Child and Adolescent Mental Health Service Models of Care

Version 4

Megan Chiu
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AASW</td>
<td>Australian Association of Social Work</td>
</tr>
<tr>
<td>AMHU</td>
<td>Adult Mental Health Unit</td>
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<tr>
<td>ACHS</td>
<td>Australian Council on Health Care Standards</td>
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<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>ACTAS</td>
<td>ACT Ambulance Service</td>
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<td>ADS</td>
<td>Alcohol and Drug Service</td>
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<td>AFP</td>
<td>Australian Federal Police</td>
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<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<td>AMC</td>
<td>Alexander Maconochie Centre</td>
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<td>ARC</td>
<td>At Risk Checklist</td>
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<td>ASUSD</td>
<td>Adolescent Step Up Step Down Service</td>
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<tr>
<td>ATOD</td>
<td>Alcohol Tobacco and other Drugs</td>
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<td>AYAMHBIU</td>
<td>Adolescent and Young Adult Mental Health Inpatient Unit</td>
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<td>BYJC</td>
<td>Bimberi Youth Justice Centre</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>CATT</td>
<td>Crisis Assessment and Treatment Team</td>
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<tr>
<td>CH</td>
<td>Canberra Hospital</td>
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<tr>
<td>CH&amp;HS</td>
<td>Canberra Hospital and Health Services</td>
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<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<tr>
<td>CRA</td>
<td>Clinical Risk Assessment</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behavioural Therapy</td>
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<td>EDP</td>
<td>Eating Disorders Program</td>
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<td>EIP</td>
<td>Early Intervention Program</td>
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<tr>
<td>FMH</td>
<td>Forensic Mental Health</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HDU</td>
<td>High Dependency Unit</td>
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<tr>
<td>HIP</td>
<td>Health Infrastructure Program</td>
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<td>LDU</td>
<td>Low Dependency Unit</td>
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<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
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<td>MHS</td>
<td>Mental Health Services</td>
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<tr>
<td>MHAGIC</td>
<td>Mental Health Assessment Generation Information Collection</td>
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<tr>
<td>MHAU</td>
<td>Mental Health Assessment Unit</td>
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<td>MoC</td>
<td>Models of Care</td>
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<td>MSE</td>
<td>Mental State Examination</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
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<tr>
<td>PTO</td>
<td>Psychiatric Treatment Order</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SUSD</td>
<td>Step Up Step Down Service</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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## Definitions

<table>
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<tr>
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<tr>
<td>Assessment</td>
<td>Process of gathering information about a person with the purpose of making a diagnosis. The assessment is usually the first stage of a treatment process.</td>
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<td>Clinical Case Review</td>
<td>Clinical case reviews are meant to comply with National Standards for Mental Health Services where the current progress of the consumer is being discussed. The review is undertaken in consultation with the consumer, carer/parent, community agency, treating doctor and General Practitioner. These reviews are conducted at a minimum every three months.</td>
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<tr>
<td>Clinical Coordinator</td>
<td>A clinical coordinator is also known as the duty officer who is responsible for all referrals to CAMHS during the day and also responds to any crisis calls from the community.</td>
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<tr>
<td>Clinical Handover</td>
<td>Handovers are key events in transitions between shifts and treating teams, including General Practitioners and the community teams or inpatient services, as well as within teams as part of how they divide their tasks.</td>
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<tr>
<td>Clinical Management</td>
<td>The provision of case coordination that includes the bio-psychosocial model with the inclusion of discipline therapeutic interventions.</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>Clinical supervision (CS) facilitates the professional and practice development of clinicians and clinically related staff [e.g., team leaders, educators, researchers, professional leaders, directorate peer workforce team] through a process that includes reflection, education and discussion.</td>
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<tr>
<td>Consultation Service</td>
<td>Consultation services are specialist services that provide specialty input to the care of consumers.</td>
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<tr>
<td>Multidisciplinary Team</td>
<td>A team that is made up of a number of different disciplines such as psychiatry, psychology, social work, nursing and occupational therapy.</td>
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<tr>
<td>Outreach</td>
<td>The provision of mental health services outside of their offices/clinics. This can be in schools, community health or youth centres.</td>
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EXECUTIVE SUMMARY

Considerable work has been undertaken by the ACT Health Directorate in preparation for the “Health Infrastructure Program” (HIP) a redevelopment of health infrastructure in the ACT. Funds have been allocated under the program for a number of initiatives including the design of an Inpatient Unit. As part of developing a Model of Care (MoC) for a health infrastructure, the Child and Adolescent Mental Health Service (CAMHS) Redesign Project aims to review all the different program areas within CAMHS to deliver a MoC based on contemporary service delivery to inform the design of the health infrastructure. The proposed model is a result of information collated from best practice guidelines, evidence based practice and workshops with key stakeholders, including children and young people, carers and clinicians.

CAMHS services children and young people¹ with complex mental health issues which can result in significant psychological, medical and social consequences. Presentation of mental health issues varies amongst people and treatment requires a flexible and multidisciplinary approach. Defining an ACT wide service model for CAMHS is a complex process. The future CAMHS MoC will ensure:

- The provision of CAMHS across the spectrum of:
  - Promotion/prevention and early intervention
  - A range of treatment modalities that focus on recovery
- The service is flexible and responsive for children and young people with a moderate to severe mental health issue
- CAMHS operates in a highly responsive manner, providing assessment, treatment, consultation, support/outreach to the ACT community which includes a specialised inpatient and subacute facilities.
- Seamless transitions across each program/service to ensure continuity of care.
- The division of CAMHS Community Teams to: Child Team (1-12 year olds) and Adolescent and Young Adult Team (13-25).
- An appropriately skilled workforce where staff can work within their scope of practice.
- Collaboration with stakeholders to ensure best practice and outcomes for children and young people.
- The establishment of a Perinatal and Infant Mental Health Advisory Group for networking, opportunities and encourage collaboration between services and for the purpose of mapping services
- Establishment of a 20 bed inpatient unit.
- Ongoing provision of teaching and research across CAMHS

This document outlines the proposed MoC framework for the Child and Adolescent Mental Health Service with the extension of young adults up to the age of 25 years of age. It describes the overarching service principles and functional relationships across all service areas within CAMHS. It will describe at a macro level the MoC for the provision of Child and Youth Mental Health Services within the Australian Capital Territory (ACT). In developing this MoC, best practice guidelines and the evidence base have been reviewed and incorporated

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¹ Children and young people are identified in this document as anyone between the ages of 1-25 years old. According to the Children and Young People’s Act 2008, a child is defined as ‘anyone under the age of 13’ and a young person ‘anyone older than 18 and not yet an adult (18 years and over). In this document the following are identified:

- **Child**: anyone under 13 years of age
- **Young person**: anyone 13-18 years of age
- **Children and young people**: anyone from 1 to 25 years of age
into the description of the service model. The development of this MoC has been informed by working groups involving key stakeholders, including children and young people, carers and clinicians.

1.0 INTRODUCTION

The redesign and development of the CAMHS MoC is currently underway within the ACT Health Directorate. The purpose is to identify the current service models and gaps within the CAMHS programs and to develop a Model of Care that will include children and young people in the 18 to 25 years age group.

CAMHS traditionally see children and young people up to the age of 18 years. In recent years, more emphasis has been put on providing youth friendly services with a number of people successfully advocating for youth friendly mental health services². In the Australian Capital Territory (ACT), CAMHS offers services in the areas of: Community Outpatient Teams, Early Psychosis, Adolescent Day Program, Dialectical Behavioural Therapy (DBT) program, Perinatal Consultation service, Eating Disorder Program and Inpatient Services (utilising existing adolescent ward through the hospital) for young people up to the age of 18 years of age with the exception of the Perinatal and Eating Disorders team that sees people of all ages. Currently, children and young people between the ages of 18-25 are seen by the Regional Adult Community Mental Health Teams.

The reconfiguration of mental health services around developmental and life milestones for children and youth aligns these services with the ACT Government’s ACT Young People’s Plan 2004-2008 and the ACT Health Directorate Mental Health Services Plan 2009-2014. The rationale for CAMHS increasing its age range to 25 is to promote service delivery that focuses on development and life milestones rather than age lines based on the four life stages developmental model. This change will encourage a transition to recovery focussed care.

The recent National Mental Health Plan (2003-2008)³ suggests the need to create new platforms to improve access and care to young people between the ages of 12-25 and to forge new models of service delivery for this age range. CAMHS as part of the ACT Health Directorate’s Mental Health Justice Health Alcohol and other Drugs Services have adopted the ‘No Wrong Door’ approach to improve access for children and adolescents attempting to access CAMHS. In view of the national health agenda to align the 18-25 more closely with Children and Adolescent Mental Health Services, the current model of service delivery was reviewed and a model of care designed which includes young people up to the age of 25.

² Birleson p & Vance A.2007. Developing the youth model in mental health services. Australasian Psychiatry
2.0 MODELS OF CARE PROJECT PLAN

The Redesign Project was established to review and redesign the CAMHS Models of Care. It aimed to:

- Develop a MoC framework to include young people up to the age of 25 years.

Objectives of the project include⁴:

- Define some of the details and criteria for components of the service
- Focus on the patient flow and connections between service streams
- Mapping a CAMHS Service wide framework on service provision
- Utilising the redesign MoC to inform the design and building of the health infrastructure

Methodology

The following methodology was utilised in developing the CAMHS Models of Care:

1. Project Plan: Establishing the scope, governance and output of project.
2. Establishing the context: A brief review of the literature on best practice models and models of service delivery for children and young people’s mental health was undertaken.
3. Establishment of steering committee, working groups and consultation groups: A Steering committee established to oversee project. Working groups with relevant stakeholders and staff were organised to provide input into project.
4. Identifying current models of service delivery: A review of current existing service models identified.
5. Redesign future models of care: All available data collated from literature research and review of current existing service models analysed to identify key themes and underpin recommendations for future models of care.
6. Consultation with stakeholders: Consultation with staff, children and young people, carers and young people via working groups, consultation groups and patient stories.

Key motivators for the project:

- A National Health Agenda to align services for the 18-25 year olds closely to Child and Adolescent Mental Health Service.
- A Human Rights Commissioner review⁵ of the Bimberi Youth Justice System with a number of recommendations for Mental Health Services delivered within the detention centre.
- The Health Infrastructure Program initiatives for an Inpatient Unit identified in the Mental Health Services Plan 2009-1014.

Tasks which inform the project:

- Establishment of a Redesign Steering Committee
- Establishment of Working Groups

⁴ See detailed project work plan and time frames in appendix 13
⁵ ACT Human Rights Commission. 2011. The ACT youth justice system 2011: A report to the ACT legislative assembly by the ACT human rights commission. ACT.
● Fortnightly meetings of Working Groups to undertake project related tasks
● Monthly Steering Committee meeting
● Focus groups with staff
● Patient Stories Interviews\(^6\)
● Consultation with the identified consultation groups\(^7\)

**Governance**

The Redesign Project is overseen by the CAMHS Redesign Project Steering Committee which is chaired by the Executive Director of Mental Health Justice Health Alcohol and Drugs Service.\(^8\) Working groups comprising of staff representatives, key stakeholders were organised to bring a broad range of views for discussion and assist with developing good change management structures. Working groups that were set up included: Community, Perinatal, Early Psychosis, Inpatient, Cottage/DBT/Eating Disorders Program and Bimberi.

**Consultation Groups**

- Children and Young People’s Commissioner
- ACT Mental Health Consumer Network
- Carers ACT
- Staff Forums
- CAMHS Consultative Committee
- Representations from relevant stakeholders in the established working groups.

\(^6\) Patient stories analysis are in appendix 5

\(^7\) Further information on the consultation groups please see appendix 2

\(^8\) Information on the project governance is in appendix 1
3.0 CURRENT MODELS OF SERVICE DELIVERY

CAMHS is a program of the Division of Mental Health, Justice Health, Alcohol and Drugs Service within the ACT Health Directorate. CAMHS is divided into: community teams, inpatient (utilisation of the pediatric ward and AMHU), Early intervention Program, DBT Program, Eating Disorders Program, Perinatal Consultation Mental Health Service and the Cottage Day Program.

CAMHS provide mental health services to children and adolescents who have a moderate to severe mental health issue for children and young people aged 0-17 years of age. A range of services including community services, inpatient services (through existing wards/units) and specialty intensive intervention programs.

Currently, young people between 18-25 are being serviced by the Adult Mental Health Teams and the AMHU within the Division. These teams are divided in 4 regional centres in ACT namely, Belconnen, Woden, City and Tuggeranong. Access to either CAMHS or Adult Mental Health Teams teams utilises a ‘no wrong door approach’. Children and young people are typically referred by the following:

- GP
- Crisis Assessment Treatment Team (CATT)
- Carers/Family
- Self
- Other health professionals (eg. Private therapists).

3.1 INPATIENT/ACUTE SERVICES FOR CAMHS

CAMHS currently does not have a specific child and adolescent mental health inpatient unit. Children and young people access inpatient services via the pediatric ward at the Canberra Hospital (if under 16 years old) and the AMHU (if over 16 years). Access into the Inpatient Units/wards can occur through the MHAU within The Canberra Hospital or direct admissions from community teams to the pediatric ward.

A CAMHS Liaison Nurse is present at the MHAU to assess any children and young people under the age of 18 years old who present to the Emergency Department for mental health issues requiring assessment during business hours. After business hours the MHAU staff are responsible for assessing these children and young people. The CAMHS Liaison Nurse also provides consultation liaison services to the pediatric ward at the Canberra Hospital.

Crisis work is undertaken by CAMHS during business hours for both registered and unregistered children and young people up to 18 years of age by the relevant community teams if they are over 18. After business hours, this function is supported by the CATT.

3.2 COMMUNITY TEAMS

Children and young people are currently referred to Community teams via CAMHS Access by anybody. This is a centralised number that provides access to a Clinical Coordinators within the Community teams. Referrals are processed by clinical coordinators and assessments are booked in. CAMHS Community teams see children and young people aged between 5-18 who present with a moderate to severe mental health issues.

Comprehensive assessments, limited group programs and clinical management are provided by the CAMHS teams.

In addition, CAMHS has a sub-acute service in the Adolescent Steps Program (Step Up Step Down) called ‘STEPS’ which is a partnership agreement between the ACT Health Directorate and a Non Government Organisation-Catholic Care. Children and young people who reside at STEPS are in the subacute stage of their...
presentation and may be stepping up to or stepping down from hospital. A registered nurse is employed to provide clinical input to Catholic Care for children and young people who access CAMHS that are referred and reside within the STEPS Program.

### 3.3 THE COTTAGE

The Cottage is the Day program provided for young people who experience severe mental health issues who need assistance and are unable to function in their daily living. Referrals to the ten week program are accepted from the Community teams. The Cottage has a focus on therapeutic and education programs. After the 10 week program, the young person is either discharged from the service or referred back to the CAMHS Community Teams for ongoing management.

### 3.4 DIALECTICAL BEHAVIOURAL THERAPY

The CAMHS DBT Program is an intensive 22 week program that includes individual therapy, group program, consultation groups and phone coaching. Referrals to the program occur via the CAMHS Community Teams where a full DBT assessment is completed. Young people are accepted into the DBT Program or referral back to the referring Community Teams. The full DBT program includes: Individual therapy, Skills Group Program, DBT consultation and phone coaching. After the completion of the full program, children and young people are either discharged back into the community services/GP or to Community CAMHS Teams for ongoing follow up.

### 3.5 EATING DISORDERS PROGRAM

The Eating Disorders Program (EDP) sees people of all ages. Self referrals as well as referrals from GPs and health professionals are accepted and people who are referred do not need to have a diagnosable eating disorder. Current programs within the program include: group programs (day programs for the over 18 year olds, the severe and enduring, body image, carers group). People who access EDP who require inpatient admission is usually admitted interstate to a specialist Eating Disorders Unit or if under 18 years old to the pediatric ward which is a joint admission between the pediatrician and CAMHS psychiatrist.

### 3.6 PERINATAL CONSULTATION MENTAL HEALTH SERVICES

The Perinatal Consultation Mental Health Services accepts referrals from GPs, Community Teams and health professionals. Women who are within the Perinatal period (from conception to when the infant turns 1 year old) with a moderate to severe mental health issues are seen by the service. The service operates in a consultation model and does clinically manage Women referred. If ongoing management is required, these Women are referred to either CAMHS or the Adult Mental Health Teams for follow up.

### 3.7 EARLY INTERVENTION PROGRAM

The Early Intervention Program currently sees young people up to the age of 25 years old who are experiencing an early or emerging psychosis. Children and young people are referred to the program via CAMHS Community Teams or Regional Adult Mental Health Teams. The team utilises an assertive treatment model where young people are generally seen at their residence and their carers are provided with support and psychoeducation at a time most convenient. The service operates extended hours from 8:30 AM to 9:00 PM weekdays and 9:00 am to 5:30 pm on weekends and public holidays. The team currently only services the South side of Canberra.
3.8 BIMBERI YOUTH FORENSIC MENTAL HEALTH

Young people who are detained in the Bimberi Youth Justice Detention Centre requiring mental health input are seen by the Forensic Mental Health (FMH) Service within the Division of MJHADS. All young people who are detained in the Bimberi Youth Justice Detention Centre receive a mental health induction by FMH. If the young person is known to CAMHS, care is transferred FMH. The Bimberi Youth Forensic Mental Health Team does not clinically manage young people after their release from detention and these young people are referred to the CAMHS Community Teams or other NGO if ongoing support is required.
DIAGRAM 1.1 ADMISSION TO HOSPITAL FOR UNDER 18’S

- **Paediatric Outpatient**
  - Discussion with CAMHS Consultant on-call
    - Safety plan put in place with consumer and carer
    - Hospital admission?
      - NO
      - YES

- **Direct admission from Community**
  - Medically cleared?
    - NO
      - Review by CAMHS Assessment Liaison Nurse (business hours) or by CATT after hours
        - Treated at ED/ Paeds until medically cleared
        - Hospital admission?
          - YES
          - Review by psychiatric registrar
            - Discussion with consultant psychiatrist on call
              - Ward/Unit consultant agrees to accept young person
              - Book bed via bed management
              - Admission to hospital: Options include paediatric ward, 2N, AMHU
        - Refer back to community team/services
    - YES
      - YES

- **Young Person presents at the Emergency Department (TCH or Calvary)**
  - Safety plan put in place with consumer and carer
  - Hospital admission?
    - NO
    - YES

- **Section 309**

- **TCH and Calvary**
Consumer attends the Emergency Department (either with or without clinical manager)

Medically cleared?

YES

Treated at ED until medically cleared

NO

Consumer attends the Emergency Department (either with or without clinical manager)

Medically cleared?

YES

Seen at MHAU

Hospital admission?

YES

Review by psychiatric registrar

Discuss with consultant psychiatrist

Book bed

Admit to:
AMHU, 2N, or any ward in TCH

NO

Treated at ED until medically cleared

Refer back to community team/services
Referral received by Perinatal Mental Health Consultative Service (PMHCS)

Face to face assessment at TCH or phone assessment

Discussion at MDT

For PMHCS?

NO

No follow up provided

Refer out and provide feedback to referrer

YES

Follow up by PMHCS

Maintain contact for couple of weeks

Medication required

Nil medication required

See by PMHCS medical staff and clinician

Seen by PMHCS clinician

- Provide recommendations
- Mobilise supports
- Review by psychiatrist
- Short term therapy

Follow up by PMHCS
Referral from community teams

Assessment at the Cottage

Suitable for Cottage?

YES

On waitlist

Accepted to attend 10 week program

Clinical management by the Cottage

NO

Not suitable

Referral back to the community team

Continue to be managed by community team
DIAGRAM 1.5 REFERAL TO EATING DISORDERS PROGRAM

Referrals from anyone

Eating disorders assessment

For EDP?

YES

Suitable for service however does not wish to engage

Refer to private provider

NO

Accepted into program

Options include:
- Severe and enduring group
- Family based therapy
- Day Program
- Individual therapy
- Carers Group
- Body image group

Not suitable

Refer elsewhere
Referral from community teams

DBT assessment

For DBT

YES

On waitlist

Not on waitlist

Refer back to community teams

Manage by community teams

Allocated DBT therapist

NO

Allocate DBT therapist

Refer back to community teams
Anyone can refer

Initial assessment

Face to face assessment

Present at MDT

For CAMHS?

YES

Clinical management

NO

Refer out to other services and provide feedback
Diagram 1.8 Referral to Adult Community Mental Health Teams

- **Anyone can refer**
- **Initial presentation**
  - **MDT**
    - **Refer out**
    - **Appointment with psychiatrist**
      - **Face to face assessment**
        - **For clinical management**
          - **YES**
            - Allocate Clinical Manager
          - **NO**
            - Refer out
Referral from Inpatient Unit (2N, AMHU)

- Read file and make contact with inpatient unit
- Discharge from inpatient unit

Referral from community mental health teams and CATT

- Register with EIP
- Read file and make contact with referrer
- Book appointment with psychiatrist or psychiatric register

For EIP?

- YES Allocate clinical manager
- NO Refer back to referring team
Young person is detained in Bimberi

Induction completed by Forensic Mental Health Clinicians

For follow up by Forensic MH in Bimberi?

YES

Allocation of clinical manager from FMH in Bimberi

Liaise with CAMHS Clinical Manager (if one is allocated)

Psychiatric review by FMH Psychiatrist

FMH CM provides therapeutic intervention

NO

Monitoring by Forensic MH as required
DIAGRAM 2: CURRENT DISCHARGE PATHWAYS FROM CAMHS

DIAGRAM 2.1 DISCHARGE FROM PAEDIATRICS (UNDER 18)

For Discharge? NO → Ongoing treatment in hospital

YES →

Discharge planning involving multidisciplinary team at Paediatric ward, the young person and carer/family

Discharge summary completed by medical and psychiatric staff and sent to GP and CAMHS Community Team

Discharge

Options include:
- STEPS
- Home
- Other accommodation (refuge)
- Other specialist hospital
MDT review to discuss appropriateness for discharge

For discharge? NO → Ongoing review and management

YES →

Discharge discuss with consumer, family, and carers

Discharge meeting with relevant teams and services involved with consumer

Follow up arranged for consumer in the community

Medications arranged (if any)

Discharge plan completed and communicated to consumer, family/carer, and forwarded to GP and relevant team
DIAGRAM 2.3 DISCHARGE FROM PERINATAL CONSULTATIVE MENTAL HEALTH SERVICE

Discuss with consumer

MDT

Medical staff involved previously

Team leader discusses with medical staff

For discharge?

YES

Letter to GP and consumer, refer to other services as appropriate

NO

Medical staff not involved previously

Ongoing review and management

Refer back to Adult community mental health if clinically managed

Team leader discusses with medical staff

For discharge?

YES

Letter to GP and consumer, refer to other services as appropriate

NO

Medical staff not involved previously

Ongoing review and management

Refer back to Adult community mental health if clinically managed
Diagram 2.4 Discharge from Cottage Day Program

1. Psychiatric assessment

2. MDT review

3. For discharge?
   - YES: Transition back to school and or refer to other services for ongoing support
   - NO: Consumer still experiencing moderate to severe mental health issues and have reached goals of individual learning plan

4. Issues resolved and no longer moderate to severe

5. Consumer still experiencing moderate to severe mental health issues and have reached goals of individual learning plan

6. Refer to community team

7. MDT at community team

8. Accepted into community team?
   - YES: For clinical management
   - NO: Refer to other services
Consumer ready for discharge due to:
- no longer requires support
- no contact
- referred elsewhere

Discuss at MDT

Consent from consumer and or carer for closure

Complete relapse prevention forms and outcome measures. Send closure letter

Fax GP informing of closure and close from MHAGIC
Reason for discharge:
- Completed DBT Group Program and Graduation Group
- Missed 3 consecutive sessions

MDT Review

Ongoing mental health issues?

YES

Refer back to community teams

NO

Refer elsewhere
Case discussed at MDT - Overview of where things are at and discuss closure

For discharge?

Discuss with consumer, parents/carer of discharge

Inform services involved – through letter or verbally

Complete outcome measures

Refer to other services

Ongoing follow up and review
DIAGRAM 2.8 DISCHARGE FROM EARLY INTERVENTION PROGRAM

MDT Case Review

If ongoing support required from mental health services:
- Transitional handover period to Adult Community Mental Health Team
  - Complete all paperwork
  - Handover to Adult Teams

Episode resolved no longer required mental health support:
- Complete all relevant discharge letters and paperwork
  - Discharge to GP and/or other services
Youth Justice organises a case conference prior to young person being released from Bimberi.

Referral to other services in the community organised.

Medications (up to 7 days provided) and script provided by FMH.

Discharge back to community with relevant supports.

FMH provides 7 day follow up post discharge.
4.0 CAMHS FUTURE MODELS OF CARE

The Child and Adolescent Mental Health Service (CAMHS) will provide mental health care for young people up to the age of 25 years who are experiencing a moderate to severe mental health issue to ACT residents. The proposed future models of care for CAMHS was the collective work from working groups including an analysis of current models of care, a gap analysis and including evidence base and legislative requirements. It is anticipated that the future CAMHS will ensure enhanced integrated care across each of the different teams, location of services to facilitate seamless transitions, expanded service provision to include a focus on outreach, early intervention and health promotion. CAMHS will continue to utilise the ‘no wrong door’ approach meaning that children and young people who are referred to the service will not be turned away and if CAMHS is not the most appropriate service then efforts will be made to find the appropriate service. Services provided by CAMHS will include:

- Early Intervention
- Early Psychosis
- Outreach to other services
- Health Promotion
- Inpatient Services
- Consultation Liaison
- Perinatal and Infant Mental Health
- Eating Disorders
- Therapeutic Group Programs

Based on the services provided, it was identified that CAMHS be divided into 3 streams:

- Community
- Inpatient/Acute
- Specialty Services

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9 For information on the gap analysis completed see appendix 4

10 For a diagram of the proposed CAMHS Models of Care Framework see Diagram 3 on page 33
# 4.1 CAMHS PRINCIPLES

**Service Principles**

Service principles for CAMHS were identified by our working groups to identify principles of care for CAMHS. The Service Principles identified for CAMHS are:

<table>
<thead>
<tr>
<th>Service Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Timely access, no wrong door approach, appropriate environment, community aware of the services available, equitable, ensure there is a transitional and discharge plan, outreach is available</td>
</tr>
<tr>
<td><strong>Person &amp; family centred</strong></td>
<td>Recovery focused, recognition of family systems and person’s needs, takes into account cultural diversity</td>
</tr>
<tr>
<td><strong>Collaboration and continuity of care</strong></td>
<td>Services work together, collaboration with person and family, partnership between services, integrated care, community linkages, continuity of care</td>
</tr>
<tr>
<td><strong>Multidisciplinary</strong></td>
<td>Service will have a range of expertises and evidence based intervention, holistic care</td>
</tr>
<tr>
<td><strong>Recovery focused</strong></td>
<td>Person and family centred, empowerment, aware of rights and responsibilities</td>
</tr>
<tr>
<td><strong>Safety and quality</strong></td>
<td>Evidence based, ongoing development of services including staff development, safe environment for staff and consumers, achieves outcomes, accountability and working within scope of practice</td>
</tr>
</tbody>
</table>
The CAMHS principles identified by the working groups as part of the project are embedded into the CAMHS Models of Care. Examples include:

1. **Access**: Access to CAMHS utilises a no wrong door approach and has the ability to provide outreach. Care is provided in an appropriate environment and in an equitable manner and that discharge planning includes a transitional and discharge plan.
   - Access to CAMHS utilises a no wrong door approach. Children and young people and their carers will be provided with alternate referral options and reasons why CAMHS is not the most appropriate service for them.
   - CAMHS will provide timely access that meets the needs of children, young people and their carers.
   - Outreach to children, young people and their carers who are difficult to engage or who are in crisis will be provided ensuring that the needs and safety of children and young people are being met.
   - The environment of the services provided within CAMHS will be safe and comfortable for children and young people, carers and staff.
   - Discharge planning will include a discharge meeting with the child/young person, carer/family and relevant agencies.
   - The care provided by CAMHS will promote independence and recovery.

2. **Person and family centred**: There is recognition of the recovery framework which takes into account family systems, person’s needs and cultural diversity.
   - The needs of the child/young person and their families will form part of the assessment and treatment within CAMHS.
   - CAMHS will provide children and young people friendly environment.
   - The children, young person and their carers/families will receive support in navigating through CAMHS and to other services if CAMHS is not the appropriate service.

3. **Collaboration and continuity of care**: CAMHS will work in collaboration with children and young people, carers and relevant stakeholders to allow for integrated and continuity of care.
   - CAMHS will work in collaboration with children, young people, their carers including relevant stakeholder as part of treatment planning and review to ensure continuity of care.
   - There will be clear communication strategies between CAMHS, the child/young person, carer/family and nominated services to ensure quality of care and continuity of care.
   - CAMHS will participate in case conferences with other services.

4. **Multidisciplinary**: CAMHS will have a range of expertise, is holistic and will provide evidence based intervention.
   - CAMHS will offer a multidisciplinary approach of service delivery with a range of staff from different disciplines. Care will be provided in a holistic manner taking into account the biopsychosocial aspects of the person.
   - Professional support and training will be available to all CAMHS staff to allow for interdisciplinary collaboration to provide evidence based care.

5. **Recovery Focused**: Care is provided with a focus on recovery which empowers children and young people and their carers and they are aware of their rights and responsibilities.
   - Are person-centred, family focused and responsive to the unique characteristics of each person and their family, inclusive of age, gender, cultural and spiritual diversity.
   - Foster a culture of hope and empowerment, valuing respectful and therapeutic relationships and building on the strengths and resources of the person, their family and their community.
   - Promote autonomy, self-determination and awareness of rights and responsibilities.
   - Take a holistic approach to the planning and delivery of services, guided by the aspirations, priorities, needs and preferences of the person and their family.
   - Actively facilitate the development of genuine collaboration and partnership with the person, their family and others identified as important to the recovery process.
• Aims to promote physical, social and emotional wellbeing and maintain or develop connection to, and participation in, the communities and activities that are valued.

6. **Safety and quality:** The care provided will be safe and of sound quality, there is an ongoing development of services and staff are accountable for their actions and work within the scope of their practice.
   - Ongoing quality improvement activities will be provided to ensure the service continue to develop and improve
   - Staff have ongoing clinical supervision within their discipline of practice and ongoing support from their direct line management.

4.2 COMMUNITY TEAMS

This section provides information on the structure and functions of the community teams within CAMHS. The Community Teams within CAMHS will be provided in a centre North and Southside of Canberra. There has also been strong support recommendation for the whole of CAMHS to sit under one central location with teams divided into North and South. The rationale is to reduce the layers of seams across the service, to increase capacity across the teams and for information sharing across all staff within CAMHS.

The age range within CAMHS will be increased from the current 18 years old to 25 year old.

The CAMHS Community Team will include:

- Child Community Team (1-12 years old)
- Adolescent and Young Adult Team (12-25 years old)
- Step Up Step Down- Adolescent (13-18 years) and Young Adult (18-25 years)
- Bimberi Youth Forensic Mental Health (through Forensic Mental Health)

The division of children and young people in the above age group is appropriate given the needs of each different age group.\(^{11}\)

**Children and Young People Characteristics**

Children, adolescents and young people who experience moderate to severe mental health issues.

It was identified that a clear definition of moderate to severe can be difficult in the mental health context and that a framework should be conceptualised. Moderate and severe mental health issues were identified as:

- Not based on diagnosis
- Symptoms based
- Should be based on level of dysfunction and its impact on functioning
- Does not solely rely on a mental health diagnosis

**Access:**

Access into the Community Team will be via Access to CAMHS which is embedded within the Community Teams. Anybody can refer to CAMHS and once a referral is received by CAMHS a triaging process will occur

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and an initial assessment over the phone provided. If CAMHS is deemed as an inappropriate service, efforts will be made to link the person into the appropriate service. If further assessment is required, a full assessment will be offered with one of the Community Team clinicians in one of the assessments slots. Following the full assessment a multidisciplinary team discussion will occur to determine if CAMHS is the most suitable service.

4.2.1 CHILDREN’S COMMUNITY MENTAL HEALTH TEAM

This team will have a focus in providing specialist Children Mental Health services for children up to the age of 13. The recommendation is for this team to have two separate teams for the 1-5 and 6-13 year as the skills and knowledge for these age groups were different. Children between the ages 1-5 also display mental health issues differently to those age 6-13.

One of the main focuses for the Children’s Community Mental Health Team for the 1-5 year old is ‘comprehensive assessment’ including the child, family and parents and provides secondary consultation to other services or collaboration with other services. The service will provide secondary consultation to schools, other health professionals and medical professionals (GP and pediatricians). Clinical management to this age group will also be provided as required. Children 6-13 years who display moderate to severe mental health issues will be provided with a full assessment and clinical management and therapy. A number of evidence based interventions will be provided for this age group including: family therapy, group based therapy, individual therapy. This team will have a focus on the family systems and the interaction of and collaboration with other services to provide holistic care for children and young people.

4.2.2 ADOLESCENT AND YOUNG ADULT MENTAL HEALTH TEAM

This team will provide assessment, interventions and programs for adolescents and young people aged between 13-25. This team will form the interface between the two Step Up Step Down facilities, the provision of mental health services to detainees in Bimberi.

The current statistics is that children and young people in this age group are the hardest to engage and where development of significant mental illnesses arise innovative models to engage adolescents and young adult have been identified. A youth worker will be part of the community team to attempt to engage the difficult to engage young people into CAMHS for therapy. This youth worker will be part of the CAMHS Adolescent and Young Adult Community Team and engage in multidisciplinary team (MDT) activities. The use of youth workers in mental health services have been widely documented. Collaboration with other services for young people


with complex needs and assertive follow up (eg. Home visiting) will be part of the roles undertaken by this team.

Group based interventions including children and young people and carers will be provided by this team which may include relevant therapeutic groups (eg. Anxiety Programs).

**Step Up Step Down**

A clinician from the Adolescent and Young Adult Community Mental Health Team (also called as the SUSD clinician) will provide the interface between, the Inpatient Services, SUSD program and the CAMHS Community Mental Health Teams. SUSD programs are available for the interface between hospital and community life for Adolescents (13-17) and Young Adults (18-25). The SUSD facilities are managed by a Non-Government Organisation (NGO) in partnership with the ACT Health Directorate. The SUSD clinicians from CAMHS Community Teams will in collaboration with the NGO running the SUSD facility, assess children and young people who have been referred to the program and monitor the status and provide input for the NGO staff within the facility. The SUSD clinician will participate in multidisciplinary team (MDT) activities with the community and inpatient unit to ensure that communications across the two areas.

4.2.3 BIMBERI YOUTH FORENSIC MENTAL HEALTH

Mental Health services for young people will continued to be offered by the Forensic Mental Health Service within the Division of Mental Health Justice Health Alcohol and Drugs Service. To facilitate through care from Bimberi to the community, a CAMHS Bimberi Liaison Clinician will attend the Bimberi Services meeting on a weekly basis. This is to facilitate any referrals that need to be made for young people who are detained and not involved with CAMHS or for the discharge planning of young people who are known to CAMHS.

For young people who are known to CAMHS and are detained in Bimberi, the clinical manager will continue to provide support and therapy (whilst the young person is detained) and the Bimberi Psychiatrist and the young person’s community treating psychiatrist will liaise closely on treatment regimes. A Justice Health Enrolled Nurse will also assist with the through care of young people from Bimberi into the community and provide outreach to these young people who are considered in the most vulnerable stage post discharge from Bimberi.

4.2.4 SERVICE PRINCIPLES

**Person and family centred**

The CAMHS Community team will provide person and family centred care. CAMHS acknowledges that families are generally the main support and strength for children and young people when they present with mental health issues. Families and carers will participate in the decision making of their child and young person. A focus on recovery where the child and young person opinions and their perceptions on their recovery is valued. The CAMHS Community team will empower children and young people and their families through the care provided. Clinicians will support families and carers in their caring role and respect people from different cultural backgrounds including their values and belief systems. The involvement of children and young people, their carers and families in the planning, delivery and evaluation of the services will be provided throughout their involvement with CAMHS.
**Collaboration and continuity of care**

The CAMHS Community Teams will work in partnership with relevant stakeholders to ensure the best possible care for children, young people and their families and carers who access CAMHS. CAMHS will work with services who are engaged with the children, young people and families that access CAMHS through regular case conferences, telephone contacts/support and the invitation of these stakeholders to case reviews.

CAMHS participates in regular networking meetings with other community services ensuring that the relevant linkages community groups are up to date and that CAMHS is also aware of the services that are provided within the community in order to inform children, young people and their families of relevant supports available elsewhere.

**Multidisciplinary**

The CAMHS Community Team will be a multidisciplinary team including psychiatrists, psychiatry registrars, registered mental health nurses, psychologists (clinical and registered), social workers, occupational therapists and youth workers. The team will provide a range of expertises including (and not limited to): assessment of occupational function, standardised psychometric and occupational therapy assessments, evidence based psychotherapy, supportive counseling, medication management/review, family based therapy.

All relevant staff within the team will be registered under the Australian Health Practitioner Regulation Agency (AHPRA) and the Australian Association of Social Work with a range of evidence based intervention provided.

**Recovery Focused**

Recovery means different things to each person. According to the National Standards for Mental Health, recovery means: gaining and retaining hope, understanding one’s abilities and limitations, engaging in an active life that has value and meaning, sense of personal autonomy, positive sense of self. The Community Team within CAMHS will work in collaboration with the young person and their carer/families and other stakeholders, to identify their recovery goals and work on achieving these goals through different intervention strategies.

**Safety and Quality**

Within the CAMHS Community Team, evidence based interventions will be provided as part of the care package provided to children, young people and their family. The environment in which CAMHS is provided will be safe, children and young people friendly.

A high quality service will be offered through ongoing feedback from the children, young people, family/carers, and stakeholders and ongoing review and quality improvement activities within the service.

**4.2.5 CO-MORBIDITY STRATEGY**

CAMHS will provide a holistic and consistent approach in the management of young people experiencing both mental health and alcohol, tobacco and other drug (ATOD) problems. Consistent with the ACT Comorbidity (Mental Health and Alcohol, Tobacco or Other Drug Problems) Strategy 2012-2014 CAMHS will provide the following to young people with mental health and co-occurring ATOD issues:
• Young people who are referred to CAMHS will receive a Youth Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)\textsuperscript{14}.
• For young people who have been screened as mild to moderate ATOD issues and experiencing a moderate to severe mental health issues, brief interventions will be provided.
• Work collaboratively with Alcohol and Drug Services (ADS) in young people with severe ATOD issues.

Clinicians will be skilled in the provision of brief interventions for mild to moderate ATOD issues through further training and for more complex ATOD issues, for consultation with ADS.

\textbf{4.2.6 KEY PARTNERSHIP GROUPS}

CAMHS is committed to a collaborative approach to future service delivery. Collaboration will exist to facilitate the recovery of children and young people and the needs of their families/carers. CAMHS has a number of key partnership groups with both government and non-government agencies including Headspace, Alcohol and Drugs Service within the division of Mental Health Justice Health Alcohol and Drugs Service.

\textit{Headspace}

A clinician will provide outreach to Headspace to undertake assessment and interventions for children and young people whose presentation may have deteriorated however have not reached the threshold for a moderate to severe mental health issue. Headspace and CAMHS work in partnership with these children and young people and if the young person continues to deteriorate and further support is required a direct referral and allocation is made to the CAMHS Community Teams by the CAMHS Headspace Clinician.

\textit{Alcohol and Drugs Services}

For young people who present with mental health and alcohol and drug issues, CAMHS will have access and work in partnerships with the Alcohol and Drugs Service (ADS) of the Division. CAMHS and the Division’s dual diagnosis clinician and ADS can provide joint assessments for children and young people who present with mental health and alcohol and other drugs issues.

\textit{Catholic Care}

CAMHS works in partnership with Catholic Care in the provision of subacute services to children and young people who attend the Step Up Step Down Program (STEPS).

\textit{School Counsellors}

CAMHS will work collaboratively with school counselors including secondary consultation, working collaboratively with Department of Education to support young people in their schooling and health promotion to schools.

\textit{General Practitioners}

Ongoing involvement of General Practitioners, in the assessment and treatment of young people within CAMHS will continue. GPs will be provided of an update of the young person’s progress within CAMHS, including

\textsuperscript{14} Youth Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) screens all levels of problem and risky substance use. A risk score is provided at the end of each substance and scores are grouped into low, moderate or high risk.
outcome of assessments and discharge planning. Secondary consultation to GPs on complex mental health issues will be provided as ongoing CAMHS service delivery.
Referral to CAMHS from anybody

Referral triaged by CAMHS Access with initial assessment completed

- CAMHS?
  - Yes: Full assessment
  - No: Referrals to other services

  - Full assessment
    - CAMHS?
      - Yes: Offer clinical management or referral to speciality services (e.g., group based programs)
      - No: Referrals to other services

  - Present to MDT
    - CAMHS?
      - Yes: Discharge from CAMHS with support services in place
      - No: MDT Review

Discharge
**4.3 INPATIENT SERVICES**

Inpatient Services within CAMHS will provide inpatient care for young people age between 13-25 years of age within ACT. Children under 13 will continue to access mental health inpatient care via the pediatric ward at The Canberra Hospital.

Adolescents and young adults of the ACT currently do not have access to mental health beds specific to the meeting their clinical needs. The Mental Health Services Plan[^15] identified the need for dedicated acute mental health beds to meet the needs of the adolescent and young adult population.

**Adolescent and Young Adult Mental Health Inpatient Unit (AYAMHIU)**

Initial Models of Care development for Inpatient Services within CAMHS has highlighted the need for the services to be located on the TCH campus so the unit retains close service integration with the pediatric service and the Acute Adult Mental Health Unit. An analysis of the current supply and demand for inpatient beds for children and young people up to the age of 25 have been completed.[^16] This demand has been incorporated into the planning brief of the proposed Inpatient Unit.

A multisystem and a multidisciplinary approach to care will be utilised for the unit. The unit will provide short term treatment in a safe and therapeutic environment to enable to focus on their recovery plans/goals. Medical, social and psychological approaches to managing symptoms and education for the young person, family and carers about their mental health and recovery will be part of the services provided.

**Young People Characteristics**

The Inpatient Unit will provide inpatient care to young people ages between 13-25 who are:

- At risk of suicide and are unable to keep themselves safe within the community
- Presenting with a severe psychotic episode or severe mood disorder where a lesser restrictive option is not appropriate
- Treatment resistant and a supportive environment required due to medication complications (eg. Young person coming off clozapine or on numerous psychotropic medications and change required in supportive environment)
- Are on orders under the Mental Health Act

**Mother and Babies**

Women and their infants who require hospital admission due to perinatal mental health issues will access the Adult Mental Health Unit in the vulnerable persons area or Ward 2N at the Calvary Hospital.

**Developmental vs. Physical Age**

There will be times when young people who are of a certain age may behave developmentally differently than their physical age. In these circumstances discussions will occur on which inpatient area will be most appropriate for young person. This will be done in consultation with the relevant unit consultants, carers and the young person.

[^15]: ACT Mental Helath Services Plan 2009-2014
[^16]: Further information on the supply and demand for inpatient beds see appendix 7
Web Management System

A web based bed management tool has been developed by the Division of Mental Health Justice Health Alcohol and Drugs to provide a ‘snapshot’ on all mental health beds (acute and subacute) within the Division for patient flow coordinators. A decision for hospital admission will be made in collaboration with the young person, carer, psychiatrist and clinical manager. Once a decision for hospital admission is made, an inpatient bed will need to be booked via the patient flow coordinator of the division who has access to the web based bed management tool. If a hospital bed is unavailable in the Inpatient Unit, the patient flow coordinator will be able to provide further information on vacancies in other areas such as the Step Up Step Down Programs or other Inpatient Units (eg. 2N or AMHU).

Access:

Access\(^1\) for young people to the Inpatient Unit will be via a number of pathways including:

- Via the Emergency Department (Calvary or TCH)
- Directly from the CAMHS Community/Specialist Teams/Programs
- Direct transfers from other hospitals

Via the emergency department:

Young people who are to be admitted to the Inpatient Unit can be assessed at the Emergency Department via the Mental Health Assessment Unit (MHAU). Children and young people arriving at the Emergency Department may be referred from GP, school counselors, other health professionals. An assessment will be completed by the CAMHS Assessment Liaison Nurse or the Assessment Team after hours. If the decision for hospitalisation is required, a review by the psychiatric registrar will be required to proceed. Once the psychiatric registrar completes the assessment and determines that hospitalisation is required, a discussion with the consultant of the unit occurs and a decision is made for hospitalisation. Relevant physical check ups and paperwork will be completed for the admission to progress.

Young people will be transported from the Emergency Department to the Inpatient Unit if a direct link from the hospital to Inpatient Unit is not established at the completion of the unit.

Directly from the CAMHS Community Teams:

Young People who are assessed at the CAMHS Community Teams or Specialist Programs can be admitted directly into the Inpatient Unit. Children and young people will need to be assessed by a CAMHS psychiatrist who makes a decision on whether hospitalisation is required. Once a decision is made regarding hospitalisation, the CAMHS community psychiatrist will liaise with the inpatient psychiatrist regarding admission and a bed can be booked via the Patient Flow Coordinator. The young person and/or their carer will then make their way directly to the Inpatient Unit.

\(^1\) Access for consumers to the Inpatient Unit will be via the pathways indicated. See the Access points in the Inpatient Unit workflow diagram in Diagram 5 on page 49. Information on physical space based on the Workflow Diagram is in Appendix 14 on page 80.
Transfer from other wards within TCH/Calvary Hospital:

Young people can be directly transferred to Inpatient Unit from other wards within TCH or Calvary Hospital. If a young person is deemed requiring an acute mental health admission following medical clearance, an assessment will be required from CAMHS Assessment Liaison Nurse and/or Consultation Liaison. If admission is required the psychiatrist will liaise with the inpatient consultant and a bed booked via the Patient Flow Coordinator.

Direct transfers from other hospitals:

Children and young people who are inpatients from other hospital can be directly admitted into the Inpatient Unit following referral from the relevant hospital.

Arrival/assessment/treatment initiation

When the young person arrives at the Inpatient Unit, they will enter via reception. For children and young people who are on Mental Heath Orders entry can be via the back of unit into the assessment area. Once the young person arrives at unit, they will be accompanied to the assessment area where the admission process including orientation and rights and responsibilities are completed. It is at this time, if a young person has not been physically examined, a psychiatric registrar will complete a physical examination.

The adoption of front of house and back of house philosophy to allow for safe and discreet transport of young people, delivery of supplies and staff resources separate to the public entry to the unit is required. Clear signage for both areas and secure access to the back of house entry will occur within the Inpatient Unit.

Upon arrival, the young person will be involved in a nursing assessment where basic admission paperwork is completed. The young person will then be involved in completing their recovery and de-escalation plan.

Stabilisation

Once all basic admission process is completed, the young person will be reviewed by the psychiatrist in the next ward round (can be the next day depending on when the young person has been admitted into the unit).

Treatment Planning

Treatment planning will occur via the multidisciplinary team ward round, where a discussion will be made on the therapeutic options available. This is a discussion that will occur with the team/young person/carer. If a clinical manager is involved within the community, they will attend the unit to assist with treatment planning and support.

Treatment Engaging

When within the unit, the young person will be allocated a nurse who will ensure that daily reviews are completed, that the young person is on track with his/her therapeutic activities. Specific allied health staff will provide the relevant therapeutic activities. The young person’s clinical manager will also attend the unit to provide support.

Consumers can enter the AYAMHIU via reception or back of the unit if on a Mental Health Order or accompanied by police.
**Review Process**

Children and young people will be reviewed at a multidisciplinary team ward round twice a week. This is when the young person’s clinical manager, the treating team within the unit comes together in conjunction with the young person/carer and relevant stakeholder around the progress of the young person. Areas of review will include current mental state, psychosocial status and medications. Relevant agencies can be invited to this multidisciplinary team ward round as required (eg. youth worker, school counselor) or if consent is obtained.

Daily review by the nurses and psychiatrists will occur as part of ongoing management and therapeutic planning for the young person.

**Therapeutic Interventions**

A number of therapeutic interventions will be provided at the unit. Structured activities and therapeutic interventions will form part of the Models of Care for the Inpatient Unit. The design of the therapeutic program at the unit will utilise a strength based and will have a recovery oriented approach. Therapeutic programs that will be provided at the unit include:

- Allied Health support - outsourced from the Canberra Hospital or within the unit
- Therapeutic programs - eg. sensory modulation, stress management etc
- Schooling (via the PATCH school)
- Vocational support/Centrelink
- Housing/ Accommodation support
- Creative arts therapy
- Physical activity - eg. gym
- Internet usage
- Visits from friends/families/other workers
- Individual therapy with clinical manager
- Visits from Public Advocate
- For older young people (18-25 years) to attend some therapeutic activities at AAMHU

**Discharge Planning**

Discharge Planning will occur from when the young person is first admitted into the unit. This will include liaising with relevant stakeholders, clinical managers, the young person and carer. Proper discharge planning is around promoting continuity of care for young people within the health system. There will be daily reviews by the nurse on unit and psychiatrist.

**Paediatric Ward**

Children 12 years and under who require admission to hospital for mental health reasons will be admitted to the paediatric ward. Admission to the paediatric ward will be a joint decision between a CAMHS consultant psychiatrist and a consultant paediatrician.

Children and young people who are admitted into the paediatric ward for medical reasons and a mental health issue will have access to CAMHS support via the CAMHS Consultation Liaison clinician. After medical stabilisation of the young person and a mental health admission is required, this will be arranged with the CAMHS consultant psychiatrist and a bed booked via the Patient Flow Coordinator.
Consultation Liaison

CAMHS will provide consultation liaison to the paediatric ward for any mental health concerns of current inpatients within the ward.

### 4.3.1 SERVICE PRINCIPLES

**Person and Family Centred**

The Inpatient Unit will provide person centred care. Young people admitted to the Inpatient Unit will have the right to timely and ongoing information about their health status, treatment strategies and the services that are available to them.

Treatment to young people will be provided in the least restrictive environment, guided by principles of recovery. Young people who have mental health issues are entitled to the same human and legal rights as any member in the community as required under the Human Rights Act, 2004 the Mental Health Treatment and Care Act 1994.

Each person is an individual with rights to respect, dignity and privacy. Cultural and gender sensitivity is required for young people who identify with various cultural and/or ethnic groups or have diverse family and social networks, educational backgrounds, religion, belief systems or socio-political views. The Inpatient Unit will have the capacity to meet cultural, gender and spiritual needs of young people.

**Collaboration and Continuity of Care**

There will be clear communication pathways between the Inpatient Unit, the young person and their family, other inpatient services, CAMHS Community Mental Health Teams, relevant government and non-government organizations to ensure collaboration and continuity of care.

**Multidisciplinary**

A flexible and integrated multidisciplinary staffing model will enable staff to rotate between the adolescents and young adult section within the unit.

The Inpatient Unit will offer a range of therapies by a range of disciplines including staff specialists, registered nurses, and allied health. Allied health services such as dieticians and physiotherapists will be sourced from The Canberra Hospital. Social workers, psychologists and occupational therapists will form an allied health team in the unit providing a range of interventions.

The team will work collaboratively and participate in the multidisciplinary ward round in reviewing the progress of young people within the unit.

**Recovery Focused**

All health professionals, community agencies and nominated support people involved with the young person during their recovery journey participate in planning and implementation. There will be clear communication pathways between Inpatient Services, the young person and their family, other inpatient services, community mental health teams, young person and carer organisations and community based services to ensure continuity of care and quality collaboration.

When a young person is admitted into the unit, a recovery plan will be completed. The aim is to establish systems and supports in place in assisting the young person in their journey of recovery by offering a range of
flexible and diverse range of service options within the unit to suit the young person’s and their family/carer needs.

**Safety and Quality**

In the Inpatient Unit, the physical environment will be safe for children, young people and their families. The therapeutic requirements and facilitate a feeling of safety with good visibility, logical flows and comfortable young person facilities and waiting areas that are designed to promote recovery.

A high quality service will be offered through ongoing feedback from the children, young people, family/carers and stakeholders. There will be ongoing review and quality improvement activities within the Inpatient Unit and staff will have up to date information on the mental health issues and interventions that affect children and young people.
Client attends ED

Client attends CAMHS

Client is an inpatient at the paediatric ward or any ward at TCH

Client attends CAMHS

Client is transferred from another hospital

Client is triaged by ED nurse

Client waits at ED

Client or carer goes to MHAU or is allocated a bed within ED

Client is reviewed by the CAMHS Ax Liaison Nurse or MHAU Ax team

Client is reviewed by psychiatrist

Hospitalisation required?

YES

Client receives a medical work up if not previously done at ED

Client is accompanied to room (can be LDU or HDU depending on assessment, ARC or CRA status)

Client’s MH status is reviewed as part of this process

NO

Hospitalisation required?

YES

Client receives medical work up by medical doctor

Client goes to unit

Client is given an orientation to the unit with rights and responsibilities

Client participates in a nursing assessment with a recovery plan and de-escalation strategies involved

Client is involved in an MDT ward round which includes a doctor, nurse, allied health and any other relevant workers

Client’s MH status is reviewed as part of this process

NO

Safety plan put in place and client returns home; options include SUSD

For discharge?

YES

Client engages in planned therapeutic activities

Client is reviewed daily by a nurse and a psychiatrist (move between LDU and HDU as per assessment)

Client takes prescribed medication daily or as required

Options include: School Visitors (friends and family) Clinical manager visit MHAU activities Creative arts Drug and Alcohol Intervention Access to Internet Therapeutic programs Physical activities

NO

Client collects belongings

Client attends discharge meeting which includes CM and relevant stakeholders

Client is discharged. Options include: SUSD, refuge, home

Client is reviewed by Calvary CL or CAMHS Ax Liaison

Client is reviewed by CL and/or psychiatrist

Client is visited by the PA (if under 18)

Client is reviewed by a CAMHS psychiatrist

Client is assessed by the clinical manager

Client attends ED

Client attends CAMHS

Client is an inpatient at the paediatric ward or any ward at TCH

Client attends CAMHS

Client is transferred from another hospital

Options include: School Visitors (friends and family) Clinical manager visit MHAU activities Creative arts Drug and Alcohol Intervention Access to Internet Therapeutic programs Physical activities
Specialty services that will be provided within CAMHS include:

- Perinatal Consultation Mental Health Service
- Specialty Day Programs
- Early Intervention

Access

Access into the 3 specialty services within CAMHS is via CAMHS Access. For the Perinatal Consultation Mental Health Service, referrals are accepted from anybody and a phone screening will be provided by one of the staff from the Perinatal Consultation Mental Health Service.

The Early Intervention Program and Specialty Day Programs will remain as tertiary services where referrals are taken from the CAMHS Community Teams via CAMHS Access.

4.4.1 EARLY INTERVENTION

Mental health promotion and early interventions are an essential component of an evidence-based child and adolescent mental health framework. It is the early identification of people with emerging signs and symptoms of mental health problems and mental disorders to enable timely, effective and appropriate treatment in order to prevent diagnosable illness and reduce the disability associated with symptoms.

The Early Intervention Team will provide assessment, consultation and health promotion for young people up to the age of 25 presenting with a range of mental health issues in the early stages. The teams will be divided into the 1-12 and 13-25 as per the community teams due to the different developmental issues and needs required for the above two age groups. This team will provide the following functions:

- Specialist Early Psychosis Service - based on EPPIC Guidelines
- Health Promotions Officer
- Behavioural Interventions Program
- Early Identification and treatment of children and young people presenting with early mental health issues

Health Promotions Officer

The Health Promotions Officer will provide health promotional activities to relevant community agencies to increase awareness of mental health issues to populations most in need.

The role of the Mental Health Promotions Officer will be:

- Provides education and training sessions for schools, other elements of the education system and health and welfare sector and the general community
- Organises other education where requested
- Provides information and resources on mental health issues
- Works collaboratively to develop and implement mental health promotion programs
- Offers consultation to the health, welfare and education sectors
The team will provide assessment and early intervention sessions to complement primary care with GPs, Community Child and Family/Youth Health. Strategic partnerships with stakeholders, conducting collaborative group programs,

**Behavioural Intervention Program**

Conduct problems affect around 3% of young people (Sawyers, et al, 2000). Data from well-controlled studies indicates that the optimal management of conduct problems in children needs to be based on an early intervention strategy, which emphasises the role of parent-child interaction factors in the development of conduct disorders. There is growing evidence that suggests added benefits when child-focused and school-focused interventions are included (Sanders, M.R. 2000).

The Behavioural Interventions Program will provide early intervention through group programs within schools (by the Health Promotions Officer) for early identification and management of young people presenting with conduct issues. A range of evidence based interventions will be provided including child focused, parent/family sessions and school based interventions. The provision of these services can be done in collaboration with other services such as Child and Family Centres, School and other Non-Government Organisations.

**Early Psychosis Services**

The 13-25 age group within the Early Intervention Program will provide specialist Early Psychosis Service for young people aged 13 to 25 presenting with an Early Psychosis. Early Psychosis is defined within the Clinical Practice Guidelines for Early Psychosis\(^1\) as:

‘While there is no single authoritative definition of early psychosis it clearly has an onset focus. It includes the period described as the prodrome and is also considered to include the criteria period up to five years from entry into treatment for the first psychotic episode.’

The Early Psychosis Team will provide assessment, treatment to young people up to the age of 25 who present with an early psychosis. This will include the screening of young people who are presenting with symptoms suggestive of an early psychosis and providing community education and partnerships to increase awareness of the signs and symptoms of psychosis. Comprehensive therapeutic programs will be provided as the care package including a range of medical, psychological and psychosocial interventions.

The service will operate extended hours with two shifts undertaken by the staff—the initial shift from 8:30-17:00pm and the second shift from 10:30-19:00 Mondays to Fridays. This is to allow for staff to offer after hours home visiting to young people and their families/carers who work.

Key components of the service will include:

- Community education and awareness
- Easy access to service
- Assertive treatment model including mobile outreach
- Access to youth-friendly inpatient care (through the Adolescent and Young Adult Mental Health Inpatient Unit)
- Continuing case management

\(^{1}\) Australian Clinical Guidelines for Early Psychosis. 2010. Orygen Youth Health Research Centre, 2\(^{nd}\) edn. Parkville.
- Psychological interventions
- Medical interventions
- Functional Recovery Programs (through Day Program within the Specialty Program)
Referral from Community Teams/ CAMHS Access

Early Intervention Assessment (early psychosis, behavioural, early intervention)

Present at MDT

For Early Intervention?

Yes

Clinical management and interventions provided

Ongoing review by Clinical Manager

No

MDT Review

Discharge?

No

Referral to other services or back to community teams

Yes
4.4.2 SPECIALITY DAY PROGRAMS

The Specialty Day Programs will provide specialist programs for children and young people who access CAMHS. The specialist day programs will have the following functions:

- Specialist assessments and programs (eg. Eating Disorders)
- Family based therapy/programs
- Clinical Management
- Dialectical Behavioural Therapy
- Opened and Closed groups

Young People Characteristics

Children and Young People who access CAMHS and have a severe and enduring psychological issue and are no longer able to function in the community and require intensive support.

Specialist assessments/programs

The Eating Disorder Program will sit under the Day Program stream and will provide services to people of all ages who have eating issues. Services provided are:

- Comprehensive eating disorders assessment
- Individual Therapy
- Family based therapy/programs
- Group therapy- eg. carers group, the severe and enduring group, day program

Inpatient services in the future will be provided by the INPATIENT UNIT with collaboration with medical officers (eg. pediatrician or others). The child or young person will need to be medically cleared before they are able to be admitted into the INPATIENT UNIT.

Dialectical Behavioural Therapy

The DBT program provides a full DBT program to young people between 13-18 and in future 18-24. The full program includes: individual therapy, group program, consultation group and phone coaching. The proposal is that when CAMHS extends its age group to 25, that a separate young adult DBT group is established. This will mean that further resources will be required to undertake the additional referrals that may arise from this.

DBT is seen as an important skill for clinician to have in the treatment and engagement of adolescents and it was recommended that a FTE is rotated into the DBT program every 12 months so as that the skill is transferred across the CAMHS community teams.

Open Group

The open group will be for children and young people who may require intensive support post discharge from hospital, from the Step Up Step Down Program or who are currently not able to engage in a closed group program. This group program is to provide children and young people with intensive support post discharge from hospital or where short term intensive support is required. The open group will provide supportive group programs with a focus on life skills and some therapeutic activities.

Closed Group

The closed group program will be for children and young people who are referred to the Specialist Day Program for a period of one term who are experiencing difficulties in their daily life due to a severe and
persistent mental health issue. The Group programs are structured into 3 streams: 1. Therapeutic 2. Educational 3. Life Skills. The day program has an educational component with the view of transitioning adolescents back to full time schooling. Clients who are referred to this closed group are clinically managed by Cottage staff for the duration of their term and referred to other services or back to the CAMHS Community Team after the completion of the program.
Referral from Community Teams/ CAMHS Access/ AYAMHIU

Assessment

Day Programs?

Yes

Identify which group to attend based on presentation

Attend group programs

Ongoing review by Clinical manager and MDT

Discharge?

No

Refer back to referring team for ongoing follow up and support

Yes

Refer to other services for ongoing support or to Community Teams
4.4.3 PERINATAL AND INFANT CONSULTATION MENTAL HEALTH SERVICE

The PMHCS will provide consultation, assessment and brief intervention for women across all ages and their infants during the perinatal period.

Consumer Characteristics

Women during the perinatal period who present with a moderate to severe mental health issue and their infants. The Perinatal period is defined as conception and up to 12 months postnatal.

Services provided

The following services will be provided by the service:

- Assessment of the mother, infant and family system
- Short term/brief interventions
- Mobilising supports for the person and family
- Collaborative group programs with stakeholder agencies

In order for the service to provide assessments for infant up to the age of 1 year old, it was recommended that a Perinatal and Infant Mental Health Advisory Group is being set up with the focus of mapping services for mothers, babies and families and increase the collaborative work for these children or young people and their families. People seen within the Specialists Programs will have access.

4.4.4 SERVICE PRINCIPLES

Person and Family Centred

The Specialist Programs within CAMHS will provide person and family centred care through the involvement of family systems. CAMHS Specialist Programs will provide person and family centred care through partnerships involving the child, young person, women in the perinatal period and their families/carers in their treatment planning and review. The program will build on individual and family strengths and respect the values, beliefs and cultural diversity of the person and their families.

The Specialist day Programs will offer family based programs in recognising the roles family have when a young person is experiencing a mental illness. The Day Programs will work with in collaboration with the young person and their family in a recovery framework in identifying their goals for recovery. The Early Intervention Program will work with children, young people and their families/carers in the treatment of a range of first onset disorders. This includes the provision of a range of different therapies and interventions to meet the needs of the child, young person and their family. The Perinatal Service will work with women, their carers/family and their infants in identifying the needs and support for the family.

Collaboration and continuity of care

CAMHS Specialist programs will work with a number of different agencies and teams to provide a holistic range of services for people accessing the service. CAMHS Perinatal Service will engage in the Perinatal and Infant Mental Health Network and work in collaboration with other services to provide specialist group programs for Women and their infants during the perinatal period.

Recognising the educational needs of children and young people, the Specialist Day Programs will work in collaboration with the Department of Education and a range of Non-Government Organisations in the delivery of group programs. The Perinatal Service will work in collaboration with a range of services in providing group
based programs to women, their families and infants who access the service. There will also be collaboration between the antenatal clinic and maternity and child health nurses in the delivery of mental health services for women and their infants. The Early Intervention Program will collaborate with a range of different services to provide psychosocial support and services that are identified by the young person in which they have been working with.

**Multidisciplinary**

The CAMHS Specialist Programs will offer a multidisciplinary approach to the delivery care to people who access the service. The Early Intervention Program will offer a range of different interventions and services through CAMHS programs to provide an integrated mental health services. These include group based programs, collaboration with non-government agencies in psychosocial support and the invitation of services to participate in reviews to promote continuity of care.

**Recovery Focused**

Promoting recovery starts from a strengths-based perspective. It aims to empower people by offering opportunities and tools that enable them to identify what works in their life, what gives them purpose, satisfaction and meaning. The focus of recovery is not purely on symptom reduction. It is about working together: a clinician and the person experiencing mental health issues; to promote understanding of the person’s experience and develop a plan to assist them in achieving their goals. The CAMHS Specialty Program will work in collaboration with the person, their identified supports, families and carers to delivery recovery focused services and interventions.

**Safety and Quality**

The care provided CAMHS Specialty Programs will be evidenced based and compliant with national and relevant legislation and standards and/or recognised best practice. There will be a coordinated and standardised approach to safety.
Referrals from anyone

Initial assessment via phone

Perinatal

- Full assessment involving Woman, infant & Family/Carer.
- Identify attachment issues

MDT

Perinatal

- Short term support
- Medication management
- Collaborative group programs

MDT

Discharge?

Yes

Refer out to supporting services

No
5.0 CARER ENGAGEMENT

The inclusion and engagement of carers is essential in the delivery of mental health services to children and young people within CAMHS. The engagement of carers is identified in the National Standards for Mental Health Services 2010 (Standard 7). Carers will be provided with information and education around their caring roles, general psychoeducation about mental health issues and treatments, support services available and strategies to care for these children or young people. The Assessment of Carer Needs will be provided within CAMHS to ensure that the identification and the effective support of carers are completed.

CAMHS will maintain ongoing engagement with carers in the delivery of care to children and young people. The care packages to carers can include:

- Assessment of carer needs
- Information on treatment plans
- Process of hospitalisation
- Orientating carers to their rights and responsibilities
- Seeking support for carers and referral to carer specific services (eg. Carers ACT) and information on how to contact these services
- Psychoeducation
- The inclusion of carers in discharge planning and review

If the young person withdraws consent for the involvement of carers, staff can continue to work with carers in providing non-personal information (National Standards for Mental Health Services 7.9 - The MHS provides carers with non-personal information about the consumer’s mental health condition, treatment, ongoing care and if applicable rehabilitation) and listening to the concerns of the carer that may aid in the treatment planning and recovery of the young person.

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20 National Standards for Mental Health Service 2010- Commonwealth Government of Australia

6.0 SERVICE RELATIONSHIPS

CAMHS will offer an integrated mental health service in the proposed future models of care. The integration of the delivery of mental health services have been well documented.\(^2^2\)

The three service areas within CAMHS will work together in providing the best care for children and young people accessing CAMHS. Current mental health programs are lined with a range of different services (eg. Alcohol and Drugs Service) and utilise a multidisciplinary approach including social workers, mental health nurses, psychologists, occupational therapists and psychiatrists. Clinicians within CAMHS will work collaboratively when young people require services from other providers or areas.

As an integrated mental health service, CAMHS will work collaboratively with all other areas within CAMHS (eg. Specialty services and inpatient services) to provide the best practice interventions for children and young people. If children and young people who access CAMHS require service that are not limited to the CAMHS Community Team (eg. Group based programs), clinicians will work together collaboratively. A coordinated management system between inpatient care and community will form part of the work within CAMHS. This includes, clinical managers and community treating doctors actively involved in the care of the child or young person whilst in the inpatient setting. Inpatient staff will also be actively involved in collaborating with community services to commence discharge planning at admission utilizing a collaborative approach with all service providers (internal and external).

7.0 RESOURCES REQUIRED FOR MODELS OF CARE

There will be resource implications in the implementation of the MoC framework identified in this document. The Mental Health Clinical Care and Prevention Model (MH-CCP) from NSW was utilised to populate resource (staffing) predictions for the CAMHS Redesign Project.

**Budget**

An analysis of the budget required to implement the redesigned CAMHS Models of Care will need to be completed.

**Environmental Requirements**

Work will need to be undertaken around the environmental requirements to implement this MoC to include the up to 25 age group in the community setting. Options include:

- Community Health Centres across the different geographical areas have designated Mental Health areas for children, adolescents, and young adult.
- Centres within Canberra (eg. University of Canberra?)

**Workforce**

Additional workforce will be required especially within the Adolescent and Young Adult Mental Health Inpatient Unit and the Early Intervention Specialty Program to include children or young people with Conduct Disorders and Mental Health Promotion Officers. In 2011-2012 the full time equivalent staff within CAMHS is 35.6. According the MH-CCP and taking into consideration the resource prediction for servicing children or young people up to the age of 18 with moderate to severe mental health issues is 31.1 FTE which includes children or young people within the community teams, consultation liaison, and post natal depression services. The MH-CCP provides a comprehensive ‘snapshot’ of the FTE required to undertake the work in this MoC Framework.

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23 The MH-CCP was utilised to populate workforce predictions of the proposed CAMHS Models of Care framework. For information on workforce predictions see appendix 12.

24 Please refer to CAMHS Establishment data on Appendix 9.
APPENDIX 1: PROJECT GOVERNANCE

CAMHS Redesign Steering Committee Members

- Executive Director, Mental Health Justice Health Alcohol and Drugs Service
- Operational Director, Child and Adolescent Mental Health Service (CAMHS)
- Clinical Director, Child and Adolescent Mental Health Service (CAMHS)
- Team Leader, CAMHS Northside
- Team Leader, CAMHS Southside
- Team Leader, CAMHS Eating Disorder Program
- Team Leader, CAMHS Cottage
- Team Leader, CAMHS Perinatal Consultative Mental Health Service
- Policy Officer, Mental Health Policy Unit
- Aboriginal Liaison Officer, Mental Health Justice Health Alcohol and Drugs Service
- Clinical Manager, Mental Health Justice Health Alcohol and Drugs Service- Adult and Older Persons Mental Health
- Director, Access and Improvement Program
- Carer Representative
- Consumer Representative
- Consumer Representative, Mental Health Justice Health Alcohol and Drugs Service
- Assistant Director of Nursing, Pediatrics, The Canberra Hospital and Health Services

Working groups Committees

- Bimberi
- Community
- Inpatient/Pediatric
- Early Psychosis
- Perinatal
- Cottage/DBT/EDP
APPENDIX 2: STAKEHOLDER CONSULTATIONS

A number of consultation groups were set up as part of this project. Consultation groups included:

- Carers ACT
- ACT Mental Health Consumer Network
- Children and Young People through the Office of Children and Young People’s Commissioner
- CAMHS Consultative Committee

Relevant service providers and stakeholders are also represented in the Working groups or Consultation Groups of the CAMHS Redesign Project:

- Care and Protection Services
- Youth Justice
- Therapy ACT
- Child and Family Centres
- Catholic Care
- Australian Federal Police
- Alcohol and Drugs Services
- School Youth Nurse
- ACT Division of GP
- Community Services Directorate ACT
- Justice and Community Safety Directorate
- Consumer Representation
- Pediatrics at The Canberra Hospital
- Youth Coalition
- Department of Education
- Mental Health Coalition
- Alcohol and Drug Services
- Marymead
- Bernardos
APPENDIX 3: ANALYSIS OF CURRENT MODELS OF SERVICE DELIVERY

INPATIENT

Strengths

- For pediatrics people seen are usually appropriate clients
- Able to provide direct admission
- Adult system has to come in with a case manager
- Full assessment must be done in 6 months (adult)
- The 2 consultant teams work well together
- Staff are fantastic – dedicated group
- Accurate diagnosis

Weaknesses

- Number of beds
- Not having a case manager
- Lack of differentiated HDU space
- 4A & 4B wards lumped together
- Not capturing mental health patient load
- Lack of clarity for pediatrics vs. mental health clients
- Mental health clients being co-located with medical clients
- Lack of consistency between consultant to consultant teams
- Mental Health clients being admitted under pediatrician
- Sub therapeutic environment
- Lack of Multidisciplinary team engagement
- Too many pathways for admission

Opportunities

- Liaison between CAMHS and pediatrics,
- Between collaboration between services
- Collaboration for bed management

Barriers

- Time
- Staff training across disciplines

Issues:

- Specialising of mental health clients – massive costs
- Ability to manage Mental Health patients in ideal way is not being able to be met
- Meeting national benchmarks are not able to be complied with
- Need to look at current model and gaps with the move to new Women’s and Children’s Hospital
- Need to clearly define admission criteria
PERINATAL CONSULTATION MENTAL HEALTH SERVICE

**Strengths**

- Flexible and open
- Forms easy to use
- No wrong door approach
- Consultation with GP as part of referral process
- Consultation to people who ring,
- Once you make a referral who are contacted
- People can find forms online
- Easy access

**Weaknesses**

- Moderate to severe mental health problems (what does it mean)
- Lack of knowledge on Perinatal medication from people who refer
- Not enough information provided for triage
- Information could be worked out prior to referral
- Availability of appointments
- No joint assessments
- Face to face vs. phone assessment
- No allocation of clinical manager when referred to adult teams
- Clients telling story multiple times
- Some lack of father & Carer involvement
- No outreach other than to The Canberra Hospital
- Unable service complex clients more efficiently

**Opportunities**

- Joint assessments
- Flexible hours
- Offer outreach services

**Barriers**

- Flexibility in Service delivery
- Availability of medical staff
- No opportunity for parallel work with attachment issues
- Environment and safety (change table and mothers area)
COTTAGE DAY PROGRAM/ EATING DISORDERS PROGRAM/ DIALECTICA BEHAVIOURAL THERAPY PROGRAM

**Strengths**
- Cottage – appropriate referrals are received by the Cottage Team. Look at referrals in depth and assessments conducted individually. Cottage staff performs assessments. Communication between Community Teams and the Cottage is good.
- Eating Disorders – No wrong door – when you call you get support, problems can be early intervention as opposed to worst case,
- DBT – referrals provided by Community Team and generally willing to engage. Specific needs assessment conducted.

**Weaknesses**
- DBT – possible duplication from client point of view, waiting periods, sometimes there are waitlists, Limited publicity to promote service
- Cottage – need clearer referral pathways. Limited publicity to promote service. 10 week timeframe – is it long enough. The cottage is a terrible name for program.

**Opportunities**
- Different pathways of referrals
- EDP – see the more complex cases & collaborate on less complex / severe cases. Easier pathways – duplication of services.
- Joint assessments.
- Cottage – work more collaboratively with working with education. (Early intervention)

**Barriers**
- DBT – resources, skill sets, assessment lengthy process, client commitment
- Cottage – referral process defined, client commitment, organisational demands around accepting clients – constraints (political), idea that they don’t go to school they should go to “the Cottage”
- EDP – client commitment, no ability to perform medical assessments.

**Analysis on current treatment pathways**

**Strengths**
- DBT – trained skilled supervised clinicians performing specific treatment. Good outcomes
- Voluntary service

**Weaknesses**
- Commitment required by client
- Capacity to attend appointments
- Group vs. individual (not all clients want to do the 4 areas.

**Opportunities**
- Can be more assertive for our clients. DBT does not do h
- Expand home visits

**Barriers**
- Cottage – 10 weeks,
- EDP – budget
- DBT – space to facilitate meeting.
CAMHS COMMUNITY TEAMS

Strengths

- CAMHS Access- one single line of entry
- Feedback referrer
- Face to face assessment
- Joint assessment with Pediatrics
- Triage referrals
- Even if there is a wait then they can be seen if there is the requirement
- Structured
- On the spot recommendations

Weaknesses

- Don’t provide outreach services
- Not well advertised
- Moderate to severe mental health issues
- No child and adolescent specific fixed 24 hour services- even though there is 24 hour coverage
- Waitlist for allocation
- Gap in communication when not accepted
- Static resources- not meeting population growth

Opportunities

- Gillick principle to assessment
- Capacity to outreach to schools and relevant stakeholders for collaboration, information sharing and secondary consultations
- Strengthen and build new partnerships
- Joint assessments with other services and work together in treatment planning

Barriers

- Stigma
- Resource / staff
- Training
CAMHS EARLY INTERVENTION PROGRAM

**Strengths**

- Non complex referral process
- Ease of access
- Timely

**Weaknesses**

- Only seeing clients Southside
- Lack of assessment phase
- Different services for north and south of Canberra
- Medicalised model used
- Difficulties and diagnostic classification
- Need to be careful around diagnosis
- Symptomology vs. diagnostics
- Difficulty in recognizing what early psychosis actually is
- 7 day service – Not enough resources to successfully provide this service- 4 staff currently

**Opportunities**

- Capacity building.
- Clarifications around referrals
- Collaboration with NGOs
- Expanding services North & South
- Rewrite the MHAGIC referral form as it is outdated and requires reflecting the developed criteria.

**Barriers**

- Lack of understanding of early psychosis from other areas/staff
- Lack of communication between referring teams
Strengths

- Excellent, care within Bimberi (there is someone there every day)
- Well serviced by a Forensic Mental Health Psychiatrist.
- FMH assists with education of staff – improving the management of young people in Bimberi.
- Work with people who do not meet criteria for mental health services in the community (can be a weakness)
- Specialised in Forensic MHS and clinicians have the relevant skills in forensic matters, court reports, criminogenic needs, physical and mental case management
- Timely access
- Forensic can go older (nature of offences)
- Communication across different sections of the team – Court Liaison Officer can provide relevant information
- FMH provides therapeutic groups which have been working very well
- There are both good and negative experiences within Bimberi

Weakness

- The service provided in Bimberi is comprehensive. Young people go from an intensive program in detention to ‘non-intensive’ programs within the community.
- Lack of through care for young people.
- Lack of continuity- for a number of young people contact with mental health services may be with a clinician in Bimberi, once they are released/discharged they have to see a new person.
- ATOD issues not being picked up.
- Rotation period of staff within Forensic Mental Health.
- Change in treatments (this has improved over the last 6-12 months).
- Disagreement of treatment / diagnosis by different doctors.
- Services outside of Bimberi are disjointed.

Opportunities

- Need to be able to see the same workers/clinicians in and out of Bimberi.
- To have ‘buy in’ from young people to attend services in the community.
- Building the capacity within Mental Health and Bimberi to do Community to provide this care.
- Single case management model similar to what Youth Justice is providing.

Barriers

- Current procedures & policies – FMH & JH
- No clear vision/strategic direction
- If the discharge/exit isn’t planned it creates issues around ongoing support / management.
APPENDIX 4: GAP ANALYSIS

A gap analysis was completed by the working groups as part of this project. Each working group undertook a review and analysis of current service delivery which identified current strengths, weaknesses, opportunities and barriers of the current service model and identified gaps as part of this.

The gaps identified by each area are identified below:

**Inpatient**

- Currently there is no Child and Adolescent specific mental health inpatient unit
- Specialising of mental health children or young people – massive costs. Ability to manage Mental Health patients in ideal way is not being able to be met.
- Meeting national benchmarks are not able to be complied with.
- Need to look at current model and gaps with the move to new Women’s and Children’s Hospital
- Need to clearly define admission criteria
- For the young person to see pediatric psychologist a medical referral needs to be completed
- CAMHS inability to cover wards over weekend
- MHAGIC is unable to capture the data for inpatient stays within the pediatric ward
- There is no environment within the pediatric ward to provide therapy from the community teams
- Lack of SOP5 on what is required or process required

**Perinatal Consultation Mental Health Service**

- Linkages with other Mental Health Teams
- Insufficient medical cover
- Opportunities for joint visits
- Knowledge of Perinatal MH issues from other mental health clinicians
- Consultation model “all care & no responsibility”
- Avenue for capacity building & interest
- Resources
- Service unable to clinically manage
- Attachment, working with infant & mother work
- Services for COPMI

**Early Psychosis**

- Unclear discharge process
- The current process is going over 2 years for children or young people with an early psychosis
- Involvement of other services at discharge
- Focus on illness
- Process of referring the chronic young person back to the regional teams.
- Current discharge process not guided by anything – is not evidence based (can we do this)?
- Lack of joint assessments and a specific early psychosis assessment at referral
- Unclear referral criteria- what constitutes an early psychosis?
- Lack of understanding of early psychosis from other areas and staff

**Community**

- CAMHS does not deal with children or young people with behavioural disturbances
- Lack of understanding of CAMHS intake criteria from other services
- Clear definition of moderate to severe that is objective- other services do not have clear understanding of what ‘moderate to severe’ is
- Gaps in timing of intervention- children or young people may be seen early however if wrong service this may take time until the right service sees them
- Lack of group interventions
- Lack of Early intervention and outreach capacity
- No capacity for CAMHS to provide an advisory role- secondary consultations
- No programs in schools
- No connections with early childhood programs
- Lack of CAMHS specific inpatient services
- Availability for brief interventions
- Possibilities for single sessions – eg. trauma informed care or consumers with no Mental Health issues but emotionally dysregulated
- Family focus – there needs to be a willingness to work with family
- Lack of COPMI / AOD type interventions
- Lack of resources Southside of Lake- all ADS and SUSD facilities North

Cottage/DBT/EDP

- No opportunities for joint assessment at first presentation to Cottage and DBT
- Restricted outreach capacity
- Can be more responsive- current service does not necessarily meet the needs of young people
- Unclear criteria for Cottage
- No clear process
- The over 18’s at discharge are not always picked up by Adult MH if required
- No places to refer out for more complex needs
- No clear processes (Cottage)- recently moved to a clinical management model
- Current process is for clinicians to assess risk if the child or young person present in crisis and contact CAMHS on call consultant and to ring police or take to Calvary ED

Bimberi Youth Forensic Mental Health

- Referrals to AOD services are being delayed
- Times when there are conflicting diagnosis of Consumers between FMH & within Community (CAMHS)
- Lack of through care.
- Clients seen in custody by FMH and not picked up by the Community Mental Health (CAMHS) post Bimberi.
- Lack of outreach in the community for Young People post discharge from Bimberi.
- Behavioural issues- continue to go into custody - lack of behavioural type management services.
- Lack of Adolescent Psychiatric Facility
- Dual diagnosis- Services do not work well together Building the capacity within Mental Health and Bimberi to do Community to provide this care.
APPENDIX 5: CONSUMER AND CARER PERCEPTIONS

A number of 14 interviews were completed for this project where children and young people and carers were asked to provide their story in accessing CAMHS. The results were as followed:

Analysis of Experiences using Picker Elements

Breakdown of information

Number of patients contacted: 13
Number of interviews held: 13

Analysis

<table>
<thead>
<tr>
<th>Positive and negative aspect of patient experience, findings from 14 interviews in CAMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
</tr>
<tr>
<td>Respect for patients</td>
</tr>
<tr>
<td>Coordination and integration of care</td>
</tr>
<tr>
<td>Information and education</td>
</tr>
<tr>
<td>Transition and continuity</td>
</tr>
<tr>
<td>Physical comfort</td>
</tr>
<tr>
<td>Emotional support</td>
</tr>
<tr>
<td>Involvement of family and friends</td>
</tr>
</tbody>
</table>

Top 3 Positive Aspects

a) Access to care was timely
b) Care from staff
c) There was respect for the child/young person or carer

Young people and carers who were interviewed all indicated that access into CAMHS was timely and they received assessments fairly quickly after their initial referral/phone call. This may be attributed to a change in model of care between 2009-2010 within CAMHS. A majority of the interviewed participants indicated that they received good care from staff and that staff were respectful of the young person and carers.

Top 3 Negative Aspects

a) Transition between each team and continuity of care
b) Integration between community teams and hospital
c) Lack of young people/children specific mental health inpatient unit in Canberra

The top negative aspect identified in the interviews conducted was around transition and continuity of care. The interviews identified that transition between each team and between hospital and community teams can be further improved.
APPENDIX 6: STAFF PERCEPTIONS

Staff forums were held and the following was determined:

- There is a lack of early intervention
- Lack of group programs
- There is a role confusion around a ‘secondary or tertiary’ service
- There is no north and south early psychosis/early intervention program
- CAMHS does not provide support for the under 5 year olds
- Lack of support and acknowledgement for infant mental health (which is a growing area)
- The lack of utilising the multidisciplinary team
- Lack of capacity for crisis work
- Lack of outreach
- There is a lot of demands on staff in ‘moving clients on’ due to the amount of referrals
- Should better utilise the role of the multidisciplinary team
- Lack of support for the younger age group
- CAMHS does not provide support with behavioural interventions which is a gap
- CAMHS works as a multidisciplinary team however clinicians provide generic roles
- CAMHS needs to consider more home visits with the extension of age range to 25
- There is no support for infants with attachment issues
APPENDIX 7: CURRENT SUPPLY AND DEMAND FOR INPATIENT BEDS

(Please see Tables below for more information)

Analysis of current activity, translated to beds, assists in identifying current demand for the new INPATIENT UNIT.

The following data was provided by the Health Service Planning Unit. It presents inpatient activity for the financial years 2008/09 to 2010/11. The data reflects ACT public sector activity (TCH & CH) as well as ACT resident demand met in NSW Public Hospitals and NSW/ACT Private Hospitals. The data was selected based on the service related groups 82 Psychiatry Acute and 83 Psychiatry Non Acute and for the age groups 13-17yrs&11mths and 18-24yrs&11mths. Overnight occupied bed days have been translated to beds assuming availability 365 days per annum and 85% occupancy.

The following observations are made:

**ACT Public Sector Supply**

- For the 13-17 yr age group
  - Activity has increased over the period 2008/09 to 2010/11 – 1.3 beds growing to 2.7 beds
  - In 2010/11 there was the equivalent of 2.7 beds occupied, of which the equivalent of 0.8 beds where in a designated mental health ward. In effect more than 2/3 of the activity provided to this age group is currently in generalist adult or pediatric wards.

- For the 18-24 yr age group
  - Inpatient episodes have decreased while bed days (and therefore beds) increased over the period 2008/09 to 2010/11, indicating an increasing average length of stay.
  - In 2010/11 there was the equivalent of 10.1 beds occupied, the majority (91%) of these beds were provided in a designated mental health ward.

- Inflows in 2010/11 from Southern LHD were minimal and the impact in terms of beds for the combined age group (13-24 yrs) was equivalent to 0.7 beds.

**ACT Resident Demand met in Other Hospitals**

- A number of ACT residents have sought care in NSW public hospitals and NSW/ACT private hospitals.

- For the 13-17 yr age group
  - In 2010/11 the equivalent of 0.3 beds were provided in NSW Public Hospitals and 0.8 beds were provided in the private sector. These beds were essentially all in designated mental health wards/hospitals.

- For the 18-24 yr age group
  - In 2010/11 the equivalent of 0.5 beds were provided in NSW Public Hospitals and 2.4 beds were provided in the private sector. These beds were essentially all in designated mental health wards/hospitals.

---

25 2N at Calvary Hospital and PSU at The Canberra Hospital

26 NSW & ACT private hospitals
Service Planning Assumptions

For the 13-17 year age group accessing overnight inpatient services in the ACT public sector, 2/3 of this activity is being met either in generalist adult wards or pediatric wards. The assumption is that this activity will be able to be more appropriately managed in the new INPATIENT UNIT.

For ACT residents receiving care in NSW Public Hospitals, the assumption is that with the new INPATIENT UNIT will no longer need to travel interstate, that this demand will be met locally.

For ACT residents receiving care in NSW/ACT private hospitals this may be reflecting patient choice as well availability of specialist services locally. It is unlikely that all this demand would flow to the new unit but it would be reasonable to assume that 1/3 of the activity might return to the public sector.

It is assumed there will be no change in the rate of inflows from Southern LHD with the opening of the new unit.

On this basis, current demand for the new Unit is estimated to be 4 beds for 13-17 yr age group and 12 beds for the 18-24 yr age group.

ACT Public Sector Supply (TCH & CH, ACT residents plus inflows)

SRG: 82 Psychiatry Acute & 83 Psychiatry Non Acute, Ages 13 yrs to 24 yrs 11 mths

Data Source: ACT FlowInfo V11.1

<table>
<thead>
<tr>
<th>Age 13-17</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/09</td>
</tr>
<tr>
<td>equiv beds @ 85%</td>
<td>1.3</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>0.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 18-24</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>equiv beds @ 85%</td>
<td>7.7</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>6.9</td>
</tr>
</tbody>
</table>

27 NSW & ACT private hospitals
**ACT Resident Demand met in NSW Public Hospitals & NSW/ACT Private Hospitals**

SRG: 82 Psychiatry Acute & 83 Psychiatry Non Acute, Ages 13 yrs to 24 yrs 11 mths

Data Source: ACT FlowInfo V11.1

<table>
<thead>
<tr>
<th>Age 13-17 - NSW Public Hospitals</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/09</td>
</tr>
<tr>
<td>equiv beds @ 85%</td>
<td>0.0</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 13-17 - NSW/ACT Private Hospitals</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/09</td>
</tr>
<tr>
<td>equiv beds @ 85%</td>
<td>0.4</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>0.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 18-24 - NSW Public Hospitals</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/09</td>
</tr>
<tr>
<td>equiv beds @ 85%</td>
<td>0.3</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>0.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 18-24 - NSW/ACT Private Hospitals</th>
<th>Overnight(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/09</td>
</tr>
<tr>
<td>equiv beds @ 85%</td>
<td>3.1</td>
</tr>
<tr>
<td>MH ward equiv beds @ 85%</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Draft Functional Relationships within the Inpatient Unit

Common Area
(Adolescent Unit)
Eg: Therapy Area, consultation areas and meeting areas.

Bedroom Area
(Adolescent Unit)
Both HDU and LDU

Shared Areas - eg reception, waiting areas

Working Area
(Eg. Staff area/stations)

Common Area
(Young Adult Unit)
Eg: Therapy Area, consultation areas and meeting areas.

Bedroom Area
(Young Adult Unit)
(HDU and LDU)

Shared areas
APPENDIX 9: CAMHS ESTABLISHMENT 2011-2012

This section outlines the number of full time equivalent (FTE) of each service area within CAMHS. In 2012 the combined population for Canberra for children and adolescents up to the age of 18 is 81,676 and 128,648 for the up to 25 year olds in 2012.

Table : CAMHS FTE Establishment 2011-2012

<table>
<thead>
<tr>
<th>Team</th>
<th>Clinical FTE</th>
<th>Non-Clinical FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS North</td>
<td>9.4</td>
<td>2.8</td>
</tr>
<tr>
<td>CAMHS South</td>
<td>10.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Eating Disorders Program</td>
<td>3.0</td>
<td>1.6</td>
</tr>
<tr>
<td>CAMHS Cottage</td>
<td>2.4</td>
<td>2.76</td>
</tr>
<tr>
<td>CAMHS Perinatal Consultation Mental Health Service</td>
<td>2.0</td>
<td>1.74</td>
</tr>
<tr>
<td>CAMHS DBT</td>
<td>4.0</td>
<td>0</td>
</tr>
<tr>
<td>CAMHS Early Intervention</td>
<td>4.0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>35.6</td>
<td>11.9</td>
</tr>
</tbody>
</table>

With the population and the CAMHS FTE provided, the following observations are made:

- There are 24.7 clinical FTE/100,000 population for the CAMHS Community Teams (CAMHS North and South).
- The total CAMHS Clinical FTE for CAMHS is 35.6 and Non-Clinical FTE (eg. Team Leaders, Operational Director and Administrative staff) is 11.9.
APPENDIX 10: CHILDREN AND YOUNG PEOPLE UP TO THE AGE OF 25 YEARS OLD SEEN BY MENTAL HEALTH SERVICES BETWEEN 2009-2011

The table below demonstrates the total number of referrals/children and Young People contacted in each year between 2009-2011 and the number of children and Young People accepted for treatment:

### 0-18 Years Total Number Clients Seen by CAMHS

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People seen</td>
<td>925</td>
<td>965</td>
<td>838</td>
</tr>
<tr>
<td>Children and Young People clinically managed</td>
<td>601</td>
<td>521</td>
<td>307</td>
</tr>
</tbody>
</table>

### 18-25 Total number clients seen by MH aged between 18-25.

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young People seen</td>
<td>454</td>
<td>526</td>
<td>581</td>
</tr>
<tr>
<td>Young People clinically managed</td>
<td>116</td>
<td>119</td>
<td>71</td>
</tr>
</tbody>
</table>

The data identified above indicates that number of children and Young People who have been contacted currently within CAMHS up to the age of 18 and within the Adult Community Mental Health Teams between the ages of 18-25.

In taking consideration on the current referral numbers of CAMHS, it was identified that there will be an extra 50% of children and Young People (based on current numbers) that will access CAMHS if the age range is extended to 25 years of age. The current data indicates that teams servicing the 18-25 age group are receiving a large proportion of referrals/contacts, however with lesser number being taken up for clinical management. This may be due to doctor only consumer models of care within the Adult Mental Health Services or that children and Young People between the ages of 18-25 are less likely to engage compared to the under 18 year olds. There are also limitations to the data regarding the number of children and Young People clinically managed extracted from MHAGIC as the practice of allocating Clinical Managers on MHAGIC differ between CAMHS and Adult Community Mental Health Teams.

The number of referrals and children and Young People managed should be taken into account as part of the Models of Care framework for CAMHS to identify the increase in workload that may occur with aligning the 18-25 year olds more closely with CAMHS which results in the increase in additional resources.
Currently the population for the 0-25 age group is estimated at 128,648. This number is expected to increase to 138,978 in 2022. The highest population for this age group is young people between the ages of 18-25. Increase in population demand will need to be taken into account when redesigning programs and models of care to ensure that there is a level of fluidity to account for future growth. The population prediction will also assist in the resource projection required for the service to be provided.

Table: Population Projection of ACT 2007-2022

<table>
<thead>
<tr>
<th>Year</th>
<th>0 - 1</th>
<th>2 - 4</th>
<th>5 - 11</th>
<th>12 - 17</th>
<th>18 - 25</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>8,999</td>
<td>12,521</td>
<td>28,743</td>
<td>26,756</td>
<td>46,898</td>
<td>339,761</td>
</tr>
<tr>
<td>2008</td>
<td>9,209</td>
<td>13,139</td>
<td>28,856</td>
<td>26,530</td>
<td>47,431</td>
<td>346,294</td>
</tr>
<tr>
<td>2009</td>
<td>9,331</td>
<td>13,586</td>
<td>29,051</td>
<td>26,440</td>
<td>47,714</td>
<td>352,189</td>
</tr>
<tr>
<td>2010</td>
<td>9,705</td>
<td>13,928</td>
<td>29,289</td>
<td>26,632</td>
<td>47,445</td>
<td>357,958</td>
</tr>
<tr>
<td>2011</td>
<td>10,001</td>
<td>14,165</td>
<td>29,793</td>
<td>26,753</td>
<td>47,111</td>
<td>363,764</td>
</tr>
<tr>
<td>2012</td>
<td>10,154</td>
<td>14,486</td>
<td>30,393</td>
<td>26,643</td>
<td>46,972</td>
<td>369,090</td>
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<tr>
<td>2013</td>
<td>10,297</td>
<td>14,928</td>
<td>31,025</td>
<td>26,322</td>
<td>46,840</td>
<td>374,435</td>
</tr>
<tr>
<td>2014</td>
<td>10,431</td>
<td>15,287</td>
<td>31,871</td>
<td>26,128</td>
<td>46,517</td>
<td>379,791</td>
</tr>
<tr>
<td>2015</td>
<td>10,554</td>
<td>15,509</td>
<td>32,830</td>
<td>25,945</td>
<td>46,251</td>
<td>385,161</td>
</tr>
<tr>
<td>2016</td>
<td>10,662</td>
<td>15,717</td>
<td>33,631</td>
<td>26,117</td>
<td>45,946</td>
<td>390,522</td>
</tr>
<tr>
<td>2017</td>
<td>10,742</td>
<td>15,893</td>
<td>34,436</td>
<td>26,285</td>
<td>45,820</td>
<td>395,370</td>
</tr>
<tr>
<td>2018</td>
<td>10,798</td>
<td>16,051</td>
<td>35,045</td>
<td>26,747</td>
<td>45,818</td>
<td>400,180</td>
</tr>
<tr>
<td>2019</td>
<td>10,830</td>
<td>16,184</td>
<td>35,614</td>
<td>27,391</td>
<td>45,690</td>
<td>404,958</td>
</tr>
<tr>
<td>2020</td>
<td>10,843</td>
<td>16,285</td>
<td>36,282</td>
<td>28,053</td>
<td>45,355</td>
<td>409,689</td>
</tr>
<tr>
<td>2021</td>
<td>10,840</td>
<td>16,352</td>
<td>36,844</td>
<td>28,778</td>
<td>44,988</td>
<td>414,367</td>
</tr>
<tr>
<td>2022</td>
<td>10,826</td>
<td>16,386</td>
<td>37,241</td>
<td>29,471</td>
<td>45,054</td>
<td>418,988</td>
</tr>
</tbody>
</table>

Observations:

- There is a decline in the 18-25 population up to 2022.
- The largest increase of population is amongst the 5-11 age group.
- The young people population (up to 25) accounts for approximately 36% of the total population.

Mental Illness has the highest burden of disease for 15-25 year olds:

- Mental illness has the third highest burden of disease in Australia, followed closely by cancer and cardiovascular disease. This figure is higher again among people of Aboriginal and Torres Strait Islander background, second only to cardiovascular disease.
- Mental disorders were the leading causes of the total burden of disease for the 15-25 year olds in the ACT accounting for 48% and 53% for males and females respectively.
- Suicide, alongside transport accidents, was the leading cause of death for the 12-25 year olds in 2001-2007 (at 25%).

Young People and Mental Illness (ABS, 2008):

- The greatest number of people with a mental illness is within the 18-24 year age group.
- Many people with schizophrenia first experience symptoms in their mid to late teen years.
- One third of people with a mental illness who are admitted to public hospitals are less than 30 years old.
• Depression is one of the most common health conditions in young people and increases during adolescence.
• Drug use can complicate diagnosis and exacerbate or trigger illness in vulnerable young people.
• Young people are more likely to experience a mental illness and prevalence of mental disorders declines with age. In 2007, 26% of 16-24 year olds had experienced a mental disorder in the previous 12 months, while only 5.9% of 75 year olds and over had experienced a mental disorder during that time.
• Data published in 2008 revealed that during a 12-month period, 7% of Australian children and adolescents aged 0-17 were experiencing mental health problems. This rate of mental health problems was similar across both gender groups.
• In 2004-2005, one in 10 young Australians had a long-term mental health or behavioural problem.
• In 2003, mental disorders were the leading contributor to the total burden of disease among young Australians, accounting for 49% of that total.
• There is a higher prevalence of child and adolescent mental health problems among those living in low-income, step/blended and sole-parent families.
• 25% of males and 19.7% of females living in step/blended families, and 22.2% of males and 26.7% of females living in sole-parent families experienced mental health problems, compared to 11.3% of males and 10.7% of females living with their original parents.

Difficulties for Young People Accessing Professional Help (ABS, 2008)

• Only one out of every four young persons with mental health problems had received professional health care.
• Family doctors, school-based counselors and pediatricians provide the services that are most frequently used by young people with mental health problems. Younger children (4-12) were more likely to visit pediatricians and family doctors, while older children were more likely to visit school-based counseling services.
• Even among young people with the most severe mental health problems, only 50% receive professional help. Parents reported that help was too expensive or they didn’t know where to get it, and that they thought they could manage on their own.
• Adolescents with mental health problems report a high rate of suicidal thoughts and other health-risk behaviour, including smoking, drinking and drug use.
• 12% of 13-17 year olds reported having thought about suicide, while 4.2% had actually made a suicide attempt. Females had higher rates of suicide ideation than males.
• In 2004-2005, there were 8,013 hospitalisations among young people for mental and behavioural disorders due to drug and alcohol use (almost 2% of all hospitalisations among young people).
APPENDIX 12: MENTAL HEALTH CLINICAL CARE AND PREVENTION MODEL- A POPULATION MENTAL HEALTH MODEL (M H-CCP) PROJECTIONS

The MH-CCP was utilised to populate resource predictions for the CAMHS Redesign Project. The MH-CCP Version 1.11 was developed by New South Wales (NSW) to identify a framework that will achieve the aim of the NSW mental health policy (MH-CCP, 2001). The model is intended to be utilised as a tool to identify the requirements for a comprehensive integrated mental health care and prevention across the lifespan in a population mental health framework. It aims to identify levels of mental health services needed for a population given definitions of appropriate clinical care for each population group.

Care packages from the MH-CCP for children and Young People within each age group was identified in the models of care framework. Care packages on children and young people with moderate to severe mental health issues, consultation liaison to the pediatric ward, early intervention, early psychosis services, and promotion and partnership were utilized as part of the project. Please see table below for detailed resource predictions.

The MH-CCP uses epidemiological studies to populate resources required. Definitions for moderate to severe mental illness were defined using epidemiological studies carried out.

A newer version of the MH-CCP has been released and was not used in the resource predictions of the CAMHS Models of Care. The current version utilized in from 2001 and will be updated once the new version is available.

Common principles and assumptions from the MH-CCP are listed below:

Child (0-17 years)

Based on epidemiological studies, from Australia and UK the MH-CCP classified that 1.85% of all children and adolescents as having severe and complex problems and approximately 0.075% as having serious persistent and complex problems. The estimate of moderate problems is an estimate between mild and severe.

**Current CAMHS Total FTE in 2012: 35.6**

Categories utilized within the MH-CCP to populate the resources required in each age group are:

- Promotion and partnership
- Moderate
- Severe Ambulatory
- Severe Persistent or Complex in Ambulatory care
- Consultation Liaison Emergency
- Consult Liaison General
- Early Intervention (in the EI section)
- Early Psychosis
0-1 including PND

The future Perinatal Consultation Mental Health Service has indicated that it will continue to provide assessment, consultation and brief intervention for women in the perinatal period in conjunction with providing infants up to the age of 1 in this group who are at risk.

As indicated in the MoC framework, the Perinatal Consultation MH Service will provide assessment, consultation and intervention with women in the perinatal period experiencing a moderate to severe mental health issues and their infants. A family systems approach will be utilised. MHCCP and predictions on postnatal depression (PND) moderate and severe ambulatory were utilised.

2-4

The Child Community CAMHS Team will provide assessment and treatment to young children to minimise disruption to family and community life and attachments. This group will also provide family oriented sessions, day programs and inpatient services.

5-11

The Child Community CAMHS Team will be servicing children and young people in this age, including children and young people with moderate to severe mental health issues, day only programs provided in the Day Programs (inclusion as part of the resource predictions in this age group).

12-17

The children and young people within this age group as per the Models of Care Framework will be serviced by the Adolescent and Young Adult Community Team. Predictions for moderate and severe ambulatory were utilised for this age group to achieve the predictions in the table below.

Care packages for this group include, community based services for adolescents with moderate to severe mental health issues, the inclusion of day programs were utilised as part of this and group based programs.

18-25

The Adolescent and Young Adult Community Team will service this age group. Care packages around comprehensive mental health assessment, evidence based treatment of acute disorders is part of the service delivery of this team. Resource predictions on moderate and ambulatory were utilise to achieve predictions in table below.

Early Intervention:

Early Intervention resources predictions are only provided within the MHCCP for the 0-18 population as research has indicated that most early intervention services include the young populations. In the MoC framework identified in this project, Early Intervention Services was identified as a specialist services. As part of developing an integrated mental health care service Early Intervention Care packages from each age group (from 2 onwards) was utilised to identify the resource predictions for EI.

Inpatient Services:

The average length of stay for inpatient stay for children and young people in this age group was identified at 14 days as per the MH-CCP utilising NSW data from 1997/1998.

Inpatient Services for the under 13:
The MH-CCP identifies children and young people in each age bracket that may require inpatient care. Resource predictions for the under 13 were pulled out to identify resources required for this age group.

**Inpatient services for the over 13 -17 and 18-25:**

Resource predictions from inpatient data for the 13-17 and 18-25 was pulled out from MH-CCP to identify the resources required for children and young people in this age bracket requiring inpatient care.

**Table I: MH-CCP FTE Predictions**

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<th></th>
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## APPENDIX 13: DETAILED PROJECT WORK PLAN AND TIME FRAMES

<table>
<thead>
<tr>
<th>Work</th>
<th>Method</th>
<th>Completed Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning of project:</strong></td>
<td>Basic data collection and research gathering by CAMHS Redesign Project Officer</td>
<td>Early February in preparation to present to initial ERG in Feb 2012. For approval and endorsement by ERG at the end of Feb 2012.</td>
</tr>
<tr>
<td>Scope, project governance and organise meetings, establishing communication strategy, identifying staff champions, decide on consumer and staff involvement strategy. Literature searches, basic data collection, benchmarking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Initial CAMHS Redesign Steering Committee Meeting.</strong></td>
<td>Meeting request to be sent out end of January 2012.</td>
<td>March 2012</td>
</tr>
<tr>
<td>Identify and agree on service principles.</td>
<td>2 steering committee meetings required for initial planning and agreement.</td>
<td></td>
</tr>
<tr>
<td>Present discussion paper for ERG on current literature review. Discuss frequency, duration and times of meetings, communication strategies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Working Groups Establishments – identification of meeting times, frequency and TOR.</strong></td>
<td>Project officer to complete and organise.</td>
<td>End of Feb 2012</td>
</tr>
<tr>
<td><strong>Initial Working Group Meetings.</strong></td>
<td>Facilitated by Project officer with identified group leaders.</td>
<td>End of Feb 2012</td>
</tr>
<tr>
<td><strong>TOR completed and endorsed for Steering Committee and Working Groups.</strong></td>
<td>1 working group meeting.</td>
<td>Early March 2012</td>
</tr>
<tr>
<td><strong>Review current CAMHS Models of Service Delivery within each working group including:</strong></td>
<td>2-3 working group meetings</td>
<td>April 2012</td>
</tr>
<tr>
<td>Reviewing current service delivery, demographics, current patient stories workflow</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Initial focus group consultations.</strong></td>
<td>Facilitated by Project Officer with support from ERG.</td>
<td>End of April 2012</td>
</tr>
<tr>
<td>Establish service to be provided; aims, principles, patient/customer, consumer characteristics.</td>
<td>2-3 working group meetings</td>
<td>End of June 2012</td>
</tr>
<tr>
<td><strong>Second focus group consultation on draft MoC.</strong></td>
<td>Facilitated by project officer with support from ERG</td>
<td>August 2012</td>
</tr>
<tr>
<td><strong>Redesign MoC Final Draft for CAMHS.</strong></td>
<td>Through input from working groups, ERG, gap analysis, patient stories and literature review collated.</td>
<td>August 2012</td>
</tr>
</tbody>
</table>
APPENDIX 14: DRAFT INPATIENT UNIT WORKFLOW SPACE

1. **Client arrives at unit**
   - All clients can arrive at the reception area of the Inpatient Unit
   - Children and young people who are brought in by police on a Mental Health Order will need to be brought in via the back of the unit into an assessment area

2. **Nurse completes admission process**
   - This is done in the assessment/consultation area

3. **Physical assessment done by medical or psychiatrist if not done previously**
   - To be completed in the client’s assessment area

4. **Client accompanied into room**
   - Bedroom of client- either HDU or LDU

5. **Nurse completes nursing care plan/recovery plan**
   - This can be done in consultation area or client’s bedroom

6. **Nurse completes notes on MHAGIC**
   - Nursing workstation area/office area

7. **Multidisciplinary Team ward round**
   - MDT Meeting room

8. **Psychiatric review and update of medications**
   - MDT meeting room/Consultation area (if not done at MDT rounds)

9. **Review of Mental Health Status (as part of MDT ward round)**
   - An office/meeting space
   - MH Tribunal area

10. **Develop a therapeutic plan (as part of MDT ward round)**
    - Meeting room

11. **Therapeutic options**
    - Area for school
    - Areas for visitors- family
    - Areas for clinical manager/other workers/public advocate/drug and alcohol
    - Area for Centrelink/vocational support
    - Area for therapeutic programs- group area and creative arts area
    - Area for physical activities- gym

12. **Daily nursing and psychiatric review**
    - Consultation room

13. **Daily medication supervision**
    - Treatment room

14. **Discuss with children and young people/carer/relevant workers**
    - Consumer- within any area within unit
    - Carers and relevant workers- either in consultation room if carers present at unit or in staff area via phone

15. **Discharge planning meeting**
    - In meeting room

16. **Complete discharge papers**
    - Staff office area

17. **Discharge from hospital**
    - Collects belongings from store room (if any)