1.0 INTRODUCTION

In 2000, Cabinet endorsed a proposal to undertake a study on the development of secure in-patient mental health services for incarcerated children and youths in youth detention centres and the redevelopment of the extended treatment adolescent in-patient services. Cabinet instructed that this study be considered in the context of the Ten Year Mental Health Strategy for Queensland 1996.

The development of the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994) provided the framework for the reform of mental health services in Queensland consistent with the objectives of the National Mental Health Strategy (1992) and the National Mental Health Plan (1998). The Ten Year Mental Health Strategy for Queensland (1996) advances the key directions and strategic framework of Queensland's mental health policy and plan for the implementation of structural and service reform.

The Ten Year Mental Health Strategy for Queensland, the Aboriginal and Torres Strait Islander People Queensland Mental Health Policy Statement (1996) and the Future Directions for Child & Youth Mental Health Services (1996) provide a complex, sensitive and interrelated multi-dimensional approach to improve the quality of life and service provision for children, youth and adults with mental disorders or mental health problems.

This multi-dimensional approach incorporates service principles of mainstreaming, integration and self-sufficiency within a consumer focussed and least restrictive framework. Key objectives include:

- significant enhancement of community mental health services;
- the reorganisation of the service delivery system, specifically the role and functions of the existing hospital system;
- the improvement of intersectoral links; and
- the review of mental health legislation and the introduction of updated legislation that supports contemporary mental health service delivery;

The Queensland Forensic Mental Health Policy Statement aims to promote, improve and maintain the mental health of children, young people and adults who have a mental disorder or serious mental health problem, and are involved in the criminal justice system. The policy emphasises the rights of the individual to optimal care, based on clinical need, and provided in the least restrictive setting. This needs to be balanced against the rights of the public to protection from risk of harm. The policy promotes a greater role for district mental health services in the provision of mental health services to the target population.

2.0 SCOPE OF THE STUDY

This study will examine the following:

2.1 the need for secure inpatient beds for young offenders based on data provided by Department of Families (DOF), Youth Justice Branch, Brisbane Child & Youth Forensic Mental Health Service (who have provided a service to the Brisbane Youth Detention Centre since February 2001), and Townsville Child & Youth Mental Health Service (who provide a service on a needs basis to Cleveland Youth Detention Centre);

2.2 service delivery models necessary to meet the mental health needs of children and young people incarcerated in detention centres who have a mental illness or serious mental health problem, and who require assessment and/or treatment in a secure setting to ensure the safety of the person and the community;

2.3 a review of the extended treatment adolescent mental health service that is delivered at the Barrett Adolescent Centre, located within the Wolston Park Hospital complex at Wacol;

2.4 population projections across the state in order to determine future child and adolescent mental health service requirements on an equitable and best practice basis.

3.0 BACKGROUND

The 10 Year *Mental Health Strategy for Queensland* (1996) outlines the provision of community mental health services for children and adolescents, as well as acute inpatient services and day treatment programs. The inpatient services foreshadowed in the Strategy include:

Children

- Royal Children's Hospital,
- Mater Misericordiae Children's Hospital
- Gold Coast District Health Service
- Toowoomba District Health Service
- In regional locations it is recommended that dedicated beds may be constructed in general paediatric in-patient settings either as part of a paediatric unit or, where the bed numbers are sufficient, as a discrete in-patient unit.

Adolescents

- Royal Brisbane Hospital
- Logan- Beaudesert District Health Service
- Gold Coast District Health Service
- Toowoomba District Health Service
- Cairns District Health Service

Using the planning guidelines outlined in the *10 Year Mental Health Strategy for Queensland* (1996), it can be determined that Queensland had the need for 94 beds for children and adolescents in 2001 and will need 117 beds (64 children and 53 adolescent) by 2006.

The number of beds actually established to date has been below the planning guidelines as illustrated by the following table that sets out the current bed capacity for children and adolescents.

	Current Beds	Age Group	Date Opened
Children:			
1. RCH – Child & Family Therapy Unit	10	0 –14 years	July 1983
Young People:			
2. Royal Brisbane Hospital	12	15 – 18 years	July 1996
3. Logan	10	15 – 18 years	July 2000
4. Barrett Adolescent Centre	15	15 – 18 years	June 1984
5. Cairns Base Hospital (Special Care Suite)	4	15 – 18 years	1997 (* not dedicated to child and youth)
Combined Children and Adolescent:			
6. Gold Coast	11	0 – 18 years	Aug 2000
7. Mater	8	0 – 14 years	July 2001
"	4	15 – 18 years	July 2001
8. Toowoomba	6	0 – 18 years	Nov 2001
Total number of inpatient beds in Queensland for Children and Adolescents	**80 BEDS**		

The number of child and adolescent beds has therefore increased from 25 (in 1996) to 80 beds (in 2002). Currently, there are 26 child beds (0-14 years) and 54 adolescent beds (15-18 years) available. With the exception of the special care suite in Cairns (that is not dedicated to use by children and adolescents), all are located in the south-east corner of the state.

4.0 CURRENT UTILISATION OF INPATIENT SERVICES

Analysis of state-wide data for 1999-2000 shows the average level of occupancy for all child and adolescent units running between 50 and 65%. However, the figures for Gold Coast, Logan and Mater units should be viewed with caution since these units were operational for a short period of time only during these years, and were still in the early stages of development. Occupancy rates may also not be entirely reflective of the level of demand as units managing particularly difficult children/adolescents may reduce their admission numbers temporarily in order to boost the staff/patient ratio to facilitate the management of a client.

Bed utilisation data for the Barrett Adolescent Centre indicates that in 2000/01 there has been a reduced demand for adolescent beds but an increased usage of the beds for the assessment and treatment of children. Despite this the bed utilisation rate is well below the 50% rate. The

reasons for this are not clear, and require further investigation, but this was beyond the scope of this study.

The admission of adolescents to the four bed Special Care Suite, operational within the adult acute mental health unit at Cairns Base Hospital, has been limited due in part to the paucity of experienced child/adolescent clinicians, and to the increased demand for psycho-geriatric patients and women with post-natal depression.

In the absence of dedicated child and adolescent mental health inpatient beds beyond the south-east corner, mental health services from regional centres in the Central and Northern Zones advise that significant numbers of young people are consistently admitted to general hospital wards or adult acute in-patient mental health units.

While collectively the numbers are significant in the regional centres, the need for dedicated facilities at all of the identified sites is clearly not supported by the data. Access to a supraregional facility located in a geographically central and accessible site would be the most desirable solution for both Central and Northern Zones In the absence of this, alternative models, such as inpatient facilities in paediatric wards should be further explored as a priority for these sites. Equally, where adolescents are admitted to adult inpatient units, appropriate expertise and treatment options for this age range must be available.

5.0 SERVICES TO INCARCERATED YOUNG OFFENDERS

[1]The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) 1985 state in part 5, sec 26.3 that juveniles *'in institutions shall receive care, protection and all necessary assistance for social, educational, vocational, psychological, medical and physical needs, that they may require because of their age, sex, and personality and in the interests of their wholesome development'.*

Whilst incarcerated young offenders were identified as a priority target group in the 10 Year Mental Health Strategy for Queensland, there has been no establishment of dedicated secure acute inpatient facilities for [2] severely mentally disturbed young offenders under 18 years of age.

A Forensic Community Mental Health Service has operated within the Royal Children's Hospital and District Health Service at Spring Hill for many years, but has focused primarily on the assessment of parental competence for child protection applications, limited psychometric testing and expert witness presentations in court in relation to these matters. Hence, it did little to meet the needs of incarcerated young offenders.

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[1] The United Nations Standard Minimum Rules for the Administration of Juvenile Justice. (The Beijing Rules) 1985

[2] The term 'severely mentally disturbed' applies to those diagnosable psychiatric conditions that adversely affect the psychosocial development of children and adolescents, and contribute to major interactional difficulties in their social environment. These diagnoses are outlined in the international classification systems ICD9-CM and ICD10, and the United States' systems DSM-IIIR and DSM-IV. They are a heterogenous group of conditions with significant differences from those which appear in adulthood. Some are categorical entities (for example, adolescent bipolar disorder) where the disorder is either present or absent. Others (for example, phobic anxiety disorder) are more dimensional, and shade from normal variation into disorder. Where the line is drawn between mild and severe disorder is a clinical decision determined by the extent of the impairment or disability caused.

Prior to February 2001, there had been a series of visiting mental health services to Sir Leslie Wilson, Cleveland and John Oxley Youth Detention Centres. These were variously sourced from Queensland Health and the private sector. Demand for the service depended largely upon the following:

- The practice of the courts in requesting pre-sentence reports, which may include a request for a mental health assessment, and
- Requests from detention centre staff concerned about the mental health of a young incarcerated person.

Overall, the response to these requests by the visiting medical services was often less than satisfactory. This was due, in part, to a lack of congruence between the requests (particularly for pre-sentence reports) and identified service priorities.

In response to recommendation 10 of the Forde Inquiry, Queensland Health committed $1 million recurrently to improving mental health and general health services to youth in detention centres. Following a substantial collaboration between Queensland Health and Department for Families, an overarching service model has been developed. The full implementation of this model is now proceeding following finalisation of the Memorandum of Understanding between the two departments. However prior to the finalisation of the MOU in September 2002, an interim mental health service had been operating at Brisbane Youth Detention Centre (from February 2001), whilst the Cleveland Youth Detention Centre had been serviced on a needs basis by the Townsville Child and Youth Mental Health Service.

Since the commencement of the adolescent units at Royal Brisbane Hospital (1997) and Logan Hospital (2000), young offenders from detention centres in Brisbane who require acute inpatient mental health treatment have been admitted to these units. When this has occurred, the young offenders are generally accompanied for the duration of the admission by staff from the youth detention centre. Admissions tend to be short, with early discharge back to the detention centre and follow-up in this setting by a visiting psychiatrist. Whilst this option for inpatient treatment is reported anecdotally to be reasonably satisfactory to the staff involved, and no adverse events have been reported, it is not seen as a desirable process in the longer term for a number of reasons. Firstly, it creates an inconsistency with the adult sector where patients are admitted from courts, watchhouses and prisons, and responsibility for their custody is handed over to health staff. Additionally, there is a significant impact on the overall therapeutic milieu of the inpatient ward by having detention centre staff 'guarding' one patient, and the potential for a significant negative impact on other patients in the ward.

There appear to have been few, if any, admissions of youth from the Cleveland Detention Centre in Townsville to an inpatient facility, hence it is not possible to comment on the practices to date in North Queensland. Townsville does not have an adolescent ward.

Data from the Department for Families, Youth Justice Branch (March, 2002) and the Cleveland Youth Detention Centre provides information with regard to the number of incarcerated young people in these two centres. The daily average number of young people incarcerated during 2001 in the two detention centres was fewer than 100. The average number in the Brisbane Youth Detention Centre was 69, and the Cleveland Youth Detention Centre was 25. 51% of this total includes young people on remand, and 55% of the total are Indigenous young people.

It should be noted that this data does not include those young people aged between 17 and 18 years who have been charged and/or convicted of an offence, and who are subject to the adult *Penalties & Sentencing Act 1992*, with the outcome that they are incarcerated within the adult correctional system.

Equally the data provided does not identify those young people included in the numbers above who are over 18 years of age. (These young people were sentenced as 17 year olds, the age they committed the offence, and there is provision within the *Juvenile Justice Act* for them to serve their sentences in a Youth Detention Centre, rather than transfer to adult corrections.)

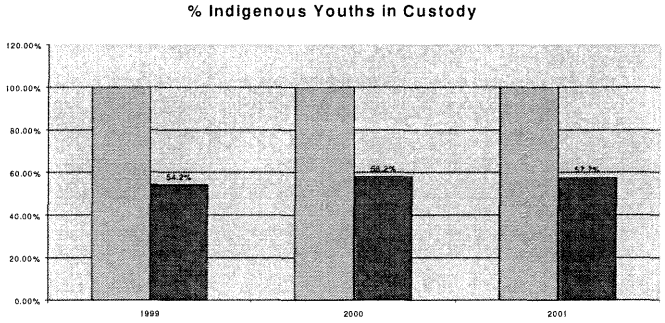
Both of these issues illustrate a lack of consistency that exists between Queensland Health, Department for Families, Youth Justice, Queensland Police and Correctional Services whereby the cut off age for inclusion within a program area shifts between 17 and 18 years.

Data obtained from the interim Brisbane Child and Youth Forensic Mental Health Service to the Brisbane Youth Detention Centre provides a greater understanding of the mental health needs experienced by young people incarcerated during the 2001 calendar year. The total number of referrals received by the interim forensic mental health services over the 12 month period was 117; this number represents 100 males and 17 females. Of the total, there were 45 indigenous young people, comprising 37 males and 8 females.

Females represent approximately 8% of the detention centre population, most of whom are referred for mental health assessment and treatment. This referral rate is consistent with national and international trends for the female offender population, where it is considered there may be a tendency to over-pathologise. Conversely, it is acknowledged internationally that there may be limited recognition of the need to refer male offenders for specialist mental health assistance.

5.1 INDIGENOUS ISSUES

The data in the following table clearly identifies the continuing over-representation of indigenous adolescents within the juvenile justice system. While indigenous children and adolescents comprise 1.41% of the [3]Queensland population between the ages of 0 – 18, they make up 55 - 60% of the [4]detention population. The over representation of indigenous children and adolescents is amplified at each stage in the criminal and juvenile justice systems, from arrest through to detention, indicating they are more likely to be treated in a manner that moves them deeper into the juvenile justice system.



[3] ABS Census data 1996
[4] Department of Families, Youth Justice Branch data 2002

At the same time, indigenous children and adolescents are under served by the mental health system. Many children and adolescents entering the juvenile justice system have either not received any assistance or have been poorly served by the systems in their communities, including the mental health system. For example:

- When they do receive services, indigenous children and adolescents with mental health problems tend to be diagnosed with more severe disorders, including disorders less amenable to treatment. [5]This suggests that prevention, early identification and early intervention services may be less available to indigenous children, adolescents and their families.

- Indigenous adolescents (particularly males) are more likely to be referred to the juvenile justice system rather that the treatment system, and indigenous juvenile offenders are less likely than their white counterparts to have previously received mental health services.

- In the past, indigenous and other immigrant groups have shown low rates of use of mental health services, due in part to the history and policies of past governments and to language differences and lack of locally based services.

5.2 SENTENCING & TREATMENT:

The available data also highlights the challenge for youth justice and mental health in their provision of services for young people incarcerated on remand, and those serving brief sentences. The average time served on remand for the year 2001 was 38 days; and the average time served for sentenced offenders was 112 days. These short periods of incarceration impact upon the type of service delivery that can be offered within the detention centre, and highlight the critical need for strong linkages between mental health services within the detention centre and those in the young person's local community, in order to provide a comprehensive continuum of care that is acceptable and sustainable to the young person, their guardian and family.

There is also a clear need for the development of a protocol between adult and adolescent services, necessary to ensure the provision of the most appropriate mental health treatment within both systems. This is critical, particularly for younger offenders who are more at risk of developing mental health problems which are of a severe, complex or life threatening nature, and which have the potential to accelerate the individual further into both the criminal and mental health systems.

5.3 SERVICES TO YOUTH DETENTION CENTRES:

The service model agreed by Queensland Health and Department of Families provides for a comprehensive mental health service to youth detention centres. This includes assessment, treatment and case management services, and liaison with the mental health service in the young person's local community, in order to facilitate their ongoing treatment upon release. In addition, the child and youth community forensic mental health service will provide a forensic consultancy service to district clinicians. The interim service operating at Brisbane Youth Detention Centre has been operating on this model since February 2001, but the interim service provided to Cleveland Youth Detention Service has only been on an needs basis by the Townsville Child & Youth Mental Health Service.

[5] Mental Health Service Needs of Indigenous Children and Youth in Queensland, June 1999

5.4 SECURE INPATIENT SERVICES:

Security when used in everyday speech encompasses notions of safety from harm and danger. In mental health settings, security refers to those practices, policies and environmental changes that provide safety to consumers with severe disturbances resulting from mental illness. It also implies measures that protect the safety of other consumers, staff, family and the community in general from consumers experiencing mental illness.[6] Common problems that are the focus of security measures include aggressive behaviour, the inability to remain in a treatment setting and severe disorganisation that poses risks to the individual and others.

All mental health services undertake measures that respond to needs associated with these problems using the principle of a least restrictive alternative. Most of these needs can be met by district mental health services within the community, inpatient facilities and high dependence/intensive care options available in some inpatient settings. Where these needs can not be met due to the severity or duration of a consumer's condition, access may be required to facilities that have practices, policies, environmental modifications and staff resources specifically designed to address these needs.

As previously described, there are no secure inpatient facilities dedicated to providing services for children and adolescents in Queensland. Whilst it would be impractical to provide care for a child in one of the existing high secure or medium secure adult units across the state, it is not inconceivable that an adolescent may be admitted to such a unit. However, such a process is seen as highly undesirable for a number of reasons, including the inappropriate peer group within this setting, and the lack of age appropriate services and staff available within these settings. (Reflective of this, admission of a young person under the age of 17 years to a high security unit requires the approval of the Director of Mental Health and triggers a prompt review by the Mental Health Review Tribunal under the *Mental Health Act 2000*).

Requests for secure care for adolescents are relatively infrequent, and it is impossible to accurately track the number of such requests because there is no mechanism in place to do so. However, consideration of the reasons for requesting secure care indicate that the largest percentage of requests are likely to involve adolescents already in a custodial setting such as a youth detention centre.

During a 12 month period in 2001, the interim forensic mental health service at the Brisbane Youth Detention Centre reported that only three young people required inpatient admission. These people were hospitalised at the Logan and Royal Brisbane Hospital inpatient adolescent units during the acute episode, and were returned to the detention centre for completion of their juvenile justice sentence, where they received ongoing care by mental health staff. Secure containment was not required for any of these individuals. No data is available from Cleveland Youth Detention Centre in relation to the number of young people who required inpatient admission.

Based on this data, the potential need for secure beds would appear to be low. However, it needs to be born in mind that this data has been available for one year only while the service was in the development phase. Analysis is required over an extended period to more appropriately estimate the potential need for access to secure facilities for youth in detention.

[6] A Model of Service Delivery for Medium Secure and High Security Treatment Services in Queensland, 2001

6.0 EXTENDED TREATMENT ADOLESCENT INPATIENT SERVICES

The Barrett Adolescent Centre located within the Wolston Park Hospital complex is the only specialised extended treatment in-patient facility in Queensland for adolescents. It is primarily aimed at servicing those between the ages of 14 and 17 years who have mental disorders or serious mental health problems. Currently, it has 15 beds of single room accommodation and the capacity for 5 day patients. Its operating budget in 2001/02 financial year was approximately $1.9 million.

Prior to 1996, the Barrett Adolescent Centre (BAC) and the Royal Children's Hospital, Child & Family Therapy Unit (CAFTU) were the only in-patient units for children and adolescents in the state. With the opening of additional acute adolescent inpatient facilities in the south-east of the state, the BAC has experienced a change in their daily operation, with acute admissions now being appropriately directed to these new units.

The Ten Year Mental Health Strategy for Queensland foreshadowed the ability to meet the extended treatment needs of children and adolescents through enhanced community based services in association with the new acute units and day treatment programs. In line with this, it was foreshadowed that the Barrett Adolescent Centre would be closed and the funds redirected to enhance community-based services. Again, consistent with this, the master plan for the redevelopment of Wolston Park Hospital did not include Barrett Adolescent Centre.

An attempt was made to close Barrett Adolescent Centre in 1997. However, this was unsuccessful due largely to a strong community response that led the then Minister for Health, the Hon M Horan, to reverse the decision articulated in the Ten Year Mental Health Strategy. It should be noted, however, that this attempt to close Barrett Adolescent Centre preceded the opening of any of the additional (acute) adolescent beds that are now available in south-east Queensland.

The Barrett Adolescent Centre was constructed in 1976 and opened in 1984. As currently constructed, it has deficient noise insulation, and inadequate indoor recreational and dining areas, and is unsuitable for its current purpose. In addition, its current location is adjacent to the new High Security Unit at The Park Centre for Mental Health, and this is considered highly undesirable. Therefore, demolition of this sub-standard unit is desirable. There is currently no provision for its re-construction within The Park Centre for Mental Health complex.

6.1 OCCUPANCY RATES – BARRATT ADOLESCENT UNIT

For the period 01 July 1999 to 30 June 2000, 81 young people were admitted to BAC, of whom 35 were 14 years of age or younger. For the period 01 July 2000 to 30 June 2001, 59 young people were admitted to BAC. Of this number, 31 were 14 years of age or younger. This data indicates a change in practice to admitting adolescents younger than the specified target group, although it is acknowledged that this data represents only a two-year window and may not necessarily reflect an ongoing trend. The centre currently operates below 50% capacity, although there may be other factors contributing to this as previously outlined in Section 4.0. Most admissions are from the south east corner of Queensland.

6.2 BEST PRACTICE

At a national and international level, there have been positive changes in the provision of contemporary mental health care treatment for children and young people. This includes a

broader range of treatment options with a move away from institutional style settings to psycho-social models which focus on treatment in the context of the social and family setting, closer to where the young person and their family, carers and support networks live.

Queensland Health has likewise attempted to broaden the range of treatment options available to this target group. As stated above, examination of our admission data reveals that the newly constructed adolescent facilities are increasing their occupancy, resulting in a reduction in the number of referrals of the target group, 15 –18 years, to the BAC. Experience however suggests that acute units remain resistant to offering extended admissions because of the difficulty in providing a program to cover both acute and extended treatment options. Therefore, there is a need to explore options for alternative community based extended treatment programs which are not dependant upon access to inpatient beds.

7.0 DISCUSSION:

On the basis of data presented above, it is readily apparent that the distribution of child and adolescent inpatient beds is inequitable across the state, both for acute care and for extended treatment. All beds (with the exception of the four beds in the special care suite at Cairns Base Hospital that are not dedicated exclusively to providing services to children and adolescents) are located in the south-east corner.

On the basis of this and the admission rates of children and adolescents to either adult mental health facilities and/or paediatric wards in centres in the Northern Zone, there is a need to establish a small number of child and adolescent beds in the Northern Zone.

Likewise, an argument could be made for a small acute unit to also be established in either the northern or central part of the Central Zone, given the distances involved to access the existing Central Zone service located at the Royal Brisbane and Royal Children's Hospitals. The occupancy figures for these facilities would suggest that they can meet the needs of the entire Central Zone. However, it is clear from the admission rates to Bundaberg and Sunshine Coast, that there are significant numbers of families and/or clinicians who prefer to treat locally rather than refer to a Brisbane based unit. This practice reflects a recognition of problems arising for young patient as a result of dislocation from their family, school and support network when admission requires a transfer to Brisbane. A small unit outside of Brisbane, perhaps on the Sunshine Coast, would better meet the needs of these patients.

Southern Zone is relatively well bedded, with acute facilities at Logan, Robina, Mater and Toowoomba, in addition to the Barrett Adolescent Centre.

Whilst acknowledging the data on admissions from the Brisbane Youth Detention Centre is limited by virtue of the fact that it is confined to a twelve month period when only an interim service was operating, the overall number of admissions was extremely small. In addition, as the daily average of residents in both youth detention centres across the state was less than 100 in 2001, there is no data to support the development of stand alone secure beds for adolescents in Queensland.

Whilst it is possible for secure care to be provided for an adolescent within an existing medium secure or high secure unit, this is highly undesirable. The development of a more containing capacity, for example, through the establishment of a high dependency unit that has the capacity to be locked when necessary is seen as a preferable alternative. A high dependency unit could be incorporated into any newly established facility for Northern Zone, and may also

be incorporated into an existing unit or a rebuilt facility in Southern Queensland. This would not be regarded as secure care for the purposes of the *Mental Health Act 2000.* However, since the number is potentially very small, a viable option may be to admit to pre-existing adult secure facilities for stabilisation, with a transfer to the adolescent high dependency units as soon as practicable.

A decision is required as a matter of urgency regarding whether Queensland Health will continue to provide extended treatment inpatient care for children and adolescents. The original intent of closing Barrett Adolescent Centre and replacing it with community based alternatives in conjunction with the acute adolescent units, as outlined in the Ten Year Mental Health Strategy, remains the preferred policy option. If pursued, this option would realise approximately $1.9 million recurrently for reallocation to support the development of alternative services. However, there are significant political risks associated with this proposal, particularly given current community attitudes and the vocal community reaction to the prospect of closure in 1997.

If extended treatment services are to be continued, an urgent decision is needed on whether to refurbish Barrett Adolescent Centre or to decommission it and rebuild a purpose built facility. The latter option would be the preferred approach, since the current building and location of the facility are considered entirely unsuitable.

The following recommendations are put forward for consideration as ways to address the combined issues outlined in the above report:

8.0 RECOMMENDATIONS

High Priority

- **The establishment of an 8-10 bed child/adolescent acute inpatient unit in North Queensland with a four-bed high dependency area for optional use for forensic patients as required.**

- **The creation of an optional four (4) bed high dependency area in the Logan Adolescent Unit or Royal Brisbane Hospital Adolescent Unit.**

- **Conduct a scoping exercise on the development of community based treatment options, such as 'step down' programs as an alternative to extended inpatient treatment.**

- **Undertake a detailed operational review of the Barrett Adolescent Centre, the Child and Family Therapy Unit (CAFTU) and the Mater Child Inpatient Unit in light of the low admission rates, with a view to assessing the capacity of CAFTU & Mater to take up the under 14 population currently serviced by the Barrett Adolescent Centre.**

- **Undertake a detailed operational review of the Royal Brisbane and Logan Adolescent Units in light of the low admission rates, with a view of assessing their capacity to take up the over 14 population currently serviced by the Barrett Adolescent Centre.**

- **Taking into account the findings of the operational reviews and the implementation of a range of 'step down' programs, consider a 50 % reduction in the number of beds at the Barrett Adolescent Centre, and relocation of these funds towards the establishment of the high priority recommendations.**

- **Review the need for an adolescent inpatient extended treatment program 12 months following the closure of 50% of beds at the Barrett Adolescent Centre and the implementation of a range of 'step down' programs.**

- **Taking into account the findings of the review consider the closure of the remainder of the Barrett Adolescent Centre beds following:**

  (a) the opening of the new unit in North Queensland;
  (b) the creation of an optional high dependency area at Logan or Royal Brisbane Hospitals; and
  (c) the implementation of a range of 'step down' community based treatment options.

Medium Priority

- **The development of small six-bed (6) child/adolescent acute inpatient facility linked to the adult acute inpatient unit on the Sunshine Coast to service the Sunshine Coast and Bundaberg regions, for inclusion within the next capital works program.**

- **Continue to monitor the bed utilisation rates in existing child and adolescent acute inpatient units.**

Summary of Issues to consider when reviewing the Model of Service Delivery for Barrett Adolescent Centre (BAC)

Previous reviews and reports have outlined concerns including:

Safety concerns – in relation to both clients and staff –

- increase in critical incidents
- increase in 'continuous observations'
- ACHS issued 'high priority' recommendation pertaining to improving patient and staff safety in recent accreditation survey.
- Aspects of building configuration deemed 'dangerous'

Director General of Health Brief noted –

- Profile of BAC is changing
- Increased complexity, increased impairment and co-morbidity
- Less referral out options
- ALOS increased from 4 months (1994) to 10 months 2006.

McDermott Review – issues identified

- Need for more defined admission criteria
- Need for improved risk assessment during admission
- Need for improved risk assessment tool
- Establish better linkages with broader Hospital (The Park)
- Need for staff training
- Issues around whether unit locked/ not locked

Community Visitors Report

- BAC over census
- BAC has clients over 18
- Safety issues for medium to long term residents
- Not all young people participate in programs – some 'optional'

QNU

- Letter of concern relating to staff injuries sustained trying to apprehend a young person absconding

Review of 3 Critical Incidents – key characteristics

- Female
- Over 18
- Severe and complex self harming
- Diagnosis did not reflect complexity, chronicity or severity of behaviors.
- Referral on to adult MHS or more appropriate services had not occurred

Issues considered by recent review (2009):

Governance

Lack of clarity or little evidence re:

- governance structures, lines of accountability to MHD/ Corporate QH
- Policies and procedures
- Staff performance reviews /performance management
- Clinical documentation – audit processes
- Complaints system
- Framework does not align with state legislation or QH policy directives
- Poorly defined scope of clinical practice for medical, nursing and allied health
- Professional development
- Clinical Supervision
- Research and evidence based practice
- Role of BAC in statewide CYMHS plan unclear
- Role of BAC in The Park hospital unclear
- Recording and review of critical incidents and 'near misses'
- Poor communication including handover impacts on continuity of care

Clinical Model

- Lack of evidence based treatments
- Current practices predominantly 'milieu therapy' and 'adventure therapy'
- Poor evaluation of current behavioral management programs and associated staff development and training despite previous recommendations to address this
- Need for individualized behavior management plans
- Alternatives to continuous observations

Nursing Model of Care

- Model unclear – best described as task allocation or functional

Patient Journey

- Long waiting times for admission
- More clarity re: Referral pathways, inclusion and exclusion criteria
- Need access to acute medical management at local hospital
- Need access for more intensive acute psychiatric care
- Intensive discharge planning at point of referral
- Integration of BAC with local community services
- Partial hospitalization – used for transition care back to community care
- Difficulties with discharge planning due to remoteness of referring services
- Out of home care / discharge placement for older adolescents

- Transition to adult MHS
- More assertive discharge planning

Treatment evaluation

- Negligible evaluation

Clinical Leadership

- Lack of clarity and structure

Staffing profiles (nursing)

- Varied skill mix
- Lack of external CYMHS experience
- Vague reporting lines – discipline meeting structures

Nursing staff training and education

- Limited opportunities for Child and Adolescent education
- Problematic Clinical Supervision structures

Question 3.

Queensland Government

Queensland Health

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19 August, 2011

TREATING DOCTOR'S REPORT

[redacted]

[redacted]

Yours sincerely

[redacted]

Stephen Stathis

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Queensland Government

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ADDENDUM - TREATING DOCTOR'S REPORT

Yours sincerely

Stephen Stathis

D.

Department of Health

Adolescent Step Up Step Down Unit – Model of Service

Queensland Public Mental Health Services

October 2015

Queensland Government

Step Up Step Down Model of Service – Queensland Public Mental Health Services
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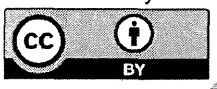

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An electronic version of this document is available at

http://qheps.health.qld.gov.au/mentalhealth/resources/resources.htm

Contents

Purpose of this document

This model of service aims to provide operational advice to support the planning and delivery of Step Up/Step Down Units (SUSDU) within the Queensland public mental health service system. The model of service is an aspirational document, intended to describe the target population, the functions, operation and governance of the service. It also includes hyperlinks to resources that inform mental health practice, including policy, standards, protocols and guidelines.

This document seeks to complement and support the delivery of high quality and safe mental health services. The accessibility of information allows greater transparency about public mental health services and informs consumers, carers, service partners, staff, managers and service planners. The document contents are sourced from reference documents, broad consultation and expert opinion from staff, service users and carers. This document does not replace clinical judgement or Hospital and Health Service specific patient safety procedures and should be read in conjunction with the Clinical Services Capability Framework (CSCF) Mental Health Services Module.

The intended outcome of the development and successful implementation of the model of service is:

- improved knowledge of how to access and navigate through mental health services
- a consumer and carer centred, recovery based continuum of care
- a more informed and supported mental health workforce
- enhanced supervision of the clinical and non-clinical workforce
- the delivery of safe, high quality, integrated, and evidence driven mental health care
- increased knowledge and understanding of other service components
- consistency and streamlining of service delivery across public mental health services in Queensland
- enhanced service development, evaluation and review
- stronger service partnerships.

This document is intended as a resource for Queensland Health HHSs to support development of local models of care.

1. Who is the service for?

SUSDU services are aimed at:

- consumers who are 13-18 years (with flexibility up to 21 years dependent upon developmental age), who are eligible for mental health services, and are experiencing psychological distress and/or mental health concerns.
- consumers who no longer require acute inpatient level clinical intervention and treatment but would benefit from short-term, intensive treatment and support in a residential setting post-discharge from an acute mental health inpatient admission.
- consumers who are living in the community and require short-term residential support with intensive clinical treatment and intervention to prevent the risk of further deterioration or relapse, which in the absence of this option may lead to admission to an acute mental health in-patient unit.

Consumers engaged with a SUSDU will present with a range of mental health problems and/or disorders at the moderate to severe end of the spectrum. Predominantly, they will have diagnoses such as depression, anxiety, adjustment, attachment, eating and developmental disorders. Consumers may also have diagnoses relating to behavioural concerns such as complex attention deficit hyperactivity and conduct disorder in the presence of comorbid mental health issues. Many consumers will also present with peer and family problems, which can exacerbate mental health problems and disorders.

One of the intentions of SUSDU services is to lessen the possible difficulties and stresses experienced by families and carers in supporting consumers who are acutely unwell and are receiving community treatment. At the same time, it offers an important alternative for early intervention for those consumers in the early phase of relapse, and for those in need of further stabilisation and recovery before returning to the community following an acute mental health admission.

The SUSDU may be suitable for consumers who need a level of monitoring and clinical care that does not require admission to an inpatient unit, but will benefit from more intensive clinical treatment and psychosocial support than can be provided through the usual continuum of care, e.g. community CYMHS, assertive mobile youth outreach services (AMYOS), CYMHS acute response team (ART), adolescent day program, etc.

The SUSDU will not be gazetted to admit involuntary consumers, although consumers on a community treatment order (CTO) may be voluntarily admitted to the SUSDU for more intensive community treatment and support.

Consumers discharged from acute inpatient settings must have recovered to the point where that service can demonstrate their risk status does not require the clinical care typically provided by an inpatient unit. If an individual is clinically assessed as requiring inpatient care he/she should be admitted to an inpatient unit.

Unsuitability for the SUSDU service is likely to be the result of a number of factors, in particular clinical or safety risk. Safety risk include concerns regarding the safety of consumers or the community; significant concerns regarding the consumer's

behaviour; the consumer's capacity to engage with service providers and comply with treatment; and, the mix of consumers in the SUSDU service at the time.

Assessment of individual consumers entering the SUSDU service should include a comprehensive risk assessment indicating that it is an appropriate and safe treatment option. If a consumer is unable to access the SUSDU on one occasion, this should not preclude his/her consideration in the future.

The SUSDU operate within established service provision parameters and service capability as per the Clinical Services Capability Framework for Public and Licensed Private Health Facilities (CSCF) – Mental Health Module.

Under the definitions of the CSCF, the SUSDU will operate as a 'Non-Acute Inpatient Service – Level 5' service. **[to be reviewed and clarified following service mapping]**

2. What does the service do?

A SUSDU provides community-based mental health care to consumers who are in recovery, but require additional support and life skills to successfully transition to independent community living.

The SUSDU is one component in the broad support network that contributes to an adolescent's recovery. The SUSDU services are delivered as part of an integrated mental health service system that includes acute and non-acute inpatient services, consultation-liaison psychiatry, and a range of specialist positions, teams and state-wide services.

The HHS should maintain appropriate referral and assessment processes for considering referrals, monitoring waiting lists, assessing available community options and facilitating smooth transition between service elements.

Clear admission criteria for the SUSDU should be developed that reflects the intended role and functions and ensures:

- People with high need for SUSDU services receive priority for admission
- Preferences of consumers, carers, family and significant others are considered as part of the admission process
- Delivery of safe and effective care
- Recovery-oriented principles are utilised, and the service can tailor the approach to each individual consumer and respond to the diversity of people with mental health disorders – see Chapter 5, Recovery-oriented service delivery from A national framework for recovery-oriented mental health services: Guide for practitioners and providers.

3. What does the service intend to achieve?

SUSDUs form part of a continuum of care for adolescents requiring mental health treatment in Queensland. SUSDUs are subacute residential units that are defined as bed-based facilities delivered in partnership and/or collaboration between clinical services and the NGO/community support sector. SUSDUs will provide overnight care and short-term residential treatment from specialist and non-specialist trained mental health staff.

The SUSDUs are provided for consumers who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness. The consumer usually requires a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community, but does not require the treatment intensity provided by acute inpatient units. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.

SUSDUs exist within the spectrum of integrated mental health services and other health services. The service will form a part of the State-wide adolescent mental health extended treatment service continuum for the recovery orientated treatment and rehabilitation of consumers aged 13 to 18 years, with severe and persistent mental health problems. These services are provided within a recovery-oriented approach that emphasises individual strengths, builds resilience and enhances opportunities for social inclusion. SUSDUs operate on the premise that consumers can and do recover from mental health problems and mental disorders.

The aims of SUSDUs are to:

- Prevent further deterioration of a person's mental state and associated disability, and in turn reduce the likelihood of admission to an acute inpatient unit (Step Up).
- Enable early discharge from acute mental health inpatient units through the provision of an intensive, safe and supportive sub-acute residential community program (Step Down).

The objectives of SUSDU services are to:

- Provide a service option for consumers, both in the inpatient setting and in the community, whose treatment and recovery is better suited to intensive, short-term treatment and support in a residential setting.
- Provide a mix of clinical, psychosocial and other support that enables gains made during the period in the inpatient setting to be strengthened, community transition and treatment plans to be consolidated, and minimises the trauma and disruption for consumers and carers that may arise from an acute episode of mental health concerns.
- Supplement crisis intervention and enhance community access to inpatient services through the prevention of unnecessary inpatient admissions and the provision of an intensively-supported early discharge alternative.

SUSDUs functions contribute to:

- implementation of intervention and prevention strategies to enhance the mental health and wellbeing of consumers and reduce the risk of future mental health problems;
- decreasing stigma and discrimination within the local community and reducing barriers to social inclusion;
- providing consumers 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 consumers 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;
- supporting consumers and their families/carers across the broad continuum of care, including facilitating smooth transition to, and from, other services;
- reducing the need for inpatient admissions;
- assisting consumers to maintain or regain engagement in developmentally appropriate functional, learning or vocational tasks; and
- working with consumers and their families/carers to develop their personal support systems, and live successfully within their community.

The SUSDU takes an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness and engagement or re-engagement in positive and supportive social, family educational and vocational connections.

The SUSDUs will be able to provide:

- A range of individual, family and group-based assessment, treatment and rehabilitation programs, aimed at treating mental illness, reducing emotional distress, and promoting functionality within the community.
- Provide phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers.
- Provide 24 hour care for adolescents in a safe, structured, highly supervised and supportive environment.
- Co-ordinate on-site and out-reach schooling to support educational and vocational goals.
- Facilitate access to indigenous and transcultural support services as required.
- Negotiate assertive discharge planning to integrate adolescents back into their community of choice, including appropriate local mental health treatment, education or vocational services, functional and living skill development.

4. Key Components

The key components of the SUSDU are defined here. These components are essential for the effective operation of a SUSDU.

4.1 Working with other service providers

Key elements	Comments
4.1.1 Strong partnerships are developed with other local health and mental health service providers, as well as with education and vocational services, Child Safety Services, Disability Services, Youth Justice, NGOs and other community support services.	The SUSDU will work in close collaboration with other service providers to meet individual needs of the consumer, and their family and/or carers. Formal agreements will be developed where required. Clear, regular contact and communication processes are maintained for all phases of care. Advice, education and support on mental health issues are provided to other services. The SUSDU will work with Service Integration Coordinators (SIC) to establish efficient, collaborative partnerships with local service providers and key clinical and non-clinical support services, including housing / accommodation, vocational, financial and social supports. .
4.1.2 There is active engagement with primary health care providers to meet the general health care needs of the consumer.	Shared care arrangements with General Practitioners (GPs), mental health nurses working in GP practices, private psychologists and counsellors are encouraged. All efforts will be made to record a nominated GP in CIMHA for 100 percent of consumers.
4.1.3 When more than one service provider is involved in service delivery, the SUSDU will initiate and participate in discussions around which service will adopt the role of lead agency.	SUSDU staff will need to develop agreed documented processes with the relevant Authorised Mental Health Service (AMHS) for the joint management of consumers subject to the *Mental Health Act 2000*.
4.1.4 When consumers have specific needs (e.g. sensory impairment, Aboriginal and Torres Strait Islander populations, Culturally and Linguistically Diverse (CALD) Backgrounds, dual disability), SUSDU will engage the assistance of appropriate	Interpreter services Hearing impaired/deafness Transcultural mental health Indigenous mental health Multicultural Mental Health – Queensland Health Multicultural Services Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 Department of Communities - Disability and Community Care Services

Key elements	Comments
services to ensure that communication and cultural issues are addressed.	
There is active engagement with local hospital emergency departments (as part of Department of Emergency Medicine (DEM)), and local police services, to support coordinated access and crisis response planning & service delivery.	

4.2 Referral, access and triage

Key elements	Comments
4.2.1 The HHS is responsible for managing the entry and discharge of consumers in to and out of the SUSDU. Typically, admissions to the SUSDU can occur from a range of referral sources including Community Child and Youth Mental Health Services (CCYMHS), Evolve Therapeutic Services, Acute Care Teams, other mental health inpatient units, consultation liaison, other wards and private psychiatrists. All consumers and their families and/or care representatives should be given information and consideration for entry into a SUSDU, as well as details of their ongoing involvement in the treatment. This information is to be provided by a SUSDU representative. A comprehensive mental health assessment must be undertaken by a SUSDU mental health clinician. A risk assessment will be conducted in accordance with the 'Risk Assessment Checklist', incorporated in the	Referrals to the SUSDU will occur through a single point of entry. A state-wide collaborative intake officer coordinates reviews of referrals in conjunction with a panel of representatives from the local adolescent mental health services and SUSDU support staff. The intake panel must include at least one consultant psychiatry representative from the adolescent mental health services. This panel will meet on a regular basis to review referrals. The nominated HHS delegates or SUSDU multidisciplinary representatives will consider all referrals to the SUSDU from a consumer needs perspective. An appropriate representative from the referring area will be included as part of this process. Clear information regarding referral and access processes will be available to referrers. Referrals may be accepted from across hospital and health service catchments. All referrals will be communicated verbally and in writing, using standardised clinical documentation. The referrer will provide an assessment that includes: - a mental state examination - risk assessment - presenting problem - substance use - medication history - physical status, and medical clearance if indicated - formulation

Key elements	Comments
CYMHS Consumer Intake Form. All consumers with identified risks must have a risk management plan documented and alerts noted in the Consumer Integrated Mental Health Application (CIMHA). Feedback will be provided to the consumer and referrer about why and how their support needs could be better met in an alternative setting. Local processes will be implemented so the consumer can access the SUSDU when support needs change over their recovery journey.	- provisional diagnosis - *Mental Health Act 2000 status* - goals for admission - accommodation and support details Consumers, their families and/or carers, the referrer and other key stakeholders will be actively engaged in discharge planning from the time of admission. Whenever possible, copies of completed assessment tools will accompany referrals and be scanned or recorded in CIMHA. All referral information will be recorded and/or scanned into CIMHA on admission. Child and Youth Mental Health Services Consumer Intake form Adult Mental Health Services Consumer Intake form CYMHS Mental Health Assessment and Referral Policy CYMHS Assessment and Management of Risk of Suicide and/or Self-Injury Policy.
4.2.2 Consent to referral will be obtained.	The young person's consent to referral must be noted on the referral form, and signed by the young person.
4.2.3 The decision to admit to a SUSDU is made by a consultant psychiatrist or an appropriately trained medical delegate, who is under the supervision of a consultant psychiatrist, in consultation with the intake panel consisting of the state-wide collaborative intake officer and representatives from the local HHS adolescent mental health services and the SUSDU.	The decision to admit will take into account the: - nature of the problem - acuity and severity of the disturbance and associated risks - complexity of the condition (including co-morbidity) - extent of functional impairment - risk assessment - benefits and risks associated with admission - geographical proximity and referrer's goals of admission - safe transfer from rural and remote sites - time of day of the referral - availability of other appropriate services If the decision is not to admit, alternatives to admission will be provided to referrers by the state-wide collaborative intake officer after consultation with the SUSDU consultant psychiatrist and intake panel.

Key elements	Comments
4.2.4 All referrals are triaged when received by the state-wide collaborative intake officer, in consultation with the SUSDU consultant psychiatrist and intake panel. Admissions are prioritised according to clinical need.	Priority for admission is to be given to consumers who are suicidal, psychotic, severely disturbed and traumatised, requiring short-term, community based, and residential mental health support. Considerations to the preferences of the consumers and their carers are to be considered as part of the admission process, as well as the capacity for the SUSDU to provide safe and therapeutic care in response to the needs of the consumer.
4.2.5 *Step-Up Referral Pathway*: Admission may occur following a range of less restrictive interventions such as: - CCYMHS assessment and treatment - enrolment in a CYMHS Day Program - for rural and remote areas, admission to the nearest hospital, with mental health care provided by paediatric staff. This can be in consultation with local Child and Youth Mental Health Services (Clinical Service Capability Framework (CSCF) level 2, 3, and 4 services). -	Where possible, admissions are conducted as part of a collaborative assessment and treatment plan between the SUSDU and referring services such as CCYMHS, Evolve Therapeutic Service, an Assertive Mobile Youth Outreach Service (AMYOS), a Youth Residential Rehabilitation Unit (Youth Resi), an Adolescent Day Program, or Consultation Liaison Psychiatry services.
4.2.6 *Step-Down Referral Pathway*: Admission may occur following a range of more restrictive interventions such as: - AAIU assessment and treatment (Clinical Service Capability Framework (CSCF) level 5 or 6	Where possible, admissions are conducted as part of a collaborative assessment and treatment plan between the SUSDU and the AAIU. Clinical Service Capability Framework
4.2.7 An introductory meeting is to occur with the consumer and/or their families / care representatives with a SUSDU representative to introduce them	The pack will include information on: - treatment and support options - the multidisciplinary team role and function outline - assessment, family meetings, and

Key elements	Comments
to the service. This meeting aims to orient them to the service and shape the expectations of the consumer and/or their families of the service. A general information and orientation pack will be provided and explained to all consumers, families, and/or carers on admission.	treatment planning - ward and school programs - contact phone numbers - general unit information, including policies on smoking, mobile phone use, property consent, ancillary services, etc. - Mental Health Act 2000 statement of rights and responsibilities - mechanisms for providing feedback - community support services - culturally diverse orientation material specific to the unique populace of the local service National Standards for Mental Health Services During the referral process, the consumer, and their carer/s, family, and/or significant others will receive support, information and education about the underlying philosophy of recovery that prevails at the SUDU. Consumers may lodge a complaint or compliment over the phone or in writing to the Complaints Coordinator of the HHS. This will ensure that feedback is documented and the appropriate protocols are followed. Complaints and compliments about health services.
4.2.8 The potential for the consumer to achieve functional gain and his/her willingness to participate in the program are measured in the referral and ongoing assessment process. The consumer's personal recovery domains are explicitly measured on referral with evidence-based, recovery-oriented tools. SUSDU representatives, preferably a SUSDU support worker and a mental health clinician, will introduce the recovery-oriented framework to the consumer and/or their families / care representatives	Evidence-based tools to measure assessment outcomes and recovery orientation of consumers are used in the referral and ongoing assessment process. Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self-Assessment (RSA) Recovery-Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)—see Recovery measures: The Australian context A national framework for recovery-oriented mental health services: Policy and theory

Key elements	Comments
as part of the assessment process. Each consumer will have a central documented recovery-oriented treatment plan in the approved format as per CIMHA Business Rules. The Recovery Oriented Treatment Plan will be developed in partnership with each consumer, and their family and/or care representative, as evidenced by their signature, and a copy offered to the consumer/care representative. As part of the 'Recovery Oriented Treatment Plan', regular process of reviewing progress towards the recovery-oriented goals with the consumer and/or family/care representatives should be negotiated (e.g. weekly review of progress towards recovery goals).	

4.3 Assessment

Key elements	Comments
4.3.1 On admission, a clinical mental health staff member will undertake a comprehensive clinical assessment that will assess: • the presenting problems • past interventions • developmental history • relationships • attachment and history of trauma • mental state examination • medical history • alcohol and other drug use • cultural factors • legal issues including custody and guardianship	A formulation of the presenting problems will be developed and contribute to a diagnosis and discussion of recovery goals. The formulation will be holistic and include: - symptoms - relationships - attachments - family dynamics and functioning - school performance - developmental trajectory - co-morbidities - protective factors. In addition to mental health concerns, the assessment will also assess the functional capacities of the consumer and available supports (including family and/or care representatives) to support recovery on

Key elements	Comments
• family history • risk assessment • consideration of whether the consumer may be a parent with care responsibilities for infants and children	discharge and prevent relapse. Assessment and care planning is a continuous process throughout the admission period. Child and Youth Mental Health Services Consumer Assessment form Adult mental health service–consumer assessment Statewide standardised suite of clinical documentation user guide
4.3.2 Assessment will involve input from family, and/or carer/s, and key service providers as appropriate. The family and/or carer assessment will include: • the history of the presenting complaint • developmental history • the family and/or carers perspectives of the issues • transitions and life cycle changes in the family • relationships • attachment and history of trauma • parenting styles • limit setting • roles and responsibilities within the family • emotional climate of the family • legal issues	Consent to disclose information and to involve key stakeholders, and family and/or carer/s in the consumer's care will be sought in every case. Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. Suite of clinical documents Queensland Health Child and Youth Mental Health Services State-wide Standardised Suite of Clinical Documentation User Guide *Hospital and Health Boards Act 2011* – Part 7 Confidentiality Right to Information and Information Privacy Information sharing between mental health workers, consumers, carers, family and significant others. *Mental Health Act 2000.* *Mental Health Act 2000* Resource Guide *Mental Health Act 2000* Forensic Provisions Mental Health Review Tribunal Mental Health Court Forensic Patient Management Policy and Procedures Policy and Practice Guidelines for the Care of Disability Forensic Patients
4.3.3 Engagement will occur with an Aboriginal and Torres Strait Islander Mental Health Worker or Hospital Liaison Worker to support and assist with the facilitation of information for a comprehensive assessment of Aboriginal and Torres Strait Islander consumers.	Where an Aboriginal and Torres Strait Islander mental health worker is not available, identification of an appropriate and recognised Aboriginal and/or Torres Strait Islander person is integral in addressing the cultural needs of the consumer. *Guideline for Mental Health Service Responsiveness for Aboriginal and Torres Strait Islander People* Aboriginal and Torres Strait Islander Cultural Information Gathering Tool User Guide for the Aboriginal and Torres Strait Islander Cultural Information Gathering Tool.

Key elements	Comments
4.3.4 The Cultural Information Gathering Tool will collect cultural information relevant to the individual and that may impact on the consumer's presentation, diagnosis, treatment and recovery.	Aboriginal and Torres Strait Islander Cultural Information Gathering Tool User Guide for the Aboriginal and Torres Strait Islander Cultural Information Gathering Tool
4.3.5 Risk assessments will be conducted by the clinical staff and will occur: • on admission as part of the comprehensive clinical assessment • prior to transfer to any other unit/facility/service • prior to and following periods of leave • prior to discharge • where clinically indicated due to change in presentation or every day.	Comprehensive risk assessments will include: - harm to self - vulnerability - risks of physical or emotional deterioration - triggers to symptoms and/or behavioural disturbance - absconding - non-adherence to treatment - harm to others - child protection issues Specific areas of risk may be evaluated more frequently as outlined in the consumer's recovery oriented treatment plan. The risk assessment will be conducted in accordance with the 'Risk Assessment Checklist', incorporated in the CYMHS Consumer Intake Form. All consumers with identified risks must have a risk management plan documented and alerts noted in the Consumer Integrated Mental Health Application (CIMHA). The discharge risk assessment will be recorded on the discharge summary in CIMHA. Risk management protocols will be consistent with Queensland Health policy and SUSDU policies. Child and Youth Mental Health Services Risk Screening Tool Adult Mental Health Services Risk Screening Tool Guidelines for Suicide Risk Assessment and Management
4.3.6 Child safety concerns will be identified through risk assessment and addressed in	*Child Protection Act 1999* Child Protection guidelines at the Queensland Health policy site

Key elements	Comments
accordance with mandatory requirements.	Working with parents with mental illness – guidelines for mental health clinicians Principles and actions for services working with children of parents with a mental illness Mental health child protection form Information sharing between mental health workers, consumers, carers, family and significant others.
4.3.7 When indicated, a physical examination by a medical officer will be completed on consumers.	This may be conducted by an external health service provider, but needs to be considered as part of the SUSDU assessment. Consumers will be encouraged to have a nominated GP. Consumers will be actively monitored in their ability to access primary health care including regular dental reviews and other physical health supports, e.g. dietetics. Potential physical health problems and ongoing monitoring information will be identified and discussed with the identified GP. CheckUP (formerly General Practice Queensland)
4.3.8 Drug and alcohol use will be routinely assessed and documented. Information and advice to address alcohol and drug use, if relevant, will be routinely provided. For some consumers alternative or additional support is required.	Elimination and reduction of cigarette smoking is encouraged with reduction strategies/aids routinely offered to consumers. Harm minimisation interventions and motivational interviewing will be available. Co-occurring alcohol and drug problems will be included in recovery planning. SUSDU is not drug and alcohol withdrawal service. Consumers who are actively using substances and requiring drug and alcohol withdrawal or rehabilitation services will be referred to other suitable drug and alcohol services. The SUSDU will follow legislation introduced under the *Health Legislation Amendment Bill 2014* to prohibit smoking on health facility land. Child and Youth Mental Health Services Drug Assessment Problem List Adult Mental Health Services Drug Assessment Problem List Queensland Health Dual Diagnosis Clinical Guidelines

Key elements	Comments
	Queensland Health Dual Diagnosis Clinician Toolkit
4.3.9 If clinically indicated, specialised diagnostic assessments may occur to ascertain specific mental health problems and identify evidence-informed therapeutic interventions.	Diagnostic assessments will be coordinated by the hospital or other health service providers, if clinically indicated for treatment and formulation of cases. If not conducted during the admission, recommendations regarding further assessments will be provided to follow up service providers through documentation on the discharge summary and recorded in CIMHA. Mental Health Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary Case Management Policy Framework Adult Mental Health Consumer End of Episode/Discharge Summary
4.3.10 The outcome of assessments will be promptly communicated to the consumer, family and/or carer/s, and other stakeholders (with consent).	A family and/or stakeholder meeting will be organised as soon as practicable after admission to communicate the outcome of assessments. *Hospital and Health Boards Act 2011* – Part 7 Confidentiality Right to Information Act 2009 Information Privacy Act 2009 Information sharing between mental health workers, consumers, carers, family and significant others.
4.3.13 Each consumer will be evaluated at assessment through the use of outcome measures.	The National Outcomes and Casemix Collection (NOCC) will be used, and other measures will be used, based on each consumer's individual requirements. Measures will include: - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) - Strengths and Difficulties Questionnaire (SDQ) - Children's Global Assessment Scale (CGAS) - Factors Influencing Health Status (FIHS). Mental Health Outcomes Collection Protocol Outcome and Casemix measures for mental health services
4.3.12 Every effort will be made to limit the repetitive nature of the information gathering process for the consumer.	

4.4 Clinical review

Key elements	Comments
4.4.1 All cases will be discussed at a Multidisciplinary Team (MDT) Review at least weekly.	A consultant psychiatrist or appropriate medical delegate will participate in all MDT Reviews (this may be via telehealth). All MDT Reviews will be documented in the consumer's clinical record, the consumer care review summary, and in CIMHA. Where consumers are part of, or are being referred to, another part of the mental health service, MDT Reviews should include an appropriate representative from that treating team. Child and Youth Mental Health Services Consumer Care Review Summary form Adult Mental Health Consumer Care Review Summary Form CIMHA business rule
4.4.2 In addition to the weekly MDT Review, 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. Best Practice Guide to Clinical Incident Management
4.4.3 The consumer's recovery plan will inform discussion at the MDT Review. Any significant changes in intervention will be incorporated into the individual care/treatment plan.	The viewpoint of the consumer, family and/or carer, and his/her community-based supports such as teachers and community mental health case managers will be considered during the reviews. Outcomes of clinical reviews will be discussed with consumers, families and/or carers. Any changes to the recovery plan will be made in collaboration with the consumer, family and/or carer. Structured risk and review processes will be utilised.
4.4.4 Each consumer's progress will be routinely monitored and evaluated including the use of outcome measures.	The National Outcomes and Casemix Collection (NOCC) will be used, and other measures will be used, based on each consumer's individual requirements. Measures will include: - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

Key elements	Comments
	- Strengths and Difficulties Questionnaire (SDQ) - Children's Global Assessment Scale (CGAS) - Factors Influencing Health Status (FIHS). Mental Health Outcomes Collection Protocol Outcome and Casemix measures for mental health services

4.5 Recovery Planning and Relapse Prevention

Key elements	Comments
4.5.1 An individual recovery-oriented treatment plan will be developed with all consumers, and their families and/or carers. Review of progress and planning of future goals will be integrated into the recovery plan. Recovery planning will occur in line with local discharge planning policies and will commence from the start of the consumers admission in to the SUSDU.	Recovery plans are developed on the premise that consumers can and do recover from mental illness. Consumers with mental illness may have disrupted developmental trajectories. Recovery plans also need to address their developmental needs. Recovery plans identify: – available supports – crisis management strategies – therapeutic goals – intervention processes – psycho-educational needs – relapse prevention strategies. Recovery plans may also include strategies for improving: – family functioning – pro-social and developmentally appropriate interests and hobbies – peer functioning – quality of life (such as time to experience developmentally relevant play and fun) – achievement at school / vocational goals – mastery over the tasks of adolescence Recovery plans will be updated at a frequency determined by change in presentation or need, but will be formally reviewed at least every week (to review routine outcome measures, treatment progress and to address any change in needs). All changes to the recovery plan will be discussed at the Multidisciplinary Team (MDT) Review. Child and Youth Mental Health Services Recovery Plan Adult Mental Health Service Recovery Plan A National Framework for Recovery Oriented Mental Health Services: Guide for Practitioners and Providers

Key elements	Comments
4.5.2 The consumer, family and/ or carer are strongly encouraged to have ownership of, and sign, his/her recovery plans.	Changes to the recovery plan will be discussed with the consumer, family and /or carer, and relevant service providers.
4.5.3 The relationship between the consumer and his/her family and/or carer and his/her resilience is important to recovery.	Whilst adolescent consumers gain further independence and mastery to separate from their family and/or carers, evidence suggests that adolescents with mental health problems require support in re-connecting with their parents and/or carers, as well as other key social support networks.
4.5.4 Every effort will be made to ensure that treatment planning focuses on the consumer's own goals.	Where conflicting goals exist (e.g. for consumers receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the consumer, and the family and /or carer's goals and values.

4.6 Recovery-oriented practice

Key elements	Comments
4.6.1 Recovery-oriented practice aims to enable consumers to reclaim their lives beyond their mental illness. The SUSDU's primary intent is to provide an environment that facilitates this process. Recovery orientation aims to support the person in his/her personal development to build self-esteem and identify meaningful roles to fulfil his/her potential. The recovery model is an active and assertive partnership between the person receiving care and those involved in the ongoing care. The SUSDU and other providers will deliver goal-	The SUSDU will operate in accordance with A National framework for recovery-oriented mental health services: Policy and theory.

Key elements	Comments
oriented and assertive care and treatment, supporting the consumer's recovery journey.	
4.6.2 Peer support promotes recovery through role modelling and lived experience that helps consumers to validate and promote wellness and recovery. Based on mutual respect and personal responsibility, peer support focuses on wellness and recovery rather than on illness and disability.	Intentional Peer Support is a system of giving and receiving support in a relationship based on shared experience, mutuality, respect and co-learning. It encourages consumers to build on effective relationships that challenge them to step outside their illness story and move towards achieving the goals that are important to them. Intentional peer support
4.6.3 Recovery-oriented treatment plans will be consumer focused and developed in consultation with all relevant people in the consumers' service and support network. The consumer and his/her family and/or carer/s need to be acknowledged as the most significant partners in the recovery, at all times. The SUSDU will ensure that the consumers, and their aspirations for the future, are central considerations in providing their ongoing care and rehabilitation.	Consumers and their family and/or carer/s are strongly encouraged to have ownership of their recovery plan. Changes to the recovery plan will occur in partnership with the consumer, carers, family and significant others, and relevant service providers.

4.7 Clinical Intervention

Key elements	Comments
4.7.1 Consumers will have access to, and will be supported to engage in, a range of evidence-based therapeutic intervention to optimise their recovery.	Clinical interventions are tailored to individual needs according to the recovery plans.
4.7.2	

Key elements	Comments
Every effort will be made to ensure that treatment and care planning focuses on the consumer's own goals.	Where conflicting goals exist, these will be clearly outlined and addressed in a way that is most consistent with consumer's goals.
4.7.3 All aspects of service will reflect the development of collaborative relationships between consumers, families and /or carers and staff.	The focus will be on strengths, connectedness, personal involvement, personal choice, empowerment and increasing confidence in accessing the system. Treatment will be provided in the least restrictive setting that properly balances the consumer's autonomy with his/her need for observation and treatment in a safe environment. Teleconference and videoconference facilities will be available for those families and/or carers unable to access the SUSDU in person.
4.7.3 Clinical interventions are guided by assessment, formulation, and diagnostic processes, using a bio-psychosocial developmental framework.	Clinical interventions will be evidence-informed, and sensitive to the consumer and their family and/or care representative/s' needs. Treatment planning will consider and build on the strengths, resilience, and protective factors within the individual, their family, culture, and community.
4.7.4 The ongoing educational and vocational needs, and documented processes with educational/vocational providers, are considered in tandem with the consumers clinical and care needs.	All efforts are made to ensure the least disruption to consumers' education, vocation or work. The SUSDU PSP (with consent) will liaise with the base school or vocational training provider representative to determine whether the consumer's mental health issues impact on his/her academic and vocational performance. Consultation and planning will occur with the base school teacher/supervisor to facilitate the educational /vocational program during the admission and support reintegration into class/work environment upon discharge. Where appropriate, the consumer will be supported by in-reaching teachers who will provide onsite education support. The SUSDU will have a dedicated study area for consumers to engage in educational activities. This space can also be used for in-reaching educational support sessions (e.g. tutoring, distance education, DET outreach support officers). This space can be used flexibly for therapeutic and group activities as well.

Key elements	Comments
	If a consumer is not currently enrolled in an education/vocational program, or currently working in a job, every effort should be made to facilitate this where appropriate.
4.7.5 Family and care representatives are integral to the mental health care process. In addition to the PSP, each consumer will be assigned a SUSDU staff member who will liaise and provide family members and care representative/s 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.	- Interventions to promote recovery are as much focussed on engaging with the family and carer as the consumer. - Recovery may include family work and parent-child work. - Time to provide emotional support to the consumer, family and/or carers will be given adequate priority. Carers matter webpage The consumer, carer and family participation framework

4.8 Care Coordination

Key elements	Comments
4.8.1 Every consumer in the SUSDU will be assigned a SUSDU care coordinator/case manager who will be identified in CIMHA as the Principal Service Provider (PSP).	Care coordinators/case managers will work in partnership with consumers to achieve the goals of their recovery plan. The care coordinator/case manager is responsible for coordinating appropriate assessment, care and review, and completing referral and ongoing care processes to ensure continuity of care and collaborative goal setting. Each service will develop local protocols to ensure there is a shared, clear understanding of responsibilities for coordinating consumer care. There needs to be agreed documented processes with the relevant AMHS for the joint management of consumers subject to the *Mental Health Act 2000*. Care coordination/case management will be managed to ensure effective use of resources and to support staff to respond to crises in a timely, effective manner.
4.8.2 Every consumer in the SUSDU will be assigned a consultant	The consultant psychiatrist will be identified as the internal contact, treating consultant psychiatrist, in CIMHA.

Key elements	Comments
psychiatrist, identified in CIMHA as 'Treating Consultant Psychiatrist'.	The consumer's treating team, consultant psychiatrist and care coordinator will be identified in the clinical record on CIMHA.

4.9 Psychological interventions

Key elements	Comments
4.9.1 Evidence based psychological treatments will be available to consumers.	A range of psychological interventions will be available and may include cognitive behavioural therapy and family therapy. The multidisciplinary team will have the skills to provide the most appropriate clinical intervention, solution focused problem solving and stress management activities.
4.9.2 Consumers will be supported to access a range of bio-psychosocial interventions which address their individual needs. Efficacy of treatment and progress will be reviewed at least monthly, throughout the episode of care.	Interventions may be individualised, group-based or generic programs. **Individualised interventions** may include but are not limited to: – psychological interventions o verbal o non-verbal therapies [e.g. play, adventure, art, yoga and music] o psycho-education – short-term family interventions and psycho-education – individualised behavioural programs – pharmacotherapy – referral to community follow up family therapy if indicated **Group interventions** may include but are not limited to: – a range of tailored group activities, predominantly activity based, targeting areas of psychological and developmental need. A structured group and educational timetable will be available to consumers, families and/or carers. **Generic interventions** may include but are not limited to: – maintaining a milieu with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and management of the consumer group to maximise each consumers care – forming appropriate therapeutic alliances – programmes and forums in the community

Key elements	Comments
	– providing opportunities for activities of daily living, leisure, social interaction and personal privacy. Interventions will include relapse prevention programs/techniques.

4.10 Psychosocial rehabilitation

Key elements	Comments
4.10.1 Evidence based psychosocial rehabilitation will be available according to individual needs.	This includes rehabilitation to gain skills for activities of daily living, including: personal care, daily living skills , parenting (if relevant), community access, education or vocation education, employment, and social skills. The multidisciplinary team will have the skills to implement rehabilitation programs. The care coordinator, in partnership with the consumer and with guidance from the multidisciplinary team, will determine the intervention required and by whom, to actively assist in providing interventions based on individual needs and results of specialist assessment.

4.11 Psycho-education programs

Key elements	Comments
4.11.1 Individual and group psycho-education programs will be available for all consumers and carers.	Topics covered will include recovery, mental health information, symptom management, medication management and side effects, alcohol and substance use interventions, mindfulness, and trauma-informed care. Psycho-education will be included in the program, which incorporates a range of components: - psycho-education and information about mental health disorder/s or problem/s - ensuring there is shared understanding of all aspects of the clinical risk management, with explicit documented evidence of the shared understanding in the clinical file - understanding the clinical care pathway within the mental health service
4.11.2 Consumers, carers, family and significant others will have access to education and information at all stages of contact with the service.	The needs of consumers of parents with a mental illness will be considered, including facilitation of age-appropriate information. Children of Parents with a Mental Illness (COPMI)

Key elements	Comments

4.12 Physical health

Key elements	Comments
4.12.1 Physical health issues will be routinely addressed in partnership with all consumers of the SUSDU and other external service providers, including GPs.	Metabolic monitoring will be maintained and documented on a Queensland Health form for all SUSDU consumers and uploaded to CIMHA. All consumers will be encouraged to have access to a GP. Information will be shared with a GP based on a mutually agreed plan. The SUSDU consultant psychiatrist will maintain written and verbal communication with the GP throughout an episode of care, and any changes in treatment will be promptly communicated. The GP will be provided with results of assessments, investigations and ongoing care recommendations. Child and Youth Mental Health Services Physical Examination and Investigation form Adult Mental Health Services Physical Examination and Investigation form

4.13 Activity of daily living assistance

Key elements	Comments
4.13.1 Assessment of activity of daily living ability, including personal care and domestic tasks will be provided. Where consumers are currently unable to perform these tasks, a skills development program will be facilitated.	A comprehensive skill assessment carried out in the initial stages of SUSDU assessment will be conducted, if clinically indicated. This assessment will form the basis of a graded rehabilitation program as indicated. Maximising activity of daily living independence for all consumers will be an essential component of the rehabilitation.

4.14 Medication management

Key elements	Comments
4.14.1	The medication goals of the consumer, family and/or carer/s

Key elements	Comments
Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision making processes between the treating team, the consumer, family and/or carers. Carers / Families of the consumer are responsible for obtaining the necessary medications.	will be integrated with evidence-based clinical treatment guidelines. Medication adherence is enhanced when rationales for pharmacological intervention are provided to consumers and carers. Framework for reducing adverse medication events in mental health services.
4.14.2 Across all treatment settings, prescribing, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards.	Medication is reviewed by the SUSDU medical practitioners at regular intervals and, where applicable, an ongoing joint medication monitoring program will be negotiated with the other health service providers involved. Monitoring of the consumer for evidence of appropriate and sufficient response to medication will be routinely conducted. Monitoring of medication side-effects will be routinely conducted with an emphasis on metabolic complications of psychopharmacological treatment. Strategies focussing on medication adherence will be in place.
4.14.3 The SUSDU will ensure that the consumer, family and/or carer are advised how to obtain supplies of medication.	Supply of prescribed medication for leave or discharge will be coordinated by the SUSDU. Mental health pharmacists or an appropriate delegate will provide medication counselling to consumers, families and/or carers prior to discharge. Information providing accurate details of discharge medications will be provided to all healthcare providers involved in the care of the consumer (e.g. GP, Community CYMHS, private psychiatrist, and community pharmacy). Medication liaison on discharge Health Support Queensland - Medicines Therapeutic guidelines-psychotropic Psychotropic Medication Information Leaflets Guidelines for the safe use of antipsychotics in Schizophrenia. Mental Health Services Metabolic Monitoring form Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary

Key elements	Comments

4.15 Alcohol, tobacco and other drug interventions

Key elements	Comments
4.15.1 Consumption of alcohol, tobacco and illicit non-prescribed drugs is prohibited in the SUSDU. Therapy and support will be provided to consumers to address co-occurring drug and alcohol issues.	The multidisciplinary team will be able to provide drug, tobacco and alcohol interventions, including motivational interviewing. SUSDU will use a multi-step motivational model of recovery. The treatment approach follows a series of actions consistent with making or sustaining a change. The treatment will consider the interaction of mental illness and substance use. It is important to note that the SUSDU is not a drug and alcohol withdrawal facility. Referrals requiring services linked to drug and alcohol use will be referred to other suitable services. The SUSDU will initiate and maintain effective links with dual diagnosis coordinators, alcohol and other drugs services and other community drug and alcohol treatment services. Queensland Health dual diagnosis policy–Service delivery for people with dual diagnosis Queensland Health Dual Diagnosis Clinical Guidelines Queensland Health Dual Diagnosis Clinician Toolkit
4.15.2 Information and advice to address alcohol, tobacco and drug use will be routinely provided. For some consumers alternative or additional support may be required.	Harm minimisation principles will be utilised where relevant. Co-occurring alcohol, tobacco and drug problems will be addressed in the recovery plan. Where other services are involved in the care of the consumer they will be included in the care planning process. Advice on alternative services will be available.

4.16 Crisis Management

Key elements	Comments
4.16.1 There are instances where increased levels of intervention are necessary for the management of symptoms and/or behaviours that increase the risk of harm to the	Crisis is seen as an opportunity to learn and reinforce coping strategies as part of recovery, and plans are to be developed in consultation with consumers and significant others. Mental health services–Crisis intervention plan.

Key elements	Comments
consumer or others.	A specific management plan will address consumer distress and any associated behavioural disturbance. The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every consumer whose risk assessment identifies actual or potential aggression as an issue. The plan will list preventative strategies and de-escalation strategies, and must also be supported by the availability of appropriately prescribed medication. Intervention strategies will include: – increased visual observation – de-escalation techniques – development of a management plan – targeting the specific behaviour or symptom – use of medication to relieve agitation/aggression – utilisation of Non-Violent Crisis Intervention (NVCI) techniques All staff working in the SUSDU Unit will have attended Non-Violent Crisis Intervention (NVCI) training. Families and /or carer/s are immediately informed of changes in a consumer's behavioural presentation. In high risk situations it may be clinically indicated for a consumer to be transferred to an acute inpatient observation area or unit to ensure the safety of other consumers on the SUSDU. *Mental Health Act 2000* Resource Guide Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services Mental health visual observations Occupational violence prevention training Searches in authorised mental health services: Clinical practice guidelines

4.17 Team Approach

Key elements	Comments
4.17.1 A multidisciplinary team approach will be provided.	The consumer, family and/or care representatives will be informed of the multidisciplinary model. Recognition of the need for Aboriginal and Torres Strait Islander mental health workers within the MDT is integral for consumers, carers and families that identify as Aboriginal and/or Torres Strait Islander.

Key elements	Comments
	Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. Clinical, discipline and peer supervision will be available to all staff. Efforts to support team functioning must focus on an integrated approach between clinical and SUSDU support staff to service provision. A regular team processes must be in place to review distinctions and similarities in the roles and responsibilities of clinical and SUSDU support staff.
4.17.2 Caseloads will be monitored by the leadership team consisting of the clinical lead (preferably a nurse) and the SUSDU support staff lead worker (and other staff as appropriate) to ensure effective use of resources and to support staff to respond to crises in a timely, effective manner.	
4.17.3 Clear clinical and operational leadership will be provided for staff and for the team.	There will be a well-defined and clearly documented local process for escalation of discipline-specific clinical issues. It is highly recommended that a regular monthly meeting is to occur between the clinical lead and SUSDU support staff lead worker, together with their respective line managers, to review service operations, and discuss issues in leadership team functioning.

4.18 Continuity and coordination of care

Key elements	Comments
4.18.1 Clearly documented mental health service contact information (covering access 24 hours, 7 days per week) is provided to consumers, families, and /or carer/s, 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. Relevant information documents detailing specific service response information will be readily available.
4.18.2 Every consumer will have a	Recorded in the CIMHA as the internal contact, treating

Key elements	Comments
designated treating consultant psychiatrist at the SUSDU.	consultant psychiatrist.
4.18.3 Every consumer will be assigned a Principal Service Provider (PSP).	Recorded in CIMHA as the internal contact, PSP. The PSP is responsible for co-ordinating appropriate assessment, care and review, and completing referral and ongoing care processes. In the event a consumer identifies as Aboriginal and Torres Strait Islander (ATSI), an ATSI mental health worker or an Indigenous health worker will be assigned to the consumer to participate in ongoing service provision.
4.18.4 Each consumer will be allocated focal clinical and SUSDU support workers for each shift.	Consumers will be aware of the focal staff on each shift.
4.18.5 The SUSDU will actively engage with other treating teams in coordination of care across inpatient (acute and non-acute) and community settings.	
4.18.6 Where applicable, the consumer's treating team will be identified in the clinical record, MDT Review documentation, and communication will be maintained with the treating team throughout the inpatient phase of care.	The PSP from Community CYMHS or other treating team will be recorded in CIMHA and remain constant during an inpatient admission.
4.18.7 Community based supports are included in recovery planning and discharge planning wherever possible.	NGO service providers who have established (or are establishing) support links with consumers, families, and/or carer/s will be given access to the SUSDU as appropriate. All community based supports will be co-ordinated prior to discharge. The process for sharing information will be explicitly documented for each case, taking existing privacy, confidentiality and consent considerations into account. *Hospital and Health Boards Act 2011* – Part 7 Confidentiality

Key elements	Comments
	Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary

4.19 Transfer / Internal Transition of Care

Key elements	Comments
4.19.1 A handover will be provided on every transfer/discharge occasion.	Guidelines for internal transfers will be clearly planned, documented and shared with the receiving teams before transfer is concluded. A verbal handover will be provided on the day of transfer. During the transition phase there will be an appropriate plan to ensure smooth transfer of care which includes the early engagement of all service providers in ongoing care. Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary Adult Mental Health Services Consumer End of Episode/Discharge Summary
4.19.2 Disengagement by the SUSDU will only occur after the receiving team and the family and/or carer/s have been contacted regarding follow up care arrangements.	Consumers admitted to a SUSDU outside of the HHS catchment that they reside in will be treated in that SUSDU, and any decisions regarding a transfer back to their area, either to inpatient or community care, will be based on the clinical needs of the consumer. It will be required that the PSP's from the referring services have ongoing input into care provision by attending (in person, teleconference or VC) the weekly case reviews. Policies and procedures for internal transfers will be clearly written, and receiving teams will make strenuous efforts to establish contact within a reasonable time period. SUSDU and Community CYMHS staff will negotiate which service will contact the family and/or carer/s regarding appointments following discharge from the SUSDU A feedback mechanism will be in place so SUSDU staff can be informed by the referring service if the consumer does not to attend the follow up. Hyperlink to Inter-District Transfer policy when available
4.19.3 Local protocols for out of area transfers will be mutually agreed and documented.	Information on inter-HHS transfers between CYMHS is available in the below document:

Key elements	Comments
	Hyperlink to Inter-District Transfer policy when available
4.19.4 Where possible, consumers will not be transferred to another HHS during crisis.	Where transfer is unavoidable, both services need to make direct contact and ensure safe transfer (service capability will be considered).
4.19.5 Consumers, family and/or carer/s will be informed of transfer procedures.	Appropriate crisis plans will be prepared with the consumer, family and/or carer/s.

4.20 Discharge / External Transition of Care

Key elements	Comments
4.20.1 Planning for discharge from a SUSDU will commence at the time of admission. Consumers will be discharged promptly, as clinically indicated and in accordance with their individual recovery plan.	Consumers, their families and/or carers, the referrer and other key stakeholders will be actively engaged in discharge planning from the time of admission. Discharge planning will be a routine component of each clinical review process. Consumers, their family, and/ or carer will be asked to sign their discharge plan. It is highly recommended that the involvement of Aboriginal and Torres Strait Islander (ATSI) mental health workers is prioritised for transfer/discharge of consumers of ATSI descent. HHS mental health services will give priority to consumers transferring back to their HHS from the SUSDU. This ensures that the consumer does not remain in the SUSDU longer than is deemed clinically necessary. Discharge planning should also consider accommodation and support needs for consumers who are homeless or at risk of homelessness.
4.20.2 Discharge planning will include a recovery plan, and incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.	Child and Youth Mental Health Services Recovery Plan form Adult Mental Health Services Recovery Plan form The recovery, relapse prevention and crisis management plans will be provided to the consumer, family and/ or carer, GP and relevant support agencies.

Key elements	Comments
4.20.3 Where consumers are absent without leave, there will be documented evidence of attempts to contact the consumer, his/her family and /or carer/s, and other service providers (e.g. QPS), before discharge.	
4.20.4 Where the consumer is subject to provisions of the *Mental Health Act 2000* there will be documented evidence that all statutory requirements have been met.	*Mental Health Act 2000*
4.20.5 Discharge will occur when the young person is at a stage of recovery where they have graduated to needing less intensive care and have supports in place to manage in the community, up to a maximum of 28 days [subject to review]	The decision to exit a consumer is at the discretion of the consultant psychiatrist in consultation with SUSDU staff and in consideration of time limits for service provision. Consideration is given to the maintenance of benefits gained from treatment interventions (e.g. involvement in a Day Program may be encouraged to assist the transition and facilitate rehabilitation and recovery goals). Child and Youth Mental Health Services Consumer End of Episode/Discharge Summary Adult Mental Health Services Consumer End of Episode/Discharge Summary
4.20.6 Comprehensive liaison and handover will occur with all service providers who will contribute to ongoing care post-discharge.	All clinicians are responsible for confirming that a follow up appointment has been made prior to discharge (where the consumer/family have refused follow up, this will be documented in the clinical record). All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within 48 hours. Discharge summaries need to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care, and procedures for re-referral. Relapse patterns and risk management information will be clearly outlined.

Key elements	Comments
	A follow-up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the discharge letter was received. Queensland Health Child and Youth Mental Health Services State-wide Standardised Suite of Clinical Documentation User Guide Suite of Clinical Documents The PSP will contact the follow up service provider to ensure they accept the referral for ongoing provision of care (this will be noted in the consumer clinical record). Consumers discharged from the SUSDU will be seen by the receiving team in a timely manner.
4.20.7 The consumer, family and or/carer/s will be supported to make a follow up appointment with their GP, or other suitable follow up service provider, prior to discharge.	

4.21 Collection of data, record keeping and documentation

Key elements	Comments
4.21.1 The SUSDU will enter and review all required information in CIMHA, in accordance with approved state-wide and HHS business rules.	CIMHA business rule
4.21.2 The SUSDU will utilise routine outcome measures as part of assessment, recovery planning and service development. These will include those mandated through the National Outcomes and Casemix Collection (NOCC): - Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) - Strengths and Difficulties Questionnaire (SDQ)	Outcomes data is presented at all formal case reviews and will be an item on the relevant meeting agendas. Results of outcomes are routinely discussed with consumers and their families and or carers. Outcomes data is used with consumers to: a. record details of symptoms and functioning b. monitor changes c. review progress and plan future goals in the recovery plan Mental Health Outcomes Collection Protocol Outcome and Casemix measures for mental health services

Key elements	Comments
- Children's Global Assessment Scale (CGAS) - Factors Influencing Health Status (FIHS).	
4.21.3 All contacts, clinical processes, recovery and relapse prevention planning will be documented in the consumer's clinical record.	Progress notes will be consecutive (according to date of event) within all hard copy consumer clinical records. Queensland Health Child and Youth Mental Health Services Statewide Standardised Suite of Clinical Documentation User Guide Suite of clinical documents Aboriginal and Torres Strait Islander Cultural Information Gathering Tool Guide .
4.21.4 Clinical records will be kept in accordance with legislative and local policy requirements.	Personal and demographic details of the consumer, family, and/or carer/s and other health service providers will be reviewed regularly and kept up to date. Mobile or tablet technology will support any increasing application of electronic record keeping. Clinical records management policy Retention and disposal of clinical records protocol Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines
4.21.5 Local and state-wide audit processes will monitor the quality of record keeping and documentation (including external communications), and support the relevant skill development.	

4.22 Working with families, carers and friends

Key elements	Comments
4.22.1 The involvement of families and carers is integral to successful outcomes and therefore their engagement is incorporated into every component of service provision.	Consumer/Guardian consent to disclose information and to involve family and/or carers in care will be sought in every case. *Guardianship and Administration Act 2000* Carers matter The consumer, carer and family participation framework *Hospital and Health Boards Act 2011* – Part 7

Key elements	Comments
	Confidentiality Right to Information and Information Privacy Information sharing between mental health workers, consumers, carers, family and significant others.
4.22.2 Education and information will be provided to the consumer, family and/or carer/s at all stages of contact with the service.	This will include a range of components such as: – education and information about the mental illness or mental health issues – the journey within the service – mental health care options – pharmacotherapy – support services – recovery pathways – contact information for the mental health service and relevant external service providers Education and information provided will be documented.
4.22.3 The needs of families and/or carer/s must be routinely addressed.	Identification of carer/s and their needs is part of the assessment process and is included in care planning.
4.22.4 Support services will be offered to families and carers regardless of whether consent is given for their involvement in the consumer's care.	Support may be provided by a member of the mental health service organisation or another organisation.
4.22.5 Consumers, who are children of parents with a mental illness, will be routinely considered as part of all assessments and interventions provided. If a consumer of a SUSDU is pregnant or a parent with primary care responsibilities, his/her infants/ children will be routinely considered as part of all assessments. Interventions will be provided/ facilitated if needed.	*Child Protection Act 1999* Mental health child protection form Family support form Children of parents with a mental illness (COPMI) website

4.23 Mental health peer support services

Key elements	Comments

Key elements	Comments
4.23.1 All consumers, families and/or carers will be offered information and assistance to access local peer support services.	Peer support services may be provided by internal or external services. Consumer and carer consultants are accessible via the local HHS mental health service.

5. Related services

Mental health services operate in a complex, multi-system environment which includes crucial interactions with other areas of Queensland Health (e.g. Alcohol Tobacco and Other Drug Services and Community Health), other Queensland Government departments (e.g. the Department of Education and Training, Department of Communities, Child Safety and Disability Services, Youth Justice and the Department of Housing and Public Works), General Practitioners, private providers, non-government organisations and other relevant services.

The SUSDU should be integrated and coordinated, with specialist mental health services and external service providers for consumers. This ensures continuity of care across the service system and through the consumer's developmental transitions. Staff should have a comprehensive knowledge and understanding of the services available that support/provide health and mental health care. Relationships should be initiated and maintained with these external service providers and support services. An up-to-date resources database should be maintained by the SUSDU.

Key internal relationships include:

- continuing care teams - including CCYMHS, AMYOS, Adolescent Day Program and the Youth Residential Rehabilitation Units (Youth Resi)
- acute adolescent inpatient unit (AAIU)

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

- consultation liaison psychiatry services
- transitional housing teams
- homeless health outreach teams
- transcultural mental health
- forensic mental health services
- HHS forensic liaison officers
- dual diagnosis coordinators
- alcohol and other drugs services
- dual disability coordinators

SUSDU should work collaboratively with Education Queensland to enable a comprehensive and tailored educational program within SUSDU.

Other key (local) relationships include (but are not limited to):

- primary care providers (e.g. GPs, community health)
- community pharmacy

- community managed mental health (CMMH) organisations and other community support services
- vocational and education support services
- health and fitness organisations
- recreational facilities and other community services
- hospital emergency departments
- emergency services (e.g. Queensland Police Service, Queensland Ambulance Service)
- National Disability Insurance Agency.

6. Caseload

The size of the caseload of a SUSDU will be determined by the bed capacity, and the capacity of the consultant psychiatrist and clinical lead / Team Leader to provide safe, high quality clinical governance. Consideration will be given to team systems and processes such as clinical pathways.

Caseload sizes will consider a range of factors, including acuity and complexity of need, and skill mix within the team. Care is provided in the form of an intensive case management/care coordination model. Case managers/care coordinators are assigned as primary or secondary service provider to an appropriate number of consumers based on skill mix, level of experience, and consumer numbers. Team work is a core component of the model of care, including the treating multidisciplinary team and other agencies in partnership with the consumer.

Psychosocial rehabilitation will be delivered via a multidisciplinary team incorporating the skills of nursing, psychology, occupational therapy, social work, peer support and medical practitioners. Partnerships will be actively sought with the community managed mental health (CMMH) sector.

The proportion of disciplines at each site will be locally determined, within the guidelines of relevant policy and funding guidelines, incorporating the following:

- every SUSDU will have a designated Team Leader and a consultant psychiatrist
- a consultant psychiatrist will be available for urgent case reviews as per the local arrangements (this may be via telephone or telehealth)
- all applicable permanently appointed clinical staff will be appointed (or working towards becoming) authorised mental health practitioners
- there will be medical representation at all multidisciplinary team reviews and ad-hoc and/or formal case reviews
- clinical staff will deliver both specialist discipline-specific assessments and interventions of a generic nature
- the staffing profile might include allied health assistants, peer support workers and psychosocial rehabilitation staff
- day to day operations of the unit may be supported by administrative staff, maintenance and hygiene staff
- administrative support is essential for the efficient delivery of service in a SUSDU
- consumers and carers will be provided with access to members of the consumer/carer workforce, ATSI workforce, and other specialist service providers

- the SUSDU will provide clinical placements for undergraduate and postgraduate students where supported by current staff skill and availability
- the rotation of staff through the SUSDU from other parts of the integrated mental health service is encouraged to support further education and skill development

SUSDU provides a 24 hour service, which requires community care staff to be continuous shift workers. Nurses on the unit will be present between the hours of 8:00 am and 10:00 pm. The model of nursing care will be a combination of case management and patient allocation. The skill mix and patient complexity is taken into consideration when allocating nursing staff. The patient will be informed of their focal nurse for each shift.

7. Workforce

The staffing profile for SUSDU is comprised of a multidisciplinary mix of clinical and non-clinical staff. Treatment and care is provided by clinical mental health workers including doctors, nurses and allied health staff, music and art therapists, as well as a range of non-clinical staff including ATSI Mental Health Workers, community care staff, and education staff from the Department of Education and Training (DET). Involvement of and access to consumer and carer consultants and recovery support workers should be facilitated within the integrated mental health service. Additionally, the multidisciplinary team is supported by administrative officers and hygiene staff who assist with the day to day operations of the unit.

All SUSDU support staff will have completed or currently enrolled in a certificate 4 in mental health as a minimum qualification.

The effectiveness of SUSDU is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of consumers accessing the service suggests the need to provide staff with continuing education programs, clinical supervision and mentoring, and other appropriate staff support mechanisms. The SUSDU undertakes evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate and post-graduate students, encouraging rotations through the unit for staff from other areas of the integrated mental health service, and supporting education and research opportunities.

8. Team clinical governance

SUSDU operate under the direction of a Clinical Director from the local HHS, Clinical Staff Team Leader (who will preferably be a nurse), and SUSDU Support Staff Team Leader. Clear reporting roles ensure effective management and the efficiency of service delivery. Multidisciplinary team work is essential. Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

All SUSDU will identify a single point of clinical accountability for every consumer.

Multidisciplinary team work is essential as consumers receive treatment and care from a range of specialist medical, nursing, allied health, therapy and SUSDU support workers, with appropriate qualifications, skills and experience.

All admitted consumers will be discussed at a clinical review meeting within 24 hours of admission and at MDT reviews conducted regularly. A consultant psychiatrist will participate in the MDT Review. A consultant psychiatrist or appropriate delegate will participate in regular clinical review meetings. This may be direct participation or via telehealth.

SUSDU exist within a continuum of integrated mental health services and other health services. Services are provided in partnership with the consumer, his/her family and carer/s as well as a range of other government and non-government organisations (NGOs).

9. Hours of operation

24 hours a day, 7 days a week. This includes public holidays.

10. Staff training

Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure that they are clinically competent. Staff are encouraged and supported in working towards the attainment of specialised mental health qualifications. All training will be based on best practice principles and evidence-based treatment guidelines, and underpinned by the National Framework for Recovery Oriented Mental Health Services.

All clinical staff must be engaged in relevant professional development to ensure contemporary and evidence-based intervention and treatment is provided to consumers, their carer/s and family. The clinical acuity and complexity of consumers accessing inpatient services is on the rise. There is growing focus on the integrated approach to managing these traumatised consumers in mental health care settings. Specialist skills are required to manage escalating behaviours as a result of trauma, including attachment issues and affect deregulation. All clinicians are to be adequately trained in these specialist skills to provide effective evidenced-informed interventions.

Involvement in research activities is also highly desirable. This is also a requirement for annual registration with the governing bodies of most disciplines.

Training should be based on best practice principles and will be underpinned by the recovery framework. Teams are encouraged to make the relevant components of their training available to their service partners (e.g. NGOs, GPs).

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

- orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- promotion, prevention, and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for children and adolescents and their families and /or carer/s
- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention

- Mental Health Act 2000
- National Standards for Mental Health Services 2010
- evidenced-informed practice in service delivery
- consumer-focused recovery planning
- routine Outcomes measurement training
- a range of treatment modalities including individual, group and family-based therapy
- an understanding of key theoretical frameworks including child & adolescent development, attachment, complex trauma, grief and loss, and family systems theory
- child safety services training
- perinatal and infant mental health training
- knowledge of mental health diagnostic classification systems
- medication management
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- cultural capability training
- alcohol and drug assessment and interventions
- family therapy

11. The SUSDU functions best when

- consumers, family and/or carers, and other service provider's are engaged and involved in all aspects of care planning and delivery
- there is an explicit attitude that consumers can and do recover from mental illness
- there is an adequate skill mix, with senior level clinical expertise and knowledge being demonstrated by the majority of staff across all shifts
- there are clear and strong clinical and operational leadership roles which recognise each other's strengths and work to form a collaborative relationship
- senior staff, including medical staff, take an active role in fostering the development of clinical skills for less experienced staff
- staff are provided with adequate professional support and training
- staff are provided with peer supervision/clinical supervision, including reflective practice
- service delivery is integrated, with established procedures that support continuity of care across settings and between services
- there is unit integration with local mental health services, specifically community Child and Youth Mental Health Services, acute hospital services, Department of Emergency Medicine (DEM), and primary care supports
- there is adherence to evidence informed care, treatments, interventions and processes
- a range of performance, quality and safety indicators are actively utilised to inform service planning and provision
- there is a culture of openness and responsiveness to service user feedback.
- clinical governance is intrinsically embedded throughout all processes and practices within the service.

12. Key Resources

12.1 Website resources

Resource
A national framework for recovery-oriented mental health services: Guide for practitioners and providers
A National framework for recovery-oriented mental health services: Policy and theory
CheckUP (formerly General Practice Queensland)
Child Protection Act 1999
Child Protection guidelines at the Queensland Health policy site
Children of Parents with a Mental Illness (COPMI)
Choice and medication
Clinical Knowledge Network
Clinical Services Capability Framework
Complaints and compliments about health services
Deafness/hearing loss and mental health service
Dual diagnosis
Fees and Charges Register
Forensic Order
Guideline for clinical incident management Health Service Directive QH-HSDGDL-032-2
Health Legislation Amendment Bill 2014
Hospital and Health Boards Act 2011
Indigenous mental health
Information sharing between mental health workers, consumers, carers, family and significant others
Intentional peer support
Mental health statement of rights and responsibilities 2012
Multicultural mental health
National practice standards for the mental health workforce 2013
National Safety and Quality Health Service Standards 2012
National standards for mental health services 2010
Principles and actions for services working with children of parents with mental illness
Protecting children and young people Policy QH-POL-078:2012
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 –2033
Queensland Health dual diagnosis policy–Service delivery for people with dual diagnosis
Queensland Health interpreter service
Queensland transcultural mental health centre
Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines
Recovery measures: The Australian context
Recovery-Oriented Practices Index (ROPI)
Recovery Oriented Systems Indicators Measure (ROSI)
Recovery Self-Assessment (RSA)
The Mental Health Act 2000–Forensic provisions
Therapeutic Guidelines–Psychotropic
Working with parents with mental illness–guidelines for mental health clinicians

12.2 Queensland Health intranet (QHEPS) resources

Resource
CIMHA–handbooks, manuals and resources
CIMHA–Standard business processes
Clinical safety and quality model governance framework– Patient safety unit
Clinical supervision guidelines for mental health services
Consumer Integrated Mental Health Application (CIMHA)
Dual diagnosis–clinical guidelines
Information sharing–Child safety
Medication liaison on discharge
Mental Health Alcohol and Other Drugs Branch resources
Mental health alcohol and other drugs quality and safety
Mental health child protection form
Mental health services–Consumer care review summary and plan
Mental health services–Consumer end of care/discharge summary
Mental health services–Crisis intervention plan
Mental health services–Risk screening tool
My recovery plan
Queensland Health mental health case management policy framework
Protecting children and young people
Clinical incident management resources
Sharing responsibility for recovery
Statewide standardised suite of clinical documentation
Statewide standardised suite of clinical documentation user guide

Abbreviations

AAIU	Adolescent Acute Inpatient Unit
ACL	Allen's Cognitive Levels
AC-QoL	Adult Carer Quality of Life
AMHS	Authorised Mental Health Service
AUDIT	Alcohol Use Disorders Identification Test
BAS	Burden Assessment Scale
BPRS	Brief Psychiatric Rating Scale
CCU	Community Care Unit
CSCF	Clinical Services Capability Framework
CMMH	Community managed mental health
CIMHA	Consumer Integrated Mental Health Application
FO	Forensic Order
GP	General practitioner
HoNOS	Health of the Nation Outcome Scale
HHS	Hospital and Health Service
ITO	Involuntary Treatment Order
LSP	Life Skills Profile
MHI	Mental Health Inventory
PRPP	Perceive Recall Plan and Perform System of Task Analysis
PSP	Primary Support Provider
ROPI	Recovery-Oriented Practices Index
ROSI	Recovery Oriented Systems Indicators Measure
RPFS	Recovery Promotion Fidelity Scale
RSA	Recovery Self-Assessment
SANS	Scale for the Assessment of Negative Symptoms
SUSDU	Step Up/Step Down Unit

Adolescent Extended Treatment and Rehabilitation Models
Summary of Site visits to Victoria

Date: Visits conducted from 14 – 16 August 2013

Purpose: To review alternative models of Adolescent Rehabilitation and Extended Treatment

Reviewers:

- Dr Stephen Stathis, Clinical Director, Children's Health Queensland (CHQ) Child and Youth Mental Health Services (CYMHS)
- Ms Judi Krause, Divisional Director, CHQ CYMHS
- Dr Leanne Geppert, A/Director of Strategy, Mental Health & Specialised Services, West Moreton HHS
- Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre (BAC).

Sites visited:

- Royal Children's Hospital (RCH) Parkville
- Orygen Youth Health, Western Hospital and Parkville sites
- Mindful Centre for Training & Research in Developmental Health
- Y-PARC Dandenong, Southern Health
- Youth Support & Advocacy Service - Residential Facility – Noble Park
- Y-PARC Frankston, Peninsula Health Service.

BACKGROUND

The site visits was precipitated by the announcement that the Barrett Adolescent Centre (BAC), a fifteen bed inpatient adolescent extended treatment and rehabilitation facility based at The Park, Wacol, would be closing in late December 2013. An Expert Clinical Reference Group (ECRG) had identified a range of recommendations across the continuum of extended treatment and rehabilitation spectrum to best meet the diverse needs of this cohort.

Characteristics of Adolescents requiring extended treatment and rehabilitation:

- severe and complex mental illness
- impaired development secondary to their mental illness
- persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- will benefit from a range of clinical interventions

Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities as outlined below:

1. Persistent depression, usually in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self-harm and dissociative hallucinoses.

2. Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder

and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.

3. Complex post-traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self-harm and suicidal behaviour resistant to treatment within other levels of the service system.

4. Persistent psychosis non responsive to integrated clinical management (including community-based care) at a level 4/5 service.

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder.

Royal Children's Hospital, (RCH) Parkville / Orygen Youth Health Service and Mindful Centre for Training and Research in Developmental Health.
These sites represented mental health care for adolescents in the Western metropolitan region of Melbourne. RCH and Orygen Youth Health (OYH), at Western Hospital provided acute inpatient services. RCH admitted an age range of 12 – 18 year olds and OYH admitted 16 – 25 year olds. Neither service had access to extended treatment and rehabilitation beds. They managed the cohort described above by offering an Intensive Mobile Youth Outreach Service (IMYOS). Dr Sandra Radavini, Child Psychiatrist from the Mindful Centre for Training and Research in Developmental Health was a co-founder of the IMYOS team.

The IMYOS model is a sub-acute program targeting difficult to engage, high risk young people with complex needs 15 – 24 years, who are experiencing mental health difficulties. IMYOS teams have caseloads of approximately eight and work as part of the integrated MH service. They provide assertive outreach mental health assessment and treatment to young people who are homeless, have substance abuse or forensic history and clients who are unable to leave their residences due to severe anxiety or psychosis. IMYOS also inreach to youth residentials managed by the Non-Government sector.

Y-PARC (Dandenong)

The Youth Prevention and Recovery Care Service (Y-PARC) is a collaboration between Southern Health (SH), Mind Australia (Mind) and Youth Support & Advocacy Service (YSAS).

SH is the largest health service in Melbourne and provides comprehensive integrated health care services to nearly 1.294 million people in the south-eastern suburbs of metropolitan Melbourne and nearby catchment populations.

The Mental Health Program is one of the largest integrated public mental health services in Victoria. The programs support more than one million people across Southern Health's geographically and culturally diverse catchment population including areas of significant socioeconomic disadvantage.

Mind Australia is a community managed mental health service supporting people recovering from the effects of mental health problems for over 30 years in Victoria and more than four years in South Australia. Mind provides support services to approximately 5,000 people every year, including families and carers. Mind is a leading non-government provider of consumer focussed, recovery oriented mental health services in the community managed mental health sector, with high levels of expertise, knowledge and skills. Mind Staff have a

minimum qualification of Certificate IV in Mental Health and the majority have Bachelor Degrees in Psychology, Social Work or a related field.

YSAS is an accredited community service organisation providing a range of innovative and client centred services to vulnerable young people aged 10 to 25 years. Operating from metropolitan and regional Victoria, services provided include: early intervention, youth outreach, short-term residential withdrawal, residential rehabilitation, home-based withdrawal, primary health, family reconciliation, day programs, youth supported accommodation, young parents support and alcohol and drug youth consultancy.

The Y-PARC is an element of the acute end of the clinical service continuum and aims to provide a short term residential treatment service in a youth friendly environment to young people aged 16 to 25 years. This 10 bed facility is a purpose built home-like environment to meet the needs of young people.

The partnership between SH, Mind and YSAS recognises the unique opportunity to provide young people and their carers/families with support during the early stages of an illness or episode and to provide them with treatment and strategies to manage mental health problems and engage them in recovery focused interventions and activities.

The Y-PARC model of care recognises the impact that mental health problems can have during the developmental stages and the resulting lower rates of participation in age appropriate activities for these young people. The model of care also recognises the importance of the formation of local partnerships with relevant services such as community mental health services, alcohol and other drug services (AOD), housing, primary health, education and vocational/training services.

The key principles of the Y-PARC model of care include but are not limited to:

- Early in life, early in illness and early in episode interventions;
- Treating young people with dignity & respect;
- Providing a supportive and safe environment, and an understanding of young people's physical, sexual and emotional safety needs;
- Gender sensitive care which considers gender identity and sexual preferences; and an awareness that a wide range of other factors interplay with gender identity which may have a negative impact on young people's health and wellbeing;
- Trauma informed care that gives insight into how trauma can have enduring effects on people that may interrelate with mental health and AOD issues, and developmental and age related issues; and
- Providing an individual client recovery focus as well as family/carers engagement in care planning.
- CALD Population sensitivity

SH have primary responsibility for the delivery of clinical services, and Mind have primary responsibility for the operational management. Staff from SH, Mind and YSAS work together and form collaborative professional working relationships in providing a clinical /recovery focussed service to clients.

Frankston Y-PARC

The Frankston Y-PARC is a collaboration between Peninsula Health Mental Health Service (PHMHS), Mind Australia (Mind) and Peninsula Support Services (PSS). PHMHS provides a range of integrated mental health services within the designated catchments of Frankston, Chelsea, and the Mornington Peninsula.

PSS is a community managed mental health service that supports people adversely affected by their mental health issues. Based in the local area PSS supports approximately 600 people per year with a range of services including; Home Based Outreach (1:1 support), Rehabilitation Groups, HACC Day Programs, Carer Support and a duty/intake service.

Y-PARC	Dandenong – 10 beds	Frankston – 10 beds
Target Population Characteristics **(same across both sites)**	• 16-25 yrs • live in catchment/ client of SH mental health • voluntarily agree • significant mental health issues/ high risk/ vulnerable • Safe to treat within community setting – low to moderate risk • Step up or step down from acute inpatient services	• 16 – 25yrs • live in catchment/ client of PHMHS • voluntarily agree • significant mental health issues/ high risk/ vulnerable • Safe to treat within community setting – low to moderate risk • Step up or step down from acute inpatient services
Exclusion Criteria (same across both sites)	• Clozapine 1st day treatment • Level of acuity or risk assessed as too high (actively suicidal, homicidal or aggressive) • No capacity to engage and comply with treatment • Milieu not conducive • Actively using illegal substances	• Clozapine 1st day treatment • Level of acuity or risk assessed as too high (actively suicidal, homicidal or aggressive) • No capacity to engage and comply with treatment • Milieu not conducive • Actively using illegal substances
Client Mix (Varies – this is a point in time snapshot only)	• At time of visit: • Male: 6 • Female: 4 • Age 19 – 22 • 60% step up • Will take clients under MHA	• At time of visit: • Male: 0 • Female: 9 • Age 16 – 19 • 80% step up • Will take clients under MHA
Client Diagnoses (similar profile across sites)	• Psychosis • Mood disorders • Borderline Personality Disorder	• Psychosis • Mood disorders • Borderline Personality Disorder
Length of Stay	• Up to 28 Days (average 2 weeks)	• Up to 28 Days
Staffing Mix (Variability re: staffing shifts, Frankston model has extended clinical coverage).	• SH Mental Health Service – determine entry • Clinical staff work day shift (0800 – 1700), YSAS staff work 3 shifts (day, evening/night) • .2 Psychiatrist and .5 Registrar (shared across acute inpatient unit AIU) • Nursing staff – closed roster with rotations from AIU • Overnight staff liaise with SH triage team for urgent/crisis mh response	• PHMHS – determine entry • Clinical staff work 2 shifts (day/evening until 2230), PSS staff work 3 shifts (day, evening/night) • .2 Psychiatrist and .5 Registrar (shared across acute adolescent inpatient unit) • Nursing staff - closed roster • Overnight staff liaise with PHMHS triage team for urgent/crisis mh response
Budget: **Facility Build** **Operational Budget**	• 3.5 million (excluding land) • 1.8 million (approx.)	• 5 million (excluding land) • 1.8 million (approx.)

Interventions
There were different levels of structure between the two Y-PARC programs. Family engagement and therapy are well supported and both therapeutic (e.g DBT) and life skills groups are offered which are supplemented by individual treatment and support. Young people have free access to the community, and some will continue with school and part time work in the local area. There are cooking and life skills groups in the evening.

Environmental Factors
Both the Dandenong and Frankston Y-PARC services are in new purpose built buildings which had in common

- Stand alone, unmarked suburban locations on a land area of approximately 3000 sq metres.
- Predominant open living design with quiet areas for art, music and sensory rooms
- Strong use of glass to connect to outdoor areas utilised for recreation, retreat and garden projects
- 10 private bedrooms with en suites. These have no internal visibility to others (including staff) which are accessed by residents with their own access card. Staff have swipe card access to all bedrooms.
- Open meal preparation areas (including access to all knives). All meals are prepared by residents, with some assistance from staff if necessary.
- Visitor rooms and family assessment/therapy rooms
- Standard anti-ligature fittings
- Staff offices

Youth Support & Advocacy Residential Facility – Noble Park
This facility provided ten beds configured in five two bedroom units on a shared campus. Young people 18 – 25 reside there for up to two years. There are support staff rostered 9 – 5pm seven days per week. There is an on call system to the Manager overnight and young people can access the crisis & triage team from SH. Young people are linked to either the SH mental health service or private psychiatry. They are supported by youth workers to engage with vocational education, tertiary studies, employment opportunities and develop their independent living skills. There is currently a waiting list for young people to access the residential facility.

ALIGNMENT OF THE Y-PARC MODEL TO THE EXPERT CLINICAL REFERENCE GROUP RECOMMENDATIONS

The Expert Clinical Reference Group (ECRG) developed a service element document which proposed four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:
Tier 1 – Public Community Child and Youth Mental Health Services (existing)
Tier 2a – Adolescent Day Program Services (existing and new)
Tier 2b – Adolescent Community Residential Service/s (new)
Tier 3 – State-wide Adolescent Inpatient Extended Treatment and Rehabilitation

Service (new)

The IMYOS service would complement Tier 1, 2 and potentially Tier 2b. It would be hypothesized that assertive outreach intervention would engage young people, provide evidence informed treatment and reduce the need for both acute and extended treatment inpatient admissions.

The Y-PARC model would complement Tier 1 by providing both a step up and a step down sub-acute contemporary bed based model of care. It would further support Tier 2 and 2b. With significant adaptations, the Y-PARC model could potentially meet some of the Tier 3 requirements.

Day Programs – the reviewing team did not visit any Day Programs in Victoria. Day Programs have been identified by the ECRG as a critical component of the continuum of care for Adolescent Extended Treatment and Rehabilitation Models (Tier 2b)

Model adaptations would include:

- Decreasing the age range to 14 – 17 years (this would impact on staffing levels required and ratio of health professionals vs. NGO/youth workers, consent and duty of care issues relating to minors)
- Broadening the catchment from local to a more cluster based or state-wide model
- Increasing the length of stay up to 3 months (extended stays can be negotiated on an individual basis by the treating team).
- Provision of in – reach educational and vocational support to the Y-PARC students with an aim of linking them back to their local community on discharge or consideration of an outreach model to local education/ vocational support facilities able to provide interim support for young people and linkages back to their community of origin.

Recommendations:

- Consider establishing assertive outreach model based on IMYOS to link to existing Tier 1 & Tier 2 CYMHS teams
- Consider establishing a range of new Day Units to support the continuum of care for extended adolescent and rehabilitation treatment
- Consider scoping a model based on Y-PARC with adaptations to meet the geographically diverse needs of Queensland and modified to suit an adolescent cohort. This would align with Tier 3
- Consider establishing Youth Residentials in local areas to support all Tiers of CYMHS
- Consideration of Activity Based Funding (ABF) in scope models being the basis of any future model developments for Queensland

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