Oaths Act 1867

Statutory Declaration

QUEENSLAND
TO WIT

I, Dr MICHAEL DAUBNEY of c/- in the State of Queensland, do solemnly and sincerely declare as follows:

1. This statutory declaration is provided in response to the 'Requirement to Give Information in a Written Statement' issued by the Honourable Margaret Wilson QC, Commissioner, Barrett Adolescent Centre Commission of Inquiry, pursuant to s5 of the *Commissions of Inquiry Act* 1950. The Commissioner's request is dated 12 February 2016.

2. In response to question 1, I am the Medical Director, Specialist Services Child and Youth Mental Health Services, Children's Health Queensland Hospital and Health Service. My roles and responsibilities are described in the document annexed hereto and marked '**MD1**'. I note the role title has changed, but that the roles and responsibilities remain the same.

3. In response to question 2(a) and (b):

   (a) In respect of the Statewide Subacute Beds programme:

      (i) I am the Chairperson of the assessment intake panel for the Statewide Subacute Beds programme (**'the Panel'**). As such, I have the roles and responsibilities of a panel member, as set out in the document entitled *Statewide Subacute Bed Referral Panel Protocol*, which is annexed hereto and marked '**MD2**'.

      (ii) I have no clinical involvement with, or responsibility for any patient treated within the Statewide Subacute Beds programme separate from my role as a Panel member.

      (iii) I am not the coordinator of the service as a whole.

   (b) In respect of the Assertive Mobile Youth Outreach Services ('**AMYOS**'):

      (i) I am the consultant psychiatrist to the Brisbane South, Brisbane North, and Redcliffe and Caboolture AMYOS teams.

      (ii) I also provide state-wide supervision to all the AMYOS teams via video-link, however, I do not have any clinical governance beyond my own teams apart from supporting teams when the local AMYOS Consultant is on leave, however this is done jointly with a local Psychiatrist.

      (iii) The other Statewide role I have been involved in has been co-ordinating education at a Statewide level and chairing Statewide quarterly video-link discussions between the different AMYOS Teams. Otherwise, I do not consider that I am the coordinator of AMYOS as a whole.

4. In response to question 2(b):

   (a) I carry out my responsibilities as Chairperson of the Panel in accordance with those requirements set out in the *Statewide Subacute Bed Referral Panel Protocol* and in a manner consistent with the aims and objectives of the programme as documented therein.

   (b) I carry out my responsibilities as a consultant psychiatrist to Brisbane North, Brisbane South and Redcliffe/Caboolture AMYOS teams to the standard which one would expect of a consultant psychiatrist, for the benefit of each of my patients.

(c) I carry out my supervisory responsibilities (within Statewide AMYOS) in a flexible manner, tailoring supervision and assistance having regard to: the experience of individual personnel and their skill base/qualifications; the resourcing of each team; and any particular challenges faced by a team at any point in time.

Section 1 – Assertive Mobile Youth Outreach Services

5. In response to question 3, the AMYOS model of care is based upon, and is similar to, the model of care of the Intensive Mobile Youth Outreach Services programme that exists in Victoria ('**IMYOS**').The most notable difference in the models being that AMYOS also embeds Mentalisation Based Therapy into its model. Documentation summarising the IMYOS model of care is annexed hereto and marked '**MD3**'. A brief excerpt from that document is provided below:

> *'The IMYOS treatment model comprises three inter-connected domains. A theoretical framework provides the basis for formulation and application of specific fundamental principles of service delivery, which guide the planning, provision and evaluation of a range of core interventions (e.g. psychotherapy, pharmacotherapy, etc.). Whilst the core interventions are comparable to those commonly provided by mainstream mental healthcare services, it is the manner in which these interventions are delivered, determined by the fundamental principles that is at the very 'heart' of IMYOS work and may distinguish it from other services.'*[1]

I refer the reader to the document marked '**MD3**' for a more in-depth explanation as to the model of care.

6. In response to question 4:

(a) the document described as the '*Assertive Mobile Youth Outreach Service: Model of Service*' (MSS.003.004.3656) is the model of service for AMYOS. That document is annexed hereto and marked '**MD4**'.

(b) I am unaware if there is a 'final', or further, version of that document, not having been involved in the drafting of the document. To my knowledge, AMYOS currently operates on the basis of the model of service described in the draft document.

(c) Annexed hereto and marked '**MD5**' is the AMYOS Referral Form, which describes the relevant intake criterion.

7. I am unable to answer question 5 on the basis that these are not matters within my knowledge. In my current role I am not charged with the responsibility of negotiating service delivery arrangements between AMYOS, Children's Health Queensland Hospital and Health Service and/or any other Hospital and Health Service.

8. In response to question 6, I am aware of the individual persons who comprise the AMYOS teams for their relevant service area. I am unaware of the exact timing the provision of services commenced within each service area, but am aware of the approximate time each person was appointed to, or commenced working with, the relevant AMYOS team. The table below summarises this information, along with the discipline of each team member:

Service Area	Staff Member	Date Commenced	Discipline
Brisbane North & Brisbane South	• Laura Quinlan	• July 2014	• Social Work
	• Michele Farbotko	• July 2014	• Psychology

[1] Carsten Schley, et al, *Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'* Children and Youth Services Review 33 (2011) 1506–1514, 1509.

	• Sean Goodwin • Christine Poole	• July 2014 • July 2014	• OT • Nursing
Redcliffe & Caboolture	• Amanda Gatti • Derek Taylor	• 14 July 2014 • 3 Nov 2014	• Psychology • Nursing
Logan	• Michelle Armstrong • Sarah Henderson	• 18 May 2015 • 18 May 2015	• Social Work • Psychology
Toowoomba	• Roslyn McCann • Graham Phillips	• 8 Dec 2014 • 8 Dec 2014	• Nursing • Nursing
Townsville	• Jonathan McClelland • Jennifer Sperring	• 8 Dec 2014 • 9 Feb 2015	• Social Work • Occupational Therapy
Gold Coast	• Jessica Allam • Corey Ham	• 9 Nov 2015 • 23 Nov 2015	• Social Work • Nursing
Cairns	• Tanya Prince • TBC	• Oct 2015 • TBC	• Psychology • TBC
Rockhampton	• Stacey Conrad • Lisa Pyper	• 5 Oct 2015 • 5 Oct 2015	• Psychology • Social Work

9. In response to question 7, the AMYOS model operates by means of assertive engagement and follow up. Annexed hereto and marked '**MD6**' is literature[2] that includes a case study of the IMYOS model, on which the AMYOS model is based. The article titled '*Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'*' (annexed at '**MD3**') also provides discussion regarding what 'assertive' means in practical terms, at paragraph 4.2.2, as well as another case study.

10. In response to question 8, the types of clinical interventions the AMYOS team provide are consistent with that referred to within the literature marked as '**MD3**' and '**MD6**'.

11. In response to question 9, the types of clinical services delivered by any clinical service is dependent upon a number of factors including staff numbers and experience, local resources available etc. To my knowledge, broadly there are no differences in the types of clinical interventions delivered by an AMYOS team, compared with a Child and Youth Mental Health Service ('**CYMHS**') clinic with the exception that currently a CYMHS clinic may not have the staff training and experience to deliver mentalization based therapy informed interventions. In general, the difference is in the level of intensity, flexibility and mobility with which those clinical interventions are delivered. The AMYOS team also incorporates home visit and outreach components.

[2] Victoria Ryall, et al, 'Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention', Social Work in Mental Health, Feb 2009, 153, at 170; Carsten Schley ibid.

12. In response to question 10, the nature and importance of family therapy to the AMYOS model is described in the literature annexed hereto and marked as '**MD3**' and '**MD6**'. I am unable to provide specific detail about the type and level of family therapy offered by CYMHS clinics and other CYMHS services around the State, except to say that the involvement and engagement of families is fundamental component of any youth mental health service.

Funding and staffing of AMYOS teams

13. In response to question 11, the AMYOS team I consult to provide services through a multi-disciplinary team. Outside of Brisbane/Redcliffe Caboolture AMYOS has 2 full time workers and a Consultant Psychiatrist 1 day per week. I am not certain 2 workers would constitute a team. Currently, to my knowledge the various AMYOS teams are comprised of the disciplines outlined above, as per my answer to question 6.

14. In response to question 12: I am unaware of how much flexibility each Hospital and Health Service has in the staffing profile of its AMYOS team.

15. In response to question 13, I am presently unaware of the factors which influence the staffing profile for each of the AMYOS teams. This information, and information regarding FTE units, is not readily available to me and I am unable to obtain same within the timeframe required to respond to the Commission's request.

AMYOS referral process, exclusion criteria and referral to other services

16. In response to question 14, there has been one exception however I am unwilling to provide details of this case as the patient has been previously treated by me in my private practice.

17. In response to question 15, the AMYOS programme is designed for clients aged 13 to 18 years of age, who display signs and symptoms of severe and/or complex mental disorder. In this regard, please see the AMYOS Model of Service, which is annexed hereto and marked as '**MD4**'.

18. Question 16 is not a question that I am able to answer in general terms. A young person's suitability for discharge from AMYOS, and referral to an alternative service, is considered on a case-by-case basis and is dependent on the comprehensive assessment of the young person by their treating clinician and their individualised management plan. The transitional arrangements put in place are also tailored to the individual – consistent with their individual management plan. The Commission may be assisted by the case studies I have annexed at '**MD3**' and '**MD6**', which provide examples of the individual considerations to be taken into account.

Client profile: age range

19. In response to question 17:

    (a) the AMYOS Model of Service prescribes an age range of 13 to 18.

    (b) AMYOS is funded to deliver a service for clients aged 13 to 18.

    (c) I am not aware of there being any flexibility in the lower age limit.

Client profile: engagement

20. In response to question 18, AMYOS is available to young people who fall into the categories set out in (a) and (b) of question 18. In respect of the category of young person described at 18(c), AMYOS is available to them, however where a young people had previously engaged with mental health services '*to a significant extent*' it would be appropriate CYMHS to give consideration to attempting to re-engage those young people and their family.

Section 2 – State-wide subacute beds

State-wide referral panel

21. In response to question 19, the representatives appointed to the state-wide referral panel have been correctly identified by the Commission.

22. In response to questions 20 and 21:

    (a) The Statewide Referral Panel was established in or about May 2015. Its first meeting was on 9 November 2015.

    (b) The Statewide Referral Panel has met on the following dates:

        (i) 9 November 2015;

        (ii) February 18, 2016.

23. In response to question 22, the minutes of the meeting 9 November 2015 are annexed hereto and marked '**MD7**'. The minutes of 18 February 2016 are still in draft form. Also annexed at '**MD7**' is a letter to the referring PSP of the patient which makes clear the Panel's deliberations and seeking more information.

24. In response to question 23, the State-wide Referral Panel's current role is limited purely to the subacute beds; it has no oversight or responsibility for referrals for any of the other AMHETI services to my knowledge.

25. In response to question 24:

    (a) The types of variable the panel considers in assessing whether a young person would be likely to benefit from an extended treatment and rehabilitation model in a hospital based subacute bed are complex and multi-faceted, in that the relevant clinician must consider variables such as the: individual patient's medical/psychiatric history and mental state assessment; patient's individual risk assessment; the patient's family involvement in treatment; present systems in place; the current treatment regime and management plan; the available resources to implement alternative treatment; and the available evidence base to support the proposed treatment.

    (b) The types of variable the panel considers in assessing whether a young person could be safely and effectively managed in a less restrictive setting are the same as those described in paragraph 25(a).

    (c) Regarding question 24(c), these are complex issues about which there is a diversity of opinion expressed in the scientific literature. I believe that this question is best posed to a suitably qualified independent expert.

    (d) In response to question 24(d), the panel members are experienced clinicians. The Panel draws upon the cumulative experience of the members to identify young people, who, in their experience, are most likely to benefit from the state-wide subacute bed model. In the document Statewide Subacute Bed Referral Protocol, section 2.1 describes the Eligibility Criteria which the Statewide Panel use for guidance.

    (e) Regarding question 24(e), again, these are complex issues about which there is a diversity of opinion expressed in the scientific literature. Again, I respectfully suggest this question is best posed to a suitably qualified independent expert.

    (f) The treatment of substance misuse is a sub-specialist area of psychiatry with specialised treatment programmes having been established to treat such patients. These patients require the sub-specialist level of care provided within such programmes

26. In response to question 25:

(a) The primary service provider is an individual case worker, not a service.

(b) The panel does not have oversight for referrals for other AMHETI services.

27. In response to question 26, I am unable to provide a response to most questions as, to my knowledge; there have not been six referrals to the Panel for state-wide subacute beds but at the date of this question asked, there has only been one referral discussed by the panel.

28. In response to question 27, I am aware that in total there have been 3 referrals to the state-wide subacute beds in the time since I commenced the role of 'chair' of the panel. I am otherwise unable to comment on the numbers of referrals to the service and/or whether the number is, or can be considered 'relatively low'. I remain unsure of what (if any) comparisons the Commission is referring to.

29. In response to questions 28(a) and (b):

(a)

(b) Apart from the Referral Protocol for the Panel and the MOSD Statewide Subacute Beds I am not aware of any guidelines, policies, procedure, criteria or priorities which the state-wide subacute assessment panel must follow when considering a request to extend a patient's stay in a subacute bed. Generally, that decision will be informed by the judgment and experience of the treating clinician, who will determine if, in all the circumstances, it is within the best interests of the patient. That is, any such decision is a clinical one.

(c) The MOSD Subacute Beds states that the potential for therapeutic benefit is an important consideration for admission. This is consistent with the Eligibility Criteria on the Referral Protocol for the Panel. The Panel would be convening a reflective discussion with the treating team to review an individual patient's progress and discuss whether a continued admission would be of therapeutic benefit and whether there are risks with a continued admission. A copy of the MOSD Subacute Beds is annexed hereto and marked with the letters '**MD8**'.

(d) The Statewide Assessment Panel might be likely to approve a request to extend a patient's stay in a subacute bed in circumstances where continued admission would be of therapeutic benefit (when weighed against the risks associated with continued admission).

Management of subacute bed patients

30. In response to question 29, I rely upon the information in paragraph 25 above. I further add that the model of care is individualised to each client through ensuring there is thorough handover, a comprehensive mental state examination, and by actively seeking collateral information regarding the client's circumstances.

31. In response to question 30, Annexed hereto and marked '**MD8**' is the model of service for the state-wide subacute beds. In response to paragraphs (a) to (h), I am unable to provide most of the information sought by the Commission as I had no clinical responsibility for the care of any patients in the subacute beds. I would respectfully suggest that these questions are best posed to the treating clinician of each patient.

32. In response to question 31, I am unable to comment on the management of any patients within the subacute beds for the reasons stated in paragraphs 3(a) and 31 above. I respectfully suggest that this question might best be directed to the author of the email dated 10 September 2015.

33. The questions at 32 and 33 are complex and the scientific literature discussing such issues voluminous. I respectfully suggest that these questions are best posed to a suitably qualified independent expert. .

34. In response to question 34:

    (a) I have never seen a subacute bed patient managed at the Lady Cilento Children's Hospital and cannot comment on same.

    (b) A policy document does not drive therapeutic milieu. Therapeutic milieu depends upon numerous factors, only one of which includes the model for service delivery. Accordingly, I am unable to answer this question in any satisfactory way.

    (c) I do not have clinical governance of any patients at the Lady Cilento Children's Hospital and therefore cannot comment on that therapeutic milieu or what may be a different milieu provided in a different program.

35. In response to question 35:

    (a) I am unable to comment on the extracted portion of email. I am unaware of the context within which the comment was made; or the author's intentions in making the comment. Further (without meaning any disrespect to the author whatsoever) I am not in a position to know whether the author of the email has correctly understood or interpreted any discussions she may have had with any other psychiatrist.

    (b) The provision of psychiatric services through a model like the subacute bed model is exceedingly complex with many and varied opinions having been expressed in the scientific literature. I respectfully suggest that such a question is best answered by a suitably qualified independent expert.

36. In response to question 36, I am aware of the Commission, however, most of my information comes from the media. I do not have any particular knowledge of the Commission's Terms of Reference apart from that which has been made publicly available.

37. In response to question 37, documents in my custody or control which are referred to in this statutory declaration have been noted and true copies have been annexed.

And I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1867*.

.....

Declarer

Taken and declared at Brisbane this 22nd day of February 2016, before me:

.....

Christine Houston

Solicitor

Queensland Government

Children's Health Queensland Hospital and Health Service

Job ad reference:	N/A – Internal Expression of Interest
Role title:	**Medical Director, Statewide Services Child & Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service (CHQ HHS)**
Status:	Permanent Part-time (0.8FTE or great) or Full-Time (This position is a full-time role. For the first 3 years of operation, this role will have accountabilities as a Medical Director. At the expiration of the 3 year period, the incumbent will retain a role as a VMO or SMO. However, the Director component of the role will be renegotiated in the employment contract).
Unit/Branch:	Division of CYMHS,
Hospital and Health Service:	Children's Health Queensland Hospital and Health Service
Location:	Brisbane *Note: Please refer to 'About CHQ HHS' section of this document for further information regarding the location of this role.*
Classification level:	CM2-CM3
Salary level:	As above; a Clinical Manager's allowance will be negotiated, likely CM2 or CM3
Closing date:	12 December 2014
Contact:	EOI should be emailed directly to Dr. Stephen Stathis, Medical Director, CYMHS CHQ HHS
Telephone:	
Online applications:	N/A

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Children's Health Queensland Hospital and Health Service (CHQ HHS) has adopted the **five core values** that guide our behaviour:

- **Caring for People:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Purpose

The Director, Child and Youth Mental Health Service – Statewide Services will:

- Lead and manage the delivery of high quality, targeted tertiary statewide child and youth mental health services that are funded or managed by CHQ HHS, as delegated by the Medical Director, CYMHS CHQ HHS.
  - Services currently targeted include: eCYMHS, Evolve, and the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative including statewide Assertive Mobile Youth Outreach Services (AMYOS), Youth Residential Service and Subacute Beds.
  - From time to time, other statewide services may be added at the discretion of the Medical Director CYMHS, CHQ HHS.
  - This position excludes statewide and local peri-natal and infant mental health services and forensic services.

Your key responsibilities

You will fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined below:

SERVICE

- Provide ethical decision making and effective issues management and communication in the achievement of organisational goals, ensuring issues are resolved effectively and in a timely manner.
- Model positive leadership behaviours and contribute to the health service and professional community and affairs.
- Develop a high functioning service inclusive of inpatient, outpatient, outreach, telehealth and evidence based models of care as appropriate within a multidisciplinary team environment.

- Actively promote and model family centred care principles and practices in the design and delivery of services. Involve consumers in design and evaluation of services.
- Build effective and timely communication and consultation processes within the service, and with families, referring clinicians and other health services.
- Support the planning and service capacity in outer locations across South East Queensland and within the context of the Southeast Queensland Paediatric Planning Report.
- Actively explore and implement alternatives to hospital admission where clinically appropriate.
- Undertake inpatient and outpatient consultation and treatment of patients in Child and Youth Mental Health.

SAFETY AND QUALITY

- Implement the Children's Health Queensland Patient Safety and Quality Improvement Strategy as it applies to Child & Youth Mental Health.
- Lead and model a 'just' approach to staff, promoting open and honest identification of hazards and incidents, and taking action to address quality and safety gaps.
- Develop, maintain and report on measures of the quality of the services provided across all domains of quality, using data to drive continuous improvement. Benchmark service performance with peer services in Australia and internationally.
- Drive reliability and consistency of clinical services through the use of standard operating procedures, procedures, care pathways, and appropriate training, assessment and coaching of staff.
- Actively engage in early identification and resolution of patient/family and staff complaints using open disclosure principles.
- Maintain a regular audit schedule focussed on known risk areas, and use this audit data to inform and prioritise improvement efforts.
- Ensure compliance with contemporary healthcare safety and quality standards and participate in CHQ assurance processes including Accreditation.

VALUE

- Develop an annual operational plan for the service in line with CHQ planning, and addressing budget, activity and quality.
- Actively monitor and manage balanced scorecard performance and take action to address poor performance.
- Explore innovative ways to improve value for money services.
- Drive transparency of service and individual performance and productivity. Benchmark with peers in Australia through Health Round Table and other relevant service groupings.

RESEARCH

- Encourage and support the development of high quality research by departmental staff across all elements of the multidisciplinary team.
- Contribute to the development of contemporary evidence in Child & Youth Mental Health.
- Use research evidence to improve practice and care outcomes.

Position Reports To

The Director, Child and Youth Mental Health Service – Statewide Services:

- Reports directly to the Medical Director CYMHS, CHQ HHS

Staffing and Budgetary Responsibilities

The Director, Child and Youth Mental Health Service – Statewide Services:

- Has service-line clinical management responsibility in accordance with the attached organisational chart.
- Has delegations in accordance with the CHQ delegations manual for financial and human resources.
- Will manage staff in accordance with Queensland Health human resource management practice and principles, equal employment opportunity and anti-discrimination requirements.

Qualifications / Professional registration / Other requirements

Mandatory

- Current registration with/or eligible for registration with AHPRA (Australian Health Practitioner Regulation Agency), as a specialist in psychiatry, and possessing a Certificate in Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists.

- Appointment to this position is dependent upon written confirmation of a Scope of Clinical Practice (SOCP) from the Executive Director of Medical Services. The candidate will be required to provide appropriately validated documents for credentialing purposes.

Are you the right person for the job?

You will be assessed on your ability to demonstrate the following key attributes. Within the context of the responsibilities described above, the ideal applicant will be someone who can demonstrate the following:

- You will be recognised by your peers for your abilities as a child and adolescent psychiatrist.
- You will have a successful track record as a leader and manager within a tertiary paediatric hospital or service.
- You will have advanced leadership abilities with demonstrated ability to build trust and positively influence professional peers in order to deliver high quality services.
- You will be an exceptional communicator; able to adjust your communication style for the audience and with a high levels of emotional intelligence.
- You will have a track record of successfully leading change at a service level. You are proficient in redesign methods and will have been responsible for driving measurable improvement in service outcomes
- You will be a team player, and will be recognised for your abilities to bring together staff from various professional disciplines and to build effective and cohesive teams.

How to apply

Please provide the following information to the panel to assess your suitability:

Resume (no more than 4 pages). Should you wish to provide a more extensive employment history, you may do so in a separate attachment. Please include two referees that can attest to your performance and conduct in the workplace. By providing the names and contact details of your referee/s, you consent for these people to be contacted by the selection panel.

- **Application** Please provide a brief summary of no more than 2 pages addressing how your skills, experience and knowledge meet the requirements of the role listed under "Are you the right person for the job" in the context of the "key responsibilities" of the role.

Additional Information for Applicants

- All relevant health professionals (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.
- Pre-employment screening, including criminal history and disciplinary history checks, may be undertaken on persons recommended for employment. Roles providing health, counselling and support services mainly to children will require a Blue Card.
- A minimum probation period of three (3) months may apply for permanent appointments.
- All newly appointed applicants who have been employed as a lobbyist in the previous two (2) years are required to provide a disclosure to the Director-General within one (1) month of taking up the appointment in accordance with the Disclosure of Previous Employment as a Lobbyist policy.
- Travel may be a requirement.
- Applications will remain current for twelve (12) months and may be considered for other vacancies which may include an alternative employment basis (temporary, full time, part time).

About Children's Health Queensland Hospital and Health Service

Children's Health Queensland provides:

- Paediatric services to its local community
- Tertiary paediatric services at the Lady Cilento Children's Hospital
- Child and Youth Mental Health Service
- Child and Youth Community Health Service
- Outreach children's specialist services across Queensland
- Implementation and support for new and enhanced emergency, inpatient and ambulatory children's services in Greater Metropolitan Brisbane
- Paediatric education and research

Want to know more?

- For details regarding salary information, leave entitlements, flexible working arrangements and other benefits please refer to the *Working for CHQ HHS, Applicant Information* provided with the advertised vacancy or visit the Queensland Health website at: www.health.qld.gov.au
- For further information about the Lady Cilento Children's Hospital please visit: www.health.qld.gov.au/childrenshospital
- For further information about the Children's Health Queensland Hospital and Health Service please visit: www.health.qld.gov.au/rch/

Statewide Subacute Bed Referral Panel Protocol

1. Panel operations

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland.

The statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will assist progression in developmental tasks that may have been arrested secondary to the mental illness, and support the safe transition of the young person to more functional or independent living on discharge.

A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to onsite schooling will be provided.

As a statewide service, a strong emphasis is placed on the development of cross-sector partnerships, working with other key service providers in the community to facilitate joint, assertive management, and discharge planning for the young person.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit.

The Statewide Assessment Panel will work with referral parties to prioritise and triage new referrals into the subacute beds. The Panel will also have oversight of case review for existing subacute patients who may require an extension to their stay.

1.1. Principles of the Panel

- Service responses are based on the goal of the best outcomes for the young person.
- Consumer and family/care giver participation is encouraged.
- Young people are considered in their social and culture context and, whenever possible, interventions will focus on developing supportive social environments and facilitating young people to access and integrate with existing community educational, vocational, recreational and other relevant programs.
- The views of the young person and their family must be considered.

1.2. Panel members

Core panel members
The core members of the panel are:

Medical Director, Specialist Services, CYMHS, CHQHHS (Chair)
Nursing Director, LCCH Mental Health Unit, CYMHS, CHQHHS
Northern Cluster Representative, CYMHS

Central Cluster Representative, CYMHS
Southern Cluster Representative, CYMHS

A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review.

In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

Quorum
The quorum for the panel consists of the Medical Director, CYMHS CHQHHS, plus two other panel members.

If any of these members (or their direct delegate) is not present for a panel meeting, a quorum will not be achieved and the meeting cannot proceed. Alternative arrangements for the panel meeting would then need to be made.

Invited parties
When the panel believes a key stakeholder (e.g. Principle Service Provider) is required to attend a panel meeting to discuss a specific young person, an invitation will be sent. If the stakeholder is unable to attend the meeting in person, they will be invited to provide advice or information on the consumer for the panel's consideration, e.g. through e-mail, teleconference, or video conference.

1.3. Coordination of panel meetings

To promote efficiency, effectiveness, and benchmarking opportunities, panel processes must be clear, documented, and consistent with best practice.

The Chair position will be held by the Medical Director, Specialist Services, CYMHS CHQHHS, or their delegate.

Other matters related to the coordination of panel meetings, such as the venue for meetings, time allocation, and arranging invitations to panel meetings for invited stakeholders, are the responsibility of the Secretariat of the panel. This will be achieved through the use of minutes, with clear action statements outlining responsibilities and timeframes.

1.4. Administration support to the panel

Secretariat support for the panel will be provided by CYMHS CHQHHS on a recurrent basis.

The role of the Secretariat includes:

- Assist with the coordination of panel meetings, and organise and distribute the agenda and associated documents e.g. new referrals, consumer reviews, etc.
- Ensure that all panel information and minutes are recorded and distributed to appropriate parties, and stored on the appropriate record and filing system.
- Ensure that all original consumer forms and information are stored on the appropriate record.
- Maintain reporting and data collection activities for the panel.

1.5. Panel meetings

The Panel will convene on an as required basis.

The agenda for panel meetings will be coordinated and set in advance of panel meetings (refer to **Statewide Assessment Panel Agenda** template).

Tasks that need to be carried out by respective agencies in between panel meetings need to be clearly identified and communicated across agencies.

The Panel Chair will need to ensure adequate information has been provided on the Consumer Intake Form together with a signed Consent to Obtain/Release Information Form (http://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs.htm).

Panel members will receive a copy of the meeting agenda and accompanying documentation (including new referrals, reports, and plans for existing referrals) at least 5 working days in advance of the panel meeting.

The recommended format for panel meetings is as follows:

- Previous Business
- Review of Consumer Summary Report (current and exiting consumers)
- New Referrals (intake and prioritisation)
- Panel Process Issues
- Other Business

The chairperson is responsible for ensuring panel meetings are:

- Effectively time managed and all agenda items are tabled
- Effectively facilitated so that relevant information and discussion points are elicited to ensure that the panel can attend to their business.

Panel discussions will be recorded in the panel minutes (refer to **Statewide Assessment Panel Minutes** template). Panel decisions regarding a new referral will be recorded on the **Consumer Summary Report**. Any subsequent discussions regarding the young person will also be recorded in this report.

It is the responsibility of the Chair, with input from other panel members, to ensure that the records are accurate and reflect the intent of the discussion.

If there is a dispute regarding panel decisions, the matter may be raised to the Chief Executive of CHQHHS.

1.6. Principles for panel decision-making

Panel discussions will be recorded in the minutes of the meeting and on the Consumer Summary Report.

Prioritisation of consumers for referral will be based on clinical grounds and the decision points will be clearly documented and discussed with referring services.

Where the panel does not recommend intake into a statewide subacute bed, the panel discussions should aim at developing alternative options for treatment. These options should also be recorded on the Consumer Summary Report.

1.7. Confidentiality and Privacy

Information raised and discussed at panel meetings will be treated with utmost care and sensitivity, and with the highest regard in respect of confidentiality and privacy. All staff participating in panel discussions should also be aware of professional and organisational ethical and legislative requirements in relation to privacy and confidentiality, including employee requirements and obligations set out in various departmental codes of conduct.

All forms which collect information for the purpose of referrals into the statewide subacute beds will comply with the Information Privacy Principles contained in the *Information Privacy Act 2009* and feature privacy notices.

All contracted service providers are required to be contractually bound to comply with the Information Privacy Principles prior to the exchange of information.

2. Referral

The referral process for the statewide subacute beds will operate in a manner that ensures young people referred are responded to in a timely way.

2.1. Eligibility criteria

A young person **may be eligible** for a statewide subacute bed if they:

- Are aged between 13 and 18 years of age, with flexibility in upper age limit depending on presenting issue and developmental age.
- Present with severe or complex mental health problems.
- Are likely to benefit from an extended treatment and rehabilitation model of care in a hospital-based subacute bed.

A young person will **not be eligible** for a statewide subacute bed if they:

- Could be managed in a less restrictive setting.
- Primarily need support with substance misuse issues.
- Their primary problem to be addressed is accommodation.

2.2. Referral Process

The PSP completes a Consumer Intake Form on CIMHA, which needs to include:

- Reason for Referral:
  - An up-to-date mental state examination and clinical formulation
  - A clear description of why an admission to a statewide subacute bed is sought at this time, including specific goals for the consumer. Include, where available, input from other CYMHS services that demonstrate the need for a more intensive bed-based intervention.
- Relevant History:
  - History of the presenting mental health issues
  - A brief summary of treatment to date
- Practical Issues:
  - Current living situation
  - Education, vocation, and /or employment status
  - Finances
  - Family supports and ability of family to travel to Brisbane for a comprehensive family assessment.
- As the statewide subacute bed service is a non-acute service, the *Response Category* and *Timeframe for Assessment* sections are not applicable.

The PSP also needs to ensure that a Consent to Obtain/Release Information Form has been signed by the young person; or a Consent to Obtain/Release Information Form has been signed by their parent/guardian.

Once complete, forms are to be emailed to the Secretariat (email: [redacted]

The PSP will receive an acknowledgement of their referral and the date of the panel meeting when their referral will be considered by the panel.

2.3. Panel discussion of referral

Once a referral has been received, and the consumer listed on the agenda for the next panel meeting, the PSP for the consumer, or their delegate, will be invited to attend the panel meeting to discuss the referral and provide additional information as required.

Panel members are likely to raise questions about the referral to ensure appropriateness (that eligibility criteria have been met and that other service options have been explored). Additional information may be sought to enable the panel to make their prioritisation decisions.

The panel will also enquire as to how the referring PSP, and the consumer's local CYMHS team, intends to remain engaged with the consumer prior, during, and post admission, if accepted.

3. Intake and prioritisation

3.1. Response to referrals

The Panel Chair (or their delegate) will be responsible for informing the PSP of the outcome of the panel discussion and decision regarding the referral. The decision will also be communicated via email to the PSP, with a copy to [redacted]

The Secretariat will upload a copy of this communication onto the consumer's case file in CIMHA.

3.2. Response to referrals that are recommended for other service options

If the decision by the panel does not recommend intake of the young person into a statewide subacute bed, it is the responsibility of the panel to provide the reasons supporting this decision (e.g. referral does not meet access criteria for statewide subacute bed, or other service agencies are better placed to respond to the needs outlined in the referral). The Panel Chair is responsible for informing the PSP.

3.3. Response to referrals that meet eligibility but statewide subacute beds are at capacity

If the panel determines a new referral meets the eligibility criteria but the statewide subacute beds are at capacity, the panel will recommend that the young person be 'accepted – pending bed'. The panel may recommend alternative services to meet the young person's therapeutic or behavioural support needs, until such time that a place becomes available and where placement is still required.

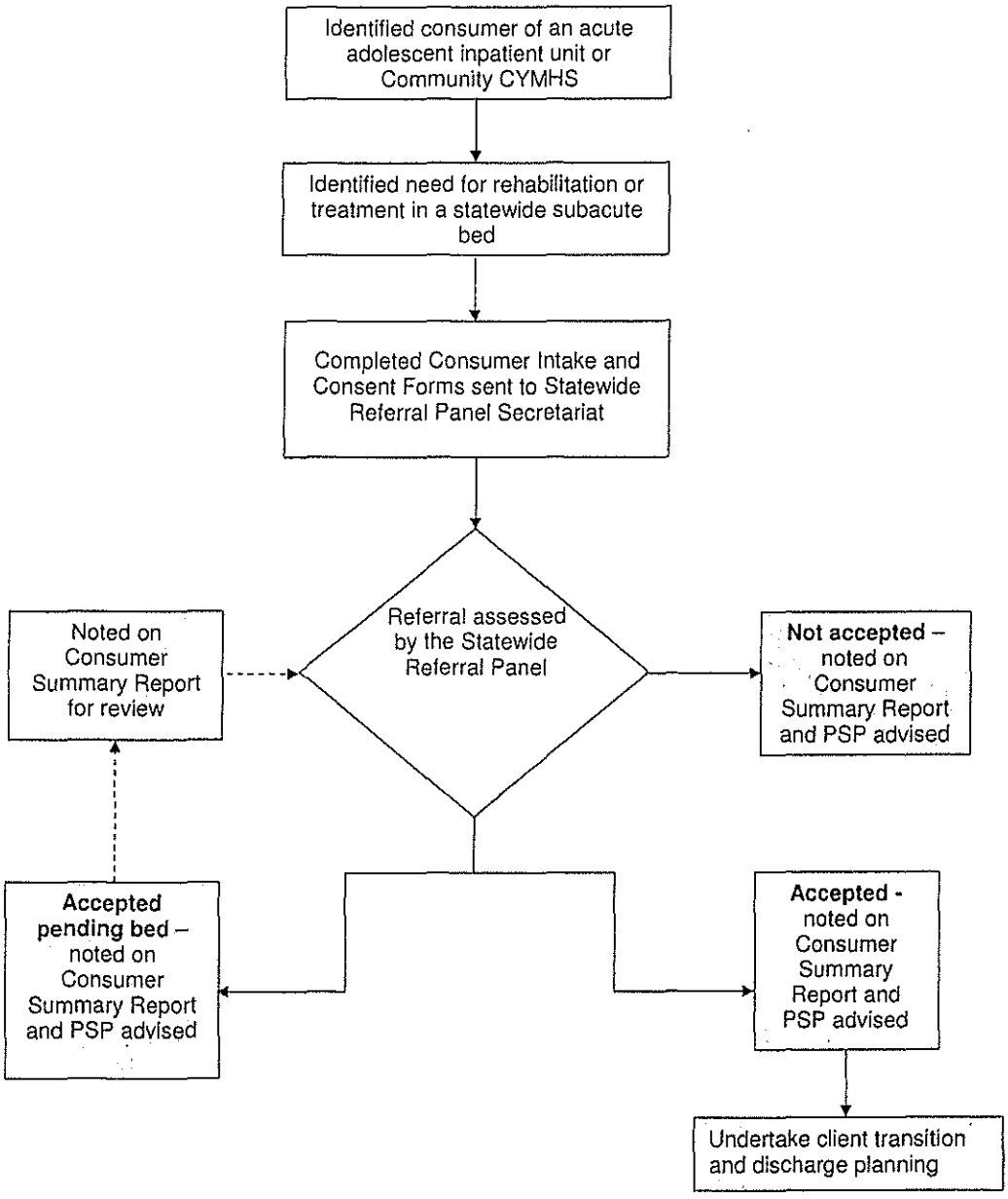
The referral will be noted in the Consumer Summary Report for review at subsequent panel meetings, to reconfirm placement need and any changes in priorities. The Panel Chair is responsible for informing the PSP.

Panel members should not provide an ongoing advisory or consultancy role for referrals that are not accepted into the statewide subacute beds.

3.4. Information collection, storage and data management

Consumer Intake and Consent Forms, any accompanying information, and the Consumer Summary Report will be kept on panel files.

Referral Process into Statewide Subacute Beds



Secretariat Process for Panel

- PSP sends referral via email to
- Secretariat confirms a completed Consumer Intake Form and signed Consent Form are attached.
- Secretariat forwards email onto Panel members for review.
- Panel Chair, or their delegate, confirms sufficient information is provided for panel assessment.
- Secretariat adds referral to next meeting agenda.
- Panel Chair contacts PSP to confirm panel meeting date for new referral assessment and invites PSP, or their delegate, to attend – Secretariat confirms via email.
- Secretariat circulates agenda, previous minutes, Consumer Summary Report, and any new referral documentation to panel members 5 days prior to scheduled meeting
- Secretariat minutes meeting of the Panel and updates the Consumer Summary Report
- Within 5 working days of the meeting, Secretariat finalises minutes and circulates meeting documentation to Panel and attendees, as appropriate.

Queensland Government

Children's Health Queensland Hospital and Health Service

Child and Youth Mental Health Service
Children's Health Queensland Hospital and Health Service Queensland Health

Enquiries to: Stephen Stathis
Medical Director
CYMHS CHQ HHS

Telephone:
Facsimile:

Dr. Donna Dowling
Clinical Director
Child, Adolescent and Young Adult Mental Health Service
Townsville Hospital and Health Service

Dear Donna

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland. Statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment. Currently, there are four statewide subacute beds located within the mental health inpatient units (Ward 8b) at the Lady Cilento Children's Hospital.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to on-site schooling will be provided within the hospital campus.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit. Referrals will occur via a Statewide Assessment Panel, who will work with referral parties to prioritise and triage new patients into the subacute beds. The Panel will also provide oversight for case review of existing subacute patients who may require an extension to their subacute admission.

Core members of the panel will include: Medical Director, Specialist Services, CYMHS, CHQ HHS (Chair); a senior child and adolescent psychiatrist representing the Northern Cluster; a senior child and adolescent psychiatrist representing the Central Cluster; a senior child and adolescent psychiatrist representing the Southern Cluster, and; the Nursing Director CYMHS CHQ HHS, who will provide liaison between the Panel and 8b. A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

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Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review. In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

In time, the duties of the Panel may evolve and include the triage and review patients in other extended mental health treatment and rehabilitation services.

I wish to invite you onto the Panel as the core member representing the Northern Cluster. Please advise me in writing of your decision by close of business, Friday 15 May 2015. Don't hesitate to contact me if you have any questions.

Kind regards

Yours sincerely

Dr. Stephen Stathis
Medical Director
CYMHS, CHQ HHS
05/05/2015

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Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'

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ABSTRACT

Intensive Mobile Youth Outreach Services (IMYOS) were developed to provide specialist mental healthcare to the most 'at risk' and hardest to engage young people living in the state of Victoria, Australia.
The purpose of this paper is to provide a description of the Orygen Youth Health (OYH) IMYOS, specialising in the treatment of 15 to 24 year-olds living in the northern and north-western region of metropolitan Melbourne, who have severe mental health problems and histories of poor engagement with mainstream mental health services.
An outline of the historic context and service development of the OYH IMYOS is followed by a detailed description of the fundamental principles for service delivery and core interventions. A case study is presented to illustrate the application of the treatment model. Finally, the current evidence base supporting the OYH IMYOS model is summarised, together with recommendations for the development of service models for 'difficult-to-engage', 'high-risk' youth.

1. Introduction

Intensive outreach mental healthcare (IOMHC) services such as Assertive Community Treatment (Stein & Test, 1980; Test & Stein, 1976), Intensive Case Management (Schaedle & Epstein, 2000), or Assertive Outreach (Sainsbury Centre for Mental Health, 2001) have a long tradition in adult psychiatry (Bond, Drake, Mueser, & Latimer, 2001). Similarly, their effectiveness in promoting favourable outcomes in adults with severe mental disorders is well documented (Herinckx, Kinney, Clarke, & Paulson, 1997; Marshall & Lockwood, 2002; Meaden, Nithsdale, Rose, Smith, & Jones, 2004; Muesser, Bond, Drake, & Resnick 1998; Smith & Newton, 2007; Ziguras & Stuart, 2000).

In contrast, much less is known about effective community-based treatment models for young people who require intensive treatment. Yet a number of service models for young people (from 5 to 18 years of age) do exist that can offer alternatives to psychiatric inpatient care (Lamb, 2009; Shepperd et al., 2009).

Perhaps one of the best known service models is multisystemic therapy (MST), originating from the work by Scott Henggeler in the 1970s in the US. (Henggeler, 1999; Henggeler et al., 1999). MST is a family-based treatment for young people with severe behavioural problems, incorporating intensive home and community-based interventions. The MST service is available 24-hours per day, seven days per week. Interventions are usually provided at home and treatment intensity and duration is determined by the needs of the young person and their family. Treatment is delivered by experienced clinicians who carry an individual caseload of about three families. Systematic reviews found that home-based MST was effective at decreasing externalising symptoms and improving family functioning, school attendance and treatment satisfaction (Shepperd et al., 2009). MST was also effective in reducing the need for psychiatric hospitalisation (ibid).

Another internationally recognised service model for young people with intensive treatment needs is 'intensive home treatment' (IHT; Lay, Blanz, & Schmidt, 2001; Mattejat, Hirt, Wilken, Schmidt, & Remschmidt, 2001; Remschmidt, Schmidt, Mattejat, Eisert, & Eisert, 1988; Schmidt, Lay, Göpel, Naab, & Blanz, 2006; Winsberg, Bialer, Kupietz, Botti, & Balka, 1980). IHT typically provides 24-hour, 7-days per week access to treatment and psychiatric emergencies response (Lamb, 2009). Interventions involve both the young person and their family and focus mainly on improving the psycho-social environment and reducing psychiatric symptoms (ibid). Duration and intensity of intervention varies between IHT programmes, as does staffing of teams (Shepperd et al., 2009). A systematic review of IHT concluded that whilst certain groups of young people with severe mental disorders can effectively be treated at home, "only about 15% of potential inpatients were suitable to be managed in this way" (Lamb, 2009, pg. 347).

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The purpose of this paper is to provide a description of an IOMHC service specifically developed for young people who have severe mental health problems and do not readily engage with mainstream mental health services.

The historic context and development of the service will be outlined, followed by a detailed description of the fundamental principles for service delivery and core interventions. A case study is presented to illustrate the application of the treatment model. Finally, the current evidence base for the service is summarised, together with recommendations for future service development.

2. Historic background and service development

Enquiries by the Australian Human Rights and Equal Opportunity Commission undertaken in the late 1980s and early 1990s highlighted that existing services were struggling to adequately care for young Australians with high and complex needs, such as those with a serious mental illness combined with other social problems, e.g. drug addictions, homelessness and unemployment (Human Rights and Equal Opportunity Commission, 1989/1993).

Consequently, in 1991, a number of service initiatives were established throughout metropolitan Melbourne to provide more accessible and intensive mental healthcare services for young people and their families. Finally, in 1998, the Victorian government released funding for a state-wide initiative called 'Intensive Mobile Youth Outreach Service' (IMYOS). With the establishment of IMYOS, existing child and adolescent mental health services (CAMHS) were provided with an enhanced community-based service model for 12 to 18 year-old 'high-risk' clients, who had traditionally been 'difficult-to-engage' in office-based service delivery.

There are currently five IMYOS teams in metropolitan Melbourne, providing assistance to young people from birth to 24 years of age.

2.1. Organisational context

The IMYOS referred to in this paper is part of Orygen Youth Health (OYH), a specialist government-funded youth mental health service located in western metropolitan Melbourne. The clinical programme at OYH offers a wide range of services for both psychotic and non-psychotic disorders, including a 24-hours, 7-days per week triage, assessment and crisis response service, several outpatient clinics, group based treatment services, and a 16-bed inpatient unit (McGorry, Parker, & Purcell, 2007; www.oyh.org.au).

2.2. Target population

IMYOS provides assistance to young people who present with complex and severe mental health problems, who are considered at 'high risk' (e.g. of suicide), and who either have a history of poor engagement with office-based services, or who require a level of support that cannot be sustained by mainstream outpatient services (e.g. due to frequent psychiatric emergencies).

Based on clinical audit data obtained from all clients seen between July 2005 and January 2009 (N = 68; Schley, Yuen, Fletcher, & Radovini, 2010), the majority of young people assisted by IMYOS have problematic upbringings characterised by e.g. early parental separation, family mental illness or childhood abuse (Table 1). Typically, clients have repeatedly engaged in behaviours which have, or could have, caused harm to them and/or others (Table 1).

Prior to referral to IMYOS, clients have been involved with office-based mental health services (e.g. continuing care teams at public mental health services) for an average of 2.4 years (SD = 2.39) and have had between one and five previous treatment 'dropouts' (mean = 2.1, SD = 1.0; Schley et al., 2008). The majority of young people (87%) supported by IMYOS are simultaneously involved with a range of other services such as Child Protection, Youth Justice and Alcohol and other Drugs Services (Schley et al., 2008).

IMYOS clients commonly present with multiple Axis-I diagnoses (American Psychiatric Association, 2000) and about half (49%) fulfil

Table 1
Characteristics of IMYOS clients[a].

	N	%
Female	54	79
Age at referral to IMYOS	median 17.4 yrs, range 14–25 yrs	
Personal and family history		
Parental separation before the age of 5	46	67.6
History of family mental illness	53	77.9
History of family suicide (attempted and completed)	22	32.4
History of family substance abuse	45	66.2
Exposure to domestic violence	39	57.4
History of childhood abuse (physical and sexual)	48	70.6
History of unstable living/homelessness	33	48.5
Risk history[b]		
History of self-harm	52	76.5
History of suicide attempt(s)	38	55.9
History of violence	38	55.9
History of criminal behaviour	29	42.6
History of problematic substance use	42	61.8
Recurrent 'risk behaviour' at time of IMYOS referral[c]		
Recurrent self-harm	25	36.8
Recurrent suicidal thoughts	33	48.5
Recurrent violence	22	32.4
Recurrent criminal behaviour	10	14.7
Recurrent problematic substance use	23	33.8
History of psychiatric hospitalisation	40	58.8
Psychiatric hospitalisation within 3 months of IMYOS referral	23	33.8

[a] Based on clinical audit data obtained from 68 clients seen between July 2005 and January 2009.
[b] 'History' indicates that the behaviour/act has occurred at least once within the client's life time preceding IMYOS referral.
[c] 'Recurrent' indicates that the behaviour/act has occurred at least once within the three months preceding IMYOS referral.

Table 2
Diagnostic profile of IMYOS clients[a].

	N	%
Axis-I disorders[b]		
Mood disorders	34	50
Anxiety disorders	33	49
Substance-related disorders	18	26
Eating disorders	6	9
Psychotic disorders	6	9
Attention-deficit and disr. beh. disorders	6	9
Pervasive developmental disorders	4	6
Other	3	4
Axis-II full-threshold disorders[b]		
Borderline personality disorder	11	16
Antisocial personality disorder	1	1
Obsessive compulsive personality disorder	1	1
Dependent personality disorder	1	1
Mild mental retardation	8	12
Axis-II sub-threshold disorders[c]		
Borderline personality disorder traits	20	29
Other personality disorder traits	9	13

[a] Based on clinical audit data obtained from 68 clients seen between July 2005 and January 2009.
[b] According to DSM-IV-TR, American Psychiatric Association (2000).
[c] Emerging personality disorder currently not fulfilling criteria for a full syndrome diagnosis according to DSM-IV-TR.

the criteria for an emerging or full-threshold personality disorder (Table 2).

2.3. Challenges in the development and implementation of IMYOS

As there was no precedent to a youth-specific intensive outreach service in the public mental health system, the OYH IMYOS team faced many challenges in the initial development and implementation of the proposed service initiative. The Victorian Government provided some staff training and support with the IMYOS roll-out. However, with no clear guidelines in existence, many questions needed to be addressed, most importantly:

- What aims would IMYOS pursue in its work and how would its 'effectiveness' be measured?
- Who should access IMYOS and for what reason(s)?
- How should the eligibility of clients for IMYOS be assessed?
- What should be the main focus of IMYOS intervention? (Re-engage clients with office-based mental health services? Treat psychiatric symptoms? Provide psycho-social rehabilitation? Manage risk?)
- What could determine how 'intensively' (i.e. how often and over what time period) clients needed to be seen?
- How long would IMYOS persist with clients who were unwilling to be involved with the service? When might 'assertiveness' become counter-productive?
- What could indicate that a client was 'ready' for discharge?
- How could IMYOS justify smaller caseloads in comparison with other clinical programmes of the public mental health service system?

Over a period of about 12 months, answers to these and many other questions informed the development of internal policy and procedure documents which continue to guide both the general service operation (see Chapter 3) and the IMYOS treatment model (see Chapter 4).

Another set of challenges pertained to the aspect of 'team functioning'. Perhaps not surprisingly, soon after IMYOS was implemented it became apparent that to 'simply' allocate a shared task (i.e. provision of an intensive outreach service) to a group of individuals did not automatically result in a functioning team. Regular group supervision and expert consultations (see Section 4.2.7) were implemented to ensure continued reflective practice and team building. Additionally, team functioning was promoted by researching and discussing evidence-based practices in the area of youth mental health, and working towards a shared understanding of the presenting issues of IMYOS clients and how to respond to them in an effective and consistent manner. This process resulted in the formulation of the theoretical framework and fundamental principles of service delivery described under Sections 4.1 and 4.2.

Finally, challenges emerged in relation to the management of 'high-risk' clients. Precautions to ensure staff safety (e.g. during home-visits) and to minimise the risk of harm to clients are described in detail under Sections 4.2.1 and 4.3.1.4.

3. Service operation and composition

3.1. Service contacts and hours of operation

IMYOS utilises an intensive outreach approach to engagement and treatment that does not depend upon clients maintaining appointments at a centre-based office. Instead, IMYOS provides services in the community, most commonly in the client's home, at their school, or in public locations such as parks or cafes.

IMYOS operates during normal business hours from Monday to Friday. At all other times clients can obtain support from the Youth Access Team (YAT) providing after-hours psychiatric emergency response to all young people seen at OYH.

The frequency and duration of client contact varies greatly depending on clinical need and complexity of presentation. According to routinely-collected service data, contacts with clients can range from 10 min up to 8 h during an average five-day working week (mean = 89 min, SD = 92.14 min).

3.2. Staffing and caseloads

IMYOS comprises a team of eight mental health professionals from a variety of professional backgrounds, including clinical psychology, social work, occupational therapy and psychiatric nursing. A full-time coordinator provides day-to-day operational management of the team and is also involved in direct clinical care. A consultant psychiatrist and senior psychiatric registrar contribute to the clinical governance, treatment provision and ongoing service development of IMYOS.

All clinicians provide mental health assessment, case management and treatment; however, certain specialised duties are carried out in line with specific professional skills (e.g. prescription of medication, psychological testing, or provision of family therapy). Caseloads for a full-time IMYOS clinician typically range from 8 to 9 clients, but can be lower in case of particular demand.

3.3. Initial engagement and assessment phase

IMYOS accepts referrals from the clinical programme at OYH. Following referral, clients are allocated to an IMYOS clinician who undertakes a comprehensive biopsychosocial assessment over a six week period. This assessment determines the eligibility of clients for ongoing IMYOS involvement against six intake criteria (Table 3), and provides a baseline for case formulation, diagnosis and treatment planning. Typically, the assessment is based on personal interviews with the client, family members[1] and other supports (e.g. welfare teacher), as well as collateral information from previous reports and assessments both from clinical and non-clinical sources (e.g. psychiatric and medical assessments, psychometric testing, speech and language assessments, school reports, child protection reports etc.). Information is summarised in a report which includes a comprehensive formulation, risk assessment and detailed management/treatment plan. In collaboration with the client and other supports, an individual service plan (ISP) outlining the main goals for intervention and steps to achieving these is devised and circulated. A 'safety plan' is developed which describes individual as well as systemic responses at times of psychiatric emergency (see Section 4.2.1).

The assessment report is presented to the IMYOS team, where a final decision regarding ongoing involvement is made. Similarly, the initial management/treatment and 'safety plan' are ratified by the consultant psychiatrist and the team.

Most clients (94%) will continue with IMYOS beyond their assessment (Schley et al., 2008). Clients who do not continue with IMYOS will typically remain under care of their referring case manager. The most common reason for non-acceptance is that clients are assessed as not requiring the intensity of support provided by IMYOS. Re-referral of non-accepted clients is possible and encouraged in case of future deterioration.

3.4. Active treatment phase

Once formally accepted, active treatment commences and is focussed on the provision of a range of case management and evidence-based interventions according to clinical needs and client goals (see Section 4.3).

[1] Throughout the text the term 'family members' is utilised for brevity, but is intended to incorporate all significant care and family relationships relevant to the clients involved with IMYOS.

Table 3
IMYOS intake criteria.

Criterion 1: Age range
• Client is between 15 and 24 years old.
Criterion 2: Difficult to engage
• Client does not attend office-based treatment or actively refuses contact.
And/or
• Client is unable to attend due to mental illness (e.g. severe agoraphobia).
And/or
• The client's complexity and/or need for repeated crisis intervention interfere with current assessment or treatment.
Criterion 3: High risk
Client presents with one or more of the following:
• History of suicide attempts
• Recurrent suicidal ideation
• Recurrent self-harming behaviour
• Risk of exploitation (i.e. through absconding, prostitution etc.)
• Criminal/offending behaviour
• Alcohol and/or other drug issues
• Challenging and/or difficult to manage behaviours
And/or
• The client's mental health is at risk of deterioration due to a suspected or untreated severe Axis-I disorder.
Criterion 4: Mentally ill
• Client displays signs and symptoms of mental illness.
Criterion 5: Case complexity
Client presents with one or more of the following:
• Frequent inpatient admissions
• Frequent mental health crisis contact
• Multiple placements/accommodation changes
• Multiple schools
• Family issues
• A history of sexual/physical/emotional abuse
• Multi-agency involvement
Criterion 6: Focus of intervention and desired outcome

Usually the same IMYOS clinician is involved with the client, family members and support systems.[2] However, depending on case complexity and therapeutic considerations, a secondary IMYOS clinician is sometimes allocated to work with family members and/or the support systems. The client, and commonly, family members will also have regular contact with the IMYOS consultant psychiatrist and/or psychiatric registrar for treatment planning, progress review and, if required, medication management.

Interventions are discussed and treatment progress reviewed during weekly team meetings. At minimum, a client's treatment progress is formally reviewed every six weeks unless an earlier review is indicated (e.g. due to escalation in 'risk'). Treatment progress is monitored in accordance with individual treatment goals and clinical judgement, but also involves formalised outcome measurement at three-monthly intervals. The active treatment phase can last for a maximum of two years. On average clients remain involved with IMYOS for 12.6 months (SD = 6.8; Schley et al., 2008).

3.5. Transition and discharge phase

Decisions about discharge from IMYOS are made on a case-by-case basis as indicated by clinical need (e.g. in relation to the level of wellbeing and functioning) and achievement of treatment goals. Discharge is also considered upon client request, or if continued involvement appears counter-therapeutic (e.g. if continued assertive involvement escalates problematic behaviours). Discharge and follow-up support is thoughtfully planned from the beginning of treatment and includes clients and others involved in their welfare and/or care. Clients and their family members are supported in managing discharge and potential transition to other services. Where a client has been referred to another service, the IMYOS clinician will attempt to work collaboratively with this service in order to transition the client in the most supportive way. Clients who refuse ongoing support post-IMYOS intervention are given written information outlining services that they can access in the future. Every attempt is made to give this information to family members and support systems. A written discharge report is distributed to all relevant parties which identifies the client's continued support and treatment needs.

About one-third of clients will be referred for further mental health treatment at the end of IMYOS involvement. Approximately 70% will receive support from a non-mental health service (Schley et al., 2008).

4. Treatment model

The IMYOS treatment model comprises three inter-connected domains (Fig. 1). A theoretical framework provides the basis for formulation and application of specific fundamental principles of service delivery, which guide the planning, provision and evaluation of a range of core interventions (e.g. psychotherapy, pharmacotherapy, etc.). Whilst the core interventions are comparable to those commonly provided by mainstream mental healthcare services (Cooper & Yarmo Roberts, 2006; Smith & Newton, 2007), it is the manner in which these interventions are delivered, determined by the fundamental principles that is at the very 'heart' of IMYOS work and may distinguish it from other services.

4.1. Theoretical framework

Fig. 2 depicts theoretical concepts that have been most influential in the development of the IMYOS treatment model.

The first tier represents the overarching influence of developmental theory for the IMYOS approach, acknowledging both the developmental trajectory of individuals as well as common biopsychosocial–spiritual transitions during adolescence and young adulthood (Feldman & Elliot, 1990; Newman & Newman, 2008).

The second tier describes the theories that determine the IMYOS team's conceptualisation of the 'multi-determined nature' of the client's presenting strengths (e.g. resilience; Werner & Smith, 1992) and difficulties (e.g. insecure or anxious attachment style; Bowlby, 1979) and how best to integrate and respond to them.

The third tier refers to concepts that have shaped the IMYOS team's 'relational model' (see Sections 4.2.2 and 4.2.3).

The integration of these three tiers occurs on a case-by-case basis and guides understanding of presenting problems and their treatment. For a detailed description of the theoretical framework and its implications for interventions refer to Ryall et al. (2008).

4.2. Fundamental principles of service delivery

The following principles are derived from the above theoretical framework and the team's experience since the inception of IMYOS. The IMYOS team considers these principles fundamental for all aspects of service planning, provision and evaluation with individual clients, family members and support systems. These principles are also followed to ensure the welfare of IMYOS clinicians and the functioning of the team.

4.2.1. 'Safety first'

The first premise of IMYOS is that no therapeutic intervention can occur unless people feel safe. The requirement for personal safety pertains to the individual client and all people involved in the client's welfare and/or care, including the IMYOS clinician or treating team.

In practice, the need for safety for both client and others is clearly articulated at the beginning of IMYOS involvement and a framework for safe interactions is developed and agreed upon. This framework,

[2] Throughout the text the term 'support system' refers to another service or services that are simultaneously involved in the client's welfare and/or care (e.g. school welfare or pastoral care, alcohol and other drugs services, child protection, youth justice, family support services, etc.).

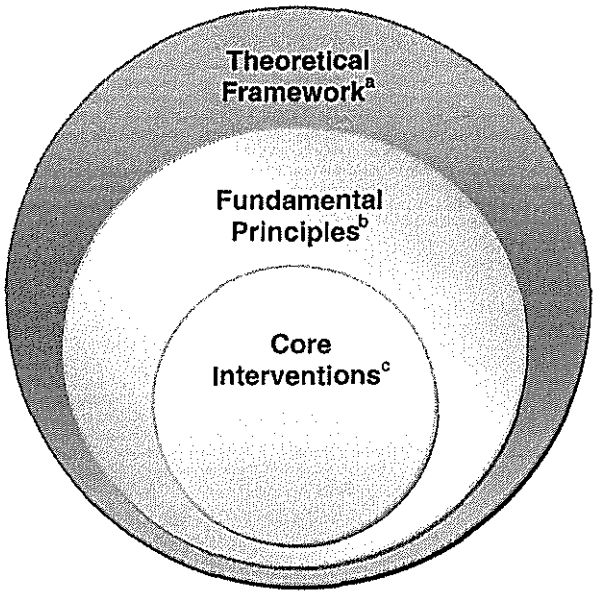

Fig. 1. Relationship between the theoretical framework, fundamental principles and core interventions of the IMYOS treatment model. [a] Theoretical framework is based on: developmental theory; trauma theory; attachment theory; systems/family theory; relationship management and collaboration/coercion principles (see Section 4.1). [b] Fundamental principles of service delivery include: 'safety first'; 'assertion, not coercion'; therapeutic relationship as fundamental tool of intervention; flexible and responsive; holistic treatment approach; team-based approach; supervision, organisational support and professional development (see Section 4.2). [c] Core interventions include: case management; practical support; risk management; individual psychotherapy; pharmacotherapy; group therapy; alcohol and other drugs counselling; family counselling/therapy; service liaison and referral; community capacity building (see Section 4.3).

which can take the shape of a flowchart or diagram, clearly outlines 'boundaries' for interaction and behaviour (e.g. 'anger is a normal emotion and acceptable, whereas aggressive behaviours are not') and what will happen when these boundaries are 'crossed' (e.g. "If you threaten me, I will remind you of everyone's need for safety and that threatening behaviour is not appropriate. If you still continue to threaten me I will have to terminate the session. We will then have to think about how we can find a way to work safely in the future"). Similarly, the safety framework is established for behaviours which may place the client at risk of harm (e.g. suicidal or risk-taking behaviour).

As many IMYOS clients may not have had many (if any) opportunities to experience safe and respectful human interactions (e.g. as a result of childhood abuse) the establishment of a 'sense of personal safety' by re-instating boundaries which have historically been violated often becomes, and for some clients remains, the main focus of intervention. Interventions aimed at promoting 'a sense of safety' involve discussion, 'role modelling' of desirable interactions, and the re-instigation of 'a safe space' (i.e. wherever treatment occurs).

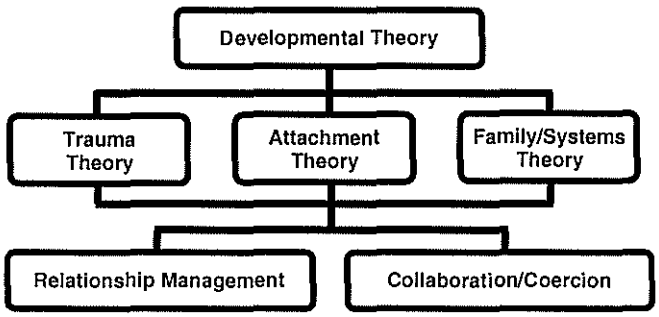

Fig. 2. Theoretical framework of IMYOS (From Ryall et al. 2008).

4.2.2. 'Assertion, not coercion'

It has been suggested that IOMHC services might be perceived as being coercive, yet little evidence has been found to substantiate this claim (Appelbaum & Le Melle, 2008).

IMYOS utilises an assertive outreach approach with a strong focus on maintaining contact with clients who have previously been 'difficult-to-engage'. Consequently, at least in the initial engagement and assessment phase (see Section 3.3), IMYOS will continue to initiate contact with the client, even if the client seems reluctant or resistant to accepting involvement. This can take the form of repeated home-visiting and/or phone calls, letter writing, leaving 'notes' at the door step, etc. However, the overarching principle of IMYOS intervention is to provide a service that empowers clients, promotes collaboration and transparency and occurs in the least restrictive environment and manner. This means that whilst IMYOS will persist in an effort to engage with clients, the emphasis lies on promoting their sense of competency and ability for independent decision-making by avoiding coercive management strategies.

However, there are circumstances when more coercive interventions become necessary, to prevent a client from committing suicide, for example. Yet, even in a situation where coercive interventions (e.g. involuntary admission to a psychiatric hospital) might be indicated, the established 'safety framework' (see Section 4.2.1) provides a clear rationale for why this form of treatment has become necessary, therefore enabling consistent and transparent communication between the client and IMYOS clinician. In the experience of the IMYOS team, if clinicians are in a position to clarify the situation in which they may need to intervene in a coercive manner, it is more likely that a collaborative relationship can be maintained overall.

4.2.3. The therapeutic relationship as fundamental tool of intervention

Early childhood trauma (e.g. sexual and physical abuse) and neglect have been shown to significantly impact on brain development and precipitate long-term difficulties in biological (neurological), psychological and social functioning (Perry, 2006; van der Kolk & McFarlane, 1996). Corrective 'relational experiences' (i.e. safe, positive and nurturing interactions with trustworthy others) are essential to help clients 'recover' from past pathological experiences in relationships (Perry, 2006). Consequently, IMYOS emphasises the importance of the therapeutic relationship in all aspects of treatment, and proposes that the skillful development of a respectful, trusting and consistent therapeutic relationship can be in itself reparative.

In practice, IMYOS clinicians aim to continuously model respectful and trusting interactions and utilise fundamental relational strategies such as collaboration, transparency, consistency and validation. With clients whose traumatic life experiences have left them feeling hope-and/or helpless (e.g. believing that there is nothing they can do to change), IMYOS clinicians will place particular emphasis on promoting a positive belief in the client's ability to transform and change, whilst simultaneously acknowledging realistic expectations for outcome (e.g. "things will hopefully improve for you, but they won't be perfect").

In addition to fostering a respectful and trusting relational stance, IMYOS employs certain practical strategies to promote both initial engagement and the therapeutic relationship throughout treatment. These include continued efforts to meet with the client in an environment of her/his choice and joint participation in a client's preferred activity (e.g. basketball, shopping, computer games) and/or conversations about topics meaningful to the client (e.g. music). For some clients this 'style' of interaction is required for some time until they feel 'safe' enough to consider more focussed treatment of their psychiatric condition. In this sense, the IMYOS team regards the formation of a therapeutic relationship as a necessary condition to the provision of more specific interventions (e.g. psychotherapy). At the same time IMYOS acknowledges that the therapeutic relationship is not a 'stable entity' but rather an interpersonal experience that can 'wax and wane' over time. Hence the therapeutic relationship remains

a fundamental process that continues throughout treatment and is central to a successful outcome.

4.2.4. Flexible and responsive

Better treatment adherence and improved outcomes have been identified for treatment approaches which match the needs of clients and offer a choice about treatment modalities (Priebe, Watts, Chase, & Matanov, 2005; Robinson, Callister, Berry, & Dearing, 2008). IMYOS interventions are individually tailored to meet the specific needs of clients, family members and support systems. As such, clients are provided with an individualised treatment which is, wherever possible, collaboratively planned. In treatment planning consideration is given to the initial assessment and formulation (see Section 3.3), as well as the changing needs of clients. Presenting issues are addressed according to their urgency, but also in relation to the client's capacity and willingness to address them.

4.2.5. Holistic treatment approach

IMYOS emphasises that a client's presentation needs to be understood and responded to in the context of his/her relationships with 'surrounding environments', in which the client and the environment reciprocally influence and sometimes change each another (e.g. Harms, 2005). Consequently, a client's strength and difficulties are viewed as 'relationally derived', rather than located exclusively within the client (e.g. Minuchin, 1974).

In practice, IMYOS clinicians routinely attempt to actively involve family members in all aspects of treatment in order to foster a shared understanding of the potential causes and maintaining factors to presenting problems and how each family member can help intervene in an effective manner (see Section 4.3.2). Similarly, the often complex service systems surrounding clients require coordination and consultation to maximise the effectiveness and consistency of service delivery (see Section 4.3.3).

Both IMYOS clinical practice and the existing evidence-base (e.g. Henggeler et al., 1999) support the use of a 'multi-systemic' approach in the treatment of 'complex' clients. However, in some instances such an approach may not be possible or even counter-therapeutic, e.g. where persistent contact with a client results in an escalation in their 'risk-taking' behaviour, or where involvement of a previously abusive family member may negatively impact on a client's recovery. Generally, the decision of who to include in the client's treatment will be determined by client preference, case formulation and 'cost–benefit' considerations.

Another important aspect of the IMYOS holistic treatment approach concerns the definition of 'therapy'. The IMYOS team explicitly holds that any intervention which is thoughtfully planned and is aimed at supporting the client can be reparative and therefore 'therapeutic'. Hence, 'therapy' as understood and provided by the IMYOS team occurs on a 'continuum of care', and ranges from basic practical support (e.g. assistance with housing issues) to evidence-based interventions (psychological and psychiatric therapy).

4.2.6. Team-based approach

Each clinician in IMYOS takes a lead role and responsibility in treatment planning and provision for their clients. However, IMYOS adopts a team-based approach which encourages joint decision-making and collaborative practices during all stages of treatment. Regular team meetings (e.g. weekly clinical review), shared office space, and a 'buddy system' (i.e. two clinicians 'checking in' over the course of the working day) underpin this process.

4.2.7. Supervision, organisational support and professional development

Due to the challenges in working with 'high-risk' clients, the IMYOS team places particular emphasis on regular staff supervision, ongoing organizational support, and continued professional development. All team members (including the coordinator) are provided with the opportunity for weekly individual supervision and fortnightly team-based supervision, facilitated by an external supervisor. Formalised review processes within IMYOS and OYH are designed to foster reflective practice and to provide continued organisational support (e.g. through ratification of management plans for particularly 'high-risk' clients). All team members are encouraged to undertake regular professional development, and professionals with specialist knowledge and expertise (e.g. in youth justice, sexual abuse counselling, etc.) are invited to consult to the IMYOS team on an ongoing basis.

4.3. Core interventions

IMYOS provides a range of interventions incorporating the individual client, their family members and support systems. Most of these interventions are directly provided by IMYOS clinicians; however, some services can be brokered if they seem more appropriately delivered by external services. For example, IMYOS works closely with both specialist alcohol and other drug and employment services and supports referrals and engagement with these services where indicated.

The following sections will illustrate some of the core interventions typically provided by IMYOS.

4.3.1. Individual interventions

4.3.1.1. Practical support. IMYOS supports clients during all phases of treatment in meeting their 'basic human needs' (food, shelter, etc.; see Maslow, 1943) in order to promote their recovery. In practice this can take the form of assisting clients with securing suitable accommodation, helping them to find employment, or taking them to medical appointments. IMYOS also offers assistance with day-to-day tasks such as financial management and administration (e.g. completing forms to access governmental benefits). Practical support is also applied to assist clients to re-engage with normative developmental tasks (e.g. education, socialisation, etc.) that may have been disrupted as a consequence of the onset of their mental illness. For example, IMYOS assists clients to return to school, or helps them engage with appropriate social groups or networks.

4.3.1.2. Psychotherapy. Psychotherapy is available to all IMYOS clients and is encouraged as part of their recovery. Psychotherapeutic interventions are directed at specific psychiatric disorders identified during assessment which most impact on the client's wellbeing and functioning. IMYOS clinicians commonly employ evidence-based therapies such as Cognitive Therapy (Beck, 1995), Cognitive Analytic Therapy (Ryle & Kerr, 2002) or Narrative Therapy (White, 2000).

IMYOS clients also have the option to engage in group-based treatment services at OYH. Individual and group treatments are coordinated and reviewed regularly for each client.

4.3.1.3. Pharmacotherapy. Pharmacotherapy forms part of the treatment of about 60% of IMYOS clients (Schley et al., 2008). Responsibility for prescription and monitoring of pharmacotherapy rests with the IMYOS team's consultant psychiatrist or psychiatric registrar. On rare occasions medication may be prescribed by an external medical practitioner (e.g. general practitioner) in consultation with the psychiatrist or registrar. In collaboration with the psychiatrist or registrar, IMYOS clinicians assist clients with the management of their medication compliance and response. Medication use is in keeping with evidence-based guidelines for the treatment of psychiatric disorders (e.g. Mellman et al., 2001).

4.3.1.4. Risk management. During regular business hours psychiatric emergencies will be managed by the allocated IMYOS clinician or, if unavailable, by a clinician rostered 'on duty'. Outside business hours clients have access to psychiatric emergency assistance through the Youth Access Team (YAT). Formalised communication structures

between IMYOS and YAT (i.e. 'hand-over' meetings, shared access to electronically stored documents, etc.) ensure that the clinician who responds to a client 'in crisis' will have access to an up-to-date management/treatment and 'safety plan', promoting a consistent management approach and continuity of care.

The aim of IMYOS 'risk management' is to assist clients to minimise the risk of serious harm whilst maximising their competence and opportunities for independent mastery. Specifically, IMYOS assumes that by avoiding (where possible) coercive or 'rescuing' responses and by taking some 'clinically indicated risk', clients will over time discover and further develop their self-management abilities. In most cases this will take time and therefore requires that IMYOS clinicians and the team are able to 'sit with' the uncertainty associated with relinquished control and the potential for harm, as clients learn to manage themselves more adaptively. Whilst this approach has proven very effective in clinical practice (Dawson & MacMillan, 1993), its use is considered carefully in the context of the cognitive and emotional developmental stages, chronological age and mental state of clients.

If psychiatric hospitalisation is indicated, it usually occurs with the client's consent. However, on rare occasions involuntary treatment may be required if the client is not able to make an informed decision (e.g. due to acuity of illness) or refuses help in the face of serious risk of death. In most cases hospitalisation is intended to 're-establish safety', rather than for psychiatric treatment. Consequently, admissions are usually very brief (e.g. 24–48 h).

4.3.2. Family interventions

The first aim of IMYOS family work is to support family members in developing a better understanding of and greater capacity for responding appropriately to the client's mental illness and associated difficulties. Secondly, IMYOS aims to repair or strengthen relationships between the client and family members in order to improve outcomes for the client, as well as for family members. Thirdly, IMYOS encourages family members to be actively involved in supporting the treatment and recovery of the client.

Family interventions are sensitive to the family members' explanatory models of illness, expectations of treatment goals and outcomes, as well as their personal strength and difficulties. Depending on 'needs' and identified goals, a variety of supports can be provided to family members, including: advocacy and brokerage for material and practical needs (e.g. application for carer support funds, carers' allowance, etc.); linkage with peer supports (e.g. OYH carer consultants); referral to Child, Youth and Family Support agencies for more intensive family case management; and supportive counselling or family therapy (e.g. solution-focused communication skills, problem solving, family therapy (see Minuchin, 1974)).

4.3.3. Systems interventions

Whenever a client is simultaneously involved with another service or services, IMYOS aims to establish collaborative (shared) care arrangements to ensure consistent and integrated treatment. Such arrangements commonly include joint treatment planning and review (e.g. through phone communication and/or case conferences), as well as shared provision of interventions and practical tasks (e.g. 'taking turns' in taking the client to an appointment with their employment consultant). The aim of inter-agency collaboration and support is to enhance favourable outcomes for clients and their family members. However, it is also acknowledged that support between agencies can be very beneficial in 'sharing the burden' of working with clients who commonly evoke high levels of anxiety about their welfare.

Another aspect of IMYOS 'systems interventions' pertains to community capacity building. IMYOS clinicians regularly provide secondary consultation to audiences such as general practitioners, school welfare staff or housing support workers. IMYOS capacity building activities are designed to develop strong relationship networks and communication channels, and to establish 'reciprocal' referral pathways and shared care practice models.

5. Case study

5.1. Background

Katie (name changed), 16 years of age, was the youngest of two children. Her early years were characterised by the absence of her biological father and disruptions to her attachment with her mother due to frequent separations and inconsistent care. Katie's mother, Leanne, (name changed) reported that she had had a conflictual relationship with her family of origin, and that her father had committed suicide when she was six years old. Leanne reported a series of relationships with men who had been violent and substance abusing. Leanne was unsure who Katie's father was.

Katie suffered repeated physical and sexual abuse from the age of eight, initially by a neighbour, later by two of her mothers' boyfriends. Child protection was first notified when Katie was eight years old. A range of services were employed to work with Katie and her family, but involvement was typically short-lasted, e.g. because of Katie and/or her mother disengaging. Following several unsuccessful placement and custody arrangements, Katie was permanently placed in a residential unit at age 14. At this time, Katie presented with a range of difficult behaviours including school refusal, violent outburst, inappropriate sexualisation, intermittent self-harm and problematic substance use. Over the next 16 months, Katie's situation deteriorated further. She repeatedly absconded from her unit, started using illicit substances (including heroin (IV) and amphetamines) and engaged in street sex work. Katie was in frequent contact with emergency services, including police (in relation to her prostitution) and emergency departments (due to substance use issues and self-harm), and on two occasions she was involuntarily hospitalised in context of disclosing suicidal intent. It was at this time that Katie was referred to IMYOS. Also involved were an alcohol and other drugs (AOD) counsellor, a case manager (contracted by Child Protection) and staff from Katie's residential unit and school.

5.2. Katie's initial engagement and assessment

The IMYOS clinician was introduced to Katie by her AOD counsellor who she had known for some time. A framework for safe interactions was established (see Section 4.2.1) and the IMYOS clinician continued to offer to meet with Katie in an environment of her choice (i.e. at her unit) at a consistent time each week. Similarly an 'acceptable' (safe) agenda for contacts was established, which initially focused on joint activities (e.g. talking about Katie's artistic interests, including her drawings). Katie's initial engagement with the IMYOS clinician was slow owing to her 'lifestyle' (e.g. being absent from the unit or being drug affected during appointments), and reluctance to talk about her difficulties.

The IMYOS assessment concluded that inadequate primary care and traumatic early life events had likely resulted in Katie 'developing' a problematic relational model (see Section 4.2.3) characterised by significant mistrust of others (e.g. due to anticipating further losses and/or abuse from others) and lack of 'appropriate boundaries' (e.g. becoming inappropriately attached (e.g. seeking physical comfort from staff) and/or avoiding emotional contact altogether). It was proposed that Katie's treatment needed to offer her an opportunity for a 'reparative' relational experience (see Section 4.2.3) through which problematic elements of her relational 'style' could be explored and addressed (e.g. assisting her with the development of 'appropriate' interpersonal boundaries).

5.3. Katie's treatment

5.3.1. Individual interventions

After eight weeks of consistent home-visiting and repeated conversations about how involvement with IMYOS could be 'useful' to Katie, her engagement slowly started to improve. Katie agreed to weekly sessions (for one hour, at the same time and place) jointly

attended by her IMYOS clinician and AOD counsellor. Each session followed the same 'rules' and structure: The session commenced with a discussion and 'contract' in relation to a topic that Katie wanted to address that week. Katie was then given a sketch pad and markers and encouraged to write and draw in relation to that topic. Each session included a short break, and Katie was able to decide whenever she wanted to terminate the session. Katie's weekly sketches repeated several themes and images including hearts, her mother, daggers, blood and men. On occasions Katie would explain the content of her sketches and how they related to her feelings or experiences, at other times not. In response to what Katie was describing, her IMYOS clinician began 'sketching out' relational patterns, drawing from principles of Cognitive Analytic Therapy (Ryle & Kerr, 2002). The most significant 'problematic relational pattern' identified was based on the dynamic of Katie either 'being abusing' (i.e. of herself and/or others), or 'being/feeling abused' (i.e. by herself and/or others). This pattern appeared relevant to Katie's self-harming, street sex work and substance abuse (i.e. Katie abusing herself), and to her experience of how her mother's 'boyfriends' had treated her (i.e. having abused her). Katie also indentified that much of her behaviour was driven by a desire to be cared for (owing to lack of care during childhood). Sessions consequently focussed on assisting Katie to notice when she was 'drawn into' problematic relational pattern and to explore more beneficial ways to relate to herself and others (e.g. to learn to express her need for care 'directly', instead of eliciting a 'caring (rescuing) response' from others by engaging in deliberate self-harm).

5.3.2. Family interventions

Katie and her mother continued to have intermittent contact after Katie had been placed in residential care. However, during IMYOS involvement neither agreed to engage in family-based interventions.

5.3.3. Systems interventions

The IMYOS clinician continued to meet with Katie's 'care team' on a fortnightly basis, comprising of her AOD counsellor, case manager, and staff from her residential unit school. These meetings focussed on establishing a joint understanding of Katie's difficulties (and strength) and a consistent management approach. As a result of these collaborative care team meetings all staff agreed that clear and consistent boundaries were crucial in encouraging Katie to develop adaptive and pro-social behaviours. Similarly, it was decided that 'developmentally appropriate' expectations of Katie's capacity for self-management were important to encourage her to take maximal responsibility for her own actions. At Katie's school this resulted in staff setting realistic educational tasks, encouraging and rewarding pro-social behaviours (e.g. talking respectfully) and responding to problematic behaviour in a consistent manner which was neither 'abusive' (e.g. punishing) nor too caring (e.g. giving Katie a hug when she was upset). At Katie's unit, staff developed a behavioural modification plan based on positive reinforcement principles, which encouraged her to e.g. attend school regularly, keep her room clean and communicate respectfully with staff. Unit staff identified that Katie valued one-on-one time with workers and activities such as shopping and going to the movies. Thus they were able to reward Katie's positive behaviours with one of these activities.

5.4. Katie's discharge

Katie remained with IMYOS for 1 ½ years. Whilst there were times when Katie struggled to engage in therapy and had 'slip-ups', her situation continued to improve. Katie was able to reduce her self-harming behaviour and she presented less often 'in crisis'. Only once did Katie require an over-night psychiatric admission, which was voluntary. With the help of her AOD counsellor, Katie was able to reduce her illicit substance use, which allowed her to engage in less sex-work. Katie commenced a beauty therapy course which she attended regularly. Katie also began to work collaboratively with her care team in exploring suitable longer-term accommodation options.

Although it was agreed that Katie no longer required IMYOS, she was referred for further psychological treatment with a private practitioner. Katie also continued to see her AOD counsellor.

At the time of discharge, Katie and her mother had decided to try and improve their relationship and were consequently referred to a specialist family therapy service.

Katie commented that her time with IMYOS had been helpful because she had understood after some time that she could "trust" her IMYOS clinician, as he had never been abusive or rejecting. Katie also expressed that she had felt "listened to" and she acknowledged that she had been given "choice" in what she had wanted (not wanted) to do.

6. Efficacy of IMYOS interventions and recommendation for service development

Since its inception, IMYOS has undertaken continued quality assurance and research activities. Results from a clinical audit suggested that IMYOS interventions were effective in lowering the risk of harm to self and others, and in reducing the number of admissions and time spent in hospital (Schley et al., 2008).

A subsequent study found that IMYOS involvement resulted in significant improvements in client engagement (compared to engagement levels at the time of intake as rated by the referring case manager) after about six weeks of the initial contact, and promoted sustained engagement in treatment (Schley et al., 2010).

As both studies were based on a retrospective design they require confirmation in a prospective setting before firm conclusions can be drawn. However, based on the findings to date, we propose that the IMYOS model, as outlined in this paper, is an effective mental healthcare service for 'high-risk' youth with problematic engagement histories, and could consequently inform future service development in this area. Perhaps the greatest advantage of an IMYOS-type service might lie in its potential to improve client engagement and consequently reduce the risk of premature treatment 'dropout'. Also, whilst psychiatric inpatient care will still be required at times of extreme risk to self and/or others, a service such as IMYOS enhances the likelihood that clients will receive most of their treatment in their 'natural environments', which is expected to foster maximal community connectedness and generalisation of treatment gains.

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Assertive Mobile Youth Outreach Service
MODEL OF SERVICE

1. What does the Service intend to achieve?

The Assertive Mobile Youth Outreach Service (AMYOS) is one element in the integrated continuum of care for adolescents within Queensland's Hospital and Health Services (HHS) Child and Youth Mental Health Services (CYMHS). Community Child and Youth Mental Health Services (CCYMHS) are generally centre-based and rely on prospective clients and their families to attend a CCYMHS office to access the services provided. Although appropriate for the majority of children and young people with mental health difficulties, and their families, this model of service delivery has proven to be less suitable for a small group of adolescent clients, many of whom have multiple, complex difficulties.

Whilst this group of young people may access mental health care services in periods of crisis, during which they may be responsive to treatment interventions, they are often hard to engage in ongoing mental health care for a variety of reasons including ambivalence about treatment or because of significant practical barriers to attending appointments. Many drop out of treatment until the next crisis, which may see the young person repeatedly presenting to the same services.

Other young people may be in contact with non-mental health service sectors, which may identify that mental health support for their clients would be advantageous, but are unable to facilitate this engagement. This is a high priority if the young person is displaying risk taking and/or highly challenging behaviours, often resulting in the use of Emergency Services and Departments to access mental health support and intervention.

As a group, these young people present a challenge to all youth sector services requiring that services provide a flexible, comprehensive and integrated response to the complexity of their needs. The goal is to ensure every adolescent in need of mental health care will receive the best support and treatment as close to their home and family as possible.

The service model is a family-centred approach that emphasises individual strengths, builds resilience and enhances opportunities for social inclusion. AMYOS operates on the premise that adolescents can and do recover from mental health problems, which is reflected in recovery-oriented treatment and discharge planning.

The key functions of AMYOS are to provide:

- Provide collaborative, system-based care to high risk and difficult to engage adolescents to treat mental illness, reduce emotional distress and promote function within the community.
- Provide intensive, developmentally-appropriate, community-centred, mental health interventions and ongoing assessment for adolescents who require higher intensity services. The overall treatment plan will include risk assessment, crisis/safety planning and management, and rehabilitation and support to recover from mental illness
- Co-ordinate and establish collaborative links with other community service providers, including other health care providers, education, child safety, housing, police, youth justice, and alcohol and other drugs services.
- Facilitate and support the safe transition to more functional or independent living in the community.

The Assertive Mobile Youth Outreach Service functions contribute to:

- Reducing barriers to service attendance.
- Improving engagement of high risk adolescents.
- Providing high quality care to adolescents with a focus on building resilience, fostering individual and family wellbeing, and assisting in the recovery of an appropriate developmental trajectory.
- Reducing CYMHS drop out and crisis re-presentations to Emergency Departments.
- Reducing the need for hospital inpatient admissions.
- Reducing the length of stay when hospitalisation is required.
- Assisting adolescents to maintain hope and progress in their recovery, and to live with mental health issues where such issues persist.
- Supporting adolescents and their families/carers, including facilitating smooth transition to other appropriate services.
- Assisting adolescents to maintain or regain engagement in developmentally appropriate learning or vocational tasks.
- Working with adolescents to develop their personal support systems, and live successfully within their community.

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- Decreasing stigma and discrimination within the local community and reducing barriers to social inclusion for adolescents.

AMYOS will be able to:

- Assertively develop meaningful engagement with service users, providing safe, high quality triage, assessment and evidence-based interventions that promote recovery.
- Ensure effective risk assessment and management.
- Provide a service that is sensitive and responsive to service users' cultural, religious, and gender needs.
- Increase stability within the service users' lives, facilitate personal growth, and provide opportunities for personal fulfilment.
- Provide mental health, alcohol, and other drug information, advice and support to adolescents and their families/carers.
- Offer information and advice to other health service providers.
- Establish and promote effective interagency collaborative partnerships internally with CYMHS, other Queensland Health services, other government organisations (Child Safety Services, Youth Justice, Dovetail and other alcohol and other drug services, etc.), Headspace, local health services, and external service providers and stakeholders, including Medicare Locals, General Practitioners (GPs), educational/vocational services, other non-government organisations (NGOs), and community groups.
- Establish a detailed understanding of local resources for the support of adolescents with mental health issues.
- Appropriately involve adolescents and their families/carers in all aspects or support.
- Support/uphold the rights of adolescents to make informed decisions and to actively participate in their recovery.
- Promote and advocate for improved access to general health care services for adolescents.
- Support health promotion, prevention and early intervention strategies for adolescents.
- Link with other Statewide Adolescent Extended Treatment Services to provide a continuum of care for adolescents requiring more intense services.
- Meet the National Standards for Mental Health Services.

2. Who is the Service for?

AMYOS services are available to CYMHS clients who:

- Are generally aged between 13 and 18 years, with flexibility in the upper age limit depending on presenting issues and developmental age.

  And

- Display signs and symptoms of complex and/or severe mental disorder such as:
  - psychosis
  - mood disorder
  - anxiety disorder
  - complex trauma
  - deficits in psychosocial functioning
  - marked social avoidance
  - severely disorganised behaviour characterised by impaired impulse control
  - substance misuse
  - emerging personality vulnerabilities
  - complex disruptive behavioural disorders
  - difficulties managing activities of daily living
  - chronic family dysfunction

  And

- Are considered to be at risk to self and/or others, due to:
  - significant self-harming behaviours
  - suicide attempts and threats
  - challenging behaviours including aggression towards property or others
  - consequences from putting themselves at serious risk of exploitation by others
  - presenting repeatedly in a state of crisis and/or
  - risk of further deterioration to their mental health

  And

- Are difficult to engage through mainstream clinic-based CCYMHS.

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3. What does the Service do?

The key components of Acute Adolescent Inpatient Mental Health Unit are defined here. These components are essential for the effective operation of an Adult Adolescent Inpatient Unit.

Key Component	Key elements	Comments
3.1.0 Working with other service providers	**3.1.1** Strong collaborative partnerships are developed with other local health and mental health service providers.	• Clear and regular contact and communication processes are maintained. • Formal agreements such as memorandums of understanding are developed where required. • Joint planning will occur for the development of programs to better meet the needs of young people and their families/carers. • Advice, education, and support for staff of other services on child and youth mental health issues are provided.
	3.1.2 As specific needs and goals are identified, young people and their families/carers will be assisted in accessing an appropriate range of non-clinical support structures.	• Clients and their families/carers will be involved in collaborative treatment planning. • Collaborative relationships will be developed with key clinical and non-clinical support services, such as housing, welfare, educational and vocational support, child protection, justice, recreational, vocational, and alcohol and other drugs service providers.
	3.1.3 When more than one service provider is involved in service delivery, AMYOS will participate in discussions regarding the young person's care, as required.	• AMYOS will initiate and participate in discussions around which service will adopt the role of lead agency. • Refer: Information sharing between mental health workers, consumers, carers, family and significant others.
	3.1.4 GPs may be involved as the primary service providers for young people across the entire diagnostic range.	• Young people will be encouraged and supported to engage with a GP, if not already, either directly or through other service links.
	3.1.5 There is active engagement with a range of primary health care providers to meet the general health care needs of young people.	• Young people will be encouraged and supported to engage with appropriate primary health care providers, as required.
	3.1.6 Young people receiving treatment in the public, private, and NGO mental health support sectors are supported to continue this engagement.	• Collaborative care agreements will be developed, including the definition of key roles and communication strategies.

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Key Component	Key elements	Comments
	3.1.7 To ensure effective communication, AMYOS will engage the assistance of appropriate services when young people have specific needs (e.g. sensory impairment, transcultural needs).	Relationships will be developed with the following services: • Queensland Health Interpreter Service • Transcultural mental health • Hearing Impaired / Deafness • Indigenous mental health
	3.1.8 AMYOS will develop strong links with local hospital emergency departments, mental health acute response teams, and mental health inpatient units so that service accessibility and crisis planning is supported.	• Partnerships with local mental health services/ teams will be developed and supported. • Refer: Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units, 2010
3.2.0 Referral, access and triage	**3.2.1** All new service referrals will be via a single point of entry through CCYMHS or acute response services, where synergies exist.	• Clear information regarding local referral pathways to CCYMHS/ AMYOS will be available to young people, their families/carers, and other service providers.
	3.2.2 Referrals will be discussed with AMYOS team members.	• AMYOS referrals will be discussed at team meetings and a decision made based on whether they meet the intake criteria. • The capacity of the AMYOS team to accept new referrals will be discussed with the referrer.
	3.2.3 Consent for referral will be obtained.	• Parent/guardian consent to referral to be noted on the intake form. • Young people presenting independently will be asked, where capable, to provide informed consent. The young person will be encouraged to involve parents and/or guardians in knowledge of treatment however; the best interests of the young person are placed above any parental right to be informed, particularly if the young person is deemed Gillick competent. • When a person is referred without his/her knowledge or consent, triage will proceed as clinically indicated, and according to the mental health statement of rights and responsibilities and the *Mental Health ACT 2000.* • Refer: Your rights as an Involuntary Patient, MHA 2000. Available in multilingual brochures.
	3.2.4 Timeframes for assessments by AMYOS will be formulated according to documented risk assessment on the	• This decision will take into account: – the nature of the problem – the acuity and severity of the young person's mental health issues – the complexity of the condition (including comorbidity) – the extent of functional impairment

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Key Component	Key elements	Comments
	Consumer Intake Form, capacity to accept new referrals, and other collateral information available on CIMHA.	– the level of distress experienced by the young person and/or family/carers – the availability of other appropriate services – the level of past engagement or predicted level of engagement with services
3.3.0 Assessment	**3.3.1** AMYOS will complete a comprehensive, ongoing assessment with each adolescent. Routine assessments will be timely, reflecting the clinical needs of individual adolescents and their families/carers.	• An ongoing assessment will explore the adolescent's strengths and goals, barriers to improvement, as well as the adolescent and family/carer perception of progress toward recovery goals outlined in the overall care plan, recovery plan, and crisis intervention plan on CIMHA. • Refer: CIMHA Standard Business Processes • Refer: State-wide Standardised Suite of Clinical Documentation • AMYOS will provide or facilitate specialist mental health assessments incorporating, where indicated, psychological, cognitive, functional, vocational, social, and physical aspects of the adolescent's functioning. • Crisis planning will be part of the overall assessment and treatment plan.
	3.3.2 Same day crisis response assessments will be provided.	• AMYOS clinicians will provide crisis response assessments during their rostered working hours. • Outside of these hours the response should align with HHS CYMHS processes commensurate with the Clinical Service Capability Framework for the service. • Crisis management plans need to be readily accessible to workers providing out of hours responses. • Local procedures will need to be developed to provide a safe and consistent approach to conducting home visits in a range of settings to minimise the risk of Workplace Health & Safety incidents.
	3.3.3 Assessments will initiate a discussion of treatment and recovery goals, including the young person's goals, strengths, and capacity for self-management. The assessment will also entail the collection of collateral information from family/carers and other service providers, including GPs and schools.	• A formulation will be developed by the AMYOS team, which will contribute to overall treatment and crisis planning. • The Consumer Care Review Summary and Plan and Crisis Intervention Plan will be updated regularly on CIMHA, following each client and case review. • Refer: State-wide Standardised Suite of Clinical Documentation
	3.3.4 Initial and ongoing assessments will include alcohol and other drugs use.	• Risks identified are incorporated into the Consumer Care Review Summary and Plan and Crisis Intervention Plan. • Detected alcohol and other drug use problems will be incorporated into treatment planning in consultation with the child/young person and family/carers. • Elimination and reduction of cigarette smoking is a focus of treatment, with quit reduction strategies/aids routinely offered to consumers.

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Key Component	Key elements	Comments
	3.3.5 Assessment will involve input from all key service providers, family/carers, and significant others where appropriate.	• Relevant information will be sought and recorded with due regard for the young person and family/carers right to Information sharing between mental health workers, consumers, carers, family and significant others.
	3.3.6 Physical and oral health will be routinely assessed, managed, and documented. This may be conducted by a health service provider external to CCYMHS but needs to be considered as part of the CCYMHS assessment. Additional resources, education, and training to improve the physical and oral health management of consumers with mental illness is available on the Activate: Mind and Body website.	• Documented evidence of physical and oral health assessments, or referral, will be recorded on the Physical Examinations Form on CIMHA. • Refer: Physical Examination and Investigations Form • Clinical alerts (e.g. medical conditions, allergies, etc.) must be recorded on CIMHA and the clinical record. • Young people will be actively supported to access primary health care services and health improvement activities. • Refer : General Practice Queensland – A Manual of Mental Health Care in General Practice • A nominated GP must be entered on CIMHA. • Any potential health issues identified will be discussed with the young person, family/carers, and GP or other primary health care provider, where appropriate.
	3.3.7 Risk assessments will be conducted prior to referral, on initial assessment, as clinically indicated in all phases of care provision and prior to transfer or discharge.	• All risk assessments will be recorded on the Risk Screening Tool on CIMHA and will be used to formulate a crisis/risk management plan, developed as part of the overall treatment plan. • Risk management protocols will be consistent with Queensland Health policy. • Refer: Risk Management Policy • Refer: Child Safety Policy • Refer: Risk Screening Tool
	3.3.8 The outcome of assessments will be communicated to the young person, family/carers, and other stakeholders as appropriate, in a timely manner, and with due respect for the young person's right to privacy.	• Crisis assessments will be recorded on CIMHA the same day. • Non-crisis assessments, written or verbal, will be completed within 24-48 hours of assessment. If there are changes with the overall treatment plan or level of risk, then this will be recorded on CIMHA the same day and communicated to relevant stakeholders. • If only verbal communication is provided initially, written communication will be provided within 48 hours. • Efforts will be made to ensure communication of the results of assessments is provided to all relevant stakeholders.
	3.3.9 Child safety concerns will be addressed in accordance with mandatory requirements.	• Refer: Child Safety - home page • Refer: National Framework for Protecting Australia's Children 2009-2020 • Refer: Report of a reasonable suspicion of child abuse and neglect • Refer: Considering and responding to the needs of children for whom a person with a mental illness has care responsibilities

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Key Component	Key elements	Comments
	3.3.10 At the time of acceptance to AMYOS, a general information pack about the service will be available for young people and their families/carers.	• Information on AMYOS, compliments/complaints processes, and young person rights and responsibilities will be provided to all young people in an accessible manner. • Refer: Australian Charter of Healthcare Rights
3.4.0 Clinical Review	**3.4.1** Team review meetings will be held weekly. Each open case and the individual service plan will be discussed at formal case review meetings at intervals of no longer than two weeks or when indicated.	• Meetings will be attended by the multi-disciplinary team including the AMYOS case manager and consultant psychiatrist either in person or via telehealth. Rural services may be supported by CHQ eCYMHS, if initially unable to recruit to the consultant psychiatry component of the AMYOS, until a local option is available. • There will be an established agenda for discussion of young people, with concise documentation of the content of the discussion and the ongoing plan of care recorded on the Consumer Care and Review Summary and Plan in CIMHA. • Local CYMHS will ensure that appropriate clinical governance structures are in place to enable AMYOS case managers, in collaboration with the treating team, to provide comprehensive assessment and management planning. • A review will provide an in-depth, resilience and recovery-oriented review of the young person. • The opinions and observations of the young person, family/carers, and other service providers/ stakeholders will be included and considered in reviews. • Outcomes of reviews will be discussed with the young person and their family/carers. Any care planning or changes to recovery plans will involve the young person.
	3.4.2 All referrals will be discussed at the next scheduled intake meeting, as soon as possible after referral	• The consultant psychiatrist is the clinical lead. • The consultant psychiatrist, or appropriate medical delegate, will participate in all multidisciplinary team intake meetings. • The consultant psychiatrist, or their delegate, will take responsibility for ensuring that assessments and management plans are adequate and that a process is in place to ensure that any onward referral is completed.
	3.4.3 Ad-hoc reviews will occur as required to review newly accepted young people, to address complex issues or following a critical event.	• A consultant psychiatrist, or appropriate medical delegate, will attend all clinical reviews (in person or via telehealth). • Critical events will be reviewed utilising the clinical management implementation standard. • Refer: Clinical Incident Management Procedure
3.5.0 Resilience and Recovery Planning	**3.5.1** A single comprehensive and individualised recovery plan will be developed with every young person, in	• Recovery plans will take into account relevant contributing, maintaining, and protective factors outlined in the case formulation (developed from the comprehensive assessment). • Refer: State-wide Standardised Suite of Clinical

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Key Component	Key elements	Comments
	collaboration with their treating CCYMHS team, AMYOS, and other stakeholders involved in the young person's support and service networks.	Documentation • All services delivered by AMYOS are based on the principles of recovery. • AMYOS considers how the concept of recovery applies to young people and their families/carers. • This includes acknowledgement that recovery takes into account developmental process related to adolescence. A greater emphasis is placed on the views and goals of the young person and there is greater involvement of the young person in the plan development and review. Young people from 13 – 18 years of age gain further independence and mastery separate to their family/carers. • Refer: National Standards for Mental Health Services, 2010 • Refer: Sharing responsibility for recovery: creating and sustaining recovery oriented systems of care for mental health • Basic human rights, such as privacy, dignity, choice, anti-discrimination, and confidentiality are recognised, respected, and maintained to the highest degree possible in all clinical interventions.
	3.5.2 The recovery plan is reviewed as needed, and at intervals of no longer than two weeks. Review of progress and planning for future goals, as well as exit from the program, will be integrated into the recovery plan.	• A copy of the most current recovery plan will be located on CIMHA. • A review of the recovery and relapse prevention plan can be initiated by any stakeholder, including team members, consumers, and families/carers. • Reviews of recovery and relapse prevention plans will be performed in collaboration with the young person, families/carers, and relevant other stakeholders. • Where clinically relevant, some components of the review process will include objective measurement tools including but not limited to routine outcome measures. • Refer: State-wide Standardised Suite of Clinical Documentation • Refer: Outcomes measures for mental health services
	3.5.3 Every effort will be made to ensure that recovery planning focuses on the young person's own goals.	• Where conflicting goals exist (e.g. for young people receiving involuntary treatment), this will be clearly outlined in the clinical record and recovery plan, and addressed in a way that is most consistent with the young person's goals and values.
	3.5.4 Recovery planning will be developed in partnership with every young person.	• Young people will contribute as much as possible to every aspect of their recovery plan. • Young people are strongly encouraged to take ownership of their recovery plan. • Any changes to the recovery plan will be discussed and changed in partnership with the young person, their family/carers, and relevant service providers.
3.6.0 Interventions	**3.6.1** Interventions, reviews, and follow up processes will occur in a manner that ensures safety and meets the young	• The extent and type of follow up methods will specifically align with clinical need and acuity levels. • Services will be delivered in the least restrictive environment possible. • AMYOS will proactively provide interventions utilising case management and co-ordination to facilitate

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Key Component	Key elements	Comments
	person's individual needs.	assertive engagement and follow up. • AMYOS will provide a flexible response to clients with an ability to meet clients in a non-threatening environment of their choice. • AMYOS will enlist support from current workers who have gained the young persons trust. • Initial contact is carefully planned, drawing on all information available and what has been learnt from the past attempts to engage the young person. • AMYOS clinicians have the capacity to inform clients at a pace and in a way that the young person understands.
	3.6.2 Interventions are guided by assessment and formulation processes, using a developmentally appropriate, biopsychosocial approach, in collaboration with the young person's treating team.	• Interventions will take into consideration the strengths and resilience of the individual, their family, and their community. • The consent of the young person/guardian to disclose information and (where needed) to involve family/carers in treatment planning and delivery will be sought in every case. • Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. • Informed consent is documented in the clinical record, detailing that the young person/guardian understands the treatment plan and that the guardian agrees to support the provision of ongoing care to the young person in the community. • Refer: Information sharing between mental health workers, consumers, carers, family and significant others • Refer: Privacy and Confidentiality Resources webpage • Refer: Consent for the Treatment of Children or Young People Under the Custody or Guardianship of the Director General Department of Communities - Child Safety Services procedure • Identification of family members/carers and their needs is part of the assessment process, and are included in care planning. • Refer: Carers matter webpage • Education and information will be provided to the young person, family/carers, and significant others at all stages of contact with the service. • A shared understanding will be fostered for all aspects of treatment, including risk management, with explicit, documented evidence of the shared understanding in the clinical file/ CIMHA.
	3.6.3 Young people will be supported to access a range of biopsychosocial, developmentally, and culturally appropriate interventions that address the young person's individual needs.	• Evidence-informed interventions to reduce the severity of symptoms and increase resilience to cope with mental health problems will be utilised (e.g. Mentalisation-Based Therapy, Dialectical Behaviour Therapy, family-based interventions, solution-focused therapies, structured problem solving, expressive therapies such as play/art/music, psychoeducation, and psychopharmacological treatments). • Interventions will be based on recovery principles and best practice. • The needs of families, carers, and significant others must be routinely addressed.

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Key Component	Key elements	Comments
	Efficacy of treatment and progress will be reviewed and evaluated throughout the episode of care.	• Multidisciplinary input will be provided to optimise consumer recovery. • Consumer and carer support interventions will be included where appropriate. • Interventions will include responsive crisis intervention, relapse prevention strategies, assistance in accessing educational/vocational services, and assistance in accessing psychosocial rehabilitation. • AMYOS will demonstrate a focus on strengths, connectedness, personal involvement, personal choice, empowerment, and increasing confidence in accessing the mental health system and other community services and supports.
	3.6.5 Administration of prescription and non-prescription medications will be supervised in accordance with relevant procedures and guidelines.	• Across all treatment settings, all prescriptions, dispensing, and administration of medicines will comply with Queensland Health policies, guidelines and standards. • Refer: Clinical Guidelines • Refer: Medication Liaison on Discharge Procedure • Refer: Acute sedation guidelines for children and young people (under development) • The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards. • The medication goals of the young person/guardian will be integrated with evidence-based clinical treatment guidelines. • Where needed, strategies focused on medication adherence will be in place. • Monitoring of medication side effects will be routinely conducted and recorded on CIMHA. • Refer: Metabolic Monitoring Form
	3.6.6 Access to interventions to improve the physical health of young people will be facilitated.	• All young people and their families/carers will receive information about physical health issues. • Young people and their families/carers will be supported to access primary health care and health improvement services. • Refer: Activate: mind & body website
3.7.0 Team Approach	**3.7.1** A multi-skilled team approach will be provided.	• The young person and family/carers will be informed of the multidisciplinary approach to mental health care upon entry to AMYOS (and at other times when needed).
	3.7.2 Clear clinical and operational leadership will be provided for the AMYOS team.	• AMYOS staff have will have access to and are encouraged to utilise specialist input (from senior clinical staff) where they need to make significant and complex clinical decisions • Clinical supervision of AMYOS staff should aim to enhance the professional development and competence of each AMYOS clinician, ensure support and guidance, offer leadership and direction, and assist the worker to perform their responsibilities.
	3.7.3 Rosters will be managed to ensure effective use	• AMYOS will operate predominantly Monday-Friday between the hours of 8am-8pm. There is flexibility to extend contact to weekends or after these hours to

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Key Component	Key elements	Comments
	of resources and to support staff to work in a safe and effective manner.	meet the recovery-oriented goals within individual treatment plans. • Outside of these hours, the AMYOS team will be required to co-ordinate out-of-hours support for AMYOS clients. This after hours responses should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service e.g. through existing CYMHS acute response services (where available), links with adult mental health service Acute Care Teams, etc.
	3.7.4 Specific skills and knowledge will be utilised as appropriate in all aspects of service provision.	• AMYOS staff will have access to peer learning, professional training and development programs, and debriefing and clinical supervision.
3.8 Care Coordination	**3.8.1** Coordination of care is an essential element of an effective service delivery system, ensuring that each young person is able to access the services they need, when they need them, and generally with one identified worker accountable for coordinating service provision.	• A range of agencies will be involved in supporting the young person. • Collaborative relationships will be developed with other service providers, including schools, primary health care, housing, welfare, educational and vocational support, justice and recreational service providers. • Local procedures for evidence-based, case management, including: – Queensland Health Mental Health Case Management Policy Framework: Positive Partnerships to Build Capacity and Enable Recovery [http://qheps.health.qld.gov.au/mentalhealth/docs/casemanage_polstate.pdf]. – Statewide standardised clinical documentation CYMHS user guide [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_user.pdf] – Meeting the needs of children of a person with a mental illness – Child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. – Early psychosis guidelines (pending) – Perinatal and infant mental health model of service (when available) – Eating disorders model of service(when available)
	3.8.2 All young people will be assigned a case manager upon entry to AMYOS.	• The case manager will be listed as the Principle Service Provider (PSP) on CIMHA. • The consultant psychiatrist will be reflected in CIMHA as the Principle Doctor. • Refer: CIMHA Standard Business Processes • The PSP has primary responsibility for the coordination of care, including working with the young person on goal-setting, recovery, and exit planning.
	3.8.3 Effort will be made to assertively link young people and their families/carers into appropriate services.	• The PSP has the primary responsibility for the coordination of care. • The PSP will develop and maintain relationships with the relevant inpatient treating teams, and negotiate appropriate involvement in inpatient care and discharge planning for the young person.

Assertive Mobile Youth Outreach Service (AMYOS)

Key Component	Key elements	Comments
		• The PSP will develop collaborative relationships with other service providers, including schools, primary health care, housing, welfare, educational and vocational support, justice, and recreational service providers. • Collaborative care arrangements are encouraged. • The AMYOS clinician may also be the Other Service Provider (OSP) for CCYMHS or other CYMHS clients, where deemed appropriate.
3.9 Continuity of Care	**3.9.1** Clear information is provided for young people, families/carers, and referral sources about how to contact the service (and/or other supports) across a 24 hour, seven day period.	• This will be documented on CIMHA and in the young person's file. • Service publications and relevant information documents will include this information from a broader perspective. • Documented crisis management plans will be recorded on CIMHA, in the young person's file, and a copy should be given to the young person and their family/carers where appropriate.
	3.9.2 The young person's PSP, treating CYMHS team, and other service providers, will be clearly identified on CIMHA, and communication maintained throughout AMYOS service provision.	• The process for sharing information will be explicitly documented for each young person. • Strategies to ensure continuity of care include good communication, coordination, collaboration, and continual reassessment between the PSP, the young person, family/carers, the young person's treating CCYMHS or other CYMHS team, the AMYOS team, Acute Response Team (where they exist), primary care providers and other service providers. • The team response will be clearly documented in the young person's recovery plan and crisis management plan. • Service links are established with acute care/extended hours teams and local emergency departments to ensure access to acute mental health crisis support outside working hours.
	3.9.3 A team response is provided for planned and crisis interventions, and is not dependent on the PSP's availability.	• Provision of crisis response and intervention occurs during the hours of AMYOS service operation / rostered shifts. • Service links are established with acute care/extended hours teams, and local Emergency Departments to ensure access to acute mental health crisis support outside working hours. • After hours response should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service, e.g. through existing CYMHS Acute Response Services (where available), links with adult mental health service Acute Care Teams, etc.
3.10.0 Exit Planning	**3.10.1** Exit planning is considered from first contact with the young person and their family/carers, with support time-limited.	• Exit planning will be a routine component of recovery planning and each review process.

Assertive Mobile Youth Outreach Service (AMYOS)

Key Component	Key elements	Comments
	3.10.2 Exit will occur between 3 and 18 months from entry, or when the young person is at a stage of recovery where they have graduated to needing less intensive care and have supports in place to manage in their community.	• The decision to exit a young person is at the discretion of the consultant psychiatrist in consultation with the multidisciplinary team.
	3.10.3 Young people will be exited in a timely manner consistent with the individual recovery plan.	• Families/carers will be routinely directly involved in exit planning wherever possible. • AMYOS will support the young person to arrange appointments with other relevant service providers prior to exit.
	3.10.4 Exit planning will incorporate strategies for relapse prevention, crisis management, and clearly articulated service re-entry processes.	• Relapse patterns and risk assessment/management information will be provided, where available.
	3.10.5 Comprehensive liaison will occur with all other service providers who will contribute to the young person's ongoing care. Wherever possible service providers responsible for the provision of ongoing care will be involved in exit planning.	• Exit letters will indicate relevant information including progress of care, recommendations for ongoing care, and procedures for re-referral. • Follow up direct contact with the young person by their PSP will occur to ensure appropriate linkages have been made and the young person has settled into their community. • A feedback mechanism will be in place so that the receiving team informs the referring team if the consumer fails to attend or if significant problems occur or recur. • A verbal and written handover will be provided on every transfer occasion. • Refer: Consumer End of Episode/Discharge Summary • Discharge Summary will be recorded in CIMHA. • The PSP is responsible for ensuring that discharge summaries are sent to key health service providers (e.g. GP) within 48 hours of exit from AMYOS.
3.11.0 Collection of data, record keeping and documentation	**3.11.1** CCYMHS will enter and review all required information in CIMHA in accordance with approved statewide and district business rules.	• Refer: CIMHA Standard Business Processes
	3.11.2 All referred and open cases will have a designated PSP.	• This will be reflected on CIMHA as the internal contact – PSP.

Assertive Mobile Youth Outreach Service (AMYOS)

Key Component	Key elements	Comments
	3.11.3 All open cases will have a designated treating consultant psychiatrist.	• This will be reflected in CIMHA as the internal contact – treating consultant psychiatrist. • Refer: CIMHA Standard Business Processes
	3.11.4 AMYOS will utilise the range of routine outcome measures mandated through the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ)	• Routine outcomes data is presented at all formal case reviews and will be an agenda item at relevant meetings. • Results of outcomes are routinely discussed with young people and their families/carers. • Routine outcomes data is used with young people and their families/carers to: – Record details of a young person's symptoms and functioning; – Monitor changes in symptoms and functioning; – Stimulate dialogue about similarities and discrepancies in measures rated by parents, teachers, clinicians and the young person; and – Review progress and plan future goals (to be documented in the Recovery and Relapse Prevention Plan).
	3.11.5 All contacts, clinical processes, and recovery and relapse prevention planning will be documented in the young person's clinical record.	• Progress notes will be consecutive within the clinical record according to date.
	3.11.6 All clinical record keeping will comply with legislative and local policy requirements for the retention and disposal of clinical records.	• Refer: Retention and Disposal of Clinical Records Policy
	3.11.7 Clinical records will be kept legible and up to date, with clearly documented dates, times, author/s (name and title), and clinical progress notes. All documentation will include consumer information labels (or equivalent details).	• Personal and demographic details of the young person, their family/carers, and other health service providers will be kept up to date. • CIMHA will be updated with this information
	3.11.8 Local and statewide auditing processes will monitor the quality of record keeping and	• The written record will align with CIMHA • Mobile or tablet technology will support any increasing application of electronic record keeping. • Refer: National Safety and Quality Health Service Standards

Assertive Mobile Youth Outreach Service (AMYOS)

Key Component	Key elements	Comments
	documentation (including written external communications), and support relevant clinician skill development.	
	3.11.9 There will be a single hard copy clinical record for each young person.	
3.12.0 Mental Health Peer Support Services	**3.12.1** All young people and their families/carers will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Consumer consultants are accessible via local mental health services. • Refer: Consumer, Carer and Family Participation Framework.

4. Related services

The future overarching model of care for CYMHS will include both inpatient and community care options. The care continuum in CYMHS will also include the development of AMYOS teams alongside CCYMHS, acute response services (where they exist), adolescent day programs, adolescent residential rehabilitation units, adolescent step up/step down units, and access to adolescent subacute beds. The specific details and location of these service options are yet to be finalised. Some service options will be available earlier than others, and implementation will be ongoing as funding and resources are made available.

Services are integrated and co-ordinated with partnerships and linkages with other agencies for infants, children, and young people and with specialist mental health services to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services will be established, including strategic district and area level linkages.

CYMHS adopts a developmentally informed approach, promoting collaboration with relevant government and non-government agencies to maximise outcomes for infants, children, young people, and their families/carers.

AMYOS services will develop service linkages with other services, including but not limited to:

- Other CCYMHS
- Acute response and inpatient services
- Specialist child and youth mental health services (e.g. forensic services, eCYMHS, and Evolve therapeutic services)
- Perinatal and infant mental health services
- Acute and non-acute inpatient and day program child and youth mental health services
- Adult mental health services, including acute care teams
- Alcohol and other drug services
- Specialist health clinics for the target population, e.g. diabetes clinic for children
- Private mental health service providers
- Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health) and local GPs
- Community pharmacies
- Local educational providers/schools, guidance officers and Ed-LinQ co-ordinators
- Child and family health and developmental services
- Department of Communities (Child Safety Services, Disability Services, and Youth Justice)
- Government and non-government community-based youth and family counselling and parent support services
- Housing and welfare services
- Transcultural and Aboriginal and Torres Strait Islander services

Assertive Mobile Youth Outreach Service (AMYOS)

5. Caseload

Caseload sizes need to consider the complexity of clinical needs presented by an AMYOS client, the flexibility and intensity of the interventions required within the treatment plan, and the liaison required with staff from other internal and external agencies. A significant time commitment is required for each AMYOS client, therefore it is expected that a typical caseload for a full time AMYOS clinician will be between 8 and 10 clients.

The total team caseload will be primarily determined by the capacity of the consultant psychiatrist to provide safe, high quality, clinical governance. The caseload for individual clinicians will be closely monitored to ensure that safe, high quality care can be provided to the consumer at all times. The clinician-to-consumer ratio will be low enough to enable the clinician to provide frequent, intensive consumer contacts, and assertive case management in line with the AMYOS model of service delivery.

Students from all disciplines may participate in case management activities under direct and specified supervision.

6. Workforce

Each AMYOS team will ideally include: 0.2 full-time equivalent (FTE) Child and Adolescent Psychiatrist and two FTE Mental Health Clinicians. CHQ CYMHS will provide statewide coordination for AMYOS across Queensland as outlined in Service Level Agreements with each HHS. This may include provision of additional psychiatry input from the Statewide AMYOS Child and Adolescent Psychiatrists, professional development opportunities, and clinical practice group supervision.

A local CYMHS may choose to add additional clinicians or psychiatry time to the AMYOS team from the CYMHS team to increase service capacity.

The local CYMHS Team Leader will be operationally responsible for AMYOS Teams.

7. Team clinical governance

The AMYOS Consultant Child and Adolescent Psychiatrist will be available to provide clinical governance to the AMYOS service, participate in assessment and intervention, individual treatment planning and review, protocol development, staff supervision, and staff training.

For rural services unable to recruit 0.2 FTE of a Consultant Child and Adolescent Psychiatrist, CHQ CYMHS may be able to initially recruit the psychiatrist to be located in Brisbane and provide input via video conferencing (Statewide AMYOS) until a local option is available.

8. Hours of Operation

AMYOS will operate predominantly Monday-Friday between the hours of 8am-8pm. There is flexibility to extend contact to weekends or after these hours to meet the recovery-oriented goals within individual treatment plans.

Outside of these hours, the AMYOS team will be required to co-ordinate out-of-hours support for AMYOS clients. This after-hours responses should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service, e.g.

- Through existing CYMHS Acute Response Services (where available)
- Through links with adult mental health service Acute Care Teams.

In order to ensure effective crisis management, AMYOS clinicians will be expected to develop a crisis management plan for each client as part of the client's treatment plan. The crisis management plan should be developed in collaboration with the young person and his/her system of care. Crisis management plans need to be readily accessible to workers providing out-of-hours response.

9. Staff Training

Staff will be provided with continuing education opportunities, AMYOS local and statewide professional development, local mandatory training, clinical supervision, and other support mechanisms to ensure clinical competence. All training will be based on best practice principles and evidence based treatment guidelines, and underpinned by the Queensland Government's Consumer, Carer and Family Participation Framework.

Assertive Mobile Youth Outreach Service (AMYOS)

AMYOS teams will have dedicated time and resources for evidence informed clinical education and clinical supervision to enhance the professional development and competence of each AMYOS clinician. Education and training will include a focus on strategies and mechanisms to manage young people with severe and complex mental health issues, who are at risk and difficult to engage in the community.

Education and training should include (but will not be limited to):

- Orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- Promotion, prevention, and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for young people and their families/carers
- Developmentally appropriate assessment and treatment
- Risk assessment and management, and associated crisis planning and intervention
- Specialist skills for the management of escalating behaviours as a result of trauma, attachment issues, and affect dysregulation
- *Mental Health Act 2000*
- National Standards for Mental Health Services
- Evidenced-informed practice in service delivery
- Consumer-focused care planning
- Routine outcome measurement training
- A range of treatment modalities including individual, group, and family-based therapy
- Child safety services training
- Knowledge of mental health diagnostic classification systems
- Communication and interpersonal processes
- Provisions for the maintenance of discipline-specific core competencies
- Work unit instruction for staff safety (home visits, etc.)
- Cultural capability training
- Supervision skills

Clinical supervision of AMYOS staff should aim to enhance the professional development and competence of each AMYOS clinician, ensure support and guidance, offer leadership and direction, assist the worker to perform their responsibilities, and promote safety. It is crucial that AMYOS staff have access to and are encouraged to utilise:

- Specialist input (from senior clinical staff) where they need to make significant and complex clinical decisions
- Peer learning
- Professional training and development programs
- Debriefing and clinical supervision

10. Research

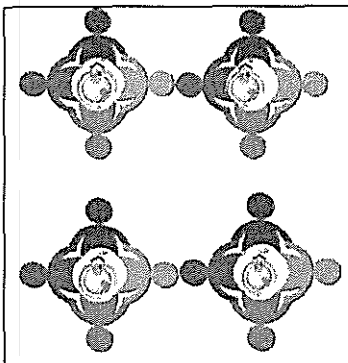
Staff will be expected to contribute to statewide research and service improvement initiatives.

11. AMYOS functions best when:

- The services are provided by senior mental health clinicians from a range of disciplines, who have advanced skills in engaging and assisting the target group and who are able to work collaboratively with community agencies.
- Clinicians work directly with the young person and systematically with the young person's family/carer/friends, and other service providers to develop wrap around systems of support and care for the young person.
- Care is provided in a flexible outreach approach to provide care in the least restrictive setting possible, as close to their home and family as possible, to maximise engagement with CYMHS services.
- Young people, their families/carers, and other service providers are involved in all aspects of care planning and delivery.
- There is an explicit attitude that young people can and do recover from mental health problems and mental disorders, and that the family or care environment plays an integral role in the recovery of the young person's developmental trajectory.
- Teams are well integrated with other AMYOS teams across the state, local mental health service components, and primary care supports.
- Teams have a good general knowledge of local resources.
- They occupy a stakeholder position in the community in collaboration with CCYMHS, or other CYMHS services, to respond to local issues relevant to mental health service delivery.

Assertive Mobile Youth Outreach Service (AMYOS)

- Clear roles and strong operational leadership, where the psychiatrist is the clinical lead, are provided.
- There is clear and explicit responsibility for a local population and clear links to specified organisations.
- Clear pathways exist for access to services and onward-referral, as clinically required.
- Crisis plans are developed as part of the overall treatment plan and are readily accessible to workers providing out-of-hours response.
- There is a focus on systems collaboration, consultation, and training.
- Collaborative care arrangements are in place across different service providers, and shared recovery plans and relapse prevention plans are utilised.
- Senior staff, including medical staff, take an active role in fostering the development of clinical skills in less experienced staff.
- Strong internal and external partnerships are established and maintained.
- Caseloads are regularly reviewed and assertively managed.
- All staff are provided with professional support, clinical supervision and training around contemporary evidenced informed care.



ASSERTIVE MOBILE YOUTH OUTREACH SERVICE

UR NUMBER:

SURNAME:

GIVEN NAME:

DATE OF BIRTH:

Affix Patient Label Here

AMYOS REFERRAL FORM

NAME			**DATE OF BIRTH**	
ADDRESS	Street Suburb Postcode		**TELEPHONE** (H): (M):	

ETHNIC BACKGROUND	

INTERPRETER REQUIRED		Client		Parents / Carer	**LANGUAGE**	

MOTHER'S NAME				
ADDRESS	Street Suburb Postcode		**TELEPHONE** (H): (M): (w):	

FATHER'S NAME				
ADDRESS	Street Suburb Postcode		**TELEPHONE** (H): (M): (w):	

CARER NAME				
ADDRESS	Street Suburb Postcode		**TELEPHONE** (H): (M): (w):	

CURRENT RELEVANT ORDERS	eg: DoCS, Youth Justice, ITO	

AGENCIES INVOLVED:

AGENCY	CONTACT PERSON	CONTACT DETAILS

Queensland Government

REFERRER INFORMATION:

REFERRER NAME		**DISCIPLINE**	
SERVICE		**PHONE NUMBER**	
DURATION OF CASE MANAGEMENT			

REASONS FOR REFERRAL:

CRITERION 1: Signs and symptoms of serious mental illness.

What are the client's current working diagnoses?

Primary Diagnosis _____

Secondary Diagnoses _____

_____

_____

Please highlight major areas of impairment and duration / severity of these symptoms.

_____

_____

_____

_____

_____

_____

_____

List prescribed medication and detail compliance.

_____

_____

_____

CRITERION 2: Age range

☐ Client is aged between 13 and 18 years

CRITERION 3A: Exhibits high-risk behaviour.

☐ Experiences recurrent suicidal ideation -
☐ History of suicide attempts (please comment on lethality)
☐ Exhibits recurrent self-harming behaviour
☐ At risk of exploitation (i.e. by absconding from placement, prostitution etc)
☐ Displays criminal/offending behaviour
☐ Has a drug and alcohol issue
☐ Displays challenging and/or difficult to manage behaviour
☐ Displays serious threats or acts of harm to others

OR **CRITERION 3B: At risk of deterioration**

☐ The client's mental health is at risk of deterioration due to a suspected or untreated severe Axis-1 disorder

In the space below please elaborate on Criteria 3 – Risk Factors

CRITERION 4: Difficult to engage

You have attempted to engage the client/ family by:

☐ Providing a number of outpatient appointments
☐ Home visiting the young person
☐ Offering to meet at an agreed neutral environment (e.g. school, other locations)
☐ Extensive phone contact with the young person or system
☐ Sending letters, texts, emails to the young person or system
☐ Providing secondary consultation to the system
☐ Other (please specify)

Please outline why you think the young person has been difficult to engage despite your attempts.

ADDITIONAL INFORMATION:

Please note below any additional information relevant to this referral (i.e. substance use, peer and family relational difficulties, abuse history, multiple placements, etc).

HOME VISITING RISK

Have you completed any previous home visits? ☐ Yes ☐ No

Are you aware of any risks present in the home (or at other outreach visiting sites)?

GOALS:

Please outline below what changes you hope will occur for the young person if they are accepted by AMYOS?

What suggestions would you make for the focus of AMYOS intervention (eg, individual intervention, family work, systems co-ordination etc).

What impact will the introduction of AMYOS have on the young person and existing supporting relationships? (including parents, others, clinicians)

How may this impact on the level of contact with current CYMHS team?

What impact may occur on the young person and their system if AMYOS involvement does not proceed beyond the assessment phase?

OUTCOMES:

An Outcomes collection occasion must be completed 7 days prior or post referral to AMYOS and entered on CIMHA

What was the date of the last Outcomes collection occasion?

_____

Outcomes will be collected by ☐ Referring PSP ☐ AMYOS

CHECKLIST:

To ensure that the referral is considered at the next team meeting, please ensure that the following have been completed:

☐ REFERRAL FORM – completed in full.

☐ ENGAGEMENT AND SUICIDALITY/HOSTILITY MEASURES completed by Referrer

☐ CONSENT FORM has been signed by parent/carer

☐ Recent Care Review Summary or Consumer Assessment (on CIMHA)

☐ Outcomes measures: CGAS,SDQ, HONOSCA entered on CIMHA

☐ Additional reports / documents that support the referral are attached if relevant.

Signed: Date:

Name:

Designation:

AMYOS USE ONLY

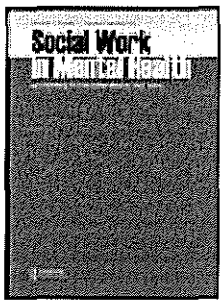
Date Received		**Intake Meeting Date**	

☐ Pending further information

☐ Accepted for Assessment — Allocated to

☐ Not Accepted for Assessment — Notes:

Other notes



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Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention

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Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention

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SUMMARY. ORYGEN Youth Health provides a unique mental health service targeting early detection and treatment for young people 12–25 years of age in the Western region of Melbourne, Australia. The Intensive Mobile Youth Outreach Service (IMYOS) is a subprogram targeting difficult-to-engage, high-risk young people with complex needs who are experiencing mental health difficulties. This report describes an integration of theoretical approaches: developmental theory, attachment theory, trauma theory, family systems theory, collaboration/coercion, and relationship management. These approaches inform the conceptualizations and

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interventions with IMYOS clients. A key part of IMYOS care relies on the therapeutic relationships. Intervention occurs at three levels - with the individual, their family and the system of professionals involved in their care. Theories and interventions are discussed in relation to young people, their family, systems and IMYOS teamwork.

KEYWORDS. Youth, mental health, high-risk, intensive outreach

This article describes the major theories influencing the model of care for the Intensive Mobile Youth Outreach Service (IMYOS). ORYGEN Youth Health is mentioned as the service context for IMYOS, which is committed to the enhancement of clinical standards in the mental health care of young people. IMYOS has focused on the development and delivery of best practice interventions and has developed this model of care over seven years of clinical practice.

While this approach with young people does not as yet have a documented evidence base, this paper reviews the theoretical framework that informs clinical practice. A brief discussion of another Intensive Outreach Model with some empirical support is included as it also advocates the need for treatment to include family and other supports. This paper focuses on integrating four major theoretical paradigms. Each theory will be discussed briefly with respect to working with high-risk and difficult-to-engage young people. The inclusion of each has been influenced by the clinical presentation of the young people seen by IMYOS.

SERVICE CONTEXT

IMYOS arose out of a climate of growing community awareness about the needs of young people (aged between 12–24) in the Australian state of Victoria at significant risk of, in particular, homelessness, suicide, drug abuse, and unemployment. IMYOS offers Child and Adolescent Mental Health Services an enhanced community-based intensive model that targets those young people who had traditionally been difficult to engage in mainstream service delivery.

The IMYOS team provide an intensive, outreach mental health service to young people, their family, and the system. The young people seen by IMYOS are experiencing mental health difficulties and are unable to be adequately treated by a clinic-based program. Many of the

young people seen by IMYOS have had extensive histories with multiple services such as (child) Protective Services and they are often not attending school or any other day program. They are likely to be experiencing family conflict and may live outside the family home. Many young people seen by IMYOS frequently present in crisis but appear to find proactive, regular help-seeking very difficult. Moreover, mental health difficulties and numerous psychosocial stressors usually compound these experiences.

IMYOS is a subprogram of ORYGEN Youth Health, a mental health service targeting early detection and treatment for young people aged 15–24 through clinical practice, research, and promotional activities.

IMYOS is a multidisciplinary team working intensively with complex clients. The team accept referrals from within the mental health system of Western Metropolitan Melbourne, Australia. Over a 12-month period, IMYOS received 38 referrals, 85% of which (19 female and 13 male) were accepted for treatment. The most prevalent diagnoses were Borderline Personality Disorder Traits, Major Depressive Disorder, Conduct Disorder, and Substance Abuse Disorders. Of the 32 accepted, 85% presented with more than one diagnosis.

IMYOS is staffed by two Psychologists, two Social Workers, one Occupational Therapist, and one Psychiatric Nurse. A Consultant Psychiatrist works two days a week. Each full-time clinician carries a caseload of 8–9 young people.

INTENSIVE PROGRAMS WITH YOUNG PEOPLE

There are few treatment approaches described in the literature for these complex young people. One approach described by Henggeler et al. (1998; 1999) outlines Multisystemic Therapy (MST) which incorporates intensive home- and community-based interventions that include the young person, their family, and local community. MST proposes that interventions with these complex young people require multifaceted interventions (Henggeler et al., 1999). Drawing on this work, the current model aims to provide a framework to guide necessarily flexible interventions for young people who are difficult to engage. IMYOS interventions are multifaceted and occur at three levels; individual, family, and systems (the other professionals/people involved in providing care to a young person).

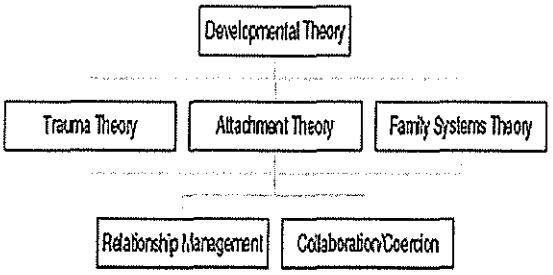
FRAMEWORK

Figure 1 depicts the integration of theoretical concepts that have been influential in the development of the IMYOS treatment model. The first tier represents the overarching influence of developmental theory in IMYOS work. The second tier describes the theories that influence IMYOS conceptualisations of the difficulties young people present with. In accordance with Henggeler et al. (1999), this acknowledges the multidetermined nature of young people's difficulties. Each of these second tier theories highlights the importance of the therapeutic relationship. IMYOS considers the therapeutic relationship the fundamental tool of intervention. The third tier describes influential examples of how we may construct the therapeutic relationship.

The integration of these ideas is developed on a case-by-case basis and aids conceptualization of the young person and guides the treatment required. IMYOS works within a case management system, which can offer interventions varying from practical support to structured therapy. The team routinely employs treatment approaches such as Cognitive Therapy (Beck, 1995), Cognitive Analytic Therapy (Ryle & Kerr, 2002) or Narrative Therapy (White, 1999; White, 2000).

Literature exploring these areas is extensive and each paradigm has emerged from a variety of theories and philosophies. While thorough exploration of these perspectives is beyond the scope of this paper, aspects most relevant to IMYOS work will be briefly considered.

FIGURE 1. Theoretical Framework of IMYOS.



DEVELOPMENTAL THEORY

Consideration of the developmental trajectory of the young people seen by IMYOS is fundamental to our treatment approach. Developmental approaches make use of the chronological age of people to understand human behaviour. There are numerous theories that fall into this category including Freudian theory, Eriksonian theory, learning theory, and Piaget's theory, to name a few (Peterson, 1996). Each theory emphasizes different aspects of development and therefore differing practical applications. The common aspect of the theories is that people progress through various stages of development, each stage comprising different tasks and psychological needs. A central tenet of developmental theories is that marked deviations from the "norm" can highlight areas of difficulty (or strength) and can therefore assist in guiding back to a normative developmental trajectory (Steinhauer & Rae-Grant, 1983).

Developmental Theory and IMYOS

The influence of developmental theory within IMYOS is twofold. First, developmental characteristics of the young person must be considered. Adolescence and young adulthood are particularly significant periods of development because of the marked transitions in biological, psychological, and social systems during this time (Feldman & Elliot, 1990; Holmbeck & Updegrove, 1995). IMYOS considers that it is essential to be sensitive to developmental norms and levels, as well as the cognitive and emotional capabilities of clients, in order to deliver effective treatment. For example, we would expect that the cognitive and emotional ability of a 12-year-old to talk about a traumatic life event is likely to be very different from the capability of a 22-year-old, thus influencing the treatment approach. In general, IMYOS would choose a more behaviorally oriented treatment approach for younger clients and integrate more cognitive elements in work with older clients.

The onset of mental illness can derail the normal developmental trajectory of adolescence and young adulthood. Typical developmental appointments of young people, such as employment, education, and social and sexual relationships may have been interrupted or postponed. The task of the IMYOS clinician is to encourage re-engagement with these developmental tasks. For example, IMYOS case management often focuses on assisting a young person to reintegrate into school.

Second developmental theory influences IMYOS's understanding of the clients' presentation in the context of past (beneficial and adverse) experiences. Research has shown that critical incidents such as early

separation from the primary carers or traumas (i.e., physical or sexual abuse) can have significant impact on the development of a young person and can influence the quality of future well-being and functioning (Lewis, 1996; Masten & Coatsworth, 1998; Cicchetti & Rogosch, 2002). Experiences will impact differently depending on the young person's level of development at the time these occurred. Furthermore, this impact will vary throughout the ongoing development. Adverse and beneficial experiences become part of a young person's developmental history and form a part of his/her resources and coping style. Thus, IMYOS considers the young person's developmental history alongside current influences and developmental challenges. The model also considers that the effects of early development are not immutable. Individual choice and subsequent experience (i.e., within therapy) can alter the course of development.

TRAUMA THEORY

This section will discuss and explore the dominance of traumatic experiences in the IMYOS population, the definition of trauma, the varying impact of trauma including its short and long term effects and the treatment implications for the individual, their family and system.

Dominance of Traumatic Experiences in the IMYOS Population

A significant majority of clients referred to IMYOS have histories of trauma and abuse, which is conceptualized as continuing to negatively affect their lives in a number of domains (i.e., individual, family, and system). While not all people who experience traumatic events suffer pathological and problematic outcomes, the experience of trauma alongside other factors appears to have a significant impact. Given the numerous psychosocial stressors experienced by many young people seen by IMYOS, the experience of trauma may have a profound impact.

Definition of Trauma

Traumatic events have been characterized by the DSM-IV (American Psychiatric Association, 1994) as involving the experience, witnessing, or confrontation of acutal or threatened death, serious injury, or threat to the physical integrity of self or others. Research has suggested that human-made traumatic events, with high levels of acute or chronic exposure to traumatic events in early development, trauma from a family member, concurrent

difficulties, and histories of multiple victimization experiences are more likely to result in lasting psychological trauma and further pathological changes (Baum, 1987, cited in Davidson, Inslicht, & Baum, 2000; Fergusson, Lynskey, & Horwood, 1996; Guthrie & Notgrass, 1992). The most frequently occurring traumatic events/stressors reported by the IMYOS client population are typically of human-made origin and can be both acute and chronic. These include childhood sexual and/or physical abuse by a family member, neglect, being the recipient of or witnessing violence, sexual assault/rape as a young adult, and other multiple victimization experiences.

The Varying Impact of Trauma

Trauma is conceptualized as affecting an individual on a variety of levels, with complex interrelationships between psychological, biological, and social systems and processes (van der Kolk & McFarlane, 1996; Pynoos, Steinberg & Piacentini, 1999). The impact is mediated by variables such as the developmental level of the individual, the pretrauma vulnerability, the nature of the trauma (i.e., natural event vs. human origin), the length of time exposed to the traumatic event, and the family and community circumstances (Shalev, 1996; van der Kolk & McFarlane, 1996). Central to this framework is an awareness of the nature of traumatic memory and its neurobiological substrates (e.g., physiological hyperarousal) that lead to the dominance of the traumatic event(s) in memory and to its maintenance over time (van der Kolk, 1996). IMYOS clinicians consider the impact of trauma at each level and work with the factors that may moderate impact on current trauma processing.

Responses to traumatic events experienced by IMYOS clients may be mild and short-lived or chronic and pathological (and may be associated with acute stress reactions and PTSD symptomatology). Short-term effects of trauma are most commonly emotional or cognitive symptoms such as fear/anxiety, panic, emotional numbing, intrusive images of the traumatic event, and confusion or dissociation (Shalev, 1996). Young people present with initial effects such as behavioral problems, eating disturbances, and symptoms of hyperarousal such as problems sleeping (O'Donohue, Fanetti & Elliott, 1998).

Long-term effects of trauma include difficulties in regulating affect, aggression against self or others, problems with social attachments and intimacy, inability to trust others, social avoidance and isolation, and alterations in cognitive neurobiological processes (van der Kolk, 1996). These effects extend beyond strictly psychological and behavioral issues. The social sequelae of trauma (seen commonly in IMYOS clients) include

isolation, increased interpersonal conflict, feelings of detachment and generally poor occupational and social functioning (Fergusson et al., 1996; O'Donohue et al., 1998; van der Kolk, 1996). In addition, the neurobiological impact of trauma can include biochemical and structural changes in the brain (Golier & Yehuda, 2002; Schwartz & Perry, 1994; van der Kolk, 1996). Trauma is remembered in the body and neuroanatomical structures in the brain (van der Kolk, 1996). In addition, traumatic experiences have been shown to change subsequent cognitive and information processing systems (Golier & Yehuda, 2002; van der Kolk & McFarlane, 1996). Cognitive problems can include activation of threat-oriented cognitive schemas and distortions of thinking containing assumptions about the dangerous nature of the environment, other people and cognitive distortions such as minimizing safety-related events and maximizing threat-related, negative events.

Implications for Intervention

Central to the process of IMYOS treatment with the individual is the quality of the therapeutic relationship. Re-establishing a sense of personal safety is one of the primary goals of treatment with IMYOS clients. General therapeutic strategies such as collaboration, consistency, and validation can be useful to guide the client into a more adaptive therapeutic relationship. The development of safety plans are also important to establish the safety of the client (if self-harm or suicidal behavior is present).

Treatments such as anxiety management training and exposure therapies can be used to address the varied psychological and behavioral problems presented by the client. Cognitive therapy can assist the client to challenge their assumptions/thoughts relating to dangerousness, hyperarousal, affective dysregulation, disassociation, and avoidance (Blake & Sonnenberg, 1998; Wagner & Linehan, 1998). IMYOS may also make use of a relational therapy in developing an understanding with a young person that helps them make sense of their current relational patterns (Ryle & Kerr, 2002). Psychoeducation for the young person, their family and other professionals is routine in IMYOS work. In relation to trauma this can include detailing aspects of biological impact and associated symptoms, which may aid family members (and others) to understand a young person's responses to trauma-related stimuli. IMYOS has undertaken family work focusing on the trauma of family members, which may be directly or indirectly related to that of the young person. Professionals

may have their own reactions to the traumatic history of a young person (and/or its behavioural effects), which may impact on the clients move towards recovery. Therefore systems work may also involve facilitating professionals'[1] explorations of their own experience of working with the traumatized client and its impact on the working relationship. In summary, psychoeducation can assist all parties in developing an understanding and, importantly, a shared framework to understand the young person's situation.

ATTACHMENT THEORY

This section will outline briefly the main premise of attachment theory as it relates to IMYOS work and the dominance of this issue in young people seen by IMYOS. It will then explore the impact of problematic attachments for young people and IMYOS clients and, finally, discuss the implications for treatment in working with people who have experienced problematic attachments.

Attachment Theory and IMYOS

Attachment theory posits that early relationships with primary caregivers provides a template for relationships with others in life. John Bowlby, who formulated Attachment Theory, argued that "many forms of psychiatric disturbance can be attributed either to deviations in the development of attachment behaviour or, more rarely, to failure of its development" (Bowlby, 1979, p. 127).

A majority of the young people seen by IMYOS have had major disruptions in their early relationships with their primary caregiver, and many have received "pathological care" (neglect physical or sexual abuse by caregivers, removal or absence of caregiver, and/or having multiple caregivers).

Impact of Attachment Difficulties

When attachment is not secure or severely disrupted, the young person may repeatedly replicate insecure attachments with others. The DSM-IV describes lack of attachment that results in functional impairment, beginning prior to 5 years of age and associated with grossly pathological care (American Psychiatric Association, 1994) as reactive attachment disorder. These early experiences affect the lack of security in subsequent relationships. For example, a young person may repeatedly tell another to

"leave them alone" which in turn results in the other giving up, thereby perpetuating their lack of a connected attachment. Attachment theory suggests that young people who are difficult to engage are not "bad" or "hopeless" but inexperienced in positive and trusting relationships and therefore avoidant of them. Attachment theory posits that the infant-parent relationship form the basis of mental life and relatedness and is the foundation of adult mental health (Lanyado, 2001). For example, if a child has little experience of reflective, reciprocal relationships that meet their emotional needs then this child will have very little sense of self and may persent with behavioural difficulties and/or mental health difficulties when older. Attachment insecurity or disturbances have been linkend to psychiatric syndromes, criminal behaviour and drug use (Shepheris, Renfro-Michel, & Doggett, 2003).

Implications for Intervention

Attachment theory offers the IMYOS model an understanding of young people's relational behavior and provides a base for formulating therapeutic interventions. IMYOS draws from attachment theory the understanding that a respectful, caring, and stable therapeutic relationship with someone can be reparative. It is suggested that the therapeutic relationship may provide an insight into the past experiences of care and current relationship building practices of the young person. For example, the clinician would hypothesize and may suggest to a young person who has had multiple losses of caregivers that it may be difficult to engage with someone for fear of experiencing another loss or seeing it as rejection.

IMYOS work is guided by an attachment framework to provide a safe relationship with young people that allows the young person to get feedback of how they appear in the relationship. This can aid the development of their sense of self, leading to improved mental health. IMYOS also puts strategies in place to foster relationships important to the young person, e.g., working towards a stable relationship between mother and daughter. The clinician may provide an outlet for the mother to express her anxieties, giving her more opportunity to be emotionally available to her daughter.

FAMILY/SYSTEMS THEORY

Many young people seen by IMYOS appear to have developed difficulties (and strengths) in the context of their family, and their behaviour

may reflect family issues and dynamics (Dembo & Schmeider, 2002). Conceptualizations such as these have led to wider acceptance that effective interventions with young people must involve the family. This section will outline the family systems theory in relation to IMYOS. It will then elaborate on a family systems perspective on the family and individual functioning, and finally discuss the implications of this view for intervention.

Family Systems Theory and IMYOS

One of the basic notions accepted within the IMYOS model to understand family and individual interactions is that experience is relationally derived. Our first and often strongest relational experiences are within the family and begin before we are even aware of them (Dembo & Schmeidler, 2002). A family is usually a child's first "social" experience and it lays the foundations for all future "relational" acts. If relationships within a family system are problematic, the development and experience of relationships for an individual will be affected. Difficult relationship styles can develop and continue throughout the generations of the family, as this is where primary observation and learning occurs. A product of these problematic relationships, and the resulting poorly constructed coping mechanisms and communication styles, can perpetuate difficulties within the family (Ackerman, 1966). IMYOS clinicians assume that family members are doing the best they can in the circumstances. Additionally, the families seen by IMYOS have often experienced trauma and similar difficulties to the young person identified as the "client." It is essential to address the family system difficulties as well as treating the individual client. Clinicians need to understand a family's relational style and ways of interacting and communicating so that an individuals behaviours and difficulties can be understood and addressed in this context. It is critical to be mindful of the impact that family dynamics have on an individual and the need to address these family issues in order for individual change to occur.

Family Systems View of Individual and Family Difficulties

Minuchin's theory of family systems is employed within the IMYOS model to understand family functioning (Minuchin, 1974). In family groups all members influence and are influenced by every other member creating a system with unique properties. These properties are rules under which the family functions, and they aim to return the family to homeostasis

(Minuchin, 1974). Each family member has an interacting role to maintain this functioning. Symptoms or difficulties of one family member are viewed as relational rather than contained exclusively within the individual (Minuchin, 1974). This understanding can be used to explain to individuals that they are not solely to blame for the difficulties they experience. A family systems conceptualization suggests that the burden of change is shared, as problems can be seen to belong to the family system and not only the responsibility of the individual (Minuchin, 1974). This notion of shared responsibility can be difficult for some families to accept as the culture and burden of blame is very strong. The concept of "relationally derived difficulties" can be hard to understand and accept, particularly as parents fear being blamed for the difficulties their child presents with (and may in fact have experienced feeling blamed). Informing the family that each family member can play a key role in the change process may move a family away from blame.

Implications for Intervention

IMYOS often allocates a second team member to work with the family. It is helpful to separate the roles of individual and family worker so that clinicians are able to clearly define their roles with little confusion between individual and family issues. Each part of the "system" is recognized as having their own needs that should be addressed separately. Additionally, clinicians work to educate family members about the way that IMYOS seeks to construct a relationship with a young person, particularly in allowing them to make choices and, therefore, mistakes. The clinician will attempt to explain the importance of attachment figure. Clinicians have found that effective family oriented interventions can occur without a commitment from all family members. When an individual client will not engage with a worker we have found that engaging the family system may be the only avenue for intervention. Clear, supportive, and improved family relationships are of central importance in the reparatory experience for the individual.

IMYOS clinicians routinely attempt to actively involve family members in all aspects of treatment. This includes participation in the creation of a safety plan (a collaborative plan usually detailing how people will support a young person when they are unable to keep themselves safe) and consideration of how each family member can help intervene in an effective manner. A difficulty that is often encountered by both families

and clinicians, is that the mental health system can be very individualistic in its view of symptoms and related treatments.

The clinician has a valuable role in providing psychoeducation to each family member so that they understand their "role" in the current family situation, while also understanding how they can help to change it. Supporting and educating families can be an effective tool in improving the functioning of the individual with the difficulties, as there is less conflict, blame and misunderstanding within the family system. The individual gains a great deal from intensive support and understanding of their circumstance and this impacts positively on their treatment and recovery (Henggeler, 1999). Transparency (i.e., the sharing of information and the process of treatment) between clinicians, young people, and families is crucial. The clinician's understanding of the individual's problems is shared with family members, who can otherwise complain of feeling neglected in the treatment. This then contributes to the family feeling an increasing sense of mastery as their understanding improves.

COLLABORATION/COERCION THEORY

The IMYOS model aims to use interventions and practices that respect and empower clients, promote collaboration and transparency, and move to equalizing client-client-clinician power. This set of principles clearly articulates key practice elements in establishing and maintaining collaboration. The current sections will begin by outlining the key elements of this theory and then discuss these as they are relevant to IMYOS.

Collaboration/Coercion Principles

The principles of collaboration/coercion guide the clinician in maintaining a collaborative relationship even when more coercive interventions are warranted (Bikerton, O'Brien, & Wallace, 2001). Dawson and Macmillan (1988), and Henggeler et al. (1999), would agree that coercive approaches in the care of young people/families are often unhelpful and unnecessary. The collaboration/coercion approach suggests that a collaborative relationship between clinician and young person incorporates a shared understanding of the problem. A willingness to work in partnership against the problem is seen as essential to collaboration (Bikerton et al., 2001). However, it is a reality in mental health that

legislative frameworks may require more coercive interventions in times of crisis, such as when a young person is at high risk of suicide.

The collaboration/coercion approach promotes transparent communication when the clinician needs to move outside collaboration. If clinicians are able to overt the situation in which they may need to "intervene" in a more "coercive" manner, it is more likely that a collaborative relationship can be maintained overall. This framework suggests that there are clear situations that will likely mean a therapeutic relationship is less collaborative; when the clinician and client have (1) no agreement on the problem or the impact of the problem, (2) no willingness to work in partnership against the problem, and (3) client, community, or clinician safety is compromised. The principles suggest that it is in these situations a clinician might shift their role to a more "coercive" one in order to prioritise safety.

Implications for Intervention

In practice, a collaborative stance is necessary in interventions with the individual, family and system. Collaboration is fostered and cultivated by (1) transparency, (2) flexibility and creativity of approaches, and (3) joint participation.

Transparency. The clinician openly shares their understanding and concerns regarding the problem and informs the young person and their family of contact with and information gained from all sources. IMYOS stresses the importance of keeping the young person actively involved and informed of the process of assessment. The clinician openly discusses the safety framework (including theoretical, ethical, legal and organizational structures as appropriate) and invites the young person to co-create an individualized "safety plan." IMYOS also invites significant others (parent, carers, teachers, etc.) to be part of that plan. Where a young person refuses to participate a safety plan is drawn up using the information available and this is communicated in detail and in writing to the young person (e.g., when it will be enacted, by whom, why, and how). We routinely share our understanding of the young persons presentation (including the Safety Plan and assessment where possible) with the family and other professionals involved. IMYOS may hold joint family and/or professionals sessions that afford the opportunity for differences of opinion to be overted and acknowledged.

Flexibility and creativity of approaches. The IMYOS model allows interventions to incorporate individual, family and systemic work. It advocates approaches that are youth/family friendly, nonblaming and respectful (e.g., when to see the young person, where, and for how long, for what purpose). The young person and their family guide the interventions, if they are willing to participate. The clinician outlines her/his role, their conceptualisation of the young persons presentation and possible interventions. This includes clinicians explicitly stating what they can and can't do, and providing a rationale for the same, for instance that, successful work can only occur in a context in which both the client and clinician are safe.

Joint participation. The IMYOS clinician extends an invitation to a young person (and their family) to participate in the co-creation of how the young persons situation and difficulties are understood and the subsequent dialogue that forms part of the intervention. These dialogues aim to empower the young person and family, and are therefore made explicit and repeatedly renegotiated.

The principles of transparency, flexibility and joint participation as part of fostering a collaborative approach are echoed in our work with the system around young people. IMYOS clinicians explain their stance of transparency to all people involved with a young person and encourage them to follow suit (this is also modelled in meetings and day-to-day liaisons). IMYOS follow up situations where this has not occurred and attempts to discuss the situation in light of the goal of collaboration and transparency across the client-family-professional system. We have noticed that if we are finding a young person "difficult" it is probable that other professionals are also struggling in some way. It is likely that we are making incorrect assumptions about roles and actions of others without verification. This can affect the overall collaboration of the system and family, leading to conflict, splitting, and fragmentation that may compromise engagement and safety.

In our experience, providing a transparent and collaborative framework for the young person, family, and system results in a greater strength of relationship. By promoting trust as the basis of all therapeutic relationships, the possibility for ongoing collaborative work exists even when coercive approaches have been necessary. Experience suggests that people can better manage more coercive interventions if they feel that they have been forewarned.

RELATIONSHIP MANAGEMENT THEORY

Relationship management is one of the "relational stances" used by IMYOS. As with different elements of the IMYOS model, it should be noted that it is not possible (or advisable) to employ this approach with all young people, but IMYOS clinicians may draw on some of these principles. This section will summarize the principles of this perspective in relation to IMYOS work, and then discuss the implications of these for intervention.

Relationships Management Principles and IMYOS

Dawson and MacMillan (1993) describe the "relationship management" theory which aids our understanding of the problematic therapeutic relationships frequently experienced by and with these complex young people. Informed by work with individuals with Borderline Personality Disorder (BPD), the idea acknowledges that the mental health system has, at times, created very problematic relationships with some clients. The main principles include: (1) assumptions regarding the competency of the individual; (2) the use of process, not content, of therapeutic sessions; and (3) the formation of a corrective therapeutic relationship. The principles emphasize that it is important to do no harm, reduce chaos, and to moderate the often distorted relationship between the young person and the health care system. These principles highlight the need to maintain positive unconditional regard through remembering that young people are having legitimate experiences even if they appear "manipulative."

The essence of "relationship management" is about *not* rescuing a client, i.e., reasserting the competence of the individual. It assumes the client will eventually come to the solution themselves, although this may take time and involve the clinician sitting with the discomfort of relinquished control and possible risk as the client learns to manage themselves more adaptively. The clinician cannot enter into this approach of "relationship management" without the full support and acceptance of his/her institution.

"Relationship management" desires relationships which are empathic, respectful, collaborative and incorporate a clear, consistent and transparent treatment approach. This is particularly important in mental health where clinical rules afford a certain power.

The developmental stage of the young person needs to be thoroughly assessed to determine if "relationship management" is an appropriate

approach. Although it has proven very powerful in empowering clients to learn to help themselves and offering a corrective relationship experience, careful consideration must be given to the cognitive and emotional developmental and environmental stages and chronological age of clients before proceeding. Discussion with team, supervisor, or managers can aid in deciding its clinical use.

Implications for Intervention

"Relationship management" proposes the idea of "no-therapy therapy," suggesting that being helpful is not always helpful. It is described as "less active assistance," offering the form of therapy without the content, thus allowing the young person to be responsible for his or her own care. The clinician would offer the client time limited regular meetings, providing an opportunity and structure for the young person to talk and the clinician to listen in a benign, neutral, yet warm manner. It is important that the "no-therapy" concept is not interpreted as being unavailable or rejecting, but rather less actively responding to the helping and problem solving behaviors the young person is often attempting to elicit from the clinician. To maintain the "no-therapy" relationship the clinician does not ask piercing questions, or offer advice, guidance, or interpretations, or enter into power and control situations/battles. The young person internalizes this as, "I am incompetent." Clinicians must assume the client comes to the process as a responsible and competent person, and overtly rescind the clinician's potentially powerful and controlling role.

IMYOS has also incorporated "relationship management" in family work. The principles are shared with family members to assist them to position themselves differently with their family member, possibly resulting in fewer control battles.

Psycho education, supervision, and consultation are fundamental in assisting clinicians who utilize a "relationship management" approach. The support of all workers is essential for this process to work. This may involve offering a supportive and reflective space for all professionals involved in the care of a young person, to develop a shared understanding of the treatment approach, and to acknowledge the inevitable difficulties encountered in working with these clients. It affords exploration of a professional's experience of control battles with young people, how they may respond differently and their self-efficacy to do so. When working with very complex young people we would *expect* difficulties to emerge between workers, and aim to create a space where these can be openly

discussed. "Relationship management" appears to deny the expression of therapeutic qualities (such as empathy, helping and caring) that attract us to the work. It is Dawson and MacMillan's (1993) thesis that these very qualities cause harm to the borderline client and using the apparently less empathic relationship management approach ultimately provides better care and help. IMYOS has found that empathy can coexist with this approach (and arguably should), and it is perhaps the paternalistic notions of helping and caring which can be experienced as problematic.

CASE STUDY

The following case study illustrates how the different theories described above can be integrated in the treatment of IMYOS clients. The process of integration generally occurs on a case-by-case basis and is informed by the clients' presentation.

Lucy (name changed), 14 years of age, was referred to IMYOS with a 2 year history of polysubstance abuse, homicidal threats, self-harming behaviors, recurrent suicidal ideation and two previous attempts. She displayed oppositional behaviors, which resulted in her being expelled from numerous schools. It was reported that Lucy presented with promiscuous behaviors and that she had communication and learning difficulties.

Initial engagement was slow. The IMYOS clinician made repeated attempts to see Lucy, often finding her door unanswered. When Lucy was absent, letters and notes were left to document the clinician's persistent efforts to build a therapeutic relationship.

Family Work/Systems Theory

The IMYOS clinician visited Lucy's parents and her paternal grandmother (with Lucy's permission) to gain insight into Lucy's childhood and family background. The family assessment revealed that Lucy had witnessed domestic violence and had experienced severe intra-familial abuse. This gave the clinician insight into why Lucy may struggle to connect with others and use violence to cope with her persistent fear that others may reject and/or abuse her (Attachment Theory/Cognitive Analytic Therapy (CAT)).

The IMYOS clinician engaged Lucy's mother by listening to her and validating her role and experience in the family (Family Systems Theory).

This trust allowed the clinician to suggest different ways of responding to Lucy rather than continuing to reject and punish her.

The IMYOS clinician met with the child protection and drug and alcohol worker every fortnight to develop and implement a consistent approach and treatment plan. This allowed Lucy to feel more in control of herself because she knew how the people around her would respond as they were communicating and had a shared understanding.

A "safety plan" was created in collaboration with Lucy. The safety plan clearly documented roles and responsibilities in responding to Lucy when she was "in crisis" and outlined a framework of how to assist Lucy most effectively. The "safety plan" was given to all the professionals and family members involved in Lucy's care, allowing the system to feel contained and mutually supported (Systems Theory).

Individual Work

The main focus of individual work with Lucy was the development of a transparent and collaborative therapeutic relationship. On the basis of this relationship, the IMYOS clinician was able to provide Lucy with important feedback about the impact of her ways of communicating and behaving. For example, when Lucy became threatening towards the IMYOS clinician, she was reminded that her abusive behavior would result in the therapy session being terminated, which consequently may lead her to feeling rejected. By informing Lucy that the IMYOS clinician didn't intend to reject her, but at the same time was unable to tolerate her threats, Lucy became increasingly aware of the potential impact of her abusive behaviors on herself and others. At times Lucy would run off from a session following a discussion about her abusive manners, threatening to never see the clinician again, but she always returned within the same week.

During therapy Lucy gained insight into the association between her traumatic past and her recurrent destructive intra-and interpersonal patterns. (Attachment/Trauma Theory/CAT). Lucy often talked about how she felt "out of control" and that no one could possibly help contain her, thus leading to a greater sense of being out of control (CAT). Lucy's problematic interactional patterns were illustrated well by the pictorial and narrative aspect of CAT, which suited Lucy's learning style and developmental stage (Developmental Theory).

Lucy was regularly seen by the IMYOS psychiatrist who prescribed an antidepressant and a low dose of an atypical antipsychotic. This medication

seemed to assist Lucy's mood and also helped her impulse control that had a great impact on her ability to tolerate therapy as well as reduce her aggressive behaviors.

Discharge

When Lucy was discharged from IMYOS after two and a half years she said that her relationship with the IMYOS worker had helped her engage because it had "clicked after some time" that the IMYOS clinician "was there" and had not been judgemental or rejecting. Lucy also said that the IMYOS clinician always explained to her all aspects of her treatment including a rationale for particular interventions. Lucy subjectively reported an improvement in her life. Possibly the greatest evidence of this is her effort to phone the IMYOS clinician on her 18th birthday and exclaim "I made it to eighteen," something she previously had not anticipated or wished for.

Lucy continues to have difficulties within her relationships but she manages her aggression much better. Lucy hasn't self-harmed for the last year of contact with IMYOS and has not attempted suicide within her episode of care. Lucy has reduced her substance use and has reconnected with her family.

IMYOS TEAM SUPPORTS

The integration of theories outlined in the IMYOS model applies not only to the work with young people, their families, and systems, but also to the functioning of the IMYOS team. The IMYOS team is an important part of the environment and many of the principles described above can be applied to the team. The team incorporates extensive support and safety practices that are considered essential to the provision of high quality service. These theories are applied to the teamwork and functioning via the leaderships in the team, modeling in interactions within the team and with other colleagues. For example, practice principles such as transparency, collaboration, and the establishment of safe relationships are overtly considered in team functioning. Additionally, attachment, trauma, and family systems theory aid the team to consider their responses to young people. A team undertaking such complex work requires opportunity to reflect on their work, just as they are asking their clients to do in their lives.

Leadership in the team can aim to model all of the above, specifically awareness of the power within relationships and its relatedness to trauma (vicarious), awareness of each member's, and the team's stage of development. Additionally, awareness of the functioning of the team is encouraged by the use of an external team (group) supervisor to allow reflection on the impact of the work on this system.

CONCLUDING COMMENTS

This model has developed from 7 years of clinical practice with high-risk, difficult-to-engage, complex-needs young people with mental health difficulties. Emerging evidence suggests that intensive outreach programs need to be multifaceted in their conceptualizations and interventions. The current model guides practical application integrating well-established theories. The IMYOS team aims to complete a procedural description of the work as well as an audit detailing the characteristics of the client group. Following these reports the team aims to undertake empirical research looking into the effect of IMYOS interventions.

NOTE

1. Refers to a person involved professionally in the care of an IMYOS client (who is not a mental health worker).

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Minutes

Statewide Assessment Panel

Date:	Monday 9th November, 2015
Time:	11.30am
Venue:	Videoconference
Chair:	Michael Daubney
Attendees:	Janelle Bowra, David Ward, Donna Dowling, Shannon March
Apologies:	Nil

Item	Details of discussion	Action/status	Officer	Timeline
1	**Meeting opening**			
1.1	**Welcome and apologies**	MD welcome everyone to the first meeting		
1.2	**Conflict of interest declaration**	None noted		
1.3	**Confirmation of the previous minutes**	First meeting		
1.4	**Statewide Assessment Panel Protocol** The members of the panel reviewed and discussed the protocols. A need to update the referral/intake form to include specific criteria that further assists the panel making decisions was identified.	 Review and discuss at next meeting		
2	**Previous Business**			
2.1	•			
3.	**Review of Monthly Consumer Summary Report**			
3.1	•			
4.	**Review of Consumer Stay Extensions**			
4.1	•			
5.	**Review of Consumer Exits**			
5.1	•			
6.	**New Referrals (intake and prioritisation)**			

Item	Details of discussion	Action/status	Officer	Timeline
6.1	[redacted]	[redacted]	MD	
7.	**Panel Process Issues**			
7.1	•			
8.	**Other Business**			
8.1	•			
	Next Meeting – as required			

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
What does the service intend to achieve? (Key functions – description)	The statewide subacute beds (SSB) form part of a continuum of care for adolescents requiring extended mental health treatment and rehabilitation in Queensland. As a statewide subacute service, the SSB will provide medium-term, intensive, hospital-based treatment and rehabilitation services in a safe, structured environment for young people with severe or complex symptoms of mental illness and associated significant disturbance in behaviour that precludes them receiving treatment in a less restrictive environment. A range of individual, group and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will support the safe transition to more functional or independent living. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic Profile: Young people aged 13-18 with a diagnosis of schizophrenia or other psychotic illness, severe mood disorder, or complex trauma with significant deficits in psychosocial functioning. Other diagnostic profiles would include adolescents presenting with marked social avoidance or severely disorganised behaviour characterised by impaired impulse control, emerging personality vulnerabilities, risk of self harm, or difficulties managing activities of daily living. Many will experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

What does the service do?
The key functions:

- Build upon existing comprehensive assessment of the adolescent (utilising the thorough treatment history obtained from service providers and carers) to assess the likelihood of therapeutic gains by attending the SSB.
- Provide individually tailored evidence-informed treatment interventions to alleviate or treat distressing symptoms and promote recovery.
- Provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness.
- Provide a 3 - 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community.

Treatment programs will include an extensive range of therapeutic, educational/vocational interventions and comprehensive activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment.

Programs will include:

- Phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers.
- A comprehensive family assessment completed within the first 4 weeks of admission.

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• Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff. • Access to schooling within the hospital campus. • Access to Indigenous and transcultural support services. • 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment. • Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community. • Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.	
Referral /Access	• Referral to the SSBs will be through the Statewide Assessment Panel. • On acceptance, the adolescent will be assigned a Case Manager, who will be responsible for organising admission and ongoing liaison with the referring HHS. • Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the SSB. It is anticipated that adolescents will also remain actively engaged with local mental health and other support services prior to, and during the course of, their admission into the SSB. • Priorities for admission will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of admitted adolescents, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. This may be done in person or via videoconference. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from the admission, the impact of being with other adolescents, and some assessment of acuity and risk.
Assessment	**Mental Health Assessment** • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. **Family/Carer Assessment** • A Family Assessment is considered essential. The Case Manager will obtain a detailed history of family structure and dynamics, or a history of care if the adolescent is in care. This process will begin with the referral and continues throughout the admission. • It is expected that the family will be available to complete a comprehensive family assessment and that parents/carers will be involved in the mental health care of the adolescent as much as possible. A significant effort will be made to support the involvement of parents/ carers. As part of this comprehensive assessment, families will be expected to travel to Brisbane for up to a week. The organisation and cost of transport, accommodation, meals, and incidentals

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	will be covered by the referring HHS. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service or other appropriate supports. **Developmental/Educational** • School-based interventions, to promote learning, educational or vocational goals, and life skills, are a key feature of the assessment process and treatment plan. Access to on-site schooling will be available to all inpatients. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during admission. **Physical Health** • Routine physical examination will occur on admission and be monitored throughout admission. • Appropriate investigations will be completed as necessary. • The SSB will have access to local tertiary paediatric consultation services if required. **Risk Assessment** • Risk assessments will be conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All adolescents will have a designated consultant psychiatrist. A Recovery Plan will be developed in consultation with the adolescent and their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidence-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks.

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	Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into the overall therapeutic approaches to the adolescent during admission and as part of their discharge plan. This may include videoconference family therapy support to local mental health services. Tasks to Facilitate Adolescent Development and Schooling: • The SSB will offer a range of interventions to promote appropriate development in a safe and validating environment. • School-based interventions to promote learning, educational or vocational goals, and life skills. • Individual and group-based interventions to promote aspects of adolescent development, which may include local adventure-based and other recreational activities. Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Secure forensic beds are not offered as part this service. • It is also not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the SSB.
Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout admission. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process. • Depending on their skill set, the Case Manager will provide therapeutic input over the course of admission.
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles, such as accommodation, engagement with other child and youth mental health services, and transition to adult mental health services. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate. • The school linked to the SSB will have primary responsibility for school reintegration, and /or vocational options, and the support required during this process.
Frequency of activity	• Access to the full multidisciplinary team will be provided weekdays during business hours.

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	• Nursing staff will be rostered to cover shifts 24 hours, 7 days a week. • An on-call consultant child and adolescent psychiatrist, with Registrar support, will be available 24 hours, 7 days per week.
Average Length of Stay	90 days with an expected maximum stay of less than 180 days.
Hours of Operation	24 x 7
Unit Size / Facility Features	Gazetted. 2 to 4 beds. Seclusion room.
Staffing/Workforce	• The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry (consultant psychiatrist and psychiatry registrar), mental health nursing, psychology, social work, occupational therapy, speech pathology, and other specialist CYMHS staff. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills. • Administrative support is essential for the efficient operation of the SSB. • All permanently appointed medical, allied health, and senior nursing staff are (or are working towards becoming) authorised mental health practitioners. • The effectiveness of the SSB is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. The SSB will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.
Geographic Location	The SSB will be located on a hospital campus in Children's Health Queensland catchment (Brisbane).
Funding	Recommended Clinical Staff per 4 beds: • Psychiatrist: 0.2 FTE • Registrar: 0.4 FTE • Total Nursing: 5.1 FTE • Psychologist: 0.2 FTE • Social Work: 0.2 FTE • Occupational Therapist: 0.2 FTE • Speech Therapist: 0.2 FTE • Recreational Officer: 2.2 FTE • Administration Officer: 0.2 FTE
Governance	• The SSB will operate under the governance of Children's Health Queensland Hospital and Health Service (CHQ HHS), within a statewide integrated mental health service.

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	• Clinical and operational governance will occur through the SSB Clinical Director reporting directly to the Divisional Director, CYMHS CHQ HHS. • Interim line management arrangements may be required.
Related Services / Other Providers	The SSB will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service system and through the adolescent developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. The SSB will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services; • Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • headspace services; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family counselling and parent support services; • Housing and welfare services; and, • Transcultural and Aboriginal and Torres Strait Islander services. The SSB will: • Provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorders requiring extended treatment and rehabilitation; • Develop the capacity to benchmark with other similar subacute adolescent inpatient units; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; and, • Drive research and publish on effective interventions for young people with severe and complex mental health disorders, who require extended treatment

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	and rehabilitation inpatient treatment. Educational resources are essential to adolescent extended treatment and rehabilitation services. Access to on-campus schooling (including suitably qualified educators) will be offered as an integral part of the SSB. All educational services will need to be evaluated and provided by the Department of Education, Training and Employment (DETE). Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes) • Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.