| Key component | Key elements | Comments |
|---|---|---|
| | will monitor the quality of record keeping and documentation (including external communications), and support the relevant skill development. | |
| **3.12.0 Mental health peer support services** | **3.12.1** All adolescents and families/carers will be offered information and assistance to access local peer support services. | • Peer support services may be provided by internal or external services.<br>• Consumer consultants are accessible via a local MHS. |

## 4. Related services

The Adolescent Extended Treatment and Rehabilitation Centre operates in a complex, multi-system environment involving crucial interactions with a range of state and commonwealth government agencies including but not limited to education providers, the Department of Communities, Child Safety and Disability Services, Queensland Police Services, child health services, alcohol, tobacco and other drug services, youth justice, private providers, NGOs, disability support providers and others. The AETRC School, under the Department of Education, Training and Employment is an integral part of the Centre.

Services are integrated and co-ordinated with partnerships and linkages with other agencies for children and adolescents and with specialist mental health services, to ensure continuity of care across the service system and through adolescent developmental transitions. Mechanisms for joint planning, developing and co-ordinating services are developed and maintained.

The AETRC will develop service linkages with services, including but not limited to:

- specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services);
- Child and Youth mental health services;
- acute and non-acute child and youth mental health inpatient services;
- adult mental health services;
- private mental health service providers;
- alcohol, tobacco and other drug services;
- specialist health clinics for the target population e.g. sexual health clinics
- community pharmacies;
- local educational providers/schools, guidance officers and Ed-LinQ co-ordinators;
- primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health) and local GPs;
- child and family health and developmental services;
- Department of Communities, Child Safety and Disability Services;
- Youth justice services;
- government and non-government community-based youth and family counselling and parent support services;
- housing and welfare services;
- transcultural and Aboriginal and Torres Strait Islander services.

The AETRC will develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC. Strong links with universities will be developed to support this process. AETRC provides education

and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder.

**5. Caseload**

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

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

**6. Workforce**

Staffing will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology, other specialist CYMHS staff (including music and art therapists) and access to a dietitian. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

A range of non-clinical staff (including Indigenous mental health workers, diversional and recreational therapists, and allied health assistants) may assist in providing services. Involvement of and access to consumer and carer consultants and peer support workers should be facilitated within the integrated mental health service. Additionally, the multidisciplinary team will be supported by administrative officers, catering and hygiene staff who will assist with the day-to-day operations of the AETRC. Hyperlink to Clinical Service Capability Framework Mental Health Services Module.

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

The effectiveness of the AETRC is dependent upon an adequate number of appropriately trained staff. The complexity of the mental health needs of adolescents necessitates the provision of continuing education and professional development programs, clinical supervision, mentoring and other appropriate staff support mechanisms. AETRC will undertake evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, encouraging rotations through the unit of staff from other areas of the integrated mental health service and supporting education and research opportunities.

**7. Team clinical governance**

Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

Clinical decision making, clinical accountability and allocation of clinical case loads will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director.

The NUM is accountable for the direct management of nursing staff. This includes:

- operational management of nursing staff(including day to day clinical support, resource and administrative management)
- systems maintenance
- staff operational/administrative supervision including performance management
- and through the Consultation Liaison Clinical Nurse, liaison with other mental health services, external organisations and community groups.

At a local level, the centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate, a Parent Representative

and the School Principal. This team will meet regularly in meetings chaired by the Consultant Psychiatrist.

The centre will be directly responsible to the corporate governance of the Health Service District within which the AETRC is located.

Strong and enduring relationships will be evident with the designated acute and community child and youth mental health services.

Clinical supervision and ongoing professional development are necessary components of maintaining a skilled mental health workforce within the AETRC. The discipline senior and/or practice supervisor provides/facilitates discipline specific and/or intervention specific opportunities for the clinician to develop identified professional skills and reflect on elements of practice. Clinicians are supported to maintain their own health and wellbeing, avoid burnout, and to access career development guidance.

The AETRC will incorporate the National Standards for Mental Health and Australian Council on Healthcare Standards into all workplace instructions, quality activities and procedures. All measures of outcomes, data and reports will be acted upon and corrective action taken if necessary. Programs and procedures will be reviewed as per workplace instructions.

**8. Hours of operation**

The AETRC provide a 24 hour service, with nursing staff rostered to cover these shifts.

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

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

24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available. A mobile response will not be available.

While some variation may occur, routine assessments and interventions will be scheduled during business hours (9am -5pm) 7 days a week.

**9. Staff training**

Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure clinical competence. All training will be based on best practice principles and evidence informed treatment guidelines, and underpinned by the Queensland Government Recovery Framework. Teams will be encouraged to make the relevant components of their training available to their service partners (e.g. GPs, NGOs). Consumers and carers will be involved in staff training and development.

AETRC will have dedicated time and resources for clinical education and clinical supervision, in addition to adequate clinical staffing numbers.

Education and training will include a focus on strategies and mechanisms to foster meaningful participation of adolescents, and families/carers across all levels of service delivery, implementation and evaluation. Adolescents and their families/carers will be involved in the development and delivery of training to staff.

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

- Queensland Health mandatory training requirements (fire safety, aggressive behaviour management, cultural awareness and training etc.)

- AETRC 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 adolescents and their families and /or carers;
- knowledge of adolescent and family development and psychopathology
- training in the principles of the service (including models of recovery and rehabilitation and staff adolescent interactions and boundaries etc.)
- developmentally appropriate assessment and treatment;
- risk assessment and management, and associated planning and intervention;
- *Mental Health Act 2000;*
- National Standards for Mental Health Services;
- evidenced informed practice in service delivery;
- consumer focused recovery planning;
- routine outcome measurement training;
- a range of treatment modalities including individual, group and family-based therapy;
- child safety services 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;
- Family therapy.
- team work
- principles and practice of other CYMHS facilities - community clinics, inpatient and day programs, alcohol and drug services and forensic outreach services

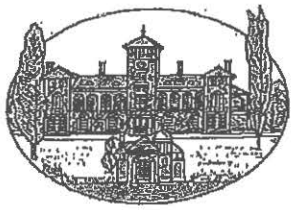
Staff from the AETRC will engage in CYMHS training. The AETRC will deliver training to other components of the CYMHS where appropriate.

**10. The AETRC functions best when:**

- Adolescents, their families and /or carers and other service providers are involved in all aspects of recovery planning and delivery;
- There is an explicit attitude that adolescents and their families/carers will progress in their recovery by maintaining hope and assisting to live with mental health problems where such problems persist in the long term;
- There is an adequate skill mix within the team, with senior level clinical expertise and knowledge regarding necessary interventions being demonstrated by the majority of staff;
- Teams are well integrated with other local mental health service components and primary care supports;
- Teams have a good general knowledge of local resources;
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service
- Clear and strong clinical and operational leadership roles are provided, and work collaboratively;
- There is clear and explicit responsibility for a local population and clear links to specified organisations;
- Clear pathways exist for onward-referral as clinically required;
- Where collaborative care arrangements are in place across different service providers, shared recovery plans and relapse prevention plans are utilised;
- Senior staff take an active role in fostering the development of clinical skills in less experienced staff;
- Strong internal and external partnerships are established and maintained;
- Caseloads are regularly reviewed and assertively managed;

- All staff are provided with professional support, clinical supervision and training.
- Service evaluation and research are prioritised appropriately

Health
Sydney
Local Health District



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

# Rivendell Unit
# Model of Service

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

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

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

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

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

The key functions of the Rivendell Unit are to:

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

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

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

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

**2. Who is the service for?**

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

- who are aged 12 – 18 years;
- who are eligible to attend high school;
- with severe and complex mental illness;
- who have impaired development secondary to their mental illness;
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including child and adolescent psychiatrists, CAMHS community clinics, private mental health clinicians, acute inpatient child and adolescent mental health services and Headspace;
- who will benefit from a range of clinical interventions;
- who have the capacity to manage voluntary treatment.

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

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

Exclusion criteria for Rivendell admission include:

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

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

**3. What does the service do?**

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

Given below are key components and elements our service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**4. Related services**

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

**5. Caseload**

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

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

**6. Workforce**

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

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

**7. Team clinical governance**

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

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

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

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

**8. Hours of operation**

The Rivendell Unit operates Monday – Friday during school terms.

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

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

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

**9. Staff training**

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

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

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

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

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

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

**10. The Rivendell Unit functions best when:**

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

**********

# Curriculum Vitae Dr Scott Harden

## *Current Roles*

Child, Adolescent and Adult Psychiatrist in Private Practice, Brisbane Queensland. 2000 April to current date.

Active Clinical Practice across the age range.
Specialist interest in ADHD and Anxiety Disorders.
Current Accreditation with Toowong Private Hospital and Lady Cilento Children's Hospital.

Forensic Psychiatry Private Practice including Family, Criminal, Civil and Child Protection Jurisdictions. 2002 to current date.

Over 750 Reports as Independent expert across the age range.
Over 300 court appearances.
Specialised risk assessment of adult recidivist sexual offenders (>190).
Family Court Reports (>250).

Medical Director Forensic Adolescent Mental Health Alcohol and Other Drugs Program QCH HHS from April 2014 (was Visiting Senior Child and Adolescent Psychiatrist, Child and Youth Forensic Outreach Service RCH and Health Service District. 2004 January to March 2014).

Provide expert opinion and review with regard to forensic mental health and risk assessment to Child and Youth Mental Health Services and Youth Justice Services.
Research including psychopathy in young people, prevalence of fire setting and animal cruelty and forensic service development.
Consultation regarding forensic mental health policy for young people.

Partner, Amicus Medical Chambers. 2010 June to current date.

Management of professional office space.
Formal provision of training and meeting services.

Appointment as Assisting Psychiatrist Mental Health Court March 2014

3 Year Terms Governor in Council

Appointment to General Medical Tribunal (Psychiatric) Worker's Compensation Regulator 2010 to Date

3 Year Terms Governor in Council

# *Previous Roles*

2001 April to 2003 January Medical Director Child and Family Therapy Unit (Inpatient Mental Health Service 0-14 years) RCH and Health Service District.

2001 – 2002 Member Secure Care Panel Brisbane Youth Detention Centre.

2000 January to 2001 April. Child and Adolescent Psychiatrist Pine Rivers Child and Youth Mental Health Service, RCH and Health Service District.

1999 January to December. Senior Psychiatry Registrar Pine Rivers Child and Youth Mental Health Service, RCH and Health Service District.

Psychiatry Registrar 1994 July to 1998 December.

1991 to 1994 June. Paediatric Registrar Royal Children's Hospital. Brisbane.

3 month rotation in 1994 to RCH Child and Family Therapy Unit
4 months in 1993 seconded to Mt. Isa Base Hospital, involving extensive exposure to indigenous and rural communities and provision of consultation about transport, evacuation and treatment of paediatric emergencies in remote centres.
Other rotations in a wide range of general and specialist paediatric units.
Approximately 9 months working in a large tertiary maternity hospital neonatal intensive care service.

1989 -1990 Intern and Junior House Officer Royal Brisbane Hospital

# *Formal Education*

1983–1988 University of Queensland Brisbane, QLD MBBS

1995 - 1999 Royal Australian and New Zealand College of Psychiatrists Training Program leading to Fellowship of the Royal Australian and New Zealand College of Psychiatry (Awarded Feb 23rd 2000)

1996-2000 Faculty of Child and Adolescent Psychiatry Advanced Training Program leading to Certificate of Advanced Training in Child and Adolescent Psychiatry.

# *Continuing Education*

Ongoing satisfactory Participation in RANZCP Continuing Professional Development Program since 2002.

Ongoing accreditation as an RANZCP supervisor.

Formal Training course in administration of the PIRS (psychiatric impairment rating scale).

Formal Training course in administration of the Hare PCL (psychopathy checklist) in 2006.

Further training in PCL – R and HCR-20 2008.

Training in Static 99, Stable 2000 and Acute 2000 administration in 2008.
Partial Attendance at RSVP training 2010

Formal training in Comcare (AMA Guides based) assessment 2007.

Training in presentation skills workshop with "Catalyst" 2009.

Convenor Qld Child and Adolescent Forensic Psychiatry and Psychopathy Checklist Peer Review Groups Qld 2006 to current date.

Australian Institute of Company Directors 5 Day Course Jan 2012

Leading Reliability Improvement for Safer Health Care (LRISH) Workshop May 2015

## *Memberships*

Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Faculty of Child and Adolescent Psychiatry RANZCP.

Faculty of Forensic Psychiatry RANZCP.

American Academy of Psychiatry and the Law.

Australia and New Zealand Association of Psychiatry, Psychology and the Law. (ANZAPPL).

Australian and New Zealand Association for the Treatment of Sexual Abuse. (ANZATSA).

## *Professional Activities (current)*

Senior Lecturer UQ Department of Psychiatry 2002-2005 and 2007 to date.

Inaugural Chair RANZCP Special Interest Group (now Section) in Child and Adolescent Forensic Psychiatry.

Chair Qld Branch Faculty of Forensic Psychiatry RANZCP

Member Membership Conduct Committee RANZCP 2014 - Current

# *Professional Activities (past)*

Organising Committee RANZCP Faculty of Child and Adolescent Psychiatry Binational Conference 2014.

Coordinator (with Dr Jacoba Brasch) Cross Examination and Advocacy Training Course. Bar Association of Qld and RANZCP 2011 and 2014.

Councillor RANZCP General Council (Governing Body) Feb 2010 to May 2013. Member Governance and Risk Committee of Council May 2011 to April 2012.

Chair Governance and Risk Committee of RANZCP Council April 2012 to May 2013, including responsibility for major governance review, redrafting constitution, new electoral and board model and first direct elections of board and President Elect.

Committee member Australian and New Zealand Association of Psychiatry, Psychology and the Law (QLD Branch) 2011 - 2013.

Member of Executive of RANZCP Faculty of Child and Adolescent Psychiatry 2003 to 2011.

Treasurer Australian and New Zealand Association of Psychiatry, Psychology and the Law (QLD Branch) 2008 – 2011.

Board Member Australian Infant, Child, Adolescent and Family Mental Health Association 2008 – 2009.

Organising committee member for the 2002 and 2007 RANZCP Bi-National Congresses.

Co-Covenor 2015 RANZCP Bi-National Congress (>1000 registrants).

Convenor RANZCP Faculty of Child and Adolescent Psychiatry Binational Conference 2008.

Convenor First Australian and New Zealand Meeting of Child and Adolescent Forensic Psychiatrists – Sydney October 2009.

Convenor Child and Adolescent Forensic Mental Health Conference Sydney Nov 2011.

Committee Member Qld Branch Committee RANZCP 2002 and 2009.

Committee Member and Deputy Chair Qld Branch RANZCP 2009 (Acting Chair June 2009 to October 2009 and November 2009 to March 2010)

Chair Qld Branch RANZCP Faculty of Child and Adolescent Psychiatry 2003 to 2008.

Executive member of Qld Association of Psychiatrists (APT) in training from 1996 - 1999. (1997 APT liaison to Qld Rotational Training Program Committee, 1998 & 1999 APT Liaison to Queensland Branch Committee of RANZCP)

Lecturer Police Child Protection and Investigation Unit Training Courses 2008 - 2011.

## *Peer Reviewed Publications*

Wagner I. Stathis S. Harden S. Crimmins J.
Models and patterns of service in child and youth consultation-liaison services.
*Australasian Psychiatry.* 13(3):273-8, 2005 Sep.

Harden S. Stathis S. Wagner I.
Redevelopment of a consultation-liaison service at a tertiary paediatric hospital.
*Australasian Psychiatry.* 13(2):169-72, 2005 Jun.

Geritz, K; Harden, S; Newman L. Chapter 63: Sexual Abuse of Children. *Expert Evidence* by Ian Freckelton and Hugh Selby 2012.

Stephen L Stathis , Scott Harden , Graham Martin & John Chalk (2013): Challenges in Establishing Adolescent Forensic Mental Health Services Within Australian Youth Detention Centres.
*Psychiatry, Psychology and Law*, DOI:10.1080/13218719.2013.768195

Bruce D. Watt, Kerry Gerritz, Tasneem Hasan, Scott Harden and Rebekah Doley. Prevalence and correlates of firesetting behaviours among offending and non-offending youth. *Legal and Criminological Psychology* (2014) DOI:10.1111/lcrp.12062

Harden, Scott; Phillips, Michelle; Stathis, Stephen; Geritz, Kerry; Hasan, Tasneem; Spiller, Mike; Watt, Bruce D and Allen, Angela. Responding to the challenge of problem sexual behaviour by young people in Queensland: An opinion [online]. *Sexual Abuse in Australia and New Zealand*, Vol. 6, No. 1, Nov 2014: 31-37

## *Publications in Development*

Current State of Child and Youth Forensic Mental Health Services in Australia and New Zealand.

# *Peer Reviewed Conference Presentations*

1999 Why do Child Psychiatry Training – A Qualitative Study
RANZCP Child and Adolescent Psychiatry Faculty Conference Brisbane

2004 Poster: Plugging the Gaps - Juvenile Justice , the Mental Health Service and the Community Bernadette Mc Dermott and Scott Harden
Australian and New Zealand Association of Psychiatry, Psychology and Law (Qld) 24th ANNUAL CONGRESS

2007 Court Liaison Service – Brisbane Children's Court Pilot
RANZCP 42nd Annual Congress Gold Coast

2007 Hubs and spokes - Development of child and adolescent forensic mental health services in Queensland.
RANZCP Child and Adolescent Psychiatry Faculty Conference Hobart

2008 Threat assessment in young people
RANZCP 43rd Annual Congress Melbourne

2008 Development of forensic child and youth mental health services in Queensland.
11th Congress of the ASEAN Federation for Psychiatry and Mental Health in Bangkok August

2008 Training in Child and Adolescent Forensic Psychiatry in Australia and New Zealand – the state of play in a super – super Speciality.
RANZCP Child and Adolescent Psychiatry Faculty Conference Port Douglas

2008 A Systematic Review of Animal Cruelty perpetuated by Juveniles with Illustrative Clinical Case Examples. Co Authored with Mr Matthew Parkyn
Australian and New Zealand Association of Psychiatry, Psychology and Law (NSW) 28th ANNUAL CONGRESS

2009 Risk assessment in children and young people and the psychopathy checklist - youth version - a Queensland experience.
Co-authored with Ms Tasneem Hasan
Australian Psychological Society College of forensic psychologists conference Melbourne

2010 Child and Youth Forensic Services in Australia and New Zealand: The State of Play.
10th International Association of Forensic Mental Health Services Conference Vancouver

2010 The risk of risk assessment in young people.
International Association of Child and Adolescent Psychiatrists and Allied Professions Conference.
Beijing

2011 Homicidal Adolescents
RANZCP 46rd Annual Congress Darwin

2011 Child and Youth Forensic Services in Australia and New Zealand
European Child and Adolescent Psychiatrists Conference Helsinki

2012 Poster: Adolescent Firesetting, Cruelty to Animals and Callous-Unemotional Traits. European Forensic Child and Adolescent Psychiatrists and Associated Professions Conference Berlin.

2012 Australian community and young offender prevalence data for fire setting, animal cruelty and callous unemotional traits. RANZCP Faculty of Forensic Psychiatry Conference. Hong Kong.

2013 "Forensic Reflections on Animal Cruelty." Child 2013 - RANZCP Child and Adolescent Psychiatry Faculty Conference Melbourne.

2014 "Child Development, Criminal Behaviour and the Law" EFCAP Manchester UK.

2014 "Who minds the minds of young prisoners?" Youth Mental Health Symposium, Brisbane, Australia.

2014 "Training in Child and Adolescent Forensic Psychiatry" RANZCP Child and Adolescent Psychiatry Faculty Conference Gold Coast.

2014 "Attachment: surely we know all about that, reflections in child and adolescent forensic psychiatric practice" RANZCP Child and Adolescent Psychiatry Faculty Conference Gold Coast.

## *Invited Presentations*

2008 Pathways away from Criminality
Youth Mental Health Symposium Sydney

2008 Child and Youth Forensic Services
RCH Child Psychiatry Grand Rounds

2009 Update on ADHD and Anxiety
Eli Lilly Summer Speaker summit
Sydney

2009 Education and Delinquency
North Brisbane Interagency Forum

2010 "Children's Stories: Fact, Fantasy or Implants?"
QLD Law Society Family Law Residential 2010

2010 "Cyber Age: High Tech or High Risk?" Singapore Mental Health Association, World Mental Health 2010 Forum.

2011 "Homicidal Adolescents" Prince Charles Hospital Mental Health Service Medical Staff Meeting.

2011 "Working with Adolescents with Conduct Disorder" Singapore Mental Health Association, Public Forum.

2011 "Working with Adolescents with Sexually Inappropriate Behaviour" Training workshop with Ms Teresa Wood and Dr Kerry Geritz 15-19th August at Singapore Institute of Mental Health.

2012 "Some thoughts about the instructing relationship between psychiatrists and lawyers". Queensland Law Society Vincents' 50th Anniversary Symposium. Brisbane.

2012 "Doc am I a Psychopath?. Qld Branch Faculty of Child and Adolescent Psychiatry Conference.

2013 "Personality Disorders". Qld Law Society and FLPA Family Law Residential. RACV Royal Pines Resort, Gold Coast.

2013 "Family Court Session" Qld Branch Faculty of Child and Adolescent Psychiatry Conference.

2014 "Dangerous and Deviant Adolescents" with Dr Michelle Phillips, Forensic Seminar Series, Brisbane.

2014 The most damaged population in Queensland. Forensic Mental Health Forum - Recovery and Diversity Treatment, Connection and Inclusion in Forensic Mental Health, Brisbane.

2015 "Courts and CYMHS: Clarity and Angst." LCCH CYMHS Grand Rounds. Brisbane.

2015 "Why are mental health staff afraid of Courts?" Qld Forensic Mental Health Service Seminar Series. Brisbane.

2015 Invited Address: "Family law and the psychiatric expert". Joint conference of the Australian and New Zealand Association of Psychiatry, Psychology and Law (ACT) and the Faculty of Forensic Psychiatrists of the Royal Australian and New Zealand College of Psychiatrists. Canberra.

## *Current Research Interests*

Development of Child and Youth Forensic Mental Health Services.

Queensland Health

Queensland Government

**Child and Youth Mental Health Service (CYFOS)**

Enquiries to: Tasneem Hasan
Forensic Psychologist-Senior
Child and Youth Forensic Outreach Service
PO Box 1507
Fortitude Valley 4006

Telephone:
Facsimile:

Dr Anne Brennan
Clinical Director
The Barrett Adolescent Centre
The Park, Orford Drive
Wacol 4076

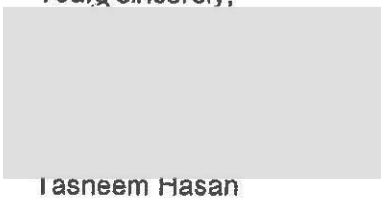
"This report is provided to the **Barrett Adolescent Unit** for use in case management. The information contained in this report should not be discussed with any other person who is not directly associated with this case or with any other agency without first seeking the approval of the author or the Child & Youth Forensic Outreach Service.

The report should not be photocopied and copies should not be provided to any person or agency other than those directly involved in this case without first seeking the approval of the author. Any material which is considered to have use for future management of this case may only be imparted to another person or agency with the express permission of the author or Child and Youth Forensic Outreach Service. **RELEASE OF THIS REPORT TO OTHER PERSONS OR AGENCIES CAN BE HARMFUL TO THE CLIENT AND THEIR FAMILY AND CAUTION SHOULD THEREFORE BE EXERCISED AT ALL TIMES WHEN DISCUSSING MATTERS ARISING FROM THE REPORT OR ANY OF ITS FINDINGS WITH THE CLIENT OR ANY MEMBER OF THEIR FAMILY WITHOUT HAVING CONSIDERED THE IMPLICATIONS AND CONSULTING WITH THE AUTHOR."**

19th November 2013

Dear Dr Brennan,

Yours sincerely,



Tasneem Hasan
Forensic Psychologist-Forensic

Approved by:



Dr Scott Harden
Visiting Senior Psychiatrist