# State-wide Adolescent Extended Treatment (AET) Model of Service (MOS)

## Queensland Public Mental Health Services

## February 2020

Queensland Government

**State-wide Adolescent Extended Treatment (AET) Model of Service (MOS)**
**February 2020**

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An electronic version of this document is available at https://www.health.qld.gov.au/improvement/youthmentalhealth

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# Preamble

In July 2016, the Queensland Government released its response to the Barrett Adolescent Centre (BAC) Commission of Inquiry (COI) Report. This included a commitment to build a new state-wide extended treatment and rehabilitation centre, named Jacaranda Place – the Queensland Adolescent Extended Treatment Centre (Jacaranda Place), for adolescents experiencing severe and complex mental health issues in south-east Queensland, with access to an integrated educational/vocational training program, including access to day treatment places for local adolescents. An undertaking was made that consumers and carers (including those associated with the former BAC) would be an important stakeholder group in planning processes for this new service element.

The *Preliminary* Model of Service released for public consultation in January-February 2017 provided broad principles and direction to guide the early development of the new, state-wide adolescent extended treatment model of service (AET MOS). Its development represented a critical step forward in the realisation of a more comprehensive continuum of mental health care options for adolescents in Queensland as described in *Connecting care to recovery 2016-2021: A plan for Queensland's state funded mental health, alcohol and other drug services.* By providing a new service element that combines public mental health, educational and vocational services to young Queenslanders it is anticipated that their capacity to lead healthy, hopeful and fulfilling lives in the future is enhanced, with benefits also flowing to their family, friends and the broader community.

The state-wide AET MOS is not a final product but embeds a process of evolution in response to feedback from a range of sources. These include clinical and service review, research, emerging evidence, and the continuing inclusion of the perspective of carers and adolescents into the future.

# Purpose of this document

The state-wide AET MOS describes a new, state-wide service element within the Queensland public child and youth mental health, alcohol and other drugs service system. This service element provides integrated mental health extended treatment and rehabilitation care with educational and vocational opportunities for adolescents experiencing severe and complex mental health issues.

The intended outcomes of the development and successful implementation of the state-wide AET MOS at Jacaranda Place are:

- an enhanced continuum of mental health service options for adolescents in Queensland
- an adolescent and carer-centred, recovery based system of care
- the delivery of safe, high quality, integrated, and evidence-driven mental health care alongside the provision of integrated, individualised educational or vocational programs that enable adolescents to re-engage with education and to undertake meaningful education or employment in the future
- stronger service partnerships with a network of providers
- enhanced service development, evaluation and review
- improved access to and navigation through mental health services
- a more informed and supported mental health workforce
- enhanced supervision of the clinical and non-clinical workforce
- consistency and streamlining of service delivery across public mental health services in Queensland
- increased knowledge and understanding of other service components
- clear and transparent governance structures.

The state-wide AET MOS seeks to be inclusive, ensuring that Aboriginal and Torres Strait Islander People, those of Culturally and Linguistically Diverse (CALD) backgrounds and people of diverse sexual orientation, gender identity or intersex variations requiring additional consideration are provided with accessible, high quality, culturally appropriate mental health treatment and care.

This state-wide AET MOS has been informed by reference documents, broad consultation and expert opinion from staff, consumers, carers and an independent reviewer. It does not replace clinical judgement or Hospital and Health Service (HHS) specific patient safety procedures and should be read in conjunction with a range of other policy, legislation and operational documents which are listed separately for reference.

# 1. What does the State-wide AET MOS intend to achieve?


*(Aspirational Words from Preliminary MOS Workshops, Oct-Nov 2016 Participants)*

The state-wide AET MOS extends the continuum of mental health service options available to adolescents experiencing severe and complex mental health issues and their families/carers across Queensland with the least possible disruption to their family, educational, social and community connections.

The core purpose of Jacaranda Place delivering the state-wide AET MOS is to provide inpatient treatment and rehabilitation for an extended period that fully integrates mental health and educational/vocational training components. The state-wide, extended treatment and rehabilitation places will be delivered in conjunction with 10 Day Treatment places accessible to adolescents from the local geographical area (see Day Program MOS).

The state-wide AET MOS is premised on the approach that adolescents can and do recover from mental health issues. Service delivery will take a recovery-oriented approach that emphasises individual strengths, builds resilience, enhances opportunities for social inclusion and works collaboratively with the young person and their family, carers and significant others to recover their health, wellbeing and developmental potential.

Adolescents and their support network will experience a smooth and continuous progression in care as they move into and out of the centre, as they access the residential beds, treatment, rehabilitation and educational/vocational training components. They will be supported to identify personal, clinical, service or other relationships that contribute positively to their mental health recovery. Whenever possible, these relationships will be supported throughout all stages of their care. Consideration of less restrictive, follow up treatment options will commence from the time of admission to optimise engagement of the adolescent, their family and carers in decision-making processes and to ensure transition occurs in a timely and progressive manner (Refer to the Department of Health *Guideline for the transition of care for young people receiving mental health services*, 2019).

*Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services* outlines Queensland's mental health, alcohol and other drug system

continuum of care[1]. The state-wide AET MOS describes only one element from the continuum of service elements available to assist adolescents (working collaboratively with their families and carers) to recover their health, wellbeing and developmental potential (see Figure 1).

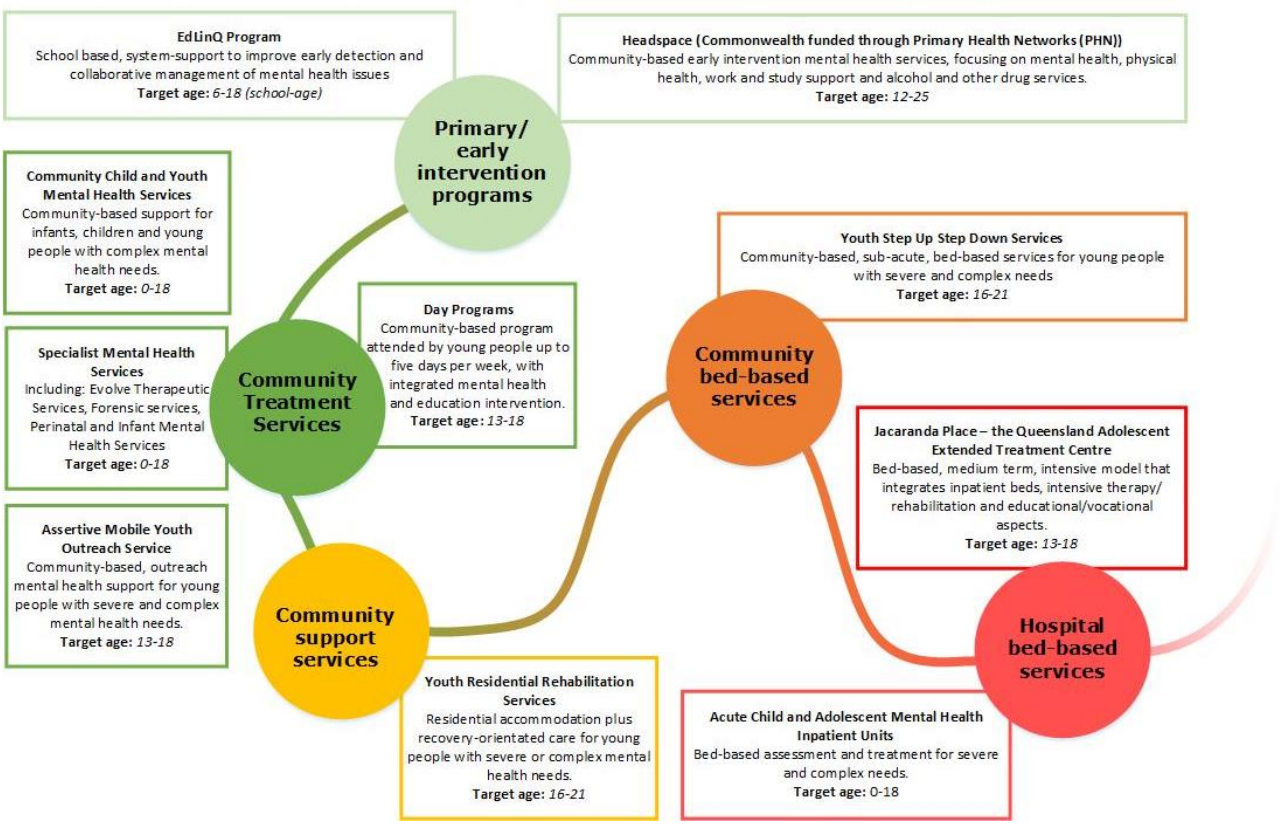


**Figure 1:** Broad overview of child and youth mental health, alcohol and other drugs service system in Queensland

The state-wide AET MOS has a target length of stay up to six months. However, clinical judgement about individual needs and circumstances is an important factor to be taken into consideration in determining this for an adolescent in Jacaranda Place.

Adolescents and their network including families, carers and significant others will be supported to actively participate in collaborative, recovery-oriented, care planning and care related, decision making processes while taking account of their developing abilities. This enables adolescents and their families to build their strengths, hope, dignity, and connectedness.

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf

The state-wide AET MOS provides for 24 hour assessment and care with integrated educational and vocational training opportunities that is safe, therapeutic, inclusive, culturally sensitive and informed by research. This includes:

- Collaborative partnerships with cultural representatives to ensure services provided are accessible, high quality and culturally appropriate to Aboriginal and Torres Strait Islander People and those from CALD backgrounds.
- Collaborative partnerships with health providers, including community based Child and Youth Mental Health Services (CYMHS), Headspace, Community Controlled Aboriginal and Torres Strait Islander Health Services and General Practitioners (GPs).
- Identification of clear and transparent governance processes that support predictable and equitable access to Jacaranda Place by adolescents from all areas of Queensland.
- Embedded regular and mandated internal and external evaluation processes which review clinical and service level factors and may contribute to the knowledge base of public mental health services for adolescents with severe and complex mental health issues.
- Reviews of the MOS by Queensland Health's Mental Health, Alcohol and Other Drugs Branch (MHAODB), and when indicated, modifications informed by evaluation, data collection, policy and research.

# 2. Who is Jacaranda Place for?

Jacaranda Place is for adolescents across Queensland with a primary diagnosis related to severe and complex mental health issues, who would likely benefit from an extended treatment and rehabilitation model (as assessed by the state-wide intake panel), who haven't been responsive to other care options (continuum of service elements) and can be safely managed in a sub-acute setting.

The state-wide AET MOS describes extended treatment and rehabilitation with a target length of stay up to six months but should be used in conjunction with clinical judgement about individual needs and circumstances. It supports the provision of a fully integrated inpatient, assessment, treatment, and rehabilitation services alongside educational/vocational training aspects with the least possible disruption to an adolescent and their family's community connections.

Consistent with the description of sub-acute service elements in the National Mental Health Services Planning Framework (NMHSPF) the state-wide AET MOS is intensive (provides a structured environment) and rehabilitative (improves overall functioning), with improvements anticipated in weeks and months as opposed to days and weeks (acute service elements).

The adolescent will:

1. Generally be aged between 13 and 18 years at the time of admission to Jacaranda Place. However, the intake panel may include adolescents up to 21 years who have developmental needs more effectively treated within an adolescent model.
2. Have severe, and probably persistent symptoms associated with some level of risk to themselves and/or others that can be managed safely in a sub-acute setting and do not require the resources of an acute inpatient unit.
3. Have a primary mental health diagnosis and this will likely be associated with:
    - indicators of complexity (e.g. social isolation, role disengagement, complex trauma, developmental delays, family problems etc.) and
    - co-morbidities (e.g. intellectual disability, substance use, physical health issues etc.).

Eligibility is not restricted to particular disorders/diagnoses but rather reflects the interaction between:

- symptom severity
- risk to self and others
- complexity
- intervention history (including previous admissions to Jacaranda Place).

Maintaining a safe and therapeutic environment for the target population of 13-18 year olds is considered a priority. However, it is recognised that the daily functioning of adolescents experiencing severe and complex mental health issues may not align well with their chronological age. Therefore, in addition to chronological age, overall functioning of the adolescent may be used to inform decision making about the appropriateness of an admission to Jacaranda Place where they are older than 18 and up to 21 years of age.

Onsite educational and vocational training programs will be facilitated for adolescents of compulsory school age or those participating in post-compulsory education or training when attending Jacaranda Place.

If an adolescent has not progressed toward collaboratively agreed treatment goals within the target length of stay (6 months), alternative or less restrictive options must be considered before extending the stay within Jacaranda Place.

The state-wide AET MOS provides guidance regarding target population, duration of stay, and clinical processes but should be used in conjunction with clinical judgment regarding individual needs and circumstances. Findings from the 'A review of existing clinical and program evaluation frameworks for extended treatment services for adolescents and young adults with severe, persistent and complex mental illness in Queensland: Final Report' (Queensland Centre for Mental Health Research, March 2017) anticipated that in 2016, no more than 0.2% of 12-24 year olds in Queensland would require this service element.

# 3. What will Jacaranda Place deliver?


*(Aspirational Words from Preliminary MOS Workshops, Oct-Nov 2016 Participants)*

**Jacaranda Place delivers key functions aligned with the state-wide AET MOS to**:

- Facilitate consumer-centred care of adolescents with severe and complex mental health issues in a safe, therapeutic, inclusive, culturally sensitive and supportive setting, which promotes hope, dignity, recovery and connectedness.
- Provide an extended assessment, treatment and rehabilitative model that fully integrates inpatient beds, intensive therapy/rehabilitation and educational/vocational training aspects thereby enhancing the continuum of mental health services available to adolescents.
- Deliver a range of evidence based assessments and interventions to adolescents with severe and complex mental health issues (and their support network) to facilitate shared responsibility for action and enhanced family capacity.
- Ensure students with severe and complex mental health needs receive specialised and appropriate educational and vocational training support at all stages of their care and recovery.
- Engage adolescents and their support network in all phases of care and assist them in their navigation of the mental health and education systems.
- Ensure continuity of care by supporting ongoing engagement and collaboration with the referring service provider and others identified as positively contributing to the adolescent's mental health recovery during all stages of the admission including care and recovery planning and transition following discharge. Contribute to the knowledge base of mental health services for adolescents with severe and complex mental health issues by participating in Queensland Health (QH) data collection protocols and evaluation framework.
- Offer training, consultation-liaison services and supervision to mental health service providers for adolescents throughout Queensland for the state-wide AET MOS cohort and related interventions.
- Operate in an open and transparent manner that invites and incorporates feedback from adolescents, carers and service providers at an individual clinical, centre and MOS level.
- Reflect annual reviews by the MHAODB, and when indicated, modifications informed by evaluation, data collection, policy and emerging evidence to maintain a contemporary MOS.
- Be monitored to identify ongoing fit between the state-wide AET MOS target population, the clinical profile of referred adolescents and prevalence data on adolescents with severe and complex mental health issues.

**Access:**
Referrals to Jacaranda Place will be reviewed by a State-wide Intake Panel (Intake Panel). Jacaranda Place Clinical Director will chair the Intake Panel, comprising senior clinicians, consumers and carers and a Department of Education (DoE) representative. Clinical regional representation will be included when appropriate. When considering referrals, the Intake Panel will consider the clinical resources available in the adolescent's community in addition to clinical presentation and treatment history. The Intake Panel will include additional representatives when other specialist perspectives (e.g. Aboriginal and Torres Strait Islander People, CALD) are required.

While it is important less restrictive treatment options in an adolescent's local community be fully explored prior to referral, it is acknowledged resources in some geographical areas in Queensland are limited and this will be an additional consideration during the intake process.

**Service provision:**
Intensive therapy and rehabilitation provided as part of delivering the AET MOS may include individual, group and family based interventions. Assessments may include medication trials, diagnostic clarification, physical health evaluations, multidisciplinary assessments, educational/vocational training assessments and family functioning assessments.

The state-wide AET MOS allows for the provision of consultation-liaison services, training and supervision to workers in an adolescent's local area to support them to remain in their community if possible and appropriate. This recognises the risks associated with relocation (especially to Aboriginal and Torres Strait Islander adolescents) and the very limited resources in rural and remote areas.

Support and maintenance of an adolescent's existing relationships (family, carer, peer and service) with their community is critical to the state-wide AET MOS for resilience/ social connectedness and continuity of care. To achieve this a variety of approaches (including use of technologies) will need to be employed. Support of the adolescent's educational and/or vocational training pathway will be facilitated through the co-located educational program.

Jacaranda Place is a gazetted authorised mental health service which will operate in accordance with the *Mental Health Act 2016* and exists within the spectrum of integrated mental health services and other health services.

The state-wide AET MOS integrates a component that is a State educational service, which will operate in line with the same legislation, industrial agreements, directives, whole of government policy and national agreements as all other State educational services (including state schools). Trained and registered teachers will deliver education and vocational training programs catering for this specialised cohort.

A day in the life of an adolescent (in Jacaranda Place delivering the state-wide AET MOS) may include activities in see Figure 2 below.


**Figure 2:** Excerpt taken from Visual AET MOS document

# 4. Standard components

The state-wide AET MOS does not detail the mandatory and fundamental operational business requirements, processes or procedures of a standard, public mental health service. These fundamental requirements should be embedded within all mental health services and aligned with national and state-wide guidelines and protocols including but not limited to:

- National Safety and Quality Health Service Standards (2nd edition)
- National Standards for Mental Health Services 2010
- Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services
- Clinical Services Capability Framework
- Mental Health, Alcohol and Other Drugs Performance Framework
- Hospital and Health Service Performance Management Framework
- National Framework for Recovery Oriented Mental Health Services
- Mandatory reporting requirements under the *Mental Health Act 2016*
- National Outcomes and Casemix Collection (NOCC)
- Guideline for the transition of care for young people receiving mental health services

Clinical forms are dynamic documents requiring regular reviews to ensure consistency with current evidence based practice and maintain efficacy of use. Forms are for documenting clinical information but are not a substitute for skills, training, supervision or judgment. Clinical judgment regarding an adolescent's needs should always guide the completion of forms.

All documentation and clinical forms referred to in this document are accessible through the QH intranet (QHEPS) MHAODB resource page.

The educational and vocational training program of instruction delivered by registered teachers is governed by and aligned to:

- The Education (General Provisions) Act 2006
- Every Student Succeeding – State Schools Strategy 2019-2023
- The Australian Curriculum
- P–12 curriculum, assessment and reporting framework
- Standards for Registered Training Organisations (RTOs) 2015
- Learning and Wellbeing Framework
- Inclusive education policy
- Department of Education and Training Strategic Plan 2018-2022

# 5. The State-wide AET MOS functions best when:

- There is a common language and understanding amongst all clinical and educational staff about the importance of:
  - the adolescent's perspective
  - a sense of hopefulness and respect
  - the importance of individualised interventions designed to minimise risk and increase protective factors
  - the need for an integrated approach to the delivery of services provided to high risk adolescents and their families.
- Adolescents, family and/or carers, and other service providers are engaged and involved in all aspects of care and recovery planning and delivery.
- Existing familial, social, educational/vocational training and service relationships are actively supported in recognition of their role in positive future mental health outcomes and integrated into holistic care and recovery planning.
- There is an explicit attitude that adolescents can and do recover from mental health issues and that recovery-oriented services emphasise individual strengths, build resilience and enhance opportunities for social inclusion.
- The physical environment supports healing.
- There is a culture of openness and responsiveness to service user feedback.
- A range of performance, quality and safety indicators are actively utilised to inform service planning and provision.
- Clinical governance is intrinsically embedded throughout all processes and practices within the state-wide AET MOS ensuring decision making from intake to discharge are transparent and accountable to stakeholders, and follow established procedures.
- Service delivery is well integrated, with established procedures that support continuity of care across settings and between services, acknowledging the particular challenges of transitioning from inpatient to community care, and adolescent to adult services.
- There is adherence to evidence informed care, treatments, interventions and processes.
- Education and vocation training programs are individually planned, monitored, adjusted where necessary and integrated as part of the holistic care plan.
- There is an appropriate mix of education staff to ensure the delivery of the educational and vocational training programs across a range of age and curriculum and extra-curricular areas.
- There are clear and strong clinical and operational and educational leadership roles which recognise each other's strengths and work to form a collaborative relationship.
- Staff are provided with strong professional support and training.
- Staff are provided with peer supervision/clinical supervision, including reflective practice and debriefing opportunities.

## 5.1 Working with other service providers

| Key elements | Comments |
|---|---|
| **5.1.1**<br>The AET MOS[2] exists within a continuum of integrated mental health services, in partnership with DoE, and within a broader network of services across both the private and public sectors.<br><br>Strong and collaborative partnerships are necessary to enable the adolescent's service and support network to be maintained and enhanced.<br><br>Given the severity and complexity of adolescent needs, their family and carer needs, and an array of services, working together from a common understanding is the optimal treatment approach. | Clear, regular contact and communication processes maintained for all phases of care.<br><br>Prior to admission ongoing specialist mental health care will be identified for post discharge support.<br><br>When adolescents attend services from outside of their usual community, these service linkages and partnerships will carry additional importance.<br><br>The AET MOS provides for advice, education, supervision and support on mental health issues to other services. |
| **5.1.2**<br>A formal agreement exists with DoE who deliver the education and vocational training program as part of the AET MOS integrated service. | DoE will provide teaching and education support staff to facilitate the provision of an age-appropriate educational and/or vocational training program for students.<br><br>DoE will utilise the facilities provided on a co-location basis and work with QH to develop protocols and processes regarding the use of these facilities during and after school hours. QH and DoE will have an agreed plan for the management of school holidays.<br><br>The partnership between QH and DoE will occur at both a state systemic level and a local level.<br><br>The partnership between QH and DoE will occur within lawful information sharing, including consideration of consent requirements. |
| **5.1.3**<br>There is engagement with primary health care providers to meet the general health care needs of adolescents when clinically indicated. | A nominated GP will be identified in the patient record on the Consumer Integrated Mental Health Application (CIMHA).<br>Existing primary health care relationships will be supported to continue. |
| **5.1.4**<br>The AET MOS is inclusive of people of diverse culture, sexual orientation, gender identity or intersex variations, ensuring these perspectives inform assessments and are incorporated within a holistic treatment framework. | Staff will proactively identify and include people able to support adolescents with their individual needs, and inform their assessment and treatment processes. The adolescent will nominate these support persons. |

[2] AET MOS refers to state-wide AET MOS unless otherwise specified.

| Key elements | Comments |
|---|---|
| When adolescents have specific needs, AET staff will proactively engage appropriate services in consultation with the adolescent. | |
| **5.1.5**<br>Development and delivery of a personalised learning plan - students are provided with educational adjustments to meet their learning needs. | Any educational program provided as part of the AET MOS will:<br>• where applicable/possible be aligned with consumer's base school program<br>• include mandated reporting to parents regarding educational achievement<br>• be developed in collaboration with and reporting to the student's base school<br>• consider diverse learning needs<br>• use appropriate practices to assist those students who have disengaged to re-engage with learning. |

## 5.2 State-wide referral, access and triage

| Key elements | Comments |
|---|---|
| **5.2.1**<br>Referrals consistent with the AET MOS occur through a single point of entry.<br><br>A range of public and private service providers can make a referral to Jacaranda Place.<br><br>Referrals are considered by a multidisciplinary Intake Panel who will work with referrers, adolescents and their carers to ensure access to appropriate treatment and care, either via Jacaranda Place, or more appropriate services.<br><br>The Intake Panel will consider referrals for access to both:<br>• the state-wide extended treatment and rehabilitation centre beds and,<br>• the 10 Day Treatment places for adolescents from the local geographical area. | Information on referral pathways, and admission criteria will be documented and available to referrers.<br><br>The State-wide Intake Panel will meet weekly and be chaired by the Clinical Director of Jacaranda Place, assisted by senior clinicians, and include carer/consumers, DoE and clinical regional input.<br><br>The Intake Panel will consider clinical presentation of the adolescent, treatment history and clinical resources available in the adolescent's community.<br><br>The Intake Panel is a resource for service providers and offers support to enable adolescents to continue in the care of community based services.<br><br>If there is a waiting period, the Intake Panel will liaise with the referrer to monitor changes in acuity and other clinical considerations until the adolescent is able to access Jacaranda Place directly.<br><br>Acceptance of referrals and facilitation of admission is part of a planned and collaborative assessment and treatment process. It is not an acute response service. |

| Key elements | Comments |
|---|---|
| **5.2.2**<br>Prior to acceptance of a referral, the Intake Panel will undertake a **preliminary assessment** to clarify:<br>• likelihood of the adolescent participating in and benefiting from admission<br>• potential impact of interactions between the adolescent and other participants at Jacaranda Place<br>• the adolescent's educational/vocational needs<br>• local service commitment and capacity for ongoing care post discharge<br>• a collaborative plan with the adolescent and parent/carers for the initial assessment phase of the admission | The preliminary assessment may involve a variety of modes of contact including videoconferencing. |
| **5.2.3**<br>Prior to admission, comprehensive general information and orientation will be provided to all adolescents, families and/or carers to promote a smooth transition into Jacaranda Place.<br><br>Technologies may be used to promote familiarity with Jacaranda Place and staff prior to arrival, especially for adolescents and families residing outside of the Brisbane area.<br><br>An education information pack will be provided on admission. | General information about the following will be provided:<br>• program components including treatment and support options<br>• expectations regarding family involvement<br>• the multidisciplinary team roles and functions<br>• assessments, family meetings and care and recovery planning<br>• educational/vocational training program contact information<br>• contact phone numbers<br>• visiting hours schedule<br>• general information, including policies on smoking, mobile phone use, property, consent, ancillary services<br>• *Mental Health Act 2016* information<br>• adolescent rights and responsibilities statement<br>• carers rights and responsibilities statement<br>• Information regarding privacy and confidentiality<br>• adolescent, family, and carer focussed information sheets on the use of restrictive practices<br>• obligations of all parties in the management of risk<br>• mechanisms for providing feedback, how to access a consumer advocate and where to get help if dissatisfied or concerned about service provided<br>• specific cultural information.<br><br>The education pack contains information including:<br>• details on the liaison to occur between education staff and the base school<br>• attendance expectations and processes |

| Key elements | Comments |
|---|---|
| | • use of Unique Student Identifier to record vocational training attainment (as required)<br>• staff information and contact details<br>• personal learning plan model<br>• responsible behaviour plan<br>• extra-curricular activities. |
| **5.2.4**<br>When a referral is accepted, education staff will commence planning for the adolescent's individualised learning program. | Where applicable and with consent, education staff will notify the base school and discuss the educational program the adolescent will undertake.<br><br>An individualised program for an adolescent who has disconnected from education or does not have a base school will be developed, consistent with recommendations from clinicians and carers.<br><br>Education staff will commence the process for registering attendance at the education program.<br><br>The treating medical specialist (Psychiatrist) to approve engagement in the educational program. |

## 5.3 Assessment

| Key elements | Comments |
|---|---|
| **5.3.1**<br>Repetition will be limited as much as possible for the adolescent in the assessment process. | A review of any current and readily available information (e.g. chart review) and referrer consultation will precede the initial assessment. |
| **5.3.2**<br>The **initial assessment process** following admission will involve a comprehensive biopsychosocial, developmental assessment of the adolescent in the context of their family and/or carer and other significant relationships.<br><br>Assessment, care and recovery planning is a continuous process throughout the admission period and identifies both protective factors and deficits. | From referral information, preliminary assessment and the initial assessment process, a **preliminary formulation** will be developed. The formulation will be holistic and may include:<br>• symptoms<br>• relationships<br>• family dynamics and functioning (e.g. current family/carer mental health issues)<br>• attachment and history of trauma<br>• psychosocial functioning<br>• sensory profile<br>• school performance<br>• developmental history and trajectory<br>• medical history<br>• co-morbidities<br>• daily living skills<br>• protective factors (including strengths, hobbies and interests)<br>• alcohol and other drug use<br>• cultural factors<br>• legal issues including custody and guardianship<br>• whether the adolescent may be a parent with care responsibilities for infants and children. |

| Key elements | Comments |
|---|---|
| **5.3.3**<br>Assessment will involve input from family, and/or carers and key service providers as appropriate.<br><br>Assessment of family structure and dynamics will continue during the course of admission and may be supported by accommodation of family members at Jacaranda Place.<br><br>Identification of family members and carers and their needs is part of the assessment process, and is included in care and recovery planning. | Consent to disclose information and to involve key stakeholders, and family and/or carers in the adolescent's care will be sought in every case.<br><br>Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.<br><br>Recovery oriented practice includes building systemic resilience within the adolescents' family and broader community supports.<br><br>Recovery oriented services facilitate and nurture connections with family members (particularly siblings and partners) and carers to gain the maximum benefit from these supports by adolescents. |
| **5.3.4**<br>Educational engagement and attainment will be considered as part of initial and ongoing assessments. | Education staff will source, where possible and necessary, information regarding school and vocational training history, including education supports. This will include, where possible, consultation with the adolescent's base school.<br><br>Through consultation with the adolescent, teaching staff will draw on educational history to inform an individualised learning program that promotes continuity of learning. This will be documented in the personal learning plan.<br><br>Education staff will share relevant educational information with clinical staff (in accordance with legislative information sharing provisions). |
| **5.3.5**<br>Initial assessments will inform the collaborative development of a **preliminary recovery-oriented Mental Health Services Care Plan (Care Plan).**<br><br>A **preliminary formulation** will be developed and contribute to a diagnosis and discussion of recovery goals. | Assessment will include the ability of the adolescent and available supports (including formal and informal carers) to maintain function and prevent relapse.<br><br>Potential recovery goals are explored with the adolescent and their family/carers including what can be provided on site during treatment and recovery.<br>My Recovery Plan |
| **5.3.6**<br>When adolescents have specific needs (e.g. sensory impairment, Aboriginal and Torres Strait Islander populations, CALD Backgrounds, dual disability, refugee services, LGBTIQ, the AET will engage assistance of appropriate services to ensure that communication and cultural issues are addressed. | • Link to services with expertise in cultural services<br>• Interpreter services<br>• Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2017-2020<br>• Queensland public sector LGBTIQ+ Inclusion Strategy<br>• Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) |
| **5.3.7** | |

| Key elements | Comments |
|---|---|
| Engagement will occur with an Aboriginal and Torres Strait Islander Mental Health Worker or Hospital Liaison Worker, as necessary, to support and assist with the facilitation of information for a comprehensive assessment of adolescents identifying as Aboriginal and Torres Strait Islander Peoples where one has not been completed previously. | Where an Aboriginal and Torres Strait Islander Mental Health Worker is not available, identification of an appropriate and recognised Aboriginal and/or Torres Strait Islander person is integral in addressing the cultural needs of adolescents identifying as Aboriginal and Torres Strait Islander Peoples. |
| **5.3.8**<br>Risk assessments will occur:<br>• on acceptance/admission as part of the comprehensive clinical assessment<br>• prior to transfer to any other service<br>• prior to and following periods of leave<br>• prior to discharge<br>• where clinically indicated due to change in presentation or at least every three months.<br><br>The state-wide Standardised Suite of Clinical Documentation (the Forms) will be used to record risk assessment. | All risk assessments will be recorded in the patient record, and will be used to formulate a risk management plan.<br><br>Comprehensive risk assessments will include at a minimum consideration of:<br>• harm to self<br>• harm to others<br>• vulnerability<br>• developmental risk<br>• risks of physical or emotional deterioration<br>• triggers to symptoms and/or behavioural disturbance<br>• risk of absconding<br>• non-adherence to treatment<br>• child protection issues.<br><br>Risk management planning will incorporate opportunities to build resilience by practicing and developing nascent skills in a supported environment where it is safe to fail.<br><br>Specific areas of risk may be evaluated more frequently as outlined in the adolescent's care plan.<br><br>Risk management protocols will be standardised and consistent with QH policy. |
| **5.3.9**<br>Child protection concerns will be identified through risk assessment and addressed in accordance with mandatory QH and DoE requirements identified in the respective Acts**.** | Liaison occurs with Child Safety services to ensure continuity of care.<br><br>The partnership between QH and DCSYW will occur at both a local level and systemic level.<br><br>DoE staff will report all incidents of harm or risk of harm to a child in accordance with DoE's Student Protection procedure and Student Protection Guidelines.<br><br>• *Child Protection Act 1999*<br>• Child Protection guidelines at the Queensland Health policy site |
| **5.3.10**<br>Assessment of physical health will be facilitated and documented as part of a holistic | The adolescent, family and/or carers will be actively supported to access and develop relationships with primary health care providers, e.g. GP. |

| Key elements | Comments |
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| health plan and needs to be considered also in reference to 5.6 Pharmacotherapy.<br><br>Potential physical or oral health problems will be identified and discussed with the adolescent, their family and or/carer, the GP, dentist and other relevant primary health care providers and is particularly important for adolescents prescribed medication. | Assessments need to be inclusive of physical health assessments which have been conducted by practitioners external to Jacaranda Place.<br><br>A nominated GP will be identified for all adolescents who will be responsible for ongoing monitoring post discharge.<br><br>Clinical alerts (e.g. medication allergies, blood-borne viruses) will be entered into the patient record in CIMHA. |
| **5.3.11**<br>Alcohol, tobacco and other drug use will be routinely assessed and documented throughout ongoing contact with the service | Information, harm minimisation interventions including motivational interviewing will be available.<br><br>Co-occurring alcohol and drug problems will be included in care planning.<br><br>Referral for alternative or additional support may be required. |
| **5.3.12**<br>Specialised assessments may assist in diagnostic clarification, assessment of symptom severity, developmental variables, informing functional assessments and identifying evidence informed therapeutic interventions. | Assessments will be prompt, timely and may include psychological, psychometric, occupational therapy, sensory, expressive therapy, and speech and language assessments.<br><br>The outcome of assessments will be promptly communicated to the adolescent, the family and/or carers, and other stakeholders (with consent of the adolescent and/or consent holder).<br><br>A range of physical health assessments will be undertaken if clinically indicated (e.g. CT scan, EEG, bone mineral density, endocrinology review). |
| **5.3.13**<br>Progress of each adolescent will be routinely monitored and evaluated using standard measures and other standardised tools as clinically indicated. | The NOCC measures will be used as part of the endorsed Jacaranda Place Evaluation Framework. |
| **5.3.14**<br>Assessment of current education program will occur via discussion with the base school to receive information required to assist the provision of appropriate curriculum delivery. | This may include decisions regarding:<br>• age appropriate curriculum<br>• delivery of the Australian curriculum<br>• adjusted program<br>• Individual Curriculum Plan (ICP)<br>• mandatory recording and reporting of educational achievement<br>• assessment to be in line with base school. |

## 5.4 Care planning and relapse prevention

| Key elements | Comments |
|---|---|
| **5.4.1**<br>Every effort will be made to ensure that care and recovery planning focuses on the adolescent's goals and in accordance with recovery-oriented principles. | Goals and interventions need to be meaningful to the adolescent and inclusive of strengths/hopes,<br><br>Parent/carer goals will also be considered in care planning.<br><br>Where conflicting goals exist (e.g. for adolescents receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the adolescent, and the family and /or carer's goals and values. Although conflicting goals may be a therapeutic opportunity to work through, they may also indicate that admission to Jacaranda Place is not helpful and review required.<br><br>Adolescents will be involved in identifying personal, clinical, service or other relationships that contribute positively to their mental health recovery. Where possible, these relationships will be supported as the adolescent transitions through care. |
| **5.4.2**<br>Care planning is driven by adolescents in partnership with their family/carers, other service providers and the clinical and teaching team.<br>Goals and interventions need to be meaningful to the young person, inclusive of strengths/hopes, and where possible, generated by them.<br><br>A young person may also develop a My Recovery Plan to assist in exploring and identifying their recovery goals. | Care plans are developed on the premise that adolescents can and do recover from mental health issues.<br><br>Adolescents with mental illness may have disrupted developmental trajectories. Care plans also need to address developmental needs.<br><br>Care plans identify:<br>• available supports resources within the adolescent and around them (including family/carers and other significant relationships)<br>• crisis management strategies<br>• therapeutic goals<br>• intervention processes<br>• psycho-educational needs<br>• relapse prevention strategies.<br><br>Care plans may also include strategies for improving:<br>• family functioning<br>• pro-social and developmentally appropriate interests and hobbies<br>• peer functioning<br>• quality of life (such as time to experience developmentally relevant play and fun)<br>• achievement at school / vocational training goals |

| Key elements | Comments |
|---|---|
| | • mastery over the tasks of adolescence including daily living skills.<br><br>The adolescent's My Recovery Plan will inform development of the Care Plan.<br><br>Care plans will be updated following change in presentation or need, but will be formally reviewed at least monthly (to review routine outcome measures, treatment progress and to address any change in needs).<br><br>Review of progress and planning of future goals will be integrated into the care plan. All changes to the care plan will be discussed at the Multidisciplinary Team (MDT) Review. |
| **5.4.3**<br>The relationship between the adolescent and their family and/or carer is an important contributor to recovery and resilience. | While adolescents gain further independence and mastery to separate from their family and/or carer, evidence suggests that adolescents with mental health issues specifically require support in re-connecting with their parents and that this reconnection can promote recovery and resilience.<br><br>Technology (e.g. videoconferencing facilities) will be available to support significant relationships when in person contact is not possible at Jacaranda Place. |
| **5.4.5**<br>A personal learning plan will be developed for each adolescent accessing the education and vocational training program. | Teaching staff will support adolescents to develop a personal learning plan, drawing on their educational history and their learning and life aspirations.<br><br>Where possible, the learning program outlined in the personal learning plan will be aligned to the adolescent's base school to promote continuity of learning.<br><br>The personal learning plan will include:<br>• learning goals<br>• age-appropriate curriculum<br>• delivery of the Australian Curriculum (which may focus on the General Capabilities, including Personal and Social Capability)<br>• educational adjustments<br>• mandatory recording and reporting of educational achievement<br>• relevant educational assessments.<br><br>Where the adolescent has disengaged with education, the personal learning plan will promote re-engagement with a desired learning pathway. |

## 5.5 Clinical interventions

| Key elements | Comments |
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| **5.5.1**<br>All aspects of any intervention will reflect the development of collaborative relationships between adolescents, families, carers and staff. | The focus will be on strengths, connectedness, personal involvement, personal choice and empowerment.<br><br>Treatment is provided in the least restrictive/disruptive manner that properly balances the adolescent's autonomy with their need for observation and treatment in a safe environment.<br><br>Technology (e.g. videoconferencing facilities) will be available to support involvement of those families and/or carers unable to attend Jacaranda Place in person. |
| **5.5.2**<br>Assessments and formulations using a bio-psychosocial, developmental, family systemic, contextual framework will guide all clinical interventions.<br><br>A range of integrated therapeutic, rehabilitation and recovery-focused interventions will be utilised to reduce the severity of symptoms, improve age-appropriate functioning, and increase resilience to cope with mental health issues. Interventions will be evidence-informed. | Interventions will consider and build on the strengths, resilience and protective factors within the individual, their family, culture and community. Interventions may be individualised, group based or generic programs. |
| **4.5.3**<br>Carers are integral to the mental health care process. Family members and carers are provided, or assisted with access to, emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and wellbeing. | Interventions to promote recovery are focussed on engaging with the family and carer as much as the adolescent.<br><br>Time to provide emotional support to the adolescent, family and/or carers will be given adequate priority. |
| **4.5.4**<br>Basic human rights, such as privacy, dignity, choice, anti-discrimination and confidentiality are recognised, respected and maintained to the highest degree in all clinical interventions. | Australian Charter of healthcare rights included in the welcome pack. |

## 5.6 Pharmacotherapy

| Key elements | Comments |
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| **5.6.1**<br>Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision making and | The medication goals of the adolescent, family and/or carer will be integrated with evidence based clinical treatment guidelines. |

| Key elements | Comments |
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| monitoring processes between the treating team, the adolescent, family and/or carers. | Adolescents, families and/or carers will be encouraged to be involved (e.g. use of medication diaries by adolescents) to support adolescents achieving independence. Parents and/or carers may need to be supported in this process.<br><br>Medication will be reviewed at regular intervals. As part of transition planning the adolescent, family and/or carer are encouraged to agree to a joint monitoring program with their local Community Child and Youth Mental Health Service (CYMHS), private service provider or GP.<br><br>Medication counselling will be provided to adolescents, families and/or carers throughout the admission and prior to discharge. |
| **5.6.2**<br>Across all treatment settings, prescribing, dispensing and administration of medicines will comply with QH policies, guidelines and standards. | Monitoring of the adolescent for evidence of appropriate and sufficient response to medication will be routinely conducted.<br><br>Monitoring of medication side-effects will be routinely conducted. |
| **5.6.3**<br>Prescribed medication will be available on discharge and the adolescent, family and/or carer are advised how to obtain ongoing supplies. | Supply of prescribed medication for leave or discharge will be coordinated as part of the delivery of the AET MOS.<br><br>Information providing accurate details of discharge medications will be provided to all healthcare providers involved in the care of the adolescent (e.g. GP, Community CYMHS, private psychiatrist, and community pharmacy). |

## 5.7 Maintaining safety in a sub-acute setting

| Key elements | Comments |
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| **5.7.1**<br>Processes will be in place to monitor, review and maintain a safe environment in Jacaranda Place, including psychological, physical and sexual safety.<br><br>There are instances where an adolescent's needs are best met by increased levels of intervention, to manage symptoms and/or behaviours that increase the risk of harm to the adolescent or others. | All staff will be familiar with specific policy and practice guidelines relating to the management of acute behavioural and emotional disturbance within the sub-acute setting as part of the AET MOS.<br><br>*Sexual health and safety guidelines, Mental health, alcohol and other drug services, 2016* will guide service delivery.<br><br>In addition to the Care Plan, a management plan will specifically address both the adolescent's emotional distress, and any associated behavioural disturbance.<br><br>The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, significance of their sensory profile and will be developed for every adolescent whose risk assessment identifies actual or potential aggression as an issue.<br><br>The Care Plan will list preventative strategies, de-escalation strategies, and may also be supported by the availability of appropriately prescribed medication.<br><br>Intervention strategies will be age appropriate and include:<br>• increased visual observation<br>• de-escalation techniques<br>• development of a safety plan<br>• a response targeting the specific behaviour or symptom<br>• use of medication to relieve agitation/ aggression<br>• utilisation of non-violent crisis intervention techniques.<br><br>Where all other de-escalation interventions have not been effective, restrictive interventions including physical restraint may be utilised for the minimum time necessary to ensure the safety of the adolescent and others. The use of restrictive interventions will be in accordance with relevant legislative and policy requirements.<br><br>These interventions are delivered by qualified staff following a comprehensive risk assessment. |

| Key elements | Comments |
|---|---|
| | All staff working at Jacaranda Place will have attended training at the level deemed appropriate to their particular work area.<br><br>Families and /or carers are immediately informed of acute changes in an adolescent's emotional and behavioural presentation and the opportunity to debrief will be offered. The adolescent will be encouraged to be involved in the debriefing.<br><br>In high-risk situations it may be appropriate for an adolescent to be transferred to an acute mental health unit to ensure the safety of themselves and other adolescents under care of the AET MOS. However, if transfer can be avoided this is clearly preferable.<br><br>Restrictive interventions will lead to a review of admission and care planning. |
| **5.7.2**<br>**Restrictive practices**<br>Interventions during access to education and vocational training programs | DoE does not permit the use of restrictive practices, such as seclusion, containment, chemical restraint, mechanical restraint and some forms of physical restraint, unless they have been recommended by a medical professional as a therapeutic intervention (for example, restraint as a postural support).<br><br>Clear operational plans will be agreed between DoE (in accordance with DoE's *Safe, supportive and disciplined school environment* procedure) and the HHS staff operating Jacaranda Place regarding the use of restrictive practices to identify respective roles, protocols and ensure an integrated response.<br><br>Use appropriate adjustments for students to access the curriculum. |

## 5.8 Clinical review

| Key elements | Comments |
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| **5.8.1**<br>All cases will be discussed at a MDT Review at least weekly. | A consultant psychiatrist or appropriate medical delegate will participate in all MDT Reviews (this may be via telehealth).<br><br>MDT Reviews will be documented using the Case Review clinical note.<br><br>When adolescents are foreseeably transitioning to another service provider an appropriate representative of that service will be present for MDT reviews. |

| Key elements | Comments |
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| **5.8.2**<br>In addition to the regular MDT review, ad hoc clinical review meetings will be scheduled when required (e.g. to discuss cases with complex clinical issues, following a critical event or in preparation for discharge). | Critical incident management protocols utilised consistent with HHS policy. |
| **5.8.3**<br>The adolescent's care plan will inform discussion at the MDT Review. Any significant changes in intervention will be incorporated into the plan. | The viewpoint of the adolescent, family and/or carer and their community based supports such as teachers and community mental health case managers will inform reviews.<br><br>Outcomes of clinical reviews will be discussed with adolescents, families and/or carers.<br><br>Any changes to the care plan will be made in collaboration with the adolescent, family and/or carer.<br><br>Structured risk and review processes will be utilised. |
| **5.8.4**<br>The progress of each adolescent will be monitored and evaluated routinely using standardised clinical measurement tools relevant to an individual's presentation. | |

## 5.9 Team approach

| Key elements | Comments |
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| **5.9.1**<br>A MDT approach will be provided. | The adolescent, family and/or carer will be informed of the multidisciplinary model, i.e. given information regarding the roles/skills of the different professions as well as the names of clinicians involved in their care.<br><br>Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision.<br><br>Recognition of the need for Aboriginal and Torres Strait Islander Mental Health Workers within the MDT is integral for adolescents, carers and families that identify as Aboriginal and/or Torres Strait Islander descent.<br><br>To be inclusive of diverse culture, sexual orientation, gender identity and intersex variations, staff will proactively identify and include people able to support adolescents with their individual needs, and inform team assessment and treatment processes. |

| Key elements | Comments |
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| **5.9.2**<br>Clear clinical and operational leadership will be provided for staff and for the team. | There will be well-defined and clearly documented processes for escalation of discipline specific clinical issues. |
| **5.9.3**<br>Caseloads will be monitored by the team leader/nurse unit manager (and other staff as appropriate) to ensure effective use of resources and to support staff in responding to crises in a timely, effective manner. | |
| **5.9.4**<br>Supervision is an important mechanism in the provision of high quality care. | Clinical, discipline and peer supervision will be available to all staff. |
| **5.9.5**<br>Jacaranda Place will provide an integrated education and vocational training program. | Education staff are considered part of the multi-disciplinary team and consulted where relevant.<br><br>The education staff may include teachers, teacher aides, guidance officers, advisory visiting teachers (disability), and therapists as required.<br><br>Where relevant, regular updates will be provided to clinical staff on participation and achievement in the educational and vocational training program.<br><br>The school Principal will supervise and manage educational staff.<br><br>The school Principal will be responsible for the effective use of the educational resources. |

## 5.10 Continuity and coordination of care

| Key elements | Comments |
|---|---|
| **5.10.1**<br>Clearly documented mental health service contact information (covering access 24 hours, 7 days per week) is provided to adolescents, families, and /or carers, referral sources and other relevant supports. | Relevant information documents detailing specific service response information will be readily available. |
| **5.10.2**<br>Every adolescent will have a designated treating consultant psychiatrist. | Recorded in the adolescent's clinical record in the Consumer Integrated Mental Health Application (CIMHA). |
| **5.10.3**<br>Every adolescent will be assigned a principal service provider (PSP). | Recorded in the adolescent's clinical record on CIMHA.<br><br>The PSP is responsible for co-ordinating appropriate assessment, care and review, and completing referral and ongoing care processes.<br><br>In the event an adolescent identifies as Aboriginal and/or Torres Strait Islander, an Aboriginal and Torres Strait Islander Mental Health Worker or an Aboriginal and Torres |

| Key elements | Comments |
|---|---|
| | Strait Islander Health Worker will be assigned to the adolescent to participate in ongoing service provision. |
| **5.10.4**<br>Adolescents will be assigned a nurse for each shift. | Adolescents will be made aware of who their assigned nurse is on each shift. |
| **5.10.5**<br>The ongoing educational or vocational training needs of the adolescent are considered in tandem with their mental health needs. | All efforts are made to ensure the least disruption to adolescents' learning pathway.<br><br>Education staff, where appropriate and relevant, will liaise with the base school to support the student's continuity of learning and progress towards learning goals throughout their admission and during their transition back to the base school.<br><br>If an adolescent is not currently enrolled in an education/vocational training program and is of compulsory school age or wishes to participate in post-compulsory education or training they will be registered to attend the education program at Jacaranda Place. Education staff will work with the adolescent to re-engage them with their desired learning pathway and support them to transition onto an appropriate education or training program.<br><br>Teaching staff will work with adolescents to regularly revise personal learning plans, as required, including revising educational adjustments in line with changing educational and mental health needs. |
| **5.10.6**<br>Educational case manager. | Each adolescent will be provided with an educational case manager with ultimate responsibility for reporting and oversight of curriculum delivery and communication regarding the adolescent's progress. |

## 5.11 Transfer of care within HHS (internal)

| Key elements | Comments |
|---|---|
| **5.11.1**<br>Transfer from Jacaranda Place will be a planned process, commencing at admission and undertaken in collaboration with the adolescent, their family and carers, within clear timeframes.<br><br>There will be an appropriate plan to ensure smooth transfer of care, which includes the early engagement of all service providers in ongoing care. | Adolescents may or may not return to the HHS where they resided prior to admission and additional consideration will be given to the risks of transition to a new service and maintaining personal relationships.<br><br>Policies and procedures for internal transfers will be clearly documented.<br><br>Staff at Jacaranda Place will support engagement of the adolescent with the follow up service provider prior to discharge from the service. |

| Key elements | Comments |
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| For adolescents under the *Mental Health Act 2016* refer to 5.11.6. | Transition of care for young people receiving child and youth mental health services |
| **5.11.2**<br>A written handover will be provided for all adolescents being transferred. | |
| **5.11.3**<br>Protocols for transfers to other HHSs will be mutually agreed and documented. | |
| **5.11.4**<br>Transfer of acutely distressed adolescents to another HHS will be avoided whenever possible. | Where transfer is unavoidable (e.g. acute admission), service collaboration will occur to ensure safe and supported transfer (service capability will be considered). |
| **5.11.5**<br>Adolescents, family and/or carers will be informed of transfer procedures. | Appropriate safety plans will be prepared with the adolescent, family and/or carers. |
| **5.11.6**<br>Adolescents transferred under the *Mental Health Act 2016* will remain the responsibility of the transferring service until a *Patient Transfer* form is made. | Clear arrangements for contact with adolescents by the receiving service should be established.<br><br>For inpatient transfers, the *Patient Transfer* form should be made prior to the adolescent being transferred.<br><br>In the case of transfers to a community service, or between community facilities, a *Patient Transfer* form should be made as soon as possible after the adolescent's relocation to the catchment area of the receiving service, and within a maximum period of one month. |

## 5.12 Transition of care to services outside of HHS (external)

| Key elements | Comments |
|---|---|
| **5.12.1**<br>Planning for transition and discharge from Jacaranda Place will commence at the time of admission. Adolescents will be discharged as clinically indicated and in accordance with their individual care plan. | Adolescents, their families and/or carers, the referrer and other key stakeholders will be actively engaged in discharge transition planning from the time of admission.<br><br>Discharge and transition planning will be a routine component of each clinical review process.<br><br>It is highly recommended that the involvement of Aboriginal and Torres Strait Islander Mental Health Workers is prioritised for transition/discharge of adolescents of Aboriginal and/or Torres Strait Islander descent.<br><br>HHS mental health services will give priority to adolescents transferring back to their HHS to ensure that the adolescent does not remain part of the AET MOS longer than is deemed clinically necessary. |

| Key elements | Comments |
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| | Discharge and transition planning should also consider accommodation and support needs for adolescents who are homeless, in care of the Department of Child Safety, Youth and Women or at risk of homelessness.<br><br>Transition of young people receiving child and youth mental health services |
| **5.12.2**<br>Discharge and transition planning will include a care plan, and incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes. | The recovery, relapse prevention and Acute Management Plan (and if required a Police and Ambulance Intervention Plan) will be provided to the adolescent, family and/ or carer, GP and relevant support agencies. |
| **5.12.3**<br>Where adolescents are absent without leave, there will be documented evidence within CIMHA of attempts to contact adolescent, family and /or carers and other service providers, before discharge. | If there are concerns for the safety of the young person, the AET staff will escalate as appropriate (e.g. Queensland Police Service).<br><br>All attempts to contact the young person and subsequent actions will be documented. |
| **5.12.4**<br>If the young person is subject to the provisions of the *Mental Health Act 2016* and is absent without approval, or fails to return from approved leave, the Chief Psychiatrist practice guidelines for managing these absences must be followed, and relevant Mental Health Act paperwork must be completed within CIMHA. | If the young person is being treated under the *Mental Health Act 2016*, the 'Involuntary patient absences' process must be followed including appropriate escalation and involvement from Queensland Police Service. |
| **5.12.5**<br>Discharge will occur when the care plan have been fulfilled to the best ability of all involved, and/or the AET MOS is no longer the most appropriate service option. | The decision to discharge is at the discretion of the Clinical Director in consultation with Jacaranda Place staff.<br><br>Consideration will be given to how best maintain benefits gained from treatment interventions (e.g. involvement in a day program may be encouraged to assist the transition and facilitate rehabilitation and recovery goals). |
| **5.12.6**<br>Comprehensive liaison and handover will occur prior to discharge and transition with all service providers who will contribute to ongoing care. | Jacaranda Place staff will remain engaged with adolescents, their families and/or carers until they are engaged in follow up care.<br><br>All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within 48 hours of discharge.<br><br>On discharge the transfer of care clinical note will be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral.<br><br>Relapse patterns and risk management information will be clearly outlined. |

| Key elements | Comments |
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| **5.12.7**<br>Educational and vocational training transition plan | The educational case manager will commence planning for the adolescent's education/ vocational training transition upon admission.<br><br>The education transition plan will be developed in consultation with the adolescent, parents/carers, the base school (where relevant), DoE guidance officers (where relevant), clinicians and the consultant medical officer (Psychiatrist).<br><br>Where the clinical transition requires a staged approach through other mental health services, (e.g. Youth Step Up Step Down Unit, Youth Residential Rehabilitation Unit or an Adolescent Day Program) the education transition plan will provide an aligned pathway of appropriate educational services and support. |

## 5.13 Collection of data, record keeping and documentation within an evaluation framework

| Key elements | Comments |
|---|---|
| **5.13.1**<br>Staff will enter and review all required information in the patient record on CIMHA, in accordance with approved state-wide and HHS business rules. | CIMHA will be used appropriately as per the CIMHA Business Processes.<br><br>It is noted that some CIMHA clinical notes are available via The Viewer. |
| **5.13.2**<br>As part of the AET MOS, standard outcome measures will be routinely utilised as part of assessment, care planning and service development. These will include those mandated through the NOCC and the evaluation framework for the AET MOS. | Outcomes data will be reviewed at all formal case reviews and patient related meetings.<br><br>Outcomes data will be routinely discussed with adolescents and their families and/or carers to:<br>• record details of symptoms and functioning<br>• monitor changes<br>• review progress and plan future goals in the care plan. |
| **5.13.3**<br>All contacts, clinical processes, recovery and relapse prevention planning will be documented in the patient record. | Progress notes will be consecutive (according to date of event) within all hard copy clinical records. The standard suite of clinical notes on CIMHA will be used to ensure availability of clinical information. |
| **5.13.4**<br>Clinical records will be kept in accordance with legislative and local policy requirements. | Personal and demographic details of the adolescent, family, and/or carers and other health service providers will be reviewed regularly and kept up to date.<br><br>Mobile or tablet technology will support any increasing application of electronic record keeping.<br><br>Retention and disposal of clinical records protocol |

| Key elements | Comments |
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| **5.13.5**<br>Recording appropriate educational information. | Education staff will collect and record student data through OneSchool, in line with other state schools. OneSchool enables an ongoing record of the student's educational data throughout their engagement in the state schooling system.<br><br>Where appropriate, the student will participate in assessments set by the base school and/or state and national testing. The student will also participate, when relevant and appropriate, in any local testing measures conducted by the educational and vocational training program.<br><br>Education staff will also collect and record the following information:<br>• documented permission from carers for communications, including receipt and sharing of educational information<br>• knowledge and support of care orders and custodial matters. |
| **5.13.6**<br>Local and state-wide audit processes will monitor the quality of record keeping and documentation (including external communications), and support relevant skill development. | Compliance with the mental health clinical documentation is the minimum requirement for documentation.<br><br>CIMHA Business Processes |

## 5.14 Working with families, carers and friends

| Key elements | Comments |
|---|---|
| **5.14.1**<br>The involvement of families and carers is integral to successful outcomes and therefore their engagement is incorporated into every component of service provision. | Adolescent/Guardian consent to disclose information and to involve family and/or carers in care will be sought in every case.<br><br>*Guardianship and Administration Act 2000*<br>Carers matter<br>The consumer, carer and family participation framework<br>*Hospital and Health Boards Act 2011* – Part 7 Confidentiality<br>Right to Information and Information Privacy<br>Information sharing between mental health workers, consumers, carers, family and significant others. |
| **5.14.2**<br>Information will be provided to the adolescent, family and/or carers at all stages of contact. | This will include a range of components such as:<br>• education and information about the mental illness or mental health issues<br>• the journey while residing in Jacaranda Place.<br>• mental health care options<br>• pharmacotherapy<br>• support services |

| Key elements | Comments |
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| | • care pathways<br>• contact information for the mental health service and relevant external service providers<br>• contact information for carer/family liaison person with lived experience.<br><br>Information provided will be documented in the adolescent's clinical file. |
| **5.14.3**<br>Support services will be offered to families and carers regardless of whether consent is given for their involvement in the adolescent's care. | Jacaranda Place will ensure family members and carers are provided, or assisted with accessing, emotional and other support to enable them to continue providing care and support without experiencing deterioration in their own health and wellbeing. |
| **5.14.4**<br>The needs of families and carers must be routinely addressed, particularly parents with mental illness, siblings, and partners of adolescents in a significant relationship. | Identification of carers and their needs is part of the assessment process and is included in care planning. |
| **5.14.5**<br>Parental mental illness will be routinely considered as part of all assessments, and interventions provided.<br><br>If an adolescent is pregnant or a parent with primary care responsibilities, their infants/ children will be routinely considered as part of all assessments. Interventions will be provided/ facilitated if needed. | Identification of families and/or carers and their needs is part of the assessment process and is included in care planning.<br><br>Child Protection Act 1999<br>Mental health child protection form<br>Family Support Plan<br>Family support plan: Child care plan supplement<br>Children of parents with a mental illness (COPMI) website |
| **5.14.6**<br>Consultation with parents and/or carers, students and the base school. | Ongoing consultation and communication will occur with the base school during the student's time registered at the education and vocational training program on site at Jacaranda Place and during transition planning.<br><br>Education staff will also consult with parents/carers as required. |
| **5.14.7**<br>Adolescents being transferred to the AET under the *Mental Health Act 2016* will remain the responsibility of the transferring service until the first medical assessment is completed. | For inpatient transfers, the *Patient Transfer* form should be made prior to the adolescent being transferred. |

## 5.15 Mental health peer worker support services

| Key elements | Comments |
|---|---|
| **5.15.1**<br>It is a critical component of the AET MOS that all adolescents, families and/or carers will be proactively supported to access peer support services as part of their recovery. | Peer support services may be provided by internal or external services, including local HHS mental health services. |
| **5.15.2**<br>Peer support workers (Consumer) have a responsibility to:<br>• engender hope<br>• guide and support adolescents through the treatment and care process and<br>• provide practical tips for recovery. | There should be a clear position description for Peer support workers to ensure they are clear about their responsibilities and scope of practice. |
| **5.15.3**<br>Peer support workers (Carer) have responsibility to:<br>• engender hope<br>• guide and support families and carers through the treatment and care process and<br>• provide practical tips for supporting their adolescent through to recovery. | There should be a clear position description for Peer support workers to ensure they are clear about their responsibilities and scope of practice. |
| **5.15.4**<br>Peer support workers work alongside and are part of the MDT. | This could be supported by clinical staff training and/ or supporting policies. |
| **5.15.5**<br>Peer support workers are provided with adequate orientation, supervision, training and professional development. | |

# 6. Related services

The AET MOS is an integrated service representing a partnership between QH and DoE, and sits within the continuum of Queensland public child and youth mental health services.

The continuum of services includes:

- Community Child and Youth Mental Health Service clinics (CYMHS)
- Assertive Mobile Youth Outreach Services (AMYOS)
- Youth Step Up Step Down (SUSD) Services
- Acute Child and Adolescent Mental Health Inpatient Units
- Adolescent Day Treatment Services
- Youth Residential Rehabilitation Units (YRRU)
- Evolve Therapeutic Services (ETS).

However, the AET MOS also interacts more broadly within a complex landscape of other services including:

1. Other Primary and Specialist QH services.
2. Other Queensland Government departments (e.g. the Department of Child Safety, Youth and Women)
3. Private providers
4. Non-government organisations.

The AET MOS promotes integration and coordination of care with the service and support networks of adolescents to ensure continuity across the care system. The AET MOS will ensure family members and carers are provided, or assisted with accessing, emotional and other support to enable them to continue providing care and support without experiencing deterioration in their own health and well-being.

The AET MOS recognises the importance of working collaboratively with the DoE to support and maintain existing relationships between adolescents and educational and vocational training options where they exist, or support the development of appropriate educational and vocational training relationships to integrate educational/vocational training needs into a holistic, integrated care plan.

It is anticipated that the educational and vocational training program will not only utilise staff and amenities based at Jacaranda Place, but also educational and vocational training staff and facilities in the local community.

# 7. Workforce

Providing a fully integrated service model incorporating assessment, treatment and educational/vocational training elements is a foundation of the AET MOS and should be reflected in both the clinical/consumer experience and workforce planning. The staffing profile for the AET MOS is comprised of a multidisciplinary mix of clinical and non-clinical staff. Treatment and care is provided by clinical mental health professionals including doctors, nurses and allied health staff, Aboriginal and Torres Strait Islander Mental Health Workers, allied health assistants and staff from DoE. Ongoing involvement of, or access to peer support workers (adolescent and carer) will be facilitated. Additionally, the multidisciplinary team is supported by administrative officers, catering, security and ancillary staff who assist with the day to day operations at Jacaranda Place.

The effectiveness of Jacaranda Place is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The AET MOS is for a complex cohort of adolescents which suggests the need to provide staff with continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. A specialist workforce is necessary to deliver the AET MOS and will require evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, encouraging rotations through the continuum of child and youth mental health services in Queensland, and supporting education and research opportunities.

The DoE will provide specialist trained teaching staff to provide the educational/vocational training program as part of the AET MOS. Professional development opportunities will be provided to ensure the staff have up to date knowledge and skills to provide a quality program to this cohort of students. Other DoE staff will be deployed as appropriate to support the delivery of the education program e.g. Guidance Officers, Advisory Visiting Teachers (disability) and therapists. Staff and resources from neighbouring educational and vocational training facilities may be utilised to enhance the student's learning program.

Jacaranda Place involves provision of 24-hour services, which requires nursing staff to be continuous shift workers. The model of nursing care will be a combination of case management and patient allocation. The skill mix and patient complexity is a factor when allocating nursing staff. Every adolescent will be informed of their assigned nurse for each shift.

# 8. Governance

The Mental Health, Alcohol and Other Drugs Branch supports the state-wide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services in the specialist areas of mental health and alcohol and other drugs services. MHAODB as the systems manager undertakes contemporary evidence-based service planning, development and review of models of service, new programs and service delivery initiatives in collaboration with key stakeholders.

Service Agreements between DoH and the operating HHS will formally document delivery arrangements for implementing the AET MOS as a state-wide service. This should include:

- defining the target population who meet criteria for entry and
- clinical service capability requirements of the host HHS.

Regular review of the state-wide AET MOS and monitoring of Jacaranda Place is required. This will include visibility of performance reported by the HHS provider:

- An annual plan should be developed documenting the key elements of the state-wide AET MOS and a list of indicators to measure performance outcomes of the service delivered.
- Additionally, the following should be documented through annual reporting:
  - Information regarding volume and outcome of services provided during the reporting period.

The state-wide AET MOS will operate:

- Under the direction of a Clinical Director (regarding clinical matters) and a Team Leader and Nurse Unit Manager (regarding administrative matters). Clear reporting roles ensure effective management and the efficiency of service delivery. Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.
- As a multidisciplinary team. This is essential as adolescents receive treatment and care from a range of specialist medical, nursing, allied health, therapy and pharmacy staff with appropriate qualifications, skills and experience.
- With a single point of clinical accountability for every adolescent.
- In partnership with the adolescent, their family and carers as well as their service and support network.

Operational and clinical leadership of Jacaranda Place is clearly defined by the operating HHS to delineate the key roles responsible for the direct management of Jacaranda Place and staff. This includes:

- Operational management (including day to day clinical support and consultation for staff)
- Resource and administrative management
- Systems maintenance
- Human resource management (recruitment, supervision and performance)
- Facilitating linkages with other mental health services, external organisations and community groups
- Clinical decision making and clinical accountability by Jacaranda Place Clinical Director
- Discipline-specific or intervention-specific mentoring and development to provide opportunities for clinicians to develop identified professional skills and reflect on elements of practice.
- Clinicians are supported to maintain their own health and wellbeing, avoid burnout, and to access career development guidance.

The DoE Regional Director, Metropolitan region has overarching responsibility for the Education staff and the operation of the school based at Jacaranda Place.

# 9. Hours of operation for Jacaranda Place

24 hours a day, 7 days a week.

As a State educational service, Jacaranda Place educational and vocational training program will operate as per the term dates set by the DoE. Jacaranda Place School Principal will determine daily operation times in line with current certified agreements.

# 10. Staff training

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

All clinical staff must be engaged in relevant professional development to ensure contemporary and evidence based intervention and treatment is provided to adolescents, their family and/or carers. There is a high proportion of the population accessing inpatient facilities that have experienced significant abuse, trauma and/or neglect. Specialist skills are required to manage escalating behaviours arising from trauma, including attachment issues and affective dysregulation. All clinicians are to be adequately trained in these specialist skills to provide effective evidenced informed interventions.

All DoE staff will be required to undertake mandatory training and the annual performance planning process. During this process individual professional development needs, particularly in relation to the work within Jacaranda Place educational and vocational training program, will be identified. Jacaranda Place School Principal will ensure that staff access the planned professional development and that an appropriate program of training and professional development is also accessed by staff on scheduled student free days.

Capacity to be involved in research activities is highly desirable.

Training should be based on best practice principles and will be underpinned by the recovery framework. The host HHS is encouraged to make the relevant components of their training available to their service partners.

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

- orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- promotion, prevention and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for, children and adolescents and their families and /or carers

- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention
- *Mental Health Act 2016*
- *National Safety and Quality Health Service Standards second edition*
- *National Standards for Mental Health Services 2010*
- evidenced informed practice in service delivery
- adolescent focused care planning
- routine outcome measurement training
- a range of treatment modalities including individual, group and family-based therapy
- an understanding of the impact of complex trauma and disrupted attachment
- child safety services training
- perinatal and infant mental health training
- knowledge of mental health diagnostic classification systems
- medication management
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- Aboriginal and Torres Strait Islander mental health, alcohol and other drug cultural capability training
- sensitivity to the needs of people of diverse sexual orientation, gender identity or intersex variations
- alcohol and drug assessment and interventions
- family therapy
- occupational violence prevention and management training.

# 11. Key Resources

| Resource |
| --- |
| Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2017-2020 |
| 'A review of existing clinical and program evaluation frameworks for extended treatment services for adolescents and young adults with severe, persistent and complex mental illness in Queensland: Final Report' |
| Child Protection Act 1999 |
| Children of parents with a mental illness (COPMI) website |
| Clinical Services Capability Framework |
| Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services |
| Department of Education and Training Strategic Plan 2018-2022 |
| Every Student Succeeding – State Schools Strategy 2019-2023 |
| Family Support Plan |
| Family support plan: Child care plan supplement |
| Hospital and Health Service Performance Management Framework |
| https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf |
| https://www.health.qld.gov.au/improvement/youthmentalhealth |
| Inclusive education policy |
| Interpreter services |
| Learning and Wellbeing Framework |
| Mandatory reporting requirements under the *Mental Health Act 2016* |
| Mental Health, Alcohol and Other Drugs Performance Framework |
| Mental health child protection form |
| National Framework for Recovery Oriented Mental Health Services |
| National Safety and Quality Health Service Standards 2nd ed |
| National Standards for Mental Health Services 2010 |
| P–12 curriculum, assessment and reporting framework |
| Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) |
| Queensland public sector LGBTIQ+ Inclusion Strategy |
| Standards for Registered Training Organisations (RTOs) 2015 |
| State-wide Standardised Suite of Clinical Documentation (the Forms) |
| The Australian Curriculum |
| The Education (General Provisions) Act 2006 |
| Transition of care for young people receiving mental health services |

# Abbreviations

| | |
|---|---|
| AET | Adolescent Extended Treatment |
| AMYOS | Assertive Mobile Youth Outreach Services |
| BAC | Barrett Adolescent Centre |
| CYMHS | Child and Youth Mental Health Services |
| COI | Commission of Inquiry |
| CIMHS | Consumer Integrated Mental Health Application |
| CALD | Culturally and Linguistically Diverse |
| DoE | Department of Education |
| ETS | Evolve Therapeutic Services |
| GP | General Practitioners |
| HHS | Hospital and Health Service |
| ICP | Individual Curriculum Plan |
| Jacaranda Place | Jacaranda Place – the Queensland Adolescent Extended Treatment Centre |
| MHAODB | Mental Health, Alcohol and Other Drugs Branch |
| MOS | Model of Service |
| MDT | Multidisciplinary Team |
| NOCC | National Outcomes and Casemix Collection |
| NMHSPF | National Mental Health Services Planning Framework |
| PSP | Principle Service Provider |
| QH | Queensland Health |
| QPASTT | Queensland Program of Assistance to Survivors of Torture and Trauma |
| RTO | Registered Training Organisations |
| YRRU | Youth Residential Rehabilitation Units |
| YSUSD | Youth Step Up Step Down |