Queensland Health

Adolescent Extended Treatment Centre / Model of Service

Purpose of this document

The Adolescent Extended Treatment Centre (AETC) Model of Service (MOS) details the target population, the functions, operation and governance involved in the delivery of high quality and safe mental health services for adolescents with severe and complex mental health issues within the new centre. This visual summary outlines some of the core elements of the full MOS.

Service snapshot – who is the AETC 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, who haven't been responsive to other care options (suite of service elements) and can be safely managed in a sub-acute setting.

A ADOLESCENT

The AETC supports individuals who

1. Will generally be aged between 13 and 18 at the time of admission. However, the intake panel may include young people up to 21 who have developmental needs more effectively treated by an adolescent model.
2. Have symptoms that are severe, probably persistent, and associated with some level of risk to themselves and or others.
3. Have a primary mental health diagnosis, which may be associated with complexities.

E EXTENDED

The centre provides one phase of the treatment process

- Planning for an adolescent's transition from the centre to less restrictive services commences at admission (e.g. maintaining relationships outside of the centre) to facilitate a smooth and integrated progression in care. The model has a target length of stay up to six months but is not a substitute for individual clinical care planning.

T TREATMENT

The centre integrates assessment, treatment and support services around each adolescent in partnership with the Department of Education (DoE):

Residential beds + **Intensive day treatment/ rehabilitation** + **Educational/ vocational services**

C CENTRE

The built environment has been specifically designed to foster integrated adolescent care

- The physical building has been carefully co-designed with consumers and carers to create a safe, inclusive environment for adolescents that supports their treatment, education relationships in a residential setting.

A more 'connected' approach to intensive support

We work with **your service and support network to keep you connected.**

We work to make sure **your school and/ or work needs** are **part of your care and recovery plan.**

A day at [the centre] might include:

- I wake up in my [centre] bedroom. Sometimes we share a room with a support person so we feel more at home.
- I always have staff close by 24 hours a day
- I have an individual therapy session
- I work with my teacher to plan my learning goals.
- We attend group lessons in the classroom, where activities are tailored to my level.
- I attend sessions in the training kitchen and café to work towards a Cert II.
- I finish the day with recreational time
- We have group therapy
- I eat dinner and take any medication I need
- I see my family for a visit or therapy. We can video conference if they are far away or can't visit me in person
- At lunch, I eat with my peers and get involved with some recreational activities
- To help me work towards living in the community I visit or talk to community services
- I work with professionals to look at my health, speech, diet, medication, learning and mood
- I eat breakfast and take any medication I need

We ensure **family members and carers have the support they need to keep supporting you.**

The AETC works best when...

- ✔ **We value the adolescent's perspective and work together to develop tailored interventions for them**
- ✔ **We involve adolescents and their family/carers/ other service providers in all aspects of care and recovery planning and delivery**
- ✔ **There is a culture of openness and responsiveness to feedback from all service users**
- ✔ **Our physical environment is maintained as a place to support healing**
- ✔ **Existing relationships are actively supported and integrated into holistic care and recovery planning (as a key contributor to positive future mental health outcomes)**

The AET model puts the adolescent at the centre of care.

1. **The REFERRAL PROCESS is the first step to understanding the adolescent's individual needs and identifying shared expectations.**
2. **ASSESSMENTS are carefully undertaken to support holistic care.**
3. **Adolescents create their own meaningful plan for RECOVERY AND RELAPSE PREVENTION.**
4. **Co-ordinated, evidence informed CLINICAL AND EDUCATIONAL/ VOCATIONAL INTERVENTIONS is provided through multidisciplinary, collaborative partnerships for adolescents.**
5. **Adolescent's individual needs are closely monitored and reviewed to ensure their physical and psychological SAFETY in the centre.**
6. **The team will REVIEW each adolescent's case at least weekly.**
7. **CONTINUITY AND CO-ORDINATION of care will be a constant focus, especially during TRANSITIONS IN CARE.**

See page 2 for more details

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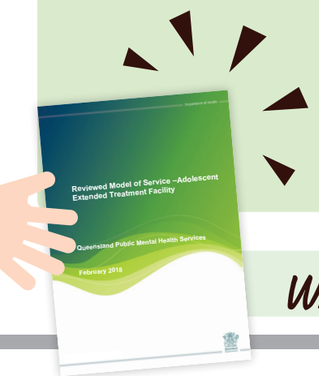
The AETC model puts the adolescent at the centre of our care

1 The REFERRAL PROCESS is the first step to understanding the adolescent's individual needs and identifying shared expectations.

- All referrals come to a multidisciplinary intake panel which meets weekly.
- The panel works with referrers, adolescents and their carers to ensure adolescents referred do get access to appropriate treatment and care. This may be either via the AETC or more appropriate services.
- The panel may need to better understand the adolescent, family and/or carers and their situation better and therefore might suggest a brief interview, to help with their decision.
- Prior to admission, comprehensive general information and orientation will be provided to all adolescents, families and/or carers to help everyone understand what to expect from the AETC and how to access support.
- When a referral is accepted, the AETC school will commence planning an individualised learning program for the adolescent.



2 ASSESSMENTS are carefully undertaken to support holistic care.

- Input from family/carers/service is actively sought as part of assessments, planning and support.
- Assessment, care and recovery planning is continuous through the admission period and identifies both protective factors and deficits.
- A comprehensive biopsychosocial, developmental approach is taken to consider the adolescent in the context of their family and/or carer and other significant relationships.
- To ensure the adolescent's whole situation is understood assessments are comprehensive and include educational history, drug and alcohol use, personal safety history and physical health needs (especially for adolescents being prescribed medication).
- Assessment of family structure and dynamics will continue throughout the admission.
- Identifying the needs of family members and carers is part of the assessment process and is included in recovery planning.
- When adolescents identify as Aboriginal and Torres Strait Islander we ensure an appropriate Aboriginal and/or Torres Strait Islander Mental Health worker or support person is available to help.
- Risk assessments will occur at potentially challenging times, e.g. on admission, prior to leave and prior to discharge.
- Progress of each adolescent will be routinely monitored and evaluated using relevant standardised tools.

3 Adolescents create their own meaningful plan for RECOVERY AND RELAPSE PREVENTION.

- Adolescents, their families and/or carers will be supported to actively participate in collaborative care planning and care related, decision making processes. This enables adolescents and their families to build their strengths, hope, dignity, and connectedness.
- Adolescents, their families and/or carers 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.
- Both the individual recovery plan and the educational and vocational transition plan need to be based on goals and interventions that are meaningful to the adolescents, include strengths/hopes and, wherever possible, be generated by the adolescent, their family and/or carers.
- Educational or vocational needs of the adolescent are considered in tandem with their mental health needs.
- The relationship between the adolescent and their family and/or carer is an important contributor to recovery and resilience. If appropriate family members may be able to access accommodation of at the AETC.

4 Co-ordinated, evidence informed CLINICAL AND EDUCATIONAL/VOCATIONAL INTERVENTION is provided through multidisciplinary, collaborative partnerships for adolescents.

- All aspects of treatment will reflect a collaborative relationship between adolescents, family, carers and staff.
- The AETC multidisciplinary team is made up of clinical staff (e.g. psychologists, social workers, nurses and psychiatrists) and educational/vocational staff (e.g. teachers, teacher aides, guidance officers, disability specialists).
- A range of integrated therapeutic, rehabilitation and recovery-focused interventions will be used to reduce the severity of symptoms and increase resilience to cope with mental health issues.
- Clinical interventions are informed by evidence.
- Strong and collaborative partnerships are necessary to enable the adolescent's service and support network outside of the AETC to be maintained and enhanced during the admission.

5 Adolescent's individual needs are closely monitored and reviewed to ensure their physical and psychological SAFETY in the centre.

- A specific management plan will be developed for symptoms and/or behaviours which increase the risk of harm to the adolescent or others.
- The plan will address both emotional distress and behaviour. It will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and the significance of their sensory profile.
- The recovery plan will list preventative strategies, de-escalation strategies, and may also be supported by the availability of appropriately prescribed medication.

6 The team will REVIEW each adolescent's case at least weekly.

- The progress of each adolescent is monitored and evaluated routinely using relevant, standardised, clinical measurement tools. Results are documented in the adolescent's health record.
- The adolescent's recovery plan will focus discussion at the multidisciplinary team.
- Any significant decisions and/or changes in intervention will be documented.

7 CONTINUITY AND CO-ORDINATION of care will be a constant focus, especially during TRANSITIONS IN CARE.

- The adolescent's core care team will be as consistent as possible. It will be made up of a consultant psychiatrist, a therapist and a designated nurse (for each shift).
- Consideration of follow up treatment options will commence from the time of admission to ensure the process is planned, timely and has involved the adolescent, their family and carers in decision-making processes.
- During the transition phase, there will be a written plan to ensure smooth transfer of care, which includes the early involvement of follow up care providers.
- Discharge planning will include strategies for relapse prevention, crisis management and clearly documented mental health service contact information (covering access 24 hours, 7 days per week).

WANT TO LEARN MORE?

The full AET MOS is available at: http://www.health.qld.gov.au/XXXXXXXXXXXXXXX