QUEENSLAND HEALTH

CHILD & YOUTH MENTAL HEALTH BEDS

REPORT

Mental Health Unit
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CONTENTS

INTRODUCTION

In 2000, Cabinet endorsed a proposal to undertake a study on the development of secure in-patient mental health services for incarcerated children and youths in youth detention centres and the redevelopment of the extended treatment adolescent in-patient service. Cabinet instructed that this study be considered in the context of the Ten Year Mental Health Strategy for Queensland 1996.

The development of the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994) provided the framework for the reform of mental health services in Queensland consistent with the objectives of the National Mental Health Strategy (1992) and the National Mental Health Plan (1998). The Ten Year Mental Health Strategy for Queensland (1996) advances the key directions and strategic framework of Queensland's mental health policy and plan for the implementation of structural and service reform.

The Ten Year Mental Health Strategy for Queensland, the Aboriginal and Torres Strait Islander Peoples Mental Health Policy Statement (1996) and the Future Directions for Child and Youth Mental Health Services Policy Statement (1996) provide a complex, sensitive and interrelated multi-dimensional approach to improve the quality of life and service provision for children, youth and adults with mental disorders or mental health problems.

This multi-dimensional approach incorporates service principles of mainstreaming, integration and self-sufficiency within a consumer focussed and least restrictive framework. Key objectives include:

- significant enhancement of community mental health services;
- the reorganisation of the service delivery system, specifically the role and functions of the existing hospital system;
- the improvement of intersectoral links; and
- the review of mental health legislation and the introduction of updated legislation that supports contemporary mental health service delivery.

The Queensland Forensic Mental Health Policy Statement 2002 aims to promote, improve and maintain the mental health of children, young people and adults who have a mental disorder or serious mental health problem, and are involved in the criminal justice system. The policy emphasises the rights of the individual to optimal care, based on clinical need, and provided in the least restrictive setting. This needs to be balanced against the rights of the public to protection from risk of harm. The policy promotes a greater role for district mental health services in the provision of mental health services to the target population.

SCOPE OF THE STUDY

This study will examine:

- the current utilisation of inpatient services statewide;
- the need for secure child and youth inpatient beds for Youth Detention Centre clients;
- the immediate, short-term and medium-term options for determining the future need for extended treatment adolescent inpatient services.

BACKGROUND

The *10 Year Mental Health Strategy for Queensland 1996* outlines the provision of community mental health services for children and adolescents, as well as acute inpatient services and day treatment programs. The inpatient services foreshadowed in the Strategy include:

Children

- Royal Children's Hospital
- Mater Misericordiae Children's Hospital
- Gold Coast District Health Service
- In regional locations it is recommended that dedicated beds may be constructed in general paediatric in-patient settings either as part of a paediatric unit or, where the bed numbers are sufficient, as a discrete in-patient unit.

Youth

- Royal Brisbane Hospital
- Logan- Beaudesert District Health Service
- Gold Coast District Health Service
- Toowoomba District Health Service

Using the planning guidelines outlined in the *10 Year Mental Health Strategy for Queensland* (1996), it can be determined that Queensland had the need for 94 beds for children and youth in 2001 and will need 117 beds (64 child and 53 youth) by 2006.

The number of beds actually established to date has been below the planning guidelines as illustrated by the following table that sets out the current bed capacity for children and young people.

Table 1. Current Child and Youth Inpatient Beds in Queensland

LOCATION	CURRENT BED NUMBERS	AGE GROUP	DATE OPENED
Children			
◆ RCH - CFTU	10	Child	July 1983
◆ Mater	12	Child	July 2001
Youth			
◆ RBH Adolescent Unit	12	Youth	July 1997
◆ Logan/Beaudesert	10	Youth	July 2000
◆ Barrett Adolescent Centre	15	Youth	June 1984
◆ Toowoomba	6	Youth	Nov 2001
Child & Youth (Combined)			
◆ Gold Coast (Robina Campus)	5	Child	Aug 2000
◆ Gold Coast (Robina Campus)	6	Youth	Aug 2000
TOTAL	**76**		

The number of child and youth beds has therefore increased from 25 (in 1996) to 76 beds (in 2002). Currently, there are 30 child beds (0-13 years) and 46 youth beds (14-18 years) available. With the exception of a special care suite in Cairns (that is not dedicated to use by children and young people), all are located in the southeast corner of the state.

CURRENT UTILISATION OF INPATIENT SERVICES

Analysis of statewide data from 1999/00 – 2002/03 shows that the average occupied bed days for all child and youth acute inpatient units is running approximately between 50% and 60%, with the exception of the RBH Adolescent Unit at approximately 70%. These occupied bed days may not be entirely reflective of the level of demand as units managing particularly difficult children/young people may reduce their admission numbers temporarily in order to boost the staff/patient ratio and may be distorted by bed status reports where children/adolescents are on leave.

Bed utilisation data for the Barrett Adolescent Centre indicates that between the 2000/01 and 2002/03 financial years there has been a reduced demand for adolescent beds but an increased usage of these beds for the assessment and treatment of older children. Despite this the occupied bed days during this period fluctuated between 35% and 67%. The reasons for these fluctuations range from adolescents being on variable periods of leave or requiring continuous observation to stable periods with higher admissions rates when staff to consumer ratios are assessed at not needing to be high.

The admission of young people to the four bed Special Care Suite, operational within the adult acute mental health unit at Cairns Base Hospital, has been limited due in part to the paucity of experienced child and youth mental health clinicians, and to the increased demand for psycho-geriatric patients and women with post-natal depression.

In the absence of dedicated child and youth mental health inpatient beds beyond the south-east corner, mental health services from regional centres in the Central and Northern Zones advise that significant numbers of young people are consistently admitted to general hospital wards or adult acute in-patient mental health units.

While collectively the numbers are significant in the regional centres, the need for dedicated facilities at all of the identified sites is clearly not supported by the data. Access to a supraregional facility located in a geographically central and accessible site is only one option. In the absence of this, alternative models, such as access to inpatient facilities in paediatric wards and adult acute units for older adolescents should be further explored as a priority for these sites. Equally, where adolescents are admitted to paediatric and adult inpatient units, appropriate expertise and treatment options must be available.

SERVICES TO INCARCERATED YOUNG OFFENDERS

[1]The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) 1985 state in part 5, sec 26.3 that juveniles *'in institutions shall receive care, protection and all necessary assistance for social, educational, vocational, psychological, medical and physical needs, that they may require because of their age, sex, and personality and in the interests of their wholesome development'.*

[1] The United Nations Standard Minimum Rules for the Administration of Juvenile Justice. (The Beijing Rules) 1985

Whilst incarcerated young offenders were identified as a priority target group in the 10 Year Mental Health Strategy for Queensland, there has been no establishment of dedicated secure acute inpatient facilities for [2] severely mentally disturbed young offenders under 18 years of age.

A Forensic Mental Health Service has operated within the Royal Children's Hospital and District Health Service at Spring Hill for many years, but has focused primarily on the assessment of parental competence for child protection applications, limited psychometric testing and expert witness presentations in court in relation to these matters. Hence, it did little to meet the needs of incarcerated young offenders.

Prior to February 2001, there had been a series of visiting mental health services to Sir Leslie Wilson, Cleveland and John Oxley Youth Detention Centres. These were variously sourced from Queensland Health and the private sector. Demand for the service depended largely upon the following:

- The practice of the courts in requesting pre-sentence reports, which may include a request for a mental health assessment, and
- Requests from detention centre staff concerned about the mental health of a young incarcerated person.

Overall, the response to these requests by the visiting medical services was often less than satisfactory. This was due, in part, to a lack of congruence between the requests (particularly for pre-sentence reports) and identified service priorities.

In response to recommendation 10 of the Forde Inquiry, Queensland Health has agreed to provide $1 million recurrently to enhance mental health and general health services to youth in detention centres. Following substantial collaboration between Queensland Health and Department of Families, an overarching service model has been developed. The full implementation of this model has now been achieved following finalisation of the Memorandum of Understanding (MOU) between the two departments

Since the commencement of the adolescent units at Royal Brisbane Hospital in 1997 and Logan Hospital in 2000, young offenders from detention centres in Brisbane who require acute inpatient mental health treatment have been admitted to these units. When this has occurred, young offenders have been sometimes accompanied for the duration of the admission by staff from the youth detention centre. Admissions tend to be short, with early discharge back to the detention centre and follow-up in this setting by a child and youth clinician. Whilst this option for inpatient treatment is reported anecdotally to be reasonably satisfactory to the staff involved, and no adverse events have been reported, it is not seen as a desirable process in the longer term for a number of reasons. Firstly, it creates an inconsistency with the adult sector where patients are admitted from courts, watchhouses and prisons, and responsibility for their custody is handed over to health staff.

[2] The term 'severely mentally disturbed' applies to those diagnosable psychiatric conditions that adversely affect the psychosocial development of children and adolescents, and contribute to major interactional difficulties in their social environment. These diagnoses are outlined in the international classification systems ICD9-CM and ICD10, and the United States' systems DSM-IIIR and DSM-IV. They are a heterogenous group of conditions with significant differences from those which appear in adulthood. Some are categorical entities (for example, adolescent bipolar disorder) where the disorder is either present or absent. Others (for example, phobic anxiety disorder) are more dimensional, and shade from normal variation into disorder. Where the line is drawn between mild and severe disorder is a clinical decision determined by the extent of the impairment or disability caused.

Additionally, there is a significant impact on the overall therapeutic milieu of the inpatient ward by having detention centre staff 'guarding' one patient, and the potential for a significant negative impact on other patients in the ward.

There appear to have been few, if any, admissions of youth from the Cleveland Detention Centre in Townsville to an inpatient facility, hence it is not possible to comment on the practices to date in North Queensland. Townsville does not have any child and youth mental health inpatient beds.

Data from the Department of Families, Youth Justice Branch (March, 2002) and the Cleveland Youth Detention Centre provides information with regard to the number of incarcerated young people in these two centres. The daily average number of young people incarcerated during 2001-02 in the two detention centres was fewer than 100. The average number in the Brisbane Youth Detention Centre was 69, and the Cleveland Youth Detention Centre was 25. 51% of this total included young people on remand, and 55% of the total were Indigenous young people.

It should be noted that this data does not include those young people aged between 17 and 18 years who have been charged and/or convicted of an offence, and who are subject to the adult *Penalties & Sentencing Act 1992*, with the outcome that they are incarcerated within the adult correctional system.

Equally the data provided does not identify those young people over 18 years of age who were sentenced as 17 year olds, the age they committed the offence, as there are provisions within the *Juvenile Justice Act* for this group to serve their sentences in a Youth Detention Centre, rather than be transferred to an adult correctional facility.

Both of these issues illustrate a lack of consistency that exists between Queensland Health, Department of Families, Youth Justice, Queensland Police and Correctional Services whereby the cut off age for inclusion within a program area shifts between 17 and 18 years.

Data obtained from the interim Brisbane Child and Youth Forensic Mental Health Service to the Brisbane Youth Detention Centre provides a greater understanding of the mental health needs experienced by young people incarcerated during the 2001 calendar year. The total number of referrals received by the interim forensic mental health services over the 12 month period was 117; this number represents 100 males and 17 females. Of the total, there were 45 indigenous young people, comprising 37 males and 8 females.

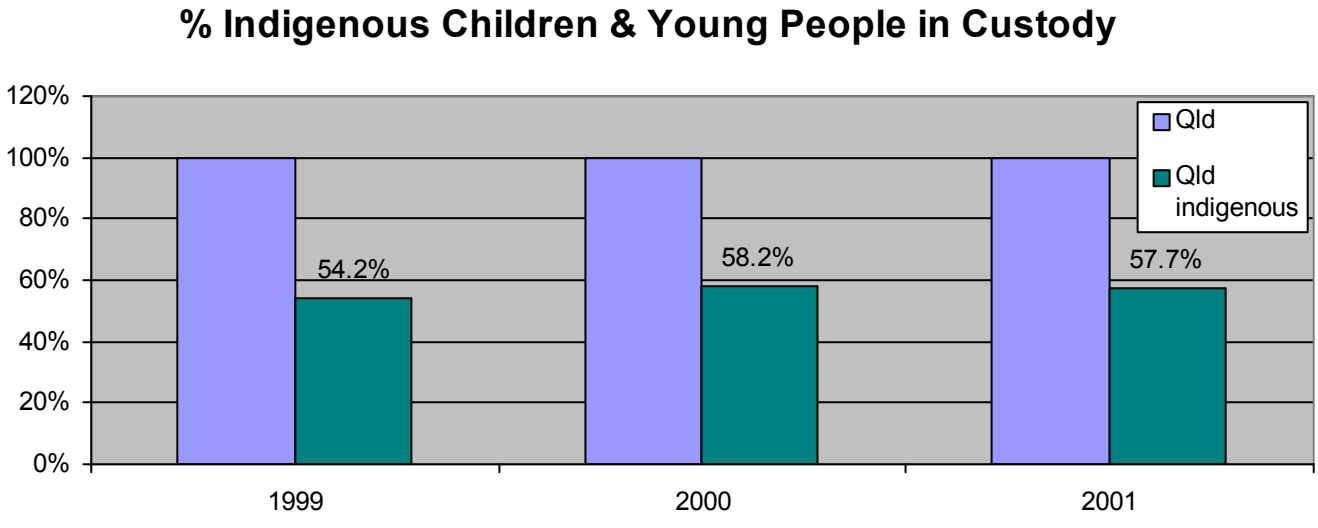
Females represent approximately 8% of the detention centre population, most of whom are referred for mental health assessment and treatment. This referral rate is consistent with national and international trends for the female offender population, where it is considered there may be a tendency to over-pathologise. Conversely, it is acknowledged internationally that there may be limited recognition of the need to refer male offenders for specialist mental health assistance.

Indigenous Issues

The data in the following table clearly identifies the continuing over-representation of indigenous young people within the juvenile justice system. While indigenous children and young people comprise 1.41% of the[3] Queensland population between the ages of 0 – 18, they make up 55 - 60% of the [4]detention population. The over representation of indigenous children and young people is amplified at each stage in the criminal and juvenile justice systems, from arrest through to

[3] ABS Census data 1996
[4] Department of Families, Youth Justice Branch data 2002

detention, indicating they are more likely to be treated in a manner that moves them deeper into the juvenile justice system.



At the same time, indigenous children and young people are under served by the mental health system. Many children and young people entering the juvenile justice system have either not received any assistance or have been poorly served by the systems in their communities, including the mental health system. For example; when they do receive services, indigenous children and young people with mental health problems tend to be diagnosed with more severe disorders, including disorders less amenable to treatment.[5] This suggests that prevention, early identification and early intervention services may be less available to indigenous children, young people and their families or where services are available they are not accessed to full potential by this client group.

Indigenous young people (particularly males) are more likely to be referred to the juvenile justice system rather that the treatment system, and indigenous juvenile offenders are less likely than their white counterparts to have previously received mental health services.

In the past, indigenous and other immigrant groups have shown low rates of use of mental health services, due in part to the history and policies of past governments, language differences, lack of locally based services and lack of cultural understand by mainstream service providers.

Sentencing and Treatment

The available data also highlights the challenge for youth justice and mental health in their provision of services for young people incarcerated on remand, and those serving brief sentences. The average time served on remand for the year 2001 was 38 days; and the average time served for sentenced offenders was 112 days. These short periods of incarceration impact upon the type of service delivery that can be offered within the detention centre, and highlight the critical need for strong linkages between mental health services within the detention centre and those in the young person's local community, in order to provide a comprehensive continuum of care that is acceptable and sustainable to the young person, their guardian and family. The data also indicates the need to consider more appropriate models of care to be established for Indigenous adolescents with a strong focus on early intervention.

There is also a clear need for the development of a protocol between adult and adolescent services, necessary to ensure the provision of the most appropriate mental health treatment within both

[5] Mental Health Service Needs of Indigenous Children and Youth in Queensland, June 1999

systems. This is critical, particularly for younger offenders who are more at risk of developing mental health problems which are of a severe, complex or life threatening nature, and which have the potential to accelerate the individual further into both the criminal and mental health systems.

Services to Youth Detention Centres

The service model agreed by Queensland Health and Department of Families provides for a comprehensive mental health service to youth detention centres. The Mental Health and Alcohol, Tobacco and Other Drug Service (MH-ATODS) has now taken over from the previous interim service. This includes assessment, treatment and case management services, and liaison with the mental health service in the young person's local community, in order to facilitate their ongoing treatment upon release. In addition, the Child and Youth Forensic Outreach Service (CYFOS) will provide a forensic mental health consultancy service to District clinicians. The full MH-ATODS service has been operating at Brisbane Youth Detention Centre since February 2003 and has been designed to meet the requirements of the adolescents in the youth detention facility. There are slight differences between the models operating in the Brisbane and Townsville Youth Detention Centres to reflect local needs; for example Townsville is a smaller facility with only 30 male beds currently and very few changes in personnel.

Secure Inpatient Services

The term security generally encompasses notions of safety from harm and danger. In mental health settings, security refers to those practices, policies and environmental changes that provide safety to consumers with severe disturbances resulting from mental illness. It also implies measures that protect the safety of other consumers, staff, family and the community in general from consumers experiencing mental illness.[6] Common problems that are the focus of security measures include aggressive behaviour, the inability to remain in a treatment setting and severe disorganisation that poses risks to the individual and others.

All mental health services undertake measures that respond to needs associated with these problems using the principle of a least restrictive alternative. Most of these needs can be met by district mental health services within the community, inpatient facilities and high dependence/intensive care options available in some inpatient settings. Where these needs can not be met due to the severity or duration of a consumer's condition, access may be required to facilities that have practices, policies, environmental modifications and staff resources specifically designed to address these needs.

As previously described, there are no secure inpatient facilities dedicated to providing services for children and young people in Queensland. Whilst it would be impractical to provide care for a child in one of the existing high secure or medium secure adult units across the state, it is not inconceivable that a young person may be admitted to such a unit. However, such a process is seen as highly undesirable for a number of reasons, including the inappropriate peer group within this setting, and the lack of age appropriate services and staff available within these settings. In rare circumstances where an adolescent under the age of 17 years may require secure care, even though highly undesirable, this can be provided through existing adult secure mental health facilities only with the approval of the Director of Mental Health and triggers a prompt review by the Mental Health Review Tribunal under the *Mental Health Act 2000*.

Requests for secure inpatient care for young people from the Youth Detentions Centres has been relatively infrequent and is predicted to further decrease with the establishment in September 2002 of the Mental Health – Alcohol, Tobacco and Other Drugs Service (MH-ATODS). The service

[6] A Model of Service Delivery for Medium Secure and High Security Treatment Services in Queensland, 2001

provides a comprehensive mental health assessment, treatment and case management service to young people in detention, and liaison with the mental health service in the young person's local community, to facilitate ongoing treatment post release. This ongoing treatment in the community will also be supported by the child and youth community forensic mental health service. An equivalent MH-ATODS team in Townsville is also now in place and should have a similar impact on the need for secure inpatient care for this client group.

During a 12 month period ending on the 26 March 2002 the interim mental health team at the Brisbane Youth Detention Centre reported that 18 young people were referred to them in relation to a psychosis. Of the eighteen, eight were clearly experiencing a drug induced psychoses, which resolved themselves quickly after incarceration and one was definitely not a psychosis. Of the remaining nine, one was already regulated and the team regulated another three who were transferred to the Logan/Beaudesert or RBH Adolescent inpatient units for treatment during the acute phase of their illness. These young people were returned to the detention centre for completion of their juvenile justice sentence, where they received ongoing care from the mental health team. The other five were treated as voluntary patients in the BYDC and did not require to be involuntarily treated and detained under the Mental Health Act.

In the last 12 months (1/03/02 – 1/03/03) the interim mental health service and MH-ATODS provided just over 200 episodes of service. Five episodes of service involved young people with a psychotic illness. All had a history of substance abuse, which may have contributed to their mental health problems. Four of these young people were treated entirely within the BYDC and did not require regulation under the Mental Health Act. Only one young person was transferred to the RBH Adolescent Unit and treated involuntarily for a few weeks. The unit had some difficulties with containment of this one referral.

Based on data over this two-year period, indications are that the need for secure beds would appear to be low. However analysis is required over an extended period to more precisely estimate the potential need for secure beds in Queensland.

EXTENDED TREATMENT ADOLESCENT INPATIENT SERVICES

The Barrett Adolescent Centre located within the Wolston Park Hospital complex is the only specialised extended treatment in-patient facility in Queensland for adolescents. It is primarily aimed at servicing those between the ages of 13 and 17 years who have mental disorders or serious mental health problems. The facility has 15 beds of single room accommodation and the capacity for 5 day patients. Its operating budget is approximately $2.4 million annually.

Prior to 1996, the Barrett Adolescent Centre (BAC) and the Royal Children's Hospital, Child & Family Therapy Unit (CFTU) were the only in-patient units for children and young people in the state. With the opening of additional acute child and youth inpatient facilities in the south-east of the state, the BAC has experienced a change in their daily operation, with acute admissions now being appropriately directed to these new units.

The Ten Year Mental Health Strategy for Queensland foreshadowed the ability to meet the extended treatment needs of children and adolescents through enhanced community based services in association with the new acute units. In line with this, it was foreshadowed that the Barrett Adolescent Centre would be closed and the funds redirected to enhance community-based services. Again, consistent with this, the plan for the redevelopment of Wolston Park Hospital did not include Barrett Adolescent Centre.

An attempt was made to close Barrett Adolescent Centre in 1997. However, this was unsuccessful due largely to a strong community response that led the then Minister for Health to reverse the decision articulated in the 10 Year Mental Health Strategy. It should be noted, however, that this attempt to close Barrett Adolescent Centre preceded the opening of any of the additional (acute) child and youth beds that are now available in south-east Queensland.

The building which houses the Barrett Adolescent Centre was constructed in 1976 for another purpose and opened in 1984 as an adolescent inpatient unit. As currently constructed, it has deficient noise insulation, and inadequate indoor recreational and dining areas, and is unsuitable for its current purpose. In addition, its current location is adjacent to the new High Security Unit at The Park Centre for Mental Health, and this is considered highly undesirable. Therefore, demolition of this sub-standard unit is desirable. There is currently no provision for its re-construction within The Park Centre for Mental Health complex.

Occupancy Rates

For the period 01 July 1999 to 30 June 2000, 81 young people were admitted to BAC, of whom 35 were 14 years of age or younger. For the period 01 July 2000 to 30 June 2001, 59 young people were admitted to BAC. Of this number, 31 were 14 years of age or younger. This data indicates a change in practice to admitting adolescents younger than the specified target group, although it is acknowledged that this data represents only a two-year window and may not necessarily reflect an ongoing trend. The centre currently operates below 50% capacity, although there may be other factors contributing to this as previously outlined in Section 4.0. Most admissions are from the south east corner of Queensland.

Best Practice

At a national and international level, there have been positive changes in the provision of contemporary mental health care treatment for children and young people. This includes a broader range of treatment options with a move away from institutional style settings to psycho-social models which focus on treatment in the context of the social and family setting, closer to where the young person and their family, carers and support networks live.

Queensland Health has likewise attempted to broaden the range of treatment options available to this target group. As stated above, examination of our admission data reveals that the newly constructed adolescent facilities are increasing their occupancy, resulting in a reduction in the number of referrals of the target group, 15 –18 years, to the BAC. Experience however suggests that acute units remain resistant to offering extended admissions because of the difficulty in providing a program to cover both acute and extended treatment options. Therefore, there is a need to explore options for alternative community based extended treatment programs which are not dependant upon access to inpatient beds.

DISCUSSION

On the basis of data presented above, it is readily apparent that the distribution of child and youth inpatient beds is inequitable across the state, both for acute care and for extended treatment. Based on this data and admission rates of children and young people to either adult mental health facilities and/or paediatric wards in the Northern Zone, there is a need to undertake a service planning exercise to determine the most appropriate model/s for responding to child and young people experiencing mental health problems, including the need for beds.

Likewise, a similar process needs to be undertaken to determine service responses for this client group in the northern part of the Central Zone, given the distances involved in accessing the existing Central Zone service located at the Royal Brisbane and Royal Children's Hospitals. The occupancy figures for these facilities would suggest that they can meet the needs of the entire Central Zone. However, it is clear from the admission rates at Bundaberg and Sunshine Coast, that there are significant numbers of families and/or clinicians who prefer to treat locally rather than refer to a Brisbane based unit. This practice reflects a recognition of problems arising for young patient as a result of dislocation from their family, school and support network when admission requires a transfer to Brisbane. A planning exercise also needs to be undertaken within the Central Zone to determine the most appropriate model/s for responding to child and young people experiencing mental health problems, including the need for beds and their possible location.

The Southern Zone appears to be relatively well serviced, with acute facilities at Logan, Gold Coast (Robina), Mater (South Brisbane) and Toowoomba, in addition to the Barrett Adolescent Centre.

Whilst acknowledging the data on admissions from the Brisbane Youth Detention Centre is only for a two year period, the overall number of admissions is extremely small. In addition, as the daily average of residents in both youth detention centres across the state is less than 100 at any one time and with the support of a fully functional MH-ATODs team there appears to be no need to develop stand-alone secure beds for adolescents in Queensland.

Whilst it is possible for secure care to be provided for a young person within an existing adult secure mental health facility, this is highly undesirable. The development of a more containing capacity, within existing adolescent acute units does not appear to be needed. The Royal Brisbane and Logan Adolescent Units have indicated that based on the low numbers of referrals received from Youth Detention Centres, care can be effectively managed through a range of options including access to adult High Dependency Units (HDUs), increased one-to-one observation and at Logan through the capacity to lock the entire unit.

Opinions about the need for an extended treatment facility such as the BAC are varied. In the medium-term (12-24 months), it appears that the facility should be maintained with some minimal capital works upgrading to enable the piloting of a range of alternative approaches. Services consulted also indicated that access to the BAC should be restrict to referrals only from acute inpatient units and an admission criteria be developed immediately between the BAC and the existing acute units to identify the most suitable target group and the diagnosis range. It is suggested that this admission criteria then be incorporated into the development of an overall child and youth mental health model of service delivery.

A decision about the long-term need for the BAC should be made following the piloting and evaluation of a range of alternatives. If the alternatives prove successful and a decision is made to close the BAC, the recurrent funds from the BAC should be retained in the child and youth mental health sector and redirected to support the planning outcomes in the Northern and Central Zones. However, if the pilots do not alleviate the need for extended treatment beds a decision will need to be made about the construction of a new extended treatment facility for adolescents in an appropriate location.

A decision to close the BAC may still raise potential community concerns similar to 1997, however this can be offset as a result of opening the new acute units in the south-east corner, the successful piloting of alternative models and the utilisation of funds from the BAC to support the planning outcomes in the Northern and Central zones.

The following recommendations are put forward for consideration as ways to address the combined issues outlined in the above report:

RECOMMENDATIONS

Existing Inpatient Bed Numbers and Child and Youth Bed Mix

1. Utilisation of the Gold Coast, Mater and CFTU child-beds be reviewed in light of occupancy rates and anecdotal evidence suggesting that the Child Planning Guidelines in the 10 Year Mental Health Strategy are in excess of requirement.

2. The client age group mix of the Gold Coast (Robina) Child and Youth Mental Health Inpatient Unit (currently servicing both Child and Youth clientele) to be reviewed and changed to either child only or youth only programs.

3. The age mix and utilisation of the Mater Child Inpatient Unit be reviewed to determine consistency with original specifications targeted at provision of services only to children.

4. The utilisation of CFTU be reviewed in light of no beds in the northern part of the Central Zone and the recent decision by the College of Psychiatry to withdraw the unit's training accreditation status for junior psychiatric registrars.

5. Review the working arrangements between the Royal Children's Hospital, which provides child inpatient services (CFTU) and child and youth community mental health services and the adult mental health program in the Royal Brisbane Hospital, which operates the adolescent beds.

Child and Youth Mental Health Inpatient Beds outside Brisbane

1. A Health Planning exercise to be undertaken to identify services models relevant to non-metropolitan locations, including the need for child and youth inpatient services in Northern and Central (non-Brisbane) Zones and alternative options.

2. Additional nursing positions to be established in community child and youth mental health teams to support children and young people admitted to local paediatric wards or adult acute inpatient units for short-term emergency responses and planned interventions.

Secure Inpatient Beds for Youth Detention Centres Clients

1. There appears to be no need at this stage for specific secure youth beds for young people referred from Youth Detention Centres as the numbers of referrals are relatively small and can be managed adequately by the RBH and Logan Adolescent Units within existing resources.

2. There is a need for ongoing monitoring of data on this client group to assess the rate and level of need for inpatient care over a longer period of time, and to determine any future staffing implications for the adolescent units.

3. There is a need to develop guidelines/protocols between Youth Detention Centres, the Logan and RBH Adolescent Units, MH-ATODS and the Child and Youth Forensic Outreach Service which addresses a range of issues including:

    - planned and after hours admissions;
    - the use of adult secure facilities for older adolescents that are at high risk to self or others;

- an appropriate communication strategy between all relevant parties in relation to all referrals for inpatient care;
- quality assurance mechanism for reviewing all cases referred for inpatient treatment; and
- identification of lead agency responsible for care coordination.

4. All staff need to be trained in the use of the protocols.

5. Cross-government discussions need to be initiated to address the legislative and program inconsistencies that exists between Queensland Health, Department of Families (including Youth Justice), Queensland Police and Correctional Services in relation to the cut off age for inclusion within a program area for those between 17 and 18 years.

6. Protocols/Guidelines need to be developed between adult and adolescent services in relation to access for this client group to adult secure facilities, including HDUs.

Extended Treatment Beds

Immediate

1. An admission criteria to be developed between the BAC and the Acute Adolescent Units. The admission criteria will specify the target group and diagnostic range, and will limit the referral source to adolescent acute inpatient units only.

2. Some minor capital works, limited to essential alterations, to be undertaken to improve the physical environment of the BAC.

Short Term (within a 6 month period)

3. A model of service delivery for Queensland's inpatient child and youth mental services to be developed which includes the admission criteria for the BAC.

4. All child and youth acute inpatient units to collect outcomes data on case complexity in relation to referrals to the BAC, to enable benchmarking.

5. Alternative models to admission for both acute and extended inpatient treatment to be explored.

6. Alternative models to be piloted and evaluated along with appropriate funding models.

Medium Term (within a 24 month period)

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

8. Any decision to rebuild the facility must take into consideration environmental, containment, and safety issues.

9. Any decision not to rebuild the BAC must ensure that recurrent funds from the BAC are retained in the child and youth mental health program area to support alternative models and outcomes of the health planning exercise in the Central and Northern Zones.