EXTERNAL REVIEW: MODEL OF SERVICE (MOS) FOR THE STATE-WIDE ADOLESCENT EXTENDED TREATMENT AND REHABILITATION FACILITY (AETF)

Dr Paul Robertson

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INTRODUCTION

I was requested by Queensland Health Mental Health Alcohol and Other Drugs Branch (MHAODB) to undertake an External Review of the Initial Model of Service (MOS) for the proposed State-wide Adolescent Extended Treatment and Rehabilitation Facility (AETF). Details of the requested External Review, including background, specific questions and guiding documents are outlined in the Terms of Reference document (Appendix A). This Report is prepared as an outcome of my Review.

I am a Child and Adolescent Psychiatrist based in Victoria with over 25 years experience. I have had clinical experience in both public and private sector child and adolescent psychiatry including community-based child and youth mental health teams and separate Parent-Infant, Child and Adolescent Inpatient Units including the establishment of clinical services and model of care development. I have experience in training and workforce development of the child and adolescent mental health sector. I have been actively involved in the RANZCP Binational Faculty of Child and Adolescent Psychiatry (FCAP).

The Terms of Reference specified 4 areas to be the focus of the external review:

1. Assess the Initial AETF MOS against current evidence for subacute inpatient services in providing extended treatment and rehabilitation services for adolescents and young people with severe and complex mental health issues
2. Review the development and consultation process undertaken for the Initial AETF MOS.
3. Provide advice on any gaps or deficiencies in the Initial AETF MOS
4. Make recommendation about any amendments necessary to the Initial AETF MOS as a result of 1-3 above.

Review of the operational or clinical management of the AETF was out of scope.

In this Report I have chosen to use the term child and youth mental health services continuum (CYMHSC) rather than the more traditional term child and adolescent mental health services (CAMHS) or the term child and youth mental health services (CYMHS). Child and youth mental health service continuum (CYMHSC) is used to describe the entirety of the mental health service system for children and youth. I recognise there is considerable overlap between these terms and those of ‘adolescence’ and ‘youth’ generally. Sometimes these services are up to the 18th birthday and at other times extend into early adulthood or until the 25th birthday. I have used the terms ‘adolescent’, ‘youth’ and ‘young person’ interchangeably in the Report.

In undertaking the review I have read a range of documentation (outlined below) and visited Brisbane for 2 days (Tuesday 18 and Wednesday, 19 April 2017) for Information Briefing Sessions and Consultations with staff from MHAODB Barrett Inquiry Recommendations Implementation Team and other stakeholders including consumers and carers. The Schedule for these 2 days of meetings is attached in Appendix B.

The documentation read and face-to-face meetings provided me with sufficient information to complete the Review. It provided:

- Understanding of the context in which the decision to develop the AETF occurred,
- Overview of the perspective of various stakeholders,
- Understanding of the process of development and consultation and

- Understanding of current and planned Queensland CYMHSC services.

DOCUMENTATION

Documents provided or available to the reviewer included:

- Barrett Adolescent Centre Commission of Inquiry Report: Volume 1
- Queensland Government Response – Barrett Adolescent Centre Commission of Inquiry Report

Documents specifically provided by MHAODB included:

- Initial Model of Service – Adolescent Extended Treatment Facility April 2017,
- A Review of Existing Clinical and Program Evaluation Frameworks for Extended Treatment Services for Adolescents and Young Adults with Severe, Persistent and Complex Mental Illness in Queensland – Draft Report February 2017 prepared by Queensland Centre for Mental Health Research and
- Preliminary Model of Service (Adolescent Extended Treatment Facility) website consultation – Thematic Analysis.

Additional information was accessed on the MHAODB Commission of Inquiry Implementation Team website (https://www.health.qld.gov.au/improvement/youthmentalhealth) including a series of Communiqué outlining the work of the Implementation Steering Committee.

Other relevant documentation providing background and contextual information was available as outlined in the Terms of Reference.

I have not attempted to summarise the documentation, but rather focused on particular aspects of the documents that pertain to my discussion and recommendations. It is assumed the reader has familiarity with these documents.

Some specific points about the documents:

- An impressive amount of work has been done and documented on reviewing available literature about what is a modern, best practice Child and Youth Mental Health System. This is outlined in Appendix C of the Barrett Adolescent Centre Commission of Inquiry Report and particularly in the report titled Statewide Sub-Acute Beds Discussion Paper-January 2016
- The review by Queensland Centre for Mental Health Research (QCMHR) into available epidemiological data to identify the likely cohort of “severe, persistent and complex mental illness” in adolescence is largely unsuccessful in identifying the potential cohort for the AETF as the epidemiological data lacks specific detail.
- The Queensland Centre for Mental Health Research (QCMHR) review looking at clinical frameworks for subacute adolescent inpatient services similar to the proposed AETF identifies no obvious similar units in the literature. The Walker Unit at Rivendell in NSW is closest. All other units are acute Adolescent Inpatient Units, community outreach services or NGO based residential units. I am not surprised this is the finding of the review.

INFORMATION BRIEFING SESSIONS AND CONSULTATIONS

I have outlined below a summary of the face-to-face meetings (Information Briefing Sessions and Consultations) undertaken on Tuesday 18th and Wednesday, 19 April 2017. I have not attempted a comprehensive summary; which would neither be possible considering the volume of information or required for the purpose of this Review. Rather I have highlighted particular points relevant to my discussion and recommendations. Written summaries of the information sessions and

consultations, prepared by administrative support, were made and some sessions were audio recorded to assist note taking for the reviewer.

MHOADB Information Briefing Session (Tuesday 18th April 9 30 – 11 AM)
Merridy Marshall, Principal Project Officer, COI Implementation Team and Judith Piccone, Manager COI Implementation Team

This session provided a wealth of contextual information about the processes leading to the decision to build the AETF and the development of the Model of Service to date. This included a PowerPoint titled *Preliminary Model of Service Development Workshops – State-wide Bed Based Facility* prepared for Workshop 1 on 20 October 2016.

The meeting described the process of consultation to date in the development of the Initial Model of Service (MOS) including:

- Role and make up of the implementation steering committee,
- Barrett Commission of Inquiry Implementation: Recommendation 4 – Preliminary Model of Service Workshops (including copies of Agenda for Workshop 1, 2 and 3),
- The Preliminary Model of Service website consultation and the Thematic Analysis that summarised its outcome,
- Process of involving organisational stakeholders particularly the Department of Education and Training (DET) and
- Process of involving consumers and carers and the role of Health Consumers Queensland (HCQ) in supporting this process.

The meeting also provided an understanding of the current or planned CYMHSC Extended Treatment Continuum including Community CYMHS, Assertive Mobile Youth Outreach Service (AMYOS), Adolescent Day Programs, Residential Units in the NGO sector, (planned) Step Up/Step Down Units, acute Adolescent Inpatient Beds and proposed subacute beds. A one-page document titled Extended Treatment Continuum outline the above services in a table form.

Carer and Consumer Information Session (Tuesday 18 April 11 AM – 12:30 PM)
Suzanna Anovic, Jeannine Kimber, Colleen Rohan and Justine Wilkinson

The focus of the session was the consultation process (point 2) but discussion extended beyond this. Participants were both consumers and carers. Some had direct experience of the Barrett Centre and some had not. The session was a free-flowing discussion with myself providing some prompting and clarifying questions. There were multiple themes. I have not attempted a complete summary but rather noted those relevant to my discussion and recommendations. Some themes related to the proposed AETF unit but many related to the broader system of mental health care for young people or CYMHSC. Some understanding of the experience around the Barrett Centre closure was gained. While there was much agreement amongst the participants understandably there were also different views.

There was a predominantly positive acknowledgement and praise for the involvement of consumers and carers in the consultation process. This was not universal and some criticism was raised by one participant including lack of focus and guidance in early consultations, lack of definition regarding the target cohort of young people, speed of progress and perceived initial exclusion of expertise and experience from previous Barrett Centre staff. There was universal agreement it had been a far better process than in the past. Past experience has been of poor or no consultation around the Barrett Centre closure.

It was acknowledged the experience was different for consumers and carers and for those with direct involvement in the Barrett closure and those who had not. The impact of the Barrett Centre

closure and experience of the Commission of Inquiry was felt more strongly by some and less by others. I was informed that young consumers with direct experience of the Barrett Centre closure had been involved in consultations. It was noted that some consumers and carers involved in the Barrett Centre were affected by the closure such that they were not able to be involved in the AETF MOS development.

There was general praise for the consumer and carer consultation process around the facility design.

There was praise for the role of Health Consumers Queensland (HCQ).

In discussion there seemed to be an uncertainty about the ongoing process and structure of carer and consumer participation and even an anxiety that it might not continue. There was a request for the process of carer and consumer participation going forward to be outlined. This included carer and consumer participation in the ongoing AETF MOS design, participation in evaluation and research aspects and ongoing involvement in AETF governance through an advisory committee or similar. Beyond the AETF there was a request for participation at a broader level around the wider CYMHSC system and my attention was drawn to an outline of this broader request in Implementation Steering Committee Communiqué Issue 4 dated 9 February 2017. The desire, energy and capability to be involved in a broader codesign around the extended CYMHSC system was evident within the consumer and carer community

Beyond the consultation process itself I noted a number of themes regarding the Initial MOS. The absence of a clearly defined cohort of young people who could be involved in the AETF created some difficulties with envisioning the future unit. There was a wish for a support structure or person in the unit for young people and families apart from a member of the clinical team as might be provided by peer workers.

Many relevant and important issues raised were beyond the scope of my Review of the AETF Initial MOS.

Presentation on the Adolescent Extended Treatment Facility build (Tuesday 18 April afternoon) including site visit to Prince Charles Hospital
Bruce Ferriday, Principal Project Officer and Anna Davis

The design process was described.

The process of codesign of the facility involving 3 infrastructure workshops including consumers and carers and broader stakeholders was described.

The facility design was described and explained. It included both residential (12 to 15 beds) and day hospital facilities.

The plan is for a specific deescalation space but not a seclusion room.

There is the possibility of accommodation for families within the facility. There also will be options locally for families to stay.

The Unit design allowed for isolation or separation of some rooms from others and for good visual observation of the Unit residential areas by staff. This will be a need to provide physical and sexual safety in a unit accomodating both young and older adolescents and young adults.

The interface with paediatric services is currently unclear.

The site at The Prince Charles Hospital was visited.

Department of Education and Training Information Session (Wednesday 19 April 9 30 – 10:30 AM)
Leanne Nixon, A/Deputy Director-General, Stacie Hensel, Executive Director State School Performance and Michelle Bond, Principal Lady Client Children's Hospital School
(note: the 2 meetings with DET listed on the Schedule in appendix B were incorporated into one longer meeting on the day)

There was recognition that the Barrett Centre closure had been challenging for all involved including DET and its staff.

There is a continuing (non-residential) school called 'The Barrett School' currently based at Tennyson.

DET had participated in the consultation process regarding the AETF MOS and were positive about the process. There was recognition it was an ongoing process and further specific details around governance and processes was expected to be worked out.

They identified the work with the consumer and carer groups as very positive. Also that HCQ had played a helpful role.

DET was responsible for providing both education and occupational training such as VET and could meet the differing educational needs of young people ranging from those more academically able and needing support in traditional educational settings to those seeking a vocational pathway. DET had the capacity to provide an individualised education plan and intervention for all young people in the AETF.

DET has the capacity to respond to and provide services for young people admitted to the AETF beyond the age of 17 years.

While recognising the AETF was a partnership with Health DET recognised it was primarily a mental health lead unit, resourced by Health and that young people were admitted for mental health reasons.

There had been considerable internal work within DET following the Barrett Centre closure and Commission of Inquiry both related to the proposed AETF and more broadly about education facilities in health, particularly mental health settings. This has included the teachers role, difference in role between clinician and teachers, recognition of the specialised skills and issues of governance. The Lady Cilento School was seen as a good model and held appropriate expertise and experience. They had commissioned a literature review of education in mental health.

The point was made that the AETF could not be seen in isolation but needed to be seen as part of a broader statewide system. This was true for individual children who came from and returned to community based education as well at the wider system level of policy and governance between DET and the broader CYMHS system.

Health Consumers Queensland (HCQ) Information Session (Wednesday 19 April 11 AM – 12 PM)
Melissa Fox, Director

This session provided an account of the role and work of HCQ. The background history of HCQ and history of involvement since the Barrett closure and Commission of Inquiry was described.

HCQ is involved in providing best practice consumer (and carer) engagement. The recent consultation process was described as the best HCQ had been involved with so far. It was very different from the process around the Barrett Centre closure.

HCQ had appointed an Engagement Advisor 4 days per week to provide support to the consumer and carer group, help recruitment of consumer and carers and support the process of consumer and carers in the consultation. Their role has been important.

The need for engagement with all stakeholders was noted including NGOs and private mental health services.

There was clear recognition that the AETF was a part of a bigger system of care and could not be seen in isolation. There was need for thought and engagement around the whole system including the broader mental health sector for young people including promotion, prevention and early intervention.

There was recognition of the need for ongoing consumer and carer consultation both for the proposed AETF and with the broader CYMHSC sector. This could include an ongoing steering committee for the further development of the AETF as well as a process to allow consumer and carer involvement in the AETF such as an advisory group that was separate to unit management.

More broadly there was a need for development of a consumer and carer engagement strategy with in the broader CYMHSC sector.

There was recognition that the proposed AETF was new and innovative and there would be a need for continuous evaluation and improvement of the facility and a need for a continuous process of change. The need for research was emphasised.

DISCUSSION

1. Assess the initial AETF MOS against current evidence for subacute inpatient services in providing extended treatment and rehabilitation services for adolescents and young people with severe and complex mental health issues

There is minimal if any contemporary evidence or experience of subacute mental health inpatient services for adolescents comparable to the proposed Adolescent Extended Treatment and Rehabilitation Facility (AETF). The Queensland Centre for Mental Health Research (QCMHR) literature review finds little evidence of described or researched subacute mental health inpatient services for adolescents. Their review mostly reveals acute adolescent inpatient units, intensive community outreach services, or residential services within the community (NGO) sector. The Statewide Sub-Acute Beds Discussion Paper-January 2016 provides a comprehensive summary of available evidence with similar findings. Historically there are descriptions of longer stay inpatient, milieu focused units both with adolescence and other cohorts but they are unlikely to be relevant in guiding development of the AETF. It is therefore not possible to benchmark the proposed AETF against any comparable inpatient services or models.

In the broader sense the direction in child and youth mental health services continuum (CYMHSC), like most mental health services, has been away from inpatient care to community based care with effective treatment being provided in the least restrictive environment. This usually means adolescents receiving treatment while living in their families and communities including their schools and with peers. Community adolescent mental health services have responded to increased severity and complexity of adolescent mental health problems with models of care that

emphasise increased intensity of treatment in their family and community; greater frequency of contact; and greater mobility of outpatient services through outreach. An example of this is seen in the Victorian Intensive Mobile Outreach Youth Service (IMOYS) model described in the QCMHR literature review and evident in the current Queensland Assertive Mobile Youth Outreach Service (AMYOS).

I can see there has been considerable work undertaken in Queensland in recent years under the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative (AMHETI), as summarised in Appendix C of the Barrett Adolescent Centre Commission of Inquiry Report and Statewide Sub-Acute Beds Discussion Paper-January 2016, looking at the most effective broader CYMHSC system. It emphases a continuum of care from community mental health teams to a range of more specialised intensive CYMHSC services including AMYOS, Adolescent Day Programs, Residential Units, acute Adolescent Inpatient Beds, and Step Up/Step Down Units. The literature provides descriptions and some outcome research to support these components as effective. Within the extended continuum of care the subacute beds such as the proposed AETF, are one component providing greater intensity of treatment however the literature about such units is sparse or absent.The AMHETI work is impressive and in line with what is seen as current best practice in CYMHSC.

A focus on the extended continuum of CYMHSC services, especially the central area based community CYMHS teams, to deliver high quality, evidence based mental health care will be central to the states long-term success at achieving the best outcomes for the mental health of young people. Within this continuum the specialised CYMHSC services, including the AETF, have a role in providing more intensive treatment when that provided by community CYMHS teams is not sufficient.

The AETF proposal reflects a new and innovative approach and will need ongoing review and the capacity to be agile and adaptable to experience and learning that occurs along the way. To support this sufficient data to provide accurate description of the AETF cohort and its outcome will need to be collected and utilised.

I am not aware of a similar subacute adolescent inpatient units in Australia or other countries with similar mental health systems comparable to the proposed AETF. However there are a number of inpatient units for young people, that while not being at all the same thing, might provide some learnings helpful to further developing the AETF MOS. These include:

- The Walker Unit at Rivendell in New South Wales,
- The Statewide Child Unit at the Austin Hospital in Melbourne which provides elective goal-directed admissions for primary school aged children,
- The Albert Road Clinic Adolescent Unit (Melbourne) which is a private hospital unit providing longer stay (1-2 months) and planned goal focused admissions for adolescents and youth.

2. Review the development and consultation process undertaken for the initial AETF MOS.

My view is that the development and consultation process to date has been impressive and those who have designed and run the process, as well as those who have participated, should be commended.

It is recognised that the decision to develop the AETF occurred in a unique historical, political and legal context that has shaped the development process and will continue to do so.

The development of the Initial AETF MOS has occurred in the context of a strong commitment to transparency; partnership with consumers and carers, education, and other stakeholders; and

engagement of consumers and carers in the process of undertaking the broader response to the Barrett Adolescent Closure Commission of Inquiry recommendations as well as the more specific Initial AETF MOS.

There has been strong interest and engagement from consumers and carers. A number of young consumers have been involved. A range of carers, some having lived experience with the Barrett Centre, have been involved. I had the opportunity to meet with some of them on Tuesday 19 April. Participation has occurred at a number of levels in the process including representation on the COI Implementation Steering Committee, the series of workshops focused on the Preliminary AETF MOS, via website feedback on the Preliminary MOS (Thematic Analysis) and through other avenues.

Health Consumers Queensland (HCQ) has been involved in facilitating consumer and carers involvement. Its role seems universally applauded. A project worker with HCQ has been actively involved. HCQ's role has been multifaceted. One aspect has been enabling and educating consumers and carers in the complex environment of policy and program development.

From consumers and carers on the whole, but not universally, there were strong positive statements about the consultation process to date with recognition of the inclusion of a range of views, early inclusion in the consultation process as well as a feeling of receptiveness to their communications and views. There was praise for HCQ in helping facilitate, educate, bringing expertise and assisting in what could be a complex and hard to understand process at times.

The less positive comments related to perceived slowness of the process, lack of specific details around MOS within early consultations, lack of clarity regarding likely cohort and some concern about whether previous expertise in the Barrett Centre was being fully included.

Concern was expressed about the opportunity for ongoing consumer and carer consultation and engagement and that the consultation process going forward was not clear. It is clear to me that within MHAOPDB there is an ongoing commitment to such consultation and engagement. There would be benefit in developing a plan or strategy for ongoing consultation.

I am pleased to see the involvement and voices of young consumers in the consultations. My experience is that engagement of younger consumers in such processes is more challenging. A particular effort needs to be made to include young consumers.

Some specific consumer and carer groups are absent from the consultations including indigenous, CALD and those from remote locations. I understand a process of active engagement is underway to collect their views. I am very supportive of this.

The breath of material both documented and discussed in the face to face sessions was broader than required for the review of the AETF MOS. Indeed there seemed a request from consumers and carers to be actively involved in the broader coproduction of policy and strategic development of the CYMHSC system. The themes are summarised in the Implementation Steering Committee Communiqué Issue 4 dated 9 February 2017. This broader focus is beyond the scope of this Report and I have not discussed them fully. There seems an exciting opportunity to align current consumer and carer engagement and capacity with supporting coproduction of the broader CYMHSC system. A structure to support ongoing consumer and carer participation in the broader CYMHSC system is recommended.

Prioritising such broader participation would help further develop of the AETF MOS which will need to take a much more narrow focus on the specifics of how the AETF will function in the context of the broader CYMHSC system. In my view the AETF is burdened by carrying the hopes and expectations for the broader CYMHSC system. This is likely to negatively impact on the future AETF unless resolved.

Similarly having the AETF central in the discussion about the broader CYMHSC system is inappropriate. Imaging the AETF as central in the system is problematic for both the AETF and the broader CYMHSC system. The ongoing consumer and carer consultation process, and that with other stakeholders, should be structured to reflect this.

There has been consultation with Department of Education and Training (DET) about the interface of health and education in AETF and the rehabilitative function of the AETF especially around educational and occupational functioning seen as crucial to the AETF. They recognise that Health is the primary lead and young people will be admitted and discharged to and from the AETF on their mental health needs not primarily their education needs and as such most operational responsibility will sit with Health. Within this context it is recognised that young people admitted to AETF will have a variety of individual educational needs and require individual educational plans. I note there is a responsiveness to both academic school progress and occupational training such as VET and the responsibility of both lie with DET. They have a capacity to respond to young people admitted beyond the age of 17 years. Beyond the interface between education and health there appears to have been significant internal work within DET around the role of education in health settings, clarity of the teachers role and recognition of the specific expertise of teachers in such a specialised field. The content of my meeting with DET on Wednesday 19 April was highly appropriate and highlighted the expertise and work done within DET.

I understand other potential community partners such as Child Safety (child protection), Youth Justice and the community (NGO) sector providing Family and Youth Support and mental health social support services have had the opportunity for input via the Implementation Steering Committee. These organisations are clearly important partners in the broader system. There is likely to be a need for future consultation around their specific interfaces with the AETF as the MOS progresses. Again this needs to be done in the context of their interface with the broader CYMHSC system and not just the AETF.

3. Provide advice on any gaps or deficiencies in the initial AETF MOS

My opinion is that the initial AETF MOS is a good document in helping frame the initial development of the AETF. I have offered a range of comments below that may facilitate further development of the MOS. I have provided them as points for consideration rather than firm recommendations. I have provided this discussion using the structure and headings of the Initial AETF MOS document.

2. Who is the AETF for?

Which young people will form the AETF cohort is an important question but hard to clarify at this point. That they will suffer ‘severe and complex mental health difficulties’ is a necessary prerequisite but really does not tell us who will be referred and benefit from the AETF. On the whole all of CYMHSC provides tertiary level mental health care and ‘severe and complex mental health difficulties’ would capture most of the cohort attending the broader CYMHSC services. This is particularly so for specialised services such as AMYOS or Adolescent Day Programs. Indeed AMYOS with its flexible capacity for intensive outreach to young people who are difficult to engage may well see a group with more severe and complex mental health difficulties then the AETF as admission to the AETF would require a capacity for sustained collaboration around agreed treatment or recovery goals. The QCMHR review, while a worthwhile synthesis, does not particularly help us understand the cohort and their clinical needs as the epidemiological data lacks sufficient detail. It does however indicate the very large need for treatment in the community from CYMHSC and highlights the large gap between community need and available resources.

Dr Paul Robertson
Child & Adolescent Psychiatrist

As a Child and Adolescent Psychiatrist working in a large interstate metropolitan child and youth mental health service supported by an intensive outreach team (IMOYS), acute Adolescent Inpatient Unit, Adolescent Day Program and an Early Psychosis Team which patients would I consider referring to a subacute unit such as the proposed AETF? I would use the principle of providing effective care in the least restrictive environment. This would mean referring young people who have not shown adequate progress in community CYMHS treatment or have failed or are unsuitable for intensive community outreach or day program intervention. Lack of progress with treatment is usually very evident but not always. Thinking about these young people they are likely to have a number of comorbid diagnoses such as Borderline Personality Disorder, Anorexia Nervosa, Major Depression and severe Anxiety Disorders complicated by severe avoidance (such as not leaving home or able to attend outpatient treatment). They would be associated with ongoing risk of suicide, deliberate self harm, starvation or other medical complications. They would have a severe level of psychosocial impairment in terms of educational or occupational functioning, peer and other relational functioning and sometimes poor self care. There would be high levels of complexity with significant psychosocial adversity, comorbid neurodevelopmental disorders, comorbid medical illnesses (starvation, Type I Diabetes complicating anorexia nervosa or BPD) and failure of multiple previous treatments. These patients would usually exhibit significant relational or psychodynamic difficulties around their engagement with services. Nevertheless these young people and their families would have the capacity to form and sustain a collaborative agreement to support the admission. I would think substantial difficulties with engagement such that there is difficulty developing a collaborative agreement for inpatient care would more likely benefit from an intensive outreach service. One group of patients who might have slightly different needs is that group with chronic psychotic illnesses, usually schizophrenia, with persistent positive symptoms and severe psychosocial impairment. The group of patients described above are likely to present certain challenges on inpatient settings, require a highly skilled and resourced professional team to manage effectively and require appropriate clinical models of care.

One suggestion to help clarify the potential cohort is to invite potential referrers, including CYMHSC, private psychiatrists and consumers and carers to provide (de identified) brief case descriptions of whom they would refer and be hopeful that the AETF could assist. This may facilitate ongoing consultation around specific case material and type of clients to help inform the further development of the MOS. Once the AETF is opened and functioning it would be important to collect sufficient data of the cohort to allow ongoing review of the clinical and operational models.

3. What does the AETF do?

While the AETF will provide a wide range of assessments and interventions the capacity to use milieu and group based interventions will be an important consideration.

3.2 Referrals, Access and Triage

3.2.1 It will be important to have clear lines of clinical accountability during the referral and pre-admission phase to ensure that clinical care and management of psychiatric risk is safely managed.

3.2.1 It would be appropriate for the referrer to commit to being available for ongoing care post discharge although the option for choosing a different post discharge care option could still remain open. A responsible community treatment service should be evident from the point of admission.

3.2.2 The pre-admission assessment should clarify the collaborative agreement between the young person, their parents or carers and the AETF clinical staff as to the purpose, goals and expectations of the admission.

3.3 Assessment

3.3.2 A timeframe should be set for the assessment phase of the admission.

3.3.2 Access to neuropsychology, occupational therapy and speech therapy should be clear.

3.3.5 and 3.3.8 A number of terms including "Preliminary Recovery Plan" and "Adolescent Care Plan" are used and their exact meanings are not clear to myself. The document would benefit from having these more clearly defined.

3.3.13 While the National Outcomes and Case-Mix Collection (NOCC) measures are necessary I do not think they are sufficient considering the novel nature of the unit and a more extensive measure of outcomes would be recommended.

3.4 Recovery Planning and Relapse Prevention

The AETF MOS should recognise the need for a sophisticated developmental model recognising the young person's interdependence with parents and family and the developmental processes of adolescence around separation and individuation, particularly as it relates to decision-making and recovery planning. Both the young person and the parents should be active participants in a collaborative recovery focus with the AETF staff with each individual adolescent and their family being understood in terms of where decision-making about treatment sits between the young person and their parents. The use of a Recovery Framework in young person requires it being framed within this developmental understanding of adolescence and family functioning around shared decision-making.

3.5 Clinical Intervention

I suggest having a section title 'Requirements of the Clinical Model' that could include this section on clinical intervention and also Section 3.6 on 'Pharmacotherapy'. While the Initial MOS should not specify the clinical model it should frame what is required of the clinical model to facilitate future discussion. There are a number of things that would be expected of a clinical model including transparency, understandability to consumers, flexibility to incorporate a breath of needs and interventions, capacity to be evaluated/researched, to be a relational orientated model and sophisticated enough to deal with severe and complex mental health needs. There may be other requirements of the clinical model that could be included.

3.6 Pharmacotherapy

See discussion above. While I imagined that most young people admitted to the AETF will receive some form of psychopharmacology it is unlikely to be the central or most important part of the intervention. Many of the practical elements of managing medications on an inpatient unit will be available in other documents.

3.7 Crisis Management

This section may be better called 'Maintaining Safety'. It is probable that managing risk associated with suicide, deliberate self harm and physical morbidity from comorbid health problems will be a major clinical focus of the AETF. Its capacity to manage risk well and to maintain a safe environment will be crucial for the AETF success.

3.8 Clinical Review

The focus on clear Multidisciplinary Team (MDT) review is strongly supported. It should have strong psychiatric leadership. I would suggest clearly articulating the relationship between the professional recommendations emerging from the Multidisciplinary Team review and the collaboratively agreed Individual Recovery Plan.

3.12 Discharge/External Transition of Care

Discharge from inpatient care is recognised as a particular period of risk and clear transfer of clinical accountability, for the ongoing clinical care and management of risk, needs to be clearly outlined.

Community CYMHS services should be obliged to take up care post discharge without delay if that is the best option for care. They should be obliged to participate in discharge planning during the admission.

Discharge after a period of inpatient care can sometimes be difficult. It is recommended that the reasons for discharge are always fully articulated, especially when inpatient care is no longer identified as the most appropriate option due to an inability to maintain a collaborative recovery plan or a failure to benefit from inpatient care. Inpatient care should only continue if there is demonstrable progress towards articulated collaborative recovery goals.

3.15 Mental Health Peers Support Services

I would suggest the document is stronger in its statements and seeks that peer support services and carer consultants are more clearly and directly available to consumers and carers involved in the AETF.

7. Hours of Operation

The AETF MOS should address what will happen during school holidays. Presumably an alternative program will need to be developed.

8. Staff Training

Workforce (Heading 5) and staff training or professional development could be considered together. For such a specialised service it is clear that considerable in-service and training of staff will need to occur to achieve a necessary level of competency.

The unit is likely to be a training site for a number of professionals such as psychiatry, psychology and nursing and will need to meet the requirements of those professional training bodies. For example the RANZCP set certain expectations and standards for psychiatric trainees. Recognition that the AETF will be involved in the training of professionals should be recognised the MOS.

Some Additional Comments on Initial AETF MOS:

AETFs role in workforce development

The Initial AETF MOS makes reference to the AETF providing professional development and supervision to the broader CYMHSC sector. While the AETF may be helpful to community referrers on a case-by-case basis as it deals with referrals it is not clear how a broader role in workforce development would occur or why the AETF would be the appropriate service to place such workforce development or training service. There is an argument to look at workforce development within the broader CYMHSC but this should be addressed through an appropriate needs analysis and clear plan rather than expecting the AETF to meet this need.

AETFs role in supporting remote CYMHS services

Reference is made in the Initial MOS that the AETF will assist, presumably via admissions and second opinions around referrals, CYMHSC and other mental health services for young people in remote or isolated circumstances often with limited clinician resources and competencies. Possibly such services will refer to the AETF earlier and more often as they will have less capacity at a

community level. This may be a useful role for the AETF but clearly it is not the ideal solution. The ultimate solution will be to improve the capability of all CYMHSC services through greater resources and training such that more effective treatment is provided at the less restrictive community level.

AETF and research

Reference is made to the AETF undertaking research. It should be obliged to collect sufficient data to allow appropriate review of its functioning. Adequate resources, funding and time should be allocated for this to occur. Research will not occur without appropriate funding and partnerships with universities or other research organisations. Both appropriate data collection and analysis and research would require an active and resourced plan.

4. Recommendations

1. Further design of the AETF needs to occur in the explicit context of the broader CYMHSC system. Area based Community CYMHS Teams should be seen as the central component supported by a range of specialised, more intensive services such as Assertive Mobile Youth Outreach (AMYOS), acute Adolescent Inpatient Units, NGO based Residential Units, Step Up/Step Down Units and the AETF. The AETF being seen as one of the specialised more intensive components supporting Community CYMHS. The AETF should not be the centre of the system nor be seen as a flagship for CYMHSC.

2. A Strategy for ongoing consumer and carer engagement should be determined. The process of participation around the broader CYMHSC services should be separated from the more narrow process of participation in the planning of the AETF as one specific part of the spectrum of care. This process should include the role of Queensland Health Consumers. It should ensure continued consumer and carer involvement in the further design of the AETF as well as a role in the ongoing operation of the AETF when opened.

3. Quality assurance processes and research needs to be explicitly outlined and appropriate resources allocated. The AETF as a novel unit should be obligated to collect sufficient data to allow review of the nature of its cohort, the nature of assessment and intervention undertaken, the clinical outcome (including cost effectiveness) for patients and families, and the units effectiveness including safety. Such quality assurance and research will only occur if there are allocated resources including funds, allocated staff time and research/evaluation expertise. This should be costed into the proposal.

4. The need for workforce development and training of the broader CYMHSC system should be addressed in its own right and not tied to the AETF. It should be based on a needs analysis looking at the current and needed staff competencies within the broader CYMHSC system to provide tertiary level care statewide. Such a workforce development and training function should be seen as separate to the AETF.

Signed on 24/05/2017 by

Dr Paul Robertson
Child & Adolescent Psychiatrist

External Review: Model of Service (MOS) for the State-wide Adolescent Extended Treatment and Rehabilitation Facility (AETR)

Queensland Health

Terms of Reference

1. Background

The Queensland Government established a Commission of Inquiry (COI) into the closure of the Barrett Adolescent Centre (BAC) on 16 July 2015. The Honourable Margaret Wilson QC, Commissioner, provided the BAC COI final report to the Premier on 24 June 2016. On 18 July 2016, the Queensland Government released its response to the BAC COI.

The COI Report made six recommendations which were all accepted in principle as part of the Government Response.

Recommendation 4 of the Government Response committed to

> *Build a new bed-based facility in south-east Queensland for young people with complex mental health issues and ensure patients have access to an integrated educational/vocational training program. The size, location and model of care provided in this facility will be informed by current research and consultation with health consumers, including families from the former Barrett Adolescent Centre.*

In considering and developing the new facility, a commitment to an unprecedented level of stakeholder engagement was made, most especially of young people (past and present) and carers of young people with severe and complex mental health issues.

2. Initial AETF MOS

The initial MOS for the state-wide AETR with integrated educational and vocational capacity aims to provide a detailed description of the AETF within the Queensland public mental health, alcohol and other drugs service system. The AETF MOS is an aspirational document with a practical purpose, intended to describe the target population, the functions, operation and governance of the AETF.

The AETF MOS details the requirements for the delivery of high quality and safe mental health services for young people with severe and complex mental health issues. The accessibility of information allows greater transparency about public mental health services and informs young people, 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 (HHS) specific patient safety procedures and should be read in conjunction with the a range of other policy, legislation and operational documents which will be listed separately for reference.

The AETF MOS also seeks to ensure that Aboriginal and Torres Strait Islander peoples and those of Culturally and Linguistically Diverse backgrounds requiring additional consideration have equitable access to high quality and culturally appropriate mental healthcare that acknowledges difference and responds accordingly.

The intended outcomes of the development and successful implementation of the AETF MOS are:

- a young person and carer centred, recovery based system of care
- the delivery of safe, high quality, integrated, and evidence driven mental health care
- an enhanced continuum of mental health service options
- improved knowledge of how to access and navigate through mental health services across the continuum
- equitable access for young Queenslanders to an extended treatment and rehabilitation service
- facilitating the provision of integrated, individualised educational or vocational programs in line with a young person's home school program to provide skills and training to enable the young person to undertake meaningful education or employment in the future
- stronger service partnerships with the network of providers
- a more informed and supported mental health workforce.

3. Project Specifications - Review of initial AETF MOS

The Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB) is seeking expert and external review of the initial AETF MOS.

In particular, the reviewer should:

1. Assess the initial AETF MOS against current evidence for subacute inpatient services in providing extended treatment and rehabilitation services for adolescents and young people with severe and complex mental health issues
2. Review the development and consultation process undertaken for the initial AETR MOS
3. Provide advice on any gaps or deficiencies in the initial AETR MOS
4. Make recommendations about any amendments necessary to the initial AETR MOS as a result of 1-3 above.

Review of the operational or clinical management of the AETF is out of scope.

4. Key deliverable

The Reviewer will provide a final written report to the Executive Director, MHAODB covering the key elements (section 3) by COB Friday 12 May 2017.

5. Key Tasks - MHAODB

1. Convene an Information Briefing Session (up to four hours) for the External Reviewer. This will include key personnel able to provide contextual information about development of the MOS to date, background issues and other relevant information.
2. Provide secretariat support as required to assist the External Reviewer.
3. Arrange and provide economy class travel, accommodation and meals for two days as per Department of Health Travel Policy QH-POL-046:2015 - https://www.health.qld.gov.au/__data/assets/pdf_file/0028/396082/qh-pol-046.pdf using allowance amounts outlined in the Domestic Travelling and Relieving Expenses (Directive 09/11) - https://www.qld.gov.au/gov/system/files/documents/2011-09-domestic-travelling-and-relieving-expenses.pdf?v=1447991623.

6. Guiding documents

6.1. Queensland Government response – Barrett Adolescent Centre Commission of Inquiry Report
6.2. Barrett Adolescent Centre Commission of Inquiry Report: Volume 1
6.3. Department of Health Strategic Plan 2016-2020
6.4. Connecting Care to Recovery: A plan for Queensland's state-funded mental health, alcohol and other drug services 2016-2021
6.5. Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019
6.6. *Hospital and Health Boards Act 2011*
6.7. National Standards for Mental Health Services 2010
6.8. Fourth National Mental Health Plan
6.9. Mental Health Act 2016
6.10. Statewide Sub-Acute Beds Discussion Paper – January 2016
6.11. QCMHR Review for Rec 3 Document.
6.12. Initial Model of Service, AETF

7. External Reviewer

The External Reviewer will be recognised by their peers as a senior Child and Adolescent Psychiatrist.

8. Confidentiality

The Reviewer may receive information that is confidential, and/or have privacy implications. By accepting the appointment, the Reviewer will sign a confidentiality agreement and conflict of interest register which acknowledges their responsibility to maintain confidentiality of all information that is not in the public domain.

9. Amendment, modification or variation to the Terms of Reference

The Terms of Reference may be amended, modified or varied by the Executive Director, MHAODB.

Terms of Reference endorsed by Associate Professor John Allan, Executive Director, MHAODB

Signed by Assoc Prof John Allan on 17/03/2017

External Review Schedule: Dr Paul Robertson

Tuesday 18th April:

9.30-11.00am: MHAODB information session
Merridy Marshall, Principal Project Officer, COI Implementation Team
Judith Piccone, Manager COI Implementation Team
Room 1.8 Butterfield St

11-12.30pm: Carer and consumer information session
Suzanna Anovic, Jeannine Kimber, Colleen Rohan, Justine Wilkinson
Room 1.8 Butterfield St

12.30-1.30: Lunch

1.30pm: Presentation on the Adolescent Extended Treatment Facility build
Bruce Ferriday, Principal Project Officer

PM: Site visit: Prince Charles Hospital

Wednesday 19th April:

9.30-10am: Department of Education and Training information session
Ms Leanne Nixon, Assistant Director General
Leanne.NIXON@det.qld.gov.au
Education House

11am -12: Health Consumers Queensland (HCQ) information session
Ms Melissa Fox, Director
Melissa.Fox@hcq.org.au
Malibu Room, Level 17 Qld Health Building

1-1.30pm: Department of Education and Training information session
Ms Stacie Hansel, Executive Director
Stacie.Hansel@det.qld.gov.au
Education House