EXTERNAL REVIEW: OPERATIONALISING THE MODEL OF SERVICE FOR THE STATEWIDE ADOLESCENT EXTENDED TREATMENT CENTRE

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INTRODUCTION

I was requested by Queensland Health Mental Health Alcohol and Other Drugs Branch (MHAODB) to undertake an External Review around operationalising the Model of Service (MOS) for the Statewide Adolescent Extended Treatment Centre (AETC). Details of the requested External Review, including background, specific questions and guiding documents are outlined in the Terms of Engagement document (Appendix A). This report is prepared as an outcome of my Review and Advise.

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 models of care development. I have experience in training and workforce development in 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 Engagement relate to the Statewide AET MOS and the Adolescent Day Treatment (ADT) MOS as it relates to the new statewide AETC that is currently being built. The Terms of Reference specified 4 areas to be the focus of external review:

1. Fidelity to the model,
2. Safe delivery of services,
3. Integration of services, and
4. Flexibility to meet the unique needs of the cohort of young people that might use the service in the future.

In this report I use the term ‘adolescent’ and ‘young person’ somewhat interchangeably. I note the AETC will largely serve adolescents between the ages of 13 – 18 years although some allowances are made for young adults who may be functioning developmentally in adolescence. For ease I have also used the terms ‘recovery’ and ‘rehabilitation’ interchangeably although I recognise there are substantial difference between them.

In undertaking the review I have read a range of documentation (outlined below) and visited Brisbane for two days (Friday 8 March and Monday 11 March 2019) for Information Briefing Sessions and Consultations with staff from MHAODB and other stakeholders including consumers and carers. The Schedule for these two days of meetings is attached in Appendix B.

Documents provided by Queensland MHAODB:

- State-wide Adolescent Extended Treatment (AET) Model of Service (MOS) - Revised (January 2019)
- Adolescent Day Treatment Model of Service (January 2019)
- Youth Step Up Step Down (SUSD) Model of Service (December 2018)
- Document (1 page diagram): Broad overview of the Child and Youth Mental Health service system in Queensland

- Clinical Excellence Division - Day Program Outcomes Workshop: Background Paper (2018)
- Queensland Centre for Mental Health Research (QCMHR) - Evaluation Framework for the AETC: Advisory Group - Terms of Reference (Consultation Draft)
- QCMHR - Evaluation framework for the Adolescent Extended Treatment Centre (AETC): Preliminary Report for the Advisory Group (Consultation Draft)
- Various photographs of the AETC Site, Proposed Building and current construction site (partially complete)
- Various architectural plans showing the AETC building.

Documents Provided by Department of Education following consultation:

- Hospital education programs across Queensland (copy of presentation)
- Supporting the education of students with severe and complex mental health conditions (January 2018)
- Literature review: Best practice in the provision of educational and vocational training programs for the adolescent with severe and complex mental health conditions (28 March 2017)

Documents Provided by Children's Health Queensland Hospital and Health Service (CHQ HHS) following consultation:

- CHQ HHS AETC Costing Summary (spreadsheet - 2 pages)
- CYMHS CHQ HHS Divisional Structure - AETF 24.11.2018.

Additional Documents provided by MHAODB during consultations:

- Queensland Day Program - Comparisons (1 page table)

- Summary Child and Youth Day Program consumer profile for period 01/01/2016 to 31/12/2018
- Assertive Mobile Youth Outreach Service (AMYOS) - MOS (August 2016)

Consultations Undertaken by Dr Paul Robertson on Friday 8 march and Monday 11 March 2019 (Appendix B) include:

- MHAODB - Sandra Eyre, Judith Piccone, Anna Davis, Bruce Ferriday and Merridy Marshall
- Consumer and Carer representatives (Supported by Health Consumers Queensland - Leonie Sanderson) - Ash Polzin, Kerry Geraghty, Marg Yandell, Mikaela Moore
- AET Centre Site Visit - Bruce Ferriday and Emma Lawson
- QCMHR - Carina Capra and Madeline Gardner
- Department of Education (DoE) - Stacie Hansel and Michelle Bond
- CHQ HHS - Stephen Stathis, Judi Krause, Emma Hart and Ingrid Adamson
- Executive Director, MHAODB - John Allan

The consultations were very helpful in providing context and orientating me to how the process has developed since my previous report 2 years ago. Most of the information in the consultations is available else. I have not summarised the content of the consultations here.

DISCUSSION

Since my previous report two years ago there has been considerable work and progress in actualising the Adolescent Extended Treatment Centre (AETC). In particular I recognise extensive work on:

- Commissioning of Children's Hospital Queensland (CHQ) Hospital and Health Service (HHS) to own and run the AETC.
- Clarity that there will be 12 residential beds (statewide catchment), 10 day program places (local community catchment) and capacity for 2 family units for families to reside at the AETC at any one time.
- Further clarification of the cohort of young people who are likely to be referred and admitted to the AETC residential beds.
- Service and consumer and carer coproduction of the process.
- More detailed development and refinement of the AET MOS and consideration of implementation including staffing profiles.
- Reviews of MOS of Youth Step up Step down (SUSD) service and Adolescent Day Treatment and integration with the developing AET MOS.

In addition the AETC is currently being built with an expected opening date in mid 2020 and planning is underway for the building of two Brisbane based Youth SUSD units. The report now discusses my ideas around some central issues faced in operationalising the AETC.

Further Discussion about the Likely AETC Patient Cohort

This discussion mostly pertains to the 12 residential beds where there is much greater uncertainty about the nature of the cohort rather than for the 10 day program places. The descriptions "adolescents with severe and complex mental health needs" is not specific and therefore not particularly helpful in aiding us understand what will be required on a day-to-day basis for the AETC residential cohort. ‘Adolescents with severe and complex mental health needs’ is useful in highlighting the cohort will be a group where the predominant need is for mental health treatment and rehabilitation as opposed to other needs such as care, custody or accommodation. So "severe and complex mental health needs" along with a psychiatric diagnosis, or multiple diagnoses, will be a pre-requisite to being in the cohort.

To take this discussion further I would think of ‘severity’ in two ways. Firstly the severity of symptoms and level of distress for the young person. Severity of symptoms and distress, especially if acute, are usually well managed by outpatient services and if needed acute adolescent inpatient units. Adolescents with persisting severe symptomatology and distress after usual intervention may benefit from subacute adolescent mental health services, including the AETC. Those with long-standing symptoms of suicidality and deliberate self harm, and a risk to self, and not responding to acute treatment (and maybe even aggravated by acute services) are particularly likely to be referred into this cohort. Those with a diagnosis of Borderline Personality Disorder (BPD) are likely to typify this cohort. Those with persisting symptoms and distress, but at less immediate risk to themselves, should also be considered for this cohort although may be less likely to be

referred. Severe Obsessive-Compulsive Disorder and Agoraphobia are diagnostic examples of these young people. Subacute services, including the AETC, would target chronic severe symptomatology and heightened persistent levels of distress.

The second way of seeing ‘severity’ is the degree of psychosocial impairment, the extent to which a young person's age-appropriate functioning is below or behind age-appropriate levels of functioning due to mental health problems. Psychosocial functioning can be considered in terms of personal care, scholarly or occupational function, peer relationship function and relational functioning with adults. Psychosocial impairment as a measure of severity will be particularly relevant for subacute services, including the AETC. Such psychosocial impairment is likely to be the target of recovery focused or rehabilitative interventions which will be the major focus of the AETC. We know impaired psychosocial functioning is less successfully treated in child and adolescent mental health (CAMH) community care and acute adolescent inpatient services. Addressing psychosocial impairment is a recognised gap in most adolescent mental health services.

The term ‘complex mental health needs’, or complexity is commonly used but rarely clearly defined. An understanding of complexity that I find a useful is one that incorporates a range of factors that contribute to or aggravate mental health problems and leads to chronicity as well as adding to the challenge of delivering successful interventions. A useful framework to think about these factors contributing to complexity is outlined below:

- Contextual factors in the family system or broader community system impacting on the young person such as poverty, deprived or unsafe communities, protective service involvement, history of traumatic events, parental incarceration or crime, parental mental illness or substance abuse problems and parental loss.

- Comorbid neurodevelopmental disorders such as Intellectual Disability, Autistic Spectrum Disorder, Language Disorders or Attention Deficit Hyperactivity Disorder.
- Chronic medical illness in the young person (and maybe also in the immediate family i.e. sibling, parent).

All these factors are likely to be frequent in the AETC residential cohort. The AET MOS will need to respond to these complexities. One can add to the concept of complexity the level of cultural and language discordance between the service providing care and the young person and their family. This would include aboriginal and Torres Strait Islander People populations and culturally and linguistically diverse (CALD) populations. The AETC needs to be receptive to and able to engage these populations although it is unclear to what extent they will be in the cohort.

More broadly I think we can predict a likely profile for the residential bed cohort. One unifying factor will be what is called ‘borderline psychopathology’. I think many patients will meet criteria for a diagnosis of BPD and most I think will exhibit features of emotional instability, problematic close relationships and difficulties with self-concept. There will commonly be associated unresolved past psychological trauma and it’s sequelae. Typically ‘borderline dynamics’ will be enacted in the relational group environment of the residential milieu setting. Potentially, and rather novelly, the interface with the 10 day treatment places will both pose challenges as these dynamics may impact on this group through contagion and also advantageous in the integration of the two groups during the day will dilute the dynamics of the residential group. Such enactments cause considerable problems and are difficult to manage or address on acute adolescent inpatient units. Such enactments are often around suicidal risk and deliberate self harm; inappropriate intimate and sexual relationships, absconding, "splitting" or idealising and denigrating different staff

members or similar patterns. Emotional impacts on the staff, potentially conceptualised through transference and countertransference concepts, are likely to be great and require considerable management. The AETC residential milieu will no doubt have to grapple and work therapeutically with these dynamics as a core aspect of its function. This will have important implications for the AETC clinical model; the capacity and function of the multidisciplinary team; workforce training, supervision and structure and processes of managing safety, both regarding suicidal and sexual risks.

Secondly the AETC residential cohort profile is likely to have significant comorbid neurodevelopmental disorders contributing to mental health problems and complicating intervention. The high frequency of comorbid neurodevelopmental disorders is true for most tertiary CAMH/CYMHS settings and I expect will be even more so for this cohort. There will be a need for expertise in both assessing such difficulties (neuropsychology, speech pathology, Occupational Therapy) and integrating specialised findings into an understanding of the current mental health problems and need for intervention. This has implications for staffing. It has implications for the type of interventions needed, for example a significant language disorder is likely to indicate activity based interventions will be more beneficial than verbal ones. The relationship between education and mental health will be important as educational failure and alienation from school are frequently associated with neuropsychiatry disorders. It will also have implications for admission criteria, for example it may be unhelpful and inappropriate to admit where there is substantial Intellectual Disability such that the young person cannot function within the adolescent age range for which the program is designed.

Thirdly the cohort is likely to have substantial difficulties, and need for intervention, within the broader family and community contexts. A high level of clinical skills to assist parents, including those with their own mental health, substance use or intellectual disability problems, to better care for the young person; intervene in problematic family dynamics and shift contextual problems around school, community and community service systems are needed. Residential facilities, especially where there is a long length of stay such as the AETC, by virtue of taking a young person out of the family home and context can on one hand significantly undermine the family's capacity to care for the young person; on the other hand, it can create an opportunity for positive change for both the young person and the family. However, without significant thought or clinical skills it is more likely to cause harm. Significant thought and clinical skills to understand and intervene in the family and contextual aspects will be required. I note the addition of two family units within the AETC, allowing families to stay on-site. This is very positive as it will allow intensive family intervention as part of treatment, as well as practical support for geographically isolated families.

Choosing a Clinical Model for the AETC

Underneath the AETC MOS there will need to be a clinical model, or theoretical framework for the clinical work, that guides the multidisciplinary team (MDT). I think the clinical model should ultimately be decided by the Clinical Director and senior leadership of the AETC MDT. However, I see there are some requirements of the clinical model which I outline below:

- That it has an evidence base and been implemented in other clinical settings with patients, ideally adolescents, with severe and complex mental health needs who might resemble the AETC residential cohort described above.
- That it is easily understood, able to bring unity through a shared clinical theoretical framework and can also function as an umbrella to allow integration of other specialist interventions and aspects.
- That it can be applied and the required skills taught and implemented by the least trained and skilled member of the MDT, for example junior nurses, allied health trainees or junior rotating psychiatric registrars.
- That it supports and integrates all aspects of intervention, including individual therapy, group therapy, milieu therapy and family therapy as well as allowing accountability and supervision of all aspects of the program.
- That is acceptable to the staff, patients and carers.

From my knowledge there are three options being Mentalization Based Therapy (MBT), Cognitive Analytic Therapy (CAT) and Dialectical Behavioural Therapy (DBT). There might be others I am not aware of. It might be possible to use a combination of these. All have an evidence base and have been developed in the treatment of BPD or similar patients who provide challenges to clinical services. None have been used or described in a subacute adolescent residential unit such as the planned AETC. While AMYOS was outside my consultation I understand MBT is a clinical model successfully used in this component of the Queensland subacute adolescent mental health services and there is experience, skills and knowledge around this model. A private adolescent inpatient unit, with some similarities to the AETC, is the Albert Road Clinic (ARC) Adolescent Inpatient Unit in Melbourne which successfully uses a DBT model. This private hospital unit for

adolescents and young adults provides elective admissions with pre-admission goal planning; group, individual and family intervention and a focus on milieu intervention over several admissions that can be up to 6 months duration in total. It functions with tight admission and discharge processes to ensure admissions are therapeutic. The CAT model has been used and investigated at Victoria's Orygen HYPE clinic for outpatient treatment of BPD as well as for consultation with acute inpatient units around managing challenging patients. Orygen Mental Health provides extensive training and supervisory support for this model. In my experience it has been a useful model when implemented at Eastern Health CAMHS in Melbourne particularly within the high risk adolescent outreach program (parallel to AMYOS) as well as more broadly in community CAMH teams and an acute adolescent inpatient unit.

The clinical model needs to be able to work at the level of the individual young person, the family and the broader context (school, community and service systems) in equal measure. If the clinical model succumbs to focusing mostly on the individual level with the young person only, a risk with an inpatient model, it will fail.

Referrals, Managing Intake, Throughput and Discharge

The demand for the services of the AETC from Queensland's child and youth mental health services (CYMHS), broader medical and adolescent focused services and the community generally is unknown. Hence there are many unknowns in these deliberations.

The background of the Barrett Adolescent Centre (BAC) Commission of Inquiry (COI); the extensive consultation processes to date and the AET MOS all envision the AETC being a

subacute residential unit with a central recovery and rehabilitative focus for adolescents with severe and complex mental health needs. In my understanding this means there will be a tripartite (young person, parents/carer and professionals) collaborative recovery and intervention plan that is goal-directed and outlines the responsibilities and commitments of each party along with an anticipated timeline. This should be established pre-admission and further detailed in an initial admission phase (that could be one or two weeks). While perfect agreement between the young person, parents/carer and professionals, is not needed it does need to be a shared enough agreement about the problems to be targeted and how these problems might be addressed within the AETC. Goals should be operationalised so as to be measurable. Disruption to the collaborative plan will occur and repair of such disruptions should be seen as therapeutic opportunities. However, an inability or unwillingness to function mostly within an agreed collaborative plan should lead to discharge. In such a case the possibility of readmission could be renegotiated in the future or alternately referral to another component of the subacute adolescent mental health system may be appropriate. This approach would allow the AETC to provide effective recovery and rehabilitative care to a range of adolescents with severe and complex mental health needs. It will also exclude a significant number of young people with severe and complex mental health needs who are unable or unwilling to enter such a collaborative arrangement. The capacity to enter and work in such a collaborative plan indicates a capacity and wish for help. As such those young people with the most severe problems may not be suitable to access the AETC. Indeed, AMYOS with its intensive community outreach capacity to meet young people where they are maybe more likely to be helpful for this group of young people who are ambivalent or rejecting of care or whose mental health difficulties prevent cooperation with services.

There will be tensions at times between whom various service systems components, the wider community and at times political powers think should be admitted (and treated) in the AETC subacute residential beds and who the AET MOS points towards who should be admitted and treated. This will be true within the broader child and youth mental health service system; it will be true between the broader service systems for young people such as youth justice and child protection services and likely more broadly within the wider sociopolitical system. The pressure maybe to move towards more coercive treatment interventions rather than negotiated collaborative approaches. Care also needs to be taken not to exclude adolescents involved in justice and child protection systems but admission should be decided on the capacity of the young person and carers to develop and function within a collaborative recovery and rehabilitative intervention plan. Ultimately there may be a perception of disappointment in the AETC and its failure to help those young people with severe and complex problems but who are unable or unwilling to enter a cooperative recovery or rehabilitative plan. These tensions will need to be managed. A mechanism to review this tension could be put in place if needed between the Department of Health and CHQ HHS, maybe through the Office of the Chief Psychiatrist. If there is a decision to broaden the function of the AETC to include more coercive interventions it should be recognised the proposed current MOS may not be applicable.

I would suggest some parameters be in place prior to admission to support the admission:

- There is agreement about who will provide post discharge mental health care. While ideally such a cohort would have access to tertiary CYMH services this may not be possible in parts of Queensland and next best would have to be identified. The follow-up arrangements could always be reviewed and changed during admission but the admission should always be underpinned by clear access to community care at

discharge. Deciding which professionals can initiate referral to the AETC will need to be decided but deciding who will provide ongoing treatment post discharge is probably most important.

- Clarity of where home is and who is the 'psychological parent' or carer should be clear prior to admission. The unit can helpfully function 'as if' family or 'as if' home but should not ultimately become the young person's home or family. Allowing the AETC to become 'home' and the major place of attachment, especially in the context of young people who are likely to have had past attachment disruptions or losses, is likely to do more harm than good. The illusion of providing psychiatric care so a young person will be 'better' behaviourally to allow placement in a future home should be avoided.

These considerations will be particularly relevant for those young people in care and while being in care should not preclude access to the AETC these matters should be resolved prior to admission. It might also include older teenagers estranged or without parents. However, I still think it should be necessary to identify next of kin, important adults providing care and maybe pre-admission discussion with the Youth Residential Rehabilitation services.

In terms of throughput I think a maximum six-month length is adequate, or maybe too long, for hospital inpatient, albeit subacute service, providing recovery and rehabilitative care. I would see inpatient care as different to a residence providing an alternative home in which a young person can finish growing up in. I also suggest considering the six months being used over a number of admissions and over a longer period of time for example, say three two-month admissions over two years. The idea of admissions interspersed by periods at home and within their community may be more useful. The length of admission and hence

number of admissions each year will also have implications for staffing which is discussed later.

Admission and discharge may also be partially determined by the cycle of school terms and holidays. Some young people may benefit most being in the AETC during school terms for example if mental health problems are most severely impacting on their capacity to attend and function within the school environment. Alternatively, if school is a relatively protected level of functioning and peers and self-care are most affected maybe admission on holiday periods may be more helpful with less disruption of school attendance.

Discharge planning should begin prior to admission in the pre-admission assessment. Identifying attainable goals, timelines and expected outcome all allow discharge to be planned for the very beginning.

Implications of the Physical Space of the AETC

The AETC is a purpose designed facility. It is a large space made up of two smaller spaces one for the residential component and a second for the day program area (with both day and residential patients attending during the school day). Both these spaces are made up of a range of purpose specific smaller spaces, for example a demonstration kitchen, music room and art room et cetera.

The AETC will be physically and organisationally distant from the Queensland Children's Hospital, being located at The Prince Charles Hospital campus which is run by a different

HHS. This has significant implications for the running of the AETC including the staffing profile.

The full implications of the space will not be fully understood until it has been operational for some time. However, some implications of the space can be anticipated at this point. Potentially all residential patients could attend the day program side during school hours, paralleling the normal community expectations of leaving home to go to school each day. In the day program they would undertake structured rehabilitation focused interventions, some of them educational or occupational, during the school day. This would allow the residential area to be closed down during the school day. It would also mean the day program needing to be operational and staffed for up to 22 patients during the school day to undertake various individual and group activities that may be educational or therapeutically focused. I think such a weekday structure for the day is likely to match the goals of most patients although I recognise some will be working towards the goal of attending school and only able to attend part of the day. I think the arrangement for all residential patients attending the day program for the school day should be the aspiration but that it might be difficult to meet on many, even most occasions, and I expect some residential patients will be in the residential section during school hours. Uncertainty of where the 12 residential patients will be brings challenges in imagining how to manage staffing across the day program and residential components on any particular school day. For example, how many staff from the residential section should participate in the day program during school hours and how many will be needed in the residential section.

The AETC will benefit from having a wealth of potential therapeutic spaces, for example art room, music room, kitchen that can potentially be used in rehabilitative interventions. If

rehabilitative plans are individualised, as is the hope, then potentially a number or all these spaces might be called upon at one time. While the broader opportunities provided by the building are clearly beneficial it will create challenges in staffing to fully make use of the various spaces and opportunities and also to adequately supervise and ensure safety across the various spaces.

A seclusion room or “de-escalation space" is part of the building. I am not aware if a de-escalation space is clearly defined or how it might be different from using a patient's bedroom to de-escalate or to have a quiet space. Seclusion is more clearly defined in the *Mental Health Act 2016* as a restrictive intervention particularly used in acute inpatient units. I cannot see how the use of seclusion or other restrictive practices fits the currently proposed AETC, broadly as outlined in the consultation processes and more specifically in the AET MOS. It may offer some safety in emergency situations where unexpected risk needing restrictive interventions emerge with a young person. However, I would suggest if an episode of seclusion occurs it should lead to transfer to an acute facility for more acute care or discharge as it is indicative that a collaborative approach to admission is not in place. Possibly one episode of seclusion could lead to renegotiation of the plan to achieve greater collaboration but certainly an ongoing need for restrictive interventions indicates it is not an appropriate admission.

Integration of the AETC across CYMHS

Subacute adolescent services

The similarities and differences in the cohorts using the various components of the subacute adolescent mental health services is yet to be determined. Which component will

most likely help and be acceptable for a particular young person will need to be determined. Adolescents may helpfully progress through one subacute component to another, for example from AETC residential to the Youth Residential Rehabilitation service; Youth SUSD service to the AETC residential or AMYOS to AETC residential. The potential will need to be clarified with time and greater experience of the service components. An opportunity to compare the component cohorts characteristics and outcomes would be useful and worth encouraging. The relative cost effectiveness of the various components should also be evaluated. I would understand one likely difference is that the AETC is likely to be most beneficial where there is enough engagement to intensively work on a shared collaborative plan and sufficient family involvement to supported admission; AMYOS particularly where flexibility and clinician mobility is needed to foster engagement with the young person who may or may not have family or alternative care systems involved; Youth Residential Rehabilitation service where there is limited family involvement and a real need for accommodation. Others may see this differently. Also, I note the age range for access to different components of the subacute residential services varies from component to component which will complicate the matter.

Acute adolescent inpatient units

It is likely some patients will enter the AETC directly from acute inpatient units for a longer period of rehabilitation following acute inpatient care. Ideally, I think it would be most useful for a young person to spend some time at home prior to admission to the AETC. Direct transfer might be particularly required when the young person does not have access to aYouth SUSD service due to where they live in Queensland.

Some adolescents will also need transfer from the AETC residential program to acute adolescent inpatient units if the acuity of care needed is better met in an acute setting. I would think the need for coercive interventions would be one such indication.

Broader CYMH services

Each HHS is likely to have different needs of the AETC due to the range and capacity of mental health care available locally (including access to other subacute components) and the impact of geographical distance.

Integration of the AETC Residential and Day Program Components

The vision of the project is for the residential and day program components to be integrated and not run as separate services. Yet there are challenges about how this should occur. The cohorts will be different with the residential cohort being drawn from the whole state and the day program cohort from more locally in the north Brisbane area. There is currently a day program located in Chermside close to the AETC run by CHQ HHS. One would expect the adolescents in the residential cohort will have more severe problems but it is not clear what this will mean in practice. However, both cohorts should be similar in being able to, for both the young person and family, engage collaboratively in a recovery or rehabilitation plan including for the school day or day program time. Currently the day program running in Chermside uses a model of two intakes annually at the beginning of the school year and commencement of semester 2 with attendance usually being usually for 2 school terms.

Ideally all young people in both cohorts will attend the day program component each weekday for the school day. In a broad sense they will be involved in educational and

vocational activities during school hours even if it is just beginning to get used to the idea of school. This will potentially put 22 young people in the day program each day. This is clearly too large to be one group. I would envisage it being split up into two or three groups, plus individual components, based on age, rehabilitation or educational needs or similar and not on whether they are in the residential or day cohort.

Integration of the staff across the residential and day program components of the AETC will be needed. AETC leadership structures should encompass both components.

Determining a Staffing Profile for the AETC

There is uncertainty, and maybe differing opinions, about the most appropriate staffing profile for the AETC residential component to operate it effectively and safely. A staffing profile for the day program component is easier as there are existing day program models in operation although integration of the AETC residential and day program components adds a new dimension. Guidance through benchmarking is difficult as the AETC is a facility where comparison with similar existing units is not available and such a subacute residential facility is not defined in the National Mental Health Service Planning Framework. I have outlined below my thoughts in a series of points below about how I would decide upon an optimal staffing profile and have then commented on the model provided by CHQ HHS.

1. The AETC residential component will be a hospital-based bed service predominantly staffed by nursing staff supported by medical, allied health and other staff. Providing safe

delivery of services to inpatients within a hospital framework will be needed and has implications for staffing.

2. There is a need to achieve fidelity to the AET and Adolescent Day Treatment MOS as well as to the broader commitment emerging from the Government response to the BAC(COI Report and subsequent consultations. This commitment is to provide a treatment and rehabilitation service to adolescents with severe and complex mental health needs. Active, individual recovery and rehabilitation focused interventions aimed at reducing chronic symptomatology and improving psychosocial functioning is a human resource focused and intensive endeavour. Inadequate or ineffectively use of staffing will result in less therapeutic endeavour than is optimal and will challenge meeting the overall commitment.

3. The building is state-of-the-art, has a large footprint and provides many spaces to facilitate intervention. Staffing will need to be adequate; in number, capacity and training, to meet the therapeutic opportunities of these spaces as well as provide support, supervision and safety for young people across the spaces. There may be opportunities to manage the space through selective closures of some sections at times to allow efficiencies of staffing and other functions, for example closing the residential section of the AETC during school hours if all patients are appropriately in the day program section. However, a risk with this is that full utilisation and therapeutic benefit of the new facility will not be achieved if such efficiency measures around staffing are overused.

4. I would aim for high efficiency of the facility in terms of bed occupancy level, throughput, monitoring overnight patient leave, tracking outcome measures as well as client, carer and

referrer satisfaction. I would staff to achieve this efficiency. The AET MOS indicates that all admissions could, and should be, elective or planned and arranged with prior planning. The same could be said for discharges. This would allow a potential goal of 100% occupancy. Such efficient use of the facility would require adequate staffing to drive processes.

5. The AETC residential and day program should be seen as part of the continuum of services, both within the subacute adolescent mental health facilities and more broadly within CYMHS and wider health services. Supporting and enabling community-based area CYMHS teams and practitioners to deliver care should be a central function the AETC through adding subacute services. This requires the AETC staff to be outward looking, engaged with other service components and active in pre-admission consultation and discharge planning. The volume of clinical work around patients who are not current inpatients (potential referrals) through consulting, pre-admission assessment or post discharge is unknown. Consultation and assessment of referred young people that does not lead to admission to the AETC will be a valuable part of the work if alternative more appropriate and less restrictive pathways of care can be identified. However, the volume of this work is unclear. There will be important implications for staffing around this as the more admissions (and shorter lengths of admission) the greater the pre-admission assessment workload and other aspects of workload, including liaison with the broader service system (see Box A).

6. I think a large proportion of the AETC referred cohort, for both residential and day program components, are likely to have comorbid neurodevelopmental disorders that are in themselves complex and not straightforward. Considerable staff resources are likely to

Box A

Modelling - Number of Referrals, Pre-admission Assessments and Admissions

Assuming number of admissions each year will depend on average length of admission.

Average length of admission is 6 months = 24 admissions/year or approx. 1/fortnight

Average length of admission is 3 months = 48 admissions/year or approx. 1/week

Average length of admission is 6 months = 72 admissions/year or approx. 1.5/week

If assume 2 referrals requiring significant pre-admission assessment (ie approx. 10 hours) for 1 admission = 144 pre-admission assessments/year of 3/week

Assume each takes approx. 10 hours of pre-assessment = 30 hours of clinician time per week for 144 pre-assessments (time for particular patient is likely to be delivered by more than one clinician simultaneously or sequentially but this does not effect modelling)

Divide 30 hours by number of clinicians undertaking pre-assessments to equal amount of time per clinician ie if 5 clinicians = 6 hours/week each; 10 clinicians = 3 hours/week.

be needed to allow further specialised assessment, integration of previous assessments and the like. In particular resources for speech pathology, neuropsychology and special education teachers will be needed. Consultation from a developmental paediatrician is also likely to be needed.

7. The cohort is likely to include (unless a decision is made to exclude) those with medical problems such as significant medical comorbidities (diabetes mellitus), chronic eating disorders with starvation and treatment failure, and complex conversion and psychosomatic disorders. The separate location of the unit, geographically and organisationally, from mainstream paediatric and adolescent medical services will be an issue. Access to the paediatric care will be needed if this cohort is to be included. This

cohort will also require greater physical nursing. Organisational pathways linking to the local paediatric service at The Prince Charles Hospital would be valuable.

8. Staffing to maintain a functional and coherent multidisciplinary team (MDT) will be essential. While this is about the overall number of staff it also involves thinking about the skills base for staff, ensuring sufficient time and commitment to team processes, reflective supervision and training et cetera. I would prioritise ensuring a coherent MDT through having a solid base of experienced mental health staff (Psychologists, Occupational Therapists, Social Workers) who are full-time or substantially part-time; have sufficient time to engage in MDT processes, reviews and reflective practice and able to bring a range of skills to the work including care coordination. The MDT could then decide the role and opportunities for more specialised skills such as art and music therapy. The risk of having a lot of staff functioning only in their specific skills, and who might be part time and without broad mental health skills is that it risks diluting the functionality of the MDT and its capacity to contain unhelpful group dynamic processes occurring in the milieu, for example ‘splitting’. It is important to determine how many mental health clinicians will be required to deliver pre-admission assessments; care coordination; individual, family and parent psychotherapy and group psychotherapy as well as function within the MDT. I have outlined below (Box B) one model (which is generous). It results in the need for 10 FTE of mental health clinicians for these functions. Possibly some of this function could be provided by psychiatric registrars or members of the nursing team or by specialist therapists having a broader mental health role.

9. The AETC residential component as an inpatient unit will function 24 hours per day including weekends and school holidays. I think it is incorrect to think intervention will only occur during the school day although evening and weekends will no doubt be less formally

organised. As such most of the work will be done by nursing staff and much therapeutic value will be achieved through the appropriate use and management of the milieu by nurses. This is not to devalue what other staff contribute but it is critical to get what the nursing staff do correct. The nurse role in the AETC will have substantial differences from the nurse role in acute adolescent inpatient units (where I expect many will be recruited from). Conceptualising and documenting the nursing role as a milieu based, recovery and rehabilitative process will be essential. Selecting, skilling and supervision through reflective practice will be critical. To fully use the physical space of the facility, i.e. demonstration kitchen, music room, sensory room et cetera, nursing staff will need to trained, supported and supervised in this specialised work as much of this activity will occur outside normal working hours. I think staff will specialised skills, for example art therapy, music therapy and exercise physiologist will have an important role in supporting, training and supervising nursing staff to make use of the whole facility, particularly outside of normal working hours.

10. The peer support workers and carer consultant roles are clearly argued for in the consultation process. I think the AETC provides a wonderful opportunity to further develop these roles. However, I understand these roles are yet to be fully developed and their full potential is hard to estimate. It is hard to know what they will mean in terms of broader staffing numbers and I would proceed initially with the idea that they are in addition to other staff. Work to develop position descriptions and a detailed understanding of their role is needed. These positions should be part of future evaluations.

11. The interface of the teaching staff and clinical staff will need to be further articulated. Differentiation of the roles and work is important. Yet nevertheless the total number of staff with adolescents in the day program during the school day is also relevant and

Box B

Modelling of Mental Health Clinician Time Delivering Care Coordination, Therapy and Group Therapy

Residential Cases (12)

Case Co-ordination	*5 hours/week*
Individual Therapy	*2 hours/ week*
Parental Intervention	*1 hours/week*
Family Therapy (2 clinicians)	*3 hours/week (see below)*
Sub-Total	*11 hours/week*
Add proportion of Group Therapy/case	*3 hours/week*
Total	*14 hours/week*

Day Program Cases (10)

Case Co-ordination	*3 hours/week*
Individual Therapy	*2 hours/ week*
Parental Intervention	*1 hours/week*
Family Therapy (2 clinicians)	*3 hours/week*
Sub-Total	*11 hours/week*
Add proportion of Group Therapy/case	*3 hours/week (see below)*
Total	*12 hours/week*

Psychotherapy Group Therapy (time from clinicians who are case coordinators only)

Assume 2 hours of psychotherapy group with 2 clinicians each day = 4 hours/day or 20 hours/week

If 22 patients I would think 3 groups = 60 hours/week

Divide 60 hours per patient (22) = approx. 3 hours/patient/week

Calculating total hours of clinician time required per week:

Residential group is 12 cases x 14 hours = 168 hours

Day Program Cases is 10 cases x 12 hours = 120 hours

Total both groups = 188 hours direct clinical time

Assume for each staff 50/50 split between direct clinical time (including case coordination) and non direct clinical time then total clinical hours = 376 hours

At a 38 hours working week = 10 clinicians to deliver case coordination and therapy across both residential and day program groups.

Note:

This does not take account of leave.

This does not include contribution to groups by teachers, nurses or specialists not being broad mental health clinicians.

understanding whether clinical staff should be actively present or available if needed during educational components may need to be decided on the needs at the particular time.

12. The AETC should be clinically led by a child and adolescent psychiatrist as Medical Director. An operational manager alongside the clinical director would be needed, maybe most appropriately the senior nurse. Adding to these 2 positions to create a small leadership team I would include the senior allied health professional (Team Leader) and the senior teacher. The leadership team should oversee both residential and day program components as one integrated team. The final management structure needs to be decided by CHQ HHS as it will need also to be compatible with their organisation structure.

Comment on QHC and their AETC staffing model

I am mostly in agreement with the CHQ HHS comments and modelling. I agree there are a great many unknowns with the residential cohort, facility and intervention model and there is a strong imperative to provide patient safety as well as effective intervention. While patient safety should be central in operationalising the AETC it is particularly pertinent considering the history from which the AETC arises. I recognise sufficient staff are needed to ensure an adequate recovery focused and rehabilitative program and make full use of the facility. I recognise there are inefficiencies for staffing around the geographical location of the AETC and current organisational structures of HHS. I recognise a hospital based mental health service has been commissioned to run the AETC and this has implications for the staffing profile. CHQ HHS should be expected to run the unit at a certain level of efficiency (see above) and be supported to do this with reporting structures in place to clearly inform the funder regarding activities.

Specifically commenting on the CHQ HHS model I understand the nursing staff numbers being proposed is essentially parallel to an acute adolescent inpatient unit. This is probably a sensible starting point but the role and day-to-day work is likely to be quite different. However, running a rehabilitation focus is staff intensive and one might hope the AETC will have a higher occupancy than acute adolescent units. Nursing staff also provide the frontline with patient safety. One might wonder if a lower number of nurses are needed considering the rehabilitation verse acute focus of the AETC. This is especially so during the weekday school hours. While recognising the roles of mental health staff and teachers are different nevertheless the total number of staff managing the patient group is also relevant and may provide efficiencies during the school day. The needs of the residential cohort during the school day is unclear and as such so is what will be required of the nursing staff.

I see the nursing unit manager (NUM) and team leader are listed as separate 1 FTE each and I assume provide operational management of the residential and day program components respectively. There is also a Program Manager who I understand they will report to.

As well as the Clinical Director (child and adolescent psychiatrist) at 1 FTE, the model makes allowance for another 1.0 FTE (2 x 0.5 FTE) psychiatrist and 2 FTE (0.5 and 1.5 FTE psychiatric registrar). This may be in line with how other day programs and subacute services are medically staffed in Queensland. This seems adequate and is likely to allow consultant and psychiatric registrars to be actively involved in case coordination and delivering therapeutic interventions rather than psychiatric overview only.

CHQ HHS lists a total of 11 FTE allied health some of who will be mental health clinicians. This includes speech pathology, occupational therapy, social work, psychologist at 2 FTE each distributed evenly between the residential and day program components. Also music therapist, art therapist and exercise physiologist at 1 FTE each. There is a dietician listed at 1 FTE. I would think the social work, psychologist and occupational therapy (6 FTE) will function as mental health clinicians and would be used in case coordination both pre-admission and during admission; provision of individual, parental and family therapy; providing milieu psychotherapy groups; plus various amounts of discipline specific assessment and active in the functioning of the MDT. From my modelling this 6 FTE of mental health clinicians (providing assessments, care coordination, individual, family and parent psychotherapy and psychotherapy groups) will be short here to meet the demand of 22 patients depending on what resources are pulled from psychiatric registrars, nursing staff and more specialist therapists functioning more broadly. The 2 FTE speech pathologist may function similarly as broad mental health clinicians or alternatively be focused on discipline specific assessment and intervention including both communication and social skills or relationship intervention which might be quite large in the AETC cohort. If providing specific speech pathology skills I expect 2 FTE is not needed and 1 FTE would be sufficient. In terms of music therapy, art therapy and dietetics each of these skills will be necessary but it is hard to see they are required for 1 FTE each. These specialists will need to provide training, supervising and support for nursing staff undertaking these activities so will need to be very skilled and ideally senior. Alternatively these specialised therapists may also function more broadly in the team as care coordinators, providing various psychotherapies, milieu group therapists et cetera and contribute to the overall mental health clinician FTE needed. To actively address physical health and exercise is needed and I imagine the exercise physiologist will coordinate this; however again it will

mostly be delivered by nursing staff and maybe peer support workers. It is hard to see a full FTE will be used.

The CHQ HHS Model includes no neuropsychologist. I think there will be a need for a neuropsychologist at least as a consultant at 0.4 FTE with need to be clarified over time.

The model lists 6 peer support workers who will be working shifts and on weekends as well one peer worker support coordinator. The model lists 1 FTE carer consultant. I do not agree with this much greater emphasis on peer support verse carer consultant. Considering the AETC statewide catchment and the distance and challenges some families will experience in accessing the AETC I think there is a greater need for carer consultants if they are to provide active support for parents/carers. These figures might be clearer when position descriptions are finalised and there is greater clarity of the roles including the part they will play in intake and advisory function to operation of the AETC.

An indigenous health worker at 1 FTE is listed. Clearly such a worker will be needed if there are indigenous young people but it is unclear currently to what extent this group will make up the cohort. The consultation process to date does not seem to have been successful in including this population. Rather than employ someone for 1 FTE I wonder if there is a better way to arrange this or at least to allow time to wait and see what is the need. Consideration for staffing and processes to support inclusion of other groups, such as CALD and diverse sexual orientation, gender identity and intersex variations needs to be considered.

Missing from the CHQ HHS model is someone responsible for managing the evaluation. This should be separately funded. The QCMHR who are developing the evaluation

framework can best give an indication of the needed allocation. I expect it needs to be 0.5 – 1 FTE.

Also worth considering is who would manage and ensure adequate IT services including videoconferencing which is likely to be an essential tool for the statewide AETC.

Other roles are listed in the CHQ HHS model are essentially out of my expertise and I have not commented on.

To help with clarity I have outlined my suggestions here for a potential staffing profile in a Table (Appendix C).

Adolescent Extended Treatment (AET) Model of Service (MOS) Document

Overall, I think this document is well progressed and on track to appropriately describe the function of the AETC. In terms of detail I have made a range of specific comments below as suggestions for improvement or raising questions to be considered. I have used the structure of the AET MOS document to outline my points:

4.1.2 Needs to address the management of school holiday periods

4.2.1 I suggest an option for ongoing specialist mental health care post discharge is clearly identified prior to admission (even if reviewed and alternative discharge care is arranged during admission).

4.2.2 I suggest not using “brief” but something like “sufficient assessment to develop a collaborative plan with the adolescent and parents/carers for the initial assessment phase of the admission”. Assessment should also include the local service systems commitment and capacity for ongoing care post discharge (i.e. beginning discharge planning prior to admission). A note could be made about the use of videoconferencing.

4.2.3 I would add in the ‘Comment’ something like “manage risk and identify obligations of all parties in the management of risk”

4.3.2 In ‘Comment’ add “psychosocial functioning” into the formulation

4.3.3 I think some definition of ‘recovery’ and ‘rehabilitation’ should occur in the document. Both can be used but they seem to be used somewhat interchangeably.

4.3.5 I do not agree here. A Recovery Plan, at least to guide the initial assessment period, is based on a problem-based initial interview. Then further assessment following initial admission period leads to collaborative review and further development of a Recovery Plan.

I think a basic agreed Recovery Plan should be in place prior to admission at least to facilitate the assessment phase.

To “Diagnosis of” add “formulation”.

4.3.6 Refer to CALD populations

4.3.7 Maybe add diverse sexually orientation, gender identity and intersex variations.

4.3.8 Under “risk assessment will occur” – I agree with this except for the last phrase “every three months” which should either be IFTE out or made more frequent.
Under ‘Comment’ re-risk assessment I think the concept of ‘Developmental Risk’ is very useful in a subacute recovery orientated/rehabilitative setting.

4.3.9 I wonder if some higher level of organisational engagement with child protection might be useful rather than just ad hoc contact around particular cases.

4.3.10 I would shift this section on metabolic monitoring for adolescents on antipsychotic medication to section 4.6.1. Identifying who is responsibility for ongoing monitoring post discharge should be addressed.

4.3.13 This section should include the Evaluation (when that is decided).

4.4.1 I think the parents/carers goal should get a mention here.
Under ‘Comment’ when “conflicting goals exist” should be considered a therapeutic opportunity to resolve. Some level of conflicting goals can be work with but this may also indicate admission to the AETC is not helpful and review is required.

4.4.2 In discussion re-Individual Recovery Plan under Key Elements the comment “where possible” makes no sense as goals must always be collaborative and the adolescent involved in planning for the admission to be helpful.
Under ‘Comment’ suggest you use term or phrase ‘developmentally informed’.
I suggest Recovery Plans are led by the adolescent but reflect the shared collaborative plan between the adolescent, their parent/carer and treating professionals that reflects

agreement about the problem, what is useful (and planned) to do and what is the desired outcome/goal. The emphasis should be on being collaborative.

4.5.2 I suggest add after “biopsychosocial, developmental…” the terms ‘family systemic’ and ‘contextual’ before “framework”.
I suggest after “reduce severity of symptoms” add “improved age-appropriate functioning”.

4.7.1 Maintaining safety will be critical. The (eventual) chosen clinical model will assist and the models will helpfully outline the responsibility of the adolescent, parents and staff/unit. Use of restrictive interventions should lead to review of admission as it seems at odds with the overall MOS of the AETC.
Suggest sexual safety on the unit needs to be addressed to a greater extent in the MOS (especially if decision is made to admit adolescents over 18 years).

4.7.2 See previously comments re-restrictive interventions.

4.8.1 I suggest a separate section on Discharge Planning may be in 4 .11.
I expect there will be a mini team of clinician, nurse and teacher for each patient and I wonder if this should be acknowledged in the MOS.

14.13.3 The document suggest progress notes and medical records will be hard copy not electronic and I wonder if this is correct.

Section 4.14 I suggest adding a section on the use of the two family units in AETC functioning and treatment.

4.9.1 I think a statement about successful functioning of the MDT is important and some comment on need for a coherent clinical approach is useful.

I do not think Aboriginal and Torres Strait Islander Peoples, CALD and diverse sexual orientation, gender identity and intersex variations belong here and have an earlier section.

Suggest the role of supervision for effective clinical functioning should be further emphasised here.

4.15 I suggest check terminology for consistency re-peer support workers (carer) or Carer Consultants used in other documents.

Section 9 Staff Education and Training – in paragraph 2 there is a sentence “Current literature identifies…” which needs to be expanded and referenced or alternately leave out for the MDT leadership to develop a clinically coherent model in due course that is based on the literature.

Some further comments:

- There needs to be some comment about drugs, nicotine and alcohol use included in the MOS.
- While I have not formally reviewed the AMOYS MOS it includes a section (4.6.2) titled Theoretical Frameworks. I think a similar section in the AET MOS would be useful although this awaits decisions about the clinical model by the MDT clinical leadership team.

Adolescent Day Treatment (ADT) Model of Service (MOS) Document

I have not provided detailed suggestions for this MOS in the same detail. I recognise it is much more developed then the AET MOS and generally reads well. There are many aspects of this MOS that could be usefully included or copied in further development of the AET MOS including:

- There is some useful terminology such as ‘Preliminary Assessment ‘, ‘Initial Assessment Process’, ‘Preliminary Formulation’, ‘Assessment of Family Structure and Dynamics’ and ‘Functional Assessment’ that might be useful in the AET MOS.
- In 5.5.1 under ‘Comment’ in part 1 it uses the description “disrupted developmental trajectories” and “recovery plans need to address developmental needs” which might be useful terms in the AET MOS.
- The Team Leader’s role providing clinical and operational guidance (in a day program) and the consultant psychiatrist’s role with clinical governance is more clearly defined here and this might be useful in the AET MOS.

The ADT MOS does not address integration across the AETC of the residential and day program components and this needs to be done separately. I note that within the ADT MOS comment is made about Day programs co-located with acute adolescent inpatient units and providing programs to inpatients alongside day patients which might provide some useful information for integration in the AETC components.

CONCLUSIONS

I have provided much commentary and discussion including about the likely cohort of the AETC; its implication for a clinical theoretical framework as well as staffing; integration the AETC into the wider child and adolescent mental health system; the integration of the AETC residential and day program components and my view about a potential staffing profile. I have made some specific suggestions to try and help further develop the AET MOS. In terms of more specific summarising comments:

- My view is the consultation process around the AETC has been very good and progress on developing the AET MOS is on track.

- It is difficult to make specific recommendations about the staffing profile but I have outlined my thought and made comment on the CHQ HHS model. I largely support their staffing profile model. In terms of my view I thought there was a need for more broader trained mental health clinicians (psychologists, occupational therapists, social workers) to manage assessments, care coordination and provision of psychotherapies; or at least to identify who would do this broad mental health clinical work. While recognising the need for specialist therapies (art, music, dietitian and exercise physiologist) I would have thought substantially less time needed to be allocated to these. I also suggest more carer consultant time and some neuropsychology time is required.

- I think many things about running the AETC are unknown and will only be known when it is up and running. In the meantime it seems prudent to make decisions that are safe. This may lead to over estimating the need for staff in the AETC. I suggest as well as ongoing evaluation of the AETC that a substantial review occur after 2 years and many of the current questions be considered again at that time.

- I think there is an obligation to evaluate this novel intervention component. The quality assurance component of this should be funded as part of the running of the AETC and include a funded position to manage the evaluation. Additional research partnerships with universities or research institutions could be explored.

Dr Paul Robertson

Child & Adolescent Psychiatrist

APPENDIX A

Youth Mental Health Program
TERMS OF ENGAGEMENT FOR INDEPENDENT EXTERNAL CONSULTANT EXPERT ADVICE

Operationalising the Model of Service for the Statewide Adolescent Extended Treatment Centre

1. Overview of statewide Adolescent Extended Treatment Centre

The statewide Adolescent Extended Treatment (AET) Centre will be a new service (with no precedent for the model in Australia) for adolescents with severe and complex mental health needs. Its development is a response to the recommendations and Government response to the Barrett Adolescent Centre (BAC) Commission of Inquiry (COI) report. A service of this type is not explicitly identified in the National Mental Health Service Planning Framework (NMHSPF), however the service demand for the cohort of young people who may use the service has been modelled across acute, subacute and nonacute bed-based services.

The Government commitment is to provide 12 residential places/beds (with a state-wide catchment) and 10 day treatment places (local community catchment) at the AET Centre with the therapeutic and rehabilitative care received by the young people residing in the AET Centre to be fully integrated with educational and vocational support. Most of the treatment and rehabilitation provided to the residents will occur during the day time.

The AET Centre will provide a statewide service for all HHSs in Queensland consistent with the Statewide Services Governance and Risk Management Framework developed as the Government response to recommendation 1 of the BAC COI report.

The build and delivery of the statewide AET Centre is part of the Youth Mental Health Program being managed in the Mental Health Alcohol and Other Drugs Branch (MHAODB) through the Child and Youth Policy Team (for Reform work) and Mental Health Strategy and Planning Team (for Capital work). This has included consultation with key stakeholders, including consumers and carers.

The AET Centre is being built on The Prince Charles Hospital (TPCH) campus in Metro North Hospital and Health Service (HHS) in Brisbane and will be operated and owned by Children's Health Queensland (CHQ) HHS.

The Department of Education (DoE) will be responsible for staffing and operating the educational and vocational support program in the AET Centre.

2. Model of Service

The development of the statewide AET Model of Service (MOS) began with a series of stakeholder workshops, public release of a preliminary MOS for comment and thematic analysis; an external MOS process review and report in May 2017[1]; and the facilitation of a series of youth mental health forums across the state in 2017. There has been ongoing revisions, feedback and development based on all these consultations including suggestions provided in the Robertson (2017) external MOS process review report.

The current revised version of the AET MOS document focuses primarily on the statewide subacute element of care for the 12 residential places/beds. The day treatment provided to both the state-wide cohort and the local cohort is reflected in a revised Day Treatment MOS (a MOS document that already guides other Day Treatment services in the state such as campus and community based Day Programs).

Both the AET MOS and the Day Treatment MOS are currently being used to inform operational planning including development of an appropriate staffing profile. The MHAODB has also engaged the Queensland Centre for Mental Health Research (QCMHR) to develop an evaluation framework for the new statewide AET Centre and this is currently underway.

The AET 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 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 HHS specific patient safety procedures and should be read in conjunction with a range of other policy, legislation and operational documents (some of which are listed in the AET MOS and others that will be available locally to the HHS).

The MOS documents also seek to support Aboriginal and Torres Strait Islander peoples and those of Culturally and Linguistically Diverse backgrounds requiring additional consideration have 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 MOS in the AET Centre 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.

[1] Robertson, P. (2017), External Review: Model of service (MOS) for the state-wide adolescent extended treatment and rehabilitation facility (AETF) accessible at: https://www.health.qld.gov.au/__data/assets/pdf_file/0034/662578/external-review-aetf-mos.pdf

3. Consultancy (external advice) specifications

As there is no precedent for this model of service in Australia, the Executive Director, MHAODB is seeking independent clinical expert advice on operationalising both the AET MOS and the Day Treatment MOS in the new statewide AET Centre. This advice will inform the staffing profile of the new statewide AET Centre.

The Consultant's advice will take into account:

- fidelity to the model,
- safe delivery of services,
- integration of services, and
- flexibility to meet the unique needs of the cohort of young people that might use the service in the future.

The MHAODB is keen to ensure that the day treatment for the 12 residents (statewide component) is integrated with the day treatment accessed by the local community participants (10 places).

Health service delivery elements will be integrated on a day-to-day basis with the educational/vocational service component provided by the DoE at the AET Centre to all students.

Staffing requirements to safely deliver the AET MOS for both the state-wide cohort and the local cohort are critical. The MHAODB and CHQ HHS both note that the AET Centre has quite a large footprint.

The Consultant will make recommendations about operationalising the MOS for the AET Centre to inform development of a staffing profile as a result of the consideration of the above issues.

4. Key deliverable

The Consultant will provide a final written report to the Executive Director, MHAODB covering the key elements (as outlined in section 3) by close of business Friday 29 March 2019.

5. MHAODB support

- Convene information briefing sessions in Brisbane (over two days on Friday 8 March and Monday 11 March 2019) for the Consultant to meet with each agreed key stakeholder/ organisation. This will include key personnel able to provide contextual information about development of the MOS to date, the initial staffing profile, background issues and other relevant information to operationalising the MOS in the new AET Centre.
- Provide other support as agreed to assist the Consultant.
- 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

MHAODB will provide a range of background documents including the AET Centre floor plans, AET MOS, Day Treatment MOS and other relevant briefing materials as background including:

- AET MOS
- Day Treatment MOS
- Youth Step Up Step Down Service MOS
- Mental Health continuum of care services diagram
- QCMHR Advisory Group Terms of Reference
- Day Program background paper
- Statewide Services Governance and Risk Management Framework
- AET Centre Site plan
- AET Centre Aerial view drawing
- AET Centre General Arrangement plans
- AET Centre De-escalation room layout
- AET Centre Seclusion room layout
- AET Centre Sensory room layout

7. External consultant

The independent external Consultant will be recognised by their peers as a senior Child and Adolescent Psychiatrist.

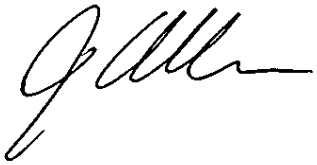
8. Confidentiality

The Consultant may receive information that is confidential, and/or have privacy implications. By accepting the appointment, the Consultant acknowledges their responsibility to maintain confidentiality of all information that is not in the public domain.

9. Amendment, modification or variation to these terms of engagement

These terms of engagement may be amended, modified or varied by the Executive Director, MHAODB in discussion with the Consultant.

Terms of engagement endorsed by:

Signed:…  Dated:…04/03/2019

Associate Professor John Allan
Executive Director, MHAODB

APPENDIX B

Youth Mental Health Program
External Advice – Consultant Run Sheet

Schedule of meetings

Time	Stakeholder
Friday, 8 March 2019	
9:00am – 10:00am	**Mental Health Alcohol and Other Drugs Branch** (MHAODB) including Child and Youth policy team & Mental Health Strategy and Planning team
10:00am – 10:30am	*BREAK*
10:30am – 11:30am	**Consumer and carer** representatives (supported by **Health Consumers Queensland**)
12:00pm – 2:00pm	**AET Centre Site Visit** (includes LUNCH BREAK)
2:00pm – 3:00pm	**Queensland Centre for Mental Health Research** (QCMHR)

Time	Stakeholder
Monday 11 March 2019	
8:30am – 9:30am	**Department of Education** (DoE)
11:00am – 1:00pm	*BREAK (includes LUNCH)*
1:00pm – 2:00pm	**Children's Health Queensland Hospital and Health Service** (CHQ HHS)
2:00 – 3:00pm	**Executive Director, MHAODB**

APPENDIX C

TABLE: Outline of Staffing Profile Suggestions by Dr Paul Robertson

Clinician	Discussion	Suggested FTE
Nursing staff	Suggest staffing at same level as acute adolescent inpatient unit but clearly document the differing nursing role in a subacute setting. Required nursing staff numbers during day program hours (school hours) will depend - on number of residential component adolescents not in the day program during the school day. - role of residential nursing staff in supporting the day program during this time.	As per numbers for acute adolescent inpatient unit.
Mental Health Clinicians - (Providing: • pre-admission assessments, • case coordination, • individual, family and parent psychotherapy, • group psychotherapy and • fully functional in MDT)	Those mental health clinicians providing broad mental health assessment and interventions in the residential and day program will be essential for the successful functioning of the multidisciplinary team (MDT). Clinicians providing this clinical input are likely to be: • Psychologists (aside from specific role in psychometric testing) • Occupational Therapists • Social Workers Some of the role may also be provided by: • Psychiatric registrars • Speech Pathologists (but more likely to be doing more focused specific professional work) • nursing staff	10 FTE

Clinician	Discussion	Suggested FTE
Speech pathologist	In term of specific assessment and intervention delivered by Speech pathologists I suggest 1 FTE. Speech pathologists may play a role as broader mental health clinicians or in delivering the group therapy program ie communication, social skills and relational interventions above the 1 FTE (and included in the broader mental health clinicians)	1 FTE
Clinicians bring specialist skills only: • Art therapist • Music therapist • Dietitian • Exercise Physiologist	These role and skills are likely to be very valuable in delivering: • Specific interventions, • Educating, supervising and supporting nursing and peer support workers in using activities and the opportunities provided by the AETC. I think the roles and allocation of time of these clinicians bring specific skills needs to be determined later after the program is more developed by the MDT leadership team.	To be determined later by the MDT Leadership team but plan for 1-2 FTE in allocation
Neuropsychology	Specific high level neuro-cognitive assessment and integration will be required. I think much of this will be complicated and required a specialist neuropsychologist (as well as some allocation of psychologist time.	0.4 FTE But may need to be reviewed after experience with cohort reveals need.
Medical Staff	I think 2 psychiatrists (including clinical director/clinical head) is appropriate. I think 2 psychiatry registrars or trainees is appropriate. Paediatrician - both developmental and adolescent health required. Amount also determined by decision to include or not adolescents with combined psychiatric and physical illness. Also determined by potential support provided through The Prince Charles Hospital paediatric service.	Psychiatrists - 2 FTE Psychiatry Registrars - 2 FTE Paediatrician 0.4 FTE (if including comorbid medical illness in cohort)
Clinical Leadership Team	Should include psychiatrist clinical director; senior nurse; team leader representing mental health clinicians and senior teacher. Leadership structure should reflect CHQ structure.	

Clinician	Discussion	Suggested FTE
Peer support workers	The idea of peer support workers working shifts in evening and weekends is positive. The impact of this on nursing workload is unknown. Clarification of specific role is required to determine recommended numbers.	To be determined
Carer Consultant	I think carer consultant role is valuable. I understand they would have a role in supporting parents. Also a (advisory) role in the broader governance and functioning of the unit. Clarification of specific role required to determine recommended numbers.	To be determined
Specific access to services of support workers: • Indigenous health worker • CALD • Diverse sexual orientation, gender identity and intersex variations	The need for these services will be determined by the cohort. These services need to be available but the best way to provide these is unclear. The size of demand in the cohort and considerable variation for time to time suggests a more flexible arrangement for these staff is needed then employing someone for set hours	To be determined
Professional to run evaluation/ research	QCMHR better able to recommend what is required. I suggest the Quality Assurance (QA) component be funded via the AETC funding. Further research to be via other arrangements (to be determined).	0.5 - 1 FTE for QA component