Child & Adolescents Mental Health Services (CAMHS) CAG

The CAMHS CAG is pleased to provide a response to the Tasmanian Government’s Green Paper.

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Response to Green Paper

The draft Tasmanian Role Delineation Framework (TRDF) does not have a specific Child and Adolescent Mental Health Service (CAMHS) service definition or profile. This ignores the national and international recognition that CAMHS are quite different from and need to be organised in a different way from Adult Mental Health Services.

In Tasmania we need an integrated Perinatal, Infant, Child and Adolescent Mental Health Service. The TRDF needs to have a dedicated section for CAMHS (including perinatal and infant mental health, or PICAMHS) in which the appropriate levels of service at inpatient and community services can be planned.

CAMHS requires developmentally appropriate services to meet the mental health needs of infants, children and adolescents which are different to those of adults\(^2\). Children are treated within the context of their family, present with a different range of mental disorders to adults, and experience different developmental challenges. CAMHS operate in a different legislative framework and engage with a different range of services from adults. CAMHS requires a developmentally specific model of care including service planning and development and a CAMHS specific organisational and clinical governance structure\(^3\).

Recommendation 1

That a separate Service Profile for CAMHS be included in the finalised TRDF (Attachment A).

Recommendation 2

A definition of Child and Adolescent Mental Health Services needs be included in the CAMHS TRDF as follows:

CAMHS are specialist multidisciplinary services for infants, children, adolescents between the age of 0 and 18 years, and their families who present with severe and complex mental health problems that cause functional impairment and have an adverse impact on social and emotional development or risk of harm. As well as the provision of specialist care, CAMHS will provide support to other service sectors to provide mental health services to children with mild to moderately severe problems.

This definition recognises the role of CAMHS in promoting healthy development as well as addressing existing disorders; the need to involve families and support the capacities of parents in order to optimise child mental health outcomes; and CAMHS role in supporting other services in the infant, child and adolescent sector.

Recommendation 3

The definition should be underpinned with the following principles of:

- promoting social inclusion and recovery in intervention services;
- enhancing prevention and early intervention services;
- improving access co-ordination and continuity of care within service systems; and
- strengthening research and performance monitoring\(^4\).

As noted above, CAMHS provides direct care to infants, children and adolescents who have severe and complex mental health problems. This represents approximately 2-4% of young people within Tasmania.


\(^3\) Williams R & Kerfoot M (2011) Child and Adolescent Mental Health Services: strategy, planning, delivery and evaluation, Oxford University Press.

However, CAMHS also has a role in supporting other stakeholder (lower level) services in the infant, child, adolescent and youth sector to meet the needs of the 14% of young people with mild to moderate mental health problems through consultation and liaison; and education and training\(^5\).

Key stakeholder services for CAMHS include paediatrics, obstetrics and neonatal services, general practitioners, education, child protection, youth justice, child health and parenting services, disability services, rehabilitation services, Tasmanian Aboriginal Centre, specialist services for refugees and Lesbians, Gays, Bisexual and Transgender population, as well as adult mental health services, non-government services and private practitioners working in the sector.

These different levels of CAMHS needs to be described in the TRDF.

**CAMHS: Issues and Service gaps**

Services in the infant, child, adolescent and family sector are currently challenged in meeting the needs of Tasmanian children and families. Tasmania has the highest proportion of children experiencing the greatest degree of social exclusion of any state in Australia\(^6\). Tasmania has a high number of children in out of home care\(^7\), high numbers of children not engaged in education\(^8\), high rates of teenage pregnancy\(^9\), significant numbers engaged in the youth justice system\(^10\), and high numbers of young people presenting with suicidal ideation and contemplating suicide\(^11\).

| Each year CAMHS should provide direct care to around 4,737 young people across the state but currently are able to see only 1,819\(^\text{12}\). |

Private practitioners can provide care to young people with mild to moderate mental health problems, but often lack the specialist knowledge and skills required to work with young people and families. Furthermore, young people have complex needs requiring clinicians to work with them not just individually but in family therapies and with wider systems including schools, child protection, etc. Funding arrangements for private practitioners do not accommodate this practice.

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8 Ibid.


12 Tasmanian Child and Adolescent Mental Health Services (2014) internal data.
Non-government organisations often do not have the skilled staff or model of care to meet the needs of young people and families they see. The sector is fragmented and care provided to children and families at high risk is often also disconnected.

**Structure and Governance**

There is a need for structural and resourcing arrangements that facilitate collaboration and joint service delivery between services in the infant, child, adolescent and family sector\(^\text{13}\). The support of a tertiary CAMHS to primary and secondary services in the sector could increasingly provide care in the community, reduce need for emergency department presentation and hospitalisation, save health dollars and improve health outcomes. It could also reduce costs in education, welfare and justice systems\(^\text{14}\).

CAMHS model of care is different to that of adult mental health services. Structurally CAMHS needs to be a separate service stream within mental health services (or within Child and Adolescent Health Services\(^\text{15}\)) with its own strategic planning, organisational and clinical governance arrangements\(^\text{16}\).

Currently CAMHS in Tasmania exist as three small regional community teams in the South, North and North-West of the state. These CAMHS teams sit within a generic regional mental health organisational and clinical governance structure with Adult Mental Health Services (MHS) and Older Persons’ MHS. There is no CAMHS Clinical Director role or organisational manager to oversee governance and operational control of CAMHS.

In any structural change for CAMHS it is crucial that current good working relationships between CAMHS and Adult MHS in regions are not compromised.

Further, under resourcing has led to significant gaps in the range of CAMHS services deliverable to children and families in this state:

- Per capita spending on CAMHS in Tasmania is the lowest of any state in Australia\(^\text{17}\).
- There is an inequity in the distribution of the mental health budget in Tasmania with per capita spending on Adult MHS being over four times that for CAMHS whereas in other states the per capita spending for CAMHS is around half that for Adult MHS\(^\text{18}\).

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\(^\text{13}\) Williams R & Kerfoot M (2011) *Child and Adolescent Mental Health Services: strategy, planning, delivery and evaluation*, Oxford University Press.


\(^\text{18}\) Ibid.
• CAMHS South is more poorly resourced per capita than CAMHS North or North West\textsuperscript{19}.

**Recommendation 4**

Development of a state wide CAMHS for infants, children and adolescents 0 - 18 years old as a separate stream within Mental Health Services (or within Child and Adolescent Health Services). This includes clearly defining strategic responsibility and operational accountability.

Governance arrangements for the operational elements of the CAMHS must include:

- A statewide Clinical Director role for CAMHS
- Management responsibilities and accountabilities including delegations
- Clinical responsibilities and accountabilities in providing the service
- Supply and allocation of human resources to provide the service
- Appropriate funding as a statewide service
- Review and monitoring; and
- A discrete and dedicated policy framework.

Planning the future of CAMHS in Tasmania should be undertaken with an awareness of other state and national planning processes which may influence funding, policy and delivery of mental health services\textsuperscript{20}.

**Workforce Development and Sustainability**

There is only a small pool of medical, nursing and allied health clinicians in Tasmania with CAMHS specific qualifications and experience. This relates to limited employment options and limited CAMHS-specific training opportunities.

Recruitment can be challenging in this context with specialist expertise potentially required to be sought interstate or internationally. Lower level positions are often filled by clinicians who do not have CAMHS-specific training and require training and supervision before they can take on clinical caseloads of the complex and high risk clients presenting to CAMHS.

Maintaining regional multidisciplinary CAMHS teams is difficult due to a lack of critical mass of appropriately trained clinicians. When staff take unplanned leave CAMHS teams struggle to maintain core service delivery. Senior allied health staff in each discipline are required to supervise and support less experienced clinicians and such key person dependency can make it impossible to develop or maintain a particular discipline in the team.

\textsuperscript{19} Mental Health and Statewide Services (2012) *Looking Ahead: A new approach to delivery of mental health services and support for Tasmania’s children and young people*, internal strategic planning document.

\textsuperscript{20} Rethink Mental Health project, the National Mental Health Service Planning framework, Youth Suicide Prevention Strategy, possible federal funding for a Youth Psychosis service, Joined Up Services Project and federally the Draft National Framework for Child and Family Health Services.
There is only one child psychiatrist in each team in the North and North-West. Cover for leave can mean this role is filled by a psychiatrist without appropriate qualifications. Also, international medical graduate (IMG) child psychiatrists seeking to obtain RANZCP Fellowship may not be able to be supported due to lack of on-site specialist supervision.

Statewide organisation of CAMHS workforce could allow key person dependencies in each region to be overcome through support from other CAMHS. Further, ongoing support to key clinicians in each region could be provided by specialist service training and supervision from a ‘hub’ and/or peer supervision. This would develop a critical mass of clinicians across the state with relevant expertise; creating sustainability; and ensuring quality and consistency of care across Tasmania.

Increasing the use of videoconferencing and online material would allow for more training and supervision. The Perinatal and Infant Mental Health team in Hobart have developed an online UTAS Perinatal and Infant Mental Health postgraduate unit in which 26 students across the state have already participated. A comprehensive CAMHS postgraduate unit could be developed in collaboration with UTAS to enhance and support education throughout the state.

Research and evaluation are also key components of service development. CAMHS would seek to implement robust evaluation of any future service development.

**Recommendation 5**
Statewide organisation of CAMHS workforce to overcome key person dependencies and ensure sustainability of core and specialist CAMHS.

**Recommendation 6**
Statewide organisation of CAMHS education, training and supervision programs.

**Recommendation 7**
That research and evaluation be recognised as a crucial component of service development and be supported in future CAMHS development.

**Youth Services: 18-25 years**

Currently, there are no youth specific (18-25 years) services in Tasmania. A number of Tasmanian policy documents\(^1\) have recommended the scope of CAMHS be increased to include youth services. Federal government funding of a youth early psychosis service has been sought and is a likely impetus for this change, if delivered.

A comprehensive youth mental health service could be developed alongside the CAMHS. However, resource allocation would need to be sufficient to meet this new clinical scope for CAMHS or delivery of service to younger age groups will be compromised. Reallocation of the current budget for this 18-25 year old population from Adult Mental Health Services

\(^1\) Including: Mental Health and Statewide Services (2012) Looking Ahead: A new approach to delivery of mental health services and support for Tasmania’s children and young people, internal strategic planning document;
to CAMHS would only partially meet this need due to the greater range of disorders meeting criteria for Youth as opposed to Adult MHS.

**Recommendation 8**

The scope of CAMHS be increased to include Youth Services (18-25 years of age) for early psychosis intervention and comprehensive youth mental health services only if adequate funding becomes available to deliver these services state-wide.

**Service Requirements for CAMHS in Tasmania**

The challenge for CAMHS is to deliver timely and accessible services, as locally as possible, of sufficient intensity and duration to address the complex difficulties experienced by young people with mental disorders.

The principal asset of CAMHS is a multidisciplinary workforce of clinicians with specialist training and expertise in child and adolescent mental health. The majority of this workforce is deployed in the community, supporting young people and families to promote recovery from mental illness and optimal development in the context of their lives.

Effective treatment requires specialist therapeutic expertise, delivered to child and family, or alternate care givers, over a number of months, and bringing together multiple service systems seamlessly and coherently. Diagnostic clarification and use of medications are less salient components of CAMHS care than in other areas of medicine; and mental health inpatient care required for only 0.07% of the 0-18 year old population.

Delivering CAMHS in the Tasmanian context must respond to a relatively small, geographically dispersed population; and high levels of social exclusion leading to an increased burden of disease in health, mental health and developmental disability. The challenge is to develop a critical mass of clinicians to develop effective, efficient and sustainable services of consistent quality delivered in an equitable manner across the State and ensuring access to remote and disadvantaged populations.

There is general agreement across Australia on the components of a comprehensive CAMHS system and these need to be taken into consideration when developing a statewide service (Recommendation 4):

1. **Centralised State wide CAMHS Intake**

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Currently access to CAMHS is via a generic Mental Health Helpline (MHH) which can result in access to CAMHS being blocked by inappropriate triage, 25 and double handling of patients between MHH and CAMHS. CAMHS intake could also play an important advice and support role to the infant, child, adolescent and family sector.

Linkage of this intake to those of other children’s services could assist families to access the right service for their child26. Within hours intake could be a centralised function or accessed at one number but directed to each region. Twenty-four hour advice might be centralised in a MHH or be viable through statewide CAMHS on-call arrangements.

**Recommendation 9**

Develop a central system for CAMHS intake separate to the generic Mental Health Helpline to ensure CAMHS provides an efficient, safe, and responsive ‘face’ to its service.

## 2. Regional CAMHS

Regionally, a Level 5 or 6 CAMHS Ambulatory Service is required to meet the needs of children and adolescent’s with mental health issues in Tasmania. Tasmania currently provides CAMHS Ambulatory Services at Level 3 or below as shown below. For some services Tasmania does not even meet a Level 1 service.

**CAMHS Community Teams**

Currently CAMHS in each region consists of small multidisciplinary teams who operate during working hours (Level 3-4 CAMHS Ambulatory Service). However, the services needs to be increased from a Level 3-4 to a Level 5-6 CAMHS Ambulatory Service in each region.

To meet Level 5 service requirements the following is required:

- extended hours service
- family and group programmes
- primary and secondary prevention
- consultation and liaison to other services; and
- off-site service provision.

Not all clinicians come into CAMHS with relevant CAMHS qualifications and require specialist training. Lack of a critical mass of clinicians and key person dependency can impact on core service delivery and make regional teams unsustainable. Statewide organisation of workforce, training and specialist programmes would support regional CAMHS teams.

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25 Yellow Submarine CAMHS South consumer and stakeholder consultation 2102
Recommendation 10

Multidisciplinary CAMHS teams in all three regions be resourced with sufficient clinicians with specialist CAMHS expertise to provide Level 5 CAMHS community care to infants, children and adolescents with the most severe and complex mental disorders and to provided assessment and educative feedback to the referrers of those of lower acuity but nevertheless in need of some guidance.

Recommendation 11

Multidisciplinary CAMHS teams in all three regions be resourced with sufficient clinicians with specialist CAMHS expertise to provide Level 6 care with support of statewide specialist services.

Hospital Consultation and Liaison Teams

There is a need for CAMHS in each region to have a Hospital Consultation and Liaison team (HCL) to respond to children and adolescents with mental disorders: presenting to Emergency Departments (ED); admitted to inpatient care; or having co-morbid medical and mental health difficulties.

Currently CAMHS South has a four person HCL team which has considerably enhanced its capacity to meet this need. However, there continues to be unmet need, especially in the psychological difficulties of medically ill young people.

CAMHS North and North West currently respond to ED presentations and inpatient care of under-18 year olds with mental health problems by in-reach services from the CAMHS community team. This impacts on CAMHS delivery of service to community clients whose appointments may need to be cancelled so that CAMHS clinicians, especially a child psychiatrist, can attend to the inpatient crisis. Also, it can be challenging for CAMHS to provide the intensity and range of inpatient care required and there can be a reliance on adult mental health staff to support admissions. HCL requires specialist expertise beyond that required by those working in the community.

There is currently a significant unmet need for specialist mental health care for young people with medical conditions, especially chronic and severe illness, pain disorders, and physical symptoms without medical explanation\(^\text{27}\). Appropriately staffed CAMHS HCL teams have specialist expertise to respond to this need.

\(^{27}\) Shooter M (2011) Chapter 15: Children and Adolescents who have chronic physical illness in Williams R & Kerfoot M (Eds) *Child and Adolescent Mental Health Services: strategy, planning, delivery and evaluation*, Oxford University Press.
Intensive Outreach Services

Currently CAMHS teams have extremely limited outreach capacity which they employ on a crisis basis only. No intensive outreach services are provided.

Adult Crisis Assessment and Triage (CATT) teams will provide limited after hours crisis response to under 18 year olds on request but do not have the specialist expertise to deliver the appropriate care and level of ongoing support which can be provided by intensive CAMHS outreach services.

Outreach services are crucial in providing access to mental health services for those who are difficult to engage with clinic-based services, often the most disadvantaged infants, children, adolescents and families with the highest level of need for mental health care.

Recommendation 13
CAMHS Intensive Outreach Teams be developed as part of each of the 3 regional services.

Rehabilitation services and Day programs

There is no CAMHS rehabilitation or day programme in Tasmania for under 18 year olds with mental disorders.

Day programmes provide week day intensive psychosocial support and rehabilitation for young people when their home or school is unable to support adequate care.

Effective day programmes can reduce need for inpatient care; avoid exclusion of children from schools; and avert removal of children into out of home care.

Service structures and leadership that facilitate collaboration between CAMHS and education, and other child and family services would facilitate this development.

Recommendation 14
Rehabilitation Services and Day Programmes be established as part of each of the 3 regional services.

Regional Satellite services

There is a recognised need to provide more effective outreach to these communities through satellite clinics and supporting non-specialist CAMHS clinicians in these communities to deliver care to young people with mental illness via consultation and liaison, education and supervision. This could be effectively delivered using a hub and spoke model with each of the 3 regional multidisciplinary teams as the hubs.
Teleconferencing can be useful for education, training and supervision. However, young people and families do not engage easily with this technology. It can be useful for assessment in a remote location if facilitated by a local clinician but is not suitable for delivery of ongoing therapy.

**Recommendation 15**

Improve access to CAMHS for remote and disadvantaged populations by development of satellite clinics and consultation liaison services as part of each of the three regional services.

### 3. Statewide Specialist CAMHS

CAMHS for some disorders require development of models of care, specialist training and supervision, and a critical mass of clinicians with specialist expertise that cannot be developed and sustained in small teams and small population catchments.

However, statewide development of these services with key clinicians in each region can ensure quality and sustainability of specialist services in Tasmania. Options for delivery of these services include hub and spoke models, rotating clinics, and statewide access to services in one region. Statewide training, online courses, and videoconference education, consultation and supervision can support regional clinicians.

Currently there are no specialist CAMHS successfully delivered statewide.

Specialist CAMHS in Tasmania include (for more information refer to Attachment 2):

1. Developmental and Neuropsychiatric Disorders:
   - There is currently no consistent pathway of care for young people in this state with intellectual disability, developmental and neuropsychiatric disorders including ADHD and Autistic Spectrum Disorders.
   - Clinics with interstate expert visiting quarterly could review patients and provide education and training to local clinicians.

2. Perinatal and Infant:
   - Perinatal and Infant Mental Health Services (PIMHS) are at a preliminary stage of development.
   - CAMHS South has a small team, which sees 25 new antenatal referrals per month.
   - CAMHS North and North West have also sought to develop a service but this has not been sustainable due to staff changes.

3. Early Psychosis Intervention:
   - There are currently no specialist services for early intervention in psychosis.
   - This service might be developed as a hub and spoke service across the State, or it may be that sufficient resources could become available for a service in each region.

4. Eating Disorders:
   - Developed in the South and North but have been unsustainable in the North-west due to staff turnover, especially paediatricians.
   - There are no specialist eating disorder services for adults, so transition, when necessary, of these patients is challenging.

5. Forensic:
• There is no specialist Forensic Child and Adolescent Service although CAMHS North supports the Ashley Youth Detention Centre where psychologist and visiting psychiatrist with specialist qualifications have provided a service.
• CAMHS South collaborates with Adult Forensic Services in the assessment of some young people.

6. Developmental Trauma (recovering from the trauma of family violence, child abuse and neglect):
• There is no single pathway of care for young people suffering from trauma, and as a result they may continue to reside with family, may be in kinship care or may be in out of home care.
• A large proportion of CAMHS clients present with developmental trauma as a component of their mental disorder, but CAMHS capacity to respond to the volume and complexity of demand is limited.
• The capacity of other support services (Australian Childhood Foundation and Take Two) is also limited.

7. Children of Parents with Mental Illness (COPMI)
• Children of parents with severe mental illness or drug and alcohol use are not currently systematically identified or routinely provided with services.
• These children are at higher risk of subsequent psychiatric disorders and adjustment reactions.
• Linkages between adult psychiatric and drug and alcohol services and CAMHS are needed to ensure the needs of these children are identified and met.
• Early intervention and prevention approaches focus on recovery of parenting capacity and family resilience.

8. Dual Diagnosis
• Mental illness and co-morbid substance use problems are commonly seen in young people. Difficulties frequently emerge early in life and are often persistent.
• These young people with dual diagnosis are difficult to engage in treatment.
• Collaboration between CAMHS and drug and alcohol services to deliver specialist care is necessary.

**Recommendation 16**
CAMHS Specialist Services be developed and organised on a statewide basis ensuring effective and sustainable specialist service delivery across Tasmania through:
• Central development of models of care and specialist expertise
• Shared training and supervision
• Key clinicians in each region.

**Statewide Specialist Inpatient Unit**
Where ever possible, young people with mental health problems and their families are supported in the community. However, for those young people with mental illness of the

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28 Tasmanian CAMHS South internal data 2015.
29 NSW COPMI Framework for Mental Health Services 2010-2015.
highest severity and complexity, there is a need for inpatient care. Other factors impacting on the need for inpatient services include:

- Lack of adequate specialised CAMH outreach services and day programmes leading to increased presentations to emergency departments.
- Lack of accommodation or respite options for young people with developmental disability results in their admission to paediatric units due to behavioural problems or psychosocial crisis.
- Lack of secure welfare options to safely support young people in out of home care.

Where young people do require inpatient care, this should be provided in a developmentally appropriate setting, separate from adults (to avoid placing them at the risk of trauma or abuse). Best practice states the facility should provide family-centred care, space and activities to meet play, leisure and educational needs and have appropriately trained clinical staff in the psychological, developmental, communicative and cultural needs of children and adolescents\(^\text{31}\).

A Level 6 CAMHS is required to provide inpatient care for young people with mental illness of highest risk and complexity (0.07% of 0-18 year old population).

**Acute Inpatient Mental Health Care for Young People in Tasmania**

There are no dedicated inpatient beds or specialist inpatient facilities for under-18 year olds with mental illness requiring acute hospital care. Further, no private hospital in Tasmania has staff or facilities appropriate for the accommodation and treatment of under 18 year olds.

Currently, options for accommodating these young people differ in each region.

In each region young people requiring acute mental health inpatient care are admitted to the Paediatric Unit.

When a young person is too unwell to be accommodated in the Paediatric Unit they are cared for on the Adult Psychiatric Unit with one-on-one nursing by adult psychiatric staff, supported by CAMHS consultation.

Where possible these young people are separated from adult patients by being placed in the high dependency unit of the adult ward.

Care is provided by a combination of CAMHS specialist clinicians, adult psychiatrists and psychiatric nurses and paediatric nursing staff.

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<td>In the South a HCL team cares for these patients with the support of paediatric nursing, medical and allied health staff.</td>
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\(^{31}\) Hill et al (2011) Position Statement: Consensus standards for the care of children and adolescents in Australian health services in Medical Journal of Australia 194 (2) 78 – 82
There is considerable bed pressure in the Paediatric Unit. Young people with mental health disorders impact on the unit in terms of bed time (prolonged admissions) and demands on staff (one-on-one nursing).

**North/ North West**

The North and North West do not have a HCL so the relevant CAMHS community team provides inreach services to these patients. This impacts on the care they can provide to their community clients. Care on the paediatric ward is provided by paediatric nursing staff, except in circumstances in which a young person needs one-to-one nursing when this is provided by an adult psychiatric nurse.

Further the lack of on-site CAMHS clinicians limits the range and intensity of therapy that can be provided to these young people.

These arrangements do not meet best practice, as the facilities are not specifically adapted to young people with mental health issues and the paediatric staff do not have the requisite training to meet their needs. Further, due to lack of staff and inappropriate infrastructure, it has not been possible to develop specialist groups or diversional programmes.

The above model of inpatient care for young people with mental health problems do not meet the requisite Level 6 service requirements. Inpatient services in each of the three regions are currently provided at a Level 4 or below.

A solution to this issue has been proposed in the planned redevelopment of RHH with a 16 bed adolescent unit with two safe rooms with indoor and outdoor living area, that could be utilised flexibly by adolescents 13-17 years old with medical, surgical or psychiatric illness depending on demand. Admissions to the unit would be on the basis of the young person’s developmental needs rather than chronological age. This would provide a more appropriate facility and developmental context for the care of young people with mental illness.

The multi-purpose space could also be used for younger children needing inpatient care; young people with developmental disability; and potentially permit accommodation of parents for a family admission.

It could also potentially provide a statewide service for those young people with the most severe and complex disorders requiring a specialist facility for highly specialised assessment or treatment. However, augmentation of the current workforce with additional, appropriately trained nursing, medical and allied health staff would be necessary.

In addition to this statewide service, there is still a need for Level 5 inpatient services to be provided regionally for moderate to high risk/complexity patients.

There is also a recognised need for youth-specific (18 – 25 year old) mental health facilities but none currently exist in Tasmania. Youth-specific areas separated from older adults could be developed within existing adult psychiatric units in each region. Not currently planned in
the RHH redevelopment but clearly required is a youth specific space within the redeveloped adult psychiatric unit for young people 18-25 years old.

**Recommendation 17**

That the 16 bed adolescent unit with two safe rooms and living space separable from other patients be established as proposed under the RHH redevelopment plan.

Further, that it is supported by the requisite appropriately trained nursing, medical and allied health staff.

**Recommendation 18**

That flexible use bed/living space units separable from other patients be developed on Paediatric or Adult Psychiatric Wards in the North and North-West.

These spaces should

a. Have 2-4 beds and living space.

b. Be supported by a CAMHS HCL team.

Statewide collaboration of HCL teams in developing models of care, training and ongoing supervision could ensure consistency in the quality of care and support the sustainability of smaller teams. Consultation and outreach from the larger Hobart team to other regions could be an option.

**Recommendation 19**

That a youth specific space be incorporated into the redeveloped adult psychiatric unit at the RHH for young people aged 18-25 years.

**Subacute, Residential or Rehabilitation Inpatient Facilities for Young People**

Another gap in facilities for young people in Tasmania is the lack of longer stay facilities for young people with complex mental health problems. Other States and Territories have units that can admit young people and families for assessment and treatment over an extended period. Further, Tasmania has no drug and alcohol detoxification facilities for young people, no secure welfare facility, and limited respite and residential options for young people with severe disability. It is not possible to accommodate this diversity of needs in one residential option and benchmarking suggests that purpose specific facilities may not be viable. Highly supported community options may be more cost effective and sustainable.

**Mother and Baby Unit**
There are no dedicated public mother-baby inpatient beds in Tasmania. Limited access to in-patient care for women with severe mental health problems and their infants in the post-natal period is provided through a private hospital in Hobart.

Extended perinatal stay in maternity beds for a mother with mild to moderate mental disorders can be suitable, supported by the perinatal and infant mental health team.

Pregnant women who require inpatient care are admitted to an acute adult inpatient unit which do not have any special facilities for their support.

Psychiatric mother–baby units (MBU) admit women with severe mental health problems or disorders. They require two different types of expertise: the first in treating women with psychiatric disorders; and the second in child care and development. Caregivers in these clinical settings face especially complex situations.

The units should also facilitate interaction between parents and infant and enable the father to participate in the child’s care and interact with him.

Whilst an inpatient mother-baby unit would ideally be developed on a statewide basis it is likely to be unacceptable in most instances due to the isolation of mother and baby from their families and communities consequent upon a single state wide location.

**Recommendation 20**

That the need for mother-baby beds in Tasmania be met by development of flexible use bed/living space units separable from other patients on Adult Psychiatric Wards in the South, North and North-West.