Evolve Therapeutic Services (ETS) Model of Service (MOS) – Updated

Queensland Public Mental Health Services

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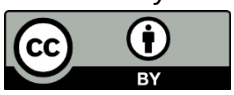

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Preamble

In 2004, the Crime and Misconduct Commission (CMC) report 'Protecting Children: An Inquiry into Abuse of Children in Foster Care'[1] identified concerns regarding a clear unmet need for therapeutic services within the care population. In response the CMC report recommended that "more therapeutic treatment services are made available to children with severe psychological and behavioural problems" and that the implemented service should be evaluated.

Following acceptance of the report recommendations, the then Department of Communities, Child Safety and Disability Services (DCCSDS) funded Evolve Interagency Services (EIS/Evolve), which was an interagency partnership between Queensland Health (QH), DCCSDS and the Department of Education, Training and Employment (DETE).

Evolve Therapeutic Services (ETS), QH's contribution to the broader EIS, was established in 2005 as a tertiary level mental health intervention service to address the mental health therapeutic needs of children/young people in out of home care. ETS is the only remaining component of EIS.

This ETS Model of Service (MOS) describes the ETS program element within the Queensland public mental health, alcohol and other drugs service system. The ETS program is funded by the Department of Children, Youth Justice and Multicultural Affairs (DCYJMA) and is delivered by QH Hospital and Health Services (HHS) as per the ETS 2019-2024 Memorandum of Understanding (MOU).

The ETS program provides specialist intensive trauma informed mental health therapeutic interventions for children and young people with severe and complex psychological issues and/or behavioural problems who are subject to active child protection interventions. In addition to direct specialist mental health service provision, ETS provides psycho-education and skill development to foster/kinship carers, residential care providers, government, non-government and private sector service providers with the aim of strengthening the service system available to meet the multiple and varied mental health needs of these children and young people.

The ETS MOS seeks to be inclusive, ensuring that 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 are provided with accessible, high quality, culturally appropriate mental health treatment and care.

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.

The ETS MOS should be read in conjunction with Attachment 1 'ETS Service Delivery Requirements' of the ETS 2019-2024 MOU, CIMHA business rules and the DCYJMA ETS Manual.

[1] https://www.ccc.qld.gov.au/sites/default/files/Docs/Public-Hearings/Abuse-of-children-in-foster-care/Protecting-children-An-inquiry-into-abuse-of-children-in-foster-care-Report-2004.pdf

1. What does the ETS MOS intend to achieve?

The key focus of ETS is to provide planned and coordinated therapeutic and behaviour supports to children/young people with care experience, aimed at improving emotional wellbeing and the development of skills to enhance participation in education and the community. The ETS service delivery model is intensive and trauma-informed, grounded in well-established theoretical perspectives (child development, systemic theory, trauma, attachment, psychodynamic theory, grief and loss, and culture) to encapsulate a collaborative 'wrap-around' model of service. Provision of service commences from point of acceptance and is achieved through a flexible use of appropriate evidence-based and informed individual, dyadic and systemic therapeutic interventions and a coordinated and sustainable partnership with key government and non-government and private sector agencies.

The key functions of the ETS program are to:

- provide specialist expertise in the assessment, formulation, diagnosis, care planning, monitoring, treatment and evaluation of children/young people in care with severe and complex mental health and/or behavioural support needs
- assist the care and support network of these children/young people to have the capacity to effectively respond to their identified needs.

The delivery of specialist training to a range of stakeholders is an important complementary aspect of ETS, specifically focused on DCYJMA priority Service User groups including foster and kinship carers, residential care workers and child safety services staff.

ETS program functions:

- facilitating access to a range of mental health service options as appropriate (e.g. specialist mental health programs and inpatient admissions) for children, young people and families
- facilitating access to adult mental health services as required
- assisting in the development of a secure, safe, responsive and nurturing environment/s
- providing high quality care to children, young people and their families/carers with a focus on building resilience and assisting in the recovery of an appropriate developmental trajectory
- enhancing the capacity of the primary carer to forge trauma-informed responsive and nurturing connection/ attachment with the child/young person with complex needs
- supporting the child/young person to enhance and maintain developmentally appropriate social and peer relationships
- assisting children/young people to maintain or regain engagement in developmentally appropriate learning/vocational tasks
- advocating for connections with cultural heritage to support the child/young person in the process of constructing/processing their personal and cultural identity and social emotional wellbeing
- clinicians working with the child/young person to plan interventions consistent with the reunification process where appropriate (i.e. where the child/young person is being reunified with their family of origin)
- decreasing stigma and discrimination within the local community and reducing barriers to social inclusion.

The ETS Program will:

- work collaboratively with stakeholders to determine trauma-informed intervention goals including recognition of stakeholder plans
- provide information, advice and support to carers and support networks (of the target population), including foster carer and residential care training
- promote culturally safe practice in engaging with Aboriginal and Torres Strait Islander and culturally diverse communities to enable effective mental health service provision and positive outcomes
- offer specialist consultation-liaison services to other service providers internal to QH, and externally across the government, non-government and private sector
- provide specialist professional development and training to staff internal to QH (e.g. child and youth mental health services (CYMHS), alcohol and other drug services, emergency departments, child health and Aboriginal and Torres Strait Islander health) as well as staff of key government departments (e.g. DCYJMA, Department of Education), private practitioners and non-government agencies (e.g. residential and support service providers)
- promote and advocate for improved access to general health and care services for children, young people and their families and carers.

The ETS MOS describes only one element from the continuum of service elements available to assist children/young people (working collaboratively with their families and carers) to recover their health, wellbeing and developmental potential (see Figure 1).

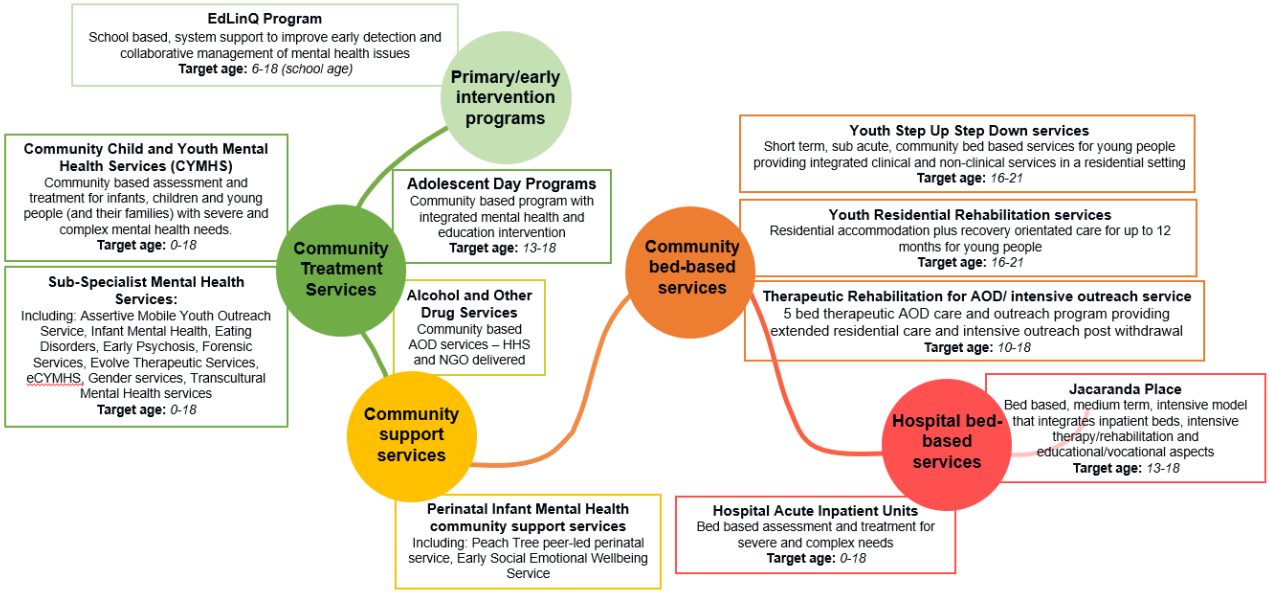

Figure 1: Broad overview of child and youth mental health, alcohol and other drugs service system in Queensland

2. Who is the ETS MOS for?

The ETS program is for children and young people with severe and complex psychological and/or behavioural problems who are subject to an interim or finalised child protection order granting custody or guardianship to the chief executive of the DCYJMA, on an Intervention with Parental Agreement and subject to a child protection care agreement; or a Support Service Case for a child or young person transitioning from care.

Children/young people receiving a service from ETS typically have severe and complex clinical presentations. Common diagnoses and presentations of these children/young people are attachment disorders, anxiety, mixed mood and conduct disturbances, post-trauma symptoms, deliberate self-harm, suicidal ideation, problematic substance use, educational difficulties, and language or communication disorders.

In addition to direct (individual, dyadic and systemic) mental health therapeutic service provision, ETS teams provide psycho-education and skill development to key stakeholders in the child or young person's safety and support network including family/carers, residential care providers, government, non-government and private sector service providers. The definition of "family/carers" includes key people involved in the life or care of the child/young person. This may include, but is not limited to, biological family, kinship carers, foster carers, residential carers, respite carers.

Referrals to ETS can only be made by DCYJMA. Following internal DCYJMA eligibility identification processes, referrals to ETS are submitted by DCYJMA directly to their respective local ETS team through a locally agreed intake process. All referrals are assessed against three criteria as outlined in the ETS 2019-2024 MOU:

- the child/young person is under 18 years of age, with priority cohort aged 5 to 17 years.
- the child/young person presents with severe and complex psychological and/or behavioural problems.
- the child/young person:
    - is subject to an interim or finalised child protection order granting custody or guardianship to the chief executive of DCYJMA;
    - on an Intervention with Parental Agreement and subject to a child protection care agreement; or
    - is subject to a Support Service Case.

Each eligible referral is also assessed against the following prioritisation criteria:

The child or young person is experiencing:

- the presence of multiple, intense and persistent psychological and/or behavioural problems;
- a level of risk to themselves and others requiring specialist and intensive therapeutic intervention;
- severe functional impairment across a variety of domains; and
- the presence of additional risk factors.

Which result in the need for:

- a collaborative interagency service response;
- specialist assessment and understanding of the psychological and behavioural impact of child abuse and neglect; and
- intensive mental health therapeutic intervention.

The majority of children/young people referred to the ETS program will present with a high level of risk. These risks generally occur within the individual, family, and system contexts and impact significantly on their daily functioning and bring some level of risk to their safety and wellbeing. ETS often manage risk beyond that of more general challenging or at-risk behaviour[2], that children/young people with care experience often exhibit.

3. What does the ETS program deliver?

The ETS program is part of an integrated mental health alcohol and other drug service system that includes acute and non-acute inpatient services, consultation-liaison psychiatry, and a range of specialist positions, teams and statewide services. ETS teams are situated within QH Community CYMHS and managed within HHS structures.

Tables 3.1-3.13 outline the key components and elements essential for the effective operation of the ETS program.

3.1 Working with other service providers

Key elements	Comments
3.1.1 The ETS program aims to enhance mental health and participation in educational and vocational activities for children/young people with care experience. This is achieved via a formalised strong, collaborative interdepartmental partnership and response between DCYJMA and QH.	• The ETS Program operates under a MOU along with strong governance structures and reporting requirements as stipulated in the MOU. • ETS works in close collaboration with the DCYJMA to meet the needs of the allocated child/young person, their family (biological, service providers, kin and foster carer/s). • Clear and regular contact and interdepartmental communication processes between partner agencies (DCYJMA and QH) are maintained by each respective departmental officer and/or delegate. • All ETS Local Steering Committees, consisting of senior management representatives from DCYJMA and QH, meet on a regular basis to monitor and review the local interdepartmental partnership.
3.1.2 Strong partnerships will be initiated and maintained with other local health and mental health service providers, as well as with education/vocation services, Child Safety Service Centres (CSSC), Youth Justice Centres, alcohol and other drug services, Aboriginal and Torres Strait Islander services, non-government	• ETS develop collaborative relationships with key stakeholders so that advice, consultation, development of expertise, facilitation of referral and access will ensure a timely and appropriate response to those potentially in need of specialist mental health assessment, intervention and care coordination. To ensure this:

[2] Child Safety Policy (604-5) - Positive Behaviour Support. Department of Child, Youth Justice and Multicultural Affairs (2020)

Key elements	Comments
organisations and other community support services, such as foster care support agencies and out-of-home care accommodation providers.	- Local protocols will enhance communication at all phase of care. - Advice, education and support regarding child and youth mental health issues, including complex trauma and attachment issues are provided to other services. • Joint planning and decision making occurs to better meet the needs of children/young people and families/carers. • As specific needs and goals are identified, the child/young person and their families/carers will be assisted in accessing an appropriate range of non-clinical support structures. • ETS teams work with educational settings, where appropriate, to assist and advocate for educational support and education specific mental health plans that promote resilience, wellbeing and developmentally appropriate skills and abilities. • Where relevant, existing service coordination programs are consulted to support cross sectoral partnerships and collaborative care models including the Ed-LinQ Program, Nurse Navigators Program and School Based Youth Health Nurse Program.
3.1.3 The ETS program is supported in its operation and function by the provisions outlined in the *Child Protection Act (1999)*.	• The *Child Protection Act (1999)* is the primary legislation providing for the protection of children in Queensland and outlines the provisions for collaboration between government departments (and non-government service providers).
3.1.4 General Practitioners (GPs) are to be involved for children/young people across the entire diagnostic range.	• Shared care arrangements are encouraged. • All effort will be made to record a nominated GP in the Consumer Integrated Mental Health and Addiction (CIMHA) Application for all children/young people with an open service episode to the ETS Program.
3.1.5 There is active engagement with a range of primary health care providers to meet the general health care needs of children/young people.	• Shared care arrangements are encouraged.
3.1.6 ETS teams develop strong links with hospital emergency departments, mental health acute care teams and mental health inpatient units so that service accessibility is ensured.	• ETS aims to be accessible and responsive to both the types of services delivered and the way in which they are delivered. • Partnerships with other mental health services/teams will be supported by local protocols, as appropriate, that: - enhance communication

Key elements	Comments
	- promote joint planning and decision making - utilise an exchange of knowledge and expertise - promote continuity of care.
3.1.7 Where the child/young person and/or their families/carers have specific needs (e.g. sensory impairment, intellectual or developmental disability, cultural/transcultural needs), ETS will engage the assistance of appropriate services to ensure that communication and cultural needs are addressed. The ETS program is inclusive of people with diverse culture, sexual orientation, gender identity or intersex variations, ensuring their perspectives inform assessment and are incorporated with a holistic treatment framework.	• Certain population groups require specific consideration and collaborative support. This includes Aboriginal and Torres Strait Islander Peoples and people from Culturally and Linguistically Diverse (CALD) backgrounds. • ETS operates under the 'Safe Care and Connection' and the Child Placement Principle within the *Child Protection Act (1999)*. • ETS operate under a trauma-informed and integrated approach, promoting collaboration with relevant government and non-government agencies to maximise child/young persons' outcomes. • Queensland Health Interpreter Services • Deafness and Mental Health Service • Queensland Transcultural Mental Health Centre • Aboriginal and Torres Strait Islander Patient Care Guideline • Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 • Queensland public sector LGBTIQ+ Inclusion Strategy • Multicultural Mental Health – Queensland Health Multicultural Services • Department of Seniors, Disability Services and Seniors and Aboriginal and Torres Strait Islander Partnerships

3.2 Referral, access and triage

Key elements	Comments
3.2.1 Referrals to ETS can only be made by DCYJMA via the ETS Team.	• The ETS referral form is held on the DCYJMA internal intranet site. • All appropriate consent needs to be obtained, e.g. referral form, from the legal guardian in accordance with QH and HHS requirements.
3.2.2 Referrals to ETS are assessed against the following three criteria:	• ETS is one part of the mental health continuum for children / young people with care experience.

Key elements	Comments
1. the child or young person is under 18 years of age 2. the child or young person presents with severe and complex psychological and/or behavioural problems 3. the child/young person: o is subject to an interim or finalised child protection order granting custody or guardianship to the chief executive of DCYJMA, o on an Intervention with Parental Agreement and subject to a child protection care agreement; or is subject to a Support Service Case.	• DCYJMA regional discretion may be utilised on an individual basis, and with agreement of the ETS Team Leader, to refer a child or young person subject to statutory child protection intervention who is in out-home-care or living at home and presents with either severe and/or complex psychological and/or behavioural problems or are assessed as being on a trajectory towards these problems, where an alternative appropriate service is unable to be accessed.
3.2.3 Children/young people are referred to ETS with severe and complex psychological and/or behavioural difficulties across a wide range of domains.	• Following receipt of an ETS Referral Form from DCYJMA, completion of a Triage Screen will inform the prioritisation process. • If the referred child/young person is an existing client of CYMHS, the existing comprehensive care documentation will assist in the referral, prioritisation and transfer process. • Where possible discussions regarding referrals and prioritisation is to occur during ETS Multidisciplinary Team Review (MDTR) meetings and/or via a discussion with the consultant psychiatrist. There will be a clear triage system for prioritisation of referrals based on risk, individual need and local capacity by considering if the child or young person is experiencing: o The presence of multiple, intense and persistent emotional and/or behavioural problems o A level of risk to themselves and others requiring specialist and intensive therapeutic intervention o Severe functional impairment across a variety of domains o The presence of additional risk factors which is considered to require the need for: ▪ a formalised interdepartmental process ▪ a specialist conceptualisation of the psychological and behavioural sequelae (both internalising and externalising) of child abuse and neglect

Key elements	Comments
	▪ an intensive mental health therapeutic intervention.
3.2.4 Not all referrals to ETS will meet the eligibility criteria. ETS is one service element in the mental health continuum for children / young people with care experience.	• When ETS is unable to accept a referral (either due to the referral not meeting criteria or if other services are better placed to respond to the needs outlined in the referral), the ETS team will advise the CSSC, as the child/young person's guardian, and provide recommendations regarding appropriate alternative services to meet the specific needs of the child/young person. • Depending on the needs of the child/young person and any identified risk issues, ETS will facilitate a referral to services such as child and youth mental health services. • If a child/young person is presenting in crisis, however does not meet the eligibility criteria for ETS and is not accepted, referral assistance to more appropriate services will be provided (taking into account the appropriate timeframe for the situation and with the permission from the guardian).

3.3 Assessment

Key elements	Comments
3.3.1 • An initial assessment, including a risk assessment, of the child/young person is conducted following agreement to accept child/young person for ETS Service Provision. • Following acceptance, ETS will complete a comprehensive clinical assessment of the bio/psycho/social/ cultural aspects for each accepted referral, including an assessment of drug and alcohol use. • Clinical intervention and stakeholder engagement will occur as appropriate during this period.	• Initial and ongoing assessment will explore the child/young person's, family/carer's, and system (individual, dyadic and systemic) strengths and goal identification, barriers to improvement, and the child/young person's and family/carer's perception of progress toward recovery focused goals. • ETS will provide or facilitate specialist mental health alcohol and other drugs assessments incorporating, where indicated, psychological, cognitive, substance use, functional, vocational, social, physical and cultural aspects of the child/young person's functioning. • A mental health assessment report will be provided to the Child Safety Officer at the completion of the assessment. • The assessment report will be recorded in CIMHA. • Every effort is made to limit the repetitive nature of the information gathering process required for this assessment for the child/young person.

Key elements	Comments
	• All appropriate consent needs to be obtained from the guardian and child/young person (if applicable) in accordance with QH and HHS requirements. • An endorsed 'Obtain and Release of Information' consent form is required to gather and release information. HHS specific research consent form also needs to be completed. • QH Comprehensive Care documentation • Chief Psychiatrist Policy Examination and Assessment • Chief Psychiatrist Policy Treatment and care of minors
3.3.2 Assessment will involve input from child/young person, their families/carers, significant others and key service providers and stakeholders as appropriate.	• Information sharing, within the provisions of the *Hospital and Health Boards Act 2011* and *Child Protection Act (1999)* will occur as required. • Relevant information will be sought and recorded with due regard for the child/young person's and family/carers' right to privacy. • Queensland Health Guideline: Information sharing between mental health staff, consumers, family, carers, nominated support persons and others.
3.3.3 Assessment will entail the collection of collateral information from the CSSC, family/carers and other key stakeholders. This process will inform the development of treatment and resilience orientated goals.	• An assessment of the circumstances, child/young person's strengths, risk and protective factors, symptoms, relationships and co-morbidities inform the development of a formulation, diagnosis and care plan. • The Principal Service Provider [3](PSP) will clarify with the child/young person who they identify as their family/carers.
3.3.4 Risk assessments will be conducted during initial assessment, and as clinically indicated in all phases of care provision, and at a minimum of three months as per clinical care review. • A risk assessment will be documented prior to transfer or discharge. • Risk assessments will include a formalised suicide risk assessment,	• Children/young people referred to ETS may be a higher level of risk (i.e. to themselves and others) than most other children and young people subject to child protection intervention. Risks can include substance use, verbal and physical aggression, suicidality and self harm, sexual vulnerability and abuse. • In the initial assessment the risk assessment will be conducted as one component of a comprehensive mental health assessment.

[3] A Principal service provider (PSP) is a Queensland Health clinician with primary responsibility for the coordination of the treatment and care provided to the consumer (and their carer(s)).

Key elements	Comments
assessment of risk to others and drug and alcohol use assessment.	• All risk assessments will be recorded in the clinical record. • Risks identified are incorporated into a comprehensive risk management plan which will be shared with key stakeholders e.g. CSSC, and QH. • Specific areas of risk may be evaluated more frequently as clinically indicated. • The discharge risk assessment will be recorded on the Transfer of Care form in CIMHA. • Risk assessments will be conducted in accordance with QH risk management procedures. • Comprehensive Care documentation
3.3.5 Physical health and dental health will be routinely assessed, managed and documented.	• Documented evidence of physical and oral health assessments or referral will be in the child/young person's clinical record. • Clinical alerts (e.g. medication allergies and blood-borne viruses) must be documented and captured within CIMHA (where appropriate). • Efforts will be made to ensure all children/young people have a nominated GP. • Children/young people and their families/ carers will be actively supported to access primary health care services and health improvement activities. • Any potential health problems identified will be discussed with the CSSC, the child/young person and family/carers, and where appropriate with the GP or other primary health care provider as appropriate. • Advocate with the CSSC for all allocated ETS child/young person to have a 'Child Health Passport'. • Where appropriate, metabolic monitoring will be carried out and documentation will occur. • Comprehensive Care documentation
3.3.6 The outcome of assessments (including outcome measures) will be communicated to the child/young person, carer and other stakeholders (including CSSC).	• The CIMHA Mental Health ETS Assessment Report/Assessment–Child and Youth Mental Health Assessment is to be used for sharing information with CSSC regarding assessment outcomes. • For Aboriginal and Torres Strait Islander consumers, engage with Indigenous Mental Health Worker or Hospital Liaison Worker to

Key elements	Comments
	support and assist with assessment and care planning. • The Cultural Information Gathering Tool (CIGT) can assist the Indigenous Mental Health Worker in collecting cultural information relevant to the individual and that may impact on the consumer's presentation, diagnosis, treatment and recovery. • Throughout the assessment of Aboriginal and Torres Strait Islander consumers the QH endorsed Social and Emotional Wellbeing Resources needs to be considered • Where an Indigenous 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 child/young person and to ensure cultural safety is upheld. • Comprehensive Care documents • Hospital and Health Boards Act 2011 – Part 7 Confidentiality • Right to Information and Information Privacy • Queensland Health Guideline: Information sharing between mental health staff, consumers, family, carers, nominated support persons and others • *Mental Health Act 2016* Information • *Mental Health Act 2016* Resources • Mental Health Act 2016 Key topics • Mental Health Review Tribunal • Mental Health Court
3.3.7 Child safety concerns will be identified through risk assessments and addressed in accordance with mandatory reporting requirements.	• When an ETS staff member forms a reasonable/reportable suspicion of child abuse and/or neglect, staff are to abide by QH and HHS processes. • ETS is to be mindful of DCYJMA policies pertaining to: o Positive Behaviour Support (Policy Number 604-5) o Managing high risk behaviour (Policy Number 646-2) • Liaison with the CSSC is essential to ensuring continuity of care. • Child Protection Act 1999 • Child Protection guidelines at the Queensland Health policy site

Key elements	Comments
	• Working with parents: guidance for mental health, alcohol and other drugs services • Reporting Forms - Report of a Suspected Child in Need of Protection
3.3.8 Once accepted to ETS, at the time of assessment a general information pack about QH and ETS will be available for all children/young people and families/carers.	• Information, for instance, regarding QH, ETS services, compliments/complaints processes, and 'consumer rights and responsibilities' will be provided to all children/young people and families/carers in an accessible manner. • Culturally diverse orientation material specific to the unique populace of the local service is to be included as required. • Complaints and compliments about health services • Chief Psychiatrist Policy Management of complaints and right to a second opinion • Chief Psychiatrist Policy Patient rights and support

3.4 Care review

Key elements	Comments
3.4.1 Each allocated child/young person will be discussed at MDTR meetings when clinically indicated, and at intervals of no longer than three months. New allocated child/young person will be discussed at the next available MDTR meeting. The child/young person's care plan will inform discussion at the MDTR.	• MDTR will be attended by a consultant psychiatrist either directly, or via telehealth. • Formal care review will provide an in-depth, recovery/resiliency focused perspective for the child/young person. • All MDTRs will be documented in CIMHA using the Care Review form. • The summation recorded on the child/young person's care review summary and plan should include attendees, a concise documentation of the content of the discussion, clinical issues raised, treatment care plan, requirements for additional collateral and those responsible for actions. • Where the child/young person is part of, or are being referred to, another part of the mental health service, MDTRs should include an appropriate representative from that treating team. • In rural and remote areas (such as spoke sites), the frequency of MDTR meetings may be determined by the team leader in consultation with the consultant psychiatrist, taking into account clinical need and service operational issues, but occur no less than once a month.

Key elements	Comments
	• Where appropriate the opinions and observations of the child/young person, their guardian and key stakeholders will be considered during the reviews. • Structured risk and review processes will be utilised. • Outcomes of clinical reviews will be discussed with child/young person and key stakeholders as appropriate. • Comprehensive Care documentation
3.4.2 Ad-hoc MDTRs will occur to address complex clinical issues where indicated (e.g. in the event of a crisis/identified risks, change in living situation, change of child/young person goals or discharge).	• Critical events will be reviewed utilising the QH Best practice guide to clinical incident management.
3.4.3 Discharge and transition planning will be a routine component of each clinical review (MDTR) and is part of the Interagency 15-month review discussion with CSSC.	• Discharge and transition planning occur in collaboration with DCYJMA and key stakeholders. • If the child or young person is still accessing ETS at 15 months after acceptance, and no closure plan process has begun, a formal review with DCYJMA will be undertaken to determine whether ongoing intervention is required, or whether the discharge stages of a consumer's care needs to be initiated. • QH Transition Guideline

3.5 Recovery focussed planning

Key elements	Comments
3.5.1 A comprehensive QH CIMHA Care Plan includes recovery focused planning and will be developed with every child/young person and their family/carers. Care Plans are developed on the premise that children/young people referred to ETS are profoundly impacted by their experiences of neglect/abuse. Recovery principles such as optimism, strengths focus, and resilience are key elements for ETS.	• The Care Plan is developed via a collaborative process with the child/young person and the CSSC. These plans need to be cognisant of the child/young person's CSSC developed care plan. • Care Plans will take into account relevant contributing, maintaining and protective factors outlined in the clinical formulation (developed from the comprehensive assessment). • ETS aims to achieve significant gains in the identified principles of recovery and considers how these concepts apply to children/young people and their families/carers. • Some children/young people and their care systems will need support in adapting to ongoing developmental delays, difficulty in

Key elements	Comments
	developing healthy attachments and other symptomatology when complete recovery is not possible. • Children/young people with a complex trauma history or disrupted attachment may have ongoing increased dependency needs into adolescence and young adulthood. • As the child/young person moves into early adolescence, a greater emphasis is placed on the views and goals of the young person. • National standards for mental health services 2010 • Care Plan • Comprehensive Care documentation
3.5.2 • Care Plans and significant changes in intervention will be formally reviewed by the MDTR and discussed at ETS stakeholder meetings. • Care Plans are reviewed and updated every 91 days.	• Care Plans are reviewed via the stakeholder process every 91 days. Reviews of the plan are to include progress towards identified goals and outline future goals. • Annual internal audits will ensure reviews are conducted. • The PSP will participate in their MDTR to table, discuss and review their plan. • Team leader or identified delegate will table Care Review Summary and Plan documents with CSSCs at regular review periods. • Comprehensive Care documentation
3.5.3 Every effort will be made to ensure that treatment planning focuses on the child/young person's own goals.	• Where conflicting goals exist (e.g. for children/young people receiving involuntary treatment) this will be clearly outlined and addressed in a way that is consistent with the child/young person's goals and values.

3.6 Clinical interventions

Key elements	Comments

3.6.1
Specialist clinical interventions, reviews and follow up processes will include a range of delivery methods to ensure safety and to meet clinical care needs. These may include, but are not limited to, home and school visits, clinic appointments, telephone contact, and input from non-clinical support workers and/or non-government service providers.
	• The extent and type of follow up methods will specifically align with clinical need and acuity levels.
	• Services will be delivered in the least restrictive environment possible and cognisant of DCYJMA policies pertaining to:
	  • Positive Behaviour Support (Policy Number 604-5)
	  • Managing high risk behaviour (Policy Number 646-2)

Key elements	Comments
Intervention occurs over the individual, dyadic and systemic level. Intensity over these three levels is guided by clinical need. Dyadic and systemic issues impact upon effectiveness of individual intervention.	• ETS will proactively provide interventions utilising care coordination to facilitate assertive engagement and follow up. • Wherever possible, clinic design will take into account the needs of children/young people and their families/carers and will provide family-centred care. • In the event that a child/young person identifies as Aboriginal and/or Torres Strait Islander descent consideration for the engagement of an Aboriginal and Torres Strait Islander mental health worker is recommended.
3.6.2 Specialist clinical interventions are guided by assessment, formulation and diagnostic processes, using a developmentally appropriate, bio/psychosocial/cultural approach.	• This will take into consideration the strengths and resilience within the individual, family/care providers, support network, and community. • The consent of the child/young person/ guardian to disclose information, and (where needed) to involve family/carers in treatment planning and delivery, will be sought in every care situation. • Informed consent is documented in the clinical record, detailing that the child/young person/guardian understands the Care Plan and that the guardian agrees to support the provision of ongoing care to the child/young person in placement and the community. • Education and information regarding clinical intervention will be provided to the child/young person, guardian/carers/family and significant others at all stages of contact with the service. • A shared understanding is fostered for all aspects of treatment, including risk management, with explicit, documented evidence of the shared understanding in the clinical file. • Comprehensive Care documentation
3.6.3 Children/young people will be supported to access a range of bio/psycho/social/cultural interventions services (individual, dyadic and/or systemic) which meet their needs.	• Treatment should be guided by a comprehensive assessment of the bio/psycho/social/cultural aspects of the child/young person, the dyadic relationship between the child/young person and carer, and the support network. • Building and maintaining a therapeutic alliance with the child/young person and their carers is at the heart of almost all clinical interventions. • A range of evidence-based models and techniques may be utilised to reduce the severity of symptoms and increase resilience

Key elements	Comments
	to cope with mental health (e.g. complex trauma and disrupted attachment) problems. • Interventions will be informed by evidence-based practice and recovery focused principles. • Multidisciplinary input will be provided to optimise the child/young person's recovery. • Carer and Systemic support interventions will be included where appropriate and evidence informed. • Interventions will include responsive crisis intervention; relapse prevention strategies; and assistance in accessing educational/vocational services. • A range of mediums may be used for intervention. For instance, children/young people may choose to express their thoughts and feelings through the medium of play and/or other forms of expressive therapy such as art and music. • Facilitate access for children/young people to a range of mental health service options as appropriate and available. • ETS will demonstrate a focus on strengths, connectedness, personal involvement, personal choice, empowerment, and increasing confidence in accessing the mental health system and other community services and supports.
3.6.4 Carers are integral to the mental health care process with the majority of children/young people in ETS.	• Interventions to promote recovery are as much focused on engaging with carers, as with the child/young person. • Recovery may include carer-child work as a way to increase optimism, strengths focus and to promote resilience. • Time to provide emotional support to the child/young person and carers, will be given adequate priority by ETS and the child/young person's stakeholder group. • Caring for somebody with a mental illness • *Mental Health Act 2016* Patient rights and support • Consumer, Carer and Family Participation Framework
3.6.5 Education and information regarding clinical intervention will be provided to the	• This will include a range of components such as: - information about the mental illness, mental health issue, complex trauma, attachment, grief and loss

Key elements	Comments
child/young person, carers and guardian at all stages of contact with the service.	- the journey within the service - mental health care options - pharmacotherapy - support services - recovery pathways. • Education/information provided will be documented in the clinical file. • Choice and Medication Leaflets

3.6.6
Medication will be administered, prescribed and monitored as indicated by clinical need and will involve shared decision making processes between the treating team, the child/young person and their guardian.
	• Across all treatment settings, all prescriptions, dispensing and administration of medicines will be informed by QH Health Service directives, policies, implementation standards, protocols and guidelines where available.
	• Further, it will be informed by DCYJMA policies pertaining to:
	  • Positive Behaviour Support (Policy Number 604-5)
	  • Managing high risk behaviour (Policy Number 646-2)
	• The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards.
	• The medication goals of the child/young person/guardian will be integrated with evidence-based and appropriate clinical treatment guidelines.
	• Strategies to improve medication compliance will be explored and documented.
	• Monitoring of medication side effects will be routinely conducted.
	• Clinical guidelines
	• Therapeutic guidelines
	• Safe medication practice unit
	• the National Safety and Quality Health Service Standards (NSQHS)
	• Acute Sedation Procedure – Child and Youth Mental Health Service
	• Chief Psychiatrist Policy Clinical need for medication

3.6.7 Most ETS interventions are medium to long-term (i.e. 12–18 months).	• It is recognised that children/young people's severe and complex psychological and/or behavioural needs will have different requirements with regard to the length and intensity of involvement.

Key elements	Comments
	• If the child or young person is still accessing ETS at 15 months after acceptance, and no closure plan process has begun, a formal review with DCYJMA will be undertaken to determine whether ongoing intervention is required, or whether care closure needs to be initiated. • Crisis and short-term interventions may be utilised to 'stabilise' the system and child/young person, so that longer term or more intensive work is possible.
3.6.8 Each child/young person receiving treatment through ETS receives a Care Plan (this includes a clinical recovery component) which outlines a range of evidence informed individual and/or systemic interventions that is supported by clinical rationale based on appropriate theories of understanding. Intervention should be both child-centred and grounded in ecological perspectives.	• QH CIMHA Care Plans are used to capture therapeutic goals and outcomes relating to relevant individual, dyad and systemic therapeutic work being undertaken during a set 91 day period. • Children/young people are to be included in the process of developing/reviewing their Care Plan • Care Plans need to be cognisant of the child/young person's DCYJMA developed care plan. • Care Plans
3.6.9 Systemic interventions are used by the ETS program.	• Working collaboratively with stakeholders to determine intervention goals including recognition of DCYJMA and stakeholder plans. • Assisting and facilitating (where needed) the development of a cohesive stakeholder group that has a shared understanding of the child/young person's strengths and needs and is working collaboratively in the child/young person's best interests. • The provision of carer support including foster carer training. • Specialist consultation-liaison services to other service providers internal to QH, and externally across government, non-government and private sector. • Specialist professional development and training to HHS staff (e.g. CYMHS, adult mental health services, alcohol and other drug services, emergency departments, child health and Aboriginal and Torres Strait Islander health) as well as staff of key government departments (e.g. DCYJMA and Department of Education), private practitioners (e.g. GPs) and non-government service providers (e.g. youth workers).

3.7 Team approach

Key elements	Comments
3.7.1 A multidisciplinary team approach will be provided.	• The child/young person, family/carers and stakeholders will be informed of the multidisciplinary approach to mental health care. • ETS will ensure that all clinicians within their respective teams are aware of the children/young people receiving a service. • Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. • Clinical and discipline supervision and enhanced professional development will be available to all staff. • Recognition of the need for Aboriginal and Torres Strait Islander mental health workers within the MDT is integral for children/young people, carers and families that identify as Aboriginal and/or Torres Strait Islander descent.
3.7.2 Clear clinical and operational leadership will be provided for the ETS team.	• There will be a well-defined and clearly documented local process for escalation of discipline specific clinical issues.
3.7.3 Caseloads will be managed by the team leader (and other staff as appropriate) to ensure effective and efficient use of resources and facilitate accessible, timely and responsive care.	• The MOU provides for caseloads of 8-10 per clinical FTE.

3.8 Care coordination

Key elements	Comments
3.8.1 Care coordination is an essential element of an integrated service delivery system, ensuring that each child/young person is able to access the services they need, when they need it, and with one clinician accountable for enabling service provision.	• To assist in the coordination of care, regular stakeholder/care team meetings to occur. Facilitation of stakeholder meetings is negotiated between PSP and CSSC. • Stakeholder meetings function to enhance/increase communication across relevant stakeholders (including the child/young person, their carers and families) in order to increase effectiveness of intervention, and to discuss service specific goals and progress to meeting these. • Frequency of stakeholder meetings are based on clinical need, however, occur at least once every three months.

	• Each child/young person is to be discussed at an Interagency Review meeting between ETS Team Leader or delegate and CSSC Senior Team Leader/Senior Practitioner or CSSC Manager at least every three months following the four-week verbal update. • High Intensity Response Meetings to occur as required. High Intensity Response meetings are formed in consultation with a CSSC Senior Team Leader/Senior Practitioner or CSSC Manager as they will require additional capacity and time invested. • In the event a child/young person identifies as Aboriginal and Torres Strait Islander, an Aboriginal and Torres Strait Islander health/mental health worker will be assigned to the child/young person to participate in the ongoing service. • Comprehensive Care documentation • Working with parents: guidance for mental health, alcohol and other drugs services • QH MHAODB models of service
3.8.2 Each child/young person accepted by ETS for ongoing assessment/intervention will be assigned a PSP. A Principal service provider (PSP) is a Queensland Health clinician with primary responsibility for the coordination of the treatment and care provided to the consumer (and their carer(s))	• The PSP has the primary responsibility for the coordination of care. • The PSP is responsible for documenting interventions provided to the child/young person within CIMHA. • The PSP details will be reflected in CIMHA as the internal contact – principal service provider. • The PSP is responsible for coordinating appropriate mental health assessments, care and review, completing mental health referral and ongoing care processes. • Comprehensive Care documentation
3.8.3 All children/young people will have a designated consultant psychiatrist.	• The consultant psychiatrist details will be reflected in CIMHA as the internal contact – treating consultant psychiatrist.
3.8.4 ETS will ensure coordination of care across other mental health settings as required (ie. acute inpatient and day program).	• The PSP has the primary responsibility for the coordination of care across QH services. • The PSP will develop and maintain relationships with the relevant inpatient treating teams and negotiate appropriate involvement in inpatient care and discharge planning for children/young people.
3.8.5 The frequency of contact for children/young people and their families/carers will vary according to clinical need.	• Capacity for increased frequency of contact (e.g. during crisis or the initial engagement period) will be built into the PSP's schedule, and may involve a team response.

3.8.6 Effort will be made to assertively link in children/ young people and their families/carers into appropriate services where care needs cannot be met by ETS.	• CSSC remain the case managers of open/allocated children/young people. As such, ETS is to provide CSSC with required support and the child/young person's guardian's approval, to help link in children/ young people and their families/carers into appropriate services as identified. • Collaborative relationships will be developed where able with other service providers, including schools, primary health care, housing, welfare, educational and vocational support, cultural support, justice and recreational service providers.

3.9 Continuity of care

Key elements	Comments
3.9.1 Clear information is provided to children/young people, carers and referral sources regarding contact details to ETS (and other appropriate local supports) across a 24-hour, seven-day period.	• This will be documented in the clinical record for individual children/young people. • Team publications and relevant information documents will include this information from a broader perspective.
3.9.2 A team response is provided for planned and crisis interventions and is not dependent on the PSP's availability.	• Provision of crisis response and intervention occurs during the hours of service operation and for those with an active service provision open to ETS.
3.9.3 The child/young person's main treating team, PSP, other service providers, carers/family and CSSC will be identified in the clinical record, and communication maintained throughout ETS service provision and regular stakeholder meetings.	• The process for sharing information will be explicitly documented for each child/young person. • Strategies to ensure continuity of care include good communication, coordination, collaboration, and continual reassessment between the multidisciplinary team, the child/young person, family/carers, DCYJMA, primary care providers and other service providers. • Child Protection Act (1999) • Sharing information with Child Safety
3.9.4 All ETS allocated children/young people discharged from an inpatient unit will be followed-up by an ETS clinician within two business days.	• Provision of Service will be recorded in CIMHA as per reporting requirements. • Appropriate crisis plans will be prepared with the children/young people, carers and DCYJMA.
3.9.5 Local acute care/after hours team may provide a time-limited backup service for ETS children/young people who require an	• Service links are established with acute care/after hours team, or to an equivalent service provider, to ensure joint care and

Key elements	Comments
out-of-hours crisis management/psychiatric crisis response. Where possible, verbal and written handovers to occur. National Safety and Quality Health Service Standards – Standard 6 Clinical Handover.	support outside the hours of service provision. • Crisis intervention/risk management plans are to be provided to the acute care/after hours team and uploaded onto CIMHA.

3.10 Transfer of care within ETS

Key elements	Comments
3.10.1 After being accepted for care by ETS it is acknowledged that the child/young person may move location/s outside the ETS team coverage area.	• When the existing ETS team identifies that the child/young person requires ongoing intervention, a transfer between respective CSSC, facilitated by DCYJMA, is to be progressed. The ETS team inform relevant ETS team of potential transfer. • In situations where a child/young person moves to another location in an unplanned way, ETS will continue to provide intervention (level of intervention will be dependent upon the distance to the new location) until the planned transfer process can be completed. • Decisions and outcomes regarding transfer between ETS teams is to be clearly documented in CIMHA. • Comprehensive Care documentation • QH Transition Guideline
3.10.2 Where possible, children/young people will not be transferred during crisis.	• Where transfer is inevitable, both transferring and receiving CSSC and ETS teams need to make direct contact and ensure a considered and safe transfer (service capability will be considered).
3.10.3 Children/young people and carers will be informed of transfer procedures.	• Appropriate crisis plans will be prepared with the child/young person and carers.
3.10.4 Children/young people transferred under a Recommendation for Assessment (*Mental Health Act 2016*) will remain the responsibility of the transferring service until the Patient Transfer is given effect.	• Chief Psychiatrist Policy Transfers and transport

3.11 Transfer of care external to ETS

Key elements	Comments
3.11.1 Discharge planning is considered from first contact with the child/young person and their carers.	• Discharge planning will be a routine component of recovery focused planning and each clinical review process and review at Stakeholder meetings and in discussion with CSSC. • QH Transition Guideline
3.11.2 The decision to discharge a child/young person from ETS will be linked with the planning, monitoring and review processes and exit criteria as outlined in Evolve Therapeutic Services - Procedural Pathways & CIMHA Business Process Guidelines	• The decision to exit a child/young person from ETS is made after a review of their CIMHA Care Plan is conducted. • If the child/young person is still accessing ETS at 15 months after acceptance, and no closure plan process has begun, a formal review with DCYJMA will be undertaken to determine whether ongoing intervention is required, or whether care closure needs to be initiated. Discussion is informed by child/young person, carers and stakeholder views and MDTR outcomes. • Once the recommendation to close is supported, children/young people will be discharged in accordance with care closure/transition planning needs. • It is highly recommended for transfer or discharge of child/young person of Aboriginal and Torres Strait Islander descent that the involvement of Aboriginal and Torres Strait Islander mental health workers is prioritised.
3.11.3 Comprehensive liaison and handover will occur with all other service providers who will contribute to ongoing care. Wherever possible, ongoing service providers will be involved in discharge planning.	• Families/carers will be routinely directly involved in discharge planning whenever possible. • PSP is responsible for ensuring that discharge documents are sent to key health service providers (e.g. GP) within one week of discharge from ETS. • Comprehensive Care documentation
3.11.4 Discharge planning will incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.	• Strategies for relapse prevention, crisis management and any other ongoing support needs are to be discussed with the child/young person, carers, DCYJMA and other key stakeholders prior to discharge. • Once recommendation for discharge has been supported, the PSP is required to complete a 'Transfer of Care' document on CIMHA. This document needs to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral.

Key elements	Comments
	• A CIMHA 'Transfer of Care' document is to be completed and tabled with DCYJMA within one month. • Comprehensive Care documentation

3.12 Collection of data, record keeping and information

Key elements	Comments
3.12.1 ETS will enter and review required information into CIMHA in accordance with endorsed Evolve Therapeutic Services - Procedural Pathways & CIMHA Business Process Guidelines. All referred and open children/young people will have a designated PSP. All open children/young people will have a designated treating consultant psychiatrist.	• All provisions of service, contact, clinical processes and recovery focused planning will be documented in the child/young person's clinical record. • Progress notes will be consecutive within the clinical record according to date. • There are specific record keeping requirements for *Mental Health Act 2016* related documents. • CIMHA business rules • Comprehensive Care documentation • Queensland Health Aboriginal and Torres Strait Islander Cultural Information Gathering Tool • Chief Psychiatrist Policy Patient records
3.12.2 ETS utilise a range of outcome measures including the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and Strengths and Difficulties Questionnaire (SDQ).	• Outcomes data is presented at MDTR every 91 days. • Results of outcomes are routinely discussed with children/young people and their carers. • Outcomes data is used with children/young people and their carers to: - record details of a child/young person's symptoms and functioning - monitor changes in symptoms and functioning - review progress and plan future goals in relevant CIMHA documents.
3.12.3 All clinical record keeping will comply with legislative and local policy requirements.	• Local auditing processes will monitor the quality of record keeping and documentation (including written external communications) and support relevant clinician skill development.
3.12.4 Clinical records will be kept legible and up to date, with clearly documented dates, times, author/s (name and title) and clinical progress notes.	• Personal and demographic details of the child/young person, their family/carers and other health service providers will be kept up to date.

Key elements	Comments
3.12.5 ETS Teams will submit monthly data as outlined in the MOU between QH and DCYJMA to the ETS Statewide Program Management team.	• ETS Statewide Program Management team will assist in the coordination and production of an annual ETS Outcomes report to DCYJMA.

3.13 Mental Health Peer Support Services

Key elements	Comments
3.13.1 All children/young people and families will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Consumer consultants are accessible via local mental health services.

4. The ETS MOS functions best when:

- There is a common language and shared understanding amongst QH and DCYJMA staff of the importance of:
    i. the child and young person's perspective
    ii. a sense of hopefulness and respect
    iii. individualised interventions designed to minimise risk and increase protective factors
    iv. the need for an integrated approach to the delivery of services.
- ETS staff members have skills and knowledge needed to work with identified services users
- Key stakeholders are working collaboratively in the best interest of the child/young person
- There is an emphasis on developing a safe and therapeutic environment for the child/young person
- Children, young people, their families/carers and other service providers are involved in all aspects of care planning and delivery
- There is an explicit attitude that children/young people can and do recover from mental health problems and mental disorders, and that the family or care environment plays an integral role in the recovery of the child/young person's developmental trajectory
- There is an adequate skill mix within the team, with senior level clinical expertise and knowledge regarding necessary interventions being demonstrated by the majority of staff
- Teams are well integrated with other local mental health service components and primary care supports
- Teams have a good general knowledge of local resources
- Clear and strong clinical and operational leadership roles are provided, and work collaboratively
- There is clear and explicit responsibility for a local population and clear links to specified organisations
- Clear pathways exist for onward referral as clinically required
- Collaborative care arrangements are in place across different service providers, shared care/recovery plans and relapse prevention plans are utilised

- Child and adolescent consultant psychiatry staff are fully integrated into ETS
- Senior staff, including medical staff, takes an active role in fostering the development of clinical skills in less experienced staff
- Strong internal and external partnerships are established and maintained
- Caseloads are regularly reviewed and assertively managed
- All staff are provided with professional support, clinical supervision and training
- Appropriate DCYJMA, HHS and Department of Health level staff engage in governance structures
- There is a 'shared language' across QH and DCYJMA regarding purpose of ETS including communication across departments to support delivery of the ETS MOS and continuation of established Interagency Governance and Local Governance as per the ETS 2019-2024 MOU.
- Acknowledge that the ETS program sits within a continuum of QH delivered mental health services for children and young people.
- Children/young people who have experienced neglect, trauma and/or abuse require specialised, sensitive and consistent care.

5. Standard components

The ETS program 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
- 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
- Chief Psychiatrist policies
- Mandatory 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 a child/young person'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 the Comprehensive Care documentation.

6. Related services

The ETS program combines two fundamental principles: operating with a child centred focus and an interagency collaborative framework. These principles are based on the goal of the best outcomes for the child/young person, rather than the capacity or responsibility of each service system or department.

At point of entry, throughout and at exit, ETS will facilitate referrals and liaise with services as required to help meet the needs of the child/young person with any of the following:

- Queensland Health Community Child and Youth Mental Health Services (see Figure 1)
- Paediatric and other services
- DCYJMA inclusive of CSSC and Youth Justice services
- Child and Youth Forensic Outreach Service
- Drug and alcohol services
- Department of Education
- Department of Housing
- Foster-care support agencies
- Non-government organisations
- Carers including foster parents and residential staff and youth workers
- Biological families
- General Practitioners
- Private practitioners such as psychiatrists, paediatricians, psychologists, speech therapists, occupational therapists, social workers.

7. Case Loads

The ETS will have a consumer-to-staff ratio that enables the provision of intensive work often including:

- the child/young person
- the child/young person and carers
- systemic interventions as needed with any and all other services supporting the child/young person (e.g. carers, care-agencies, schools, judicial systems)
- facilitation of the collaborative process through stakeholder meetings
- documentation requirements
- outreach and required travel.

Caseload numbers are influenced by the acuity and severity of a child/young person's experience of the clinician, acceptance of sibling groups and status of child/young person within the legal system. Attachment 1 of the ETS 2019-2024 MOU 'Service delivery requirements' outlines a caseload capacity of 8-10 Service Users per 1 Full Time Equivalent clinician.

8. Workforce

ETS was established with a strong focus on clinical as well as professional development, service evaluation and research. Although there may be variations, ETS teams may comprise of the following positions:

- Team Leader
- Consultant Child and Adolescent Psychiatrist
- Clinician (Allied Health and Nursing)
- Administration Officer
- Professional Development Coordinator
- Indigenous Program Coordinator
- Multicultural Liaison Officer (Cultural Consultant)

The ETS operates on a collegiate multidisciplinary basis with a range of functions and skills shared within and across teams. Discipline specific skills and professional specialist areas are contributed through the team, and where necessary via other service providers, to tailor treatment planning and interventions. Typically, team leaders and discipline leaders work together to develop the skill and professional mix within teams to ensure that a balance of ability is available. The consultant child and adolescent psychiatrist will be consulted during this process where appropriate. All applicable permanently appointed clinical staff will be appointed (or working towards becoming) authorised mental health practitioners.

9. Governance

9.1 Team Clinical Governance

The team leader is accountable for the direct management of the team to ensure that appropriate services are delivered equitably and efficiently, and that team performance indicators are achieved. This includes:

- operational management (including day to day clinical support and consultation to staff); resource and administrative management
- systems maintenance
- staff operational/administrative supervision including performance management, liaison with other mental health services, external organisations and community groups.

The ETS team leader is a standing member of any relevant monthly Interagency Review Meetings and attends all meetings (or delegates when necessary).

Strong and enduring relationships will be evident within the designated acute and relevant non-acute inpatient and day program units to ensure continuity of service provision.

The consultant child and adolescent psychiatrist provides clinical governance, leadership and oversight within their delegation and in consultation with the team leader as required.

Clinical supervision and ongoing professional development are necessary components of maintaining a skilled mental health workforce within ETS. The discipline senior and/or practice supervisor provides/facilitates discipline specific and/or intervention specific opportunities for the clinician to develop identified professional skills and reflect on elements of practice (Clinical

Supervision Guidelines for Mental Health Services). Clinicians are supported to maintain their own health and wellbeing, avoid burnout, and to access career development guidance.

Team leaders, child and adolescent consultant psychiatrists and discipline seniors/practice supervisors have a strong working relationship established so that clear clinical, operational and professional leadership may be communicated to all stakeholders.

9.2 Internal Statewide Governance

ETS teams sit within QH (CYMHS) across the state and are managed within standard HHS structures, policies and procedures. Each ETS team also have statewide responsibilities and reporting requirements as per the MOU.

As per the ETS 2019 – 2024 MOU, the ETS Program is supported by a statewide program management team to assist with coordination, planning, monitoring, research and evaluation, professional and resource development activities.

10. Hours of operation

ETS provide mental health care for their targeted population during weekday, business hours (usually 8.30 am to 5.00 pm).

Crisis assessments presenting outside of business hours will generally be seen by extended hours services such as the acute care team, hospital emergency department and mental health inpatient services as per local HHS arrangements.

As required, all ETS teams will have a mechanism to provide and/or facilitate extended hours of service to meet the individual needs of children, young people and their families/carers through linkages with CYMHS.

All HHS will have clearly documented local clinical pathways and processes for children/young people and their families/carers presenting for mental health services outside of business hours. The specialised needs of these children/young people must be taken into account, ensuring after hours, senior clinical expertise is accessible (e.g. child and adolescent psychiatric registrar on call).

11. Staff training

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-based treatment guidelines, and underpinned by the sharing responsibility for recovery: creating and sustaining recovery oriented systems of care.

ETS will ensure dedicated time and resources for clinical education and clinical supervision, in addition to clinical staffing numbers. Education and training will include a focus on strategies and mechanisms to foster meaningful participation of children, young people and families/carers across all levels of service delivery, implementation and evaluation.

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

- orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- promotion, prevention and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for children/young people and their families/carers
- developmentally appropriate assessment and treatment
- risk assessment and management, and associated planning and intervention
- Suicide risk assessment and management
- Mental Health Act 2016
- National Standards for Mental Health Services 2010
- evidenced based practice in service delivery
- consumer focused care planning
- routine outcome measurement training
- a range of treatment modalities including individual, group and family-based therapy, particularly those pertaining to the resolution of complex trauma and development of healthy attachments
- an understanding of the impact of complex trauma and disrupted attachment
- knowledge of mental health diagnostic classification systems
- child safety services training
- alcohol and drug assessment and intervention
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- cultural capability training.

12. Abbreviations

CIMHA	Consumer Integrated Mental Health & Addiction
CMC	Crime and Misconduct Commission
CSSC	Child Safety Service Centres
CYMHS	Child and youth mental health services
DCCSDS	Department of Communities, Child Safety and Disability Services (*historic)*
DETE	Department of Education, Training and Employment (*historic)*
DCSYW	Department of Child Safety, Youth and Women (*historic*)
DCYJMA	Department of Children, Youth Justice and Multicultural Affairs
EIS	Evolve Interagency Services (*historic*)
ETS	Evolve Therapeutic Services
HHS	Hospital and Health Service
MOS	Model of Service
MDTR	Multidisciplinary Team Review
MOU	Memorandum of Understanding
PSP	Principal Service Provider
QH	Queensland Health