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Re: New Barrett

From: Judi Krause [redacted]
To: Stephen Stathis [redacted]
Cc: Ingrid Adamson [redacted]
Date: Tue, 17 Mar 2015 17:32:00 +1000

I agree we need the voice of reason here, surely Bill has an obligation to give a clinical mental health opinion to the Premier, sad reflection of our politics really!! Go hard Stephen, happy to help if I can. Having fun at kangaroo Island, local seals are very cute!!
Talk soon
Judi

Sent from my iPhone

On 17 Mar 2015, at 5:32 pm, "Stephen Stathis" [redacted] wrote:

Thanks Ingrid.

I am happy to talk to the Premier's office and Health Minister, even if the Branch feel constrained (Bill's position as the Acting Dep DG may cause a conflict of interest here).

I would strongly support this being escalated to Fionnagh; aim for a meeting between her, us and the gov't.

This needs to be actioned asap.

Stephen

Sent from my iPad

On 17 Mar 2015, at 4:23 pm, "Ingrid Adamson" [redacted] wrote:

Hi Judi/Stephen,

I just need to raise my escalating concern that there seems to be an absence of clinical justification in our briefing to the Minister and/or Premier regarding the election proposal for a "new Barrett". MHAODB forwarded the attached brief that they prepared last week - Bill decided, after discussion with the Minister's Office, to pull it. The plan of attack now is to prepare a Policy Submission to go to the "Election Commitment Team" for consideration - this is due Friday.

I note that the Brief doesn't make any reference to the kind of literature review/research Michael provided below, and doubt the Policy Submission will either.

I have been getting my messages through Anna at the Branch and, if I have understood correctly, they don't feel they can tell the Premier that it is not a good idea, but rather are working on the "hope" that the costs alone will turn them off building a new centre. Rest assured the ex-BAC community won't give a hoot how much it costs...in the absence of any other argument/option, they will just want a new centre.

This seems like a very uninformed approach to quite a significant change in service approach. I wonder if this is something we should be escalating to Fionnagh to see if there is any way we can facilitate a conversation with the

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Minister and/or Premier's Office to discuss the clinical reasons why CHQ has adopted the AMHETI model of service, and how the current research and evidence does not support long term (>12mths) inpatient admission for extended treatment; nor does the population support diversion of significant financial resources to Townsville when 74% of adolescents reside in SE Qld.

What are your thoughts???

...or should I just prop myself up in the corner with a bottle and start rocking? ☺

-----Original Message-----

From: EMILY DAUBNEY [REDACTED]

Sent: Friday, 13 March 2015 9:31 AM

To: Ingrid Adamson; Stephen Stathis; Marie Kelly; Anna Davis; Judi Krause

Subject: Literature Summary: Management of Adolescents severe

Hi everyone from Perth.

Below is a literature summary with references. Please feel free to edit etc. if it is due in today I won't be able to make changes as I am training all day.

However if it is due next week I can look at it again over the weekend.

Best wishes

Michael

Literature Summary: Management of Adolescents severe and persistent Mental Health Problems.

Adolescence is an important time for mental health intervention. The prevalence of adolescent mental health problems in Australia is substantial accounting for more than half of the disease burden in this age group. Mental health problems in adolescence are associated with ongoing social and academic difficulties and increased morbidity and mortality later in life. (Kennair 2011) Adolescents with severe mental health difficulties receive intervention from a broad range of services internationally and the is an overview of the literature.

Whilst there are recognised methodological challenges and limitations to this literature, multiple reviewers of this area come to a number of similar conclusions: An integrated system of care is required and current international trends are for a continuum of care approach, adequate community treatment being important in any system of care including assertive outreach services and there is a growing evidence base for predominantly outpatient based interventions for emerging personality disorder (Gowers 2005). The parts of a continuum with an evidence base are inpatient units, day programs, residential treatment, intensive mobile outreach services and community clinics.

Inpatient treatment has been influenced internationally by managed care funding, an adoption of treating adolescents in the least restrictive environment and the concern that there is the risk of potential harm by an admission e.g. regression. This had lead to a significant decrease to average length of stay with the average being under five days (Carlisle 2012). Of note, acute inpatient adolescent units treat adolescents with multiple risks and severe presentations. (Tongue 2008, Usman 2014). A number of factors have been found to consistently associated with improvement, including involvement of the family in intervention, a coherent framework of

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management on the ward and the availability of community services.

A consistent finding has been that length of stay in an adolescent unit has not been a consistent factor in outcome. (Blank 2000, Hansen-Bauer 2011) Whilst some authors have noted an increase in re admission rates with briefer length of stay, in general this is affected by the level of community services available. The outcomes studies of acute inpatient unit show an improvement in a number of domains post discharge and with maintenance of this improvement being influenced by community intervention. Reviews note that inpatient units remain essential treatment settings for selected adolescents (Garrison 2006) with evidence of good clinical outcomes (Hansen-Bauer 2011, Mathai 2009)

A number of articles were reviewed where the length of stay was longer than what has been defined in the literature as an acute admission (30 days). (Blanz 2000, Green 2001, Hoyer 2002, Harnett 2005, Nadkarni 2012, Pfeiffer 1990, Rothery 1995) A striking finding was that only one article had admissions for longer than 6 months, with many being between 1 and 3 months. (Paterson 1997) The authors found improvement in a number of domains during admission. Similar factors were found as for acute inpatient units in terms of improvement and in one study, most of the improvement occurred in the first month of hospitalisation. (Green 2001) Like acute inpatient units, these units treat adolescents and families with severe and complex presentations and risk factors. (Paterson 1997) When studied, the most common diagnosis was a psychotic illness.

Several reviews of day programs have found improvement in symptoms and general functioning in adolescents and their families. (Deenadayalan 2010; Kennair 2011; Kiser 1996). There is a growing evidence base for specialist adolescent outreach services including a decrease in hospitalisation, improvement in symptoms and risk, and increased engagement with education. (Assan 2008, Chia 2013, Duffy 2013, Lamb 2009, Preyde 2011, Schley 2008, Schley 2011, Simpson 2010). Rapid response outpatient follow up has been associated with decreased admission rate with a decrease in suicidality and increase in function. (Greenfield 2002). Whilst a complex literature, in general Residential mental health treatment for adolescents has been shown to be effective (James 2011, Lamb 2009, Rishel 2014) however maintenance of improvement may be dependent on community follow up after placement.

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Sent from my iPad

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