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**COMBINED ACUTE/EXTENDED TREATMENT UNITS**

1. Compromise Option 1

Existing acute adolescent units have an allocated number of beds for long term kids and run their own treatment and rehabilitation program using their existing staff.

2. Compromise Option 2

Existing acute adolescent units have an allocated number of beds for long term kids and run a rehabilitation program and have nursing support coordinated from a new metro day program (which has staff from the existing BAC staff)

3. Compromise Option 3

Existing acute adolescent units have an allocated number of beds for long term kids and adolescents are transported to a new metro day program for the rehabilitation component.

**Comments**.

These options cannot provide a replacement Level 6 Extended Treatment and Rehabilitation Service within the CSCF.

**1. Systemic Implications**

Allocation of Extended Treatment and Rehabilitation Beds within Acute Adolescent Inpatient Units has multiple systemic effects.

- Adolescents requiring acute admission will spend longer in emergency departments awaiting appropriate admission arrangements.
- There will be significant periods when adolescents from the Greater Brisbane Area will need to be transferred to a unit in the Gold Coast or Toowoomba. For an adolescent from Beenleigh to go to the Gold Coast, or from Booval to go to Toowoomba may seem tolerable at first. Both of these would need to be assessed at Logan before transfer, however. It would be far more complicated if an adolescent from Caboolture had to go to the Gold Coast, or one from Redlands to Toowoomba.
- Some adolescents requiring acute admission will spend overnight in an emergency department or a paediatric ward while awaiting appropriate arrangements for transfer.
- More adolescents are likely to be admitted into adult inpatient units.
- Adolescents requiring several acute admissions are less likely to be re-admitted to the same Acute Adolescent Inpatient Unit. The implications are two-fold. First, the lack of continuity of care can have a significant impact on the adolescent. Secondly, other units are not likely to have the same level of liaison with the adolescent's local CYMHS, child psychiatrist or school.

**2. Clinical Implications**

Allocation of Extended Treatment and Rehabilitation Beds within Acute Adolescent Inpatient Units has multiple effects on the young person requiring extended admission.

- Clinicians in Australia and the United Kingdom report the difficulties in attempting to provide a suitable rehabilitation program in an acute environment.
- Adolescents report despondency at seeing others come and go while they are still there.

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- Adolescents report being activated by seeing adolescents in the early stages of treatment, a stage they may have been at 12 months or more before. Being continually reminded of early stages impedes current progress.
- Interaction with a range of peers is an important component of rehabilitation. Experience suggests that less than 10 peers limits the range to an extent where some will not benefit from this process. Three or four adolescents in a unit for an extended admission is unlikely to be a critical mass to promote social rehabilitation.
- Individual units will not be able to provide the same range of treatment interventions.
- Due to limitations of space and time, a comprehensive range of rehabilitation interventions will not be available in Compromise Options 1 and 2. Option 2 will afford access to more expertise, but the amount of time will be limited.
- Treatment and rehabilitation will not be as integrated in Option 2 because staff advising on these will be different to those implementing these interventions.
- Compromise Option 3 provides the best opportunities for rehabilitation and a wider range of intensive therapeutic interventions. It does have significant implications for travel. The lack of continuity of staff will impair therapeutic outcomes.