Admission to child and youth mental health acute inpatient units

1. Purpose
This Guideline provides recommendations regarding the consideration, planning and administrative requirements for children and adolescents (0 up to 18 years) who require admission to a Child and Youth Mental Health Acute Inpatient Unit (CYMHAIU).

2. Scope
This Guideline provides information for all employees, contractors and consultants working within Hospital and Health Services (HHS) in Queensland.

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

Authorising Policy and Standard/s:
- Mental Health Act 2000
- Mental Health Act 2000 Resource Guide
- National Standards for Mental Health Services, 2010
- National Safety and Quality Health Service Standards, 2012
- Clinical Services Capability Framework (CSCF) v3.2

Procedures, Guidelines and Protocols:
- Guiding Principles for the Management of Adolescents in Queensland Health Adult Acute Mental Health Inpatient Units, 2012
- Guideline for the transition of care for young people receiving mental health services, 2015
- Guideline for acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents), 2015 (pending approval)
- Information sharing between mental health workers, consumers, carers, family and significant others, 2011
- Mental Health Act 2000 (MHA) Recordkeeping
- Reporting a Reasonable / Reportable Suspicion of Child Abuse and Neglect, 2015
- Safe transport of people with a mental illness, Queensland interagency agreement, 2014
4. **Introduction**

4.1. The aim of this Guideline is to set out the overarching approach to admitting a child or adolescent to a CYMHAIU and to support practitioners in their decision making. It places emphasis on promoting and sharing best practice whilst recognising the differences of approach and services within Queensland.

4.2. CYMHAIU provide assessment and short to medium term intensive 24 hour inpatient assessment and treatment, as part of the continuum of care, for children and adolescents (aged <18 years) experiencing acute episodes of mental illness. Admissions occur after assessment and when the presenting behaviour cannot be safely managed in the community, or when treatment cannot be provided at a less intensive level. They provide safe, structured, highly supervised and supportive environments for children, adolescents and their parents and carers. Transfer of care is negotiated and occurs in a planned and coordinated way.

4.3. This Guideline is based on the following principles:

- all stakeholders work collaboratively and in partnership to provide health care that best supports the child’s or adolescent’s developmental and clinical needs
- the child or adolescent, as well as their parents and/or carers, are consulted and involved in the development and implementation of their care plan
- the safety and wellbeing of the child or adolescent is ensured within a recovery focused approach to delivering the optimal outcome in a developmentally appropriate environment, to the greatest extent practicable
- the best interests of the child or young person receiving care are recognised and promoted
- the cultural and social diversity of the child or adolescent and their parents and/or carers is acknowledged and their needs are met
- periods of separation of the child or adolescent from their parents, carers and/or communities are minimised; therefore periods of hospitalisation are kept to a minimum.

4.4. The effectiveness of these principles is dependent on all parties maintaining open and honest communication throughout the admission process. This Guideline should therefore be used to facilitate discussions to produce and implement local protocols and procedures to improve service delivery and outcomes.

4.5. This guideline defines:

- the process for determining whether an admission is appropriate – section 5
- the referral and admission processes – section 6
- transport between health facilities – section 7
- referral and admission pathways – section 8
- alternatives to admission – section 9.
5. **Admission criteria**

5.1. Admissions will only occur after an assessment and may be planned or follow a crisis assessment in an emergency department or community setting. The decision to admit is a clinical judgement and integrates:

1. clinical criteria
2. risk criteria
3. admission priorities
4. risks associated with admission
5. other (non-clinical) considerations.

**Clinical criteria**

5.2. A child or adolescent is admitted for the following reasons:

- recognised, or probable mental illness or disorder, and reasonable likelihood that inpatient care will result in substantial benefit
- 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, where the illness or disorder cannot be adequately treated in a community setting
- requirement for specialised psychiatric treatment such as the provision of intensive psychotherapeutic intervention or the introduction of medication that is not able to be safely delivered in a less restrictive setting
- diagnostic or systemic complexity of the case requires a range of assessments which cannot be done in a less restrictive setting.

5.3. It is not appropriate for children and adolescents with autism and/or intellectual impairment (without comorbid mental illness) to be admitted.

**Risk criteria**

5.4. High level risk will be evidenced by one or more of the following:

**Danger to self:**

- significant previous life threatening attempt at 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.

Admission priorities

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

Primary consideration

<table>
<thead>
<tr>
<th>Priority</th>
<th>Level of current risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>immediate risk of death or serious physical harm, either to self or others</td>
</tr>
<tr>
<td>2</td>
<td>clear risk of suicide, self-harm or violence, but without immediate intentions or access to means</td>
</tr>
<tr>
<td>3</td>
<td>distressing and incapacitating symptoms being presented, or progressive deterioration and loss of function with regard to self-care and social functioning</td>
</tr>
<tr>
<td>4</td>
<td>child or adolescent requires complex multi-disciplinary assessment in an inpatient setting</td>
</tr>
</tbody>
</table>

Secondary consideration

<table>
<thead>
<tr>
<th>Priority</th>
<th>Level of current care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>care is provided at home or in another community setting</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
</tr>
<tr>
<td>3</td>
<td>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</td>
</tr>
<tr>
<td>4</td>
<td>care is provided in an adult mental health unit</td>
</tr>
</tbody>
</table>

Risks associated with admission

5.6. The benefits of admission must be weighed against the associated potential risks. The alternatives to admission (see section 9) may consequently 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. Aboriginal or Torres Strait Islander children and adolescents, and those from culturally and linguistically diverse backgrounds, may find separation from family, friends and community particularly distressing
- it may be difficult to provide effective family therapy and other systemic interventions due to significant distance between the inpatient unit and the child’s or adolescent’s home
outcomes of previous admissions may have demonstrated that further admissions are likely to be unhelpful or counterproductive

• exposure to behaviour from others may have a negative impact on recovery.

Other considerations

5.7. Other factors to consider in determining an admission are:

• consent is provided by the child or adolescent’s parent or legal guardian

• wherever possible inpatient treatment and care should be provided separately from adults, if practicable and appropriate to the individual’s circumstance

• the current balance of children and/or adolescents within the unit, in particular the number of short stay versus medium stay patients

• whether admitting a particular child or adolescent may create difficulties regarding confidentiality or the specific management of another child or adolescent.

6. Referral and admission processes

6.1. The referral and admission pathway is illustrated in 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.

6.2. The referral can occur at any time (24/7) and is initiated by a telephone call to the intake officer at the CYMHAIU (see section 10 for contact details). A referral can be made by:

• CYMHS clinician in consultation with the treating CYMHS psychiatrist

• adult mental health psychiatrist, private psychiatrist or psychiatric registrar

• hospital medical officer, in rural or remote areas, in consultation with a child or adult psychiatrists.

6.3. Assessment is an integral part of the referral process and therefore should be completed with input from the local on-call CYMHS psychiatrist or adult mental health psychiatrist.

6.3.1. Children’s Health Queensland HHS provides specialised urgent after-hours child and adolescent psychiatry support, particularly to rural and remote areas where resources are limited. It is expected that cases will have first been raised with local after-hours adult psychiatry support. Consultant to consultant discussion of cases is preferred. This service can be contacted via the Lady Cilento Children’s Hospital switchboard on (07) 3068 1111.

6.3.2. Where the referrer and intake officer are unable to agree on the suitability of an admission, a consultant to consultant discussion should be arranged at the earliest opportunity to achieve a clear outcome.
Figure 1: Referral and admission flow chart

Presentation of child / adolescent

Child / adolescent assessed by mental health clinician. If no mental health specialist is available then by a private psychiatrist or hospital medical officer. Prior to making the referral, the referrer should seek expert advice.

Referrer contacts CYMHAIU Intake Officer and agrees the format and content of written assessment.

Bed available but child / adolescent requires medical attention (e.g. overdose).

Appropriate assessment by medical officer in consultation with admitting unit to ensure medically - stable for transfer.

Bed available in Qld.

Is the transfer being carried out in business hours?

CYMHAIU provides feedback and management advice, if required.

No bed available in Qld.

CYMHAIU advises referral to local paediatric or adult unit for stabilisation.

Is the consumer be safely transported and the safety of staff and other consumers in the admitting unit be ensured?

Yes

No

Can the consumer be safely transported and the safety of staff and other consumers in the admitting unit be ensured?

Yes

No

Is there a medical officer in CYMHAIU to complete the medical / physical Assessment?

No

Yes

Is the child / adolescent sedated and requires admission to an Emergency Department prior to transferring on to the unit?

Yes

No

Emergency Department

Medical officer, in consultation with admitting unit, ensures the child / adolescent is physically and medically-stable for transfer to unit. Also ensures appropriate medication has been prescribed.

Child / adolescent admitted to CYMHAIU.

Child / adolescent admitted to a local paediatric or adult unit.

Child / adolescent re-assessed to identify the most appropriate continuation of treatment.
6.4. 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, taking into account the child’s or adolescent’s history and current condition and must not delay the transfer or admission. The assessment should preferably be recorded electronically through the Consumer Integrated Mental Health Application (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.

6.5. If the child or adolescent has been admitted to a local service, it is advisable that they are re-assessed when a bed becomes available, to ensure that admission remains the most appropriate option to meet their needs.

6.6. 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 status
   • medication history
   • risk assessment and management plan
   • accommodation and support details
   • referrer’s goals for admission.

Decision to accept the referral

6.7. The intake officer will consider the referral based on the criteria and priorities outlined in section 5. The admission will be accepted after consultation with the accepting inpatient team, receipt of the agreed assessment and if appropriate a transport risk assessment (see section 7).

7. Transport

7.1. Once the referral has been accepted, transportation needs must be carefully evaluated. Transfer 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 young person. Consequently it is preferable that the 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.

7.2. 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.

7.3. For further information, refer to:
   • Safe transport of people with a mental illness: a Queensland interagency agreement, 2014; and
   • The Mental Health Act 2000 Resource Guide, Chapter 8 – Moving and transfer of patients, sets out the legislative and Director of Mental Health policy requirements for transporting patients under the Mental Health Act.
Transport risk assessment

7.4. 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 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.

Mode of transport

7.5. 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 young person, 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).

7.6. 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, QPS vehicle or aircraft will be used, it is the responsibility of the transferring unit to coordinate the arrangements with the relevant communications centre.

7.7. 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.

Air retrieval

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

Police assistance

7.9. Police should be involved in transport only where their assistance is required for the safety of the young person 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. 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 young person and their family and carers and can contribute to stigma. If the young person is to be transported in a police vehicle, the health practitioner or ambulance officer must
accompany the person to the health service, and where practicable accompany the young person in the same vehicle as police.

Sedation for purposes of transfer

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

- Guideline for acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents), 2015 (pending approval)
- the air retrieval service provider’s Guidelines.

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

7.12. Depending on the level of sedation, the child or adolescent may be taken to the emergency department for assessment prior to admission to the CYMHAIU. This decision needs to be made in consultation with the admitting unit prior to the transfer.

8. Referral and admission pathways

Mental Health Act

8.1. All relevant Mental Health Act documentation should be attached to the patient’s clinical record which accompanies the patient. For more information refer to the Mental Health Act 2000 (MHA) Recordkeeping Guideline.

Subacute beds

8.2. The Lady Cilento Children’s Hospital operates the statewide subacute unit for young people, 13-18 years old. The service provides medium-term, intensive treatment and rehabilitation services in a safe, secure, structured, hospital-based environment for adolescents with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment.

8.3. Referrals will be through a CYMHS service and assessed via a formal statewide Assessment Panel. Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted. It is expected that adolescents will also remain actively engaged with local mental health and other support services prior to, and during the course of, their admission.

Children and adolescents under the care of Department of Communities, Child Safety and Disability Services (Child Safety Services)

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

- prior to admission, there is an identified child safety officer (CSO) for purposes of liaison, support and care planning
- consent for the admission is obtained from the parent/legal guardian where appropriate with due consideration of individual risk factors
- the admission criteria are met (see section 5)
- Child Safety Services will identify a discharge residential address during the time the child or adolescent is admitted
- Child Safety Services and the inpatient unit 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.

**Aboriginal and Torres Strait Islander children and adolescents**

8.5. The support of an Aboriginal and Torres Strait Islander mental health/health worker, where
available, must be offered to:
- assist the referrer, advise on treatment needs, and provide cultural advocacy
- provide advice and support the child or adolescent, their family and carers including but not
limited to communication, translation, information about diagnosis, treatment plans and
medications and, if needed, to be present during the admission process.

**Other referral and admission pathways**

8.6. CYMHAIU should plan for the needs of children and adolescents from culturally and linguistically
diverse backgrounds. In addition, they should consider the unit’s design to meet the needs of
patients who, or whose parents and/or carers, have a significant physical disability.

**Transferring children and adolescents from court or custody to authorised mental health services as a classified patient**

8.7. For information on transferring children and adolescents from court or custody to an authorised
mental health service as a classified patient, refer to the *Mental Health Act 2000 Resource Guide*,
Chapter 5 – Classified Patients.

Consideration may need to be given to the level of acuity of the young person being admitted to
ensure that the receiving inpatient unit is able to meet their nursing needs, including if there is a
requirement for staff providing 1:1 continuous observations, security support on the unit or
admission to an adult High Dependency Unit, if required.

If the unit receiving the referral has concerns regarding their capacity to safely and effectively
manage the transfer and care of the young person, then they must discuss the identified issues at
the appropriate level, with alternative adolescent units or adult services to develop an appropriate
alternative plan for transfer and care.

**9. Alternatives to admission**

9.1. Alternative options to admission must be discussed with the child or adolescent and their parents
and/or carers. When admission is not possible or appropriate, the inpatient unit consultant
psychiatrist (or other appropriate clinician) can advise on:
- other inpatient services which might have capacity
- measures which will assist with short term treatment, crisis management and crisis resolution
  if already in an inpatient service, such as a general medical, paediatric or adult mental health
  unit
- short term measures to ensure the child’s or adolescent’s safety in a community setting
  (see 9.7).

**Admission to out of area child and youth mental health acute inpatient units**

9.2. When there is no bed available, the inpatient unit should advise the referrer on which alternative
unit(s) to contact. This advice may be derived from the intake officer’s knowledge, daily CYMHS
patient flow or standing arrangements (see section 10).
9.3. The alternative unit must consider the clinical need and urgency of the request for admission and prioritise allocation of beds based on the presented clinical need. The receiving inpatient unit is to adopt responsibility for the child’s or adolescent’s treatment. The decision to admit a child or young person to an inpatient unit out of area must reflect a balance between the child’s or adolescent’s needs, as well as the ease of access for parents and/or carers to the inpatient unit, whilst maintaining continuity of treatment and avoiding disruption to the child or adolescent’s routine. Any decisions regarding a transfer back to the local area, whether to inpatient or community care, will be based on the clinical needs of the consumer. The unit where the child or adolescent is admitted will ensure appropriate treatment is commenced as soon as possible and will ensure that the treatment plan is provided to the receiving unit if a transfer of the child or adolescent occurs.

9.4. When past or existing patients of a local unit are admitted out of area, the local unit must liaise with the receiving catchment inpatient unit about the treatment needs and discharge arrangements to ensure follow up by appropriate services in the child or adolescent’s local catchment area.

**Adult mental health or paediatric units**

9.5. It may be appropriate, for temporary care and stabilisation, for a child or adolescent to be admitted to a paediatric or medical ward. Admission to a paediatric or medical ward should only be until the child or adolescent can be safely discharged to the community or transferred to an available CYMHAIU.

9.6. In rare circumstances, it may be clinically indicated and developmentally appropriate for care to be provided in an adult mental health acute inpatient unit. For further information see Guiding principles for the management of adolescents in Queensland Health adult acute mental health inpatient units (2012).

**Short term management in a community setting**

9.7. The intake officer, in consultation with the inpatient psychiatrist, must assist the referrer in developing a plan for alternatives to hospitalisation or options for short term community management whilst awaiting an inpatient bed.

9.8. The CYMHAIU clinician must take into account the clinical capabilities of the community service and if possible, assist in identifying available resources.

9.9. The referring team, admitting unit working with the child or adolescent and their parents and/or carers will identify the best alternative option. The best alternative option should consider the length of time the current situation can be reasonably managed as well as risks. Local Emergency Departments, Acute Care Teams, Assertive Mobile Youth Outreach Services, linkages with Adult Mental Health, Acute Response Teams, inpatient staff phone support, non-government agencies etc. may be able to assist in crisis management.

**10. Catchment and contact details of inpatient units**

10.1. The table below provides a guideline to assist in identifying the appropriate unit when seeking to admit a child or adolescent. If the CYMHAIU is at capacity, an alternative unit must be found using the principles and approaches detailed in this document as a guide. The catchments are current as of June 2016 and will change when the Sunshine Coast University Hospital Adolescent Unit commences operations.
Contact details

<table>
<thead>
<tr>
<th>Site</th>
<th>Contact number</th>
</tr>
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<tbody>
<tr>
<td>Gold Coast</td>
<td>0414 698 774</td>
</tr>
<tr>
<td>LCCH</td>
<td>(07) 3068 2520</td>
</tr>
<tr>
<td></td>
<td>(07) 3068 2559</td>
</tr>
<tr>
<td>Logan</td>
<td>(07) 3299 8482</td>
</tr>
<tr>
<td>RBWH</td>
<td>(07) 3636 1179</td>
</tr>
<tr>
<td>Toowoomba</td>
<td>(07) 4616 5767</td>
</tr>
<tr>
<td>Townsville</td>
<td>(07) 4433 9700</td>
</tr>
</tbody>
</table>

Notes: LCCH – Lady Cilento Children’s Hospital; PAH – Princess Alexandra Hospital; RBWH – Royal Brisbane and Women’s Hospital

Catchment areas

<table>
<thead>
<tr>
<th>Referring HHS</th>
<th>Adolescent</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns and Hinterland</td>
<td>Townsville</td>
<td>LCCH</td>
</tr>
<tr>
<td>Central Queensland</td>
<td>RBWH</td>
<td>LCCH</td>
</tr>
<tr>
<td>Central West</td>
<td>Toowoomba</td>
<td>LCCH</td>
</tr>
<tr>
<td>Children’s Health Queensland</td>
<td>LCCH</td>
<td>LCCH</td>
</tr>
<tr>
<td>Darling Downs</td>
<td>Toowoomba</td>
<td>LCCH</td>
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<td>Gold Coast</td>
<td>Gold Coast</td>
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<td>Mackay</td>
<td>Townsville</td>
<td>LCCH</td>
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<td>Metro North</td>
<td>RBWH</td>
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<td>LCCH</td>
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<td>Metro South PAH catchment</td>
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<td>LCCH</td>
</tr>
<tr>
<td>North West</td>
<td>Townsville</td>
<td>LCCH</td>
</tr>
<tr>
<td>South West</td>
<td>Toowoomba</td>
<td>LCCH</td>
</tr>
<tr>
<td>Torres Strait and Cape</td>
<td>Townsville</td>
<td>LCCH</td>
</tr>
<tr>
<td>Townsville</td>
<td>Townsville</td>
<td>LCCH</td>
</tr>
<tr>
<td>West Moreton</td>
<td>East of Gatton</td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Wide Bay</td>
<td>RBWH</td>
<td>LCCH</td>
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</table>

11. Review

This Guideline is due for review on: June 2018

Date of last review: June 2016

Supersedes: Guiding principles for admission to Queensland Health child and youth mental health acute inpatient units, 2010.
### 12. Business Area Contact

Office of the Chief Psychiatrist  
Mental Health Alcohol and Other Drugs Branch  
Clinical Excellence Division  
Department of Health  
GPO Box 2368  
Fortitude Valley BC 4006 Australia  
Tel (+61) (07) 3328 9374  
OCP-MHAODB@health.qld.gov.au  

### 13. Definitions of terms used in the guidelines

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hour/s</td>
<td>Unless otherwise stated, refers to 24 hours a day, 7 days a week.</td>
<td>CSCF v3.2</td>
</tr>
<tr>
<td>admitting unit</td>
<td>The child and youth mental health acute inpatient unit</td>
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</tr>
<tr>
<td>adolescent</td>
<td>For the purpose of this document the term adolescent refers to those aged over 13 and less than 18 years.</td>
<td>Mental Health Data set specification v4 January 2015</td>
</tr>
<tr>
<td>child</td>
<td>For the purpose of this document the term child refers to those under the age of 14 years.</td>
<td>Mental Health Data set specification v4 January 2015</td>
</tr>
<tr>
<td>CYMHAIU</td>
<td>Child and youth mental health acute inpatient unit: see paragraph 4.2.</td>
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<tr>
<td>CYMHS</td>
<td>Child and youth mental health service</td>
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<tr>
<td>escort</td>
<td>An escort is someone other than the driver of a vehicle who accompanies a child or adolescent 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.</td>
<td>Safe transport of people with a mental illness, Queensland interagency agreement, 2014</td>
</tr>
<tr>
<td>parent and/or carer</td>
<td>Refers to the parent(s) or person(s) that take legal responsibility for the child / adolescent and provides direct care. This includes birth parents, step parents, adopted parents, foster parents, legal guardians, custodial parents or other appropriate primary care givers.</td>
<td>The Royal Australasian College of Physicians. Standards for care of children and adolescents in Health Services 2008, Paediatrics and Child Health Division, RACP, Sydney Australia.</td>
</tr>
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</table>

### 14. Approval and implementation

**Policy Custodian:**  
Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division
15. Version Control

<table>
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<tr>
<th>Version</th>
<th>Date</th>
<th>Prepared by</th>
<th>Comments</th>
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<tr>
<td>V1</td>
<td>2 Sept 2016</td>
<td>Office of the Chief Psychiatrist</td>
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