3. The United Kingdom has a process of unofficial accreditation of adolescent inpatient units against a set of standards[7]. (This is described in Appendix 1, together with a self rating of how Barrett Adolescent Centre performs against these standards.) This measure provides some objective means of evaluating aspects of the unit. It is acknowledged within the UK[8,9,10] that they do not, provide a guide to the Model of Clinical care underpinning the service. (This is in the same way that the National Mental Health Standards provide a standard for services which allows for a number of differing models of clinical care.) These standards are the closest document to anything accepted as "best practice", although they actually only define some elements of practice.
4. No consensus exists in the literature about "Accepted best practice" for a clinical model. The literature describes multiple models of clinical care of individual units. Many variables are evident in the literature which does exist - some have a mix of acute and long term patients, others operate Monday to Friday, others do not take patients who are regulated or who are of high acuity. Many of these variable are critical to developing a clinical model.
5. Reference is made to the previous comments about developing an "evidence base". Had the Reviewers specifically enquired, they would have been shown the process of developing an evidence base for the unit. The naivety of their comments about "evidence base" will be discussed in more detail later. The evidence base for our clinical model has been drawn from an extensive literature, including that of interventions for particular disorders or behaviours, literature around rehabilitation and recovery, developmental and attachment literature etc. This is totally consistent with the **process** of evidence based practice – asking the question, seeking relevant research, critically examining the research and observing its applicability.

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[7] Davies G, Thompson P, Landon G (Eds) (2007) Quality Network for Inpatient CAMHS 4th Edition Royal College of Pyschiatrists.
[8] Gowers SG, Cotgrove AJ, (2003) The future or in-patient child and adolescent inpatient services *British Journal of Psychiatry 183:479-80*
[9] O'Herlihy A, Worrall A, Lelliott P, Jaffa T, Hill P, Banerjee S (2003) Distribution and characteristics of child and adolescent inpatient services in England and Wales *British Journal of Psychiatry 183:547-551*
[10] Tulloch S, Lelliott P, Bannister D, Andiapan M, O'Herlihy A, Beecham J, Ayton A (2008) The costs, outcomes and satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study. *Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSD0)*

6. The Reviewers were presented with a brief overview of the Model of Care on 26/2/2009, (including the methodology for examining the literature to develop the model, and an evaluation of the impact of this model for adolescents with histories of severe abuse). This overview was given so that the Reviewers had time to think about it overnight, and ask questions of the Director on the morning of 27/2/2009. They asked nothing about the model – only questions about the impact of the move to Redlands, procedures for selecting nursing staff etc.

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

FACTS: This statement lacks specifics, with no clarification in the recommendations as to what is meant. One of the Reviewers co-authored a paper[11] reviewing nursing handovers. This paper defined the aims of nursing handover being to directly improve patient care, decrease repeated patient questioning, attempt to reduce errors and enable every clinician treating a patient where the last clinician left off. To achieve these aims, they outline a number of optimal conditions for handover. Handover is in a comfortable room away from high stress environments where confidentiality is assured. It is done at set times, attendance is mandatory, is patient focussed, allows provision for questions, led by most senior nurse, and both reviews the most recent shift as the planning of care for the day. It is preferably multidisciplinary. It allows for staff support and debriefing. The amount of information should be monitored, so that there is enough to be adequate, but not too much to be overwhelming. They also discuss the medium for information – both written and verbal (and raise issues with respect to utilising technology).

The process of communication at Barrett is consistent with these conditions, within the constraints of the nursing conditions at The Park (8 hour shifts potentially do not allow for handover). This is addressed in part by staggered shifts to ensure some overlap. There are nursing handovers from night to morning, and from morning to

[11] Cleary M, Walter G, Horsfall J 2009 Journal of Psychosocial Nursing and Mental Health Services 47:28-33 Handover in psychiatric settings: is change needed?

afternoon staff. The biggest potential loss of information is not between shifts, but across shifts – incidents form the previous evening may not be adequately communicated to staff the next day.

In addition, there is a formal multidisciplinary handover on four mornings a week (the Monday Case Conference replaces this handover). The Reviewers had access to the Report books which contain a summary of relevant information for each patient, which is supplemented by verbal information.

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit. (See Appendix 2)

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

FACTS: Adventure Therapy and other Therapeutic Interventions. The Reviewers spent only an hour over lunch at a workshop we were running with 6 staff involved in delivering specific therapies. Only two of these staff were involved in adventure therapy. Adventure therapy is less than 15% of the time spent for these two clinicians in the total of their therapeutic interventions. Components of the adventure therapy program are run on 20 days a year. Given the limited number of staff involved and limited time devoted to Adventure Therapy, it is hardly likely they would have given the Reviewers the impression it was a major component of the service.

Had the Reviewers taken the opportunity to ask all of those staff and the Psychiatrist, about therapeutic interventions, a range of interventions would have been described including a range of CBT based therapies, some interventions from a more

psychodynamic perspective for adolescents with backgrounds of trauma (including utilisation of different media e.g. art, sand play), family therapy, a range of group interventions (including DBT), behavioural interventions for anxiety disorders, interventions specific to a range of Occupational Therapy interventions, specific interventions by nursing staff for symptoms of trauma which occurred more often in the evening and night..

Entries in the Clinical Record (including the three available to the Reviewers) of specific interventions are clearly marked "Care Coordinator". "Family Therapy", "Individual Therapy", "Groups", "Occupational Therapy", "Speech Pathology" etc. In the charts available to the Reviewers, there is clear documentation of the content of individual sessions with adolescents which make it clear in most cases about the nature of the intervention, and processes or goals of that session.

Milieu Therapy: It is acknowledged that the term "therapeutic milieu" has resulted in understandable confusion, although it is used in a general sense in a similar way in the child and adolescent inpatient literature[12,13]. We have deliberately chosen an environment which is not similar to that of "Milieu Therapy". Barrett Adolescent Centre is definitely not run as a "Therapeutic Community". The following outlines our approach to the environment or "milieu" in which adolescents live. This environment is not simply a passive context for therapeutic and rehabilitative interventions, but has the potential to enhance those interventions and provide an intervention in itself for rehabilitation.

1. Severe, persistent and complex mental illness in many adolescents is associated with impairments in adolescent development – the ability to negotiate school, develop peer relationships, develop competencies for independence, adequately care for themselves, develop organisational skills, occupy leisure skills, plan for the future, individuate from families, achieve moral maturities, identify and explore boundaries etc. These moratoriums on

[12] Green J, Jacobs B, Beecham J, Dunn G, Kroll L, Tobias C, Briskman J (2007) Inpatient treatment in child and adolescent psychiatry – a prospective study of health gains and costs *Journal of Child and Adolescent Psychology and Psychiatry 48:1259-1267*

[13] Jacobs B, Green J, Kroll L, Tobias C, Dunn G, Briskman J (2009) The effects of inpatient care on measured Health Needs in children and adolescents. *Journal of Child and Adolescent Psychology and Psychiatry 50:1273-1281*

development then perpetuate the mental illness or may engender others – e.g. prolonged absence from school secondary to persistent depression may be associated with secondary social anxiety.

2. The difficulties many adolescents have being able to recognise, identify, and appropriately express emotions contributes to the perpetuation of their mental illness.
3. The literature on rehabilitation in adolescents is relatively sparse, but there is an extensive literature on adolescent development. We have identified from this developmental literature 14 tasks of adolescent development (some of which are listed in point 1 above.
4. We use these 14 tasks as a framework to assess an adolescent's functioning in each task to gain a profile of strengths and impairments. This is an application from standard developmental literature to adolescent rehabilitation, given the lack of literature.
5. The BAC utilises numerous interventions to specifically address many of these developmental moratoriums.
6. There is an important non-specific opportunity to use the day to day routine, the day to day structure and underlying principles and regulations governing the unit to actively promote adolescent development rather than simply provide custodial care.
7. As well as day to day routine, the daily adolescent-adolescent interactions provide opportunities to promote various tasks of adolescent development e.g. social development, boundaries, moral development, leisure etc.
8. Adolescent-staff interactions in day to day life are also important in enabling the adolescent to reflect on qualities of parenting which may have been a major contributing factor to their current mental state.
9. Interactions with staff and other adolescents inevitably will arouse some emotions which the adolescent has found confusing in the much closer family context. These can be discussed with care co-ordinators, staff they trust at the time and with their individual therapist.
10. The day to day environment also provides opportunities to generalise skills learned in other tailored interventions.

11. Regular meetings between staff and adolescents enable the adolescent to have an input into their environment which contributes to their development of life schemas.

These apparently unstructured, but thoughtfully considered processes in points 6 – 11 describe what was referred to as the "therapeutic milieu". Nursing staff typically oversee these periods. The fact that it requires the observational, conceptual, assessment and capacity to implement interventions of the registered nurse rather than semi-skilled carers is an indication of the level of this intervention. It is an important component of the therapeutic and rehabilitative process. All elements are drawn from published literature, although not from one single comprehensive model. It awaits being given a more suitable name which encapsulates all of the above functions.

There is no doubt that while the value and nature of these interventions have been understood and incorporated into day to day interactions by many senior and key staff, this "therapeutic milieu" requires a less confusing name, better articulation, and specific training of staff.

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

COMMENT: There is an overlap between what was described previously as occurring in the day to day environment of Barrett and the thrust of Milieu Therapy as described by the Reviewers in last sentence of the above paragraph. There are two fundamental differences. The program at Barrett is more structured, with more directions from adults compared to traditional Milieu Therapy. Secondly, group dynamics and interventions (particularly reflections on the intra-group dynamics in the milieu and group decision making) play an important role in Milieu Therapy, This contracts with the milieu at Barrett where interventions by nursing staff are much more individualised, so that the adolescent is assisted to progress and implement new skills within the context of the milieu.

There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence.

FACTS: Multiple lines of evidence were available to the Reviewers of planned specific interventions for enhancing social skills and building confidence which are generalised through the everyday events and interactions. These would be documented in the clinical record as joint interactions between the care co-ordinator and the occupational therapist, psychologist, speech pathologist, teachers etc, and communicated to other staff via specific plans or in case conference and reinforced within the intensive case workup.

Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

FACTS: There are three issues here.

1. Structured activities e.g. groups, do occur in the afternoon into early evening on two afternoons a week. These groups were certainly running in February 2009. Little is planned on Friday afternoons because of the variable times a number of adolescents go on leave.
2. This is balanced against the need to make some time available for individual therapies and assessments outside of school time, as there are already a number of incursions into that time. These are scheduled into the other two afternoons of the Monday – Friday week.
3. All week day evenings contain some structured time for homework both to support the school program and because this is developmentally normalising.
4. During the so called "unstructured time" in the evening and on weekends, a range of interactions between nursing staff and adolescents occur. Some of these are planned e.g. an outing, a particular activity in which some adolescents are interested. These activities generalise the effects of specific group processes with respect to social interactions, leisure skills etc as well as generalising therapeutic interventions for anxiety etc.

5. The comments about nursing staff spending so much time on continuous observations is a clear indication by the nursing staff of their awareness of the impact that the lack of these interactions has on those adolescents for whom they are not available.
6. A decision was made some years ago to incorporate unstructured time into the program because adolescents going home on leave to unstructured environments retreated back to isolative activities, without knowing how to fill that time. We considered this to be more developmentally normalising, than providing structure throughout the evening and weekend.
7. Although nursing-adolescent interactions are important during this unstructured time, it is also important to provide opportunity for adolescent-adolescent interaction with supervision that it is maintained within appropriate parameters. Adolescents who have been socially isolated for lengthy periods typically find it easier to interact with adults than with peers. Ensuring there are opportunities for peer only interactions is important to overcoming social isolation outside the unit

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

COMMENT: We would not disagree with any of these observations about adventure therapy, although only partially describes the adventure therapy program at Barrett. As was noted previously, it is not a major intervention, but rather one which is considered as facilitating other, more primary interventions. The literature is indeed equivocal at best. All the literature we have examined has considered the outcomes of Adventure Therapy as a stand alone intervention. We incorporate it into our program on the basis of A-B-A outcomes in an individual (which varies from individual to individual and from disorder to disorder). It is has many components, some of which are described above.

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

FACTS: The loss of positions and facilities has had an impact on structured out of hours activities, but not the Adventure Therapy Program.

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

FACTS: The A1-A7 programs are a relatively minor part of the overall behavioural management program. Individual programs are a greater component, and were very much evident in the charts which the Reviewers reviewed. This is consistent with a fundamental principle of behaviour management programs that they are designed around an individual after an assessment of behaviour.

There is also a requirement from an adolescent's perspective that staff responses are consistent and perceived as being fair. This is the place of the A1-A7 programs for reinforcing the basic rules of the Centre. There can be tensions between the principle of providing individual behaviour programs and the principle of having a consistent response to challenging behaviours.

The A1-A7 programs are basic programs in managing a range of behaviours e.g. self harm, absconding, aggression, teasing, smoking etc. Adolescents are not automatically placed on a program when a behaviour is first manifest. The first decision is whether one of these programs is the most appropriate response. . An incident of physical aggression may result in an interview with police, and suspension from the unit rather than being placed on the A1 program.

Basically the programs describe a change in access to a range of activities available to the adolescent over a period of 24 hours. Modifying access to these activities has the potential for that behaviour being repeated. The effectiveness of this program is

reviewed after a 24 hour period. Contrary to the Reviewers comments, this is then documented in the chart at the end of the 24 hour period, and patterns of behaviour over a week are reviewed at Case Conference, and documented in the chart. The programs provide some process of uniformity of approach from the adolescent's perspective.

If behaviour continues beyond the 24 hour period, or patterns of behaviour are noted at the Case Conference to exist, individual behaviour programs are developed in consultation with key staff – typically the Care Coordinator, the psychologist and the Registrar or Psychiatrist. These are documented in the charts, and often individual behaviour programs are drawn up and displayed in the Nurses Station (with a copy in the chart).

The Reviewers examined charts of three adolescents. These contained many incidents of behaviours with a potentially damaging outcome for the adolescent or others. Instances of the use of the A programs was rare – mostly we relied on individual behaviour programs specific to that adolescent, with a clear indication of expected outcomes, documented evidence of reviews of the behaviour and the outcome.

In summary, comments about the A programs need to be considered in the context of their documented reviews at the time, and their rather limited scope in the range of behavioural interventions utilised at BAC.

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

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

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being

individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

FACTS: The clinical records which the Reviewers were asked to Review contained multiple examples of highly individualised behaviour management plans, with evidence of monitoring outcomes and adjusting the plan according to the outcome. Any variations or decisions not to follow through with a particular plan were documented in the chart. There was clear evidence in these adolescents with complex behaviours that behaviour programs were overwhelmingly individualised rather than using pre-typed forms.

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

FACTS:

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities.

FACTS: Issues around unstructured time were mentioned previously. This comment relates to the risk of critical incidents occurring during unstructured time.

1. Of 18 critical incidents occurring in the six months prior to the review, 10 occurred in structured time (0800 – 1700 hours).
2. 4 of the 8 incidents occurring in the period of "unstructured time" (1700 – 0800 hours) .

3. [redacted]

4. Attention is drawn to a paper around critical incidents from the Rivendell Unit[14] in which at lest one of the Reviewers worked. This describes a not dissimilar pattern of critical incidents. Half the critical incidents (mainly aggression) occurred during structured times. [redacted]

[redacted]

5. The evidence available to the Reviewers does not support the claim that critical incidents were related to periods of unstructured activities.

The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

FACT: There was ample evidence available to the Reviewers that they are.

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

FACTS: There is no disagreement that Adventure Therapy and Milieu Therapy should not be the cornerstone of a contemporary treatment program. They never have

[14] Barton G, Rey JM, Simpson P, Denshire E (2001) Aust NZ J of Psych 35:155-159 *Patterns of critical incidents and their effects on outcomes in an adolescent inpatient service.*

been a cornerstone at Barrett, although thinking through the various aspects of the milieu is a core part of the program,

The Reviewers propose alternate cornerstones namely two therapies specific to particular clinical issues. The Maudsley Eating Disorders Model is regarded as the closest to being an evidence based treatment for eating disorders in adolescents. DBT has an evidence base in the treatment of dysregulated behaviours in adults with Borderline Personality Disorder. Recommending these therapies highlight some issues with evidence based treatments in practice which are rarely made explicit.

1. In recommending these treatments, the Reviewers did not seem to appreciate that Barrett Adolescent Centre is a quaternary service. One could anticipate that as these approaches are most commonly recognised, they will have been tried in community CYMHS and acute adolescent inpatient units in the 12 – 24 months before the adolescent is admitted to BAC.
2. The Reviewers seem to be unaware of both the limitations in any treatment described in the literature to be effective for all people with a disorder and also the gap between treatments described in the literature for a disorder and difficulties in treating that disorder when it is severe and persistent. For example, the Maudsley model involves stages of family therapy over a period of time (around six months) according to gains in weight. Nowhere does the relatively sparse literature on the model describe repeated cycles of the treatment when the disorder relapses. Yet this is implied in the Reviewers recommendation
3. The Reviewers appeared to be unaware of potential difficulties in the application of an essentially adult based disorder (DBT) to adolescents. A literature is emerging, but even so there can be difficulties in its application I practice (a cornerstone of evidence based practice. Had they asked, the Reviewers would have been informed of our experience with DBT, the difficulties in its use with adolescents, and how the core elements have been adapted for adolescents at BAC. Among the difficulties we have encountered in adapting it to adolescents are difficulties in recognising emotions, difficulties in monitoring cognitions and difficulties for those who have experienced abuse in tolerating increased levels of awareness. Had they asked, they would have been informed of a capacity to utilise a therapeutic

intervention at one stage of treatment which they had not been able to utilise some months before.

4. The Reviewers appeared to be unaware that although the two mentioned have an evidence base for the treatment of the specific disorders, there are in fact multiple types of single interventions are described in the literature as being effective for a range of disorders. These trials of interventions either involve small numbers, or have no control groups. For example, Motivational Enhancement Therapy and Acceptance Commitment Therapy have both been described in the treatment of an eating disorder. Whilst the evidence base is not as strong, they may have a role in a particular adolescent. Our approach has been to encourage staff to gain expertise in a range of interventions, so that they can be adapted to a particular adolescent.
5. The Reviewers appeared to be unaware of an implicit paradox in the literature between evidence based treatments and clinical guidelines. For example, the RAZCP Guidelines on Anorexia Nervosa[15] describe a range of interventions delivered by a multidisciplinary team (including a Dietitian) in the management of anorexia. In contrast, the treatment literature describes single modes of intervention. Neither the Maudsley Model nor CBT-E includes a Dietitian in their approach. It is clear from a careful examination of the literature that the Maudsley Model is applicable to a sub-set of the whole population covered by the Clinical Guidelines.
6. The Reviewers ignore the considerable literature which attempts to examine the complexities of how measuring and describing the interaction of multiple interventions which clinicians in many settings utilise for those with more severe and persistent disorder. Because of these complexities, the level of evidence base for multiple interventions will never approach that for single interventions. The failure to recognise this ensures that interventions for adolescents with severe and complex illness will always lag behind those with less severe forms of disorder.

Finally a previous review noted that "not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are

[15] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*

comfortable with on a voluntary basis" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

FACTS: These comments are based on comments from the Community Visitor's Report, not from interviews with staff. The process of developing and participation in groups is outlined below.

1. Adolescents are assessed with respect to a range of skills, needs, emotional problems etc. Group interventions are designed around the needs of groups of adolescents (this different groups will be run from time to time to meet the needs of a group of adolescents).
2. Clinicians decide which adolescents will participate in any particular group. Factors taken into account in forming a group include clinical need (as outlined above), risk issues, benefits from any previous similar groups, potential for negative adolescent-adolescent interactions for particular combinations of adolescents, potential for disruptive behaviours.
3. Adolescents are informed about their inclusion or non-inclusion in the group.
4. Participation is mandatory if the group is regarded as core to their treatment or rehabilitation, unless there is a clinical reason not to e.g. level of risk has changed.
5. A suitable behavioural management program is implemented for non-participation in a group due to simple non-compliance.
6. The only exception have been where the level of anxiety involved in participation are greater than initially assessed, and the adolescent would be likely not to benefit.

Recommendations:

1. The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

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

FACTS: Barrett Adolescent Centre for many years utilises the Primary Nurse Model with components of the Case Management Model. This would have been clear to the Reviewers with multiple entries in the clinical records they had at their disposal marked "Care Coordinator" and signed by the relevant staff member with RN besides the name. In addition one of the Reviewers worked for several years at BAC in this model. They were very proficient in the role of Primary Care Nurse, did Case Management and should have been well aware of these roles. In addition the other two Reviewers attended a section of the Recovery Intensive where the Nursing Model was presented, and ways in which it could be generalised to community settings discussed.

These models are used in combination to facilitate a supportive environment and high standard of care for adolescents in longer term care with a stable core of staff. Adolescent and staff needs can be addressed on a shift basis. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Primary Nursing Model are:

- Continuity of care, better discharge planning
- Improved patient satisfaction
- Professional satisfaction – more sophisticated nursing skills developed
- Works well in mental health etc.

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Needs full time staff to work well *(Generally stable staffing at BAC with average lengths of stay in excess of two years. This may have not been as evident to the reviewers as a number of longer term staff had resigned in the preceding twelve months.)*
- Assumes longer length of stay *(therefore applicable to BAC)*
- Resource intensive – all RN workforce with high level of skill *(therefore applicable to BAC)*
- Lack of variety –care of same patients/long inpatient stay *(because of the active rehabilitation/treatment environment, the reverse is true – it enhances professional satisfaction)*
- Medical staff may resist due to perceived loss of control *(the reverse is true – the Director perceives the value to enhanced patient outcomes by having a skilled nursing staff whose professionalism is stimulated by the role)*

Aspects of the Case Management Model relate to continuity of care into the community and when the adolescent is on trial leave, or changes status from full inpatient to either partial hospitalisation or day patient. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Case Management Model are:

- Patient centred
- Better for chronic illness
- Better transition to the community
- Improved quality of care for the patients
- Early intervention – prevent readmission

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Attachment of nurse, patient and patient dependence on nurse. *(Adolescents have inputs from a number of staff besides the care co-ordinator. This minimises the risks of attachment to an individual. On the other hand, where an adolescent has experienced disrupted attachments over a considerable period, the Primary Nurse Model and Case Management Model enables*

stability and the opportunity to work through issues pertaining to the qualities of parenting they have experienced.

Each patient is assigned a Case Coordinator (CC), a Registered nurse, who is responsible for the Coordination of care from the time of admission until discharge. It is felt that this model is best for continuity of care, consistency, development of a therapeutic alliance with the patient and allows for ongoing contact with the patient following discharge. In addition it helps to streamline communication with the multidisciplinary team, primarily through the weekly Case Conference meetings and the bi-monthly Intensive Case Workups. On a shift-by-shift basis the Case Coordinator or associate (registered nurse, enrolled nurse) is the main contact for the patient and at times when they are not on shift the Clinical Nurse acts as 'surrogate CC'. When the CC is on leave a detailed handover is given to an acting CC who fills the role in their absence. Care co-ordination is a means of advocating for the adolescent, providing personalised care and adds to job satisfaction.

The allocation of tasks is part of the day to day management of any inpatient nursing environment. Task allocation is seen as the most practical and safe way to effect certain tasks on a daily basis:

- Risk Management. Both continuous and intermittent observations are shared amongst the staff as evenly as possible according to a roster drawn up by the CN at the beginning of each shift. In line with The Park observation policy, staff are not allocated more than two hours continuously (in practice usually one hour); or more than four hours total per shift (usually less) of continuous observation. The same consideration is given to the allocation of intermittent observations.
- There is a "clinic nurse" assigned to medications, first aid, physical obs etc. This is rostered among RNs on a shift by shift basis. This leaves less room for medication error through miscommunication.
- A nurse is assigned by the Clinical Nurse on shift to carry a two way radio to respond to duress alarms
- If a heightened need for consistency is identified, a patient may be assigned an 'allocated nurse' for each shift.