Queensland Health

Admission of children and adolescents to acute mental health inpatient units

Queensland Health Guideline

QH-GDL-484:2021

1. Purpose

This guideline is for admission of a child or adolescent (aged < 18 years) to a Queensland Health inpatient unit for acute mental health care. This may include admissions to a child or adolescent acute mental health inpatient unit (AMHIU), an adult AMHIU, and in some situations a paediatric or general medical ward. This guideline is intended to support services to develop local protocols, recognising variations in local resources, and the need to individualise decision making. It should be used with information and advice from relevant local services and the young person and their family and/or carers.

Specialised advice and support

Children's Health Queensland Hospital and Health Service (HHS) provides specialised urgent after-hours child and adolescent psychiatry support, particularly to rural and remote services. It is expected that the care of the young person will have first been considered with local after-hours psychiatrist support. Consultant to consultant discussion is preferred.

This service can be contacted via the Queensland Children's Hospital switchboard on (07) 3068 1111.

2. Scope

This guideline provides information for all Queensland public health system employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors and consultants.)

3. Related documents

Queensland Health policies and guidelines are available by searching the Policies and Standards section of www.health.qld.gov.au.

Legislation, standards, procedures and guidelines

- *Mental Health Act 2016* (Qld)
- *Human Rights Act 2019* (Qld)
- Chief Psychiatrist Policies and Practice Guidelines under the *Mental Health Act 2016*
- Less Restrictive Way Guideline, Queensland Health, 2019
- National Safety and Quality Health Service Standards (second edition), 2017
- National Standards for Mental Health Services, 2010

- Clinical Services Capability Framework (CSCF) v3.2
- Guideline: Transition of care for young people receiving child and youth mental health services, Queensland Health, 2019
- Guideline: Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents), 2017
- Information sharing between mental health workers, consumers, carers, family and significant others, Queensland Health, 2017
- Therapeutic visual observation for mental health alcohol and other drugs services guideline, Queensland Health, 2020
- Guideline: Reporting a reasonable / reportable suspicion of child abuse and neglect, Queensland Health, 2015
- Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care, 2019
- Sexual Health and Safety Guidelines for Mental Health Alcohol and Other Drugs Services, Queensland Health, 2016
- Queensland Health Guide to Informed Decision-making in Health Care (second edition), 2017
- Guideline: Safety and security of children and young people in Queensland Health facilities, Queensland Health, 2016

Forms, templates

- Mental Health Alcohol and Other Drugs Comprehensive Care Documents https://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs
- Inter Hospital Transfer Request Form http://qheps.health.qld.gov.au/caru/networks/qedsap/inter-hospital-transfer.htm
- *Mental Health Act 2016* forms https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/forms
- Aboriginal and Torres Strait Islander Cultural Information Gathering Tool (available on the Consumer Integrated Mental Health Application - CIMHA)

4. Admission criteria and considerations

When considering admission, alternative care options such as enhanced community support must be considered, with specific risk assessment.

The decision to admit is a clinical judgement based on assessment, inclusive of risk, and other considerations, including the preferences and capabilities of the young person, their support networks, and relevant service system capacities. Admission may be planned or follow a crisis assessment. Local child and youth mental health services (CYMHS) and other treating clinicians or services should be included in the assessment process.

The clinical risk assessment process is supported by using the risk screening tool and the child and adolescent mental health assessment form, which include prompts for the assessing clinician to consider a range of developmentally specific risk and protective factors. A risk assessment of the family situation is recommended, to highlight any support needs or child protection concerns.

4.1 Clinical criteria

A child or adolescent is admitted in the following circumstances:

- recognised, or probable mental illness or disorder, and reasonable likelihood that inpatient care will result in substantial benefit

And at least one of the following:

- previous unsuccessful trial of intervention in a less restrictive setting, or circumstances do not allow such a trial to be considered
- high level of vulnerability to harm (as defined in the risk criteria below)
- significant impairment of self-care skills and social functioning at home and at school, as a result of a mental illness or disorder which cannot be adequately treated in a community setting
- requirement for specialised treatment such as intensive psychotherapeutic or biological intervention not able to be safely delivered in a less intensive setting
- diagnostic or systemic complexity requiring a range of assessments most effectively performed as an inpatient.

In the absence of a high level of suspicion of concurrent mental illness, young people with a primary diagnosis of autistic spectrum disorder and/or global intellectual impairment are unlikely to benefit from admission to AMHIU and are potentially at higher risk of iatrogenic harm.

4.2 Risk criteria

Level of risk where admission may be considered will be evidenced by one or more of the following:

Danger to self:

- significant previous life-threatening self-harm with confirmed imminent risk
- specific suicidal intentions with high lethality and availability of means
- risk of suicide or serious self-harm that cannot safely be managed in a less restrictive setting
- a level of impulsiveness and impaired judgement which places the child or adolescent at significant risk of misadventure or being harmed by others.

Danger to others:

- significant previous violent acts and continued imminent risk
- specific threats of violence with high lethality and available means

- behaviour that poses a significant risk of social, financial or psychological harm to others
- a level of dangerousness to others that cannot be managed in a less restrictive setting.

4.3 Admission priorities

It is important that there is state-wide consistency when determining the need for inpatient resources. Prioritisation must therefore be made on clinical need, with consideration for maintaining ward milieu, patient mix and a safe environment.

Table 1 below provides a guide to prioritising admission based on the degree of assessed risk and the level of care available in the young person's current situation.

Table 1: Admission priorities

Primary consideration	
Priority	**Level of current risk**
1	immediate risk of death or serious physical harm, either to self or others
2	clear risk of suicide, self-harm or violence, but without immediate intentions or access to means
3	distressing and incapacitating symptoms being presented, or progressive deterioration and loss of function regarding self-care and social functioning
4	child or adolescent requires complex multi-disciplinary assessment in an inpatient setting

Secondary consideration	
Priority	**Level of current care**
1	care is provided at home or in another community setting
2	the child or adolescent is in a setting that can provide a level of safety but only for a very limited time e.g. an emergency department
3	the current level of care cannot provide adequate mental health treatment, but it is safe e.g. a paediatric or medical ward, or a youth detention centre
4	care is provided in an adult mental health unit

4.4 Risks associated with admission

The benefits of admission must be weighed against the associated potential risks. Alternatives to admission may deliver the same or better outcomes. Potential risks to consider include:

- negative clinical reaction to the environment and other inpatients
- separation from family, friends, school, and other ecological support systems, including cultural impacts
- difficulty in providing effective family therapy and other systemic interventions where there is significant distance between the inpatient unit and the young person's home
- outcomes of previous admissions assessed as unhelpful or counterproductive
- exposure to behaviour from others may have a negative impact on recovery.

4.5 Other considerations

Other factors to consider in determining an admission are:

- consent is usually provided by the parent or legal guardian of the child or adolescent (see subsection 4.6 Consent)
- inpatient treatment and care should be provided separately from adults, if practicable and appropriate to the individual's situation (refer to subsections 5.6 Admission to an alternative unit and 5.7 Additional considerations for admission to an adult acute mental health inpatient unit).
- the current balance of children and/or adolescents within the unit, in particular the diagnostic mix and resulting milieu
- whether admitting a particular child or adolescent may create difficulties regarding confidentiality or the specific management of another child or adolescent.

4.6 Consent

Unlike adults, minors are not presumed to have capacity to consent to their own treatment and care unless an assessment shows evidence of capacity to consent, referred to as 'Gillick competence'.

The 'less restrictive way' of treatment includes a parent providing consent for a minor. This means that a Recommendation for Assessment is only to be made if it is likely that the minor would not be able to receive care with the consent of a parent/guardian.

If seeking consent from a parent, the doctor and/or mental health practitioner should be satisfied that the person providing consent is a parent as defined in the *Mental Health Act 2016* (refer to section 9. Definitions of terms used in the guideline). If the parent decides not to consent, the reasons for this decision are taken into consideration. However, an authorised doctor may make a Treatment Authority if treatment is considered necessary and no less restrictive options are appropriate to meet the minor's needs. A parent cannot consent to the use of seclusion or restraint on a minor, or to the administration of electroconvulsive therapy.

For further information on the use of the *Mental Health Act 2016* and 'less restrictive way', refer to section 5. 'Referral and admission processes and pathways' and section 8. 'Use of restrictive interventions on children and adolescents'.

5. Referral and admission processes and pathways

5.1 Making a referral for admission

The referral and admission flowchart is illustrated below (Figure 1). Each HHS may have a slightly different approach and process. It is therefore recommended that the steps are discussed and agreed as soon as practicable.

Referral can occur at any time (24/7) by the standard referral process within the relevant admitting unit. A referral can be made by:

- a CYMHS clinician in consultation with the treating CYMHS psychiatrist
- a psychiatrist, including a private psychiatrist, or a psychiatric registrar
- a medical officer, in rural or remote areas, in consultation with a psychiatrist.

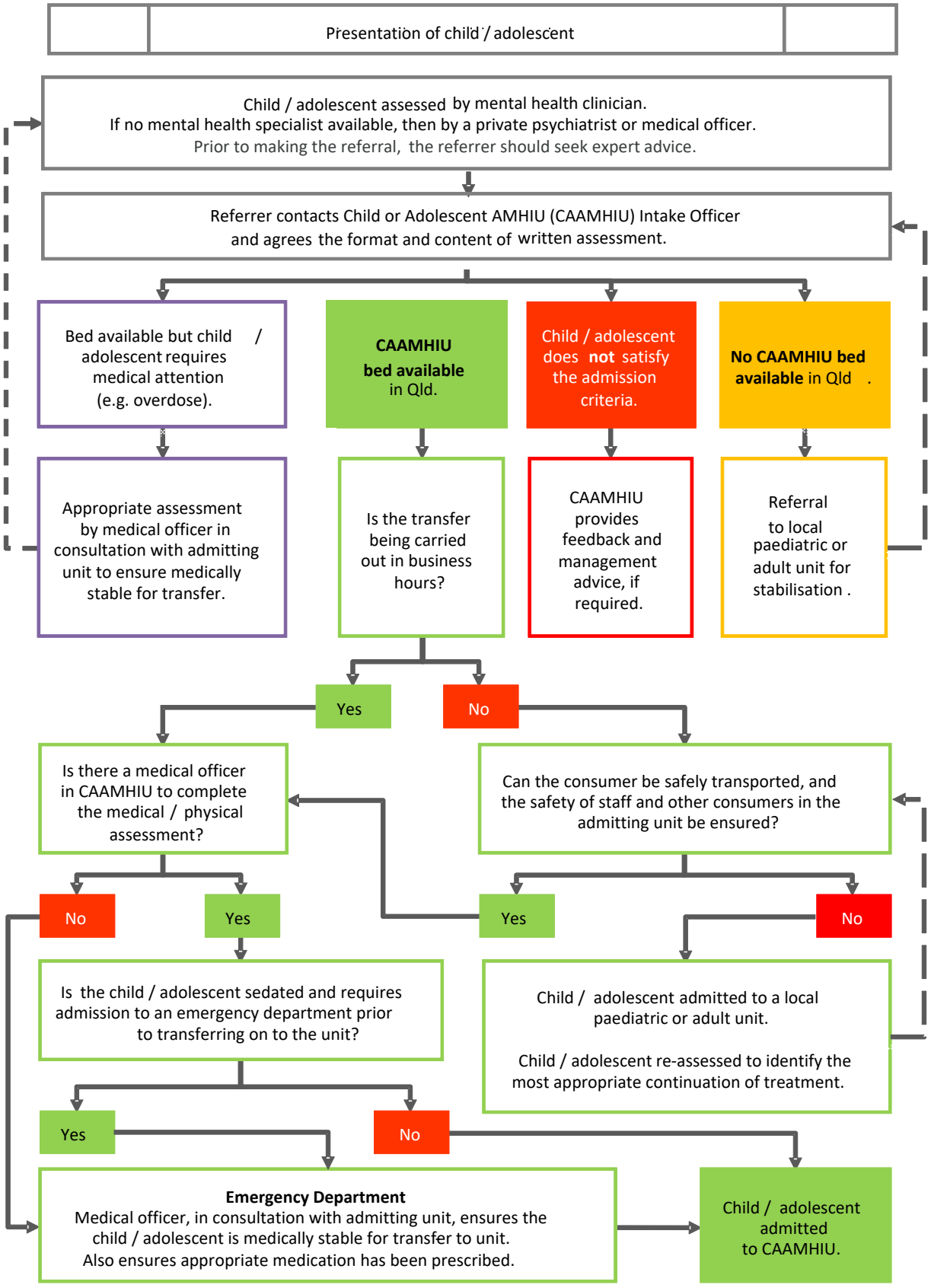
The referrer must discuss the referral directly with the intake officer who will, if necessary, discuss the referral with the on-call consultant psychiatrist. The referral information will include:

- mental state examination
- diagnosis/provisional diagnosis and formulation
- *Mental Health Act 2016* status
- medication history
- plan for risk management and immediate care
- copy of Care Plan (or an indication that a current Care Plan is available on CIMHA)
- accommodation and support details
- referrer's goals for admission.

Assessment is an integral part of the referral process and therefore should be completed with input from the appropriate local psychiatrist, where possible the CYMHS psychiatrist.

The content and format of the assessment must be agreed between the referrer and the intake officer. The approach to recording the assessment must remain proportionate, considering the young person's history and current condition, and must not delay the transfer or admission. The assessment should preferably be recorded electronically in CIMHA. Information recorded on the clinical file and/or CIMHA should be readily accessible to facilitate communication of relevant clinical information to other departments, units and services.

Figure 1: Referral and admission flow chart



5.2 Decision to accept the referral

The intake officer will consider the referral based on the criteria and priorities outlined in section 4, in consultation where needed with the on-call consultant psychiatrist. If the referrer and intake officer are unable to agree on the suitability of an admission, escalation appropriate to the clinical urgency and complexity of the situation should occur. This may include a consultant-to-consultant discussion.

An agreed decision regarding admission will be confirmed by the intake officer, following receipt of any agreed assessment and (where appropriate) a transport risk assessment (see section 6. Transport, in particular 6.1 Transport risk assessment).

The referring team and the admitting child or adolescent AMHIU will adopt joint responsibility for the young person's transfer and care, ensuring that appropriate treatment is commenced as soon as possible. This is especially important where the admitting AMHIU is not located in the HHS in which the young person lives or is currently receiving care.

Sections 5.6 and 5.7 provide guidance for situations where no bed is available within the child or adolescent AMHIU in whose catchment area the young person resides (the 'responsible' AMHIU). General guidance regarding catchment areas for each unit can be found in Appendix 1: Catchment and contact details of child and adolescent inpatient units.

5.3 *Mental Health Act 2016*

In determining whether a child or adolescent is to be admitted voluntarily or involuntarily under the *Mental Health Act 2016*, clinicians must consider least restrictive principles in providing treatment and care. The *Mental Health Act 2016* refers to this as 'less restrictive way'. Alternatives to involuntary care are employed wherever possible. For children and adolescents, this generally means with the consent of a parent or legal guardian (refer to section 4.6 Consent). 'Less restrictive way' resources and forms, including those specific to young people, can be accessed on the Queensland Health *Mental Health Act 2016* internet site at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act.

5.4 Children and adolescents subject to a Child Protection Order

When a child or adolescent is admitted from foster care or residential care, it is expected that:

- prior to admission, there is liaison with the Child Safety Service Centre and the identified Child Safety Officer (CSO) for purposes of liaison, support and care planning
- consent for the admission is obtained from the Child Safety Service Centre and/or parent/legal guardian where appropriate with due consideration of individual risk factors
- Child Safety Services will identify a discharge residential address during the time the child or adolescent is admitted

- Child Safety Services and the inpatient treating team work collaboratively to deliver the best outcome, focusing on care planning and ensuring adequate support is provided by coordinating visiting arrangements for parents and/or carers, non-government organisations, service providers and the CSO.

Community Visitors are employed by the Office of the Public Guardian (OPG) to visit children and young people in out-of-home care (including foster and kinship care and mental health inpatient units), to advocate for them and to provide support, including providing independent information about rights, reporting any concerns to OPG about the quality of care provided, and making referrals to other agencies for assistance where needed. Community Visitors will undertake activities as outlined by the *Public Guardian Act 2014,* available at https://www.legislation.qld.gov.au/view/pdf/2017-06-05/act-2014-026.

5.5 Transferring a child or adolescent from court or custody to an authorised mental health service as a classified patient

Refer to *Chief Psychiatrist Policy: Classified Patients* at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/policies-guidelines.

Consideration may need to be given to the level of acuity of the child or adolescent being admitted, to ensure that the admitting inpatient unit is able to meet their needs, including if there is a requirement for continuous therapeutic visual observation.

If the unit receiving the referral has concerns regarding the unit's capacity to safely and effectively manage the transfer and care of the child or adolescent, the identified issues must be addressed by appropriate strategies (including security support on the unit, admission to an adult High Dependency Unit or transfer to an alternative adolescent or adult unit) to ensure an appropriate plan for transfer and care is agreed.

5.6 Admission to an alternative unit

At times a bed may not be available within the child or adolescent AMHIU in whose catchment area the young person resides (the 'responsible' AMHIU) (refer to Appendix 1: Catchment and contact details of child and adolescent inpatient units). In these circumstances an admission to an alternative unit may be negotiated. This will generally be a child or adolescent AMHIU, but may be an adult AMHIU or a paediatric unit or general medical ward.

The decision to admit a child or adolescent to an inpatient unit other than the responsible AMHIU must reflect a balance between the young person's clinical needs; access to parents, carers and other supports; maintaining continuity of care; and minimising disruption to routine for the young person and their family.

Where admission to an inpatient unit other than the responsible AMHIU is considered necessary, the referring service in collaboration with the responsible AMHIU should work with AMHIUs and where necessary paediatric or general medical inpatient services to identify an appropriate alternative unit that will accept the young person's transfer and care. Services are encouraged to

work together to develop agreed local processes regarding how the responsibility for identifying an alternative unit will be shared between referring services and the responsible AMHIU.

All services involved should work collaboratively, with a particular focus on consideration by AMHIUs of clinical need and associated urgency of the request for admission, to prioritise allocation of beds. Close liaison should be maintained with the young person and their family/carers. Decisions should be made jointly, and clearly communicated to the young person, family, carers and relevant service providers.

During the admission, collaborative liaison should occur between the admitting unit, the referring service, the responsible AMHIU and other relevant services providers in relation to ongoing care and possible transfer of care arrangements. Any decisions regarding a transfer back to the local area, whether to inpatient or community care, will be individualised based on the clinical needs of the young person and the available local supports.

Admission to a paediatric or medical ward or an adult AMHIU

Where no child or adolescent inpatient bed is available, it may be appropriate for a child or adolescent to be admitted to a paediatric or medical ward or an adult AMHIU for temporary care and stabilisation. This must be done in negotiation with the relevant admitting unit, and is subject to:

- considerations regarding acuity and the admitting unit's capacity to meet the young person's clinical needs as outlined in subsection 5.5
- risk assessment and safety planning in consultation with the admitting unit
- a clear treatment/care plan
- clarity regarding responsibility for clinical decision-making during admission
- agreement on appropriate in-reach to be provided by CYMHS or other mental health staff during admission.

In general, admission to a paediatric or medical ward or an adult AMHIU should only be until the child or adolescent can be transferred to an available child or adolescent AMHIU. In some situations it may be appropriate where safe discharge to the community is anticipated prior to a bed becoming available in a child or adolescent AMHIU.

During a temporary admission, ongoing assessment should occur to identify whether or not admission remains the most appropriate option to meet the young person's needs, including when a child or adolescent AMHIU bed becomes available.

NOTE: This section does not apply where a child or adolescent with a comorbid mental health problem is admitted to a paediatric or medical ward primarily for treatment of a medical condition, for example medical stabilisation for refeeding in a young person with an eating disorder.

5.7 Additional considerations for admission to an adult acute mental health inpatient unit

A young person is only to be admitted to an adult AMHIU when it is assessed as the most appropriate option for that person at that time. This decision should be made in consultation with relevant service leaders and is to be based upon factors including:

- the clinical assessment or diagnosis
- urgency for admission based on clinical risk assessment
- unavailability of a child or adolescent AMHIU bed
- the young person's age, developmental stage and level of independent living (particularly relevant for those approaching their eighteenth birthday who require ongoing care)
- the need to remain in geographical proximity to family, carers, friends, school or work, and other ecological support systems
- the expressed needs and choices of the young person and their family and/or carers
- the need for a level of care consistent with a High Dependency Unit due to acuity, clinical risk and/or the likely risk to other consumers
- assessed transportation risks (see section 6. Transport, in particular subsection 6.1 Transport risk assessment)
- the need for short term stabilisation prior to transfer to a specialised unit, especially where this may involve acute sedation.

In determining whether the admission of a young person to an adult AMHIU is an appropriate option, the therapeutic milieu of the unit is to be considered. Where admission to an adult unit occurs, the unit environment should be continually assessed to determine current and/or potential risks, as the milieu may rapidly change. Risks to the adolescent's emotional, physical and sexual safety are to be assessed as well as the needs of the other adult consumers currently on the inpatient unit. There is an obligation to ensure that safeguards are in place and continuously reviewed to protect the young person's wellbeing, especially as a minor within an adult facility. When a child or adolescent AMHIU bed becomes available, the potential for transfer should be considered.

When any young person is admitted to an adult AMHIU, a clinician with child and youth mental health experience and/or expertise should provide in-reach support within a consultation liaison framework to facilitate the planning and delivery of care, and linkages with developmentally appropriate community supports. This in-reach may be provided by a CYMHS hospital-based team (this may be within the responsible child and adolescent AMHIU), a CYMHS community team or a member of an integrated mental health community team. During the young person's admission, collaboration is maintained between the services to facilitate discharge planning and post-discharge community contact.

Written notice must be provided to the Office of the Public Guardian (OPG) when a minor is admitted to a mental health inpatient unit other than a child or adolescent inpatient unit. Notice is provided by email to OPGvisitingpractice@publicguardian.qld.gov.au and includes:

- name of admitting authorised mental health service and treating unit
- CIMHA identification number
- age of young person
- name, designation, phone and email details for an appropriate contact person at the AMHS e.g. Nurse Unit Manager, Shift Coordinator.

5.8 Short term management in a community setting

Where immediate admission is not possible, a decision may be made to opt for short term management in the community whilst awaiting an inpatient bed. Such a decision should be made collaboratively between the referring team, the admitting unit (including the inpatient psychiatrist) and the child or adolescent and their parents and/or carers. The decision must consider the risks for the child or adolescent and their family/carers, the duration the current situation can be reasonably managed, the clinical capabilities and capacity of the community service, and other available resources in the community.

Available resources should be identified to assist with crisis management. These may include private and primary care providers with whom the child or adolescent is already linked, local emergency departments, acute care teams, CYMHS teams, adult mental health services, Acute Response Teams, non-government agencies, and telephone support from the local child or adolescent inpatient team.

6. Transport

Once a referral for admission has been accepted, transportation needs must be carefully evaluated. Transfer between facilities should occur when the child or adolescent is medically stable and can be safely transported, and the admitting unit is able to ensure the safety of the child or adolescent. It is therefore preferable that transfer between facilities is carried out during business hours.

Inter-hospital transfers which are not time critical should be requested using the Inter Hospital Transfer Request Form available on the Queensland Health intranet.

The referrer must maintain contact with the admitting unit, in particular confirming the status and travel arrangement at the time of departure. Children and adolescents must not be left unattended at any time and must be accompanied by an appropriate escort. Families/carers should be notified of all transportation arrangements including safe arrival of the young person at the admitting unit.

Arrangements for safe transport are to be guided by *Chief Psychiatrist Practice Guidelines – Transfer and Transport*, and the *Queensland interagency agreement for the safe transport of people accessing mental health assessment, treatment and care* (2019).

6.1 Transport risk assessment

The referring clinician, in consultation with the admitting unit, must agree the scope and content of the transport risk assessment. This assessment must consider the possible risks to the young person and staff during the transport process (such as absconding, violence, self-harm, suicide, and undue distress to the child or adolescent). In addition, it should include plans to minimise these risks such as the nature of the escort, level of observation, the mode of transport, medication prior to departure, Pro Re Nata (PRN) medication during transport, contingency plans and who to contact in the event of a crisis.

6.2 Mode of transport

The mode of transport will depend on clinical factors as well as distance. The appropriate mode of transport, escort and crew mix will therefore be agreed upon by the referring clinician, the intake officer, the child's or adolescent's parents and/or carers, and if appropriate the child or adolescent, Queensland Ambulance Service (QAS) Transport Centre, the Queensland Police Service (QPS), or the Queensland Emergency Medical System Coordination Centres (for emergency and/or air transport).

Air transport should be considered when the journey time by road will be more than two hours (one way), however local protocols may vary. Where a private vehicle, public transport, or a Queensland Health vehicle will be used, it is the responsibility of the referring service to coordinate transport arrangements. Where a QAS or QPS vehicle or aircraft will be used, it is the responsibility of the transferring unit to coordinate the arrangements with the relevant communications centre.

Non-emergency transport options should be used when there are no urgent medical needs and risks of harm are low. Transport options therefore include:

- private vehicle
- public transport (taxi, bus, rail or aircraft)
- Queensland Health vehicle
- QAS vehicle
- QPS vehicle
- air retrieval as coordinated through Retrieval Services Queensland.

6.3 Air retrieval

The director of the admitting unit must be involved in the planning of all admissions where air transport is required. Factors to consider include the level of possible distress, *Mental Health Act 2016* requirements, and the need for safe extubation of an anaesthetised child or adolescent at the admitting hospital. Additionally, the referrer must be aware of the relevant air retrieval service provider's policies for risk assessment and management.

6.4 Police assistance

Police should be involved in transport **only** where their assistance is required for the safety of the child or adolescent or others. Police are obligated to respond as soon as practicable when their assistance is requested by a health practitioner or ambulance officer under the *Mental Health Act 2016*. In practice, this process involves negotiation between police and the requesting agency.

Transport in a police vehicle should be an option of last resort and should be restricted to short distances wherever possible. Transport in a police vehicle can cause heightened distress and agitation for the child or adolescent and their family and carers and can contribute to stigma. If the child or adolescent is to be transported in a police vehicle, the health practitioner or ambulance officer must accompany the person to the health service. Where practicable this should be in the same vehicle as police.

6.5 Sedation for purposes of transfer

Sedation may be necessary before or during the transfer. If used, a sedation plan must be developed and discussed with the intake officer, and must align with:

- *Guideline: Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents)*, 2017
- Where air transport is involved, the air retrieval service provider's guidelines.

A list of all medication prescribed before and during transfer must accompany the escort, who must record the time and dose of all medications administered.

Depending on the level of sedation, the child or adolescent may be taken to the emergency department for assessment prior to admission to the AMHIU. Wherever possible, this decision should be made in consultation with the admitting hospital prior to the transfer.

7. Care of children and adolescents in an acute inpatient setting

The focus of inpatient care is on the stabilisation of acute symptoms, reduction of clinical risk, the development of a therapeutic alliance, the development of a diagnostic formulation and care plan, and the provision of a range of interagency recovery focused treatments within an appropriate developmental framework. Throughout admission, the care and treatment needs of the child or adolescent and the appropriateness of the treatment setting are continuously monitored.

The child or adolescent and their family/carers are informed of their rights and supported to access the local Independent Patient Rights Adviser for support, advocacy and advice about their rights under the *Mental Health Act 2016*. The Independent Patient Right Adviser plays an important role in liaising between the treating team, the child or adolescent and their family and/or carers. This includes helping the child or adolescent and their family and/or carers to communicate their views and preferences about treatment and care to the treating team.

7.1 Environment

A young person admitted to a child/adolescent inpatient unit is placed on continuous therapeutic visual observation only if this is deemed clinically appropriate. It is recommended that a young person/adolescent admitted to an adult inpatient unit be placed on continuous therapeutic visual observation initially, until a thorough risk assessment is completed to inform the most appropriate level of visual observation. Thereafter, ongoing therapeutic visual observation requirements are to be at the discretion of the treating team. Decisions about visual observation requirements should be based on clinical judgement, the young person's developmental vulnerability, their emotional, physical and sexual safety, the design and layout of the unit and the current unit milieu. The possibility that the child or adolescent may pose a risk to the safety of others should also be considered.

Every effort is to be made to provide an environment that has:

- a safe, secure, comfortable and private space where the child or adolescent can meet with their family and/or carers
- access to a suitable outside space. A member of staff may escort the child or adolescent outside of the inpatient unit, as part of the care plan, after obtaining parental consent
- a private bedroom. If this is not possible, the child or adolescent should share with another child or adolescent of the same sex; this includes the sharing of bathing facilities.

7.2 Treatment planning

The engagement of the child or adolescent and their family and/or carers in collaborative, recovery focused treatment planning is essential for future engagement with community mental health services. Recommendations regarding treatment and care should involve collaboration and linkage with a range of community service providers. This enables the child or adolescent to build on their strengths and improve their self-esteem, and enhances opportunities for social inclusion and recovery focused outcomes upon discharge.

Treatment is provided within a 'less restrictive way' framework (refer also to section 5. Referral and admission processes and pathways; in particular subsection 5.3. *Mental Health Act 2016*).

Collaborative work is to be undertaken with children and adolescents and their family and/or carers to formulate individualised crisis prevention or safety plans by identifying triggers that can cause distress, strategies to support de-escalation, and strategies to build coping skills and resilience.

As much as possible, the transition of mental health care between the acute inpatient unit and the community should be a planned and systematic process that is responsive to the needs and diversity of the child or adolescent, and inclusive of their family and/or carers and appropriate others. Transition of care should align with the principles within the Queensland Health guideline *Transition of care for young people receiving child and youth mental health services* (2019).

7.3 Communication, collaboration and engagement

During admission, a clear and open communication channel is to be maintained between the inpatient and referring teams, and the child or adolescent and their family and/or carers, to enable:

- comprehensive discussion of the assessment and management of risk, and diagnostic formulation
- development of care and recovery plans
- transition planning in readiness for discharge, including arrangement of post-discharge community contact with relevant services
- opportunities for the young person and their family and/or carers to provide feedback on their experience with this process.

The information below may assist clinicians to engage a young person and their family/carers.

Child/adolescent engagement

- Structure – enhanced by setting fair and consistent expectations, and by establishing routine, predictability and suitable activities.
- Boundaries – clear and firm boundaries are required, while seeking to identify the precipitants and appreciate the meaning of behaviours as adolescents may communicate more readily through their actions.
- Rapport – time needs to be taken to develop rapport with adolescents, however, it is important that staff retain a professional position and relationship with the adolescent.
- Therapeutic relationship – often most readily developed through regular non-intrusive contact. Adolescents may present as more anxious or hostile towards authority figures than adults.
- Engagement – to lessen anxiety, regular face to face interviews with an adolescent is usually required. The format and process of the clinical interview may need to be different. Engaging adolescents in activities such as a game of pool, basketball or music is a useful strategy.

Family/carer engagement and information sharing

- Engaging families and/or carers is central to care.
- Parents, carers, legal custodians and legal guardians, which may include Child Safety Services, are to be informed when a child or adolescent is admitted to hospital. The treating team should arrange a meeting with the family and/or carers as soon as practical to discuss the reasons and goals for the admission. Regular family meetings should occur throughout the admission to facilitate support and opportunities for discussion and psychoeducation.

- It is useful to plan and conduct meetings with families and/or carers in a way that the young person is comfortable with, wherever possible. Parental expectations are to be explored early in the admission so that the objectives of the inpatient admission are clear. Joint discharge planning is to be undertaken wherever possible.
- For further information on involving families and/or carers please refer to the *Queensland Health Consumer, Carer and Family Participation Framework* (2010).
- Good clinical practice requires the sharing of relevant and appropriate information with families and/or carers regarding the treatment and progress of the child or adolescent, whilst also safeguarding an adolescent's rights to confidentiality. For further detail on information sharing with families and carers please refer to the Queensland Health guideline *Information sharing between mental health workers, consumers, carers, family and significant others* (2017).

7.4 Aboriginal and Torres Strait Islander children and adolescents

An Aboriginal and Torres Strait Islander mental health/health worker is an integral part of the treating team to advise on the young person's treatment needs, and to provide advice, support and advocacy to the child or adolescent and their family and/or carers. This might be via communication, translation, assisting with discussions about diagnosis, care planning and medications, and if needed, by being present during the admission process.

The 'Aboriginal and Torres Strait Islander Cultural Information Gathering Tool' (available on CIMHA) and other available tools can provide valuable cultural information to support assessment, care planning, and engaging the young person and their family. Aboriginal and Torres Strait Islander mental health/health workers may be able to assist by completing these tools with the young person and their family and providing relevant advice to treating clinicians based on the information received.

7.5 Additional considerations for culture

All admitting units should plan for the needs of children and adolescents from culturally and linguistically diverse backgrounds.

7.6 Supporting staff through clinical supervision

It is not unusual for young people to evoke strong feelings, either positive or negative, in staff. Staff interactions with children and adolescents should be monitored, and appropriate support provided.

8. Use of restrictive interventions on children and adolescents

Chief Psychiatrist Policies on seclusion, mechanical restraint and physical restraint apply. The policies are available on the Queensland Health *Mental Health Act 2016* internet site.

The use of restrictive interventions carries a risk of psychological and physical harm. Additional caution is required when using restrictive interventions on children and adolescents, especially those with comorbid physical health conditions or heightened vulnerability to psychological trauma. All efforts must be made to prevent and manage challenging behaviour without the use of restrictive interventions. As far as is practicable and safe, verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation must be used to help the child or adolescent safely gain control of their behaviour.

Should a child or adolescent be placed in physical restraint, seclusion or mechanical restraint, parents and/or carers are contacted as soon as practicable after the event. All consumers, families, carers and staff are offered the opportunity to be involved in appropriate review of the restraint event as soon as clinically appropriate after the event to discuss the reasons for, and circumstances of, the restrictive intervention, and to plan for future prevention.

8.1 Acute pharmacological management

Refer to the *Guideline for acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents)*, 2017.

9. Catchment and contact details of child and adolescent inpatient units

Refer to Appendix 1.

10. Definitions

Term	Definition / Explanation / Details	Source
adolescent	For the purposes of this document the term 'adolescent' refers to those aged 13-17 years	
AMHIU	Acute mental health inpatient unit	
responsible AMHIU	The child or adolescent acute mental health inpatient unit in whose catchment area a young person resides or is receiving care	

Term	Definition / Explanation / Details	Source
child	For the purposes of this document the term 'child' refers to those aged 0-12 years	The Mental Health Data Set – Definitions v5 (2018)
CIMHA	Consumer Integrated Mental Health and Addiction application	
CYMHS	Child and Youth Mental Health Service	
escort	Someone other than the driver of a vehicle who accompanies a consumer during transport to provide monitoring, support or treatment. Common escorts include a family member, carer or close friend, a health or mental health worker (usually a nurse, doctor or allied health professional), an ambulance officer or a police officer	Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care, 2019
minor	Refers to a person under the age of 18 years	*Acts Interpretation Act 1954*
parent	Parent, of a minor includes: A guardian of the minor A person who exercises parental responsibility for the minor, other than a person standing in the place of the parent of the minor on a temporary basis For an Aboriginal minor – a person who, under Aboriginal tradition, is regarded as a parent of the minor For a Torres Strait Islander minor – a person who, under Island custom, is regarded as a parent of the minor.	*Mental Health Act 2016*
young person	For the purposes of this document the term 'young person' is used synonymously with 'child or adolescent', and refers to a person under the age of 18 years	
24 hour/s	Unless otherwise stated, refers to 24 hours a day, 7 days a week.	Clinical Services Capability Framework v3.2

11. Document approval details

Document custodian

Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland

Approval officer

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland

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Guideline: Admission to child and youth mental health acute inpatient units, Queensland Health, 2016

Guiding Principles for the Management of Adolescents in Queensland Health Adult Acute Mental Health Inpatient Units, 2012

12. Version Control

Version	Date	Prepared by	Comments
V1.0	June 2021	Clinical Governance Team, Office of the Chief Psychiatrist	First publication

Appendix 1

Catchment and contact details of child and adolescent inpatient units

Child and adolescent unit contact details

Site	Contact number
Gold Coast	0414 698 774
Queensland Children's Hospital (QCH)	
Child Unit	(07) 3068 2520
Adolescent Unit	(07) 3068 2559
Logan	(07) 3299 8482
RBWH	(07) 3636 1179
Sunshine Coast	(07) 5202 3277
Toowoomba	(07) 4616 5767
Townsville	(07) 4433 9700

Catchment area guide

NOTE this guide is under review.

Referring HHS	Adolescent	Child
Cairns and Hinterland	Townsville	QCH
Central Queensland	RBWH	QCH
Central West	Toowoomba	QCH
Children's Health Queensland	QCH	QCH
Darling Downs	Toowoomba	QCH
Gold Coast	Gold Coast	QCH*
Mackay	Townsville	QCH
Metro North	RBWH	QCH
Metro South **Excluding PAH catchment** **PAH catchment**	 Logan QCH	 QCH
North West	Townsville	QCH
South West	Toowoomba	QCH
Sunshine Coast	Sunshine Coast	QCH

Referring HHS	Adolescent	Child
Torres Strait and Cape	Townsville	QCH
Townsville	Townsville	QCH
West Moreton **East of Gatton** **West of Gatton**	 Logan Toowoomba	 QCH QCH
Wide Bay	RBWH	QCH

* Pending confirmation

Abbreviations within table:

QCH – Queensland Children's Hospital

PAH – Princess Alexandra Hospital

RBWH – Royal Brisbane and Women's Hospital