Youth Step Up Step Down (SUSD)

Model of Service

Queensland Public Mental Health Services

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Youth Step Up Step Down Model of Service – Queensland Public Mental Health Services, 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 Youth Step Up Step Down (SUSD) Model of Service (MOS) describes a new service element within the Queensland public child and youth mental health, alcohol and other drugs service system. The Youth SUSD service is a community bed-based (sub-acute) mental health service operating in a rehabilitative and residential environment where the Hospital and Health Service (HHS) provides clinical services alongside provision of non-clinical support services by a non-government organisation (NGO).

The intended outcomes of the development and successful implementation of the MOS are:

- an enhanced continuum of mental health service options for young people in Queensland
- an individual (young person) and carer centred, recovery based continuum of care
- the delivery of safe, high quality, integrated, and evidence driven mental health care through an integrated approach to clinical services and non-clinical support services within an intensive, short-term rehabilitative and residential environment in the community
- stronger service partnerships with the networks 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 Youth SUSD MOS describes a 24-hour integrated care model delivered collaboratively by the HHS and NGO that is safe, therapeutic, inclusive, culturally sensitive and informed by research.

The Youth SUSD MOS seeks to be inclusive, ensuring that Aboriginal and Torres Strait Islander People, those from Culturally and Linguistically Diverse (CALD) backgrounds and people of diverse sexual orientation, gender identity or intersex variations requiring additional consideration are provided with accessible, high quality, culturally appropriate mental health treatment and care.

The Youth SUSD MOS has been informed by reference documents, broad consultation and expert opinion from staff, service users and family/carers. It does not replace clinical judgement or 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 Youth SUSD service intend to achieve?

Youth SUSD services extends the continuum of mental health service options for young people with severe and complex mental health issues and their families/carers across Queensland with the least possible disruption to their community connections.

Operating as an integrated model with the HHS providing clinical services alongside provision of non-clinical support services by a NGO, it is designed to provide a service option for young people whose treatment and recovery is better suited to intensive, short-term (up to 28 days) treatment and support in a rehabilitative and residential setting in the community, 24 hours a day, 7 days a week.

Youth SUSD services operate on the premise that young people can and do recover from mental health problems and mental disorders. These services take a recovery-oriented approach that emphasise individual strengths, builds resilience, enhances opportunities for social inclusion and works collaboratively with the young person and their family, carers and significant others to recover their health, wellbeing and developmental potential.

The Youth SUSD MOS 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).

Young people and their support network will experience a smooth and continuous progression in care, by being supported to either remain engaged with their community mental health service provider or linked to ongoing community mental health supports. Young people will be involved in identifying other supports and relationships that contribute positively to their mental health recovery. Wherever possible, these relationships will be supported as the young person transitions through care.

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.[1] The Youth SUSD MOS describes only one element from the continuum of service elements available to assist young people recover their health, wellbeing and developmental potential (see Figure 1).

Other service elements also exist within Adult Mental Health Services (AMHS), the NGO sector such as *headspace*, the private sector and other primary care providers, e.g. General Practitioners (GP).

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf

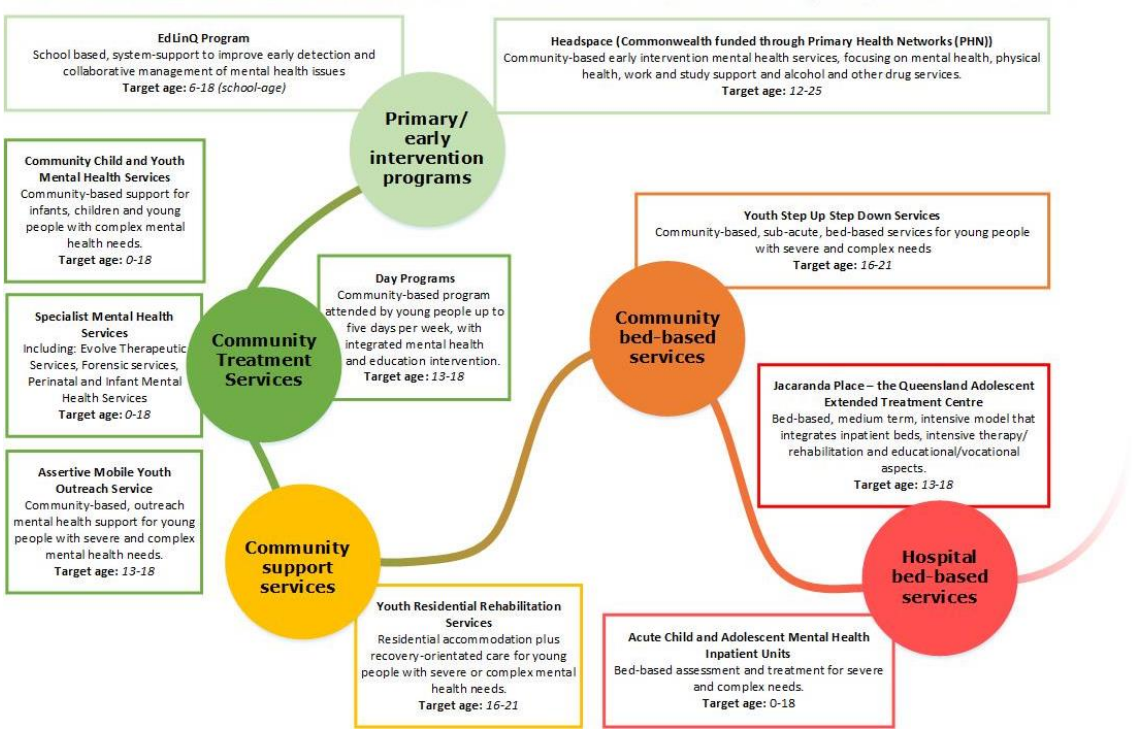


Figure 1: Broad overview of child and youth mental health, alcohol and other drugs service system in Queensland

The Youth SUSD MOS seeks to ensure:

- young people and their network including families, carers, significant others are supported to actively participate in collaborative recovery-oriented 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[2] and those from CALD backgrounds
- collaborative partnerships are developed with other health providers
- identification of clear and transparent integrated governance processes that support predictable and equitable access to the service by young people within the catchment of the Youth SUSD 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
- annual reviews of the MOS by Queensland Health's Mental Health, Alcohol and Other Drugs Branch (MHAODB), and when indicated, modifications informed by evaluation, data collection, policy and research.

[2] Mental illness is the leading contributor to the Aboriginal and Torres Strait Islander burden of disease in Queensland, contributing up to 20 per cent of the total disease burden.

2. What does the Youth SUSD service do?

The Youth SUSD services provide 24-hour intensive, short-term support for young people with mental health issues in a safe, supportive residential environment with the anticipated length of stay to be no more than 28 days.

The Youth SUSD MOS is a community bed-based (sub-acute) mental health service that is part of the broader mental health service system, offering care in the least-restrictive environment.

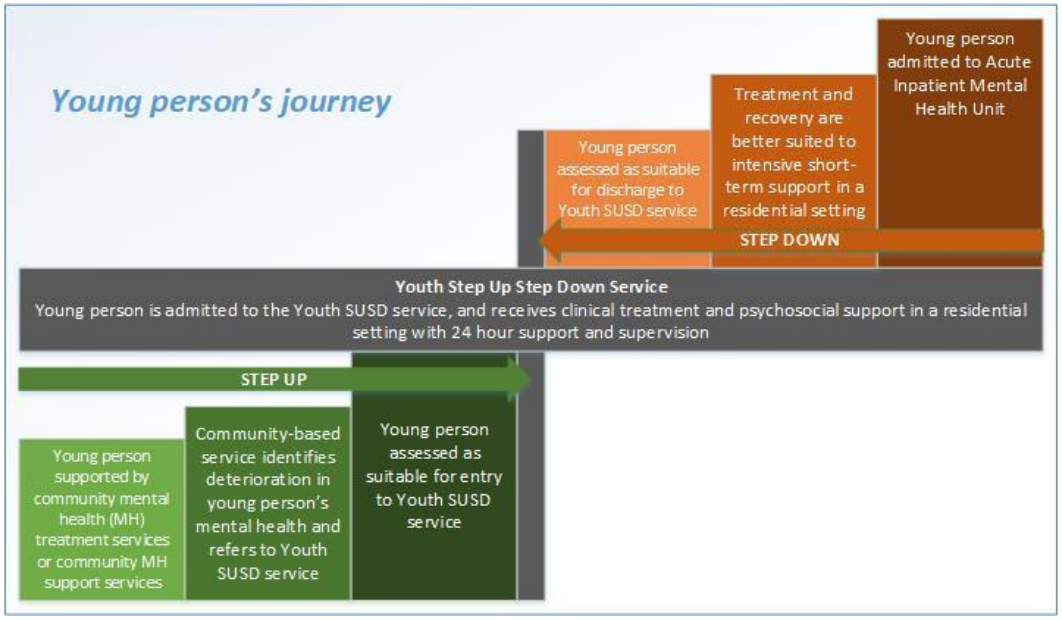
Youth SUSD services operate as an integrated model with the HHS providing clinical services alongside provision of non-clinical support services by a NGO. They aim to:

- prevent further deterioration of a young person's mental health and associated disability, and so reduce the likelihood of admission to an acute mental health inpatient unit (step up)
- enable timely discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (step down)
- enable better access to mental health services for young people whose treatment and recovery is better suited to intensive, short-term support in a residential setting
- prevent unnecessary inpatient admissions to an acute mental health unit when more intensive support is required than can be provided in a community setting
- provide an integrated approach to clinical services and non-clinical support services inclusive of care planning with the young person and their family, carer and significant others that:
    - enables gain from the period in the inpatient setting to be strengthened and recovery focused treatment plans to be consolidated
    - minimizes the trauma and disruption for the young person that may arise from an acute episode of mental ill health
    - supports strong engagement with family, carers and significant others
    - provides an opportunity for the young person to engage or re-engage in positive educational and vocational connections and other community supports as appropriate
    - facilitates a smooth transition to their home and community
- culturally appropriate and safe services for the diverse population
- practical assistance with developmentally appropriate daily living tasks
- supervision and monitoring in a safe, structured and supportive environment.

Key features of the developmentally appropriate therapy and rehabilitation provided as part of delivering the Youth SUSD MOS include:

- a range of developmentally appropriate individual, family and group-based assessment, treatment and rehabilitation programs, aimed at treating the mental health issue, reducing emotional distress, and promoting functionality within the young person's familial, social and community environment
- treatment programs that are developed in partnership with young people and their families and/or carers

- support to assist the young person's engagement or reengagement in education/vocation
- facilitating access to support services as required for Aboriginal and Torres Strait Islander People, people from CALD backgrounds, and people of diverse sexual orientation, gender identity or intersex variations
- working collaboratively with the young person and their family, carer and significant others to ensure smooth transition of care and return to their home and community, including appropriate local mental health treatment, engagement or re-engagement with education or vocational programs and other social and support systems.



3. Who is the Youth SUSD service for?

The Youth SUSD service is for young people aged 16 to 21 years[3] who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness or further deterioration of mental health. The young person usually requires a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community, but does not require the treatment intensity provided by an acute mental health inpatient unit.

In particular, it is aimed at young people who:

- are living in the community and require short-term residential support with intensive clinical treatment and psychosocial support to prevent the risk of further deterioration or relapse, which in the absence of this option may lead to admission to an acute mental health inpatient unit (step up)
- no longer require acute inpatient level clinical intervention and treatment but would benefit from short-term, intensive treatment and support in a rehabilitative and

[3] The NMHSPF has a target age for Youth SUSDU of 16-24 years; which aligns with national data collection age range for specialised mental health service target population group for 'youth' according to Australian Institute of Health and Welfare.

residential setting post-discharge from an acute mental health inpatient unit (step down)

- need intensive mental health and psychosocial support within a structured residential environment with recovery oriented treatment provided by both clinical mental health staff and community mental health support workers to enable the young person to achieve their care plan goals and return to their family and/or carer and community and engage or reengage with social and educational/vocational activities within their community.

Young people engaged with a Youth SUSD service will present with a range of mental health problems and/or disorders at the moderate to severe end of the spectrum. Eligibility is not restricted to disorders/diagnoses, but rather reflects the interaction between symptom severity and complexity. Many young people will also present with peer and family problems, which can exacerbate mental health problems and disorders.

One of the intentions of the Youth SUSD services is to lessen the possible difficulties and stresses experienced by families and carers in supporting young people who are acutely unwell and are receiving community treatment. At the same time, it offers an important opportunity for early intervention for those young people in the early phase of relapse, and for those in need of further stabilisation and recovery before returning to the community following an acute mental health admission.

Importantly, young people discharged from acute mental health inpatient settings must have recovered to the point where that service can demonstrate their risk status does not require the clinical care typically provided by an inpatient unit. If the young person is assessed as requiring inpatient care he/she should be admitted to an inpatient unit. If a young person is unable to access the Youth SUSD service on one occasion, this should not preclude his/her consideration in the future.

The Youth SUSD service will not be gazetted to be an Authorised Mental Health Service under the *Mental Health Act 2016*, although young people on a community category of their involuntary order, e.g. Treatment Authority or Forensic Ordermay be admitted to the Youth SUSD service.

Youth SUSD services operate within established service provision parameters and service capability as per the Clinical Services Capability Framework for Public and Licensed Private Health Facilities – Mental Health Module[4].

[4] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/modules

4. Standard components

The Youth SUSD MOS does not detail the mandatory and fundamental operational business requirements, processes or procedures of a standard, public mental health service. These fundamental requirements should be embedded within all mental health services and aligned with national and state-wide guidelines and protocols including but not limited to:

- National Safety and Quality Health Service Standards (2nd edition)
- 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
- 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 judgment. Clinical judgment 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 QH intranet (QHEPS) Mental Health, Alcohol and Other Drugs Branch resource page under Suite of clinical documents[5]

[5] Refer to Suite of clinical documents:
http://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs.htm

5. The Youth SUSD MOS functions best when:

- There is a common language and understanding among all Youth SUSD service staff about the importance of:
  - the young person's perspective
  - a sense of hopefulness and respect
  - the importance of individualised interventions designed to minimise risk and increase protective factors
  - the need for an integrated approach to the delivery of services provided to high risk young people and their families and/or carers.
- Young people, family and/or carers, and other service providers are engaged and involved in all aspects of care planning and delivery.
- Existing familial, social, educational/vocational and service relationships are actively supported in recognition of their role in positive future mental health outcomes and integrated into holistic care planning.
- The physical environment supports healing.
- There is a culture of openness and responsiveness to service user feedback.
- A range of performance, quality and safety indicators are actively utilised to inform service planning and provision.
- Clinical governance is intrinsically embedded throughout all processes and practices within the Youth SUSD service ensuring decision making from intake to exit are transparent and accountable to stakeholders, and follow established procedures that demonstrates the integrated model.
- Service delivery is well integrated, with established procedures that support continuity of care across settings and between services, acknowledging the challenges of transitioning from inpatient to community care, and youth to adult services.
- There is ongoing collaboration with local mental health services, specifically community CYMHS/AMHS, acute mental health inpatient units, emergency department, and primary care supports.
- There is adherence to evidence informed care, treatments, interventions and processes.
- There is an appropriate mix of clinical and non-clinical support including peer support.
- There are clear and strong HHS and NGO leadership roles which recognise each other's strengths and work to form a collaborative relationship.
- The HHS and NGO staff are provided with strong professional support and training.
- The HHS and NGO staff are provided with peer supervision/clinical supervision, including reflective practice and debriefing opportunities.

5.1 Working with other service providers

Key elements	Comments
5.1.1 The Youth SUSD service will work in close collaboration with other service providers to meet individual needs of the young person, and their family/carers/significant others. A common understanding of the mental health issue is the optimal treatment approach.	• Clear, regular contact and communication processes maintained for all phases of care. • Formal agreements will be developed where required. • The Youth SUSD service will provide advice, education and support on mental health issues to other services. • There is active engagement with primary health care providers including GPs to meet the general and physical health care needs of the young person. • The GP will be provided with any results of assessments, investigations and ongoing care recommendations, via the completion of a Transfer of Care document • Transfer of Care • The Youth SUSD service will establish efficient, collaborative partnerships with local service providers and key clinical and non-clinical support services, including educational/ vocational, social supports and housing/accommodation (if appropriate).
5.1.2 There is active engagement with local acute mental health services, local hospital emergency departments and local police and ambulance services, to support coordinated access and crisis response planning and service delivery.	• When more than one service provider is involved in service delivery, the Youth SUSD service will initiate and participate in discussions around which service will adopt the role of lead agency including agreed documented processes.
5.1.3 The Youth SUSD 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 young people have specific needs, the Youth SUSD service will proactively engage appropriate services in consultation with the young person.	• Staff will proactively identify and include people able to support young people with their individual needs, and inform their assessment and treatment processes. The young person will nominate these support persons. • Queensland Health Interpreter Services • Deafness and Mental Health Service • Queensland Transcultural Mental Health Centre • Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2017-2020

Key elements	Comments
	• Queensland public sector LGBTIQ+ Inclusion Strategy • Multicultural Mental Health – Queensland Health Multicultural Services • Department of Communities, Disability Services and Seniors

5.2 Referral, access and triage

Key elements	Comments
5.2.1 The HHS is responsible for managing the entry and exit processes of the Youth SUSD service. This should be done in collaboration with the NGO provider. The Youth SUSD service may be suitable for young people who need a level of monitoring and clinical treatment that does not require admission to an inpatient unit, but will benefit from more intensive clinical treatment and psychosocial support than can be provided by community based services. The young person's capacity to engage with service providers and benefit from psychosocial and clinical treatment is an important consideration for whether the young person is suitable for a Youth SUSD service. The Youth SUSD service will not be gazetted to be an Authorised Mental Health Service under the Mental Health Act 2016, although young people on a community category of their involuntary order, e.g. Treatment Authority or Forensic Order, may be admitted to the Youth SUSD service.	• As an integrated service, the HHS and NGO will develop and agree on processes to support the young person to enter the Youth SUSD service, including referral and assessment processes for considering referrals, monitoring waiting lists, assessing available community options and facilitating smooth transition between service elements. • Referrals to the Youth SUSD service can occur from a range of referral sources including the continuum of community-based and hospital-based mental health services, consultation liaison, other wards, private psychiatrists/psychologists and other community service providers. • Referrals will be accepted as per agreed flows and identified catchments for the local geographical area where the service operates. • Referrals to the Youth SUSD service will occur through the intake coordinator role to provide a single point of entry. • The intake coordinator role will be fulfilled in partnership by the HHS clinical service representative (Clinical Lead or delegate), and NGO representative (Service Manager or delegate). • The intake coordinator role will review referrals in consultation with the Youth SUSD Consultant Psychiatrist. • The intake coordinator will consider all referrals to the Youth SUSD service

Key elements	Comments
	from a young person's needs perspective. • An appropriate representative from the referring area will be included as part of this process. Clear information regarding referral and access processes will be available to referrers. • All referrals will be communicated verbally and in writing, using standardised clinical documentation. • The referrer will provide comprehensive assessment information • Whenever possible, copies of completed assessment tools will be scanned or recorded in Consumer Integrated Mental Health Application (CIMHA). • All referral information will be recorded and/or scanned into CIMHA on entry. • Suite of clinical documents
5.2.2 The Youth SUSD service is a community-based sub-acute residential facility. The decision to have a young person enter the Youth SUSD service is made by the intake coordinators in consultation with the consultant Youth SUSD Psychiatrist or an appropriately trained medical delegate under the supervision of a consultant psychiatrist. A young person's rate of emotional and physical development varies considerably for each individual. Consideration of the young person's developmental age/stage in the context of other young people within the Youth SUSD service is essential when deciding who and when a young person may enter the Youth SUSD service.	• The entry decision will take account of the: – nature of the problem – acuity and severity of the disturbance and associated risks – complexity of the condition (including co-morbidity) – persistence of illness – extent of functional impairment – risk assessment – to self and others – benefits and risks associated with admission to the Youth SUSD service – geographical proximity and referrer's goals of admission – safe transfer from rural and remote sites – time of day of the referral – availability of other appropriate services – current cohort of young people within the Youth SUSD service including age, gender and presenting problems – substance misuse issues that may interfere with engagement and mental health treatment

Key elements	Comments
	• If a referral is not accepted, feedback will be provided to the young person, their family and/or carer, and referrer about why and how their support needs could be better met in an alternative setting. Local processes will be implemented so the young person can access the Youth SUSD service when support needs change during their recovery journey. • If agreement cannot be reached, the escalation process will involve the Clinical Director of the HHS, where the Youth SUSD service is located and, if relevant, the Clinical Director of the referring HHS. • Considerations to the preferences of the young person and their family and/or carers are to be considered as part of the referral process, as well as the capacity for the Youth SUSD service to provide safe and therapeutic care in response to the needs of the young person.
5.2.3 A comprehensive mental health assessment must be undertaken by a Youth SUSD service mental health clinician. A risk assessment will be conducted in accordance with the 'Risk Assessment Checklist', incorporated in intake processes.	• All young people with identified risks must have a risk management plan documented and alerts noted in CIMHA. • Risk Screening Tool • Guidelines for Suicide Risk Assessment and Management
5.2.4 An introductory meeting is to occur with the young person and their family/carer with a Youth SUSD service representative to introduce them to the service. This meeting aims to orient them to the Youth SUSD service and shape the expectations of the young person and their family and/or carer of the service. A general information and orientation pack will be provided and explained to all young people, families, and/or carers on entering the service.	• The pack will include information on: – assessment, treatment and support options – the multidisciplinary team role and function outline – treatment planning and family meetings – psychosocial programs school/vocational support – staff information and contact details – general Youth SUSD service information, including policies on smoking, mobile phone use, property consent, ancillary services, etc. – *Mental Health Act 2016* statement of rights and responsibilities – Consumer rights and responsibilities

Key elements	Comments
	– Carers rights and responsibilities – information regarding privacy and confidentiality – mechanisms for providing feedback – community support services – culturally diverse orientation material specific to the unique populace of the local service • National Standards for Mental Health Services • Complaints and compliments about health services.
5.2.5 The potential for the young person to achieve functional gain and his/her willingness to participate in the program are measured in the referral and ongoing assessment process.	

5.3 Assessment

Key elements	Comments
5.3.1 Repetition will be limited as much as possible for the young person in the assessment process.	• A comprehensive chart review and referrer consultation precedes the initial assessment.
5.3.2 The recovery oriented framework will be introduced to the young person and their families and/or carers as part of the assessment process. The **initial assessment process** following entry will involve a comprehensive biopsychosocial, developmental assessment of the young person in the context of their family and/or carer and other significant relationships. Assessment and care planning is a continuous process throughout the young person's stay and identifies both protective factors and deficits. Initial assessment will inform the collaborative development of a **preliminary recovery-oriented Mental Health Services Care Plan (Care Plan)**.	• The **preliminary formulation** will be holistic and include: – symptoms – relationships – family dynamics and functioning (including current mental health issue impacting family/carers) – attachment and history of trauma – psychosocial functioning – sensory profile – school performance including engagement in education/vocational activities – developmental history and trajectory – medical history – co-morbidities – developmentally appropriate daily living skills

Key elements	Comments
Potential recovery goals are explored with the young person and their family/carers as appropriate. My Recovery Plan	– protective factors (including strengths, hobbies and interests) – ability of young person and available supports to maintain function and prevent relapse – alcohol and other drug use – cultural factors – legal issues including custody and guardianship – whether the young person may be a parent with care responsibilities for infants and children • Child and Youth Consumer Assessment form • Statewide standardised suite of clinical documentation user guide
5.3.3 Assessment will involve input from family, and/or carers, and key service providers as appropriate. Assessment of family structure and dynamics will continue during the young person's stay. Identification of family members and carers / significant others and their needs is part of the assessment process and is included in care planning.	• Consent to disclose information and to involve family and/or carers, and key stakeholders in the young person's care will be sought in every case. • Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. • Recovery oriented practice includes building systemic resilience within the young person, their family and/or carers and broader community supports. • Recovery oriented services facilitate and nurture connections with family members and carers to gain the maximum benefit from these supports by the young person. • Suite of clinical documents • Hospital and Health Boards Act 2011 – Part 7 Confidentiality[6] • Right to Information and Information Privacy • Information sharing between mental health workers, consumers, families and significant others[7] • *Mental Health Act 2016.*

[6] Refer to the Queensland Government website – Queensland Legislation under Current legislation - https://www.legislation.qld.gov.au/OQPChome.htm

[7] Refer to Queensland Health external site, Clinical practice - Mental health practice guidelines – Information Sharing Guidelines https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/default.asp

Key elements	Comments
	• *Mental Health Act 2016* Resource Guide • *Mental Health Act 2016* Forensic Provisions • Mental Health Review Tribunal • Mental Health Court • Treatment and care of forensic order, treatment support order and high-risk patients[8]
5.3.4 When young people have specific needs (e.g. sensory impairment, Aboriginal and Torres Strait Islander populations, CALD Backgrounds, dual disability, refugee services, LGBTIQ, the Youth SUSD service will engage assistance of appropriate services to ensure that communication and cultural issues are addressed.	• Link to services with expertise in cultural services • Interpreter services • Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2019-2022 • Queensland public sector LGBTIQ+ Inclusion Strategy • Queensland Program of Assistance to Survivors of Torture and Trauma
5.3.5 Engagement will occur with an Aboriginal and Torres Strait Islander Mental Health Worker, as necessary or Hospital Indigenous Health Worker to support and assist with the facilitation of information for a comprehensive assessment of young people identifying as Aboriginal and Torres Strait Islander and their families and/or carers where one has not been completed previously.	• Where an Aboriginal and Torres Strait Islander mental health worker is not available, identification of an appropriate and recognised Aboriginal and/or Torres Strait Islander person is integral in addressing the cultural needs of the young person. • Guideline for Mental Health Service Responsiveness for Aboriginal and Torres Strait Islander People • Aboriginal and Torres Strait Islander Cultural Information Gathering Tool • User Guide for the Aboriginal and Torres Strait Islander Cultural Information Gathering Tool
5.3.6 **Risk assessments** will be conducted by the clinical staff and will occur: • on acceptance/entry as part of the comprehensive clinical assessment • prior to transfer to any other unit/facility/service • prior to and following periods of leave • prior to exiting • where clinically indicated due to change in presentation	• All risk assessments will be recorded in CIMHA and will be used to formulate a risk management plan. • Comprehensive risk assessments will include at a minimum consideration of: – harm to self – harm to others – vulnerability – developmental risk – risks of physical or emotional deterioration

[8] Refer to Mental Health Act 2016: Chief Psychiatrist policies and guidelines

Key elements	Comments
The standards suite of clinical documents will be used to record risk assessment.	– triggers to symptoms and/or behavioural disturbance – risk of absconding – non-adherence to treatment – child protection issues. • Risk management planning will incorporate opportunities to build resilience including developing skills in a supported environment. • Risk management protocols will be consistent with Queensland Health policy and Youth SUSD service policies. • Risk Screening Tool • Guidelines for Suicide Risk Assessment and Management
5.3.7 Child protection concerns will be identified through risk assessment and addressed in accordance with mandatory reporting requirements**.**	• Liaison with Child Safety services is essential to ensuring continuity of care. • *Child Protection Act 1999* • Child Protection guidelines 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[9]
5.3.8 Assessment of physical health will be facilitated and documented as part of a holistic health plan. Potential physical health problems and ongoing monitoring information will be identified and discussed with the young person, their family/carer, identified GP and/or other primary health care provider.	• This may be conducted by an external health service provider, but needs to be considered as part of the Youth SUSD service assessment. • Young people will be encouraged to have a nominated GP. • Young people will be actively monitored in their ability to access primary health care including regular dental reviews and other physical health supports, e.g. dietetics.

[9] Refer to Queensland Health external site, Clinical practice - Mental health practice guidelines – Information Sharing Guidelines https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/default.asp

Key elements	Comments
	• Clinical alerts (e.g. medicine allergies, blood-borne viruses) will be recorded in CIMHA. • CheckUP (formerly General Practice Queensland)
5.3.9 Consumption of alcohol, tobacco and illicit non-prescribed drugs is prohibited in the Youth SUSD service. Alcohol and other drug use will be routinely assessed and documented.	• Information and advice to address alcohol and drug use, if relevant, will be routinely provided. For some young people, alternative or additional support is required. • Co-occurring alcohol and drug problems will be identified and included in care planning. • However, the Youth SUSD service is not a drug and alcohol withdrawal/detox service. Young people will be referred to drug and alcohol withdrawal/detox services as required. • The Youth SUSD service will follow legislation introduced under the *Health Legislation Amendment Bill 2014* to prohibit smoking on health facility land. • Drug Assessment Problem List • Queensland Health Dual Diagnosis Clinical Guidelines • Queensland Health Dual Diagnosis Clinician Toolkit[10] • Child and Youth Substance Use Assessment
5.3.10 Specialised assessments may assist in diagnostic clarification, assessment of symptom severity, developmental variables, informing functional assessments and identifying evidence informed therapeutic interventions.	• Diagnostic assessments will be coordinated by the HHS, if clinically indicated for treatment and formulation of cases. • Assessments may include psychological, psychometric, occupational therapy, sensory, expressive therapy, and speech and language assessments. • If not conducted during the admission, recommendations regarding further assessments will be provided to follow up service providers through documentation on the transfer of care form and recorded in CIMHA. • Transfer of Care • *Hospital and Health Boards Act 2011 –*

[10] Refer to MHAODB Resources page and search under 'Clinicians toolkit 2011'

Key elements	Comments
	Part 7 Confidentiality • Right to Information Act 2009 • Information Privacy Act 2009 • Information sharing between mental health workers, consumers, families and significant others[11]

5.4 Care planning and relapse prevention

Key elements	Comments
5.4.1 Every effort will be made to ensure that care planning focuses on the young person's own goals.	• The young person will be involved in identifying personal, clinical, community or other relationships that contribute positively to their mental health recovery. • Where possible, these relationships will be supports as the young person transitions through care.
5.4.2 Each young person within the Youth SUSD will have an individual care plan. Each care plan will be developed collaboratively with the young person, their family, carers and significant others in accordance with recovery-oriented principles. Goals and interventions need to be meaningful to the young person, inclusive of strengths/hopes, and where possible, generated by them. A young person may also develop a My Recovery Plan to assist in exploring and identifying their recovery goals.	• Care plans are developed on the premise that young people can and do recover from mental illness. • Care plans need to address general development when it has been disrupted by mental illness. • Care plans identify: – available supports and resources within the young person and around them (including family/carers and other significant relationships) – crisis management strategies – clinical and psychosocial goals – clinical and psychosocial intervention processes – psycho-educational needs – relapse prevention strategies The young person's My Recovery Plan will inform development of the Care Plan. • CIMHA Standard Business Processes • A National Framework for Recovery Oriented Mental Health Services: Guide for Practitioners and Providers

[11] Refer to Queensland Health external site, Clinical practice - Mental health practice guidelines – Information Sharing Guidelines https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/default.asp

Key elements	Comments
5.4.3 Review of progress and planning of future goals will be integrated into the careplan. Progress of each young person will be routinely monitored and evaluated using standardised tools as clinically indicated.	• All changes to the care plan will be discussed at the clinical review. • The National Outcomes and Casemix Collection (NOCC) will be used, and other measures will be used, based on each young person's individual requirements. Measures may include: – Health of the Nation Outcome Scales for Children and Young persons (HoNOSCA) – Health of the Nations Outcome Scales (HoNOS) – Strengths and Difficulties Questionnaire (SDQ) – Children's Global Assessment Scale (CGAS) – Factors Influencing Health Status (FIHS). • Mental Health Outcomes Collection Protocol • Outcome and Casemix measures for mental health services
5.4.4 The relationship between the young person and their family and/or carer are important contributors to their recovery and resilience.	• While young people gain further independence and mastery to separate from their family and/or carer, evidence suggests that young people with mental health issues specifically require support in re-connecting with their parents and/or carers, and other key social support networks, and that this reconnection can promote recovery and resilience.

5.5 Recovery oriented practice

Key elements	Comments
5.5.1 Youth SUSD services provide an environment to enable young people to reclaim their lives beyond their mental health issues and support the young person in their personal development to build self-esteem and identify meaningful roles to fulfil their potential.	• The recovery model is an active and assertive partnership between the young person receiving care and those involved in the ongoing care. • The Youth SUSD service will deliver goal-oriented and assertive care and treatment, supporting the young person's recovery journey. • Each young person in the Youth SUSD service will be assigned a Youth SUSD service care coordinator/case manager who will be identified in CIMHA as the

Key elements	Comments
	'Other Service Provider' (OSP) if the young person is already a service user. If the young person is new to the service they will be identified in CIMHA as the Principal Service Provider (PSP). The consultant psychiatrist will be identified in CIMHA as the 'Treating Consultant Psychiatrist'. The HHS and NGO will develop local protocols to ensure there is a shared, clear understanding of responsibilities for coordinating the care of the young person. • The Youth SUSD service will operate in accordance with A National framework for recovery-oriented mental health services: Policy and theory.
5.5.2 Peer support workers form part of the recovery oriented practice.	• Peer support promotes recovery through role modelling and lived experience that helps young people to validate and promote wellness and recovery. Based on mutual respect and personal responsibility, peer support focuses on wellness and recovery rather than on illness and disability. • Peer workers provide individual advocacy, peer support, health promotion, education and training and cultural support. • Intentional Peer Support is a system of giving and receiving support in a relationship based on shared experience, mutuality, respect and co-learning. It encourages young peoples to build on effective relationships that challenge them to step outside their illness story and move towards achieving the goals that are important to them. • Intentional peer support
5.5.3 The young person and their family and/or carer need to be acknowledged as the most significant partners in their recovery, at all times.	• The Youth SUSD service will ensure that the young person, and their aspirations for the future, are central considerations in providing their ongoing care and rehabilitation. • The Youth SUSD service will ensure that care plans are developed in consultation with the young person, and their family and/or carer, and

Key elements	Comments
	include engagement with family and/or carers and broader support systems.
5.5.4 The ongoing educational or vocational needs of the young person are considered in tandem with their mental health needs. The Youth SUSD service will support the young person's engagement or reengagement in educational/vocational activities.	• All efforts are made to ensure the least disruption to the young person's schooling, tertiary or work training. • The Youth SUSD service (with consent) will liaise with the nominated school or vocational training/employment provider representative to determine whether the young person's mental health issues impact on his/her academic and vocational performance and to support reintegration into class/course/work environment upon discharge. • Consultation and planning will occur with the school guidance officer/teacher or supervisor to facilitate the educational/vocational program during the young person's stay in the Youth SUSD service to support reintegration into class/course/work environment upon exiting. • If a young person is not currently enrolled in an education/vocational program, or not currently working in a job, every effort should be made to facilitate this where appropriate.
5.5.5 The young person's family and/or carers are integral to the young person's recovery process. Family members and carers are provided, or assisted with access to, emotional and other support.	• Interventions to promote recovery are as much focussed on engaging with the family and/or carer as much as the young person. • Recovery may include family work. • Time to provide emotional support to the young person, family and/or carers will be given adequate priority. • Each young person will be assigned a Youth SUSD service staff member who is a family/carer support worker, to liaise and provide family/carers with emotional and other support to ensure they are able to continue to provide care and support without experiencing deterioration in their own health and wellbeing. • Carers matter webpage

Key elements	Comments
	• The Consumer, Carer and Family Participation Framework[12]

5.6 Clinical interventions

Key elements	Comments
5.6.1 Assessments and formulations using a bio-psychosocial, developmental framework will guide all clinical interventions.	• Interventions will be evidence-informed, and sensitive to the young person and their family /carer needs. • Interventions will consider and build on the strengths, resilience, and protective factors within the individual, their family and/or carer, culture, and community. • Interventions may be individualised, group based or generic programs.
5.6.2 Young people will be supported to access a range of clinical interventions which address their individual needs. A range of integrated therapeutic, rehabilitation and recovery-focused interventions will be utilised to reduce the severity of symptoms, and increase resilience to cope with mental health issues.	• Clinical interventions may be individualised, group-based or generic programs. • Efficacy of treatment and progress will be reviewed regularly throughout the episode of care. • Interventions may include relapse prevention programs/techniques.
5.6.3 Clinical services will include mental state and risk assessments including risk management plans and management of mental health crises.	• Outcomes of mental state and risk assessments will be communicated to all Youth SUSD staff. • Risk management plans will be current.
5.6.4 Clinical interventions will include medication management, supportive psychotherapy and psycho-education with the young person and their families, carers and significant others.	• A range of interventions may be delivered with the Youth SUSD community support workers.
5.6.5 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.

[12] The Consumer, Carer and Family Participation Framework provides a guide to adopting a young person-driven, recovery-oriented, and carer and family inclusive mental health service model. It provides direction to mental health services across the state regarding enhancing young person and carer participation at the local level.

5.7 Non-clinical support

Key elements	Comments
5.7.1 24-hour care and supervision Provision of 24-hour care and supervision of young people within a rehabilitative and residential environment. Day-to-day program structure including facilitating groups and community linkages.	• Regular review of recovery needs and evaluation towards recovery goals. • Family/carer support and advocacy.
5.7.2 Psychosocial rehabilitation Evidence based psychosocial rehabilitation will be available according to individual needs. Psychosocial rehabilitation may also focus on connecting or re-connecting to family, carers, friends and other community supports.	• Psychosocial interventions may be individualised, group-based or generic programs. • This includes developmentally appropriate rehabilitation including: personal care, daily living skills, education or vocation education, social skills, community access, employment, and parenting (if relevant). • A range of tailored group activities will be available targeting areas of psychosocial and developmental need to promote functionality. • A range of unstructured activities will include discussion around wellbeing, issues relevant to young people, and peer led activities.
5.7.3 Psycho-education Individual and group psycho-education programs will be available for all young people and their families and/or carers. Young people, family, carers and significant others will have access to education and information at all stages of contact with the service.	• Topics covered will include recovery, mental health information, symptom management, medication management and side effects, alcohol and substance use interventions, mindfulness, and trauma-informed care. • The needs of young people who have a parent with a mental illness will be considered, including facilitation to age-appropriate information. • Children of Parents with a Mental Illness (COPMI)
5.7.4 Family support Provide family/carer emotional and other support.	• Young person's family, carers and significant others are integral to the young person's recovery.
5.7.5 Peer support All young people and their family and carers will be offered peer support within the Youth SUSD service.	• Peer support promotes recovery through role modelling and lived experience that helps young people to validate and promote wellness and recovery.

Key elements	Comments
5.7.6 Community connections Coordinate schooling/vocational supports to assist the young person's engagement or reengagement in education/vocation. Coordinate other community supports as indicated, for example, social, recreational and broader community supports.	• Recovery-oriented approach that enhances opportunities for social inclusion and community connections.
5.7.7 Activity of daily living assistance Mental health issues can impact a young person's developmental trajectory.	• Assessment of the young person's developmental stage and activity of daily living ability (developmentally appropriate), including personal care, social skills and domestic tasks will be provided. Where young people are currently unable to perform developmentally appropriate tasks, a skills development program will be facilitated.

5.8 Medication management

Key elements	Comments
5.8.1 Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision-making processes between the Youth SUSD staff, the young person, family and/or carers. The HHS clinician is responsible for administering medication, monitoring response to medication and monitoring medication side effects. The NGO support staff can support the young person in taking their medication.	• The medication goals of the young person and their family and/or carer will be integrated with evidence-based clinical treatment guidelines. • Young people and their families and/or carers will be encouraged to be involved (e.g. use of medication diaries by the young person) to support them achieve independence. Parents and/or carers may need to be supported in this process. • Medication adherence is enhanced when rationales for pharmacological intervention are provided to the young person and their families and/or carers. • Framework for reducing adverse medication events in mental health services.
5.8.2 Across all treatment settings, prescribing, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards.	• Medication is reviewed by the Youth SUSD service medical practitioners at regular intervals.

Key elements	Comments
5.8.3 The Youth SUSD service will ensure that prescribed medication is available on exiting and that the young person, their family and/or carer are advised how to obtain ongoing supplies.	• Supply of prescribed medication for leave or exiting will be coordinated by the Youth SUSD service. • Information providing accurate details of discharge medications will be provided to all healthcare providers involved in the care of the young person (e.g. GP, Community CYMHS, private psychiatrist, and community pharmacy). • Medication liaison on discharge • Medicines • Therapeutic guidelines-psychotropic • Psychotropic Medication Information Leaflets • Guidelines for the safe use of antipsychotics in Schizophrenia. • Metabolic Monitoring form • Transfer of Care

5.9 Maintaining safety in a sub-acute setting

Key elements	Comments
5.9.1 Processes will be in place to monitor, review and maintain a safe environment in the Youth SUSD service, including psychological, physical and sexual safety. There are instances where increased levels of intervention are necessary for the management of symptoms and/or behaviours that increase the risk of harm to the young person or others. The standards suite of clinical documents will be used to record risk assessment and management.	• All staff will be familiar with specific policy and practice guidelines relating to the management of acute behavioural disturbance within the Youth SUSD service. • Crisis is seen as an opportunity to learn and reinforce coping strategies as part of recovery, and plans are to be developed in consultation with the young person and significant others. • A specific management plan will address the distress experienced by the young person and any associated behavioural disturbance. • The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every young person whose risk assessment identifies actual or potential aggression as an issue. • The plan will list preventative strategies and de-escalation strategies, and must also be supported by the availability of appropriately prescribed medication.

Key elements	Comments
	• Intervention strategies will include: – increased visual observation – de-escalation techniques – development of a management plan – targeting the specific behaviour or symptom – use of medication to relieve agitation/aggression – utilisation of non-violent crisis intervention techniques • These interventions are delivered by qualified staff following a comprehensive risk assessment. • Families/carers are immediately informed of changes in a young person's behavioural presentation. • In high risk situations it may be clinically indicated for the young person to be transferred to an acute inpatient mental health observation area or unit to ensure the safety of other young people in the Youth SUSD service. • *Mental Health Act 2016* Resource Guide • Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services • Mental health visual observations[13] • Occupational violence prevention training • Searches in authorised mental health services: Clinical practice guidelines

5.10 Clinical review

Key elements	Comments
5.10.1 An initial clinical discussion will occur between the HHS and NGO within 24 hours of the young person entering the Youth SUSD service.	

[13] MHAODB Resources page: search under 'Observation Guidelines'

Key elements	Comments
5.10.2 All young persons within the Youth SUSD service will be discussed at clinical review conducted at least weekly.	• A psychiatrist or appropriate medical delegate will participate in all clinical reviews (this may be via telehealth). • Where this is not possible, a senior clinician e.g. Clinical Lead will be present, with psychiatrist access sought where required.[14] • Clinical reviews will include both HHS and NGO staff. • Outcomes of clinical reviews will be documented in the young person's clinical file and the consumer care review summary in CIMHA. • Consumer Care Review Summary
5.10.3 In addition to regular clinical review, ad hoc clinical review meetings will be scheduled when required (e.g. to discuss cases with complex clinical issues, following a critical event, or in preparation for discharge).	• The HHS and NGO will identify relevant critical incident management protocols consistent with their service/organisation policy. • Care Plan
5.10.4 The young person's care plan will inform discussion at the clinical review. Any significant changes in intervention will be incorporated into the individual care plan.	• The viewpoint of the young person, their family and/or carer, community based supports and community mental health case managers will be considered during the reviews. • Outcomes of clinical reviews will be discussed with the young person, their families and/or carers. • Any changes to the care plan will be made in collaboration with the young person, their family and/or carer. • Structured risk and review processes will be utilised.

5.11 Team approach

Key elements	Comments
5.11.1 Youth SUSD services operate as an integrated model where the HHS provides clinical services alongside provision of non-clinical support services by a NGO.	• The young person, family and/or carer will be informed of the multidisciplinary model, i.e. given information regarding the different roles/skills of the clinical and community support staff as well as the names of all staff involved in their care.

[14] Refer to National Standards for Mental Health Standard 10.4 Assessment and Review

Key elements	Comments
A multidisciplinary integrated team approach will be provided. Efforts to support team functioning must focus on an integrated approach to service provision between clinical and community support staff. Regular team processes must be in place to review the roles and responsibilities of clinical and community support staff.	• Recognition of the need for Aboriginal and Torres Strait Islander Mental Health workers is integral for young people, families and/or carers that identify as Aboriginal and/or Torres Strait Islander. • Peer workers will be part of the multidisciplinary integrated team. • To be inclusive of cultural and sexual diversity, staff will proactively identify and include people able to support young people with their individual needs, and inform team assessment and treatment processes. • Clinical, discipline and peer supervision will be available to all Youth SUSD staff.
5.11.2 Clear clinical and operational leadership processes will be established highlighting the integrated model. Caseloads will be monitored by the Youth SUSD service leadership team (HHS Clinical Lead and NGO Service Manager) and other staff as appropriate to ensure effective use of resources and to support staff to respond to crises in a timely and effective manner.	• There will be a well-defined and clearly documented local process for escalation of clinical and operational issues. • A regular monthly meeting is to occur between the Youth SUSD service leadership team representatives (HHS and NGO) and their respective line managers, to review service operations, and discuss issues in leadership team functioning.

5.12 Continuity and coordination of care

Key elements	Comments
5.12.1 Clearly documented mental health service contact information (covering access 24 hours, 7 days per week) is provided to the young person, families, and/or carers, referral sources and other relevant supports.	• Relevant information documents detailing specific service response information will be readily available.
5.12.2 Every young person in the Youth SUSD service will have a designated treating consultant psychiatrist**.**	• Recorded in young person's CIMHA record.
5.12.3 Every young person in the Youth SUSD service will be assigned a OSP/or PSP within the Youth SUSD service.	• Recorded in young person's CIMHA record. • The OSP/PSP is responsible for coordinating appropriate assessment, care and review, and completing referral and ongoing care processes.

Key elements	Comments
	• It is highly recommended that involvement of an Aboriginal and Torres Strait Islander mental health worker is prioritized to participate in ongoing service provision for young people of Aboriginal or Torres Strait Islander descent. • The PSP from the community mental health team will be recorded in CIMHA and remain constant during the young person's stay in the Youth SUSD service.
5.12.4 Each young person will be allocated a consistent community support staff for each shift. Each young person will be allocated a consistent clinical staff member when the clinical team is on-site.	• The young person will be aware of their allocated staff member for each shift.
5.12.5 The Youth SUSD service will actively engage with other mental health treating teams/community support staff (as appropriate) in coordination of care.	• Collaboration with other applicable services will be planned and documented.

5.13 Exiting/ transfer of care

Key elements	Comments
5.13.1 Planning for transfer of care/exit from the Youth SUSD service will commence at the time of entry. Transfer of care may be to community-based services or to acute inpatient services. This will be a planned process considering the needs of the young person, their family and/or carer, and available community resources, including ongoing engagement (or early engagement) of all service providers in ongoing care post exiting.	• Planning for transfer of care/exit will involve the young person, their family, carers and significant others, community-based treatment/support services and other key stakeholders. • Exit planning will be a routine component of each clinical review process and will involve development of a transition/exit plan. • A verbal handover will be provided on the day the young person leaves the Youth SUSD service. • A written handover/transfer of care will be provided on every transfer occasion. • Exit planning should also consider accommodation and support needs for young people who are homeless, in the care of the Department of Child Safety, Youth and Women (DCSYW) or at risk of homelessness.

Key elements	Comments
	• It is highly recommended that involvement of an Aboriginal and Torres Strait Islander mental health worker is prioritised for the transfer/exit of young people of Aboriginal and Torres Strait Islander descent. • HHS mental health services will give priority to young people transferring back to their HHS from the Youth SUSD service. This ensures that the young person does not remain in the Youth SUSD service longer than is deemed clinically necessary. • Exit planning should also consider accommodation and support needs for young people who are homeless, in the care of the DCSYW or at risk of homelessness. • Transfer of care • Transition of care for young people receiving mental health services
5.13.2 Disengagement by the Youth SUSD service will only occur after the receiving team and the family and/or carers have been consulted regarding follow up care arrangements	• If a young people has been admitted to a Youth SUSD service outside their usual residing HHS, any decisions regarding a transfer back to their residing HHS, (either to inpatient or community care), will be based on the clinical needs of the young person. • Policies and procedures for internal transfers will be clearly written, and receiving teams will make strenuous efforts to establish contact within a 7-day period. • Transfer of care documentation needs to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care, and procedures for re-referral. • Transition of care for young people receiving mental health services
5.13.3 Exit will occur when the Youth SUSD service is no longer the most appropriate service option and the care plans have been undertaken.	• The decision to exit is at the discretion of the Consultant Psychiatrist in consultation with Youth SUSD service staff. • Consideration will be given to how best maintain benefits gained from treatment interventions. • Transfer of care
5.13.4	• The Youth SUSD service will remain engaged with the young person, their

Key elements	Comments
Comprehensive liaison and handover will occur with all service providers who will contribute to ongoing care following the young person exiting the Youth SUSD service.	family and/or carers until they are engaged in follow up care including confirming that a follow up appointment has been made prior to discharge (where the young person/family have refused follow up, this will be documented in the clinical record). • Discharge letter/summaries are sent within 48 hours of exit and need to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care, relapse patterns, risk management and procedures for re-referral. • Suite of Clinical Documents • The OSP will contact the follow up service provider to ensure they accept the referral for ongoing provision of care (this will be noted in the young person's clinical record) and the young person is seen by the receiving team in a timely manner. • Transition of care for young people receiving child and youth mental health services
5.13.5 Community based supports are included in care planning and exit planning wherever possible.	• NGO service providers external to the Youth SUSD service, who have established (or are establishing) support links with the young person, families, and/or carers will be given access to the Youth SUSD service as appropriate. • The process for sharing information will be explicitly documented for each case, taking existing privacy, confidentiality and consent considerations into account. • *Hospital and Health Boards Act 2011 –* Part 7 Confidentiality • Transfer of Care • Care Plan
5.13.6 Local protocols for out of area transfers will be mutually agreed and documented.	• Information on inter-HHS transfers between CYMHS is available in the below document: • Transition of care for young people receiving mental health services
5.13.7 Where possible, young people will not be transferred to another HHS during crisis.	• Where transfer is unavoidable, both services need to make direct contact

Key elements	Comments
	and ensure safe transfer (service capability will be considered).
5.13.8 The young person, their family/carers will be consulted on and informed of the transition process and transfer procedures.	• Appropriate crisis plans will be prepared with the young person, family and/or carers.
5.13.9 Exit and transfer planning will include a care plan, and incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.	• Care Plan • The recovery, relapse prevention and crisis management plans will be provided to the young person, family and/or carer, GP and relevant support agencies.
5.13.10 Where the young person is subject to provisions of the *Mental Health Act 2016* there will be documented evidence that all statutory requirements have been met.	• Mental Health Act 2016
5.13.11 If it is considered inappropriate that the young person is to remain within the Youth SUSD service, the Youth SUSD staff should conduct an immediate clinical review involving all relevant stakeholders.	• This may relate to behaviour, breach of house rules of other significant concerns about the young person, staff or other residents. • The Youth SUSD staff will liaise directly with either the Consultant Psychiatrist regarding the potential unplanned exit, or appropriate clinical contact if after hours, e.g. Acute Response Team.
5.13.12 All planned leave will be discussed and agreed with the young person as part of their clinical review and documented in the young person's Care Plan.	
5.13.13 For unplanned leave, staff will discuss with the young person, and if there are concerns regarding risk, these concerns should be escalated with the Consultant Psychiatrist if available or HHS After Hours service. When young people are absent without leave or fails to return to the Youth SUSD service as expected, staff will attempt to contact the young person via their mobile phone or through their family, carer or significant others.	• If there are concerns for the safety of the young person, the Youth SUSD staff will consult again with the Consultant Psychiatrist or HHS After Hours service and escalate as appropriate (e.g. Queensland Policy Service). • All attempts to contact the young person and subsequent actions will be documented within CIMHA. • The Youth SUSD service is not an authorised mental health facility. Where Mental Health Act 2016 provisions apply, the young person will be treated in accordance to their needs and risk with all relevant paperwork completed within CIMHA.

5.14 Collection of data, record keeping and documentation

Key elements	Comments
5.14.1 The Youth SUSD service will enter and review all required information in CIMHA, in accordance with approved state-wide and HHS business rules.	• The Youth SUSD service clinical staff are responsible for CIMHA input. • CIMHA Standard Business Processes
5.14.2 The Youth SUSD service will utilise routine outcome measures as part of assessment, care planning and service development. These will include those QH mandated through the NOCC: HoNOSCA, HoNOS, SDQ, CGAS and FIHS. The NGO may have additional outcome measures that will be used.	• Outcomes data is presented at all formal case reviews and will be an item on the relevant meeting agendas. • Results of outcomes are routinely discussed with young persons and their families and/or carers to: – record details of symptoms and functioning – monitor changes – review progress and plan future goals in the care plan. • Mental Health Outcomes Collection Protocol • Outcome and Casemix measures for mental health services
5.14.3 All contacts, clinical processes, recovery and relapse prevention planning will be documented in the young person's clinical record.	• Progress notes will be consecutive (according to date of event) within all clinical records. • Suite of clinical documents • Aboriginal and Torres Strait Islander Cultural Information Gathering Tool Guide • Aboriginal and Torres Strait Islander Cultural Information Gathering Tool.
5.14.4 Clinical records will be kept in accordance with legislative and local policy requirements.	• Personal and demographic details of the young person, family, and/or carers and other health service providers will be reviewed regularly and kept up to date. • Mobile or tablet technology will support any increasing application of electronic record keeping. • Clinical records management policy • Retention and disposal of clinical records protocol • Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines

Key elements	Comments
5.14.5 Local and state-wide audit processes will monitor the quality of record keeping and documentation (including external communications), and support the relevant skill development.	

5.15 Working with families and/or carers

Key elements	Comments
5.15.1 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.
5.15.2 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 Youth SUSD 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.
5.15.3 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 Youth SUSD 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

Key elements	Comments
	deterioration in their own health and wellbeing.
5.15.4 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 Youth SUSD 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

6. Related services

The Youth SUSD MOS is an integrated service representing a partnership between Queensland Health and the NGO, and sits within the continuum of Queensland public mental health services. Mental health services operate in a complex, multi-system environment which includes crucial interactions with other areas of Queensland Health (e.g. Alcohol, Tobacco and Other Drug Services and Community Health), other Queensland Government Departments (e.g. Department of Education (DoE), DCSYW, Department of Communities, Disability Services and Seniors (DCDSS) and the Department of Housing and Public Works), GPs, private providers, other NGOs and other relevant services.

The Youth SUSD service should be integrated and coordinated, with specialist clinical mental health services, community support services and external service providers for young persons. This ensures continuity of care across the service system and through the young person's developmental transitions. Staff should have a comprehensive knowledge and understanding of the services available that support/provide health and mental health care. Relationships should be initiated and maintained with these external service providers and support services. An up-to-date resources database should be maintained by the Youth SUSD service. These include, but not limited to, other Health services, Education, Employment services, Housing services and other primary care providers.

Youth SUSD service should work collaboratively with the young person's educational and/or vocational provider to enable engagement or reengagement of educational and vocational connections.

7. Workforce

Providing a fully integrated service model where the HHS provides clinical services alongside provision of non-clinical support services by a NGO collaboratively within a developmentally appropriate rehabilitative and residential environment in the community is the foundation of the Youth SUSD MOS.

The HHS clinical staffing profile is comprised of a mix of clinical mental health professionals including a consultant psychiatrist, a designated Clinical Lead and a multi-disciplinary team including nurses and allied health staff to provide clinical coverage between 8am and 10pm, 7 days a week.

The NGO community mental health worker staffing profile is comprised of a Service Manager, community mental health workers, peer workers and other specialist roles as required, i.e. Aboriginal and Torres Strait Islander Mental Health Workers and family worker. The Youth SUSD MOS provides 24-hour services which require NGO staff to be continuous shift workers.

Additionally, the Youth SUSD service is supported by administrative officers, and other HHS staff as appropriate to assist with the day to day operations of the unit.

For both the HHS and NGO staff, a blend of knowledge and skills is required to deliver a recovery focused model within a community bed-based (sub-acute) service element encompassing both clinical and psychosocial aspects of treatment and care. The skills mix and complexity of the young person is a factor when allocating both clinical and non-clinical staff, with the young person informed of their focal staff each shift.

Staff to young person ratios should be based on the age and developmental requirements of the cohort, and aligned with the NMHSPF.

The effectiveness of the Youth SUSD MOS is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. Youth SUSD staff should have experience in working with young people with mental health issues, an understanding of the developmental needs of the cohort, or demonstrate the ability to gain this understanding.

The complexity of the young person accessing the service suggests the need to provide staff with continuing education programs, clinical supervision and mentoring, and other appropriate staff support mechanisms.

The HHS and the NGO undertakes evidence-based recruitment and retention strategies such as providing placements for students, encouraging rotations through the unit for staff from other areas of the integrated mental health service or NGO, and supporting education and research opportunities.

8. Governance

The 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.

Service agreements between Queensland Health and the NGO will document the delivery arrangements for the services implementing the Youth SUSD MOS including a list of indicators to measure performance outcomes of the service delivered.

An integrated governance structure will be determined collaboratively between the HHS and the NGO. This documented governance structure and clear reporting roles will ensure effective management and the efficiency of service delivery.

Multidisciplinary integrated team work is essential with clear clinical, operational and professional leadership established and communicated to all HHS and NGO stakeholders.

The Youth SUSD Consultant Psychiatrist has overall clinical responsibility for the treatment and care provided to young people accessing the Youth SUSD service, including management of risk assessment and overall decision making as to the entry/exit to/from the Youth SUSD service.

Services are provided in partnership with the young person, their family and carers as well as their community-based service and support network.

Youth SUSD services will incorporate the *National Standards for Mental Health Services 2010*.

9. Hours of operation

24 hours a day, 7 days a week. This includes public holidays.

10. Staff training

Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure that they are clinically competent. Staff are encouraged and supported in working towards the attainment of specialised mental health qualifications. All training will be based on best practice principles and evidence-based treatment guidelines, and underpinned by the National Framework for Recovery Oriented Mental Health Services.

All staff must be engaged in relevant professional development to ensure contemporary and evidence-based intervention and treatment is provided to young people, their family and carers. The clinical acuity and complexity of young people accessing mental health services is increasing including a high proportion of the population that have experienced significant abuse, trauma and/or neglect. There is growing focus on the integrated approach to managing these traumatised young people in mental health care settings.

Specialist skills are required to manage escalating behaviours as a result of trauma, including attachment issues and affect deregulation. Staff are to be adequately trained in these specialist skills to provide effective evidenced-informed interventions.

This is a requirement for annual registration with the governing bodies of most disciplines. Involvement in research activities is also highly desirable.

Training should be based on best practice principles and will be underpinned by the recovery framework. Teams are encouraged to make the relevant components of their training available to their service partners.

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
- promotion, prevention, and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing young people and their families and/or carers
- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention
- *Mental Health Act 2016*
- National Standards for Mental Health Services 2010
- evidenced informed practice in service delivery
- young person focused recovery-oriented care planning
- routine outcomes measurement training
- a range of treatment modalities including individual, group and family-based therapy
- an understanding of key theoretical frameworks including adolescent development, attachment, complex trauma, grief and loss, and family systems theory
- child safety services training
- knowledge of mental health diagnostic classification systems
- medication management
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- cultural capability training
- alcohol and drug assessment and intervention
- family therapy
- occupational violence prevention and management training

11. Key Resources

11.1 Website resources

Resource
A national framework for recovery-oriented mental health services: Guide for practitioners and providers
A National framework for recovery-oriented mental health services: Policy and theory
CheckUP (formerly General Practice Queensland)
Child Protection Act 1999
Child Protection guidelines at the Queensland Health policy site
Children of Parents with a Mental Illness (COPMI)
Choice and medication
Clinical Knowledge Network
Clinical Services Capability Framework
Complaints and compliments about health services
Consumer, Carer and Family Participation Framework
Deafness/hearing loss and mental health service
Dual diagnosis
Fees and Charges Register
Forensic Order
Health Legislation Amendment Bill 2014
Hospital and Health Boards Act 2011
Indigenous mental health
Information sharing between mental health workers, consumers, carers, family and significant others
Intentional peer support
Mental Health Act 2016
Mental health statement of rights and responsibilities 2014
Multicultural mental health
National practice standards for the mental health workforce 2013
National Safety and Quality Health Service Standards 2nd Edition 2017
National standards for mental health services 2010
Principles and actions for services working with children of parents with mental illness
Protecting children and young people
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 –2033
Queensland Health dual diagnosis policy–Service delivery for people with dual diagnosis
Queensland Health interpreter service
Queensland transcultural mental health centre
Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines
Therapeutic Guidelines–Psychotropic
Working with parents with mental illness–guidelines for mental health clinicians
Youth Mental Health website

11.2 Queensland Health intranet (QHEPS) resources

Resource
CIMHA–handbooks, manuals and resources
CIMHA–Standard business processes
Clinical services capability framework
Clinical supervision guidelines for mental health services
Consumer Integrated Mental Health Application (CIMHA)
Dual diagnosis–clinical guidelines
Information sharing–Child safety
Medication liaison on discharge
Mental Health Alcohol and Other Drugs Branch resources
Mental health alcohol and other drugs quality and safety
Mental health child protection form
Mental health services – Care Plan
Mental health services–Consumer care review summary and plan
Mental health services–Consumer end of care/discharge summary
Mental health services–Substance Use Assessment
Mental health services–Risk screening tool
My recovery plan
Queensland Health mental health case management policy framework
Protecting children and young people
Clinical incident management resources
Sharing responsibility for recovery
Statewide standardised suite of clinical documentation
Statewide standardised suite of clinical documentation user guide
Transfer of care
Transition of care for young people receiving child and youth mental health services

Abbreviations

AAIU	Adolescent Acute Inpatient Unit
AMHS	Adult Mental Health Service
AMYOS	Assertive Mobile Youth Outreach Service
ART	Acute Response Team
CALD	Culturally and Linguistically Diverse
CIGT	Cultural Information Gathering Tool
CGAS	Children's Global Assessment Scale
CTO	Community Treatment Order
CSCF	Clinical Services Capability Framework
CMMH	Community managed mental health
CIMHA	Consumer Integrated Mental Health Application
CYMHS	Child and Youth Mental Health Service
DCSYW	Department of Child Safety, Youth and Women
DCDSS	Department of Communities, Disability Services and Seniors
DEM	Department of Emergency Medicine
DoE	Department of Education
FIHS	Factor Influencing Health Status
GP	General practitioner
HoNOSCA	Health of the Nation Outcome Scale for Children and Adolescents
HoNOS	Health of the Nation Outcome Scale
HHS	Hospital and Health Service
MDT	Multi-Disciplinary Team
MHAODB	Mental Health Alcohol and Other Drugs Branch
MOS	Model of Service
NMHSPF	National Mental Health Service Planning Framework
NGO	Non-Government Organisation
NOCC	National Outcome and Casemix Collection
PSP	Principal Service Provider
ROPI	Recovery-Oriented Practices Index
ROSI	Recovery Oriented Systems Indicators Measure
RPFS	Recovery Promotion Fidelity Scale
RSA	Recovery Self-Assessment
SDQ	Strengths and Difficulties Questionnaire
Youth SUSD	Youth Step Up Step Down service
YRRU	Youth Residential Rehabilitation Unit