Youth Specific Inpatient Services

A Submission
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1. The Context for Investment in Youth Mental Health

Mental health and related substance use disorders affect around 1 in 5 Australians in any given year, account for around 30% of the total non-fatal burden of disease and cost the

community billions of dollars a year in direct and indirect costs. They are clearly common and disabling.

The incidence and prevalence of these disorders varies with age peaking around late adolescence and early adulthood. Over 75% of all serious mental health and related substance use disorders commence before age 25 years and approximately 14% of 12-17 year olds and 27% of 18-25 year olds experience such problems each year.

Much of the disability associated with mental disorders develops in the early years following illness onset and this period represents a critical period for prevention and intervention. Early, effective treatment during adolescence and young adulthood has the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the 'best buys' for future reforms.

A stronger focus on youth mental health is therefore required, which builds on but is qualitatively different from existing child and adolescent and adult approaches which have struggled to address the mental health needs of the 12-25 year old age group. Youth specific approaches are defined by their developmentally oriented approach to the management of mental disorders which acknowledges the evolving nature and complex pattern of mental illness in this age group, young peoples' individual and group identity and unique life-stage issues, and their discerning help-seeking behaviours.

While youth-specific approaches are required across the continuum of care, particular emphasis needs to be placed on creating a new tier of youth-specific specialist mental health services across Australia for young people aged 12-25, at very high risk of developing psychotic or major mood disorders as well as young people experiencing their first onset of such difficulties.

Youth-specific specialist mental health services would provide a range of services for young people living within their catchment zone including: triage and assessment services; a mobile youth access service providing intensive community based crisis care; an intensive mobile youth outreach support (IMYOS) service for young people who are at-risk and difficult to engage; generic case management and therapeutic individual and family services; specialist disorder specific services for young people with higher intensity needs based on slow recovery, or other factors; co-morbidity clinics; consumer and carer peer support programs; comprehensive group-based personal, social and vocational recovery programs; and acute inpatient care. Preferably, acute inpatient services should be provided through youth specific units. Alternatively, existing adolescent or adult acute inpatient units could be redesigned to meet the needs of this client group. A proposed model is outlined below.

2. Youth-specific acute inpatient units

Psychiatric inpatient units are an essential feature of a comprehensive mental health service system. Traditionally, inpatient units have been used for two broad purposes:

- to assist at-risk people who require close supervision and high intensity therapeutic assistance, and
- to assist people who require a secure, structured, supportive environment to promote their recovery and rehabilitation.

While in the past, these two functions were delivered through a mix of acute, subacute, and extended care units operated by stand-alone psychiatric hospitals, these functions are now split between acute inpatient units provided within mainstream hospital settings, secure extended care and community care units managed by health services but delivered within hospital campuses or in community settings, and supported residential rehabilitation services managed by non-government agencies. While this policy of deinstitutionalisation and mainstreaming has generally worked well, it has been seriously under-resourced, at both the inpatient and community level. As a consequence, the move from institution to mainstream and community care has resulted in a net loss of beds which is now being manifest as critical bed shortages across all levels of inpatient care.

Acute inpatient units are now more or less exclusively focused on providing short-term assistance to acutely unwell people who require close supervision and high intensity therapeutic assistance until their treatment needs can be safely managed through community based services. The average length of stay in adult acute inpatient units has declined dramatically across Australia and was only 10.5 days in 2003-2004. While in many instances a short-term admission is all that is required, concerns have been raised that increasing numbers of patients are being discharged before their condition has been adequately stabilised because of the growing demand on acute inpatient unit services. An increase in the pool of acute, subacute and extended care beds and increasing the system's capacity to provide longer lengths of stay is clearly a priority for mental health service reform. However, while increasing the availability of bed based services is important, better models of care must also be developed.

Managing the levels of acuity within an acute inpatient setting requires a collaborative approach involving medical and nursing staff, allied health mental health clinicians and administrative support staff. While medication to stabilise acute symptoms remains an integral component of care, behavioural and milieu strategies remain the mainstay of treatment. Staffing profiles, clinical protocols and physical environments need to be structured to support this focus. A person's developmental stage has a major impact on what behavioural and milieu strategies may be required. For example, young people requiring specialist mental health services are more likely to:

- be using the mental health (or health) system for the first time,
- have carers who are being exposed to the mental health system for the first time,
- be treatment naïve and more sensitive to iatrogenic effects (medical or environmental),
- experience multiple co-morbidities that require an integrated model of care,
- be a heterogenous group, with varying, and clinically uncertain illness trajectories,
- be prone to lapses and relapses as they have not had the time to learn about their illness and how to manage it successfully,
- be prone to exhibit more disruptive behaviour when acutely unwell because they are cognitively less mature, are younger and fitter and more likely to have co-morbid substance use disorders.

Over a decade of experience in assisting young people with serious mental illness has led the ORYGEN program to conclude that young people need service environments which are geared to these clinical and contextual realities. The ORYGEN Research Centre therefore

calls on the Council of Australian Governments to approve funding for the development of youth-specific acute inpatient units with the following key features:

- Substreamed mini-units
- Better staff-patient ratios
- Integrated mental health and drug and alcohol service provision
- Peer support workers

Sub-streamed mini-units

Within the Victorian context acute inpatient units range between 24–54 beds each, although the typical unit has around 25 beds. Usually 4 of these beds are designated as high dependency beds with higher staff-patient ratios. Experience suggests that this model is not particularly well-suited for young people.

Based on the extent and diversity of the care needs of this population cohort a small-group 'mini-unit' model may be more effective. Under this arrangement, acute inpatient units would be divided into clusters of 8 bed units, each providing a high level of care. The approach taken in Scandinavian countries provides a useful working example. Mental health services in these countries have shown that modular units, with a more home-like environment, coupled with high staff-patient ratios enables a safer and more therapeutic environment to be created.

It is therefore suggested that psychiatric inpatient units for young people should be arranged as three self-contained mini-units of 8 beds each, developed as spokes off a central hub. These mini-units could be flexibly substreamed by age/developmental stage, gender or level of risk. While the unit would generally operate with an open door policy, a lockable section for periodic use with more acutely ill patients would be required. A 3 bed high dependency area would also be required to manage highly at risk clients to avoid the disruption that would otherwise be caused if one or more of the 3 mini-units had to be locked. This unit would be linked to the central hub.

Each inpatient unit should attempt to replicate a home environment as much as possible and remove potential barriers to activities of daily living. Units should include facilities to make young people feel as comfortable as possible such as lounge areas, activity areas with sports equipment, board games, TV, CD players and books and quiet areas. Each unit should also operate a structured activities program. These activities would need to be youth specific and arranged to cover every day of the week, including evenings as well as day times. Contact with family and friends would be encouraged. Direct phone lines and flexible visiting hours would help family and friends to stay in contact. Spaces to facilitate family involvement, including stay-over rooms, should also be included.

While youth-specific inpatient units could be located on campus within paediatric or adult hospital settings, they may be better co-located with other community-based and/or inpatient services, such as drug and alcohol treatment services, within a youth-services precinct model. Alternatively, they could be co-located with sub-acute or extended care units.

Better staff-patient ratios

Staffing ratios would need to be configured according to the real present day needs of patients. Present staffing levels and work practices have not kept pace with the increase in

severity, distress, turnover or risk. Workforce skill and clinical leadership are also crucial challenges.

Given the issues described above, staffing levels would need to be greater than in adult units, to allow more 1:1 time between clinical staff and patients for explanation, education and reassurance and to manage the greater levels of supervision typically needed by this cohort. Minimum staffing requirements are outlined below.

Discipline	Staffing requirements
Medical	3 consultant psychiatrists and 3 psychiatric registrars
Nursing	A minimum of 3 RPNs per day and afternoon shifts 2 RPNs per night shift/per unit = 36 EFT (27 EFT AM & PM shifts, 9 EFT night shifts) 1 Shiftleader per shift shared between three 8 bed units in hub = 4.5EFT 1 Nurse Unit Manager in hub 1 Clinical Nurse Educator in hub 2 RPNs per shift in HDU = 9 EFT Total Nursing EFT = 51.5 (NB the above RPN positions cannot be substituted with Div 2 nursing staff).
Allied health	2 group workers (OT), 1 social worker, 1 Psychologist, 3 specialist co-morbidity clinicians (see below)
Administrative	1 Ward clerk

Integrated mental health and drug and alcohol service provision

Mental health and substance use co-morbidity is now common place among young people receiving specialist mental health service care, occurring in up to 60% of first presentations. Left untreated, concurrent substance use has been found to be associated with more severe psychiatric symptoms, slower treatment response, poorer functional and clinical outcomes and higher rates of relapse. A more robust approach to co-morbid substance use is required.

Current treatment strategies typically utilise either sequential or parallel approaches to the treatment of co-morbid disorders in which one disorder is treated after the other or both disorders are treated simultaneously by different professionals. However, such models have been found to produce poorer psychiatric and substance use outcomes compared to more integrated models of service delivery. Integrated models provide treatment of the mental illness and the substance use disorder by the same treating team at the same time. Integrated treatment models have demonstrated superior outcomes in regard to engagement, and clinical and substance use outcomes of people with dual disorders, particularly when motivational interventions are incorporated into the intervention. Not surprisingly, they have emerged as the best practice approach to the treatment of dual disorders over the past 15 years.

Each youth specialist mental health acute inpatient unit will therefore need to include an integrated focus on substance use co-morbidity within its overall assessment and treatment framework. This integrated approach would focus on ensuring that screening for and comprehensive assessment and management of co-morbidity would be a fundamental

component of the admission process. Under this arrangement an integrated treatment plan would be developed for each young person based on the above assessment and formulation, outlining relevant interventions (including detox management) and the person or persons responsible for implementation.

While in most instances interventions will be delivered by existing inpatient clinical staff, each unit will also need to include clinicians with specific training and experience in dual diagnosis assessment and management. These clinicians would contribute to treatment planning and provision, provide training and consultation support to other staff and assist in evaluation and continuous quality improvement initiatives relating to the detection and management of dual diagnosis in the inpatient setting.

Peer support workers

The experience of serious mental illness is a confusing and distressing time for patients and carers alike at the best of times, yet alone during the first episode. First-episode consumers usually have very low levels of mental health literacy and are typically being exposed to the mental health system or even the health system for the first time. A supportive and empathic approach to care is required to minimise the possible iatrogenic effects of treatment, such as post-traumatic stress disorder, which may lead to long-term problems with treatment adherence.

In recognition of this, the ORYGEN Youth Health Service introduced its Peer Support Program in 2004. Peer Support workers are past clients who visit clients within the ORYGEN inpatient unit. Peer Support workers receive training and support and are paid for their time. The involvement of these para-professional Peer Support workers within the inpatient setting allows ORYGEN to provide greater levels of support to young consumers in an informal, non-threatening manner. Given their own experience with mental illness, Peer Support workers have an intimate understanding of what new clients are experiencing and can provide accurate and useful information. They are also able to serve as positive role models demonstrating to new clients that full recovery is possible. The Peer Support program is well regarded by clients, clinicians and peer support workers alike. More tellingly, since its inception there has been a 30% decrease in the number of critical incidents in the inpatient unit.

Given its success, the Peer Support program at ORYGEN has now been extended to its community-based service. Peer Support workers now also staff a ‘drop-in’ room where current clients of the service can seek support from a Peer Support worker any time they are attending the service. In addition, a family/carer Peer Support program which operates from a similar framework has also been introduced. Drawing on the success of this model, the ORYGEN Research Centre proposes that consumer and carer Peer Support programs should become integral components of each youth mental health service.

3. Budget

The capital funding allocation required for the development of youth specific acute inpatient units across Australia depends on the current number and distribution of beds available within CAMHS and adult services and whether these beds could be reconfigured as described

above or whether new purpose built units would need to be designed and developed. The recurrent costs depend on the current number and distribution of beds available within CAMHS and adult services and the model of care that is adopted.

Taking a figure of 25 beds per 100,000 population as a reasonable benchmark for bed numbers, a total of 875 beds targeted to 12-25 year olds would be required across Australia.

The 2005 National Mental Health Report found that the average national bed day rate in 2002-2003 was $518 for adult inpatient services and $872 for CAMHS inpatient services. The service model described above with its focus on modular mini-units, multidisciplinary, peer and professional input and high staff-patient ratios would probably require a bed day rate closer to that of CAMHS inpatient units which are typically smaller and more staff intensive. Using $872 as the benchmark price, the total cost of operating 875 youth-specific acute inpatient beds across Australia would be $278.5 million per annum recurrent.

It is now widely acknowledged that an increase in acute beds is required across Australia. If a new stream of youth inpatient units is created as described, this would take the pressure off the existing set of acute inpatient beds. Some existing units could be expanded to take on the role of youth inpatient care so some discounting of the figure of $278.5M may be achievable. Clearly the capital costs of adding up 875 new beds nationally would also need to be estimated.