EXHIBIT 280

Statewide Sub-Acute Beds Discussion Paper

January 2016

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Queensland Government

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Executive Summary

Overview

Contemporary mental health care acknowledges the need to deliver treatment to young people in the least restrictive setting and as close to home as possible, based on the assumption that sufficient resources exist in the community to enable this to occur. It requires a sound understanding and application of the concept of recovery, which has been defined as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Commonwealth of Australia, 2013, p.2). Evidence-informed treatment services should be tailored to meet the needs of the young person wherever they are in their recovery journey, taking into account their individualised developmental needs, and aligned to national standards of mental health care. Active engagement of families is important. Young people with severe mental illness are likely to come from complex families whose own experiences may create challenges accessing treatment. Family-focused treatment interventions delivered in community settings have demonstrated benefits for a range of severe mental illnesses experienced by young people. However, a small sub-group of young people may benefit from an extended admission, especially if compounded by significant comorbidity, including intellectual/developmental impairment. The small sub-group of young people that may benefit from a longer admission with a rehabilitative focus are likely to comprise those experiencing severe psychosis and/or eating disorders compounded by significant risk factors and a lack of protective factors, or those young people with severe and/or complex mental illness that have failed to respond to the less restrictive form of care.

In Queensland, the Child and Youth Mental Health Service (CYMHS) provides public treatment of severe and/or complex mental health problems in children and young people 0-18 years old. Community CYMHS clinics, day programs and acute inpatient units are provided across Queensland in an integrated system of mental health care, with inpatient treatment based upon a statewide model of service.

Inpatient Care for Young People

Inpatient units serve an important function in acutely stabilising a young person's mental health problems. Nationally, new acute inpatient units have a model of service that focuses on brief admissions, and are located according to population need to enhance easy access. Besides being the most restrictive form of care, inpatient units are also the most expensive. In Queensland, adolescent inpatient care in 2015-16 is estimated to cost $2,456 per patient per day. This needs to be considered in the context of limited public funding as well as increasing complexity of presenting mental health problems.

Inpatient care is also associated with considerable physical and emotional risks for young people, with episodes of aggression increasing with a longer length of stay. There are also the risks of exposure to other acutely unwell young people; removal of the young person from their family, friends and school community; stigma; challenges to individual identity; and the management of challenging behaviours through strategies such as seclusion and restraint. Satisfaction with inpatient treatment is not necessarily associated with treatment outcomes. There is inconsistent evidence to demonstrate that longer stays are associated with improved outcomes, with findings suggesting the greatest improvement occurs in the early part of the admission. Readmission rates are especially high in the weeks after discharge, but appear to be reduced with access to - and intensity of - aftercare services.

Internationally, mental health services have established a wide range of treatment options across the continuum of care within the community. There is a growing evidence base that the outcomes associated with inpatient care can be achieved in less restrictive settings. Similar models have been developed in Australia and are increasingly recommended by State and National policies.

With the closure of the BAC in January 2014, there remains only one long-stay adolescent inpatient centre in Australia, the Walker Unit in Sydney, which has an average length of stay of approximately three months and a cohort of patients diagnostically different to those who were admitted into the BAC.

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Children’s Health Queensland’s Service Continuum
In 2013, Children’s Health Queensland Hospital and Health Service (CHQ) CYMHS was tasked with the development and implementation of the Adolescent Mental Health Extended Treatment Initiative (AMHETI), which recommended a more comprehensive continuum of care: an expansion of existing Day Programs across Queensland; the development of Assertive Mobile Youth Outreach Services (AMYOS) and Youth Residential Rehabilitation Services (Youth Resis); and, the introduction of Step Up/Step Down Units (SUSDU) and Statewide Sub-Acute Beds (SSB).

Day Programs offer intensive community-based support for young people whose mental health needs cannot be met through outpatient treatment but which are not severe enough to warrant an inpatient admission. Participation has been associated with improved mental health and functioning (including in Australian settings) and, in the case of eating disorders, has yielded comparable results to inpatient care. There are now four Day Programs available across Queensland.

The **Assertive Mobile Youth Outreach Service** (AMYOS) aims to support young people who have disengaged from, or not engaged at all in, treatment through their local community CYMHS clinic. It is modelled on Victoria’s Intensive Mobile Youth Outreach Services (IMYOS), which have been associated with greater and sustained engagement in treatment by young people, reduced risk of harm to self and others, and a decrease in the number of admissions and lengths of stay in adolescent units.

There are now nine AMYOS teams in place across Queensland. Preliminary analysis identifies AMYOS clients as a very high-risk group experiencing ongoing suicidal ideation and a need for considerable family support.

Youth Residential Rehabilitation Units (Youth Resis) aim to assist young people who require long-term accommodation and recovery-oriented care, including learning life skills to achieve and maintain independence and emotional well-being. They are based on a similar model in Victoria and have been positively received, but an independent review identified that they should have better representation of young people aged 16 to 18 years (Victorian Department of Health, 2012). Children’s Health Queensland currently provides a Youth Resi in south Brisbane and in Cairns, with two more to be opened in Townsville by early 2016.

Step-Up/Step-Down Units have shown positive benefits for adults and have been widely taken up in Victoria. Victoria has four such units for young people aged 16-24 years to provide short-term residential support to avoid the need for a hospital admission ("step up"), or following discharge prior to their return to the community ("step down”). Such an approach has been recommended for Western Australia and also introduced for adolescents in the Australian Capital Territory, where preliminary analysis has suggested it contributes to increased hope and self-efficacy, and a reduction in mental health symptoms. Most participants also indicated it assisted their development of life skills, increased their social involvement, and enhanced their relationships. There are currently no such units in Queensland. Establishing these services in collaboration with Children’s Health Queensland CYMHS will require significant capital and recurrent expenditure from local Hospital and Health Services and/or the Department of Health.

Statewide Sub-Acute Beds (SSBs) are for young people requiring extended inpatient care supported by onsite schooling. The SSBs were included in the AMHETI continuum of care based on recommendations by the Expert Clinical Reference Group convened to identify alternative service options for the BAC target group. It was intended that an SSB model adopt a rehabilitative focus over a longer period for young people who are not able to be treated via a less restrictive form of care, and would benefit most from this form of intervention. Following the BAC closure, two interim beds were provided at the Mater Children's Hospital and, upon amalgamation, these beds were increased to four in total at the Lady Cilento Children's Hospital from November 2014. Despite widespread promotion of AMHETI components, including the SSBs, only two young people have required the SSBs over the following 18 months. Each young person admitted had treatment tailored to their individual needs.

Current State

CHQ CYMHS was tasked with developing a SSB model of service. Since their introduction there have been limited referrals. This coupled with a lack of recurrent funding, prompted the development of this discussion paper in order to consider the evidence, costs, risks, and level of need for SSBs as part of the continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland, and to inform future service planning. Despite extensive literature review, there is a lack of compelling evidence to support an extended inpatient admission for most young people

Recovery-informed care has benefited greatly from considering the expertise of those with a lived experience of mental illness. As such, this discussion paper also examined three qualitative studies reflecting admission to a short-, medium- and long-term Adolescent Inpatient Unit. There is evidence that young people can both obtain significant benefits and be exposed to considerable emotional risk in even a short-term admission (Moses, 2011). An examination of experiences on a medium-term (Gill, 2014) and long-term unit, specifically the BAC (Ward, 2014), rounded out this picture. Gill (2014) examined experiences on a medium-term unit and explicitly included a spotlight on impending discharge from the unit following an admission averaging 3.5 months, with a number of concerns raised by young people about their ability to cope in the community. In each case, participants across all three studies identified a range of benefits obtained from peers, staff, therapy and psychoeducation, and the physical environment. They also related to the risks identified by Hannigan, et al. (2015), namely contagion and a series of dislocations arising from the admission. The research by Ward (2014) in relation to a long-term unit (specifically the BAC) added further value by incorporating the perspectives of parents and staff. Parents expressed their relief at the admission while at the same time acknowledged the pain of feeling they were relinquishing their care giving role. Feedback from staff in this study highlighted the importance of relationships, structure, and hope in recovery, and suggested the drawbacks of an extended admission may include the possibility of young people sabotaging their recovery when approaching discharge and/or struggling after leaving the unit. It was noted "…the recovery process for the teenagers was rarely straightforward. It was often a disjointed and confusing experience ‘seen from afar. The inpatient experience [included] a range of experiences for the adolescents, ranging from confusion to almost terror." (Ward, 2014, p.168) He added that "teenagers were at the Barrett Adolescent Centre in the first place because the community clinics could not offer the intensive treatment they required" (p.213).

The Future

The wider range of service options offered by AMHETI across a broader continuum of care has been developed at a time of great reform. In line with a growing evidence base and contemporary practice, the National Mental Health Service Review recommended a redistribution of resources over time, from acute settings to more community-based services. Similarly, the Queensland Health Mental Health Drugs and Alcohol Services Plan (2016-2021) under development by Queensland’s Mental Health, Alcohol and Other Drugs Branch is expected to realign more resources to community-based models of care. The Plan is due for release in early 2016.

Given consideration of the above information, the following recommendations are proposed:

1. Most adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care, as per the statewide model of service;
2. Any proposed service for CYMHS be based on a clearly-articulated model of service with explicit attention to addressing the risks outlined above; and,
3. Additional resources be directed towards establishing a comprehensive continuum of community-based adolescent mental health services across Queensland

1. Background Information

1.1. Mental Illness in Young People

Most young people in Australia experience good mental health and well-being, but a significant proportion will struggle. The most recent national snapshot of mental illness in children and young people estimated that a total of 14.4 percent of the 12-17 year olds surveyed had experienced at least one mental disorder in the previous twelve months, with comorbidity common across conditions (Lawrence et al., 2015). It should be noted that the survey focused only on anxiety disorders, major depressive disorder, attention-deficit hyperactivity disorder (ADHD), and conduct disorder. This finding therefore underestimates the full extent of youth mental illness as it did not include conditions such as post-traumatic stress disorder (PTSD), eating disorders or psychosis.

Mental illness in childhood and adolescence can have a significant and long-lasting impact on a young person's developmental pathways into adulthood, and in some cases across generations. From the age of approximately 12 until the early to mid-20s, a critical period of brain development helps shape future physiological responses as well as patterns of thoughts, feelings and behaviour. Besides physical and sexual maturation, normal adolescent experiences include movement toward social and economic independence, the formation of identity, the capacity for abstract reasoning and acquisition of skills needed to carry out adult relationships and roles. Without appropriate and timely intervention, mental illness may interrupt these experiences and therefore place a young person at greater risk of a wide range of adverse biopsychosocial outcomes. These include poor physical health, impaired social relationships, lower well-being, impaired functioning and greater adversity, including well into adulthood (Chen et al., 2006). Young people experiencing mental health problems may also engage in risky behaviour such as non-suicidal self-injury and/or suicide attempts/completion. A 'downward developmental trend' has been noted, such that disorders appear to be starting at younger ages (Zubrick, Silburn, Barton & Blair, 2000). Anecdotally, there has also been increasing complexity and acuity of mental health problems noted over time.

Parents and carers (as well as siblings) often experience significant distress in the face of such challenges. For many it creates a profound and pervasive sense of loss that generates a complex grief reaction often associated with reduced social support, and requires a juggle of their caregiving role with other responsibilities that results in a need for assistance from professional services (Richardson, Cobham, McDermott & Murray, 2013). These difficulties may in turn impact on a parent or carer's capacity to provide the best support for their child, and the wider family unit.

The emergence and trajectory of a mental disorder occurs through a complex interplay of risk and protective factors. Risk factors contributing to the onset and/or exacerbation of mental illness are complex and interrelated, as each of the adverse outcomes noted above can themselves contribute to the development and/or maintenance of mental health and related problems. In addition, particular groups might be at heightened risk of developing a mental disorder. These include indigenous young people; those from a culturally and linguistically diverse (CALD) background; children of parents with a mental illness and/or substance use; those with low socio-economic status; young people affected by homelessness; those living in rural and remote areas; and young people with a chronic health condition (Royal Australian and New Zealand College of Psychiatrists, 2010). One of the key risk factors that may be common across disorders and groups is the experience of trauma. This can take multiple forms, including neglect, abuse (physical, sexual and/or emotional), bullying, being the victim of assault and/or experiencing a natural or manmade disaster. People witnessing a distressing event experienced by others may experience trauma vicariously. Children and young people can also experience what is known as complex trauma, a type of psychological injury that results from protracted exposure to prolonged social and/or interpersonal trauma from which they feel they can't escape. It can result in a lack or loss of control, helplessness, and changes in a person's identity, and can contribute to a range of adverse biopsychosocial outcomes across the lifespan, including mental illness (Cook et al., 2005).

It has been estimated that 50 percent of adult mental illness starts before the age of 18 (Kessler, et al., 2007). In addition, mental disorders disproportionately account for the largest burden of disease in Australian young people relative to other age groups (Begg, et al., 2007). These figures have led Insel and Fenton (2005) to characterise mental illness as the chronic diseases of the young. Lawrence, et al.(2015) found that 65 percent of 12-17 year olds with a mental disorder had accessed a support service in the last 12 months, with increasing severity associated with a higher likelihood of use (43 percent for mild problems, 76.3 percent for moderate problems, and 89.6 percent for severe problems). Of 12-17 year olds with a mental disorder, 8.1 percent had attended an emergency, outpatient or inpatient service, and 5.1 percent had accessed a specialist mental health service. (Gulliver, Griffiths and Christensen, 2010) found that stigma and embarrassment, problems recognising symptoms, and a preference for self-reliance comprised the most important barriers, and that facilitators are comparatively under-researched. However, there was evidence that young people perceived positive past experiences as well as social support and encouragement from others as aids to seeking help.

Beside the toll it exacts on individuals and their loved ones, mental illness is financially very costly to society. In 2012-13, more than $7.6 billion was estimated to have been spent directly on mental health- related services in Australia (Australian Institute of Health and Welfare, 2014). This represents 5.15 percent of the total federal health budget, despite mental illness contributing to 13 percent of the burden of disease in Australia in 2003, placing third in the ranking as a broad category of disease after cancer and cardiovascular disease (Begg, et al., 2007). Mental illness also imposes often-hidden financial strain on multiple other sectors and costs the Australian workforce an estimated $10.9 billion per year. With limited financial resources available, these factors together highlight both the need for mental health promotion, mental illness prevention, and early intervention, and greater focus on responsive, effective and developmentally-appropriate treatment for mental disorders in children and young people.

1.2. Contemporary Mental Health Care for Young People with a Mental Illness

Contemporary mental health care is articulated in the National Standards for Mental Health Services (Commonwealth of Australia, 2010), which together with related guidelines provide direction regarding the high-quality provision of mental health services across a range of settings in Australia. The Standards have been designed to assist with the measurement of service compliance, with the most recent edition including for the first time a Standard regarding recovery-oriented care.

The recovery model has in its roots a series of events that started more than 60 years ago to help restore the human rights and full inclusion of people with a mental illness. Examination of the conditions of adults in large-scale psychiatric institutions sparked an international transformation of the public mental health system. In a move that became known as deinstitutionalisation, large psychiatric hospitals were rapidly downsized or closed from the 1960s in the hope of enabling more people to access mental health services in their own community. This trend was further reinforced by the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (United Nations, 1991). It noted that for their human rights to be upheld, a person with a mental illness must be treated in the least restrictive alternative via an individualised plan that is reviewed regularly. They also have the right to be treated and cared for as much as possible in their community in a way that respects their cultural background. This landmark document highlighted that in order to meet these objectives community services must also have adequate resources to provide effective care.

In 1992, all Australian Governments initiated the National Mental Health Strategy to assure the rights of people with mental illness, including establishing the Burdekin Inquiry into the Rights of People with Mental Illness. What became known as the Burdekin report (Commonwealth of Australia, 1993) was released the following year, and found widespread community ignorance and discrimination regarding mental illness as well as misperceptions that people with a mental illness are dangerous and never recover. The report resulted in major changes to mental health policy, including a more rapid move to deinstitutionalisation. The cumulative impact of personal testimony and research has been the driving force behind the development of the recovery movement. It has been widely embraced by those with a mental illness, their loved ones and many service providers, and has increasingly helped shape policy development and research efforts.

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Development of the National Framework for Recovery-Oriented Services (Commonwealth of Australia, 2013) was based on extensive submissions and consultations, as well as a wealth of research, reports and policy documents both national and international. Most importantly, the framework was informed by those with a lived experience of mental health problems, and their families. It acknowledges that there is no single definition or description of recovery, but for the purpose of the Framework it was defined as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (p 2). It is a very active, empowering and respectful approach, in which people are acknowledged as possessing unique and important personal strengths that may assist their recovery journey. It is also more than the absence of symptoms or a diagnosis:

> "You're not recovered if you no longer [redacted] ...that's not a life. For most people you're recovered if you have friends, if you have family or if you have a job." (Focus group participant; Bird, Leamy, Tew, Le Boutillier, Williams & Slade, 2014, p. 645)

The Framework therefore articulates the fact that recovery can be assisted by many other avenues in a person's life, and so family, friends, neighbours, church, clubs, school and workplace may have an important part to play. Recovery-oriented services should facilitate and nurture community connections to maximise a person's opportunities in striving for wellness. The role of service providers should not be to "fix" or "cure" people but to tailor their support to best meet the needs of a person wherever they are in their recovery journey. The Framework also requires services to confront the tension between the dignity of conscious risk-taking on one hand, and duty of care and promoting safety on the other. This may require an understanding of the illusory, damaging and sometimes discriminatory nature of the goal of reducing harmful risks (Slade, 2013). The Framework outlines five practice domains (with related capabilities) to guide the provision of contemporary mental health care, as outlined in Table 1 below.

As noted in Domain 2, recovery includes the provision on rehabilitation in supporting holistic, person-centred care. The Framework makes the point that while rehabilitation is not the same thing as recovery, best-practice rehabilitation is recovery-oriented. This includes techniques that aim to "provide a range of tools that can be used to help an individual to gain or regain their independence and strive towards their recovery" (Commonwealth of Australian, 2013, p. 25) and notes that rehabilitation should be available in all settings and begin as soon as possible. The National Framework quotes the *Framework for recovery-oriented rehabilitation in mental health care* developed in South Australia, which states that

> "Rehabilitation services that are shaped by goals of promoting hope, healing and empowerment ensure mental health services foster an underlying attitude that recovery is possible, offer opportunities for consumers to maximise their own experience of recovery, and create a service environment that is flexible, responsive and accessible" (Government of South Australia, 2012, p. 9).

The principles of Connectedness, Hope and Optimism, Identity, Meaning and Empowerment (CHIME) underpin the recovery model developed by Leamy, Le Boutillier, Williams and Slade (2011) following their analysis of 30 international documents to identify the key characteristics of recovery-oriented practice guidance. Their findings support the domains and capabilities outlined above, and also align with the National Standards for Mental Health Services and the recovery model adopted locally (Queensland Health, 2005).

Table 1 Domains and capabilities of the Recovery Framework (Commonwealth of Australia, 2013)

Domain 1: Promoting a culture and language of hope and optimism	
A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism—this is central to recovery-oriented practice and service delivery.	
Capability 1A	The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.
Domain 2: Person-first and holistic	
Putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person's life situation holistically.	
Capability 2A	Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support
Capability 2B	Responsive to Aboriginal and Torres Strait Islander people, families and communities
Capability 2C	Responsive to people from immigrant and refugee backgrounds, their families and communities
Capability 2D	Responsive and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting
Capability 2E	Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities
Capability 2F	Responsive to families, carers and support people
Domain 3: Supporting personal recovery	
Personally defined and led recovery at the heart of practice rather than an additional task.	
Capability 3A	Promoting autonomy and self-determination
Capability 3B	Focusing on strengths and personal responsibility
Capability 3C	Collaborative relationships and reflective practice
Domain 4:Organisational commitment and workforce development	
Service and work environments, and an organisational culture that are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.	
Capability 4A	Recovery vision, commitment and culture
Capability 4B	Acknowledging, valuing and learning from people's lived experience and from families, staff and communities
Capability 4C	Recovery-promoting service partnerships
Capability 4D	Workforce development and planning
Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing	
Upholding the human rights of people experiencing mental health issues, and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.	
Capability 5A	Supporting social inclusion and advocacy on social determinants
Capability 5B	Actively challenging stigmatising attitudes and discrimination, and promoting positive understanding
Capability 5C	Partnerships with communities.

Applicability of the model in relation to young people has been questioned by some, given its evolution amongst adult consumers, with the suggestion it may not be sufficiently sensitive to the developmental needs of young people (e.g. Friesen, 2007). However, the CHIME model has recently been endorsed in an Australian study comprising young consumers, family members and clinicians (Mental Health Coordinating Council, 2014). Recovery was conceptualised as enabling a young person to participate in treatment to re-emerge from the constraints of their mental health problems in order to get enjoyment from life, re-focus on achieving goals and stay strong. While acknowledging the factors that may impede the delivery of recovery-informed care and highlighting the need for more research, participants supported the principles of the CHIME mode in its applicability to young people. The resulting discussion paper makes five recommendations to progress this field:

a) Language, literacy and opportunities for reflection;

b) Ensure participation of young people and their families in developing service delivery, programs and quality improvement strategies;

c) Address physical health;

d) Development of youth peer support and participation as a workforce competency; and

e) Trauma-informed care and practice.

(Mental Health Coordinating Council, 2014)

Application of the recovery model to young people has also been supported by a recent study conducted with 20 young adults (with an average age of 19.25 years) with a mental illness living in New South Wales (Honey, Coniglio & Hancock, 2015). Five "building blocks" were identified which together constituted well-being for participants: sense of self; relationships; sense of the future; feelings and experiences; and agency (or a sense of mastery and control). These may be supported or undermined by seven foundations, only one of which was mental illness, with the six remaining foundations comprising activities; having things; the past; coping strategies; environmental supports and barriers; and personal characteristics. The authors noted that well-being and recovery are not the same as the latter concept refers specifically to the experience of mental illness. However, they conclude that they have many features in common and that, in the case of young people, recovery refers to "building a life rather than rebuilding one that is lost"(p. 285). Ward (2015) has similarly viewed recovery in this group as a “developmental reconstruction that allows young people to continue to progress towards a satisfying and productive adult life” (p.88).

The National Standards also stipulate the individualised application of evidence-based treatment:

> "Treatment and support provided by the mental health service reflects best available evidence and emphasises early intervention and positive outcomes for consumers and their carer(s)" (Commonwealth of Australia, 2010).

With a growing understanding of the impact of mental health problems across the lifespan, research resources have over time turned to expanding the knowledge base of effective interventions for different disorders, settings and population groups, including amongst children and young people (e.g. Hoagwood, Burns, Kiser, Ringeisen & Schoenwald, 2001). Collins, Insel, Chockalingham, Daar & Maddox (2013) recommend that "the integration of care for mental, neurological and substance disorders should (1) occur through intersectoral collaboration and health system-wide responses; (2) use evidence-based interventions; (3) be implemented with sensitivity to environmental influences: and (4) attend to prevention and treatment across the life course" (p.2). It is on this basis that the current delivery of treatment to children and young people in Queensland is considered.

1.3. Public Mental Health Treatment for Children and Young People in Queensland

Evolution of the Child and Youth Mental Health Service (CYMHS) in Queensland has been informed by international trends in providing care to vulnerable children and young people (see Gahan & Kijas, 2014, for a summary). In the early 20th century, progressive social policy efforts led to the child guidance movement, which adopted elements from the evolving fields of psychology, psychoanalysis, social work, nursing and medicine.

These were followed by the rise of academic sub-specialisation, the establishment of treatment facilities and institutions and the revolution of paediatric psychopharmacology (Lourie & Hernandez, 2003).

On the basis of the recovery movement, an expanding evidence base and introduction of the National Mental Health Strategy and related policy, the landmark Queensland policy statement *Future Directions for Child and Youth Mental Health Services* (*Future Directions*) recommended that:

> "Contemporary treatment for children and youth is individualised, using a range of therapeutic approaches, appropriate to different ages, developmental stages, conditions and situations. Treatment approaches need to be open to review, as new evidence becomes available on effective interventions." (Queensland Health, 1996, p.6)

This policy has since then significantly informed the development of CYMHS service provision across Queensland in delivering integrated care across community and hospital settings. Although *Future Directions* is now 20 years old, it has been a seminal and visionary document in driving the uptake of contemporary mental health care to date for children, young people and their families across Queensland.

CYMHS is a free public health service that provides tertiary care to children and young people aged 0-18 years (and their families) who are at risk of, or experiencing, severe and/or complex mental health problems. Services are provided in each of the state's 16 Hospital and Health Services (HHS). In 2013/14, CYMHS received $112 million funding, representing 10.25 percent of the state's total mental health budget. Prior to introduction of the Adolescent Mental Health Treatment Initiative in 2014 (see section 1.7) and despite increasing service demand, CYMHS had not received any recurrent growth funding for the previous five years.

Children's Health Queensland (CHQ) is the only HHS focussed exclusively on delivering mental health services to 0-18 year olds, and with a statewide focus. Following amalgamation with Mater CYMHS in November 2014, CHQ CYMHS is now the largest paediatric mental health service in Queensland and one of the largest in the country, with approximately 1000 clients open at any one point in time. CHQ CYMHS holds significant expertise in the delivery of innovative, integrated, evidence-based treatment for infants, children and young people and their families experiencing severe and/or complex mental health problems. It has received national awards and excellent feedback from the Australian Council of Healthcare Standards (ACHS) for its integrated model of care and high standards of clinical quality and safety. This includes its commitment to meaningfully engaging young people and carers to draw upon their lived experience to inform all aspects of service planning, delivery and evaluation.

CYMHS differs from adult mental health services in a number of significant ways. It is in a prime position to interrupt developmental trajectories so that a child or young person's mental health problems don't become more entrenched, chronic and entwined with their emerging identity. For example, CYMHS staff may be engaged to assess suspected learning or developmental issues which can then be integrated into treatment, and fed back to school personnel for consideration in the classroom setting. In addition, CYMHS recognises that children and young people often receive mental health services within a family context, rather than in isolation. Wherever possible, families are actively engaged as a resource to complement and sustain treatment gains. (See Section 3 for more information about the evidence regarding family involvement). The nature of work with children and young people involves longer assessments in the family context, as well as the engagement of more individuals and services. It has been suggested that adopting a systems approach in this way requires up to a three-fold commitment in resources compared with the support provided to adults (Parker, et al., 2002, p. 5).

Upon entry to CYMHS, children, young people and their families are provided with information about the service and informed of their rights and responsibilities. Treatment is designed to address issues identified during a comprehensive biopsychosocial assessment, and targets goals generated collaboratively in discussion with the young person and, where possible, the family. It is delivered by an individual case manager, with assessment, treatment planning and delivery, case reviews and discharge planning informed by input from members of a multidisciplinary team. These include psychologists, social workers, mental health nurses, occupational therapists and speech pathologists, with clinical oversight provided by the team's Consultant Psychiatrist in discussion with the Team Leader. Other members of the team may be engaged to provide specialist assessment and/or intervention that support the identified treatment goals. These are clearly documented on a recovery plan that is signed by the child or young person and their family (who are given a copy for their records), and should comprise evidence-based approaches for this population and the presenting problems. (See Section 2 for a summary of the evidence for a range of diagnoses). Progress towards treatment goals is regularly reviewed with the young person, parents/carers and multidisciplinary team. As required of all mental health services in Queensland, clinicians access regular supervision from a senior clinician to reflect on their practice and identify and action priorities for professional development.

The overarching goal of the CYMHS clinical service is to sufficiently upskill a child or young person (and their family) so that over time they are able to expand and draw upon their own knowledge, strengths and existing networks to the point that they no longer need CYMHS support, or can be successfully transferred to a less restrictive service component. In each case, careful planning should be undertaken by CYMHS to facilitate the young person's smooth transition to a new treatment setting. For those clients approaching 18 years of age, proactive efforts are made to explore support options for their timely exit from the service. These may include accessing their local headspace clinic, private practitioners and in some cases the local adult mental health service.

Listed below are the three most common settings for CYMHS service provision identified by the *Future Directions* policy statement in 1996 (Queensland Health, 1996). These are also geographically depicted in Figure 1 below.

1.3.1. Community clinics

For most young people accessing the public mental health service, "least restrictive care" refers to the provision of outpatient treatment through a community CYMHS clinic following a referral from a secondary source such as a general practitioner, guidance officer or non-government organisation (NGO). These are associated with their catchment area of surrounding suburbs to help young people access the nearest clinic, and located close to a range of public transport options. However, a young person can attend another clinic (where available) if this is more convenient to their circumstances. There is no defined maximum length of care stipulated for outpatient treatment as this is determined by the individual needs of clients and their families, and they are able to re-engage with the service if the young person's severe and/or complex mental health problems return again before the age of 18. There are a total of approximately 45 CYMHS outpatient (or remote area) clinics across Queensland.

1.3.2. Day programs

Three HHSs offer a CYMHS Day Program as part of their continuum of care: Townsville, Toowoomba and CHQ (which operates one program at the Lady Cilento Children's Hospital in South Brisbane for 5-18 year olds, and more recently from a North Brisbane site for young people aged 13-18 years). These facilities offer a treatment option to young people whose needs cannot be sufficiently met in an outpatient setting, but are not severe enough to warrant an inpatient admission. They provide multidisciplinary support to improve emotional, social, family and educational functioning, and are offered for up to two school terms during business hours on an outpatient basis. Although they vary in scope and delivery, all (except the North Brisbane site) are co-located with an adolescent inpatient unit. However, they are all considered outpatient services and provide access to on-site schooling.

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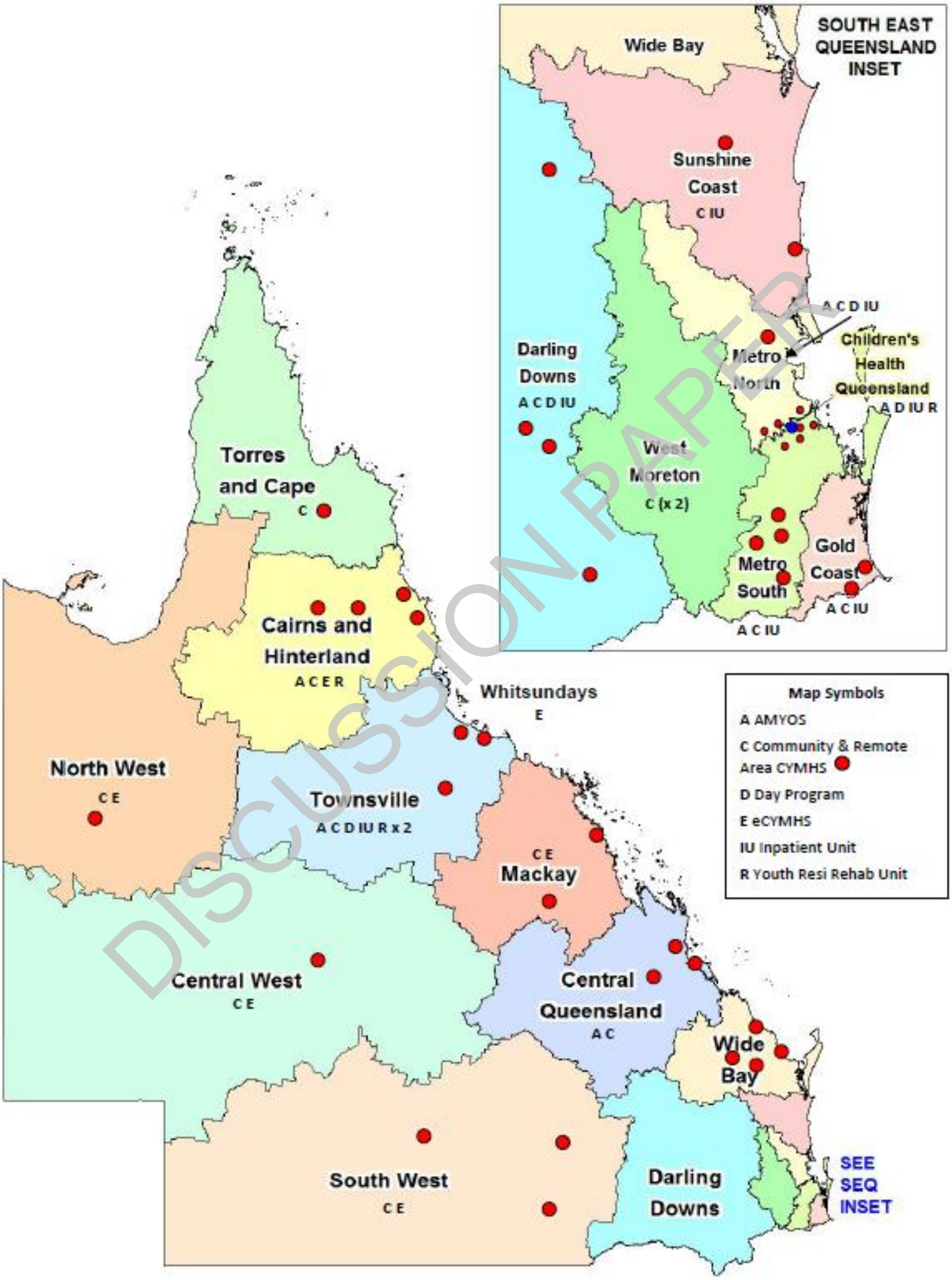
Figure 1 **Geographical representation of CYMHS services across Queensland**



1.1.1. Adolescent Inpatient Units

Another key setting for CYMHS intervention is acute adolescent inpatient units. These have been progressively introduced in response to the recognition that adult units are not a developmentally-appropriate environment for children and young people, and so their use by this cohort should be restricted as much as possible. In 1996, the only adolescent inpatient beds available were those provided by the Barrett Adolescent Centre (BAC) but by 2002 a number of additional units had opened across the state (Queensland Government, 2003). They are staffed 24 hours a day, seven days a week by specialist multidisciplinary teams.

Periods of hospitalisation should be kept to a minimum (Queensland Health, 1996), with either a planned or a crisis admission offered in these settings. Both types of admissions are accepted in each of the six adolescent inpatient units available across Queensland, with the Robina site including beds for children. In addition, there is a statewide child-only inpatient unit located at the Lady Cilento Children's Hospital in Brisbane (comprising nine beds). It has facilities for a family admission to reduce the emotional impact of an admission and enable a more thorough assessment and treatment of systemic family issues impacting on the child. The proposed establishment of an adolescent unit on the Sunshine Coast in 2016 will bring this to a total of 63 child/adolescent beds across seven sites. This is thought to match current population distribution, with 76 percent of young people under 18 years of age currently living in south-east Queensland (Australian Bureau of Statistics; 2011).

Historically, many inpatient units drew on therapeutic community principles whereby little or no specific individual work took place but change was instead expected to occur through the social environment or milieu. Milieu therapy is based on psychoanalytic theory and involves five functions: containment, support, structure, involvement, and validation (Gunderson, 1978). Containment is achieved through ensuring the physical and interpersonal safety of each client to promote perceptions of trust and security as the foundation on which all other interventions are based. Support refers to the ability of staff to foster a feeling of hope and related attitudes and behaviours. Structure is established through the daily schedule, implementation of rules/consequences and behaviour management practices. Involvement refers to features that prompt clients and family members to attach value to therapeutic community membership and reaching goals established during individual care planning. Finally, validation of each client’s unique treatment needs should be accomplished by the primary therapist who develops and implements a problem-oriented individual treatment plan. This mode of working appears to be no longer viable as the primary intervention for adolescent units, which have to treat a wide range of disorders using evidence-based treatments. However, some principles from milieu therapy are still used to facilitate positive change and encourage a young person to take on individual responsibilities (Cotgrove, 2013).

Key staff from adolescent units across Queensland have provided considerable input into the acute adolescent inpatient model of service to enhance statewide uniformity of service provision. The model has undergone extensive consultation and has been endorsed by the Statewide Child and Youth Mental Health Alcohol and Drug Advisory Group. It notes that the key functions of an adolescent inpatient unit are to:

- Deliver acute mental health care and crisis intervention in a safe and therapeutic setting;
- Provide inpatient multidisciplinary care, diagnostic assessment, treatment and evidence-informed clinical interventions, including recovery and discharge planning for consumers generally aged between 13 and 17 years;
- Arrange, coordinate and support access to a range of services for consumers, their families and/or carers to ensure seamless service provision;
- Provide a therapeutic milieu with an emphasis on positive communication, interactions and healthy relationships; and
- Provide a range of evidence-informed therapies within a neurobiological developmental framework.

(Queensland Health, 2015a)

Regardless of the length of stay, at some point a young person will need to be discharged. Enhancing a young person's confidence about leaving the containment offered by an inpatient unit is an important part of this transition. In some cases, embarking on brief periods of home leave can help a young person maintain contact with their family, assist in testing the strength of treatment gains and gauge their level of readiness for returning home. Planning for discharge should occur throughout the admission, with active efforts made to involve community support services prior to the young person's departure.

Mental health services are required to report annually on compliance with federal key performance indicators (KPIs). Listed in Appendix A are the most recent KPIs relevant to (adolescent) inpatient units in Queensland.

1.1.2. Other Child and Youth Mental Health Service Components

The availability of other youth-specific CYMHS components and programs varies subject to the individual priorities and resources of the HHS. Evolve Therapeutic Services (ETS) have been delivered by CYMHS since 2007 to provide intensive medium- to long-term mental health support for children and young people in the care of the Child Safety Services (Department of Communities, Child Safety and Disability Services) who have severe and complex behavioural and psychological issues and/or disability behaviour support needs. It is now available in ten HHSs across Queensland. See Section 6.3.2 for a more detailed description of the outcomes of the Evolve model and treatment outcomes.

The Ed-LinQ initiative, which is funded by Queensland Health, is delivered in 12 HHSs to enhance early intervention for primary and secondary students with emerging mental health problems. This is achieved through fostering strategic partnerships between schools, CYMHS, and primary care providers; enhancing capacity through the delivery of training and circulation of resources; and provision of clinical guidance. The latter comprises consultation-liaison to schools to inform their support of students with mental health needs, and can assist CYMHS staff to enhance educational support available to consumers. The Ed-LinQ initiative was favourably reviewed by an independent evaluation in achieving the objectives noted above (Mendoza et al., 2014), and the model is currently undergoing further examination to make it more widely and consistently available across Queensland.

CHQ CYMHS offers a telepsychiatry service known as eCYMHS. This involves the use of videoconference and teleconference technology to link mental health practitioners and their clients in nine rural and remote areas of northern and central Queensland with specialist CHQ CYMHS psychiatry and allied health expertise. The aim is to deliver appropriate mental health services and treatment locally to avoid, whenever possible, the need to transfer clients to services away from home. Services include case review discussions, direct clinical assessment and treatment planning, and professional development as well as multiple annual outreach visits. Referrals to this service are made via the CYMHS Community Clinics by participating rural sites. A review in 2012 showed that staff perceived eCYMHS as a valuable mechanism for improving skills (87 percent); enhancing their decision-making (87 percent) and obtaining timely advice (94 percent). The majority of respondents (94 percent) agreed that all or most needs were met by the service. Provisions of services almost doubled from 681 in the 2008/9 financial year to 1365 in 2010/11. Over this time, 441 children or families were assessed, many of whom were seen on multiple occasions, reflecting the complexity of the cases. Given eCYMHS' support, local clinicians reported feeling more comfortable seeing young people without the need for a face-to-face psychiatric assessment, and case consultations increased by 127.4 percent from 444 in 2008/9 to 1010 in 2010/2011. By 2012, a total of 3982 eCYMHS consultations had been conducted to support CYMHS consumers and staff in rural and regions across Queensland (Wood, Stathis, Smith & Krause, 2012).

A number of CYMHS services also deliver evidence-based programs aimed at improving the care offered to specific at-risk target groups. In the case of CHQ CYMHS this comprises families affected by parental mental illness, children and young people from a CALD background, those with co-existing substance use and service integration for those with especially complex care needs.

1.2. State Contextual Factors

In July 2012, the Queensland Child Protection Commission of Inquiry was established under the leadership of the Honourable Tim Carmody QC (and became known as the Carmody Inquiry) following mounting public concern over the increasing number of children and young people coming into care. It was tasked with conducting a far reaching review of Queensland’s child protection system; to find out if the system was failing children; and, if so, why and what should be done to fix it. In July 2013, the Commission presented to the Queensland Government its final report, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Queensland Government, 2013). It concluded that the existing system was not adequately ensuring the safety, wellbeing and best interests of children, and made 121 recommendations to improve the state's child protection system. After reviewing the report, the Queensland Government accepted 115 of the recommendations in full, and six in principle. As a result of this work, the Government has committed to building a new child and family support system. On the basis of their positive outcomes for clients, Evolve Therapeutic Services will continue to be delivered as a cross-departmental commitment to treat severe and/or complex mental health needs of children and young people in out-of-home care.

The Queensland Mental Health Commission (QMHC) was established in July 2013 to improve the mental health and wellbeing of all Queenslanders and minimise the impact of substance misuse. Its formation reflected the establishment of Mental Health Commissions in other states, as well as nationally. Its overarching vision has been profiled in the Queensland Mental Health, Drug and Alcohol Strategic Plan, 2014-2019 (QMHC, 2014a). The QMHC supports the approach of the National Recovery Framework (Commonwealth of Australia, 2013) in advocating least-restrictive practices within inpatient units, as evidenced in its statement paper outlining options for reform on the topic (QMHC, 2014b). The QMHC Suicide Prevention Plan (Queensland Mental Health Commission, 2015a) was launched in September 2015, and includes four priority areas: stronger community awareness and capacity; improved service system responses and capacity; a stronger more accessible evidence base; and focused support for vulnerable groups, including people living in rural and remote areas, and children and young people. As part of this plan, Queensland Health will be implementing a 12 month suicide prevention project focused on enhanced training and resources to help Emergency Department staff better recognise, assess, manage and refer people at risk of suicide. CHQ CYMHS is involved in this consultation to ensure the content reflects the experiences and needs of suicidal young people, and their families. The Mental Health Promotion, Prevention and Early Intervention Plan (Queensland Mental Health Commission, 2015b) was launched in October 2015 to promote mental health and well-being across the lifespan, including a focus on children and young people. It has also released a plan targeting drug and alcohol use (which includes a focus on young people; QMHC, 2015c), and will shortly be releasing plans targeting Aboriginal and Torres Strait Islander populations and people living in rural and remote areas. CHQ CYMHS is currently coordinating a project funded by the QMHC until June 2016 to review and update the Ed-LinQ model.

Mental health service funding is allocated to the state government for distribution to HHSs via the Mental Health, Alcohol and Other Drugs Branch (MHAODB). Although mental health services are accountable to their local HHS, MHAODB governance mechanisms help standardise, inform, and enhance public mental health care across Queensland. This includes the development of clinical models of service as well as maintenance of the Consumer Integrated Mental Health Application (CIMHA), in which contact information, service provision, clinical notes and outcome measures for all clients accessing public mental health services in Queensland is recorded. The Statewide Child and Youth Mental Health Alcohol and Other Drugs Clinical Group (SCYMHAODCG) meets every two months to discuss, consult about and advocate for issues of relevance to 0-18 year olds and their families. There are also statewide forums to discuss strategic issues relating to specific diagnostic groups including early psychosis and eating disorders. Issues from these forums are raised with the MHAOD Statewide Reference Group for integration with strategic planning across the state. In late 2015 the MHAODB consulted with mental health services and stakeholders in all HHSs to guide planning and delivery of state funded mental health and alcohol and other drug services. Internationally-recognised, contemporary, evidence-based population planning frameworks will also be utilised to inform the Queensland Health Mental Health Drugs and Alcohol Services Plan 2016-2021 (The Services Plan). Preliminary funding priorities suggest a move to a broader continuum of care to enable more people to access mental health support in their community to enable the establishment of services such as day programs and step-up/step-down units, with the gradual reduction in resourcing for inpatient and (adult) community care beds. The Services Plan is due for release in early 2016.

An important addition has been the availability of headspace centres, which are designed to provide brief interventions for young people 12-25 years with mild to moderate mental health problems. headspace is based on a primary care model with a focus on easy access and early intervention. There are a total of 17 headspace centres across Queensland. Given the time-limited nature of headspace interventions, however, young people with severe and/or complex mental health problems will need to be referred to other services that provide more intensive, long-term support in their community.

1.3. Barrett Adolescent Centre

Of particular relevance to this discussion paper is the Barrett Adolescent Centre (BAC), which provided mental health treatment for young people aged from 13 to 18 years. It preceded the establishment of community CYMHS clinics or adolescent inpatient units in Queensland. The BAC opened in 1983 on the grounds of what is now known as The Park Centre for Mental Health after an adult facility there was closed down in the era of deinstitutionalisation. For its first 18 months, the BAC only offered a day program and outpatient services. These were maintained when it opened its inpatient service as a statewide facility with 16 beds in October 1984. The BAC operated 24 hours a day, seven days a week (with weekend leave available for some young people living locally) and, consequently, the majority of clinical staff for the inpatient unit were nurses. Referrals to the inpatient unit were accepted from community CYMHS clinics, acute adolescent units, private psychiatrists and, anecdotally, general practitioners and headspace. In 2001-02 its annual operating budget was $1.9 million, which had grown by 2012-13 to $3.3 million. (Prior budgets exceeded five million dollars, as by 2012-13 a number of staff had taken redundancies in anticipation of the impending closure).

This figure also does not reflect the investment from Education Queensland to run the on-site school to support young people accessing the BAC day program and inpatient unit. In 2012, the school had an operating budget of around $870,000 and employed nine teaching staff and nine non-teaching staff. Core classes included literacy, numeracy and information technology, with these being complemented by classes in art, drama, music, media, construction, home economics, and horticulture. The teachers also assisted in delivering a range of activities including swimming, self-defence and gardening, and taking students on outings to the movies, gyms, restaurants, camps and art galleries.

With the introduction of routine outcome measures to all Australian mental health services in 2003, implementation of one of the measures at the BAC was reviewed (Harnett, Loxton, Sadler, Hides & Baldwin, 2005). The Health of the Nations Outcome Scale for Children and Adolescents (HoNOSCA; Gowers, et al., 1999) is an assessment and outcome measurement tool intended to be used routinely to score the behaviour, impairments, symptoms and social functioning of children and young people with mental health problems. It is completed by clinicians for 3 - 18 year olds in all CYMHS settings in Queensland. Outpatient CYMHS treatment has been associated with significant change of 3.61 in HoNOSCA scores over a six month period, with improvement noted across all sub-scores, and the greatest change associated with the greatest severity at baseline (Garralda, Yates & Higginson, 2000). Analysis by Harnett, et al. (2005) confirmed that the HoNOSCA was a sound measure to use with BAC's target group of inpatients. They noted that the overall HoNOSCA score (of 15.86) at the time of BAC admission was comparable to that of young people accessing Australian outpatient clinics (of 15.21; see Brann, Colemann & Luk, 2001). Reviewing individual HoNOSCA items suggested that relative to BAC inpatients at intake, outpatient samples were more likely to report problematic substance use and poor school attendance and less likely to report attentional problems, hallucinations/delusions, self-care or relationship problems with peers or family members. Total HoNOSCA scores for BAC consumers did not change compared to their intake scores when re-administered at three months (when the only individual item to have improved was family life and relationship problems) and six months (when they were more likely to report scholastic/language difficulties and less likely to report hallucinations/delusions and family life and relationship problems). This may imply treatment yielded little overall clinical improvement over time.

In 2000, Cabinet endorsed a proposal to undertake a study on the development of secure in-patient mental health services for incarcerated children and adolescents in youth detention centres, and the redevelopment of the extended treatment adolescent in-patient services. The report subsequently produced by Queensland's Mental Health Unit (now known as the MHAODB) noted that the *Ten Year Mental Health Strategy* (Queensland Health, 2006) foreshadowed the ability to better meet the extended treatment needs of children and adolescents through enhanced community based services in association with the new acute units and day treatment programs (Queensland Health, 2003). The report proposed that the BAC would be closed and its annual operating budget redirected to enhance community-based services. The master plan for the redevelopment of Wolston Park Hospital therefore did not include the BAC. The report also noted that an attempt was made to close the BAC in 1997, but this was unsuccessful due largely to a strong community response that led the then Minister for Health, Mike Horan, to reverse this decision. However, the report noted that the closure attempt preceded the opening of any additional (acute) adolescent beds. The report concluded with a number of recommendations including:

Immediate:

- Develop admission criteria between the BAC and acute adolescent units.

Short-term (within a six month period):

- Develop an inpatient model of service delivery, including admission criteria to the BAC.
- All child and youth acute units to collect data on case complexity in relation to referrals to the BAC to enable benchmarking.
- Explore models for admission to both acute and extended inpatient treatment.
- Pilot and evaluate alternative models.

Medium-term (within a 24 month period):

- Make a final decision on the need for an extended treatment facility (BAC) following the implementation of clear admission criteria to the BAC and piloting and evaluation of a range of alternatives.

(Queensland Health, 2003)

In 2003, an external review of BAC service delivery identified concerns regarding admission criteria, risk assessment and management, BAC management practices and the Centre’s response to critical incidents (McDermott, 2003; cited in Walter, Baker & George, 2009). A second external review six years later (Walter, Baker & George, 2009) highlighted significant issues regarding governance structures; clinical leadership; sufficient handover between shifts; performance reviews of staff; limited clinical scope, professional development, leadership options or CYMHS experience amongst nurses; negligible evaluation of BAC treatments (including consistent completion of outcome measures or promotion of quality activities); no clear processes for managing complaints; and the young person's timely and seamless entry into and exit from the Centre. In particular, the reviewers noted an increasing average length of stay (including young people remaining past the age of 18 years), although the governance process through which this occurred was unclear. The reviewers made a number of recommendations regarding the patient journey, including that discharge planning should be held throughout the admission, and exploration for access to step-up/step-down facilities to assist the transition of young people back into the community.

Walter, Baker and George (2009) suggested that milieu therapy and adventure therapy (cited by staff as the main therapeutic interventions used) were not sufficient and instead strongly recommended developing a model of care using evidence-based interventions, such as Dialectical Behaviour Therapy or the Maudsley model for eating disorders. They also recommended that individual treatment plans be developed using evidence-based treatments to meet the individual needs of young people, and that staff be trained and supervised in their delivery. Finally, the 2009 review noted that significant use of continuous observations (for monitoring the safety of young people) used up considerable staff time that could have been better devoted to delivering therapeutic interventions. They also raised ongoing concerns regarding the number of critical incidents (including "near misses") in the unit.

In 2008, ACHS provided a high priority recommendation regarding the need to improve staff and patient safety. The number of reportable incidents for 1997-2007 is summarised in Figure 2 below.

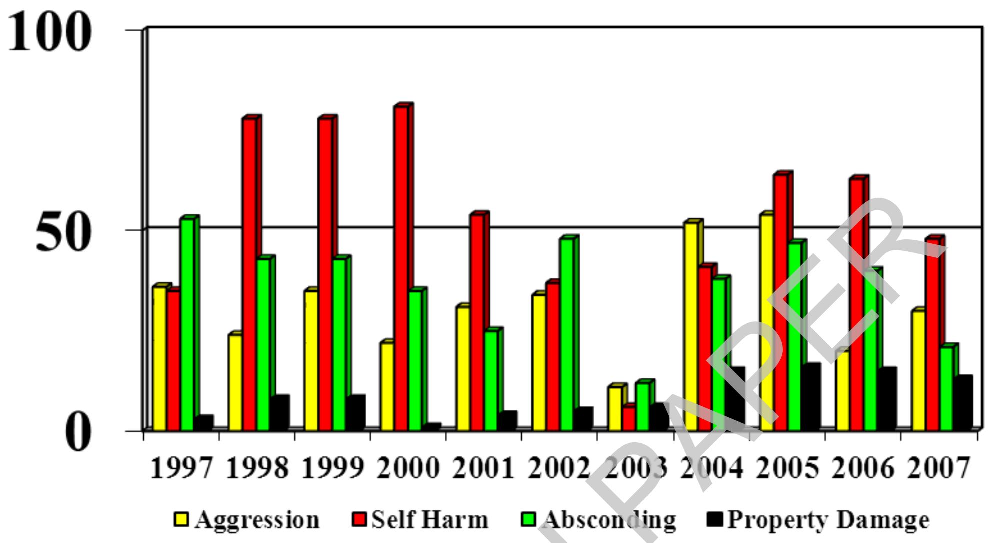


Figure 2: Number of reportable incidents, 1997-2007 (Sadler, 2007)

To help address these concerns, a working group was briefly convened in early 2010 to develop a model of service (as required by Queensland Health specifications) to inform ongoing BAC service provision. It comprised seven senior representatives from CYMHS sites from across Queensland, including the BAC Director. Although consensus regarding the optimal length of stay was difficult to reach, clear processes were identified to address clinical governance issues, better position adolescent extended treatment in the CYMHS continuum of care, and refine referral, treatment and discharge processes. It had been intended that the model would be implemented following the planned move of the Centre to a new site in Redlands which did not occur when the Redlands redevelopment was ceased with delays due to environmental considerations.

One of the consequences of the extended lengths of admission appears to have been a growing waiting list, which by 2012 had reached six months (News in Mind, 2012). Anecdotal reports suggest that young people on the waiting list had not necessarily been referred to community CYMHS for support to maintain their severe and/or complex mental illness during the time they were awaiting admission. It has been reported that a number of young people completed suicide while on the BAC waiting list (News in Mind, 2012).

At the time of the announcement of its closure in August 2013, young people admitted to the BAC inpatient unit came from the following areas:

- 1 from Central Queensland
- 2 from North Queensland
- 3 from Sunshine Coast
- 3 from Metro North
- 3 from Metro South

The top three primary diagnoses amongst this group were Social Phobia, Post-Traumatic Stress Disorder and Mixed Anxiety Disorder. These young people had been admitted for an average of 17 months, ranging from one to 32 months.

Consistent with state and national mental health reforms, the decentralisation of services and the reform of TPCMH site to offer adult-only forensic and secure mental health services, it was decided that the BAC was unable to continue operating in its current form. The BAC building was also identified as being beyond refurbishment. Consequently, in late 2012, an Expert Clinical Reference Group (ECRG) comprising experienced child and youth mental health clinicians, a consumer representative, a carer representative and key stakeholders from the BAC (including the Director and Principal) was convened by the Barrett Adolescent Strategy Planning Group to explore and identify alternative service options for this target cohort.

In April 2013, the ECRG made a number of recommendations to the West Moreton HHS Board, one of which was that "a Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness"[1]. This recommendation was accepted with the consideration that:

> "Further work was needed to develop a Tier 3 model of service. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation". (Barrett Adolescent Strategy, 2013, p. 2-3)

A collaborative partnership was established between the MHAODB and Children's Health Services (now known as CHQ) to translate ECRG recommendations into a statewide continuum of care, including implementation and funding plans.

1.4. Development of the Adolescent Mental Health Extended Treatment Initiative (AMHETI)

CHQ CYMHS considered the ECRG recommendations and consulted widely with mental health experts and care providers throughout Australia to learn about and explore alternative, progressive approaches to adolescent extended treatment and rehabilitation care as part of the Adolescent Mental Health Extended Treatment Initiative (AMHETI). This included hosting a statewide forum to consider current service options and future opportunities, and travelling to related services interstate to visit and consider a range of contemporary services and models. On this basis, CHQ CYMHS developed an adolescent extended treatment continuum, comprising the following five service elements listed below. CHQ CYMHS was resourced to establish seven AMYOS teams, a new Day Program and a Youth Resi in South Brisbane using the operational funds from the BAC.

1.4.1. Assertive Mobile Youth Outreach Services (AMYOS)

These services provide recovery-oriented assessment and assertive treatment and care for young people aged 13-17 years with complex mental health needs who are considered high-risk, but who have disengaged from their local community CYMHS team. This service is delivered by multidisciplinary CYMHS clinicians, who see young people in either the family home or the community. The Queensland AMYOS model is based on a similar Victorian service (Intensive Mobile Youth Outreach Service; IMYOS) who are regarded as the leading current provider in this area.

AMYOS teams have been established in north Brisbane, south Brisbane, Redcliffe/Caboolture, Logan, Darling Downs, and Townsville, with recruitment underway for the Gold Coast, Cairns and Rockhampton teams. Young people are referred by their local community CYMHS, following which (if accepted) an AMYOS case worker will work intensively with the young person (and where possible their support networks) for up to two years. See Section 6.3.3 for a profile of the young people accessing CHQ CYMHS AMYOS support.

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[1] It should be noted that the concept of tiers is not used in Queensland Health and does not correspond with the draft National Mental Health Service Planning Framework. The ECRG's use of the term, Tier 1 was conceptualised as outpatient clinics and Tier 2 covered Day Program and the Assertive Mobile Youth Outreach Service.

1.4.2. Adolescent Day Programs

Day Programs provide intensive individual, group and family therapy and facilitate access to specialised schooling to enhance the educational outcomes of young people. In addition to the Day Programs already available at the Lady Cilento Children's Hospital, Toowoomba, and Townsville, a new Day Program in north Brisbane commenced operation in January 2015 to support young people aged 13-18 years. Young people are referred by a CHQ Community CYMHS team when outpatient treatment is insufficient, and the young person's mental health problems are not considered serious enough for a psychiatric admission.

1.4.3. Youth Residential Rehabilitation Units (Youth Resis)

Youth Resis 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 them 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. Similar programs are offered in Victoria for young people aged 16 to 25 years with serious mental illness and who are at risk of - or experiencing - substantial functional impairment and psychosocial disability. CHQ currently provides a Youth Resi in south Brisbane and in Cairns, with another two opening in Townsville in early 2016. A model of service has been developed to inform the delivery of this service in Queensland.

1.4.4. Step Up / Step Down Units (SUSDU)

This AMHETI component has been proposed for future funding to offer short-term residential treatment in purpose-built facilities that are delivered by mental health specialists in partnership with NGOs. The units are based on the Youth Prevention and Recovery Care (Y-PARC) services currently delivered in Victoria. The target group is 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 earlier discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (step down).

Several studies have found step-up/step-down units to be effective in providing positive clinical outcomes (Thomas & Rickwood, 2013). The ACT operates a step-up step-down program for adolescents as well as those over 18 years of age. Preliminary data suggests it contributes to increased hope and self-efficacy, and a reduction in mental health symptoms. Most participants also indicated it assisted their development of life skills, increased their social involvement and enhanced their relationships.

Establishing these services will require significant capital and recurrent expenditure from local Hospital and Health Services and/or the Department of Health in collaboration with CHQ.

1.1.1. Statewide Sub-Acute Beds

In line with ECRG recommendations, CHQ established interim sub-acute beds to offer medium-term, intensive, hospital-based treatment in a safe and structured environment with on-site schooling for young people from across the state who's severe or complex symptoms of mental illness and associated significant disturbance in behaviour preclude them from receiving treatment in a less restrictive environment. Unlike acute inpatient units, this service includes a comprehensive assessment of issues, complicated by a high degree of complexity and chronicity, which young people and their families may present with. Organisation of ongoing care in these complex and chronic clinical presentations requires extensive collaboration and coordination that was thought to be beyond the scope and time available to acute inpatient units, and would lend itself to a more rehabilitative and extended form of treatment.

This component was not intended to be a replication of the previous extended treatment approach at BAC.

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Specific differences include:

- Assessment and referral by a multidisciplinary Statewide Assessment Panel (as opposed to a local clinical team) to ensure equity of access (see Appendix A for an overview of Panel processes);
- Maximum three month stay, with extension based only on clinical requirements ;
- Discharge planning on entry, with the referring HHS undertaking to accept the young person on discharge, to ensure consumers are returned to their families and communities in an optimal timeframe to meet their clinical and care needs; and,
- Intensive process of family assessment for integration into the individual treatment plan.

These beds were established as an interim arrangement to assess demand to inform future planning.

1.2. Statewide Sub-Acute Beds: Demand and Future Directions

It was noted by the ECRG that this service was an essential component of an overall model of care. As such, from February 2014, the availability of sub-acute beds was made known through a wide range of forums, including the SCYMHAODCG, and in direct communication with the Consultant Psychiatrists and Team Leaders of all Queensland adolescent inpatient units. An external website promoting the AMHETI continuum of care (including descriptions of the individual components and contact details for enquiries) was also established in November 2013 for access by the general community. This was updated to a new address to reflect the amalgamation of the Mater and CHQ. As of September 8th 2015, the external website and an internal Qld Health website had received a combined total of 3,995 hits.

Over the past 18 months, there have only been two consumers who required a sub-acute bed admission (both based in Brisbane). [redacted]

Development of a SSB model of service by CHQ CYMHS was delayed by the work arising from the amalgamation of the CHQ CYMHS with Mater CYMHS, but development of a draft model commenced in April 2015. In June 2015, confirmation was received that there would be no recurrent funding to resource the sub-acute beds, which prompted senior CHQ CYMHS staff to reflect on continuation of service provision. They proposed this discussion paper to review the evidence, benefits, and risks of such a service, with a focus on the lived experience, to help inform the level of need and scope for an ongoing SSB model of care.

The remainder of this discussion paper will review the evidence base for treatment of severe mental illness in young people, and provide recommendations for ongoing service delivery in the Queensland context.

2. Evidence-Based Treatment for Relevant Clinical Presentations in Young People

Young people requiring inpatient treatment present with multiple complexities and high mental health needs. To develop a comprehensive profile of this group, Tonge, Hughes, Pullen, Beaufoy and Gold (2008) undertook an in-depth analysis of 88 young people accessing a Melbourne inpatient unit over a five year period. Results showed a high rate of comorbid Axis I diagnoses, with depressive disorders the most common principal diagnosis, and two-thirds experiencing clinical levels of internalising problems. Clinical levels of thought disturbance and behaviour problems were reported for most adolescents by parents, although the adolescents themselves self-reported fewer of these symptoms. Conversely, adolescents reported greater levels of family dysfunction than their parents. Educational and social difficulties were common, as was a high level of family dysfunction reported by multiple informants. Non-English-speaking background and low socioeconomic status were associated with a principal diagnosis relating to psychosis. The authors concluded that treatment focusing on only some of these complexities may have limited effectiveness, reflecting the need for holistic care. In another study, Niethammer and Frank (2007) found a high prevalence of substance use and disorder in adolescent inpatients. Around 76 percent reported regular use of tobacco, 44 percent reported regular alcohol use, and 40 percent reported regular use of illegal substances. A substance-related diagnosis (abuse or dependence) was made in 50 percent of cases for nicotine, 29 percent for alcohol, and 26 percent for illegal substances.

A review of Adverse Childhood Experiences (ACEs such as sexual abuse, parental mental illness, substance use or criminality) found that young people with a higher number of ACEs were more likely to be admitted to an inpatient unit (Rytilä-Manninen et al., 2014). Compared with those not admitted to a unit, the Inpatient Unit Group also reported poorer social support from both family and friends, and were more likely to have experienced school bullying. Internalising disorders in the inpatient group were associated with physical abuse, parental psychiatric and substance use problems, and witnessing intimate partner violence. Externalising disorders were related to physical abuse, parental psychiatric and substance use problems, and parental divorce. The risk for having either type of disorder increased if the person had experienced sexual abuse, which was reported by 21 percent of the inpatient group, or school bullying.

The following section outlines the main mental health presentations that may require an admission. Commentary is provided regarding best practice in the provision of psychosocial treatments including recommendations for treatment settings (for a detailed overview of the evidence base for a range of mental illnesses experienced by children and young people, see Fonagy, et al. (2015)). Information regarding service delivery in Queensland is noted where appropriate.

2.1. Anxiety

A National Survey by Lawrence, et al. (2015) focused on the four anxiety disorders that are most common and cause the greatest distress in children and adolescents: social phobia, separation anxiety disorder, generalised anxiety disorder (GAD) and obsessive-compulsive disorder (OCD). Among Australian adolescents, both social phobia and separation anxiety disorder were found to be equally common (3.4 percent), followed by GAD (2.9 percent) and OCD (0.8 percent)[2]. Overall, 7 percent had experienced at least one anxiety disorder in the past 12 months.

Given the heterogeneity of symptoms and presentations within anxiety disorders, there have been no known clinical guidelines developed that collectively cover all of these conditions. As such, the primary focus is on social phobia as one of the most common disorders, and one of the top three diagnostic groups experienced by BAC consumers.

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[2] It should be noted that with the introduction of the Diagnostic and Statistical Manual for Mental Disorders - 5th edition (DSM-5), OCD is no longer considered an anxiety disorder. However, for the paper of this discussion paper it is retained in this section.

Guidelines developed by the National Institute for Health and Care Excellence (NICE, 2013) recommend individual and/or group cognitive behaviour therapy in treating social anxiety disorder, including for children and young people. They make a number of recommendations for this age group, including:

- offer to provide treatment in settings where children and young people with social anxiety disorder and their parents or carers feel most comfortable, for example, at home, in schools or community centres;
- if possible, organise appointments in a way that does not interfere with school or other peer and social activities; and
- offer parents and carers an assessment of their own needs, including personal, social and emotional support; support in their caring role including emergency plans; and advice on and help with obtaining practical support.

While the Guidelines don't explicitly focus on the inpatient setting, the preference appears to be that treatment occur within the community. As noted in Sections 4 and 5 of this paper, inpatient units may expose young people to behaviours that can be very foreign and distressing to them. In addition, admission may separate young people from the very things that are causing them anxiety and inadvertently serve as a form of avoidance which only reinforces their disorder. They may also have limited opportunities in an inpatient unit to develop skills and confidence to confront and overcome their social anxiety in the real world. As such, it may be counterproductive to deliver treatment for severe anxiety in this setting, especially if the distance from home does not allow opportunities for testing treatment gains during periods of leave.

Parental involvement can complement individual anxiety treatment by motivating the young person to attend appointments, supporting their implementation of treatment strategies in the home environment and acting as a 'consultant' in the therapeutic process in recognition of their growing independence (Suveg, Hudson, Brewer, Flannery-Schroeder, Gosch & Kendall, 2009).

2.2. School Refusal

Anxiety may be one factor that contributes to the development of school refusal. This has been described by Berg (1992) as a condition characterised by reluctance and often outright refusal to go to school in a child who:

- seeks the comfort and security of home, preferring to remain close to parental figures especially during school hours;
- displays evidence of emotional upset when faced with the prospect of having to attend school, although this may only take the form of unexplained physical symptoms;
- manifests no severe antisocial tendencies, apart from possible aggressiveness when attempts are made to force school attendance; and
- does not attempt to conceal the problem from parents.

In this way, school refusal can be distinguished from truancy but can similarly result in substantial absences from school.

Factors contributing to the development of school refusal are complex and inter-related. Several authors (Heyne & King, 2004; Thambirajah, et al., 2008) note that these may include:

- Individual factors (e.g. behavioural inhibition, fear of failure, low self-efficacy, physical illness),
- Family factors (e.g. separation/divorce, parental mental health problems, overprotective parenting)
- School factors (e.g. bullying, transition to secondary school, structure of the school day); and/or
- Community factors (e.g. pressure to achieve academically, inconsistent professional advice).

A systematic review by Maynard, et al. (2015) noted that CBT is the most studied intervention in the treatment of school refusal and found that it positively contributed to a significant improvement in school attendance. However, CBT did not achieve comparable post-test reductions in anxiety, which may require a more targeted intervention in its own right. The @school program is a CBT intervention designed to promote developmental sensitivity when planning and delivering treatment for school refusal amongst adolescents in particular, and has found promising results (e.g. Heyne, Sauter, Ollendick, van Widenfelt & Westernberg, 2014). Treatment outcomes of a CBT-based group intervention (delivered in an outpatient CYMHS clinic for young people with severe social anxiety disorder) yielded a significant reduction in severe social anxiety and saw a number of participants successfully return to school (see also Section 6.3.1.2).

A scoping study on school refusal undertaken by a Brisbane youth service identified the need for greater recognition and resourcing of the issue, and highlighted the importance of early intervention, peer support, care coordination, school-based responses, and alternatives to mainstream school (Community Connections, 2009). The final report made a number of recommendations to support young people and families, including suggestions targeting stakeholder services as well as public policy.

2.3. Depression

Lawrence, et al. (2015) found that five percent of Australians aged 12-17 years had experienced a depressive episode in the preceding 12 months. Patton, et al. (2014) found that almost 60 percent of Australians who had an episode during adolescence reported another episode as a young adult, with this pattern twice as common amongst young women than men. However, shorter episodes (less than six month's duration) in adolescence appeared to reduce the likelihood of recurrence in adulthood. This highlights the need for responsive care delivered as soon as possible to achieve better outcomes for young people and their families.

The NICE guidelines for depression in children and young people suggest to "offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months" (p.23). They further state that:

- When considering admission for a child or young person with depression, the benefits of inpatient treatment need to be balanced against potential detrimental effects, for example loss of family and community support
- When inpatient treatment is indicated, child and adolescent mental health professionals should involve the child or young person and their parent(s) or carer(s) in the treatment process wherever possible; and
- Commissioners and strategic health authorities should ensure that inpatient treatment is available within reasonable travelling distance to enable the involvement of families and maintain social links.

(National Institute for Health and Care Excellence, 2005a, p 28-29)

In 2010, BeyondBlue released Clinical Practice Guidelines for Depression in Adolescents and Young Adults. This was coordinated by an expert reference group, which consulted widely with the evidence base as well as input from consumers, carers and clinicians, and was chaired by Queensland Psychiatrist, Associate Professor Brett McDermott. The Guidelines state that:

> "In complex presentations, a longer assessment phase and accessing information from multiple informants across a longer developmental period can clarify the young person's course and ultimately the diagnosis. There may be a role for a brief (4–7 day) inpatient admission to assist this process, especially to determine the consistency and stability of the young person's depressed mood and his or her interpersonal functioning." (p.69)

It was also noted that:

> "All admissions for inpatient care should be time limited, with clear goals set for the duration of stay. Risks associated with admission, such as regression, acting out, and the potential for adoption of unhelpful behaviour modelled by other inpatients, must be considered and carefully managed." (p 70)

The Guidelines furthermore note that treatment for depression in adolescents and young adults is likely to be more successful if parents or carers are informed and involved. The two psychological treatments with the best evidence base for adolescent depression are CBT and interpersonal therapy (IPT). The IPT model conceptualises four specific interpersonal problems present in people with depression: interpersonal disputes, role transitions, grief, and interpersonal deficits. The adolescent version differs from adult IPT in three major ways: shortening of treatment duration from 16–20 weeks to 12 weeks of individual psychotherapy, the reconceptualisation of the sick role to have a more limited focus, and adding the involvement of parents throughout the therapy process. This includes the provision of psychoeducation, improvement of communication and a review of treatment progress, and the need for further support (Mufson, Moreau, Weissman & Klerman, 1993). IPT has been successfully delivered in community settings (Mufson, 2010). Delivery both individually and in groups has yielded improvements in depression, attachment style, communication and social factors in a study of Queensland adolescents, with many of these effects enduring over the 12-month follow-up period (O'Shea, Spence & Donovan, 2015).

2.4. Trauma Responses

Post-traumatic stress disorder can occur from a single event, such as a natural disaster or accident. Adverse childhood experiences are not uncommon amongst young people who may require inpatient admission (Rytilä-Manninen, et al., 2014), and may also contribute to the experience of trauma. High rates of trauma exposure (46-96 percent) and significant symptoms of post-traumatic stress disorder (PTSD; 21–29 percent) have been found amongst adolescent psychiatric inpatients (Allwood, Dyl, Hunt & Spirito, 2008; Havens, et al., 2012). Keeshin, et al. (2014) moreover found that physical and sexual abuse were independently associated with increased length of inpatient admissions for children and young people. Trauma-informed care was one of the five principles considered important in application of the recovery model to young people. However, inpatient units have been perceived by young people as more challenging in providing recovery-oriented care as hospital policies may be considered unnecessarily intrusive and potentially impinging on the young peoples' rights and notions of empowerment (Mental Health Coordinating Council, 2014).

Trauma-focused CBT (TF-CBT; Cohen, Mannarino, Berliner & Deblinger, 2000) is a highly structured therapy that consists of a series of manual-based sessions (typically 10-18 sessions lasting one hour each). The intervention focuses on stress management, education about symptoms, creating a narrative of the trauma (as a means of exposure), and cognitive reprocessing of the trauma and resultant symptoms. Randomised clinical trials have found TF-CBT to be an effective treatment plan for a variety of disorders in both children and adolescents (Cohen, Deblinger, Mannarino & Steer, 2004; Cohen, Berliner & Mannarino, 2010; Cohen, Mannarino & Iyengar, 2011). Compared with routine care in a community mental health clinic, young people accessing TF-CBT were found to yield lower post-traumatic symptoms, depression and general mental health problems, greater improvements in functional impairment and be less likely to be diagnosed with PTSD (Jensen, et al., 2014). The NICE Guidelines for the management of PTSD recommend, in the first month after the traumatic event, older children with severe post-traumatic symptoms/severe PTSD (including that related to sexual abuse) should be offered a course of TF-CBT that is tailored appropriately to their age, circumstances, and level of development (National Institute for Health and Care Excellence, 2005b).

Another intervention that holds significant promise is the Integrative Treatment of Complex Trauma for Adolescents (ITCT-A; Briere & Lanktree, 2011). This is a multi-modal therapy that integrates treatment principles from the complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of CBT. Unlike most structured trauma treatment approaches for children and adolescents, ITCT-A does not have a pre-established number of sessions to be applied for every client. Instead, therapy may range from several months to a year or more, although most clients appear to require an average of approximately six to eight months of treatment. Treatment typically involves joint sessions with parents or carers to address their own traumatic reactions and attachment issues and improve their parenting skills. Family and group therapy sessions are included when indicated. Lanktree, et al. (2012) found significant reductions in anxiety, depression, post-traumatic stress, anger, dissociation, and sexual concerns amongst children and young people accessing ITCT. The longer a child was in therapy, the greater their symptomatic improvement.

2.5. Non-Suicidal Self-Injury (NSSI)

A large Australian study of community NSSI found a mean age of onset of 17 years, peaking for males slightly earlier (10-19 years) compared with females (15-24 years). Amongst adolescents aged 15-19 years, 17 percent of females and 12 percent of males reported self-injuring at some points in their lives (Martin, Swannell, Hazel, Harrison & Taylor, 2010). Psychiatric conditions that are specifically associated with NSSI in adolescents include internalising disorders (primarily depression, but also post-traumatic stress disorder and generalised anxiety), externalising disorders (including conduct disorder and oppositional defiant disorder), and substance abuse disorders (Jacobson & Gould, 2007; Nock, Joiner, Gordon, Lloyd-Richardson & Prinstein, 2006). A study of young people admitted to an adolescent inpatient unit in Brisbane identified four main reasons for engaging in NSSI: emotional regulation; communicating to/influencing others; punishment/excitement; and psychoses/a lack of insight (Swannell, Martin, Scott, Gibbons & Gifford, 2008).

Guidelines developed by the National Institute for Health and Care Excellence (NICE) on the short-term management of NSSI advise that:

- Children and young people under 16 years of age who have self-harmed should be triaged, assessed, and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.
- Children and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed.
- All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary

(National Institute for Health and Care Excellence, 2004, p.27)

The statewide child and adolescent inpatient unit in Adelaide offers planned admissions for young people that have a history of presenting to the emergency department (ED) for an episode of NSSI. The admission is for 48 hours duration, usually starting every two weeks, and the young person is admitted voluntarily during office hours. The aim of the intervention is to promote engagement with the community team, and change the young person's perspective about the need to access support in hospital. As they progress, their planned admissions are spaced out from three to four weeks and/or can be reduced in length to 24 hours, or as a day patient. Follow-up care is provided by their community CAMHS team.

A retrospective cohort study of young people offered planned admissions to this unit in Adelaide found that there was a mean 50 percent reduction of ED presentations as well as a reduction in lethality from overdoses to self-poisoning. The authors concluded this evidence supports the use of planned admissions as a means of reducing ED presentations in young people who engage in NSSI (Usman, Dryden-Mead & Crouch, 2014).

Guidelines on the longer-term management of NSSI recommend that "mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS" (referring to primary care and community CYMHS respectively; National Institute for Health and Care Excellence, 2011, p. 21).

The Royal Australian and New Zealand College of Psychiatrists is currently reviewing its Clinical Practice Guidelines, in which consensus-based recommendations for interventions to prevent repetition of NSSI in children and young people target motivation to change, maintenance of sobriety, familial or non-familial support, promotion of positive affect, and healthy sleep. It also notes that Cognitive Behaviour Therapy (CBT), Mentalisation-Based Therapy for Adolescents (MBT-A), and Dialectical Behaviour Therapy for Adolescents (DBT-A) are promising, and further evaluation is warranted (RANZCP, 2015a). These were the three treatments associated with the greatest effect sizes in a recent systematic review and meta-analysis of therapeutic interventions (excluding pharmacology) for NSSI and suicide attempts in adolescents (Ougrin, Tranah, Stahl, Moran & Rosenbaum, 2015).

Whereas adult DBT lasts for a year, the adolescent adaptation (Rathus & Miller, 2000) is delivered twice-weekly for 12 weeks. It also differs by including parents in treatment, placing a greater emphasis on the family and teaching a smaller number of skills using language that is appropriate for an adolescent. A clinical trial of DBT-A suggested it was well accepted by participants and their families, and associated with improvement in multiple domains including suicidality, non-suicidal self-injurious behaviour, emotion dysregulation and depression from the beginning of therapy to the one-year follow-up (Fleischhaker, et al., 2011). MBT-A is a year-long, manualised, outpatient psychodynamic psychotherapy program involving weekly individual MBT sessions, plus monthly mentalisation-based family therapy (MBT-F) sessions (Bleiberg, Rossouw & Fonagy, 2012). The focus of MBT-A is on increasing the adolescent and family's capacity to understand action in terms of thoughts and feelings, which in turn is hypothesised to augment self-control and affect regulation. In a trial amongst 80 adolescent outpatients, those receiving MBT-A reported reduced NSSI, suicidal behaviour, and depressive symptoms compared with those outpatients who accessed routine care (Rossouw & Fonagy, 2012).

In a retrospective file audit of children and young people admitted to an inpatient unit in Sydney over three years, several factors were identified that increased the likelihood of NSSI. These included female gender, increasing age, being Australian-born, living with a step parent, not having received previous mental health care, a diagnosis of depression, having a history of trauma, and having other stressors including problems within the family (de Kloet, et al., 2011). The authors concluded that family factors, in particular living with a step parent, significantly add to the risk of self-injury and so treatment should involve parents as well as the child or young person.

2.6. Suicidal Behaviour

Amongst young people aged 15-19 years in 2013, the suicide rate amongst males was 14.3 per 100,000 and amongst females was 5.6 per 100,000 (Australian Bureau of Statistics, 2015). Although this age group does not have the highest rate of completions, suicide is the leading cause of death of young people aged 15-24 years in Australia (Australian Institute of Health and Welfare, 2015). During the last decade, suicide has been the leading or second-leading external cause of death for Queenslanders aged 10-17 years (Commission for Children and Young People and Child Guardian (CCYPCG), 2014).

Further review of this data identified the following groups particularly at risk of suicide completion: 15-17 year olds, males, Aboriginal and Torres Strait Islander children and young people, those known to the child protection system; residents of moderate socio-economic status area; and those experiencing diagnosed or suspected mental health problems, substance use, history of childhood abuse, previous suicidal behaviour and thoughts, previous NSSI, and/or the influence of a significant other's suicide attempt or completion (CCYPCG, 2013). Based on such factors, suicide prevention has been identified as the responsibility of the entire community and not simply the province of health services (Queensland Mental Health Commission (QMHC), 2015a).

In February 2014, the QMHC engaged CHQ CYMHS to undertake a five-month project to identify priorities to improve the detection, assessment and management of suicide risk in children and young people in Queensland.

The scope focused on a review of programs, policies, and empirical literature; analysis of available data from the Queensland Police Service and the CCYPCG; and consultations with a wide range of key stakeholders, including young people and carers. The findings collectively generated a rich profile of the issues experienced by vulnerable children and young people, and their support networks, and proposed the follow recommendations to improve system responses for those experiencing suicidal behaviour:

- More mental health promotion, prevention and early intervention in schools;
- Greater provision of gatekeeper training with follow-up support available to workers, young people, parents, carers and families;
- Training, development and support of a peer mentor workforce comprising young people and parents/ carers with a lived experience of child and youth mental health problems;
- Mechanisms to support integration of care across services;
- Improving the extent of appropriate and timely information sharing across services;
- Strengthening consultation liaison models of care and existing partnerships between CYMHS and other services;
- Improving the current acute or after-hours crisis mental health response; and
- More flexible models of service delivery, in particular greater capacity for assertive and mobile outreach, and extended hours of service delivery.

A report prepared for the National Mental Health Commission found that implementing the following policies reduces suicide deaths: assertive follow-up in the week after discharge from inpatient care; assertive outreach for non-compliant patients; and 24-hour crisis teams. This requires a coordinated approach to make sure that people do not fall between the gaps in systems (NHMRC National Centre of Excellence in Suicide Prevention, 2015).

As noted above, CBT, DBT-A, and MBT-A delivered in community settings are associated with the strongest effect sizes for treating NSSI and suicidal behaviour in young people (Ougrin, et al., 2015) and have been designed to include the involvement of parents and carers. In a recent analysis of treatment interventions, family conflict was one of the stronger predictors of suicidal events in young people with SSRI-resistant depression (Brent, et al., 2009). Conversely, family support is a significant protective factor against adolescent suicidal behaviour (Rusu, Cosman & Nemes, 2012). For example, parental care has been found to protect young people experiencing suicidal thoughts from going on to attempt suicide (Saffer, Glenn & Klonsky, 2015). Supporting families therefore represents an important opportunity to reduce suicide risk in adolescents. It has been suggested that as a minimum, good mental health practice should include the involvement of family, especially to contain suicide risk (Bickerton, Hense, Benstock, Ward, & Wallace, 2007).

2.7. Borderline Personality Features

Borderline personality disorder (BPD) is characterised by a pattern of impulsivity and instability of behaviours, interpersonal relationships and self-image, which is present by early adulthood, occurs across a variety of situations and contexts, and is more likely to be diagnosed amongst women (American Psychiatric Association, 2013). Amongst those over 18 years, BPD has a prevalence rate of 5.9 percent in community samples with equal prevalence amongst men and women (Grant, et al., 2008). Studies in clinical settings found BPD was present in 9.3 percent of psychiatric outpatients (Zimmerman, Rothschild & Chelminski, 2005) and about 20 percent of psychiatric inpatients (Comtois & Carmel, 2014), with many frequently presenting in psychiatric crisis to emergency departments (Koehne & Sands, 2008).

Pietrek, Elbert, Weierstall, Muller, and Rockstroh (2013) found that BPD was characterised by marked increase of adverse childhood experiences (56 percent) relative to major depressive disorder (40 percent) and schizophrenia (18 percent). These adverse childhood experiences were a predictor of BPD, but not of the other two diagnoses. Symptoms among adolescents that predict the development of BPD in adulthood may include problems with body-image, extreme sensitivity to rejection, behavioural problems, NSSI, attempts to find exclusive relationships, and severe shame (Gunderson, 2011). Many adolescents experience these symptoms without going on to develop BPD, but those who do experience them are nine times more likely than their peers to develop BPD. They are also more likely to develop other forms of long-term social disabilities (Gunderson, 2011).

Clinicians are reluctant to diagnose BPD in adolescence as it is a time of major developmental transition, and many experience BPD as a highly stigmatising diagnosis. Moreover, this diagnosis may become only apparent with time and the young person’s problems may be maintained by psychosocial adversity including unrecognised abuse. However, the *Clinical Practice Guidelines for the Management of Borderline Personality Disorder* (National Health and Medical Research Council, 2012) suggest that the diagnostic criteria for BPD in a person under 18 years of age are as reliable and valid as in adults. They note that the diagnosis is similarly stable over time as for adults, and so it can be made with reasonable confidence when a person aged 12–18 years meets diagnostic criteria for BPD.

Greenfield, et al. (2008) found that persistent suicidal behaviour amongst young people six months after initial presentation to an ED can be predicted by gender, borderline personality disorder, previous suicide attempts and drug use. Interestingly, depression did not predict future suicidality. When combined with their earlier findings showing no incremental benefit to hospitalisation (Greenfield, et al., 2002), it suggests that hospitalisation of young people with borderline personality traits presenting with suicidality is not effective in preventing future suicidal risk.

The National Guideline notes the harm that may be caused by short- or long-term psychiatric admission to people with BPD, and states that:

> "Overall, available evidence and expert opinion suggest that inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. It should be directed towards achieving specific goals that are agreed before admission" (National Health and Medical Research Council, 2012, p.96).

Hellemann, Goossens, Kaasenbrood and van Achterberg (2014) have noted the harm that may be caused by long or unplanned admissions for BPD and also advocated the strategic use of brief admissions. Their literature review identified five key components to enhance their effectiveness for this cohort: discussion of goals; organisation of a brief admission; clear admission procedures; specification of any other interventions during admission; and stipulation of conditions for premature (i.e. forced) discharge.

The National Guidelines go on to stipulate that:

> "For most people with BPD, effective treatment with a structured psychological therapy can be provided within mainstream public or private community-based mental health services, via individual appointments (with or without group sessions), by therapists with access to peer consultation and clinical review." (National Health and Medical Research Council, 2012, p.98)

It is noteworthy that, in addition to reducing NSSI and depression, treatment through outpatient delivery of MBT-A (including family therapy) was associated with improvement in emergent BPD symptoms and traits amongst young people (Rossouw & Fonagy, 2012). A clinical trial of DBT-A from the beginning of therapy to one-year follow-up was found to significantly reduce emotional dysregulation, one of the hallmarks of BPD (Fleischhaker, et al., 2011).

2.8. Eating Disorders

With the recent change to diagnostic criteria for anorexia and bulimia nervosa, it is too early to ascertain the current prevalence of eating disorders, including binge eating disorder, in the DSM-5 (American Psychiatric Association, 2013). However, concerns regarding body image are common amongst Australian adolescents (Cave, Fildes, Luckett & Wearring, 2015). All disorders are typically associated with marked distress, functional impairment and, in many cases, comorbid mental illnesses and/or significant physical health problems. Eating disorders have an overall mortality rate of up to 20 percent, with an increased risk of premature death for all types of eating disorders (Arcelus, Mitchell, Wales, & Nielsen, 2011).

Queensland Health operates the Eating Disorders Outreach Service to provide specialist consultation-liaison, education and training to mental health services across the state to enhance their clinical care of people experiencing eating disorders. The Queensland Health Eating Disorders Forum meets quarterly to identify and progress related issues across the state, including providing feedback to the MHAODB to inform their strategic planning.

The National Eating Disorders Collaboration was established by the Australian Department of Health to develop a consistent, evidence-based approach to the prevention and management of eating disorders in Australia. It states that "a community-based environment is the preferred treatment setting for people with eating disorders. Community-based organisations focus on health promotion, prevention, early intervention, acute illness and recovery and relapse-prevention. In situations where a community-based environment is inappropriate or unsafe for treatment (e.g. due to low weight, purging or self-harm behaviours) or unfeasible (e.g. no local community treatment), treatments may need to be provided in a hospital setting." (See www.nedc.com.au/treatment-options)

Inpatient treatment may be required for anorexia nervosa to help stabilise weight and physical functioning, but long-term intervention is required to facilitate recovery. A recent study found that inpatient treatment (combining weight restoration by structured supervised meals with individual and group cognitive-behavioural therapy, parental training/family intervention, and educational activities) produced a reduction in the general severity of eating disorder symptoms and depression, but had no impact on the core thoughts and perceptions in adolescents with anorexia (Fennig, et al., 2015). These factors may account for the high rates of relapse if not adequately addressed, including in an outpatient setting. Fenner and Kleve (2014) demonstrated positive outcomes for the treatment of anorexia nervosa and eating disorders not otherwise specified (EDNOS) in a community CYMHS clinic, as well as high satisfaction ratings amongst consumers.

In their review of psychological treatments for adolescent anorexia nervosa, le Grange and Lock (2005) concluded that the majority of patients, even those who are severely ill, can be treated successfully as outpatients provided that parents participate in treatment. This is due to the need to identify and address in treatment those family factors that may have contributed to the development and/or maintenance of the disorder/s. Following initial inpatient stabilisation, the Maudsley family-based outpatient treatment was associated with a significantly improved outcome compared with individual treatment over the course of a year amongst those under 18 years of age with an episode of anorexia of less than three years duration. This outcome was maintained at a five year follow-up by 90 percent of those who had completed family-based treatment, compared with 36 percent who had accessed individual therapy (Eisler, et al., 1997). (See Section 6.3.2.1 for an overview of treatment outcomes for local CYMHS delivery of the Maudsley model for adolescents with anorexia nervosa, and their families.)

Family-based therapy has also been successfully applied to the treatment of bulimia nervosa in adolescents. In a randomised controlled trial le Grange, Crosby, Rathouz, Bennett, and Leventhal (2007) found that family-based therapy was associated with significant improvement in treatment outcomes (including at six month follow-up) compared to supportive individual psychotherapy, as well as a more immediate reduction in core bulimic symptoms.

There is likely to be a small sub-group of young people with a life-threatening eating disorder compounded by medical complications and other risk factors (including family members who are not available/refuse to participate in treatment) whose needs cannot be as readily met in the community. Hospital data from England has found that people (across the age range) admitted for an eating disorder were more likely to stay in a hospital for a longer period of time compared to all other admission episodes. One in 17 patients with an eating disorder stayed in hospital for longer than six months compared to three in 10,000 of all admission cases (0.03 per cent; Health and Social Care Information Centre, 2014). Strik et al (2009) found that the following factors predicted an increased length of stay among young people accessing a specialised eating disorders unit in France: duration of their anorexia at admission, use of tube feeding during the stay, accomplishment of the therapeutic weight contract and presence of a comorbid disorder. Young people experiencing a particularly complex eating disorder may therefore benefit from a longer admission to help make and consolidate treatment gains in a supportive, stable, therapeutic environment with a rehabilitative focus.

2.9. Psychosis

Psychotic disorders are rare before the age of 14 years, but there is a sharp increase in prevalence between the ages of 15-17 years (Kessler, et al., 2007). A psychotic episode can occur in a number of different disorders, including drug-induced psychosis, bipolar disorder, psychotic depression, and schizophrenia. The World Health Organisation ranks schizophrenia as amongst the most disabling and economically catastrophic disorders (Murray & Lopez, 1996), with one-third of episodes occurring before the age of 19 years (Morgan, Castle and Jablensky, 2008).

Many young people experiencing a psychotic episode recover, but their long-term prognosis can depend on how quickly and effectively support is provided. There is a growing evidence base supporting positive outcomes for timely intervention amongst those experiencing their first episode (e.g. Kane, et al., 2015). The Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne developed a service implementation guide to inform rollout of their model nationally (Stavely, Hughes, Pennel, McGorry & Purcell, 2013). It is underpinned by a number of key principles, including being easily accessible, holistic, youth- and family-friendly, collaborative, highly skilled, guided by available evidence and characterised by a spirit of hope for recovery. Services are ideally delivered across a range of treatment settings including home-based care, intensive mobile outreach, and step-up/step-down facilities. The Guide also noted that:

> "There will be occasions where a short-term stay (in most cases) in an inpatient facility is necessary. This is usually based on the severity of the presentation, the assessed level of risk, and the extent and quality of the social and family support. When acute inpatient care is required for a young person, the ideal setting is an inpatient facility that can cater specifically for young people, with staff trained in working with youth and first episode/early psychosis care. Where a hospital admission is required but there is no identified first episode psychosis stand-alone unit, then a special section of an existing general unit should be provided. To minimise the trauma of having an inpatient stay for a young person, admissions are aimed to be as short as possible, with an average length of stay being no longer than ten days. This is in order to return the young person to their familiar environment and to gain ongoing support and treatment by the community teams." (p. 51)

The NICE Guidelines for Schizophrenia and Psychosis in Children and Young People states that:

> "Before referral [to an inpatient unit], think about the impact on the child or young person and their parents, carers and other family members, especially when the inpatient unit is a long way from where they live. Consider alternative care within the community wherever possible. If hospital admission is unavoidable, provide support for parents or carers when the child or young person is admitted." (National Institute for Health and Care Excellence, 2013, p. 31-32)

There is a substantial evidence base for psychosis interventions that includes the family, including once the acute phase of psychosis has been stabilised. Family psychoeducational programs decrease relapse requiring hospitalisation by 20 to 50 percent (Gearing, 2008), and can improve symptoms, social and vocational functioning and access to and engagement in treatment amongst young people with clinical high-risk and first-episode psychosis (McFarlane, Lynch & Melton, 2012).

As Crisp and Gleeson (2009) have stated, the principles of family work in the EPPIC program include the fact that:

- Collaborative treatment should empower family members to cope and adjust to the crisis of the psychotic illness;
- The overall intervention goals are to minimise the disruption to the family and maximise their adaptive functioning after the acute episode; and
- The specific needs of the family should be acknowledged both because the family environment may impact on the experience and recovery of a young person, and to support family members through a distressing period.

The NICE guidelines state that family intervention should:

- Include the child or young person with psychosis or schizophrenia if practical;
- Be carried out for between three months and a year;
- Include at least 10 planned sessions;
- Take account of the whole family's preference for either single-family or multi-family group intervention;
- Take account of the relationship between the parent or carer and the child or young person with psychosis or schizophrenia; and,
- Have a specific supportive, educational or treatment function, and include negotiated problem solving or crisis management work.

(National Institute for Health and Care Excellence, 2013, p. 31-32)

A systematic review of treatment components for early psychosis (Bird, et al., 2010) found that when used alone, CBT reduced the severity of symptoms with little impact on relapse or hospital admission, while family intervention reduced relapse and hospital admission rates. They concluded that delivering both CBT and family interventions within an emerging intervention service contributes to improved outcomes amongst people with their first/early psychosis.

Social cognition and interaction training (SCIT; Penn, Roberts, Combs & Stern, 2007) is also attracting significant research attention. SCIT is a group psychotherapy delivered over 20 sessions to address impairments in social functioning amongst people with schizophrenia, which can predict relapse rates (Couture, Penn & Roberts, 2006) and hinder them from living meaningful, socially-connected lives. A pilot study amongst adult inpatients found SCIT was associated with improvements on all three cognitive domains, social functioning and aggressive behaviour on the ward (Combs, et al., 2006, cited in Couture, Penn & Roberts, 2006). It has since yielded positive results in community settings (Roberts, Penn, Labate, Margolis & Sterne, 2010), including in a variation examining family-assisted SCIT (Tas, Danaci, Cubukcuoglu & Brüne, 2012) and in relation to young people in Victoria experiencing their first episode of psychosis (Bartholomeusz, et al., 2013).

Queensland Health operates a number of Early Psychosis teams around the state to provide developmentally-appropriate clinical care for young people aged 15-25 years who are experiencing their first psychotic episode, or are at risk of a psychotic disorder. One of the teams in Metro North HHS is running SCIT groups twice a week (for 45 minutes) over ten weeks for young people. Participants have described them as helpful, fun, and equipping them with relevant skills, with attendance rates exceeding 70 percent (Metro North HHS Mental Health Services Research Review, 2013). Federal funding has also been made available to headspace to deliver early psychosis services for this target group at Logan and on the Gold Coast.

The EPPIC Service Implementation Guide notes that:

> "In some cases, longer inpatient stays may not only be necessary, but are desirable, as no young person should ever be discharged to an unsafe community setting or to be homeless, and some young people may require longer treatment to promote their recovery." (p. 51)

As such, young people with severe and/or complex psychosis compounded by other complications (including co-existing substance use, poor social/family support and high levels of risk) are another sub-group that warrant treatment via an extended admission with a rehabilitative focus prior to discharge to a less-restrictive form of care.

2.10. Severity and Complexity

It is recognised that many young people with severe and/or complex mental health problems are likely to experience comorbidity with these and other conditions (including intellectual disability, developmental delay, and/or substance use), often in the context of adverse personal and/or family circumstances. These complexities need to be considered alongside any protective factors in designing and delivering appropriate clinical care. The young person (and in some cases their family) may need additional resources, including the provision of long-term, flexible support to enable sufficient time for a relationship to be developed with the treating service in achieving identified goals.

The World Health Organisation (2012) has highlighted the principles of accessibility, acceptability, equitability, appropriateness and efficacy as being a guide for adolescent-friendly health services. Crago, Wigg and Stacey (2004) furthermore note that:

> "Being youth friendly means adopting practices and strategies of engagement which make and sustain positive connections with young people and through which they feel valued, respected and increasingly capable of taking charge of their lives." (p.39)

Although not specifically targeting mental health services, this statement aligns with the principles of the recovery model in relation to young people. It is especially important in the case of young people with severe and/or complex mental health problems as they are likely to have had multiple experiences with caregivers and systems they perceive have let them down, including the child protection and/or education sectors. Services may also be required to take on a coordinating role to help meet the multiple needs of a young person to help promote and sustain their individual recovery, which again requires additional service resources. There need to be clearly-articulated referral pathways within and between mental health services and their partner agencies, as well as a commitment to evidence-based practices.

Significant learnings may be gleaned from other sectors working with vulnerable young people. In their review of service options for young people in out-of-home care, who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood, Morton, Clark and Pead (1999) note three key principles for best practice, namely: establish physical and emotional safety; provide and support relationships that offer the possibility of secure attachments; and address the aftermath of trauma. They also provided a description of characteristics for successful treatment responses, such as:

- Creating a safe, non-intrusive and empowering context and aiming to avoid reinforcing or recreating situations of helplessness;
- Respect for the young person as a survivor and acknowledging that many of their behaviours may have some adaptive, survival functions, even those that appear to be the opposite such as self-harming behaviours;
- Work towards integrating the young person's awareness of the present and the past and being able to tolerate conflicting emotions;

- Reprocessing their understanding of the trauma that challenges self-blaming, powerlessness, and fear so that they can integrate their thoughts and emotions;
- Addressing particular symptoms related to post traumatic stress;
- Modelling and teaching positive psychosocial skills and challenging aggressive behaviours towards others;
- Providing a developmentally appropriate balance between empowerment and limit setting;
- Reinforcing positive behaviours rather than punishing negative behaviours; and
- Effective use of consultation with other services.

These principles should be considered in the provision of contemporary mental health care, including in an inpatient setting. As noted above, presentations of young people with severe and/or complex psychosis and/or eating disorders and insufficient protective factors may warrant an extended admission. This may also be true of young people with severe and/or complex mental problems who have not demonstrated sufficient treatment gains in a less restrictive treatment setting/s.

2.11. Conclusions

In each of the above disorders and high-risk behaviours, there is a significant and growing evidence base for the effective treatment of severe and complex mental disorders in adolescents. Treatment within the community, with the explicit involvement of family, appears to be strongly associated with positive outcomes. The focus, setting, and length of treatment should be tailored to match individual needs. The addition of other conditions or complexities does not necessarily change the treatment setting per se, as long as they are taken into account in the collaborative design and delivery of an individualised recovery plan. A change in the acuity of presenting issues may therefore require a change in setting to accommodate their individual needs at that point in time, but should always be delivered in the least restrictive way possible. An extended admission with a rehabilitative focus may be potentially warranted in a small sub-set of young people experiencing a psychosis and/or eating disorder compounded by significant complexities, and/or those who have not adequately responded to the next-most restrictive form of care.

It is also clear from the above review that families have a role to play in supporting vulnerable young people and so, where possible, parents and carers should be meaningfully engaged and supported to maximise treatment outcomes. This area is reviewed briefly in Section 3.

3. Engaging and Supporting Families

Supporting young people requires, wherever possible, working with the systems around them to inform and promote their treatment. This means extending the focus from just the child to ideally include the active engagement of parents and carers, and in some case siblings. Family-centred practice is based on three key elements: (1) an emphasis on strengths, not deficits; (2) promoting family choice and control over desired outcomes; and (3) the development of a collaborative relationship between parents and professionals. It has yielded a wide range of benefits across a number of fields for both young people and their families, who find it to be more helpful than other models of practice (Espe-Sherwindt, 2008).

It is acknowledged that it may not always be possible to include families in clinical care. The BeyondBlue Depression Guidelines (2010) note that treating a young person without the involvement of parents/carers may be necessary when:

- The young person *cannot rely on their support* or they contribute to the stresses the young person is experiencing (e.g. through abuse, homophobia, etc.);
- They are *opposed to the young person's wishes* or likely to undermine effective treatments (to which the young person is able to give informed consent);
- *Mental health problems in the parent*(s) affect presentation and engagement; or
- The *young person does not reside* with his or her family of origin (e.g. is homeless or in foster care).

It is suggested that these conditions relate equally to the treatment of any mental health problem in young people, not just depression, and reinforces the need to accommodate their wishes to ensure their engagement in - and commitment to - clinical care. This includes respecting the young person's right to confidentiality, although in cases where the family is aware of treatment there are a number of ways that they can be appropriately engaged and informed without breaking confidentiality (Queensland Health, 2011).

Despite their growing autonomy, the role of caregivers in the life of most adolescents remains important and is often underestimated (e.g. Schofield & Beek, 2009). A growing body of literature indicates that many family-related protective factors - such as providing a secure base, being caring, providing a feeling of connectedness and being valued, providing support and giving a sense of belonging - are linked to positive outcomes in adolescence and beyond. For example, one longitudinal American study found adolescents who felt highly valued and were able to confide in family members at age 15 had substantially reduced risks for mental illness at age 30 (Paradis, et al., 2011).

The Recovery Framework states that services should "help families or support people to understand their family member's experiences and recovery processes and how they can assist in their recovery while also helping them with their own needs for counselling, therapy, education, training, guidance, support services, peer support and advocacy." (Commonwealth of Australia, 2013, p. 15) A meta-analysis concluded that, compared with individual treatment, active parental participation in treatment is associated with improved outcomes across a range of domains for children and adolescents (Dowell and Ogles, 2010). MacKean, et al., (2012) found that engaging families in mental health treatment contributes to improved child and family management skills and functioning, an increased stability of living situation, improved cost-effectiveness, increased consumer and family satisfaction, and improved child and family health and well-being.

Young people (aged 16-25 years) with a history of mental illness who were consulted regarding the CHIME model of recovery (Leamey, et al., 2011) saw themselves very much part of a family system, and indicated that making independent decisions was not always possible or beneficial for them. They stated that empowerment is instead about being consulted, feeling that they are being listened to, and having the support to make decisions as a part of a family (Mental Health Coordinating Council, 2014).

As noted previously, the development of a mental illness in adolescence may be associated with a range of family factors. A systematic review and meta-analysis of the role of parental factors in depression and anxiety found that those with a sound evidence indicating increased risk for both depression and anxiety include less warmth, more inter-parental conflict, over-involvement, and aversiveness; and for depression additionally they include less autonomy granting and monitoring (Yap, Pilkington, Ryan & Jorm, 2014). Poor parental monitoring has also been linked to other negative outcomes such as antisocial behaviour, substance use, and sexual risk-taking in adolescence (e.g. Hayes, Smart, Toumbourou & Sanson, 2004).

The development, acuity and/or longevity of more severe mental illness in young people is more likely to be associated with complicated family presentations, especially those associated with an intergenerational history of complex trauma and/or biopsychosocial disadvantage. Parents themselves may experience significant disadvantage:

> "Treatments also can fail through the cumulative weight of chronic adverse circumstances that render the parent unable to change and that exhaust the therapist's capacity to persist in attempting to promote improvement. The failure of empathy in these cases is more general: society at large creates conditions in which some individuals and families are held at a distance as "others", their plight unwitnessed and their cries unheard by those with power to change the circumstances of their lives." (Lieberman & van Horn, 2008, p. 265)

Whilst not suggesting that the experiences of all families contribute to the development of the illness in a young person or experience chronic adversity, it is important to keep in mind that some of them may and that this may create additional barriers to engagement for the young person, family, clinician and/or services. To obtain optimal outcomes, where possible it is therefore imperative to actively engage families to identify and enhance individual and systemic risk, and protective factors.

Themes identified from the broader literature on family adjustment to child and youth mental illness may be generalised across treatment settings. These include the emotional experiences by parents and carers of loss, guilt, shame, anger and despair, accompanied by a feeling of significant burden, and the need for support, information and hope (e.g. Richardson, et al., 2013; Ward & Gwinner, 2014). There has been surprisingly little examination of the experiences of parents of young people admitted to an inpatient unit.

One notable exception is research undertaken in Brisbane regarding the work of CYMHS consumer carer consultants in supporting the families of recently-admitted children and young people (Gerraghty, McCann, King & Eichmann, 2011). The consultants provided fortnightly sessions to the unit, which had an average length of stay of 12 days. One of the themes raised by parents related to emotional challenges associated with the admission for the family, including disruption to siblings, isolation, and difficulties managing a normal parental role. The second major challenge related to practical difficulties regarding the admission, including economic costs associated with transport, parking, and, in some cases, accommodation in visiting the unit, finding somewhere to stay during the admission (for those not residing in Brisbane), and having to take time off work. Parents also requested more information about treatment options and community support, and their own support to enhance their emotional well-being in order to cope better with their child's problems. These findings reinforce other studies that suggest parents want to recover some control over their family's lives and become active partners in treatment, rather than passive recipients of information. They also want recognition of the contribution they can make to the recovery of their child (e.g. Honey, et al., 2015; Noble & Douglas, 2004).

Research has demonstrated the importance of engaging families of young people admitted to an inpatient unit in order to enhance positive treatment outcomes (e.g. Haynes, Eivors & Crossley, 2011). Gross and Goldin (2008) discuss a number of guiding principles when working with families in this setting. These include empathy with the crisis of an admission, avoiding the culture of blame, learning from the expertise of families and engaging in a spirit of partnership and collaboration with parents and carers.

In acute admissions, the focus of family work involves support, psychoeducation, assistance with crisis management, and to help prepare the parents to support the young person after discharge (Nurcombe, 1995). There is little empirical literature on family therapy on inpatient units despite the central importance of the young person's family. Given the nature of its role, an acute inpatient unit may not be the best setting in which to address systemic family issues in any great depth. However, it is ideally placed to engage parents and carers in the process of a smooth discharge to other settings where these can be addressed more comprehensively. Parental perceptions regarding ease of access and their involvement in treatment account for more of their satisfaction with outpatient CYMHS intervention for their child's mental health problems than do demographic or clinical factors (Holmboe, Iversen & Hanssen-Bauer, 2011).

In conceptualising family involvement, it is useful to refer to a model developed by Mottaghigpor and Bickerton (2005), known as the Pyramid of Family Care (see Figure 2). Although it was generated with regard to adult mental health services, its themes are of relevance in understanding the range of interventions useful for families of young people. Psychoeducation is identified as the minimum level of intervention for family members required, and family therapy is likely to benefit young people with especially complex difficulties. Each of these components is explored below in relation to the needs of young people with severe mental illness/es.

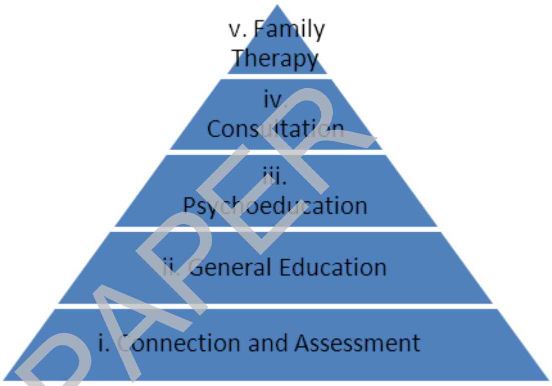

Figure 2: Pyramid of Family Care

3.1. Connection and Assessment

Evidence attests to the support, information, affirmation, dialogue and collaborative partnership often sought by families who access services (Jakobsen & Severinsson, 2006; Scharer, 2002). Service models that acknowledge parents’ expertise regarding their child, and promote parent–practitioner partnerships in the implementation of treatment, are considered empowering and effective (Scharer, 2002). Clinicians’ efforts to understand the dynamic needs of the young person's parents is important and this process may, as Scharer (2002) suggests, "best be accomplished by listening to what they tell us.’’ (p. 622)

Young people with severe mental illness are more likely to have a prejudicial family background that makes their families more difficult to reach and/or engage. See Table 2 for a summary of the factors of families that are hard to engage as suggested by Boag-Munroe and Evangelou (2010) from their systematic review of the topic across a wide range of sectors. They conclude that:

> "In order to reach such families, the literature repeatedly points to the need for outreach and specialist workers; careful, active, attentive listening skills; contextualised, holistic, community-based work; and the provision of appropriate buildings and facilities. One message above all others stands out: services need to build relationships of trust with families and with each other. Such relationship building is not only time-intensive but requires adequate and sustained funding to ensure continuity of staffing and provision. It is suggested that implicit in the literature is an understanding that unless such sustained and adequate funding is in place, all other measures to reach the hard-to-engage can only scratch the surface of the issue." (p. 234-235)

Table 2: Potential reasons for disengagement

- Anxiety about children's behaviour
- Anxiety about leaving child in crèche
- Anxiety about paedophilia in the setting
- Anxiety about leaving child in crèche
- Difficulty in asking for help
- Problems in articulating need
- Anxiety about establishing rapport with new people
- Anxiety about the kinds of people they might meet in the setting
- Fear of losing control of the situation
- Anticipation of rejection or unwanted criticism
- Distrust of others
- Concern about expressing opinions that are different
- Conflict with other service users
- Fear of authority
- Fear of staff interference or prying
- Family does not meet the threshold for entry to the program
- No/uncertain perception of need
- Not yet ready to engage
- In denial of problems
- Lack of knowledge/insufficient information about the service
- Lack of interest
- Wariness
- Disenchantment with service
- Lack of will to engage
- Distrustful of service
- Prefer to keep themselves to themselves
- Expectations of service have not been met in the past
- Anticipated services have not materialised
- Negative prior experience of service
- Weary of new initiatives
- Service has proved unreliable in the past
- Service resistance
- Refusal to co-operate
- Incompatibility with service staff

Boag-Munroe and Evangelou, 2010

Active efforts need to be made to engage families throughout the therapeutic process (including those outlined below) to maintain rapport, enhance participation in treatment, and achieve optimal clinical outcomes. This should not be overlooked or considered peripheral, but prioritised as a goal of treatment in its own right and therefore worthy of careful consideration, effort and resourcing. Engagement may in part include developing an understanding of the range of numerous services potentially already involved in supporting the young person/family, and the demands this may place on parents in attending appointments, and understanding, integrating and implementing service recommendations. In the absence of anyone else taking on this role, with informed consent, the clinician may assist with the coordination of services to help alleviate the load on the family and incorporate multiple service perspectives into the treatment plan.

Treatment needs to be guided by a comprehensive assessment of the young person's biopsychosocial history, including the capacity of the parents to attune and appropriately respond to the young person's needs. This process can be challenging for the clinician, who must "simultaneously hold in mind the experience of the parents(s) and of the child without rigid alignment to either" (Lieberman & van Horn, 2008, p. 247). For example, if the clinician over-identifies with the vulnerabilities of the young person, they risk alienating the parent as a valuable resource in the therapeutic process. Conversely, a clinician's over-identification with the parent may serve to reinforce the young person's sense of feeling unimportant or unheard. It is important to acknowledge the difference in treatment goals that may be held by the clinician, young person, and/or parent/s, and allow the time needed to explore and negotiate common ground between them. The engagement and assessment process with both parties is an important and cumulative one, and informs the development of a case formulation and treatment plan. These should be reviewed over time to incorporate additional relevant information as it comes to light, as well as consider the young person's progress towards identified goals.

3.2. Education

Mottaghigpor and Bickerton (2005) indicate that this component for families includes further education about the resources offered by the mental health service and other services, the illness and expected treatment, family and client's rights, as well as community and non-government organisations available to assist carers. The process of education includes using information gathered during the assessment phase to collaboratively generate a case formulation and treatment with the young person and, wherever possible, their family members. Engaging family members should be an open, respectful, joint discussion aimed at enhancing their understanding of the factors that have led to this point, increasing their commitment to progress, identified treatment goals, and instilling a sense of hope for recovery.

A recent study evaluated the efficacy of a two-hour information session combined with bi-weekly telephone support aimed at increasing parent/caregiver knowledge about eating disorders, increasing self-efficacy by empowering parents to support their child's recovery, and decreasing the impact of eating disorder symptoms on the family (Spettigue, et al., 2015). The intervention was targeted at parents/caregivers whose child was waiting to be assessed for an eating disorder. Participants included 51 parents/caregivers (as well as 36 young people awaiting treatment). Relative to a control group (which received no intervention), this brief intervention successfully increased parent/caregiver knowledge of the illness, feelings of self-efficacy, and help-seeking behaviours.

Some have argued that even the notion of what constitutes a mental illness cannot be ascertained without knowledge of the interaction between the child and his or her family (e.g. Carr, 2000). Although involvement of caregivers is important in implementation of evidence-based practices for adults, amongst children and young people the family is central not only to the development of the treatment or service but also to the understanding of the diagnosis itself (Hoagwood, Burns, Kiser, Ringeisen & Schoenwald, 2001). Brown (2008) highlighted the dilemma for clinicians supporting complex families, in which a request to "fix" the child lays the blame and onus for change squarely on the child. If therapists otherwise choose to expand the family's view to include their potential part in the child's symptoms (such as the experience of familial abuse and/or neglect), the risk is that the family will drop out of therapy. She reiterates the importance of building rapport to maintain families in treatment at this important juncture, and beyond.

In Queensland, there are a range of services available outside those offered by CYMHS to provide information and assistance to families. These include:

- Association of Relatives and Friends of the Mentally Ill, which provides workshops and groups in a range of locations throughout Queensland, as well as information available online and through their 24 hour phone line. (www.arafmiqld.org)
- Mental Illness Fellowship Queensland, which provides specialised programs and services for people living with mental illness, and their families and carers, in metropolitan, regional and rural Queensland. (www.mifq.org.au)
- Mental Health Association of Queensland, which provides information, support groups, resources and advocacy for people living with mental illness, and their loved ones. (www.mentalhealth.org.au)
- Eating Disorders Association, which provides information, support, referrals and support group services for all people affected by eating disorders in Queensland. (www.eda.org.au)
- Alcohol and Drug Information Service, which offers confidential information, counselling and referral support regarding substance use (and related issues, including mental health problems), 24 hours a day, seven days a week across Queensland. (www.health.qld.gov.au/tpch/documents/ads_insert1.pdf)
- Parentline, which offers telephone support and advice for parents across Queensland 8am -10pm seven days a week. (www.parentline.com.au)

In addition, the Youth Mental Health First Aid program; (see www.mhfa.com.au) is a 14-hour course designed to inform and equip anyone supporting young people aged 12-18 years with emerging or existing mental health problems. It is available for parents, carers, and service providers through a number of CYMHS services, as well as via private providers and in some cases headspace teams.

There are also a wide range of online services that may be of use, especially in rural and remote areas. These include BeyondBlue and headspace (both of which offer a telephone helpline for young people and their families, with the latter service also providing an online counselling service (www.eheadspace.org.au). Online CBT is also available via www.moodgym.anu.edu.au.

Finally, there is an ever-increasing range of online applications available through smartphones to increase mental health knowledge and strategies, including for parents: (www.mindhealthconnect.org.au/mental-health-apps).

Mental health services should be aware of supports available for families, and recommend and/or facilitate access to those that complement the identified treatment goals for the young person (including linking a parent in to their own individual support if required).

3.3. Psychoeducation

Psychoeducation refers to interventions in which the family is offered coping strategies or specific ways of dealing with the challenges of mental illness. It can take place with family members in a group format, or amongst family members in individual sessions. The latter format was adopted by Pineda and Dadds (2013) in evaluating the effectiveness of a family intervention, the Resourceful Adolescent Parent Program (RAP-P), to reduce adolescent suicidal behaviour and associated psychiatric symptoms. The authors undertook a randomised controlled trial comparing RAP-P plus routine care to routine care only in Western Sydney. The intervention comprised one session aimed at increasing parental understanding of youth suicidal behaviour and practical strategies, followed by the standard three-session RAP-P program (covering existing parental strengths and enhancing stress management, information on adolescent development, strategies for promoting self-esteem, balancing independence and attachment issues, and the provision of strategies to promote family and reduce conflict). RAP-P was associated with higher recruitment and retention, greater improvement in family functioning, and greater reductions in adolescents' suicidal behaviour and psychiatric disability compared to routine care alone. Benefits were maintained three and six months after the program, with a strong overall effect size. Changes in adolescent's suicidality were largely mediated by changes in family functioning. Pineda and Dadds (2013) concluded that the study provides preliminary evidence for the use of family-focused group interventions as an acceptable, cost-effective treatment option for adolescent suicidal behaviour in a community setting.

3.4. Consultations

This approach refers to the provision of additional support to the family by a clinician other than the one assigned to support the young person. It has helped address the challenges inherent in the one clinician seeing both a young person and their family, including concerns about confidentiality and perceived bias in supporting parties that may have differing views on the presenting problem/s.

In this case, one clinician may work with the young person while another is engaged separately to consult with the parents regarding specific issues (such as enhancing their parenting skills, although they are encouraged to seek their own therapy externally). This approach has the additional advantage of being more efficient (as both sessions can be held concurrently when the family attends for treatment), and so more ground can be covered than if only one clinician had to spend time consulting with both the young person and the parent/s. It also means that any friction created through discussions with the parents may be directed at - and hopefully contained by - someone other than the person providing support to the young person. The two clinicians maintain close communication between sessions to share their perspectives, which are integrated into the treatment plan to ensure it reflects the experiences and goals of the whole family.

The consultation approach is a model often used within CYMHS in supporting families with complex needs and, although more resource intensive, helps to address the needs of multiple parties in improving outcomes for a young person. It may also help achieve some early treatment gains, including facilitating shared conversations between the young person and their parent/s about common issues. In the case of more complex families, it may also lay the foundations for the introduction of family therapy if required.

3.5. Family Therapy

Family therapy refers to sessions provided by a specialist therapist aimed at creating change in the family interactional system, and is only likely to be needed by families presenting with the most complex needs (Mottaghipur & Bickerton, 2005). Attachment-based family therapy has been found to significantly reduce suicidal ideation amongst adolescents compared with routine care, with these benefits maintained at a two-year follow-up (Diamond, et al., 2010). A systematic review and meta-analysis of family-based treatments for adolescents with eating disorders (Couturier, Kimber & Szatmari, 2013) found that end of treatment data was not significantly different from individual treatment, but achieved superior outcomes at six and twelve month follow-up. Similarly, a trial comparing adjunctive family therapy to routine care for severely-ill young people with anorexia nervosa found that it achieved significantly improved outcomes at 18 months follow-up (Godart, et al., 2012).

Given its positive outcomes with adults, recent research has adapted and evaluated DBT for adolescents with the main difference being the involvement of family in treatment. Most DBT-A evaluations have focused on features of borderline personality disorder, but other studies have targeted young people with a range of other disorders including depression, anxiety, PTSD, externalising disorders, eating disorders, and risky behaviours (especially suicidal ideation and NSSI) across a range of treatment settings (e.g. outpatient, inpatient, residential, correctional facility). The rationale for using DBT with these young people rests in the common underlying dysfunction in emotion regulation among the aforementioned disorders and problem behaviours. Treatment outcomes for DBT-A to date appear very promising (e.g. Cook & Gorraizx, 2015). Similarly, family therapy has begun integrating DBT principles to positive effect (e.g. Johnson, O'Gara, Koman, Baker & Anderson, 2015).

3.6. Conclusions

Even this brief review of the evidence overwhelmingly demonstrates the importance of involving families in the treatment of young people with severe mental illness. This is especially critical in complex families where intergenerational vulnerabilities may have contributed to the development – and/or ongoing maintenance – of the presenting problem/s. Parents and carers possess important expertise regarding their child, and so can serve as a valuable resource in informing the clinical journey. In addition, supporting parents and carers can enhance their own adjustment, which in turn means they are better able to attune and respond to the needs of the young person (as well as any siblings). This can include reinforcing strategies covered during treatment, encouraging the development of new skills, celebrating successes, and identifying and managing potential triggers for relapse. As such, supporting the family system should be maximised in settings across the continuum of care for treating severe mental illness in young people.

4. Review of Inpatient Treatment for Youth Mental Illness

4.1. Trends in the Delivery of Inpatient Treatment

Prior to the 1980s, psychiatric hospital beds for children and young people were difficult to access (Nurcombe, 1995). Those who were successful in finding inpatient care had to contend with limited restrictive choices, generally in adult settings, and/or for long periods of time. Long-stay hospital treatment has been criticised for leading to stigmatisation, for being overly restrictive and causing disruption to families and estrangement between children and their parents, who were often encouraged not to visit (Nurcombe, 1995). One of the earliest papers on the subject of inpatient services warned that, without available aftercare services, any of the positive effects of inpatient care would be undone (Dunkin & Dunkin, 1975; cited in Gahan & Kijas, 2014, p.125).

In a historical review of inpatient and residential programs for children and adolescents with mental illness, Leichtman (2006) traced its path from a peak in confidence between the 1950s and 1970s to a fall in the 1990s, by which stage it was seen by many in the mental health community as "overused and, at best, as an unfortunate necessity rather than a valuable treatment tool" (p.286). He argued that a growth in family therapy and the community health movement brought a greater understanding of how these programs separated children from their families, paid too little attention to family risk factors, and neglected the task of reintegrating children back into their family and community.

In part through acknowledgment of these issues, the length of treatment provided to children and adolescents has generally fallen over time in both inpatient and residential settings (Pottick, McAlpine & Andelman, 2000; Leichtman, 2006). In recent years the focus has shifted from comprehensive evaluation and treatment to briefer intensive interventions "as part of a continuum of care in which children move quickly from inpatient to outpatient programs as their level of acuity diminishes." (Leichtman, 2006, p. 287)

4.1.1. International Trends

To enable comparability to the Australian context, an international review of inpatient service provision for adolescents is limited to North America, England and New Zealand.

4.1.1.1. North America

There does not appear to be a standardised model of inpatient treatment in North America. Young people with severe mental illness may be treated in general adolescent units, diagnosis-specific units, in general hospital wards, or in adult mental health units. In their large-scale analysis of adolescent inpatient admissions across multiple American hospitals and states, Gifford and Foster (2008) found that the type of setting had more influence on length of stay than the clinical or demographic characteristics of the young person. Patients in general hospital facilities had a shorter stay (averaging 3.5 days) than did those admitted to other health units (28 days) or psychiatric units (average of 10.5 days).

Geller and Biebel (2006) provide a useful overview of the state of inpatient care in America, in which the reduction in access to units appears to be part of a wider under-resourcing generally. Access to inpatient beds also needs to be contextualised much more broadly within the system of care a unit is a part of. In commenting on access to inpatient beds, the American Academy of Child and Adolescent Psychiatry (1989) notes that "other available less restrictive treatment resources must have been considered and determined to be not available or not appropriate to the patient's needs or have been attempted and proven unsuccessful. Examples of less restrictive treatment resources would include, but not be limited to, residential treatment, day treatment, or intensive outpatient care". However, Geller and Biebel (2006) note that many of the more intensive community-based services, which families report as most helpful to them and are current best practice for young people with severe mental illness, are not traditionally covered by states in their Medicaid State Plans. These may include, but are not limited to, crisis services, intensive in-home services, day treatment, substance abuse counselling, social and daily living skills training, case management, behavioural aide services, and other intensive community–based care.

Shumway, et al. (2012) examined the impact of a 50 percent reduction in acute psychiatric beds by the San Francisco General Hospital, and found no evidence of anticipated negative consequences such as increased demand for emergency services, an increase in suicides, or more jail psychiatric evaluations. A key factor was the collaboration of inpatient and outpatient providers, which reduced length of stay and enabled the hospital to continue serving the same number of patients.

Extended treatment for young people instead appears to be more likely delivered in residential treatment programs, which are based outside of a hospital setting. Centres are available in Canada (such as the George Hull Centre in Ontario, and the William Hull Centre in Calgary) as well as across America. In information written for parents, the American Academy of Child and Adolescent Psychiatry (2011) states that:

> "Residential treatment programs provide intensive help for youth with serious emotional and behaviour problems. While receiving residential treatment, children temporarily live outside of their homes and in a facility where they can be supervised and monitored by trained staff. Residential treatment can help children and adolescents whose health is at risk while living in their community. For example, the programs are helpful for youth that have not responded to outpatient treatments, who have education needs that cannot be met in less restrictive settings or who are in need of further intensive treatment following inpatient psychiatric care." (p. 1)

After inpatient admissions, residential treatment is the most restrictive and costly treatment for mental illness in children and young people. Approximately eight percent of those with mental health needs utilise residential care, and 25 percent of public mental health funding for children and young people is spent on this form of treatment (Butler & McPherson, 2006) despite the observations made by Leichtman (2006) as outlined in Section 4.1. Bettman and Jasperson (2009) suggest residential treatment programs may be associated with favourable short-term outcomes, but note that several significant deficits exist within the literature. One of these appears to be an apparent lack of comparison with less-restrictive treatment settings. Trout, et al. (2013) also note that long-term studies of young people leaving standard residential care demonstrate poor outcomes across a range of domains in reintegrating into the community. Given the current focus on inpatient care, however, a comprehensive review of residential treatment programs is considered largely outside the scope of this discussion paper.

4.1.1.2. England

There has been considerable work over the last 15 years in England to examine the provision of mental health care for children and young people in general and inpatient care in particular. Admission criterion varies between individual units, but now generally falls into three broad categories (Cotgrove, 2013):

- *High risk due to mental disorder.* Admission may be indicated when there are high levels of risk to the child/ young person, secondary to suicidal thoughts or behaviours, self-neglect, disordered/abnormal thinking, risk-taking behaviour, or aggression in the context of mental disorder and which is beyond the capacity of the family and community based services to manage. Admission should be expected to reduce this risk.
- *Intensive assessment.* An in-patient unit can offer 24 hours-a-day assessment and supervision by a multi-disciplinary team to gather information to guide further management. This may involve observing the child/young person's behaviour and their interaction with others, observing the effects of a specific intervention, such as the use of medication, or allowing time for a range of investigations to be carried out, such as cognitive assessments, occupational therapy assessments, speech and language assessments, or physical investigations.

- *Intensive treatment.* This is when the intensity of treatment needed is not available from other services. This is commonly the case when a disorder is associated with other psychosocial difficulties, and/ or comorbid disorder resulting in difficulties pervading all aspects of their life.

Inpatient units appear to have developed over time based on a commissioning process by local councils rather than an overall planning strategy administered by the National Health Service. In 1999, the Department of Health identified a lack of emergency beds and facilities, insufficient number of beds overall, poor provision for severe or high-risk cases, and poor liaison with other services. It also found that two-thirds of adolescent units in the United Kingdom provided no emergency admission service, and that the average length of hospital stay of those admitted to a ‘general adolescent unit’ was 104 days with a very wide range (O’Herlihy, et al., 2001).

In planning for the development of the first sub-regional acute inpatient unit in London (introduced in 2004), Kaplan and Racussen (2012) outlined a model of service similarly aimed at reducing the length of stay while maintaining quality of care commensurate with the recovery model. They noted that:

> "For some young people, admission to psychiatric hospital as part of the recovery process is inevitable. In those cases it makes sense, psychologically and economically, to keep the inpatient segment of this process as short as possible while working intensively with the community services to promote stable rehabilitation." (p. 247)

Their model integrated systemic theory, solution-oriented therapy, motivational interviewing and performance coaching, and articulated a number of phases in applying the model: (1) managing disorganisation; (2) systemic functional analysis of the presenting problem; (3) agreeing the minimum change (to enable discharge); and (4) empowerment. Over the course of five years, the unit was able to maintain an average length of stay below that required in their contract with funders (80 percent admissions should be of less than 42 days on average) but achieve comparable clinical outcomes to medium-stay units. Satisfaction from young people, parents/carers, and referring agents was also generally very favourable. Kaplan and Racussen (2012) noted the need for a balance to be struck between brevity of stay and relapse prevention, and that limiting factors can include the "meagre mental health, special education and social care resources, relative to need, available to the community teams to support intensive rehabilitation" (p. 255). However, staff aim to achieve improvements beyond the immediate crisis and undertake extended work with the receiving community team to take on young people who are still experiencing considerable difficulties. The authors conclude that "if the community teams are able and willing to take on intensive rehabilitation, the model could be used to engineer ultra-short stay admissions" (p. 256).

In April 2014, a report into the early effectiveness of the NHS commissioning of inpatient units noted that the main challenges identified in working with young people far from home were a lack of contact with family and friends, and difficulties with community relationships and reintegration. Inadequate community resources were noted to be the most frequently endorsed reason for inappropriate referrals to a unit, with social care issues, lack of alternative inpatient placements, and lack of community aftercare identified as the most common reasons for delayed discharge. The report noted that units with access to intensive outreach services showed a consistently lower length of stay, although 64 percent of units denied access to these resources locally. The report noted that a range of services are needed alongside in-patient services, including crisis assessment and crisis management services; intensive outreach services; planned intensive home treatment services; specialist treatment services; and specialist services for children/young people with complex neurodevelopmental or neuropsychiatric difficulties, and other rare disorders requiring specialist expertise (NHS England, 2014). Following the above review, NHS England announced the availability of 50 new beds to add to the 1,264 already available. It was noted that unless it was a speciality unit focusing primarily on one diagnostic group, it should not be a long way from home to enable easy access by families.

4.1.1.3. New Zealand

There do not appear to be any extended inpatient treatment facilities in New Zealand, which has a total of three acute inpatient units designed to accommodate adolescents. The first of these was established in Auckland and includes a day program, with units also in Christchurch and New Zealand's central region. Van Kessel, Myers, Stanley and Reed (2012) found that between 1998 and 2007, over 90 percent of patients discharged from Auckland's combined child and adolescent psychiatric inpatient unit (and comprising mainly 13-18 year olds) had a length of stay of less than 90 days. In the same unit, the greatest clinical change was found to occur in the first three weeks of admission (Swadi & Bobier, 2005; see also section 4.2). CYMHS services are also delivered in community clinics.

4.1.2. National Trends

The Walker Unit (based in Sydney) is the only known medium-stay inpatient unit in Australia. It is designed for young people (aged 12-18 years) who require treatment due to continuing risk or unremitting symptoms that are slower to respond to treatment. It has been open since 2009, but as of the CHQ CYMHS site visit in October 2013, it had yet to finalise a model of service. Admission criteria include the presence of severe mental illness, with evidence of significant functional impairment, and demonstrated treatment resistance. Diagnostic profiles include unrelenting self-harm, psychosis, bipolar disorder, borderline IQ, learning difficulties, developmental delays, and emerging borderline personality disorders, although it does not accept young people with eating disorders. (Anecdotal feedback from CHQ CYMHS staff suggested that the majority of the young people admitted at the time of their visit appeared to have intellectual impairment and/or a severe psychosis). The majority of young people are admitted under the Mental Health Act, usually via acute adolescent units, and much less frequently by community CAMHS clinics with referrals taken over the phone. Referrals are accepted from across NSW, including from regional centres. The Unit operates 24 hours a day, seven days a week and is staffed by a multidisciplinary team, with a Consultant Psychiatrist as the single point of accountability for clinical outcomes. All young people are assessed by two clinicians who will visit the home of the family, even if out of the district, although the Unit indicated in 2013 they would be reviewing this model as it is very labour-intensive. There are three points of family involvement: on admission; at a mid-point for family therapy; and in the lead up to discharge. In 2013, the unit was exploring the capacity for families to stay for short periods of time. Recovery planning commences at admission and referring Health Services are kept engaged with varying degrees of success. It was noted that it is especially difficult to successfully transition young people requiring adult mental health care. The Unit offers daily ward programs and individual therapy, and onsite schooling provided by the Rivendell School funded through the State Government. The average length of stay is six months, although in some cases this can last for up to two years. Young people are assessed by a range of measures (including the national CAMHS outcome measures), but there are no known studies on the effectiveness of the Walker Unit model.

NSW otherwise offers a range of CYMHS services including community clinics, day programs, inpatient services, specialist outreach services (including tele-psychiatry), support for children of parents with a mental illness, and forensic services for adolescents.

Victoria appears to lead the way in treatment options with a plethora of integrated community and inpatient treatment settings across the continuum of care (including for young people up to age 25). This includes the services offered by Orygen Youth Health, day programs, EPPIC, Youth Prevention and Recovery Centres (Y-PARC; also known as a Step Up/Step Down service), Youth Residential Rehabilitation Units, and Intensive Mobile Youth Outreach Services (IMYOS), alongside traditional outpatient clinics and acute inpatient units.

The Australian Capital Territory delivers its CAMHS services to young people up to 25 years of age, with separate teams supporting children, adolescents and young adults, along with an adolescent day program, early psychosis service, and separate inpatient units each for children, adolescents and young adults. In addition, a step-up/step-down facility (run by Catholicare Canberra) is available as an alternative to hospital admission for up to 12 weeks for young people aged 14 -18 years who are experiencing moderate to severe mental health issues.

Western Australia offers community CYMHS clinics and specialist services, covering complex attention and hyperactivity disorders, multi-systemic therapy, and eating disorders, as well as a Youth Residential service. It also provides the following acute services: inpatient units for children and young people; a paediatric consultation-liaison team; an acute response service to provide telephone support and face-to-face assessment for urgent after hours; and an acute community intervention team to provide an alternative to hospital-based care by stabilising high-risk children and young people over 6-8 weeks before their return to appropriate community-based care.

South Australia's Department of Health coordinates CAMHS through a range of services, including community clinics, country outreach services; an emergency mental health team, consultation-liaison service, and a child and inpatient unit at the Women and Children's Hospital. Youth Link is also available as a short-term, responsive and accessible mobile service for young people to facilitate a referral on to follow-up services, if required. A state-wide tertiary service at the Adolescent Services Enfield Campus in Adelaide provides therapeutic support to the metropolitan area and consultative work for country regions for young people aged 5 –17 years who have significant mental health issues. It also runs a day program through group interventions (onsite and offsite), and individual and family work through a variety of mediums.

Tasmania runs three CAMHS outpatient clinics, with an adolescent unit and day program to be made available as part of the upcoming redevelopment of the Royal Hobart Hospital opening in 2017.

There is no adolescent-specific inpatient unit in the Northern Territory; however, CAMHS services in community clinics form part of an integrated mental health service.

4.2. Treatment Outcomes for Adolescent Inpatient Treatment

Pfeiffer and Strzelecki (1990) have completed the most comprehensive study of child inpatient care in the United States to date for the period 1975-1990. They concluded that inpatient treatment was more likely to be beneficial if part of a specialised treatment program, when aftercare was available; for patients presenting with less dysfunction; and when there was family involvement. Barfield and Petr (2001) included the review by Pfeiffer and Strzelecki (1990) in their examination of nine outcome studies examining inpatient and residential treatment for children and young people, and drew the following conclusions:

- Parental involvement, follow-up with community mental health service, and therapeutic alliance is associated with positive outcomes;
- Inpatient and residential treatment does not seem any more effective than day treatment, multi-systemic treatment, or community mental health services, and is more costly;
- Length of stay is not correlated with successful outcomes, with extended hospitalisations generally adding little benefit over shorter inpatient programs. Extended hospitalisation should be avoided in favour of intense community-based support and treatment, supported by brief inpatient hospitalisations with coordinated aftercare; and,
- Inpatient care is generally thought of as a part of a comprehensive treatment program that includes continued treatment as an outpatient following discharge from the inpatient facility.

Although the years since then have seen an increasing evidence base for treatment in child and adolescent outpatient settings, it remains limited for inpatient care. Evaluating effectiveness within an inpatient unit is especially difficult due to the complexity, heterogeneity, and comorbidity of the population. In addition, care often consists of multiple components, making it difficult to identify those responsible for clinical change. There are also practical and ethical difficulties associated with carrying out research in such settings. Methodological limitations include the lack of tightly controlled studies, the use of single outcome measures and the use of small sample sizes and single units.

A number of authors have attempted, to varying degrees, to address these limitations in evaluating inpatient care. A landmark study by Green et al. (2001) used independent research assessments and multiple informants in a prospective cohort of two inpatient units for children and adolescents. They found positive outcomes compared to the subjects' waiting list condition that were sustained for at least six months, and which were predicted by the strength of the therapeutic alliance and pre-admission family functioning.

In an extension of this research, Green, et al. (2007) undertook the most robust study to date on the process and effectiveness of child and adolescent inpatient care. They found a significant improvement in clinical symptoms following admission (which averaged 16 weeks) of children and adolescents that exceeded their change in functioning over a pre-admission period of a comparable duration. This improvement was found across all diagnoses, corroborated by independent ratings by teachers and parents and maintained 12 months after discharge from the unit. Longer stays, positive therapeutic alliance and better premorbid family functioning predicted better outcomes independent of their level of functioning at admission. Unfortunately a control group was not used in either study led by Green to compare treatment outcomes across settings.

In contrast to the research by Green, et al. (2007), other studies have focused on the outcomes of brief admissions for adolescents. Herdzik (2008) reviewed the administration of self-reported measures of symptoms and functioning in 60 American adolescents at admission, during hospitalisation, and at discharge to ascertain their level of improvement, and how patient and treatment characteristics impacted their outcome. Results suggest that significant improvement occurred for the majority of participants, but that a minority of participants worsened and there was wide variability in outcomes. Factors associated with improvement were: more severe symptoms at admission; prior hospitalisation; prior legal involvement; high exposure to trauma and abuse; low SES; high family satisfaction; high family flexibility; and low family chaos. Symptoms at admission appeared to be among the greatest predictors of variance in improvement. Consistent with previous studies, diagnosis was not significantly related to the degree of clinical improvement. Herdzik (2008) concluded that the achievement of the greatest improvement amongst those with more severe symptoms at admission reflects the stabilising influence of inpatient units.

Similarly, Hanssen-Bauer, et al. (2011) examined the characteristics and clinical outcomes for 192 adolescents accessing an acute inpatient unit across one of four sites in Norway. The median length of stay was 8.5 days, and 75 percent stayed for less than a month. As with the findings by Herdzik (2008), a high HoNOSCA total score at admission (along with child protection service involvement) predicted improvement by discharge. Hanssen-Bauer, et al. (2011) concluded that the units admitted the young people when they were in crisis, and successfully adjusted the length of stay to ensure they were sufficiently stabilised to access outpatient treatment or primary care. The mean change on the HoNOSCA total score was 5.1, with the median discharge score close to that reported by adolescents upon entry to an outpatient clinic. Scores reflecting self-injury and emotional symptoms reduced during their stay, although 54 percent still reported clinical levels on the latter scale at discharge. There was also wide variability in clinical improvements across units, which highlighted the opportunity for local procedures and resources to influence the delivery of care.

4.2.1. Length of Stay

Given its relevance to the discussion paper, it is worth considering the evidence regarding impact of the length of stay on clinical outcomes. Babalola, Gormez, Alawan, Johnstone and Sampson (2014) reviewed all randomised controlled trials, comparing planned short/brief with long/standard hospital stays for people with serious mental illnesses. There were no significant differences between the two groups in long-term improvement in clinical symptoms, readmission rates or mortality rates. There was a significant difference favouring short admissions for social functioning. While acknowledging the varying quality of the studies examined, the authors concluded that short planned admissions do not encourage a "revolving door" of admissions and disjointed care for people with serious mental illness.

The associations between length of stay and treatment outcomes in adolescents have been mixed, with some research (such as that undertaken by Green, et al., 2007) showing an association between longer admissions and improved treatment outcomes. Others have not demonstrated this finding, such as Hanssen-Bauer, et al. (2011), or, in an Australian setting, Mathai and Bourne (2009). However, longer stays in an acute adolescent unit have been associated with greater episodes of aggression (Baeza, et al., 2013).

Swadi and Bobier (2005) examined the treatment outcomes of 72 adolescents admitted for inpatient care in New Zealand. The most common diagnostic category was mood disorder, followed by anxiety or adjustment disorder,

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and major psychosis. The mean length of admission for the whole population was 27.3 days (23.7 days for mood disorders, 18.9 days for anxiety disorders, and 46.9 days for psychosis). According to HoNOSCA clinician ratings, the major portion of improvement occurred within the first three weeks of admission. The authors conclude that a relatively short stay is feasible as a treatment setting for young people, echoing the recommendation by Barfield and Petr (2001).

Herdzik (2008) found no significant relationships between length of stay and changes in depression, psychological health and well-being, and the Internalising Problems, Inattention Hyperactivity and School Problems Self-report Scales of the Behavioural Symptom Assessment for Children - 2nd edition (Kamphaus, & Reynolds, 2007). However, in the case of two subscales of the latter measure, the relationship to length of stay was not linear. For Emotional Symptoms, there appeared to be a drop in symptoms in the first five days, then slower improvement up to day 20. After 20 days and until 60 days, symptoms begin to increase with each additional day in the hospital. After day 60, symptoms improved rapidly again. A similar pattern was seen in Personal Adjustment improvement, except the curve was flatter suggesting less dramatic change. This pattern also suggests that the greatest improvement occurs within the early part of an admission, but suggests that emotional and functional adjustment may initially decline after a short admission.

Finally, all patients across 130 Italian public and private psychiatric units who had been hospitalised for more than three months were compared on a range of measures with patients who were discharged during the same period after an admission of less than three months (Gigantesco, de Girolamo, Santone, Miglio & Picardi, 2009). No overall differences emerged in terms of symptom severity or diagnosis. However, admission to a private facility and a lack of violent behaviour were the most powerful predictors of a long stay, while a lack of housing and community support were the reasons most commonly cited by treatment teams as barriers to discharge.

4.2.2. Relationship of Treatment Outcomes to Satisfaction

Research has also examined service satisfaction in relationship to treatment outcomes, and has again found mixed results. Similar to findings in child and adolescent outpatient settings (e.g. Turchik, Karpenko, Ogles, Demireva & Probst, 2010), there may be little association between a young person's symptomatic and functional progress and their satisfaction in an inpatient context. For example, Marriage, Petrie and Worling (2001) found that most (83 percent) of the 105 young people accessing a Canadian inpatient unit had improved by discharge. Their satisfaction ratings correlated with improvement of self-identified problems and the perceived usefulness of discharge recommendations, but were not associated with symptomatic and functional progress. By contrast, Madan, Sharp, Newlin, Vanwoerden and Fowler (2014) found that while both adolescents and parents gave favourable overall ratings of inpatient care, adolescents were more critical than their parents and there was little agreement between them. Adolescents' ratings on the Perceptions of Care (CPOC) scale frequently related to outcomes, whereas parents' ratings rarely did. The authors conclude that the perceptions of young people may be a better gauge of treatment outcomes than those of parents, and may affect treatment adherence.

4.2.3. Readmission of Young People to Inpatient Units

Regardless of the length of stay, at some point young people will need to be discharged. One of the areas increasingly being examined is the rate of readmission to an inpatient unit. This is due to the emotional toll of (re)admission on young people and their families, the expense associated with inpatient care, and the questions it may raise about both the quality of inpatient treatment and the availability of services post-discharge. As such, readmissions are viewed as a target for quality improvement with associated interest in how to reduce them. As noted in Appendix A, the average rate of readmission varies according to age. In 2012-13 in Queensland, 8.8 percent of those 14 and under had been readmitted within 28 days of discharge, with this figure rising to 16.5 percent for 15-24 year olds. This increased risk may be due to the differing developmental models adopted by CYMHS and adult mental health services in catering to the needs of young people.

Fonatella (2008) examined the influences of clinical, treatment and system factors on readmission rates of young people across three American inpatient units. One-year readmission rates were 38 percent, with the majority occurring within three months of the initial discharge. Demographic, clinical severity and comorbidity, suicidality, and level of family risk were associated with higher rates of readmission. However, treatment factors including type of aftercare, post-discharge living environment, medication noncompliance and hospital provider were among the strongest predictors of readmission. The results highlight the importance of careful discharge planning and linkage to appropriate aftercare, and suggest that factors at the organisational level may play a role in determining treatment outcomes.

James, et al. (2010) examined post-discharge services more specifically amongst 186 children and young people following their first psychiatric admission, of whom 43 percent experienced at least one readmission during the 30 month follow-up period. The risk of readmission was again found to be highest for the first 30 days, and remained high for a total of three months. During the study period, the majority (72 percent) received post-discharge services, which significantly reduced their risk of readmission. A higher discharge risk score and longer length of stay (which was not found to be associated with discharge diagnosis or functional impairment) were related to an increased likelihood of readmission. Most recently, Trask, Fawley-King, Garland and Aarons (2015) examined the relationship between readmission rates and the type and amount of aftercare received amongst 6–18 year olds. Seventy percent received aftercare, and 28 percent were readmitted within six months of discharge. The total hours of aftercare services received was significantly related to a smaller risk of readmission, while a diagnosis of schizophrenia was associated with a higher risk. Trask, et al. (2015) concluded that given the restrictiveness and cost of inpatient care, clinicians should focus on improving access to, engagement with and quality of aftercare services.

4.3. Financial Costs of Inpatient Treatment

Research is increasingly considering the financial cost of clinical care, including making a compelling case for savings associated with effective mental illness prevention and early intervention amongst infants, children and young people (Royal Australian and New Zealand College of Psychiatrists, 2010). Beside the emotional burden it alleviates, a strong argument for appropriately funded mental health services for children and young people is that costs can be recouped through savings in other systems, such as juvenile justice (Foster & Connor, 2005). It can also save significant costs over a person's life that might otherwise be lost due to absenteeism, unemployment, and welfare payments. At the extreme end of the continuum, inpatient units are the most expensive setting for managing mental illness in supporting what is a comparatively low number of young people. In an environment of limited resources and many competing priorities for government funds, it is therefore necessary to consider financial costs of inpatient care and balance this with the evidence base and available alternative options for care.

The Independent Hospital Pricing Authority found that in 2011–12 in Australia, there were 108,235 hospital admissions for mental diseases and disorders across all age groups. This came to a total cost of $1.1 billion and an average cost of $10,248 per admission (which is more than double the cost of a general admission). The funds spent on one admission (averaging nine days) could enable a community mental health service to provide support to a person for a full year (National Mental Health Commission, 2014). In America, hospitalisation for psychiatric disorders have accounted for approximately one-third of all hospital days among youth and adolescents, and psychiatric disorders are the leading reason for hospitalisation among 5–19 years olds (Pottick, et al., 2000). Inpatient services are estimated to account for approximately half of their annual mental health costs for children and young people (Geller & Biebel, 2006).

In 2015-16, the cost for a single day stay in a Queensland acute adolescent inpatient unit is projected to be $2,456 per patient (Queensland Health, 2015b). This figure would equate to the daily salary for 6.1 senior Health Professionals (HP4.4 level) in a community CYMHS setting, where clinicians carry a caseload of approximately 25 children and young people. Similarly, the cost of admission to an adolescent inpatient unit would equate to the following services over time:

- 10 days (the average length of stay in the LCCH adolescent inpatient unit): $24,560, which would cover the salary of an HP4.4 AMYOS clinician in a community setting for three months.

- Three months: $223,496, which would cover the salary for two HP4.4 AMYOS clinicians in a community setting for over a year.
- Six months: $442,080, which would cover the costs of leasing a vehicle and employing four HP4.4 AMYOS clinicians, who could case manage 32-40 young people combined, over the period of a year.

It also needs to be considered that while the demand for inpatient units remains high, the number of young people accessing them is small relative to the number of young people accessing existing community-based services and the need for more mental health support in the community, including in rural and remote areas.

In November 2013, the Federal Government requested a review of mental health services and programs to consider how existing funding could be better oriented to improve outcomes for people with a mental illness. This report was released in April 2015. On the basis of expenses associated with inpatient care and the treatment outcomes associated with less restrictive community care, one of its key recommendations was that part of the growth in hospital funding, totalling one billion dollars, be redirected to community programs aimed at hospital avoidance (National Mental Health Commission, 2014). This did not mean closing existing hospital beds, but using future funds to better resource outpatient care. It was thought that this would particularly benefit those living in rural and regional Australia who suffer most from the current lack of effective community and professional services in their own local area.

4.4. Risks Associated with Inpatient Treatment

The Child and Family Therapy Unit (CAFTU) was established in Brisbane in 1983 and, in line with international research, its policy statement noted:

> "The value and place of non-selective residential treatment for disturbed children and adolescents has been increasingly questioned in recent years. Removal of a child from home into a residential treatment centre must be viewed as a serious step. It places restrictions on the child's freedom. It may increase the sense of alienation and rejection from the family of origin. It brings the child into contact with other troubled children, with the risk that he/she may pick up maladaptive behaviours from others. Thus CAFTU recognises that the potential beneficial, and detrimental effects of residential treatment, needs to be balanced carefully, even for short-term admissions." (CAFTU policy statement, cited in Gahan & Kijas, 2014, p.125)

Given young people with severe and/or complex mental illness are already vulnerable, it is important to weigh up what additional risks an inpatient unit may expose them to when considering an admission.

4.4.1. Aggression

Aggression is a common behaviour in mental health services, but little research has examined exposure to aggression in children and adolescent settings. Analysis of a child and adolescent inpatient unit in Brisbane found that 23.1 percent of young people exhibited physical aggression during their admission, 64.5 percent of whom exhibited more than one episode (Dean, et al., 2008). Factors that predicted physical aggression included a previous history, use of medication at admission, absence of NSSI, and increased length of stay. The latter association was found in a subsequent study conducted in the same site (Dean, Gibbon, McDermott, Davidson & Scott, 2010), as well as an acute adolescent unit in New Zealand (van Kessel, Milne, Hunt & Reed, 2012) and New York (Baeza, et al., 2013). Dean, et al. (2010) also interviewed staff members to examine exposure to aggression and perceptions about the impact of aggression. They found involvement in episodes of physical aggression was common (it had been experienced by 84.8 percent of staff) and often subsequently associated with difficulties attending work and emotional adjustment.

In some cases, episodes of harm to one's self or others may require intervention by staff through seclusion or restraint. To date, the most clearly articulated policy to emerge from the trauma-informed care movement in Australia has been the agreement to reduce and, wherever possible, eliminate the use of seclusion and restraint on inpatient units (Muskett, 2014). In May 2015, the National Mental Health Commission released the following position statement:

> "There is a lack of evidence internationally to support seclusion and restraint in mental health services. There is strong agreement that it is a human rights issue, that it has no therapeutic value, that it has resulted in emotional and physical harm, and that it can be a sign of a system under stress." (National Mental Health Commission, 2015, p. 1)

The Commission further outlined a range of priorities aimed at reducing and, where possible, eliminating the use of seclusion and restraint. The 2013-14 national average of seclusion episodes for children and young people was 9.6 percent, which is its lowest level for several years, but had been nearly double this in 2011-12. It is therefore vital that units monitor episodes of seclusion and restraint, and make active efforts to reduce their use over time.

Lebel and Goldstein (2005) analysed the financial outcomes of the introduction of a restraint reduction program to an adolescent unit in America. Use of restraint in 2003 fell to 373 episodes from 3,991 episodes in 2000, prior to introduction of the program. This represented a 91 percent reduction in episodes and a 92 percent reduction in estimated costs (from $1,446,740 to $117,036). What the authors didn't expect was a range of other positive effects, including a reduction in sick time, staff turnover and replacement costs, workers' compensation, injuries to adolescents and staff, and decreased readmission rates. Adolescent Global Assessment of Functioning scores at discharge also significantly improved. Lebel and Goldstein (2005) concluded that the program enabled the return of the unit to its core mission: clinical care. Introduction of a behavioural management program to a child and adolescent inpatient unit in Brisbane similarly led to a significant reduction in the number of episodes of aggressive behaviour and other unwanted outcomes, including injuries, use of physical restraint and the duration of seclusion. These outcomes were achieved without reducing the number of admissions, changing the type of patients admitted, increasing staff costs, or increasing the use of PRN (pro re nata; on request) medication (Dean, Duke, George and Scott, 2007).

Against the backdrop of the systemic analysis of adolescent inpatient care underway in the United Kingdom, Hannigan, et al. (2015) completed a literature review of risk identification, assessment and management for 11-18 year olds accessing inpatient treatment. They noted that the reduction of the risk to safety via admission to an adolescent inpatient unit was sometimes achieved at the expense of other less obvious factors. As Magellan Health Services (2008) state, "the belief that it is ‘better to be safe than sorry’ in terms of erring on the side of containment is frequently not in the best interest of the youth or society." (p.5)

In their initial literature review Hannigan, et al. (2015) conceived risk as a very broad term covering a range of areas including physical harm to self or from others. However, follow-up consultation with former adolescent inpatients concentrated on the examination of psychological rather than physical risks of an admission. This enabled a more focused examination of related research, which for their purpose included evidence relating to both inpatient units and residential treatment centres. Hannigan, et al. (2015) divided risk into two main themes: contagion and dislocation. These are briefly reviewed below.

4.4.2. Contagion

Another challenge associated with inpatient care is the fact that vulnerable young people come into contact with other mentally unwell patients (as well as the use of strategies including seclusion and/or restraint by staff to manage distressing behaviours). One of the young people in the focus group engaged by Hannigan, et al. (2015) commented:

> “You go into prison and you are good at cannabis…and you come out with a PhD in cocaine. Self-harm, eating, medication abuse. CAMHS units expose you to things that you are not ready for, that are not part of your life.” (Young Minds, 2013, p.2)

One of the few examinations of the impact of this phenomenon was by Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen and Helenius (1998). Their review of episodes of NSSI found that most were committed by depressed females with borderline personality disorder, who had an average length of admission of three months. Incidents were "clustered", such that the majority occurred in close proximity together in what was thought to be small-group rites to achieve a sense of togetherness. This included young people who had previously not engaged in NSSI, which was characterised by the authors as a form of contagion. A similar pattern was not noted by King, Franzese, Gragan, McGovern, Ghaziuddin and Naylor (1995) in their study of an inpatient stay averaging 25 days duration. A retrospective examination of incidents on a child and adolescent inpatient unit (Bernsten, et al., 2011) attributed a decline in incidents of both aggression and NSSI to the introduction of restraint training, changes in leadership, and a full staff complement.

Contagion in an inpatient setting has been identified as particularly concerning amongst young women with anorexia. As noted by Allison, Warin and Bastiampillai (2013), this is often a socially-reinforced condition:

> "By succeeding where many others may fail (at dieting, self-discipline and thinness), the progression towards an eating disorder offers the appeal of a new adolescent identity and social distinction within the group." (p. 166)

Two of the studies reviewed by Hannigan, et al. (2015) describe young people admitted for anorexia nervosa as very quickly copying the behaviour of others with the same condition and competing to be thin. Exposure to others, especially over a long admission, may therefore serve to undermine treatment gains made. Moreover, social media and online networks greatly increase the ability of young people to remain in contact following discharge, including those with anorexia nervosa who may be linked in with larger online communities that encourage an unhealthy competitiveness to be thin.

4.4.3. Dislocations

From their review of 34 studies, Hannigan, et al. (2015) also identified six dislocations (with related sub-themes) reflecting the challenge of removing a young person from their normal environment for the delivery of inpatient care. See Table 3 for a summary, with the six dislocations reviewed briefly below.

Table 3: Summary of dislocations identified as potential risks of admission (Hannigan, et al., 2015)

Category of risk	**Sub-categories**
Dislocation: Family	• Impact on family relationships • Family involvement • Maintaining contact with families
Dislocation: Friends	• Relationships with young people outside hospital • Relationships with young people in hospital
Dislocation: Education	• Education provision and facilities • Quality of inpatient education • Academic progress • Reintegrating with school after discharge
Dislocation: Identity	• Mental health problems as identity-changing • Responding to threats to identity
Dislocation: Stigma	• Young people’s experiences during admission • Young people’s experiences after discharge
Dislocation: Normal Life	• Everyday life and interactions in hospital • Missing out on life outside and transition home

4.4.3.1. Dislocation from Family

Half of the studies reviewed identified dislocation from family as a potential risk of admission. Despite striving for independence as a normal developmental task, adolescents will generally still need and seek out the security of their family. A review of the Queensland profile of the 2015 Mission Australia Survey noted that the majority (75.9 percent) of young people aged 15-19 years turn to their parents for support when facing an important issue (Cave, et al., 2015). Even young people experiencing complex intergenerational trauma may benefit from maintaining this connection, such is the strength of their attachment. It is for this reason that a decision may be made by the Department of Child Safety to maintain a child in the family home with sufficient support, rather than further damage the attachment relationship and potentially create additional trauma by placing them in care.

As noted by Geraghty, McCann, King and Eichmann (2011), admission to an inpatient unit can be very disruptive to the family. Parents may feel ambivalent at relinquishing responsibility for their child's care to an institution, and so it is important to validate their interest and encourage them, as much as possible, to support the young person's timely return to the family home. Young people may experience considerable homesickness, loneliness, and anxiety during an admission, at a time when their mental health is already vulnerable. It is for these reasons, as well as optimising clinical outcomes, families are ideally involved in the treatment offered by an inpatient unit. However, this may be difficult if they live far away, with research noting the strain on parents accessing healthcare that is not in close proximity to the family home (Yantzi, Rosenberg, Burke & Harrison, 2001). When providing families with information about residential treatment programs, the American Academy of Child and Adolescent Psychiatry (2011) advises them to "seek out programs that are close to home to provide appropriate care for your child. If the program is far from home, be sure that there is a plan for intensive family and community involvement. Be wary of programs that withhold family contact."

It is therefore important for young people to maintain contact with their families during an admission. Unfortunately, communication to people admitted to inpatient units in Queensland is limited to physical visits, phone conversations, and letters. The use of technology, such as Skype, is not permitted for people who live far from home. Young people may access weekend leave to both maintain contact and test their readiness for discharge, but again this can be challenging if the unit is far from home.

4.4.3.2. Dislocation from Friends

One of the tasks of adolescence is establishing autonomy and an identity, in part, through a connection with peers. Amongst Queensland adolescents, 75.5 percent highly value their friends and 87 percent would turn to them for support about an important issue (Cave, et al., 2014), and yet a young person may lose contact with their friendship circles during the course of an admission. This may be due to their embarrassment regarding their mental illness, and the fear of telling anyone about their admission. Even if friends do visit, the unit may not be perceived as very welcoming or emotionally safe.

Maintaining social connections is not helped by the fact that inpatient units prohibit the use of the internet and mobile phones, in part to protect the privacy of other patients and limit a person's exposure to potentially distressing communication or content. Almost all young Australians are online, with 90 percent of 16-29 year olds using the internet daily and spending more time online (an average of 22 hours per week) than any other age group. The key reasons for usage are entertainment, seeking information, shopping/banking, and engaging with others. The importance of social network services (such as Facebook, Twitter and Instagram) is indisputable, with 90 percent of 12 to 17 year olds, and 97 percent of 16-17 year olds, using them (Australian Communications and Media Authority, 2009). Young people derive a range of positive benefits from social network sites, including accessing information, facilitating supportive relationships, assisting with identity formation and promoting a sense of belonging and self-esteem (Collin, Rahilly, Richardson & Third, 2011). Depriving them of these benefits against their will - and possibly raising their anxiety about what their online absence is being attributed to amongst peers during the course of an admission - may impact on their maintenance of existing friendships as well as impair their treatment gains.

This dislocation also refers to the relationship established with other young people during the course of an admission. As noted earlier, other young people can be a source of distress when saying unhelpful things or engaging in risky or extreme behaviour while in the unit. Fellow inpatients can equally be a source of comfort in creating a sense of belonging, in which a young person may feel more understood than they do with their own family or friends. The nature of an inpatient unit means that there will also be a lot of movement of young people being admitted and discharged at varying times. This can destabilise a young person's sense of connection if a peer they have become close is discharged home before them. It may also be harder to stay in touch with other inpatients in person with a longer admission if the unit is not in close proximity to where they both live.

4.4.3.3. Dislocation from School

Amongst Queensland respondents, 69.2 percent noted that they valued school or study satisfaction (Cave et al, 2015). Connectedness to school has been shown as a protective factor against adolescent depression (Schochet, Dadds, Ham & Montague, 2006). Half of the studies reviewed by Hannigan, et al. (2015) identified dislocation from school as a risk of admission, which justifies the need for on-site education for young people admitted to a unit. For this reason, all child and adolescent inpatient units in Queensland have access to specialised schooling.

The most significant difficulty, identified by Hannigan, et al. (2015), was in re-entry and reintegration to a young person's regular school post-discharge, with Svanberg & Street (2003) noting this may be especially true when the unit is far from home.

If their absence from school has been extended, young people experiencing psychosocial disadvantage (including mental illness) may find their needs are best met by one of a growing number of alternative education sites designed to flexibly cater to those who have disengaged from mainstream school. This includes the 12 schools coordinated across Queensland by Edmund Rice Education, with programs designed to engage, support and educate vulnerable young people in a small, inclusive setting (see www.youthplus.edu.au)

4.4.3.4. Identity

It has been suggested that young people may be more likely than adults to take on a 'sick role' or the identity of a ‘mentally ill person’ because of the fluidity of their developmental stage. Due to the prominence of concrete thinking in under 16 year olds, young people may be particularly likely to struggle with reconciling two conflicting identities - that of a competent person and that of a person who is experiencing a mental illness (Simonds, Pons, Stone, Warren & John, 2014). CYMHS consumers consulted about the applicability of the CHIME model of recovery (Leamey, et al., 2011) to young people agreed that they may be more likely than adults to take on an illness identity, and so measures to prevent this from happening are important. They saw identity formation as more of a developmental process, where ideally young people successfully reach milestones in the first place rather than need to regain their pre-illness identities. Participants felt early intervention is important in reducing the chances of a young person's identity being arrested by the onset of a mental illness (Mental Health Coordinating Council, 2014).

Supporting the development of a positive identity independent of their illness is also important for families to foster hope for recovery for their child. It may be difficult for a parent to believe their child will improve if they have developed a narrative to the contrary. They may convey this directly and/or indirectly to their child, who may themselves internalise this viewpoint in what may become a vicious cycle. Hope is an important element of recovery and services should provide accurate information about treatment outcomes as well as inspire and celebrate success. This may include the gradual achievement of tasks while on weekend leave to build their confidence about coping with an impending discharge.

4.4.3.5. Stigma

As noted above, young people may choose to not inform their friends of their admission due to embarrassment. This may also be true of parents and carers in communicating with extended family, which in turn can reinforce to the young person that their experience is something to be ashamed of. Moses (2014) found that within six months of discharge from an inpatient unit, 70 percent of young people reported experiencing enacted stigma (comprising rejection, devaluation, and exclusion), with disrespect or devaluation more common than outright social rejection. Baseline factors that were found to predict higher levels of stigma included affiliating more with friends with mental health problems, identifying with a popular peer group, higher ratings of internalising symptoms and self-reported disciplinary problems at school.

4.4.3.6. Normal Life

During an admission, a young person may greatly miss what they have left behind, including their family, friends, privacy, pets, belongings and ability to engage with the wider world, and yearn to return home. They are also likely to miss out on key events including excursions, birthdays, parties, and graduations, with this more likely during longer admissions and when far from home. In line with both the national data and 2013 findings, young people across Queensland have been found to most value friendships and family relationships, followed by school or study satisfaction, then physical and mental health (Cave et al, 2015). As suggested by a developmentally-appropriate application of the recovery model to young people (Honey, Coniglio & Hancock, 2015; Mental Health Coordinating Council, 2014; Ward, 2015), these themes would be equally applicable to young people admitted to an inpatient unit in striving for a normal life.

An inpatient admission may be simultaneously both emotionally containing and very stressful for a young person and their family. For the young person, focused attention on their illness may prove challenging while activities on the unit may not be sufficiently interesting or engaging. As noted above, contact with young people who are also struggling may not be especially helpful or inspire hope, while the intensive support provided by staff may be very foreign and at times overwhelming to many. Young people also have very limited contact with the outside world to stay abreast of the news or meet new people. One such study of the inpatient experience has likened it to "living in an alternate reality" (Haynes, Eivors & Crossley, 2011), with its own rules and culture, and limited opportunities to trial treatment approaches in the real world. As one young person consulted by Hannigan, et al. (2015) noted, "People who have been in units for years have some risk of getting institutionalised and not being able to cope when getting out." (Young Minds, 2013, p.1)

It is worth considering that for particular groups from a collective culture (such as young people from an Aboriginal or Torres Strait Islander background), removal from community for an admission far from home may be particularly distressing and further impede the timely achievement of treatment goals.

4.5. Principles of Inpatient Care

In considering the risks of inpatient care - as well as the target group of young people with severe mental illness more generally - it is important to carefully consider the design and delivery of that care. In their examination of outcome literature and evidence-based treatment programs, Bateman and Krawitz (2013) extrapolated from interventions with people with borderline personality disorder to identify the following treatment factors common to high-risk patients across settings:

- *Clinicians* are in their role by choice, enthusiastic about their work, hopeful about improvement and welcoming and compassionate to clients;
- *Organisational willingness* that demonstrates enthusiasm, indicates a welcome to high-risk clients, validates challenges of the work and provides sufficient time, training, supervision and support to staff;
- *Therapy relationships* that involve regular monitoring of a client's response to treatment and the therapeutic relationship, and is underpinned by interest, curiosity, respect, warmth, flexibility and authenticity on the part of the clinician;
- *Collaborative agreement on goals* with the client to enhance engagement and motivation to change;
- *Skills in managing suicidality* that are based on a balanced response from the clinician, model of service, and the organisation that takes the presenting issues seriously without creating excessive anxiety;

- *Supervision* is provided in a safe environment that encourages clinicians to explore their own reactions to clients;
- *Clinician self-observation* to develop their capacity for reflective practice;
- *Client self-observation* to identify emotions and develop the capacity to analyse events; and,
- *Treatment model* that is well structured and theoretically coherent, and supported by clinicians who actively undertake treatment via regular clinical sessions.

These are thought to be equally applicable to young people with severe mental illness, with the addition of explicit engagement of parents and carers where possible.

Similarly, the following factors were highlighted as important by inpatient staff in England in delivering are to adolescents:

- *Local resources* that facilitate strong links between units and their surrounding communities, and assist with the re-integration of young people into community care after an inpatient stay.
- *Involving young people* as far as possible in their care in order to take an active part in helping themselves to make sense of and work through their difficulties.
- The *size of the unit*, and the *influences of the peer group* within the unit, need to be considered.
- *Staffing* to provide a strong team of well-supported staff. There needs to be clarity of roles within the team so that everyone understands their roles and those of others. Staff need to share an ethos of service, which requires a clear ethos of purpose. Staff are to be trained in developmental and mental health issues, and also de-escalation training to increase confidence in handling aggression. And a commitment to effective systems of regular staff support to underpin all of this.
- *Communication* between different services and between different professionals must be strong to allow staff and agencies to feel supported by each other, to understand what each other does, and to identify and address gaps so that young people, instead of falling through the gaps, are effectively supported.

(Svanberg & Street, 2003)

Given the adverse post-discharge outcomes associated with traditional residential treatment of mental illness (e.g. Trout, et al., 2013), learnings may be gained from the suggestions made to improve the care delivered in this setting. These are summarised by Chance, Dickson, Bennett (2010) below:

- Short-term, intensive treatment with parallel community-based services to promote the youth's fastest possible return to a less restrictive setting, as well as help for parents or other primary caregivers to maintain or develop a connection with the child and prepare for the child's return;
- Aftercare services to support the stability of the child and family following reunification or transition to family-based care;
- Improvements in the service delivery decision-making pathway; and,
- Better integration of residentially-based services within a county's continuum of care.

As noted earlier, there has been a wide variability observed across sites regarding length of stay (Gifford and Foster, 2008), treatment outcomes (Hanssen-Bauer, et al., 2011), and readmission rates (Fontanella, 2008), suggesting an impact of local resourcing and policies on clinical service provision in adolescent inpatient settings.

Development of Queensland's statewide model of adolescent inpatient treatment was undertaken to clearly articulate the delivery of effective inpatient treatment and minimise associated risks. As in any setting designed to respond to vulnerable people, the importance of maintaining clear boundaries is essential in delivering high-quality care. This includes teaching staff working in an on-site school associated with an inpatient unit. While teachers need to have additional knowledge of youth mental illness to inform their work, it is important that there is a clear delineation of their role from the clinical work undertaken by inpatient staff. They also need to have sufficient professional support in effectively undertaking their work with vulnerable young people.

The importance of clinician hope for recovery is an important consideration. Coppock, Owen, Zagarskas and Schmidt (2010) found that amongst adults accessing therapy, client-rated hope was not significantly related to clinical outcomes. However, therapists' hope for their clients after their first and last session was significantly related to client outcomes. It is suggested this may be even more important for young people given the potential impact a mental illness may have on their emerging identity and views of the future (Mental Health Coordinating Council, 2014). The capacity for clinicians to genuinely believe, and actively demonstrate, the fact that people can and do improve is therefore a key factor in recovery.

Maintaining a sense of hope may be especially important in the case of young people requiring extended lengths of stay in an inpatient unit, who are also likely to experience greater exposure to the risks outlined earlier. As such, designing a model of care for the small sub-set of young people who may benefit from an extended admission would therefore need to make explicit efforts to minimise these risks, including their potential impact on the rehabilitative focus of extended treatment. The model would also need to articulate the delivery of evidence-based treatments, and ensuring clear referral pathways in preparing the young person (and their family) for timely discharge to a less restrictive form of care.

It is important to seek out and incorporate the perspectives of young people (as well as parents and staff, where possible) in effectively delivering mental health treatment. The following section therefore profiles the lived experience of inpatient care across three units providing differing lengths of stay.

5. The Lived Experience

As noted above, young people have reported both beneficial and detrimental experiences of inpatient care. The recent emergence of this evidence base is commensurate with the recovery movement in enabling the voices of consumers and carers to be heard, and to inform the development of contemporary mental health treatment. Sinclair (2004) has moreover identified three main factors as the drivers behind the involvement of children and young people in service improvement: 1. a growing influence of the consumer in society; 2. the children's rights agenda; and 3. new social science research that promotes better understanding of children and young people as agents rather than passive recipients of social change.

This section draws upon a sample of direct quotes, primarily from the following three recent research papers, to demonstrate the experiences and risks of admission to an adolescent inpatient unit. They have been chosen as a cross-section of units across differing lengths of stay, with the latter two not yet available when the literature review by Hannigan, et al. (2015) was undertaken.

- *Moses (2011):* Between June 2007 and March 2010, 80 adolescents hospitalised voluntarily and for the first time in Wisconsin, USA were interviewed within a week after their discharge following a brief admission (averaging 7.6 days), and asked to describe what did and did not help them during their inpatient stay. Most (62.5 percent) had been admitted for suicidal behaviour or non-suicidal self-injury, 12.5 percent had demonstrated aggression or 'out-of-control behaviour' (including substance use) and 6.3 percent required treatment for medication assessment or school refusal. The admission was planned for a quarter of the study participants. Each consultation lasted approximately two hours and included a semi-structured interview.
- *Gill (2014):* This PhD thesis aimed to explore the perspectives of 12 adolescents (aged 13-18 years) on the benefits and drawbacks of their inpatient care in London, UK and specifically their own expectations about an impending transition back into the community. Participants were recruited across three units, with an average length of stay of 3.5 months (ranging from two to eight months). Each interview last approximately one hour and was conducted via semi-structured interview.
- *Ward (2014):* This PhD thesis was completed by a social worker employed at the BAC for eight years, and is a valuable addition to the literature as it appears to be the first qualitative examination of an adolescent inpatient unit in Australia. Ward interviewed 13 young people during their admission about their experiences at the BAC over a series of up to three interviews, with participants given a digital camera in the second and third interviews to capture their experiences visually for further discussion. The average length of stay for participating young people was 21 months. This ranged from a minimum of ten months to a maximum of four years, with young people ranging in age from 15 to 20 years old. In addition, Ward interviewed eight parents of young people admitted at the time, as well as ten staff via individual interviews, and a focus group comprising a nursing, allied health and education representative. Given its relevance to the current paper and the dearth of qualitative research on adolescent inpatient care, the experiences and risks as noted by parents and staff are also included here.

Interviews in all three studies were transcribed, with direct quotes analysed by the authors to draw out common themes.

5.1. Experiences of Inpatient Treatment: Young People

All but one of the 80 young people interviewed by Moses (2011) could identify at least one helpful aspect of their care: interpersonal support (from peers and staff); therapy and psychoeducation; and the environment. These are reviewed in turn, according to quotes from young people admitted to the type of inpatient setting (short, medium and long) as reviewed by the authors above.

5.1.1. Short-Term Admission (Moses, 2011)

Interpersonal support (peers):

> *"*And I was sort of up there for suicidal thoughts and cutting … And naturally, I felt like doing it again and that's why I went up and she just helped me because she was going through similar stuff and just always had good input on things." (Caucasian female, aged 17; p 125)

Interpersonal support (staff):

> ''And everyone there was actually, like, trained in recognising, like, how you feel. And they were trained to listen. Like, a lot of adults just don't get it. They just, especially parents, they just don't get it.'' (Caucasian female, aged 17; p.127)

Therapy and psychoeducation: Over half (56 percent) of the participants in Moses's (2011) study spoke of gaining cognitive and behavioural coping skills during their brief admission, which allowed them to better anticipate their reactions to things and people as well as utilize a new repertoire of strategies:

> "Well, the coping skills I learned that if I do get overwhelmed what can I do to help me challenge that. Like what can help me solve the problem without cutting myself, shooting myself, or hurting myself in any physical way, or thinking about suicidal, or thinking about hurting somebody else. That was really helpful because I didn't know how to do any of that. And what I learned was I can go for walks, I can listen to music, I can read, I can – you know, I have a friend I can ask for help if I ever need it." (Caucasian female, aged 18; p. 127)

Environment: The physical and interpersonal hospital environment was notably helpful to 34 percent of participants with several indicating it helped create a sense of emotional containment.

> "The nurses there always came and checked up on you or someone every fifteen minutes, every half an hour came in and said, ''Time for this class or time for that class.'' …they would come in and check on you and be like, ''Just wondering where you were'', or ''Wondering what you're doing.'' (Moses: Was that good or bad?) "Um, I felt that kind of actually, like, kept me safe. I thought that was good." (Caucasian female, aged 18; p. 128)

5.1.2. Medium-Term Admission (Gill, 2014)

Interpersonal support (peers):

> "When I talk to [a fellow inpatient] about my experiences I feel that they know what I'm talking about and that they've been through a similar sort of situation." (Female, 14 years, diagnosed with depression, anxiety and PTSD, 2 month admission; p.72)

Interpersonal support (staff):

> "The [staff member] I was attached to... I just particularly felt like I could talk to her… I think she just stood out for me and I found someone special in her." (Female, aged 15 years, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 75)

Therapy and psychoeducation:

> "I have the right tools and the right skills [that] I think will help me, like mindfulness and breathing exercises." (Male, aged 17 years, diagnosed with paranoid schizophrenia, 3 month admission; p 82)

Environment:

> "I feel like this is my safe zone where I can talk and I won't sound silly…when I say something people won't laugh at me." (Female, 14 years, diagnosed with depression, anxiety and PTSD, 2 month admission; p.79)

5.1.3. Long-Term Admission (Ward, 2014)

Interpersonal support (peers):

> "Well the one thing – even though it's a big disadvantage - lots of people having the same issues - it's also good in some ways. Because there's an understanding. Like sure there's also a lot of backstabbing. Like you can say "Oh yeah, I've got post-traumatic stress disorder" and someone will be like "No, she doesn't. Geez. God.", and just go and talk behind your back about it. And that happens a lot. But at most times if you are really suicidal or something, you can go up to your friends and say "Well I'm really bad right now. Can you help me out?" and they'll help you use your techniques, which are like distraction and thinking about other stuff. And it really helps." (Female, 15 years, 2year 3 month admission; p. 111)

Interpersonal support (staff):

> "That's my hand and Beth's hand. I don't know. It's kind of just the proof that here even though we're very different people as you can tell – Beth's got very old wrinkly hands but I've got a younger kind of hand but I've also got scars on my hands – so we're two very different people but we're holding hands and it's just that to let me know that no matter what happens here there's going to be people around that care and that are basically going to hold my hand every step of the way no matter what comes along, I guess, the bumpy road that people say. And, yeah, I don't know. It's comforting knowing that – I don't know – I've got someone that loves me and cares for me as much as Beth does." (Female, 15 years, 2year 3 month admission; p. 148)

Therapy and psychoeducation:

> "Well, what I am now is a person who can get along with say, random Bob on the street and I get along with them all right, but previously—like I could have known someone really, really well and then I'd bite their head off for the stupidest little things." (Male, 16 years, 1 year 6 month admission; p.123-124)

Environment:

> "You miss them (family) a lot. But at the same time it's good to have a break as well. Like I tend to worry a lot about my family as well when I'm at home. Especially with mum. She has some problems as well. And it's good not having to worry about that sort of stuff while I'm here." (Male, 16 years, 10 month admission; p.112)

5.2. Experiences of BAC Parents

As noted by Ward (2014), the inclusion of parental perspectives was a belated but valuable addition to his research. Many of the parents interviewed described feelings of self-blame, grief and loss regarding their child's mental illness, and a sense of relief at the admission and the respite it offered. The latter experience is demonstrated in the quotes below:

> **"**And things seemed to change and I knew they would when she went there because it is just set up for more long term stay. Which I have to say gave me a huge sense of relief. And that's when I felt relieved and could breathe again. And I just felt more a sense of hope because I knew that she'd get all the help that she possibly could there." (p. 157)
>
> "I suppose the pressure was off from the daily grind of having to go to her bedroom and try and coerce her into getting dressed or talking about going to school. Then obviously there was the 'sending away' feelings because she's going to be there for a [initial] fourteen day stint sort of thing before you could go and see her. But obviously I knew it was good for her so she had to take that step." (p. 174)
>
> "They're [BAC staff] genuinely knowledgeable in the area as well. That is another big thing. Is that they all seem to be specialised in the mental health industry or mental health field. But they also just seem to care. They'll call you or they'll stop and actually talk to you. When you arrive to see your daughter they'll actually stop and actually speak to you and they're always friendly, and say hello and say goodbye. And

> they tell you to ring... And the doctor – I know [Doctor] is not here anymore - but that just one thing that always I'll remember – and he said to me "We will fix your daughter. We will help her and we will fix it" and I'd never heard that from the two years of seeing that many doctors, psychologists, social workers, counsellors - you name it. Nurses, just specialists that different – not one of them said "Well we'll do something. We'll help you". Yeah. And that was a big thing for me too. Yeah" (p. 130-31)

One parent acknowledged the benefits of the peer support available to her daughter:

> "It was just a massive improvement because she was terribly bullied at school. So her high school experience was all negative...she didn't experience any of that at Barrett. And in fact that was one of the main things that helped her was forming those friendships. Having a peer group who accepted her, and they were all going through similar issues. That was just something also that she gained there. She didn't have that anywhere else." (p. 132)

Another parent acknowledged the benefits of the support offered to her:

> "No, look what's helped me with the – time. I think just time. And talking about it of course. Being able to – I think also with – what I've found with Barrett was that there always someone to talk to. Yeah. Just always asking – because everyone would focus so much on [patient] - which is great. Understandable and that's what I wanted – but for someone to actually say now and then "How are you? How are you coping? Are you okay?" That sort of – it was almost like someone's on my side too." (p. 151)

5.3. Perspective of BAC Staff

Similarly, Ward's profile of staff experiences sheds light on their perspective on the care provided to the young people admitted to the BAC:

> "I'm thinking those sort of students who've come to us with not a single relationship of any consequence. Within a space of six or seven months, a year, they've developed 10. They have a relationship with 10 at least, more than 10 adults and other children in their own social [unclear], when they're at the ward. They've developed all these relationships that are workable, positive relationships. I think that is, that's got to be what heals in the end. Not the teaching, not the knowledge, not the content, not the whatever. It's that being able to relate to people." (Teacher, p. 135)
>
> "Being able to go on outings and show people experiences that they just never got before. They have - some will come from families who've never, ever taken to the beach or taken them to the mountains or taken them to the river to do canoeing. Just experiences that they've never done; it's great to be able to see them do things like that and interact with staff and their peers." (Nurse, p. 175)
>
> "The fact that we're very structured and they know what's coming in lots of ways. They know ICW, case conference, and yes that can lead to institutionalisation, but it also can be consistency which they haven't had." (Allied Health worker, p.174)
>
> "The male staff, they [male adolescents] connect with they follow around like puppy dogs. They crave that male role model and we give it to them, very happy to give it to them...You can just see it, it's craving of the nurturing and the caring and the looking up to people. It comes out at the other end when these kids want to become a nurse, want to become a social worker, want to become a psychologist. I can't tell you how many kids have wanted to follow in the footsteps of their role model, as a kid in a normal home will say, I want the job that my parent has because I admire them. That sort of stuff is hugely important." (Nurse, p. 151)
>
> "The students, when they first come in, are great. Then they all get worse. They all get a lot worse...then, the general pattern is that they start to get better and then they are discharged. So they're good when they first come in, there is a big drop and then there is a slow, gradual climb back up. That's the pattern I've noticed." (Teacher, p. 157-8)

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> "I think it always has to be individualised. Not only individualised but one has to go at the adolescent’s rate and that’s really quite important. It certainly makes manualised therapies very difficult and it also makes research difficult because you might at a certain time, say for instance, with adventure therapy or with sand play or one of the other interventions, an intervention may not mean much to a certain adolescent but then five or six months down the track they’re able to process things differently and it may be really quite pivotal in making changes." (Psychiatrist, p. 158-9)

> "I opened the door one day - the doorbell rang on Sunday. Must have been when [patient] and [patient] were here because we were locked. And I opened the door and this bloke said “Can I see inside your seclusion room?” and I said “What?” And he was playing – he was on the golf course. And he said “I spent many years in that seclusion room”. And I said “Did you?” He said “Yeah, I’m a lawyer now." (Nurse, p.159)

5.4. Perceived Risks of Inpatient Treatment: Young People

As noted above, there may also be a range of challenges associated with an inpatient admission beyond the need for keeping consumers physically safe. These are again considered according to the three categories developed by Moses (2011): 1) Rigidity and confinement; 2) Lack of treatment responsiveness; and 3) Frightening/anxiety-provoking experiences. (His review also generated a fourth category of "other", reflecting a dislike of the food, and not getting along with peers). For each of the three main categories, related quotes are again included from the three inpatient settings. In addition, each section includes relevant quotes to reflect a range of dislocations from the themes identified by Hannigan, et al. (2015).

5.4.1. Short-Term Admission (Moses, 2011)

Rigidity and confinement: Despite some young people liking the structure offered by an inpatient unit as noted earlier, many found it restricting with Moses (2011) noting that one in five participants referred to a general sense of confinement, using words such as ‘‘jail’’ or ‘‘prison.

> "I guess they have to be strict on it, but, like, they wouldn’t even let me call, like, to work things out with my mom … Like, if it really needed to be done (phone call), like, they wouldn’t let it happen…I was being encaged, put in a place like that. It felt kind of like jail except the bars weren’t there." (Caucasian male, aged 17 years; p. 130)

Lack of treatment responsiveness:

> "Dr. —— he was just like ‘‘oh well, you need to take the medicine. You’re never gonna get better. You’re never gonna get fixed if you don’t let us try this on you’’. And I said, ‘‘I’m tired of being your lab rat!’’ (Caucasian female, aged 14; p.130)

Frightening/anxiety provoking experiences: The majority of concerns in this category related to being uncomfortable sharing about themselves with others (especially when done repeatedly), although a range of other issues were experienced, including those relating to exposure to the distressing behaviour by other patients:

> "The staff handled it the best I thought they could … (but) girls still cut while they were there. [redacted]… some of the cuts that I saw were very, very terrifying." (Mixed race female; aged 14; p. 132)

Dislocations:

- Everyday life and interactions in hospital: ‘‘Being alone sometimes was really bad. You’d feel, like, so alone and with your own feelings and you’d just get so depressed.’’ (Caucasian female, aged 14; p. 129); “I just thought that it, like, all the rules were kind of ridiculous and stuff. Like, no touching and stuff, like, I don't know. I feel like it's those times when you need, like, a hug the most, you know?" (Mixed race male, aged 15; p. 129); "A few of them would, like, they would, like, yell at certain kids, like, like, other teens and stuff, and, you know, like, for something that wasn't necessary. Like, they didn't have the patience…'' (Caucasian male, aged 16; p. 131); "They wanted to create safety plans and stuff like that so I wouldn't hurt myself, or anything. But, like, I don't know, I felt that they were kinda pointless." (Caucasian female, aged 17; p. 131)

- Identity: ''Like, 'cause it's called a mental hospital and that kinda makes you feel like if you're there, you must be mental, you must be crazy." (Caucasian female, aged 14; p. 132)
- Missing out on life outside and transition home: "'It kinda made me feel down 'cause I mean, you get this room and it's not your room and you don't get to see your family or your animals.'' (Mixed race; female, aged 17; p. 132); "So I truly was not even ready, and I was not even expecting to get discharged…(I) ended up getting discharged sooner and… I thought, like, I wanted to be ready. Like, for my parents I wanted to be ready, but I'm not." (Caucasian female, aged 13; p. 131)
- Stigma: "I just thought I was going to be there for a long time…weeks, I thought I was gonna be there for weeks." (Latina female, aged 14; p. 132)
- Families: ''The family meeting made me super upset… And I don't, I don't like her (therapist) 'cause she's not, like, trying to listen to my side of the story or anything.'' (Caucasian female, aged 16 years; p. 131)

5.4.2. Medium-Term Admission (Gill, 2014)

Rigidity and confinement:

"[Staff are] telling me what to do and [they're] in charge of my medication and [they're] literally in charge of… they're like in control of your life." (Female, aged 17, diagnosed with depression and emotional dysregulation, 2.5 month admission; p. 78)

Lack of treatment responsiveness: No direct quotes appeared to reflect this theme.

Frightening/anxiety-provoking experiences:

"That's the only problem, you put a load of people with problems together you're going to trigger each other off." (Female, aged 17, diagnosed with depression and emotional dysregulation, 2.5 month admission; p. 73)

Dislocations:

- Normal life: "Staff almost become your parents in the sense that they nag you sometimes and you've got to ask permission for things… And the patients almost become like brothers and sisters because you are so close." (Female, aged 15, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 76); "I don't want to get comfortable because one day I will have to leave, and I want to be prepared when this day comes. I don't want to be really attached with this place because I will just get disappointed in the end." (Female, aged 16, diagnosed with anorexia nervosa, 2 month admission; p. 76); "When you're out in the community you're exposed to everything whereas here you're not exposed to that. And it's frustrating because I wish I was." (Female, aged 15, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 79); "Doing things for myself… simple things like making food or doing your own washing…it's going to be difficult to get back into when you are so used to everything being done for you here." (Female, aged 15, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 83); "I know that when I get out of here, I'm not going to be mentally better…there's some things that've gotten worse since I've been in here." (Female, aged 17, diagnosed with PTSD, OCD and emerging borderline personality disorder, 4 month admission; p. 84)

  "Gill: What then are your biggest fears about leaving here?

Participant: “Missing it! And wanting to come back! But I’ve already made a deal with my therapist in the community, that if I ever felt like coming back to see [staff member] that she would use her nursing powers to get me to speak to her. So that I didn’t need to hurt myself to get back in." (Female, aged 15, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 87)

- Identity: "I was quite an independent person… but here you got to rely on people because everything you do has got to be checked with staff members." (Female, aged 15, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 82)
- Friends: "I haven’t told many people I’m here because people get this stereotype about people in mental health and I just don’t want to be treated differently.” (Female, aged 16, diagnosed with anxiety and emotional dysregulation, 2.5 month admission; p. 90)
- Stigma: "No one has time to spend alone, because as you can see all these doors are locked. You can’t go into your bedroom… the only place you could possibly have all by yourself is the loo." (Male, 17, aged 17, diagnosed with paranoid schizophrenia, 3 month admission; p. 74); "[When] I go back I’ve got no one who’s really close to me… You go from here where you see young people every single day, to back home and it’s just you basically…then you’re gonna start feeling a bit crap." (Female, aged 17, diagnosed with PTSD, OCD and emerging borderline personality disorder, 4 month admission; p. 88); "I think you realise how much of not reality this is because you are so used to being so safe and everything, whereas when [I went on leave] I was petrified! And I think that’s going to be really hard to get back into." (Female, aged 15 years, diagnosed with attachment disorder and emotional dysregulation, 6 month admission; p. 88); "This [hospital] kind of symbolizes everything that went wrong. Everything that went wrong that led to me coming here... So I kind of want to forget about it." (Female, aged 16 years, diagnosed with psychosis and Asperger's syndrome; p. 87)
- Families: "I think that the staff, because you are spending so much time with them, especially when I was isolating myself from my family, a few of them became my substitute parents and I found it quite hard to disconnect.”

  Gill: "And what impact do you think that had on your relationship with your parents?"

  Participant: "I think it drove me further away from my parents and it made me feel like my parents were a bit inadequate in comparison." (Female, aged 16, diagnosed with anorexia, 8 month admission; p. 76-77)

5.4.3. Long-Term Admission (Ward, 2014)

Rigidity and confinement:

"So much routine is in the clocks at Barrett. When you wake up, when you have your meal times, when it’s homework time, when it’s bed time. It’s just 15 minute observations so every 15 minutes if you look at the clock then there’s going to be a nurse peering through your window or telling you to go to school. At 7:30 every morning it’s time to get up and get ready. At five o’clock every day it’s dinner time and it’s just like clocks are kind of really daunting at Barrett because they can either – you can either be – for me I wait every Friday afternoon for four o’clock because that’s when I go on weekend leave, so I’m staring at the clock all the time just like “Hurry up. Hurry up. Hurry up for me four o’clock!” But other times when it’s like – I don’t know – Sunday afternoon, I’m driving back and I’m just like “Oh my God”. I look at the clock and it’s just like “Oh”. But it can be both – when you look at the clocks it could be like “Yay!” because you’re going to do something, or it could be like “Oh my God, I just want to pull the batteries out and just burn the clock!” because it just means so much." (Female, 15 years, 2 year 3 month admission; p. 181)

Lack of treatment responsiveness:

"It’s definitely helping getting – sort of socialising and being around people my age and getting back on track. Yeah, it is helping. Not so much that I see a huge difference though." (Male, 16 years, 10 month admission; p. 111)

Frightening/anxiety provoking experiences:

> "I know I've set off a few of them [duress alarms]. They're probably like the worst thing to see people going to press or pretending to press. Because once that little red button is pressed the never ending ringing and sound is in your head for so long. And it's just people come running, patients are getting anxious but also are very nosy, so want to know what's happening and where people are and stuff like that. Nurses get stressed out and are telling you to "Get back!" or "Get into your room!" or "Shut the curtains!" And they're running around everywhere. This noise is never ending, going off. Usually there's a person kicking and screaming and being like, dragged away into seclusion. And it's really upsetting, and it's just – I don't know. I don't know. It's depressing." (Female, aged 15 years, 2 year 3 month admission; p. 119)

Dislocations:

- Normal life: "But it's very hard with the nurses and the doctors making – because a lot of the time they – well they are basically making big decisions and little decisions about every aspect of your life and your daily functioning. And that takes away the personal autonomy." (Female, aged 16; 2 year 2 month admission; p.108); "Mostly when I've been upset and distressed, and the restrictions that have made it really hard. And the lack of personal space and privacy. And the nurses checking up on you and sharing with other girls, and just lack of – you can't – there's no private space you can go, without the nurses being there with you." (Female, 16 years, 2 year 2 month admission; p. 171)
- Identity: "When you go home from a really rough day at school you're just like "Yes!" and you go into your bedroom and you can just like listen to music or go on the computer, and it just feels good. Whereas here, it's kind of like, rough day and you're like "Oh, I'm still in a psychiatric unit!" (Female, aged 15 years, 2 year 3 month admission; p. 172)
- Friends: "It is quite awkward. Usually I've been – I mean because everyone expects you to be in school and they're like "What school are you going to?" and "Where do you live" and my family lives in Townsville so I'm like, "Do I live in Townsville or do I live in Brisbane?" And it is confusing." (Female, aged 16, 2 year 2 month admission; p.162); "With all the new patients that are coming in, like they're bringing in, like, their new problems and they are affected with everyone else's problems that have already been dealt with, or are still in the process of dealing with them." (Male, 16 years, 1 year 6 month admission; p. 164)
- Stigma: "If I was to describe it to a stranger, I'd tell them it's a – to be honest, I normally tell them it's a hell hole. That's what I used to say. Because I didn't like sleeping there every day. But it's a lot better when you sort of get out more." (Male, aged 15, 1 year admission; p. 171)
- Families: "When I'm at home and I'm going to bed my mum and my little sisters will come and say 'Goodnight' to me. And they'd give me a kiss and a hug, and sometimes my little sisters will sleep in my bed with me if I'm like scared or if I have a nightmare, or if they do too. And this just shows that down the end of the hallway I'm in my bedroom and if I'm scared I have no one to hop in my bed with me, no one to keep me warm, no one to say goodnight or comfort me when I'm scared and stuff like that. Because it says no visitors are allowed down to the bedrooms. And so it makes me very sad and very homesick because even though my parents and family won't be there at night time it's just my room – I dance in my room and also with my little sisters when I go home and – I don't know. My room is very like – I do a lot of things with my sisters in my room and stuff like that, whereas here it's just like – makes me very homesick." (Female, 15 years, 2 year 3 month admission; p. 113-114)

  "That's the only telephone that we can – I don't know – use. And if you look at it, it doesn't look like a very happy telephone to be using every day because my mum calls me every night. And so I pick up that phone every night. And if you look at it, it's just – it doesn't look like you could have a happy conversation through the other person on the other line. And it's just – I don't know. It also symbolises that you can't call out. So you've got to wait for someone to call in. That's also very – it sucks because you can't just pick up the phone whenever you want and call someone. It also is a fact that if your mum's on the other side

> of the line and you're feeling very homesick and you want to talk to her you're picking up this ugly rusty old phone to talk to your lovely beautiful mum on the other side. So you don't really feel very happy picking up this phone because straightaway looking at it, it just doesn't show any warmth or niceness at it. It's just – so it doesn't really make the person on the other side of the line feel good." (Female, aged 16 years, 2 year 2 month admission; p. 179)

5.5. Perspectives of BAC Parents on Risks

Many of the above themes regarding dislocation were echoed by BAC parents as challenges of admission:

> "And to be a part of the family. Because she's missed out on that as well. It was nice last night. We picked her up. She went home with us. She had a bit of dinner with us, even though she'd had some dinner here as well. And then her and [sibling] sat at the coffee table and [sibling] did her homework [young person] did some of her art homework. It was just a nice normal family thing. And we haven't had that in a long time. [Sibling] came and talked to me in the kitchen. [Patient] could hear that we were joking around. That's something very rare in our household these days, as in [patient] being there and able to enjoy the family setting." (p.129)
>
> "Just not being able to sort of be there and hug him and say everything's going to be okay. So it was very hard…it was knowing that we couldn't sort of ring every day to find out what was going on. That was hard. Because we knew that things had to go on and he couldn't know that we were in contact and that's otherwise he'd want to come home all the time." (p. 131)

In addition, while sharing their relief at the admission, parents expressed ambivalence at having handed over their role as a parent:

> "So that's been an issue – trying to stay involved and still – because I felt in a way I didn't – you feel in a way like you're abrogating parental responsibility. That the parents become Barrett. It's like putting children into childcare. If you put them into childcare continually who's parenting them? I mean the only good thing is you get them back at the end of the day and then you parent and you try and cover all that. So there's nothing much can you do about it. If they've got to go into childcare, they got to go into childcare. Like if they've got to come to Barrett, they've got to come to Barrett. So that's been a really big issue for me." (p.130)

As Ward noted, "in contrast to the adolescents, the parents in this study saw recovery bound with the admission to Barrett (p.156)…their particular narratives suggested that their hope was invested in the organisation; that they had finally found a facility that could do what other treatment facilities could not do." (p. 195)

5.6. Perspectives of BAC Staff on Risks

Interviews with BAC staff generated a range of themes reflecting potential risks of admission. They also noted the role they took in "parenting" the young people:

> "It's interesting because it does – because I'm not a parent – but it does feel like I'm a parent sometimes. Because I do run a lot of activities and at times I got to organise adolescents to get up and get them ready for school, go through all the homework stuff. Even during the holidays make sure their lunches are packed, all that money budgeting, all of that stuff. After school activities like swimming or whatever it is." (Nurse; p. 136)
>
> "I mean you're in an inpatient setting and people are here, it's their home here. And for all intents and purposes, call us what you like, but we are the parent figures here, because we're the ones that are enforcing – it's our household and we're enforcing what rules and regulations we are having in our household...We know in the list of the 15 or 20 odd tasks of parenting nursing staff probably address three quarters of them at least." (Nurse; p. 136)

> "I think a difficulty is unlike a home where you have a mum and a dad, here there's lots of mums and dads." (Allied Health worker; Ward, 2014, p. 137)

In addition, staff reflected on the potential risks of long admissions:

> Allied Health Worker: "I think those who stay here too long get worse. Yeah. That's like [patient with a four year admission]. Because when she first came in she had an eating disorder but when she left it was worse, so I think she overstayed her accommodation"
>
> Ward: "Do you have any theories as to why it gets worse?"
>
> Allied Health Worker: "Yeah. I think maybe they become so attached to us. I think they become so attached and dependent on us and they can't see themselves being anywhere else but here. I guess it's like being in a jail where your whole life is between those walls and you don't really see the outside world and for us to sort of discharge them or allow them to go out, it's like a scary or whatever world out there for them. Therefore for them not to go there, they decompensate for us to keep them in. So we just keep taking care of them. So I think they just develop this sicker role...I don't know. I think they just become so dependent on us and that they just develop new mental illnesses for us to keep them here." (p. 134)
>
> "[Patient] was here way too long. I don't think we take the chance on kids. I come from a community clinic where you had to take a chance on kids and give the responsibility to the parents. I think we tend to take away the parental rights a little bit...I think this becomes a safe place for kids. So safe that they don't want to leave and then they often sabotage their treatment so that they end up here longer because they're frightened of what's going to happen on the outside." (Nurse, p. 134)
>
> "So that's what I'd say would be the negatives for the kids, that we're delaying that process of potentially moving on to something that's better than us." (Allied Health Worker; 2014, p. 183)

A number of staff reflected in the challenges of making decisions regarding the best possible options for care:

> "They can't stay here forever. It's upsetting them and it's upsetting for quite a lot of staff. In fact we have some of our more spirited discussions in case confidence [sic] over when to discharge someone or when someone should move on. You're going to have a lot of staff who have different ideas on all of this. Can we help them? Can we continue to help them or is it time to move on and accept the fact that there is nothing much more we can do?" (Nurse, p. 165)

Ward (2014) also referred to a number of organisational challenges as well as the need for staff to "cling on to hope" (p. 195) in the face of working with these young people, as noted in the following quotes:

> "I just remember hearing about her case and it was probably one of the worst cases that we've had and just how sad that was. I mean, often when [School Principal] has told us about kids who come in at staff meetings, and there's not a dry eye in the house." (Teacher; p. 167)
>
> "The thing that keeps me here is you really can build up much closer relationships with students and know them to a far greater extent than you could in a class of – when you've got say 100 students that you're teaching. Yeah. I find that is what's kept me here, despite the rather difficult times that I've experienced with seeing students – dissociating and screaming out loud for half the night, despite hearing of suicides of ex-students. These are very terrible things, and that's also very stressful I find. However I'm hoping that I'm making some sort of real difference to some of the students here." (Teacher, p.143)

It is also useful to consider the experiences of staff at a Californian residential treatment centre in reflecting upon the many challenges inherent in their traditional model of care (Chance, Dickson, Bennett & Stone, 2010). They acknowledged the fact that many former clients were not connected to permanent, dependable adults or struggled to adjust after discharge. The following story was shared as one example of these challenges:

> "The recognition of a need for change was clear at the funeral for a young girl who we had worked with intensively for a year and a half ...During her time with us we had successfully built meaningful relationships with her and had helped her valiantly resurface from a debilitating depression. We had helped her find the courage, for the first time in her life, to make plans for herself—including college and a career—and had helped her actually believe that she could make them happen. In spite of this success, however, something was still missing. Several months after leaving the program she succumbed, again, to her depression and took her own life. As painful as this news was for those of us who loved her, the real blow came at the funeral when it became incredibly clear what it was that we had missed: there, in the pews of the small funeral home, were rows and rows of family members that we had never met." (p. 134)

Ward (2014) notes that, "the recovery process for the teenagers was rarely straightforward. It was often a disjointed and confusing experience 'seen from afar'. The inpatient experience itself held a range of experiences for the adolescents, ranging from confusion to almost terror." (p. 168)

He concludes his research with the observation that "the adolescents were experiencing many processes; living away from home in a hospital that is now their home; living with peers from whom they rarely can escape and in whom they find both solace and distress. They form attachments with adults who offer a nurturing parenting role thereby encouraging attachment while being mindful that this parenting relationship is temporary and will one day come to an end. The adolescents lived through a kaleidoscope of experiences that few other teenagers would ever understand." (p. 184)

In having undertaken their extensive review of the risks associated with inpatient treatment for young people, Hannigan, et al. (2015) note that it should not be interpreted as undermining the value of this setting for those with the greatest level of mental health need. However, they state that "one way of mitigating the less obvious risks associated with hospital admission is to admit only when all other options have been exhausted, for periods as short as possible and close to home" (p. 72). This warrants further investigation of the scope and availability of such options.

6. Treatment of Severe Youth Mental Health Illness across the Continuum of Care

Least restrictive care as close to home as possible are enshrined principles to protect the human rights of people with a mental illness (United Nations, 1991). They are strongly endorsed by consumers and carers, and have been integrated into national policies and frameworks to guide the delivery of contemporary mental health care as underpinned by the recovery model. However, the additional principle that adequate resources be available to deliver this care in the community does not seem to have been sufficiently achieved internationally in the years since then. In leading the deinstitutionalisation movement, advocates have called for a wider continuum of care. This has been defined as "an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care"(Evashwick, 1989, p. 30).

Research is increasingly starting to examine whether comparable outcomes to inpatient treatment can be achieved through less restrictive settings for young people. Gowers, et al. (2010) assessed adolescents with anorexia nervosa one, two and five years after clinical intervention and found no additional benefits from prolonged inpatient treatment compared with specialist or generalist CAMHS treatment. Specialist and outpatient treatments were more cost-effective than generalist and inpatient treatments. Parental satisfaction with treatment was generally good, though better with specialist treatment than generalist treatment. Young people's satisfaction was much more mixed, but better with specialist treatment. Similarly, a large-scale European randomised control trial found no benefit 12 months after the completion of an ongoing inpatient stay compared with day program treatment for young people with anorexia (Herpetz-Dahlmann, et al., 2014).

Similarly, Madden, et al. (2015) undertook a randomised control trial comparing the effectiveness of longer periods of hospitalisation for weight restoration to shorter admissions for medical stabilisation (each followed by 20 sessions of outpatient, manualised family-based treatment) for adolescents admitted to psychiatric units in Sydney. Adolescents in the weight restoration group required a greater number of days of readmission over the following 12 months after the initial admission, as well as more FBT sessions. Participants with higher eating psychopathology and compulsive features reported better outcomes in the medical stabilisation group. The authors concluded that the greatest cost savings would result from combining short hospitalisation with community-based FBT.

A number of approaches have been suggested in meeting the varying clinical needs of adolescents across a wider continuum of care. Proposed approaches include multi-systemic therapy for psychiatric disorders (Huey, et al., 2004), wrap-around care (e.g. Bruns, et al., 2010) and hospital in the home (e.g. Boege, Corpus, Schepker, Kilian & Fegert, 2015) as well as the service components included in the Queensland adolescent extended treatment continuum of care. Reviews of alternatives to adolescent admission have examined a varying combination of these approaches and criteria for inclusion in studies (e.g. Shepherd, et al., 2009; Lamb, 2009; Gill, 2014; McDougall & Cotgrove, 2013), with findings suggesting differing levels of evidence for individual components.

Kwok, Yuan, and Ougrin (2016) conducted a systematic review of randomized controlled trials (RCTs) reporting the efficacy of intensive community services versus inpatient care in children and young people (to 18 years). While few of these examined children and adolescents with severe immediate risk to self and others, the authors concluded that:

> “Inpatient psychiatric hospitalisation of youth with severe psychiatric disorders does not appear to be more clinically effective than intensive and comprehensive community-based services. The results of the RCTs (a) support the value of intensive community services as alternatives to inpatient hospitalization, and (b) indicate that using intensive community services is associated with similar or better clinical outcomes to inpatient care at a lower cost and linked with greater family satisfaction.” (p. 7-8)

They attributed these differences to a range of potential factors, including alleviation of the adverse effects of admission, facilitation of autonomy and self-confidence for life outside hospital, engagement of the young person and family and a reduction of the need to transfer treatment effects across settings.

As yet there is no standardised continuum of mental health care developed for young people, but the emerging focus of research and policy is consistent with a growing call to redress the continued over-reliance on psychiatric hospitals and better resource less restrictive care. In its Mental Health Plan 2013-2030, the World Health Organisation (2013) stipulates service reorganisation and expended coverage as one of its priorities, as described below:

> "Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions including the use of stepped care principles (as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing." (p. 22)

Their proposed options for implementation include:

- Developing a phased and budgeted plan for closing long-stay psychiatric institutions and replacing them with support for discharged patients to live in the community with their families;
- Provide outpatient mental health services and an inpatient mental health unit in all general hospitals;
- Build up community-based mental health services, including outreach services, home care and support, emergency care, community-based rehabilitation and supported housing; and,
- Establish interdisciplinary community mental health teams to support people with mental disorders and their families/carers in the community.

6.1. International Policy Directions

6.1.1. North America and Canada

Increasing access to mental health services and treatment by adolescents and young adults is one of the four steps proposed to protect American communities from gun violence (US Government, 2013). However, the main focus appears to be on access to support through schools, and service delivery does not seem to be standardised across the country, with variable readiness to change.

Canada's Mental Health Commission has identified young people (16-25 years) with mental health and substance use problems as a particularly vulnerable group in need of additional support to make a successful transition to adulthood. In September 2015, they released *Taking the Next Step Forward*, their national service reform plan for this group. It includes a tiered approach to care ranging from a universal public/community response through to comprehensive inpatient services, community-based day and mobile treatment options, and highly specialised inpatient/residential settings. The plan notes "a flexible system is able to ensure access to a required tier at any given time, based on individual needs, complexity of situation, and service intensity requirements." (Mental Health Commission of Canada, 2015, p. 49)

6.1.2. England

A Health Select Committee appointed to hold a parliamentary inquiry into England's CAMHS services (House of Commons, 2014) included a chapter on bridging the gap between inpatient and community services, which started with the following paragraph:

> "Intensive services provided in the community can act as a bridge between inpatient services and community services, with the aim of preventing the need for an admission, or facilitating more swift

> discharge back to the community. These services are variously described as 'Tier 3.5', 'Tier 3+', 'assertive outreach' or 'intensive community' CAMHS services. Out-of-hours and crisis services are also essential for responding to children and young people who need urgent assessment and treatment; paediatric liaison services, based within acute hospitals rather than CAMHS services, can also act as an important link, where they are available. The evidence we have received has described the important contribution these services can make, but has highlighted the fact that provision of such services is highly variable, and has suggested that this might be a more useful focus for investment than inpatient services." (p. 68)

In the UK's *Achieving Better Access to Mental Health Care to Mental Health Services by 2020* (NHS England, 2014), it was noted that "the extraordinary gravitational pull of acute hospitals has distorted the distribution of resources, an imbalance that has been perpetuated and exacerbated by treatment targets and payment systems for physical health which have diverted resources from mental health services." (p. 1)

In March 2015, a manifesto was launched by The Times newspaper calling for urgent action by government to improve the well-being of children and young people, and their families. Amongst other things, it recommends adequate funding, the provision of evidence-based treatment, early intervention and prevention, and better access to treatment, in particular that:

> "Frontline support services for parents and young people must be available face to face, online, and on the phone 24 hours a day, seven days a week. Better access is needed to out-of-hours crisis services, paediatric liaison teams within acute hospitals, and community-based assertive teams" (see http://extras.thetimes.co.uk/public/timetomind/)

In the same month, a report was released regarding the views of child and adolescent psychiatrists (in community and inpatient settings across the United Kingdom) regarding their experience of working with children and young people "stuck in the gap" between community and inpatient care. The report made a number of recommendations, including that "resource investments need to be targeted at strengthening community services to reduce admission rates." (Royal College of Psychiatrists, 2015, p. 17)

Finally, in August 2015, the NHS launched *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing* (NHS England, 2015).This plan aligns with the *Better Access to Healthcare Services* plan and outlines a five year vision to build the capacity of services and communities. It identified as its immediate priorities the following two goals:

- An investment of £7 million to end the practice of young people being admitted to mental health beds far away from where they live, or from being inappropriately admitted to adult wards. At the same time, NHS England will work to ensure that provision for this vulnerable and important group of people is put on a sustainable basis for the future. This work will include supporting faster implementation of good practice commissioning of child and adolescent services both in the community and inpatient settings; and
- An investment of £33 million to support people in mental health crisis, and to boost early intervention services. This includes funding for liaison psychiatry with the expectation that every £1 of investment should realise a £2.50 to £3 saving in the acute sector. Crisis Resolution Home Treatment Teams will be supported to reduce admissions to acute inpatient beds, facilitate early discharge, and offer an alternative to admission through the delivery of intensive care and support to people at home.

6.1.3. New Zealand

New Zealand is currently implementing *Rising to the Challenge: The Mental Health and Addiction Services Plan 2012-17* (Ministry of Health, 2012). Infants, children and young people are one of the priority groups identified, with one of the strategies for New Zealand public health services and NGOs being to enhance responsiveness and flexibility of specialist youth services focusing on:

- reducing waiting times for entry into specialist mental health and AOD services;

- providing Kaupapa Māori services for Māori communities;
- delivering services from settings within the local community that are family, whānau and youth friendly, such as schools, youth-specific health services (including one-stop shops) and integrated family health centres;
- co-locating and integrating of mental health services, and alcohol and other drugs services for youth;
- obtaining input from young people into planning and delivery of specialist mental health, and alcohol and other drugs services;
- developing dedicated roles and other options for youth and their family and whānau to provide peer-to-peer support;
- proactively involving and supporting family, whānau and friends; and,
- actively working to ensure young people remain engaged with age-appropriate, natural community supports.

(Ministry of Health, 2012)

6.2. National Policy Directions

While the availability of headspace centres around the country has been a significant federal investment in youth mental health, it does not target the smaller but more impaired cohort of young people who need longer, more specialised treatment for severe mental illness. Public mental health services are funded and administered by the State Governments, and so resourcing is at their discretion. However, there is an expectation that state priorities will align with those outlined in national policies and frameworks.

The National Mental Health Services Review, released in April 2015, noted there is evidence that far too many people suffer worse mental and physical health because of the treatment they receive, or are "condemned to ongoing cycles of avoidable treatment and medications, including avoidable involuntary seclusion and restraint" (National Mental Health Commission, 2014, p.15). It also found that programs are not set up to promote early intervention, that people may need to inflict serious physical harm to gain access to support, and that there is a "missing middle" of people who fall through the gap between their general practitioner and hospital care. The Federal Government's response to the Review is expected to inform the development of the Fifth National Mental Health Plan due for release in early 2016.

In preparation for the new National Plan, the federal government also undertook a comprehensive consultation with more than 200 experts from across Australia (including consumers and carers, and those specialising in child and youth mental health care). This generated for the first time two documents designed to strategically inform state provision of mental health services across the continuum of care: the *National Reporting Framework for Mental Health Services* and the *National Drug and Alcohol Clinical Care and Prevention* tool. These population planning models are designed to be used in concert to support transparent, consistent, and evidence-based health planning in Australia, and although still in draft have already been used to inform the development of service priorities in a number of states.

In regard to young people with severe physical, mental or intellectual disabilities, the Royal Australian and New Zealand College of Psychiatrists recommends that "wherever possible, young people should be supported to move out of institutional settings and into the community" and that "adequate community supports must be made available for transition into the community to be made possible" (Royal Australian and New Zealand College of Psychiatrists, 2015b, p.4).

The Walker Unit in Sydney opened in 2009 in the context of limited acute adolescent inpatient units across the state (which has since been rectified with the provision of three new units in regional NSW), and only two youth-specific day programs. During a site visit by CHQ CYMHS in October 2013, a senior clinician from the Walker Unit suggested that if NSW Health were to expand their service provision they should invest in mobile youth outreach services as this would support their consumers better than more inpatient units.

The statewide lack of Step Up/Step Down and Residential facilities for adolescent rehabilitation and extended treatment has also been identified as a priority. To counter such gaps, *Living Well, A Strategic Plan for Mental Health in NSW 2014-2024* (Mental Health Commission of NSW, 2014) was informed by contributions from over 2100 consumers, clients, health professionals, and community members through forums and workshops. It states that "community is the heart of positive mental health and wellbeing. Extensive research shows that even people with more severe mental illness can best be supported at or close to home" (p.17). The plan acknowledges that long-term institutionalisation is a continuing practice, and goes on to note that:

> "The failure to fund and develop community-based services has meant consumers and their families and carers have had limited access to services that would enable people with severe mental illness to live well in their community. This creates a revolving door for consumers. Because there is inadequate care in the community, people are readmitted to hospital. For the mental health system, it creates a vicious circle: the lack of care in the community increases pressure for expensive inpatient mental health care, which draws more money from community-based services." (p.55)

In January 2015, the NSW government announced $2.1 million funding for the first stage of the planned statewide expansion of the successful Youth Community Living Support Service (YCLSS) for 16-24 years olds with severe mental illness who are living in the community. YCLSS employ youth workers who provide intensive, practical assistance on an outreach basis to assist these young people in developing living skills, accessing education and training, improving relationships with family and friends, and making healthy lifestyle choices related to diet, exercise, smoking, and drug and alcohol use. They also provide access to other services to address psychosocial needs, such as income support, employment, drug and alcohol and other health services, accommodation, and recreation, while ongoing clinical care is provided by the local mental health service. An independent evaluation of a pilot of YCLSSs found an 80 per cent reduction in the amount of time spent in hospital by young clients. In addition, all participants made significant and demonstrable progress across a number of aspects of their lives, such as social engagement, employment and/or education, independent living skills, health and well-being, self-esteem and confidence levels (NSW Government, 2015).

The Victorian government is currently developing its ten year mental health plan. Its "research suggests that the most effective ways to improve mental health for children and families involve a combination of complementary models such as intensive outreach services, crisis intervention teams, and age-appropriate day patient and inpatient services" (Victorian Government, 2015, p. 12). One of their proposed strategies is to "increase the capacity of services to provide treatment and support to children and their families by gradually readjusting the balance of investment in specialist mental health services" (p.13).

Of particular relevance to Queensland is service provision in Western Australia, given its size, decentralised service delivery, higher proportion of indigenous people, and comparable suicide completion rate (Australian Bureau of Statistics, 2015). It is worth noting that a petition initiated by a parent was tabled in West Australian Parliament in December 2013 calling for an increase in the number of mental health beds at the new Princess Margaret's Children's Hospital. A parliamentary committee established to respond to the petition held three public hearings in July 2014. It found that existing units were not always at full occupancy, and heard that the "turn away" rate is a subjective experience as "the offer of community treatment may not be what a parent/carer or referral source wished for" (Government of Western Australia, 2015, p 13). They also heard that admission to hospital should be the last resort:

> "Removing a child from their home and going into hospital is often very traumatising and something that should really only occur when all other options have failed. It is in that regard that planning and thinking about the number of beds needs to be taken into consideration...our acute bed settings are adequate based on our population and epidemiology, but they are adequate if we also have the other elements of

> the system in adequate supply. At the moment we do not have the other elements of the system in adequate supply. We are letting people get too sick and they need the highest severity of treatment. A big part of the modelling we are doing is telling us that we need to invest more in the sub-acute [referring to Step Up/Step Down] and community-based care settings." (p.11)

The committee found that the 20 mental health beds planned for Perth Children's Hospital would only be sufficient if community-based sub-acute care is adequately funded and supported. The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Western Australian Mental Health Commission, 2015) has a strong focus on community-based care, including establishing Step Up/Step Down facilities for young people.

In Queensland, there appears to be a growing call toward less-restrictive care. The following quote is by Jan Kealton, a long-standing carer advocate and Deputy Chair of the QMHC Advisory Group (see www.qmhc.qld.gov.au/qmhdac/council-members/jan-kealton/):

> "It seems that the State Government is grappling with the issue of balancing risk management and community safety with human rights. Where this has happened previously, the result has almost always been a further erosion of human rights and an escalation of stigma. This is both unjust and unnecessary. We are all aware that mental health services are seriously under-resourced, even when recent funding increases are taken into consideration. There is increasing evidence that the vast majority of consumers could best be supported in the community rather than in hospitals. The P300 report clearly identified that a high level of community support is able to be provided at a significantly lower cost than either hospital treatment as an inpatient, or long-term residential treatment; and that the outcomes for consumers are significantly improved. With appropriate levels of proactive support in the community, consumers are much more likely to stay well and are also far less likely to come in contact with police and the criminal justice system. The natural conclusion is that adequate funding for both acute and community mental health resources will significantly improve the management of risk factors, as well as increasing the safety of all members of the community, including the safety of the consumers themselves."
>
> (Queensland Voice, 2013, p.2)

Outlined below are five community-based, developmentally-appropriate services, available across Queensland, to help address the severe mental health needs of young people and their families, including negotiation of transition across the continuum of care. It is noted that clinicians from most CYMHS teams can also access specialist local Ed-LinQ advice to help maximise the educational outcomes of young people accessing treatment.

6.3. Community CYMHS Service Provision

6.3.1. Community CYMHS clinics

As noted earlier, services across a number of sectors have anecdotally reported increasing complexity of children and young people presenting for care. This includes CYMHS as a tertiary setting for the treatment of severe and/or complex mental illness. Data accessed for CHQ identified that the top three primary diagnoses reported for young people 13-18 years across its seven community clinics for the period January - June 2015 (inclusive) comprised a moderate depressive episode (10.6 percent of all cases), mixed anxiety and depression (8.9 percent) and other reactions to severe stress (8.4 percent), which is often a precursor to a diagnosis of PTSD. Young people 13-18 years seen in CHQ community CYMHS clinics during this period have an average of 2.2 diagnoses (ranging from 1-5), although this is likely to be an underestimate. CIMHA also allows for entry of a variety of ICD-10 contextual factors that may impact on a person’s functioning, and can reflect the complexity of their experiences, for example problems relating to education and literacy, physical environment, social environment, and negative life events. The young people in this cohort examined in this period experienced an average of 2.9 such contextual factors, ranging from 0-16. Their overall initial HoNOSCA score averaged across all seven community clinics came to 17.5, with the highest scores (of 19.3 and 19.8) associated with the Inala and Pine Rivers clinics respectively. This is likely to reflect the higher level of social disadvantage experienced in these catchment areas.

The highest scores for individual items was associated with item 9 (problems with emotional and related symptoms) and item 12 (problems with family life and relationships).

In the month of May 2015, there were a total of 740 consumers aged 13-18 years open across the seven CHQ CYMHS community teams, with 75 attending as part of a new episode and 120 discharged that month. Amongst consumers open to community clinics, 432 (58.78 percent) had been with the team for less than six months, 175 (23.64 percent) had been open 6-12 months, 80 (10.81 percent) 1 to 2 years and the remainder 2 to 5 years. Young people were seen in May 2015 for an average of 2.75 hours and their parents/carers/family members for a total of 1.15 hours (of which 85 percent was also with the young person). In addition, a total average of 25 minutes support was provided over the telephone for each case (of which five minutes was with the young person and 20 minutes with a parent/carer/family member).

Young people in community clinics thus present with high levels of severity and/or complexity, and they (and, in many cases, their families/carers) access significant CYMHS support over extended periods of time to achieve better mental health and well-being.

In light of the complexities experienced by CHQ CYMHS consumers, and with the consent of the young person (and, where needed, their family), community clinics have the opportunity to arrange a complex case review involving the expertise of stakeholders outside their team. This can include CYMHS staff from other teams/HHSs with specialist knowledge relevant to the case, as well as representatives from schools, other government departments and NGOs. The review is clearly documented on CIMHA with minutes outlining stakeholder actions circulated to all parties, including the young person (and, where needed, their family). Providing such a forum enables new perspectives from expert sources to be integrated in progressing identified treatment goals, and is consistent with the recovery model in delivering holistic care.

Despite limited funding and increasing demand, CYMHS has made effective use of existing resources to identify and respond to areas of unmet need. Examples of two such initiatives are profiled below:

Family-based therapy for anorexia nervosa

Since 2007, CHQ CYMHS has had an outpatient treatment clinic based on the Maudsley model of family-based therapy (Lock, Le Grange, Agras & Dare, 2001) for the specialised treatment of adolescent anorexia nervosa. (For an overview of local application of the model, see Withington, Litster, Catania & Krause, 2014). Introduction of the Maudsley Clinic has seen a significant increase in referrals for family-based treatment (FBT), increased percentages in families completing FBT, halving the length of stay in the paediatric inpatient unit prior to community treatment, and a reduction in the average length of time for families to complete treatment (Catania, Withington & Litster, 2015). These learnings have been shared at a number of forums (including the statewide Eating Disorders Network and at national conferences) to promote real-world service delivery, including the uptake of such a model in other CYMHS sites across Queensland. Through consultation with the MHAODB to inform development of the Services Plan, CHQ CYMHS highlighted the exponential increase in eating disorders amongst both male and female adolescents. It also identified the intention (should additional funding become available) to establish a specialised day program to extend the range of treatment options available for young people with eating disorders.

Group treatment for severe social anxiety

A community clinic of CHQ CYMHS has undertaken a preliminary evaluation of four groups held targeting social phobia in young people. It utilised *Stand Up, Speak Out* (Albano & di Bartolo, 2007), an evidence-based treatment program that uses CBT techniques to help groups of 5 to 8 young people (aged 13-18 years) with social anxiety learn how to cope in social situations. It differs from the adult version by engaging parents and including training in social skills and problem solving, as anxiety is thought to interfere with the development of these skills. Each program targeted CYMHS clients with severe social anxiety, and involved weekly attendance at their local CYMHS clinic for a one-hour session over two school terms (totalling 18 weeks). The program also included attendance by a graduate of a former program during the first session to share their experiences with the participating young people. The later sessions were devoted to exposure exercises, including visiting a local shopping centre where participants took part in activities such as eating in front of others in the food court, asking for items at a supermarket, making small talk with the cashier and going to shops they used to visit before the onset of their anxiety. Issues of individual clinical risk were monitored by a young person's clinician as needed for the duration of the program, but treatment otherwise comprised only attendance at the weekly sessions.

A total of twenty-five young people attended across the four groups, with the following clinical profiles present at the start of the program:

- Social anxiety: 64 percent very severe social anxiety, 20 percent severe, 15 percent moderate, 4 percent mild (with the latter young person having accessed significant individual CBT prior to the group).
- Depression: 59 percent extremely severe, 6 percent severe, 35 percent moderate, 6 percent mild.
- Anxiety (general): 66 percent extremely severe, 17 percent severe, 17 percent moderate.
- Stress: 29 percent extremely severe, 41 percent severe, 13 percent moderate, 6 percent mild, 11 percent normal.

A significant number of the young people had difficulties attending school, and several had recently been hospitalised for their depression, suicidal behaviour, NSSI and/or severe school refusal. Preliminary analysis revealed that by the end of the group, there was a statistically significant decrease in social anxiety, depression, anxiety (general) and fear of negative evaluation ($p<0.000$) and stress ($p<.005$). Specifically, at post-treatment 41 percent of the young people reported normal levels of social anxiety, with 25 percent each reporting mild and moderate levels, 8 percent reporting a severe level and no one scoring within the extremely severe range. (Any clients and their families who did require ongoing support had this addressed via individual treatment at the end of the group). In addition, a number of young people had successfully returned to full-time attendance at school and re-engaged with their former activities and friendship groups. Participants highlighted the content, access to peers, role playing, and exposure activities as the most helpful elements of the program. One young person noted, "Thank you so much as this has helped me so much".

Accounting for the time a senior allied health staff member would take to run the group for one hour a week over 18 weeks (with a total of one extra hour for work preparation and documentation for each session), including the purchase of participant manuals, the entire group costs no more than $2,000 for up to eight young people. This is less than the expense of one night's stay for a young person in an adolescent unit and equates to $250 per participant, demonstrating a very cost-effective means of achieving significant treatment gains over a relatively short space of time amongst very functionally impaired young people. It also had the advantage of being held in the real-world setting of a CYMHS outpatient clinic so that young people could practice strategies and consolidate their learnings in their own environment. Discussions are underway about how the group might be made more widely available to other CYMHS clinics.

6.3.2. Evolve Therapeutic Services (ETS)

ETS were established across the State following a recommendation of the report *Protecting Children: An Inquiry into the Abuse of Children in Foster Care (Crime and Misconduct Commission (CMC), 2004).* It stated there was a clear unmet need for therapeutic services for children in care, including treatment services and therapeutic placements. Recommendation 7.5 of the CMC report stated that "more therapeutic treatment programs are made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated" (CMC, 2004, p.194).

The aim of the Evolve program is to enhance the mental health, behaviour support, and participation in education for children and young people in the care of the Department of Communities, Child Safety and Disability Services (DCCSDS) through a collaborative interdepartmental response by DCCSDS, Queensland Health, and the Department of Education and Training.

The Queensland Health component of the collaborative sits within the continuum of care provided by CYMHS. It works within an overarching interagency model to provide specialist trauma-informed mental health interventions for children and young people in out-of-home care with severe and complex mental health support needs. There is a strong focus on direct clinical work and capacity-building provided by highly qualified, experienced staff.

As noted in a recent ETS performance review (Queensland Health, 2015c), seven ETS teams were operational with a caseload of 283 children and young people in 2009. The caseload increased significantly to 595 in 2013, when all ten teams were operational. Children and young people seen by ETS are on average 9.5 years of age, 60 percent are male and one-third identify as Aboriginal and/or Torres Strait Islander. Service contact duration is consistent with the Evolve recommendations of 18 months and the majority of children and young people exit due to achievement of Evolve Plan goals. Half of all young people seen in 2013 had a primary diagnosis at admission of Reactive Attachment Disorder, PTSD, and a Behaviour and Emotional Disorder. ETS staff provided an average of 4.25 hours of clinical intervention per young person per week, including direct contact, stakeholder meetings, and face-to-face/phone contact with stakeholders or carers. Statistically significant improvements were found from pre to post-treatment on measures of overall functioning and well-being, engagement in educational activities and relationships with carers, peers, and the larger community. There was a reduction in placement changes from pre- to post-treatment, and measures of stakeholder collaboration and communication have been rated highly by carers and clinicians alike. ETS staff have, to date, provided training to over 8,000 carers, government, and non-government stakeholders, and key partner staff.

Past cost-benefits analysis has indicated that the net present value of Evolve can be estimated at around $360,238 per child/young person, with benefits being realised over the course of a decade. There has also been a positive reduction in average costs per child/young person at a conservative saving of $47,000 per annum.

Overall, the findings reveal a wide range of converging evidence demonstrating that ETS continues to provide an effective, community-based treatment for children and young people in out-of-home care with severe and/or complex mental health needs.

6.3.3. Adolescent Mobile Youth Outreach Service (AMYOS)

The Intensive Mobile Youth Outreach Service was established to provide specialist mental health care to the most at risk and hard to engage young people 15-24 years old living in Victoria. Schley, et al. (2011) provide an overview of the IMYOS model, which is characterised by small caseloads, active engagement and treatment processes, and careful discharge planning to ensure a smooth transition from the service.

The treatment model is based on a clear theoretical framework as well as the following principles:

- safety first; assertion, not coercion;
- use of the therapeutic relationship as a fundamental tool of intervention;
- flexible and responsive;
- holistic treatment approach;
- team-based; and,
- the provision of supervision, organisational support and professional development.

Interventions include practical support, psychotherapy, pharmacotherapy, and risk management all offered individually. In addition, the service focuses on family work to increase the capacity of family members to understand the young person's mental illness, strengthen family relationships, and facilitate their active involvement in treatment and recovery.

Clinical reviews have suggested IMYOS intervention results in greater engagement in treatment by young people, reduced risk of harm to self and others, and a decrease in the number of admissions and lengths of stay in adolescent units (Schley et al., 2008). A subsequent study found that IMYOS involvement resulted in significant improvements in client engagement and promoted sustained engagement in treatment (Schley et al., 2012). Similar positive results were found by the Adolescent Intensive Management (AIM) team, which is an extension of the IMYOS model in providing after-hours and weekend on-call telephone consultations to clients, their families, and service providers (Chia, et al., 2013). Duffy and Skeldon (2013) found that the introduction of an intensive treatment service in Scotland nearly halved the length of psychiatric admission as well as reducing the admission of young people to adult wards.

On the basis of such findings, AMYOS was included in the adolescent extended treatment continuum of care developed by CHQ CYMHS. Learnings from IMYOS implementation have heavily influenced development of the AMYOS model of care, which is standardised across the state while allowing for nuances of local delivery.

A profile of young people accessing the CHQ AMYOS team in September 2015 reflects the high level of risk and complexity, and includes two consumers previously admitted to the BAC:

- 77 percent had presentations consistent with emerging borderline personality disorder
- 69 percent had attempted suicide one or more times
- 92 percent experienced ongoing suicidal ideation
- 69 percent had a history of abuse or major trauma
- 53 percent had a history of intergenerational trauma
- 84 percent had co-existing substance use
- 92 percent were unemployed
- 77 percent were disengaged from education of any type
- 77 percent had a history of presentations to emergency departments
- 62 percent had previously had a psychiatric admission/s

An in-depth review of a sample of young people receiving CHQ AMYOS support revealed that prior to AMYOS intervention they had experienced an average of 1.67 admissions and 5.4 acute/emergency department presentations. In the average of 5.3 months since receiving AMYOS support, they had experienced an average of 1.22 admissions. Of these 54.54 percent were planned, leaving an average of 0.66 unplanned admissions per young person since their commencement with AMYOS.

A review of the initial total HoNOSCA scores for CHQ AMYOS consumers yielded an average of 20.1 (ranging from 14 to 31). The Children's Global Assessment Scale (CGAS; Shaffer, et al., 1983) is a numeric measure (1 to 100) used by mental health clinicians to rate the general functioning of children (under the age of 18) independent of the diagnosis of a mental illness/es. Amongst these AMYOS clients:

- 38 percent had a CGAS score of 31-40, which reflects "Major impairment of functioning in several areas and unable to function in one of these areas, i.e. disturbed at home, at school, with peers, or in society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school."
- 46 percent had a CGAS score of 41-50, which reflects "Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, e.g. suicidal preoccupation or ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships."
- 16 percent had a CGAS score that reflected variable functioning.

An evaluation is currently being undertaken to examine outcomes of AMYOS treatment thus far. A review of qualitative feedback regarding service provision suggests that it is meeting a need amongst young people and their families in delivering flexible, holistic care for high-risk young people. Discussion amongst AMYOS team members has identified that the name of the service does not adequately reflect the significant engagement with families required in supporting at-risk young people. AMYOS also appears to fill a need in assisting vulnerable parents and carers, who may not be engaging with support systems to help address their own individual or family risk factors.

6.3.4. Day Programs

Day programs (sometimes referred to as partial hospitalisation) represent a valuable addition to the continuum of care. They provide more frequent and intense treatment than outpatient care but avoid the risks associated with inpatient treatment as young people continue to live at home. It is also a less costly setting in which to provide care, and actively promotes family interventions and re-engagement in school. As noted earlier, day program treatment has been found to yield comparable outcomes to inpatient care for eating disorders and is associated with fewer days of readmission (Herpetz-Dahlmann, et al., 2014).

There is an increasing evidence base for the benefits of day programs amongst adolescents, with improvements in areas such as social skills, anxiety, aggression, and OCD symptoms (Deenadayalan, Perraton, Machotka & Kumar, 2010). Significant improvements in symptoms and relationships have been found in a program as brief as six weeks duration, with focus groups noting a subjective sense of renewed well-being, improved peer relationships, and an endorsement of the program's individual therapy, group interventions, and art therapy (Lenz, Del Conte, Lancaster, Bailey & Vanderpool, 2014).

Therapeutic benefits have also been noted in an Australian context, with Fothergill (2005) finding comparable clinical improvements amongst young people treated in either an outpatient or day program setting in Canberra but greater school/work re-engagement more associated with the latter setting. In their examination of an adolescent day program in Melbourne, Kennair, Mellor and Brann (2011) found that treatment outcomes for 84 young people were at least comparable, and sometimes significantly better, when compared to the outcomes following outpatient treatment amongst matched adolescents.

There are currently four Day Programs located across Queensland in Townsville, Toowoomba, south Brisbane and north Brisbane.

6.3.5. Youth Residential Services

Youth Residential Services (Youth Resis) are designed to provide long-term residential support and recovery-oriented care for young people with severe and/or complex mental illness who need additional support to achieve and maintain independence and emotional well-being (Magor-Blatch & Ingham, 2015).

Youth Resis may fill a gap where young people are forced to leave an intolerable situation with no appropriate, accessible, or affordable housing options (National Crime Prevention, 1999). The Burdekin Report (Commonwealth of Australia, 1993), supported by many subsequent studies, identified a number of such ‘intolerable’ factors contributing to youth homelessness, including family stress, neglect, abuse, and fragmentation; family poverty and isolation, experiences of children in care of the state, and youth unemployment. Rosenthal, Mallett, and Myers (2006) identified family conflict as one of the single most important reasons why young people choose to leave home. Young people who are victims of family violence and experience out-of-home care are at increased risk of couch-surfing and homelessness (Flatau, Thielking, MacKenzie & Steen, 2015).

Residential rehabilitation services are delivered in Victoria for young people 16 to 25 years of age with a serious mental illness who are at risk of - or experiencing - substantial functional impairment and psychosocial disability. The Resi service focuses on supporting young people to:

- Improve their capacity to manage and be responsible for self-care;
- Enhance their adaptive coping skills and decrease self-harming behaviour;

- Enhance their social and daily living skills to improve their ability to live independently in the community; and
- Develop and maintain links with the community, family, and social networks, education and vocational opportunities.

An independent review found they were associated with positive outcomes but suggested there should be better representation of young people aged 16 to 18 years (Victorian Government, 2012).

There are currently two Youth Resis in Queensland, in Greenslopes and Cairns, with another two Youth Resis being established in Townsville with a view to opening in early 2016.

7. Discussion

Reviewing the proposal for a statewide model of adolescent sub-acute care in Queensland is not a simple matter as it draws upon many complex and interweaving threads. It needs to be contextualised within the history of psychiatric care as well as current and proposed access to treatment for young people with severe and/or complex mental illness. It is also set against the backdrop of: the recovery model, evidence-based practice, a range of national and state influences, increasing complexity of clinical presentations, the irrefutable need for family involvement, and limited financial resources.

Inpatient units play an important role in the care of young people with severe and/or complex mental illness. As Lamb (2009) notes, “current evidence suggests that the adolescent inpatient unit has a particular ability to provide stabilisation and rapid reduction of symptoms and risk” and that "intensive treatment is unlikely to fully replace hospitalisation" (p. 348).

The literature has made clear the severity and complexity of the young people accessing inpatient care, with high levels of comorbidity common. There are numerous evidence-based treatments available to be delivered in community settings for this population, with expert guidelines for a range of disorders advocating that inpatient care be minimised as much as possible. A small sub-group of young people may benefit from extended inpatient admission, specifically: those experiencing severe psychosis with limited social and family support; young people with life-threatening eating disorder and co-existing medical complications that requires considerable supervision, in the context of minimal family support; and/or those young people with severe and/or complex mental illness that have not sufficiently responded to treatment in a less restrictive setting. In each case, an extended admission with a rehabilitative focus may be necessary, with access determined by a State Clinical Care Panel and guided by a clearly-articulated model of care.

There is also overwhelming evidence for the need to engage and involve parents and carers in treatment. The Pyramid of Family Care proposed by Mottaghipor and Bickerton (2005) highlights the increasing levels of intensity at which this may occur. The first level - of connection and assessment - is especially important for hard-to-engage families whose own complexities may act as a significant barrier to effective treatment. Flexible models of care need to be sufficiently resourced to overcome such barriers and to optimise treatment outcomes for the young person. The evidence base has demonstrated the considerable benefits of providing education about services, diagnoses and treatment; skills to cope with challenges relating to the illness; and, in the case of particularly complex cases, family therapy. Contemporary mental health care for young people therefore has the therapeutic involvement of families as one of its key features. Failure of services to meaningfully engage families in treatment is likely to significantly limit the extent of therapeutic change achieved.

A brief overview of inpatient treatment for young people nationally and internationally identified a wide variability in the range of models available. The available evidence for inpatient treatment for young people suggests that it is effective in stabilising symptoms and enhancing functioning. There have been inconsistent findings between treatment outcomes and length of stay, but studies have implied that the greatest improvement occurs in the early part of an admission (Swadi and Bobier, 2005; Herdzik, 2008; Barfield & Petr. 2001). While satisfaction is not necessarily a prediction of treatment outcomes, feedback from young people (rather than their parents) may be a better gauge of treatment adherence. A readmission is most likely to occur in the weeks and months immediately following discharge, although treatment factors including the length of stay (independent of psychiatric impairment), type of aftercare and post-discharge environment are stronger predictors of readmission rates than individual factors. Given the restrictiveness of inpatient care, Trask, et al. (2015) recommend clinicians focus on improving access to, engagement with, and quality of aftercare services.

Inpatient units are also the most expensive setting in which to deliver treatment, with the cost of caring for each young person in a Queensland adolescent acute unit totalling $2,456 per day. This needs to be considered in the context of limited public resources available to the sector, and how these resources could be best used to support unwell young people.

The emotional costs of inpatient care are also considerable. Aggressive incidents on inpatient units are common, increase with the length of stay, and can have a significant impact on staff as well as the young person, although they (and other adverse outcomes) can be effectively reduced with management programs. Studies highlighted the challenges of exposure to other young people with disturbing behaviours, as well as the following six themes of dislocation: removal from family, removal from friends, removal from school, challenges with identity, the experience of stigma and separation from a normal life. These risks are likely to be more pronounced when admission is far from home, for an extended period of time, and/or incongruent with a young person's cultural background.

An examination of the lived experience of young people suggested that they can both obtain significant benefits and be exposed to considerable emotional risk in even a short-term admission (Moses, 2011). An examination of experiences on a medium-term (Gill, 2014) and long-term unit (Ward, 2014) rounded out this picture. Gill's work explicitly included a spotlight on impending discharge from the unit following an admission averaging 3.5 months, with a number of concerns raised by young people about their ability to cope in the community. In each case, participants across all three studies identified a range of benefits obtained from peers, staff, therapy and psychoeducation, and the physical environment. They also related to the risks identified by Hannigan, et al. (2015), namely contagion and a series of dislocations arising from the admission. The research by Ward (2014) added further value by incorporating the perspectives of parents and staff. Parents expressed their relief at the admission while at the same time acknowledged the pain of feeling they were relinquishing their care giving role. Feedback from staff in his study highlighted the importance of relationships, structure, and hope in recovery, and suggested the drawbacks of an extended admission may include the possibility of young people sabotaging their recovery when approaching discharge and/or struggling after leaving the unit. Ward (2014) noted "…the recovery process for the teenagers was rarely straightforward. It was often a disjointed and confusing experience ‘seen from afar’. The inpatient experience [included] a range of experiences for the adolescents, ranging from confusion to almost terror." (p. 168)

Features of good inpatient care (including development of a clear model of service, providing sufficient support for staff, and appropriately engaging young people and parents/carers) were outlined as being able to maximise treatment gains and minimise such potential risks. These features should also be considered in any model of care developed for a small sub-set of young people who may benefit from an extended admission.

There appears to be strong and converging evidence regarding the acceptability and effectiveness of community-based care in supporting young people with severe mental illness. This is matched by growing advocacy for its greater availability and resourcing in order to better meet individual human rights through the service principles of proximity and least restrictive care. Community-based care is also commensurate with the spirit of the recovery model in supporting people to apply treatment strategies in their own community. It is interesting to note that as a medium- to long-term facility, the Walker Unit in Sydney was established in the context of insufficient acute inpatient units or day programs, and the current NSW mental health plan promotes the need for mobile treatment, crisis resolution teams, and whole-of-person support services. Similar themes are supported by the Victorian and West Australian Governments, as well as the recent National Mental Health Service Review.

An examination of community-based models operated by CYMHS throughout Queensland demonstrated their effectiveness for young people with severe and/or complex mental illness. In each case, treatment ideally includes the active participation of family members, is delivered and reviewed by a highly-skilled multidisciplinary team, and is offered at a frequency and length that best meets individual need.

Young people accessing outpatient CYMHS clinics experience significant distress and high levels of comorbidity. Application of evidence-based treatment via existing CHQ CYMHS resources for the debilitating illnesses of anorexia nervosa and social anxiety have yielded very positive results in a real-world setting, with the possibility of these being transferrable to other interested CYMHS sites. Evolve Therapeutic Services throughout the state support children and young people in out-of-home care with significant emotional and behavioural problems. Their specialist treatment and strong interagency approach have yielded very positive outcomes for clients, carers and stakeholders. Day programs also meet a need in providing more intense services than a community CYMHS team can offer, but still enables young people to remain in their community rather than undergo an admission. They have been associated with improvement in symptoms and functioning. More recently, the introduction of AMYOS teams across the state as a component of the Adolescent Extended Treatment continuum of care has helped fill a significant gap in supporting young people who have disengaged from treatment. It has been based on the IMYOS model successfully undertaken over many years in Victoria. Analysis of the young people accessing CHQ CYMHS AMYOS has profiled a very high-risk cohort, the majority (three-quarters) of who have emerging borderline personality disorder. Most also have a history of abuse or major trauma, are disengaged from school and/or are unemployed, also engage in substance use, have had previous ED presentation/s and psychiatric admission/s, have attempted suicide at least once, and experience ongoing suicidal ideation. Examination of early data suggests AMYOS has contributed to a reduction in unplanned psychiatric admissions amongst clients.

It is worth noting that these issues are occurring in a time of significant reform. At a National level, consideration of the National Mental Health Service Review as well as two new population planning tools will help inform development of the Fifth National Mental Health Plan in 2016. At a State level, it is anticipated that significant investment arising from the Carmody Inquiry will help build the capacity of vulnerable families, thereby reducing the future burden on the child protection system. Plans developed by the Queensland Mental Health Commission will ensure greater cross-sectorial commitment to mental health promotion, prevention and early intervention, suicide prevention, reducing substance use, rural and remote needs and Aboriginal and Torres Strait Islander populations. Finally, in line with the growing evidence base, contemporary practice and international and national policies, the Services Plan under development by the MHAODB is expected to reflect a redistribution of funding from psychiatric hospitals to better resource a wider continuum of community-based public mental health care. It is due for release in early 2016.

Ward (2014) stated that "teenagers were at the Barrett Adolescent Centre in the first place because the community clinics could not offer the intensive treatment they required" (p.213). It is suggested that the wider range of service options offered by AMHETI across a broader continuum of care may help meet this need. Having access to a wider array of less restrictive treatment settings may serve to reduce the need for inpatient admissions, and help alleviate the enormous burden mental illness can place on a young person and their family.

8. Conclusions and Recommendations for Discussion

The recovery model in part evolved in opposition to extended hospital-based treatment and, at its heart, honours the human rights of people with a mental illness. Services that fail to embed the principles of least restrictive care delivered as close to home as possible with sufficiently-resourced community support are not commensurate with the delivery of contemporary mental health treatment.

An extensive review of the literature found limited compelling evidence regarding the benefits of extended inpatient care for most young people. While inpatient units serve to help stabilise acute mental health problems, and are a necessary part of the continuum of mental health care, the greatest gains for young people appear to occur in the early part of an admission. An extended admission with a rehabilitative focus may be warranted for a small sub-set of young people, with provision made on a case by case basis considering the needs of individual young people and their circumstances.

The recovery model appears applicable to young people if taking into account their developmental needs, including the active involvement of family members in treatment wherever possible.

The considerable risks associated with inpatient admission may pose a significant challenge to a young person's achievement of developmental milestones in forging a meaningful and contributing life. These risks may be even more pronounced if a unit is far from home and the admission is of an extended duration and/or incongruent with a young person's cultural background. Treatment gains (including those offered from a rehabilitative perspective) may therefore be undermined by the inpatient setting itself if not carefully managed. An admission should be considered only once all other options have been exhausted, with inpatient care guided by a clearly-articulated, evidence-based model of service.

Regardless of the length of stay, a young person will at some point need to be discharged to less-restrictive treatment. Consideration of inpatient care is inextricably linked to other treatment options along the continuum of care, with evidence suggesting that a young people experiencing an extended admission may have more difficulties successfully transitioning into the community. Mental health options across a wider continuum may prevent and/or reduce the risks associated with inpatient care by enabling the young person timely access to treatment in a way that better meets their developmental needs. Sufficient access to community-based options appears to be associated with both a reduced need for inpatient care, and a reduced rate and length of admission. Research is increasingly demonstrating that comparable - or better - outcomes associated with inpatient care may be achieved in less restrictive settings.

It is proposed that establishing the adolescent mental health services outlined by the AMHETI Business Case will complement existing services and provide an even wider range of responsive, age-appropriate, evidence-informed, treatment options for young people across Queensland. These services will enable young people to consolidate treatment gains and develop resilience within the context of their everyday life, as promoted by the recovery model.

Having reviewed the available evidence base, it is proposed that:

1. Most adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care, as per the statewide model of service;
2. Any proposed service for CYMHS be based on a clearly-articulated model of service with explicit attention to addressing the risks outlined above; and,
3. Additional resources be directed toward establishing a comprehensive continuum of community-based adolescent mental health services across Queensland.

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9. Appendices

Appendix A: Summary of key performance indicators relevant to adolescent inpatient units in Queensland

KPI	Definition	Scope of Data	Results	Comments
KPI 11: Rate of pre-admission community contact	Proportion of inpatients who had been seen in person by a public mental health service 1-7 days prior to admissions	2012-13 in Queensland	Less than 15 years: 55.0 percent 15-24 years: 51.3 percent	This does not capture support offered in other ways (e.g. telephone) or to other people (e.g. parents). People may have not been a client of a public mental health service prior to admission, and/or accessed support from other sources e.g. guidance officer, GP, etc.
KPI 15: Rate of seclusion episodes	Number of seclusion events per 1,000 bed days for public sector acute mental health units.	National data for 0-17 year olds	2013-14: 9.6 percent (down from 17.0 percent in 2008-9 when data collection began).	The figure peaked at 18.1% in 2011-12. Northern Territory has the highest 2013-14 average for all ages at 21.6%, followed by Tasmania (15.2%) and Queensland (11.1%). The recent national average for adults is 9.5%, and the average for all ages is 8.0%.
KPI 4: Average length of stay	Number of days from the time of admission to the time of discharge	For young people 0 -17 years 2010-11 to 2011-12	NSW: 22.1 QLD: 11.5 VIC: 7.3 WA: 7.2 SA: 3.1	The national average for this age group is 10.5 days, and the national average for all age groups combined is 14.6 days.
KPI 12: Rate of discharge to community care	Proportion of inpatients who were seen in person by a public mental health service within 1-7 days of discharge from a public mental health unit	Available by state in 2012-13, and averaged across all ages.	72.8% for QLD (second only to ACT at 73.9%)	This figure does not reflect those who accessed support other than from a public mental health service, did not attend the scheduled appointment 1-7 days after discharge, were supported via other means (e.g. telephone), or if support was offered to other people (e.g. parents). National data shows this rate as 54.9% for those under 15 years of age (lowest national rate for any age) and 59.7% for 15-24 year olds. The highest rate is for 55-64 year olds (62.3%).
KPI 2: 28 day readmission rate	Proportion of people admitted to a public psychiatric acute unit within 28 days of discharge	2012-13 in Queensland	Less than 15 years: 8.8% 15-24 years: 16.5%	The difference between age groups may reflect the different model adopted by adult mental health services for those over 18 years of age. National averages are 13.8% for those under 15 and 15.9% for those aged 15-24 years.

Appendix B: Statewide Sub-Acute Bed Referral Panel Protocol

1. Panel operations

The statewide sub-acute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland.

The statewide sub-acute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will assist progression in developmental tasks that may have been arrested secondary to the mental illness, and support the safe transition of the young person to more functional or independent living on discharge.

A key function of the statewide sub-acute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to onsite schooling will be provided.

As a statewide service, a strong emphasis is placed on the development of cross-sector partnerships, working with other key service providers in the community to facilitate joint, assertive management, and discharge planning for the young person.

It is anticipated that the majority of patients accepted into the sub-acute beds will be current patients of an acute adolescent inpatient unit.

The Panel will work with referral parties to prioritise and triage new referrals into the sub-acute beds.
The Panel will also have oversight of case review for existing sub-acute patients who may require an extension to their stay.

1.1. Principles of the Panel

- Service responses are based on the goal of the best outcomes for the young person.
- Consumer and family/care giver participation is encouraged.
- Young people are considered in their social and culture context and, whenever possible, interventions will focus on developing supportive social environments and facilitating young people to access and integrate with existing community educational, vocational, recreational and other relevant programs.
- The views of the young person and their family must be considered.

1.2. Panel members

Core panel members
The core members of the Panel are:

Medical Director, Specialist Services, CYMHS, CHQHHS (Chair)
Nursing Director, LCCH Mental Health Unit, CYMHS, CHQHHS
Northern Cluster Representative, CYMHS
Central Cluster Representative, CYMHS
Southern Cluster Representative, CYMHS

An Administration Officer will perform the Secretariat function for the Panel.

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review.

In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the Panel, as required, to discuss particular consumer cases.

Quorum

The quorum for the Panel consists of the Medical Director, CYMHS CHQHHS, plus two other panel members.

If any of these members (or their direct delegate) is not present for a panel meeting, a quorum will not be achieved and the meeting cannot proceed. Alternative arrangements for the panel meeting would then need to be made.

Invited parties

When the Panel believes a key stakeholder (e.g. Principle Service Provider) is required to attend a panel meeting to discuss a specific young person, an invitation will be sent. If the stakeholder is unable to attend the meeting in person or via teleconference, they will be invited to provide advice or information on the consumer for the Panel's consideration through e-mail.

1.3. Coordination of panel meetings

To promote efficiency, effectiveness, and benchmarking opportunities, panel processes must be clear, documented, and consistent with best practice.

The Chair position will be held by the Medical Director, Specialist Services, CYMHS CHQHHS, or their delegate.

Other matters related to the coordination of panel meetings, such as the venue for meetings, time allocation, and arranging invitations to panel meetings for invited stakeholders, are the responsibility of the Secretariat of the panel. This will be achieved through the use of minutes, with clear action statements outlining responsibilities and timeframes.

1.4. Administration support to the Panel

Secretariat support for the Panel will be provided by CYMHS CHQHHS on a recurrent basis.

The role of the Secretariat includes:

- Assist with the coordination of panel meetings, and organise and distribute the agenda and associated documents e.g. new referrals, consumer reviews, etc.
- Ensure that all panel information and minutes are recorded and distributed to appropriate parties, and stored on the appropriate record and filing system.
- Ensure that all original consumer forms and information are stored on the appropriate record.
- Maintain reporting and data collection activities for the panel.

1.5. Panel meetings

The Panel will convene on an 'as required' basis.

The agenda for panel meetings will be coordinated and set in advance of panel meetings (refer to **Statewide Sub-Acute Bed Referral Panel Agenda** template).

Tasks that need to be carried out by respective agencies in between panel meetings need to be clearly identified and communicated across agencies.

The Panel Chair will need to ensure adequate information has been provided on the Consumer Intake Form together with a signed Consent to Obtain/Release Information Form (http://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs.htm).

Panel members will receive a copy of the meeting agenda and accompanying documentation (including new referrals, reports, and plans for existing referrals) at least 5 working days in advance of the panel meeting.

The recommended format for panel meetings is as follows:

- Previous Business
- Review of Consumer Summary Report
    - Current and exiting consumers
    - Waitlist consumers
    - New Referrals (intake and prioritisation)
- Panel Process Issues
- Other Business

The chairperson is responsible for ensuring panel meetings are:

- Effectively time managed and all agenda items are tabled
- Effectively facilitated so that relevant information and discussion points are elicited to ensure that the panel can attend to their business.

Panel discussions will be recorded in the panel minutes (refer to Statewide Sub-Acute Bed Referral Panel Minutes template).

Panel decisions regarding a new referral will be recorded on the Consumer Summary Report. Any subsequent discussions regarding the young person will also be recorded in this report.

It is the responsibility of the Chair, with input from other panel members, to ensure that the records are accurate and reflect the intent of the discussion.

If there is a dispute regarding panel decisions, the matter may be raised to the Chief Executive of CHQHHS.

1.6. Principles for panel decision-making

Panel discussions will be recorded in the minutes of the meeting and on the Consumer Summary Report.

Prioritisation of consumers for referral will be based on clinical grounds and the decision points will be clearly documented and discussed with referring services.

Where the panel does not recommend intake into a statewide sub-acute bed, the panel discussions should aim at developing alternative options for treatment. These options should also be recorded on the Consumer Summary Report.

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1.7. Confidentiality and Privacy

Information raised and discussed at panel meetings will be treated with utmost care and sensitivity, and with the highest regard in respect of confidentiality and privacy. All staff participating in panel discussions should also be aware of professional and organisational ethical and legislative requirements in relation to privacy and confidentiality, including employee requirements and obligations set out in various departmental codes of conduct.

All forms which collect information for the purpose of referrals into the statewide sub-acute beds will comply with the Information Privacy Principles contained in the *Information Privacy Act 2009* and feature privacy notices.

All contracted service providers are required to be contractually bound to comply with the Information Privacy Principles prior to the exchange of information.

2. Referral

The referral process for the statewide sub-acute beds will operate in a manner that ensures young people referred are responded to in a timely way.

2.1. Eligibility criteria

A young person **may be eligible** for a statewide sub-acute bed if they:

- Are aged between 13 and 18 years of age, with flexibility in upper age limit depending on presenting issue and developmental age.
- Present with severe or complex mental health problems.
- Are likely to benefit from an extended treatment and rehabilitation model of care in a hospital-based sub-acute bed.

A young person will **not be eligible** for a statewide sub-acute bed if they:

- Could be managed in a less restrictive setting.
- Primarily need support with substance misuse issues.
- Their primary problem to be addressed is accommodation.

2.2. Referral Process

The PSP completes a Consumer Intake Form on CIMHA, which needs to include:

- Reason for Referral:
    - An up-to-date mental state examination and clinical formulation
    - A clear description of why an admission to a statewide sub-acute bed is sought at this time, including specific goals for the consumer. Include, where available, input from other CYMHS services that demonstrate the need for a more intensive bed-based intervention.

- Relevant History:
    - History of the presenting mental health issues
    - A brief summary of treatment to date

- Practical Issues:
    - Current living situation
    - Education, vocation, and /or employment status
    - Finances
    - Family supports and ability of family to travel to Brisbane for a comprehensive family assessment.

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- As the statewide sub-acute bed service is a non-acute service, the *Response Category* and *Timeframe for Assessment* sections are not applicable.

The PSP also needs to ensure that a Consent to Obtain/Release Information Form has been signed by the young person; or a Consent to Obtain/Release Information Form has been signed by their parent/guardian.

Once complete, forms are to be emailed to the Secretariat (email: [redacted]

The PSP will receive an acknowledgement of their referral and the date of the panel meeting when their referral will be considered by the panel.

2.3. Panel discussion of referral

Once a referral has been received, and the consumer listed on the agenda for the next panel meeting, the PSP for the consumer, or their delegate, will be invited to attend the panel meeting to discuss the referral and provide additional information as required.

Panel members are likely to raise questions about the referral to ensure appropriateness (that eligibility criteria have been met and that other service options have been explored). Additional information may be sought to enable the Panel to make their prioritisation decisions.

The Panel will also enquire as to how the referring PSP, and the consumer's local CYMHS team, intends to remain engaged with the consumer prior, during, and post admission, if accepted.

3. Intake and prioritisation

3.1. Response to referrals

The Panel Chair (or their delegate) will be responsible for informing the PSP of the outcome of the panel discussion and decision regarding the referral. The decision will also be communicated via email to the PSP, with a copy to [redacted]

The Secretariat will upload a copy of this communication onto the consumer's case file in CIMHA.

3.2. Response to referrals that are recommended for other service options

If the decision by the Panel does not recommend intake of the young person into a statewide sub-acute bed, it is the responsibility of the Panel to provide the reasons supporting this decision (e.g. referral does not meet access criteria for statewide sub-acute bed, or other service agencies are better placed to respond to the needs outlined in the referral). The Panel Chair is responsible for informing the PSP.

3.3. Response to referrals that meet eligibility but statewide sub-acute beds are at capacity

If the Panel determines a new referral meets the eligibility criteria but the statewide sub-acute beds are at capacity, the Panel will recommend that the young person be 'accepted – pending bed'. The Panel may recommend alternative services to meet the young person's therapeutic or behavioural support needs, until such time that a place becomes available and where placement is still required.

The referral will be noted in the Consumer Summary Report for review at subsequent panel meetings, to reconfirm placement need and any changes in priorities.

The Panel Chair is responsible for informing the PSP.

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Panel members should not provide an ongoing advisory or consultancy role for referrals that are not accepted into the statewide sub-acute beds.

3.4. Information collection, storage and data management

Consumer Intake and Consent Forms, any accompanying information, and the Consumer Summary Report will be kept on panel files.

4. Secretariat Process for Panel

- PSP sends referral via email to [redacted]
- Secretariat confirms a completed Consumer Intake Form and signed Consent Form are attached.
- Secretariat forwards email onto Panel members for review.
- Panel Chair, or their delegate, confirms sufficient information is provided for panel assessment.
- Secretariat adds referral to next meeting agenda.
- Secretariat contacts PSP to confirm panel meeting date for new referral assessment and invites PSP, or their delegate, to attend.
- Secretariat circulates agenda, previous minutes, Consumer Summary Report, and any new referral documentation to panel members 5 days prior to scheduled meeting
- Secretariat minutes meeting of the Panel and updates the Consumer Summary Report
- Within 5 working days of the meeting, Secretariat finalises minutes and circulates meeting documentation to Panel and attendees, as appropriate.
- Secretariat uploads Panel Chair's communications with PSP, regarding outcome of the referral, onto CIMHA.

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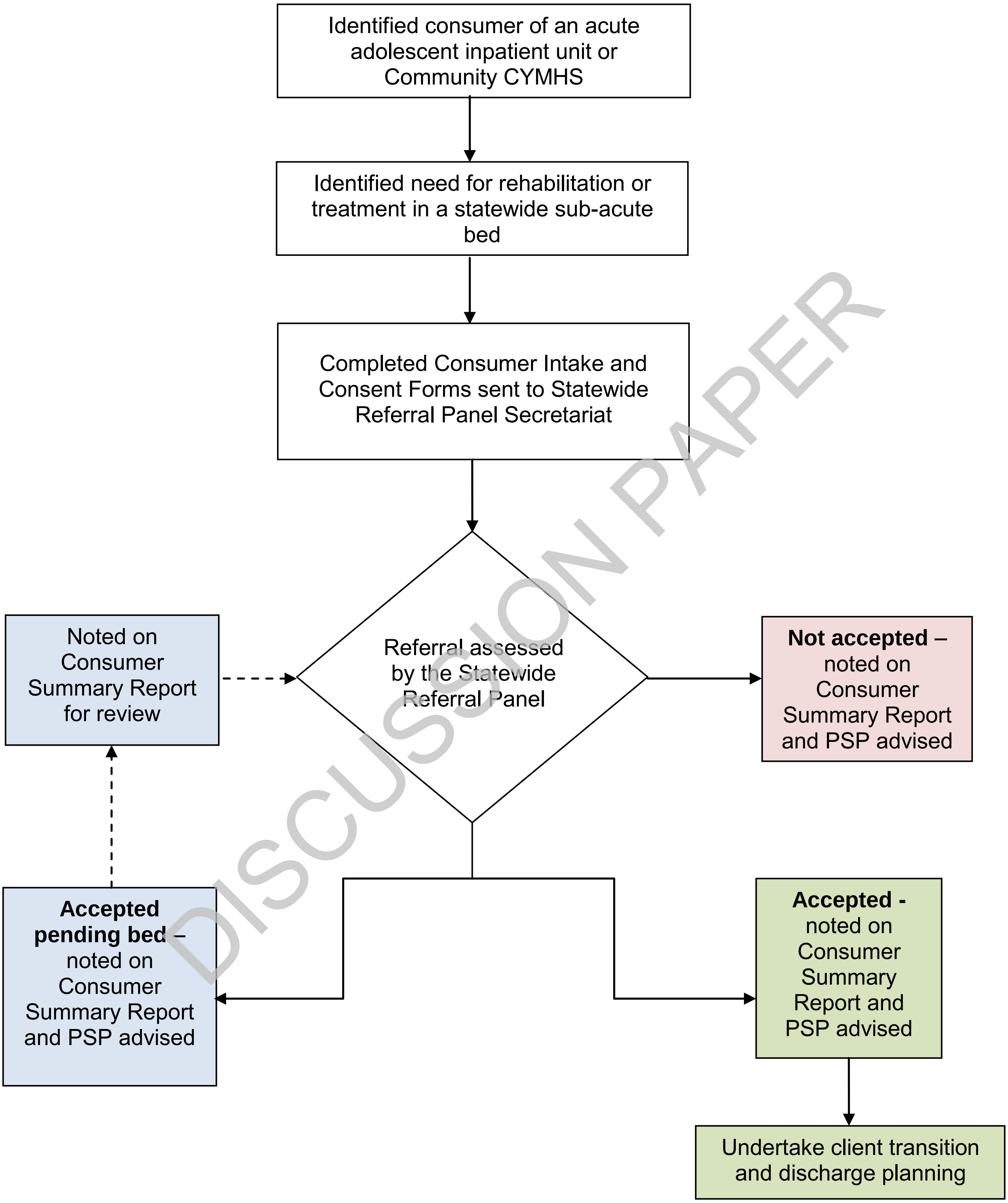
Referral Process into Statewide Sub-Acute Beds



10. References

Albano, A.M & diBartolo, P.M. (2007). *Cognitive-behavioural therapy for social phobia in adolescents: Therapist guide.* Oxford University Press.

Allwood, M.A., Dyll, J., Hunt, J.I., & Spirito, A. (2008). Comorbidity and service utilisation among psychiatrically hospitalised adolescents and posttraumatic stress disorder. *Journal of Psychological Trauma, 7*, 104-121.

Allison, S., Warin, M., & Bastiampillai, T. (2014). Anorexia nervosa and social contagion: Clinical implications. *Australian and New Zealand Journal of Psychiatry, 48* (2), 116-20.

American Academy of Child and Adolescent Psychiatry (1989). *Policy Statement: Inpatient Hospital Treatment of Children and Adolescents*. Accessed from www.aacap.org/aacap/policy_statements/1989/Inpatient_Hospital_Treatment_of_Children_and_Adolescents.aspx

American Academy of Child and Adolescent Psychiatry (2011). Residential treatment programs. Accessed 27/10/15 from www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Residential-Treatment-Programs-097.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry, 68* (7), 724-731.

Australian Bureau of Statistics (2011). Census of Population and Housing.

Australian Bureau of Statistics (2015). *Causes of Death, Australia, 2013*. Accessed 27/10/15 from www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0

Australian Communications and Media Authority (2009). *Clink and connect: Young Australians' use of online social media*. Accessed from www.acma.gov.au/

Australian Government (2010). *National Standards for Mental Health Services 2010*. Accessed from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10

Australian Institute of Health and Welfare (2014). *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178.Canberra: AIHW. Retrieved from www.aihw.gov.au/publication-detail/?id=60129547205

Australian Institute of Health and Welfare (2015). Leading causes of death. Accessed on 27/10/15 from www.aihw.gov.au/deaths/leading-causes-of-death/#data

Babalola' O., Gormez, V., Alwan, N.A., Johnstone, P., Sampson, S. (2014). Length of hospitalisation for people with severe mental illness. *Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.CD000384.pub3.

Baeza, I., Correll, C.U., Saito, E., Amanbekova, D., Ramani, M., Kapoor, S., Chekuri,R., … & Carbon, M. (2013). Frequency, characteristics and management of adolescent inpatient aggression. *Journal of Child and Adolescent Psychopharmacology, 23* (4), 271–281

Barfield, S.T., & Petr, C. (2001). *Best practice in children's mental health: Inpatient treatment of children and adolescents*. University of Kansas School of Social Welfare. Accessed from https://kuscholarworks.ku.edu/handle/1808/3871.

Barrett Adolescent Strategy (2013). *Adolescent Extended Treatment and Rehabilitation Services (AETRS) recommendations submitted to the West Moreton Hospital and Health Board.* Queensland Government: Brisbane.

Bartholomeusz, C.F., Allott, K., Killackey, E., Liu, P., Wood, S.J,. & Thompson, A: (2013). Social cognition training as an intervention for improving functional outcome in first-episode psychosis: a feasibility study. *Early Intervention in* Psychiatry; *7*(4), 21-6.

Bateman.A., & Krawitz, R. (2013), *Borderline personality disorder – an evidence-based guide for generalist mental health professionals*. Oxford: Oxford University Press.

Begg, S., Vos T, Barker, B., Stevenson, C., Stanley, L., & Lopez, A.D. (2007). *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: AIHW. Accessed from www.aihw.gov.au/publications/index.cfm/title/10317

Berntsen, E., Starling, J., Durheim, E., Hainsworth, C., de Kloet, L., Chapman, L., & Hancock, K. (2011). Temporal trends in self harm and aggression on a paediatric mental health ward. *Australasian Psychiatry, 19*(1), 64-9.

Berg, I. (1992). Absence from school and mental health. *British Journal of Psychiatry, 161*, 1154-1166.

Bettmann, J., E., &. Jasperson. R.A. (2009). Adolescents in residential and inpatient treatment: A review of the outcome literature. *Child & Youth Care Forum, 38* (4), 161–83.

beyondblue (2010). *Clinical practice guidelines: Depression in adolescents and young adults.* Melbourne: *beyondblue*: *the national depression initiative*. Accessed from www.beyondblue.org.au/resources/health-professionals/clinical-practice-guidelines/adolescents-and-young-adults-guidelines

Bickerton, A., Hense, T., Benstock, A., Ward, J., & Wallace, L. (2007). Safety first: A model of care for working systematically with high risk young people and their families in an acute CAMHS service. *Australian and New Zealand Journal of Family Therapy*, *28*(3), 121-129.

Bird V, Leamy M, Tew J, Le Boutillier C, Williams J, Slade M (2014) Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry, 48* (7), 644-653.

Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J. & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *British Journal of Psychiatry, 197* (5), 350-6.

Bleiberg, E., Rossouw, T., & Fonagy, P. (2012). Adolescent breakdown and emerging borderline personality disorder. In A. W. Bateman and P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 463–511). Washington, DC: American Psychiatric Publishing.

Boag-Munroe, G., & Evangelou, M. (2010) From hard to reach to how to reach: A systematic review of the literature on hard to reach families. *Research Papers in Education*, *27* (2), 209-239.

Boege, I., Corpus, N., Schepker, R., Kilian, R., & Fegert, J.,N. (2015). Cost-effectiveness of intensive home treatment enhanced by inpatient treatment elements in child and adolescent psychiatry in Germany: A randomised trial

Brann, P., Coleman, G., & Luk, E. (2001). Routine outcome measurement in a child and adolescent mental health service: an evaluation of HoNOSCA. *Australian and New Zealand Journal of Psychiatry, 35*, 370–376.

Brent, D.A., Emslie, G.J., Clarke, G.N., Asarnow, J., Spirito, A., Ritz, L., Vitiello, B., & Keller, M.B. (2009). Predictors of spontaneous and systematically assessed suicidal adverse events in the treatment of SSRI-resistant depression in adolescents (TORDIA) study. *American Journal of Psychiatry, 166* (4), 418-26.

Briere, J. & Lanktree, C.B. (2011). *Treating complex trauma in adolescents and young adults*. Thousand Oaks, CA: Sage.

Brown, J., (2008). *We* don't need your help, but will you please fix our children. *Australian and New Zealand Journal of Family Therapy, 29* (2), 61-69.

Bruns, E.J., Walker ,J,S, Zabel, M., Matarese, M., Estep, K., Harburger, D., Mosby, M., & Pires, S.A. (2010). Intervening in the lives of youth with complex behavioral health challenges and their families: the role of the wraparound process. *American Journal of Community Psychology, 46* (3-4), 314-31.

Butler, L.S. & McPherson, P.M. (2006). *Is residential treatment misunderstood*? *Journal of Child and Family Studies.* 465-472

Carr, A. (2000). *What works for children and adolescents: A critical review of psychological interventions with children, adolescents and their families*. London: Routledge.

Catania, S., Withington, T., & Litster, R. (2015) *Outcomes of a Single Site Clinic for Eating Disorders in Child and Youth Mental Health (oral presentation).* 13th Annual Conference of the Australian and New Zealand Academy for Eating Disorders, Gold Coast.

Cave, L., Fildes, J., Luckett, G., & Wearring, A. (2015). *Mission Australia's 2015 Youth Survey Report*. Mission Australia. Accessed from www.missionaustralia.com.au/what-we-do/research-evaluation/youth-survey

Chance, S., Dickson, D., Bennett, P., & Stone, S. (2010). Unlocking the doors: how fundamental changes in residential care can improve the ways we help children and families. *Residential Treatment for Children and Youth, 27* (2),127–148.

Chen, H., Cohen, P., Kasen, S., Johnson, J.G., Berenson, K., & Gordon, K. (2006). Impact of adolescent mental disorders and physical illnesses on quality of life 17 years later. *Archives of Paediatric Adolescent Medicine, 160* (1), 93-9.

Chia, A., Assan, B., Finch, E., Stargatt, R., Burchell, P., Jones, H., & Heywood-Smith, J. (2013). Innovations in practice: Effectiveness of specialist adolescent outreach service for at-risk adolescents. *Child and Adolescent Mental Health*, *18(2)*, 116-119.

Cohen, J.A., Berliner, L., & Mannarino, A. (2010). Trauma focused CBT for children with co-occurring trauma and behavior problems. *Child Abuse and Neglect, 34*, 215-224.

Cohen, J.A, Deblinger, E, Mannarino, A.P., & Steer, R.A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402.

Cohen, J.A., Mannarino, A.P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence, 15* (11), 1202 – 1223.

Cohen, J.A., Mannarino, A.P., & Iyengar ,S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Archives of Paediatric and Adolescent Medicine, 165* (1), 16-21.

Collin, P., Rahilly, K., Richardson, I. & Third, A. (2011) *The benefits of social networking services: A literature review*. Cooperative Research Centre for Young People, Technology and Wellbeing. Melbourne.

Collins, P.Y., Insel, T.R., Chockalingam, A., Daar, A., & Maddox.Y.T. (2013). Grand challenges in global mental health: Integration in research, policy, and practice. *PLOS Medicine, 10*(4), e1001434. doi:10.1371/journal.pmed.1001434

Commission for Children and Young People and Child Guardian. (2013). *Annual Report: Deaths of children and young people Queensland 2012-13*. Brisbane: The State of Queensland.

Commission for Children and Young People and Child Guardian. (2014). *Trends and issues paper: Child deaths – prevalence of youth suicide in Queensland*. Brisbane

Commonwealth of Australia (1993). *Human Rights and mental Illness. Report of the national inquiry into the human rights of people with mental illness*. Canberra: Australian Government Publishing Service. Accessed from http://apo.org.au/research/national-inquiry-concerning-human-rights-people-mental-illness

Commonwealth of Australia (2010). *National mental health standards.* Accessed from www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10

Commonwealth of Australia (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Retrieved from www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde

Community Connections (2009). *School refusal scoping study: An abridged report of an investigation into options for new responses to students who are often absent from school without their parent' knowledge*. Accessed from www.qldalliance.org.au.

Comtois, K.A., & Carmel, A. (2014). Borderline personality disorder and high utilization of inpatient psychiatric hospitalisation: Concordance between research and clinical diagnosis. *Journal of Behavioural and Health Service Research*. doi: 10.1007/s11414-014-9416-9.

Cook, N.E., & Gorraiz, M. (2015). Dialectical behavior therapy for nonsuicidal self-injury and depression among adolescents: preliminary meta-analytic evidence. *Child and Adolescent Mental Health*. doi:10.1111/camh.12112

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., ….van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35* (5), 390-398.

Coppock, T.E., Owen, J.J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research, 20* (6), 619-26.

Cotgrove, A. (2013). Inpatient services. In T. McDougall & A.Cotgrove (Eds). *Specialist Mental Healthcare for Children and Adolescents : Hospital, Intensive Community and Home Based Services* (pp34 - 53). London: Routledge.

Couture, S.M, Penn, D.L., & Roberts DL. (2006). The functional significance of social cognition in schizophrenia: A review. *Schizophrenia Bulletin, 32* (1), 44-63.

Couturier ,J., Kimber, M., & Szatmari, P. (2013). Efficacy of family-based treatment for adolescents with eating disorders: a systematic review and meta-analysis. *International Journal of Eating Disorders, 46* (1), 3-11.

Crago, A.; Wigg, C. and Stacey, K. (2004) First you have to "see" them: Youth-friendly practice in mental health work. *Youth Studies Australia, 23*, 38–45.

Crime and Misconduct Commission (2004). *Protecting Children: An Inquiry into the Abuse of Children in Foster Care.* Queensland Government, Brisbane.

Crisp, K., & Gleeson, J. (2009). Working with families to prevent relapse in first-episode psychosis. In F Lobhan & C. Barrowclough (Eds). *A Casebook of family interventions for psychosis* (pp 67 – 88). Sydney: Wiley.

de Kloet, L., Starling, J., Hainsworth, C., Berntsen, E., Chapman, L., & Hancock K. (2011). Risk factors for self-harm in children and adolescents admitted to a mental health inpatient unit. *Australian and New Zealand Journal of Psychiatry, 45* (9), 749-55.

Dean, A.J., Duke, S.G., George, M., & Scott. J. (2007). Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(6),711-20.

Dean, A.J., Duke, S.G., Scott, J., Bor, W., George, M., & McDermott, B.M. (2008). Physical aggression during admission to a child and adolescent inpatient unit: predictors and impact on clinical outcomes. *Australian and New Zealand Journal of psychiatry, 42* (6), 536-43.

Dean, A.J., Gibbon, P., McDermott, B.M., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact of staff in a child and adolescent inpatient unit. Archives of Psychiatric Nursing, 24 (1), 15-25.

Deenadayalan, Y., Perraton, L., Kumar, S., & Machotka Z. (2010). Day therapy programs for adolescents with mental health problems: A systematic review. *Internet Journal of Allied Health Sciences and Practice, 8* (1), 165–173.

Diamond, G.S., Wintersteen, M.B., Brown, G.K., Diamond, G.M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(2), 122-31.

Dowell, K.A.' & Ogles. B.M. (2010). The effects of parent participation on child psychotherapy outcome: a meta-analytic review. *Journal of Clinical Child and Adolescent Psychology, 39*(2), 151-62.

Duffy, F., & Skeldon, J. (2013). Innovations in practice: The impact of the development of a CAMH Intensive Treatment Service and service redesign on psychiatric admissions. *Child and Adolescent Mental Health, 18* (2), *120–123.*

Eisler, I, Dare, C., Russell, G.F., Szmukler, G., le Grange, D., & Dodge E. (1997). Family and individual therapy in anorexia nervosa. A 5-year follow-up. *Archives of General Psychiatry, 54* (11), 1025-30.

Espe-Sherwindt, M. (2008). Family-centred practice: collaboration, competency and evidence. *Support for Learning, 23*, 136-143.

Evashwick, C. (1989). Creating the continuum of care. *Health Matrix, 7* (1), 30-9.

Fenner, M., & Kleve, L. (2014). An evaluation of a CAMHS outpatient service for adolescent eating disorders. *Child and Adolescent Mental Health, 19*:64–6.

Fennig, S., Klomek, A.B., Shahar, B., Sarel-Michnik, Z., & Hadas, A. (2015). Inpatient treatment has no impact on the core thoughts and perceptions in adolescents with anorexia nervosa. *Early Intervention in Psychiatry*. doi: 10.1111/eip.12234

Flatau, P., Thielking, M., MacKenzie, D., & Steen, A. (2015). *The cost of youth homelessness in Australia study: Snapshot report 1,* Swinburne Institute for Social Research, Salvation Army Australia, Mission Australia, Anglicare Australia, Centre for Social Impact. Accessed from http://apo.org.au/research/cost-youth-homelessness-australia-study.

Fleischhaker, C., Böhme, R., Sixt, B., Brück, C., Schneider, C., & Schulz, E. (2011). Dialectical Behavioral Therapy for Adolescents (DBT-A): A clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a one-year follow-up. *Child and Adolescent Psychiatry and Mental Health, 5*(1). doi: 10.1186/1753-2000-5-3

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D, Glaser, D., & Allison, E. (2015). *What works for whom? A critical review of treatments for children and adolescents*. New York: Guilford Press.

Fontanella, C. (2008). The influence of clinical, treatment, and healthcare system characteristics on psychiatric readmission of adolescents. *American Journal of Orthopsychiatry*, *78*(2):187–198.

Foster, E. M., & Conner, T. (2005). Public costs of better mental health services for children and adolescents. *Psychiatric Services, 56*, 50-55.

Fothergill, J. (2005). *An evaluation of mental health gains in adolescents who participate in a structured day treatment program*. Unpublished dissertation, Bond University. Accessed from http://epublications.bond.edu.au/theses/fothergill/

Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal, 31* (1), 38-48.

Gahan, K. & Kijas, J. (2014). *The mental welfare of children: A history of child and adolescent mental health services in Queensland*. University of Queensland Press: Brisbane.

Garralda, M.E., Yates, P., & Higginson, I. (2000). Child and adolescent mental health service use – HoNOSCA as an outcome measure. *British Journal of Psychiatry, 177*, 52 - 58.

Gearing, R.E. (2008). Evidence-based family psychoeducational interventions for children and adolescents with psychotic disorders. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 17* (1), 2-11.

Geller, J.L., & Biebel K. (2006). The premature demise of public child and adolescent inpatient psychiatric beds : Part I: overview and current conditions. *Psychiatric Quarterly, 77 (3)*, 251-71.

Geraghty, K., McCann, K., King, R., & Eichmann, K. (2011). Sharing the load: Parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. *International Journal of Mental Health Nursing, 20* (4), 253-62.

Gifford, E., & Foster, E.M. (2008). Provider-level effects on psychiatric inpatient length of stay for youth with mental health and substance abuse disorders. *Medical Care, 46* (3), 240-246.

Gigantesco**,** A., de Girolamo, G.**,** Santone**,** G., Miglio, R., & Picardi, A. (2009). Long-stay in short-stay inpatient facilities: risk factors and barriers to discharge. *BMC Public Health, 9* (306). doi: 10.1186/1471-2458-9-306.

Gill, F. (2014). *The transition from inpatient care back to the community: Young people's perspectives*. Unpublished dissertation, University College London. Accessed from *discovery.ucl.ac.uk/1448703/3/**Gill**_Freya_Thesis.redacted%20pdf.pdf*

Godart, N., Berthoz, S., Curt, F., Perdereau, F., Rein, Z., Wallier, J., Horreard, A., & Jeammet, P. (2012). A randomized controlled trial of adjunctive family therapy and treatment as usual following inpatient treatment for anorexia nervosa adolescents. *PLoS ONE, 7* (1), e28249.

Government of Western Australia (2015). Report 40, Standing committee on environment and public affairs. Petition 23 – Increase numbers of mental health beds in new Perth Children's Hospital. Accessed from www.parliament.wa.gov.au.

Gowers ,S,G,, Clark, A,F., Roberts, C., Byford, S., Barrett, B., Griffiths, A., Edwards, V., & …. Roots P. (2010). A randomised controlled multicentre trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability - the TOuCAN trial. *Health Technology Assessment, 14* (15), 1-98.

Gowers, S.G., Harrington, R.C., Whitton, A., Lelliott, P., Beevor, A., Wing, J., & Jezzard, R. (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry, 174*, 413–416.

Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., & Ruan, W. J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, *69*(4), 533–545.

Green, J., Jacobs, B., Beecham, J., Dunn, G., Kroll, L., Tobias, C., & Briskman, J. (2007). Inpatient treatment in child and adolescent psychiatry – a prospective study of health gain and costs. *Journal of Child Psychology and Psychiatry, 48* (12), 1259–1267.

Green, J.M., Kroll, L., Imre, D., Frances, F.M., Begum, K., Gannon, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 40* (3), 325–332.

Greenfield, B., Henry, M., Weiss, M., Tse, S.M., Guile, J., Dougherty, G., Zhang, X., …. & Harnden, B. (2008). Previously suicidal adolescents: Predictors of six month outcome. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 17* (4), 197 -201.

Greenfield, B., Larson, C., Hechtman, L., Rousseau, C., & Platt, R. (2002). A rapid-response outpatient model for reducing hospitalisation rates among suicidal adolescents. *Psychiatric Services, 53*(12), 1574-1579.

Gross, V.,' & Goldin, J. (2008). Dynamics and dilemmas in working with families in inpatient CAMH services. *Clinical Child Psychology and Psychiatry, 13*(3):449-61.

Gulliver, A., Griffiths, K.M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10* (113), 113 – 121.

Gunderson, J.G. (1978). Defining the therapeutic processes in psychiatric milieus. *Psychiatry, 41* (4), 327 – 35.

Gunderson, G.J. (2011). Borderline personality disorder. *New England Journal of Medicine, 364*, 2037-2042.

Hannigan, B., Edwards, D., Evans, N., Gillen, E., Longo, M., Pryjmachuk, S., & Trainor, G. (2015). An evidence synthesis of risk identification, assessment and management for young people using tier 4 inpatient child and adolescent mental health services. *Health Services and Delivery Research, No. 3(22).* Accessed from http://www.journalslibrary.nihr.ac.uk/hsdr/volume-3/issue-22#abstract

Hanssen-Bauer, K., Heyerdahl, S., Hatling, T., Jensen, G., Olstad, P.M., Stangeland, T., & Tinderholt, T. (2011). Admissions to acute adolescent psychiatric units: A prospective study of clinical severity and outcome. *International Journal of Mental Health Systems, 5* (1). doi: 10.1186/1752-4458-5-1.

Harnett, P.H., Loxton, N.J., Sadler, T., Hides, L., & Baldwin, A. (2005). The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian and New Zealand Journal of Psychiatry, 39*, 129–135.

Havens, J.A., Gudino, O.G., Biggs, E.A., Diamond, U.N., Weis, R., & Cloitre, M. (2012). Indentification of trauma exposure and PTSD in adolescent psychiatric inpatients: An exploratory study. *Journal of Traumatic Stress, 25* (2), 171-178.

Hayes, L., Smart, D., Toumbourou, J.W., & Sanson, A. (2004). *Parenting influences on adolescent substance use*. Australian Institute of Family Studies: Melbourne. Accessed from https://aifs.gov.au/publications/parenting-influences-adolescent-alcohol-use

Haynes, C., Eivors, A., & Crossley, J. (2011) 'Living in an alternative reality': Adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health, 16*, 150–157.

Health and Social Care Information Centre (2014). *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2013 to October 2013*. Accessed from www.hscic.gov.uk/article/3880/Eating-disorders-Hospital-admissions-up-by-8-per-cent-in-a-year

Helleman, M., Goossens, P. J. J., Kaasenbrood, A. & van Achterberg, T. (2014), Experiences of patients with borderline personality disorder with the brief admission intervention: A phenomenological study. *International Journal of Mental Health Nursing, 23*:442–45.

Herdzik, K.M. (2008). *Brief inpatient psychiatric outcomes of adolescents: Outcomes and effectiveness*. Unpublished dissertation, State University of New York. Accessed from gradworks.umi.com/33/20/3320472.html

Herpertz-Dahlmann, B., Schwarte, R., Krei, M., Egberts, K., Warnke, A., Wewetzer, C., Pfeiffer, E., & Dempfle, A. (2014). Day-patient treatment after short inpatient care versus continued inpatient treatment in adolescents with anorexia nervosa (ANDI): A multicentre, randomised, open-label, non-inferiority trial. *The Lancet, 383* (9924), 1222-1229.

Heyne, D., & King, N. J. (2004). Treatment of school refusal. In P. M. Barrett & T. H. Ollendick (Eds.), *Handbook of interventions that work with children and adolescents: Prevention and treatment* (pp. 243-272). London: John Wiley & Sons, Ltd.

Heyne, D., Sauter, F.M., Ollendick, T.H., Van Widenfelt, B.M., & Westernberg, P.M., (2014). Developmentally sensitive cognitive behavioural therapy for adolescent school refusal: rational and case illustration. *Clinical Child and Family Psychology Review, 17* (2), 191 -215.

Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S.K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52* (9):1179-89.

Holmboe, O., Iversen, H.H., & Hanssen-Bauer, K. (2011). Determinants of parents' experiences with outpatient child and adolescent mental health services. *International Journal of Mental Health Systems, 5 (1),* 22 – 31.

Honey, A., Chesterman, S., Hancock, N., Llewellyn, G., Hazell, & Clarke, S. (2015). Knowing what to do and being able to do it: Influences on parent choie and use of practices to support young people living with mental illness. *Community Mental Health Journal, 51* (7), 841-51.

Honey, A., Coniglio, F., Hancock, N. (2015). Conceptualising wellbeing for young people living with mental illness. *International Journal of Therapy and Rehabilitation*, *22*(6), 272-276.

House of Commons (2014). *Children's and adolescents mental health and CAMHS*. Health Committee Third Report of Session 2014-15. Accessed from www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf

Huey, S., Henggeler, S., Rowland, M.D., Halliday-Boykins, C.A., Cunningham, P.B., Pickrel, S.G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (2), *183-190.*

Insel, T.R., & Fenton, W.S. (2005). Psychiatric epidemiology: It's not just about counting anymore. *Archives of General Psychiatry, 62* (6), 590-2.

Jacobson, C.M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. *Archives of Suicide Research, 11* (20), 129-47.

Jakobsen, E.S., & Severinsson, E. (2006). Parents' experiences of collaboration with community healthcare professionals. *Journal of Psychiatric and Mental Health Nursing, 13,* 498–505.

James, S., Charlemagne, S.J., Gilman, A.B., Alemi, Q., Smith, R.L., Tharayil, P.R., & Freeman, K. (2010). Post-discharge services and psychiatric rehospitalisation among children and youth. *Administrative Policy in Mental Health, 37* (5), 433-445.

Jensen, T.K., Holt, T., Ormhaug, S.M., Egeland, K., Granly, L., Hoaas, L.C,, Hukkelberg, S.S., …. & Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. Journal of Clinical Child and Adolescent psychology, 43 (3), 356-69.

Johnston, J.A., O'Gara, J.S., Koman, S.L., Baker, C.W., & Anderson, D.A. (2015). A pilot study of maudsley family therapy with group dialectical behavior therapy skills training in an intensive outpatient program for adolescent eating disorders. *Journal of Clinical Psychology, 71*(6), 527-43.

Kamphaus, R.W., & Reynolds, C.R. (2007). *BASC-2 Behavioral and Emotional Screening System Manual.* Circle Pines, MN: Pearson.

Kane, J.M., Robinson, D.G., Schooler, N.R., Mueser, K.T., Penn, D.L., Rosenheck, R.A., Addington, J., & Heinsenn, R.K., (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program, the American Journal of Psychiatry. doi: 10.1176/appi.ajp.2015.15050632

Kaplan, T., & Racussen, L., (2012). A crisis recovery model for adolescents with severe mental health problems. *Clinical Child Psychology and Psychiatry. 18*(2), 246-59.

Keeshin, B.R., Strawn, J.R˙, Luebbe, A.M., Saldaña, S.N., Wehry, A.M., DelBello, M,P., & Putnam, F.W˙ (2014). Hospitalized youth and child abuse: a systematic examination of psychiatric morbidity and clinical severity. *Child Abuse and Neglect. 38*(1),76-83.

Kennair, N., Mellor, D., & Brann, P. (2011). Evaluating the outcomes of adolescent day programs in an Australian child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *16 (1)*, 21-31.

Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T.B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry, 20* (4), 359-364.

King, C., Franzese, R., Gargan, S., McGovern, L., Ghaziuddin, N., & Naylor, M. (1995). Suicide contagion among adolescents during acute psychiatric hospitalisation*. Psychiatric Services, 46* (9), 915-918.

Koehne, K., & Sands, N. (2008). Borderline personality disorder: An overview for emergency clinicians. *Australasian Emergency Nursing Journal, 11*(4):173-177.

Kwok, K.H.R., Yuan, S.N.V., & Ougrin, D. (2016). Review: Alternatives to inpatient admission for children and adolescents with mental health disorders. *Child and Adolescent Mental Health*, 21 (1), 3-10.

Lanktree, C.B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., Adams, B., Maida, C., & Freed, W. (2012). Treating multitraumatized, socially marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828.

Lawrence, D., Johnson, S., Hafekost. J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S.R. (2015) *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Department of Health, Canberra.

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Lamb, C. (2009). Alternatives to admission for children and adolescents: providing intensive mental healthcare services at home and in communities: what works? *Current Opinion in Psychiatry*, 22 (4), 345-350.

Lebel, J., & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56* (9), 1109-14.

le Grange, D., & Lock, J. (2005). The dearth of psychological treatment studies for anorexia nervosa. *International Journal of Eating Disorders, 37*(2), 79-91.

le Grange, D.; Crosby, R.D., Rathouz, P.J., & Leventhal, B.L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archive of General Psychiatry, 64* (9), 1049-56.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry, 199* (6), 445-52.

Leichtman, M. (2006). Residential treatment of child and adolescents: Past, present and future. *Journal of American Orthopsychiatry, 76 (3)*, 285 – 294.

Lenz, A. S., Del Conte, G., Lancaster, C., Bailey, L., & Vanderpool, E. (2014). Evaluation of a partial hospitalisation program for adolescents. Counseling Outcome Research and Evaluation, 5, 3-16

Lieberman, A.E., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. The Guilford Press: New York.

Lock, J., Le Grange, D., Agras, W.S., & Dare, C. (2001). *Treatment manual for anorexia nervosa. A family-based approach*. New York: Guilford Press.

Lourie, I.S., & Hernandez, M. (2003). A historical perspective on national child mental health policy. *Journal of Emotional and Behavioural Disorders, 11* (1), 5-9.

Madan, A., Sharp, C., Newlin, E., Vanwoerden, S. and Fowler, J. C. (2014), Adolescents are less satisfied with inpatient psychiatric care than their parents: Does it matter? *Journal for Healthcare Quality*. doi:10.1111/jhq.12081

Madden, S., Miskovic-Wheatley, J., Wallis, A., Kohn, M., Lock, J., Le Grange, D., Jo, B.,…. & Touyz, S. (2015). A randomized controlled trial of in-patient treatment for anorexia nervosa in medically unstable adolescents. *Psychological Medicine. 45*(2), 415-27.

Magellan Health Services (2008). *Perspectives on residential and community-based treatment for youth and families*. Magellan Health Services Children's Services Task Force. Accessed from www.magellanhealth.com

MacKean, G˙, Spragins, W˙˙, L'Heureux, L., Popp, J., Wilkes, C., & Lipton, H. (2012). Advancing family-centred care in child and adolescent mental health: a critical review of the literature. *Healthcare Quarterly, 15* (4), 64-75.

Magor-Blatch, L. E. & Ingham, L. (2015). Youth with mental illness: Attitudes towards and therapeutic benefits of residential stepped care. *Community Mental Health Journal, 51* (3), 338-346.

Marriage, K., Petrie, J., & Worling, D. (2001). Consumer satisfaction with an adolescent inpatient psychiatric unit. *Canadian Journal of Psychiatry, 46* (10), 969-75.

Martin,G., Swannell, S.V., Hazell, P.L., Harrison. J.E., & Taylor, A. (2010). Self-injury in Australia: A community survey. *Medical Journal of Australia, 193* (9), 506- 510.

Mathai, J., & Bourne, A. (2009).Patients who do well and who do less well in an inpatient adolescent unit. *Australasian Psychiatry, 17* (4), 283–286.

Maynard, B. R., Brendel, K. E., Bulanda, J. J., Heyne, D. H., Thompson, A. M., & Pigott, T. D. (2015). Psychosocial interventions for school refusal with primary and secondary school students: A systematic review. *Campbell Systematic Reviews, 12*. DOI: 10.4073/csr.2015.12

McDougall,T., & Cotgrove, A (2013). *Specialist Mental Healthcare for Children and Adolescents: Hospital, Intensive Community and Home Based Services.* London: Routledge.

McFarlane, W.R., Lynch, S., & Melton, R.P. (2012). Family psychoeducation in clinical high risk and first episode psychosis. Adolescent Psychiatry, 2 (2), 182-194.

Mendoza, J., Wands, M., Salvador-Carulla, L., Hackett, M., Najlepszy, L. & Fernandez, A (2014). *Evaluation of the Queensland Ed-LinQ Initiative: a school-community mental health initiative*. Report for the Queensland Mental Health Commission, Brisbane.

Mental Health Commission of Canada (2015). *Taking the next step forward: Building a responsive mental health and addictions system for emerging adults*. Ottawa. Accessed from www.mentalhealthcommission.ca/English/document/76936/taking-next-step-forward

Mental Health Commission of NSW (2014). *Living Well, A Strategic Plan for Mental Health in NSW 2014-2024.* Accessed from nswmentalhealthcommission.com.au/our-work/strategic-plan

Mental Health Coordinating Council (2014). *Recovery for Young People: Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS): Discussion Paper,* MHCC, Sydney, NSW. Accessed from www.mhcc.org.au/sector-development/research-and-development/youth-recovery-project.aspx

Mental Health Unit (2002). *Report on the need for child and adolescent secure inpatient services and the re-development of extended treatment adolescent in-patient services*. Queensland Health: Brisbane.

Metro North HHS Mental Health Services Research Review (2013). Accessed from www.health.qld.gov.au/metronorth/mental-health/documents/mnhhs-mh-research-2013.pdf

Ministry of Health (2012). *Rising to the Challenge: The Mental Health and Addiction Services Plan 2012-17*. Auckland, New Zealand. Accessed from www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

Morgan, V.A., Castle, D.J., & Jablensky, A.V. (2008). Do women express and experience psychosis differently from men? Epidemiological evidence from the Australian National Study of Low Prevalence (psychotic) Disorders, *Australian and New Zealand Journal of Psychiatry*, 42, 74-82.

Morton, J., Clark, R., & Pead, J. (1999). *When care is not enough: A review of intensive therapeutic and residential service options for young people in out-of-home care who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood*. Department of Human Services, Melbourne.

Moses, T. (2011). Adolescents perspectives about brief psychiatric hospitalisation: What is helpful and what is not? *Psychiatric Quarterly. 82, 121-37.*

Moses, T. (2014). Determinants of mental illness stigma for adolescents discharged from psychiatric hospitalisation. *Social Science and Medicine, 109*, 26-34.

Mottaghipour, Y., & Bickerton, A. (2005). The Pyramid of Family Care: A framework for family involvement with adult mental health services. *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 4* (3). Accessed from www.atoda.org.au/wp-content/uploads/mottaghipour.pd

Mufson, L. (2010), Interpersonal psychotherapy for depressed adolescents (IPT- A): Extending the reach from academic to community settings. *Child and Adolescent Mental Health*, *15(2),* 66–72.

Mufson, L., Moreau, D., Weissman, M.M., & Klerman, G.L. (1993). *Interpersonal Psychotherapy for Depressed Adolescents*. Guilford Press, New York.

Murray, C.J. & Lopez, A.D. (1996). *The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA, Harvard School of Public Health, (Global Burden of Disease and Injury Series, vol. I).

Muskett, C. (2014), Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23 (*1), 51–59.

National Crime Prevention (1999). *Pathways to Prevention: Developmental and Early Intervention Approaches to Crime in Australia*. National Crime Prevention, Attorney-General's Department, Canberra, ACT.

National Health and Medical Research Council (2012). *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. Melbourne: National Health and Medical Research Council.

National Institute for Health and Care Excellence (2004). *Self-harm in over 8s: Short-term management and prevention of recurrence. Clinical guideline*. Accessed from www.nice.org.uk/guidance/cg16

National Institute for Health and Care Excellence (2005a). *Depression in children and young people: identification and management. Clinical guideline*. Accessed from www.nice.org.uk/guidance/cg28

National Institute for Health and Care Excellence (2005b). Post-traumatic stress disorder: management. *Clinical guideline*. Accessed from www.nice.org.uk/guidance/cg26

National Institute for Health and Care Excellence (2011). *Self-harm in over 8s: Long-term management. Clinical guideline*. Accessed from www.nice.org.uk/guidance/cg16

National Institute for Health and Care Excellence (2013). *Psychosis and schizophrenia in children and young people: Recognition and Management. Clinical guideline.* Accessed from www.nice.org.uk/guidance/cg155.

National Institute for Health and Care Excellence (2013). *Social anxiety disorder: recognition, assessment and treatment. Clinical guideline*. Accessed from www.nice.org.uk/guidance/cg159

National Mental Health Commission (2014): The National Review of Mental Health Programmes and Services. National Mental Health Commission, Sydney. Accessed from www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx

National Mental Health Commission (2015*). A case for change. Position paper on seclusion, restraint and restrictive practices in mental health services*. Accessed from www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project/our-position-paper-a-case-for-change.aspx

News in Mind (28/11/2012). *Youth commits suicide on mental health wait list.* Accessed from www.newsinmind.com/general-news/youth-commits-suicide-on-mental-health-wait-list

NHMRC National Centre of Excellence in Suicide Prevention (2015). Care after a suicide attempt: A report prepared for the National Mental Health Commission. Accessed from www.blackdoginstitute.org.au/newsmedia/newsdesk/index.cfm

NHS England (2014). Achieving better access to mental health services by 2020. London. Accessed from www.gov.uk/government

NHS England (2015). *Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing*. London. Accessed from www.gov.uk/government

Niethammer, O. & Frank, R. (2007). Prevalence of use, abuse and dependence on legal and illegal psychotropic substances in an adolescent inpatient psychiatric population. *European Child and Adolescent Psychiatry, 16*(4), 254–9.

Noble, L.M. & Douglas, B.C. (2004). What users and relatives want from mental health services. *Current Opinion in Psychiatry, 17* (4), 289-296.

Nock, M. K., Joiner, T. E., Gordon, K., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144,* 65–72.

NSW Government (2015). Media release *titled NSW government announced $2.1 million expansion of community-based support for young people with severe mental illness*, 30/01/15. Accessed from http://nsw.liberal.org.au/nsw-government-announces-2-1-million-expansion-community-based-support-young-people-severe-mental-illness/

Nurcombe, B. (1995). The future of psychiatric hospitalisation for children and adolescents. In L. Bickman and D. J. Rog (Eds.), *Children's mental health services: research, policy, and evaluation* (101-116). Thousand Oaks CA: SAGE Publications.

O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., & Lelliott, P. (2001). *National In-patient Child and Adolescent Psychiatry Study. Final Report to the Department of Health*. London: Royal College of Psychiatrists' Research Unit.

O'Shea, G., Spence, S.H., & Donovan, C.L. (2015). Group versus individual interpersonal psychotherapy for depressed adolescents. *Behavioural and Cognitive Psychotherapy , 43* (10), 1-19.

Ougrin, D., Tranah, T., Stahl, D., Moran, P. & Rosenbaum Asarnow, J. (2015) Therapeutic interventions for suicide attempts and self-harm in adolescents: Systematic review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 54*(2), 97–107.

Paradis, A., Giaconia, R., Reinherz, H., Beardslee, W., Ward, K., & Fitzmaurice, G. (2011). Adolescent family factors promoting healthy adult functioning: A longitudinal community study. *Child and Adolescent Mental Health*, *16*(1), 30-37.

Parker, Z., Steele, M., Junek, W., Morin, L., Davidson, S., Fleisher, W.,….. & Yates, T. (2002) *Position Statement Canadian Academy of Child Psychiatry Physician Resource Committee*. Child Psychiatry in Canada: Physician Resources. Accessed from https://ww1.cpa-apc.org/Publications/Position_Papers/child.asp

Patton, G.C., Coffey, C., Romaniuk, H., Mackinnon, A., Carlin, J.B., Degenhardt, L., Olsson, C.A., & Moran, P. (2014). the prognosis of common mental disorders in adolescents: A 14-year prospective cohort study. *The Lancet, 383*, 1404-1411.

Penn, D. L., Roberts, D. L., Combs, D., & Sterne, A. (2007). Best practices: The development of the Social Cognition and Interaction Training program for schizophrenia spectrum disorders. *Psychiatry Services, 58*(4), 449-451.

Pfeiffer, S.I., & Strzelecki, S.C. (1990). Inpatient psychiatric treatment of children and adolescents: a review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*(6), 847-53.

Pietrek, C., Elbert, T., Weierstall, R., Müller, O., & Rockstroh, B. (2013). Childhood adversities in relation to psychiatric disorders. *Psychiatry Research, 206* (1), 103-10.

Pineda, J., & Dadds, M.R. (2013). Family intervention for adolescents with suicidal behavior: A randomized controlled trial and mediation analysis. *Journal of the American Academy of Child and Adolescent Psychiatry. 52*(8), 851-62.

Pottick, K.J., McAlpine, D.D., & Andelman, R.B. (2000). Changing patterns of psychiatric inpatient care for children and adolescents in general hospitals, 1988-1995. *American Journal of Psychiatry, 157* (8), 1267-73.

Queensland Health (1996). *Future Directions for Child and Youth Mental Health Services.* Queensland Government, Brisbane.

Queensland Health (2003). *Child and youth mental health beds report*. Prepared by the Mental Health Unit.

Queensland Health (2005). *Sharing responsibility for recovery: Creating and sustaining recovery orientated systems of care for mental health*. Queensland Government, Brisbane.

Queensland Health (2006). *Ten Year Mental Health Strategy.* Queensland Government, Brisbane.

Queensland Health (2011). *Information sharing between mental health care workers, consumers, carers, family and significant others*. Queensland Government, Brisbane. Accessed from www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/info_sharing.pdf

Queensland Health (2015a). *Acute Adolescent Inpatient Unit Model of Service*. Queensland Government, Brisbane.

Queensland Health (2015b). *Queensland ABF and NEP price weights 2015-16.* Queensland Government, Brisbane.

Queensland Health (2015c). *Evolve Therapeutic Services performance review.* Queensland Government, Brisbane.

Queensland Government (2013). *Taking Responsibility: A Roadmap for Queensland Child Protection*. Accessed from http://www.childprotectioninquiry.qld.gov.au

Queensland Mental Health Commission (2014a). *Queensland Mental Health, Drug and Alcohol Strategic Plan, 2014-2019*. Accessed from www.qmhc.qld.gov.au/work/queensland-mental-health-and-drug-strategic-plan/

Queensland Mental Health Commission (2014b). *Options for reform: Moving towards a more recovery-oriented, least restrictive approach*. Accessed from www.qmhc.qld.gov.au/wp-content/uploads/2014/06/REPORT_QMHC-Options-for-Reform_PUBLISHED.pdf

Queensland Mental Health Commission (2015a). *Queensland Suicide Prevention Action Plan 2015-17*. Accessed from www.qmhc.qld.gov.au/work/promotion-awareness/suicide-prevention-action-plan/

Queensland Mental Health Commission (2015b). *Early action: Queensland Promotion, Prevention and Early Intervention Action Plan 2015-17.* Accessed from www.qmhc.qld.gov.au/work/promotion-awareness/promotion-prevention-early-intervention/

Queensland Mental Health Commission (2015c). *Queensland Alcohol and Other Drugs Plan 2015-17*. Accessed from www.qmhc.qld.gov.au/work/queensland-mental-health-and-drug-strategic-plan/alcohol-and-other-drugs/

Queensland Voice (2013). QV update newsletter, July 19th 2013. Accessed from http://qldvoice.org.au/publications/qv-update/

Rathus, J.H., & Miller, A.L. (2000). DBT for adolescents: Dialectical dilemmas and secondary treatment targets. *Cognitive and Behavioral Practice, 7* (4), 425-434.

Richardson, M., Cobham, V., McDermott, B., & Murray, J.A. (2013). Youth mental illness and the family: Parents' loss and grief. *Journal of Child and Family Studies, 5,* 719-736.

Roberts, D.L., Penn, D.L., Labate, D., Margolis, S.A., & Sterne, A. (2010). Transportability and feasibility of Social Cognition and Interaction Training (SCIT) in community settings. *Behavioural and Cognitive Psychotherapy, 38* (1), 35-47.

Rosenthal, D. A., Mallett, S., & Myers, P. (2006*)* Why do homeless young people leave home? *Australian and New Zealand Journal of Public Health*, *30* (3), 281-285.

Rossouw, T.I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(12), 1304-1313

Royal Australian and New Zealand College of Psychiatrists (2010). The prevention and early intervention of mental illness in infants, children and adolescents. Position statement 63. Accessed from www.ranzcp.org/News-policy/Policy-submissions-reports.aspx

Royal Australian and New Zealand College of Psychiatrists (2015a). *Clinical Practice Guideline – Deliberate self-harm*. Draft for consultation. Accessed from www.ranzco.org

Royal Australian and New Zealand College of Psychiatrists (2015b). *RANZCP submission into the Community Affairs Reference Group inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Accessed from www.ranzcp.org

Royal College of Psychiatrists (2015). *Survey of inpatient admission for children and young people with mental health problems: Young people stuck in the gap between community and inpatient care*. Accessed from www.rcpsych.ac.uk/pdf/FR%20CAP%2001%20for%20website.pdf

Rusu, I.R., Cosman, D., & Nemes, B. (2012). Family-protective factor to prevent suicidal behavior in adolescents. *Human and Veterinary Medicine, 4* (3), 103 -105.

Rytilä-Manninen, M., Lindberg, N., Haravuori, H., Kettunen, K., Marttunen, M., Joukamaa, M., & Fröjd, S. (2014). Adverse childhood experiences as risk factors for serious mental disorders and inpatient hospitalisation among adolescents. *Child Abuse and Neglect, 38* (12). 2021-32.

Sadler, T. (2007). *Barrett Adolescent Centre – Cinderella of Queensland Mental Health Services?* Presentation to the Statewide Child and Youth Mental Health, Alcohol and Other Drugs Advisory Group, Queensland Health.

Saffer, B.Y., Glenn, C.R., & Klonsky, D. (2015). Clarifying the relationship of parental bonding to suicide ideation and attempts. *Suicide and Life-Threatening Behaviour, 45* (4), 518-528.

Scharer, K. (2002). What parents of mentally ill children need and want from mental health professionals. *Issues in Mental Health Nursing, 23* (6), 617-40.

Schley, C., Radovini, A., Halperin, S. & Fletcher, K. (2011). Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and high-risk. *Child and Youth Services Review, 33*(9), 1506–1514.

Schley, C., Ryall, V., Crothers, L., Radovini, S., Fletcher, K., & Marriage, K., (2008). Early intervention with difficult to engage, 'high-risk' youth: Evaluating an intensive outreach approach in youth mental health. *Early Intervention in Psychiatry, 2*(3), 195-200.

Schley, C, Yuen, K, Fletcher, K. & Radovini, A. (2012). Does engagement with an intensive outreach service predict better treatment outcomes in 'high-risk' youth? *Early Intervention in Psychiatry, 6* (2), 176-184.

Schofield, G. and Beek, M. (2009), Growing up in foster care: providing a secure base through adolescence. *Child & Family Social Work, 14 (3),* 255–266.

Shaffer, D., Gould., M.S., Brasic, J;., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry, 40* (11), 1228-31.

Shepperd, S., Doll, H., Gowers, S., James, A., Fazel, M., Fitzpatrick, R., & Pollock, J. (2009). Alternatives to inpatient mental health care for children and young people. *Cochrane Database of Systematic Reviews*, 15, CD006410.

Shochet, I.M., Dadds, M.R., Ham, D., & Montague, R. (2006). School connectedness is an underemphasized parameter in adolescent mental health: Results of a community prediction study. *Journal of Clinical Child and Adolescent Psychology, 35* (2), 170–179

Shumway, M., Alvidrez, J. Leary, M., Sherwood, D., Woodard, E., Lee, E.K., Hall, H., ….& Dilley, J.W. (2012). Impact of capacity reductions in acute public-sector inpatient *Psychiatric Services, 63*(2),135-41.

Simonds, L.M., Pons, R.A., Stone, N.J,. Warren, F .& John, M. (2014), Adolescents with anxiety and depression: Is social recovery relevant? *Clinical Psychology & Psychotherapy*, 21 (2), 289-298.

Sinclair, R. *(*2004*).* Participation in practice: making it meaningful, effective and sustainable*. Children and Society*, *18* (2)*,* 106–118.

Slade, M. (2013). *100 ways to support recovery. A guide for mental health professionals.* Rethink recovery series: Volume 1. London: National Schizophrenia Fellowship. Accessed from www.rethink.org/about-us/commissioning-us/100-ways-to-support-recovery

Spettigue, W., Maras, D., Obeid, N., Henderson, K.A., Buchholz, A., Gomez, R., Norris, M.L. (2015). A psychoeducation intervention for parents of adolescents with eating disorders: A randomized control trial. *Eating Disorders: the Journal of Treatment and Prevention, 23* (1), 60-75.

Stavely, H., Hughes, F., Pennel, K., McGorry, P.D., & Purcell, R. (2013). EPPIC model and service implementation guide. Orygen Youth Health Centre, Melbourne.

Suveg, C., Hudson, J.L., Brewer, G., Flannery-Schroeder, E., Gosch, E., & Kendall, P.C. (2009). Cognitive-behavioral therapy for anxiety-disordered youth: secondary outcomes from a randomized clinical trial evaluating child and family modalities. *Journal of Anxiety Disorders, 23* (3), 341-9.

Svanberg, J. *, &* Street, C. (2003). Where next? New Directions in in-patient mental health services for young people. Report 2. *Issues emerging: views from young people, parents and staff.* London*:* YoungMinds. Accessed from www.youngminds.org.uk

Swadi H., & Bobier, C. (2005). Hospital admission in adolescents with acute psychiatric disorder: How long should it be? *Australasian Psychiatry 13*(2):165-8.

Swannell, S., Martin, G., Scott, J., Gibbons, M., & Gifford, S. (2008). Motivations for self-injury in an adolescent inpatient psychiatric population. *Australasian Psychiatry, 16*(2), 98-103.

Strik, L.L., urt, F., Wallier, J., Perdereau, F., Rein, Z., Jeammet, P., & Godart, N. (2009). Predictive factors of length of inpatient treatment in anorexia nervosa. *European Child and Adolescent Psychiatry, 18* (2), 75-84.

Taiminen, T.J., Kallio-Soukainen, K., Nokso-Koivisto, H., Kaljonen, A., & Helenius H. (1998). Contagion of deliberate self-harm among adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(2), 211-7.

Tas, C., Danaci,A.E., Cubukcuoglu, Z., & Brüne, M. (2012). Impact of family involvement on social cognition training in clinically stable outpatients with schizophrenia -- a randomized pilot study. *Psychiatry Research, 195* (1-2), 32-8.

Thambirajah, M.S., Grandison, K.J., & de-Hay, L. (2008). *Understanding school refusal: A handbook for professionals in education, health and social care*. London: Jessica Kingsley Publishers.

Thomas, K. A., & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and sub-acute residential mental health services: A systematic review. *Psychiatric Services, 64*(11), 1140-1149.

Tonge, B.J., Hughes, G.C., Pullen, J.M., Beaufoy, J., & Gold, S. (2008). Comprehensive description of adolescents admitted to a public psychiatric inpatient unit and their families. *Australian and New Zealand Journal of Psychiatry, 42*(7), 627-35.

Trask, E.V., Fawley-King, K., Garland, A.F., & Aarons, G.A. (2015). Do aftercare mental health services reduce risk of psychiatric rehospitalisation for children? *Psychological Services*.

Trout, A.L., Lambert, M,C,, Epstein, M.H., Tyler, P., Thompson, R.W., Stewart, M., & Daly, D.L. (2013). Comparison of On the Way Home aftercare supports to traditional care following discharge from a residential setting: A pilot randomized controlled trial. *Child Welfare, 92* (3), 27-45.

Turchik, J.A., Karpenko, V,, Ogles, B.M,, Demireva, P., & Probst, D.R. (2010). Parent and adolescent satisfaction with mental health services: does it relate to youth diagnosis, age, gender, or treatment outcome? *Community Mental Health Journal, 46* (3), 282-8.

United Nations (1991). *The protection of persons with mental illness and the improvement of mental health care.* Accessed from www.un.org/documents/ga/res/46/a46r119.htm

US Government (2013). Now is the time: The President's plan to protect our children and our communities by reducing gun violence. Washington DC. Accessed from *www.whitehouse.gov/sites/default/.../wh_now_is_the_time_full.pdf*

Usman, M., Dryden-Mead, T., & Crouch, C. (2014). Planned psychiatric admission to reduce emergency presentations: A retrospective cohort study of adolescents. *Psychology Research, 4* (1), 25-30.
van Kessel, K., Milne, D., Hunt, K., & Reed, P.W. (2012). Understanding inpatient violence in a New Zealand child and adolescent psychiatric setting. *International Journal of Mental Health Nursing, 21 (4)*, 320-329.

van Kessel, K., Myers, E., Stanley, S., & Reed, P.R. (2012). Trends in child and adolescent discharge at a New Zealand psychiatric inpatient unit between 1998 and 2007. *The New Zealand Medical Journal, 125* (1355), 55-61.

Victorian Government (2012). *Review of the PDRSS day program, adult residential rehabilitation and youth residential rehabilitation services*. Accessed from www2.health.vic.gov.au

Victorian Government (2015). *Victoria's next 10-year mental health strategy*. Accessed from www.mentalhealthplan.vic.gov.au/children.

Walker, G., Baker, M., & George, M. (2009). *2009 Review of Barrett Adolescent Centre (Final Report).* Queensland Health.

Ward, D. (2014). *The long sleep-over: The lived experience of teenagers, parents and staff in an adolescent psychiatric unit*. Accessed from https://espace.library.uq.edu.au/view/UQ:356717

Ward, D. (2015). 'Recovery': Does it fit for adolescent mental health? *Journal of Child and Adolescent Mental Health, 26* (1), 83-90.

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Ward, L., & Gwinner, K. (2014). “It broke our hearts”: Understanding parents’ lived experiences of their child’s admission to an acute mental health care facility. *Journal of Psychosocial Nursing and Mental Health Services, 52* (7), 24-29.

Western Australian Mental Health Commission (2015). The Western Australian Mental Health, alcohol and other drugs plan 2015-2025. Accessed from www.mentalhealth.wa.gov.au/ThePlan.aspx

Withington, T., Litster, R., Catania, S., & Krause, J. (2014). Feast or famine: embedding a specialist clinic in a tertiary child and youth mental health service. *Journal of Eating Disorders, 2* (1). doi: 10.1186/2050-2974-2-S1-O15

Wood, J., Stathis, A., Smith, A., & Krause, J. (2012). E-CYMHS: Expansion of a child and youth telepsychiatry model in Queensland. *Australasian Psychiatry*, *20* (4), 333-337.

World Health Organisation (2012). *Making health services adolescent friendly.* Geneva. Accessed from www.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf

World Health Organisation (2013). *Mental health action plan 2013-2030*. Geneva. Accessed from www.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

Yantzi, N., Rosenberg, M.W., Burke, S.O., & Harrison, M.B. (2001). The impacts of distance to hospital on families with a child with a chronic condition. *Social Science and Medicine, 52* (12), 1777-91.

Yap, M.B., Pilkington, P.D., Ryan, S.M., & Jorm, A.F. (2014). Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis. *Journal of Affective Disorders, 156*, 8-23.

Young Minds (2013). An evidence synthesis of risk identification, assessment and management for young people using tier 4 inpatient child and adolescent mental health services (CAMHS): Young people’s consultation. Accessed from *www.ncbi.nlm.nih.gov/books/NBK294056/bin/Appendix_5.pdf*

Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry. 162*(10), 1911-8.

Zubrick, S.R., Silburn, S.R., Burton, P., & Blair, E. (2000). Mental health disorders in children and young people: Scope, cause and prevention. *Australian and New Zealand Journal of Psychiatry*, *34* (4), 570-578.