PRELIMINARY Model of Service – Adolescent Extended Treatment Facility

Queensland Public Mental Health Services

December 2016

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Preliminary Model of Service – Adolescent Extended Treatment Facility -– Queensland Public Mental Health Facility December 2016

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Preamble

In July 2016 the Queensland Government provided a Government Response to the Barrett Adolescent Centre Commission of Inquiry Report. In this response the Government undertook to give consideration to the establishment of an extended treatment and rehabilitation service for young people with severe and complex mental health issues.

In considering and developing the new facility a commitment to an unprecedented level of stakeholder engagement was made, most especially of young people (past and present) and carers of young people with severe and complex mental health issues and the Department of Education and Training (DET). This document represents a critical step in the realisation of the commitment to provide a more comprehensive continuum of mental health care options for young people and to meaningfully engage carers and young people as an important stakeholder group in planning processes.

It is intended that the Preliminary Model of Service will continue to evolve by entrenching a model of mandated clinical and service review, by being available for critical external review, by participating in and integrating new research and will continue to include the perspective of carers and young people into the future.

By extending the continuum of public mental health services and educational and vocational services available to young Queenslanders it is anticipated their capacity to lead healthy, hopeful and fulfilling lives in the future is enhanced, with benefits also flowing to their family, friends and the broader community.

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Purpose of this document

The preliminary Model of Service for the state-wide Adolescent Extended Treatment Facility (AETF) with integrated educational and vocational capacity aims to provide a detailed description of the AETF within the Queensland public mental health, alcohol and other drugs service system. The model of service is an aspirational document with a practical purpose, intended to describe the target population, the functions, operation and governance of the AETF.

The AETF model of service details the requirements for the delivery of high quality and safe mental health services for young people with severe and complex mental health issues. The accessibility of information allows greater transparency about public mental health services and informs young people, carers, service partners, staff, managers and service planners. The document contents are sourced from reference documents, broad consultation and expert opinion from staff, service users and carers. This document does not replace clinical judgement or Hospital and Health Service (HHS) specific patient safety procedures and should be read in conjunction with the a range of other policy, legislation and operational documents which will be listed separately for reference.

This model of service seeks to ensure that Aboriginal and Torres Strait Islander people and those of Culturally and Linguistically Diverse backgrounds requiring additional consideration have equitable access to high quality and culturally appropriate mental healthcare that acknowledges difference and responds accordingly.

The intended outcomes of the development and successful implementation of the model of service are:

- the delivery of safe, high quality, integrated, and evidence driven mental health care
- an enhanced continuum of mental health service options
- equitable access for young Queenslanders to an extended treatment and rehabilitation service
- a young person and carer centred, recovery based system of care
- facilitating the provision of integrated, individualised educational or vocational programs in line with their home school program to provide skills and training to enable the consumer to undertake meaningful education or employment in the future
- stronger service partnerships with the network of providers
- stronger service development, evaluation and review
- improved knowledge of how to access and navigate through mental health services
- a more informed and supported mental health workforce
- enhanced supervision of the clinical and non-clinical workforce increased knowledge and understanding of other service components
- consistency and streamlining of service delivery across public mental health services in Queensland

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1. What does the AETF intend to achieve?

Hope holistic child-centred adolescent/young adult transitional/integrated appropriate open wellness complementary creative safe/emotional security dignity concise connection contemporary inclusive collaborative progress effective empowering helpful systemic supportive equitable inclusive targeted

(Aspirational Words from Workshop Participants)

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The AETF will extend the continuum of mental health service options available to young people with severe and complex mental health issues and their families/carers across Queensland. It will provide a model that fully integrates inpatient, intensive therapy and rehabilitation, and educational/vocational components. The model is based on a length of stay up to 6 months with transition planning being integrated from the time of admission. It is not a substitute for secure, forensic, acute inpatient, respite or less intensive community service options

The focus of care is on maintaining a person centred approach that empowers the young person and their support network (personal and professional) in sharing responsibility for actions and interventions, while bearing in mind a young person's developing abilities.

It will provide 24 hour mental health assessment and care to young people, in a safe, therapeutic, culturally sensitive and supportive environment for a period up to 6 months. The AETF operates on the premise that it is only one phase of the treatment process in assisting young people, families and carers to recover their health, wellbeing and developmental potential.

The AETF:

Acknowledges the need for young people to experience safety, cultural sensitivity and the minimum possible disruption to their family, educational, social and community networks. The engagement of young people, families and carers in collaborative, recovery focussed treatment planning is paramount. This process enables young people to build their strengths, hope, dignity, and connectedness.

Seeks to ensure that people of Aboriginal and Torres Strait Islander people and those from Culturally and Linguistically Diverse backgrounds requiring additional consideration have equitable access to quality mental healthcare and culturally appropriate service delivery through engagement and collaborative partnerships.

Will complement and develop the knowledge base of public mental health services for young people with severe and complex mental health issues. In this role it will provide training, consultation-liaison services and supervision to mental health service providers for young people throughout Queensland. The AETF will contribute to the evidence base around this cohort of young people by engaging in clinical research and participating in Queensland Health data collection protocols.

The AETF is a gazetted authorised mental health service (AMHS) in accordance with the Mental Health Act 2016 and exists within the spectrum of integrated mental health services and other health services.

An integrated component of the AETF is a gazetted state school to facilitate provision of educational and vocational programs. It will operate in line with the same legislation, industrial agreements, directives, whole of government policy and national agreements as all other state schools. Trained and registered teachers will deliver education and vocational programs catering for this specialised cohort.

The key functions of the AETF are to:

- Facilitate client-centred care of young people with severe and complex mental health issues in a safe, therapeutic and culturally sensitive and supportive setting, which promotes hope, dignity, recovery and connectedness.
- Provide an extended assessment, treatment and rehabilitative model which fully integrates inpatient beds, intensive therapy/rehabilitation and educational/vocational aspects thereby enhancing the continuum of mental health services available to young people.
- Deliver a range of empirically supported assessments and interventions to young people with severe and complex mental health issues (and their support network) to facilitate shared responsibility for action.
- Develop and implement a state-wide continuum of educational delivery to ensure that students with severe and complex mental health needs receive specialised and appropriate educational support at all stages of their illness.
- Engage young people, and their support network in all phases of care and assist them in their navigation of the mental health system.
- Work collaboratively with referrers, young people and their family/carers to ensure transition into the AETF, care planning within the AETF, and transition out of the AETF results in continuity of care rather than discrete episodes of care.
- Complement and develop the knowledge base of mental health services for young people with severe and complex mental health issues. Ensure this expertise is available to young people of the AETF (and their carers) but also supports the broader mental health community to provide contemporary, evidence informed care.
- Incorporate feedback, regular evaluative processes and emerging evidence to maintain a contemporary model of care.
- It is intended that this Preliminary Model of Service will continue to evolve by entrenching a model of mandated clinical and service review, by being available for critical external review, by participating in and integrating new research and will continue to include the perspective of carers and young people into the future.

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2. Who is the AETF for?

The AETF is intended for young people across Queensland. Generally aged 13 to 21 years at admission, with severe and complex mental health issues that have not been responsive to other care options and who research indicates will likely benefit from a

medium term, intensive model for up to 6 months which fully integrates inpatient beds, intensive therapy/rehabilitation and educational/vocational aspects.

Many young people may have a primary diagnosis of psychosis, eating disorders or intractable mood disorders complicated by trauma, multiple psychosocial stressors and secondary diagnoses. However, eligibility for admission is not limited to these diagnoses. Current research suggests the cohort of young people with severe and complex mental health issues represents approximately 0-5% of young people in Australia.

The AETF will provide training, consultation-liaison services and supervision to mental health service providers for young people throughout Queensland.

The provision of educational and vocational programs will be facilitated for young people of compulsory school age or those participating in post-compulsory education or training.

3. What does the AETF do?

Provides hope, safe/emotional security, connections, inclusive, collaborative, effective, empowering, systemic, supportive, equitable, wellness, recovery oriented, open, appropriate, holistic, complementary, contemporary, creative, flexible, centre for excellence, integrates evaluation/feedback, manages the edges, transitions, mentors, research, individualised, least intensive option, information sharing/data, clear purpose of care (between clinicians, family and young people), respite, trial medication changes, fosters continuity, family therapy/engagement, face to face, website: virtual tours, info sheets, review post discharge?, keep in touch post discharge?, seeks feedback, state wide referral panel, clear referral processes, consultation and liaison to reduce likelihood of admission, smooth take-off and landing -step up/down, information sharing challenges, wait list management, integrated educational/vocational options

(Aspirational Words from Workshop Participants)

The AETF enhances the continuum of mental health services available to young Queenslanders and their families/carers by providing a medium, intensive model (for up to 6 months) that fully integrates inpatient, intensive therapy/rehabilitation and educational/vocational aspects. It is not a substitute for secure, forensic, acute inpatient, respite or less intensive community service options.

Access to the AETF is via referral to an Intake Panel chaired by the Clinical Director of the AETF and supported by senior clinicians including regional representation. In reviewing referrals the Intake Panel will consider the clinical resources available in the young person's community in addition to clinical presentation and treatment history.

For young people with significant mental health issues, their chronological age may not be a good indicator of overall functioning, therefore developmental age may also be considered in assessing if AETF is the most appropriate option.

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While it is important that treatment options in a young person's local area are fully explored prior to referral it is acknowledged that resources in some areas are limited and this will also be a consideration in the intake process.

Intensive therapy/rehabilitation will be available to young people on an inpatient or a day patient basis as clinically indicated. A young person may change from an inpatient to a day patient as their treatment progresses or may commence as a day patient. The intensive therapy/rehabilitation may include individual, group and family based interventions. Assessments may include medication trials, diagnostic clarification, physical health checks, multidisciplinary assessments, educational/vocational assessments and family functioning assessments.

It is a fundamental cornerstone of this model that a young person's existing relationships (family, carer, peer and service) with their community are maintained and supported during inpatient admissions. A variety of approaches including the use of videoconferencing will be used to achieve this goal. The continuation of the young person's educational pathway will be facilitated through the co-located educational program.

The AETF will:

Provide training, consultation-liaison services and supervision to mental health service providers for young people throughout Queensland and contribute to a hub of clinical research. The AETF will contribute to the evidence base around this cohort of young people by engaging in clinical research and participating in Queensland Health data collection protocols.

Operate in an open and transparent manner that invites and incorporates feedback from young people, carers and service providers at an individual clinical, service and model level. The AETF will regularly use feedback, evaluation, reviews and emerging evidence to inform and modify practice to maintain a contemporary model of service.

Monitor the clinical profile of referred young people against data on young people with severe and complex mental health issues to identify ongoing fit with the model of service and target population.

As a component of the AETF, DET will facilitate the development and delivery of a model of state-wide educational and vocational service for students with severe and complex mental health concerns. Partnering with key stakeholders they will ensure the continued provision of high quality, up to date and evidence based teaching practices for students.

DET's educational and vocational program will be informed by:

- learnings from staff at the previous and current Barrett Adolescent Centre Special School and the Lady Cilento Children's Hospital School;
- a literature review of up-to-date national and international research into the provision of educational and vocational programs in similar facilities;
- consultation with departmental officers with expertise in the area of educating students with chronic and complex mental health issues, including guidance officers, mental health coaches and therapists; and
- consultation with young people and carers.

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A day in the life of a young person may include:

- *Wake in an inpatient bed. Room shared with support person due to cultural issues. Supervision provided overnight.*
- *Assistance with daily living tasks prior to meal*
- *Supervised meal with possible medication intake*
- *Individual therapy session*
- *Attendance at school or vocational program with mental health staff support for engaged students during school hours*
- *Offsite visit (or videoconferencing) with community services to facilitate transition*
- *Supervised meal with some recreational activities with peers*
- *Formal assessments – e.g. psychometric, speech and language, dietetic, physical health checks, medication reviews*
- *Family therapy or visit (may involve videoconferencing if family regional or remote)*
- *Evening meal with possible medication intake*
- *Group therapy*
- *Recreational time*

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Standard components

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

- National Standards for Mental Health Services 2010
- Connecting Care to Recovery 2016-2021
- Mental Health 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*
- Queensland Outcomes protocol

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

- The Education (General Provisions) Act 2006
- Every Student Succeeding – State Schools Strategy 2016-2020
- The Australian Curriculum
- Standards for Registered Training Organisations (RTOs) 2015
- Learning and Wellbeing Framework
- Department of Education and Training Strategic Plan 2016-2020

Links to these documents is available on our **Model of Service Documents** page.

In keeping with standard business processes, all documentation and clinical forms referred to in this document will be accessible through the Mental Health Alcohol and Other Drugs resource page (under development).

Clinical forms are dynamic documents requiring regular reviews to ensure consistency with current evidence based practice and maintain efficacy of use. Forms are intended for documenting clinical information. The forms are not a substitute for skills, training, supervision or judgment. The completion of forms should always be guided by clinician judgement regarding a young person's needs.

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3.1 Working with other service providers

Key elements	Comments
3.1.1 The AETF exists within a continuum of integrated mental health services, in partnership with DET, and within a broader network of services across both the private and public sectors. Strong and collaborative partnerships are necessary to enable the young person's service and support network to be maintained and enhanced. Given the severity and complexity of young person, their family and carer needs, an array of services working together from a common understanding is the optimal treatment approach.	Clear, regular contact and communication processes are maintained for all phases of care. When young people attend services from outside of their usual community, these service linkages and partnerships will carry additional importance. Advice, education, supervision and support on mental health issues are provided to other services.
3.1.2 A formal agreement with DET defining roles and responsibilities (including the necessity of collaboration) is critical to effectively operating integrated services within the AETF.	DET will facilitate the provision of an age-appropriate educational and/or vocational program for students. DET will utilise the facilities provided on a co-location basis and work with DOH to

Key elements	Comments
	develop protocols and processes regarding the use of these facilities during school hours.
3.1.3 There is engagement with primary health care providers to meet the general health care needs of young people when clinically indicated.	All efforts will be made to record a nominated general practitioner in the patient health record for 100 per cent of young people.
3.1.4 When young people have specific cultural and developmental needs The AETF will engage the assistance of appropriate services to ensure issues are addressed and incorporated in a holistic treatment framework.	
3.1.5 Development and delivery of a personalised learning plans - students are provided with educational adjustments to meet their learning needs.	Any program provided at the AETF school will: • Where applicable/possible be aligned with consumer's home school program • Include mandated reporting to parents regarding educational achievement • Be developed in collaboration with and reporting to the consumer's home school Consider diverse learning needs.

3.2 Referral, access and triage

Key elements	Comments
3.2.1 Referrals to the AETF can be made by a range of service providers via an Intake Panel for either day or residential components. The Intake Panel will be chaired by the AETF Clinical Director and assisted by senior clinicians including regional representation. The Intake Panel will consider clinical presentation of the young person, treatment history and clinical resources available in the young person's community. Referrals will be reviewed at weekly	Referrals to the AETF will occur through a single point of entry. Information on referral pathways, and admission criteria will be documented and available to referrers. Diagnostic mix may be considered when prioritising referrals. Admissions are conducted as part of a planned and collaborative assessment and treatment process.

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Key elements	Comments
Intake Panel meeting. If there is a waiting period, the Intake Panel will liaise with the referrer to monitor changes in acuity and other clinical considerations until the young person is able to access the AETF directly. The Panel will work with referrers/young people and their families to facilitate alternate and appropriate treatment and care if referrals are not accepted for admission to the AETF.	
3.2.2 Prior to acceptance of a referral, the Intake Panel may recommend an assessment. This assessment enables further determination of the potential for therapeutic benefit from entry to the AETF, the impact of or on being with other young people, and clarification of educational/vocational needs.	Potential barriers to participating in the AETF (e.g. no smoking, transport) may be assessed and discussed.
3.2.3 Prior to admission general information and orientation will be provided to all young people, families, and/or carers to promote a smooth transition into the AETF. An education information pack would be provided to the student on admission. Technology may be used to promote familiarity with the AETF and staff prior to arrival, especially for young people and families residing outside of the Brisbane area.	General information about the following will be provided: • Program components including treatment and support options • the multidisciplinary team role and function outline • assessments, family meetings and treatment planning • educational/vocational program contact phone numbers • contact phone numbers • visiting hours schedule • general information, including policies on smoking, mobile phone use, property, consent, ancillary services • Mental Health Act 2016 information • Young person rights and responsibilities statement • information regarding privacy and confidentiality • young person, family, and/or carer information sheets on the use of seclusion.

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Key elements	Comments
	• mechanisms for providing feedback • specific cultural information. The education pack contains information including: • Liaison to occur between AETF school and home school • Attendance will be recorded • Use of Unique Student Identifier to record vocational attainment (as required) • Staff information • Contact numbers • Responsible behaviour plan • Extra-curricular activities.
3.2.4 On acceptance of referral the AETF school should be notified to enable the commencement of planning.	Where applicable the home school Principal will be notified and liaison between AETF school Principal and home school Principal to discuss educational program will be undertaken. On admission the student will be registered to attend the program (enrolment to stay with home school). The consulting treating medical specialist (Psychiatrist) to approve engagement in the educational program.

3.3 Assessment

Key elements	Comments
3.3.1 Every effort will be made to limit the repetitive nature of the information gathering process for the young person.	A comprehensive chart review and referrer consultation precedes the initial assessment.
3.3.2 The initial assessment following acceptance of the referral will involve a detailed assessment of the nature of the mental health issues, their behavioural manifestations, effect on functioning and development (including capacity to engage in educational/vocational activities), and the course of any mental	The assessment interview allows clinicians to gauge how the young person, their family and carer talks about current symptoms and their level of understanding of mental illness. Provides an opportunity to understand development over several years and how

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Key elements	Comments
illnesses.	development has been impacted by mental issues if this is not available in referring information. A formulation of the presenting problems will be developed and contribute to a diagnosis and discussion of recovery goals. The formulation will be holistic and may include: • symptoms • relationships • family dynamics and functioning • attachment and history of trauma • school performance • developmental history and trajectory • medical history • co-morbidities • protective factors • 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. Assessment and care planning is a continuous process throughout the admission period.
3.3.3 Initial assessments will inform the collaborative development of a Preliminary Recovery Plan.	Assessment will include the ability of the young person and available supports (including formal and informal carers) to maintain function and prevent relapse. Potential recovery goals are explored with the young person and their family/carers including what the AETF can provide.
3.3.4 Assessment will involve input from family, and/or carers and key service providers as appropriate.	Consent to disclose information and to involve key stakeholders, and family and/or carers in the young person's care will be sought in every case.

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Key elements	Comments
	Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.
Assessment of family structure and dynamics will continue during the course of admission and may be facilitated by accommodation of family members at the AETF.	Recovery orientated practice includes building systemic resilience within the young people family and broader community supports.
Identification of family members and carers and their needs is part of the assessment process, and is included in recovery planning.	Recovery orientated services facilitate and nurture connections with family members and carers to gain the maximum benefit from these supports by young people.
3.3.5 Educational history and attainments will be collated and record from admission/acceptance to the AETF and throughout service provision.	The education program staff for the AETF will determine schools attended history of attendance, educational attainments and history of educational support where appropriate. The education program staff will assess current levels of attainment in different subjects. The education program staff will undertake appropriate educational assessment relevant to the program being undertaken.
Vocational assessments.	The education support staff will assist with identifying appropriate vocational options where educational options are not appropriate.
3.3.6 Consideration of cultural factors is essential when working with all young people, carers and families. Appropriate tools will be used whenever they are available to collect cultural information relevant to the young person's presentation, diagnosis, treatment and recovery.	
3.3.7 Engagement will occur with an Aboriginal and Torres Strait Islander Mental Health Worker or Hospital Liaison Worker to	Where an Aboriginal and Torres Strait Islander mental health worker is not available, identification of an appropriate

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Key elements	Comments
support and assist with the facilitation of information for a comprehensive assessment of Aboriginal and Torres Strait Islander young people.	and recognised Aboriginal and/or Torres Strait Islander person is integral in addressing the cultural needs of young people.
3.3.8 Risk assessments will occur: • on acceptance/admission as part of the comprehensive clinical assessment • prior to transfer to any other service • prior to and following periods of leave • prior to discharge • Where clinically indicated due to change in presentation or every three months.	All risk assessments will be recorded in the patient health record, and will be used to formulate a risk management plan. Comprehensive risk assessments will include: • harm to self • vulnerability • risks of physical or emotional deterioration • triggers to symptoms and/or behavioural disturbance • absconding • non-adherence to treatment • harm to others • child protection issues. Specific areas of risk may be evaluated more frequently as outlined in the young person's treatment plan. Risk management protocols will be standardised and consistent with Queensland Health policy.
3.3.9 Child safety concerns will be identified through risk assessment and addressed in accordance with mandatory requirements**.**	
3.3.10 Physical health will be assessed, managed and documented. This may be conducted by a health service provider external to the AETF but needs to be considered as part of the assessment process.	Clinical alerts (e.g. medication allergies, blood-borne viruses) will be recorded in the clinical file and in the health record. Potential physical or oral health problems will be identified and discussed with the young person, their family and or/carer, the GP, dentist and other relevant primary health care providers.

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Key elements	Comments
	The young person, family and/or carers will be actively supported to access primary health care and health improvement. All efforts will be made to record a nominated GP for 100 per cent of young people.
3.3.11 Drug and alcohol use will be routinely screened, 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 may be required.	Harm minimisation interventions and motivational interviewing will be available. Co-occurring alcohol and drug problems will be included in recovery planning.
3.3.12 Targeted assessments will be prompt and timely and may include psychological, occupational therapy, expressive therapy, and speech and language assessments. Specialised diagnostic assessments may occur to ascertain specific mental health problems and identify evidence informed therapeutic interventions.	These assessments may assist in diagnostic clarification, assessment of symptom severity, developmental variables and informing functional assessments. The outcome of assessments will be promptly communicated to the young person, the family and carers, and other stakeholders (with consent of the young person and/or consent holder). A range of diagnostic assessments will be undertaken if clinically indicated for treatment and formulation of cases (e.g. CT scan, EEG, Bone mineral density, Psychometric assessments, Endocrinology review). If not completed during the admission, recommendations regarding further assessments will be provided to the community follow up service providers through documentation on the discharge summary and recorded in the health record.
3.3.13 The outcome of assessments will be promptly communicated to the young person, family and/or carer and other stakeholders (with consent).	A family meeting will be organised as soon as practicable after admission to communicate the outcome of assessments.

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Key elements	Comments
3.3.14 Each young person's progress will be routinely monitored and evaluated including the use of standard outcome measures.	The National Outcomes and Casemix Collection (NOCC) will be used, and additional measures will be used, based on each young person's individual requirements.
3.3.15 Assessment of current education program will occur via discussion with home school to receive information required to assist the provision of appropriate curriculum delivery.	This may include decisions regarding: • Age appropriate curriculum • Delivery of the Australian curriculum • Adjusted program • Individual Curriculum Plan (ICP) • Mandatory recording and reporting of educational achievement • Assessment to be in line with home school.

3.4 Recovery planning and relapse prevention

Key elements	Comments
3.4.1 An individual recovery plan will be developed with all young people, and their families and/or carers. Review of progress and planning of future goals will be integrated into the recovery plan.	Recovery plans are developed on the premise that young people can and do recover from health issues. Young people with mental illness may have disrupted developmental trajectories. Recovery plans also need to address their developmental needs. Recovery plans identify: • available supports • crisis management strategies • therapeutic goals • intervention processes • psycho-educational needs • Relapse prevention strategies. Recovery plans may also include strategies for improving: • family functioning • pro-social and developmentally appropriate interests and hobbies

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Key elements	Comments
	• peer functioning • quality of life (such as time to experience developmentally relevant play and fun) • achievement at school / vocational goals • Mastery over the tasks of adolescence. Recovery plans will be updated at a frequency determined by change in presentation or need, but will be formally reviewed at least three monthly (to review routine outcome measures, treatment progress and to address any change in needs). All changes to the recovery plan will be discussed at the Multidisciplinary Team (MDT) Review.
3.4.2 The young person, family and/ or carer are strongly encouraged to have ownership of, and sign, their recovery plans.	
3.4.3 The relationship between the young person and their family and/or carer and their resilience is important to recovery.	Whilst adolescents gain further independence and mastery to separate from their family and/or carer, evidence suggests that adolescents with mental health issues specifically require support in re-connecting with their parents. Technology (e.g. videoconferencing facilities) will be available to support significant relationships when in person contact is not possible at the AETF.
3.4.4 Every effort will be made to ensure that treatment planning focuses on the young person's own goals.	Where conflicting goals exist (e.g. for young people receiving involuntary treatment), the goals will be clearly outlined and addressed in a way that is most consistent with the young person, and the family and /or carer's goals and values.
3.4.5 An educational and vocational transition plan will be developed.	Will be developed in conjunction with the consumer's home school where possible.

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Key elements	Comments
	Will be developed in collaboration with Guidance Officer/Senior Guidance Officer and in consultation with student. Planning commences on admission. May require a staged transition back to school including: • Step Up Step Down • Use of day program. A dedicated case manager in education setting will be appointed. Final plan to be agreed upon by clinicians/parents/home school. Facilitation of enrolment in a home school where no current enrolment exists for compulsory participation phase. Facilitation of attendance at a vocational education program if required.

3.5 Clinical intervention

Key elements	Comments
3.5.1 All aspects of intervention will reflect the development of collaborative relationships between young people, families and /or carers and staff.	The focus will be on strengths, connectedness, personal involvement, personal choice, empowerment. Treatment will be provided in the least intensive/disruptive setting that properly balances the young person's autonomy with their need for observation and treatment in a safe environment. Technology (e.g. videoconferencing facilities) will be available to support involvement of those families and/or carers unable to attend the AETF in person.
3.5.2 Clinical interventions are guided by assessment, formulation and diagnostic processes, using a bio-psychosocial	Treatment planning will consider and build on the strengths, resilience and protective factors within the individual, their family,

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Key elements	Comments
developmental framework.	culture and community.
3.5.3 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. Interventions will be evidence-informed.	Clinical interventions will be evidence informed, sensitive to the young person, their culture, family and/or carer's needs. Interventions may be individualised, group based or generic programs. *Individualised interventions* may include but are not limited to: psychological interventions • verbal • non-verbal therapies [e.g. play, adventure, art, and music] • psycho-education. individualised behavioural programs daily living skills pharmacotherapy electroconvulsive therapy (ECT) *Group interventions* may include but are not limited to: • tailored group activities, predominantly activity based, targeting areas of psychological and developmental need • family interventions and psycho-education • A structured group and educational timetable will be available to young people, families and/or carers. *Generic interventions* may include but are not limited to: • maintaining a milieu with professional staff reflecting appropriate levels of care, supervision, personal boundaries, safety, problem solving and management of the young person group to maximise each young people care • forming appropriate therapeutic alliances • programmes and forums in the community.
3.5.4 Interventions during access to education program	DET does not permit the use of restrictive practices, such as seclusion, containment,

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Key elements	Comments
	chemical restraint, mechanical restraint and some forms of physical restraint, unless they have been recommended by a medical professional as a therapeutic intervention (for example, restraint as a postural support). Physical restraint should only be used after preventative and de-escalation strategies have not been successful and must be applied in line with DET's Safe, supportive and disciplined school environment procedure. Physical restraint should only be used in crises, when the student's behaviour presents imminent danger of serious physical injury to themselves or others. Physical restraint procedures that inhibit breathing, place pressure on the neck, joints or chest, cause the free fall of the student, involve sitting or kneeling on a student, or inflict pain should never be used, including in crisis responses. Using appropriate adjustments for students to access the curriculum. Clear separation of duties for medical and educational staff and development of relevant protocols and processes.
3.5.5 The ongoing educational or vocational needs of the young person are considered in tandem with their mental health needs.	All efforts are made to ensure the least disruption to young people' schooling or work training. Staff from the education program (with consent) will liaise with the home school representative to determine whether adjustments are required to support the student's educational achievement. Consultation and planning will occur with the home school teacher/supervisor to facilitate the educational /vocational program during the admission and support reintegration into class/work environment upon discharge. If a young person is not currently enrolled in an education/vocational program and is of compulsory school age or wishes to participate in post-compulsory education or

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Key elements	Comments
	training they will be registered to attend the AETF School.
3.5.6 Carers are integral to the mental health care process. Family members and carers are provided 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.	Interventions to promote recovery are as much focussed on engaging with the family and carer as the young person. Recovery may include family work and parent-child work. Time to provide emotional support to the young person, family and/or carers will be given adequate priority.

3.6 Pharmacotherapy

Key elements	Comments
3.6.1 Medication will be prescribed, administered and monitored as indicated by clinical need, and will involve shared decision making processes between the treating team, the young person, family and/or carers.	The medication goals of the young person, family and/or carer will be integrated with evidence based clinical treatment guidelines. Medication compliance is enhanced when rationales for pharmacological intervention are provided to young people and carers.
3.6.2 Across all treatment settings, prescribing, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards.	Medication is reviewed by the AETF at regular intervals, but wherever possible, the young person, family and/or carer are encouraged to agree to a joint monitoring program with their local Community Child & Youth Mental Health Services (CYMHS), private service provider or GP. Monitoring of the young person for evidence of appropriate and sufficient response to medication will be routinely conducted. Monitoring of medication side-effects will be routinely conducted. Strategies focussing on medication adherence will be in place.

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Key elements	Comments
3.6.3 The AETF will ensure that prescribed medication is available on discharge and that the young person, family and/or carer are advised how to obtain ongoing supplies.	Supply of prescribed medication for leave or discharge will be coordinated by the AETF Mental health pharmacists/psychiatrist or an appropriate delegate will provide medication counselling to young people, families and/or carers prior to discharge. 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).

3.7 Crisis management

Key elements	Comments
3.7.1 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.	All staff will be familiar with specific policy and practice guidelines relating to the management of acute behavioural disturbance within the AETF. A specific management plan will address a young person's distress 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 may also be supported by the availability of appropriately prescribed medication. Intervention strategies will include: • increased visual observation • de-escalation techniques • development of a management plan • targeting the specific behaviour or

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Key elements	Comments
	symptom • use of medication to relieve agitation/aggression utilisation of non-violent crisis intervention techniques. Where all other interventions have not had a therapeutic effect seclusion may be utilised. These interventions are delivered by qualified staff following a comprehensive risk assessment. All staff working in the AETF will have attended training at the level deemed appropriate to their particular work area. Families and /or carers are immediately informed of changes in a young person's behavioural presentation. In high-risk situations it may be appropriate for a young person to be transferred to an acute mental health unit to ensure the safety of themselves and other young people in the AETF.

3.8 Clinical review

Key elements	Comments
3.8.1 All cases will be discussed at a Multidisciplinary Team (MDT) Review at least weekly.	A consultant psychiatrist or appropriate medical delegate will participate in all MDT Reviews (this may be via telehealth). All MDT Reviews will be documented in the young person's clinical record, the care review summary, and in CIMHA. Where young people are part of, or are being referred to, another part of the mental health service, MDT Reviews should include an appropriate representative from that treating team

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Key elements	Comments
3.8.2 In addition to the weekly MDT 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).	
3.8.3 The young person's recovery plan will inform discussion at the MDT Review. Any significant changes in intervention will be incorporated into the individual care/treatment plan.	The viewpoint of the young person, family and/or carer and their community based supports such as teachers and community mental health case managers will be considered during the reviews. Outcomes of clinical reviews will be discussed with young people, families and/or carers. Any changes to the recovery plan will be made in collaboration with the young person, family and/or carer. Structured risk and review processes will be utilised.
3.8.4 Intervention during access to education program.	DET does not permit the use of restrictive practices, such as seclusion, containment, chemical restraint, mechanical restraint and some forms of physical restraint, unless they have been recommended by a medical professional as a therapeutic intervention (for example, restraint as a postural support). Physical restraint should only be used after preventative and de-escalation strategies have not been successful and must be applied in line with DET's Safe, supportive and disciplined school environment procedure. Physical restraint should only be used in crisis situations, when the student's behaviour presents imminent danger of serious physical injury to themselves or others. Physical restraint procedures that inhibit breathing, place pressure on the neck, joints or chest, cause the free fall of the student, involve sitting or kneeling on a student, or inflict pain should never be used, including in crisis responses.

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Key elements	Comments
	Using appropriate adjustments for students to access the curriculum. Clear separation of duties for medical and educational staff and development of relevant protocols and processes.
3.8.5 Each young person's progress will be routinely monitored and evaluated including the use of standard outcome measures.	The National Outcomes and Casemix Collection (NOCC) will be used, and other measures will be used, based on each young person's individual requirements.
3.8.6 Review of educational program.	Discussion and sharing of information with clinical staff at morning meetings/handover. Adaptions to be made in conjunction with student, teacher/s and carer (if appropriate) Inform Individual Curriculum Plan (ICP) if appropriate. Reporting to home school as appropriate. Will inform input into transition plan.

3.9 Team approach

Key elements	Comments
3.9.1 A multidisciplinary team approach will be provided.	The young person, family and/or carer will be informed of the multidisciplinary model. Recognition of the need for Aboriginal and Torres Strait Islander mental health workers within the MDT is integral for young persons, carers and families that identify as Aboriginal and/or Torres Strait Islander descent. Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision. Clinical, discipline and peer supervision will

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Key elements	Comments
	be available to all staff.
3.9.2 Clear clinical and operational leadership will be provided for staff and for the team.	There will be a well-defined and clearly documented processes for escalation of discipline specific clinical issues.
3.9.3 Caseloads will be monitored by the nurse manager (and other staff as appropriate) to ensure effective use of resources and to support staff to respond to crises in a timely, effective manner.	
3.9.4 AETF school	Education staff are considered as part of the multi-disciplinary team and consulted where relevant. The education staff may include teachers, teacher aides, guidance officers, advisory visiting teachers (disability and therapists as required. Regular updates will be provided to clinical staff on participation and achievement in the educational and vocational program. AETF school Principal will have supervision and monitoring of educational staff workload. AETF school Principal will be responsible for the effective use of the educational resources.

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3.10 Continuity and co-ordination of care

Key elements	Comments
3.10.1 Clearly documented mental health service contact information (covering access 24 hours, 7 days per week) is provided to young people, families, and /or carers, referral sources and other relevant supports.	Provision of this information will be documented in the clinical record, including the recovery plan and the discharge summary. Relevant information documents detailing specific service response information will be

Key elements	Comments
	readily available.
3.10.2 Every young person will have a designated treating consultant psychiatrist.	Recorded in client record
3.10.3 Every young person will be assigned a principal service provider (PSP).	Recorded in client record The PSP is responsible for co-ordinating appropriate assessment, care and review, and completing referral and ongoing care processes. In the event a young person identifies as Indigenous, an Indigenous mental health worker or an Indigenous health worker will be assigned to the young person to participate in ongoing service provision.
3.10.4 Each young person will be allocated a focal nurse for each shift.	Young people will be aware of who their focal nurse is.
3.10.5 Educational case manager.	Each young person will be provided with an educational case manager with ultimate responsibility for reporting and oversight of curriculum delivery and communication regarding the student's progress.

3.11 Transfer/internal transition of care

Key elements	Comments
3.11.1 Disengagement from the AETF will be a planned process with a clear transition period during which there will be contact between the young person, their family/carers and the AETF providing follow up prior to discharge.	During the transition phase, there will be an appropriate plan to ensure smooth transfer of care, which includes the early engagement of all service providers in ongoing care. Young people may or may not return to their HHS at admission and additional consideration will be given to the risks of new service and personal relationships

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Key elements	Comments
	Policies and procedures for internal transfers will be clearly documented. A feedback mechanism will be in place so that the referral agency informs the referee if the young person fails to attend arranged follow up. The referral agency will follow internal processes when patients do not attend follow up appointments.
3.11.2 A written handover will be provided on every transfer/discharge occasion.	
3.11.3 Local protocols for out of area transfers will be mutually agreed and documented.	
3.11.4 Where possible, young peoples will not be transferred to another HHS during crisis.	Where transfer is unavoidable, both services need to make direct contact and ensure safe transfer (service capability will be considered).
3.11.5 Young peoples, family and/or carers will be informed of transfer procedures.	Appropriate crisis plans will be prepared with the young person, family and/or carers.
3.11.6 Young people being transferred under an Involuntary Treatment Order will remain the responsibility of the transferring service until a *transfer order* under the *Mental Health Act 20*16 is made.	Clear arrangements for contact with young peoples by the receiving service should be established. For inpatient transfers, the *transfer order* should be made prior to the young person being transferred. In the case of transfers from the AETF to a community service, or between community facilities, a *transfer order* should be made as soon as possible after the young person's relocation to the catchment area of the receiving service, and within a maximum period of one month.

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3.12 Discharge/external transition of care

Key elements	Comments
3.12.1 Planning for transition and discharge from the AETF will commence at the time of admission. Young people will be discharged as clinically indicated and in accordance with their individual recovery plan.	Young people, their families and/or carers, the referrer and other key stakeholders will be actively engaged in discharge transition planning from the time of admission. Discharge and transition planning will be a routine component of each clinical review process. Young people, their family, and/ or carer will be asked to sign their discharge plan. It is highly recommended that the involvement of Aboriginal and Torres Strait Islander mental health workers is prioritised for transfer/discharge 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 AETF. This ensures that the young person does not remain in the AETF longer than is deemed clinically necessary. Discharge planning should also consider accommodation and support needs for young people who are homeless, in care of the Department of Child Safety or at risk of homelessness.
3.12.2 Discharge planning will include a recovery plan, and incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.	The recovery, relapse prevention and crisis management plans will be provided to the young person, family and/ or carer, GP and relevant support agencies.
3.12.3 Where young people are absent without leave, there will be documented evidence of attempts to contact young person, family and /or carers and other service providers (e.g. QPS), before discharge.	

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Key elements	Comments
3.12.4 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.	
3.12.5 Discharge will occur when the AETF is no longer the most appropriate service option and the Treatment Plan has been undertaken.	The decision to discharge is at the discretion of the Clinical Director in consultation with AETF staff. Consideration will be given to how best maintain benefits gained from treatment interventions (e.g. involvement in a day program may be encouraged to assist the transition and facilitate rehabilitation and recovery goals).
3.12.6 Comprehensive liaison and handover will occur with all service providers who will contribute to ongoing care post-discharge prior to discharge.	All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within 48 hours. Discharge summaries need to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral. Relapse patterns and risk management information will be clearly outlined.
3.12.7 Educational and vocational transition plan.	Will be developed in conjunction with the young person's home school. Will be developed in collaboration with Guidance Officer/Senior Guidance Officer and in consultation with student. Planning commences on admission. May require a staged transition back to school including: • Step Up Step Down • Use of day program

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Key elements	Comments
	A dedicated case manager in education setting will be appointed. Final plan to be agreed upon by young person/clinicians/parents/home school and endorsed by the consultant medical officer (Psychiatrist). Facilitation of enrolment in a home school where no current enrolment exists for compulsory participation phase.

3.13 Collection of data, record keeping and documentation

Key elements	Comments
3.13.1 The AETF will enter and review all required information in client health record, in accordance with approved state-wide and HHS business rules.	
3.13.2 The AETF will utilise routine standard outcome measures as part of assessment, recovery planning and service development. These will include those mandated through the National Outcomes and Casemix Collection (NOCC).	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 people and their families and or carers. Outcomes data is used with young people to: • record details of symptoms and functioning • monitor changes • review progress and plan future goals in the recovery plan.
3.13.3 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 hard copy clinical records.
3.13.4 Clinical records will be kept in accordance with legislative and local	Personal and demographic details of the young person, family, and/or carers and

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Key elements	Comments
policy requirements.	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.
3.13.5 Recording appropriate educational information.	For students from state schools, use OneSchool to record information to enable an ongoing record of the student's educational data throughout their attendance or registration/enrolment in a state school. For students from non-government sector, record information to enable an ongoing record of the student's educational data. Liaise with a non-state home school to determine if additional record keeping is required. Where appropriate the student will participate in the appropriate assessments as set by the home school and/or state and national testing. Participation as appropriate in any local testing measures conducted by the AETF school. AETF school to undertake any scheduled planning requirements (i.e. QSR, development of School Plan, AIP, I4S, School Annual Report, SIU review, School Curriculum Plan). Development of a Responsible Behaviour Plan by the AETF school with appropriate personalised individual behaviour plans as required. Documented permission from carers for communications — including receipt and sharing of information across specialist areas. Knowledge and support of care orders and

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

3.14 Working with families, carers and friends

Key elements	Comments
3.14.1 The involvement of families and carers is integral to successful outcomes and therefore their engagement is incorporated into every component of service provision.	Young person/Guardian consent to disclose information and to involve family and/or carers in care will be sought in every case.
3.14.2 Education and information will be provided to the young person, family and/or carers at all stages of contact with the AETF.	This will include a range of components such as: • education and information about the mental illness or mental health issues • the journey within the AETF • 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 in the clinical file.
3.14.3 Support services will be offered to families and carers regardless of whether consent is given for their involvement in young person's care.	Support may be provided by a member of the mental health service organisation or another organisation.
3.14.4 The needs of families and carers must be routinely addressed.	Identification of carers and their needs is part of the assessment process and is included in care planning.

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Key elements	Comments
3.14.5 Young people who are children of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided. If a young person of the AETF is pregnant or a parent with primary care responsibilities, their infants/ children will be routinely considered as part of all assessments. Interventions will be provided/ facilitated if needed.	•
3.14.6 Consultation with carers, students and home school.	Ongoing consultation and communication will occur during the student's time registered at the AETF school and during transition planning.
3.14.7 Young people being transferred under an Involuntary Treatment Order will remain the responsibility of the transferring service until the first medical assessment is completed.	

3.15 Mental health peer support services

Key elements	Comments
3.15.1 All young people, families and/or carers will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Young person and carer consultants are accessible via the local HHS mental health service.

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4. Related services

The AETF is an integrated service representing a partnership between Department of Health and Department of Education and Training, and sits within a continuum of Child and Youth Mental Health Services.

The continuum of Child and Youth Mental Health Services includes:

- Community Child & Youth Mental Health Service clinics (CYMHS)
- Assertive Mobile Youth Outreach Services (AMYOS)

- Day Programs
- Residential
- Acute Inpatient Beds
- Step Up Step Downs (planned)

However, it also interacts more broadly within a complex landscape of other Queensland Health services (e.g. Alcohol Tobacco and Other Drug Services and Community Health), other Queensland Government departments (e.g. the Department, Department of Communities, Child Safety and Disability Services), private providers and non-government organisations.

The AETF will integrate and coordinate care with the service and support networks of young people to ensure continuity across the care system. Family members and carers will be provided 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 well-being.

The AETF will work collaboratively with DET to support and maintain existing relationships between young people and educational and vocational options if these exist, or support the development of appropriate educational and vocational relationships in order to integrate educational/vocational needs into a holistic, integrated treatment plan.

It is anticipated that the educational and vocational program will not only utilise staff and amenities based at the AETF, but also educational and vocational staff and facilities in the surrounding area.

The AETF will provide 24 hour services, which requires nursing staff to be continuous shift workers. The model of nursing care will be a combination of case management and patient allocation. The skill mix and patient complexity is taken into consideration when allocating nursing staff. The patient will be informed of their focal nurse for each shift.

5. Workforce

Substantially still under development.

The staffing profile for the AETF is comprised of a multidisciplinary mix of clinical and non-clinical staff. Treatment and care is provided by clinical mental health workers including doctors, nurses and allied health staff, as well as a range of non-clinical staff including Indigenous mental health workers, and allied health assistants and staff from the DET. Involvement of and access to young person and carer consultants and recovery support workers should be facilitated within the integrated mental health service. Additionally, the multidisciplinary team is supported by administrative officers, catering, security and hygiene staff who assist with the day to day operations of the AETF.

The effectiveness of the AETF is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of young people accessing the AETF suggests the need to provide staff with continuing education programs, clinical

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supervision and mentoring and other appropriate staff support mechanisms. The AETF will undertake evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, encouraging rotations through the continuum of CYMHS's, and supporting education and research opportunities.

Recruitment and appointment of education staff will be the responsibility of the AETF school Principal in consultation with regional and central office staff. The AETF school Principal will have line and professional management of the staff. Other DET staff will be deployed as appropriate to support the delivery of the education program e.g. Guidance Officers, Advisory Visiting Teachers (disability) and therapists. The AETF school Principal may also utilise staff and resources from neighbouring educational and vocational facilities to enhance the consumer's learning program.

6. Team clinical governance

Substantially still under development.

The AETF will operate under the direction of a Clinical Director and a Nurse Manager/ Team Leader. Clear reporting roles ensure effective management and the efficiency of service delivery. Multidisciplinary team work is essential. Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

The AETF will identify a single point of clinical accountability for every young person.

Multidisciplinary team work is essential as young people receive treatment and care from a range of specialist medical, nursing, allied health, therapy and pharmacy staff with appropriate qualifications, skills and experience.

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

The Regional Director, Metropolitan region has overarching responsibility for the staff and the operation of the school. Teachers employed in the program will be registered with the Queensland College of Teachers. The AETF school is subject to the regular compliance processes of the Department.

7. Hours of operation

24 hours a day, 7 days a week.

As a state school the AETF school will operate as per the term dates set by DET. The AETF school Principal will determine daily operation times in line with current certified agreements.

8. Staff training

Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure that they are clinically

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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 clinical staff must be engaged in relevant professional development to ensure contemporary and evidence based intervention and treatment is provided to young people, their carers and family. The clinical acuity and complexity of young people accessing inpatient services is on the rise. There is a high proportion of the population accessing inpatients that have experienced significant abuse, trauma and/or neglect. The current literature outlines the limitations of verbal treatments with traumatised adolescents, with a paradigm shift away from these traditional therapies. There is growing focus on the integrated approach to managing these traumatised young people both in the community and within inpatient settings. Specialist skills are required to manage escalating behaviours as a result of trauma, including attachment issues and affect dysregulation. All clinicians are to be adequately trained in these specialist skills to provide effective evidenced informed interventions.

All education staff will be required to undertake mandatory training and the annual performance planning process. During this process individual professional development needs, particularly in relation to the work within the AETF school, will be identified. The AETF school Principal will ensure that staff access the planned professional development and that an appropriate program of training and professional development is also accessed by staff on scheduled student free days.

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

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.

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 and adolescents 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 planning
- routine outcome measurement training
- a range of treatment modalities including individual, group and family-based therapy
- an understanding of the impact of complex trauma and disrupted attachment
- child safety services training
- perinatal and infant mental health training

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- knowledge of mental health diagnostic classification systems
- medication management
- communication and interpersonal processes
- provisions for the maintenance of discipline-specific core competencies
- supervision skills
- Aboriginal and Torres Strait Islander mental and alcohol and other drug cultural capability training
- alcohol and drug assessment and interventions
- family therapy
- non-violent crisis intervention training/ABM training.

9. The AETF functions best when

- There is a common language and understanding amongst all clinical and educational staff about the importance of the young person's perspective, the importance of individualized interventions designed to minimize risk and increase protective factors, and the need for an integrated approach to the delivery of services provided to high risk young people and their families.
- 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 treatment planning
- there is an explicit attitude that young people can and do recover from mental health issues and that recovery-oriented services emphasise individual strengths, build resilience and enhance opportunities for social inclusion
- 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 AETF ensuring decision making from intake to discharge are transparent and accountable to stakeholders, and follow established procedures
- service delivery is well integrated, with established procedures that support continuity of care across settings and between services, acknowledging the particular challenges of transitioning from inpatient to community care, and adolescent to adult services
- there is adherence to evidence informed care, treatments, interventions and processes
- the education and vocation program is individually planned, monitored, adjusted where necessary and integrated as part of the holistic care plan
- there is an appropriate mix of educational staff to ensure the delivery of the educational and vocational programs across a range of age and curriculum areas
- there are clear and strong clinical and operational and educational leadership roles which recognise each other's strengths and work to form a collaborative relationship

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- staff are provided with strong professional support and training
- staff are provided with peer supervision/clinical supervision, including reflective practice and debriefing opportunities.

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