INTRODUCTION

The Context of CYMHS in Queensland

Child and Youth Mental Health Services in Queensland arose out of the Division of Youth Welfare and Guidance. In the 1970s the Division consisted of community based clinics in the Greater Brisbane area, Toowoomba and Townsville and a forensic service to the youth detention centre at that time. In the past 25 years, a further 19 community CYMHS clinics have opened in regional and rural Queensland, and another five in three of the four Council areas adjoining Brisbane. In the 2010 – 11 financial year, community CYMHS in Queensland had a face to face service with over 9,000 children and adolescents. In addition, specialised CYMHS – Evolve Therapeutic Services provide therapeutic services to young people in the Care of the Department of Child Safety in most Health and Hospital Services.

Private child and adolescent psychiatrists see more than 4,000 young people. They are predominantly in south-east Queensland, from the Sunshine Coast to the border and west to Toowoomba. An unknown number of young people see private psychologists and social workers under the Better Access scheme. They are more likely to be in all major regional areas.

The first inpatient unit – the Child and Family Therapy Unit – opened in 1980 at the Royal Children's Hospital for children 12 and under. The Barrett Adolescent Centre began as a day program in 1982, and was officially opened as a day patient and inpatient Centre in 1983. In the early 1990s, the Faculty of Child and Adolescent Psychiatrists wrote to the Mental Health Branch about their concerns about the impacts on young people who were admitted to adult inpatient units. Adolescent acute inpatient units were opened at Royal Brisbane, Logan, Robina, Mater, Toowoomba and Cairns Hospitals between 1996 and 2001. The Toowoomba unit was closed owing to its unsuitable construction. A new unit opened in 2012. The Cairns unit was not opened because of difficulties attracting staff. A new unit in Townsville is due to open in June 2013. The current number of inpatient beds in Queensland is consistent on a population basis with the United Kingdom (O'Herlihy, Worrall, Lelliott, Jaffa, Hill, & Banerjee, 2004).

Adolescent Acute Inpatient Services are Level 5 services within the Clinical Services Capability Framework. These units aim to stabilise the symptoms within the context of family functioning and return to the community for continuing treatment. (Queensland Mental Health Policy Statement, 1996). Average length of stay is less than two weeks. An occasional adolescent may stay three to five months. Adolescents are admitted with psychotic disorders, mood and anxiety disorders, eating disorders and a small number for behavioural disturbances. Ratings on admission on the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA) is similar to those reported in the United Kingdom. (O'Herlihy, et al., 2004). Significant improvements are recorded on the HoNOSCA for the majority of adolescents admitted to Adolescent Acute Inpatient Units.

Adolescent Acute Inpatient Units report an increase in occupancy from 2008 to 2012. A proportion of adolescents who have multiple admissions to an acute inpatient unit may be admitted to more than one unit because of a shortage of beds in the designated regional

unit. On occasions, young people may stay for short periods in paediatric wards waiting for a bed in an Adolescent Acute Inpatient Unit.

Younger adolescents in regional Queensland who may need a brief, crisis admission will often be admitted to the local paediatric ward rather than transfer them to Brisbane.

Only one private hospital in Brisbane will admit teenagers below 18 years of age.

Day programs are an important component of regional extended treatment and rehabilitation services for children and adolescents. Apart from day patients admitted to the Barrett Adolescent Centre over the past 30 years, the first dedicated day program began at the Mater Children's Hospital in 1998. A day program was opened in Toowoomba in 2012, and is scheduled to open in Townsville in 2013. They are Level 5 services within the Mental Health Clinical Services Capability Framework.

The Barrett Adolescent Centre

Every year approximately twenty-five to thirty adolescents with persistent severe and complex mental illness with subsequent impairments in function are referred to the Barrett Adolescent Centre, a Level 6 facility under the Clinical Services Capability Framework. The observation that some adolescents have a persisting disorder requiring inpatient admission is consistent with overseas studies considering alternatives to acute inpatient admission for adolescents. (Henggeler, et al., 1999; Henggeler, et al., 2003; Evans, Armstrong, Greenbaum, Brown, & Kuppinger, 2003; Simpson, Cowie, Wilkinson, Lock, & Monteith, 2010; Schmidt, Lay, Gopel, Naab, & Blanz, 2006; Gowers, et al., 2010; Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002; Corrigall & Mitchell, 2002)

These are referred from any of the services described in the preceding section with the exception of private psychologists. All have had intensive treatments ranging from 1 – 4 years prior to admission to Barrett. The mean age at admission is 15 year and 10 months (median age 16 years).

Between 2002 – 2012, nearly 70% of adolescents were referred by services in the Greater Brisbane area – 58% from Child and Youth Mental Health Services, and more than 11% from private child psychiatrists. Another 10% were referred by services from the Sunshine Coast to Rockhampton. Eleven percent of referrals came from Toowoomba and the Gold Coast combined, although the number from these regions has declined in the past 5 years. Nearly 9% were referred from Queensland north of Mackay. Numerous factors contribute to the significant under-referrals from regional areas.

The percentage of those with Indigenous heritage has been constant at about 2% over the past two decades. No adolescents from non-English speaking backgrounds have been referred in the past five years.

Adolescents admitted to the Barrett Adolescent Centre have a range of primary diagnoses – Major Depressive Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Schizophrenia, Bipolar Disorder or a range of eating disorders. They typically have a range of co-morbid disorders including other anxiety disorders a range of developmental disorders including Aspergers Syndrome. A number exhibit life threatening behaviours including persisting suicidality or inability to maintain adequate nutrition. Over a third have

experienced multiple forms of childhood abuse over several years, often at the hands of more than one perpetrator.

Fifty-two percent of adolescents admitted in the past five years have been on an Involuntary Treatment Order. Over the past five years, staff were required to provide an average of 5,200 hours of continuous observations a year to prevent self harm or maintain adequate nutritional status. These are indicators of the level of persisting unwellness of many of the adolescents admitted.

Apart from the persisting severe mental illness, adolescents have been substantially estranged from family, educational, social or community networks.

- 98% had disengaged from their educational networks for at least 6 months prior to admission. (Frequently it is a year or more.) Those that had not were either able to be admitted as a partial day patient and involved in the educational setting, or the educational setting was a continuing stressor which adversely affected their mental health.
- 90% had no face to face contact with peers. Some had even disengaged from online networks.
- 83% had disengaged from community networks – they either did not or rarely went to shops, caught public transport etc.
- 12% had been abandoned or removed by family networks. 35% had tenuous family networks – they slept under the same roof as the parent, but parents were disengaged, neglectful or abusive.
- 55% had adequate family networks. These families however describe tremendous strain from needing to support a young person with severe mental illness – sleepless nights, giving up jobs, sometimes severe family conflict, sometimes fear of the young person dying, younger siblings having to witness lacerated arms.

Admission to the Barrett Adolescent Centre necessitates a thorough evaluation of a range of developmental and psychological assessments. Further assessments complement or update those that are available. This is an important component of identifying factors which may contribute to persistence of a disorder, associated behaviours or impairment.

Treatment includes a range of interventions including pharmacotherapy, a range of psychotherapies (both verbal and non-verbal), family therapy, and on occasion electroconvulsive treatment. Consistent with the range of disorders treated, psychotherapeutic and family interventions contribute the most to treatment. The rate of change in psychotherapy is determined by adolescent's capacity to monitor and regulate emotions and to monitor cognitions. Difficulties in both of these functions are evident in many adolescents with severe and persisting disorder. Psychotherapeutic interventions are delivered both individually and in groups. Nursing staff extend the range of therapeutic interventions by helping an adolescent to generalise strategies, supporting them with emotional dysregulation, enabling them to process distressing stimuli during periods of flashbacks associated with trauma. Treatment interventions are intensive, occurring throughout the week and in different settings.

Rehabilitation and promoting recovery are integrated with treatment progress.

The Barrett Centre School has been an integral part of both rehabilitation and recovery. It is a multi-skilled team which has been able to offer intensive support to adolescents to

- re-engage with education
- identifying deficits
- providing a range of educational pathways for adolescents who may not have completed primary school to those doing Year 12
- assist with evaluating educational goals
- assist with integration to school
- assist with developing vocational pathways and educational opportunities to those pathways.
- promote physical activity

Other interventions are essential to rehabilitation. These include specific activities such as social skills groups, accessing community activities, organising time, budgeting, develop physical fitness, explore a range of leisure activities, develop self-sufficiency skills e.g. preparing meals, preparation for driver's licence, developing resumes and for some adolescents, finding appropriate accommodation. Non-specific rehabilitation interventions include day to day self care skills, contributing to the maintenance of their area and helping with chores negotiating activities and boundaries with peers.

Unlike some Acute Adolescent Inpatient Units, Barrett Adolescent Centre is an open unit, where adolescents can freely access outside areas. Although there are highly suicidal adolescents, rates of absconding are relatively low. It is important in long term treatment to be able to work with the adolescent committed to being there. The open unit facilitates mutual trust and both commitment and responsibility in the adolescent. They report that the environment has a positive impact on their mental health, and they become agitated if the doors do need to be locked for a week or more, even though they can ask staff to go outside. Opportunities to use external spaces to regain emotional regulation have been important in maintaining the relatively low rates of seclusion over the years 2007 - 2012.

An open unit does require a highly skilled, stable workforce experienced in monitoring mental states, recognising early warning signs, being able to recognise behaviours which may be associated with various disorders and being able to respond appropriately to an individual adolescent at different times in their treatment.

The process of integration back to the community is intensive. The referring CYMHS or psychiatrist is informed of their progress throughout admission. Leave and family therapy help to address significant family issues. Through the rehabilitation program, the adolescent is encouraged to become more independent in accessing leave. The adolescent is supported intensively to integrate into a school, a TAFE or other vocational course, work experience, establishing leisure and fitness activities and in accessing community groups where they may meet other adolescents.

While most adolescents are able to return to live with their families, some cannot do so. Lack of a step-down unit has been a major impediment to these adolescents in independent living.

Bibliography

Corrigall, R., & Mitchell, B. (2002). Service innovations: Rethinking in-patient provision for adolescents: A report from a new service. *Psychiatric Bulletin* , 26:388-392.

Evans, M. B., Armstrong, M., Greenbaum, P., Brown, E., & Kuppinger, A. (2003). An Experimental Study of the Effectiveness of Intensive In-Home Crisis Services for Children and Their Families : Program Outcomes. *Journal of Emotional and Behavioral Disorders* , 11:92-121.

Gowers, S., & Rowlands, L. (2005). Inpatient services. *Current Opinion in Psychiatry* , 18:445-448.

Gowers, S., Clark, A., Roberts, C., Byford, S., Barrett, B., Griffiths, A., et al. (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.

Greenfield, B., Larson, C., Hechtman, L., Rousseau, C., & Platt, R. (2002). A Rapid-Response Outpatient Model for Reducing Hospitalization Rates Among Suicidal Adolescents. *Psychiatric Services* , 53:1574–1579.

Halliday-Boykins, C., Henggeler, S., Rowland, M., & DeLucia, C. (2004). Heterogeneity in Youth Symptom Trajectories Following Psychiatric Crisis: Predictors and Placement Outcome. *Journal of Consulting and Clinical Psychology* , 72:993-1003.

Halliday-Boykins, C., Henggeler, S., Rowland, M., & DeLucia, C. (2004). Heterogeneity in Youth Symptom Trajectories Following Psychiatric Crisis: Predictors and Placement Outcome. *Journal of Consulting and Clinical Psychology* , 72:993-1003.

Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry* , 42:543-551.

Henggeler, S., Rowland, M., Randall, J., Ward, D., Pickrel, S., Cunningham, P., et al. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry* , 38:1331 - 1339.

O'Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Hill, P., & Banerjee, S. (2004). Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales. *British Journal of Psychiatry* , 18:547-551.

O'Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Mears, A., Banerjee, S., et al. (2004). Characteristics of the Residents of In-Patient Child and Adolescent Mental Health Services in England and Wales. *Clinical Child Psychology and Psychiatry* , 9:579-588.

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

Schmidt, M., Lay, B., Gopel, C., Naab, S., & Blanz, B. (2006). Home treatment for children and adolescents with psychiatric disorders. *European Child & Adolescent Psychiatry* , 15:265–276.

Simpson, W., Cowie, L., Wilkinson, L., Lock, N., & Monteith, G. (2010). The effectiveness of a community intensive therapy team on young people's mental health outcomes. *Child and Adolescent Mental Health* , 15:217-223.