



# **Evaluation Framework for the Adolescent Extended Treatment Centre (AETC)**

**Preliminary Report for the Mental  
Health Alcohol and Other Drugs  
Branch (MHAODB)**

Queensland Centre for Mental Health Research

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## List of Abbreviations

AETC	Adolescent Extended Treatment Centre
ACE	Adverse childhood experiences questionnaire
AMYOS	Assertive Mobile Youth Outreach Service
AQoL	Assessment of quality of life
CAD	Child and Adolescent Day program
CIMHA	Consumer integrated mental health application
CYMHS	Child and Youth Mental Health Service
ED	Emergency Department
GARF	Global assessment of relational functioning
GBO	Goal based outcomes
HoNOSCA	Health of the nation's outcome scales child and adolescent
HREC	Human Research Ethics Committee
KPI	Key performance indicator
MHADC	The Mental Health Activity Data Collection
MHAODB	Mental Health and Other Drugs Branch
MHEC	Mental Health Establishments Collection
MOS	Model of service
PLP	Personalised learning plan
QHAPDC	Queensland Hospital Admitted Patient Data Collection
RAS	Recovery assessment scale
RD	Role Description
RSS	Relative stress scale
SDQ	Strengths and difficulties questionnaire
SOFAS	Social and occupational functional assessment scale
YES	Your experience of Service
YRRU	Youth residential rehabilitation Units

# Chapter 1: Background

The purpose of this report is to describe the development of the evaluation framework for the new state-wide Adolescent Extended Treatment Centre (AETC) in Queensland, to introduce the framework, and to make recommendations for how it should be implemented. This report will describe the logic and evidence base used to determine the instruments and tools that will accurately measure the clinical and service outcomes of the State-wide Adolescent Extended Treatment Model of Service (AET MOS).

## Introduction

Program evaluation is defined as the systematic collection of information about activities, characteristics, and outcomes of programs. It is used to determine the effectiveness of a program and, subsequently, inform decision-making (Patton, 1998). An evaluation framework sets out the components of a program evaluation while also functioning as a tool to assess whether the evaluation will be useful, viable, ethical, and accurate. When properly designed through an evidence-based framework, program evaluation has several benefits. These include allowing services to reflect on service delivery and improve program quality, informing policymakers and funders, building community capacity and engaging key stakeholders; disseminating information for evidence-based care, ensuring funding and sustainability, and strengthening accountability. An evaluation framework also ensures that program evaluations focusses on key issues of importance to stakeholders and that a wide range of stakeholders can make use of the results.

This report presents an evaluation framework that emphasises program evaluation as a practical and ongoing process involving program staff, consumers, carers, key stakeholders, and evaluation experts.

## Background

In July 2016, the Queensland Government released its response to the Barrett Adolescent Centre Commission of Inquiry Report. The Government accepted the Commissioner's recommendation to engage the Queensland Centre for Mental Health Research (QCMHR) to identify existing clinical and program evaluation frameworks for extended treatment services for adolescents and young people with severe, persistent, and complex mental illness.

In March 2017, a comprehensive evidence-based report was completed, titled 'Review of services to inform clinical frameworks for adolescents and young adults with severe, persistent and complex mental illness' (Woody, in press). The report found that no program evaluation frameworks applicable to a service such as the AETC were available. However, key principles and requirements for such an evaluation framework were identified. In 2018, QCMHR was engaged by the Mental Health Alcohol and Other Drugs Branch (MHAODB), Clinical Excellence Division, to lead the development and implementation of an evaluation framework for the AETC.

## State-wide Adolescent Extended Treatment Model of Service

Mental health services for young people within the Queensland public system consist of several service components. These range from early intervention and community-based services through to sub-acute services and acute hospital care. The sub-acute service element in the National Mental Health Service Planning Framework (NMHSPF) describes intensive care services that provide short- to medium-term treatment and rehabilitation in a safe and structured environment. The new state-wide AETC for adolescents, which has extended the continuum of service options in Queensland, will operate on the premise that adolescents can and do recover from mental illness. The goal is to provide the young person an opportunity to build on their strengths, enhance their self-esteem, build on opportunities for social inclusion, and promote recovery-focused outcomes.

The *AETC State-wide AET MOS* (*insert link*) describes the elements of the AET continuum of sub-acute and non-acute services. These services aim to provide adolescents experiencing severe, persistent, and complex mental illness with extended treatment, rehabilitation, and integrated educational and vocational opportunities. Consistent with the description of a range of sub-acute and non-acute service elements in the NMHSPF, the AET MOS is intensive (i.e. providing a structured environment) and rehabilitative (i.e. improving overall functioning), with improvements anticipated to occur over weeks and months as opposed to days (as with acute service elements). The core purpose of the AETC is to provide personalised treatment and rehabilitation, for an extended period, that fully integrates mental health and educational/vocational training components.

*Table 1.1* outlines the sub-acute services in Queensland, their foci of care, targeted age range, and location. These sub-acute service elements have had staggered starts over the past four years and many of the MOS and service components interrelate. From an evaluation perspective, this provides an opportunity to examine how these services relate to each other and understand the journey of the consumer through these services. However, not all of these services have started clinical service operation nor have evaluation frameworks in place. Linking evaluation across these sub-acute service elements provides an opportunity to understand the cohort who utilise these services as well as benchmark and improve outcomes for service users.

**Table 1.1** Services within the AET continuum.

Service	AMYOS	Day Program	Step Up/ Step Down Unit	Adolescent Extended Treatment Facility	Youth Residential Rehabilitation service (YRRUs)
Primary referral	CYMHS	CYMHS	CYMHS/ Acute Inpatient units 16-21yrs	State-wide admission panel	CYMHS or Adult MH services 16-21 yrs
Length of stay	Case by Case	120days, Max 180 days	28 days	120 days, Max 180 days	Up to 365 days
Location	Community	Community or Hospital campus	Residential	Hospital campus	Residential
Governance	Local HHS	Local HHS	Local GGS, NGO operated	CHQ HHS	Local HHS, NGO operated
Profile	<ul style="list-style-type: none"> <li>- Supportive assertive services required out of hours</li> <li>- No fixed address</li> <li>- High risk disengagement</li> <li>- Absence bed based or day program</li> </ul>	<ul style="list-style-type: none"> <li>- Does not require inpatient care</li> <li>- History of school exclusion or refusal</li> <li>- Poor social skills requiring group based work</li> <li>- Lives in geographical area of DP</li> </ul>	<ul style="list-style-type: none"> <li>- Requires increased intensity of treatment to prevent admission to acute unit</li> <li>- Enables early discharge from acute/subacute-safety not ensured at home</li> <li>- Not to manage TA</li> </ul>	<ul style="list-style-type: none"> <li>- Level of acuity or risk requires admission</li> <li>- Improvements in MH not expected to occur within short term</li> <li>- Requires therapeutic milieu not provided by acute unit</li> <li>- Allows for TA (inpatient)</li> </ul>	<ul style="list-style-type: none"> <li>- 16-21 yrs</li> <li>- Home environment not supportive enough for safety / or access to MH service</li> <li>- Requires additional support to develop independent living skills</li> <li>- Does not require inpatient care</li> </ul>

Further details on the MOS for these sub-acute service elements, including Adolescent Mobile Youth Outreach Service (AMYOS), Child and Adolescent Day program (CAD), Youth Residential Rehabilitation Units (YRRUs), and Step up / Step down unit services and their respective MOS are available in Appendix A.

# **Chapter 2: Development of the evaluation framework**

This Chapter is divided into two parts. First, the development of the evaluation framework is outlined. Second, key findings of this development process are summarised.

## **Process for developing the Evaluation Framework**

The process for developing the evaluation framework covered four key components which are summarised below:

### **1. Review of the literature**

A systematic literature review was conducted as reported in ‘Review of services to inform clinical frameworks for adolescents and young adults with severe, persistent and complex mental illness’ (Woody, *in press*). The focus of this report was to look at the epidemiological profile of severe, persistent, and complex mental illness in adolescents and young people in Queensland, to identify evidence-based clinical interventions and identify any relevant program evaluation framework for the delivery of services to this cohort.

As noted earlier, no applicable existing program evaluation frameworks were found. However, a number of key requirements for such an evaluation framework were identified. These included:

- (i) the evaluation framework should stem directly from a model of service and be based on project logic processes);
- (ii) routine data collections, analyses and reporting protocols should be clearly defined;
- (iii) a range of consumer, parent/carer and clinician reported measures to provide a comprehensive overview of services should be included;
- (iv) Results of evaluations should regularly be made available to participants to maximise learning and maintain the commitment of all involved.

### **2. Consultation with stakeholders**

The development of the evaluation framework was informed by consultation with an Advisory Group formed specifically for this purpose. The Advisory Group consisted of a range of internal and external stakeholders and specialists. Members of the Advisory Group, along with their position and organisation, are available in Appendix B. The Advisory Group provided expertise on the development of the proposed evaluation framework for the AETC. The Advisory Group met every three months. Broader consultation with other stakeholders was also tabled at these meetings. The key roles of the Advisory Group were as follows:

- Provide advice on the feasibility, sensitivity, evidence base, and alignment of evaluation tools for the AET MOS;
- Consider the proposed AETC evaluation framework in the context of the sub-acute

- service structure and national mental health frameworks;
- Provide feedback and support to achieve a final agreed evaluation framework for the AETC.

### **3. Utilisation of the mandated minimum data set**

A minimum set of data was planned for collection. This included the compulsory State and National Data collection items, and the evaluation tools already utilised by [AMYOS](#).

Using existing evaluation tools and processes provides an opportunity to build on routinely collected data and to benchmark and compare existing Queensland sub-acute and non-acute services for adolescents. In Queensland, a range of data are collected routinely for mental health which are relevant to the evaluation framework of the AETC, including:

- Consumer Integrated Mental Health Application (CIMHA). CIMHA is a consumer-centric clinical information system designed to support mental health clinicians in the provision of mental health services.
- Your Experiences of Services (YES) survey. This survey is a measure of mental health consumer experiences about the care they receive from public mental health services. It is collected and reported back annually to participating Hospital and Health Services.
- Mental Health Establishments Collection (MHEC). The MHEC collects a range of establishment information from Hospital and Health Services, including consumer and carer participation, the types of services provided, available bed numbers, patient activity data, FTE numbers, and service expenditure.
- Queensland Hospital Admitted Patient Data Collection (QHAPDC). Mental health inpatient activity (admission, transfer, and discharge) is collected as part of the QHAPDC. Collection is facilitated via HBCIS and is managed by the Statistical Services Branch, Strategy, Policy and Planning Division.
- The Mental Health Activity Data Collection (MHADC). MHADC is a state-wide resource for specialised mental health services activity data to inform local and state decision-making, support the development and reporting of national and state performance indicator frameworks, activity based funding models, and classifications.

AMYOS, a sub-acute and non-acute service element that is already operational, has implemented an evaluation framework. While AMYOS does have some operational differences, such as being an assertive outpatient service, it does focus on a group of sub-acute adolescent users similar to the projected users of the AETC. Therefore, it was decided that AMYOS data tools and processes were to be considered in the AETC evaluation framework.

### **4. Consideration of the AET MOS as a key guiding document.**

The rehabilitation-oriented focus of the AET MOS denotes that improving functioning is a key outcome of this service and, therefore, must be incorporated into the evaluation framework.

## **Objectives of the evaluation framework**

As a result of the four key components of the development process, key objectives of the evaluation framework were determined. These are described below.

### **Short-term objective: Cohort**

In the short-term, the key objective is to ascertain the expected cohort of consumers who will attend the AETC and be most likely benefit from the AETC's rehabilitative intervention model. This information supports timely and targeted referrals, providing the greatest opportunity for positive outcomes. Although the AET MOS outlines a description of the likely cohort, it is currently not known who will access the AETC when operational.

### **Medium-term objective: Consumer outcomes**

The medium-term objective is to identify consumer outcomes achieved by the AETC. This would include improved access and improved opportunities to education and employment, increased client and family satisfaction with services, reduced acute hospitalisation and crisis care, and comparison of outcomes with other community-based sub-acute and non-acute services.

### **Long-term objective: Broader outcomes**

The long-term objective is to better understand the cohort who attends the AETC and their journey through the health sector. This will support opportunities for earlier intervention and provide cost-effective treatment to reduce the incidence of severe and complex mental illness and subsequent need for extended inpatient care.

In keeping with the key short-, medium-, and long-term objectives outlined above, guiding evaluation questions were considered when developing the evaluation framework. As shown in Table 2.1 below, these questions were asked in order to identify the most appropriate measures, key performance indicators, and reporting outputs.

**Table 2.1.** Questions to guide the selection of evaluation tools and development of clinical indicators to meet the short, medium and long-term outcomes.

Process	<ul style="list-style-type: none"> <li>• Has the AET MOS been implemented as intended?</li> <li>• Has the intake panel been effective?</li> <li>• Have program participants (staff, community organisations, community members) been satisfied with the AETC?</li> <li>• Have all the service activities been delivered?</li> <li>• How effective were: <ul style="list-style-type: none"> <li>○ The team serving the designated population of adolescents with severe and persistent mental illness according to AET MOS?</li> <li>○ The AETC staff at participating in the evaluation process?</li> </ul> </li> </ul>
Outputs and Outcomes	<ul style="list-style-type: none"> <li>• Have the AET MOS key objectives been achieved?</li> <li>• Who are the adolescents that attended the AETC?</li> <li>• What is the experience of young people who accessed the AETC?</li> <li>• Has the AETC team functioned effectively? Have people adhered to their RD?</li> <li>• What have been the critical success factors and barriers to achieving the impacts and outcomes?</li> <li>• What outcomes are experienced by young people involved in the AETC in relation to functioning?</li> <li>• How do young people's family members experience the ATEF?</li> <li>• How do the outcomes of the AETC compare with other models of sub-acute services?</li> <li>• What is the impact post-AETC on consumer's acute admissions and ED presentations?</li> <li>• What is the impact of an AETC admission on consumer's school attendance or vocational status?</li> <li>• Is the cost reasonable in relation to the magnitude of the benefits?</li> <li>• Have levels of partnership and collaboration increased?</li> </ul>
Implications for future program and policy	<ul style="list-style-type: none"> <li>• Should the program be continued and developed further?</li> <li>• What performance monitoring and continuous quality improvements arrangements should be maintained in the future?</li> <li>• How will the program, or the impacts of the program, be sustained?</li> <li>• What earlier-orientated intervention programs in a consumer's journey through Queensland mental health services could possibly stop the need for a sub-acute admission to the AETC?</li> <li>• How does an AETC admission compare with longer term multiple acute admission?</li> </ul>

## **Key findings from the development of the evaluation framework**

Findings from the above four-step development process, in addition to ongoing consultations with key stakeholders, resulted in several key findings. While these findings have been summarised individually below, all are interrelated and will need to be considered concurrently during the implementation phase of the evaluation framework.

### ***Complexity***

The AETC is a unique service element in terms of being a stand-alone sub-acute and non-acute inpatient facility. As such, there are not any existing similar services that could be assessed in terms of their evaluation framework. As a state-wide service, there are additional complexities that require formal and informal partnerships, including Children's Health Queensland (CHQ), the Hospital and Health Service that will operationalise the AETC, the policy and strategic drivers of the AET MOS, and the state-wide public mental health Clinical Systems, Collections and Performance Unit (Analysis and Accountability team). While many steps to establish the AETC have been completed, there are still several unknowns as the service has not commenced. This evaluation framework was developed ahead of the AETC opening, meaning staffing, final inputs, and operationalisation the AET MOS are yet to be determined.

### ***Cohort***

One of the key issues identified during consultation has been the actual cohort who will utilise the AETC. The AET MOS outlines admission criteria such as; (i) adolescents across Queensland with a primary diagnosis related to severe and complex mental health issues, (ii) would likely benefit from an extended treatment and rehabilitation model, (iii) who have not been responsive to other care options, and can be safely managed in a sub-acute setting. As outlined earlier, a key objective of this evaluation framework is to identify the cohort who will be most likely to utilise and to benefit from the AETC. This requires the collection of demographic and other relevant data relating to those attending the AETC, as well as equivalent data for those who do not meet eligibility criteria. Analysis of these referrals, the outcome of referrals (accepted/not accepted), and key community stakeholders involved in the entry into (and exit from) the AETC will be recommended as part of the evaluation framework.

### ***Data Collection***

The AETC will require data collection in addition to the established routine collections to ensure the evaluation is comprehensive. It is critical that the complexity and burden of administration imposed on staff, consumers, and carers is considered. The interaction between the current state-wide data collection systems (CIMHA, YES, MHEC, QHAPDC), balanced with the need to collect additional data, has to be considered in the implementation phase to ensure that any additional instruments added are effective, feasible, related to existing services, and meaningful to service improvement and clinical outcomes.

### **Culture**

It will be critical to develop a culture of evaluation and research to support staff engagement in data collection. Providing support and feedback to staff, adolescents, and their families will be important in the implementation phase of the framework in order to ascertain how evaluation guides longer term clinical and operational outcomes. Culture pertaining to the staff, staff mix, and environmental milieu within the AETC has also been raised as an important issue for consideration within the design of an evaluation of the effectiveness of a rehabilitation focussed model of service.

### **Consumer and Carer Feedback**

Consultation with consumer and carer representatives has highlighted the need to obtain direct feedback from consumers and families about *their* experiences from *their own* perspective of their mental health. Consideration of how these may be collected in a way that is timely and reasonable must be considered in the implementation of the framework. Furthermore, the data needs to be representative of all consumers and carers involved with the AETC. It is recommended that simple youth-friendly methods of data collection, such as tablets, be investigated during the implementation phase. Furthermore, a means of demonstrating to adolescents *why* data is collected and how they will receive feedback needs consideration.

### **Consumer journey**

The importance and potential significant value of establishing the AETC's role in the journey of an adolescent through Queensland child and adolescent public health services was highlighted. Consultations with stakeholders identified a number of key factors that provide information about the consumer journey: reductions in incidence or prevalence of health conditions, changes in mortality, sustained behaviour change, or improvement in quality of the earlier intervention programs aimed at reducing the prevalence of severe, persistent, and complex mental illness, and subsequent need for extended inpatient care. While the evaluation will be implemented at the start and end of admission to the AETC, how data can be meaningfully collected over the long-term needs consideration as well as collaboration between all major stakeholders (e.g. CHQ, Clinical Systems, Collections and Performance Unit) during the implementation phase.

### **Ongoing evaluation**

While the evaluation framework needs to be incorporated into sustainable and existing processes, the AETC will collect data that is currently only collected in some elements of the sub-acute services. Evaluation and resulting analysis of evaluation data often largely depend on external drivers separate from clinical duties. It would be highly desirable, and likely necessary for the success of the evaluation, to embed research into the AETC, e.g. through employment of a researcher or externally-led benchmarking.

The findings from the development of the evaluation framework highlighted several complexities, many of which are subject to a number of unknown factors. The AETC evaluation framework needs to be

dynamic and complemented by processes that are developed jointly (by AETC staff, key stakeholders, and staff with evaluation or research expertise); a commitment from management and staff to support quality evaluations; and a commitment from management and staff to use the results of the evaluation in future program reviews and re-designs.

## Chapter 3: Framework

A comprehensive evaluation framework is critical to the effective management of resources and delivery of evidence-based care and achievement of patient outcomes in mental health services. This evaluation framework aims to focus on measures of consumer outcomes, as well as investigating aspects of service delivery and program operations and how they relate to the AETC MOS. The evaluation framework will provide a comprehensive description of proposed data collection instruments, performance monitoring, and reporting processes linked to clearly identified key performance indicators (KPIs).

A program logic model was used to structure the evaluation framework. Program logic models illustrate the causal connections between activities and desired outcomes, highlighting key program activities and elements. These models are not static, and can be modified and enhanced as programs evolve. The inputs are the key elements of a program and include variables such as the number and composition of staff, funding, access to services (partnerships), and consumer referrals. Outputs are the actions of the AETC, such as activities and functions on the ward. These include the integration of health and education staff, development of individual consumer goals and service planning, the provision of cohesive and evidence-based teamwork, and a focus on rehabilitation and recovery-orientated care.

*Table 3.1* below provides an outline of the evaluation framework for the AETC. Given that the evaluation framework has been designed prior to the finalisation and commencement of the AETC, it is anticipated that some adjustments to the evaluation framework will be required.

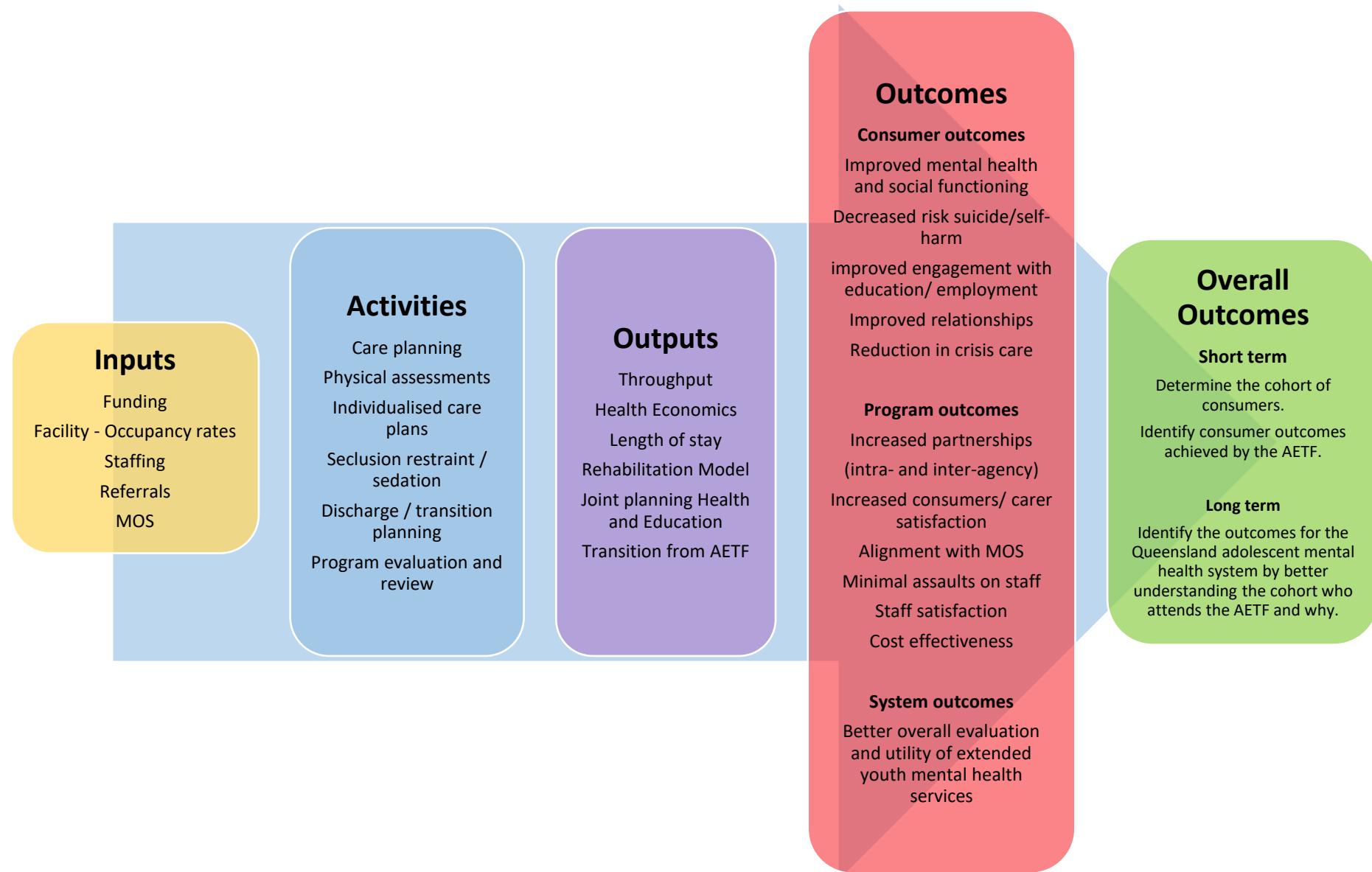
**Table 3.1.** Evaluation Framework.

Program component	Indicators	Timing	Measure
Inputs	Funding	Annually	Ratio of expenditure to budget.
	Facility	Annually	Bed Occupancy rates
	Qualified staff: • Clinical <ul style="list-style-type: none"><li>◦ support for suitable level of clinical skill in a complex role</li><li>◦ clinicians with a rehabilitation focus and expertise</li></ul> <ul style="list-style-type: none"><li>• Non-clinical</li><li>• Management</li><li>• Administration</li></ul>	Annually	Mental Health Establishments Collection (MHEC) annually
	Referrals / cohort Patterns	Updated Weekly	Complete separate data based (refer to Appendix C)
	Care planning	Collected at intake, during service delivery, and at discharge, reviewed monthly	Refer to instrument section in Appendix C
Activities	Physical assessments	Intake and at agreed intervals in care plan	Refer to instrument section in Appendix C
	Individualised treatment plans and therapy	Collected weekly and reviewed monthly	Type and frequency compared to benchmark defined in care plan
			Consumer satisfaction on treatment received
			Clinician rated consumer engagement
			KPIs around Multidisciplinary review and collaborative treatment focus to support rehabilitation orientated culture and therapy planning
Outputs	Consumer seclusion and restraint	Monthly	Monthly rates are compared to those reported for similar services and to the national target of 0.
	Discharge/transition planning	Monthly	Identification of discharge planning in initial care plan, and at case reviews.  Comparison with what is defined in Model of Care  Developed KPIs
	Program evaluation and review	Annually	Evaluation report to describe service operations and impacts, including for consumers function, carers experiences and staff milieu and functioning.
Outputs	Throughput of adolescents staying in the AETC	Annually	Evaluation report templates to be developed with the Clinical Systems, Collections and Performance Unit.

	Amount spent per patient	Annually	In addition to direct dollar cost calculations (averaged) looking at a benchmarking for other sub-acute service elements using the SDQ
	Time in AETC	Annually	Number of bed days per adolescent
	Rehab MOS being utilised	Monthly	KPIs established to look at multidisciplinary case-mix, therapy services offered and frequency
	Joint planning between Health and Education	Monthly	KPI looking at evidence of joint weekly meetings and joint PSP (personalised support plans) for each adolescent.
	Smooth transition from AETC	Annually	KPI to be developed
Consumer outcomes	Reduced risk of suicide and self-harm	Intake, discharge and 1-year post-discharge*	Measures may include number of suicide attempts and occasions of self-harm.
	Improved mental health and social functioning	Intake, discharge and 1-year post-discharge*	Refer to selection of instruments (Appendix C)
	Improved engagement with education and employment	Intake, discharge and 1-year post-discharge*	Refer to selection of instruments Appendix C
	Improved relationships	Intake, discharge and 1-year post-discharge*	Refer to selection of instruments Appendix C
	Reduced hospitalization and crisis care*	1-year pre-intake and post-discharge	Look to link data sets via CIMHA and state-wide reporting
Program outcomes	Partnerships with other MH services support continuity of care	Annually	Evidence of follow-up communication with referrers upon intake and discharge and in the case of unsuccessful referral. Survey of referrers, external service providers, consumers and carers on views of referral pathways and continuity of care.
	Interagency partnerships support wraparound care	Intake, discharge	Evidence of shared care plans (including consent to share information) with referrers and community services at intake and following discharge.
	Consumers and carers are satisfied with the service	Intake, discharge and Annually (YES survey)	Refer to selection of instruments (Appendix C)  Use of YES survey
	Program is aligned with service model/ program fidelity	Annually	Adherence to program principles e.g. Rehabilitation and Health/ Education integration  CIMHA activity on Multidisciplinary team activity and developed KPIs
	Assaults on staff	Monthly	Monthly assault rates are compared to those reported by other health services and a target rate of 0.
	Staff are satisfied with the service and work environment	Annually	Internal staff interviews, focus groups and rates of staff turnover and sick leave may provide insight into satisfaction and risk of burnout.

	Culture and workplace integration suitable to a rehabilitation MOS		Staff surveys on workplace culture to be implemented annually.
	Allocated funding is aligned with actual service costs*	Annually	Allocated funding is compared to actual costs including evaluation activities.
	Cost effectiveness. Program reduces burden on acute MH services and associated costs*	Annually	Benchmarking with other sub-acute service elements using HoNOSCA adjusted for QoL
<b>System outcomes</b>	Better understanding of Appropriate access to extended youth mental health services	Annually	Benchmarking with other Sub-Acute service elements.

**Figure 3.1.** A diagrammatic representation of the evaluation framework.



# Chapter 4: Implementation of the Evaluation Framework

## Implementation of the Evaluation Framework

Five key recommendations relating to the implementation phase of the evaluation framework are outlined below.

These recommendations have been consulted with and supported by the AETC evaluation framework Advisory Group. Final discussions from the Advisory Group have been written in *Italic* script at the end of each recommendation to provide clear feedback to the MHAODB. QCMHR is seeking a position on each recommendation from the MHAODB in order to progress the project into the implementation phase.

## Recommendations

### **RECOMMENDATION 1: ENSURE HIGH-LEVEL SUPPORT FOR AETC EVALUATION**

#### **FRAMEWORK AND IMPLEMENTATION.**

- R.1.1 Ensure support and buy-in from high-level decision makers at the MHAODB and CHQ
- R.1.2 Establish formal and informal partnerships with other key data agencies (e.g., Analysis and Accountability team, Clinical systems, collections and Performance Unit) and other services within the sub-acute and non-acute continuum (e.g. AMYOS and Day programs).
- R.1.3 Provide representation from QCMHR on a CHQ-lead AETC implementation team.

*Representation from senior leadership at CHQ supported this recommendation and already QCMHR has been invited to work with the AETC implementation team at CHQ to ensure the evaluation framework implementation occurs concurrently to the broader implementation of the AETC.*

### **RECOMMENDATION 2: DEVELOP A SIMPLE SET OF CONCRETE MEASURES THAT ARE FEASIBLE TO COLLECT THE DATA FOR DURING IMPLEMENTATION.**

- R.2.1 Develop a simple set of measures that are easy to collect in a consistent manner.  
*The Advisory Group has endorsed a set of data instruments for adolescents, carers or significant others, and clinicians. This recommendation has been completed and is presented in Appendix C.*
- R.2.2 Identify and investigate potential platforms for electronic data collections to ensure efficient data collection from adolescents, carers, and clinicians.

- R.2.3 Identify where it will be important to link data collection to mechanisms that are already underway. The Clinical System, Collections and Performance Unit has well-developed performance monitoring frameworks and indicator reports that the AETC evaluations can utilise.
- R.2.4 Program and system outcome reports (identified by key stakeholders involved in the implementation of the AETC) should be linked to data collection collated by the state-wide Analysis and Accountability team.

*The Advisory Group has discussed each measurement tool and selected its inclusion or exclusion based on careful consideration and balance of the five parameters outlined in Appendix C. The Advisory Group unanimously supported utilisation of an electronic platform to collect data from consumers and carers. Paper and pen was considered not suitable for this target group and more likely to result in collection and input error. Ongoing partnership and support from The Clinical System, Collections and Performance Unit within the MHAODB was discussed as critical as the AETC will be a state-wide service.*

### **RECOMMENDATION 3: EXPLORE OPTIONS FOR SOFTWARE SPECIFIC TO AETC DATA COLLECTION AND OTHER SUB-ACUTE SERVICES.**

- R.3.1 Explore the feasibility, cost, and ongoing ethics restrictions associated with the use of an electronic data collection platform (e.g., RedCap).
- R.3.2 Explore feasibility of a 2-3-year pilot study to test an electronic data collection platform. This is to be presented and discussed at the AETC Advisory Group.
- R.3.3 Explore legal, hardware-related, and other issues associated with data management systems within Queensland Health.

*The Advisory group supported QCMHR to go and review the three most desirable options and provide feedback regarding these options. A discussion paper has been developed outlining three options:*

1. *RedCap electronic platform housed by CHQ*
2. *RedCap electronic platform housed by MHAODB*
3. *PDF fillable forms uploaded to CIMHA*

*QCMHR is seeking the MHAODB to assess these options in full (provided in Appendix E) and provide a preferred option. Discussion regarding a 2 or 3 year pilot study was not resolved. A discussion that the data collection costs and processes would need to be determined first to balance feasibility and cost.*

## **RECOMMENDATION 4: IMPLEMENT THE EVALUATION FRAMEWORK.**

- R.4.1 Work with the CHQ AET Implementation team and (to be appointed) Clinical Director of the AETC to establish effective, feasible, and streamlined processes and business rules to support the data collection.
- R.4.2 Develop an online training program to orientate clinical staff to the evaluation tools and standardise processes. This will ensure; (i) fidelity of the data collection; (ii) explain the rational and benefits of collection; and (ii) develop a culture of best practice evaluation.
- R.4.3 Design and create a brief animated educational video for consumers regarding the evaluation framework and tools used within the AETC.
- R.4.4 Pilot the evaluation tools with a sample of consumers prior to the AETC opening to assess the level of feasibility, sensitivity, and accuracy.
- R.4.5 Complete (if required) an application to the CHQ Human Research Ethics Committee (HREC) in order to collect data.

*The Advisory group supported all of Recommendation 4.*

- *Support was given from the advisory group for QCMHR to explore the options and costs associated with R.4.2. A discussion document has been developed. QCMHR is seeking the MHAODB to assess these options (provided in Appendix F) and provide a preferred option for progressing R.4.2.*
- *Recommendation 4.3 was discussed and highly supported by the consumer and carer representation as an important recommendation. CHQ youth consumer group can be engaged by QCMHR, in addition to the evaluation framework consumer, to support script development and review the educational video. At this stage the costs can be covered within the existing QCMHR budget allocated at the start of this project. The advisory group supported the engagement of an external graphics/ video company as it would (a) make the production more appealing to young people (b) have a professional presentation and (b) allow the final product to be available as a link that could be housed at MHAODB, QCMHR/L, and on the electronic platform of CHQ.*
- *A decision that QCMHR would be best position to write the ethics application was agreed.*

## **RECOMMENDATION 5: COLLECT AND ANALYSE DATA BASED ON COHORTS OF CLIENTS**

### **WHO ATTENDED THE AETC.**

- R.5.1 Collection and analysis of the data over the pilot period will be complex. A balance between ensuring that data collection and ‘cleaning’ occurs in addition to an ability to report, analyse and ensure quality processes are progressed will be critical to the success over the recommended pilot study period and developing a longer term processes based on outcomes of the pilot evaluation period.

- R.5.2 Following the implementation of the framework and the collection of data, a thorough evaluation needs to occur to provide responses to the identified short-term outcomes guiding the evaluation framework. This would include responding to the questions pertaining to process, impact and outcomes, and implication for future program and policy for adolescents experiencing severe, persistent, and complex mental health issues. A guide of questions to be answered is presented in Table 2.1, p8, Chapter 2.

*While the advisory group supported these recommendations in principal, they were seeking a position from the MHAOBD for how this recommendation may be implemented into the future.*

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## APPENDIX A

**Adolescent Mobile Youth Outreach Service (AMYOS)** has been in operation since 2014 and provides services across the state for adolescents aged 13-18 who present with complex and severe mental health problems, exhibit high risk behaviour or risk of deterioration, are difficult to engage or require a level of support that cannot be sustained by mainstream outpatient services. AMYOS is a mobile service and delivered by multidisciplinary teams in community settings with a capacity to support adolescents for up to two years. AMYOS has an already established state-wide evaluation framework that has been in place for more than two years. Utilising the learnings and outcomes from this sub-acute service has been important in developing the AETC. [MOS link](#)

**A Child and Adolescent Day (CAD) Program** provides specialist multidisciplinary assessment and integrated treatment and rehabilitation to children and adolescents generally between 6 and 18 years of age with severe, persistent mental illness/es which results in severe psychosocial impairment. Presentations are often complicated by developmental co-morbidities. The average length of stay at a CAD Program is up to six months. CAD Programs are designed to provide treatment to children and adolescents in the least restrictive environment possible. This recognises the need for safety, with the minimum possible disruption to their family, educational, social and community networks. [MOS link](#)

**The Youth Residential Rehabilitation Services (YRRU's)** have had a staggered start since 2014 and provide longer-term residential care across the state for young adults aged 16-21 years. Their main goal is for young people to achieve independence to return other accommodation options by providing a range of support services and life skills training and education. Four sites currently exist, each consisting of 4-5 beds in; Townsville (2 YRRUs), Cairns, Greenslopes, and Aspley. The YRRUs are run by NGO providers and are able to support young people for up to a year. A key goal of the YRRUs is to provide holistic care that involves families, carers, and organisations. They are run with a recovery-oriented approach based on an individual's strengths, building resilience, and enhancing opportunities for social inclusion. [MOS link](#)

**The Youth Step Up Step Down (SUSD)** services are community bed-based (sub-acute) mental health services operating in a rehabilitative and residential environment in the community, 24 hours a day, 7 days a week. Operating as an integrated model where the Hospital and Health Service provides clinical services alongside provision of non-clinical support services by a non-government organisation, it is designed to provide a service option for young people aged 16 to 21 years of age whose treatment and recovery is better suited to intensive, short-term (up to 28 days) treatment and support. The Youth SUSD model of service aims to reduce the likelihood of admission to an acute mental health inpatient unit (step up) for young people and enable timely discharge from acute care and the successful transition back to the young person's community (step down).

## **APPENDIX B**

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# **Evaluation Framework for the AETC**

## **Advisory Group – Terms of Reference**

**NOT FOR DISSEMINATION OR CITATION**

Queensland Centre for Mental Health Research

# 1. Background and Purpose

This document defines the roles and responsibilities of the Advisory Group for the development of the Evaluation Framework for the Adolescent Extended Treatment Centre (AETC).

## 2. Members of Evaluation Framework for the AETC Advisory Group

Name	Representation	Entity
Brigid Minogue	Northern Queensland	NUM, Adolescent inpatient and Day Service, Child, Adolescent and Young adult program.
Carina Capra	Project Manager	QCMHR
Harvey Whiteford	Principal Investigator	QCMHR
Holly Erskine	Project Director	QCMHR
James Scott	Clinical Expert	QCMHR
Judi Krause	CHQ	Divisional Director CYMHS
Judith Piccone	MHAODB	Manager Child and Youth Team
Kathy Moodie	Consumer	Health Consumers QLD
Michael Daubney	Comparative evaluation expert	Medical Director, CHQ Specialist Teams
Michelle Bond	Education	Executive Principal Statewide education continuity for students with chronic Mental Health conditions,
Raymond Ho	Allied Health	Deputy Director. Child and Youth Academic Clinical Unit, Metro South
Ruth Fjeldsoe (Kristen Breed)	Data Services	MHAODB Clinical systems, Collections and Performance
Stephen Parker	Subacute Evaluation Expert	Psychiatrist, DoT Metro South
Stephen Stathis	CHQ	Medical Director Child and Youth Services
Tina Pentland	Carer	Health Consumers QLD
Yong Yi Lee	Health economist	QCMHR

## 3. Role of the Advisory Group

The role of the Advisory Group is to provide expertise on the development of the proposed evaluation framework for the AETC. The Advisory Group has been convened in order to support the timely and successful delivery of the approved evaluation framework by June 2019.

Members of the Advisory Group will:

1. Consider the proposed AETC evaluation framework in the context of the CYMHS sub-acute service structure;
2. Provide advice on the feasibility, sensitivity, evidence base, and alignment of evaluation tools for the AETC MOS, and with other sub-acute services and national Mental Health frameworks;
3. Provide feedback and support to achieve a final agreed AETC evaluation framework
4. Engage in out of session work such as reading preparatory materials prior to each meeting.

## **4. Responsibilities of Group Members**

The Chair is responsible for:

- Encouraging all participants to voice their opinions and create a meeting environment where consumers and carers feel valued and safe to contribute;
- Accepting nominations for changes to membership;
- Establishing meeting times;
- Providing relevant guidance;
- Overseeing development/updating the terms of reference (TOR) in collaboration with members; and
- Ensuring the Group focuses on matters relevant to its functions and considers each matter with appropriate care and propriety.

Members of the Group will commit to the following as appropriate to the area they represent:

- Put the young people and families at the centre of deliberations;
- Facilitate and support the resolution of risks and issues that may arise; and
- Facilitate and support appropriate consultation with stakeholders and ensure the effective management of issues that may arise.

The Secretariat will be provided by the QCMHR AETC project team and is responsible for:

- Compiling and disseminating agendas, minutes and agenda papers (via email to members);
- Coordinating and preparing background information;
- Maintaining administrative aspects of the Group and associated TOR; and
- Coordinating and facilitating meeting logistical requirements (e.g. venue, travel, parking).

## **5. Conduct**

Frequency of meetings:

- The Group will be convened to meet every 3 months. The frequency of meetings (including additional meetings) will be scheduled by the Secretariat, after initiation by the Chair.

Lifespan:

- The Group is a time limited group established to oversee the agreement of the evaluation framework.
- Members who are absent from a meeting may have a proxy attend on their behalf. Proxies should be briefed and be able to contribute to meetings as if they were a nominated Group member.

Conflict of interest:

- Members must declare any actual or perceived conflicts of interest regarding any issues discussed that may have a direct influence on their ability to make an objective decision.

Membership and chair:

- Membership may be altered following Group consultation and endorsement by the Chair.
- The Group will be chaired by Associate Professor James Scott or their delegate.

Other participants and guests:

- The Chair may invite participants or groups to present to, or observe, meetings.
- A guest's attendance is limited to the duration of discussion on that specific topic.

Out of session business:

- Business may be initiated and progressed out of session by the Chair. Papers will be circulated to members for feedback by a specified date. In these circumstances, the Chair will determine the final position based upon member feedback. The Secretariat can update members accordingly.

Confidentiality:

- Members may receive information that is regarded as 'commercial-in-confidence', clinically confidential, or have privacy implications. By accepting membership of the Group or an invitation to attend as a guest, meeting attendees acknowledge their responsibility to maintain confidentiality of all information that is not in the public domain.
- Members and proxies acknowledge their responsibility to maintain the confidentiality of all information that is not in the public domain or deemed 'in confidence'.
- By accepting to be a member of the AETC Advisory Group the members agree to keep the advisory group meeting and discussion confidential. Disclosure or dissemination of any key documents and discussion would require prior permission from the project manager, Carina Capra.

## APPENDIX C

# Description of agreed Instruments to be included into the AETC Evaluation Framework

Recommendation 2.1 for the AETC has been completed by the advisory group. The advisory group has already met and selected the instruments to be included into the AETC Evaluation framework as part of the *clinical outcomes for consumers who attend the AETC*. In order to develop a comprehensive set of measures for the AETC, **five key questions** were developed.

**1. Are the evaluation tools worthwhile?**

That is, are they reliable and valid? Do they measure what they say they measure? Are they user friendly and easy to administer?

**2. Are the evaluation tools feasible?**

That is, can they be completed reasonably? Some assessments may be feasible while the consumer is admitted to the AETC but longitudinal follow up using the same measures may be impractical.

**3. Are the measures sensitive to change?**

These measures need to be able to be utilised at the start of the admission to the AETC and at the point of transfer of care from the AETC. The AETC has a target length of stay up to six months.

Furthermore, evaluation tools that offer the ability to provide feedback to adolescents and their families / carers may improve uptake into programs and interventions aimed at providing support.

**4. Do they meet the outcomes required from the Queensland Government's Youth Mental Health Framework?**

The evaluations have been selected based on the endorsed AET MOS and the foci of care. The Mental Health, Alcohol and Other Drugs Branch is progressing a Youth Mental Health Work program including a reform stream with one of the five key areas of work focussing on evaluations, research, clinical quality, and safety of child and youth mental health. The final evaluation framework needs to fit within this brief.

**5. Do the evaluations align with other sub-acute services elements evaluations processes and tools?**

The AET MOS describes a new state-wide service element within the Queensland public child and youth mental health, alcohol and other drugs system which has extended the continuum of service options. The AET MOS fits within the Child and Youth Mental Health Service that can be categorised as 'sub-acute'. It has been important to consider the other elements of the child and youth continuum and evaluation processes when developing this proposed framework.

These key questions guided the decision regarding which measures were most suitable for the evaluation framework

Table 3.2 provides a summary of the selected measures and relevant activities based on the outcomes outlined in the evaluation framework. All **included** instruments are available in Appendix C. Measures

that were excluded as per the five criteria listed above or were considered duplicates of others can be found in *Appendix D*. The following measures have been selected for inclusion in the final evaluation framework (some can be seen in duplicate in *Table 3.2* as they cover multiple domains):

#### *Consumer/ Carer and Clinical Tools*

- Demographic and psychosocial questions
- Strengths and difficulties questionnaire (SDQ)
- Drug/alcohol use
- Suicide risk indicator
- Personalised learning plan (PLP)
- Recovery assessment scale (RAS)
- Relative stress score (RSS)
- SCORE-15 Index of family functioning and change
- Parent/carer contextual outcomes
- Adverse childhood experiences questionnaire (ACE)
- Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA)
- Goal based outcomes (Y/N) (GBO)
- Physical health questions
- Previous service history
- Recovery plan

#### *Program Outcomes*

- Your experience of service (YES)
- Education information pack
- Chart review (KPIs)
- Consumer integrated mental health application (CIMHA) reports
- Panel data sheet
- Ongoing annual reports

**Table 3.2.** Summary of selected measures for the AETC evaluation framework.

		Adolescent	Family, carers, friends	Clinician, treating team	Operational	AET-MOS
Category	Symptom Change	Likert scale (how I am feeling)		Preliminary diagnosis		4.3.1
	Co-morbidities	SDQ		TA status		4.3.2
	Trauma History			ACE*		4.2.3
	Culture			HoNOSCA		4.3.6
	Substance Use	Drug/alcohol use		Drug/alcohol use		4.3.7
	Risk Assessments	Suicide risk indicator		HoNOSCA		4.5.2
	Work Education	PLP GBO satisfaction		Suicide risk indicator		4.8.3
	Social Connectedness Relationships	RAS SDQ GBO satisfaction		Psychosocial info HoNOSCA PLP		4.3.8
	Gender Identity	Gender Q		Goals Based Outcomes (GBO) (Y/N) HoNOSCA		4.3.9
	Physical Health GP relationships			Gender Psychosocial info		4.1.2
	Functioning	RAS SDQ GBO satisfaction		Physical health questions HoNOSCA		4.1.5
	Family/Carers Family functioning		Relative Stress Scale (RSS) SCORE-15 Parent/carer Contextual Outcomes	Psychosocial info HoNOSCA		4.4.1
	Service, partnerships, transfer of care	YES.....†		Family therapy consideration		4.4.3
	Individualised, integrated, client-centred, recovery-based care	PLP	PLP	Previous Service History* Post-collection tool†	CIMHA business rules Mandatory clinical documentation CIMHA quarterly reports	4.5.3
	Referral/cohort			Education information pack PLP	Recovery plan CIMHA Report	4.1.1
	Informed, supported workforce				Panel Data Sheet Quarterly Reports	4.3.13
					Ongoing Annual reports (TBD)	4.7.1
					CIMHA Quarterly Reports	4.7.2
						4.10
						4.11
						4.12
						4.2.3
						4.4.2

\* Intake Only

† Discharge Only

## Symptom Changes, Comorbidities, Psychosocial and Demographic information

### STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)

The SDQ is a brief behavioural screening questionnaire for 3-16 year olds. It is brief, easy to understand and use for participants, easy of scoring, and has high validity and reliability from previous studies (Goodman, 1997). The SDQ is already familiar to staff and some consumers within the data set on CIMHA and is freely available. Studies that have examined the psychometric properties of the SDQ within a large community sample (N = 1,359) of Australian children found moderate to strong internal reliability (0.59 to 0.80) across all SDQ subscales (Hawes & Dadds, 2004).

Over the last month:	None of the time	A little of the time	Some of the time
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches, or sickness			
I usually share with others, for example CDs, games, food			
I get very angry and often lost my temper			
I would rather be alone than with people of my age			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, depressed or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get along better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I'm doing. My attention is good			

### Key Components:

Young person completes this assessment

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**Self-report rated on a 3-point scale**

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**Pros:** It is easy to use, high concurrent validity, free access, already used by CYMHS routinely in CIMHA. Extensively utilised within research and evaluation

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**Cons:** Relies of the clinician to hand it out, collect, and enter on CIMHA for collection points other than while in the AETC.

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#### **CLINICIAN INITIAL DATA COLLECTION SHEET**

The following are a series of Questions that have been developed to provide an initial (pre) assessment of an adolescent's level of complexity, severity and intervention history. The questions include demographics (age/date of birth), date of arrival and referral source to service, Mental Health Act status, preliminary and secondary diagnosis, medication types, employment or study, housing and accommodation status, family relationships, trauma history, substance use and physical health. The questions are a mixture of dichotomous responses (Y/N) and scales.

#### **ADVERSE CHILDHOOD EXPERIENCES (ACE) QUESTIONNAIRE**

The Adverse Childhood Experiences (ACE) questionnaire was developed by Felitti and colleagues in 1998 as part of the ACE Study, which is a collaboration between the Kaiser Health Plan's Health Appraisal Centre and the Centres for Disease Control and Prevention (Felitti et al., 1998). It measures the extent of childhood abuse and household dysfunction experienced by those under the age of 18. Abuse questions were adapted from the Conflict Tactics Scale (CTS) and Childhood Trauma Questionnaire (CTQ), both of which have shown good validity and reliability (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Straus & Mickey, 2012). Neglect variables were adapted CTQ items. Finally, household dysfunction variables were a combination of adapted CTQ items and questions developed by the ACE study coordinators.

**Referral Information**

Date: \_\_\_\_\_

Client code: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender

- Female
- Male
- Other

AETF Clinician: \_\_\_\_\_

Suburb (currently living): \_\_\_\_\_

Currently under TA? Yes No

Preliminary diagnosis: \_\_\_\_\_

Current medications: \_\_\_\_\_  
\_\_\_\_\_**Previous Service Contact**

Total number of months open service episode with CYMHS prior to referral: \_\_\_\_\_

No. of emergency departments psychiatric presentations: \_\_\_\_\_

No. of mental health acute inpatient admissions: \_\_\_\_\_

Attended AMYOS program? Yes No

Attended YRRU? Yes No

Attended Day Program? Yes No

**Physical Health**

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_

BMI: \_\_\_\_\_ Waist circ.: \_\_\_\_\_

Minimum HDL (mmol/L): \_\_\_\_\_

Type 2 diabetes: Yes No

Has a GP been identified? Yes No

**Psychosocial Information**

Gender incongruence? Yes No

Sexual identity/Sexual Orientation:

1. Same sex attracted/Bisexual
2. Heterosexual
3. Unknown

Culture:

1. Aboriginal and/or Torres Strait Islander
2. CALD. If yes, Ethnicity: \_\_\_\_\_

Refugee Background or Asylum Seeker: Yes No

Education:

- Disengaged
- Flexi
- Special Ed
- Mainstream
- TAFE or vocational training

What current level at school? (e.g. Year

9) \_\_\_\_\_

In the last 3 months, how often did the adolescent not want to go to school?

- Never
- Hardly ever
- Sometimes
- Most of the time
- All of the time

As a result of these problems, how many days has the adolescent been absent from school in the last 3 months? \_\_\_\_\_

When these problems were at their worst, how much did they affect the adolescent's grades or their ability to do their schoolwork?

- Not at all
- A little
- Somewhat
- A lot
- Extremely
- Don't know
- Refuse to answer

Employment:

Has the consumer started any of the following?

1. Paid full-time work
2. Paid part-time work
3. Volunteer work
4. Other: \_\_\_\_\_

If yes to employment, was it stopped prior to admission?

Yes No

Child Safety Involvement:

- Past
- Current
- Nil

Family Structure (young person's current living situation):

- Step or blended family
- Single parent
- Intact family
- In out-of-home care (foster or 'self-placed' with other than biological parents)

History of custody: Yes No

<p><b>Screening/outcome tools</b></p> <p>Suicidal ideation</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p>Suicide attempts</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p>Recurrent self-harm</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p>Unsafe/risky sex/at risk of exploitation</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p>Violence/aggression</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p><b>Drug/alcohol use</b></p> <p>Drug and alcohol use:</p> <ul style="list-style-type: none"> <li>• Most days</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Less than monthly</li> <li>• Nil</li> </ul> <p>Primary drug of concern</p> <ul style="list-style-type: none"> <li>• Alcohol</li> <li>• Cannabis</li> <li>• Tobacco</li> <li>• Amphetamine type</li> <li>• Hallucinogens</li> <li>• Opiates</li> <li>• Benzodiazepine</li> <li>• Inhalants</li> <li>• Synthetics</li> <li>• Caffeine</li> <li>• Other: _____</li> </ul>	<p><b>Trauma History:</b> Yes      No</p> <p>Trauma type (tick all that apply):</p> <ol style="list-style-type: none"> <li>1. Physical abuse</li> <li>2. Sexual abuse</li> <li>3. Emotional abuse</li> <li>4. Neglect</li> <li>5. Witness DV/FV</li> <li>6. Sexual assault</li> <li>7. Physical assault</li> <li>8. Serious accident</li> <li>9. Natural disaster</li> <li>10. War</li> <li>11. Death/serious illness of a significant other</li> </ol> <p>Intergenerational history of trauma?      Yes No</p> <p><b>Adverse Childhood Experience/s (ACE) Questionnaire</b></p> <p>1. Have you ever been scared that your parents or other adults were going to hurt you badly (so that you were injured or killed)?      Yes No</p> <p>2. Have you ever been scared or felt really bad because grown-ups called you names, said mean things to you, or said they did not want you?      Yes      No</p> <p>3. Has there ever been a time of your life when you were totally on your own and had to take care of yourself for more than a short time?      Yes No</p> <p>4. Have you ever felt like you are not loved or cared about?      OR Have you ever felt like you have no one that protects you?      Yes No</p> <p>5. Has an adult ever touched you in your private parts except when being bathed?      OR Has an adult ever attempted or forced you to have sexual intercourse?      Yes No</p> <p>6. Have you ever been bullied or threatened by boys or girls?      OR Have you ever been slapped, hit or otherwise been physically hurt by a boy or girl in a way that you did not want?</p> <p>7. Have your parents/guardian ever drank too much alcohol or used drugs so they came home and were really abusive to you or your family? Yes      No</p> <p>8. Have you ever seen your mother or father so sad that they couldn't take care of you? Yes      No</p> <p>9. Have you ever seen your mum being hit, beaten or threatened?      Yes      No</p> <p>10. Have any of your parents ever been in prison/jail?      Yes      No</p> <p>11. Has your family ever been forced to leave your home/house?      OR Has there ever been a time when your family did not have enough food because they had no money?      Yes      No</p>
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## **Key Components:**

Clinician completes this assessment as part of a comprehensive assessment period at intake.

Elicited through clinical assessment

**Pros:** Important as part of a comprehensive assessment period. Supports the KPIs from the MOS. Good utility across the time frame of the AETC

**Cons:** Possible inconsistency and internal reliability could be an issue without appropriate training.

## **HEALTH OF THE NATIONS OUTCOME SCALES CHILD AND ADOLESCENT (HoNOSCA)**

The Health of the Nation Outcome Scales for Children and Adolescent (HoNOSCA) is a clinician rated instrument comprising 15 simple scales measuring behaviour, impairment, symptoms, social problems and information problems for those under 18 years of age. Each scale is based on a 4 point Likert scale, where; 0 is no problem, 1 is a minor problem requiring no action, 2 is a mild problem but definitely present, 3 is a moderately severe problem, and 4 is a severe to very severe problem (Gowers, 1998). Members of an expert national mental health committee found the HoNOSCA instrument to be a suitable assessment for determining symptom severity across a number of subscales in youth mental (Brann, Alexander, & Coombs, 2012). An exception is that the HoNOSCA ‘School attendance’ question needed to explicitly include vocational attendance to make the instrument useful with youth mental health. However, further questions relating to vocation attendance is included throughout the AETC tools.

### **Section A**

#### **1. Problems with disruptive, antisocial or aggressive behaviour**

**Include** behaviour associated with any disorder, such as hyperkinetic disorder, depression, autism, drugs or alcohol.

**Include** physical or verbal aggression (e.g. pushing, hitting, vandalism, teasing), or physical or sexual abuse of other children.

**Include** antisocial behaviour (e.g. thieving, lying, cheating) or oppositional behaviour (e.g. defiance, opposition to authority or tantrums).

**Do not include** overactivity rated at scale 2. Truancy, rated at scale 13, self-harm rated at scale 3.

- 0 No problems of this kind during the period rated.
- 1 Minor quarrelling, demanding behaviour, undue irritability, lying etc.
- 2 Mild but definite disruptive or antisocial behaviour, lesser damage to property, or aggression, or defiant behaviour.
- 3 Moderately severe aggressive or antisocial behaviour such as fighting or persistently threatening or very oppositional or more serious destruction to property or moderate delinquent acts.
- 4 Disruptive in almost all activities, or at least one serious physical attack on others or animals, or serious destruction to property.

## **2. Problems with overactivity, attention or concentration**

**Include** overactive behaviour associated with any cause such as hyperkinetic disorder, mania or arising from drugs.

**Include** problems with restlessness, fidgeting, inattention, or concentration due to any cause, including depression.

- 0 No problems of this kind during the period rated.
- 1 Slight overactivity or minor restlessness etc.
- 2 Mild but definite overactivity and/or attentional problems but these can usually be controlled.
- 3 Moderately severe overactivity and/or attentional problems that are sometimes uncontrollable.
- 4 Severe overactivity and/or attentional problems that are present in most activities and almost never controllable.

## **3. Non-accidental self-injury**

**Include** self-harm such as hitting self and self-cutting. Suicide attempts, overdoses, hanging, drowning etc.

**Do not include** scratching, picking as a direct result of a physical illness rated at scale 6.

**Do not include** accidental self-injury due e.g. to severe learning or physical disability, rated at scale 6. Illness or injury as a direct consequence of drug/alcohol use, rated at scale 6.

- 0 No problem of this kind during the period rated
- 1 Occasional thoughts about death, or of self-harm not leading to injury. No self-harm or suicidal thoughts
- 2 Non - hazardous self-harm, such as wrist scratching, whether or not associated with suicidal thoughts.
- 3 Moderately severe suicidal intent (including preparatory acts e.g. collecting tablets) or moderate non-hazardous self-harm (e.g. small overdose)
- 4 Serious suicidal attempt (e.g. serious overdose), or serious deliberate self-injury.

## **4. Problems with alcohol, substance/solvent misuse**

**Include** problems with alcohol substance/solvent misuse taking into account current age and societal norms.

**Do not include** aggressive/disruptive behaviour due to alcohol or drug use, rated at scale 1. Physical illness or disability due to alcohol or drug use, rated at scale 6.

- 0 No problems of this kind during the period rated
- 1 Minor alcohol or drug use, within age norms.
- 2 Mildly excessive alcohol or drug use
- 3 Moderately severe drug or alcohol problems significantly out of keeping with age norms.
- 4 Severe drug or alcohol problems leading to dependency or incapacity.

## **5. Problems with scholastic or language skills**

**Include** problems in reading, spelling, arithmetic, speech or language associated with any disorder or problem, such as a specific developmental learning problem, or physical disability such as hearing problem. Children with generalised learning disability should not be included unless their functioning is below the expected level.

**Include** reduced scholastic performance associated with emotional or behavioural problems.

**Do not include** temporary problems resulting purely from inadequate education.

- 0 No problems of this kind during the period rated
- 1 Minor impairment within the normal range of variation
- 2 Mild but definite impairment of clinical significance
- 3 Moderately severe problems, below the level expected on the basis of mental age, past performance or physical disability

- 4 Severe impairment much below the level expected on the basis of mental age, past performance or physical disability

## 6. Physical illness or disability problems

**Include** physical illness or disability problems that limit or prevent movement, impair sight or hearing, or otherwise interfere with personal functioning.

**Include** movement disorder, side effects from medication, physical effects from drug/alcohol use, or physical complications of psychological disorders such as severe weight loss.

**Include** self-injury due to severe learning or physical disability or as a consequence of self-injury such as head banging.

**Do not include** somatic complaints with nor organic basis, rated at scale 8.

- 0 No incapacity as a result of physical health problem during the period rated
- 1 Slight incapacity as a result of a health problem during the period (e.g. cold, non-serious fall etc.)
- 2 Physical health problem imposes mild but definite functional restriction
- 3 Moderate degree of restriction on activity due to physical health problem
- 4 Complete or severe incapacity due to physical health problems

## 7. Problems associated with hallucinations, delusions or abnormal perceptions

**Include** hallucinations, delusions or abnormal perceptions irrespective of diagnosis.

**Include** odd and bizarre behaviour associated with hallucinations and delusions.

**Include** problems with other abnormal perceptions such as illusions or pseudo-hallucinations, or overvalued ideas such as distorted body image, suspicious or paranoid thoughts.

**Do not include** disruptive or aggressive behaviour associated with hallucinations or delusions, rated at scale 1. Overactive behaviour associated with hallucinations or delusions, rated at scale 2.

- 0 No evidence of abnormal thoughts or perceptions during the period rated.
- 1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
- 2 Abnormal thoughts or perceptions are present (e.g. paranoid ideas, illusions or body image disturbance) but there is little distress or manifestation in bizarre behaviour, i.e. clinically present but mild.
- 3 Moderate preoccupation with, abnormal thoughts or perceptions or delusions, hallucinations, causing much distress and/or manifested in obviously bizarre behaviour.
- 4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations or abnormal perceptions, with severe impact on child/adolescent or others.

## 8. Problems with non-organic somatic symptoms

**Include** problems with gastrointestinal symptoms such as non-organic vomiting or cardiovascular symptoms or neurological symptoms or non-organic enuresis or encopresis or sleep problems or chronic fatigue.

**Do not include** movement disorders such as tics, rated at scale 6; physical illnesses that complicate non organic somatic symptoms, rated at scale 6.

- 0 No problems of this kind during the period rated.
- 1 Slight problems only; such as occasional enuresis, minor sleep problems, headaches or stomach-aches without organic basis.
- 2 Mild but definite problem with non-organic somatic symptoms.
- 3 Moderately severe, symptoms produce a moderate degree of restriction in some activities.
- 4 Very severe or symptoms persist into most activities. The child is seriously or adversely affected.

## **9. Problems with emotional and related symptoms**

**Rate** only the most severe clinical problem not considered previously.

**Include** depression, anxiety, worries, fears, phobias, obsessions or compulsions, arising from any clinical condition including eating disorders.

**Do not include** aggressive, destructive or overactive behaviours attributed to fears, phobias, rated at scale 1.

**Do not include** physical complications of psychological disorders, such as severe weight loss, rated at scale 6.

- 0 No evidence of depression, anxieties, fears or phobias during the period rated.
- 1 Mildly anxious; gloomy; or transient mood changes.
- 2 A mild but definite emotional symptom is clinically present but is not preoccupying.
- 3 Moderately severe emotional symptoms, which are preoccupying, intrude into some activities and are uncontrollable at least sometimes.
- 4 Severe emotional symptoms which intrude into all activities and are nearly always uncontrollable.

## **10. Problems with peer relationships**

**Include** problems with school mates and social network. Problems associated with active or passive withdrawal from social relationships or problems with over intrusiveness or problems with the ability to form satisfying peer relationships.

**Include** social rejection as a result of aggressive behaviour or bullying.

**Do not include** aggressive behaviour, bullying rated at scale 1; problems with family or siblings rated at scale 12.

- 0 No significant problems during the period rated.
- 1 Either transient or slight problems, occasional social withdrawal.
- 2 Mild but definite problems in making or sustaining peer relationships. Problems causing distress due to social withdrawal, over-intrusiveness, rejection or being bullied.
- 3 Moderate problems due to active or passive withdrawal from social relationships, over intrusiveness and/or to relationships that provide little or no comfort or support: e.g. as a result of being severely bullied.
- 4 Severe social isolation with no friends due to inability to communicate socially and/or withdrawal from social relationships

## **11. Problems with self-care and independence**

**Rate** the overall level of functioning: e.g. problems with basic activities of self-care such as feeding, washing, dressing, toileting, also complex skills such as managing money, travelling independently, shopping etc., taking into account the norm for the child's chronological age.

**Include** poor levels of functioning arising from lack of motivation, mood or any other disorder.

**Do not include** lack of opportunities for exercising intact abilities and skills, as might occur in an over-restrictive family, rated at scale 12; enuresis and encopresis rated at scale 8.

- 0 No problems during the period rated; good ability to function in all areas.
- 1 Minor problems only; e.g. untidy, disorganised.
- 2 Self-care adequate, but definite inability to perform one or more complex skills (see above).
- 3 Major problems in one or more areas of self-care (eating, washing, dressing) or inability to perform several complex skills.
- 4 Severe disability in all or nearly all areas of self-care and/or complex skills.

## **12. Problems with family life and relationships**

**Include** parent-child and sibling relationship problems. Include relationships with foster parents, social workers/teachers in residential placements. Relationships in the home and with separated parents/siblings should both be included. Parental personality problems, mental illness, marital difficulties should only be rated here if they have an effect on the child.

**Include** problems with emotional abuse such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect/rejection, over restriction, sexual and/or physical abuse.

**Include** sibling jealousy, physical or coercive sexual abusive by sibling.

**Include** problems with enmeshment and overprotection

**Include** problems associated with family bereavement leading to re-organisation.

**Do not include** aggressive behaviour by child, rated at scale 1.

- 0 No problems during the period rated.
- 1 Slight or transient problems.
- 2 Mild but definite problem e.g. some episodes of neglect or hostility or enmeshment or overprotection.
- 3 Moderate problems e.g. neglect, abuse, hostility. Problems associated with family/carer breakdown or reorganisation.
- 4 Serious problems with child feeling or being victimised, abused or seriously neglected by family or carer.

## **13. Poor school attendance**

**Include** truancy, school refusal, school withdrawal or suspension for any cause.

**Include** attendance at type of school at the time of rating e.g. hospital school, home tuition etc.

**If school holiday, rate the last two weeks of the previous term.**

- 0 No problems of this kind during the period rated.
- 1 Slight problems, e.g. late for two or more lessons.
- 2 Definite but mild problems, e.g. missed several lessons because of truancy or refusal to go to school.
- 3 Marked problems, absent several days during the period rated.
- 4 Severe problems, absent most or all day

## **Section B**

Scales 14 and 15 are concerned with problems **for the child, parent or carer** relating to lack of information or access to services. These are not direct measures of the child's mental health but changes here may result in long term benefits for the child.

## **14. Problems with knowledge or understanding about the nature of the child's/adolescent's difficulties (in the previous two weeks)**

**Include** lack of useful information or understanding available to the child/adolescent, parents or carers.

**Include** lack of explanation about the diagnosis or the cause of the problem or the prognosis.

- 0 No problems during the period rated. Parents/carers have been adequately informed about the child's problems
- 1 Slight problems only
- 2 Mild but definite problem
- 3 Moderately severe problems. Parents/carers have very little or incorrect knowledge about the problem which is causing difficulties such as confusion or self-blame
- 4 Very severe problem. Parents have no understanding about the nature of their child's problems.

## **15. Problems with lack of information about services or management of the child's/adolescents difficulties**

**Include** lack of useful information available to the child/adolescent, parents or carers or referrers.

**Include** lack of information about the most appropriate way of providing services to the child such as care arrangements or educational placements or respite care or statementing

- 0 No problems during the period rated. The need for all necessary services has been recognised
- 1 Slight problems only
- 2 Mild but definite problem
- 3 Moderately severe problems. Parents/carers have been given little information about appropriate services or professionals are not sure where a child should be managed
- 4 Very severe problem. Parents have no information about appropriate services or professionals do not know where a child should be manage

### ***Key Components:***

Clinician completes this assessment

Elicited through clinical assessment and direct questioning

**Pros:** Already familiar and compulsory collection by CIMHA business rules, high validity and determined to be suitable in a youth population.

**Cons:** Need to ensure it is not used in isolation for the purpose of vocational and educational outcomes.

### **OPERATIONAL KPIS**

In order to meet the AET MOS key elements and recommendations the evaluation framework needs to have clear operational KPIs and compulsory quarterly reporting outcomes developed. Consultation and further input from various quality and data management services with the MHAODB and other benchmarking services will continue.

The final evaluation framework will be developed in consultation with, and with support from, MHAODB Data teams, CIMHA business rules, chart audit processes, and CIMHA generated quarterly and annual reports against developed KPIs.

## **3.2 Substance Use**

### **DRUG/ALCOHOL USE**

*Recent substance use* will be assessed using questions that are currently utilised within the other sub-acute child and youth mental health services. The type of drug or substance and frequency is determined through clinical interview and by directly asking the adolescent questions pertaining to recent drug and alcohol use.

#### **Drug/alcohol use**

Drug and alcohol use:

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

Primary drug of concern

- Alcohol
- Cannabis
- Tobacco
- Amphetamine type
- Hallucinogens
- Opiates
- Benzodiazepine
- Inhalants
- Synthetics
- Caffeine

- Other: \_\_\_\_\_

### **Key Components:**

Clinician completes this assessment based on interview with adolescent and family/ carer

Clinical interview

Pros: Already used by other sub-acute services (AMYOS)

Cons: Not yet researched to determine reliability and effectiveness of the questions. Doesn't include days without substance use and binges.

### **HONOSCA**

Please see section 2.1

Question 4 pertains specifically to Substance use.

## **Risk Assessments**

### **RISK SCREEN**

In addition to the standard risk screens that are completed as part of a standard CIMHA suite of entry/ transfer of care assessments, five additional questions have been added. These questions are also used within other sub-acute CYMHS services and provide a frequency that can be measured over time.

Suicidal ideation

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

Suicide attempts

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

Recurrent self-harm

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

Unsafe/risky sex/at risk of exploitation

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

Violence/aggression

- Most days
- Weekly
- Monthly
- Less than monthly
- Nil

### **Key Components:**

---

Clinician completes this assessment

---

Based on thorough clinical assessment

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**Pros:** Quick, able to measure change over the period of the AETC stay, used by AMYOS with great success

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**Cons:** Brief – only provides a snapshot. Detailed information would need to be elicited via a chart audit.

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## HONOSCA

Please see section 2.1.

Question 3 pertains specifically to Non-accidental self-injury.

## Education and work

### PERSONALISED LEARNING PLAN (PLP)

The personalised learning plan will be used by the education staff within the AETC to look at the adolescents focus for educational and vocational goals. It will include relevant health related information that would impact on educational and vocational outcomes (e.g., ability to concentrate and participate in sessions; executive functioning skills). A record of collaborative participation will be recorded in an operational report. It is anticipated that the PLP will be recorded as a dichotomised score (Y/N).

1. That the PLP is completed
2. That the PLP was developed with the adolescent, education, health and family input.

### ***Key Components:***

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Adolescent, Education and Health staff all complete this assessment

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Target is to look at the collaborated and integrated approach of educational / vocational plans, and health.

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**Pros:** Collaborative, goal-based, consumer lead

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**Cons:** Difficult to measure. The quality of the plan is not assessed.

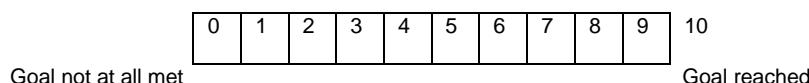
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### GOAL BASED OUTCOMES (GBO)

Goal based outcomes (GBOs) are a way to evaluate progress towards a goal in clinical work with children and young people, and their families and carers. They compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input). GBOs use a simple scale from 0-10 to capture the change. The outcome is simply the amount of movement along the scale from the start to the end of the intervention.

*On a scale from zero to ten, please circle the number below that best describes how close you are to reaching your goal today. Remember: zero is as far away from your goal as you have ever been, and ten is having reached your goal completely.*

Goal 1: \_\_\_\_\_



Goal 2: \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

Goal not at all met

Goal reached

**Goal 3:** \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

Goal not at all met

Goal reached

### **Key Components:**

Adolescent and clinician both complete this assessment

Self-report 10-point Likert scale

**Pros:** Focused around Adolescent being able to reflect on what is important to them. Able to set a clear target and focus for clinical intervention. Used already within other sub-acute services (AMYOS)

**Cons:** Need to ensure consistency in how the Goal is developed and, if plausible, have the same clinician rate it with the young person at the end.

### **CLINICIAN INITIAL DATA COLLECTION SHEET**

The following are a series of questions that have been developed to provide an initial (pre) assessment of an adolescent's level of education, and educational engagement, and work history.

#### **Education:**

- Disengaged
- Flexi
- Special Ed
- Mainstream
- TAFE or vocational training

What current level at school? (e.g. Year 9) \_\_\_\_\_

In the last 3 months, how often did the adolescent refuse to go to school?

- Never
- Hardly ever
- Sometimes
- Most of the time
- All of the time

As a result of school refusals, how many days has the adolescent been absent from school in the last 3 months? \_\_\_\_\_

When school refusal was at its worst, how much did this affect the adolescent's grades or their ability to do their schoolwork?

- Not at all
- A little
- Somewhat
- A lot
- Extremely
- Don't know
- Refuse to answer

#### **Employment:**

Has the consumer been involved in any of the following in the past?

- Paid full-time work
- Paid part-time work
- Volunteer work

Other \_\_\_\_\_

Is the consumer involved in any of the following currently?

- Paid full-time work
- Paid part-time work
- Volunteer work
- Other \_\_\_\_\_

If yes to current employment, was it stopped prior to admission?

Yes      No

### **Key Components:**

---

Clinician completes this assessment as part of a comprehensive assessment period at intake.

---

Elicited through clinical assessment

---

**Pros:** Good baseline of educational / vocational functioning, would support intervention and planning

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**Cons:** A snapshot only, detail would need to be obtained from education records about accurate school participation etc.

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### **HONOSCA**

Please see section 2.1.

Questions 5, 10, 12, and 13 pertain specifically to education and work.

## **Social connectedness and relationships**

### **RECOVERY ASSESSMENT SCALE**

The Recovery Assessment Scale (RAS) is a self-report instrument of mental health recovery designed facilitate collaborative, recovery-oriented practice and measure recovery-focused outcomes. It was developed to measure five factors deemed important to recovery: (i) personal confidence and hope, (ii) willingness to ask for help, (iii) goal and success orientation, (iv) reliance on others, and (v) not being dominated by symptoms. Over 70% of consumers reported taking 15 minutes or less to complete the RAS-DS and rated the instrument as easy or very easy to use (Hancock, Scanlan, Honey, Bundy, & O'shea, 2015). Qualitative data from both consumers and staff indicated that, for most, the RAS-DS was an easy to use, meaningful resource that facilitated shared understandings and collaborative goal setting.

Exploratory factor analysis of the RAS produced five factors that were replicated using confirmatory techniques. Each factor has satisfactory internal reliability (Cronbach  $\alpha$  range = 0.73–0.91). The factors displayed convergent validity with positive and significant correlations with other recovery measures (McNaught, Caputi, Oades, & Deane, 2007). Concurrent validity was demonstrated with significant but lower correlations with symptoms and clinician-rated measures of psychiatric functioning. The factors of the RAS are consistent with the consumer literature on recovery. Correlations with other variables suggest that the RAS is measuring something different from traditional symptom or functional mental health measures.

DOING THINGS I VALUE				
	Untrue	A bit TRUE	Mostly TRUE	Completely TRUE
It is important to have fun	1	2	3	4
It is important to have healthy habits	1	2	3	4
I do things that are meaningful to me	1	2	3	4

I continue to have new interests	1	2	3	4
I do things that are valuable and helpful to others	1	2	3	4
<b>LOOKING FORWARD</b>				
	<b>Untrue</b>	<b>A bit TRUE</b>	<b>Mostly TRUE</b>	<b>Completely TRUE</b>
I can handle it if I get unwell	1	2	3	4
I can help myself become better	1	2	3	4
I have the desire to succeed	1	2	3	4
I have goals in life that I want to reach	1	2	3	4
I believe that I can reach my current personal goals	1	2	3	4
I can handle what happens in my life	1	2	3	4
I like myself	1	2	3	4
I have a purpose in life	1	2	3	4
If people really knew me they would like me	1	2	3	4
If I keep trying, I will continue to get better	1	2	3	4
I have an idea of who I want to become	1	2	3	4
Something good will eventually happen	1	2	3	4
I am the person most responsible for my own improvement	1	2	3	4
I am hopeful about my own future	1	2	3	4
I know when to ask for help	1	2	3	4
I ask for help when I need it	1	2	3	4
I know what helps me get better	1	2	3	4
I can learn from my mistakes	1	2	3	4
<b>MASTERING MY ILLNESS</b>				
	<b>Untrue</b>	<b>A bit TRUE</b>	<b>Mostly TRUE</b>	<b>Completely TRUE</b>
I can identify the early warning signs of becoming unwell	1	2	3	4
I have my own plan for how to stay or become well	1	2	3	4
There are things that I can do that help me deal with unwanted symptoms	1	2	3	4
I know that there are mental health services that help me	1	2	3	4
Although my symptoms may get worse, I know I can handle it	1	2	3	4
My symptoms interfere less and less with my life	1	2	3	4
My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4
<b>CONNECTING AND BELONGING</b>				
	<b>Untrue</b>	<b>A bit TRUE</b>	<b>Mostly TRUE</b>	<b>Completely TRUE</b>
I have people that I can count on	1	2	3	4
Even when I don't believe in myself, other people do	1	2	3	4
It is important to have a variety of friends	1	2	3	4
I have friends without mental illness	1	2	3	4
I have friends that can depend on me	1	2	3	4
I feel OK about my family situation	1	2	3	4

### **Key Components:**

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Young person completes this assessment

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Self-report rated on a 4-point scale

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**Pros:** Easy and quick to use with good validity. Already used by other sub-acute adolescent services (AMYOS). Adds to the depth of measures looking at functional measure.

---

**Cons:** Further research is needed to clarify the extent to which the RAS is able to capture the range of recovery experiences that have been described by patients.

---

### **STRENGTHS AND DIFFICULTIES QUESTIONNAIRE**

Please refer to Section 2.1

### **GOAL BASED OUTCOMES**

Please refer to Section 2.4

### **HONOSCA**

Please see Section 2.1

Questions 1, 10, and 12, pertain specifically to social connectedness and relationships.

## **Gender Identity**

### **CLINICIAN INITIAL DATA COLLECTION SHEET**

The following are a series of Questions that have been developed to provide an assessment of an adolescent's gender identity.

Gender

- Female
- Male
- Other

Gender incongruence?      Yes      No

Sexual identity/Sexual Orientation:

- Same sex attracted/Bisexual
- Heterosexual
- Unknown

## **Physical Health, GP relationships**

### **PHYSICAL HEALTH**

As per the current procedure for Metabolic and Physiological Monitoring for Mental Health Consumers, the reasons for increased vulnerability of people with severe mental illness (SMI) to coronary vascular disease (CVD) are complex and incompletely understood (Metro North Hospital and Health Service, 2016a). As with the general population, interlinked personal (biomedical, health behaviours) factors are entangled with social influences. People with SMI are two to three times more likely to smoke tobacco, to be physically inactive and obese, and have suboptimal nutrition (Metro North Hospital and Health Service, 2016a). Treatment of mental illness is also implicated; antipsychotic medications cause metabolic changes leading to weight gain and dyslipidaemia, increasing risk of diabetes and CVD (Metro North Hospital and Health Service, 2016b).

While much of screening is mandated for consumers on antipsychotic medication, a comprehensive adolescent inpatient service should consider mandatory physical measures, especially if clinically indicated or taking antipsychotic medications.

Screening parameters for **all** adolescent inpatients:

Physical measurements:

- Weight
- Height
- BMI
- Waist circumference
- Blood Pressure (BP)

Blood tests (if taking antipsychotic medications):

- Full blood count (FBC)
- Urea, electrolytes and liver function tests (LFTs) including fasting BGL.
- Lipid profile (total cholesterol/HDL/LDL/TG). Lipid testing does not need to be fasting as total cholesterol and HDL are measured accurately in non-fasting samples, and these are the lipid parameters used to calculate cardiovascular risk.

### **Physical Health**

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_

BMI: \_\_\_\_\_ Waist circumference: \_\_\_\_\_

Minimum HDL (mmol/L): \_\_\_\_\_

Type 2 diabetes: Yes No

Has a GP been identified? Yes No

### **Key Components;**

---

Clinician completes this assessment

---

Clinician weighs and measures consumer at intake and medical staff collect relevant metabolic information

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**Pros:** Early intervention targets for any adolescent experiencing metabolic concerns

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**Cons:** Invasive

---

### **HONOSCA**

Please see Section 2.1

Questions 6 and 8 pertain specifically to physical health.

### **OPERATIONAL KPI'S**

In order to meet the AET MOS key elements and recommendations that every adolescent has

1. A CIMHA Quarterly report that audit against the following KPI's.
  - 100% of adolescents staying at the AET will have an identified GP
  - X% of GP have been contacted and provided with a letter from the medical staff

### **Functioning**

A key aspect of the AET MOS is the "...delivery of safe, high quality, integrated, and evidence driven mental health care alongside the provision of integrated, individualised, educational or vocational programs that enable adolescents to re-engage with education and to undertake meaningful education or employment in the future". In order to capture the functional changes across numerous areas such as education, work, relationships, leisure, and activity participation

of an adolescent over a period of no more than 6 months, more sensitive evaluation measures need to be utilised. The following measures are considered to have aspects that would allow for a measure of functional change over a short period of time. It is important to note that as part of comprehensive multidisciplinary treatment – observational functional assessment such as task analysis and PRPP are likely to be utilised in addition to these tools suggested.

#### **RECOVERY ASSESSMENT SCALE**

See Section 2.5

Functional aspects include the questions relating to:

- Helping oneself getting better / being able to handle if oneself gets unwell

#### **STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)**

Please refer to Section 2.1

#### **GOAL BASED OUTCOMES (GBO)**

Please refer to Section 2.4

#### **HONOSCA**

Please see Section 2.1

Questions 1, 2, 5, 6, 7, 10, 11, and 12 pertain specifically to functioning.

## **Family/Carers and Friends and family functioning**

#### **RELATIVE STRESS SCALE (RSS)**

The Relative Stress Scale (RSS) is a 15-item self-report tool that is used to identify carer and patient characteristics associated with various aspects of burden of care. A factor analysis of the RSS has resulted in three subgroups: 'emotional distress', 'social distress' and 'negative feelings' (Ulstein, 2007). This offers an opportunity to differentiate between different patterns of distress, possibly facilitating the creation of tailored intervention to reduce the strain of caring. The RSS is a useful instrument to stratify carers according to their risk of psychiatric morbidity.

	Never	Rarely	Sometimes	Often	Nearly Always
Did you ever feel that you can no longer cope with the situation?					
Do you ever feel that you need a break?					
Do you ever get depressed by the situation?					
Has your own health suffered at all?					
Do you worry about accidents happening to you?					
Do you ever feel that there will be no end to the problem?					
Do you find it difficult to get away on holiday?					
How much has your social life been affected?					
How much has the household routine been upset?					
Is your sleep interrupted by _____?					
Has your standard of living been reduced?					
Do you ever feel embarrassed by _____?					

Are you at all prevented from having visitors?					
Do you ever get cross and angry with_____?					
Do you ever feel frustrated at times with_____?					

### **Key Components;**

Family member, carer or friend completes this assessment

Self-report

**Pros:** A way to guide and support family and carers needs. Used across areas of health with high burden of care (e.g., dementia carers)

**Cons:** A similar assessment to the Score-15. Could be seen as doubling up.

### **SCORE-15**

SCORE (Systemic Clinical Outcome and Routine Evaluations)-15 is a self-report outcome measure designed to be sensitive to the kinds of changes in family relationships that systemic family and couples therapists see as indications of useful therapeutic change. It contains both positively and negatively worded items, and has been found to be a valid and psychometrically sounds tool to measure the overall quality of family life (Stratton, 2014).

For each line, would you say <u>this describes our family:</u>	Very well	Well	Partly	Not well	Not at all
In my family we talk to each other about things which matter to us					
People often don't tell each other the truth in my family					
Each of us gets listened to in our family					
It feels risky to disagree in our family					
We find it hard to deal with everyday problems					
We trust each other					
It feels miserable in our family					
When people in my family get angry they ignore each other on purpose					
We seem to go from one crisis to another in my family					
Things always seem to go wrong for my family					
People in my family are nasty to each other					
People in my family interfere too much in each other's lives					
In my family we blame each other when things go wrong					
We are good at finding new ways to deal with things that are difficult					

### **Key Components;**

Family member, carer or friend completes this assessment

---

### Self-report

---

**Pros:** Quick for families to complete, sensitive to change, good utility across all presenting problems, free to use

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**Cons:**

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### PARENT/CARER CONTEXTUAL OUTCOMES

The parent/carer contextual outcomes item is a 10-question carer tool that has been developed by AMYOS to specifically meet their needs. The key aim to look at a set of consistent and comparable tools across sub-acute services, these 10 question are proposed for used on the AETC.

Please rate the following statements based on the responses provided:	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
I feel <b>supported</b> by my child's AETC clinician					
I feel AETC improved my child's <b>emotional stability</b>					
I feel AETC improved my understanding of my child's mental health problems					
I feel AETC helped me <b>accept</b> my child's mental health problems					
I feel AETC <b>improved</b> my child's mental health problems					
I feel AETC assisted to <b>decrease the frequency</b> of my child's mental health problems					
I fell AETC met my <b>child's expectations</b>					
I feel AETC met my expectations					
I feel AETC assisted to <b>decrease the severity</b> of my child's mental health problems					
I feel more <b>hopeful</b> about my child future because of AETC					

### Key Components:

---

Family member, carer or friend completes this assessment

---

Self-report, 5-point Likert scale

---

**Pros:** Developed and used successfully in AMYOS services across QLD

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**Cons:** Not yet a validated tool

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### CLINICIAN INITIAL DATA COLLECTION SHEET

The following are a series of Questions that have been developed to provide an initial (pre) assessment of family relationships and functioning:

Culture:

- Aboriginal and/or Torres Strait Islander
- CALD. If yes, Ethnicity \_\_\_\_\_

Refugee Background or Asylum Seeker: Yes No

Child Safety Involvement:

- Past

- Current
- Nil

Family Structure (young person's current living situation):

- Step or blended family
- Single parent
- Intact family
- In out-of-home care (foster or 'self-placed' with other than biological parents)

History of custody:      Yes      No

## Service delivery, partnerships, transfer of care

### PREVIOUS SERVICE HISTORY

The following are a series of questions that have been developed to provide an initial (pre) assessment of an adolescent's service history within child and youth mental health services:

Total number of months open service episode with CYMHS prior to referral: \_\_\_\_\_

No. of emergency departments psychiatric presentations: \_\_\_\_\_

No. of mental health acute inpatient admissions: \_\_\_\_\_

Attended AMYOS program?      Yes      No

Attended YRRU?      Yes      No

Attended Day Program?      Yes      No

### YOUR EXPERIENCES SURVEY (YES)

The active involvement of consumers and carers in the development, planning, delivery and evaluation of services is a hallmark of a quality mental health system. Your Experience of Service (YES) is an annual survey designed to gather information about the experiences of care received by people accessing public mental health services in Queensland.

YES was developed in consultation with mental health consumers and carers and is based on the recovery standards in the 2010 National Standards for Mental Health Services. It includes a Family of Youth (FoY) survey which is directed towards parents, families or carers of children and adolescents accessing mental health services. Participation for these groups is voluntary and anonymous.

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	Never	Rarely	Sometimes	Usually	Always	Not applicable
You felt welcome at this service						
Staff showed respect for how you were feeling						
You felt safe using this service						
Your privacy was respected						
Staff showed hopefulness for your future						
Your individuality and values were respected (such as your culture, faith or gender identity, etc.)						
Staff made an effort to see you when you wanted						
You had access to your treating doctor or psychiatrist when you needed						
You believe that you would receive fair treatment if you made a complaint						
Your opinions about the involvement of family or friends in your care were respected						

The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)						
You were listened to in all aspects of your care and treatment						
Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)						
Staff discussed the effects of your medication and other treatments						
You had opportunities to discuss your progress with the staff caring for you						
There were activities you could do that suited you						
You had opportunities for your family and carers to be involved in your treatment and care if you wanted						
<b>Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:</b>	Never	Rarely	Sometimes	Usually	Always	Not applicable
Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)						
Explanation of your rights and responsibilities						
Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)						
Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)						
Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.)						
The effect the service had on your hopefulness for the future						
The effect the service had on your ability to manage your day to day life						
The effect the service had on your overall well-being						
Overall, how would you rate your experience of care with this service in the last 3 months?						

## Individualised, Integrated, client-centred, recovery-based care

### OPERATIONAL KPIS

In order to meet the AET MOS key elements KPIs need to be developed that identify and set target that demonstrate the focus of individualised, integrated, client centre, recovery-based care. Many of these KPIs would need to be established with an appointed clinical director and as part of the implementation of the service.

It is anticipated that reporting of the number of care plans completed, the contacts with a multidisciplinary mix will be collected.

A procedural Pathway and CIMHA business processes will be developed for the AETC to follow through

- Entry
- Assessment
- Intervention and review
- Exit

It will provide a standard baseline for all AETC admissions. Completion of all mandatory Clinical data collection tools as per CIMHA Business rules will be audited.

#### A CIMHA QUARTERLY REPORT THAT AUDIT AGAINST THE FOLLOWING KPI'S

It is anticipated that the type of KPI's would include:

- An explicit nominated ratio of expenditure to budget
- Occupancy rates for inpatient admission and as an outpatient (program only)
- Reporting on mandatory inpatient data such as consumer seclusion and restraint, consumer sedation, assaults on staff

## Referral and Cohort

A key focus of the AET MOS is to provide a service for adolescents who meet the criteria of having: a primary diagnosis related to severe and complex mental health issues; a need for a sub-acute extended rehabilitation; been non-responsive to other care options.

In order to evaluate the consumer characteristics and geographic distribution attending the AETC, specific questions regarding request for referrals, the panel's decisions, and transfer from the AETC has been developed.

Data will be collected on referrals, referral patterns, and transition planning discharge.

This is proposed to include:

Referral source	
HHS referring (if applicable)	
Date referred to the panel	
Key issues for referral	
Date panel met	
Panels outcome (accepted/ not accepted)	
If not accepted, why not?	
Date started at AETC	
Date data entry at start of admission completed	
Length of stay (in days)	
Date closed to AETC	
Referral post AETC?	
Was a written handover provided on every transfer / discharge occasion?	
Was a protocol for transfer of care followed?	
If disengaged from AETC was the process planned and with a clear transition period?	
End of AETC service data collection completed?	

## Team Variables

### Informed and supported workforce

The effectiveness of the AET MOS is dependent upon adequate and appropriately trained clinical and non-clinical staff. In order to ensure a specialised care is provided a trained, informed and skilled workforce is required. KPIs and reporting against clinical supervision, interdisciplinary supervision, ongoing training and support to staff and review of occupational burnout.

#### OPERATIONAL KPIS TO MEASURE THE LEVELS OF TRAINING AND SAFETY INTRODUCED AND MAINTAINED BY THE AETC INCLUDE:

- Budget/actual funds used (or hours per staff) per team for initial training
- Budget/actual funds used per team (or hours per staff) for ongoing training and education about AETC
- Participation in continuing education, workshops, and communities of practice
- Number of multidisciplinary clinical team meetings per month
- Number of joint sessions for both health and education staff per month

**Although education, training and safety are recognised as important areas for evaluation, they will not be formally monitored given that there are few accurate and reliable indicators to assess this area. Once teams are more established, appropriate measurement tools or qualitative interviews could be conducted with staff and/or clients to assess this area. The Children's Health Queensland, child and youth services will maintain responsibility for monitoring these areas.**

#### TRANSFER OF CARE

Many key stakeholders involved in this project indicated an interest in evaluating where consumers go following an AETC stay, as well as ensuring the safe and smooth transfer of care between the AETC and ongoing service partners. The AETC MOS clearly outlines the importance of safe and XX transfer of care.

#### Operational KPIs Indicators to measure transfer of care from AETC:

- Proportion of clients discharged from the team's care each year
- Reason(s) for discharge from the team's care
- Are clients successfully transferred to secondary case management services?
- Are clients successfully transitioned from hospital to community-based care?

## APPENDIX D

### List of Instruments discussed, but not included into the AETC Evaluation Framework

#### THE K10

*Psychological distress.* The 10-item Kessler scale assesses depressive and anxious symptoms in the past month, on a scale from 1, ‘*none of the time*’, to 5, ‘*All of the time*’ (R. C. Kessler, Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Norman, S.L., Walters, E.E., Zaslavsky, A.M., 2002), giving a potential total score of 10-50. The K10 has high reliability and validity for detection of depressive and anxiety disorders in general population surveys (R. C. Kessler, Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Norman, S.L., Walters, E.E., Zaslavsky, A.M., 2002; R. C. Kessler, Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M., 2003).

In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
About how often did you feel tired out for no good reason?					
About how often did you feel nervous?					
About how often do you feel so nervous that nothing could calm you down?					
About how often did you feel hopeless?					
About how often did you feel restless or fidgety?					
About how often did you feel so restless you could not sit still?					
About how often did you feel depressed?					
About how often did you feel that everything was an effort?					
About how often did you feel so sad that nothing could cheer you up?					
About how often did you feel worthless?					

#### Key Components:

---

Young person completes this assessment

---

Self-report rated on a 5-point scale

---

**Pros:** It is easy to use, high reliability measure of distress and is sensitive to change over the time period of the AETC, has been used to collect data on 12-19 year age group

---

**Cons:** Could be seen as similar to the SDQ; may have a ceiling effect as most young people entering the service would be presumed to be severe

## SOCIAL AND OCCUPATIONAL FUNCTIONAL ASSESSMENT SCALE (SOFAS)

The severity of mental ill-health is not simply measured by the presence or absence of symptoms, it is also important to consider the level of functional impairment that the illness is causing. Functional impairment can be measured in several different domains, however the domains focused on in the SOFAS are as follows: academic performance, peer relationships, activities of daily living (self-care).

Clinicians should use “worst level of function during the past month” as the rating period. The SOFAS has three columns. On the right is a numerical rating from 0-100. The left column contains the five broad categories against which clinicians should rate the consumer. The center column breaks each of these five broad categories into an ‘upper’ and ‘lower’ range that clinicians can use to add greater accuracy to their Clinician rated numerical assessment scales (0-100) of social, occupation, and relationship functioning in patients with physical, neurological, and mental health conditions.

**Social and Occupational Functioning Assessment Scale (SOFAS)**

Copes very well with roles and responsibilities. Happy, well adjusted and effective individual	Superior functioning in a wide range of activities	100 I 91
	Good functioning in all areas, occupationally and socially effective	90 I 81
Generally copes well but with some evidence of difficulties coping with roles and responsibilities, and minor interpersonal difficulties	No more than slight impairment in social, occupational, or school functioning. (eg: infrequent interpersonal conflict, temporary falling behind in schoolwork)	80 I 71
	Some difficulty in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships	70 I 61
Moderate difficulties in coping with problems, holding a job, and frequent interpersonal difficulties or no friends. Needs welfare support or family assistance. Often in need of case management to remain in the community	Moderate difficulty in social, occupational, or school functioning (eg: few friends, conflicts with peers or co-workers)	60 I 51
	Serious impairment in social, occupational, or school functioning (eg: no friends, unable to keep a job)	50 I 41
Severely dysfunctional with major difficulties attending to own welfare needs. On welfare support, requires family supervision and / or case management. Poor interpersonal relationships	Major impairment in several areas, such as work, or school, family relations (eg: depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school)	40 I 31
	Inability to function in almost all areas (eg: stays in bed all day, no job, home or friends)	30 I 21
Unable to function independently. Inability to attend to Activities of Daily Living (ADLs) much or all of the time	Occasionally fails to maintain minimal personal hygiene. Unable to function independently	20 I 11
	Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (eg: nursing care and supervision)	10 I 1
	Inadequate information because (please specify)	0

*Patient functioning*

**Patient SOFAS** \_\_\_\_\_

### Key Components:

Clinician completes this assessment

Clinician identifies level based on a full and comprehensive assessment

**Pros:** Quick and easy to use, high validity, used in many research orientated evaluations.

---

**Cons:** unlikely to be used in other sub-acute CYMHS services, not validated for use in adolescent population, has reported publications from 15-18 years but limited below age 15.

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#### **ADOLESCENT ASSESSMENT OF QUALITY OF LIFE (AQOL) – 6D**

The Assessment of Quality of Life (AQoL) instruments are health-related multi-attribute utility quality of life instruments. Initially they were designed for use in economic evaluation studies (cost utility analysis [CUA]). However, their use is broader and need not be limited to economic related work. The AQoL-6D is a 20 question self-report scale. An adolescent version was created in 2009 which was adapted from the AQoL-6D so that the semantic and cultural equivalents were relevant to adolescents. This version has six separately scored dimensions including: (i) independent living, (ii) relationships, (iii) mental health, (iv) coping, (v) pain, and (vi) senses.

How much help do you need when you do jobs around where you live (e.g. cleaning, helping with meals, working in the garden)?

- I can do all these tasks very quickly and easily without any help
- I can do these tasks relatively easily without help
- I can do these tasks only very slowly without help
- I cannot do most of these tasks unless I have help
- I can do none of these tasks by myself
- I never do jobs where I live although I am able to do so. (*same score as second response*).

How easy or difficult is it for you to get around by yourself outside your home (e.g. at school, going out with friends)?

- Getting around is enjoyable and easy
- I have no difficulty getting around outside my house
- A little difficulty
- Moderate difficulty
- A lot of difficulty
- I cannot get around unless somebody is there to help me

How well can you walk or run?

- I find walking or running very easy
- I have no real difficulty with walking or running
- I find walking or running slightly difficult. (*I cannot run to catch a bus or train, I find walking uphill difficult.*)
- Walking is difficult for me. (*I walk short distances only. I have difficulty walking up stairs.*)
- I have great difficulty walking. (*I cannot walk without a walking stick or frame, or someone to help me.*)
- I am bedridden

How easy is washing yourself, going to the toilet, dressing, eating or looking after your appearance?

- These tasks are very easy for me
- I have no real difficulty in carrying out these tasks
- I find some of these tasks difficult, but I manage to do them on my own
- Many of these tasks are difficult, and I need help to do them
- I cannot do these tasks by myself at all

How happy do your close friendships make you?

- Very happy
- Generally happy
- Neither happy nor unhappy
- Generally unhappy
- Very unhappy

Does your health affect your relationship with your family?

- My relationship with my family is unaffected by my health
- Some parts of my relationship with my family are affected by my health
- Many parts of my relationship with my family are affected by my health
- Every part of my relationship with my family is affected by my health

Does your health affect your involvement in groups, clubs, sporting or school activities?

- My involvement in such group is not affected by my health
- There are some group activities I am not involved in because of my health
- There are many parts group activities I am not involved in because of my health
- I am not involved in any group activities because of my health

How often did you feel in despair (lost and hopeless) over the last seven days?

- Never
- Occasionally
- Sometimes
- Often
- All the time

How often did you feel worried in the last seven days?

- Never
- Occasionally
- Sometimes
- Often
- All the time

How often do you feel sad?

- Never
- Rarely
- Some of the time
- Usually
- Nearly all the time

How often do you feel calm or agitated (stressed)?

- Always calm
- Usually calm
- Sometimes calm, sometime agitated
- Usually agitated
- Always agitated

How much energy do you have to do the things you want to do?

- Always full of energy
- Usually full of energy
- Occasionally full of energy
- Usually tired and lacking energy
- Always tired and lacking energy

How often do you feel you manage your life well?

- Always
- Mostly
- Sometimes
- Only occasionally
- Never

How much do you feel you can cope with life's problems (such as conflict with family or friends, doing exams etc.)?

- Completely
- Mostly
- Partly
- Very little
- Not at all

How often do you experience serious physical pain?

- Very rarely
- Less than once a week
- Three to four times a week
- Most

How much physical pain or discomfort do you experience?

- None at all
- I have moderate pain
- I suffer from severe pain
- I suffer unbearable pain

How often does physical pain interfere with your usual activities?

- Never
- Rarely
- Sometimes
- Often
- Always

How good is your vision (with your glasses or contact lenses if you wear them)?

- I have excellent sight
- I see normally
- I have some difficulty focusing on things, or I do not see them sharply. (*E.g. small print or seeing objects in the distance.*)

- I have a lot of difficulty seeing things. (*My vision is blurred. I can see just enough to get by with.*)
- I only see general shapes. I need a guide to move around.
- I am completely blind

How good is your hearing (with your hearing aid if you wear one)?

- I have excellent hearing
- I hear normally
- I have some difficulty hearing or I do not hear clearly. (*I have trouble hearing softly-spoken people or when there is background noise.*)
- I have difficulty hearing things clearly. (*Often I do not understand what is said. I usually do not take part in conversations because I cannot hear what is said.*)
- I hear very little indeed. (*I cannot fully understand loud voices speaking directly to me.*)
- I am completely deaf.

How well do you communicate with others (e.g. by talking, listening, writing or using sign language)?

- I have **no** difficulty speaking to them or understanding what they are saying
- I have **some** difficulty being understood by people who do not know me. I have no trouble understanding what others are saying to me.
- I have **great** trouble understanding what others are saying to me. I am understood only by people who know me well.
- I cannot communicate with others.

### **Key Components:**

---

Young person completes this assessment

---

Self-report

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**Pros:** No fee for the assessment. Well utilised in research and evaluation. Quick to complete and wording to reflect adolescent population. Good overview of functioning

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**Cons:** Reasonably long, self-report.

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## GLOBAL ASSESSMENT OF RELATIONAL FUNCTIONING (GARF)

Research has shown that family function is highly related to the illness of mental health patients. This relationship goes in both directions i.e. the level severity of the individual with mental ill-health will often have an adverse impact on the family, and similarly, a highly dysfunctional family will often exacerbate the symptoms already present in the client with mental ill-health

**Global Assessment of Relation Functioning (GARF) scale**

Warm caring family that is highly supportive of its individual members	Superior functioning in a wide range of activities	<b>100</b> I <b>91</b>
	Good functioning in all areas	<b>90</b> I <b>81</b>
Family generally functioning well, with occasional episodes of disharmony, tension, disregard, failure to communicate or disruption of routines. However, family still offers a supportive environment to its members	No more than slight impairment	<b>80</b> I <b>71</b>
	Some difficulty in functioning, but generally functioning well.	<b>70</b> I <b>61</b>
Moderately dysfunctional. Family rarely functions highly and individual members often feel unsupported. There are frequent occasions of conflict, tension, disregard, failure to communicate or disruption to routines. The atmosphere is often critical or unhappy	Moderate difficulty in functioning	<b>60</b> I <b>51</b>
	Moderately severe impairment in functioning	<b>50</b> I <b>41</b>
Severely dysfunctional. Family systems are maintains but usually don't work and do not meet the needs of its members. There are major difficulties with painful conflict, frustrating failures in problem solving, tyrannical or ineffective decision making, frequent remoteness open hostility. Members do not feel supported. There is infrequent periods of enjoyment together, and usually evidence of serious marital disorder	Severe impairment in several areas	<b>40</b> I <b>31</b>
	Severe impairment in most areas	<b>30</b> I <b>21</b>
Family is persistently unable to function because systems have broken down. Routines are negligible, little effective communication, personal responsibilities are not recognised, whereabouts of family members often unknown. The family causes harm and is regularly unsafe for individual members. Pervasive cynicism or despair and almost no sense of attachment, commitment or concern about the needs or welfare of one another.	Persistent inability to function, and a harmful environment	<b>20</b> I <b>11</b>
	Family too dysfunctional to stay together, poses potential dangers to individuals	<b>10</b> I <b>1</b>
	Inadequate Information because (please specify) .....	<b>0</b>

**Relational Functioning**  
Family GARF \_\_\_\_\_

### Key Components:

Clinician completes this assessment

Clinician identifies level based on a full and comprehensive assessment

**Pros:** Quick and easy to use, high validity, used in many research orientated evaluations.

**Cons:** Unlikely to be used in other sub-acute CYMHS services.

## APPENDIX E

### Discussion document for managing the consumer/ carer data collected as part of the AETC evaluation.

Currently, a number of issues are being explored to support the complexities around the interaction between the current state-wide data collection systems (CIMHA, YES, MHEC, QHAPDC), balanced with the need to collect additional consumer and carer data. The AETC advisory group has met and endorsed recommendations 3.

#### **RECOMMENDATION 3: EXPLORE OPTIONS FOR SOFTWARE SPECIFIC TO AETC DATA COLLECTION AND OTHER SUB-ACUTE SERVICES.**

- R.3.1 Explore the feasibility, cost, and ongoing ethics restrictions associated with the use of an electronic data collection platform (e.g., RedCap).
- R.3.2 Explore feasibility of a 2-year pilot study to test an electronic data collection platform. This is to be presented and discussed at the AETC Advisory Group.
- R.3.3 Explore legal, hardware-related, and other issues associated with data management systems within Queensland Health.

The following three options have been identified as the most suitable to pursue as solutions to the collection and storage of addition consumer/ carer data.

Option 1:	Option 2:	Option 3:
Redcap electronic platform housed by CHQ	Redcap electronic platform housed by MHAODB	PDF fillable forms uploaded to CIMHA

**These options will be presented with both “Pro’s/ Con’s” and “Other Factors” to consider.**

<b>Option 1</b>		
Redcap electronic platform housed by CHQ		
Pros	Cons	Other Factors
<ul style="list-style-type: none"> <li>• Already established with a license (at least for the next 2 years (following this an \$8000k for a further 3 years for the cost of the operating system)).</li> <li>• The functionality on an iPad is feasible as long as it's connected to the QH network.</li> </ul>	<ul style="list-style-type: none"> <li>• CHQ staff using CHQ REDCap to store CHQ patient data is straight forward – CHQ owns the data, and is used for CHQ purposes. But, sharing the data with <b>non-CHQ staff</b> is governed by (generally) data access rules. This will become challenging with changes to management at CHQ, external or independent reviews, and careful ethical considerations.</li> <li>• Collaborators who are non-CHQ staff getting access to CHQ REDCap is a bit more complicated (as in, it is currently only accessed using a QH computer). These process and data governance issues are being worked on at CHQ.</li> <li>• There is also the hardware cost (the physical computer, and hard drives that REDCap is stored on).</li> </ul>	<ul style="list-style-type: none"> <li>• The use of a CHQ URN or CIMHA Consumer ID may be the easiest linkage key to use in RedCap which would allow later linkage to other datasets. There would be a margin of error with this as you'd be relying on staff to enter the identifier in RedCap. Although with the relatively small cohort of the AETC and the collection of some other demographics it might be easy enough to validate/cleanse/correct the IDs where errors are made.</li> <li>• To access CIMHA any person involved in collection, storage, and management of data must be paid by QH.</li> <li>• Consideration of who will be managing / linking the data needs to be considered (RA).</li> <li>• Currently the operational staff structure for CHQ indicated no RA position in the AETC.</li> </ul>

## Option 2

Redcap electronic platform housed by MHAODB

Pros	Cons	Other Factors
<ul style="list-style-type: none"> <li>• MHAODB custodians of the Redcap data.</li> <li>• The functionality on an iPad is feasible as long as it's connected to the QH network.</li> <li>• Can have external review from non-CHQ staff of data</li> </ul>	<ul style="list-style-type: none"> <li>• Who will run this?</li> <li>• The cost of the operating system (e.g., RedHat LINUX is \$8000K for a licence for 3 years in a HHS. – Who would pay for this?)</li> <li>• There is also the hardware cost (the physical computer, and hard drives that REDCap lives on)</li> </ul>	<ul style="list-style-type: none"> <li>• The use of a CHQ URN or CIMHA Consumer ID may be the easiest linkage key to use in RedCap which would allow later linkage to other datasets. There would be a margin of error with this as you'd be relying on staff to enter the identifier in RedCap. Although with the relatively small cohort of the AETC and the collection of some other demographics it might be easy enough to validate/cleanse/correct the IDs where errors are made.</li> <li>• To access CIMHA any person involved in collection, storage. Management of data must be paid by QH.</li> <li>• Consideration of who will be managing / linking the data needs to be considered (RA).</li> <li>• Currently the operational staff structure for CHQ indicated no RA position in the AETC</li> </ul>

### Option 3

PDF fillable forms uploaded to CIMHA

Pros	Cons	Other Factors
<ul style="list-style-type: none"><li>• Closest to how data is currently collected</li><li>• Easy and cheap</li></ul>	<ul style="list-style-type: none"><li>• More chance of data not being completed (as per current consumer data collections rates). Less engaging for young people.</li><li>• Still have to pay an RA to extract the data and link/evaluate it.</li></ul>	<ul style="list-style-type: none"><li>• Will be a long PDF fillable form.</li><li>• More chance of missing data</li></ul>

## **APPENDIX F**

### **Discussion document for options relating to the development of an on-line clinician training package for ‘understanding evaluation’\***

\*this is not necessarily the title; it is simply for a description in this document.

#### **RECOMMENDATION 4.2:**

**DEVELOP AN ONLINE TRAINING PROGRAM TO ORIENTATE CLINICAL STAFF TO THE EVALUATION TOOLS AND STANDARDISE PROCESSES OF THE AETC. THIS WILL ENSURE; (I) FIDELITY OF THE DATA COLLECTION; (II) EXPLAIN THE RATIONAL AND BENEFITS OF COLLECTION; AND (III) DEVELOP A CULTURE OF BEST PRACTICE EVALUATION.**

Throughout the development of the AETC evaluation framework consultations with various stakeholders resulted in a clear message regarding the importance of developing a ‘culture’ that recognised, supported, and actively sought to engage in quality improvement processes, specifically evaluation of the AETC. An on-line interactive clinical training program was considered a good solution.

QCMHR were happy to take the lead for the content component of the proposed training program, but were looking to engage a ‘professional’ service to create the on-line training package/presentation. It is anticipated that the training program on ‘understanding evaluation’ would look to provide information on (a) why complete evaluations, (b) how to collect data in an effective way that is reliable and valid, (c) what happens to the data, (d) how data provides a quality loop for services, and (e) how evaluations longitudinally help with planning services, running services, supporting consumers and determining how health dollars are spent.

In order to achieve this recommendation, the following three concepts have been identified as options for implementation of the training program.

Option 1:	Option 2:	Option 3:
Engage in a MOU of joint ownership project between QCMHR and MSHHS	Pay to have the training program graphically built but solely housed within CHQ or QCMHL	Do not continue with the online training program and rather offer face to face training to staff when the AETC is operational.

***These options will be presented with both “Pro’s/ Con’s” and “Other Factors” to consider.***

<b>Option 1:</b> Engage in a MOU of joint ownership project between QCMHR and MSHHS		
Pros	Cons	Other Factors
<ul style="list-style-type: none"> <li>QCMHR project manager for the AETC has previously developed training packages with MSHHS learning and development team and is familiar with both (a) their professionalism, and (b) the high quality of on-line program output</li> <li>While the AETC and other AET service elements will benefit most from the proposed training package, all MH clinicians could utilise and benefit from an introduction to 'understanding evaluation'.</li> <li>It would be of no cost and hosted via MSHHS who are already familiar and operate these types of training packages.</li> <li>They have an ability to host on-line training packages state-wide and therefore be accessible to any HHS.</li> <li>An on-line training program can be utilised as frequently as required and accessed by new AETC Staff. It could be utilised by all of the AET services.</li> <li>Training could be re-done by clinical staff as a 'refresher' annually.</li> </ul>	<ul style="list-style-type: none"> <li>Governance and who would ultimately review and modify the program would need to be arranged.</li> <li>It becomes more complex having another HHS involved, although they would 'house' the training package and also have AET staff within their service.</li> </ul>	<ul style="list-style-type: none"> <li>While QCMHR could write the content to support the AETC evaluation framework project, ultimately another team / service would need to be responsible for any changes to content and updates on the content.</li> </ul>

### Option 2:

Pay to have the training program graphically built but solely housed within CHQ or QCMHL

Pros	Cons	Other Factors
<ul style="list-style-type: none"><li>• QCMHR could provide the content and support the development of the package which could then be housed by any HHS.</li><li>• An on-line training program can be utilised as frequently as required and accessed by new AETC staff. It could be utilised by all of the AET services.</li><li>• Training could be re-done by clinical staff as a 'refresher' annually.</li></ul>	<ul style="list-style-type: none"><li>• The cost of the time for professional service to develop the on-line aspect of the program. It is estimated that this could be upwards of \$8000.</li><li>• Longer term 'hosting' of the on-line program would need to be considered and likely have an in-built cost.</li></ul>	<ul style="list-style-type: none"><li>• While QCMHR could write the content to support the AETC evaluation framework project, ultimately another team / service would need to be responsible for any changes to content and updates on the content.</li></ul>

### Option 3:

Do not continue with the online training program and rather offer face to face training to staff when the AETC is operational.

Pros	Cons	Other Factors
<ul style="list-style-type: none"><li>Engagement for evaluation processes in the AETC could be supported via face to face training.</li><li>Face to face training is often highly desired by staff.</li><li>It resolves the issues relating to storage and revision of an on-line training program.</li></ul>	<ul style="list-style-type: none"><li>Someone would need to facilitate this training.</li><li>It is harder to open this to staff outside the AETC who may be interested in evaluation.</li><li>It is unlikely that this could be revisited annually.</li></ul>	