Overview of the Adolescent Mental Health Extended Treatment Initiative

Decision to close the Barrett

In alignment with the Queensland Plan for Mental Health 2007-17 (QPMH), a key area for reform within Mental Health and Specialised Services in the West Moreton Hospital and Health Service (WM HHS) was the development of The Park Centre for Mental Health (The Park) as an adult-only forensic and secure mental health campus. The high secure services were expanded and, in July 2013, a new service option was established on campus, the Extended Forensic Treatment and Rehabilitation Unit.

In light of these significant changes, it was considered no longer safe or contemporary to provide long-term inpatient care for adolescents at the Barrett Adolescent Centre (BAC) on The Park campus. Compounding these changes at a service provision level, the existing infrastructure of the BAC was unable to be refurbished and the building was marked for decommissioning.

Through Stage 1 of the QPMH, an adolescent extended treatment unit was funded to replace the existing 15-bed BAC. The replacement service was to be located at Redlands, and had an indicative commissioning date of November 2013. Upon operation of the replacement 15-bed unit, the existing BAC would be decommissioned.

The Redlands adolescent extended treatment capital program encountered multiple delays and a significant budget over-run. There were unresolvable environmental barriers associated with the site, and the Department of Health ceased development and redirected the capital funds toward other high priority health initiatives. Operational funding for the Redlands Facility, of approximately $1.8 million for 2013/14, was retained and approved by the Department of Health to fund new adolescent mental health extended treatment and rehabilitation service options.

Expert Clinical Reference Group

In December 2012, WM HHS initiated the Barrett Adolescent Strategy to identify new service options for adolescents requiring mental health extended treatment and rehabilitation in Queensland.

An Expert Clinical Reference Group (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Adolescent Psychiatrist, multi-disciplinary Child and Youth Mental Health clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a Planning Group, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

Between 1 December 2012 and 24 April 2013 the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types.

In May 2013, seven recommendations were submitted by the ECRG to the WM HHS Board. This was followed by consultation with the Minister for Health, the Queensland Mental Health Commissioner, Children's Health Queensland Hospital and Health Service (CHQ HHS), Department of Education Training and Employment, and the Department of Health. The seven recommendations were accepted by the WM HHS Board.

A key principle for child and youth mental health services, which was supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.

Children's Health Queensland

On 6 August, 2013, the then Minister for Health made an announcement that adolescents requiring extended mental health treatment and rehabilitation would receive services through a new range of contemporary service options from early 2014. Young people receiving care from the BAC at that time would be supported through their transition to other contemporary care options that best met their individual needs. It was at this time, CHQ HHS took the lead to develop and implement the statewide Adolescent Mental Health Extended Treatment Initiative (AMHETI).

The closure of the BAC provided an opportunity to review the model of care for adolescent extended treatment and rehabilitation to ensure young people receive contemporary, family-centred services in the least-restrictive environment as close to their home and community as possible.

The BAC represented just one service on a continuum of adolescent mental health care provided by the Queensland State Government. While the BAC provided care for 12 to 15 young people at any one time, Queensland Health is providing mental health care for a much larger cohort of young people across the state.

Children's Health Queensland commenced exploration and research into the best way to enhance current care options for young people, as well as the addition of new services, to address recognised service gaps in the continuum of care for adolescent mental health. The goal was to ensure every adolescent in need of mental health care would receive the best support and treatment as close to their home and family as possible.

Consultation

Queensland's public mental health system has undergone significant reform over the past ten years. The reform agenda includes a shift from institution-based service models, including extended treatment and rehabilitation, to more contemporary models of care that align with state and national policy. The impact of these important reforms has seen the care of consumers move primarily into community-based settings, where they are supported to engage in their own local neighbourhoods and facilities. This has been particularly vital for consumers requiring medium to longer-term care.

CHQ independently undertook comprehensive research and consultation to determine how extended mental health treatment and rehabilitation care for young people should be delivered. CHQ also engaged with mental health experts and care providers throughout Australia to explore alternative, progressive approaches to adolescent extended treatment and rehabilitation care. This included site visits to child and youth mental health services in New South Wales and Victoria to observe first-hand the delivery of innovative models of service delivering for young people.

CHQ completed the work under the governance of a Chief Executive and Department of Health Oversight Committee and an Executive Steering Committee, which included consumer and carer representation. Statewide forums were also convened to seek a broad range of input and feedback from key stakeholders across the sector.

Research

Adolescents with severe mental health difficulties receive intervention from a broad range of services internationally and this is an overview of the literature.

Whilst there are recognised methodological challenges and limitations to this literature, multiple reviewers of this area come to a number of similar conclusions: an integrated system of care is required and current international trends are for a continuum of care approach, adequate community treatment being important in any system of

care including assertive outreach services, and there is a growing evidence base for predominantly outpatient-based interventions for emerging personality disorder (Gowers 2005). The parts of a continuum with an evidence-base are inpatient units, day programs, residential treatment, mobile outreach services, and community clinics.

Inpatient treatment has been influenced internationally by managed care funding, an adoption of treating adolescents in the least restrictive environment, and the concern that there is the risk of potential harm by an admission e.g. regression. This has led to a significant decrease to the average length of stay with the average being under five days (Carlisle 2012). Of note, acute inpatient adolescent units treat adolescents with multiple risks and severe presentations (Tongue 2008, Usman 2014). A number of factors have been found to be associated with improvement, including involvement of the family in intervention, a coherent framework of management on the ward, and the availability of community services.

A regular finding has been that length of stay in an adolescent unit has not been a consistent factor in outcome (Blank 2000, Hansen-Bauer 2011). Whilst some authors have noted an increase in re-admission rates with briefer length of stay, in general this is affected by the level of community services available. The outcomes studies of acute inpatient units show an improvement in a number of domains post-discharge and with maintenance of this improvement being influenced by community intervention. Reviews note that inpatient units remain essential treatment settings for selected adolescents (Garrison 2006) with evidence of good clinical outcomes (Hanssen-Bauer 2011, Mathai 2009).

A number of articles were reviewed where the length of stay was longer than what has been defined in the literature as an acute admission (30 days) (Blanz 2000, Green 2001, Hoger 2002, Harnett 2005, Nadkarni 2012, Pfeiffer 1990, Rothery 1995). A striking finding was that only one article had admissions for longer than 6 months, with many being between 1 and 3 months (Paterson 1997). The authors found improvement in a number of domains during admission. Similar factors were found as for acute inpatient units in terms of improvement and in one study, most of the improvement occurred in the first month of hospitalisation (Green 2001). Like acute inpatient units, these units treat adolescents and families with severe and complex presentations and risk factors (Paterson 1997). When studied, the most common diagnosis was a psychotic illness.

Several reviews of day programs have found improvement in symptoms and general functioning in adolescents and their families (Deenadayalan 2010; Kennair 2011; Kiser 1996). There is a growing evidence base for specialist adolescent outreach services including a decrease in hospitalisation, improvement in symptoms and risk, and increased engagement with education (Assan 2008, Chia 2013, Duffy 2013, Lamb 2009, Preyde 2011, Schley 2008, Schley 2011, Simpson 2010). Rapid response outpatient follow up has been associated with decreased admission rate, a decrease in suicidality, and an increase in function (Greenfield 2002). Whilst a complex literature, in general residential mental health treatment for adolescents has been shown to be effective (James 2011, Lamb 2009, Rishel 2014); however, maintenance of improvement may be dependent on community follow up after placement.

Demand for Services

In Australia, mental illness is the largest cause of disability, accounting for 24% of the burden of non-fatal disease[1]. Furthermore, 75% of severe mental health problems emerge before the age of 25. Of the total population of young people aged between 13 and 18 years of age, it is estimated that 10% have mental health needs and 2.3% have a severe mental illness[2]. This equates to 35,044 young people with mental health needs and 8,060 with a severe mental health illness in Queensland[3].

The last national survey of child and youth mental health services was conducted in 1998 with a more recent study conducted from May through to December 2013. Results from the 2013 study will not be published until late 2015. As a consequence, there is no recent data regarding mental health services for young people in Australia at this time.

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[1] *National Mental Health Report*, 2010, and *Mental Health Services In Brief*, 2011
[2] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch
[3] Australian Bureau of Statistics, 2011, Census of Population and Housing

The National Mental Health Report 2013, commissioned by the Federal Government, did however find that the demand for services is on the rise, reflected in an increased rate of contact with primary mental health care by children and young people. This has increased three-fold from 2006-2007 to 2011-2012, where the increase was most marked for those aged 18-24 (rising from 2.2% to 7.5%) followed by those aged 12-17 (rising from 1.1% to 5.5%)[4].

It is also a well-known fact that young people are the most disengaged cohort along the mental health continuum, as demonstrated in the Great Smoky Mountains Study (Costello, et al, 1996). Consequently, the true extent of demand for services is difficult to quantify.

A significant complexity for service delivery in Queensland is the geographic spread of consumers across the state. As demonstrated below, Queensland has the third highest population in Australia with the second largest land mass, over double the size of NSW and up to seven times that of Victoria.

State[5]	Population in millions	Square Kms in millions
New South Wales	7.407	0.801
Victoria	5.737	0.227
Queensland	**4.658**	**1.731**
Western Australia	2.517	2.529

The location and implementation of services has been prioritised based on population data. 2011 Census data estimates the adolescent population of Queensland (aged between 13 and 18 years of age) at 350,442[6], approximately 74% of which live in south-east Queensland. This data is presented in the table below:

Table: Young Persons Aged 13 to 18yo by Mental Health Cluster.

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs	2.3% with Severe Illness	By Mental Health Cluster
Gold Coast	42,809	4,281	985	Southern
Logan/ Bayside/ Beenleigh	41,348	4,135	951	Southern
Brisbane South	39,961	3,996	919	Southern
Darling Downs	26,067	2,607	600	Southern
West Moreton	14,056	1,406	323	Southern
South West	1,779	178	41	Southern
TOTAL	**166,020**	**19,386**	**4,459**	
Brisbane North	43,958	4,396	1,011	Central
Redcliffe/ Caboolture	23,095	2,310	531	Central
Sunshine Coast	27,842	2,784	640	Central
Central Queensland	18,657	1,866	429	Central
Wide Bay	16,199	1,620	373	Central
Central West	796	80	18	Central
TOTAL	**130,547**	**10,271**	**2,362**	
Cairns and Hinterland	19,745	1,975	454	Northern
Townsville	18,501	1,850	426	Northern

[4] Department of Health and Ageing, 2013, *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*. Commonwealth of Australia, Canberra

[5] http://www.ga.gov.au/education/geoscience-basics/dimensions/area-of-australia-states-and-territories.html

[6] Australian Bureau of Statistics, 2011, Census of Population and Housing

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs	2.3% with Severe Illness	By Mental Health Cluster
Mackay	13,776	1,378	317	Northern
Torres Strait-Northern Peninsula and Cape York	1,358	136	31	Northern
North West	495	50	11	Northern
TOTAL	**53,875**	**5,388**	**1,239**	

Model of Care

The proposed Model of Care provides recovery-oriented treatment and rehabilitation for young people aged 13-18 years with severe and persistent mental health issues that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural, and psychological functioning and development. It is anticipated that there will be flexibility in the upper age limit, dependent upon presenting issues and developmental age, as opposed to chronological age.

The proposed Model of Care was developed based on the recommendations from the ECRG and in accordance with the principles and services outlined in the current draft of the National Mental Health Services Planning Framework (NMHSPF). The NMHSPF aims to provide a population-based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments. The NMHSPF, when completed, will allow for more detailed understanding of the need for and types of mental health services across a range of environments.

The above recommendations, research, and findings have culminated in a model of care comprising five service elements for extended treatment and rehabilitation.

1. Assertive Mobile Youth Outreach Services (AMYOS)

These services provide recovery-oriented assessment and assertive treatment and care for young people with complex mental health needs. They are delivered by multidisciplinary mental health clinicians in either the family home or the community. They are particularly useful for young people who are high risk and difficult to engage in traditional clinic-based services. The Queensland AMYOS were modelled on a similar Victorian service regarded as the leading current provider in this area. Clinical reviews have shown that mobile youth outreach services result in greater engagement in treatment by young people. They have also been effective in significantly lowering the risk of harm to self and others, and in reducing the number of admissions and lengths of stay in hospitals.

We currently have AMYOS teams in north Brisbane, south Brisbane, Redcliffe/Caboolture, Logan, Darling Downs, and Townsville, with recruitment to the Gold Coast Rockhampton and Cairns teams underway.

2. Adolescent day program units

These units provide a range of intensive individual and group therapy and extended treatment options for young people with social difficulties and a history of school refusal or exclusion. Day programs have been shown to significantly improve peer and school relationships, and overall mental health and wellbeing for young people.

There are now four day programs at the Lady Cilento Children's Hospital (south Brisbane), Toowoomba, Townsville, and, the most recent, in north Brisbane.

3. Residential Rehabilitation Units (Youth Resi)

These units assist adolescents with severe or complex mental health needs who require long-term accommodation and recovery-oriented care. A Youth Resi aims to teach young people the life skills they need to achieve and maintain independence and emotional well-being. They also help young people to develop and maintain links with the community, their family, and social networks, as well as education and work opportunities. These services are delivered by non-government organisations in partnership with mental health specialists.

CHQ currently provides a Youth Resi in south Brisbane and another in Cairns. Processes are underway to procure services for two more Youth Resis in Townsville, with the successful service provider to be announced in late October 2015.

4. Subacute beds

These Tier 3 beds are for adolescents who require medium-term, intensive treatment and rehabilitation services in a safe, secure, structured, hospital-based environment. They provide 24 hours per day, seven days per week care for young people with severe and complex mental health issues, who require extended treatment and rehabilitation, and access to onsite schooling. This service is aimed at a small group of young people, whose needs cannot be safely and effectively met through alternative services. The subacute beds are available at the Lady Cilento Children's Hospital in south Brisbane.

5. Step Up / Step Down Units (Proposed Future Service)

These units offer short-term treatment in purpose-built facilities that are delivered by mental health specialists in partnership with non-government organisations. These units are based on the Youth Prevention and Recovery Care (Y-PARC) services currently delivered in Victoria. They are for young people who require a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community (Step Up), but do not require the treatment intensity provided by acute inpatient units. Likewise, these units enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (Step Down).

Establishment of these units will require significant capital and recurrent expenditure from local Hospital and Health Services and/or the Department of Health.

Service Continuum

All of the above new services are supported by CHQ's existing Child and Youth Mental Health Service (CYMHS), including Community CYMHS and e-CYMHS telehealth service, and six existing child and adolescent acute inpatient units located throughout Queensland (the Lady Cilento Children's Hospital, Royal Brisbane and Women's Hospital, Logan Hospital, Robina Hospital, Toowoomba Hospital and Townsville Hospital).

CHQ also continues to work closely with the Department of Education and Training to ensure that important educational programs are part of all services being provided.

Alignment with ECRG

The proposed model of care aligns with the recommendations made by the ECRG:

1. *Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework.*
   CHQ undertook broad consultation and planning processes, and ensured alignment with the NMHSPF.

2. *Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component.*
   CHQ has implemented Tier 3 subacute beds as part of the service continuum. These beds were available at the Mater shortly after closure of the BAC and transitioned to the Lady Cilento Children's Hospital in November 2014. These Tier 3 beds have access to onsite schooling at the Children's Hospital.

3. *Interim service provision if BAC closes and Tier 3 is not available is associated with risk.*
   Detailed transition planning for each young person was undertaken and implemented to ensure that the young people requiring ongoing care were well supported during transition to alternative care options. These plans were developed by WM HHS in close consultation with the young people and their families, and tailored to individual needs and care requirements. To confirm the appropriateness of transition planning undertaken, the Department recently appointed an external health service investigator to review the transition and care

planning process. This investigation culminated in a report, titled Transitional Care for Adolescent Patients of the Barrett Adolescent Centre. The report has concluded that the Barrett Adolescent Centre clinical team "undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process."

4. *Duration of Treatment*
   It is acknowledged that the duration of treatment is dependent upon the nature of the mental health service being delivered and the complexity and severity of the mental health problems being treated. The service elements in the proposed model of care range in duration from short term stay (4 weeks) in the Step Up/Step Down Units through to long term stay (up to 12 months) in the Youth Resi.

5. *Education resource essential: on-site school for Tiers 2 and 3.*
   CHQ has engaged with the Department of Education and Training to ensure appropriate education options are available to all services. Educators are onsite in all Day Programs and the subacute beds have access to the special purpose school at the Lady Cilento Children's Hospital.

6. *Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration.*
   The Youth Resi service has been established in partnership with a non-Government Organisation (NGO) and governance has been clearly articulated in the overarching model of service. The model of service recognises that clinical governance of consumers remains with their treating CYMHS team. Statewide governance and funding of this service remains with CHQ HHS. Operational and strategic governance of Youth Resis are managed through a Statewide Governance Panel established in partnership with the NGO.

7. *Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas).*
   In January 2014, Townsville HHS opened a new adolescent inpatient unit and day program service. Since then, CHQ has worked with Townsville and Cairns to expand services with the establishment of an AMYOS team in Townsville, and the conversion of the Cairns TOHI into a Youth Resi.

   Equitable access to all statewide services is ensured through the establishment of a statewide panel, which will include representation from North, Central and Southern mental health clusters. This panel will have oversight of all referrals into services to ensure the most appropriate service option is made available to consumers.

Future Services

New recurrent operational and capital funding is sought to implement the full model of care (as listed below).

Service	Currently Funded Services	Additional Services Proposed
AMYOS	North Brisbane, South Brisbane, Redcliffe/Caboolture, Logan, Gold Coast, Toowoomba, Rockhampton, Townsville, Cairns	North Brisbane, South Brisbane, West Moreton, Sunshine Coast, Mackay, Wide Bay, South West, Central West, North West, Cape York
Day Programs	North Brisbane, South Brisbane (LCCH), Toowoomba, Townsville	Logan, Gold Coast
Youth Resis	Greenslopes, Cairns, Townsville	North Brisbane
Step Up/Step Down	None	Brisbane, North Qld, Southern Qld
Subacute Beds	4 beds funded by service underspend	

The AMHETI Business Case prepared in July 2014 has been updated to reflect the latest Government announcements and investment in new services. The amount of funding now being sought has reduced by one residential rehabilitation unit and two AMYOS teams (from $22m down to $20m recurrent) as per the table below.

Proposed services have been grouped in order of priority and based on possible funding amounts that might be provided.

Proposed Services	2015/16	2016/17
Subacute Beds (4 beds)	$1,005,880	$1,031,317
AMYOS Psychiatrists x 2	$734,131	$752,639
AMYOS x 10 Teams (rest of Qld)	$3,176,041	$3,172,132
TOTAL	**$4,916,052**	**$4,956,088**
Day Program (Logan)	$1,528,015	$1,568,101
Residential Rehabilitation Unit (north Brisbane)	$1,570,550	$1,527,111
Step Up/Step Down Unit 1 (Brisbane)	$3,586,651	$3,648,007
TOTAL	**$6,685,216**	**$6,743,219**
Day Program (Gold Coast)	$0	$1,568,101
Step Up/Step Down Units x 2 (Northern & Southern Qld)	$3,586,651	$7,330,981
TOTAL	**$3,586,651**	**$8,899,082**
GRAND TOTAL	**$15,187,919**	**$20,598,389**

Capital Funds

In addition to operational funding, capital funding will be required to fit out suitable premises for Adolescent Day Programs and purpose-built facilities for the Step Up/Step Down Units. The following capital estimates are based on fit out and building estimates for the construction of similar bed-based units in Queensland, and are an indication of the type of capital investment that would be required. The accuracy of these estimates would need to be verified by an appropriately qualified quantity surveyor.

Capital Fit-Out Costs ($2,000/sqm)	2015/16	2016/17
Day Program (2 units)	$501,272	$516,310
Step Up/Step Down Unit (3 units)	5,092,320*	$ 2,622,545
Total	**$5,593,592**	**$3,138,855**
Capital Construction Costs ($3,200/sqm)		
Day Program (2 units)	$1,612,568	$1,660,945
Step Up/Step Down Unit (3 units)	$10,863,616*	$5,594,762
Total	**$12,476,184**	**$7,255,707**

* Cost for establishing two Step Up/Step Down Units in 2015/16.

In Conclusion

It is important that each service element is not viewed as a stand-alone component of the model but rather as a necessary integrated element along a continuum. To deliver a robust and comprehensive model for adolescent mental health care, it is strongly recommended that the full spectrum of services be funded.

In the absence of appropriate community care, there is an increased risk of recurrence in mental illness, self-harm, and suicide upon discharge from acute inpatient units, greater number of admissions into acute inpatient units, and longer lengths of stay in acute inpatient units. The ability for consumers, and their families, to navigate their way through clinical and community services will continue to be challenging and difficult without the support of intensive case management and coordination. Furthermore, without appropriate funding, adolescent mental health services in rural and regional areas will remain limited. Young people will need to be removed from their families and communities in order to receive appropriate mental health treatment. Risks of institutionalisation and deskilling as a result of lengthy hospital inpatient admissions will continue, and the follow up and recovery of consumers on discharge will be compromised.

Supporting References and Project Documentation

- Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care and Detailed Service Elements
- Adolescent Mental Health Extended Treatment Initiative Project Plan
- Victorian Site Visit Report, 2013
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