Day Program Model of Service

Queensland Public Mental Health Services

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Queensland Government

Day Program Model of Service – Queensland Public Mental Health Services, February 2020

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An electronic version of this document is available at
https://www.health.qld.gov.au/improvement/youthmentalhealth

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Purpose of this document

The Day Program Model of Service (MOS) describes a service element within the Queensland public mental health, alcohol and other drugs service system. The MOS is delivered in partnership with an educational/vocational service from the Department of Education (DoE) as a Day Program. A Day Program service is a part of an overall treatment strategy integrated with either inpatient or community based mental health treatment services to enhance continuity in service provision and provide a flexible range of intensive therapy, treatment and rehabilitation options to maximise recovery within a therapeutic milieu. The intended outcomes of the development and successful implementation of the MOS are:

- an enhanced continuum of mental health service options for adolescents in Queensland
- an adolescent and carer centred, recovery based system of care
- 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 or remain engaged with education and to undertake meaningful education or employment in the future
- stronger service partnerships with a network of providers
- enhanced service development, evaluation and review
- improved access to and navigation through mental health services
- a more informed and supported mental health workforce
- enhanced supervision of the clinical and non-clinical workforce
- consistency and streamlining of service delivery across public mental health services in Queensland
- increased knowledge and understanding of other service components
- clear and transparent governance structures.

The MOS seeks to be inclusive, supporting Aboriginal and Torres Strait Islander People, those of Culturally and Linguistically Diverse (CALD) backgrounds and people of diverse sexual orientation, gender identity or intersex variations requiring additional consideration access high quality, culturally appropriate mental health treatment and care.

The MOS has been informed by reference documents, broad consultation and expert opinion from staff, adolescents who have accessed or are accessing the service, carers and delivery partners (DoE). It does not replace clinical judgement or Hospital and Health Service (HHS) specific patient safety procedures and should be read in conjunction with a range of other policy, legislation and operational documents which are listed separately for reference.

1. What does the service intend to achieve?

Day Programs extend the continuum of mental health service options available to young people with severe and complex mental health issues and their families/carers across Queensland with the least possible disruption to their family, education, social and community connections.

Day Programs provide specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents aged between 13 and 18 years of age[1] with severe, complex and persistent mental health problems, often associated with complex developmental comorbidities and significant functional impairment across multiple domains.

These services are part of the state-wide child and youth mental health service continuum of care designed to provide treatment to adolescents in the least restrictive environment possible. This recognises the need for safety, with the minimum possible disruption to their family, education, social and community networks.

Day Programs operate on the premise that adolescents can and do recover from mental illnesses. A range of interagency, recovery-focused rehabilitation, psychosocial, physical health and educational/vocational programs tailored to the adolescent's self-identified and assessed clinical and rehabilitation needs are facilitated in collaboration with a range of service providers. This enables adolescents to build on their strengths, enhance their self-esteem, build on opportunities for social inclusion and promote recovery-focused outcomes upon discharge.

Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services outlines Queensland's mental health, alcohol and other drug system continuum of care[2]. The MOS describes only one element from the continuum of service elements available to assist adolescents (working collaboratively with their families and carers) to recover their health, wellbeing and developmental potential (see Figure 1).

The MOS seeks to ensure:

- adolescents and their network including families, carers, significant others are supported to actively participate in collaborative care planning and care related, decision making processes while taking account of their developing abilities
- collaborative partnerships are developed with cultural representatives to ensure services provided are accessible, high quality and culturally appropriate to Aboriginal and Torres Strait Islander People and those from CALD backgrounds
- collaborative partnerships are developed with other health providers
- identification of clear and transparent integrated governance processes that support consistent and equitable access to the service by young people within the catchment of the service
- embedded regular and mandated internal and external evaluation processes which review clinical and service level factors and may contribute to the knowledge base of public mental health services for young people with severe and complex mental health issues
- Reviews of the MOS by Queensland Health's Mental Health, Alcohol and Other Drugs Branch, and when indicated, modifications informed by evaluation, data collection, policy and research.

All existing Day Programs are gazetted as authorised mental health services in accordance with the *Mental Health Act 2016*.[3]

[1] The Queensland Children's Hospital (Children's Health Queensland Hospital and Health Service) also provide a 'primary school aged' Day Program.
[2] https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf
[3] See Authorised Mental Health Services Schedule at https://www.health.qld.gov.au/__data/assets/pdf_file/0021/444360/amhs_schedule.pdf

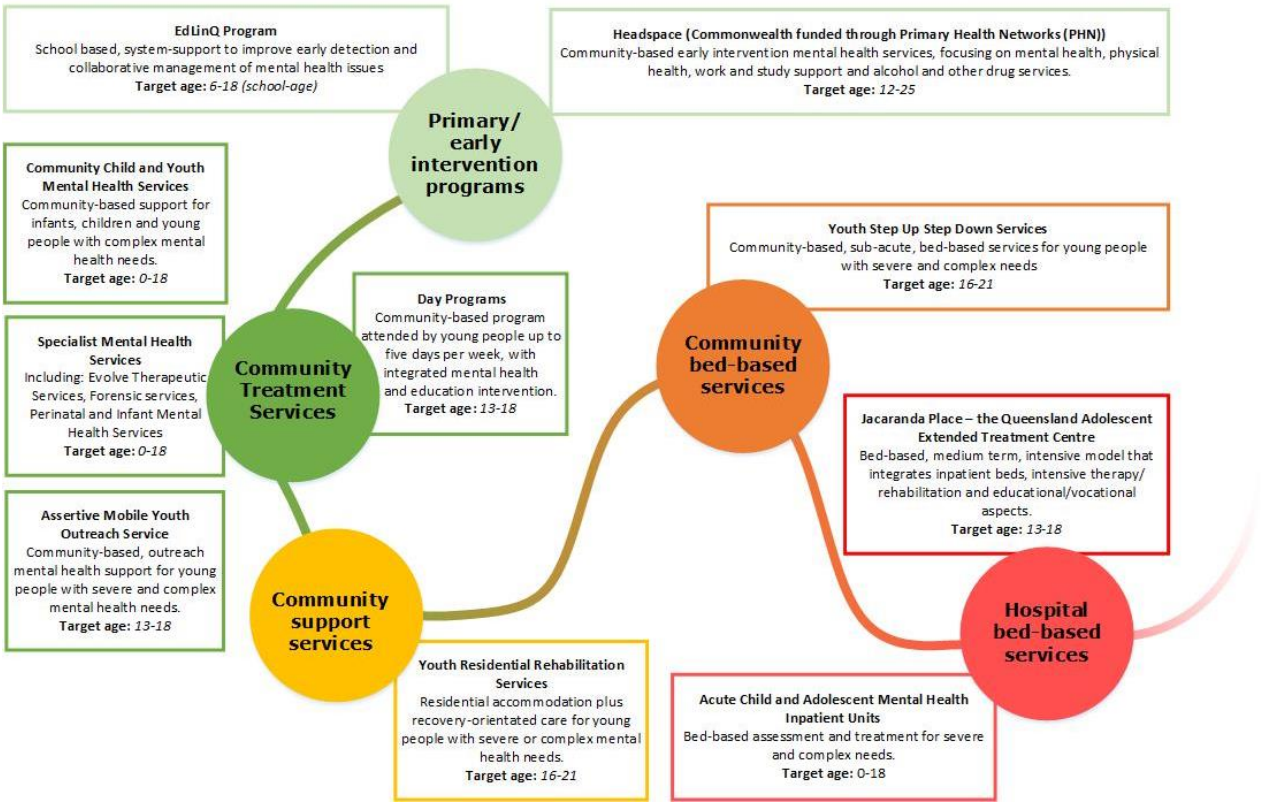

Figure 1: Broad overview of child and youth mental health, alcohol and other drugs service system in Queensland

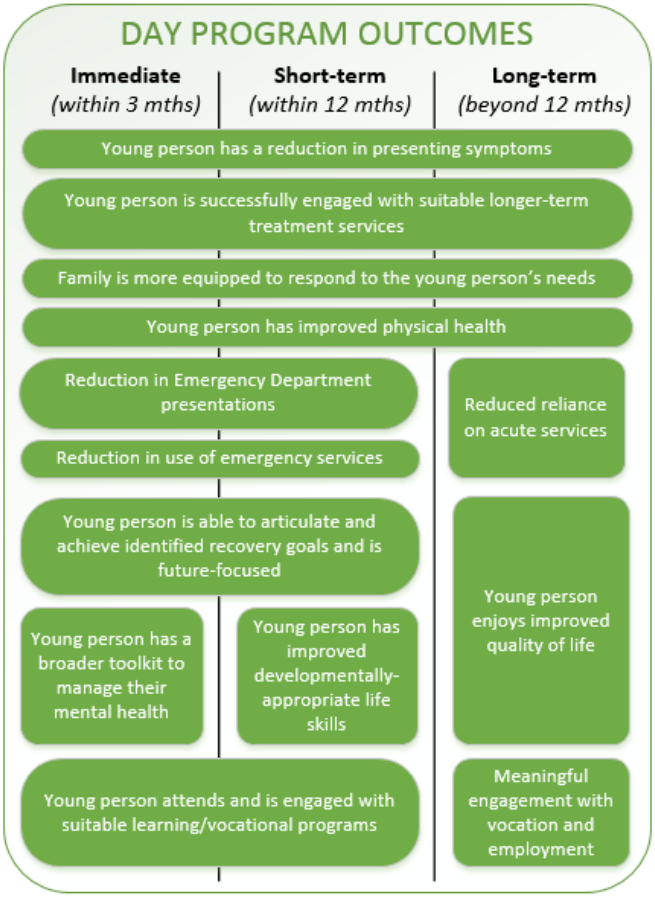

Figure 2: Day Program service outcomes across a number of domains.

2. Who is the service for?

Day Programs are for adolescents, aged 13 to 18 years[4], who:

- Have accessed a range of less restrictive interventions, such as intensive community based child and youth mental health service involvement and support, but still have persisting symptoms and functional impairments that are impacting their schooling; **or**
- Require extended and intensive clinical intervention due to functional impairments that impact schooling but do not need or would not benefit from an acute inpatient admission; **and**
- Are considered reasonably likely by the referrer and the service to substantially benefit from service engagement.

The diagnostic profile of the Day Program includes severe and complex mental health issues such as extreme anxiety, chronic depression, eating disorders, early psychosis, and complex trauma that are linked to school refusal or social exclusion. Acuity is such that the adolescent does not require an inpatient stay and the home environment is supportive enough to ensure safety and facilitate attendance daily. If acuity increases, an inpatient admission may be considered as clinically appropriate.

The decision around acceptance of referrals is not solely restricted to disorders/diagnoses. A local intake panel reviewing referrals considers a range of additional factors including:

- case complexity and functional impairment
- case formulation and risk formulation
- responses to previous interventions
- geographic constraints
- motivation for change
- consumer and carer preferences
- current mix of adolescents and therapeutic milieu.

The benefits of acceptance to a Day Program must be weighed against the associated potential risks to self and to others. Risks elements to be considered are:

- Risks associated with diagnoses (both mental health and developmental) and acuity, although it is acknowledged that some adolescents who present with complex acuity may respond positively to the MOS
- Risks associated with challenging behaviour, aggression, problematic sexual behaviour or intimidation of other adolescents, noting that the service milieu is impacted by disproportionate mixes of internalised and externalised presentations
- Risks associated with the physical environment, including access to potential self-harming implements or proximity to traffic, as Day Programs are not secure or acute environments, and
- Risks associated with the suitability of the service, noting some adolescents may become reliant on the model, while others lack commitment that compromises the potential benefit.

Maintaining a safe and therapeutic environment for adolescents is a key consideration and priority in the MOS.

Onsite educational and vocational training programs will be facilitated for adolescents of compulsory school age or those participating in post-compulsory education or training.

In some situations where a Day Program is co-located or in proximity to an inpatient unit, the service may also support adolescents admitted to an inpatient unit. An adolescent attending a Day Program may also be supported by other child and youth mental health treatment services.

[4] Day Program South (based at the Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service) provides an age appropriate program to children based in the community (as well as adolescents). In the context of this MOS, 'adolescent' should be taken to include children accessing Day Program South.

3. What does the service do?

Day Programs provide an integrated recovery-focused mental health treatment and educational support program to improve functioning in an adolescent's life. This occurs through social, educational and vocational engagement and individual and group therapies. Practically, services support adolescents to remain living in the community with intensive, wrap-around support service to support their recovery and reintegration to longer-term school/vocational educational options and treatment services.

Day Programs sits within the wider child and youth mental health service continuum of treatment services. They provide more intensive and multi-pronged support than community child and youth mental health services, but less intensive support than an acute or sub-acute bed-based service.

Adolescents who access a Day Program acknowledge that it provides more support than a community child and youth mental health service clinic, with therapy-based interventions (individual and group) supported by more frequent psychiatric contact and regular case management to progress towards recovery. The benefit of a flexible and staged reintegration to school, and the opportunity to 'practice' classroom engagement in a smaller, safe, lower-pressure environment is recognised as a positive component of the MOS.

4. Standard Components

The key components outlined in this MOS refer to operational practices specific to Day Programs. This MOS does not detail the mandatory and fundamental operational business requirements, processes or procedures of a standard mental health service. These fundamental requirements should be embedded within all mental health services and aligned with national and statewide guidelines and protocols including but not limited to:

- Mental Health Act 2016
- Mental Health Act 2016 Patient Rights and Support resources
- National Safety and Quality Health Service Standards
- National Standards for Mental Health Services 2010
- Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services
- Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-21
- Clinical Services Capability Framework
- Mental Health, Alcohol and Other Drugs Performance Framework
- Hospital and Health Service Performance Management Framework
- National Framework for Recovery Oriented Mental Health Services
- Mandatory reporting requirements under the Mental Health Act 2016
- National Outcomes and Casemix Collection

Clinical forms are dynamic documents requiring regular reviews to ensure consistency with current evidence based practice and maintain efficacy of use. Forms are for documenting clinical information but are not a substitute for skills, training, supervision or judgement. Clinical judgement regarding an adolescent's needs should always guide the completion of forms.

All documentation and clinical forms referred to in this document are accessible through the Queensland Health intranet, via the Mental Health, Alcohol and Other Drugs Branch resource page.

The educational and vocational training program of instruction delivered by registered teachers is governed by and aligned to:

- The *Education (General Provisions) Act 2006*
- Every Student Succeeding – State Schools Strategy 2019-2023
- The Australian Curriculum
- Standards for Registered Training Organisations (RTOs) 2015
- Learning and Wellbeing Framework
- Department of Education and Training Strategic Plan 2018-2022
- P-12 curriculum, assessment and reporting framework
- Inclusive education policy statement.

5. The service functions best when:

- All aspects of service delivery involve the adolescent and their families/carers and focus on their recovery goals
- Adolescents and their families/carers lead all aspects of learning and care planning and collaborative goal setting – this engagement is paramount
- There is an explicit attitude that adolescents and their families/carers will progress in their recovery by maintaining hope and learning to live with mental health problems where such problems persist in the long term
- There is a culture of openness and responsiveness to service user feedback,
- The physical environment supports healing
- Service delivery is well integrated, with established procedures that support continuity of care across settings and between services
- Education and vocational training programs are individually planned, monitored, adjusted where necessary and integrated as part of the holistic care plan
- Queensland Health, the DoE and other partner service providers collaborate on individual interventions and relevant service-wide initiatives
- There is an adequate skill and discipline mix within the Day Program team, with senior level clinical expertise and knowledge regarding necessary interventions demonstrated and passed on to new and less experienced staff
- Teams are well integrated with, and have a good knowledge of, other local mental health and primary health service components and primary care supports
- Day Programs occupy a stakeholder position in the community, and respond to local issues relevant to mental health service delivery
- Clear and strong clinical, operational and education leadership roles are provided, and work collaboratively.

5.1. Working with other service providers

KEY ELEMENTS	COMMENTS
5.1.1 Strong partnerships are developed with other local health and mental health service providers (including primary services), other government agencies, community support services and allied health services.	• Day Programs will work in close collaboration with other service providers to meet the needs of the adolescent, their family and carers and significant others. • This may include general practitioners and other primary health providers, including culturally appropriate service providers such as Aboriginal or Torres Strait Islander community-controlled health services. • Formal agreements with other agencies and providers will be developed where a benefit is identified. • Clear and regular contact and communication processes are maintained between Day Programs and partner agencies
5.1.2 Strong partnerships are developed with the DoE, who provide teaching staff and education programs for Day Programs.	• Integration between mental health services and education service provision is a defining characteristic of the MOS. • The partnership between Queensland Health and the DoE occurs at both a systemic and local level • The partnership between Queensland Health and the DoE will occur within lawful information sharing, including consideration of consent requirements.
5.1.3 Strong partnerships are developed in accordance with service-wide needs and the individual adolescent's needs.	• There is a role for each Day Program to establish strategic and ongoing partnerships with local services, agencies and providers at a sector-level. • Day Programs may support the capacity of partner agencies/providers through advice, education and support regarding mental health issues. • There is also a role for Day Programs to build partnerships arising from the specific needs of adolescents which may not require ongoing relationships. • Cultural competence and capability is developed through strong partnerships with local community services.
5.1.4 The service is inclusive of people of diverse culture, sexual orientation, gender identity or intersex variations, ensuring their perspectives inform assessment and are incorporated with a holistic treatment framework. When adolescents have specific needs, the service will proactively engage appropriate services in consultation with the adolescent.	• Staff will proactively identify and include people able to support adolescents with their individual needs, and inform their assessment and treatment processes. The adolescent will nominate these support persons. • Interpreter services • Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2017-2020 • Queensland public sector LGBTIQ+ Inclusion Strategy • Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

5.2. Referral, access and triage

KEY ELEMENTS	COMMENTS
5.2.1 Day Programs should only accept referrals from providers of specialist child and youth mental health services. This may include Queensland government child and youth mental health services, specialist non-government providers and private mental health practitioners who are recognised as specialists in child and youth mental health.	• Referrals will be directed to a single point of contact. • Clear information about referral pathways, processes and criteria will be made available to potential referrers. • Referrers are supported to remain actively involved during service engagement.
5.2.2 All referrals are triaged and prioritised according to documented clinical need and risk assessment.	• Day Programs will have clearly defined triage and intake assessment processes • Day Programs will consider the risk of accepting the referral and the risk of not accepting the referral, and will consider the suitability of current treatment for the adolescent. • Triaging and prioritisation should involve the Multi-Disciplinary Team (MDT) and the teaching team.
5.2.3 Referrals that are initially accepted are further assessed, with this assessment focusing on the adolescent and their family/carers.	• Assessment may occur through a Stakeholder Pre-Admission meeting, with attendance including the adolescent, their family/carers, the referrer and teaching staff. • The Stakeholder Pre-Admission meeting enables the adolescent and their family/carers to meet some of the Day Program team and negotiate their expectations of engagement/ attendance. • The Stakeholder Pre-Admission meeting enables further determination of the potential therapeutic benefit from service engagement and the impact of the referral on other adolescents accessing the program.

5.2.4 Suitability for entry to the Day Program will be assessed by the MDT that will consist of (as a minimum):
• Consultant Child and Adolescent Psychiatrist
• Team Leader
• Designated intake officer
• Clinician
• Teacher (or education representative) from the Day Program.
	• MDT intake panel meetings will occur regularly based on service needs.
	• The decision about suitability will ultimately rest with the Consultant Psychiatrist and will consider:
	  ○ The level of risk
	  ○ Clinical criteria
	  ○ Admission priorities
	  ○ Diagnostic mix
	  ○ Ability and willingness to engage in the service.
	• Referrers, adolescents and their families/carers are made aware of their rights and responsibilities and the process for making complaints.

5.2.5 Where a referral is not to be accepted, advice and relevant support to pursue alternate treatment options should be provided.	• Where the decision not to accept is based on suitability, feedback should be provided to the referrer regarding what might be done to increase the family's preparedness to benefit from the service.

KEY ELEMENTS	COMMENTS
5.2.6 If there is a waiting period prior to entry to the Day Program, the Team Leader will maintain regular liaison with the referrer until the adolescent is able to access the service.	• Adolescents on waiting lists are prioritised according to acuity, noting that this could change whilst waiting for a place. • Liaison with the referrer may include interim support planning for the adolescent. • Each Day Program will have an intake procedure that guides smooth transitions when places become available.
5.2.7 General information and orientation will be provided to adolescents and their families/ carers on acceptance to the Day Program.	• Information to be provided includes: ○ treatment and support options ○ the multidisciplinary team role ○ assessments, family meetings and care planning ○ privacy and confidentiality ○ general information including policies on smoking, mobile phone use, property, consent ○ culturally diverse orientation material specific to the unique populace of the local service ○ contact details for clinical staff ○ Australian Charter of Healthcare Rights ○ *Mental Health Act 2016* . • An education information pack will be provided and will include: ○ Information on the liaison to occur between teaching staff and the base school, ○ Attendance expectations and processes ○ Staff information/contact details, ○ Personal Learning Plan model ○ Responsible Behaviour Plan.
5.2.8 When a referral is accepted, teaching staff will commence planning for the adolescent's individualised learning plan.	• Where applicable, and with consent, teaching staff will notify the base school and discuss the educational program the adolescent will undertake while attending the education program. • Teaching staff will commence the process for registering attendance at the education program, • The Consultant Psychiatrist to approve engagement in the education program.

5.3. Assessment

KEY ELEMENTS	COMMENTS
5.3.1 Assessment is timely, undertaken in line with evidence and fidelity and occurs at all points during service engagement.	• All assessments will incorporate available information and avoid duplication. • Assessments will be targeted, assist in diagnostic clarification and treatment and care planning, and will be undertaken by suitably-qualified clinicians. • Assessment outcomes will be promptly communicated to the adolescent and their family/carers with consent.
5.3.2 Prior to confirming entry to the Day Program, a designated officer will undertake a **preliminary assessment**, obtaining a detailed history of the mental health assessments and interventions to date for the adolescent and their family/carer.	• The preliminary assessment assists in determining whether the adolescent is suitable for the service. It should also consider the young person's readiness to engage with the service and explore their understanding of the benefit to them. • Information from preliminary assessments is integrated into subsequent assessments. • Barriers to participating in the service, e.g. transport, no smoking policy, will be assessed and discussed. • Where the referrer is another treatment service, intake will occur collaboratively in support of the adolescent's needs. • Suite of clinical documents .
5.3.3 An **initial assessment process** occurs upon acceptance to the Day Program. This involves a detailed assessment of the nature of the adolescent's mental illness, behavioural manifestations, effect on functioning and development and the course of the mental illness.	• A comprehensive chart review and referrer consultation precedes the initial assessment. • This initial assessment allows the clinician to gauge how the adolescent and their family/carer talks about symptoms, their understanding of the mental illness and the impact of mental illness on the adolescent's development. • It provides opportunity to gather specific information which may be relevant to rehabilitation and recovery goal planning. • Discussion of goals at this stage allows assessment of the understanding and commitment of the adolescent and their family/carer regarding attendance and engagement with the service.

5.3.4
From referral information, preliminary assessment and the initial assessment process, a **preliminary formulation** is developed. This is presented to the MDT to plan further targeted assessments and develop an initial care plan.
	• A formulation of the presenting problems is developed and contribute to a diagnosis and discussion of recovery goals. The formulation will be holistic and include:
	  ○ symptoms
	  ○ co-morbidities
	  ○ family dynamics and functioning
	  ○ strengths and protective factors
	  ○ relationships
	  ○ attachment and history of trauma
	  ○ developmental trajectory
	  ○ school performance, attendance and engagement
	  ○ educational experiences

KEY ELEMENTS	COMMENTS
	○ alcohol and other drug use ○ cultural background ○ other personal or identify factors ○ intersection of minority groupings e.g. race, refugee status, gender, sexuality, religion.
5.3.5 **Risk assessments** will occur: • on admission as part of the comprehensive clinical assessment • prior to transfer to any other unit/facility • prior to discharge • where clinically indicated due to change in presentation or every three months. Risk assessments are conducted collaboratively between Queensland Health and teaching staff and shared between agencies as required (with consent).	• All risk assessments are recorded in the clinical record and used to formulate a risk management plan. In the initial assessment, the risk assessment will be conducted as one component of a comprehensive mental health assessment. • Risk management protocols will be consistent with Queensland Health policy. • Suite of clinical documents .
5.3.6 **Child protection concerns** are addressed in accordance with mandatory requirements, (noting that independent processes exist for Queensland Health and the DoE.	Liaison occurs with Child Safety services to ensure continuity of care. • *Child Protection Act 1999* • Child Protection guideline at the Queensland Health policy site • Working with parents with mental illness – guidelines for mental health clinicians • Principles and actions for services working with children of parents with a mental illness • Mental health child protection form • Information sharing between mental health workers, consumers, families and significant others • DoE Student Protection procedure and guidelines for teaching staff.
5.3.7 **Alcohol, tobacco and other drug use** will be routinely screened and documented throughout ongoing contact with the Day Program.	• Education, harm minimisation interventions, motivational interviewing and other treatment approaches will be used to support adolescents. • Co-occurring alcohol and drug problems will be included in care planning. • Clinicians will form strong linkages with Alcohol Tobacco and Other Drugs Services to assist in the management of issues associated with intoxication, withdrawal management and overdose.
5.3.8 **Physical health** will be routinely assessed, managed and documented. This may be conducted by a health service provider external to the service, but needs to be integrated into assessments and treatment.	• Physical health referrals or assessments will be documented in the clinical record in Consumer Integrated Mental Health Application (CIMHA). • Clinical alerts (e.g. medication allergies, blood-borne viruses) are documented. • All adolescents have a general practitioner recorded on the clinical record. • Any potential health problems identified will be discussed with the adolescent and family/carers, and where appropriate with the

KEY ELEMENTS	COMMENTS
	general practitioner or other primary health care provider. • Adolescents and their families/carers will be actively supported to access primary health care services and health improvement activities. • Relevant health information will be provided to Education staff (e.g. allergies, conditions).
5.3.9 **Educational engagement and achievements** will be considered as part of all preliminary, initial and ongoing assessments.	• Education staff will source, where possible and necessary, information regarding school history including educational supports. • In consultation with the adolescent, Education staff will draw on educational history to inform an individualised learning program, which is documented in the personal learning plan. • Education staff will share relevant information with clinical staff (in accordance with legislative information sharing provisions).
5.3.10 Assessment of **family structure and dynamics** will continue while the adolescent is engaged with the Day Program, and identification of family/carer needs is part of the assessment and care planning process.	• Formulation and care planning will consider family functioning. • Involvement of families and carers is documented in the consumer chart. • Recovery-oriented practice includes building systemic resilience within the adolescent's family and broader community supports. • Recovery-oriented services facilitate and nurture connections with family members and carers so adolescents gain the maximum benefit from these supports.
5.3.11 A **functional assessment** will be obtained or arranged for the adolescent appropriate to their stage of development.	• These assessments occur throughout service provision e.g. psychometric, occupational therapy, speech pathology, education, group therapy. • A range of clinical assessment tools and measures may be used in addition to the National Outcomes Casemix Collection activities (NOCC)

5.4. Care planning and resilience

KEY ELEMENTS	COMMENTS
5.4.1 Each adolescent will have an individual care plan. Each care plan will be developed collaboratively with the adolescent, their family, carer and significant others. Goals and interventions need to be meaningful to the adolescent, inclusive of strengths/hopes, and where possible, generated by them. An adolescent may also develop a My Recovery Plan to assist in exploring and identifying their recovery goals.	• Adolescents with mental illness may have disrupted developmental trajectories. Care plans also need to address developmental needs. • Every effort will be made to ensure that care planning focuses on the adolescent's own goals, • Care plans identify available supports, crisis management strategies, therapeutic goals, interventions, psycho-education needs and relapse prevention strategies. • Care plans also include strategies for improving family functioning, pro-social and developmentally appropriate interests and hobbies, peer functioning, quality of life (such as time to experience developmentally relevant play and fun), achievement at school/vocational goals, mastery over the tasks of adolescence and support transitions to more suitable long-term supports. • Care plans will be updated according to need, at a minimum three monthly (to review routine outcome measures, treatment progress). • The adolescent's My Recovery Plan will inform development of the Care Plan.
5.4.2 Care planning is driven by adolescents in partnership with their family/carers, other service providers and the clinical and teaching team.	• The relationship between the adolescent and their family/carer are important contributors to the adolescent's recovery and resilience. • Changes to care plans are driven by adolescents in the first instance, supported by their family/carers, other service providers and the clinical and Education team. • Changes to the care plan are discussed at the MDT review, with all relevant stakeholders receiving a copy of this plan (with the adolescent's consent).

5.6. Interventions

KEY ELEMENTS	COMMENTS
5.5.1 Service delivery involves the development of collaborative relationships between Queensland Health, Education staff, families/ carers and adolescents (within the parameters of lawful consent and the adolescent's identified recovery needs).	• Day Program services will focus on strengths, connectedness, commitment, personal choice and empowerment. • Building and maintaining a therapeutic alliance with the adolescent and their family/carers is at the heart of almost all clinical interventions. • Family members and carers are provided with support to ensure they can support adolescents without experiencing deterioration in their own health and wellbeing. • Information sharing between relevant agencies (particularly Queensland Health and Education staff) will occur with the adolescent's (and/or their caregivers') consent. Where there are barriers to this consent, the service's ability to support the adolescent may be compromised. • A shared understanding will be fostered for all aspects of treatment, including risk management with family/carers. This is clearly documented in the clinical file. • Identification of family/carer needs is part of assessment, and is included in care planning. • Carers Matter . • Information Sharing between mental health staff, consumers, family, carers, nominated support persons and others .
5.5.2 Clinical interventions are provided in the least restrictive setting that balances the adolescent's autonomy with their need for supervision and treatment in a safe environment. Interventions are guided by assessment, formulation and diagnostic processes, using a developmentally appropriate, bio-psychosocial approach that meets individual needs and optimises relapse prevention, rehabilitation, resilience and recovery.	• Care planning builds on strengths, resilience and protective factors. • Interventions are based on evidence-based recovery principles and will include relapse prevention elements. • Multidisciplinary input will be provided to optimise the adolescent's recovery. • Clinical care and the development of both prevention and treatment elements recognises the complex and multi-factorial nature of mental illness. • A range of mediums will be used for intervention, responding to individual needs and capacity.
5.5.3 Interventions may be individualised, group based or generic programs.	• Individualised interventions may include psychological interventions, family therapy and interventions, non-verbal therapies (play, art and music therapies), therapeutic activities (yoga, outdoor/adventure, movement), psycho-education, cognitive behavioural therapy and pharmacotherapy. • Education staff will support adolescents to develop personal learning plans. • Group interventions may be activity or skills-based, psycho-educational or process-orientated, targeting areas of psychological

KEY ELEMENTS	COMMENTS
	and developmental need, and may occur on-site or in the community. • A structured group and educational timetable will be available to adolescents and their families/carers. • Generic interventions include providing opportunities for activities of daily living, leisure, cultural connection, social interaction, personal privacy, supporting healthy lifestyle decisions and encouraging adolescents and families/carer to appropriately engage with past adolescents, families/ carers for peer support
5.5.4 The maintenance of a therapeutic milieu is an intervention, and provides the therapeutic environment in which other interventions can be delivered.	• Milieu is maintained with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and environmental management.
5.5.5 Basic human rights, such as privacy, dignity, choice, anti-discrimination and confidentiality are recognised, respected and maintained to the highest degree in all clinical interventions.	• Australian Charter of healthcare rights included in the welcome pack.
5.5.6 Clinical and educational interventions are delivered concurrently and both contribute to the adolescent's recovery.	• Education staff contribute to the Day Program MDT as part of the MOS. • Education staff will ensure adolescents are engaged in a suitable education program tailored to their needs. • Queensland Health and Education staff, family/carers and adolescents work collaboratively to support reintegration to a suitable education/vocational training program following service engagement. • During the non-school term period, ongoing individual therapy will continue.
5.5.7 Adolescents are supported by a range of multi-disciplinary strategies to manage psychiatric emergencies to ensure the safety of the adolescent and others within the immediate environment.	• The use of an increased level of intervention is based on the clinical need to ensure the safety of the adolescent as well as the safety of others. • Adolescents are supported to regulate their emotions and behaviour through environmental measures, such as centre layout, fittings, furniture and staff training • Day Program staff (Queensland Health and Education staff) will utilise a range of interventions and de-escalation strategies, including sensory interventions, behavioural interventions, distractions and safety plans. • Families/carers are informed of changes in the adolescent's behavioural presentation.
5.5.8 Medication will be prescribed, administered, and monitored as indicated by clinical need and will involve shared decision-making processes	• All pharmacological interventions including prescriptions, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards.

KEY ELEMENTS	COMMENTS
between the MDT, the adolescent and their family/carer.	• Antipsychotics and other psychotropic medication will be prescribed in accordance with Queensland Health clinical practice guidelines including metabolic monitoring. • Strategies to improve compliance with a medication regime must be in place. • Monitoring of medication side-effects will be routinely conducted. • The metabolic monitoring form will be used for all adolescents on antipsychotic or mood stabiliser medication. • The adolescent's personal goals for medication will be incorporated with staff's clinical knowledge. • The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards. • Suite of clinical documents • National Health and Medical Research Council (NH&MRC) Guidelines • Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents) • Therapeutic guidelines - psychotropic • Framework for reducing adverse medication events in mental health services. • INTERNAL Queensland Health Medicines page
5.6.9 The adolescent's physical health needs will be met collaboratively with a primary health provider. This might include a general practitioner, but might also include dental, nutrition and dietetic specialists.	• Adolescents will receive information about physical health issues and goals are incorporated into care planning where appropriate. • Queensland Health staff will take a proactive role in supporting adolescents to access primary health care services.

5.7. Clinical review

KEY ELEMENTS	COMMENTS
5.6.1 Cases will be discussed at a MDT review regularly.	• The regularity of this review may be weekly or fortnightly dependent on the service and the adolescent's needs • A consultant psychiatrist or appropriate medical delegate will participate in all MDT reviews (this may be via telehealth). • Education staff will be invited to participate in MDT reviews (in accordance with legislative information sharing provisions). • All MDT reviews will be documented in the adolescent's clinical record in CIMHA.
5.6.2 An in-depth review of a case will occur a minimum once every three months in alignment with the NOCC measures.	• Where the adolescent is supported by, or is being referred to, another mental health service element, the in-depth review will include an appropriate representative from that treating team. • Education staff will be invited to participate in in-depth reviews (in accordance with legislative information sharing provisions).
5.6.3 In addition to the regular MDT review, ad-hoc clinical review meetings will occur as required (e.g. to discuss cases with complex clinical issues, following a critical event or in preparation for discharge).	• Critical incident management protocols utilised consistent with HHS policy.
5.6.4 Each adolescent's progress will be routinely monitored and evaluated including the use of outcome measures.	• A standard suite of evaluation measurement tools will be used across all services. • The NOCC and additional measures will be used based on each adolescent's individual requirements.
5.6.5 The adolescent's care plan will inform discussion at the MDT review. Significant changes in intervention will be incorporated into the care plan.	• Views of the adolescent, their family/carer, and their support network (e.g. teachers, community mental health case managers) are considered when reviewing and making changes to the care plan. • Assessment measures and other clinical tools will contribute to the MDT discussion and inform care planning. • Structured risk and review processes will be utilised. • Outcomes of clinical reviews will be discussed with the adolescent and their family/carer.

Team approach

KEY ELEMENTS	COMMENTS
5.7.1 The involvement of families/carers is integral to service success and the pursuit of recovery goals, therefore their engagement is incorporated into every component of service provision.	• Consent to disclose information and to involve family/carers is sought at the time of intake. Where consent is not provided, the appropriateness of the service as an intervention option for the adolescent should be considered. • INTERNAL Queensland Health Consumer, Carer and Family Participation Framework
5.7.2 Day Programs are always delivered through a multi-disciplinary approach.	• Adolescents and their families/carers are informed of the MDT approach. • Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. • Clinical, discipline and peer supervision will be available to Queensland Health staff. • Education staff are supervised by the DoE with relevant professional development and support. • Education staff are considered integral partners to the MDT for provide an integrated education service as part of the MOS. • Recognition of the need for Aboriginal and Torres Strait Islander Mental Health Workers within the MDT is integral for adolescents, carers and families that identify as Aboriginal and/or Torres Strait Islander descent. • To be inclusive of diverse culture, sexual orientation, gender identity and intersex variations, staff will proactively identify and include people able to support adolescents with their individual needs and inform team assessment and treatment processes.
5.7.3 Clear clinical and operational leadership will be provided for the MDT.	• A Team Leader will provide clinical and operational leadership. • A Consultant Child and Adolescent Psychiatrist will provide clinical governance. • While Education staff contribute as members of the MDT, their operational leadership is provided by the DoE. • There will be a well-defined local process for escalation of issues between Queensland Health and the DoE, as well as other service providers.
5.7.4 Case management forums, meetings and mechanisms will be coordinated to ensure effective use of resources and to support staff.	• Any case management forum, meeting or mechanism will be scheduled in a way that allows for participation of the full MDT. • The frequency of forums or meetings should not compromise the ability to effectively offer MOS elements.

KEY ELEMENTS	COMMENTS
5.7.5 Critical incidents and emergent issues will be addressed collaboratively by all relevant service stakeholders.	• A decision to cancel MOS elements is collaboratively made between Queensland Health and Education staff. • A decision to make significant program changes is escalated through senior and executive leadership channels within Queensland Health and the DoE.
5.7.6 All adolescents and families/carers will be offered information and assistance to access local peer support services	• Peer support services may be provided by internal or external services. • Consumer consultants are accessible via child and youth mental health services.

5.8. Continuity and coordination of care

KEY ELEMENTS	COMMENTS
5.8.1 Clearly documented contact information is provided to adolescents, carers/families, referral sources and other relevant supports.	• Provision of this information will be documented in the clinical record, including the care plan and the discharge summary. • Relevant information documents detailing specific service response information will be readily available.
5.8.2 Every adolescent will have a designated treating Consultant Psychiatrist.	• This will be recorded in CIMHA.
5.8.3 Every adolescent will be assigned a Principal Service Provider (PSP).	• This will be recorded in CIMHA. • In most cases, an Day Program clinician will be the Principal Service Provider. • Exceptions are made only with the agreement of the Team Leader and Consultant Psychiatrist, who will work closely with the Principal Service Provider during the service engagement.
5.8.4 Where the adolescent is supported by multiple treating teams, the Day Program service will actively engage with these other teams in coordination of care.	• Day Program services, whether PSP or Other Service Provider, will maintain clinical/professional contact with other treating teams through various case management mechanisms and communication channels. • It is recommended that all adolescents engaged in the service have an Acute Management Plan (when clinically indicated) recorded on the clinical record in CIMHA, for after-hours crises.

KEY ELEMENTS	COMMENTS
5.8.5 Transition planning, for both clinical and education/vocation needs, will occur at all times during engagement with the Day Program.	• Education staff will support adolescents' longer-term learning pathways by working with base schools or supporting adolescents to identify future schooling/vocational training programs. • Transitions from the service will be supported by service staff to ensure continuity of care and continuity of education. Transitions will commence prior to an adolescent's exit from the Day Program. This might involve receiving clinical or Education teams to MDT meetings or case reviews.
5.8.6 Adolescents and their families/carers will take ownership of pathways from the Day Program to other services, including identifying these pathways.	• Adolescents and families should be given sufficient information and advice to know what their future support needs are. • Day Program service staff will play an active and proactive role in building relationships with receiving services.
5.8.7 Community-based supports are included in care planning and discharge planning wherever possible.	• Service providers who have established (or are establishing) support links with the adolescent and their family/carers should be integrated into service processes where relevant. • All community-based supports will be coordinated prior to discharge. • Information sharing protocols with service providers will be explicitly documented for each case, considering privacy and confidentiality elements.

5.9. Discharge/transition planning

KEY ELEMENTS	COMMENTS
5.9.1 Planning for discharge from the service will commence at the time of referral.	• Discharge planning includes transitions to more suitable clinical services (which may be longer-term) and longer-term education or vocational training services. • The MDT will make it clear, at all stages of service engagement, that participation in, and commitment to, transition planning and implementation is essential to service success. • Recovery goals will reflect the outcomes needed to support safe transitions. • The MDT, at the time of intake, will consider what services might be suitable for the adolescent following service engagement and explore this with the adolescent as part of the assessment.

KEY ELEMENTS	COMMENTS
5.9.2 Transition from the Day Program will occur in alignment with relevant guidelines, involve development of an individual transition plan and confirm engagement with new services prior to discharge. This applies to transitions to clinical services and education/vocational training services.	• The adolescent, in collaboration with the MDT and their families/carers will prepare for as recovery goals are being met and/or in response to changing needs. • The MDT will be aware of their responsibilities in the transition process. • The key goal of transition planning is to ensure service provision is matched as closely as possible to the needs of the adolescent and their family. Adolescents and their family/carers are the key decision makers. • Responses are developed across a dynamic continuum of specialist and primary services. Processes are in place to identify and respond early in the event of mental health relapse, to be included in transition plans. • Adolescents and their families/carers may disengage prematurely from the service. • Assertive follow up will occur for unplanned transitions. • Transition of care for young people receiving child and youth mental health services.
5.9.3 Where possible, transitions to other services will not occur during a crisis.	• Where transfer during crisis is unavoidable, the Day Program will liaise closely with the service to which the adolescent is to be transitioned. This should include a face-to-face handover wherever possible. • Where transportation is required, this will be negotiated as per local protocol. • Day Program services will ensure the clinical record is accurate and up-to-date to support critical information handover.
5.9.4 Relevant written documentation will be provided on every transition/discharge occasion.	• Internal transfer protocols will be locally determined. • Treating clinicians will ensure discharge letters are sent to key health service providers on the same day as discharge. • A follow-up direct contact with ongoing key health service providers will occur to ensure the discharge letter was received. • Discharge summaries will be comprehensive and indicate relevant information including diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral. • Compliance with mental health clinical documentation standards is the minimum requirement for documentation.
5.9.5 Adolescents and their families/carers will be the primary drivers of the development of their transition plan.	• The development of this transition plan occurs concurrently with other assessment and intervention elements. • Evidence of adolescents and family/carer's active contribution to discharge planning will be evidenced in the clinical chart.

KEY ELEMENTS	COMMENTS
5.9.6 Where a discharge occurs pursuant to powers under the Mental Health Act 2016 (e.g. treatment authority), relevant lawful and regulatory actions apply.	• See relevant guidelines regarding application of the *Mental Health Act 2016*

5.10. Collection of data, record keeping, and documentation

KEY ELEMENTS	COMMENTS
5.10.1 Queensland Health staff will enter and review all required information into CIMHA in accordance with approved business rules.	• CIMHA will be used appropriately as per the CIMHA Business Processes. • It is noted that some CIMHA clinical notes are available via The Viewer.
5.10.2 All contacts, clinical processes, recovery and relapse prevention planning are documented in the adolescent's clinical record.	• Suite of clinical documents
5.10.3 Clinical records will be kept in accordance with legislative and local policy requirements.	• Personal details of the adolescent and their family/carer and other relevant stakeholders will be kept up to date. • Retention and disposal of clinical records protocol
5.10.4 Local and state-wide audit processes monitor the quality of record keeping and documentation (including external communications) and support relevant skill development.	• Compliance with the mental health clinical documentation is the minimum requirement for documentation. • CIMHA Business Processes.
5.10.5 Services will utilise routine outcome measures as part of engagement and service development, including those mandated through the Mental Health National Outcomes Casemix Collection (NOCC): • Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) • Strengths and Difficulties Questionnaire (SDQ) • Children's Global Assessment Scale (CGAS) • Factors Influencing Health Status (FIHS).	• Data from clinical tools that monitor change in functioning and mental health, including outcomes data, is presented at MDT case reviews. • Results of outcomes data are routinely discussed with the adolescent and their family/carers. • Outcomes data is used with the adolescent to record details of symptoms and functioning, monitor changes, review progress and plan future goals in the care plan.

KEY ELEMENTS	COMMENTS

5.10.6
Recording appropriate educational information**.**
	• Education staff will collect and record student data through OneSchool, in line with other state schools. OneSchool enables an ongoing record of the student's educational data throughout their engagement in the state schooling system.
	• Where appropriate, the student will participate in assessments set by the base school and/or state and national testing. The student will also participate, when relevant and appropriate, in any local testing measures conducted by the educational and vocational training program.
	• Education staff will also collect and record the following information:
	  ○ documented permission from carers for communications, including receipt and sharing of educational information
	  ○ knowledge and support of care orders and custodial matters.

5.10.7 Other outcome measurement tools may be identified for use by Queensland Health or the DoE.	• Additional tools should be agreed upon and, wherever possible, coordinated state-wide. • The use of any additional outcome measurement tools will be compliant with all legislation and be by consent of all participants.

5.11. Working with families, carers and friends

KEY ELEMENTS	COMMENTS
5.11.1 The involvement of families and carers is integral to successful outcomes and therefore their engagement is incorporated into every component of service provision.	• Consumer/Guardian consent to disclose information and to involve family and/or carers will be sought in every case. • *Guardianship and Administration Act 2000* • Carers matter • The consumer, carer and family participation framework • *Hospital and Health Boards Act 2011* – Part 7 Confidentiality • Right to Information and Information Privacy • Information sharing between mental health workers, consumers, carers, family and significant others.

KEY ELEMENTS	COMMENTS

5.11.2
Information will be provided to the young person, their family and/or carers at all stages of contact with the service.
	• This will include a range of components such as:
	  ○ education and information about the mental health issues
	  ○ the journey within the Day Program service
	  ○ mental health care options
	  ○ pharmacotherapy
	  ○ support services
	  ○ recovery pathways
	  ○ contact information for the mental health service and relevant external service providers
	• Education and information provided will be documented.

5.11.3 Support services will be offered to families and carers regardless of whether consent is given for their involvement in the young person's care.	• The service will ensure family members and carers are provided, or assisted with accessing, emotional or other support to enable them to continue providing care and support without experiencing deterioration in their own health and wellbeing.
5.11.4 The needs of families and/or carers must be routinely addressed, particularly parents with mental illness, siblings and partners of young people in a significant relationship. If a young person of the Day Program service is pregnant or is a parent with primary care responsibilities, his/her infants/children will be routinely considered as part of all assessments. Interventions will be provided/facilitated if needed.	• Identification of families and/or carers and their needs is part of the assessment process and is included in care planning. • *Child Protection Act 1999* • Mental health child protection form • Family Support Plan • Family support plan: Child care plan supplement • Children of parents with a mental illness (COPMI) website
5.11.5 Consultation with parents and/or carers, students and the base school.	• Ongoing consultation and communication will occur with the base school during the student's time registered at the education and vocational training program on site at the Day Program and during transition planning. • Education staff will also consult with parents/carers as required.

6. Related services

Day Program services are a distinct treatment service within the child and youth mental health service treatment continuum, as previously outlined in Figure 1.

Other services within the continuum may make referrals to Day Programs, be referred to by Day Program services, or co-deliver support to adolescents alongside Day Program services. As with Day Programs, the availability of other services within the child and youth mental health service treatment continuum differs geographically.

The partnership between Queensland Health and the DoE is a defining element for the MOS and is a major distinction from other programs within the child and youth mental health service treatment continuum. The fidelity of the MOS requires that educational elements of the program are delivered by registered teachers and other education professionals employed by the DoE. These professionals are supported by the DoE's industrial provisions and receive supervision, training and professional support through this system. Queensland Health recognises the value of teachers supported by their professional community of practice.

Service linkages for services will centre on the needs of adolescents and should be place-based. Service linkages may be made with other child and youth mental health service elements including:

- Commonwealth-funded mental health programs
- Private mental health treatment providers
- Community support services (including those funded by other government providers)
- Primary health care providers and networks
- Local general practitioners, other specialist public, and private health services
- Transcultural and Aboriginal and Torres Strait Islander Services
- Housing providers and
- Other Non-Government Organisations and Government Agencies.

7. Caseload

Caseload sizes need to consider a range of factors, including case complexity, local population and demography, size of the team, the needs and functions of other mental health teams in the HHS, current position vacancies within the team, and skill mix of the team.

The size of the caseload of a team will be determined by the capacity of the consultant psychiatrist and Team Leader to provide safe, high quality clinical governance. Consideration will be given to team systems and processes such as clinical pathways. The caseload within a service may vary seasonally according to the overall risk profile of adolescents currently accessing the service, however significant variations that impact service utilisation should provide cause for re-evaluating risk thresholds and service criteria.

8. Workforce

In addition to the requirements contained in the *Clinical Services Capability Framework: Mental health services*, services will comprise a multidisciplinary mix of clinical and non-clinical staff providing a variety of recovery- and resilience-oriented interventions. Treatment and care will be provided by clinical mental health workers (including doctors, nurses and allied health staff) as well as a range of non-clinical staff (including Aboriginal and Torres Strait Islander Mental Health Workers, diversional and recreational therapists, and allied health assistants). Involvement of, and access to, consumer and carer consultants and peer support workers is encouraged within the integrated mental health service. Additionally, the multidisciplinary team is supported by administrative officers, and other support staff to assist with day-to-day operations.

The effectiveness of Day Program services is dependent on all clinical and non-clinical staff possessing contemporary, evidence-based skills for a broad diagnostic cohort, noting that work is undertaken with adolescents, their families, carers and support network. There is, therefore, a need to provide staff with continuing education and professional development, clinical supervision, mentoring and other staff support mechanisms.

Recruitment and retention strategies for the Day Program workforce may include the provision of clinical placements for undergraduate students, encouraging rotations of staff from other areas of the integrated mental health service, succession planning and supporting education and research opportunities.

The role of registered and suitably experienced teachers and education staff is also acknowledged as an important factor for a successful Day Program. The provision of Education staff for Day Programs is provided by the DoE.

9. Governance

The Mental Health, Alcohol and Other Drugs Branch (MHAODB) supports the state-wide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services in the specialist areas of mental health and alcohol and other drugs services. MHAODB as the systems manager undertakes contemporary evidence-based service planning, development and review of models of service, new programs and service delivery initiatives in collaboration with key stakeholders.

Operational and clinical leadership of the Day Program is clearly defined by the operating HHS to delineate the key roles responsible for the direct management of the Day Program and staff. This includes:

- Operational management (including day to day clinical support and consultation for staff)
- Resource and administrative management
- Systems maintenance
- Human resource management (recruitment, supervision and performance)
- Facilitating linkages with other mental health services, external organisations and community groups
- Clinical decision making and clinical accountability by the Consultant Child and Adolescent Psychiatrist
- Discipline-specific or intervention-specific mentoring and development to provide opportunities for clinicians to develop identified professional skills and reflect on elements of practice.

- Clinicians are supported to maintain their own health and wellbeing, avoid burnout, and to access career development guidance.

Education provision and leadership is provided by Education staff employed through the DoE. These staff are an important part of the Day Program team and receive supervision, mentoring, professional development and other occupational support through DoE.

It is not expected that these leadership functions will be delivered in isolation and crossover (within delegation) is considered beneficial for the effective operation of the service. It is also acknowledged that any of these responsibilities may be linked with other roles and responsibilities within the broader integrated mental health services.

Day Program services will incorporate the *National Standards for Mental Health Services 2010* and *National Safety and Quality Health Service Standards 2nd Edition 2017* into all workplace instructions, quality activities and procedures. All measures of outcomes, data and reports will be acted upon and corrective action taken if necessary. Programs and procedures will be reviewed as per workplace instructions.

10. Hours of Operation

During school terms, adolescents will be supported to attend a structured program reflective of a general school day.

During school holidays, the educational element is not generally provided by the DoE therefore a modified 'school holiday' program will be delivered to adolescents.

An on-call consultant Child and Adolescent psychiatrist will be rostered on during weekday business hours and after hours as per local arrangements.

A fully operational multidisciplinary team will be available during weekday business hours. Access to mental health clinicians after hours will be by local arrangement.

11. Staff training

Day Program staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure clinical competence. All training will be based on best practice principles and evidence informed treatment guidelines, underpinned by the *National framework for recovery oriented mental health services*. Teams will be encouraged to make the relevant components of their training available to their service partners (for example, shared training sessions between Queensland Health staff and DoE staff). Where possible, adolescents and their families/carers will be involved in staff training and development.

Day Programs will have dedicated time and resources for clinical education and clinical supervision, in addition to adequate clinical staffing numbers.

Staff education and training will include a focus on strategies and mechanisms to foster meaningful participation of adolescents, and families and carers across all levels of service delivery, implementation and evaluation.

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

- orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- a range of evidence-informed treatment modalities including individual, group and family-based therapy
- promotion, prevention and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for adolescents and their families/carers and significant others
- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention
- *Mental Health Act 2016*
- *National Standards for Mental Health Services*
- evidenced-informed practice in service delivery
- consumer-focused recovery-oriented care planning
- an understanding of the impact of complex trauma and disrupted attachment
- routine outcome measurement training (NOCC) and other clinical tools for assessment and measuring change
- trauma informed care training
- child safety services training
- perinatal and infant mental health training
- knowledge of mental health diagnostic classification systems
- medication management including the role of side effect monitoring and metabolic monitoring
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- cultural capability training
- Education staff access mandatory training and professional learning through the DoE.

12. Key Resources

Resource
Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2017-2020
Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents)
Australian Charter of Healthcare Rights
Carers matter
Child Protection Act 1999
Children of parents with a mental illness (COPMI) website
Child Protection guideline at the Queensland Health policy site
CIMHA Business Processes.
Clinical Services Capability Framework
Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services
Department of Education and Training Strategic Plan 2018-2022
DoE Student Protection procedure and guidelines for teaching staff.
Framework for reducing adverse medication events in mental health services.
Family Support Plan
Family support plan: Child care plan supplement
Guardianship and Administration Act 2000
Hospital and Health Boards Act 2011 – Part 7 Confidentiality
Health Service Directive – Guideline for Clinical Incident Management.
Hospital and Health Service Performance Management Framework
https://www.health.qld.gov.au/improvement/youthmentalhealth
Information sharing between mental health workers, consumers, carers, family and significant others.
INTERNAL Queensland Health Consumer, Carer and Family Participation Framework
INTERNAL Queensland Health Medicines page
Interpreter services
Mandatory reporting requirements under the *Mental Health Act 2016*
Mental Health Act 2016
Mental Health Act 2016 Patient Rights and Support resources
Mental Health Act 2016 Schedule of Authorised Mental Health Services
Mental Health, Alcohol and Other Drugs Performance Framework
Mental health child protection form
National Health and Medical Research Council (NH&MRC) Guidelines
National Outcomes and Casemix Collection
National Framework for Recovery Oriented Mental Health Services
National Safety and Quality Health Service Standards
National Standards for Mental Health Services 2010
Principles and actions for services working with children of parents with a mental illness
Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-21
Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
Queensland public sector LGBTIQ+ Inclusion Strategy
Retention and disposal of clinical records protocol
Right to Information and Information Privacy
Standards for Registered Training Organisations (RTOs) 2015
Suite of clinical documents
The Australian Curriculum
The consumer, carer and family participation framework
The *Education (General Provisions) Act 2006*
Therapeutic guidelines - psychotropic
Transition of care for young people receiving child and youth mental health services
Working with parents with mental illness – guidelines for mental health clinicians

Abbreviations

CGAS	Children's Global Assessment Scale
COPMI	Children of Parents with a Mental Illness
CIMHA	Consumer Integrated Mental Health Application
CALD	Culturally and Linguistically Diverse
DoE	Department of Education
FIHS	Factors Influencing Health Status
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
HHS	Hospital and Health Service
MOS	Model of Service
MTD	Multi-Disciplinary Team
NH&MRC	National Health and Medical Research Council
NOCC	National Outcomes Casemix Collection Application
PSP	Principal Service Provider
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma
RTOs	Registered Training Organisations
SDQ	Strengths and Difficulties Questionnaire