| Key Component | Key Elements | Comments |
|---|---|---|
| | | psychiatrist |
| **Case Review** | • the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months | • the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed<br>• the adolescent, referring agencies and other key stakeholders will participate in the Case Review process |
| | • all members of the clinical team who provide interventions for the adolescent will have input into the case review | • the consultant psychiatrist will chair the case review meeting<br>• documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions |
| | • ad hoc case review meetings may be held at other times if clinically indicated | • these will be initiated after discussion at the case conference or at the request of the adolescent |
| | • progress and outcomes will be monitored at the case review meeting | • where possible this will include consumers and carers<br>• appropriate structured assessments will be utilised<br>• the process will include objective measures<br>• annual audits will ensure that reviews are being conducted |
| **Case Conference** | • a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan | • a consultant psychiatrist should be in attendance at every case conference |
| | • risk assessments will be updated as necessary in the case conference | • the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed<br>• risk will be reviewed weekly or more frequently if required |
| **Record Keeping** | • all contacts, clinical processes and care planning will be documented in the adolescent's clinical record | • progress notes will be consecutive within the clinical record according to date |
| | • clinical records will be kept legible and up to date, with clearly | • personal and demographic details of the adolescent, their |

| Key Component | Key Elements | Comments |
|---|---|---|
| | documented dates, author/s (name and title) and clinical progress notes | parent/carer(s) and other health service providers will be up to date |
| | • there will be a single written clinical record for each adolescent | • the written record will align with any electronic record |
| **Record Keeping** | • all case reviews will be documented in the adolescent's clinical record | • actions will be agreed to and changes in treatment discussed by the whole team and recorded |
| **Discharge Planning** | • discharge planning should begin at time of admission with key stakeholders being actively involved. | • the adolescent and key stakeholders are actively involved in discharge planning<br>• discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service |
| | • discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family | • the AETRC School will be primarily responsible for and support school reintegration |
| | • discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge | • the Registrar and Care Coordinator will prepare this letter<br>• it should identify relapse patterns and risk assessment/ management information<br>• follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter |
| | • a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AETRC | • this will be prepared by the clinicians involved in direct Interventions |
| | • if events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord | |

| Key Component | Key Elements | Comments |
|---|---|---|
| | with their risk assessments<br>• in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion | |
| **Transfer** | • depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit<br>• transfer to an adult inpatient unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs | |
| **Continuity of Care** | • referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission | • referrers and significant stake holders are invited to participate in the Case Review meetings<br>• the Care Coordinator will liaise more frequently with others as necessary |
| **Team Approach** | • specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave | • joint interventions can only occur if clear communication between the AETRC and external clinician can be established |
| | • responsibility for emergency contact will be clearly defined when an adolescent is on extended leave | • this will be negotiated between the AETRC and the local CYMHS |
| | • case loads should be managed to ensure effective use of resources and to support staff | |
| | • staff employed by the Department of Education and Training will be regarded as part of the team | |

## 4. Service and operational procedures

### The AETRC will function best when:

- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- team members are provided with regular supervision
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service

**Caseload**

Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team.

Under normal circumstances, care coordination will not be provided by students or staff appointed less than 0.5 FTE. Typically Care Coordinators are nursing staff.

**Staffing**

The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology and other specialist CYMHS staff. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

Administrative support is essential for the efficient operation of the AETRC.

All permanently appointed medical and senior nursing staff be appointed (or working towards becoming) authorised mental health practitioners.

**Hours of Operation**

- access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
- nursing staff are rostered to cover shifts 24 hours, 7 days a week
- an on-call consultant child and adolescent psychiatrist will be available 24 hours, 7 days per week
- 24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available. A mobile response will not be available
- routine assessments and interventions will be scheduled during business hours (9am - 5pm) 7 days a week

**Referrals**

Referrals are made as in Section 3 above.

**Risk Assessment**

- written, up to date policies will outline procedures for managing different levels of risk (e.g. joint visiting)
- staff safety will be explicitly outlined in risk assessment policy

- risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team

**Staff Training**

Consumers and carers will help inform the delivery of staff training where appropriate.

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

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

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

## 5. Clinical and corporate governance

The AETRC will operate as part of the CYMHS continuum of care model.

Clinical decision making and clinical accountability will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director. At a local level, the centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate, a Parent Representative and the School Principal. This team will meet regularly in meetings chaired by the Consultant Psychiatrist.

The Centre will be directly responsible to the corporate governance of the Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. Interim line management arrangements may be required.

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services

- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC.

## 6. Where are the Services and what do they look like?

The Adolescent Integrated Treatment and Rehabilitation Centre is currently located at Wacol (the Barrett Adolescent Centre). It is anticipated it will move to Redlands Hospital in 2011.

## 7. How do Services relate to each other?

- formalised partnerships
- Memorandum of Understandings between government departments
- guidelines
- statewide model of CYMHS
- the AETRC is part of the CYMHS network of services in Queensland as described in Section 3

## 8. How do consumers and carers improve our Service?

Consumers and carers will contribute to continued practice improvement through the following mechanisms:

- consumer and carer participation in collaborative treatment planning
- consumer and carer feedback tools (e.g. surveys, suggestion boxes)
- consumers and carers will inform staff training

Consumer and carer involvement will be compliant with the National Mental Health Standards.

## 9. What ensures a safe, high quality Service?

- adherence to the Australian Council of Health Care Standards (ACHS), current accreditation standards and National Standards for Mental Health Services
- appropriate clinical governance structures
- skilled and appropriately qualified staff
- professional supervision and education available for staff
- evidence based treatment modalities
- staff professional development
- clear policy and procedures
- clinical practice guidelines, including safe medication practices

**The following guidelines, benchmarks, quality and safety standards will be adhered to:**

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007: http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.
- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html
- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

**Legislative Framework:**

The Adolescent Extended Treatment Centre is gazetted as an authorised mental health service in accordance with Section 495 of the *Mental Health Act 2000.*

## 10. Key resources and further reading

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*
- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program

- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

{ FILENAME \p }

# Adolescent Extended Treatment & Rehabilitation Centre Model of Service

## Queensland Public Mental Health Services

Queensland Government

# 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. 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. Their 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. This continuum of care ensures that adolescents are treated in the least restrictive environment possible, which recognises the need for safety, with the minimum possible disruption to their family, educational, social and community networks.

The AETRC operates on the premise that adolescents can and do recover from mental illness. A range of treatment and recovery focused rehabilitation, psychosocial, educational and vocational programs tailored to the adolescent's assessed clinical and rehabilitation needs is facilitated in collaboration with a range of service providers. This enables the adolescents to build on their strengths, progress in their development and promote recovery focused outcomes upon discharge. Education programs provided by the dedicated school (an integral part of the AETRC) provide essential components of rehabilitation programs and restoration of developmental tasks.

AETRC are gazetted as authorised mental health services in accordance with Section 495 of the Mental Health Act 2000 [http://www.health.qld.gov.au/mha2000].

The key functions of an AETRC are:

- 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.
- Providing multidisciplinary and collaborative consultation, diagnostic assessment, treatment and evidence informed clinical interventions and rehabilitation including recovery and discharge planning for adolescents to facilitate reintegration back to community based treatment.
- Providing flexible, and targeted programs that can be delivered in a range of contexts including, school, community, group and family
- Provide individually tailored, targeted, phased, evidence informed 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.
- To provide family centred support and clinical interventions for families and carers to optimise adolescent functioning within their home environment.
- Provide intensive support to enable successful transition back to the community through arranging, coordinating and supporting access to a range of services for adolescents, to ensure seamless service provision. 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.

AETRC functions go towards:

- providing high quality care in the least restrictive environment to adolescents and their families/carers with a focus on building resilience, fostering individual and family wellbeing, and assisting in the recovery of an appropriate developmental trajectory
- assisting adolescents and their families/carers to maintain hope and progress in their recovery, and to live with mental health problems where such problems persist in the long term
- provide varying levels of care on the basis of acuity of behaviours associated with mental illness; with consideration to providing a safe and therapeutic environment for adolescents, staff and visitors
- assist with establishment of care systems for transition to the community

The AETRC will be able to:

- Appropriately involve adolescents, their families and/or carers in all phases of care and support them in their navigation of the mental health system.
- Convey hope, optimism and a belief in recovery either from mental illness or to living optimally with a mental illness for adolescents, families and /or carers.
- Provide evidence informed assessment and treatment services.
- Provide treatment and rehabilitation within an appropriate timeframe. (In specific cases when the admission exceeds 6 months the adolescent must be reviewed with the referring team to ascertain the potential clinical gains of continued inpatient admission or community treatment.)
- Provide appropriate levels of observation, supervision and individual support.
- Provide information, advice and support to families and/or carers.
- Establish a detailed understanding of local resources for the support of adolescents with mental health problems.
- Promote and advocate for improved access to general health and care services for adolescents.
- Manage psychiatric emergency situations safely and effectively.
- Ensure a timely discharge and a return to community-based services.
- Support adolescents, and their families/carers cross the broad continuum of care, including facilitating smooth transition to other appropriate services and post discharge support and follow up.

Following involvement within the AETRC, it is expected that adolescents will have:

- remission of or optimal improvement in the symptoms of their mental illness through intensive treatment;
- stabilisation of behavioural and emotion regulation patterns impacting on their function;
- improved functioning in key areas of development that had been impacted by their mental illness including educational or vocational programs, involvement in social networks, leisure and recreational pursuits;
- improved functioning in areas which have been impacted by developmental co-morbidities;
- a recovery plan which ranges in concepts from recovery from mental illness to recovery which necessitates adjustment to mental illness;
- a management plan to identify potential precipitants to and warning signs of a relapse of mental illness;
- supported, intensive re-integration into the community through implementation of a comprehensive discharge plan negotiated with the adolescent and their family or carers.

## 2. Who is the service for?

The AETRC is available to Queensland adolescents who are aged 13 – 17 years with severe and complex mental illness:

- have had a range of less restrictive interventions with specialist services in adolescent mental health, but still have persisting symptoms of their mental illness and consequent functional and developmental impairments; and
- who will benefit from a range of clinical interventions and
- require extended and intensive clinical intervention ranging from day admission to an inpatient admission.

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. This is often 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 Personality Disorder and Separation Anxiety 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 AETRC. 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 the AETRC School

In making a decision the panel will consider the:

- 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 AETRC
- 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)
- potential adverse impacts posed by the adolescent to other inpatients and staff. (e.g. the risks posed by substantiated forensic history of offences of a violent nature or evidence of inappropriate sexualised behaviour)
- potential adverse interactions with other adolescents at a particular time
- possible safety issues

A comprehensive recovery and preliminary 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

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.

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?

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.<br>• Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc.<br>• This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders<br>• This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities |

| Key component | Key elements | Comments |
|---|---|---|
| | | (Housing & Homelessness) and Education Queensland |
| | **3.1.4**<br>AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect. | • Mandatory child protection reporting of a reasonable suspicion of child abuse and neglect.<br>Hyperlink to:<br>• 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].<br>child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf].<br>• mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf] |
| | **3.1.5**<br>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.<br>Hyperlinks to:<br>• interpreter services [http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp]<br>• hearing impaired/deafness [http://www.health.qld.gov.au/pahospital/mentalhealth/docs/damh_con_info.pdf]<br>• transcultural mental health [http://www.health.qld.gov.au/pahospital/qtmhc/default.asp]<br>• Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 [http://qheps.health.qld.gov.au/atsihb/docs/atsiccf.pdf]<br>• Indigenous mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/indigenous.asp]<br>• multicultural mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/multicultural.asp] |

| Key component | Key elements | Comments |
|---|---|---|
| | **3.1.6**<br>Provision of appropriate educational services | • The AETRC School is a dedicated facility provided by the Department of Education, Training and Employment. It is regarded as an integral part of the AETRC. |
| **3.2.0**<br>**Referral, access and triage** | **3.2.1**<br>Referrals to the AETRC are made by Queensland services providing specialist adolescent mental health treatment. | • All new service referrals will be to the Clinical Liaison Clinical Nurse as a single point of entry.<br>• Clear information regarding referral pathways to AETRC, including service entry criteria, will be available to referrers.<br>• Referral agencies are supported to remain actively involved during AETRC admission and continue their role as a major service provider following discharge (unless another appropriate referral is made). |
| | **3.2.2**<br>An initial decision is made at intake whether or not to accept an adolescent for assessment for provision of service. | • This initial decision will take into account<br>- The age of the adolescent referred<br>- Level of risk<br>- Clinical criteria<br>- Ability/willingness to engage in the AETRC Program<br>• This decision is made by the Consultation Liaison Person and the intake panel. |
| | **3.2.3**<br>Prior to admission, an assessment interview is arranged. This assessment involves the adolescent, their parent(s) or carers and significant others where appropriate. | • This assessment interview helps to clarify suitability for admission and potential interactions within a particular mix of adolescents on the AETRC.<br>• This assessment interview is an opportunity to orientate the adolescent to the AETRC.<br>• A general information pack will be available on first presentation for all adolescents and families/carers.<br><br>Hyperlinks to:<br>• Information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. |
| | **3.2.4**<br>The initial assessment interview will extend the information available | • The assessment interview allows the clinician to gauge how the adolescent and their families/ |

| Key component | Key elements | Comments |
|---|---|---|
| | from the referrer to obtain a detailed assessment of the nature of mental illness, its behavioural manifestations, impact on function and development and the course of the mental illness<br><br>Hyperlinks to:<br>• consumer assessment form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_conass.pdf].<br>• risk screening tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf]. | carer talks about current symptoms and their level of understanding of the mental illness<br>• It provides opportunity to understand development over several years, and how development has been impacted by the mental disorder if this is not available in the referring information<br>• It provides opportunity to gather specific information which may be relevant to rehabilitation and recovery. |
| | **3.2.5**<br>Potential treatment, rehabilitation and recovery goals will be explored with the adolescent and their families and/ or carers. | • Although prior to developing a formulation, these goals are indicative to the adolescent and their families/carers of what the AETRC may be able to provide.<br>• Discussion of goals at this stage allows some assessment of the understanding and commitment of the adolescent and their families/carer to the process of attending and being involved with the AETRC |
| | **3.2.6**<br>Suitability for entry to the CAPD will be undertaken by a multidisciplinary team (MDT) intake panel that will consist of CADP:<br>• Consultant psychiatrist<br>• Clinical Liaison Clinical Nurse<br>• NUM<br>• Allied health representative<br>• Principal AETRC school | • MDT intake panel meetings will occur weekly.<br>• This decision will take into account<br>o Level of risk<br>o Clinical criteria<br>o Admission Priorities<br>o Diagnostic Mix<br>o Ability/willingness to engage in the AETRC. |
| | **3.2.7**<br>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. | • Where possible, admissions are conducted as part of a collaborative assessment and treatment plan between the AETRC and the specialist adolescent mental health service referring the adolescent. |
| | **3.2.8**<br>If there is a waiting period prior to admission, the Clinical Liaison Clinical Nurse will liaise with the | • This process monitors changes in acuity and the need for admission to help determine priorities for |

| Key component | Key elements | Comments |
|---|---|---|
| | referrer until the adolescent is admitted. | admissions.<br>• 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.<br>• This expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted. |
| **3.3.0 Mental Health Assessment** | **3.3.1** Prior to admission the Consultation Liaison Clinical Nurse will obtain a detailed history of the mental health assessments and interventions to date for the adolescent and their family | • The preliminary assessment helps to avoid unnecessary duplication of assessments.<br>• Information from the preliminary assessment is integrated into subsequent assessments<br>Hyperlinks to:<br>• mental health clinical documentation [http://qheps.health.qld.gov.au/mentalhealth/clinical_docs.htm].<br>• statewide standardised clinical documentation CYMHS user guide [http://qheps.health.qld.gov.au/mentalhealth/docs/cyms_user.pdf]. |
| | **3.3.2** From the referral information and the interview arranged on referral, a preliminary formulation is developed and presented to the team to plan further targeted assessments and develop an initial treatment and rehabilitation plan | • The formulation is reviewed and refined at case review meetings |
| | **3.3.3** Targeted assessments will be prompt and timely. | • Targeted assessments include formal psychological, occupational therapy, speech and language assessments.<br>• These assessments may assist in diagnostic clarification, assessment of symptom severity, developmental variables and functional assessments<br>• The outcome of assessments will be promptly communicated to the adolescent, the families and/or carers, and other stakeholders (with consent of the adolescent) |
| | **3.3.4** | • All risk assessments will be |

| Key component | Key elements | Comments |
|---|---|---|
| | Risk assessments will be conducted on admission in to the AETRC and be routine thereafter. A risk assessment will be documented prior to transfer or discharge. Risk assessments will include:<br>• a formalised suicide risk assessment, assessment of risk to others and absconding risk<br>• a component of standardised measurement processes. | recorded in the clinical record, and will be used to formulate a risk management plan. In the initial assessment the risk assessment will be conducted as one component of a comprehensive mental health assessment.<br>• Risk management protocols will be consistent with Queensland Health policy.<br>Hyperlinks to:<br>• integrated risk management policy [http://qheps.health.qld.gov.ay/audit/IRM_Stream/RM_Policy/13355_08_2.0.pdf].<br>• risk screening tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf].<br>• child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. |
| | **3.3.5**<br>Child safety concerns will be addressed in accordance with mandatory requirements.<br>Hyperlink to:<br>• child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf], | Hyperlink to:<br>• child abuse and neglect [http://qheps.health.qld.gov.au/csu/childabuseneglect.htm].<br>• 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. |
| | **3.3.6**<br>Assessments of alcohol and drug use will be conducted on entry to the Program and routinely throughout ongoing contact with the service. | |
| | **3.3.7**<br>Physical and oral health will be routinely assessed, managed and documented.<br>Hyperlink to:<br>• physical examination and investigations form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_physical.pdf]. | • Documented evidence of physical and oral health assessments or referral will be in the clinical record and included in the consumer integrated mental health application (CIMHA) database.<br>• Clinical alerts (e.g. medication allergies and blood-borne viruses) must be documented.<br>• 100 percent of adolescents have a nominated GP.<br>• Adolescents and their families/ carers will be actively supported to access primary health care |

| Key component | Key elements | Comments |
|---|---|---|
| | | services and health improvement activities.<br>• Any potential health problems identified will be discussed with the adolescent and family/carers, and where appropriate with the GP or other primary health care provider.<br>Hyperlink to:<br>• CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm].<br>• General Practice Queensland - A Manual of Mental Health Care in General Practice [http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mangp]. |
| | **3.3.8**<br>The outcome of assessments will be communicated to the adolescent, family/carer and other stakeholders as appropriate, in a timely manner. | |
| | **3.3.9**<br>Educational history and attainments will be assessed from admission to the AETRC and throughout the admission | • The education provider for the AETRC will ascertain schools attended, history of attendance, educational attainments and history of educational support where appropriate<br>• The education provider will assess current levels of attainment in different subjects<br>• The education provider will assess progress in subjects |
| | **3.3.10**<br>Assessment of family structure and dynamics will continue during the course of admission to the AETRC | • This process begins with the assessment interview and continues throughout the admission. |
| | **3.3.11**<br>The AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development | • This assessment occurs throughout the admission. |
| | **3.3.12**<br>*Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor. | Hyperlink to:<br>• *Mental Health Act 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf]. |
| **3.4.0**<br>**Clinical review** | **3.4.1**<br>All adolescents will be discussed at a multidisciplinary team review | • A consultant psychiatrist or appropriate medical delegate will participate in all MDTRs. |

| Key component | Key elements | Comments |
|---|---|---|
| | (MDTR) at least weekly to integrate information from and about the adolescent, interventions that have occurred, and to review progress within the context of the case plan | • All MDTRs will be documented in the adolescent clinical record, the consumer care review summary, and in CIMHA.<br>Hyperlink to :<br>• Child and Youth Mental Health Services Consumer Care Review Summary form [http://qheps.health.qld.gov.au/mentalhealth/docs/cy_cc_review_sum.pdf]<br>• CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm].<br>• Individual care/treatment plans (ICTP) [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_recplan.pdf]. |
| | **3.4.2**<br>In addition to the weekly MDTR, ad hoc clinical review meetings will be scheduled when required (e.g. to discuss cases with complex clinical issues, following a critical event or in preparation for discharge). | • Critical events will be reviewed utilising the clinical incident management implementation standard.<br>Hyperlink to:<br>• clinical incident management implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf]. |
| | **3.4.3**<br>Continual monitoring of the adolescent's progress towards their recovery plan goals will occur through a process of structured clinical reviews involving the adolescent and their parents or carers, the AETRC multi-disciplinary team (including the AETRC School) and relevant external community agencies including the referring specialist adolescent mental health service provider and potential discharge provider if these may differ. | • Care Plans are formally reviewed and updated at intervals ideally of two months, but not more than three months.<br>• The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed<br>• The viewpoint of the adolescent, family and/or carer and their community based supports such as teachers and community mental health case managers will be considered during the reviews.<br>• 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 |

| Key component | Key elements | Comments |
|---|---|---|
| | | summary, A copy is to be downloaded and included in the clinical file.<br>• Outcomes of clinical reviews will be discussed with adolescent and family and/or carer.<br>• Any changes to the recovery plan will be made in collaboration with the adolescent, family and/or carer.<br>• Structured risk and review processes will be utilised.<br>• National Outcomes and Casemix Collection, and others based on each adolescent's individual requirements. |
| | **3.4.4**<br>Each adolescent's progress will be routinely monitored and evaluated including the use of outcome measures. | Hyperlink to |
| **3.5.0 Recovery planning and Relapse Prevention** | **3.5.1**<br>Recovery plans are developed in way that assists adolescents and their families/carers to maintain hope and progress in their recovery, and to live with mental health problems where such problems persist in the long term. | • Services are based on the principles of recovery which in relation to adolescent's includes developmental processes and may also be applied to parents, carers and entire families.<br>Hyperlink to:<br>• Child and Youth Mental Health Services Recovery Plan (http://qheps.health.qld.gov.au/mentalhealth/docs/cy_recovery_plan.pdf.)<br>• Sharing responsibility for recovery: creating and sustaining recovery oriented systems of care for mental health (http://qheps.health.qld.gov.au/mental health/docs/recovery.pdf.) |
| | **3.5.2**<br>An individual recovery plan will be developed with all adolescents and their families and/or carers. Review of progress and planning of future goals will be integrated into the recovery plan. | • Recovery plans identify:<br>- available supports<br>- crisis management strategies<br>- therapeutic goals intervention processes<br>- psycho-educational needs<br>- relapse prevention strategies.<br>• Recovery plans may also include strategies for improving:<br>- family functioning<br>- pro-social and developmentally appropriate interests and hobbies,<br>- peer functioning<br>- quality of life (such as time to |

| Key component | Key elements | Comments |
|---|---|---|
| | | experience developmentally relevant play and fun)<br>- achievement at school/ vocational goals, and mastery over the tasks of adolescence.<br>• Recovery plans will be updated at a frequency determined by change or need, but will be formally reviewed at least three monthly (to review routine outcome measures, treatment progress and any change in needs). |
| | **3.5.3**<br>Recovery and relapse prevention planning is discussed in partnership with every adolescent, their family and/or carers, and in collaboration with other service providers. | • Adolescent's, their families and/or carer's are strongly encouraged to have ownership of, and sign, their recovery plans.<br>• Changes to the recovery plan will be discussed with the adolescent, family/carer, and relevant service providers.<br>• All changes to the recovery plan will be discussed with the MDTR. |
| | **3.5.4**<br>Recovery planning is almost always partially or fully reliant on the relationship between the adolescent, family and/or carer, their resilience and their individual circumstances. | • Whilst adolescents 13-17 years gain further independence and mastery to separate from their family and/or carer, evidence suggests that adolescents with mental health problems require support in re-connecting with their parents. |
| | **3.5.5**<br>Every effort will be made to ensure that recovery planning focuses on the adolescent's own goals. | • Where conflicting goals exist (e.g. for adolescents receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the adolescent and the family/carer goals values. |
| **3.6.0 Clinical interventions** | **3.6.1**<br>All aspects of service delivery will reflect the development of collaborative relationships between adolescents and staff. | • AETRC will demonstrate a focus on strengths, connectedness, personal involvement, personal choice and empowerment and increasing confidence in accessing the system. |
| | **3.6.2**<br>Adolescents will be supported to access a range of biopsychosocial interventions and rehabilitation services which meet their individual needs. All interventions must demonstrate attention to developmental frameworks and will | • Clinical interventions will demonstrate evidence informed practice.<br>• Interventions will be based on recovery principles.<br>• Multidisciplinary input will be provided to optimise adolescent recovery. |

| Key component | Key elements | Comments |
|---|---|---|
| | be evidence informed | • Interventions will include relapse prevention programs and/or techniques.<br>• Basic human rights, such as privacy, dignity, choice, anti-discrimination and confidentiality are recognised, respected and maintained to the highest degree possible in all clinical interventions. |
| | 3.6.3<br>Clinical interventions are guided by assessment, formulation and diagnostic processes, using a developmentally appropriate, biopsychosocial approach. | • This will take into consideration the strengths and resilience within the individual, their family and their community.<br>• The consent of the adolescent or parent/guardian to disclose information, and (where needed) to involve family/carers in recovery planning and delivery, will be sought in every case.<br>• Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent<br>• Informed consent is documented in the clinical record, detailing that the adolescent/guardian understands the recovery plan.<br>• In most case it is necessary that the guardian agrees to support the provision of ongoing care to the adolescent in the community. Where an adolescent is admitted without adequate involvement of a guardian, alternate supports in the community will be developed<br>• Education and information will be provided to the adolescent, family/carers and significant others at all stages of contact with the service.<br>• A shared understanding will be fostered for all aspects of treatment, including risk management, with explicit, documented evidence of the shared understanding in the clinical file.<br>Hyperlinks to:<br>• information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].<br>• *Health Services Act 1991;* |

| Key component | Key elements | Comments |
|---|---|---|
| | | Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf].<br>• right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp].<br>• *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf].<br>• carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp] |
| | **3.6.4**<br>Clinical care and the development of both prevention and treatment services should derive from the best available evidence and recognise the frequently complex and multi-factorial nature of mental disorders in adolescents. | |
| | **3.6.5**<br>During service provision, adolescents and their families/carers will have access to and be supported to engage in a range of evidence-informed therapeutic interventions to optimise their rehabilitation, resilience, recovery and relapse prevention. | • Treatment will be provided in the least restrictive setting that properly balances the adolescent's autonomy with their need for observation and treatment in a safe environment. |
| | **3.6.6**<br>A range of flexible and integrated therapeutic, resilience, rehabilitation and recovery focussed interventions are delivered and/or coordinated by the multidisciplinary team. | • Interventions may be individualised, group based or generic programs. |
| | **3.6.7**<br>Individualised evidence-informed interventions include:<br>• Psychological interventions (verbal and non-verbal therapies and education);<br>• Pharmacotherapy<br>• Family therapy and education;<br>• Individualised behavioural programs.<br>• Individualised life skills | • Interventions may include art therapy, music therapy, sand play therapy.<br>• ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000*<br>*Hyperlink to:*<br>• electroconvulsive therapy guidelines<br>• [http://qheps.health.qld.gov.au/me |

| Key component | Key elements | Comments |
|---|---|---|
| | programs<br>• Individual sensory modulation<br>• Biological treatments e.g. Electroconvulsive Therapy | ntalhealth/docs/ect_guidelines_31960.pdf] |
| | **3.6.8**<br>Interventions delivered in groups include:<br>• Individual educational or vocational plans; and<br>• A range of information and skills building groups which are adapted to the needs of a group of adolescents<br>• A range of predominantly activity-based groups which are tailored to meet the needs of a particular group of adolescents and aimed at intervening in areas of psychological and developmental need. | • Examples of information and skills building groups include social skills, dialectical behaviour therapy groups<br>• Examples of activity based groups include community access, adventure therapy groups |
| | **3.6.9**<br>Generic interventions include:<br>• Maintaining a milieu with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and management of the adolescent group to maximise each adolescent's care;<br>• Encouraging peer support opportunities, where available, for adolescents and/or families to appropriately engage with past consumers/carers for peer support;<br>• Forming appropriate therapeutic alliance;<br>• Providing opportunities for activities of daily living, leisure, social interaction and personal privacy; and<br>• Supporting healthy lifestyle decisions. | • Building and maintaining a therapeutic alliance with the adolescent and their family/carers is at the heart of almost all clinical interventions with young people.<br>• A range of mediums may be used for intervention as adolescent may choose to express their thoughts and feelings through the medium of play and other forms of expressive therapy such as art and music. |
| | **3.6.10**<br>Individualised educational or vocational programs will be developed for each adolescents | • The AETRC School will develop individual educational goals with the adolescent taking into account academic capacities and mental |

| Key component | Key elements | Comments |
|---|---|---|
| | and are integrated with their clinical state | state<br>• Curriculum will be provided by external education providers including an adolescent's current school curriculum,.<br>• The school program is determined by the School Principal after continuing consultations with clinicians.<br>• The AETRC School will contribute to life skills programs to prepare the adolescent for work skills or transition to the community |
| | **3.6.11**<br>Carers are integral to the mental health care process<br>Family members are provided with emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and well being. | • Adolescents under 18 years of age are a child at law[1] and are developmentally dependent on adult guidance and support, which reduces from infancy to adulthood at a rate that ideally promotes achievement of the appropriate developmental tasks and developmentally appropriate family relationship.<br>• Consequently, interventions to promote recovery are as much focussed on engaging with the carer as the adolescent and are frequently based around family work and parent-adolescent work.<br>Hyperlink to:<br>• carers matter [http://www.health.qld.gov.au/mhcarer/]. |
| | **3.6.12**<br>Mental health services implement a range of multidisciplinary strategies to manage psychiatric emergencies to ensure the safety of the adolescent and others within the immediate environment | Interventions for self harm behaviours include:<br>• using questionnaires to determine the reasons for the incident of self harm<br>• increased visual observations<br>• restricting access to areas of the ward where an adolescent can be observed<br>• 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<br>• use of medication if indicated<br>• The adolescent is informed of and encouraged to utilise strategies to |

[1] CYCMHS (like all health services for children and adolescents) must be cognisant of the implications of this legal status.

| Key component | Key elements | Comments |
|---|---|---|
| | | use alternatives to self harm, e.g. talking with staff, use of the sensory room, utilising non-verbal therapies. |
| | **3.6.13**<br>Staff will utilise a range of de-escalation behavioural interventions for behaviours which may be a threat to the safety of others. | • Parents/carers are immediately informed of changes in a adolescent's behavioural presentation<br>Behavioural interventions for behaviours which cause harm to others include:<br>• verbal de-escalation<br>• use of outside environment where safe<br>• use of safe forms of reducing aggression e.g. sensory room, punching bag<br>• 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<br>• use of medication if indicated<br>• review of precipitants to aggression<br>• 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. |
| | **3.6.14**<br>Medication will be prescribed, administered, and monitored as indicated by clinical need and will involve shared decision making processes between the treating team and the adolescent.<br>All pharmacological interventions including prescriptions, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards | • Antipsychotics and other psychotropic medication will be prescribed in accordance with Queensland Health clinical practice guidelines.<br>• Strategies to improve compliance with medication regime must be in place.<br>• Monitoring of medication side-effect will be routinely conducted.<br>• The metabolic monitoring form will be used for all adolescents on antipsychotic or mood stabiliser medication.<br>• Adolescent's personal goals for medication will be incorporated with staff's clinical knowledge.<br>• The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards. |

| Key component | Key elements | Comments |
|---|---|---|
| | | Hyperlinks to:<br>• Metabolic monitoring form [http://qheps.health.qld.gov.au/mentalhealth/docs/metabolic_mon_form.pdf]<br>• clinical guidelines [http://qheps.health.qld.gov.au/mentalhealth/guidelines.htm].<br>• medication liaison on discharge [http://qheps.health.qld.gov.au/medicines/documents/general_policies/medic_liaison_discrg.pdf].<br>• National Health and Medical Research Council (NH&MRC) Guidelines for Management of Depression (when available)<br>• acute sedation guidelines for children and young people (under development)<br>• therapeutic guidelines-psychotropic [https://online-tg-org-au.cknservices.dotsec.com/lp/]. |
| | **3.6.15**<br>Management of physical health of adolescents will be in association with a primary health care provider. | • All adolescents will receive information about physical health issues.<br>• Adolescents will be supported to access primary health care and health improvement services.. |
| | **3.6.16**<br>Time to provide emotional support to the adolescent and carer/s will be given adequate priority. | • This type of support will assist with engagement, concordance with treatment regime, etc |
| | **3.6.17**<br>Education and information will be provided at all stages of contact with the service. | • This will include a range of components such as education, information about the mental health disorder/s or problem/s, progression through the service, mental health care options, medications (benefit, usage, potential side effects and potential effects of missing doses/stopping), support services, recovery pathways, etc |
| **3.7.0**<br>**Team approach** | **3.7.1**<br>A multidisciplinary team approach will be provided. The AETRC School is an integral part of the team. | • The adolescent, family and/or carer will be informed of the multidisciplinary model.<br>• Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision.<br>• Clinical, discipline and peer supervision will be available to |

| Key component | Key elements | Comments |
|---|---|---|
| | | individual staff and the team. |
| | **3.7.2**<br>Clear clinical and operational leadership will be provided staff and for the team | • There will be a well defined and clearly documented local process for escalation of discipline specific clinical issues. |
| | **3.7.3**<br>Case management processes will be managed to ensure effective use of resources and to support staff to respond to crises in an effective manner. | Hyperlink to:<br>• case management policy [http://qheps.health.qld.gov.a/mentalhealth/docs/casemanage_polstate.pdf]. |
| **3.8.0**<br>**Continuity of care and care co-ordination** | **3.8.1**<br>Clear documented 24 hours, 7 days per week, mental health service contact information is provided to adolescents, families, carers referral sources and other relevant supports. | • Provision of this information will be documented in the clinical record, including the recovery plan and the discharge summary,<br>• Relevant information documents detailing specific service response information will be readily available. |
| | **3.8.2**<br>Every adolescent will have a designated treating consultant psychiatrist. | • This will be recorded in the CIMHA as the internal contact, treating consultant psychiatrist. |
| | **3.8.3**<br>Prior to admission, a Care Coordinator will be appointed for each adolescent will be noted on CIMHA as principal service provider | • The Care coordinator will be responsible for:<br>• providing centre orientation to the adolescent and their parents/carers<br>• assisting the adolescent to identify, develop and implement goals for their recovery and crisis management plans in partnership with the family/carer where appropriate.<br>• acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process<br>• assisting the adolescent in implementing strategies from individual and group interventions in daily living<br>• providing a detailed report of the adolescent's progress for the care planning meeting.. |
| | **3.8.4**<br>AETRC will actively engage with other treating teams in coordination of care across inpatient (acute and non acute) and community settings. In particular, responsibility for | • Referring services providing specialist and adolescent mental health treatment to maintain clinical/professional contact with the PSP via case reviews, email, tele-links, video – links, telephone |

| Key component | Key elements | Comments |
|---|---|---|
| | emergency contact will be clearly defined when an adolescent is on extended leave. | and face to face contact.<br>• Open communication between the AETRC and the local ACT team is essential for after hours crisis care for the adolescent and their family/carers. |
| | **3.8.5**<br>The adolescent's treating team will be identified in the clinical record, MDTR documentation and communication will be maintained throughout the phase of care. | • The PSP and other service providers [redacted] will be recorded in the CIMHA and remain constant during the phase of care. |
| | **3.8.6**<br>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<br>• An example would include the referrer providing parent support while the adolescent is in the AETRC |
| | **3.8.7**<br>Community based supports are included in recovery planning and discharge planning wherever possible. | • Non-government organisation service providers who have established (or are establishing) support links with the adolescent, families and/or carers will be given access to AETRC as appropriate.<br>• All community based supports will be co-ordinated prior to discharge.<br>• The process for sharing information will be explicitly documented for each case taking existing privacy and confidentiality considerations into account.<br>Hyperlink to:<br>• Health Services Act 1991 part 7 Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/confguidelines.pdf]. |
| **3.9.0 Transfer/transition of care** | **3.9.1**<br>Disengagement with AETRC will not occur before the receiving team has made contact, scheduled a first appointment and confirmed attendance at the scheduled appointment. | • Guidelines for internal transfers will be clearly written, and receiving teams will make assertive efforts to establish contact within a reasonable time period.<br>• The time period will be individually determined at a local level between AETRC and the receiving team/s.<br>• A feedback mechanism is in place so that the receiving team informs the referring team if the |

| Key component | Key elements | Comments |
|---|---|---|
| | | adolescent fails to attend or if significant problems occur or recur. |
| | **3.9.2**<br>Clearly documented provisions will be outlined between the AETRC, community services and acute inpatient units for adolescents who may experience crisis during the transition phase. | • Where transfer is inevitable, all services need to make direct contact and ensure safe transfer (service capability will be considered). |
| | **3.9.3**<br>A timely written handover will be provided on every transfer occasion.<br>Hyperlink to:<br>• consumer end of episode/discharge summary [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_consumer.pdf] | • Both a written and verbal handover will be provided to the receiving team within a week of day of transfer. |
| | **3.9.4**<br>Adolescents and their families/carers will be informed of transfer procedures. | • Families/carers will be informed of the transfer in a timely manner as consent will be required for the transfer.<br>• Families/carers will be provided with relevant information concerning reasons for transfer and expected outcomes.<br>Hyperlinks to:<br>• *Health Services Act 1991*: Confidentiality Guidelines [http://www.health.qld.gov.au/fol/docs/conf_guidelines.pdf]<br>• right to information and information privacy [http://www.health.qld.gov.au/fol/default.asp]<br>• Information sharing between mental health workers, consumers, carers, family and significant others. [http://www.health.qld.gov.au/mentalhealth/docs/info_sharing.pdf]. |
| | **3.9.5**<br>Adolescents transferred under an involuntary treatment order will remain the responsibility of the transferring service until the first medical assessment is completed. | Hyperlinks to:<br>• Mental Health Act 2000 [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf]<br>• MHA2000 Resource Guide [http://qheps.health.qld.gov.au/mhalu/resource_guide.htm] |
| **3.10.0 Discharge/external** | **3.10.1**<br>Planning for discharge from AETRC | • The referring specialist adolescent mental health service providers |

| Key component | Key elements | Comments |
|---|---|---|
| transition of care | will commence at the time of referral. | and families/carers will be included in all aspects of discharge planning.<br>• DMHS will give priority to adolescents transferring back to their district from AETRC.<br>• The decision to discharge is at the discretion of the consultant psychiatrist in consultation with the MDT. |
| | **3.10.2**<br>Discharge planning is a component of each adolescent's Recovery and Relapse Prevention Plan. | • it is anticipated that support may be required on discharge for the adolescent and their family and/or carers.<br>Hyperlink to:<br>• recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf]. |
| | **3.10.3**<br>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 adolescent and their family<br>• 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<br>• Discharge planning recognises the needs at times that re-admission may be necessary where risk of relapse is high. |
| | **3.10.4**<br>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<br>• The adolescent will be integral to all planning for accommodation on discharge<br>• Parents providing a safe and supportive environment will always be involved in planning for accommodation on discharge.<br>• 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?<br>• Any decision to not return the |

| Key component | Key elements | Comments |
|---|---|---|
| | | 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<br>• 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<br>• The adolescent will be equipped to live independently in preparation for discharge outside of home<br>• 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 |
| | **3.10.5**<br>AETRC discharge planning and support for adolescents includes:<br>• Facilitating contact between the adolescent, their family or carers and their community case manager (PSP) as well as relevant other support services; and<br>• Maintaining collaborative relationships with a wide range of service providers including general practitioners, education providers, extended family and carers, general community health services and/or adult mental health services to meet the needs of the adolescent and enhance their capacity to effectively manage in a less intensive environment and enable recovery. | • |
| | **3.10.6**<br>The discharge plan will include a relapse prevention plan, crisis | Hyperlink to:<br>• crisis intervention plan [http://qheps.health.qld.gov.au/pati |

| Key component | Key elements | Comments |
|---|---|---|
| | management plan, and service re-entry plan. | entsafety/mh/documents/mh_cip.pdf] |
| | **3.10.7**<br>Comprehensive liaison and handover will occur with all other service providers who will contribute to ongoing care. | • All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) same day as discharge.<br>• Relapse patterns and risk assessment/management information will be provided where available.<br>• A follow-up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the discharge letter was received.<br>• Discharge summaries will be comprehensive and indicate relevant information including diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral.<br>• Compliance with the mental health clinical documentation is the minimum requirement for documentation.<br>Hyperlink to:<br>• mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm]. |
| | **3.10.8**<br>Adolescents will be encouraged to actively contribute to (and countersign) their discharge plan. | • Family/carers will also be directly involved in discharge planning.<br>• Where adolescents are lost to follow-up, there will be documented evidence of attempts to contact adolescents, family/carers and other service providers before discharge. |
| | **3.10.9**<br>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. | • Every attempt to engage with specialist mental health service providers will be made on discharge and the adolescent supported to attend |
| | **3.10.10**<br>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. | • Transfer procedures will be discussed with adolescents, their family and carers.<br>• Processes for admission into an adult acute mental health inpatient unit will be followed, with written |

| Key component | Key elements | Comments |
|---|---|---|
| | | and verbal handover provided. |
| **3.11.0 Collection of data, record keeping and documentation** | **3.11.1** AETRC will enter and review all required information into the CIMHA in accordance with approved statewide and district business rules. | Hyperlink to:<br>• CIMHA business rules [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm]. |
| | **3.11.2** AETRC will utilise routine outcome measures as part of assessment, recovery planning and service development. These will include those mandated through the National Outcomes and Case mix Collection (NOCC):<br>- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)<br>- Strengths and Difficulties Questionnaire (SDQ)<br>- Children's Global Assessment Scale (CGAS)<br>- Factors Influencing Health Status (FIHS). | • Outcomes data is presented at all formal case reviews and will be an item agenda on the relevant meeting agendas.<br>• Results of outcomes are routinely discussed with the adolescent and their family and/or carers.<br>• Outcomes data is used with the adolescent to:<br>a. record details of symptoms and functioning<br>b. monitor changes<br>c. review progress and plan future goals in the recovery plan.<br>Hyperlink to :<br>• NOCC collection protocol: http://qheps.health.qld.gov.au/mhlnfo/documents/collproty1.6.pdf |
| | **3.11.3** All contacts, clinical processes, recovery and relapse prevention planning will be documented in the adolescent's clinical record. | • Progress notes will be consecutive (according to date of event) within all hard copy consumer clinical records.<br>Hyperlinks to:<br>• Queensland Health Child and Youth Mental Health Services Statewide Standardised Suite of Clinical Documentation User Guide [http://qheps.health.qld.gov.au/mentalhealth/docs/cyms_user.pdf]<br>• Clinical Documentation [http://qheps.health.qld.gov.au/mentalhealth/clinical_docs.htm] |
| | **3.11.4** Clinical records will be kept in accordance with legislative and local policy requirements.<br>Hyperlink to:<br>• retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf]. | • Personal and demographic details of the adolescent, their family/carer and other health service providers will be kept up to date.<br>• Mobile or tablet technology will support increasing application of electronic record keeping. |
| | **3.11.5** Local and statewide audit processes | |