivendell Unit orientation training
- CAMHS Key Skills training
- principles of the service (including models of recovery and rehabilitation and staff/young person interactions and boundaries etc.)
- risk assessment and management with special reference to suicide risk.
- knowledge of adolescent and family development and psychopathology
- developmentally appropriate assessment and treatment
- specific clinical and therapeutic skills
- team work
- principles and practice of other CAMHS facilities - community clinics, inpatient and day programs, alcohol and drug services and forensic outreach services
- medication management
- *NSW Mental Health Act 2007*
- engaging and interacting with other service providers

Staff from the Rivendell Unit will engage in CAMHS training. The Rivendell Unit will deliver training to other components of the CAMHS where appropriate.

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

10. The Rivendell Unit functions best when:

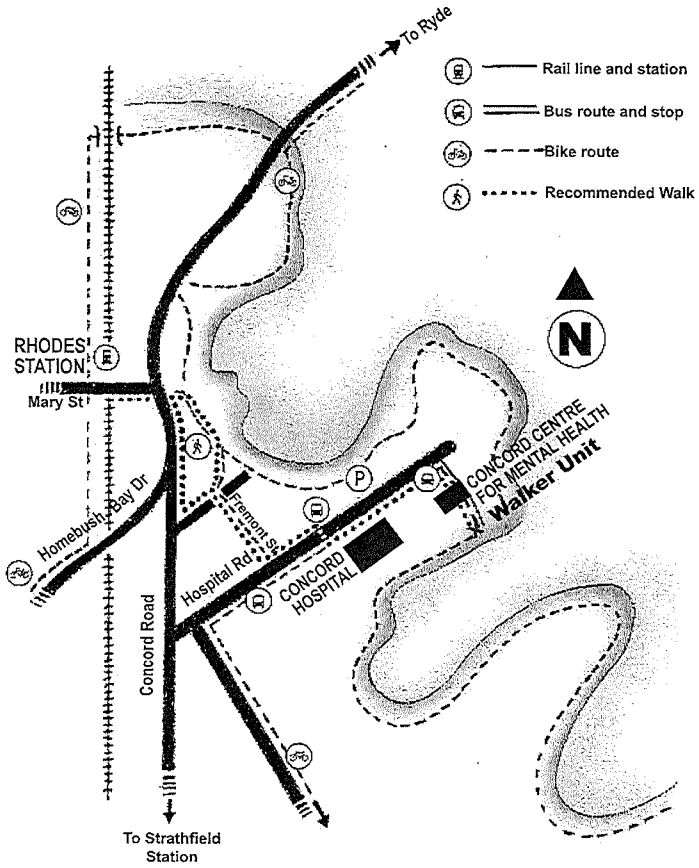
- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- all staff are provided with regular supervision, professional support and training
- Rivendell Unit is seen by all CAMHS staff as integral and integrated with the CAMHS continuum of service
- there is an explicit attitude that young people can and do recover from mental illness
- service evaluation and research are prioritised appropriately
- young people and their family/carers are involved in all aspects of care.

****

We aim to help young people and their families in a holistic way, recognising that young people often need help with a variety of issues not just illness.

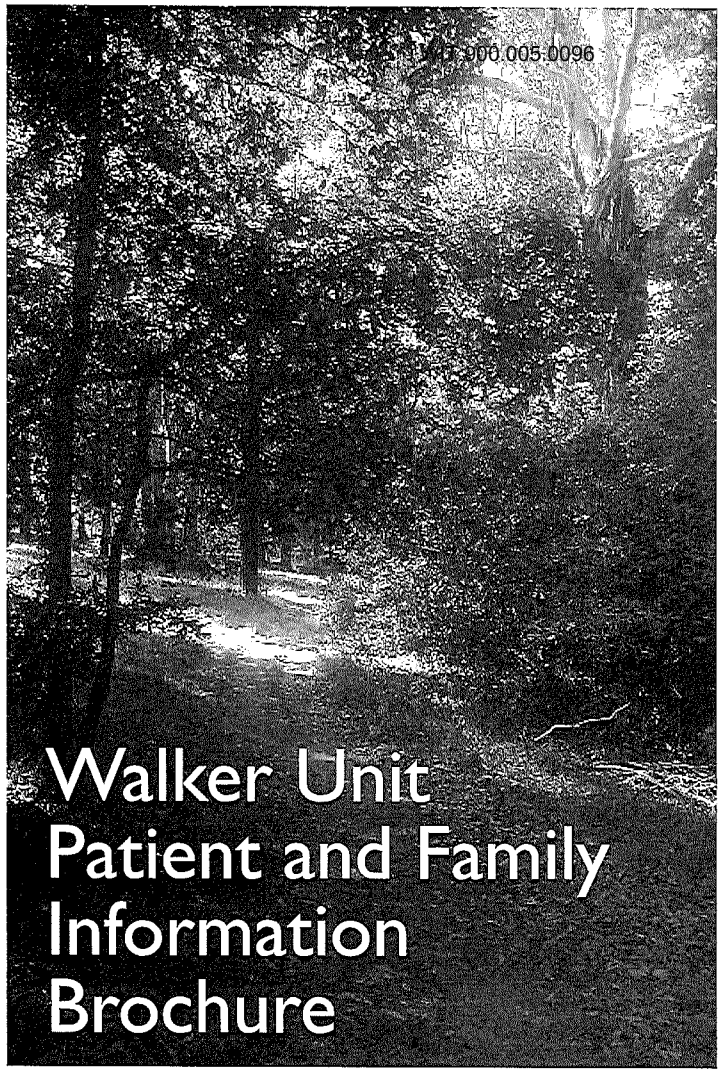
We try to create a supportive and therapeutic environment with clear expectations, limits and boundaries.

When a young person is referred to us, several members of the Walker team visit the young person and family in the first instance. This meeting determines whether we are likely to be able to help, and how best to do so.



NSW GOVERNMENT Health
Sydney
Local Health District

The Walker Unit.
Building 105,
Hospital Road.
Concord Centre for Mental Health.
Concord NSW 2137
Telephone



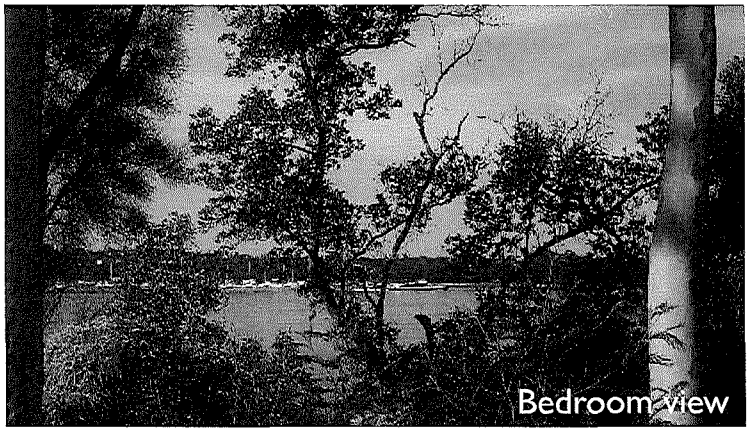
Walker Unit Patient and Family Information Brochure

The Walker Unit is a specially designed long stay unit for young people aged between 12 and 18 who have complex mental illness problems. It is part of the Concord Centre for Mental Health, located in the grounds of Concord Hospital.

PLH-5

Coming to Walker.

Following an assessment involving the young person, their carers and treating team, a decision is made on whether to admit to the Unit. Admission is based on agreed goals. Most young people are admitted under the Mental Health Act. Our aim is to work with the young person so they are well enough that they no longer need to be under the Mental Health Act. Their family then can help them make decisions about their care.



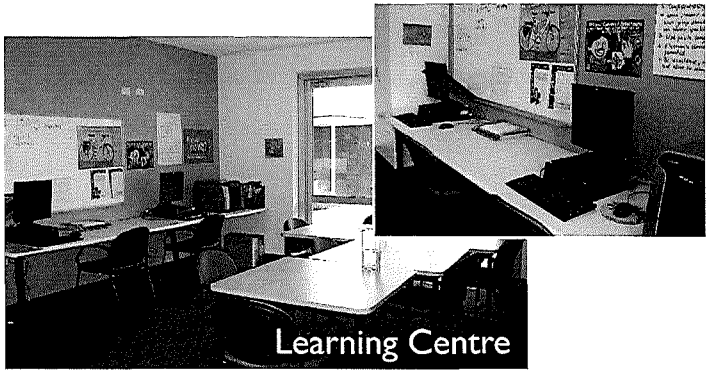
Bedroom view

Our building is secure, so people cannot walk in or out whenever they feel like it. Many young people feel nervous about admission: they worry about missing their family and friends, sleeping away from home, enrolling in a new school or having to meet new people. This is normal and eases with time but please speak to us if you have any concerns. We try to adapt our programs to manage these fears and any other worries you may have.

How we can help.

Treatment at the Walker Unit is provided by a multidisciplinary team including nursing staff, social workers, psychiatrists, clinical psychologists, neuropsychologist, sports psychologist, chaplaincy, occupational therapist and an art therapist. Young people admitted to the Unit are offered individual and group therapy.

Parents, carers and siblings will be requested to participate in weekly family therapy sessions.. If we believe other members of the family need support, they will be directed to the appropriate service.



Learning Centre

The Rivendell School runs a learning centre within the Walker Unit staffed by teachers and school learning support officer. The staff members involved will depend upon our assessment of what is most likely to help.

The average stay here is six months and can be more or less depending on the young persons needs. We run fun, supervised group outings to places such as movies, the swimming pool, the beach and shopping centres. These outings help young people with their independence, confidence and social skills and reflect normal adolescent activities.

Young people need to be on their gold achievement level (which means they are being responsible and working hard towards their goals) to be invited to take part in group outings.

You may have many questions about the Walker Unit. The pre-admission meeting is usually the best time to ask, when you will meet some of the clinicians who will be working with you.

We have detailed information on therapeutic programs and activities and we will discuss these in more detail when we meet with you.

Lounge room

Art room

THE WALKER UNIT

Concord Centre for Mental Health

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Walker Unit Referral Form

The Walker unit is a twelve bed, state wide, medium stay unit which provides care for young people experiencing severe and unremitting mental illness. The unit has the capacity to provide involuntary treatment for patients under the NSW Mental Health Act.

Admission criteria for the Walker Unit will include the presence of severe mental illness, with evidence of significant functional impairment and demonstrated treatment resistance. All patients that will be considered for admission will have had treatment at a secondary health care service and will be referred from a child and adolescent mental health service. Most patients have had a substantial period of treatment in an acute inpatient setting, although patients who fulfil admission criteria but are currently sustained in the community will also be considered. Given the eligibility criteria, we expect that most of the patients will have a significant level of risk.

Each referral will be reviewed for eligibility, and if appropriate, an assessment will be offered. The assessment process will involve multi disciplinary team visiting the patient in their current treatment setting, and also meet with the referring team and the family. During the visit the team will begin the engagement process with the young person and their family. If the patient is accepted for admission to the Walker unit, the assessment team will seek to set achievable goals for the admission. If the patient is not accepted for treatment at the Walker program, we will provide an opinion on the patient, including reasoning as to why the patient is not suitable for admission, and if requested, suggestions for ongoing management.

The goals of the program are to stabilize the psychiatric symptoms, and if possible, achieve a reduction or remission of the presenting symptoms. The unit also aims to achieve an improvement in the level of independent functioning for the young person, with the aim of engagement with an educational or vocational programme congruent with an individual young person's developmental trajectory. Treatment will be multidisciplinary, with the emphasis on functional recovery, and will be delivered in collaboration with educational and vocational training services. This will include an in-reach Department of Education program which will be accessible at a Learning Centre on the ward.

Coexisting physical conditions requiring medical monitoring/support will require negotiation for access to appropriate paediatric and medical care.

The referring agency will be asked to have ongoing participation in the treatment process, before, during and after the admission. In particular, it will be important for the referring agency to work with the Walker Unit, the patient and the family to assist in planning for discharge from the program. A collaborative approach will be required to find appropriate accommodation, to facilitate access to educational or occupational programs, and to arrange treatment with local mental health services. The Walker will offer consultation services to the treating team following discharge from the program.

The Walker Unit
Building 105
Concord Centre for Mental Health
Concord Hospital
Hospital Road, Concord West, NSW 2138

Additional Documentation

A summary and formulation of the patient's history is needed from a child and adolescent psychiatrist. This should indicate how the young person fulfils the admission criteria, and outline the aims of admission to the Walker Unit.

We suggest you include any relevant reports or information that will assist in the assessment process. These may include:

1. Developmental history
2. Family history, assessment of the family system and past family interventions
3. Psychological treatments
4. Educational and Occupational history, educational / occupational reports
5. Past medical history, medical reports or episodes of treatment
6. Important investigations (Eg. Neuroimaging, Electrophysiology, Pathology)
7. Neuropsychological testing
8. History of interaction with DOCS and any relevant reports

Referral Details

Referring Agent Details

Referrer Name: .....

Designation: .....

Organisation: .....

Health Service: .....

Contact person for this referral (if different from above): .....

Telephone Number: .....

Fax: .....

Email: .....

Details for Teleconferencing Facilities: .....

Client Details

Client Name: .....

Date of Birth: .....

Address: .....

Gender: .....

Mental Health Act Status: .....

Care (legal) status: .....

Address patient will return to: .....

Educational/Vocational Status: .....

Primary Carer: .....

Address of Primary Carer: .....

Telephone number for Primary Carer: .....

Risk Assessment

The Walker unit expects to manage patients who exhibit disruptive, aggressive, self harming, suicidal and other hard to manage behaviours. It is vital for the referring agency to accurately identify the Risk issues for the referred patient and his or her family so that an effective Risk Management Plan can be devised. The referring agency is encouraged to fill out the following risk assessment form. Alternatively the standard MHOAT risk assessment form can be filled out and supplemented by relevant additional information.

GENERAL RISK FACTORS					Y=Yes	N=No	UK= Unknown
Background factors	**Y**	**N**	**UK**	**Current factors**	**Y**	**N**	**UK**
Major psychiatric illness				Disorientation or disorganisation			
Diagnosed Personality Disorder				Disinhibition/intrusive/impulsive behaviour			
Significant alcohol/drug abuse history				Current intoxication/withdrawal			
Serious medical condition				Significant psychical pain			
Intellectual disability/cognitive deficits				Other *(specify)*			
Significant behavioural disorder *(<18 years)*							
Other *(specify)*							
Further Discussion of Identified General Risk Factors							

SUICIDE RISK FACTORS							
Background factors	**Y**	**N**	**UK**	**Current factors**	**Y**	**N**	**UK**
Previous suicide attempts				Recent significant life events			
History of other self harm				Hopelessness/despair			
Family history of suicide				Expressing high levels of distress			
Separated/widowed/divorced				Expressing suicidal ideas			
Isolation/lack of role				Self-harming behaviour			
Other (specify)				Current plan/intent			
				Other (specify)			
Further Discussion of Identified Suicide Risk Factors							

VIOLENCE/AGGRESSION RISK FACTORS							
Background factors	**Y**	**N**	**UK**	**Current factors**	**Y**	**N**	**UK**
Previous incidents of violence				Recent/current violence			
Previous use of weapons				Command hallucinations			
Criminal history				Paranoid ideation about others			
Previous dangerous/violent ideation				Expressing intent to harm others			
Childhood abuse/maladjustment				Anger, frustration or agitation			
History of predatory behaviour				Reduced ability to control behaviour			
Other (specify)				Access to available means			
				Contact with vulnerable person/s			
				Other (specify)			
Further Discussion of Identified Violence / Aggression Risk Factors							

FAMILY RISK FACTORS							
Background factors	**Y**	**N**	**UK**	**Current factors**	**Y**	**N**	**UK**
History of domestic violence				Current domestic violence			
History of violence between family members				Current violence between family members			
Forensic history in a family member				Current significant drug or alcohol use			
History of drug and alcohol use by a family members				Current risk of withdrawal from drug and alcohol use			
History of medical illness in a family member				Significant current mental illness in a family member impacting on functioning			
History of predatory behaviour by a family member							
Further Discussion of Identified Family Risk Factors							

OTHER VULNERABILITIES							
Background factors	**Y**	**N**	**UK**	**Current factors**	**Y**	**N**	**UK**
History of absconding				Desire / Intent to leave hospital			
History of sexual vulnerability				Vulnerability to sexual exploitation / abuse			
History of financial vulnerability				Current delusional beliefs			
History of falls				Physical illness			
History of harm to children				Parental / carer status or access to children			
History of blood borne virus infection				Non-adherence to medication / treatment			
Further Discussion of Identified Vulnerabilities							
Protective Factors							

Global Assessment of Risk	**High**	**Medium**	**Low**
Suicide			
Self harm			
Violence / Aggression			
Vulnerability			
Absconding			
Other			

Current Risk Management Plan

Adolescent Extended Treatment & Rehabilitation Centre Model of Service

Queensland Public Mental Health Services

Queensland Government

The model of service template - Queensland public mental health services

- The model of service (MOS) template used in the development of this service component is part of a larger document that will describe public mental health services in Queensland.

- The template for the individual MOS has been developed utilising the UK Department of Health document 'Mental Health Policy Implementation Guide - Community Mental Health Teams' [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf]

- A model of service is being developed to describe each team/service component of the public mental health service in Queensland. It is a 'living' document.

- At this time there are 30 MOS in various stages of development.

- The finalised MOS will:
    - be visionary – the aim is not to describe what currently happens in services but describe what services should be aiming towards in the next five years (2015)
    - include content that describes evidence based best practice
    - include content that is clinically driven, positive and inclusive
    - clearly state targets to measure change and provide a benchmark.

- The attached 10 point template must be used when completing a draft MOS for a service component or team.

- The key components in the table can be adapted to describe the key functions of a particular service. Language that is definitive, succinct and action focussed should be used. Dot points are fine.

- Generic information regarding the Queensland public mental health service will be addressed in the introduction to the MOS document e.g. role descriptions, where to find a service, policy and practice frameworks.

Please note that all drafts need to be forwarded to Leianne McArthur prior to broad dissemination.

For more information, please contact the A/Manager of the Model of Service Project – Leianne McArthur at Leianne_McArthur@health.qld.gov.au or 0439924992.

Adolescent extended treatment and rehabilitation centre model of service

1. What does the service intend to achieve?

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

The Child and Youth Mental Health Service (CYMHS) Adolescent Extended Treatment and Rehabilitation Centre (AETRC) is a statewide service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of adolescents present with severe psychosocial impairment as a result of their mental illness/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.

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 adolescent. The program will follow structured phases incorporating assessment, establishing a therapeutic alliance and developing realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community based treatment.

The key functions of an AETRC are:

- to plan an admission to accommodate the individual characteristics of adolescent.
- ensure a level of admission consistent with least restrictive care and capacity to access the service. Level of admission will range from day admission to partial hospitalisation to providing 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment.
- 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
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- provide
    - individually tailored,
    - targeted,
    - phased,
    - evidence based

  treatment interventions to alleviate or treat distressing symptoms and that will ultimately assist recovery and reintegration back into the community
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide intensive support to enable successful transition back to the community. This will include the provision of step down accommodation for adolescents who cannot return home, who are in transition to the community and who remain in need of substantial clinical care while preparing for independent living in the community

The aim of these functions of the AETRC contribute to:

- targeted, phased treatment and rehabilitation incorporating a range of therapeutic interventions delivered by appropriately trained staff.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

The principles underlying these functions of the AETRC are to:

- provide care in the least restrictive environment appropriate to the adolescent's developmental stage
- develop treatment and rehabilitation programs in partnership with adolescents and where appropriate their parents or carers.
- provide treatment and rehabilitation with an appropriate timeframe. (In specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review 6 month after admission).
- provide varying levels of care on the basis of acuity of behaviours associated with mental illness; with consideration for the safety of self and others and after consideration of the adolescents capacity to undertake daily self care activities
- assist with establishment of care systems for transition to the community

2. Who is the service for?

The AETRC is available for Queensland adolescents:

- who are aged 13 – 17 years
- who are 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 child and adolescent psychiatrists, CYMHS community clinics, Evolve, day programs, acute inpatient child and adolescent 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:

- 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.

- 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.

- 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.

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

- 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 CYMHS in the relevant districts.
- 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

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

When determining the admission of adolescents where recurrent absconding is a significant risk, the likelihood that the adolescent will experience a positive therapeutic outcome needs to be considered.

In specific cases when the admission exceeds six months the case must be presented to the AETRC panel for review following the initial six month admission.

Treatments provided by the ADP will be based on evidence based practices 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 AETRC is gazetted as an authorised mental health service in accordance with Section 495 of the Mental Health Act.

3. What does the service do?

The key components of an AETRC are defined here. These components are essential for the effective operation of an AETRC.

Table 1: Key components and elements of an adolescent extended treatment and rehabilitation centre

Key component	Key elements	Comments
3.1.0 Working with other service providers	**3.1.1** 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.
	3.1.2 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.
	3.1.3 The AETRC panel will develop and maintain partnerships with other relevant health services that interact with adolescents with severe and complex mental illness.	• This includes formal agreements with health service district (HSD) 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. • Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc. • This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness)

Key component	Key elements	Comments
		and Education Queensland • Mandatory child protection reporting of a reasonable suspicion of child abuse and neglect. Hyperlink to: • meeting the needs of children for whom a person with a mental illness has care responsibilities [http://qheps.health.qld.gov.au/mentalhealth/html/careofchild.htm]. child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf]
	3.1.4 AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect.	
	3.1.5 When adolescents have specific needs (e.g. sensory impairment, transcultural) to ensure effective communication, AETRC will engage the assistance of appropriate services	• Certain population groups require specific consideration and collaborative support. This includes people from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people. Hyperlinks to: • interpreter services [http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp] • hearing impaired/deafness [http://www.health.qld.gov.au/pahospital/mentalhealth/docs/damh_con_info.pdf] • transcultural mental health [http://www.health.qld.gov.au/pahospital/qtmhc/default.asp] • Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 [http://qheps.health.qld.gov.au/atsihb/docs/atsiccf.pdf] • Indigenous mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/indigenous.asp] • multicultural mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/multicultural.

Key component	Key elements	Comments
		asp]
3.2.0 Referral, access and triage	**3.2.1** Statewide referrals are accepted for planned admissions.	
	3.2.2 Responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC.	• This supports continuity of care for the adolescent.
	3.2.3 All referrals are made to the Clinical Liaison, Clinical Nurse and processed through the intake panel.	• A single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness.
	3.2.4 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.
	3.2.5 If there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted.	• This process monitors changes in acuity and the need for admission to help determine priorities for admissions. • The Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness following consultation with the treating team. • This expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted.
	3.2.6 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.	
3.3.0	**3.3.1**	• Initial assessments of mental

Key component	Key elements	Comments
Assessment	Assessments will be prompt and timely.	health, development and family are to be completed within two weeks of admission. Hyperlink to: • mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm] • All assessment processes will be documented and integrated into the care plan. Hyperlink to: • child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf] • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian, and other stakeholders (with consent of the adolescent) Hyperlink to: • *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • carers matter [http://www.health.qld.gov.au/mhcarer/].
	3.3.2 A comprehensive clinical formulation is developed from the assessment, which is refined and updated secondary to ongoing assessment processes	• The formulation is reviewed and refined at case review meetings
3.4.0 Mental Health Assessment	**3.4.1** 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. • mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm] • adolescent assessment form child

ADOLESCENT EXTENDED TREATMENT AND REHABILITATION CENTRE MODEL OF SERVICE

Key component	Key elements	Comments
		and youth [http:qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_conass.pdf].
	3.4.2 The Consultation Liaison Clinical Nurse will obtain a detailed history of the interventions to date for the mental illness.	• This is obtained by the time of admission.
	3.4.3 *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor.	Hyperlink to: • *Mental Health Act 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf].
3.5.0 Family/Carers Assessment	**3.5.1** 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.
3.6.0 Developmental Assessment	**3.6.1** 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.
	3.6.2 The AETRC will obtain information on schooling as it is available.	• This occurs upon admission and will primarily be obtained by the AETRC school.
3.7.0 Functional Assessment	**3.7.1** The AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development.	• This assessment occurs throughout the admission.
3.8.0 Physical and Oral Health Assessments	**3.8.1** Routine physical examination will occur on admission.	• Appropriate physical investigations should be informed as necessary. Hyperlink to: • physical examination and investigations form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_physical.pdf]. Link to:  metabolic monitoring form
	3.8.2 Physical and oral health will be routinely assesses and monitored	• Documented evidence of the physical and oral health assessment will be included in the

Key component	Key elements	Comments
	throughout the admission. Additional resources, education and training to improve the physical and oral health management of adolescents with mental illness is available at: Hyperlink to: • activate: mind & body [http://www.activatemindandbody.com.au/]	adolescent clinical record. • Outcomes of physical health assessments will be incorporated in recovery planning. • All efforts will be made to ensure 100% of adolescents have a nominated GP. • Potential physical and oral health problems will be identified and discussed with the GP and/or other primary health care provider
3.9.0 Risk Assessments	**3.9.1** A key function of the panel will be to assess risk prior to admission.	• 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. • The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents) Hyperlink to: • CYMHS Risk Screening Tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf]
	3.9.2 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. • The frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed, with a minimum of weekly reviews to occur.
3.10.0 Alcohol and Other Drug	**3.10.1** Assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service.	Hyperlink to: • Drug Assessment Problem List [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_drug.pdf] • dual diagnosis policy 2008 [http://www.health.qld.gov.au/mh/docs/ddpolicy_final.pdf]. • Interventions range from evidenced for substance use disorders to treatment of primary mental illness

Key component	Key elements	Comments
		and incorporated in their recovery plan.
3.11.0 Recovery Planning	**3.11.1** 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. • recovery plan [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_recplan.pdf]. • sharing responsibility for recovery: creating and sustaining recovery orientated systems of care for mental health [http:qheps.health.qld.gov.au/mentalhealth/docs/Recovery.pdf].
	3.11.2 Every effort will be made to ensure that treatment care planning focuses on the adolescent's own goals	• Where conflicting goals exist they will be clearly outlined and addressed in a way that is most consistent with the adolescent's own goals and values.
3.12.0 Clinical interventions	**3.12.1** Clinical interventions will be individualised according to the adolescent's treatment needs. All interventions must demonstrate attention to developmental frameworks and will be evidence based.	• 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.

Key component	Key elements	Comments
3.13.0 Psychotherapeutic Interventions	**3.13.1** Psychotherapeutic Interventions can include: • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy) • individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.) • 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) • psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy).	• 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. • Can be 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
3.14.0 Behavioural Interventions	**3.14.1** Behavioural Interventions can include: • individual tailored behavioural intervention for a specific clinical problem (e.g. desensitisation program for anxiety) • group tailored behavioural interventions for a group of adolescents manifesting a common problem • individual general behavioural interventions to reduce specific behaviours (e.g. absconding). These general behavioural interventions will be tailored to individual circumstances • general or specific behavioural interventions to modify the behaviours of a number of adolescents involved in group behaviours **3.14.2** Behavioural interventions for self harm behaviours include: • using questionnaires to determine the reasons for the incident of self	• Behavioural programs are constructed under appropriate supervision. • Evidence for effectiveness of intervention will be monitored. • Effectiveness of behavioural program at individual and Centre level will be reviewed. • Group based interventions are individualised according to adolescents in the group with common issues and may include adventure based and community based activities • All staff should be familiar with specific policy and practice guidelines related to the management of acute behavioural disturbance within the AETRC. • A specific management plan will address the adolescents distress and any associated behavioural disturbance. The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every

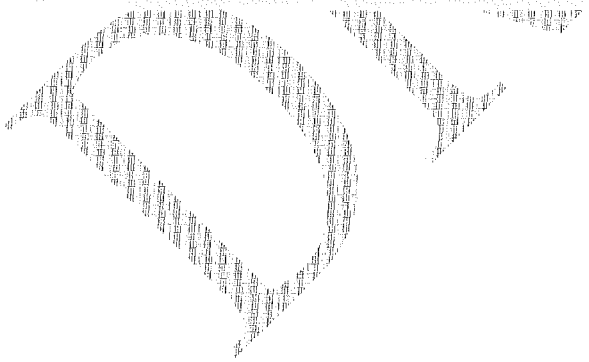
Key component	Key elements	Comments
	harm • increased visual observations • restricting access to areas of the ward where an adolescent can be observed • use of the de-escalation area ranging from an area to which an adolescent voluntarily withdraws as a safe place up to restraint and seclusion as a last resort • use of medication if indicated The adolescent is informed of and encouraged to utilise strategies to use alternatives to self harm, e.g. talking with staff, use of the sensory room, utilising non-verbal therapies. **3.14.3** Behavioural interventions for behaviours which cause harm to others include: • verbal de-escalation • use of outside environment where safe • use of safe forms of reducing aggression e.g. sensory room, punching bag • use of the de-escalation area ranging from an area to which an adolescent voluntarily withdraws as a safe place up to restraint and seclusion as a last resort • use of medication if indicated • review of precipitants to aggression The adolescent is informed of and encouraged to utilise strategies to use alternatives to aggression, e.g. talking with staff, use of the sensory room, utilising non-verbal therapies.	adolescent whose risk assessment identifies actual or potential aggression as an issue. The plan will list preventative strategies and de-escalation strategies. Intervention strategies will include: • increased visual observation • de-escalation techniques • development of a management plan targeting the specific behaviour/symptom • service provision in a designated de-escalation area with the capacity for high dependency and seclusion • use of medication to relieve agitation/aggression • Only when all other interventions have not had a therapeutic effect, restraint and/or seclusion will be utilised. These interventions are delivered by qualified staff following a comprehensive risk assessment.
3.15.0 Psycho-education interventions	**3.15.1** Psychoeducation includes general specific or general psycho-education on mental illness.	• Available to adolescents and their parents/carers

Key component	Key elements	Comments
3.16.0 Family Interventions	**3.16.1** Family interventions are offered to support the family/carer while the adolescent is in the AETRC. **3.16.2** Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent.	• This will include and allows for: - psycho education for parents/carers - monitoring of mental health of parents/carers and supporting access to appropriate mental health care as needed - monitoring the risk of abuse or neglect, and fulfilling statutory obligations if child protection concerns are identified - promoting qualities of care which enable reflection of qualities of home - support clinicians in reviewing interactions with and attitudes towards adolescents. • Evidence for effectiveness of the intervention and interactions with staff will be reviewed. • Therapist will have recognised training in family therapy and access to continuing supervision.
3.17.0 Interventions to Facilitate Tasks of Adolescent Development	**3.17.1** Interventions are provided to promote appropriate development in a safe and validating environment.	• Individual based interventions are provided to promote an aspect of adolescent development. • Group based interventions are individualised according to adolescents in the group which promote aspects of adolescent development which may include adventure based and recreational activities. • Interventions are provided under the clinical direction of a nominated clinician and have defined goals. • Schooling is individualised according to an adolescent's current school curriculum, academic capacities and mental state. • The school program is determined by the School Principal after continuing consultations with clinicians.
3.18.0 Pharmacological Interventions	**3.18.1** Medication will be administered, prescribed and monitored as	• Across all treatment settings all prescriptions, dispensing and administration of medicines will

Key component	Key elements	Comments
	indicated by clinical need, and will involve shared decision making processed between the treating team and the adolescent and their family/carers. - Administration of psychotropic medications will occur under the direction of the consultant psychiatrist. - Administration of non-psychotropic medications (including medications for general health) will occur under medical supervision	comply with Queensland Health policies, guidelines and standards. Hyperlink to: • National Inpatient Medication Chart [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/D0DABD9912D44A14CA257516000FDABB/$File/20795.pdf]. • clinical guidelines [http://qheps.health.qld.gov.au/mentalhealth/guidelines.htm]. • medication liaison on discharge [http://qheps.health.qld.gov.au/medicines/documents/general_policies/medic_liaison_discrg.pdf]. • safe medication practice unit [http://qheps.health.qld.gov.au/medicines/]. • therapeutic guidelines-psychotropic [https://online-tg-org-au.cknservices.dotsec.com/ip/]. • Queensland Health Medication Management Plan [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/0AAD5CC37045BF99CA257751001C2543/$File/medicationsafetyplan.PDF] • Education is given to the adolescent and parent(s)/carer about medication and potential adverse effects. • The medication goals of the adolescent/guardian will be integrated with evidence based clinical treatment guidelines. • Where needed, strategies focussed on medication adherence will be in place. • Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment. • Regular administration and supervision of psychotropic medications occurs.
3.19.0	**3.19.1**	

Key component	Key elements	Comments
Other Interventions	Sensory Modulation is an approach aimed at teaching clients to learn to use their sensory systems to modulate their responses, in order to improve participation in meaningful life activities. **3.19.2** Electroconvulsive therapy (ECT) will be available where indicated and will be provided according to Queensland Health guidelines.	• Sensory modulation is utilised under the supervision of trained staff. • Effectiveness of the approach is monitored. • ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000* *Hyperlink to:* • electroconvulsive therapy guidelines [http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf].
		• All staff will have ABM training at the level deemed appropriate within AETRC 7 Refer: High Dependency Unit Guidelines?/hyperlink to policy statement on reducing and where possible eliminating restraint and seclusion in Queensland Mental Health services/Visual observations policy/occupational violence prevention training 7 Parents/carers are immediately informed of changes in a child□s behavioural presentation.
3.20.0 **Care Coordination**	**3.20.1** Prior to admission, a Care Coordinator will be appointed for each adolescent.	• The Care Coordinator can be a member of the AETRC treating team and is appointed by the AETRC director

Key component	Key elements	Comments
	3.20.2 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 • providing a detailed report of the adolescent's progress for the care planning meeting.	• An orientation information pack will be available to adolescents and their parent(s)/carer(s). • The care coordinator will be noted on CIMHA as principal service provider. Hyperlink cimha business rules Statement on documentation All adolescents have a designated psychiatrist on CIMHA • The frequency of monitoring will depend on the levels of acuity. • Adolescents at high risk and require higher levels of observations will be reviewed daily • 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.



Key component	Key elements	Comments
3.21.0 Clinical Review	**3.21.1** Continual monitoring of the adolescent's progress towards their recovery plan goals will occur through a process of structured clinical reviews involving the AETRC multi-disciplinary team and relevant external community agencies.	• Care Plans are formally reviewed and updated at intervals ideally of two months, but not more than three months. • There will be an established agenda for discussion of cases, with concise documentation of the content of the discussion and the ongoing plan of care recorded on the adolescent integrated mental health application (CIMHA) and on the adolescent care review summary. A copy is to be downloaded and included in the clinical file. • Outcome measures and the adolescent's progress will be reviewed. • The summation should include attendees, clinical issues raised, treatment care plan, requirements for additional collateral and those responsible for actions. • The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed • The adolescent, referring agencies and other key stakeholders will participate in the Clinical 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 and take responsibility for ensuring that assessments and management plans are adequate, and for decisions taken during formal case reviews. • Annual audits will ensure that reviews are being conducted
	3.21.2 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, or may be required to address complex clinical issues and following a critical event. Hyperlink to: • Clinical Incident management

Key component	Key elements	Comments
		implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf]. • child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf] • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • child adolescent care review summary form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_creview.pdf]
3.22.0 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	• available members of the treating team should attend each case conference
3.23.0 Collection of data, record keeping and documentation	**3.23.1** AETRC will enter and review all required information into the CIMHA in accordance with approved statewide and district business rules. **3.23.2** All clinical record keeping will comply with legislative and local policy requirements	Hyperlink to: • CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. • progress notes will be consecutive within the clinical record according to date • personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up 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 • all contacts, clinical processes and care planning, including case review, will be documented in the adolescent's clinical record • there will be a single clinical record for each adolescent which will align with any electronic record Hyperlink to: • retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf].

Key component	Key elements	Comments
		Clinical Documentation Accepted Terminology
	3.23.3 AETRC utilise the range of routine outcome measures mandated through the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ).	• Routine outcomes data is utilised at all formal case reviews • Results of routine outcomes data will be discussed with adolescents and their family/carers to consider and monitor changes in symptoms and functioning • Outcomes data is used in developing and reviewing recovery plans.
3.24.0 Discharge Planning	**3.24.1** Planning for discharge from AETRC should commence when the assessment phase has been completed with key stakeholders and the adolescent being actively involved. **3.24.2** Discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family **3.24.3** Discharge planning will require the ascertainment that the potential accommodation is safe and appropriate. In most cases, this will be the family home, or established care arrangements. Where the family home is unsafe, unable to provide the necessary support or	• Discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service. • The decision to discharge is at the discretion of the consultant psychiatrist in consultation with the multidisciplinary team. • Discharge planning will occur in close collaboration with the adolescent and their family • Discharge planning will consider the adolescent's potential for optimal functioning and determine the level of care required to support that functioning as an inpatient, partial inpatient, day admission or in the community • Discharge planning recognises the needs at times that re-admission may be necessary where risk of relapse is high. • Where the family home or usual care arrangements are appropriate and supportive, every endeavour will be made to encourage the adolescent to return • The adolescent will be integral to all planning for accommodation on discharge • Parents providing a safe and

Key component	Key elements	Comments
	where care arrangements do not exist, safe supervised accommodation with adequate supports will be sought.	supportive environment will always be involved in planning for accommodation on discharge. • The Department of Child Safety will remain primarily responsible for providing timely and appropriate accommodation for an adolescent in their care. ?Hyperlink to MOU between Queensland Health and Department of Child Safety? • Any decision to not return the adolescent to the home of origin will be made in collaboration with the adolescent and their parents as their guardians if they are under the age of 18 • If parents are unavailable or unwilling to be involved in negotiations about accommodation, a referral will be made to the Department of Child Safety on the grounds of neglect. If this referral is not accepted, accommodation options will be sought by the AETRC on the basis of being age appropriate, safe, and levels of supervision and support available • The adolescent will be equipped to live independently in preparation for discharge outside of home • The adolescent will be offered trial of independent living in the step down facility attached to the unit as long as they are safe enough to stay there, but require reasonable levels of clinical support during the day and evening
	3.24.4 Discharge summaries need to be comprehensive and indicate diagnosis, treatment and interventions provided, progress of care, recommendation for ongoing care and procedures for re-referral.	• The Registrar, Care Coordinator and key clinicians will prepare this letter and the consultant psychiatrist is responsible for ensuring that discharge summaries are sent to key health service providers (E.g. GP) on the day of discharge. • Follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure discharge information was received. • Discharge summary should identify relapse patterns and risk

Key component	Key elements	Comments
		assessment/ management information. • this will be prepared by the clinicians involved in direct Interventions
	3.24.5 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.	
3.25.0 Transfer/Transition of care	**3.25.1** All appropriate community based support will be co-ordinated prior to discharge. The adolescent's community treating team will be identified in the clinical record and communication will be maintained during the transition period.	• Guidelines for internal transfers will be clearly written, and receiving teams will make contact before transfer is concluded. A written and verbal handover will be provided with every transfer/discharge process. • During the transition phase there will be an appropriate plan to ensure smooth transition of care. This will support continuity of care for the adolescent and ensure the early engagement of all service providers in ongoing care. • The AETRC School will be primarily responsible for and support school reintegration. • For adolescents not returning to their homes, the AETRC will ensure adolescents have appropriate accommodation to be discharged to. Preparation for this leave may include trials of leave while still resident in the step down facility. • A community living and management plan will be developed with the adolescent, the community follow up service and the accommodation provider when the young person is not able to live at home. • The community mental health service, whether in the public or private sectors will become the principal service provider when the young person no longer requires any level of inpatient or day service at the AETRC
	3.25.2	• Transfer procedures will be

Key component	Key elements	Comments
	Depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit. **3.25.3** Transfer to an adult inpatient unit or community care unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs.	discussed with adolescents, their family and carers. • Processes for admission into an adolescent acute inpatient unit will be followed, with written and verbal handover provided. • Transfer procedures will be discussed with adolescents, their family and carers. • Processes for admission into an adult acute mental health inpatient unit will be followed, with written and verbal handover provided.
3.26.0 Continuity of Care	**3.26.1** Referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission. Local CYMHS may remain as other service providers.	• 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
	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
	3.27.2 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 • An example would include the referrer providing parent support while the adolescent is in the AETRC
3.27.0 Team Approach	**3.27.1** A multidisciplinary team approach to care is provided.	• Adolescents and family/carers will be informed of the multidisciplinary approach to mental health care on admission to AETRC. • The discipline specific skills of the multidisciplinary team will be utilised as appropriate in all aspects of service provision.
	3.27.4 Staff employed by the Department of Education and Training will be regarded as part of the team.	Department of Education and Training supports the AETRC in providing teaching and resource staff for the school.
3.28.0 Working with families, carers and friends	**3.28.1** Adolescents and carers will contribute to continued practice improvement of the service.	• This will occur via: -consume and carer participation in collaborative treatment planning - adolescent and carer feedback tools - adolescent and carers will inform

Key component	Key elements	Comments
		staff training.
	3.28.2 Every effort will be made to contact family, carers and significant others promptly on acceptance into EATRC. Family/carers/significant others will be involved in the mental health care as much as possible. Significant effort will be made to support this involvement.	• Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. • The family/carer is identified in the adolescent clinical record and where relevant, it is clearly identified that they understand the treatment plan and agree to support the provision of ongoing care to the adolescent in the AETRC. • Adolescent/guardian consent to disclose information to and to involve the family/carers in the care will be sought in every case. Hyperlink to: • *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf]. • right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp]. • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. • *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf]. • Decision making for children and young people [http://www.childsafety.qld.gov.au/right-to-information/publications/viewpublication.aspx?publication=94].
	3.28.3 Parents/carers will have their needs assessed as indicated or requested. 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.	• Identification of family/carers and their need is part of the assessment process and is included in care planning. Hyperlink to: • carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp
	3.28.4 Support services will be offered to	• Adolescent consent is not required

Key component	Key elements	Comments
	families and carers. **3.28.5** Adolescents of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided/facilitated if needed.	to offer family/carers education and support. • Support may be provided by a member of the MHS or another organisation. Hyperlink to: • *Child Protection Act 1999* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf]. • child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. • meeting the needs of children for whom a person with a mental illness has care responsibilities [http://qheps.health.qld.gov.au/mentalhealth/html/careofchild.htm]. • mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf]. • Family Support Form http://qheps.health.qld.gov.au/patientsafety/mh/documents/family_supp.pdf • information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].
3.29.0 Mental Health Peer Support Services	**3.29.1** All adolescents will be offered information and assistance to access local peer support services	• Peer support services may be provided by internal or external services.

4. Related services

The AETRC is part of the CYMHS network of services in Queensland and as such maintains strong operational and strategic links to the CYMHS network. AETRC provides education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder.

AETRC operate in a complex, multi-system environment involving crucial interactions with education providers, the Department of Communities (including Child Safety, Disability Services, and Housing and Homelessness services), child health services, alcohol and other drugs services. AETRC will establish and maintain effective, collaborative partnerships with general health services, in particular CYMHS and services to support young people eg Child Safety Services. AETRC will develop Memorandums of Understanding to facilitate these relationships.

??statement about AETRC school
Check if all listed below are correct, or is some missing

The AETRC will 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. Strong links with universities will be developed to support this process.

Key internal relationships include

- Child and Youth Mental Health Services (CYMHS) including Child and Youth Forensic Outreach Services, Evolve Therapeutic Services
- Other specialist child and youth mental health services (e.g. Early Psychosis)
- Acute inpatient mental health teams (child and youth, adolescent, adult)

Effective relationships (and a working knowledge of the service they provide) will also be developed with other internal service providers including (but not limited to):

- Aboriginal and Torres Strait Islander mental health services
- Queensland Transcultural Mental Health services
- Adult mental health services
- Acute Care Teams
- Community Care Units

Key external (district) relationships include:

- Primary Care Providers
- Department of Education (in particular ADP School)
- Department of Communities
- Queensland Public Trustee

5. 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.

6. Workforce

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 appointed (or working towards becoming) authorised mental health practitioners.

7. Team clinical governance

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 Health Service District within which the AETRC is located. The operation of this corporate governance structure will occur through the AETRC clinical director reporting directly to the Director, Child and Adolescent Mental Health Services, within the relevant Health Service District. Interim line management arrangements may be required.

8. Hours of operation

The AETRC provide a 24 hour service, with nursing staff rostered to cover these shifts.
An on-call consultant child and adolescent psychiatrist is available 24 hours, 7 days per week.
Access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
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.
While some variation may occur, routine assessments and interventions will be scheduled during business hours (9am -5pm) 7 days a week.

9. Staff training

Staff will be provided with continuing clinical education opportunities, mandatory training, clinical supervision, and other support mechanisms to ensure that they are clinically competent. All training and education will be based on best practice principles and evidence-based treatment guidelines, and will be underpinned by the Queensland Government Recovery Framework.

Education and training will include a focus on strategies and mechanisms to foster meaningful adolescent and carer participation across all levels of service delivery, implementation and evaluation. Adolescents and carers need to be involved in the development and delivery of education to staff and other service providers.

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

- 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
- *Mental Health Act 2000*
- developmentally appropriate assessment and treatment
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

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

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

10. The AETRC functions 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
- all staff are provided with regular supervision, professional support and training
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service
- there is an explicit attitude that adolescents can and do recover from mental illness
- service evaluation and research are prioritised appropriately
- adolescents and their family/carers are involved in all aspects of care.

From: Philip Hazell
Sent: Wednesday, 28 November 2012 1:08 PM
To: Michelle Fryer
Subject: RE: Qld review of service provision for adolescents with serious mental illness

Hi Michelle,

I will need to clear it with my director of mental health (I think I will wait until after EQuIP next week before asking him) but that should be fine. Would be good to see the terms of reference asap.

Regards

Phil

Philip Hazell
BMedSc MBChB PhD FRANZCP Cert Accred Child Psychiatry

Director | Infant Child and Adolescent Mental Health Services Sydney and South Western Sydney Local Health Districts; Head, Discipline of Psychiatry, Sydney Medical School

Rivendell, Thomas Walker Hospital, Hospital Rd, Concord West 2138

-----Original Message-----
From: Michelle Fryer
Sent: Wednesday, 28 November 2012 12:54 PM
To: Philip Hazell
Subject: Qld review of service provision for adolescents with serious mental illness

Dear Phil,

The only medium to long-term facility in Queensland for adolescents with serious mental illness has to cease operating at its current location and this has prompted a review of the model of care which is planned to involve an expert reference group including specialists from inter-state. The Qld branch of FCAP has nominated you, as a child and adolescent psychiatrist with the requisite expertise, to take part and, on behalf of the planning team, I have been asked to make an informal approach to you in the first instance. If you are interested, a formal invitation from the convenes of the planning group will follow.

It is anticipated that the review will occur over the next 6 months, and the planning group is keen to have the members of the expert reference group identified as soon as possible.

If you'd like further information or to discuss, please contact me on or email me your number and when you are available.

Regards,

Michelle Fryer.

From: Vaoita Turituri [redacted]

Sent: Wednesday, 5 December 2012 10:54 AM

To: [redacted] David Hartman; Emma Hart; James Scott; Josie Sorban; Michelle Fryer; Ray Cash; Trevor Sadler; Amanda Tilse; [redacted] Philip Hazell; [redacted]

Cc: Emma Foreman; Leanne Geppert

Subject: Expert Clinical Reference Group_Agenda

Attachments: Meeting scheduled_2013.doc; Draft Agenda_ BAC ECRG.doc

Dear members,

Thank you for agreeing to participate as a member of the Expert Clinical Reference Group established to recommend a model(s) of care that will meet the needs of adolescents requiring subacute mental health care in Queensland.

Please find attached an agenda for our inaugural meeting scheduled for Friday 7 November from 9.00 am - 10.30 am at Level 2, Room 2.3, 15 Butterfield St, Herston. Also attached is a draft schedule of meetings for your information.

If would like to video or teleconference to this meeting, can you please respond back to me by COB today to enable us to organise the technology please.

If you require parking, please also let me know at your earliest convenience by reply email so that I can organise this for you also.

Many thanks
Vaoita

Vaoita Turituri
Planning and Partnerships Unit
Mental Health Alcohol and Other Drugs Branch
Health Services and Clinical Innovation Division
Level 2, Queensland Health Building
15 Butterfield Street
BRISBANE QLD 4006
GPO Box 2368
FORTITUDE VALLEY BC QLD 4006
[redacted]

West Moreton Hospital and Health Service
TERMS OF REFERENCE

Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy					
Date:	30.11.12	Review Date:	N/A	Version:	Final Draft

1. Purpose:

1.1 The purpose of the Expert Clinical Reference Group is to:
Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who require subacute treatment and rehabilitation.

2. Scope and functions:

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland
- will be evidenced based, sustainable and align with Queensland mental health policy, National mental health policy, National mental health service planning frameworks and future funding models.
- will take into account the Clinical Services Capability Framework (for Mental Health) and
- will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.

3. Membership (position held only):

3.1 Members:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Dr Ray Cash, VMO Consultant Psychiatrist, CYMHS, Children's Health Qld HHS
- Professor Philip Hazel, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace
- Ms Emma Hart, NUM, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rogers, Principal, Barrett Adolescent Centre School

The Chair on behalf of the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide additional input into the development of a contemporary evidence based model of care.

3.2 Proxies:
Due to the time limited nature of this reference group, it is unlikely that the use of proxies will be effective.

4. Chairperson

4.1 Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch (MHAODB)

5. Secretariat (position held only):

5.1 MHAODB will provide the secretariat to the Expert Clinical Reference Group.

6. Reporting relationships:

6.1 The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy.

7. Sub Committees:

7.1 Nil.

8. Frequency of meetings:

8.1 Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet on at least a fortnightly basis (in person or tele/videoconference) until a recommended model of care is developed. It may reconvene on an as needs basis to examine plans regarding the implementation of an endorsed model of care.

9. Quorum:

9.1 The quorum for Expert Clinical Reference Group meetings will be half of membership plus one.

10. Authorisation:

These Terms of Reference may be altered following committee consultation and endorsement by the Chief Executive West Moreton HHS and A/Executive Director MHAODB on the recommendation of the Expert Clinical Reference Group.

Chairperson: Dr Leanne Geppert, Director Planning and Partnerships Unit, MHAODB

Date: Signature: