Preliminary Model of Service (Adolescent Extended Treatment Facility) website consultation

Thematic Analysis Report

Purpose:

The preliminary Model of Service (MOS) is an aspirational and evolving document intended to provide broad principles and direction to guide the new, state-wide Adolescent Extended Treatment Facility (AETF) for young people with severe and complex mental health issues in south-east Queensland, including access to an integrated educational/vocational training program.

Process:

The engagement of key stakeholders in planning the new state-wide AETF has to date occurred in two stages.

Stage 1: A series of workshops (attended by a variety of stakeholders) were conducted and supplemented by a number of targeted consultations to assist development of the preliminary MOS.

Stage 2: The preliminary MOS was released on the Mental Health Alcohol and Drug Branch's Commission of Inquiry (COI) Implementation team website (https://www.health.qld.gov.au/improvement/youthmentalhealth) with an invitation to provide comment. This opportunity was open to any interested parties and was promoted via a wide range of networks.

This document is a summary of the submissions provided during the two consultation processes and will inform development of the next iteration of the MOS (the *initial* MOS). It is intended to reflect the **opinions of workshop participants and survey respondents** and is not Department of Health policy.

As outlined in the Next Steps section at the end of this document the development of the Model of Service is an ongoing process and engagement of stakeholders (e.g. consumers, carers, Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse people, and regional representatives) in meaningful consultation will continue.

What we heard:

The interest, engagement and responsiveness from stakeholders (organisations and individuals) in the development of the new state-wide AETF was substantial.

There were 3,525 unique webpage views recorded indicating the preliminary MOS introductory page was accessed from 3,525 different IP addresses or devices. A total of 31 submissions were received (including a number of group responses).

Responses	Submission on MOS received from
21	Direct feedback via website, generally anonymous
1	Child and Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service (CHQ HHS) – representing state-wide child and youth mental health network
1	Royal Australian and New Zealand College of Psychiatrists (RANZCP)
1	Health Consumers Queensland (HCQ) – representing a range of carers and consumers
1	Queensland Mental Health Commission (QMHC)
1	Department of Education and Training (DET)
1	Queensland Program of Assistance to Survivors of Torture and Trauma Inc. (QPASTT)
1	CYMHS, West Moreton Hospital and Health Service (WM HHS)
1	Consumer and Carer Co-ordinator, CYMHS, CHQ HHS – group response
1	Consumer & Carer Consultant, CYMHS, CHQ HHS
1	Department of Communities, Child Safety & Disability Services (DCCSDS)
31	**TOTAL**

On the website, people were invited to comment on specific questions (listed below) with the option to provide additional information.

1. Are there other goals the new facility might seek to achieve?
2. Do you have views about the proposed age range or who it is for?
3. Is there anything else the new facility should do?
4. Is there any other feedback you'd like to contribute?

Feedback was received across a broad range of themes but three (3) areas stood out as drawing the most comments. These were:

1. Age range
2. Continuity of care
3. Research

The table below summarises the range of feedback which was received sorted into themes. It is therefore intended to reflect the **opinions of workshop participants and survey respondents** and not the Department of Health.

General themes	Feedback from workshop participants and survey respondents
1. Proposed age range (13-21 years)	A diverse range of responses were received, however they broadly supported the suggested age range with some challenges/concerns noted as below: • potential vulnerability of younger age group when co-located with older age group • possibility of older age range monopolizing beds/places due to more established conditions • consideration of how developmental versus chronological age is accommodated • potentially different clinical and developmental needs for upper and lower ends of age range • decreasing age at which young people are developing severe and complex mental health issues.
2. Continuity of care/ community follow up/ transfers/ discharge planning/ transitions	Very strong consensus regarding the importance of continuity of care between the state-wide AETF, referrers and follow up services. Transitioning to adult services identified as a particularly high risk time due to different service models. Concerns raised about the resources available in the community to provide follow up care, especially in rural and remote areas.
3. Research	Strong consensus that the state-wide AETF be based on current evidence and undertake research, including evaluation of the service model.

General themes	Feedback from workshop participants and survey respondents
4. Recovery focussed/ strengths based	Strong consensus on the importance of embedding this approach throughout the model. Amplification and consistency of recovery and strength focussed language recommended.
5. Client engagement/ centred	Very strong support for this approach.
6. Length of stay (up to 6 months)	Broadly supported with suggestions made that length of stay be reviewed regularly to ensure it aligns with emerging research. Clarification required regarding readmissions. Consumers and Carers raised concerns in regards to a definite length of stay (up to 6 months) and instead requested that a consumer's length of stay be flexible to ensure that consumers' needs are appropriately met prior to discharge (*maximum* length of stay of *approximately* 6 months)
7. Physical environment, building	Consensus to minimise institutional feel and maximise sense of being a place of healing and recovery which encourages strong connections with family and community. *"It is not a hotel nor an institution but a place where young people feel secure, and where their many needs are addressed … a place of healing."*
8. Consumer and carer supports, peer supports, family inclusive	Broad support on the importance of embedding this perspective throughout the model. Clarification of how this will work day to day will be required. Capacity to support families to be involved, e.g. accommodation and leave arrangements will be very important. Request for Child Safety Officers to be more specifically identified as part of family and support systems. *"The inclusion of consumers and families has been very good."* *"It is a fundamental cornerstone of this model that a young person's existing relationships (family, carer, peer and service) with their community are maintained and supported during inpatient admissions."*

General themes	Feedback from workshop participants and survey respondents
9. Target population	Broadly supported but some concerns there would be different sub groups who may require different types of interventions and environments. General (but not unanimous) support for the concept of the target population being defined by individual complexity and severity rather than by specific diagnosis. Identification of gaps regarding services available to other young people with severe and complex issues but without a primary mental health condition (developmental disorders, substance use, personality disorders, intellectual impairment). Who does the evidence suggest will benefit from this model?
10. Cultural and special needs groups	Strong support for recognising the specific needs of various groups including Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds. Further consideration suggested about the needs of other groups including refugees, asylum seekers, lesbian, gay, bisexual, transgender and intersex and those with intellectual disabilities. Some groups (e.g. migrants) may be reluctant to share personal information with unknown workers potentially hindering identification of mental health needs. Importance of family, friend and community involvement to many groups.
11. Education	Strong consensus on the value of integrated mental health and education service model. Some concerns regarding providing adolescents with an alternative to their educational and vocational provisions during school holidays.
12. Governance and reviews	Strong support for the governance of the state-wide AETF to be very transparent with clear lines of accountability. Specific hierarchy of governance for the state-wide AETF substantially under development at the time of writing.

General themes	Feedback from workshop participants and survey respondents
13. Rural and remote/state-wide	Strong support for use of technologies to develop and/or maintain relationships outside of the state-wide AETF. Further development required, especially for Aboriginal and Torres Strait Islander people populations. *"Too often taking people out of their environments disengages them from supports and solutions that they require when they re-engage. Always keep this in mind, otherwise it will just be another aversive, medical institution which people are required to recover from."*
14. Staffing	Strong consensus about the need to recruit and support sufficiently skilled and respectful staff. Recruitment of an Aboriginal and Torres Strait Islander people workforce highlighted as important.
15. Intake panel and process	Two different approaches to assessing referrals expressed in the feedback, with much stronger support for the second. 1. Preference for very specific criteria to be applied (possibly diagnosis based). 2. Preference for clinical judgment to be used to take into account individual factors (e.g. developmental age, diagnoses, previous treatment and personal supports). Potential inclusion of carers and consumers and Department of Education and Training (DET) representatives on the Panel. Concerns identified regarding day to day details including: 1. How referrals will be prioritised 2. Wait list management 3. Clarification assessments
16. Physical health services	Broad support for adopting a holistic/inclusive approach to health rather than a narrow focus on mental health in isolation. Engagement of young people in these processes encouraged, e.g. monitoring medication.
17. Technology	Strong support for use of technologies to support relationships outside of the state-wide AETF.

General themes	Feedback from workshop participants and survey respondents
18. Consultation- liaison	Broad support for the state-wide AETF to be a resource available to service providers throughout Queensland, especially in rural and remote areas with limited access to local services.
19. Sensory considerations	Broad consensus there needs to be greater inclusion of sensory considerations.
20. Seclusion	Operational clarity is required.
21. Interagency Liaison	Importance of good liaison with staff from other agencies highlighted, e.g. National Disability Insurance Scheme (NDIS) and Department of Communities, Child Safety and Disability Services. Will need to be supported by operational guidelines to cover information sharing, agency responsibilities, impact of staff operating under different *Acts* etc.
22. Interventions and facility components (day program / beds/ school)	Strong interest in the specifics of interventions that will be available. Greater clarity sought regarding the focus, capacity and relationships between the day program, inpatient beds and school components.
23. Crisis/acute	Support for greater emphasis on capacity to manage crises to minimise potential transfers to acute beds. Some questions were raised about how the new *Mental Health Act 2016* would influence practice, e.g. management of adolescents on Involuntary Treatment Orders.
24. Record keeping/information sharing/confidentiality	Clarification sought about information sharing, especially between Health and DET.

Limitations:

The *preliminary* Model of Service is the first step of what is an ongoing development and refinement process. Several important processes were incomplete at the time of writing (points 1 and 2 below) and other processes (point 3) will follow in the future to create a more complete package of information.

1. At the time of the preliminary Model of Service being written the work undertaken by Queensland Centre for Mental Health Research (QCMHR) regarding the target population, clinically effective interventions and evaluations frameworks (Government response to Recommendation 3) was unavailable. Therefore the preliminary Model of Service was focussed to a large extent on stakeholder perspectives with the expectation that when the findings became available they would be used to inform the next iteration of the model of service, i.e. the *initial* Model of Service.

2. Some decision making in relation to Hospital and Health Service governance of the state-wide AETF was unresolved at the time of writing.

3. A model of service document is intended to reflect aspirations and principles rather than focus on specific day to day ("operational") details which are generally created at a later stage. The number of comments about the lack of details suggests that many respondents had a greater interest in how these principles would be translated into day to day practices.

4. Engagement of some key groups was limited, e.g. consumers/carers and services representing Aboriginal and Torres Strait Islander people. Input from stakeholders representing regional and remote areas was also very limited.

5. The challenge of making the state-wide AETF as appropriate and accessible as possible to young people in all areas of Queensland is ongoing.

Next steps:

March 2017

Feedback from workshop participants/survey respondents and findings from QCMHR (Recommendation 3) will inform development of the "*Initial* Model of Service"

April 2017

Initial Model of Service provided to external reviewer with clinical and academic credentials (review completion mid-May)	Further engagement and consultation with Aboriginal and Torres Strait Islander people (to be ongoing)	Further rural and remote engagement and consultation (to be ongoing)

May 2017

Feedback from additional consultations and external review will inform *Reviewed* Model of Service"

12 Youth Mental Health Forums occurring across the state for further consultation

Internal review processes and ongoing refinements

It is the intended the Model of Service will continue to evolve by:

1. being available for critical external review
2. continuing to include the perspective of carers and young people into the future
3. entrenching a model of mandated clinical and service review
4. by participating in and integrating new research.

Further updates:

Updates will continue to be provided on the Queensland Health, Mental Health Alcohol and Other Drugs Branch (MHAODB) COI Implementation team website at https://www.health.qld.gov.au/improvement/youthmentalhealth.

Thank you for your interest in this process.