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## 2. INTRODUCTION

**The Journey**

This scholarship has become a symbol of a major journey that I have undergone both professionally and personally, and with that it has evolved, changed and grown as I have. Even now as I continue to evolve so too does this project, and as such what is presented here is in fact a summary of a work in progress.

The original scholarship was awarded to explore and learn from organisations overseas who were working with High Risk Youth from a clinical perspective, and particularly those who had an attachment theory (1.) focus. This was very much in keeping with the role I was in at the time as one of five clinicians in Victoria piloting the first Mental Health Intensive Youth Support (MHIYS) Outreach positions for Homeless Youth.

Almost as the scholarship was being awarded, the government announced the allocation of a further $2.3 million dollars to set up other services across the state based on the Mental Health Intensive Youth Support Model. This quickly changed my role from being a clinician piloting a model to having a major role in establishing the new services.

Within this role the focus broadened from direct clinical work to project management and service development in the metropolitan region, which then also expanded to include both of these roles and clinical management of a specific service for high-risk youth in Barwon South Western regional Victoria. As a result the focus of the scholarship broadened to include these new areas.

The next metamorphosis occurred when the high-risk service was relocated and expanded to become an Adolescent Mental Health Service collocated with the Barwon Health Youth Drug Treatment Service and Youth Community Health positions. This was to form a "one stop" health and support service in what had become a "youth precinct" in Geelong. Again my role grew; now it had become the Clinical Coordinator of the Adolescent Mental health Service as well as having a key role in developing the Collaborative Youth Service.

Then finally the scholarship tour began, and as each country and service was encountered there were yet further questions that arose on the broader socioeconomic and political levels. This occurred as I tried to locate the services in their respective contexts to understand the similarities and differences to my experience of services in Australia. What was highlighted was the huge impact the political focus and direction of respective countries had on what and how services were developed and delivered. This led to yet another level of enquiry, which has become a major piece of work itself. This is an analysis of Australian policy and structures that have and continue to determine the shape and direction of service delivery of Mental Health Services to Australian Youth, and is currently a work in progress.

The outcome of this evolution and expansion of my professional role was that the Scholarship became a massive project, which involved having contact with a huge amount of services, attending a number of conferences, delivering and attending training, as well as leading to the ongoing political enquiry outlined above. The initial

intention was to include a political analysis within this report, however it became clear this was somewhat optimistic due to the magnitude of the task.

Therefore what will be presented within this report is a "collage" of services visited, using in-depth reviews of four services from four different countries rather than trying to describe all of the services visited. This is to both reflect the depth of involvement and knowledge gained, and to represent some of the range of what was seen and experienced, then finally to use this material to reflect how the learning from this may have relevance to the Australian context. (Individual summaries of other services are available).

**Acknowledgments**
First and foremost I would like to thank the Australian Winston Churchill Memorial Trust for the award of the Fellowship, and to acknowledge Sir William Kilpatrick for the specific scholarship that I received. I would like to thank in particular Mr. Paul Tys, Chief Executive Officer, for his understanding and support regarding the more difficult times, Ms Elvie Munday for her monitoring and pragmatic assistance, and the other Victorian Churchill Executive Members, in particular Mr. Graeme Henderson and Mr. Gary Jamieson, who were always there with a warm welcome and encouragement at functions; something which is a reminder of the true nature of what it is to be a Churchill Fellow.

I would like to thank my referees, Dr Petra Steiger, Prof Bob Adler and especially Mr. Harry Gelber. Mr Gelber has supported and encouraged me through many of my professional and personal transitions.

Thanks go to my colleagues in many areas. Firstly to those at Barwon Health who enabled me to have the time away, particularly the staff of the Adolescent Mental Health Service and to Ms Deb McDonald, who 'held the fort' in my absence. Next is to express my appreciation to the other Churchill Fellows (Simon Crisp, Stephanie Dowden and Graeme McConnell), who gave practical and emotional advice and support, and to Mr. John Toumborou of the Centre For Adolescent Health, for initiating connections with a range of people overseas and for the time he made to link up while we were both over seas.

Thanks also to Mrs. Cheryl Baxter for the conversations, contacts and guidance, and for sharing her documentation, all of which proved to be invaluable, and to Mr David Heyne from the Child Psychiatric Training Center, for providing a major forum for me to feed back about the Scholarship to my peers across the state.

Finally, the hugest thanks go to the people overseas for their hospitality and support, and for their honesty, openness and willingness to share information with me so that I could learn.* Special thanks go to those who welcomed me into their homes, Dr Nisha Dogra, in Leicestershire, United Kingdom; Dr Kjetil Hustoft and Jan Erick Neilsen, Rogaland Psychiatric Hospital, Norway; Dr Roy Holland, Mr Ken Brown, and the staff at The Maples Centre, Vancouver, Canada; and Mr Ken Peake, Mnt Sinai Hospital, New York. In addition I would like to thank Karen Jepsen and her partner Greg, Tina Grimberg, and Jamie and Beth Cade and their family for the warmth of their hospitality. * (Refer to methodology section for acknowledgements of specific information utilized within this report).

## 3. EXECUTIVE SUMMARY

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**PROJECT DESCRIPTION**
To explore and learn from innovative programs that engage and treat homeless young people who demonstrate severe at risk behavior (i.e.: suicide, self-harm, drug abuse, violence) as a Sequelae to serious psychological and / or psychiatric problems, with the aim of reducing their risk of continuing social and psychological adversity.

**AIMS / AREAS OF INTEREST** The initial clinical area of interest broadened to also include organizational aspects as outlined below:

**1. Clinical:** The initial enquiry was to explore services working with High Risk Youth from a Clinical perspective, with specific areas of interest being the interface with attachment and other co-morbidity issues. This expanded to include generalist CAMHS services and became a fact-finding endeavor to look at a broad range of treatment methods and models used with adolescents, the problems and successes encountered, staff profiles and training, and evaluation and research methods.
**2. Organizational and Broader Mental Health Service Systems:** To explore elements of good service development, service management and service delivery, particularly in relation to collaborative models.
**3. Specific Research questions:**
1. What is really needed by the Young Person, the Clinician and the System for Mental Health Intervention to be Effective with (high risk) adolescents?
2. What are the best Theories to support the most Effective Clinical Interventions with (high risk) Young People / Adolescents, and how are these Translated into Practice?
3. What are the best Models of Research and Evaluation for this client group?

## AIMS OF REPORT

I visited a smorgasbord of services**,** all of which had elements of good practice; so much so the challenge to synthesize the information obtained from the diverse settings was too great. Therefore this report will focus on 4 in-depth service reviews from the Macro to the Micro, to exemplify some of the major lessons learnt and to explore the application or relevance to Australia.

The four services chosen were, Leicestershire & Rutland Child and Adolescent Mental Health Service, United Kingdom, Rogaland Psychiatric Centre, Norway, The Maples, Residential and Outpatient Service for Young People with Conduct Disorder, Canada; and Mnt Sinai Adolescent Health, United States. These are the services where the longest time was spent which created the richest learning experience.

## KEY FINDINGS / THEMES

The services reviewed in this report were all exceptional service on many domains, and demonstrated a wonderful mix of sophisticated program development, innovative and comprehensive clinical work, and reflective practice based research within the context of a very grounded and pragmatic approach to the client and their needs.

The combination of the above with the integration of a range of theories and models into practice provided a strong and cohesive framework for the programs to develop within. This created a structure that held the services accountable to young people, the community, and the staff for what service was provided and how it was provided.

The outcome was a solid service culture that promoted professionalism, a strong commitment to client needs, positive and enthusiastic staff who took pride in owning the work they did and the programs they had helped develop, and very much created the culture of life long learning that was valued highly within each organization.

How this translated into practice was reflected in the use of multi-modal interventions and a comprehensive range of therapeutic approaches (for example, psychodynamic, systemic, and psycho-educative multi-family group work, mixed with pragmatic approaches such as social coping and building networks of supports for the client and their family).

Overall the programs seen and the people met were impressive in the level of professionalism that was demonstrated. The pride the staff had in their services clearly reflected the fact that they were well supported and encouraged on a clinical and an organisational level.

### Common Challenges

Challenges that nearly all the services had in common included fragmentation of service systems and the negative impact this had on collaborative service delivery, which was compounded by the increasing complexity of clients presenting. The profile of the client was extremely challenging with complex family and psychosocial issues that gave rise to multiple needs and therefore multi-service involvement. The minimal resources and the resulting pressure on service provision further exacerbated this, as did the difficulties in getting enough trained staff in the child and adolescent area (and particularly the High Risk end of the continuum). All this was in the context

of managing constant change because of changes in policy, funding, legislation and client population.

## MAJOR LESSONS LEARNT

In addition to the above, it is important to highlight one of the major lessons learnt from my experiences during this study tour that has prompted the next level of enquiry beyond this scholarship; that is the need to know and understand the impact of the Socio-Political context as fundamental to any enquiry about services such as those visited on the study tour and in general.

The Socio – Political context has a profound impact on all levels in relation to the mental health and well-being of children and families and the services established to support them. This was evident in each of the countries visited, and is equally as powerful within Australia. This is something that as a manager and practitioner I had always been aware of on a local level, however I became increasingly aware of the universality of just how profound an impact the permutations from the Socio-Political context have.

The reality of working with the larger social and political structure as a significant component of programme development was also acknowledged, as the introduction of new treatment approaches was often hampered by social and political agendas. It was also recognised that mediating the impact of the complex forces that impinge on programme delivery required skill and political sophistication that challenged even the most experienced practitioners. (Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie & Hamilton, 1997).

### Addressing the Original Research Questions and areas of Enquiry

In revisiting the original research questions and areas of enquiry for this scholarship study, it was clear that the programs seen and data obtained has given an incredible amount of information that is of relevance and can have direct application to the Australian context. Such things as the challenges faced, what has or hasn't worked, program models and treatment methods, and how theory was translated into practice were discussed in depth on both the clinical and organizational level. This has gone a long way to embellishing my understanding of what is really needed for young people, clinicians and service systems. Finally the strength of the research models seen, that were well integrated into practice and inclusive of the staff within the service, demonstrated how programs can be informed by and linked with research in a user friendly and accessible way.

## RECOMMENDATIONS

Within this report a range of recommendations have been made that fall under the headings of Socio-Political, Structural, Organisational and Clinical. The latter 3 areas were drawn directly from the key elements common to each of the organisations reviewed and were fundamental to good service delivery.

## DISSEMINATION / IMPLEMENTATION

To compliment the recommendations made, a range of strategies for the dissemination and implementation of the findings are listed under 6 main headings or areas. A more detailed outline of specific strategies is given within the body of the report.

### 1. Clinical

**a).** Further Study and Training in Attachment Theory.
**b).** Run Training Seminars and Lectures.
**c).** Project Involvement.
**d).** Offering Mentoring Relationships.

### 2. Organizational/ Program Development

**a).** Feedback to CAMHS Managers.
**b).** Review current Organizational / Management Structures.
**c).** Secondary and Tertiary Consultation.
**d).** Committee of Management and Advisory Boards.

### 3. Combination of Clinical and Organizational

**a).** Apply the elements of the Best Practice from the services seen to the development of a Specific Service Model for a Retreat and Training Centre for High Risk Youth.
**b).** Further Research. This will be utilized to inform specific clinical practice and service development.

### 4. Government / Political

**a).** Participate in Reviews / Audits of service systems as a specialist in the field.
**b).** Participate in Specific Liaison and Advisory Groups to the Mental Health Branch
**c).** Feedback Scholarship Findings. Provide expert presentations to the Mental Health Branch and other significant bodies / organizations,
**d).** In-depth political analysis as outlined within the recommendations above.

### 5. Community

**a).** Public Lectures outside of the Care Professions, ie: Rotary Clubs
**b).** Projects that involve awareness raising about Adolescent Mental Health

### 6. Documentation

**a).** Winston Churchill Report dissemination (hard copy and Webb site access).
**b).** Training and education material / manuals.
**c).** Further research projects written up as papers, as outlined above
**d).** A Book to further expand on all of the above.

**In Summary**

The scholarship was a rich and rewarding experience on both a personal and professional level. It has begun an enquiry rather than completed one, and given the nature of the recommendations and strategies planned, will function as a platform for sparking even further enquiry beyond those that have already emerged. Therefore it will continue to have a huge influence on my endeavors to truly make a difference for young people and the community for a long time to come.

## 4. OVER VIEW OF PROGRAM

**33 Programs, across 25 agencies, over 3 Continents, and 4 Countries (United Kingdom, Norway, United States, and Canada)**

**Attended 2 Conferences**

**Presented at 1 Conference**

**Participated in 5 Public Consultations**

**Ran 5 Training Sessions**

**Attended 2 Training Sessions**

**UNITED KINGDOM (8 Programs)**

**1.** Michael Maher Group, Surrey; Mr Michael Maher
**2.** Trust for The Study of Adolescence, Brighton; Ms Eddie Piper
**3.** Denmark Hill / Maudsley / Bethlem Hospital; Ms Janet Gill
**4.** Institute of Child Health, London; Prof Skuse
**5.** University of Leicester Child and Adolescent Mental Health *****
**6.** Suicide Task Force, National Study; Ms Karen Smith
**7.** Lighthouse Foundation, London; Chris Birch

**NORWAY (6 Programs)**

**Rogaland Psychiatric ***
**1.** Child In-patient Unit
**2.** Adolescent In-patient Unit
**3.** Youth Team
**4.** T.I. P.S (Early Intervention)
**5.** Langor Island Conduct Disorder Residential
**6.** Eikerly – Dual Diagnosis, Outpatient and Residential

**CANADA (6 Programs)**

**1.** The Maples Centre, Vancouver *****
**2.** Dallas Youth Services, Vancouver Island; Ms Kristen Berg
**3.** Hinksdellcrest Child and Adolescent Centre, Toronto; Dr Korenblum
**4.** George Hull, Toronto- Ms Jane Bray & Ms Elizabeth Ridgley
**a).** School for Dual Diagnosis Clients **b)** Family Therapy Centre
**5.** South Fraser Adolescent Services, Vancouver; Ms Tanis Evans
**6.** The Farm, residential program for Conduct Disordered young people, Toronto
Dr Helen O'Halpin

***** Refer to In-depth Reviews

**UNITED STATES (12 Programs)**

**SEATTLE (5 Programs)**
1. Communities that Care; Mr Kevin Haggerty
2. Kings County Crisis Centre, Ms Kathleen Southwick
3. Seattle Children's Home, Ms Carol Barber
4. Washington University Psychology & Nursing Departments, Ms A M Cauce
5. Collaborative Communities; Prof Charley Huffine

**NEW YORK (5 Programs)**
1. Mnt Sinai Centre for Adolescent Health *****
2. Safe Place, Mr Eric Mercer
3. The Door, Ms Christal Baker
4. Montefiores Medical Centre, Dr Alec Millar
5. Albert Einstein College of Medicine, Dr Alec Millar

**HAWAII (2 Programs)**
1. Hale Kaipa Youth Services, Mr Mike De Mattos
2. Youth At Risk, Mr Marvin Uhera

**CONFERENCES**

**Attended**
1. Family Therapy & Attachment, Niagra-on-the- Lake, Canada
2. 47th AACAP Conference, New York

**Presented**
1. 47th AACAP Conference, New York

**PUBLIC CONSULTATIONS (5)**

1. Youth Outreach Forum, Vancouver Island
2. Mayoral Drug Summit, Seattle, Washington
3. Multi Agency Training Day, Leicestershire, United Kingdom
4. Ministry Of British Columbia Secure Containment Reference Group
5. United Kingdom Suicide Summit

**TRAINING RECEIVED (2)**

1. Gordon Neufeld, "The defended Learner" Vancouver, Canada
2. Train the Trainer, Greenwood University Department of Child Psychiatry, United Kingdom

**TRAINING DELIVERED (5):**

1. Triage Services, Leicestershire Child and Adolescent Mental Health.
2. Michael Maher Group, Surrey, United Kingdom
3. Outpatient Youth Services, Rogaland Psychiatric, Norway
4. Mnt Sinai Adolescent Mental Health
5. University of New York, Department of social work.

## OVERVIEW OF SPECIFIC FOCUS OF PROGRAMS REVIEWED

| | |
|---|---|
| **1. UNITED KINGDOM** | **Leicestershire and Rutland CAMHS* (Refer below)**<br>Generalist CAMHS Services, Primary Mental Health, Community Collaboration,<br>Joint Academic / Practice Based Research<br>Rural, Metropolitan and Semi- Urban |
| **2. NORWAY** | **Stavanger / Rogaland Psychiatric**<br>Large Cross Spectrum Psychiatric Hospital<br>(Child, Adolescent, Adult, Aged Mental Health)<br>Inpatient, Outpatient, Residential,<br>Community Development<br>Early Psychosis, Education, Prevention, & Intervention<br>Joint Academic / Practice Based Research<br>Health Promotion, Primary Intervention and Prevention, |
| **3. CANADA** | **Vancouver / The Maples Centre**<br>Specialist Residential Services for High Risk Youth (with Conduct Disorder)<br>Attachment Theory<br>Joint Academic / Practice Based Research |
| **4. UNITED STATES** | **New York / Mnt Sinai Adolescent Health**<br>Integrated Primary Health / Mental Health Partnerships, Group Programs<br>Adolescent Sensitive Philosophy<br>Joint Academic / Practice Based Research<br>Centre for Excellence, Academic Research Unit |

## CATEGORIES OF ADOLESCENT / YOUTH SERVICES VISITED

**1.** Generalist Child and Adolescent Mental Health Services (CAMHS)*****

**2.** Collaborative / Multi- agency projects

**3.** Large Hospital Based Psychiatric Services

**4.** Primary Mental Health

**5.** High Risk Youth Programs

**6.** Non – government Youth and Family Support Agencies

**7.** Residential Programs

**8.** Specific Diagnostic Based Programs
- (Early Psychosis, Dual Diagnosis, Conduct Disorder)

**9.** Research / Academic and Research Based Training

## 5. BACK GROUND

**Australia**

In Australia many studies have highlighted the disturbing incidence of young people who become homeless as a result of family breakdown or severe physical, emotional or sexual abuse, and who subsequently show severe at risk behaviours but are unable or unwilling to engage with mainstream services. As a result the spiral of destructive behaviour escalates which leads placements to breakdown and hence further social and psychological adversity.

"The increase of mental health problems in children and particularly adolescents, includes one of the highest suicide rates in young people in the world; a situation of great concern. This calls for more effective and more accessible means for not only treating, but also providing protection against severe mental health problems in adolescence and adulthood" (Crisp, 1996, p 2).

Whilst conventional mental health treatment for adolescents are typically based upon methods developed for use with adults, the needs of adolescents are significantly different in many important respects.

**The Initial High Risk Target Group**

"This is a complicated group of behavioral and emotional problems in young people. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way. Their expression of anger is a major problem. Other children, adolescents, adults and social agencies often view them as bad or delinquent. They are often not considered to have a psychiatric disorder.

It is common for large numbers of agencies and interventions to have provided services for such young people. The involvement of multiple systems puts considerable strain on finite resources" (Cheryl Baxter, 1998,p1).

**This scholarship: / My professional involvement**

My project was initially closely related to and an extension of the work I was doing within Mental Health Intensive Youth Support Service (MHIYS), the pilot outreach Child Psychiatry program to High Risk Youth. The program was first established in August 1995, by Mental Health Services in collaboration with Child, Adolescent and Family Welfare Division, and operated in collaboration within the designated non-government organization. There were 5 positions, 2 in Northern Region, 1 in Eastern Region, 1 in Southern Region, and 1 in Western Region.

In practice the position translated into outreach mental health counselor, trainer, educator, consultant, researcher, program developer and general new frontier explorer. When I say frontier explorer, it had been very much like stepping into foreign lands with both learning and creating as you go. Being outreach, the position was located out of the hospital alongside the Intensive Youth Support Teams within Non-Government Organizations. This was done for many reasons: firstly it was seen that these young people rarely accessed mainstream mental health services, unless via casualty where they would present with medical issues, often following some form of suicide attempt. However they did access Non-Government services like the Salvation Army, so the aim was to take psychiatry and mental health support to these services.

The position was designed as an outreach position to be able to meet the young people in their own environment and as much on their own terms as possible in an attempt to engage them where they felt safest, and to empower them to utelise the services to get the assistance they required.

This was also in recognition that homeless young people present with a whole range of issues, for example; food, shelter, safety, money, medical, education / employment, before you can even get to the emotional needs. Sadly because of the extensive and multiple abuse within their life experience, many young people turn to drugs as a way of coping, to petty crime, or to violence, which may further complicate their care and stretches what is required of the individual practitioner to the hilt, as well as the system of services attempting to deal with their needs and behaviours.

By working alongside the community services it bridged the gap between workers in the field and Child and Adolescent Mental Health services by building a greater understanding of the needs of services as well as the young person, hence creating a stronger collaborative approach, and in turn preventing the young person from falling through the gaps.

The initial success of this model led to it being incorporated into strategic plans for Mental Health Services Redevelopment, however despite this favorable outcome, there were a number of key issues common across regions particularly around systemic issues, which lead to a number of questions and areas for further exploration (Refer to research questions below). Also because it was such a new initiative in Victoria, it was vital to learn from and incorporate what had been done overseas, to ensure the very best model was developed to assist these young people to move from their vulnerable and disadvantaged position to one where they are better able to realize their potential.

This lead to:

**1. Literature Review**

An extensive literature review revealed little had been written in Australia about best practice models used in Australia for this target group, with the majority of information coming from America or the United Kingdom.

**2. Disrupted Attachment Research Project**

Given the lack of Australian based research in this area, it was felt important to design a research project specific to the work being done, that may begin to address a small part of this gap. The project had two components, firstly an action research component aimed at testing the value of attachment the theory for understanding high risk young people and the possible implications for practice using a specific case history, and secondly using a reflective practice approach to match and describe practice in theoretical terms, and to articulate and promote the theory behind the practice.

**3. Winston Churchill Scholarship application** To explore what others were doing overseas first hand. (How the Scholarship evolved from this point to go beyond the focus on only High Risk Youth is outlined in the introduction.)

## 6. METHODOLOGY

### a). Data Collection and Selection of Agencies

This qualitative study was undertaken using a descriptive, exploratory approach. A semi-structured interview schedule was used to inform my discussions, which sought information on issues relating to the development, structure, function and service delivery issues for each organization (Refer Appendix).

The countries and services were chosen primarily by a combination of personal knowledge, consultation with other professionals (both locally and over seas), Internet searches, and 2 major literature reviews looking at best practice models using Attachment theory and broader Adolescent Mental Health Service delivery.

Data was derived from a combination of semi structured and unstructured interviews, program literature (where available), direct observation and participation in training programs and other activities, and via internet Webb sites of respective agencies.

### Research Questions

Whilst the intention of the study tour was to look at services quite broadly on both a clinical and an organisational level as outlined within the interview schedule, there were 3 specific areas of enquiry or research questions. These arose from the work with high-risk youth in the MHIYS pilot program; however were equally relevant to the broader CAMHS service system.

These were:

**1.** What is really needed by the Young person, the Clinician and the System for Mental Health Intervention to be Effective?

**2.** What are the best Theories to support the most Effective Clinical Interventions with Young People / Adolescents, and how are these Translated into Practice?

**3.** What are the best models of Research and Evaluation for this client group?

### b). Presentation of information within the Report

The information presented within the report is a combination of the data obtained by the methods outlined above, my own thoughts and reflections, and with the permission of the respective agencies, direct reproduction of information and reports available on individual agencies Webb sites. In particular, a large part of the information about the Primary Mental Health Team and the Mental Health Services for Homeless Children and Families Program within Leicestershire and Rutland CAMHS came from the published works of Tischler and Vostanis (2001) and are highlighted within the scholarship bibliography. Specific quotes have been used from the work of Mr Simon Crisp, (Winston Churchill Report, 1996), Mrs Cheryl Baxter, (Study Tour Report, 1998), and Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie & Hamilton (The Treatment of Conduct Disorder: Perspectives from Across Canada, 1997).

## 7. SOCIO-POLITICAL CONTEXT AND THE IMPACT ON SERVICE DEVELOPMENT AND DELIVERY

### Introduction

Whilst undertaking this study tour, it quickly became apparent the profound influence the Socio- Political context had on all levels, from the macro to the micro, in relation to the mental health and well being of children and families and the services established to support them. As stated by Crisp (1996), "notions of mental health and the sociological influence on problems, effects how programs are developed and what their place is relative to other services. Together with historical precursors, this has contributed to the diversity of program types and how they are applied"(p3).

Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie & Hamilton (1997), develop this further by saying, "It is important to recognise that the introduction of new treatment approaches is often hampered by social and political agendas" (p639). They highlight that the reality of working with the larger social and political structure as a significant component of programme development needs to be acknowledged, as it is within this context that programme development takes place. They go on to say, "Mediating the impact of the complex forces that impinge on programme delivery requires skill and political sophistication that challenge even the most experienced practitioners" (p640).

This is something that as a manager and practitioner I had always been aware of on a local level, however I became increasingly aware of the universality of this and just how profound an impact the permutations from the Socio-Political context have.

The work of Moretti, et al, and two reports from the United Kingdom, The Big Picture report (1999) and Together We Stand (Jan 1993- Feb 1995), are utilised below to highlight the impact of the socio-political issues. The reports from the United Kingdom explore in-depth the broader social and political context and the impact this has on the mental health of children and young people within the United Kingdom, as well as the impact this then has on the structure and delivery of Child and Adolescent Mental Health Services. Many of the issues covered were common to other countries visited, and have particular relevance to Australia; therefore they have been outlined in detail. The relevance to the Australian context will be explored in the discussion to follow.

### The Social & Political Context (From The Big Picture Report, Spring 1999)

The Big Picture: Promoting Children and Young Peoples Mental Health (National Mental Health Foundation, , Spring 1999), is a report that formed part of the 3 year Bright Futures Program of work designed to inform the first ever major enquiry into all the factors affecting the mental health and emotional development of children and young people in the United Kingdom. Bright Futures included a one million pound research program, over 1,000 pieces of written evidence from relevant professionals and the oral testimony of a mix of health and education professionals, service providers, academics, parents and children.

The report covered problems and issues, risk and resilience factors, factors that support mental health and emotional development, the services available, policies and programs, and views of range of people. It examined the social changes and pressures

that have created a situation where Mental Health problems in young people are increasing, defined mentally healthy children, looked at the incidence of mental health problems and factors affecting mental health, and the cost of caring. It provided a practical blue print for action, and explored aspects of early intervention and inter-agency collaboration.

**Social Context.** The reports referred to a time of rapid change on the social, economic, political and managerial levels, in which people have to cope with increasing complexity, instability, diversity and conflict in both their personal and working lives. A number of important societal changes were outlined that have impacted on children and young people in the United Kingdom; these fall under a number of headings such as the family role, structure and function, the developmental stages of adolescence, and the increasing and different pressures upon youth today, as well as changes of the broader social structure that permeates both families and opportunities for youth.

**Social Structure.** The growth of individualism, competition and the erosion of a number of mechanisms for maintaining social cohesion were seen to have contributed to a greater social differentiation and income inequity. The changing labour market with greater geographical mobility, fewer unskilled jobs and the expectations on many workers to work unsociable hours was also said to have had a significant impact on families and young people trying to enter the work force.

**Role of Children and Young People.** The report stated that, "We claim to be a child-centered society but in reality there is little evidence that we are. In many ways we are a ruthlessly adult centered society where children are defined almost exclusively in terms of their impact on adult lives and by governments in terms of their economic potential" (p4).

It goes on to say, "The myths and priorities of the late 20$^{th}$ century life have separated many children from their wider communities and it is therefore small wonder that some feel little sense of involvement with or responsibility to the society around them and vice versa. Our acquisitive society tends to see children as the sole property and responsibility of their parents rather than also members of a community or even as citizens" (p5).

**Adolescence.** The report recognized that adolescence is now a longer, more complex and less predictable transition from childhood to adulthood, where some young people may lose their way, that there has been an increased emphasis in the education system on academic attainment and an increase in school exclusions, juvenile crime and suicide/self harm rates. It also outlined a heightened concern about the dangers faced by children, particularly around abuse, the increased opportunities and access to drugs and opportunities for crime, and states that a decline in the availability of publicly funded leisure services compounds the lack of alternatives that may be available to young people.

**Families.** The impact of parental separation and the fragmentation of the extended family networks were also seen to have reduced the contact many children have with fathers, grandparents, aunts and uncles. The suggested consequences of this are a growing number of children who may have no more than two or three significant

adults in their life with all that that means for lack of role models and the absence of wider adult influences, and whose physical domain or territory is limited to home and school.

It highlighted that although there is a broad political consensus that supporting families was seen to be the best way society has devised so far to raise children, many of the changes in society are making this more difficult, especially as the role of the State in supporting families has in recent years been reduced.

It also highlighted that the stresses on the family make it increasingly difficult for vulnerable parents to meet their children's needs, yet the roles of government and public services in this area have been changing and their ability to solve social problems has been questioned.

**Incidence of Mental Health Problems**

The Big Picture report noted that in increasing numbers children and young people are failing to thrive emotionally, are less able to cope with the ups and downs of life, and increasing numbers of them are going to develop severe and enduring mental health problems. The difficulties were seen to already manifest in the growing numbers of families experiencing multiple problems, school exclusions, juvenile crime and the worrying suicide and self-harm rates among young people.

Statistics given regarding the incidence of mental health problems highlighted that fifteen million children and young people less than 20 years old in UK (25% population) will experience some form of mental illness in their lives, and that at any one time 20% of the population experiences mentally ill health (1:5). In addition to this it stated that there has been a clear increase in psychosocial disorders in youth since World War II in nearly all developed countries. Disorders varied according to age and to some extent gender, and included such percentages as Anxiety Disorders12%, Disruptive Disorders 10%, Attention Deficit Hyperactive Disorder 5%, and Specific Developmental Disorders 6%. Surprisingly statistics were not provided for Depression given it is estimated that depression alone will constitute one of the greatest health problems worldwide by 2020 (Murray and Lopez, 1996).

The report states that, “They are causing immense distress to the individuals and their families, limiting the potential of future generations and yet we, adult society, are largely blind to the problems. But it is a blindness of the ostrich. We do not want to see it because it’s too uncomfortable, because to recognise the need in others we would have to confront too many painful facts about our own emotional and mental vulnerabilities” (p4).

**Political / Policies and Programs**

The report states that we are often told that no government will invest in long-term programs that will not yield results in their lifetime; however it saw the government as beginning to acknowledge the need for government departments to work together to address at least some of these issues, although inconsistencies were still evident. It stated that successive recent government proposals on children and families * are a great improvement on what has gone before, “nevertheless still fail to address the fundamental fact that the root cause of so much dysfunction in individuals, families,

in schools, organizations and in society as a whole is poor mental and emotional health and that as a result can only be partially successful" (p5).

*Recent government proposals included the aim to reduce social exclusion, to support those who are vulnerable, to strengthen the family, and to promote joint solutions to complex problems.

In addition to the above, Moretti, et al, (1997), gave specific examples of the influence of political agendas on program selection and funding. They highlighted the fact that, "during the past decade, public outcry regarding youth crime has prompted politicians to implement programmes that respond to concerns regarding public safety and restitution that are often designed to appease public demands rather than to implement new programmes based on research" (p647). They cite the example of programs for Conduct disorder within Canada, stating that, "Despite the fact that conduct disorder is extraordinarily costly and that early intervention strategies are well foundered in research and promise effective returns, prevention programmes are rarely considered. This again likely reflects the short-term political agendas that focus on appearing to solve current problems and demands rather than long-term investment in preventing future ones" (p647). They see this as a means to gain immediate favour from the voters (i.e. for the term of their political office).

**Impact on CAMHS Service provision**

The Big Picture report outlined that work relating to the mental health of children and young people – like most work on modern social issues – involves a continuous process of reconciliation between different conflicting pressures. These include the conflict between personal freedom and public protection, diversity and uniformity, local discretion and central control, open access and targeted provision, equity in process and effectiveness in outcome, risk and safety, and inclusion and exclusion.

It goes on to say that these tensions can arise in the formulation of policy and legislation, in the development of professional practice, and in the management of organisations, and that such pressures tend to underpin and reverberate across the many tiers of influence from the political decisions made down to the conflicting pressures experienced by clinicians in delivering their day-to-day service.

Moretti, et al, (1997), emphasize that, "when services are not integrated with a common goal, a common paradigm for understanding the social problem, a common language of how to work together, families and children fall prey to fragmented services and interagency debates about mandates and responsibilities" (p646).

**Current Situation CAMHS Services**

This is reinforced by the findings outlined within The Big Picture regarding the current situation in Child and Adolescent Mental Health Services in the United Kingdom. It states that specialist services are patchy, under-funded and plagued by lack of co-ordination and discontinuity's between agencies. Similarly, vital universal and early intervention services are piecemeal, subject to short-term funding and unintegrated, and that a major difficulty facing these institutions is whether they can work within the present labyrinthine structures, guidance, legislation and funding regimes.

It also states that mental health services for children and young people are starved of resources, and that other recent reports, most notably the Health Select Committee report, have also highlighted the lack of services, funding and priority given to services for children with mental health problems. The issues specific to Child and Adolescent Mental Health Services (CAMHS) are outlined in more detail in the report Together We Stand below.

**Together We Stand: The National Health Advisory Services Report (January 1993 – February 1995)** The National Health Advisory Services Report (Together we stand) is a thematic review of Child and Adolescent Mental Health Services (CAMHS) in England and Wales that was conducted from January 1993 to February 1995. It concentrated on the commissioning, role and management of CAMHS, highlighted processes and key tasks rather than espousing any one model of service organization, outlined principles supporting roles, delivery and monitoring of CAMHS and gave examples of good practice. Senior clinicians, managers, and academics from a wide range of disciplines/services, including National Health Service Units, Social Services, the Education Department, and Higher Education, carried it out. Throughout the steering committee was mindful of the essentials of professional practice and training, and also of the epidemiology and nature of mental health problems in the CAMHS field.

**Methodology:** Data was gathered by a series of service visits, analysis of latest research into clinical and managerial practice in CAMHS and related fields, and questionnaires to purchasers and providers.

**Summary of Findings:** There was a fundamental recognition of the high quality of work that is being carried out by many services and by many committed staff in a range of disciplines, however what was also found was that:

**1.** Mental Health Services for children and adolescents are essentially unplanned and historically determined.

**2.** Their distribution is patchy.

**3.** The work they do is variable in quality and composition, and seems unrelated in strength or diversity to systematically considered local need.

**5.** More could be achieved by better understanding and better management of these services and through improved co-ordination of the work.

Summary of Emerging Themes:

**1.** The first and probably the leading theme in the review was the recognition of the need for improved interactional processes of cooperation, collaboration and integration at every level of service management and delivery within and across services, as well as closer working relationships between practitioners/disciplines.

**2.** That services must be sensitive and appropriate to the needs of the local population and based on achieving the best from partnerships in care.

**3.** That there is a need for services that are directed to older adolescents/young adults that are culturally sensitive and appropriate to the position in society of this group.

**4.** That further emphasis and development of the role of staff at primary level is required to relieve the strain on the specialist level services

**5.** The need for training and continuing professional development was also seen as essential to good practice.

**Recommendations: The Big Picture (1999)**

**1. National Frameworks**

The message which emerged consistently from evidence to the inquiry was that plans and programs relating to the mental health of children and young people should be locally owned and delivered, within a national framework of legislation, standards and funding mechanisms, and that there should be a structure of accountability for ensuring that they are provided on the scale and to the quality that are required.

**2. Risk & Resilience Factors**

It was noted that there is good enough evidence that children can benefit by our knowledge of risk and protective factors, even if we cannot be entirely clear about causation, and that it is possible to utilize these factors to identify the main factor/s and recommend effective interventions at the level of the (individual) child, the child within the family, and in the wider social context.

**3. Promoting Children's Emotional Well-Being**

The implications of promoting the well-being of all our children were seen to be widespread and that to achieve this would require commitment across society. This would mean a change in priority and would have an impact on the importance given to universal community, arts and sports provision for children, and on the development of community responses to promoting children's well being.

The focus was outlined as needing to be on family, friends, and informal networks and mainstream services that were seen to be the most important sources of emotional well-being identified by children and young people themselves. Under this heading were support for parenting to be universally available through non-stigmatizing settings, involvement of the views of children, young people and their carers, access to high quality childcare, reviewing the role of schools in the balance between academic achievement and developing the "whole child", and the need for mental health agencies to recognize the importance of supporting the development of these initiatives.

**4. Early Intervention**

One of the most consistent messages to emerge from the wealth of written and oral evidence was the necessity of early interventions for children at risk of developing mental health problems, and that interventions should not be overtly or solely about mental health problems but should target the whole range of difficulties experienced by children which can potentially develop into more serious and troubling behavior problems. To support this it was seen to be important to ensure help was available at key transition points in the life of families. However the "inverse care law" was noted, where families most at risk are often the hardest to engage.

Characteristics of successful early intervention were outlined as: early identification aimed at 'at risk populations' and directed at risk and protective factors; the need for long term and intensive intervention in the prevention of serious disturbance to ensure outcomes achieved through early intervention can be sustained; and that not only the type of intervention, but the manner and location of its delivery affects its outcomes, i.e. community and parent participation and locality, and early interventions aimed at families and in schools. Also a focus on social and emotional development as well as

intellectual development was required. It was reported that non-specific poorly structured programs were unlikely to be effective.

**5. Interagency Collaboration**
The report highlighted that the emphasis on social exclusion, families and children all have implications across health, education, social services, the criminal justice system and beyond that to policies on housing, employment and taxation.

"A major difficulty facing these institutions is whether they can work within the present labyrinthine structures, guidance, legislation and funding regimes. Most rely heavily on collaboration across several local agencies in both the statutory and voluntary sector, concerns are that in the longer term this may prove difficult to sustain" (p14).

**6. Increased Resources**
The report stated clearly that without the input of resources at both a primary care and specialist level, it will not be possible to develop the range of services needed at a local and national level for children and young people experiencing mental health problems, and that, "Evidence suggests that Child and Adolescent Mental Health needs a greater share of an expanded health budget" (p14).

**7. Social Changes**
The report concluded that, "Unless as a society we can overcome our discomfort with the very notion that we are all mental beings and that our mental health and that of our children is a fragile and precious commodity, fundamental to societies' well being and something that needs nurturing, protecting and investing in, the evidence clearly indicates that the consequences for all our futures will be very worrying indeed. If we are to change things, action is needed now" (p5).

**Principle Recommendations: Together We Stand**
At the heart of its recommendations, the report proposed the adoption of a coordinated, tiered, strategic approach to the commissioning and delivery of Child and Adolescent Mental Health Services. The findings and recommendations within the report build largely on good practice that was seen to be already in play.

**1. Promotion and application of the Model of Joint Health and Social Care (Joint Commissioning).** A major recommendation was that service provision needs to occur within multi-agency partnerships at both the strategic and operational level in order to meet children's complex and inter-related mental health, developmental, educational and social needs. This was seen to give rise to collaboration that is structured from the top down, with a range of partnerships, and that is community owned (Refer below).

Joint Commissioning, included:
- Joint assessment of population needs, individual needs, agency needs, research and development needs and staff training needs.
- Joint agreement of strategy and service planning.
- Joint care planning, care management, and care programming.
- Joint purchasing and sharing resources.
- Joint evaluation and monitoring.

**Models of Commissioning**
Based on local assessment of need, health gain, and outcomes, via:
**a)** Epidemiological and expert professional evidence regarding the level and types of mental health problems in population of children and known risk factors.
**b)** The treatment and management strategies available with known efficacy.
**c)** The views of local people - users and the general public regarding what services are most important, their accessibility and acceptability.

**Specific Models**
**1.** The Strategic Approach: Population assessment and service planning.
**2.** Locality: Care Packages - purchasing of services components for individuals.
**3.** Specialised Service Approach: Joint funding and cost splitting by the 3 main statutory sectors for specialised services
**4.** Service Alignment Approach: Pooled resources, co-location and trading of services.

**2. The adoption of a Co-ordinated, Tiered, Strategic approach to Commissioning and Delivery of Child and Adolescent Mental Health Services.**
The Health Advisory Service proposed four tiers, each representing a distinct level of service, from direct contact services through to highly specialized interventions. Individually and in combination, these tiers would provide a conduit for developing CAMHS strategy, resources, skills and delivery to meet local needs. They also provide a framework for pooling the multi-disciplinary efforts of health services, social services, the educational authorities, the police and local services and the voluntary sector.

This reflected the need to improve partnership and collaboration between purchasers and providers of the health service, between health services, social, educational services, others professional and voluntary agencies involved in the care of young people, and to remove duplication, ensuring that no group of young people fall into a gap in service provision.

**<u>Outline of the Four Tiers:</u>**
**Tier 1 - Primary or Direct Contact Services**
Those who directly and indirectly influence the mental health of children through their work with them, i.e. General Practitioners, community teams, voluntary sectors, school staff, and police. Primary Mental Health workers were seen to be essential to bridge the gap between this and more specialized areas by discussion, referral, advice, liaison, consultation and preliminary formulations.

**Tier 2: Interventions by Individual Specialist CAMHS professionals**
Professionals who work individually with children and adolescents within clinics, homes, schools, social services, and court, and are usually members of and co-ordinated by specialist (multidisciplinary) teams. A role of this level of professional is to facilitate two-way communication between tiers, provides support/training to tier 1 staff and other professionals and act as gatekeepers to tiers 3 and 4.

**Tier 3: Interventions offered by Teams of Specialist CAMHS staff**
Members of specialist multidisciplinary mental health services who work in specific therapeutic teams and with children, young people and families who have increased

complexity of problems not manageable by tiers 1 and 2, e.g. Risk Assessment Teams, Day Unit, Family Treatment, and Psychotherapy. They also provide a valuable teaching and training resource, and in providing liaison and consultation with other teams and tiers also act as gatekeepers to tier 4 services.

**Tier 4: Very Specialized Interventions and Care**
For highly specific and complex problems which require considerable skills and resources. e.g. In-patient, Severe Eating Disorder, Chronic or life threatening pediatric. This level of professional also provides consultation to tiers 1, 2 and 3.

**Developing the Tiered Approach**
The specific strategies outlined for developing the tiered approach were:

- Identifying, strengthening and supporting direct contact services (Tier 1)
- Clarifying the components, roles, functioning, leadership, management and communications of current specialist (tier 2 and 3) child and adolescent services.
- Identifying and sustaining very specialized services (Tier 4) in the health service. These include very specialized Outpatient Mental Health Services, Day and Inpatient Services, which are capable of dealing with children, and young people (and their families) who require complex programs of intervention and management, and high levels of professional skill.
- The need for collaboration between services, particularly at the tier 4 level, and for joint purchasing between health authorities in particular (Refer above).

**3. Managing CAMHS**
Considerable focus was given to the need for improved leadership, communications, management, and performance monitoring within the specialist provider services, predominantly in Tiers 2, 3 and 4, for the effective management of a child and adolescent mental health service. To facilitate this, such areas as outlined below were seen to be essential:

- A cohesive and coherent strategic plan.
- Clear service specifications and supporting information.
- A sensitive, appropriate and clear approach to philosophy
- A clear and credible operational management structure
- An effective hierarchy with an identified leader for both strategic planning and operational management.
- A clear grasp of the work of the services and of the professional constraints.
- A view about the gaps in provision of the present service.
- A view of the opportunities for service development and of the way the capacity of the current services is developing.
- Aware of the developments in management thinking and technique.

**4. Appropriate Components of the Services**
The report recommended that the full range of Child and Adolescent Mental Health Services should include:

- Assessment services, which would include testing, investigation and diagnostic services.
- Specialist reporting services, including those for the Courts.
- Advice and short-term interventions, including the recognition and containment of concern and anxiety about children's welfare, education and health

- Management and treatments of a range of differing styles, including those for individuals, groups, parents, and families.
- Management and treatment of different types, including counselling, dynamic psychotherapy, psycho-analytic psychotherapy, play therapies, behavioural and cognitive therapies, social skills training and activity-based and creative therapies, prescription of medication (including psychotropic drugs), and marital therapies for parents.
- The ability to advise families and other agencies.
- Referral to other sources of expertise, investigation, diagnosis and management.
- Collaborative work, including advice to agencies, involvement in case conferences and statutory proceedings.
- Liaison and consultation services.
- Training and Research.

It also recommended that assessment and intervention should take place in a range of different places, including community clinics, health centres, hospital clinics, care and inpatient units and resource centres, social services department facilities, school and other education facilities, and family/homes and alternatives to home.

In addition to this, managed packages of care orientated to the assessed needs of children, adolescents and their families were recommended with the specialist focusing on the development of care packages geared to each individual's particular problems and exploring integrated care pathways. These approaches were intended to be helpful in shaping specialist services

**5. The creation of Youth Specific Services**
The vision was of Child, Adolescent and Young Adult Mental Health Services, linking seamlessly with services for Adults. (Refer to summary of themes, number three).

**6. Training**
The need to develop multidisciplinary, shared training alongside uni-disciplinary staff development.

## DISCUSSION

The Big Picture (1999) and Together We Stand (Jan 1993- Feb 1995) are two major pieces of research or enquiry carried out on a national level into both the mental health and well being of children and adolescents and the service systems that influence and support this. Both reports are on a scale that has not been done in Australia and have been outlined in detail, as there are many issues that are similar to what is being struggled with in Australia and in many of the other countries visited, on both the broader social level and on the service level; specifically the issues discussed in relation to Child and Adolescent Mental Health.

On the social level the reports encapsulate many of the shifts and changes that are occurring on many levels in Australia and other countries, leading to similar dilemmas and challenges for young people, families, services and governments; particularly those relating to changes in social structure with the move to economic individualism, competition and the erosion of mechanisms for maintaining social cohesion. The interplay between these factors has had a profound effect on both the structure and function of the family and of the role of children within our society.

As stated within the Big Picture, and also evident in Australia, the impact of parental separation and the fragmentation of the extended family networks have increased the sense of isolation of both families and children. The fact that children have become viewed in terms of economic commodities by governments, with more and more the sole responsibility for their social, emotional, physical and financial well being placed within the nuclear family adds further stress to the family unit, that is making it “increasingly difficult for vulnerable parents to meet their children’s needs” (The Big Picture, p10).

The shifts in the labour market, with the greater social differentiation and income inequity, the emphasis competition, academic achievement and the diminution of unskilled employment has become more and more evident in Australia, with now 2nd and 3rd generation unemployment, and has far reaching effects on the circumstances our children and young people are growing up within and the opportunities open to them.

As Stated by Brian Mitchell (1987) in his report "Helping Families in Great Need: An American Perspective, "With Australia's poverty and social problems following on the heels of the American experience, it is clear that the numbers of excluded families in our community is going to increase, perhaps dramatically. Left untreated the problem that these families present will be at great social and economic costs to all Australian people" (p65).

He goes on to say “As a people we are poor performers in cherishing our children and valuing them as our most precious national resource. With one in five Australian children in poverty and our children being the largest single group among the nations poor, our sense of national justice remains under developed" (p66). Entrenched in out "I'm all right, Jack" attitudes, it is time we started to care about other people's children" (p65). The question is equally true of what value we place upon our children and their well being on a broader social level, despite the rhetoric that has been espoused on the political level, that “Children Are Our Future.”

It is little wonder that, as highlighted within The Big Picture, “some feel little sense of involvement with or responsibility to the society around them and vice versa,” when, as in the United Kingdom, “we claim to be a child-centred but in reality there is little evidence that we are” (p4). Perhaps it is no accident that there has been a clear increase in the incidence of psychosocial disorders in youth since World War Two.

As in United Kingdom and elsewhere, here in Australia the possible sequelae to this are evident in the increasing numbers of children and young people who are failing to thrive. The ratio of those who will experience some form of mental illness in their lives at any one time is similar to that cited within the United Kingdom, there is also evidence that are a growing number of families are experiencing multiple problems and that there has been an escalation in juvenile crime. However what is perhaps most disturbing is the increasing suicide and self-harm rates in Australia and the fact that we have one of the highest suicide rate in the world. This sheds a significant shadow on the myth of Australia as the lucky country; perhaps the question is for whom?

This also highlights the fact of the lack of awareness of the adult population and governments in relation to this, as cited within The Big Picture. However whilst acknowledging the view espoused, that the reason adults are blind to this is due to their discomfort about facing painful facts about emotional and mental vulnerabilities, the blindness also has to be considered in light of the discussion above regarding the role of children within our society and the view of them as economic commodities; for to recognise that the basic nuclear family unit is perhaps failing, would mean a need to totally rethink and reconfigure the very fabric that our western society has evolved upon, both socially and economically.

The statistics on divorce, separation and blended family are certainly there to question the validity of the nuclear family as the most effective unit for structuring our society upon, especially in relation to the needs of our children. Perhaps in some way, but for the conflict that often accompanies such reconfigurations, the new blended family may be a means by default of recreating the lost extended family.

The combination of all of the above has had fear reaching effects on government policy and funding priorities and the structure of service systems. As in the United Kingdom, there has been a lack of priority given to services for children with mental health problems. This has led to a general lack of focus or funding to these services, and an overall lack of support, direction or resources; in keeping with the situation outlined in the United Kingdom, mental health service for children and adolescents in Australia have been starved of resources.

Whilst in any work with children and young people the conflicting social pressures outlined within The Big Picture (et al) are operative, there are additional conflicting pressures on a service delivery level in a culture where on a ministerial and policy level, services are not thought about and are ill defined.

As stated by Moretti, et al (1997), “Good structural organization is essential to the delivery of multimodal programmes that cut across domains (eg, family services, mental health, education) that traditionally have been represented by separate ministries or government agencies. When services are not integrated with a common goal, a common paradigm for understanding the social problem, a common language

of how to work together, families and children fall prey to fragmented services and interagency debates about mandates and responsibilities"(p646).

There is evidenced of this on two main levels. The first is when service parameters are not defined services tend to get pulled in all directions with a pressure to be all things to all people. CAMHS services in Victoria have traditionally had extremely unrealistic expectations placed upon them for what they have been asked to deliver within such limited resources. This has perhaps been contributed to by the fact that in Victoria, Mental Health Services have been clustered into Area Mental Health Regions, of which Child and Adolescent Mental Health Services form a miniscule part. This has led to a general lack of focus or funding to these services, and an overall lack of support, direction or resources.

The second that also derives from this general lack of focus or definition, as was found in the United Kingdom, Canada and USA and outlined within The Big Picture and Together We Stand reports, that whilst there is a recognition of the high quality of work that is being carried out by many services and by many committed staff in a range of disciplines in Victoria, specialist services are also under funded, their distribution is patchy, are essentially unplanned and historically determined, and are plagued by lack of coordination and discontinuity's between agencies. Also similar to the findings within the United Kingdom, the work they do is variable in quality and composition, and often seems unrelated in strength or diversity to systematically considered local need. Similarly vital universal and early intervention services are piecemeal, are subject to short term funding and are unintegrated.

This is a situation that has in some ways been created by the funding of short term pilot projects without any real long-term planning or overall management across service systems. This has been exacerbated in Victoria until recently by a policy of competitive tendering that led to severe decimation and fragmentation of service systems, something that has only just begun to be rectified. As stated by Moretti, et al, "This again likely reflects short-term political agendas that focus on appearing to solve current problems and demands rather than long-term investment in preventing future ones" (647), and the seduction of politicians by the "lure of appearing to do something about it with short term, quick-fix programs" (p647), to gain votes for their political term.

Again, as in the United Kingdom, more recently there has begun to be a shift in focus toward Child and Adolescent services generally, however there is still a long way to go in both the support of existing services and in effective service development; and as highlighted by Moretti, "clinicians struggle to implement the best strategies they can within these parameters" (p646). Some of the recommendations outlined within the United Kingdom reports therefore, have major relevance to Australia on a broader social and structural level, as well as on the more specific service level, and are summarizes as part of the recommendations below.

## RECOMMENDATIONS

### POLITICAL

Throughout this report, the need to acknowledge the reality of working with the larger social and political structure as a significant component of programme development has been highlighted. This translates into the issues and recommendations below:

**1. Changes on a Political and Social level**

To reiterate again the points emphasized above within The Big Picture, 1999, rather than being like the ostrich, as a society we need to address the fundamental fact that the root cause of so much dysfunction in individuals, families, in schools, organizations and in society as a whole is poor mental and emotional health. To do so we need to overcome our discomfort with the very notion that we are all mental beings, and to recognize and acknowledge that our mental health and that of our children is a fragile and precious commodity, fundamental to societies' well being and something that needs nurturing, protecting and investing in.

This means as a society we need to think about children, young people and families and their position within our society, and to review such things as the structure and function of families and the pressures upon them, and the role of children within our society and opportunities open to them.

Linked closely to this is the need to review whose responsibility it is to promote and maintain the social and emotional health of our children and society generally and with this review the role of Government, State and Public Services and their ability to solve social problems. The application of the notion of shared responsibility on all levels, Ministerial / Government, Communities and parents, is an important aspect within this to promote joint ownership as a "Society" rather than place the responsibility exclusively on the shoulders of elected political parties. The flow on from this is to influence governments to not respond with the short-term solutions to appease voter's demands, and promote the implementation of more holistic, long-term solutions.

Closely linked to this is the need to recapture the value of the "humanness" and the whole person, and what this means in practice in how we nurture, protect and invest in children, young people and families as fundamental components of our society. The dehumanizing concepts underlying economic rationalism need to be challenged, where worth is measured in monetary terms and within this our children and families valued as economic commodities rather than for their inherent worth as human beings; something that cannot be measured against these values.

Specific strategies that can begin to address this are outlined in the recommendations to follow.

**2. Promote the application of Qualitative as well as Quantitative Measures when valuing and evaluating Mental Health and other Social Services.**

While we continue to measure human / social services against purely economic and quantitative measures we will continue to miss the essential and holistic needs of the human beings that the services are meant to be addressing. As a result this will

perpetuate the fragmentation of humans into their component parts and with it the problems that cannot be dealt with in such a fragmented manner.

**3. Identify and target Underlying Systemic and Social Problems that contribute to the Maintenance of Mental and Emotional Problems.**
Review the current research and promote further research into the above factors and promote the use of this in determining further policy and service development.

**4. Early Intervention and Opportunities for Children, Young People and Families.**
Further to the above utilize risk and resilience factors to identify main factors and recommend effective interventions at the level of the individual child, the child within the family, and in the wider social context.

Promote child emotional well-being by focusing on family, friends and informal networks, and by promoting the importance given to universal community responses to promoting children's well-being.

Promote broader spectrum opportunities for young people beyond the emphasis on academic excellence / achievement and promote a revaluing of a range of skills and talents within our education and broader social systems.

**5. Advocate for Children, and Young People on a State and National Level**
Lobby for appropriate resources, support structures and policy directions (refer below) for children and young people, emphasising the impact on services, service delivery and the cost to clients and society generally of the current situation in social, economic and emotional terms.

**6. Increased Resources**
Clearly without the input of resources at both a primary care and specialist level, it will not be possible to develop the range of services needed at a local and national level for children and young people experiencing mental health problems. "Evidence suggests that child and adolescent mental health needs a greater share of an expanded health budget" (The Big Picture, 1999, p14).

**7. Further Enquiry**
Given that politics and policy has such a major impact service development and delivery, there is a need to be informed of the current policies and directions to be able to identify and lobby strategically for sensitive service development. Further information is required before more detailed or informed discussion is possible (which is the next phase of this scholarship project currently underway).

**STRUCTURAL**
**1 a). The need to develop National Frameworks of Legislation, Standards and Funding Mechanisms.**
The message which emerged consistently was that plans and programs relating to the mental health of children and young people should be locally owned and delivered, within a national framework of legislation, standards and funding mechanisms, and that there should be a structure of accountability for ensuring that they are provided on the scale and to the quality that are required.

**b). The appointment of an Effective Hierarchy with an Identified Leader.** To facilitate the above, there needs to be a dedicated portfolio for both strategic planning and operational management to fill the void that exists currently under the present structure, where CAMHS is a minor portfolio that gets lost under a management responsible for a range of other areas that traditionally have overshadowed child and adolescent issues.

**c). The creation of a Single Ministry for Children and Young people.** In an attempt to address this problem, the Province of BC has created a single ministry for children. The development of a central agency to co-ordinate and integrate services is critical to the implementation of multi model intervention strategies.

**2. Application of the Model of Joint Health and Social Care (Joint Commissioning)**
Good structural organization is essential to the delivery of multimodal programmes that cut across domains (eg, Family Services, Mental Health, and Education) that traditionally have been represented by separate ministries or government agencies.

To facilitate dynamic collaboration at every level of service management and delivery within and across services, it is recommended that the model of service provision within a multi-agency partnership at both the strategic and operational level be utilized. This promotes true collaboration that is structured from the top down within a broad range of partnerships. Such measures ensure the partnerships are community owned and integrated into all aspects of service development and delivery, and are sensitive to the needs of the local population.

**SPECIFIC TO CAMHS**

**1. Managing Child and Adolescent Mental Health Services (CAMHS)**
More could be achieved by having a better understanding and better management of CAMHS services and through improved co-ordination of the work. It is essential to ensure that CAMHS services are well supported and managed on all levels, as outlined in the Together We Stand above, (for example in the areas of Leadership, communications, management and planning), in the context of a sensitive, appropriate and clear approach to philosophy, and a clear grasp of the work of the services and the professional constraints.

**2. Tiered Structure**
The adoption of a coordinated, tiered, strategic approach to the commissioning and delivery of Child and Adolescent Mental Health Services. In addition to this, adopting the stages of developing the tiered approach as outlined within the Together We Stand report, as an integral part of this process.

**3. Essential Components of CAMHS Services**
The components of CAMHS services as outlined in Together We stand are those that should be seen as fundamental to all CAMHS services. However clear funding and resources needs to be put in to support these functions, rather than what occurs currently, where such comprehensive functions are expected from an already over extended service system.

**4. Primary Mental Health**.
Further emphasis of the role of staff at primary level is required and needs to be supported by the creation of a Primary Mental Health Worker positions integrated into the tier system and formally linked with CAMHS as first contact for primary level professionals. This is to ensure clear boundaries for the service yet facilitate linkages between CAMHS and other levels of the service system, community and client.

Currently Primary Mental Health (PMHW) Teams have been established in Victoria, however these are linked to Adult Mental Health services, therefore tend to focus on early intervention and prevention in the major mental disorders and the interface between adult psychiatric services and primary health services, rather than being seen as part of the CAMHS service system. The concern is that without the role and function of the PMHW as established in the United Kingdom, any implementation of a tiered service system for CAMHS in Victoria will be missing a fundamental link and therefore will encounter major difficulties.

**5. Creation of Youth Mental Health Services**
The creation of Youth specific services with a strong focus on services that are accessible, developmentally sensitive and adolescent friendly may assist in overcoming the current gap that exists in service provision. This culture is just beginning to emerge in Victoria, however once again many of the youth focused services in mental health are currently geared to dealing with major mental disorders as opposed to the range of mental health issues that need to be thought about and addressed from a youth specific perspective.

**6. Training**
There is a need to develop multidisciplinary, shared training alongside uni-disciplinary staff development

## 8a). LEICESTERSHIRE & RUTLAND CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

**Address**

Westcotes House
Westcotes Drive
Leicester LE3 OQU
Tel: 0116-225-2885 or 2880 or 2900
Fax: 0116-225-2881

**CONTACT** Dr Nisha Dogra, Snr Lecturer, Honorary Consultant.

**PROGRAMS VISITED/ INTERVIEWS WITH**

Prof Panos Vostanis, Professor of Child Psychiatry, University Of Leicester, Director of greenwood Institute.
Dorothy Sebuliba, Multi-agency training Co-ordinator, Primary Mental Health, attended training day, and train the trainer seminar
Dr Andy Parkin, Senior Lecturer in Child and Adolescent Psychiatry, Honorary Consultant
Fiona Gale, Senior Primary Mental Health Worker
Tanglewood child in-patient Unit
City West Outpatient Team, Triage Day
Mental Health Services For Homeless Children and Families
Young People's Team
Greenwood Institute

**HIGHLIGHTS**

**1.** The comprehensiveness of the CAMHS service and the range of innovative programs for High Risk Youth that were a major component of the overall service.

**2.** Program development linked with and supported by broader National policy, which provided a clear framework for the service to evolve within (i.e. as part of a Big Picture Strategy for Children's Services on a National level).

**3.** What stood out about the service was the number of staff who were actively involved in and enthusiastic about developing new programs and in the development of the service generally. The strong encouragement and support of clinical staff to be involved in practise based research relating to the specific program they were part of was very much a part of this.

**4.** The rich links with research was heightened by the cross-fertilization between the Greenwood Institute of Child Health, Division of Child and Adolescent Psychiatry, University of Leicester and the CAMHS service. The guidance and resources provided to the CAMHS staff made a significant contribution to making the above possible.

**KEY FEATURES/ KEY STRENGTHS OF SERVICE**

**Learning Organization.** The application of a Learning Organization Philosophy and strong commitment to promoting a real "Culture of life long learning" across all clinical areas, supporting continuous professional development.

**Program Development Models.** Program development that was driven by identified client needs, based on research, extensive consultation and involvement of the community and carers.

**Integrated Research.** Staff who were excited and inspired by research and who saw it as a fundamental part of program development.

**Clear boundaries and definition of service structures and of service delivery.** Defined as a tertiary service (tier 3 –4), but with Primary Mental Health Workers and specific programs to ensure the service is still accessible and has community based linkages (Refer to section 6 for a detailed outline of the tier structure).

**Community Collaborative and Integration.** a). Joint Commissioning: This is an example of innovative systemic thinking to find ways to overcome beaureacratic "Silos" with broad and practice based partnerships. b). Comprehensive Community Based Training: Ongoing training available to a broad range of practitioners, based on the identified needs of the participants.

**Specialist Team based structure**. To meet an identified client need and to build specialist areas of expertise to better address these specific needs.

**Specific Young People's Team.** Based within the CAMHS service, that recognises the specific needs of this target group, and is designed to be responsive to their needs.

**EXAMPLES OF PROMISING PRACTICE (Refer to detailed outline below)**

**1.** Primary Mental Health teams
**2.** Young People's Team
**3.** Mental Health Service for Homeless Children and Families
**4.** Greenwood Institute of Child Health

**PROGRAM LIMITATIONS / CHALLENGES**

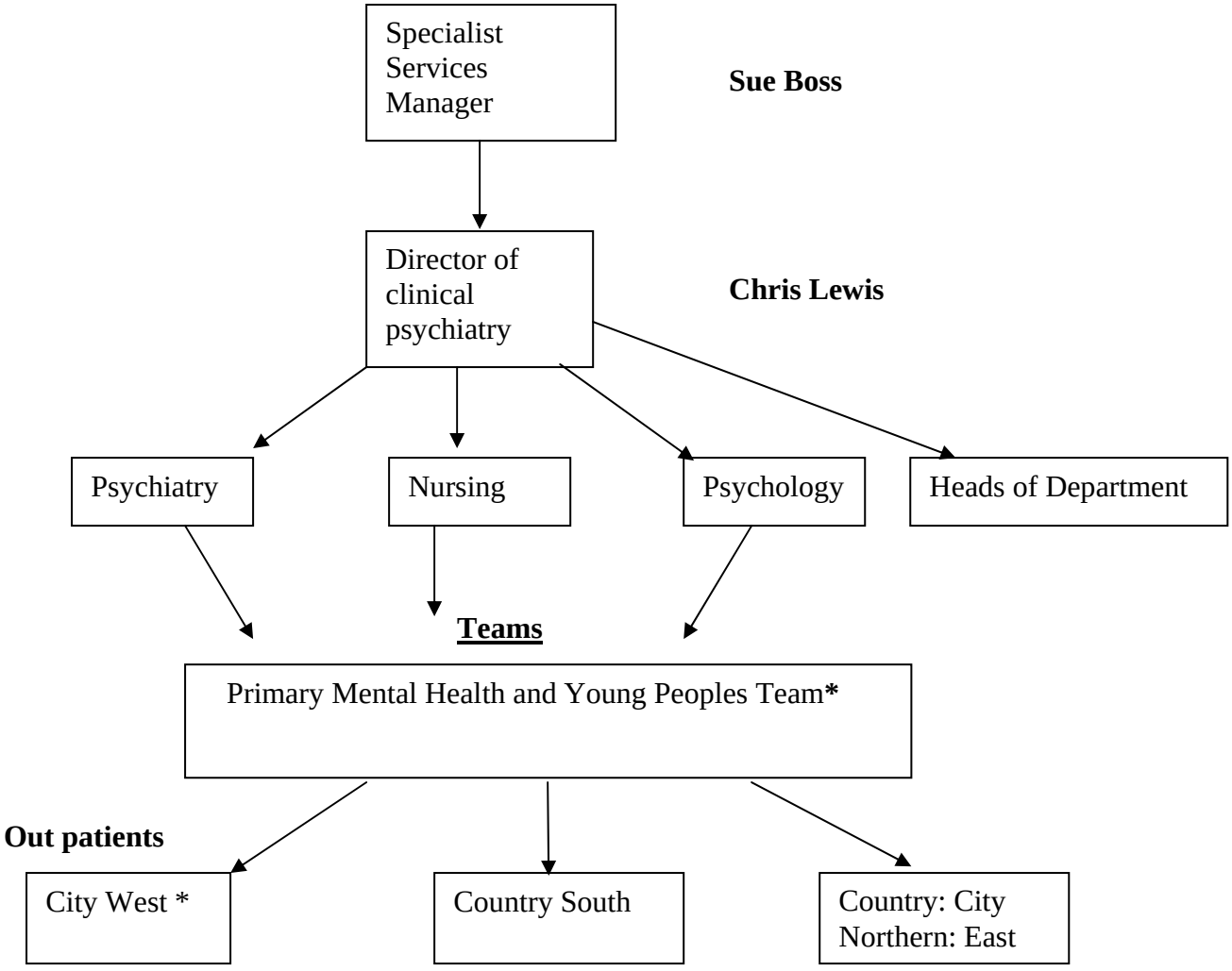
The complexity of client is increasing, and constantly needing new solutions or services, and despite recognition that attachment is important for children, there was a predominance of time-limited interventions; ie Cognitive Behavioral and Brief Supportive psychotherapy.

**CONCLUSIONS/ RECOMMENDATIONS:**

**1. Promotion and application of the model of Joint Health and Social Care (Joint Commissioning)** ie: Service provision within a multi-agency partnership at both the strategic and operational level, in order to meet children's complex and inter-related mental health developmental, educational and social needs. Collaboration that is structured from the top down, with a range of partnerships, that is community owned.
**2. Development of Specific Mental Health Youth Teams.**
**3. Promotion and use of the Program Development Package** as a process linked to research, and is client needs driven.
**4. Promotion** and application of a **Learning Organisation** philosophy and approach.
**5. The establishment of a structured Community Training Schedule,** available in an ongoing manner.
**6. Primary Mental Health Workers integrated** into the tier system and formally linked with CAMHS to ensure linkages to other levels of the Service System.

**LEICESTERSHIRE & RUTLAND CHILD AND ADOLESCENT MENTAL HEALTH SERVICE**

The Leicestershire and Rutland Child and Adolescent Mental Health Service (CAMHS), is a generic Child and Adolescent Mental health Service and is sole secondary provider for a population of 900,000 receiving approximately 2,000 referrals per anum. The region covers Rural, Semi Urban and City.




***** Currently being trialed.

## ORGANISATION OF SERVICE

The Leicestershire and Rutland Healthcare Trust provide an integrated, comprehensive Child and Adolescent Mental Health Service.

### Management Group

The management group is comprised of 15 people and is both team and discipline based. This structure has been seen to be problematic in relation to inequities in influence on decision-making; therefore there are plans to take discipline heads out to form an advisory group to focus on clinical issues.

### Funding

CAMHS has a budget of 3 million pounds per year from State funding. The service has six main components:

## PROGRAMS

### 1. Multidisciplinary Teams

There are two community teams, one based in the North of the county and East of the city and the other covering the South of the county and the West of the city (although there is a trial of *City West being an independent team at present to establish whether there should be discrete divisions into rural and city teams, as the areas are seen to have very different needs). These teams are based at Westcotes House. Satellite clinics are held at Coalville, Hinckley, Loughborough, Market Harborough, Melton and Oakham. Each team includes representation from a number of disciplines including child psychiatry, clinical psychology, occupational therapy, community psychiatric nursing and child psychotherapy.

### 2. Learning Disabilities Team

This is a multidisciplinary team offering a district wide service to children with learning disability and their families. As well as representation from the disciplines of child psychiatry, clinical psychology and community psychiatric nursing, there is a home intervention project, which provides intensive support to families (Refer below).

### 3. The Children's Resource / Day Unit

Tanglewood is a separate unit based at Westcotes House, which provides in-depth assessment and treatment for children under 12 who may have emotional, behavioural, interpersonal or developmental difficulties and their families, or where there are uncertainties about diagnosis. Members of the outpatient teams who initially assess their needs refer children to Tanglewood.

The Unit works with 5 – 6 children at a time and offers the opportunity to work in a range of groups for both assessment and treatment. These include:

**Assessment groups -** to thoroughly assess children by observing them in a variety of different situations using structured and unstructured play sessions, and formal Individual Assessment in Psychology, Speech and Language and Occupational Therapy.

**Family Day Program -** intensive work with a small group of families on improving family relationships and finding more effective ways of managing children's behaviour.

**Family Assessment Days -** an assessment involving everyone living at home designed to meet the family's needs and requirements, that is generally run over two days.

**Social Skills Group** - a group of 8-10 young people around the same school age are aided by staff to think about how to improve their present difficulties through play or creative activities.

**A.D.H.D. Group** - the group aims to assess each child whilst they carry out activities which are designed to promote their strengths and work on the areas which they find difficult; in this way effective ways of approaching each child and managing any difficult behaviours are identified.

**Music Therapy** - the music therapist works with the child or with the family group to address a variety of issues such as self-esteem, self-confidence, communication and expression. It can be a useful way of working with children who struggle to communicate or express their emotions using language and can offer family groups a way of communicating and having fun together.

The staff is comprised of psychiatrists, occupational therapists, psychiatric nurses, creative therapists and psychologists. There is always 2 staff attached to a family, (covering alternate weeks) and an allocated Care Co-ordinator, who is responsible for report production and feedback to the clinician or joint clinician\ family.

**4. <u>Oakham House Adolescent In Patient Unit</u>**

Oakham House is a seven-day psychiatric in-patient unit offering assessment and treatment to adolescents aged 12 to 16 years, referred mainly by the Child and Family Out Patient Teams at Westcotes House. Once a referral is accepted there is normally no waiting time and pre-admission visits to the unit are organised to provide information on the program of activities, school times, different group therapies and visiting times. Rules which young people are expected to observe whilst on the Unit are also explained.

The Unit can accommodate up to 12 young people of both sexes and has a two-fold task to achieve during the adolescents stay:

- To assess and treat the presenting problems, and

- To meet their developmental needs

The multi disciplinary team comprising of, psychiatrists, psychiatric nurses, occupational therapists, art therapist, psychologist and teachers, aims to create a therapeutic environment for the youngsters. Each young person receives a weekly program of daily activities tailored to his/her needs and a clinical review, (including teachers, professionals) with the clinical team is held every 6/8 weeks. Ongoing issues for review are always discussed with the family and the young person in regular meetings before a clinical review.

Stays on the Unit vary between an average six-week assessment period up to fourteen months treatment. It is expected that once the admission objectives have been met the child would be discharged from Oakham House back to the referrer. Therefore, referrers are actively encouraged to maintain contact and input where appropriate.

There are also two additional acute beds at Oakham House. These are designated to meet the needs of adolescents who present with acute psychiatric crises that cannot be resolved in the community. The aim is to keep acute admission as short as possible; the patient retains the referring Responsible Medical Officer and the in-patient environment is separate from the main unit, although staffing resources are shared across the Unit as a whole.

**5. Primary Mental Health Team**

In line with the model offered in 'Together we stand' and the requirements of the National Health Service Plan, a new CAMHS professional has been introduced to the area. This is a group of 7 primary mental health workers (PMHW's), whose role is to provide consultation, support and advise to frontline Tier 1 professionals (Refer below for detailed outline).

**6. The Young People's Team**

This is a new initiative, which combines mental health input to the 'Youth Offender Teams' (YOT) and also to the 'Looked After Children Service' (LAC). Originating in the provision of dedicated services to 'Looked After Children' in residential care since 1997, it increased to support the development of new 'Youth Offending Teams' (YOT) in April 2000. This has developed into a support team to vulnerable young people offering primary mental health work, psychology and psychiatry with access to other specialist skills. Staff work as part of Looked After Children and Young Offender Teams as well as the Young People's Team. (Refer below for a detailed outline).

**7. Psychology**

There is also clinical psychology input to hospital paediatrics.

**REFERRALS**

Referrals are accepted from a variety of sources: general practitioners, hospitals, school doctors, health visitors and school nurses following consultation and consent from the general practitioner, educational psychologists, social workers, probation officers and courts for psychiatric reports. There are no direct referrals from parents or young people.

**AGE GROUP** Children up to school leaving age, which for most children in mainstream school is 16. If an adolescent is still at school beyond the age of 16, s/he would still be seen by the service. Adolescents who have left school to attend colleges of further education are referred to adult services. Children with learning disabilities who go to a special school are seen until the age of 18.

**CRITERIA**

Children can be referred for a number of reasons- depression, self-harming behaviour, emotional problems with symptoms of anxiety, phobias, psychosomatic symptoms, psychosis, autism, attention deficit hyper-activity disorder, developmental disorders,

pathological bereavement reactions, children with emotional sequelae to abuse and anti-social behaviour.

**Exclusion criteria**
Referrers need to take into account whose primary / statutory responsibility it is to deal with a given problem, eg: dyslexia or those displaying behavioural problems specifically in school are referred to the school psychology clinic. Where there are concerns regarding child protection issues, children are referred to social services department.

**Priorities**
Given the huge demands on the service there is an inevitable prioritisation of cases depending on what constitutes core work. Thus suicidal, depressed, self-harming children, young people presenting with anorexia and children presenting with psychotic symptoms receive priority over children beyond parental control, anti-social young people and those excluded from school. Prioritising criteria is in keeping with the 4 Tier system of Mental Health Care.

**Psychiatric emergencies**:
Urgent presentations, such as acute psychosis and deliberate self-harm, are assessed by the on-call service providing immediate response to medical referrals only.

**P1** Problems or symptoms that may suggest severe acute disorders such as depression, anorexia, psychosis, anxiety disorder, hysterical conversions: this would include disorders with immediate risk of harm to self or others. (Seen within 1 week)

**P2** Any of those in P1 where there is no immediate sense of urgency or less immediate risk of self-harm to self or others. Presentations where time is a component (eg; school phobia). Other neurosis (eg: obsessive/compulsive disorders, phobias, etc). Pervasive Developmental Disorder (Autistic Spectrum), Attention Deficit Disorder or other specific disorder- where early assessment and/or management may provide specific benefit. (Seen within 2 months.)

**P3** Disorders listed in P4 below, where there are mitigating circumstances such as chronic physical illness in the child, significant mental illness in then parent.
(Currently seen in 3-6 months)

**P4** Anti-social behaviour. Long-standing problems eg: tics, elimination disorders with mental health need, developmental disorders.
(Currently seen within 12 months.)

The Learning Disability Team do not differentiate between P3 and P4. The waiting lists vary across teams.

## METHODS OF INTERVENTION

Following an assessment, treatment is offered depending on what is required and what is acceptable to the family. A range of treatment modalities are offered – behavioural therapy, cognitive therapy, family therapy, marital therapy, individual and play therapy for the child. In addition, groups are run for parents to improve their parenting

skills. Social skills groups for children, music, drama and art therapies are used in tertiary resources (ie: Tanglewood Child and Family Inpatient Unit). Where relevant, medication is prescribed by psychiatrists.

**Other Services Offered**
Consultation services to health, education and social services, (including community children's homes run by local authorities), training, liaison with paediatric wards and a 24-hour emergency service. Like other specialist services in health, an emergency service is accessible only through the child's practitioner or through Accident and Emergency department at Leicester Royal Infirmary through the casualty officer.

## SPECIFIC MODERNISATION STRATEGIES:

**Training by Primary Mental Health Workers (Refer below)**
Three strands of training have evolved from the strategy. Firstly, a jointly financed project to develop and deliver an integrated range of basic awareness and improved understanding courses aimed at all primary care workers in health, education, care and voluntary settings. Training takes place generally in multi-disciplinary settings. Secondly a skills based training course has been developed for staff, who though not specialists, work with children and families in situations where a greater knowledge of positive parenting, solution focused approaches and group work can improve the situation. Finally, from January 2001 Leicester University will offer a modular Cert/Dip/MSc/ in Primary Mental Health Work designed to provide a standard of training to PMHW's and other staff who work with children who experience poor mental health.

**Child Behaviour Intervention Initiatives (CBII)**
These are co-ordinated teams of 2-5 multi-disciplinary staff providing early intervention and prevention programmes that are locally based and operate in the settings that children and families feel secure in such as schools, health/family centres and homes. Accepting referrals from frontline staff and families they respond to the referrer's perceptions of the problem and can offer a range of responses including intensive support or consultation/joint working. They also act as an effective assessment and filter to more specialised services. There are currently 7 teams operating in localities across the three local authorities.

**Young Persons Team (Refer below)**

**Home Intervention Project (HIP)**
The learning disabilities team have developed a specialised service which is offered to a small number of children with learning disability who have complex, multiple, chronic and severe needs and severely challenging behaviour, to prevent the breakdown of family care at home, minimise the use of emergency placements or minimise the length of open but un-improving cases. The service aims to provide parents with intensive supported opportunities to try new ways of responding to and managing their child's behaviour and gain control of what is happening in their own homes. Nurses and trained home-workers (provided through contracts with local voluntary/private organisations) provide this service. It is a response line to (Tier) 4 services.

The service has had the advantage of following through this small number of families over long periods of time and has seized the opportunity to develop structures to collect a wide variety of data. In addition means of auditing the service have been built into a Care Pathway approach.

It has been shown that the design of the service and the creative use of a limited budget means that the service can be delivered at the times parents want the service, by the most appropriate worker and at the intensity that will bring about change in the child's behaviour.

Within the fortnightly Learning Disability Team meeting, Project cases are discussed at length and an ethos of reflective practise has developed within the Team. Providing support for parents to implement a behaviour programme is only part of the intervention. Equally important is the continued input of the clinician from the Learning Disability Team who facilitates parents to explore the barriers and difficulties of implementing the behaviour programmes. These barriers are often emotional rather than practical. Clinicians may also undertake specific pieces of work with the child or other family members, for example, working with siblings. It is thought that it is the dual approach of support to implement behaviour programmes and 'therapy' that provides a formula of effective treatment for this small but potentially service needy group.

**Other initiatives:** It is intended to jointly commission services for learning difficulties/challenging behaviour and conduct disorder in the future and to provide a 'Joint Solutions' approach to young people who may require out of area placements or alternative services.

## EVALUATION

As much of the work undertaken by this strategy is relatively new or untested, partners commissioned a series of evaluation projects for each of the new services as part of the measurement of their success. The evaluations generally include measurements of the experience of service users and carers. Over the next two years they will be reporting on their findings. These and the associated papers written by staff will form an important part of the dissemination.

## EXAMPLES OF INNOVATIVE PRACTICE

### 1. CHILD AND ADOLESCENT MENTAL HEALTH SERVICE PRIMARY MENTAL HEALTH TEAM

This team is a new initiative set up within Child and Adolescent Mental Health Services (Westcotes House). It represents a recognition that most of the mental health support children, young people and their families receive come from professionals working within 'frontline' settings (teachers, nursery nurses, youth workers, social and welfare workers, community nurses G.P.'s etc).

Primary Mental Health Worker's (PMHW's) offer a flexible and swift response to work with children, young people and families, working in their communities alongside the frontline professionals who provide the longer-term support or care, and as part of the Young People's Team, are key members of the Child Behaviour Intervention Initiatives (CBII), the Looked After Children Project (those "Looked After "by the local authorities), and Young Offenders Team, which are a new development combining health and local authority personnel.

**Aim**

The aim is to enable frontline staff to provide appropriate and early intervention to families in their localities. By screening out less severe issues, and by supporting Primary Health to take responsibility for being the first point of contact for Mental Health intervention, the PMHW's support the aim of the Child and Adolescent Mental Health Service, of ensuring that children who present with severe mental ill-health are offered a rapid service by CAMHS as a specialist service.

**Models**

Various models are being applied that include PMHW's being located within the out patient teams where they continue to work primarily as a clinician with an extended role, working as totally independent practitioners, and working somewhere in between these two positions where they are attached to a specific team / area, but have a designated primary mental health role.

**Staffing**

The team comprises of staff from various professional backgrounds. All have considerable expertise in working with children and young people with emotional and behavioral difficulties and have trained as CAMHS specialists All have a good working knowledge of the services available to them. There are currently 7 staff, 1 Manager, and 6 Primary Mental Health Workers, who cover the 7 areas within the region.

**Roles**

Their workload is a mix of supporting primary care workers, providing education and training, filtering referrals to specialist teams and providing direct services at an early and preventative point. Set between 1st, 2nd and 3rd Tiers, the PMHW's act as a point of first contact for mental health and therefor have a role to assist in triaging for CAMHS.

**Specific roles include:**
Advice and consultation to individuals and groups. Phone advice, resources, and face-to-face review of cases re mental health issues.

Free training. On promoting good mental health in children and their parents.

Liaison with other services. Participation in multi-agency planning meetings, resourcing and awareness raising.

Some short focused therapeutic interventions. They may do a full assessment and brief focussed interventions (6 – 8 sessions) to help clarify the child or young person's needs, or to help with the management of the situation by frontline staff. Eg: Solution focussed brief therapy, or joint working with Primary Care Professionals on some cases versus taking the case off them.

Supervision Groups. Supervision groups are open to any primary care person, ie: Health Visitors or school nurses. Groups are run for 20 practitioners on a monthly basis, to discuss cases, or to cover specific topics such as ADHD, Solution focused therapy, etc.

**Meetings and supports**
All workers meet weekly as a team to discuss cases and strategies, as well as the different aspects of the job. There is a strong team identity and the National Network meets regularly.

**Problems**

- Some ambivalence regarding the roles initially from other outpatient clinicians due to their fear that increased exposure may create an influx of referrals to an already stretched team.
- No clear model initially regarding the balance between secondary and primary work and how they relate to the team or interact as a specialist service.
- Problems with the level of Primary Resources as back up.
- Trying to maintain the level of staff and experience.
- Regions cover City, Semi-rural, and very rural, that each have very different issues.
- Different teams work in different ways and everyone has a view of the model and what the service is about.

## 2. CHILD & ADOLESCENT MENTAL HEALTH SERVICES YOUNG PEOPLE'S TEAM

A specialist program within the service in which the Primary Mental health workers play a key role is Child and Adolescent Mental Health Services Young People's team. It is a mental health service for vulnerable Children, Young People and Families in transition.

**Operational Objectives**
The Young People's team is a specialist Tier 2/ 3 CAMHS outpatient mental health team for the provision of different levels of interventions to identified children and Young People who are "looked after" by the Local Authorities in Leicester, Leicestershire and Rutland, their carers, agencies involved, within the Youth Offending Teams, and within the Hostel for homeless families

**The Principles of Service for the Young People's Team are based on:**

1. Quality Protects.
2. Modernising Health and Social Services: National Priorities Guidance.
3. The Children's Act and Associated Guidance and Regulations, as general background.
4. The Crime and Disorder Act.
5. Youth Justice Board Objectives.
6. Leicester and Leicestershire Youth Justice Plans.
7. The Joint Mental Health Strategy.

## Team Aims And Objectives

### Philosophy

The philosophy of the team is to provide an accessible, designated, effective and high quality service to socially excluded children, young people and their families, who could not previously access mental health services. The philosophy is based on a model of joint health and social care, i.e. service provision within a multi-agency partnership at both strategic and operational level, in order to meet children's complex and inter-related mental health, developmental, educational and social needs.

### Principles Underpinning The Service to Young People Within The Youth Offending Teams:

1. Children and young people should be valued as individuals, treated with respect, and their welfare must be taken into account at all times. They must also be helped to take responsibility for their actions and to face up to the consequences of their offending behaviour.
2. Diversity is welcomed and valued and the service is committed to the principles of anti-discriminatory practice that must underpin all of the work of the Service.
3. The service ensures that the needs of victims are fully taken into account in all work with young people and their families. Every opportunity is given to enable young people to make amends, either directly where it is appropriate or indirectly through some form of work which benefits the community.
4. Partnership is central to the work of the Service and provides the framework for activity, all of which must be directed at preventing offending by children and young people.

## Service Aims and Goals

1. Detection of mental health problems and psychiatric disorders among a high-risk young population.
2. Treatment of psychiatric disorders and prevention of psychopathology in later life.
3. Development and support of the skills of professionals working with children, young people and their families, in relation to prevention, recognition of mental health problems and early intervention with those who are appropriate to be managed at that level
4. Accessibility and timely response to children and families in transition.
5. Contribution to the Youth Justice Board objective of reducing recidivism rates among young people.
6. Reduction of family breakdowns, and successful community re-integration of families who have become homeless; prevention of further episodes of homelessness.

**7.** Promotion of mental health and well being of vulnerable children and young people.
**8.** Development of an innovative, clinically and cost- effective, generalisable and sustainable CAMHS model.

**Specific Mental Health Goals**

To improve provision of appropriate, high quality care and treatment for children and young people by building up locally based Child and Adolescent Mental Health service (CAMHS). This should be achieved through improving staffing levels and training provision at all tiers; improved liaison between primary care, specialist CAMHS, Social Services and other agencies; and should lead to users of the services being able to expect:

- A comprehensive assessment and, where indicated, a plan for treatment without a prolonged wait;
- A range of advice, consultation and care within primary care and Local Authority settings;
- A range of treatments within specialist settings, based on the best evidence of effectiveness; and
- In-patient care in a specialist setting, appropriate to their age and clinical need.

**Specifically in relation to Looked After Children**

**1.** Ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood.
**2.** Reduce the number of changes of main carers for looked after children.
**3.** The Young Peoples Team in partnership with relevant agencies will address the complex needs of looked after children, providing a service promptly.
* There are also specific requirements about 'Breaking down barriers between services' and 'Making services faster and more convenient'.

**Priorities**

Out of the above aims, the priorities are to provide
**a).** Assessment and treatment of psychiatric disorders for the whole target population, i.e. depressive, anxiety, post-traumatic disorders; anorexia and bulimia nervosa; psychotic disorders; self-harm behaviour; attention deficit- hyperactivity disorders (ADHD); and pervasive developmental disorders.

**b).** Support, consultation and training in relation to children's mental health to the professionals who work with the target population

**Staffing And Resources**

The Team based at Westcotes House:
1.00 Consultant Child and Adolescent Psychiatrist
0.40 Project Development Manager (until end of Sept 2002)
2.00 Clinical psychologists
6.0 Primary Mental Health Workers – (2 for Looked After Children's program and 4 for Youth Offending Team).
0.20 Additional Psychology Input to Secure Units
1.50 Secretarial

**Based at Border House Hostel for Homeless families**

1.00 Family Support Services Co-ordinator
3.00 Family Support Assistants

**Staff Roles**

**Primary Mental Health Workers (PMHWs*)***

Two full-time PMHWs provide input to residential units (children's homes) and foster families. This involves consultation and training to Tier 1 staff; liaison and joint work with agencies involved; screening and initial assessments, where appropriate, and treatment within the care settings, i.e. solution focused and behavioural therapy, and group therapy for foster carers.

Four full-time Primary Mental Health Workers provide similar input to the Youth Offending Teams including the Bail Supervision Teams

**Provision to Young People in Secure Placements**

There is 0.2 of Psychologist time to provide input to secure placements at Onley and Tiffield. Presently, Young Peoples Team staff are unable to provide a service to those children placed in secure provision out of county, however, it is recognised that this aspect of service provision needs to be considered. In the interim however, 0.10 PMHW time has been allocated to provide input to Leicestershire young people placed in Tiffield Secure Unit on a needs led basis.

The present service configuration offered by the Primary Mental Health Worker to the group of children placed in other secure provision consist of liaison with identified professionals before the child's move to their placement, in respect of their mental health needs, liaison with staff at their placement during the child's stay, and liaison with the placement and local agencies in Leicestershire before returning. This is to enable planning for the child's return, in respect of any identified mental health needs.

**Psychology**

One Clinical Psychologist works mainly with children in fostering and pre-adoption placements. The post provides specialist (Tier 3) assessment and treatment, i.e. psychometric testing; assessment of children with autism, ADHD, and attachment disorders; cognitive behavioural therapy, family therapy and group therapy for young people.

A second Psychology position is being advertised to provide similar input to children placed in residential homes and young offenders.

**Child and Adolescent Psychiatry**

Consultant clinical duties include emergency assessment; diagnostic assessment of psychiatric and developmental disorders; pharmacological treatment and some therapy i.e. brief psychodynamic psychotherapy; cognitive therapy.

**Family Support Services Co-ordinator for homeless children (employed by Leicester City Housing Department)**

One Family Support Services Co-ordinator co-ordinates the activities of the 3 Family Support Workers input to the main hostel for homeless families, which accommodates up to 90 children at any one time. Duties also involve assessment of behavioural and emotional problems; parenting assessment; liaison with related agencies; behavioural therapy and parent training; membership of the Young Peoples Team; identification of children with mental health concerns and liaison with the Young Peoples team about such concerns. The post is jointly managed and supervised by the Young

People's Team and the Housing Department, Leicester City Council. (Refer below section for more detail).

**Secretarial Staff**
The two secretaries are central to the co-ordination of the team and its liaison with external agencies. Requests for consultation or clinical work are processed systematically to provide an accessible service with rapid response, whilst retaining its mental health remit.

**Management**
There is 0.4 temporary managerial input from a Senior Project Development Manager, who is also the Head of the CAMHS Primary Mental Health Workers. The role is to work alongside the Consultant Child Psychiatrist in developing service specification and operational criteria; setting up screening procedures; supervising staff; developing training programmes; liaising with the rest of CAMHS, the NHS Trust, the Local Authorities and YOTs at operational and strategic level.

**Operational Processes**
**Client Groups**
All children in Local Authority Residential Homes within Leicestershire and Leicester.
Children from Rutland residing in Leicestershire Residential Homes.
Clients from the Fostering services of Leicester, Leicestershire and Rutland
Children and Young People who are placed for adoption. (Children who have been adopted Heads of Dept will be eligible for a Service from the CAMHS community outpatient teams)
All young people within the YOTs
Children resident at the Hostel for Homeless Families (Border House)
Children looked after by other Local Authorities during their residence in Leicestershire.
All professionals working with these groups

Children placed out of the Leicester, Leicestershire and Rutland boundaries are eligible for the following services:
Liaison with identified professionals before the child's move to their placement, in respect of their mental health needs
Liaison with staff at their placement during the child's stay
Liaison with the placement and local agencies in Leicestershire before the young persons return. This is to enable planning for the child's return, in respect of any identified mental health needs.

**Access to the Young People's Team**
Where there are concerns about a young person's mental health needs, initial access to the Young People's Team is through discussion with the Primary Mental Health Workers (PMHW's). Initial contact with the PMHWs takes place via the telephone or a meeting. During the initial discussion the PMHW undertake a consultation with the professional and complete a screening assessment (see following section). Written referrals can be made to the team, however, the referrer may be contacted to complete the screening assessment where more information is required.

Allocated Social Workers, YOT Officers, General Practitioners and Paediatricians are able to refer to the Young People's team. First access to the team for Social Workers and YOT officers is via the appropriate PMHWs. Young People from the Homeless Hostel are referred via the Family Support Services Co-ordinator, in the Team meeting or through supervision.

It is preferred that all referrers contact the PMHWs first, in order to identify the best approach to meet the needs of the Young Person.

**Screening Process**

The following screening process is intended to be a guide for identifying Young People with Mental Health needs:

**i)** Social Services, Youth Offending Teams and the Homeless Hostel (through the Family Support Services Co-ordinator) screen young people using their own risk assessment tools and criteria.

**ii)** Young People identified as high risk through this screening are then presented to the relevant Primary Mental Health Worker from the Young People's Team

**iii)** Young People identified as high risk at the Homeless Hostel are presented to the team by the Family Support Services Co-ordinator

**iv)** The young person's case is then considered according to mental health criteria within the Young People's Team Screening assessment. This helps to determine the level of intervention. There is close liaison with an identified professional with responsibility for the case within Social Services, Youth Offending Teams or the Homeless Hostel. City and County adopt a similar approach to ensure a consistent approach form the Young People's Team.

**Assessment**

Individual assessment is provided to a number of children identified by the agreed referral protocol.

**Intervention**

**1.** Intervention is primarily Consultation and Liaison to support social services, youth offending staff and hostel staff to ensure earlier and more effective identification of the mental health needs of young people, and in devising and implementing appropriate intervention programmes.

**2.** Contribution to the development of inter-agency work within Social Services, YOTs, the Hostel for Homeless Families and the Young People's Team and also to develop links with Primary Care professionals who may provide a service to young people. Joint work with relevant agencies where the young person falls with in the remit of both and with services providing a therapeutic input to looked after children i.e. Therapeutic Social Work Team and Family Service Unit.

**3.** A range of therapeutic groups for both young people with mental health needs and their carers

**4.** A rapid response service is provided in cases of acute mental health need for children in the identified client groups.

**5.** Co-ordination of responses from CAMHS and adult mental health services, where further referral is indicated for young people referred to the YOTs

**6.** Contribution to the co-ordination of effective through care and sentence planning

and, where necessary, ensure appropriate referral to specialist mental health services for young people released from custody.

**Training**

The Young Peoples Team contribute to the planning and implementation of training programmes in relation to children and young people's mental health for staff and carers. This includes a two day course 'Introduction to Children and Young People's Mental Health in Looked after Children and Young Offenders', which is available to all staff who work with the identified client groups and foster carers.

There have also been additional courses developed to complement the introductory course, and agreed pathways to the Multi-agency Child Mental Health Training programme. The courses are presented in a rolling programme to increase accessibility and consistency of input to community agencies within the region.

**Research / Evaluation**

There is a strong research / evaluation emphasis, and part of the role of the program staff is to identify, design and facilitate relevant research which will add to the understanding of the mental health needs of looked after children, young offenders and homeless families

All components of the service are currently being evaluated through external research funding. There are three full-time researchers based at the Division of Child and Adolescent Psychiatry of the University of Leicester, who conduct the following projects:

Assessment of mental health needs of children looked after and youth offenders: 2000-2002, funded by the Youth Justice Board and the Leicester and Leicestershire Social Services; Evaluation of mental health service for youth offenders: 2000-2002, Youth Justice Board; Evaluation of mental health service for children looked after: 2000-2002, Leicestershire Health Authority; and Evaluation of mental health service for homeless families: 2000-2002, PPP Healthcare Medical Trust.

**Accountability**

The Young People's Team have a responsibility to the Joint Agency Young People's Team Steering Group (Refer below), to report on the activities of the service through the Clinical Director (CAMHS) in respect of agreed targets, objectives and outcome measures. Referral protocols are to be developed between service managers of the Young People's Team, LAC service, YOTS and Housing and will be approved by the Young People's Steering Group and Clinical Director of CAMHS.

**Quality Measures**

1. Focus groups with staff and carers involved with the client groups in terms of impact of and satisfaction with the assessment and intervention services.
2. Surveys of managers in respect of contributions to the LAC management systems.
3. Elicited feedback from staff/carers attending training sessions.
4. Standardised mental health screening of young people
5. Semi-structured Interviews with young people regarding experience and satisfaction with the service

6. Semi-structured interviews with carers regarding ability to cope with difficulties of Young People in their care
7. Clinical audits within Young People's Team system.

**Indicators of Effectiveness**
As a new service, indicators of effectiveness are being further developed but a range of possible measures suggested are as follows:

**i).** Short-term measures include: Recording of client numbers, Utilisation of standardised screening assessment, Recording of consultation, training and management sessions, Response times to rapid intervention requests, and Recording of outcomes of the range of interventions.

**ii).** Long-term measures include: Service and operational indicators/Response to need; Reduction in the number of changes of main carers for Looked After Children; Lower rates of staff turnover; Satisfaction of adoptive and foster parents with support services; Satisfaction of young people using the service; Reduction in waiting times for a CAMHS response and intervention, where appropriate; Reduction in offending, specifically amongst those young people looked after by the Local Authority; Effective identification and treatment of mental health problems amongst young offenders; Consistency of assessment and planning processes; Responsive and appropriate services; and Increase in skill and confidence amongst staff and carers, in the recognition of and intervention with young people with mental health difficulties, through access to training and consultation.

**Psychosocial functioning and satisfaction include:**
Reduction in the severity and frequency of problem behaviours; Use of more appropriate coping strategies and confidence to solve/or cope with difficulties amongst young people; Increase in social skills and social support amongst young people; and Increase in carers' ability to cope with difficulties in the young people they are caring for.

**Provisions**
The Service Specification is subject to regular 6 monthly reviews at the discretion of the Young People's Team Steering Group. An annual report on the scope, quality and effectiveness of the service is to be provided by the Clinical Director of the CAMHS.

**Composition of the Young People's Team Steering Group**
Children's Joint Strategy Officer; City Council - two members (Service Managers or representative); County Council - two members (Service Managers or representative); CAMHS - Clinical Director; Operational staff - Consultant Psychiatrist and Clinical Psychologist; Manager - Project Development Manager; Leicester YOT - Service Manager; Leicestershire YOT - Service Manager; Leicester City Housing Department - Services Manager for Homeless Families;

**An example of an Evaluation of Primary Mental Health Workers Within Youth Offending Teams.**

The aims of this study were, to describe:

The direct clinical work conducted by PMHWs in Youth Offending Teams, through data on referral characteristics, assessment and intervention; and

The PMHW consultation role, through referral and YOT staff satisfaction data.

The views of YOT professionals on the links between YOT's and CAMHS through staff focus groups.

The mental health characteristics of sixty young people consecutively referred to these PMHWs, and the assessment, interventions and consultation offered (as detected by a mental health screening process specifically designed for the study and through focus groups) are summarized as follows:

In addition to the anticipated concerns about oppositional/aggressive behaviour, young people were referred for a range of mental health problems, which included high levels of emotional problems, self-harm, peer and family relationships difficulties, and school non-attendance.

PMHWs offered a range of direct interventions, as well as consultation to YOT staff.

Qualitative data from YOT professionals' focus groups indicate that the accessibility and responsiveness of PMHWs, as well as their clinical assessment and therapeutic interventions skills, were consistently valued. There was mixed response on the evolution of roles within the team, and the nature of consultation and training.

The findings from the quantitative and qualitative study indicate the usefulness of such an inter-agency model in strengthening the links between specialist CAMHS and YOTs, and providing an accessible, responsive and effective service to a needy group of young people.

## 3.MENTAL HEALTH SERVICE FOR HOMELESS CHILDREN & FAMILIES

The Mental Health Service for Homeless Children and Families was based on the findings of an Epidemiological Survey with the intention of using the outcomes regarding psychiatric morbidity in homeless mothers\children (to 50%)in a constructive way in policy planning and service development.

**Background**

Previous research has revealed high levels of mental health problems in homeless parents and children. Homeless families are subject to multiple and complex difficulties including low levels of social support, poor educational records, histories of unsettled housing, and experiences of domestic and neighbor violence. It has therefore been recognized that specialist services need to be developed to serve the particular needs of this growing population who find it difficult to access mainstream services.

**Research Findings**

**1** Approximately 1,000 families with 2,500-3,000 children become homeless each year in Leicester and Leicestershire, and are admitted to the 11 hostels. Families become homeless because of domestic violence, neighbourhood harassment and other forms of community violence, or through seeking asylum.

**2.** The estimated figures are an underestimate, as there are many children targeted by the team who may not fulfil these official criteria (e.g. living with relatives or friends after family breakdown). The prevalence of mental health problems in the general population is around 20%, with 10-15% of psychiatric disorders. These rates have been found to be at least double in this population.

**3.** The main homeless hostel (Border House) in Leicester providing for this group of children regularly encounters mental health problems identified through the Family Support Services staff located there and needs the support from CAMHS.

The Family Support Service was established in 1999 in the largest hostel for homeless families in Leicester city. It was led by a sole Family Support Worker (FSW). The FSW received some regular assistance from a hostel assistant and a health visitor. In addition, a weekly multi-agency meeting was held and involved input from community adult psychiatric nurses and a child psychiatrist.

**Process**

**1.** Epidemiological, Cross Sectional, and Longitudinal Studies undertaken.
**2.** Conferences Organised and participation of all sectors were involved.
**3.** Problems identified in multi-agency workshops and summarised in a conference report.
**4.** Directors of education; social services, housing and health reported on the progress of each sector, but also involved "front-line" staff from all agencies working with homeless families.
**5.** Funding for a designated community psychiatric nurse.
**6.** Directors and Senior Managers. (Commissioners and policy-makers) set the framework and directions of the service.
**7.** Multi Agency group formed to:
**a)** Identify homeless children and families with unmet needs within each sector.

**b)** Improve existing services (eg: health & schooling) and to advocate for new resources.
**c)** Ensure inclusion of families in policy documents.

**Participants Included:**
A General Practitioner, Health visitor, Community Psychiatric Nurse for the homeless, Child psychiatrist Consultant, Paediatrician, a representative of Women's Aid, managers from Housing, Health, Education and Social Services.

**Service Objectives (pragmatic aims, taking into account the characteristics of homeless families)**
**1.** Assessment and brief treatment of mental disorder in children and parents.
**2.** Liaison with appropriate agencies to facilitate reintegration of the family into the community – particularly local services.
**3.** Training of homeless centres staff in the understanding, recognition and management of mental illness in children and parents.

**Function of the Service**
To maximise impact of limited resources, and to provide regular outreach sessions held at identified centres for homeless families.

**Referral Criteria**
Families or Children identified as having possible Mental Health Concerns or identified High Risk families. (Victims of domestic violence or established or suspected child protection issues). Over 40 families and 122 children have been seen over 12 months.

**Process**
Referrals are made directly to the Family Support Worker of the Youth Team who is connected to the hostel or through the weekly Inter-agency meeting that is held at each hostel, when all families are discussed.

**Treatment**
Treatment includes time limited behavioural therapy, advice on management of behaviour, and brief supportive psychotherapy for those suspected of major trauma.

**<u>Evaluation Findings</u>**
**Qualitative Data**
Preliminary analysis revealed high levels of satisfaction with the Family Support Service, as the vignettes below describe.

‘Before I saw her [family support worker] I felt that nobody cared and I felt unloved and that nobody would listen. She is the only one that would listen.’

‘She told me how to discipline my kids. It was very good to speak to her.’

‘It was very helpful; they gave me guidelines on how to deal with his [son’s] behaviour. He had sessions with FSW to talk about his feelings; he reacted to my depression and was worried about me. His behaviour changed after the input, his behaviour improved’

The service targeted a wide range of difficulties. Services offered included provision of counselling, liaison with, and access to services, child behavioural advice, and mental health assessments.

**Challenges Identified**

There were a number of challenges identified particularly the multiple needs of children and families in the homeless services that include social, educational, and mental health problems, for example, 25% did not attend appointments as their – mental health needs were not their first priority. There were also difficulties separating out the child's from the mother's problems.

In addition to this the service is constantly evolving, often because of changes in the housing legislation and the homeless population (for example the increasing refugee population).

**Recommendations from the evaluation**

The needs of families require a multidimensional response with a greater number of resources involved.

**Action:**

1. Need to link with hostel staff as first line access.
2. Designated time to work with the population secured for staff in the team who have an additional generic caseload and therefore competing pressures to deal with.
3. Monthly Steering group established in an endeavour to engage and co-ordinate other agencies (re: social services, primary care and the voluntary sector). To increase the range of services available.
4. Rolling training programme to housing staff to increase awareness of mental health issues and ensures appropriate referrals to the team.
5. A quarterly newsletter is produced to try to raise awareness of the problems that homeless families face.
6. Evaluation of the service model by a research team funded by the NHS Research and development programme.

**Outcomes**

Benefits and service improvements during the course of the study that occurred were:

1. The Family Support Worker post that was initially jointly funded for three years by the Leicestershire Health Authority and the Leicester Housing Department, became permanent.
2. The Family Support Service has developed rapidly towards the end of the study. It now comprises a team co-ordinator and three full-time Family Support Workers. The three additional recurrent Family Assistants posts have been funded by the Leicester Housing Department. The Family Support Team now covers a number of hostels and supports families after rehousing, when they are most vulnerable.
3. A resettlement (tenancy support) team was piloted in a Leicester locality. This has since expanded to cover the whole of the city.
4. The Family Support Team is now attached to the Leicestershire Child Mental Health Service (Young People's Team).
5. The parent-training manual is used by the Family Support Team.
6. There are plans to set up additional Family Support Workers posts to cover the voluntary (non-statutory) hostels for homeless children and families, and to develop a Primary Mental Health Worker role to work with homeless children and families throughout the County.

## 4. GREENWOOD INSTITUTE

**History and Objectives**

The Division of Child and Adolescent Psychiatry of the University of Leicester was founded in June 1986 with the appointment of Professor Rory Nicol, Foundation Professor of Child Psychiatry. The Division was originally accommodated in the Department of Psychiatry at the Leicester Royal Infirmary and moved to the Greenwood Institute of Child Health when it officially opened in October 1993, on the site of the outpatient base of the Leicestershire Child & Family Mental Health Service. This was an academic development supported by the University of Leicester, the Leicestershire and Rutland NHS Trust, and the Institute Benefactor, Mr. Hugh Greenwood. The Division has responsibilities in teaching and research, organises and teaches the undergraduate child psychiatry curriculum, is involved in teaching on other related parts of the medical undergraduate curriculum, and actively supports and participates in teaching postgraduate child mental health.

The aim is to work collaboratively with other departments and agencies in teaching and research in order to achieve appropriate skills mix in each area of activity, ensuring a high standard of attainment.

It conducts, supervises and manages research in child mental health and related areas. The dynamic interface that occurs between The Greenwood Institute and CAMHS gives a strong academic presence within Child Mental Health, and adds a validity, accountability, and strength to the program development that is undertaken by CAMHS that is essential to the principles of a Learning Organisation. It also encourages broad based involvement in clinically driven research projects by staff who normally would not have the time or experience to do so (ie: Clinicians), by providing a mentor type role and a framework for research that is readily accessible to the non-academic.

## DISCUSSION

Leicester and Rutland CAMHS had many similarities to CAMHS services in Victoria on a number of levels. It struggled with many of the same issues, but had managed to find fairly creative ways of dealing with these challenges that involved and inspired the staff and the community to be part of the process.

The similarities included the overall mandate for service delivery as a Government funded Child and Adolescent Mental Health Service, which lead to a similar profile of client, similar legislative requirements and similar challenges for scarce resource management. This had become an increasing challenge, in keeping with Australia, with the increasing complexity of the problems the young people and their familles were presenting with.

The differences however were quite significant, particularly on an organisational level and the influence of the broader National Policy in providing a structure and context for service development, and how this in turn supported the range of innovative programs within the CAMHS service.

Two major reviews, Together We Stand (1993-1995) and The Big Picture (1999) had informed the development of a National Children's Services Plan. This over arching plan outlined specifications for Clinical Governance Plans for Health Care on a

County level, as well as a clearly defined 4-tiered structure for the broad spectrum of Mental Health Services (of which CAMHS was only a part on a more tertiary level).

What was notable about the Leicestershire and Rutland Plan was both the process of consultation and the cross sector Children and Young Persons Strategic Partnerships that were formed between Health, Education, Social Services, the Voluntary and Community Sectors and Parents and Carers, as part of the joint strategy between Leicestershire Health Care and Child and Adolescent Mental Health. In some instances in Victoria collaborative thinking has occurred on a policy level, but there have been major difficulties in translating this into formal and functional structures and day-to-day practice.

This clarity of policy direction and dynamic partnerships created a framework that was both inclusive and expansive, yet gave a clearly defined structure for the CAMHS service to operate within that has been lacking in Australia. The positive effect of this combination was seen on many levels in the Leicestershire and Rutland CAMHS services.

**Clinical**

On a clinical level there were a range of innovative programs that complimented and were supported by these structures.

The role of the Primary Mental Health Worker (PMWH) within the service helped to reinforce clear boundaries for the CAMHS, but created a link between the tiers of the service system, which is something that doesn't exist for CAMHS in Victoria at present. There are Mental Health Promotion Officer positions that share some of the functions, but the role has not been established as the formal link to the community with the same screening capacity of the PMWH's at Leicestershire CAMHS.

Also, whilst Primary Mental Health teams have been established in Victoria, the current link is with Adult Psychiatric services in which they are located. The emphasis is in on early intervention and prevention of major psychiatric disorders such as psychosis and depression, which gives the service more of an adult focus. Given that the tier structure is currently being considered for Child and Adolescent Health Services, with CAMHS in a tier 3-4 tertiary level, the lack of a direct link with PMHW's will create a major interface problem with the community for CAMHS; particularly with the more troubled, high-risk client group and the sector of services who work with them.

**Programs for High Risk Youth**

There were a number of programs linked directly to the PMH teams that specifically targeted High Risk young people and families. These specialist programs formed the Young People's Service, and included the Youth Offenders Team, The Looked After Children's Team, The Homeless Children and Families Service and the Multi-Agency Training program.

**The Young People's Team**

The Young People's Team is an excellent example of a collaborative, multi-agency, multi-level program that offers a broad spectrum of interventions and reflects application of systemic thinking to program development. With "partnership" central

to the work of the service, the fact that it is a program funded and owned across service systems (called joint commissioning) gives validity to the collaboration from the top down.

The range of services that have been formally included in this structure are much more comprehensive than many programs that have been established in Victoria (ie: Hostels, Family Support Services, Juvenile Justice, Social security, Secure Welfare and CAMHS) where programs tend to be established under the umbrella of one service system with a mandate to collaborate with other services. The responsibility to establish the collaboration is then often left to the practitioner within that service and can be extremely difficult to achieve from that position; as has been my personal experience working in and developing the Mental Health Intensive Youth Support role, the Homeless Agencies Resource Person role, an Adolescent Mental Health Service and participating in the Working Together Strategy in Victoria.

These are Australian examples where collaboration has been specified in policy without any standard or concrete management and programmatic structures to formally operationalize the policy at a central level. As a result in some areas, these strategies have stalled or may have been achieved by the personality in the position and lost when that person vacates the position.

The Young People's Program has many similarities to the Mental Health Intensive Youth Support Service and the Mental Health Promotions officers in Victoria. This is reflected in the fact that the service is based within and supporting the community services who primarily work with High Risk Young people and their families, and has the capacity for initial assessments, select intervention and joint work with other agencies, and screening and referral to CAMHS, with however, the focus being to support the services predominantly through secondary consultation and training. The major difference is the clarity of structure and supports around the Leicestershire programs within the overall CAMHS service and the more formal links with training and research.

This clarity of structure extended to the community training delivered by the Primary Mental Health Workers linked to the program. This was established by a formal two and three day "rolling" (on going) training schedule that was developed from a process of consultation and review with community services about their needs, and offered in a way that was made meaningful and accessible to these services. This reflected a process of community needs based program development as opposed to a service driven one. The fact that the PMHW training linked directly with a formalized academic course designed as an extension to what was offered to practitioners within that training validated the link between the academic and practitioner and reinforced the goal of making training accessible to all.

**Program Development**

The Young People's Program and the Homeless Mental Health Service for Children and Families within that are good examples of a model of program development that matches research with practice in an extremely comprehensive way. Programs were established in response to an identified and researched need, involved extensive community consultation, then were developed within a research and evaluation framework that incorporated clear and comprehensive quality measures.

The clear expectation and framework for evaluation also built in formal and transparent accountability within the program. This is sometimes lacking within many

of the programs developed within Victoria, where there is often a reference to the need for evaluation without any formal structure, specifications, guidelines or resources to do so.

This contributed to a model of program development that was philosophically driven, and used theory to inform practice, which in turn promoted a solid sense of shared goals, paradigms and vision, and a solid way of promoting a cohesive and comprehensive service.

**Learning Organisations**

Further to this, these programs among others at Leicester and Rutland CAMHS were fine examples of the application of a learning organization philosophy. As mentioned in the Highlights of the visit above, what stood out about the service was the number of staff who were actively involved in and enthusiastic about developing new programs and about the development of the CAMHS service generally, and were involved in some form of research or other type of study or professional development.

Attempts to tackle a combination of qualitative and quantitative research again encouraged practitioners to get involved, and the formal links with the Greenwood Institute enriched and encouraged this by providing both resources and expertise in research and evaluation.

The specialist program based structure appeared to facilitate this link with research further, where practitioners became part of developing a specialist team and were both supported and expected to develop specialist skills on both the clinical and research level as part of this process. This promoted a strong sense of ownership of the program and very much linked with the goal of supporting continuous professional development and creating a "Culture of life long learning" across all clinical areas.

Finally the involvement of the Greenwood Institutes / University of Leicestershire Division of Child and Adolescent Psychiatry, in developing and delivering training programs to the broader community in conjunction with the CAMHS service, and particularly the PMHW's, is another example of the integration of practice and academic. This is highlighted by the specific example given above where training programs offered by the Youth Team, are extended upon in the new Cert / Dip / Msc Primary Mental Health Work that was developed by the Institute in conjunction with the CAMHS Service specifically to make more formal study accessible and relevant to community practitioners and those who may use the initial training.

**Summary:**

The Leicester and Rutland CAMHS was a comprehensive service that had a range of innovative programs for High Risk Youth that were well integrated and supported as a major component of the overall service. It demonstrated a service development model that emphasised effective and dynamic cross sector partnerships and an integration of theory, research and practice, which appeared to provide a solid framework and promoted the strong sense of cohesion and involvement of the staff and the community.

## 8b). ROGALAND PSYCHIATRIC

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**CONTACTS**

Director / Chief Psychiatrist – Dr Jan Olav Johannessen
Dr Kjetil Hustoft (Psychiatrist in TIPS assessment team)

**PROGRAMS VISITED/ INTERVIEWS WITH**

Jan Olav Johanssen, Chief Psychiatrist
Anne Lise Oxnevad and Trond Gronnestad; psychiatric nurses
- TIPS Family Intervention

Inge Joa, psychiatric nurse, and Kjetil Hustoft, psychiatrist
- TIPS Detection / assessment team

Ingunn Hove, psychologist, Psychiatric Youth Team
Margot Bratteteig, and Torbjorg Skalnes, Psychologists Eikerly
Jan Erik Neilsen, Psychiatric Nurse, Department Youth and Adolescent Psychiatry
Londoy Island, Social work, Conduct Disorder Youth program

**HIGHLIGHTS**

One of the highlights of this visit was the people met, the hospitality shown, and the generosity of information shared. On the service level, the clarity of the organization was refreshing as was the enthusiasm, pride and commitment demonstrated by the staff met. The physical structures and location of the various components of the service also demonstrated thoughtfulness on the organisational level for the differing needs of each component of the service. This had been the result of specific attention given in the planning and building of the hospital (Refer below).

**KEY FEATURES/ KEY STRENGTHS OF THE SERVICE**

**Resource Rich**. There has been a significant amount of funds dedicated to Mental Health generally and to Youth within that more recently ($5 billion to Mental Health, $10 million for youth).

**The range of programs.** There were a comprehensive range of programs that included generalist Youth, Adolescence, Child and families, and Specialist Programs for Early Psychosis, Dual Diagnosis, Personality Disorders, and Conduct Disorders. Also long-term treatment options were included within each program.

**Research / Learning Organisation**

A strong feature was the use of clinically driven research and outcomes as an honest critique to inform and modify practice, service development and delivery, and the dissemination of this information in a range of modalities (ie: published articles, internet, and training materials).

Staff training, support and supervision of staff and their active involvement in research was also seen as an important aspect of the service.

**Philosophy**
There was a philosophy where the human factors were thought about, for example the acknowledgment and work with the issues of grief, loss, guilt, blame, fear etc as important factors to the clients and families recovery. The client was not viewed in isolation or as purely a diagnosed disorder for treatment, and the relationship with the therapist was seen as an important part of the treatment. The client was viewed as a whole person within their context, which lead to a holistic approach to treatment and the use of a rich mix of philosophy and models to directly inform practice.

**Models**
The models of therapeutic interventions were a refreshing combination of the use of relationships, thinking in psychodynamic terms but with a more pragmatic here and now application, systemic and family therapy interventions, and support for continuity and long term interventions (ie: treatment may go on for years – on and off). Other models informing the treatment were crisis theory, a stress- vulnerability model, group dynamics, McPharlane (USA) model of Early intervention and treatment of first episode psychosis, EPPIC (Australia) model of case management and outreach, Prof Jan Olav's (Norway / Rogaland) model of schizophrenia, and Milieu therapy.

**Family work**
An exceptional model of family work had been developed that was extremely comprehensive. It demonstrated how to work with and advocate for families and parents within the system, in a way that takes blame off parents and in a way that the group leaders and clients/families felt good about.

**A comprehensive and innovative health promotion, marketing and education strategy.** An extremely sophisticated and extensive marketing and education campaign was designed and implemented as an integral part of the TIPS project. The campaign targeted the general Public, General Practitioners, Schools, Primary Health, and Psychiatric Services, and utilised a range of mediums and materials, including Radio, TV, Brochures, Adds Local Newspapers, Video, Early course Lectures, and a T.I.P.S. Manual

**EXAMPLES OF PROMISING PRACTICE (Refer to detailed outline below)**
**1. T.I.P.S -** This is an innovative and holistic service package for the health promotion, early intervention and prevention, and research in relation to first episode psychosis. It is an exemplary program in areas such as program development, clinical richness, and comprehensiveness of the research model. The program includes detection, assessment, and intervention, with an early intervention and prevention focus that includes an extensive marketing / education project component. The design and refinement of the first multi-family groups for 1st episode psychosis in the world is also a strength of this program.
**2. Psychiatric Youth Team** - This is a specialist service for young people / youth with a Dual diagnosis and complex presentations. The program applies a range of paradigms including having a systemic and collaborative approach and offers holistic long-term treatment within a therapeutic community framework. The program is very popular, as it is seen to take the hardest clients.
**3. Lindoy Island -** This is a long-term residential program within the Adolescent Program for young people with Conduct Disorders, based on a therapeutic community / Milieu therapy model.

## PROGRAM LIMITATIONS / CHALLENGES

### Overall

**1.** The process of Deinstitutionalisation was commenced in 1960's where clients were emptied out of the psychiatric institutions; however the resources did not follow out into the community. This has put increasing strain on families and support services, and often contributed to the delay in young people with an emerging psychosis being detected and receiving treatment. This has often exacerbated their illness and negatively affected their prognosis.

**2.** Difficulties getting enough trained staff in the child and adolescent area. The goal for the service is for 120 staff to be trained by 2006, however the view is this probably won't achieve until 2010.

### TIPS

**1.** System issues had become evident, especially the lack of rehabilitation services.
**2.** The challenge to maintain the integrity of the program and ensure all the components were covered.
**3.** The integration to the rest of the hospital/service.
**4.** The practicalities of the intensive time involved and the cost of delivering the service. Developing the model took time and energy to get people to refer initially.

### Psychiatric Youth Team & Adolescent program / Lindoy Island

**1.** The profile of client is extremely challenging with complex psychosocial issues.
**2.** Insufficient number of beds in the therapeutic community (Eikely), hence long waiting lists (Generally 25 people on the waiting list who can wait for up to a year).
**3.** Detoxification is offered via a drug treatment centre/ detoxification unit but it is too small, has long waiting lists and is seen to not be responsive; all of which adds to the delay in clients getting treatment. This has extremely negative ramifications in the dual diagnosis client group, where it is usually being able to cease a window of opportunity when the client feels motivated to get help that has them enter treatment. Also there are no dedicated detoxification facilities for young people 13 – 16 years old, they have to be admitted to the youth psychiatric unit.

## CONCLUSIONS / RECOMMENDATIONS

1. Continue to **build on the Existing Links in Australia** (ie: with EPPIC) and broaden them to other services.

2. **To promote the TIPS package use in total,** not just aspects of it (Refer below): ie: Education / Marketing, the Treatment package, including medication, psychodynamic supportive psychotherapy, and family work (especially the long term, more comprehensive work with clients and families, including psychodynamic, systemic therapies and the multi-family psycho-education groups), the research model and the staff training and education.

3. **Advocate for New Policy Directions with a Focus on Youth** (16-25year olds) and the establishment of specific youth services

4. **Promote a revisiting of the focused use of Milieu Therapy and the principles of therapeutic community in residential settings,** and explore the relevance to the proposed retreat and training centre (Refer to dissemination section).

# ROGALAND PSYCHIATRIC HOSPITAL

Rogaland Psychiatric Hospital is a large psychiatric facility that provides services for children, adolescents, adult and the aged. It covers the Stavanger Region (pop 300,00) within the County of Rogaland (pop 380,000). A community clinic in the north covers the remaining 80,000 for outpatient treatment. Services include In-patient (120 adult beds, and 12 Adolescent beds), Residential, Outpatient, Community / Outreach, and a Day hospital (Refer below for more detail).

## ORGANISATION AND MANAGEMENT

The Norwegian Public Health Service reorganised 10 separate health institutions to form the Stavanger Hospital Trust – Central Hospital of Stavanger. The institutions were Rogaland Central Hospital, Rogaland Psychiatric Hospital, The Rehabilitation Unit, and Kloggergarden, Dalane, Lassahagen, Vartatun, Randaberg, Strand and Engelsvoll Psychiatric Centres.

Stavanger Hospital Trust is one of five health enterprises which belong to the regional health enterprise Helse Vest, which is owned by the State. It is also one of the largest employers in the area.

The Central Hospital of Stavanger is divided into 10 clinics and three support divisions. A clinical director manages each clinic. The Managing director, Mr. Erik Tjemsland, is head of the organization. The three support divisions are Economy and finance, Internal Service and Medicine and development.

The management group consists of 14 people. They have regular monthly meetings, in addition to strategy and planning seminars. Every clinic and unit has established management groups following the same pattern as the rest of the organization. To involve the employees and unions in all major decisions is perceived as very important in the Stavanger Health Trust.

### Values and Goals

1. An organization that delivers results
2. An organization with a high level of competence
3. An organization which cares about it's patients
4. An organization, which is perceived as responsible to the community.

### Commissioning and Design of the Hospital

The division into the Stavanger Trust was important for the realisation of a long-term plan for Psychiatric Health services within Rogaland County. It was part of a strategy that began in the 1980's. The main elements included:

1. Establish and build Psychiatric Polyclinics post the decentralising pattern
2. Build a number of purpose built Psychiatric Facilities (9 centres have been built between 1982 – 1996).
3. Build a new Countywide Psychiatric hospital at Stavanger.

The reasoning behind this strategy was to have psychiatric services closer to where people lived and to decrease the use of the old Dale Asylum.

**Planning**
As new hospitals are costly and don't get built very often, it was seen as essential not to repeat old mistakes and to plan a building that could be used for years to come, remain functional, keep abreast of the changes in psychiatric treatment and to give the best care and treatment.

The main emphasis was to satisfy patient needs and to have an aesthetically pleasing environment for both staff and patients, which would inturn help promote a good social environment.

**Main Principles**
1. Get rid of the institutional type atmosphere
2. Aesthetic value of buildings
3. Privacy for patients
4. Safety for staff and patients
5. Promoting a good social environment
6. Good conditions attract good personnel, which inturn creates a high quality working environment

**Design Specifics**
**1.Overall structure**
The hospital was divided into 3 levels with 8 wards and 92 beds. Each area has 2 wings, with the bedrooms on one wing and group rooms and a separate assessment / high dependency area for new admissions in the other wing. The central area between both wings is a recreational, meals and activity area. This assists to promote the staff / patient interaction.

**2. Function of Bedrooms**
The bedrooms were specifically designed to facilitate optimal treatment based on passed experience. The emphasis was on patient needs and privacy and respect. Therefore each client has their own bedroom as opposed to the small 4 bedrooms where the possibility of privacy was non-existent.

**3. Atmosphere**
To get rid of the institutional type atmosphere, there was specific attention paid to daylight and angles, i.e. not long streamlined corridors. There was also a mix of materials used (such as timber and brick) and the décor chosen was light and fresh colours.

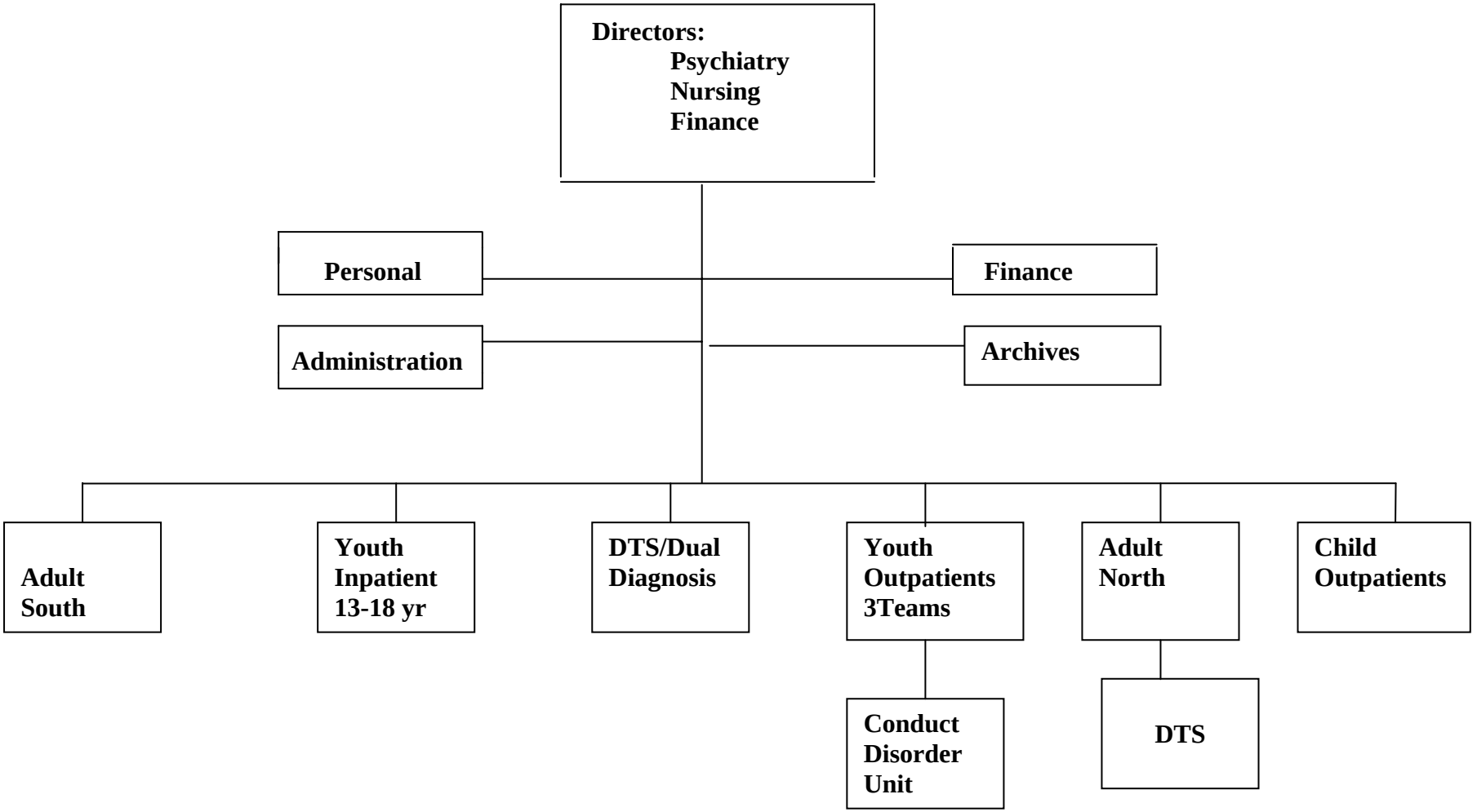
**4. Safety of Staff and Patients**
Specific aspects to promote safety were wide passages, good views, open space to decrease conflict that can arise from over crowding, and a personal alarm system for staff with location signals.

**Outcome**
The overall outcome is a hospital that is functional, aesthetically pleasing, creates a space where clients can be treated with dignity, and in dollar terms was built to schedule and on budget ($A32.6 million).

## OVERVIEW OF ROGALAND PSYCHIATRIC HISTORY

| | |
|---|---|
| 1913 | Big State Hospital with 700 patients located 20kms outside of Stavanger at Dale. |
| 1970 | Rogaland Psychiatric opened as an integrated service within mainstream medical to service the lighter psychiatric population (0-65) |
| 1970' s- 1980's | Became sectorised. Stavanger covered 100,000 and the old State hospital in the South decreased capacity to 150 patients. Acute went to Stavanger and more intransigent to the State hospital. |
| 1970's | Began separate department for children under 13 yo. Built a separate unit – developed gradually. |
| 1980's | Interest in early intervention began at Stavanger as main presentation was psychosis, but most of the funding had been going to chronic rehabilitation. |
| 1990-1992 | Commissioning and building of purpose built Psychiatric facility.<br>Separated out from the Somatic Hospital and took 20% of General Hospital budget. |
| 1992 | Established new unit for Adolescents in old State hospital. |
| 1996 | New buildings built for adolescents – 2 wards of 6 places each. Outpatient unit with 10 staff. Seen 300-400 patients per year outpatients and 100-130 admissions. *Work very closely with Social Security.<br><br>2 different services for Child & Adolescents – the only place in Norway. (There was resistance at a National level as adolescents were seen more from an adult framework). |
| 1990's | Schizophrenia Centre began – got funding for a pilot study. The T.I.P.S project has built on this. |
| 2000 | New acute wards will be opened focussing on early intervention. T.I.P.S model. The service is becoming more decentralized with Out Reach teams/district psychiatric services, and 5 Community Clinics are planned within the County eventually. |

**ROGALAND PSYCHIATRIC ORGANIZATIONAL CHART**



## PROGRAMS

**1. Dept Adult Psychiatry**

The Adult Psychiatric service has sectorised outpatient units connected to In-patient wards. They use an integrated approach where if an outpatient client gets admitted, the case manager still has responsibility for the treatment throughout.

The service is comprised of 9 wards of 14 beds with 3-day patients each, 1 forensic unit of 10 beds, 1 geriatric unit of 14 beds and an out patient unit, 1 rehabilitation unit, and 3 satellite clinics (to increase to 5).

**2. Day Hospital**

The day hospital is an outpatient unit that runs modular groups for adult clients. Each group runs for 3 months and there are13 places.

**3. T.I.P.S. Program (Refer below for more detail)**

T.I.P.S is an innovative and holistic service package for the health promotion, early intervention and prevention, and research in relation to first episode psychosis. It is an exemplary program in areas such as program development, the clinical richness, and the comprehensive research model.

**4. Specialised Youth Dual Diagnosis Program (Refer below for more detail)**

The Youth Program is a specialist service for young people / youth with Dual Diagnosis and complex presentations. The program applies a range of paradigms including a systemic and collaborative approach. It also offers holistic long-term treatment on an outpatient level that includes outreach engagement and follow up, and inpatient treatment within a residential therapeutic community framework (Eikley).

**5. Adolescent Program (Refer to Lindoy Island below for more detail)**

The adolescent program is comprised of two In-patient Units for adolescents 13-18 years old, one Outpatient Clinic integrated to the 2 Units, and also has a small school linked with both in-patient and out patient teams.

There are 60 staff from a range of disciplines including a Psychiatrist, Psychologists, Special Education Teaching, Psychiatric Nurses, a Physiotherapist, a Music Therapist, and Milieu Therapists.

Referrals are 90% Voluntary, and 10% Involuntary, with the most acute referrals coming from General Practitioners. The presenting problems are predominantly first episode psychosis, Affective Disorder, (20%), Eating Disorder (17-18%) and Behavioural Disorder now 16%. Behavioural disorders were 38%, however this has been decreased due to close work with Social Security, an increase in training, an increase in resources in outreach and an increased focus on collaboration – especially with primary health, families and community services.

The philosophy is of flexibility and responsiveness to identified need.

When a Young Person is admitted a treating team is formed that includes a Psychologist, 1 Primary Nurse, 1 Teacher, who liaises with mainstream schooling, a Social Worker, who works with the parents, and 1 Milieu Therapist, who is the

allocated primary clinician who works intensively with the young person when they are on the unit.

Lindoy Island is linked with the Adolescent Program and provides long-term residential treatment for young people 11 – 16 years old who have been diagnosed with a conduct disorder. (Refer below for more information).

**6. The Children's Program**

The Children's Program is for those under 14 years old and is comprised of an In-patient Unit, a Family Unit, and 3 Out-patient Teams that are geographically based. There are also strong links with the teaching centre.

Presenting problems were largely ADHD and Conduct Disorder and were predominantly boys (71%), where as girls only make up 28%. The age distribution is age – 0-6 (12%), 6 – 12 (63%), and 13 – 14 yo (24%). If families are admitted, the young person does not get a diagnosis.

The Family Unit admits families for 4 weeks to go through a program where they work intensively on their relationship with their child. A lot of preparatory and post admission work is done. In-patient stays are short-term admissions (6 weeks maximum).

There are 62 staff from a range of disciplines, with one teacher in each team.

Outpatient Treatment includes Family, Psychodynamic, and Cognitive Behavioural therapies, with a strong liaison and support component to parents, schools and kindergartens.

**7. State Project Pending** MST teams (Mobile Support). This is a proposed intensive outreach program that will target Conduct Disorder /Social Security clients with criminal records and long-term problems.

## EXAMPLES OF INNOVATIVE PRACTICE

### 1. T.I.P.S PROGRAM

TIPS (early intervention in psychosis) stands for early detection and treatment in serious mental illnesses, particularly first episode psychosis**.** The main goal is to reduce the time it takes from when a patient first develops serious symptoms to when the treatment is started, and to test whether this has an impact on the patients long term functioning.

As a part of the project, the patients are offered a treatment package, which is considered to be most suitable and most efficient, (as outlined in detail below). The TIPS project also seeks to further develop psychiatric health services so that the most effective help can be offered when it is most needed, i.e. before and during the first onset of serious mental illness.

**Background**

The psychoses, for example schizophrenia, represent the biggest challenge in psychiatry in Norway when it comes to treatment. The psychiatric illnesses, and in particular schizophrenia, place enormous strain on the health services and involve large costs to the society. It is estimated that schizophrenia alone costs the Norwegian society up to 5 billion NOK per year, and it is the most costly single illness irrespective of category. Schizophrenia alone costs the society more than all heart diseases, cancer or other comparable groups of illnesses.
Yet despite the great amount of suffering connected to the condition, and the strain it puts on the individual and on society, this group of patients is often not given priority.

This is a condition where the person affected often suffers for a long time, and the illness involves serious consequences for the individual patient and his/her family. However it is known that it is still possible to offer effective treatment and that many people can be cured. Schizophrenia is in fact a rarely occurring disease. A town such as Stavanger, with 100 000 inhabitants, will have approximately 5-10 new cases per year. If offered extensive treatment in the acute phase, it would be possible to reduce the long-term consequences considerably.

The time it takes from when a person develops such a serious "state of confusion" for the first time until treatment is started is often very long. In Rogaland, as in rest of the country, it can take years from when the first signs of illness occur to when the patient receives treatment from the psychiatric services. Studies from Rogaland psychiatric hospital (the TIPS-1 project 1992-1996) show that the average duration of untreated psychosis (DUP) was 2 years from onset of psychosis to when adequate treatment was given.

There were many reasons why the patients were given treatment so late. Among others, they were often not considered severely mentally ill when they had first contact with the primary health services. It also seems that the specialised health services outpatient units often did not diagnose as soon as possible, and thereby offer adequate treatment early enough.

Another aspect that has influenced treatment outcomes for this client group is the process of Deinstitutionalisation that occurred around 1960, when the psychiatric

institutions were gradually emptied of patients. Many patients moved to their own housing or home to their families after hospitalisation. This caused the patients families to play an important role in taking care of family members with chronic mental illnesses. Despite this, the resources have not been moved out of the hospital to assist the families and the community in taking care of the new responsibilities. This situation has led to heavier burdens on the families, and often as a consequence of this, to the dissolution of the families' social networks.

This implies that the early intervention and treatment model developed by the TIPS program is an appropriate strategy to offer this client group and their families, to help improve prognosis and future prospects.

**History of TIPS evolution**
TIPS is in many ways a pioneering work, yet it builds on earlier experiences from England, Australia and also Norway.

Initially 3 pilot groups were run 1996 based on the application of William McPharlane's model of early intervention and treatment for first episode psychosis and multi family psycho-education groups. The result was excellent, and the T.I.P.S program model was developed from that point. The program commenced in 1997.

There have been strong links with EPPIC Australia for some time, with an exchange of staff visits, training and information that have contributed to both programs development. TIPS have been informed by the EPPIC Case Management and Out Reach approach.

**TIPS is a collaborative initiative between:**

- Rogaland psychiatric hospital
- The county hospital in Haugesund
- Ullevål hospital in Oslo, psychiatric clinic
- The county hospital Fjorden, Roskilde, Denmark
- Yale Psychiatric Institute, New Haven, Connecticut, USA

Rogaland County, Oslo commune, Roskilde County and the Norwegian Department of Health and social affairs have also contributed to the project.

**Funding**
In total the funding is approx. 50 million NOK ($A10 million), for a period of five years, targeted to the work with early detection and treatment of psychoses in young people, plus $A9 Million over 5 years for a massive universal education component to the project.

Funding comes from a range of sources including; The Norwegian research council, The Governmental Health Authorities, Rogaland County, Oslo Commune, Rogaland Psychiatric Hospital, The County Hospital in Haugesund Helsefonden (Denmark), Lægevidenskabelig Forskning ved Sygehusene i Region 3 (Denmark), and Janssen Cilag og Lundbeck Pharma (Denmark)

**Project co-ordinators**
Dr Ingrid Melle (Oslo); Dr Ulrik Haahr (Denmark); Dr Tor K. Larsen (Rogaland)

**Philosophy**
The philosophy underpinning the program was a non-judgemental one where "human factors " were thought about which has led to an acknowledgment of the feelings experienced by the client and their families and the need to work with the issues of grief, loss, guilt, blame, fear etc as important factors to the clients and families recovery. The client is not viewed in isolation, and relationships (therapeutic and others), are seen as an important part of the treatment. There is also emphasis on a comprehensive approach to thinking about and treating the illness and support for continuity and long term interventions (ie: treatment may go on for years – on and off).

**Philosophy informing treatment**
This work with relationships is informed by a combination of psychodynamic thinking, but with a more pragmatic here and now focus, and systemic thinking. This leads to a holistic approach to treatment and the rich mix models of practice utelised that are client driven, family focused, long term, and use the therapeutic relationship as a major therapeutic tool. The acknowledgment of feelings and the range of factors that are associated with and impacted by first episode psychosis also assist in taking the judgement off parents, and leads to a major component of the model of the family work done within the TIPS program. The Multi-family group work establishes a vehicle where group leaders and clients/families feel good and make positive connections, and which looks at how to work with and advocate for families/parents within the system.

**Models of Intervention**
The blend of philosophy and models directly inform practice. The TIPS program utilises a refreshing combination of models including systemic, psychodynamic, crisis theory (locally derived), stress- vulnerability model, group dynamics, McPharlane (USA) model of Early intervention and treatment of first episode psychosis, EPPIC (Australia) model of case management and outreach, Jan Olav's (Norway / Rogaland) model of schizophrenia, milieu therapy, and finally the family work / therapy.

**THE RANGE OF TASKS UNDERTAKEN**

**1. Development of the health services**
The development of early and comprehensive treatment in first episode psychosis in young people. The aim is to prevent patients from becoming chronically ill and to improve the prognosis. TIPS prioritise treatment resources towards the acute phase of the illness.

**2. Information and education**
Marketing concerning treatment of serious psychiatric disorders is rare in Norway as well as in other countries. In connection with the TIPS project, Rogaland County received resources to carry out extensive marketing of the project. The aim is to analyse how this affects the population's help seeking behaviour compared to Oslo County (Ullevål Sector) and Roskilde County, which do not have any marketing activities.

The aim of the marketing is simple; get as many people as possible to make contact as early as possible when they suspect that a serious psychiatric disorder is developing. The target group can be divided into 3 main groups; health and social workers, schools and the public. Health professionals and schools have received material to facilitate lessons, diagnosis and treatment. The campaigns addressed to the public have been general information, with the emphasis on which symptoms to look for and that there is an offer of quick treatment. The effect of these efforts in attitude changes and level of knowledge is measured through opinion polls.

**a. Public**

Via information campaigns in the mass media; newspapers, radio, cinema and different information efforts, the aim is to improve the public's knowledge on early signs of serious mental illness, and to inform about how to get help for those experiencing problems or those who know someone in need of assessment or treatment; ie: A brochure was sent to every household in Rogaland on the introduction to program with early warning signs.

**b. Schools**

Teachers, particularly in high schools, are the first to notice signs of "something wrong". TIPS offer education for schoolteachers, counsellors, school nurses and others working in for instance the follow-up services in the high schools. Joint training is delivered with the counsellor services for the schools. All teachers in Rogaland's high schools receive education on early signs of serious psychiatric illness in young people, and where to enquire to get advise or guidance regarding individual students.

**c. The primary health services**

Through courses for all General Practitioners and other groups of health personnel in the primary health services, the aim is to improve the knowledge and level of awareness concerning signs of psychosis in young people (In particular the time factor in detecting and treating psychosis and its impact on prognosis, and the importance of not losing any time is emphasised). The education consists of seminars with lectures, videos and introduction of specially prepared TIPS manuals.

**3. Collaboration between schools and psychiatry**

In preventive health work the high schools have an important role (as mentioned above), therefore it is important that schools, school authorities, the health services and health authorities develop good working relations and a common knowledge base concerning psychiatric illnesses in young people. The county's office for education and health and social services collaborate with the TIPS-project to achieve this aim.

**4. Collaboration between primary health services and psychiatry**

An important reason that DUP (duration of untreated psychosis) is as long has been the lack of collaboration between the primary and the secondary health services. In addition to education of the primary health services, the project also involves regular meetings between professionals of the primary and secondary health services.

**Evaluation and research activities**

In co-operation with Ullevål sector in Oslo (the University of Oslo), Roskilde in Denmark and Yale Psychiatric Institute in USA, the TIPS-experiment also has a comprehensive research component. It is a comparative study of Rogaland County to Ullevål sector in Oslo and Roskilde in Denmark. Rogaland is an "experiment county", where great effort is put on reducing DUP (duration of untreated psychosis). In Ullevål and Roskilde nothing special is done to start treatment earlier. The treatment is the same in all sites. In this way the research aims to verify whether reduction of DUP has any significance or not. The research project will last until 2005.

**STANDARD TREATMENT**

**Introduction/background**

To ensure that patients receive optimal treatment and to ensure comparability between the different regions, the treatment must always contain at least three elements, which are carried out as similarly as possible in all treatment places. These three elements were chosen after extensive studies of the literature regarding schizophrenia. The research showed that the best-documented treatment forms include medication, family work and supportive psychotherapy with emphasis on continuity. The prerequisites are that the treating clinician is stable and actively working to reach patients who do not show up for appointments. The intervention is also directed towards the patient's concrete needs. In addition every patient may be in need of other types of help that will be initiated after individual assessment. Such needs may vary between patients and in the course of the treatment period for the individual patient.

**Detection team (DT)**

To start treatment earlier, a detection team (DT) was established consisting of 5 full time staff, whose main task is to assess patients who have either developed a psychosis or who appear to have signs or symptoms that may indicate they are about to develop one. The DT is on call five days a week between 0800 and 1530 hrs. The team is divided in two; in the north part of the county (the Haugesund region) the team is led by chief psychologist Sigurd Mardal, and in the south part of the county (the Stavanger and Sandnes region) by psychiatrist Marthe Horneland.

**Referrals**

Patients, relatives, general practitioners, teachers, friends etc. can in principle contact the DT. The DT will in some cases give advice over the phone, in other cases set up an appointment for assessment in the hospital, make home visits or arrange to see relatives in the GP's office or at the school.

**Assessment team (AT)**

Patients, who are included in the TIPS-experiment after being evaluated by the detection team, are offered an extensive assessment and treatment program. Several professionals at Rogaland Psychiatric Hospital, Ullevål Hospital and in Roskilde have received special training in assessment that puts an emphasis on good diagnostics so that the patient can be offered the best possible treatment.

**Treatment Team (MTT)**
There is a guarantee of an assessment within 24 hours after first contact, and if the patient is suffering from a psychosis, treatment within a week.

## ELEMENTS IN THE PROJECT'S STANDARD TREATMENT

The project's standard treatment protocol contains three parts and includes guidelines for each aspect. These are Medication, Active Outreach Supportive Psychotherapy, and Family work.

**Medication**
In cases where the psychotherapist (or case manager) is not a doctor, the Treatment Team (MTT) leader is responsible for ensuring that a qualified doctor takes care of the medication according to the protocol, and monitors any side effects. This doctor has a joint responsibility with the MTT leader to make sure the guidelines in the protocol are followed, and that registration regarding dosage, side effects and compliance is carried out.

The protocol provides guidelines for the treatment of psychotic symptoms in all diagnostic categories covered by the inclusion criteria, and also includes recommended treatment for some common related problems or symptoms, ie: anxiety and uneasiness, affective symptoms, periodic aggression or extra pyramidal side effects.

The therapist is free to treat symptoms and problems that the protocol does not cover in the way he or she finds to be best, but it is important that all pharmacological treatment of psychiatric symptoms or treatment of possible side effects of the psychopharmacological treatment are registered.

**Supportive Psychotherapy**
The considerable individual variations in the patients' needs make it difficult to give exact and precise instructions for the form and content of the psychotherapy. The protocol provides a framework established for the psychotherapeutic work

**The contents of the Supportive Psychotherapy**
All patients included in the project are offered psychotherapy. As the patients' needs will show considerable variations, the frequency, duration and therapy technique of the consultations vary between patients, and also within the course of the treatment for each patient. Supportive psychodynamic oriented psychotherapy however, always constitutes an important part of the treatment. In some cases the therapist will, for long periods of time, have to work primarily on establishing contact or on getting the patient to show up for appointments. Other patients may be highly motivated for treatment and therefore enter a more insight-oriented process.

The therapist must be flexible and oriented towards the patient's needs, and this must include a willingness to offer practical help. A main focus is on helping the patient develop internal coping strategies and an enhanced awareness of their personal vulnerability, thus improve the understanding and acceptance of illness related experiences and the need for treatment. Focus is also put on handling loss, giving hope, family and personal development, avoiding demoralization and on encouraging reintegration into the society.

The psychotherapist has a main responsibility for other areas in the patient's treatment, including medication and psychosocial rehabilitation. Active outreach is also one of the psychotherapist's explicit responsibilities, and includes calling if the patient does not show up for an appointment and, if necessary, conducting home visits. The psychotherapist is free to have contact with the patient's family if necessary (general information, planning of visits or vacations, crisis intervention etc), provided that this contact does not counteract the organized family work.

The psychotherapist's require specific qualifications or training in psychotherapy or alternatively may be an experienced therapist under the supervision of a psychiatrist or clinical psychologist with such training.

**Duration and frequency/number of consultations**

The duration of the treatment is at least two years, with a minimum of one planned consultation a week. Total contact time is stipulated as at least 30 minutes a week. If the patient has more consultations or other consultations, this is registered as "other treatment".

**Family Work**

Studies have shown that treatment programs for psychotic patients that include family work as a part of the treatment, give good results regarding the prevention of relapse and re-hospitalization. This family work is called psycho-educational, which means procurement of knowledge and advice on how to deal with the illness. The goal is to assist families to cope with the illness and the strain that follows. The families are included as important resource persons in the treatment of the patient and as an important support for the patient in the further rehabilitation work.

In this project, family is defined as parents, stable and close stepparents, spouse, stable and close live in partner, children over 18 years and siblings over 18 years. Any of these under 18 years have to be considered individually, and may be invited to some meetings. It is not a prerequisite that they should live under the same roof. They receive help and education in applying the knowledge in dealing with daily life with the patient in a better way.

The psycho-educative multi-family model is the model TIPS applies. This combines an effective and very efficient method that families appreciate. This model contributes to families and patients making use of both the health services and each other to cope with problems in a better way. The model also contributes to reducing myths, enhancing the participants' social network and allowing families to benefit from each other's experiences. This leads to better coping for both the patient and family.

Elements in the family work:

**1.** Single-family groups (SFG)
**2.** Multi family group (MFG)
**3.** Workshop for the families

**Multi-Family Group Work in TIPS**

Five patients and their relatives are invited to take part in a group lead by two group leaders. Relatives are given education on psychoses and are afterwards helped to implement this understanding in their daily meetings with the patient. The education

consists of themes such as crisis theory, understanding of psychosis, stress/vulnerability model, early signs of illness, warning signs, treatment, the patient's needs, the family's situation and what the family can do to be of help and support. Legal (ie: The Mental Health Act) and confidentiality issues are also covered. After the groups have run for one year the education is repeated for the entire group.

The groups meet in the afternoons/evenings over a period of two years. Each session lasts for ninety minutes. The meetings concentrate on solving problems that arise in the daily lives of patient and relatives in relation to the illness.

The group offers a community through extending the network around each family, however a number of additional effects are obtained compared to offering families help individually. For example, being able to share such feelings with others who have had similar experiences reduces guilt and feelings of shame, loss and grief connected to the illness.

The group leaders have received special training and participate in regular supervisory groups. Training for psycho-educative group leaders is available in Oslo, Stavanger and Roskilde.

The treatment effect of the family education is estimated by measuring the expressed emotion at start and conclusion of the groups. After the first and second year, both patients and relatives are asked if they were satisfied with the arrangement.

**Rehabilitation**

Psychosocial rehabilitation is an important part of the treatment directed towards first episode psychotic patients. The patients' needs in this area show considerable variations, and local rehabilitation resources may vary. Because of this, the treatment protocol does not give specific instructions, recommendations or guidelines for psychosocial rehabilitation. It is still an integrated part of the individual treatment, but the explicit responsibility lies with the person who is responsible for the treatment.

**Treatment Outline in Case Of Relapse**

Patients that relapse after discontinuation of maintenance treatment are started with the same drug that they responded favourably to during their first psychotic episode. Patients that relapse after reductions in maintenance dosages continue with the same drug in higher dosages. Patients that relapse on a stable dosage are treated individually. Repeatedly noncompliant patients are treated individually

## RESEARCH

TIPS' goal is to reduce the duration of untreated psychosis in Rogaland County. The research aims at showing proof that the treatment program actually works as intended.

**Purpose**

The study has the following main goals:

1. To examine whether a program designed to reduce duration of untreated psychosis (DUP) in Rogaland county actually does reduce DUP.
2. To investigate if the public's knowledge about psychosis was changed by information campaigns and describe which clinical problems the patients referred to the Detection Team, to form the basis for the further development of the early

detection work and continuous development of the program in the necessary direction.

**3.** To examine whether reduction of DUP in Rogaland will improve the long-term prognosis or outcome for patients with a first episode non-affective functional psychosis.

**4.** To examine how the course is for such patients in short and long terms (5 years), when they are offered an optimal treatment program (2 years duration), which among other things consists of psychotherapy, medication, and a family program.

**5.** To examine which problems the health services meet when trying to establish an optimal treatment program for patients with a first episode psychosis and to determine what modifications (if any) must be done to offer the optimal treatment to patients with very short DUP?

Some evaluation measures include Qualitative measure of how the client and their families feel about the program post 1year, and quantitative measures such as a pre and postvention study, and an expressed emotion measure.

**Follow-Up**

All patients in the project are routinely followed up after three months, after two years and after five years after having been included in the project. Patients who have moved away from Rogaland or Oslo are also followed up, independent of where they live. After three months all patients are assessed by use of the following instruments: PANSS, GAF, St. Hans scale for side effects and Neuropsychological tests.

**Research results**

There have been convincing results when it comes to preventing patients from relapse. The relapse rates after one year have been reduced to a third compared to outpatient medical treatment. Relatives who have participated in these groups report experiencing being included in the treatment in a way that they appreciated.

**Other outcomes**

**1.** Education, training and health promotion

The extensive marketing and health promotion / education campaign has successfully targeted a range of services and the community more broadly. General Practitioners, Schools, Primary Health and Psychiatric Services have been accessed by Training and education Videos, Early course Lectures, and a specific T.I.P.S. Manual, and an extensive marketing strategy via adds in Local Newspapers, Radio, TV, Brochures, has been directed to the Public.

Media exposure about mental health generally has increased over last 2 years especially since Prime Ministers declaration of a national Schizophrenia Day and as a result of the Public Awareness Campaign over last 10 years.

There are 1-2 Education Programs per year for professionals /community that have 20 places, as well as one that targets the whole county, and specific programs for Hospital Education as well.

**2.** Family Multi Group Program

At the time of the scholarship, there had been 16 groups run with 5 patients in each group, 32 group leaders had been trained, the training had been accredited within a

School for family group work as a Certificate course, there was a strong peer supervision team, and specific training for supervisors to supervise other groups.

**3.** Overall Outcomes
Statistics have shown that people who normally don't get access to services now do, that first episode psychosis in the male population is now detected a lot sooner, and that the stigma and negative attitude to psychiatric hospitals and treatment was now changing.

**Most Important Things Learned**
How to work with and advocate for families/parents within the system and the right model that takes the blame off parents.

**Challenges**
- System issues shown up – especially the lack of rehabilitation services.
- To maintain the integrity of the program and ensure all the components are covered.
- Culture of hospital – people were initially afraid of the model.
- Practicalities – time and money involved
- Developing the model – took time and energy to get people to refer initially.
- Integration to the rest of the hospital

## 2a). YOUTH DUAL DIAGNOSIS TEAM

In Rogaland there are 3 public Psychiatric Youth Teams, (PUT's), located in Haugesund, Stavanger and Sandes, that work with 15-30year olds, and serve the different regions of the county. Sandes and Stavanger are linked with Eikely, a dual diagnosis in-patient treatment facility that treats young adults 18 – 30 years old, under the division for Drug Related Psychiatry (ARP).

**Target Population**
The target population are youth and young adults with a combination of complicated psychosocial difficulties, drug related problems and mental disorders – personality disorders, depression and anxiety.

**Referrals**
The service is free and referrals are mostly from general practitioners, social workers and families, or self-referrals, as the teams are well known amongst substance abusers. During a year the team will have contact with some 210 clients and a number of parents and spouses.

**Intake**
There is an intake meeting once a week, which prioritises urgent and under 18 year old referrals. There is generally a waiting list; the worst was many months, now it is a few weeks. A screening assessment is utilized promptly for "at risk" young people.

**Case Loads**
Caseloads are 15-20 clients per clinician, with a range of difficulties. Many are seen for a very long time.

**Statistics**
The program sees 200-220 clients per year, with 76 new referrals, 47 re-referrals and others ongoing.

**Location and Staffing**
The youth team in Stavanger is located by the hospital. The staff consists of one secretary and seven therapists; 4 social workers and 3 psychologists. There are no doctors employed in the program, as the link is made with primary health for medical interventions required. The staffing group have been very stable and are very experienced. All take part in a national training program for postgraduate training.

**Treatment Philosophy**
The treatment philosophy supports a restrictive drug policy, does not supply clients with medication that can replace the addictive substances, and to some degree focuses on the individuals' own responsibility and choice. This is balanced by the client experiencing a sense of being cared for with a lot of patience by stable and reliable therapists.

The team uses eclectic methods and believes in the effect of a young person establishing a relationship with people who are clearly against substance use, but very interested in the young person. In addition the treatment is system and relationship focussed, is informed by psychodynamic thinking as a basis but with more active here and now pragmatism that includes crisis response when needed. The program doesn't use motivational interviewing, though some of the principles are used.

**Treatment**
The range of treatment offered includes outpatient psychotherapy, supportive therapy, counselling and case management. It is usually individual treatment with some degree of couple or family and network orientation. The idea is to be flexible as when an alliance is established, the client will often be in contact with the team over a time span of some years if that seems needed and fruitful. It is the long-term work that gives the opportunity to see that over time the condition is relatively improved for many clients.

Inpatient In addition to the team's direct outpatient treatment, some 20% of the clients receive inpatient treatment, often in therapeutic communities. There is a pro-active use of frequent short-term admissions, as financial problems make it difficult to cover the need for long-term inpatient treatment.

Out Reach There is an intensive use of outreach where required to begin to engage with clients and to catch dropouts.

Detoxification Detoxification is offered via a drug treatment centre/detoxification unit for adults. There is no detoxification treatment for 13-16 year olds, who have to be admitted to youth psychiatric unit.

**Collaboration**
The team collaborates with other agencies, services and institutions concerning a majority of the clients. There is a significant amount of work with other services that may involve joint clinical work, secondary consultation, or referral and transition

support. Treatment that involves different agencies is often co-ordinated by the youth team, as the therapist of the Youth Team represents continuity and a stable relationship for the client.

**Rehabilitation**
The social security system of Norway makes it possible for a recovering addict to receive financial support for educational or vocational training. A large number of clients of the youth team take up education as part of their rehabilitation plan.

**Other Services Offered**
PUT is seen as a specialist service, and the staff are available for a range of services (such as social, medical, education vocational and legal / police) as consultants, supervisors and for education and information. Thus the team is also engaged in prevention. The team takes part in planning processes in the community and is involved in the development of other services.

**Outcomes and Evaluation**
The outpatient aspect of the Youth team at this stage has not undergone formal evaluation, however this is seen as a priority for the next year to bring the program in line with the other components of the service that have.

**Reported outcomes**
It is the long-term work that gives the opportunity to see that over time the condition is relatively improved for many clients. Though the target group as a whole has a relatively high mortality rate, very few clients die while in treatment. Substance abuse is also often rapidly reduced. What takes a longer time is the complicated psychosocial problems of many clients.

## 2b). EIKERLY IP TREATMENT

Eikerly is a dual diagnosis residential rehabilitation facility that treats young adults 18 – 30 years old, under the division for Drug Related Psychiatry (ARP). The program was commenced in 1990 and is located at Dale, the old asylum 21 kms outside of Stavanger. It is a long-term program of 1 – 2 years and has a bed capacity of 20 spread over 3 Houses and 4 Apartments.

**Referrals**
Clients are referred by the Youth Dual Diagnosis Team or by other professionals.

**The Program**
The Program has 2 Phases
**1st phase**
The initial phase includes an assessment of problems and specifics of abuse, setting realistic goals and making a plan for post discharge.

For the first 3 Months the clients are not allowed outside the area except with a staff member (especially the 1st month). They must apply to a committee of staff for leave with a detailed explanation of what they are going to do. After this initial period they can apply to the committee for regular leave out, but they must let the committee know where they are going and then report in on return. Weekend leave requires an application.

**Treatment**
The program itself is comprised of milieu, group and individual therapy and the houses are run on the principles of therapeutic communities. For example, the residents run the house themselves, are responsible for cleaning and maintenance, and run a house meeting every morning. The residents work during the day, cleaning, gardening, making food, or in the wood project, which involves cutting trees to sell as firewood in co-operation with the company that manages the whole area. There is also a strong recreation focus using the gym, pool and the boat (also used for fishing).

**2nd Phase**
The second phase has more of a vocational rehabilitation and reintegration focus.
Residents can apply to the State office for financial support. If goals of retraining have been identified, they can get 3-4 years of funding while retraining. Preparation for discharge involves reintegration to local community under a Local Community Treaty, where Eikley continues to retain treatment and follow up responsibility post discharge until the client is well linked within the community supports.

**Staffing**
There are 24 Staff (8 Therapists and16 Milieu Social Workers). Shifts are from 5.00 am to 3.00 pm, with 2 evening shift staff, 1 over night and 2 on weekends.

**Philosophy**
The program is based on the principles of a therapeutic community that in practice involves lots of meetings to have the residents deal with the issues that arise themselves.

**Evaluation**
Clients complete a package of questionnaires at the beginning, mid way in their treatment, at discharge and 3, 6 and 12 months post discharge. There are plans to add an additional 5-year follow up to this regime. (The tools include MMPI, Skid, and Life Skills).

**Problems**
The main problems involve long waiting lists of people, usually of about 25 or more who can wait for between 6 months to 1 year for admission. Other problems include the fact that clients need to be detoxified first, and there are long waiting lists for limited detoxification facilities, and finding appropriate housing post discharge

**Future**
There are a range of ambitious and exciting plans for the future that include a new purpose built setting, plans for building units for 13-18 year olds and 18-23 year olds, and an application to establish a Centre of Excellence, that will create a strong link with research and evaluation.

## 3. LINDOY ISLAND

Lindoy Island is a joint initiative between Psychiatric and Social Security, and in many ways is the adolescent equivalent of Eikely, however with the focus on dealing with young people who have a Conduct Disorder diagnosis. It provides long-term treatment for youth aged 11-16 yo with a capacity for a maximum of 8 young people.

**Referrals**

Referrals are made by an order from the Courts or from parents and the average length of stay is 2-3 years. There have been 20 young people who have received treatment in the program since 1995.

**History**

1992 Lindoy closed as a special school for boys
1994 Working parties formed between Social Security and Rogaland
1995 Group developed model – first client Dec 1995, Model evolved as it went
1996 All staffing positions filled.

**Staffing**

There are 23 staff comprised of social work, psychology, youth work and nursing that cover morning, afternoon, evening, over night and weekends shifts. Each young person has 2 main staff allocated who support the young person to work on their goals.

**Program**

The program is also run along the lines of a therapeutic community and involves school to 2.00 pm, a post school community meeting and evening activities. Evenings are seen as a critical point for intervention using milieu therapy.

**Staff Support**

To be able to deal with the challenges of working intensively with young people with conduct disorders, there is a strong focus on staff support and team building. To achieve this there is a culture of openness, reflection and learning from mistakes. Each morning at 9.00am staff talk things through, and staff meetings are held weekly to reflect on the young people, the work and what support is needed for both the young people and the staff. There are 2 social events per year, but above and beyond this the team leader makes it a point to be very accessible

**Challenges**

There is a general frustration that the program is continually fighting for resources, especially when seen that the State is rich. This raises many questions about how these young people are viewed on the broader social and political level (Refer discussion below).

# DISCUSSION

## Overall: ROGALAND

Rogaland Psychiatric as a service stood out for a number of reasons. Firstly the physical setting was quite special in its freshness and diversity, where different components of the service were housed in buildings that appeared to really compliment the nature of the work being done (For example certain programs being located out of the main building or off site, such as the youth service, Eikley and Lindoy). What also stood out about this was the fact that as a large psychiatric service that covered the range of services from child, adolescent, adult and geriatric, there appeared to be a balance of attention to most aspects of the service. This is often not the case in Victoria if Child and Adolescent are collocated with adult services.

The external order and clarity was reflected in the internal organisational order and clarity. This promoted professionalism and a commitment to high standards and was reflected in aspects such as the broad range of services offered and the strong research and academic emphasis.

## TIPS

The TIPS program stood out as an exceptional service on many domains, and demonstrated a wonderful mix of sophisticated program development, innovative and comprehensive clinical work, and reflective practice based research within the context of a very grounded and pragmatic approach to the client and their needs.

The integration of a range of theories and models into practice provided a strong and cohesive framework for the program to develop within. Having such philosophies as the relationship being an important therapeutic tool and fundamental to treatment, that families are an important part of the work and support for them is also integral to improved outcomes for the client, and that it is important to acknowledge and work with the pain and suffering, and the feelings of grief, loss, guilt and shame that are experienced by clients and families, creates a very human and humane context for the therapeutic work / treatment. Also the recognition and support that such work needs to be intensive and long term to provide the basis for such in depth work to occur is a combination that is often missing in more clinical, purely medical model approaches.

How this translates into practice is reflected in the use of multi-modal interventions and a comprehensive range of therapeutic approaches (for example, psychodynamic, systemic, psycho-educative multi-family group work model, mixed with pragmatic approaches such as social coping, and building networks of supports for the client and their family).

The other important components are the many levels of marketing and education and the research and evaluation that has been built in as central to the overall model of the program. Finally the fact that this is all backed with a range of documentation such as protocols, published articles, books, Webb sites, educational pamphlets and training manuals and materials reinforces the sophistication and professionalism of the program and the comprehensiveness of the program model.

Whilst both EPPIC and The Compass Project in Australia have adopted some aspects of the TIPS program, it is in fact the richness of the TIPS program in its entirety and how the various aspects are integrated, that makes it such an exemplary service.

**YOUTH PROGRAM, EIKELY, LINDOY ISLAND**

Due to less time being spent with the Youth Program, only an overview of the services involved was obtained, however within that there was still evidence of good practices occurring that were worthy of comment, particularly because of the work done with the more challenging, high risk young people.

The youth team had a lesser profile than the TIPS program, however the staff met were equally as proud of their programs and the work being done, and appeared equally as committed to delivering a high standard of practice.

The youth outpatient team was said to be popular within the service as it took the hardest end of clients and worked well with them (dual diagnosis clients with complex presentations and with significant co-morbidity). The commitment to flexible, long term treatment and active follow up and outreach was seen to be a combination of elements that assisted clients to utelise the service, and the clarity of the philosophy of supporting the client but not the drug abuse also made this service accessible and acceptable to the client group.

The intensive and long term work being done at both Eikley and Lindoy Island using the therapeutic community model provided a program model that was popular in Australia many years ago, but is not often seen in Australia any more. There is a mixture of views about the efficacy of using the therapeutic community model, however more recently there have been moves to create intensive therapeutic residential services again, which possibly reflects the gaps that both Deinstitutionalisation and the closure of therapeutic communities may have created.

In addition to this, it was refreshing to see the emphasis on Milieu Therapy as a specialist treatment and the valuing of Milieu Therapists, which has been lost in Victoria in some in-patient treatment settings.

**Summary:**

In summary on a clinical, organisational and program development level, Rogaland Psychiatric Service had many strong features and demonstrated a sophisticated, comprehensive and integrated level of service delivery. The TIPS program package exemplified this with its combination of clinical richness, the education, training and marketing components, and a strong research framework. The support for developmentally sensitive work with more complex and at risk young people was also demonstrated by the specialist service for young people and those with a dual diagnosis and complex presentations. Overall, the programs seen and the people met were impressive in the level of professionalism that was demonstrated, and the enthusiastic pride the staff had in the service reflected the fact that they were well supported and encouraged.

## 8c). THE MAPLES CENTRE

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**CONTACT** Mr Jim Brown – Co-ordinator Community Services

**PROGRAMS VISITED / INTERVIEWS WITH**
Dr Roy Holland – Clinical Director
Jim Brown – Coordinator Community Services
Ryan O'Connor – A/Coordinator Community Services
Ms Lindsay Setzer- Director
Dr Marlene Morretti – Professor Dept Psychology, Simon Fraser University
Consulting Psychologist to The Maples
Mr Ken Moore – Manager Secure Care Implementation
Jody Al-Molky - Co-ordinator Orinoco
Lesley Derksen: Social Work Department Manager/ head of Response Program
Dr Balwant Sanghera – Educational Psychologist
Dr Susan Cross - Psychologist
Ms Charlene Harvey- Care Plan Integration Team
Ms Tanis Evans - Coordinator Sth Fraser Adolescent Crisis Response Program
Ms Sonja Macgregor- Unit Manager Crossroads Program

**Conferences and seminars attended**
Family Therapy & Attachment, Niagra-on-the-Lake
Gordon Neufield, The Defended Learner

**Presentations**
Ministry of British Columbia Secure Containment Reference Group

**HIGHLIGHTS**
One of the main highlights was the level of involvement I was invited to have in a range of programs and activities within the Maples, that included both attending and presenting at conferences, training seminars and advisory panels. Closely related to this were the many discussions with like-minded colleagues that I found exciting, challenging and stimulating, which also crystallised a lot of my own thinking and validated a lot of my own beliefs and models of practice that I have developed.

Closely linked to this was the degree of honesty with which people from all levels shared their expertise and experiences, particularly Prof Roy Holland, who outlined their history as a service, the mistakes made and the search for a paradigm that would help understand the meaning of the difficulties that the young people presented.

## KEY FEATURES/ KEY STRENGTHS OF SERVICE

**Attachment Theory**
The Maples receives visits from mental health professionals who see it as a model for the attachment theory underlying its programs. Also, Maples' Clinical Director Dr. Roy Holland is widely considered to be the foremost adolescent psychiatrist working with conduct-disordered youth in Canada and the United States. Dr Holland has drawn heavily on attachment theory to restructure the Maples programs and utelised it to integrate multi systemic interventions and to support communities in the care of youth with conduct disorder.

The attachment model looks at each child's unique experiences and expectations for relationships with caregivers. They call this 'attachment style' and use it to determine the most effective services to deliver.

They have been able to look at Conduct disorder Diagnostic Criteria DSMIV and in conjunction with diagnostic overlap have been able to develop new insight into otherwise confounding behaviours. This serves the purpose of an attempt to gain a common understanding of what is going on for the young person in their world and demonstrates how their behaviour ends up making sense as a rational response to a difficult circumstance.

This perspective provides a conceptual framework for working with youth and parents and is supportive of the premise that mental health care for children and families is provided in several childcare systems (including mental health, social welfare, juvenile justice, education, primary health care).

In summary, the model gives a framework for understanding behaviour, is predictive, yields pragmatic strategies, and is measurable.

**Community Oriented**
Maples' goal is for young people to return to their home community. To achieve this end it supports communities in developing the capacity to plan and care for their youth through outreach, respite care and educational events and more specifically through Community Care Plans. Finally, offering mentoring relationships with communities where Maples professionals can assist the community professionals in developing expertise and competence is invaluable.

**Community Care Plans**
Community Care Plans are a partnership process with the client, family, and the community, which leaves the responsibility for the young person in their community.

**Supportive of Families**
Families generally feel listened to without judgement in a way not listened to before and feel that genuine time has been given to them. Professionals found it hard initially to be as frank with the family, but now accept it. As a result it has changed the model of the way professionals work with the family by including them as part of the team.

**Community Ownership**
All of the above has increased each participant's level of commitment to the outcome. The community has finally begun to accept the Maples view that it is the Community that needs to manage the young person, versus putting them away.

**Organisational Model**
The Maples has a clear organisational model that incorporates and supports the theories it promotes and adheres to on a practice level. This includes utilising Attachment Theory and Learning Organisation Principles to inform what is viewed as essential components of a service and service development / change management.

## EXAMPLES OF PROMISING PRACTICE

**1. Response Program**
This is a 24-bed co-educational residential mental health program that provides assessment, care planning and ongoing follow-up of clients aged 11-17 years old. It is an excellent example of all of the key features outlined above, and in particular of Community Care Plans, Collaboration and Community ownership.

**2. Orinoco C.A.R.E Program**
This is a program designed to provide adolescents and their families with an intensive, short-term intervention and follow up phase. The short term intervention consists of a three-month, Monday to Friday, residential component and two or three weeks of community based support. The follow up phase is tailored to the individual needs of the family and the young person. Whilst the program also exemplifies similar essential features of the Response Program, it has a particular focus on direct application of attachment theory based interventions and measures, matched with a strong attachment based research project.

## PROGRAM LIMITATIONS /CHALLENGES

1. Services development has been driven by Political pressures therefor have grown as a "hot potch". This has led to the provision of services for youth and families being fragmented so that co-ordination of services is extremely difficult. This has often resulted in a situation where providers have attempted to define service requests as outside their mandate in order to preserve limited resources.

2. The intrusion of outside "experts" from the program can be resisted.

3. Competing against the "street" in relation to the young person, with often the question of what is being offered instead that may have a young person want to leave the street life, where they at least have a sense of belonging?

4. Some families associate Maples with Protective Services and hence can be anxious / reluctant to engage initially.

## CONCLUSIONS / RECOMMENDATIONS

**1a). Support the application of the Attachment Theory conceptual framework being disseminated across the spectrum of service providers in Victoria.**
This would provide a common perspective from which to work with young people that would enable and empower staff to respond creatively to their individual needs and capabilities.

**b). Use of the Attachment Model** for interpreting and responding to what is being communicated and use of the attachment profiles as tools to monitor interventions.

**c). Educational component.** Discussion and / or direct training with staff from the Maples Treatment Centre.

**d). Implement a principle based model of practice** (Refer 7 attachment principles).

**2. Specific Youth Services.** In keeping with the services from the previous countries presented, the development of developmentally appropriate youth specific services is strongly advocated.

**3. The use of Community Care Plans**. These are care plans that consider all aspects of young person and family need, are based on an extremely comprehensive assessment, are owned by the young person, their parents and the community, and are transparent and accessible.

**4. Application of the organizational model and some of the essential components within that for service delivery to young people with conduct disorder (As outlined by C Baxter, 1999).** These include:
Interventions: **a).** Conduct disorder is a multi-factored, multi-determined condition that requires long-term intervention **b).** Interventions must address the bio-psychosocial domains of the youth **c).** Community based interventions are optimal.
**d).** Interventions should be guided by a single over-arching philosophy of care for optimal impact and sustainability **e).** Interventions require a program of support and clinical consultation for optimal impact and sustainability

Organisational level: Requires **a).** A Common Vision **b).** A Common Paradigm **c).** A Common Language and **d).** A Common Working Agreement

**5. Use of similar strategies as outlined by the Maples in moving the Response Program out into the community.**

**a).** To enlist support at a political, organisational and community level, provide research documenting the impact of this program and expert presentations that highlight the compatibility of the program with the changes in legislation for the delivery of services to children.

**b).** Offer mentoring relationships with the staff at the Maples to assist Australian professionals in developing expertise and competence in working within the Attachment Paradigm. This has been discussed with and approved by the Maples senior staff

**c).** Offer a mentor relationship myself, in addition to The Maples staff, as a point of local access to a specialist in Attachment Theory and it's application, as well as advice and or liaison about the Maples model.

# THE MAPLES ADOLESCENT CENTRE

The Maples is a specialised Tertiary Provincial resource for Young People with Conduct and Mental Disorders. It is located on two sites in Burnaby, BC and is a 46 bed and outpatient facility, which serves young people between the ages of 12 – 17 years. It is a service of the Ministry for Children and Families, operating within the context on the Mental Health Act. The Maples is also a designated facility for young people who are found unfit to Stand Trial or Not Criminally Responsible due to a mental disorder as a disposition of a Youth Court.

Services are designed to maintain youth in their communities and to provide short-term care when required.

**Summary History**

The care of Conduct Disordered Young people in British Columbia has undergone radical changes during the last 10-15yrs. In the mid to late 1980s young people with conduct disorder were contained within a secure facility (Maples Contained Adolescent Treatment Centre) for long-term residential treatment, which primarily consisted of behavioural and pharmacological interventions. Several factors prompted re-examination and re-organization of care.

Firstly, it became increasingly clear that the use of behavioural strategies that emphasised control and coercion was clinically ineffective in producing desired outcomes. Secondly, the resources required for long-term treatment were simply too expensive to maintain and defend in the context of fiscal restraint. Thirdly this secure residential system tended to disaffiliate youths from communities and created a stuck system where the young people remained dependent on the facility to be contained; this disabled community resources and transferred responsibility to the Maples for the young persons long term care rather than empowering those within the young persons system to gain the skills to care for them in their own community. It also showed that "Geognatherapy" did not work, as it did not deal with the root cause within the young person's network, and the problem re-emerged on re-entering his or her own environment. Finally, a review of the Mental Health Act in 1989 provided adolescents with a review of their rights so that it was no longer possible to detain them in secure units simply on the basis of guardian consent. These factors combined to produce a unique opportunity for change in the delivery of service to conduct disordered youth.

Concerns raised in Ontario Child Health Studies showed there was a 5 – 15% incidence of Conduct Disorder within the population, however systems often excluded the 15% they were set up to treat, the ones that needed it most.

Transforming the clinical direction and model of practice with the Maples from 1988 to the present has been a gradual process guided by research on the factors that contribute to conduct disorder and promising treatment strategies. However the work of Maples Adolescent Centre now attracts national and international interest.

**Demographics**

Responsible for program operations in Lower Mainland

**Referral Source**
There are no acute admissions to the Maple Centre. Access to most programs is through the Child and Youth Mental Health delivery system of the Ministry for Children & Families (MCF). Community based services are the first point of contact prior to referral to the Maples.

**Mechanisms**
Every referral must have a designated case manager in the community. That individual remains the case manager throughout the Youth's time with The Maples.

**Age range**
12 – 17 years old (mostly 14- 15yo)

**Diagnostic types**
The primary diagnostic category young people are referred with is Conduct disorder, however they also have major co- morbidity issues such as depression, post traumatic stress disorder, attention deficit hyperactivity disorder, anxiety, learning difficulties, and substance and other abuse issues (only 10% have a single diagnosis of conduct disorder). Co-morbidity in young women exceeds young men (4-5 diagnosis, especially in substance use and Post Traumatic Stress Disorder). Violence is also becoming more of an accepted norm in the young women referred. Overlapping risk factors include poor economic circumstances, poor individual functioning, and poor family functioning.

**Staffing**

Maples' staff includes childcare counselors, nurses, social workers, psychologists, and psychiatrists. A team of teachers from the Burnaby School Board also works closely with the Maples staff.

## PHILOSOPHY: ATTACHMENT THEORY

A new paradigm has evolved that emphasises Attachment Theory as an integrative model for understanding the problems of conduct disorder and for giving a direction and cohesion to intervention strategies. Attachment Theory proposes that experiences within the child – caregiver relationship are reflected in the development of "internal working models" or belief systems. These models have important survival value.

When children experience aversive parenting they are likely to develop a view of adults as unwilling or unable to provide care, support and direction for them. The children are also likely to develop a sense of themselves as unworthy of care of others, or as possessing negative qualities that lead others to reject them. Once established, internal working models of self and others guide interpersonal expectations, interpretations and responses to social situations. These expectations and interpretations tend to elicit responses from others that confirm the underlying beliefs. Consequently these belief systems have a self-perpetuating quality. Although Attachment Representations may change, changes are unlikely to occur quickly or easily.

**Using Attachment Theory to integrate care**
The above theory gives a framework to operate in that doesn't preclude a range of interventions, seen as a developmental issue over the life span. Attachment theory

does not specify that one type of intervention is critical in meeting the needs of conduct-disordered youth. Rather, this theory offers a developmentally sensitive structure for organising multiple therapeutic strategies (eg: family therapy, therapeutic foster care, parent management training, social cognitive and school interventions, and vocational training) that are most relevant depending on a youth's predominant interpersonal orientation (ie: attachment style) and their social context. This model is used at the Maples Adolescent Centre to integrate various interventions and support communities in the care of youth with Conduct disorder. In this sense attachment theory provides a developmentally and individually sensitive integrative framework for the program analogous to the social ecological model that underlies multi systemic therapy.

**Attachment Based Interventions**

There are however, a number of specific interventions utelised to address attachment issues as listed below.

**Systemic**

This involves looking at the "system" (of people / organisations) that surround and influence the young person, especially the family and their patterns of attachment. It gets parents and significant others involved and helps them to understand the young person. In that it is designed to capture the person who refers the young person as much as the young person.

**Attunement**

The principle tool of attachment theory is the engagement and the attunement.
Attunement is where the young persons behaviour is responded to by understanding their attachment style, so the negative attachment is not reinforced. It is referred to as a type of therapeutic "dance," where the young person has an experiential difference of attachment in situ whilst attending the Maples.

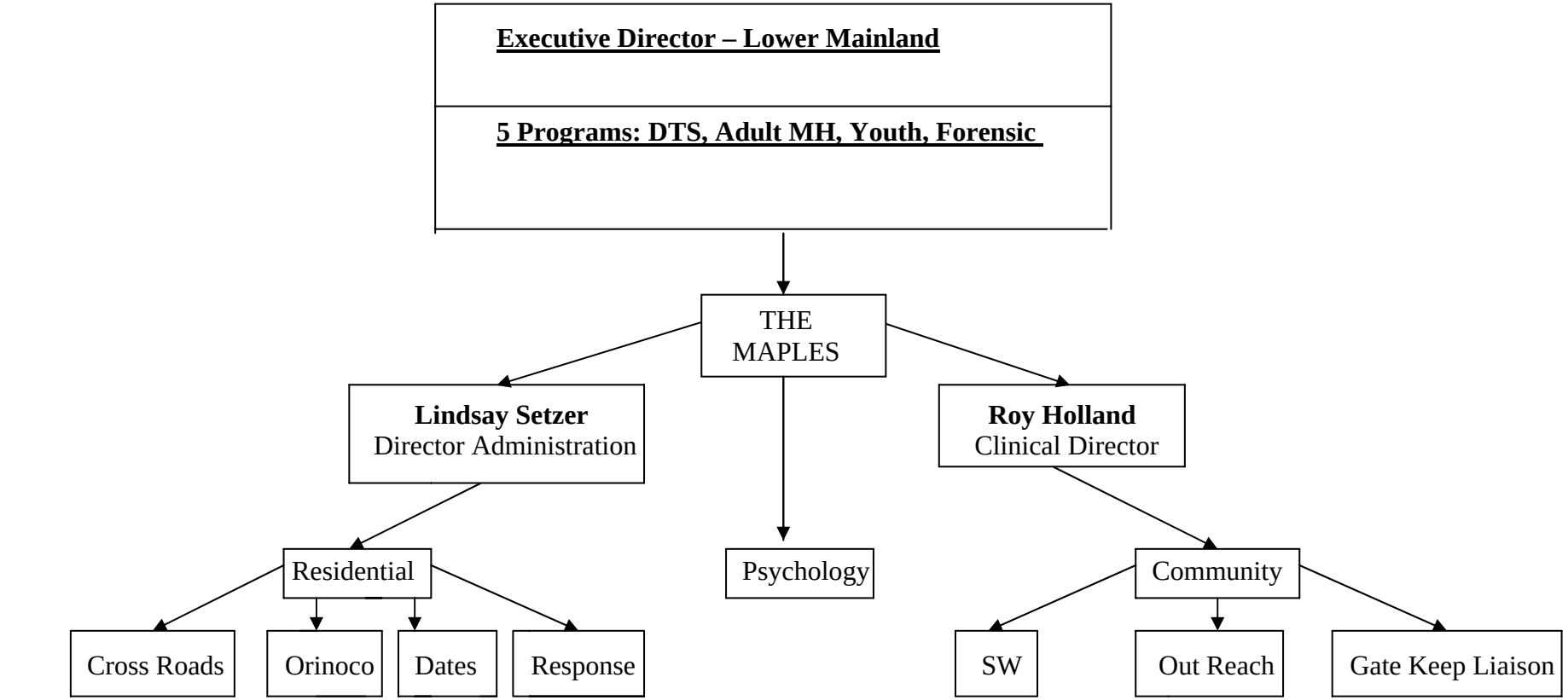
This involves a matching of the staff's "attachment style" to the young person. Closely linked to this is the requirement that the staff member also has to reflect on their own attachment style and the impact it has on the young person.

This dynamic is closely monitored (refer below), and the insights gained are used to inform the development of specific management strategies for the individual, that are then given as recommendations to assist others to better understand and work with the young person more effectively.

**Process**

Attachment profiles, using specific research tools to gather the information on a daily basis, are reviewed with staff weekly. This is to ascertain what is happening in their behaviour that is influenced by their attachment dynamics. This is subsequently translated into specific interventions, both on the practical and therapist / client relational level, that are documented within an individual service plan and reviewed daily (Refer to The Response and Orinoco program outlines below).

# THE MAPLES - ORGANISATIONAL CHART



## MANAGEMENT OPERATIONS

The management operations and the structures that support these are seen as an integral part of providing the holding and containment for the staff. This is an extension of attachment theory principles that closely considers the environment and how it impacts relationship formation.

There are a few essential meetings that provide an avenue for all levels of staff to have a space to reflect on and contribute ideas about organisational functioning and performance. These include the **Strategic Management Group,** involving Unit Supervisors and all levels of management and discipline heads that meets weekly, a **Unit Supervisors Meeting**, that meets fortnightly, where representatives from disciplines attend, and a **Management Meeting**, where the senior managers meet every Monday morning to discuss functional and process issues. The latter is something that emphasises the how and why things are happening, not just what is happening.
Finally a weekly **All Staff Meeting** provides the forum for all staff to reflect on, discuss and contribute to the running of the centre.

## PROGRAMS

**Overview of the respective components of the service that a young person receives:**

**1 a).**Short-term residential care and treatment programs for conduct-disordered and thought- disordered adolescents, utilising a treatment approach based on attachment theory

Or

**b).**Care and treatment for youth found unfit to stand trial or not criminally responsible because of a mental disorder

**2.** Community care plans developed through multidisciplinary assessments

**3.** Maples Secondary School, which provides instructional and assessment programs in a positive learning environment.

## SPECIFIC PROGRAMS

### 1. Response

Is a 24 bed residential assessment and care-planning unit. A Community Care Plan is developed over a four-week period and is supported on an outreach basis. (Refer below).

### 2. Orinoco

Is a short-term residential treatment unit that works intensively with young people and their parents for a 3-month period. Follow up and respite is also offered (Refer below).

### 3. Dala

Is a six bed residential program that provides therapeutic care for psychiatrically ill youth, either as a voluntary (informal) admission or due to special circumstances through committal under the Mental Health Act. Referrals to the Dala program usually require a complete psychiatric assessment with diagnosis, confirmation of the

refractory nature of the disorder, and recommendation of a residential treatment process.

Treatment includes further assessment, Individual Psychotherapy, Assistance for family members involved in the treatment and care giving process, Development of a Care Plan, and Case Management Services to assist the youth in the Dala program to reintegrate into their community. This is usually three months after admission, although some youth continue to receive benefit for an additional period of time based on their clinical needs. Discharge may take place on a gradual basis through involvement in the program on a non-residential basis if that appears advisable.

Members of the treatment team remain available on a consultative basis after the youth's discharge. This might include consultative services by the program staff or it might involve a brief continuation of family work by the Dala program social worker, or consultative services to support a community practitioner. A Care Plan consultant is available for outreach follow up.

The unit is staffed by a range of disciplines; social work, psychiatry, childcare and nursing. Educational services are provided either through the Maples Secondary School or through community schools.

**4. <u>Crossroads</u>**

The Crossroads Program is a "secure" facility available to families and communities throughout the province. It provides for youth requiring intensive supervision. Most youth are in the program by voluntary admission, however The Crossroads Program is also the designated facility for youth who have been found unfit to Stand Trial under the Young Offenders Act and youth who have been found Not Criminally Responsible because of a Mental Disorder

It is a further development of the principles of the Response Program of the Maples centre, however where the relationship is so disrupted that additional assistance seems advisable. For all residents the program is as open as possible within the constraints necessary for those residents who are in the program on an involuntary basis.

Referrals come from community-based services, and usually require a completed psychiatric assessment with diagnosis and recommendation of a residential treatment process, or a specific court order for treatment.

Treatment includes the development of Individualized treatment plans that emphasise age appropriate autonomy and competence on daily living skills and the use of positive attachment experiences. This is achieved by providing structure in the form of healthy routines, consistent values, a safe and predicable environment, and the modelling of co-operative and principled care giving. Positive social, educational, vocational, recreational and life skill experiences are also an important component of care; as are support and mediation of the youth caregiver relationship, work experience, and the development of a Community Care Plan.

Young people are discharged from the program when they are no longer receiving treatment benefit or when the treatment benefit could be provided in a less intrusive manner. This is usually 3 months after admission, although some youth continue to

receive benefit for an additional period based on their clinical needs. Length of stay for young people admitted under the designated criteria is determined in conjunction with the legal process.

**5. Outreach**
Care Plan Consultants support the operation of the Community Care Plan in the community and on a long-term basis if required.

**6. Respite**
Flexible and readily accessible short-term respite supports the youth and their caregivers, particularly post treatment within the Orinoco program, and is available until the young person's 19th birthday.

**7. School**
The maples secondary school is funded on a provincial level from the Burnaby Education Department. It has 3 components: **1. Classroom:** This has a staff of 3 Teachers and covers the specific subjects of Social Studies and English, Science and Maths, and Woodwork. **2. Educational Assessment:** This component has 4 teachers who do the educational assessment component of the Community Care Plans for the respective residential units. **3. Reintegration into mainstream:** There is a strong interface with mainstream schooling to support and advocate for the young person and to provide assistance and consultation to teachers to support management and understanding of the young person. The school is available for further consultation by phone to schools.

Referrals are only from within the Maples programs, and classrooms numbers limited to 6.

The Program also includes Recreation, Outings and Vocational assistance and training, and aims to create interest and a sense of success and positive learning as opposed to negative past experiences. The Philosophy is based on an Individual approach, on starting where the young person is, and on seeing the importance of and consciously using school as a social experience.

Challenges have included the fact that the young person may initially be extremely challenging, the mainstream schools attitudes to the young person, and the limited resourcing in mainstream regarding reintegration support. Achievements have been major shifts in mainstream school attitudes, and the fact that the young people generally settle once they see the difference to their past experiences.

**8. Psychology**
The role of the psychologists within the service is to provide Psychological assessment of young people as a component of the Care Plan Assessment, undertake Research Projects and Evaluation of programs, Presentations and conferences, Community projects (ie: Mentoring other projects), Policy development, and Psycho-education.

**9. Teleconferencing** Maples also hosts weekly Educational Teleconferences with topics chosen in advance by participating care providers. (For example, a series on addiction concurrent with mental illness).

## EXAMPLES OF GOOD PRACTICE

**1. THE RESPONSE PROGRAM.** The Response program was initiated in 1989 to assist communities to provide care for young people within their communities.

**Mandate**

The Response Program is a Provincial 24 bed co-educational residential mental health program (in 2 locations) established to provide 28 day assessment, care planning and on going follow up for clients aged 11-17 years old. Six of the beds form a respite care component allowing youth to return to the facility for short periods to help maintain community placements, and are available at short notice. This is provided for clients and caregivers who may not have an extended support network and where behavioural severity requires specific support or where quick response is indicated.

While most young people stay on a residential unit while the care plan is being prepared, the option also exists for a non-residential Care Plan in which the young people remain within their home or placement, only coming to the Maples to see the relevant professionals. The latter option is available to young people within commuting distance.

While at the Maples young people are provided with educational services through the Maples Secondary School. A variety of recreational opportunities are provided as well.

**Mission Statement**

In collaboration with the client, parents / legal guardian and relevant community supports, the intention is to collectively determine an understanding of behaviour (from an attachment / developmental perspective) as well as develop an optimum, realistic and concrete strategy for addressing the referral concerns. Strategies are within an empirically based attachment frame and issues of a "closer to home context" are emphasised.

**Response Program Values**

The Response Program ascribes to several well-articulated, empirically based belief and value systems developed after a comprehensive literature review and currently supplemented with ongoing research and program evaluation (Refer below).

The program recognises the importance of community collaboration and acknowledges the importance of systems of care that are multi-systemic, multi-dimensional, community based and supported over time.

Secondly it acknowledges the importance of viewing behaviour as evolving from both biological and environmental factors that influence crucial infant attachment and subsequently consolidate into predictable patterns of behaviour. Such a theoretical framework aids in understanding the intention behind behaviour as rooted in unresolved attachment difficulties ie: early attempts to address childhood needs and fears. Often such understanding allows caregivers to perceive problem behaviour in healthier ways. Finally the program supports the inherent values of the Psycho-education Model as outlined by Larry Brendtro.

**Principles Underpinning Values and beliefs**

The program articulates 7 underlying principles on which the program philosophy is based. They are:

**Principle One**

All behaviour has meaning. Understanding the internal working model of the person generating the behaviour reveals the meaning of the behaviour.

**Principal Two**

Biological legacies such as cognitive and physical capabilities are an interactive part of our experience and contribute to our working model of relationships with self and others.

**Principle Three**

Early and repeated experiences with people who care for us set a foundation for our internal working models of relationships with self and others. Our earliest experiences have a profound affect on how we approach relationships, school, work, and play.

**Principle Four**

Internal working models are works in progress developing in the context of relationships and experience. These models are constantly under revision based on experience. Experience can add to but not subtract from.

*The optimistic view has shown it is possible to make a difference through relationships with them, and that relationships are in fact "the most important tool."

**Principle Five**

Inter personal relationships are a process of continuous and reciprocal interplay of each persons internal working model with others. It is not possible to hold yourself separate from this interplay.

*This reflects the need to understand conduct disorder differently or else it reinforces the behaviours and beliefs. Control is through connection; first you connect then you correct, and you can't forget that you are part of the equation.

**Principal Six**

We understand ourselves in relation to others. Our sense of self includes our sense of how others view us and respond to us.

**Principle Seven**

Enduring change in an individual's behaviour occurs only when there is change in their internal working model supported by change in the systems that they live in and there is sufficient time, opportunity, and support to integrate the new experience (Our past is not necessarily our destiny).

Attachment principles such as these are significant in that:

**a).** They provide a very workable framework that can co-ordinate interventions delivered within a mental health system by one or more mental health professions, so there is a common understanding of the goal of intervention.

**b).** They provide a coherent framework from which parents care givers and other significant individuals can understand the reciprocal relationship between their interventions and the behaviour of the child.

**Aim**
To understand why the young person acts this way and what can be done to help, from the perspectives of the young person, the family, the School, and the Community.

**Referrals**
Serves the entire Province of British Columbia.

Youth are referred by local Mental Health centres to ensure that those agencies with the greatest knowledge of their community's metal health needs control access to the program. The agencies identify youth in their community with severe behavioural problems who are most in need of services.

Possible benefits are weighed against potential risks of youth spending a month in a specialized residential milieu, and also to determine if the Maples is the least intrusive / restrictive option per Mental Health Act, 1989.

Maples Social workers coordinate admissions and discharges (but are not involved in day to day running of the unit). They also collect the Social History and do the Family Assessment prior to the young person's admission.

**Target Population**
Those young people for whom a thorough assessment of strengths and concern areas, and the development of intervention strategies would be useful to support communities to better understand and support the identified young people, and / or where on going residential and consultative back up would be helpful

**Age**
The program accepts all young people between the ages of 11- 17 years with the exception of children who have been identified as functioning within the intellectually deficient range.

**Staffing**
The Clinical team is multi-disciplinary and includes psychiatry, psychology, education, social work, nursing, childcare, caregivers, youth and community agencies as a collaborative entity (At present 3 psychology, 3 teachers, 2 psychiatrists, and 3 social work). There are 4 staff during the day, 4 staff of an evening, and 2 staff over night.

**Philosophies (Refer above for detailed outline)**
These include use of an Attachment Focus, Family Narrative and Family of Origin, having a Developmental Perspective, using the Mc Master model of Assessment, and having a Collaborative, Systemic approach that gives rise to Multi- systems Interventions.

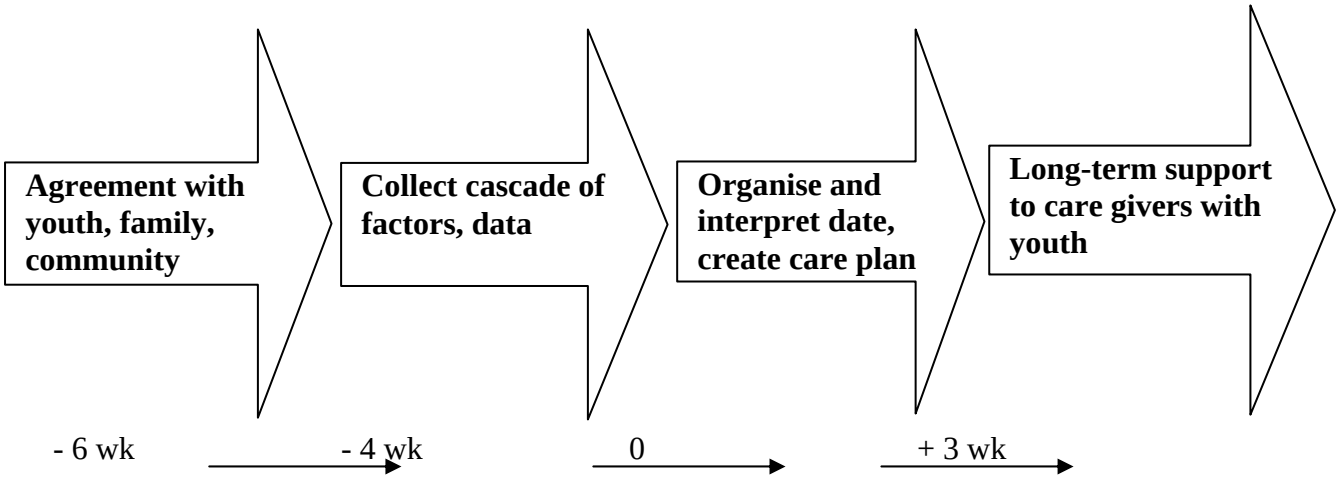
**PROCESS (Summary)**

1. **Referrals:** from Mental Health Services (Referral Package).
2. **Social History**: Outreach by Social Worker prior to admission
3. **Comprehensive Assessment**: Four week Assessment Admission:
    - Psychology
    - Milieu / Relational
    - Education
    - Psychiatry

4. **Care Plan Development:** This describes the experiences of a young person's life in a variety of areas of functioning. It then recommends strategies for caregivers to use in assisting the young person's development in those areas. An understanding of the youth's ecology is developed through information from the fields of social work, psychology, psychiatry, education and child care / nursing.

The development of a Care Plan indicates a long-term commitment by the Maples and by community caregivers to provide care for the young person.

**RESPONSE PROGRAM MODEL**




**Process**

Young people are in residence for four weeks. The program is housed in two units, each with a capacity for 12 young people. Care is provided in the least restrictive, most normative environment as is clinically appropriate. Young people are encouraged to attend school on the complex and engage in recreational activities. The program begins with an intake meeting. At this time, the young person, all concerned caregivers (eg; parents, foster parents, legal guardian), community support systems, the case manager from the community, and the Response Program staff meet to form an agreement regarding the process and purpose of developing a care plan.

During the 3 weeks following intake, the multidisciplinary staff gather information regarding the social ecology and functioning of the young person by focusing on attachment and affiliation issues. This understanding aids in providing an understanding of the young person’s troubled and troubling behaviour as rooted in unresolved attachment difficulties and as attempts to address childhood needs and fears. This generally allows a less pejorative understanding of the young person’s behaviour.

The information derived from these investigations is presented to all individuals involved in the young person's care (parents, alternate care givers, social service and school representatives) and the young person in a Care Plan Development meeting 21 days following admission to the program. This is an open meeting in which professionals discuss their findings and the contribution of all participants is encouraged. The Care Plan is developed from the information shared at that meeting. It is written from the theoretical basis of Attachment Theory and Systems Theory. The combination of both is highly effective in understanding the dynamics of a young person's life and for developing recommendations to assist the community in providing care.

The open format of the Care Plan conference is unique and challenging to professionals, families and adolescents. The focus of the discussion is on understanding the unique problems of the youth within a context of their pattern of attachment, affiliation and social interaction in their social environment (ie: family, peers, school and community members). The most beneficial care situations and strategies from this perspective are discussed.

It is seen as critical to include all members of the ecology in this meeting to ensure that they participate in this understanding of the young person and to establish their inclusion and commitment in the intervention process.

## COMPONENTS OF COMPREHENSIVE ASSESSMENT

### Social History

A Narrative: The family gives their story prior to young person's admission. Parents report their view with a clear understanding about how the material is going to be used, that it is a voluntary process and that the recommendations that come from it are not directive. The background is seen as crucial regarding the parent's attitude to parenting, aetiology and resources to fall back on.

1. **Birth parents** - (regardless if the young person in placement or not)
2. **Home interview -** A Social Worker goes to the parents home to interview them in their own environment (the focus is on making them feel comfortable, building rapport and getting it from their perspective and their experience, and the emotional load that goes with that, ie: how it has impacted the family members).
3. **Attachment focus**- Patterns of family relating internal and external
4. **Family of Origin**
5. **Parents**
   - Education,
   - Employment,
   - Substance use
   - What happened of significance prior to parents meeting
   - Their relationship (parents) how they met, their early relationship
6. **Children**
   - Birth, bonding (all children)
   - Temperament
   - Family circumstances
   - Developmental
   -? Abuse issues
7. **Functioning** - Enuresis, encopresis, eating, sleeping hygiene, sexuality

**Educational Assessment**

1. Cognitive Academic Functioning
2. Social Relationships
3. School placement

**Testing:** Woodcock Johnson's Psycho educational (revised), Cognitive and achievement battery, School file from the outside school attended, analysed in relational to other documents ie: referral and school history.

**Psychological Assessment**

**Aim: 1.** To get the young person's point of view

**2.** Psychological profile, Individual Assessment,? How the young person thinks

**Process: 1.** Interview young person **2.** Formal Testing

**Interview:** (lasts as long as the young person can manage). The presented aim is to represent the young person's point of view so that those involved can come up with a good plan (that's not a waste of time). The content focuses strongly on relationships.

**Testing:** The standard tests performed are the Wisc and the Stanford Binet. These are followed up with additional assessments if indicated, ie: Neurological, speech / language, adaptive functioning

**Self Reports**: A range of self reports are also taken that include, the Youth Self Report, Personality Structure, Maci-Milan Adolescent Clinical Inventory, the BDI & CDI Depression Scales, and the SJR Suicidal Thinking - the way that I feel questionnaire. (Other options include Connors regarding anxiety, and Bill Reynolds - about my life).

**Parents**: Parents are also given a range of questionnaires, however the psychologists don't see parents themselves as the questionnaires are done with the Social worker during Social History. These include the CBCL Screening measure, the Attachment and parenting style and the Parenting stress index. This was seen as the weakest link as the parents don't always do it.

**Other:** Occasionally Rorscach or Projective drawings.

**Gathering Together Of Information**

**1.** Go to Ministries files (Health, Education, Social Security).
**2**. Organise into one chronological Narrative using the McMaster Model
**3.** A lot of time is spent on the report: What can we do? Here is the young person, how can we best assist them?
**4.** A positive slant and the cognitive profile regarding how they learn and relate, are used to formulate some recommendations; ie activities that may be of benefit, where they should live, type of care giving, treatment if required etc

**Formulation / Hypothesis:** Using the above as well as talking to staff and asking for pragmatic behaviours on a day-to-day basis, the psychologist then pulls it all together and relates it to what has been done before.

**CARE PLAN (The living Lab, shared pieces of a puzzle)**

The information discussed in the Care Plan meeting is summarised in the Care Plan Document. Information is organised into 3 sections:

**1.** Life Style Issues
**2.** Home life issues
**3.** School issues.

Within each domain, personal and family attachment dynamics and management strategies are addressed. Management strategies typically include family therapy or parent training interventions, involvement of childcare or other appropriate mentors, vocational and recreational and school recommendations as well as individually based interventions as necessary.

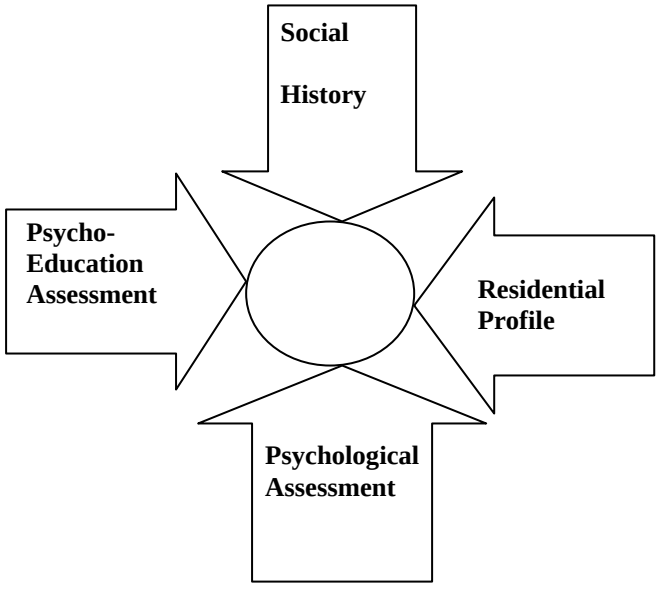
The Care Plan is designed to be a "portable" document as youth and families may move. Consequently, it is not written to conform to a specific community or to specific resources within a community. Instead, the Care Plan outlines what a young person ideally needs for optimal development, thus enabling caregivers to examine the resources available to them and make the best possible fit.

The broad range of the Care Plan ensures that attention is directed to the numerous domains in which the young person typically has difficulties. The Care Plan is written in such a way as to ensure that a wide range of caregivers can easily understand it.

The report back takes 3-4 hours. The meeting is chaired by the Chief Psychiatrist (Dr Roy Holland). The challenge is about how to present the information back in a way that respects the sensitivity of the material. This can be a powerful tool if delivered with sensitivity, where the parents feel supported. The process before during and after is vital.

Post the meeting the Care Plan consultant sets up a time for an integration meeting in the community with relevant agencies and family to Operationalize what set up (Refer below).

**CARE PLAN COMPONENTS**



## DISCHARGE

Discharge from the Maples typically occurs one week after the Care Plan development meeting. This is when participants receive their copies of the completed Care Plan.

A discharge meeting is held one week following the Care Plan meeting and at this time the Care Plan document is reviewed. This meeting provides an opportunity for members of the community to respond to the process and to problem solve around issues related to the implementation of the Care Plan.

The Care Plan can be complex, difficult to understand, and challenging to implement. Consequently the Maples provide Care Plan Consultants who assist service providers and care givers to understand the care Plan in the context of Attachment Theory. This also marks the beginning of the relationship between Outreach workers and the community. A Care Plan consultant begins active involvement with the young person's care giving system at this time to assist service providers as they develop strategies to implement the Care Plan in their community.

## CARE PLAN CONSULTANTS: INTEGRATION MEETING

A long term Care Plan consultant is allocated at the Care Plan meeting and sets up a time for an Integration meeting in the Community post discharge:

1. To explain why the understanding of the young person was reached.
2. How to Operationalize recommendations with available resources
3. To educate the community and the client as well
4. To advocate for the young person via the concepts in the plan.

### Aim

To export the Care Plan to the Community and have it owned by them versus The Maples.

## Care Plan Consultants

There are 6 care plan consultants allocated to (5) regions, Northern Region, Opanagun, Coutneys, Coast and Lower Mainland. They carry a caseload of 140 clients who they will follow long term on an outreach basis (Until the young person is 19years old).

### Role

1. To help the community to do the work with the young person. Care Plan consultants don't do direct therapy with young people.
2. Presentations / education to the community.
3. Support to parents over the phone or in person.
4. Ongoing co-ordination of the Integration meeting if required.

The Response Program is not a "quick fix". Instead, it maintains a long-term commitment to assist young people, families, and communities. The first 28 days is only the beginning of the Response Program as the development of the Care Plan is followed by its implementation. The Response Program makes a commitment to assist the community in interpreting the Care Plan throughout the Young person's adolescence.

In addition, the program commits to providing respite care, a non-emergency planned break for young person and adults that is available to support the implementation of the Care plan. It can range from two days up to 2 weeks as often as required to support the preservation of a placement during the young person's adolescence. Care Plan Consultants and respite care are available to support the Care Plan implementation until young person achieves their nineteenth birthday.

Efforts are now under way to devolve the program to local communities. This process is occurring in the context of a new mental health framework that emphasises community care “closer to home”

## EVALUATION

Evaluations of this program have shown reduction in the level of problem behaviour (including symptoms of Conduct Disorder, Oppositional Defiant Disorder and Attention Deficit Disorder) and emotional difficulties (Anxiety and Depression) reported by youth and their caregivers for a follow up period of 18 months (Holland et al, 1993, Moretti et al, 1994).

The model has also led to the development of a multi modal program for young people who remain in residence during the week and return to their caregivers on weekends. The success of both programs ultimately depends on the continued support of the communities and caregivers providing continuity of care for young people.

Respite care has been particularly important in helping to prevent the break down of placements.

Often the behaviour isn't extinguished, but peoples responses change as they understand the behaviour and manage the situation better which over time will assist the young person to feel more contained and internalise a shift in their internal working model.

## OUTCOMES

### Negatives

The assessment is a snap shot in time, and whilst it gathers developmental and relationship information it doesn’t necessarily view parent - child relationships themselves in the here and now and over time.

Some families associate Maples with Protective Services and hence can be anxious / reluctant to engage initially.

### Positives

It serves the purpose of an attempt to gain a common understanding of what is going on for the young person in their world; their behaviour ends up making sense as a rational response to a difficult circumstance.

Families generally feel listened to without judgement in a way not listened to before and feel that genuine time has been given to them.

Professionals found it hard initially to be as frank with the family, but now accept it. As a result it has changed the model of the way professionals work with the family by including them as part of the team

All the above has increased all participants level of commitment to the outcome. The community has finally begun to accept the Maples view that it is the Community that needs to manage them versus putting them away.

**Moving the Program into the Community**

A founding principle of the Response program is to maintain young people in their home communities. A long-term goal is to move the process of developing and supporting Care Plans into the community as well. With the impetus of the "New Directions" health care initiatives in British Columbia, which calls for "Closer to Home", there is a rare conjunction of clinical direction and practice with political and economic imperatives. The Response program at The Maples is well positioned for the next stage of evolution – where communities bring the clinical and practice model "Closer to home". Through formal and informal networks they have provided consultative services to develop local programs and services that replicate or compliment attachment based services such as the Response and Orinoco programs. In the past year there have been half a dozen partnership initiatives with communities ranging from immediate neighbours around The Maples' Burnaby location to communities in the provinces north.

Common challenges in moving the program from The Maples to the community have arisen. These are characteristic of the problems that are encountered whenever duplication of newly developed programs is attempted. First, the provision of services for youth and families is fragmented so that co-ordination of services is extremely difficult. This often results in a situation where providers attempt to define service requests as outside their mandate in order to preserve limited resources. In an attempt to address this problem, the Province of BC has created a single ministry for children. The development of a central agency to co-ordinate and integrate services is critical to the implementation of multi model intervention strategies. The second obstacle encountered is that the intrusion of outside "experts" in program reorganisation can be resisted. Thus, it has been necessary to find methods to carry the new program forward. Several strategies have been helpful in this regard. Firstly, it is fortunate that changes believed to be clinically advantageous are aligned with the changes in legislation for the delivery of services to children. Highlighting the compatibility of the program with these policy changes has been useful in enlisting support at a community level. Providing research documenting the impact of this program and providing expert presentations to communities has also been persuasive. Finally, offering mentoring relationships with communities where Maples professionals can assist the community professionals in developing expertise and competence has been invaluable.

## 2. ORINOCO C.A.R.E PROGRAM
### (Caregiver, Adolescent Resource Enhancement)

The Orinoco C.A.R.E Program is designed to provide adolescents and their families with an intensive, short-term intervention and follow up phase. Family is defined broadly to include birth, step or adoptive parents, extended family members, foster parents, or resource care staff.

The sort term intervention consists of a three-month, Monday to Friday, residential component and two or three weeks of community based support. The follow up phase is tailored to the individual needs of the family and the young person.

The general goal of the program is to increase each family's capacity for constructive problem solving and mutual support in moving toward individual life goals. This is done in the context of each young person's unique social environment with an emphasis on maintaining and enhancing existing relationships.

**Program Rationale**

Adolescence is a period of change and readjustment for young people and their families. Sometimes when a young person or family experience difficulty, it is because of a lack of resources or skill, or problems in understanding. Some adolescents present extra challenges to their caregivers.

By working together in an intensive, short-term format, the Orinoco CARE Program provides the opportunity for families to explore alternative methods of relating and problem solving while ensuring support for their efforts to change.

The short-term nature of the program makes it clear to the family that they will not be involved in a never-ending process. The program believes that there are skills relevant to the problems families' experience, and these skills can be learned and practiced during a relatively brief but intensive intervention. The practice of spending weekends at home ensures that the youth maintain connections to their home communities.

The model also requires that the community agencies remain actively involved in the young person's care while they are in the Orinoco CARE Program. In an effort to work in tandem with families and communities, the program sessions run roughly concurrent with school schedules.

**Aims**

Orinoco is a tertiary service that aims to reintegrate young people back into the community, to increase each family’s capacity for constructive problem solving, and to utelise relationship and support building as a major tool for achieving the above.

**Philosophy**

The philosophy of the Orinoco program is in keeping with those outlined under the Response Program and The Maples as an organization.

Among those that were emphasised were the belief that programs should hold empirically based belief and value systems that are closely tied to theory. The theorists of particular relevance to the Orinoco Program are Bowlby, Ainsworth, and Cichetti (Developmental). The staff strongly advocated and demonstrated the

Learning Organisation Paradigm, that upheld the need for ongoing research and training to ensure the program was run by expert staff.

Two other important elements were the emphasis on being community focused to ensure home remains the community, not the institution, and that interventions need to be multi-modal.

**Model**
Attachment Theory forms the basis for the program model, however Narrative Therapy and Externalising Strategies are also seen to be an important compliment to the model; where young people and families get to tell their story and are heard and validated, and that the young person is coached to be able to relate and understand their feelings and experience as opposed to purely acting it out in an oppositional or destructive way.

**Structure**
8-bed Voluntary unit

**Clients**
The young people who are referred are between 12-18yo, * Mixed gender, and primarily have a diagnosis of Conduct Disorder.

*Support services are available to their 19th birthday.

**Criteria**
Young people who are difficult to manage in the community, ie: the worst end of continuum that have complex presentation and often involved with multiple systems and services.

**Exclusion**
Young people who are psychotic, who are refusing to come, who have been coerced via courts and do not wish to be there, or who have no ongoing placement.

**Referrals**
As a tertiary service, referrals come from other Mental Health Professionals.
(The bulk work best if the young person has been through the Response Program and have an existing Care Plan).

**Staff**
The staff comprise of 10-child care staff, 5 nurses, 1 Shift supervisor, a psychologist, and a psychiatrist. The childcare staff work on a 7.78 rotating roster with 5 days on 2 days off, and 4 on, 3 off when on evening shift. There are also links to the school and other disciplines as required.

**Process**
Two Primary Workers are allocated to one young person and carry all the decision making for that young person. One Primary worker works each alternate shift. In admission week both meet with all parties to set goals and formulate a plan that is documented in a **Clinical Operations Report (ISP).**

## PROGRAM

The program operates 5 days per week with 1 admission week and 12 weeks of treatment. There is a 2 weeks community reintegration process (Care Plan formation), and then long term Care Plan follow up by Care Plan Consultants (Until the young person's 19th birthday).

### Admission week

During admission week there is a meeting of all relevant parties to set goals with the Primary Nurses, looking at what is referred to as the 5 W,s of who, what, when, where, why. This forms the basis for the Clinical Operations Report (ISP). It is during this week that community liaison emails and calls are followed up.

### Clinical Operations Report (ISP)

The ISP is reviewed daily by the Primary Case workers, and weekly at a Clinical meeting (Thurs). The young person is not involved in this, however all staff attend.
There are meetings with all relevant people including parents and the young person to review the overall admission plan on admission, midway, and at discharge.

## TREATMENT

Treatment is conducted primarily via the relationship with a key worker. Each key worker has primary responsibility for 2 young people. The therapy is conducted in a range of individual and group settings and involves a considerable amount of time outside the unit with the key worker involved in a range of activities.

### Specific Attachment Goals

1. To enhance family communication and problem solving capabilities so that stresses are decreased and family members can better support each other.
2. To enhance education or employment readiness to enable the youth to experience a more productive identity and to enhance self esteem.
3. To build problem-solving skills at a personal level through participation in a model of group living based on respectful relationships.
4. To provide recreation and leisure opportunities in order to enhance social skills.
5. To work with other resources to co-ordinate services appropriate to the needs of the family.
6. Development of a Community Care Plan

### Caregiver commitment

In keeping with the program philosophy of enhancing all resources involved in the care of the young person, the program provides opportunities for parents or alternative care givers to participate.

These include a weekly group meeting (1 ½ hrs, Tues pm, 7.00 – 8.30pm) run by 2 staff with all parents and caregivers to share experiences, explore developmental issues, to discuss communication and problem-solving strategies, and to develop self care strategies. In addition to the support group, weekly sessions with the social worker are available for family, marital or individual therapy.

**The Goals Of The Family Intervention Are:**

1. To provide external support and modification in the care giving system to maintain the youth in the community and reduce risk to themselves and others.

2. To provide a place where families feel they are supported and not isolated / alone, to give them space to debrief, to explore strategies, and receive coaching. Guest speakers are also invited if the parents identify a need or area of interest that would enhance their understanding of their child.

3. To encourage the internalisation of this external structure by the young person, and in doing so, to build a stronger basis for self-regulation in the child.

**Community advocacy**

There is also strong advocacy for the young person and their families, to help them negotiate their way through services previously too imposing for them.

**Links with Research**

The young people's attachment profile and behaviours are measured (utilising adolescent attachment tool, per Brennan, Moretti) and reviewed along with their ISP each week. This information is utilised to design specific intervention strategies based on the young person's attachment profile.

**RESEARCH / ACADEMIC**

The Orinoco program has been set up as a major research project in itself. Extensive data is being collated and analysed on the use of the effectiveness of using attachment measurements to inform practice and of their application to deepening the understanding of the young people who present, by facilitating an intensive analysis of their attachment style.

One strong link between research, academic work and the practice of the Maples are the papers that have been published by Dr Morretti, Dr Holland and others, and have been presented at various National and International conferences, on the Orinoco research, the response program and the experiences of developing the attachment model as applied at the Maples.

Dr Morretti is also on staff at The Simon Fraser University in Victoria, Canada, which creates strong links between the University and The Maples. To formalise this link, there was a proposal to set up a joint research project between Simon Fraser University and The Maples to pilot a specifically designed Masters in Child and Youth Care and evaluate the impact this had on the staff from the Maples who undertake the course.

## DISCUSSION

The Maples Centre is another impressive example of an organization that functions at a very sophisticated and professional level. This was primarily achieved in the first instance by the management having the ability to reflect on existing practice within the service, acknowledge the problems, initiate research into best practice models, develop a holistic model, and then change the service to integrate that model within all aspects of the service from the Management through to the clinical levels.

What was most striking was that integration and how, by providing a solid and clearly defined framework, it held the service together and supported the staff in their work with extremely challenging young people. However, not only did it support the staff, it encouraged them to take pride in their organization and grow within it.

**Clinical**

On a clinical level the attachment model looks at each child's unique experiences and expectations for relationships with caregivers. They call this 'attachment style' and use it to determine the most effective services to deliver. They have been able to look at Conduct disorder Diagnostic Criteria DSMIV in conjunction with diagnostic overlap, and have been able to develop new insight into otherwise confounding behaviours. This has been an endeavor to gain a common understanding of what is going on for the young person in their world, and to demonstrate that their behaviour ends up making sense as a rational response to a difficult circumstance.

What is really important is that whilst the framework helps promote this common understanding it doesn't preclude or dictate the type of interventions, and in fact emphasises the need for multifaceted, multimodal interventions based on individual need. However underpinning all this was the belief that the use of the relationship with the young person is the fundamental tool for therapeutic change to occur.

The attachment perspective provides a conceptual framework for working with youth and parents and is supportive of the premise that mental health care for children and families is provided in several childcare systems (including mental health, social welfare, juvenile justice, education, primary health care). This challenges the "silo" mentality that often occurs when a number of services become involved with the one young person, where services stick rigidly to their domains and fail to integrate the services that a young person and their family receive. This often creates a systemic replica of the fragmentation and confusion that the young person has already experienced within their life context to date.

The model gives a framework for understanding behaviour, is predictive, yields pragmatic strategies, and is measurable. Both the Response Program and Orinoco are good examples of how this all fits together in practice. Both utelised underlying attachment principles that were clearly articulated, that had a sense of holding the staff and the clients together in a solid yet dynamic way. The interventions utelised reinforced this and were pragmatic translations or applications of attachment theory. Both programs utelise the relationship as a fundamental tool, particularly the Orinoco program, where both the staff members and the young persons attachment profiles were measured and monitored to directly inform the interventions chosen on a daily basis. The Community Care Plan also acts as a holding and containing tool for the young person and the system around them, and provides the tool for communicating

the understanding of the young person gained from the comprehensive assessment undertaken.

**Organisational Model**

The Maples has a clear organisational model that incorporates and supports the theories it promotes and adheres to on a practice level. This includes utilising Attachment Theory and Learning Organisation Principles to inform what is viewed as essential components of a service and service development / change management. Having a Common Vision, a Common Paradigm, a Common Language and a Common Working Agreement, were seen as a fundamental component of this, all of which the Attachment model provided. Also having a management group who focused on process as much as the task and formalised this in the structure of their meetings reinforced this.

**In summary:**

The combination of both the clinical and organisational factors outlined above was something that was truly inspiring to see, as it is a combination that I have felt quite strongly about over the years and to see it functioning well was very affirming of my beliefs. The model of practice that I had developed for working with High Risk Youth had much in common with the Maples model, and as a result it provided a strong platform for the many in-depth discussions during my time there. The important outcome in relation to this was a deepened understanding of how attachment theory can be implemented on a broader organisational level not just on the specific program level, and how it can be taken to another level of sophistication in matching practice and research. The use of the attachment profile measures on the Orinoco Unit was very much an example of this.

## 8d). MNT SINAI CENTRE FOR ADOLESCENT HEALTH

**Address**
Adolescent Health Centre
312 East 94th Street
New York, New York, 10129

Ph: (212) 423-2981 Mental and Behavioural Health
(212) 423-3000 Medical
(212) 423-2999 Emergency

**CONTACT**
Mr Ken Peake, Assistant Director email: Ken.peake@mountsinai.org

**PROGRAMS VISITED**
The programs visited were a broad mix that ranged from meeting with a health economist researcher who talked about the broad social policy context and adolescents, to service coordinators and clinicians.

**Meetings and Issues Discussed**
**Dan Medeiros, MD Medical Director of the Behavioural and Mental Health Program**
The staffing of services of the BMHP, overall supervisory / staff development package, and issues in the evolution of the supervision / staff development package.

**Ruth Hoffman, CSW Social Work Supervisor and Manager BMHP**
Over all psychosocial services provided at AHC, as well as systems issues and program development between the AHC's BMHP and its medical services, school based services, and overall collaborative efforts between AHC and other organisations.

**Kelly Celony, Social worker, coordinator HIV. AIDS services**
Program development, staffing, services and funding, as well as issues faced

**Mavis Seehus, CSW/MPH, Psychosocial Health Education Services (within Primary care medical services)** Arranged to attend primary care team meeting

**Vaughn Rickert, Psy.D, Psychology Services**
The psychology services and the BMHP's practice based research development efforts

**Sylvia Alemany, Coordinator Peer Education / Community Outreach**
Described the Community Outreach and Peer education programs and facilitated meeting some of the peer educators.

**HIGHLIGHTS**
A major highlight was the pure cultural shock of New York and the extreme difference to the other cities travelled to, and how this impacted the Mnt Sinai Adolescent Health Centre, making it significantly different when compared to other

services seen on many levels (especially in relation to the client group and the type of services required by them).
Again, as with the other services outlined in this report, the level of welcome, inclusion and freedom to be an active participant where I chose was truly amazing. So much so, that I was invited to run a training seminar for the Social Work undergraduates at New York University, which was a really wonderful opportunity to meet and exchange ideas with a whole different culture again.

## KEY FEATURES/ KEY STRENGTHS OF SERVICE

**1. Relevance versus rigour.** Programme development was based on identified needs of the population attending: ie: pregnant mothers, date rape, HIV, as opposed to diagnosis.

**2**. **Peer education model**. The peer education model as applied in the SPEEK program was an affective mechanism to promote adolescent consumer involvement and empowerment. (Refer below for more detail).

**3. Adolescent Sensitive Philosophy that directly informed practice:** The service was based on a solid philosophy that promoted a strong belief in and need to be sensitive to Adolescents. This underpinned how the service was run, what programs were developed, what staff were employed, the training for the staff, how the environment was set up, and especially for New York, how the services provided were delivered and paid for ie: Confidentially, flexibly, and for minimum fee. The age range of young people seen (to 22years old) also reflected the needs of older youth and young adults as being different to older adults. Out reach services and proactive follow-up when young people don't turn up for sessions also reinforced the sensitivity and accessibility of the service for type of young people / client population it serves.

The line quoted in service policy documents of "Adolescence Is Not Just A Phase, Adolescents Are Our Future," appeared to be more than just a catch phrase, and was evident through out the service.

**4. Mental Health and Primary Health integration.** Services effectively integrated in a way that respected, retained and utelised each areas specialist skills.

**5. Strong focus on Group work**. Group work that was flexible, accessible and tailored to young peoples needs and was an important component of service delivery.

**6. Policy Advocacy.** Advocacy on a National level was seen as an essential role of the service to effect a positive change in the position of adolescents in national health care policy.

**7. Comprehensive and inter disciplinary services**. The breadth of the services offered and how they evolved was quite remarkable. The summary of the history of the Adolescent Health Centre is outlined below because it truly highlights the extent of work that has occurred and the achievements gained in the centres endeavour to provide comprehensive services for young people. It also demonstrates how these programs have evolved from a client needs focus, and reflects the very different needs of the population of young people it serves.

## KEY EXAMPLES OF GOOD PRACTICE

**1.** Integrated Primary Health, Mental Health
**2.** Extensive, flexible, and well integrated Group Work Program*.
**3.** SPEEK peer education program
**4.** Violence Prevention and Intervention Group*
**5.** Centre of Excellence

## PROGRAM LIMITATIONS / CHALLENGES

**1.** Funding difficulties were an ongoing concern due to the way funding is structured in America. A large portion of funding is obtained by grants, that specify what number and type of clients may be seen for that particular grant and are often fixed term grants that need to be reapplied for annually. Other funding comes from the main Mnt Sinai Medical Hospital and can be difficult to access.

**2.** Hard to engage and complex client population: A large proportion of young people drop out after 1-3 appointments. Parents also do not follow through, as many families are from the slums and other issues become a priority over mental health. The problems are complex on an individual and family level, ie: the service rarely sees families simply stuck in a developmental phase.

**3.** There is also a tension between seeing the Adolescent Individually versus Family Therapy, particularly when it is clear that the problems are family based; however the need for protecting the young person's confidentiality is paramount.

## CONCLUSIONS / RECOMMENDATIONS:

**1. Adolescent Sensitive Philosophy:** Promote the use of the AHC service principles as a model for the development of a truly Adolescent Sensitive Philosophy to underpin service delivery.

**2**. **Advocacy:** Advocate on a State and National policy level for the needs of Adolescents and Young People.

**3. Adolescent Consumer Involvement** Promote the SPEEK peer education program as a Model of Adolescent consumer involvement and empowerment.

**4. Needs Based Programs:** Lobby for Flexible Program development based on client needs rather than diagnosis.

**5. Primary Health:** Use the AHC as an example of how the links between Mental Health and Primary Health can be effectively and efficiently achieved, in a way that respects and utilises the skill base of both areas, and to reflect what sort of joint work can also be developed.

# THE ADOLESCENT HEALTH CENTRE

The Adolescent Health Centre is located at 312 East 94th Street between first and second Avenues. It is an Adolescent Medical Centre with a large Mental Health component, and is part of Mnt Sinai Medical Centre, which is the biggest specialist service in USA.

The Adolescent Health Centre (AHC) was established in 1968 as the first primary care program in New York specifically designed for the health needs of adolescents. The Adolescent Health Centre provides confidential and comprehensive medical, mental health, family planning, and health education services to young people between the ages of 10-21and stands as the nations largest provider of health care services to adolescents. It is the only program of its kind in the country, and is used as a model for effective healthcare programs for urban adolescents.

**Demographics**

The Adolescent Health Centre is based in East Harlem and sits on the boarder of the wealthiest and poorest part of New York. It has no specified catchment area and supports primarily a broad, otherwise underserved population of children, adolescents, and young adults in East and Central Harlem. In a typical year, the AHC sees more than 10,000 patients, who log more than 50,000 visits. In addition to the young people from the neighbouring community, others from throughout the five boroughs travel for up to five hours round trip to benefit from the AHC's services. Of all AHC's clients, 49% are Latino, 43% are African-American, 5% are White, 2% are Asian, 1% are Native American, and 99% are from East Harlem, Central Harlem, South Bronx, or other low-income New York City communities.

**AHC Services (Over view)**

To respond to the diversity of young people seen, the service is staffed by bilingual healthcare providers who are available to assist teenagers with services, information, and support programs on a wide range of healthcare matters and strive to help young people make informed decisions. Other special programs at the Center include support groups for rape and incest survivors and a parenting program for young adults. The Adolescent Health Center also operates school-based clinics in two local high schools and 12 community-based mental health and/or health education services.

The facilities are easily accessible and welcoming, the information shared between care provider and young person is always private and confidential. The AHC respects the rights of minors to receive confidential health care, and maintains its own confidential registration process and record room.

Programme development is based on identified needs of the population attending: ie: pregnant mothers, date rape, HIV

**History (Over view)**

The Adolescent Mental Health Centre (AHC) was established in 1968 by Dr Joan Morgenthau as the first primary care program in New York State specifically designed for the health needs of adolescents. Initially it was run out of a trailer in the car park of the hospital by a small multi-disciplinary team. Today, the Adolescent Health Centre is a freestanding facility of the Mnt Sinai Hospital and has led the nation in offering high quality, comprehensive and appropriate care for this age group.

**Summary of the History of the Adolescent Health Centre**

The summary of the history of the Adolescent Health Centre outlined below highlights the extent of work that has occurred and the achievements gained in the centres endeavour to provide comprehensive services for young people. It also demonstrates how these programs have evolved from a client needs focus, and reflects the very different needs of the population of young people it serves.

**1968** The Adolescent Health Center (AHC) of the Mount Sinai Medical Center becomes the first primary care program in New York specifically designed for the health needs of adolescents

AHC introduces the first Family Life Education Program

**1971** AHC receives a grant from New York State to establish the first adolescent-focused drug prevention and treatment program for teenagers in New York City

**1972** AHC establishes the first Fellowship Program to provide training in adolescent medicine

**1974** AHC introduces an in-house GED program, creating the first link between educational outcomes and good health

**1983** AHC establishes New York State's first school-based health center at Manhattan Center for Science and Mathematics High School

**1984** AHC establishes a second school-based clinic at Julia Richman High School

The Summer Youth Employment Program begins, placing young people from low-income families in summer jobs at Mount Sinai Medical Center

The Vocational/Mentor Program starts, creating work/study opportunities for inner-city youth, at Mount Sinai Medical Center

**1986** R.E.A.C.H. (Ready to Enjoy Achieving Cardiovascular Health) program begins providing medical services, mental health counseling and nutrition counseling to youth at risk for cardiovascular disease

**1987** AHC hires health educators to focus exclusively on pregnancy prevention and STD and HIV risk reduction among teens

AHC establishes the first Adolescent HIV/AIDS Prevention Program to include peer education, community outreach and theater company

**1988** The S.P.E.E.K. (Sinai Peers Encouraging Empowerment through Knowledge) Peer Education Project begins training youth to lead pregnancy prevention and HIV/AIDS workshops at schools and community organizations

**1989** Angela Diaz, MD, a former patient of the Adolescent Health Center, becomes Director

AHC introduces the first HIV Bereavement program for adolescents in New York

**1990** Patients make 26,000 visits annually to the Adolescent Health Center.

**1992** AHC is one of the few adolescent clinics to receive Ryan White funding for Mental Health Services to HIV-affected and infected youth

**1994** Dr. Angela Diaz is named a White House Fellow

**1995** AHC moves to its present facility at 320 East 94th Street, expanding its space by one third, in order to expand its much-needed services to more adolescents.

**1996** C.H.O.I.C.E. (Choosing Healthy Options in Controlling Eating Disorders) program begins providing comprehensive medical and psychological care to adolescents suffering from eating disorders

The Violence Prevention and Treatment Program, begun in 1988, expands to provide comprehensive services to adolescent survivors of incest, rape and dating violence

**1998** Patients make 45,000 visits to the Adolescent Health Center annually, making it the largest health center in the nation exclusively serving adolescents.

Both Governor Pataki and Mayor Guiliani declare December 3rd "Adolescent Health" Day.

**2000** New York State Department of Health designates AHC as one of only two Centers for Excellence.

In June, AHC holds the "Common Morbidities in Urban Youth" conference in New York.

In September, AHC holds "Guidelines for Adolescent Preventive Services (GAPS)" Conference in September.

In December, AHC holds "Youth Development in Action: Identity, Resilience and Community" Conference in New York.

AHC receives a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and is designated one of 17 nationally recognized youth trauma centers as part of the National Child Traumatic Stress Initiative. The goal of the initiative is to create and nationwide network trauma centers to improve access to and provision of services to children with traumatic stress.

AHC is designated a Child Health Plus Enrollment site.

**Landmarks and Awards** The AHC and its work have received numerous prestigious awards, among them:

- AMA's National Congress on Adolescent Health Award for Excellence in Education and Prevention of HIV/AIDS
- New York State Department of Social Service's No Time to Lose Award, for outstanding community services
- United States Department of Health and Human Services' Exemplary Substance Abuse Prevention Program Award
- Special recognition from the New York City Council for the Violence Prevention and Treatment Program.

**Mission**
The mission of the Mount Sinai Adolescent Health Centre is to help each adolescent grow up happy, healthy, and well educated, with hopes and opportunities for the future, by preventing disease and promoting health.

**Aims**
1. The provision of primary medical, mental health and reproductive care
2. Education and training of both patients and health care professionals
3. Research into effective intervention and effective service delivery
4. The dissemination of information on best practices in adolescent health care
5. The enhancement of health care policy to foster health promotion and disease prevention in the adolescent population at the state and federal level.
6. To advocate for the young people on a range of levels based on identified need.

**Service Philosophy and values**

**1. Age and developmentally appropriate care**
AHC Services respect adolescent's desires to make their own decisions while simultaneously providing them with important counselling based on their particular age and social environment.

**2. Holistic / Comprehensive Care under one roof.**
The Adolescent Health Centre AHC provides primary care, mental health care, reproductive health care and health educations services all at the one site, minimizing the need for adolescents to travel for referrals or follow up care. It ensures that every patient who visits the Centre receives comprehensive health care. All patients can access the range of health care services at any time.

**3. Interdisciplinary approach**
The Adolescent Health Centre employs staff to work as a team reflecting the need for a holistic approach to adolescent health care. Primary Care and Mental Health Teams include doctors; social workers, nurses and health educators from all medical disciplines who work together to ensure the most appropriate services are delivered.

**4. Confidential services**
AHC services are provided confidentially, however counsellors work with patients to involve their families in long-term care.

**5. Culturally sensitive**
AHC employs a multi lingual and multi cultural staff. Outreach materials ensure that services are accessible to young people of diverse backgrounds.

**6. Adolescent Sensitive Care**
The Adolescent Health Centre is built upon respect for its patients. Care is provided to adolescents in a manner that respects their rights to make informed decisions, request confidential services and be co-partners in their own health care. All AHC staff are trained in providing services in a developmentally appropriate manner to ensure that the young people feel comfortable.

**7. Accessible Services**
The Adolescent Health centre is both financially and geographically accessible**.** It is situated in a freestanding building that is accessible and conveniently located to most public transportation, and is beneficial to adolescent patients because it is a place specifically designated for confidential adolescent care. The AHC offers flexible hours, treatment regardless of ability to pay, and extensive community outreach in schools and where patients live. The Centre also provides a single point of entry for multiple services, including health education, prevention and counselling

**Management Team**
The management team consists of the Director: Dr Angella Diaz, the Assistant Director, Mr Ken Peake, and Administrative managers, Mr Rueben Santiago and Vaughan Richet.

Meetings are kept to the minimal that are seen to be essential; they include a weekly Management Meeting, a fortnightly Operations Meeting, and a fortnightly Staff Meeting.

**Budget**
The budget received from the State Government is $US3 million, however the service actively pursues grants, which is a survival necessity in USA.

**Referrals**
Young people and families can refer themselves, and the young person can be seen without their parents. Other referrals come from agencies such as Schools, Community Agencies and Hospitals.

**Diagnosis**
The main diagnostic groups referred are for Depression, Anxiety and Personality problems. There are not a lot of prodromal psychosis referrals, as these tend to go straight to the psychiatric units. The problems rarely relate to families stuck in a developmental phase, and are usually intergenerational and complex, for example, the service sees a lot of families with no male present (may be dead, gone or in jail).

**Age**
The age range is from 12 years old* up until the 22nd birthday. (Unless the young person is HIV +, then the age extends to 24years old as these young people are often developmentally delayed, and it is recognised that younger adults have different issues to older adults who are often chronic IV users). *Note the lower age is also younger if the problems appear to be adolescent issues.

**Length of Treatment**
The average length of treatment is approximately 1 year, depending on if the young person drops out or not. Some may attend longer due to the length of time the problems have existed.

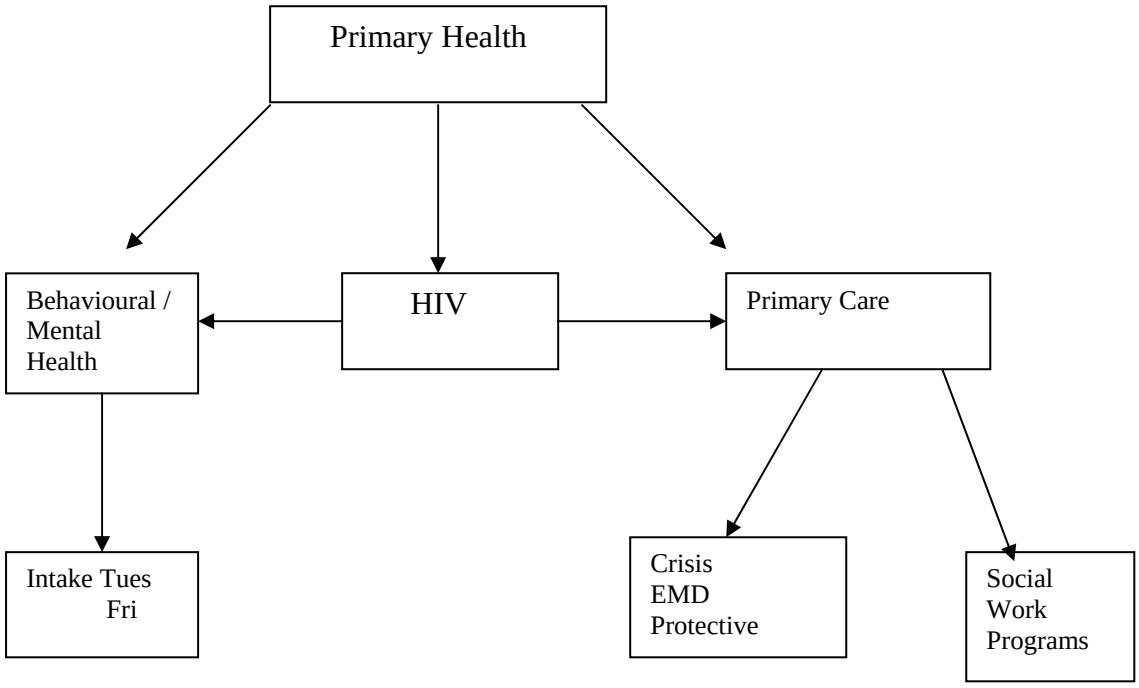
**Contacts**
There are 20,000 visits to the Mental Health Services per year, which constitutes 40 % of the total visits of 50,000 visits to the service as a whole. There are also 4,000 street visits and outreach contacts per year.

**Cost**
Basic Services are free. X-ray, and basic biopsy are done at the hospital and carry a charge of $US 9.00. Anything more the hospital covers. There is only one other place in the city that does this.

**Staffing**
The service has 40 staff from a range of disciplines, which includes paediatricians who specialize in Adolescent Medicine, nurses and nurse practitioners, physician assistants, psychiatrists, social workers, health educators, and support staff specially trained to work with adolescents. Clinically most therapists are psychodynamic / analytical, or self- psychology trained. There is also a strong multi-ethnic focus and many bi-lingual staff.

**Training**
There is a strong culture of ongoing training and supervision that emphasises family therapy and live supervision.

**3 PROGRAMS:** 1. Primary Care 2. HIV 3. Mental Health




**Program Streams**
The overall service is organised into 3 main streams from which a range of programs are delivered. These are Primary care, HIV Prevention, testing and treatment, and Behavioural and Mental Health. However there is still a strong overlap / interface between each stream on all levels such as the physical location, intake structures and aspects of program delivery.

**Special Programs**

There are huge range of specialist programs (as listed below) that highlight just how comprehensive the services are that are offered to the young people and reflects the unique needs of the client population. These are:

Health Promotion, Education and Counselling
Reproductive care
Nutrition services
Teen parenting program
Mental health support service for HIV infected and affected Youth
REACH Cardiovascular program
SNAP – smoking cessation program SPEEK
School based Health and community programs
Health Promotion,

| | |
|---|---|
| Primary Care | Psychology |
| Ryan White HIV+ | Group |
| School based health clinics | Mental health teams |
| SPEEK Peer Education | Eating Disorders- C.H.O.I.C.E |
| Violence Prevention & Treatment | Family Therapy |
| Transgender | Behavioural Health |
| Outreach - Safe house / safe space. | School based health centres |

Research Unit / Centre for Excellence.

**Other Service Linkages**

1. Adolescent In-patient Psychiatric Unit in the Main Hospital: 12-14 beds
2. Out patient Methadone Program at hospital: For adults, not really for youth
3. St Lukes or residential treatment for acting out high risk young people – Young People who are functioning really badly get referred for day treatment to the Hawthorn Centre, Jewish Board. Referrals have to go via Child Welfare System post the courts.

**FUTURE GOALS**

1. To increase male involvement through the development of special programs to meet their needs.
2. To establish a research unit for the purpose of conducting extensive study, and fine tuning of present programs.
3. To become more visible in legislative efforts that promotes the well being of adolescents in the country through wider access to care and increased coverage.
4. To build an endowment that will provide health services to uninsured adolescents and to address newly emerging health needs.

**PROGRAMS**

**1. The Adolescent Substance Abuse Program**

The Adolescent Substance Abuse Program (ASAP) is a SAMHSA grant funded program designed to provide drug and alcohol treatment to adolescents ages 12-21 within a comprehensive mental health program. ASAP includes comprehensive screening, psychosocial assessment, and individual treatment planning based on the goals of either abstinence or harm-reduction. Additional services include individual therapy, group therapy, family therapy, psychological testing, psychiatric evaluation, and medication management. All services are funded by SAMHSA and are both

confidential and voluntary. Eligible adolescents will agree to take part in data collection (confidential) at the date of admission, as well as additional collection at 3, 6, and 12 months following admission. ASAP participants will also have access to all AHC services available.

**2. AIDS Prevention and Treatment**

AHC's comprehensive HIV care includes risk reduction, education and counseling, pre- and post-test counseling, HIV testing, viral load testing and CD4 counts, education on re-infection and secondary infection, respite counseling, stress reduction, nutrition, permanency planning, bereavement counseling, and medical treatment. In the past year, AHC provided 1,537 HIV tests and ran New York City's largest adolescent HIV/AIDS mental health program.

AHC is also a site for a five-year National Institutes of Health-funded research project on adolescent HIV/AIDS. HIV+ youth are monitored for adolescent development, the medical course of the illness, and the effects of health education on treatment adherence, nutrition, and at-risk behaviors. They are then compared to a control group of HIV-negative youth. The program seeks to develop HIV clinical management guidelines that reflect the biological and behavioral characteristics of adolescence. Additionally, specimens from 2,000 general population AHC clients are submitted to the New York State Department of Health as part of a statewide-blinded HIV seroprevalence study.

**Services Include:** Peer education – SPEEK; HIV risk reduction and testing; Support service for HIV-infected teens; HIV/Aids medical treatment; Ryan White Mental Health Project

**3. Counseling Services**

AHC runs New York City's largest program for adolescent mental health, including individual, group, and family psychotherapy; psychological testing; psychiatric services; diagnostic and psychopharmacological services; and specialized clinical social workers for mentally ill/chemically abusing and substance abusing adolescents. AHC provides specialized mental health services for incest and sexual abuse survivors, sexual assault survivors, crime victims, children of alcohol and substance abusers, and adolescents with eating disorders. AHC's Ryan White programs provide intensive clinical services and case management for HIV+ adolescents, and clinical support and bereavement counseling for HIV-affected youth and families. AHC has twenty clinical treatment groups, making it New York City's largest and most diverse adolescent group therapy program.

**Services Include:** Individual, family, and group therapy, Sexual abuse support services, Alcohol and substance abuse support services and referral, Teen Mom and Baby Program, HIV/AIDS support service

**4. Psychology**

There are two psychologists who provide Psychometric testing, supervise: individual, group, family therapies, pre-doctoral students, teach, provide consultation, and have an active involvement in research. Referrals are only from other team members.

**5. Health Education**

AHC's professional health educators provide programs in HIV prevention, teen parenting, asthma care, smoking cessation, substance abuse prevention, breast/testicular self-examination, and cardiovascular health.

**6. Medical Services**

AHC health providers are specialists in adolescent medicine and provide preventive medical services, acute care, management of chronic illnesses, and inpatient services. Each adolescent knows his or her own provider, and the provider serves as both primary care practitioner and case manager for all health care needs. Physical health and psychosocial problems are identified and addressed by a multidisciplinary - interdisciplinary staff.

**Services Include:** Complete Physicals for sports, camp, work, or school, Acute Care/walk-in services, Teen Mom and Baby Program, Nutrition and Wellness Program.

**7. Nutrition and Wellness Program**

The Mount Sinai Adolescent Health Center is proud to offer The Nutrition and Wellness program. The Nutrition and Wellness program offers comprehensive medical, nutritional and mental health services to those teenagers concerned about eating disorders, obesity/overweight, and/or problems with high cholesterol.

**8. The Eating Disorders Program**

The Eating Disorder Program provides medical, nutritional and mental health assessment and treatment for those adolescents with anorexia nervosa, bulimia nervosa, female athlete triad, binge eating disorder and other types of disordered eating patterns.

The Eating Disorders Program provides a comprehensive medical evaluation including physical exam and laboratory tests; nutritional evaluation, that includes assessment of diet, diet plans, individual and group dietary counseling and nutrition education offered by a registered dietitian; and Mental Health Evaluation that includes evaluation and ongoing mental health treatment provided by a Certified Social Worker with consultation by an attending psychiatrist.

**9. The Weight Management Program**

The Weight Management Program provides medical and nutritional assessment for the prevention, evaluation and treatment of pediatric and adolescent obesity/overweight and high cholesterol.

**10. Reproductive Health Services**

AHC provides reproductive health care which includes routine gynecological care, family planning, birth control education and provision, pregnancy testing, pregnancy options counseling, STD testing and treatment, HIV/STD risk reduction counseling, and HIV testing and counseling. AHC provides on-site colposcopy evaluation and treatment and is a major New York City referral center for the diagnosis and treatment of abnormal pap smears in the adolescent population.

In 1999, AHC introduced a new program for emergency contraception that has brought hundreds of new patients to AHC who receive access to on-going methods of birth control.

**Services include:** Family planning. Pregnancy prevention project, Pregnancy testing, Birth control advice and information, Sexually transmitted diseases treatment, Condom distribution, Colposcopy (dysplasia) services

**11. School-Based Health Clinics**

The AHC operates two adolescent school-based health centres at Manhattan's Julia Richman Education Complex and Manhattan Centre for Science and Mathematics which provide more than 1,800 students with medical, reproductive health, mental health, and health education services every year.

**12. Teen Parenting Program**

Through a multi-disciplinary team, AHC's Teen Parenting Program provides comprehensive services to approximately 200 infants, toddlers, school-age children and their adolescent parents. Parenting services include primary care and urgent medical services, social work, counselling, health education, child life services and evaluation, advocacy, and educational counselling and school placement for the teen parent.

**13. Trauma Program**

AHC is one of 17 original national sites to have been awarded a grant through the National Child Traumatic Stress Network, an organization created to care for and improve the lives of youth who are survivors of psychological trauma.

The AHC Team treats victims and survivors of traumatic events. The team is comprised of psychiatrists, psychologists, and social workers that specialize in the treatment of psychological traumas and related issues of bereavement and loss. The program provides individual, group and family therapy. Psychopharmacology is also utilized within the program. The Violence Intervention and Treatment Program is also part of this treatment team and provide a service for victims of sexual abuse and assault.

AHC operates New York State Department of Health-funded programs to provide comprehensive mental health services, preventive education, and advocacy within the criminal justice system for teen survivors of rape, incest, sexual abuse, dating violence, domestic violence and criminal assault. The teen sexual assault survivor program is the first of its kind in New York City.

The program also provides consultation, training and educational programs for agencies and schools within the NYC area

## KEY EXAMPLES OF GOOD PRACTICE

### 1. INTEGRATION OF PRIMARY CARE, MENTAL HEALTH AND GROUP PROGRAMS

A fundamental component of the service is the integration of Primary Care, Mental Health and Group programs that enable the service to provide the comprehensive, accessible and flexible care that it does to the young people, and demonstrates theory and philosophy translated into practice.

**PRIMARY CARE**

Primary Care staff work directly with the doctors at the medical clinic downstairs. Their role includes Crisis work ie: suicidal clients, Brief assessment and intervention, Group work and Specialist Medical requiring Mental Health input.

Medical Clinics are covered with at least 2 staff per shift for referrals. There are 12 clinics per week (including Saturdays), and on Tuesday and Thursday evenings there is a young women's clinic.

**Staffing**

There are 5 Primary Health staff, 4 Social Workers and 1 psychiatrist. There is a staff member located within the Eating Disorder Program and the violence prevention program, and 2 in the parenting program.

**Case Loads**

Each staff member has a mix of crisis, short term, long term and assessment cases, with 8 - 10 long term / ongoing clients.

**MENTAL HEALTH TEAMS**

There are 2 Mental Health teams that have different foci and are linked to different primary health programs within the service. There is the Tuesday Team (has intake assessment appointments on Tuesday mornings) that specialises in Substance issues Conduct disorders, HIV; and the Friday Team, that specialises in Violence prevention, Post Traumatic Stress Disorder, Depression and Anxiety.

**Referrals**

Cases are referred via the Intake Co-ordinator

**Intake**

The Intake worker is either contacted by phone, or a primary health staff member will request a time to see the intake worker, who is located within the primary health service.

The intake worker completes an Intake Proforma, gives a Risk Questionnaire to the staff member to give to the client, and in non-urgent cases, makes an Intake assessment appointment for the Tuesday or the Friday morning. The intake worker then collates information in readiness for the intake assessment appointment.

**Intake Assessment:** An intake assessment is done that covers a psychosocial assessment, a Mental Status Examination, safety, capacity to be in the community and family issues / supports. The young person is seen for 3 sessions, and then reviewed at the team allocation meeting to evaluate if the young person requires ongoing clinical input or not.

**Team meeting for allocation:** This occurs Friday lunchtime on a weekly basis. Cases are presented to be considered for ongoing treatment and in addition to this, there is a follow up discussion on the progress of the last week's intake assessments.

**Documentation:** 1. Intake sheet 2. Adolescent risk survey 3. Psychosocial 4. Problem sheet 5.Intake-recording sheet 6. Assessment disposition

## GROUP PROGRAM

There is an extremely comprehensive and dynamic group program that evolves and changes depending on the needs of the client group attending the Health Centre. AHC has twenty clinical treatment groups, making it New York City's largest and most diverse adolescent group therapy program.

There are groups run on Parenting, Relationships, for Sexual Assault survivors, for young people with Conduct Disorder, for Homosexual and bi-sexual young people, and for children of Substance Users.

### History

The program started small and was introduced gradually so that staff felt supported and "fed," making them feel like they were getting something out of it as well. Many people were anxious about running groups initially, however the anxiety was acknowledged and the coordinator made themself extremely available for support and coaching. The program started with the HIV Bereavement, the Young Women's,
The Rape Survivors (Via medical link), and the Adolescent Mothers Groups. From this point there has been a capacity for people to develop groups based on their interests, if they come up with a solid plan and demonstrate the need within and benefit for the client group.

### Diagnosis

The group programs are not based on diagnostic category but by identified needs and problems.

### Numbers

There are 6 - 8 young people per open group, and 12 young people in HIV group, which is a closed, fixed membership group.

### Screened

A group screening tool and psychosocial assessment are used to screen the young people for their readiness and / or capacity for group work involvement. It is felt that it is better to be rigorous and have fewer people that fit and can benefit from the group, than have large numbers of young people that were not ready or could not benefit from group work at that stage. The screening is done by the group therapist so they can feel they have control over the group process, rather than being forced to take all and sundry.

**Model**
The model involves a spectrum of activity, and an activity level depending on problem; for example the Conduct Disorder group is highly structured where as groups for older adolescents can be more open and flexible. The general emphasis of the groups is on discussion and sharing.

There are a number of tools or aspects focused on that are seen as important for the type of young people who attend the groups. Attention is paid to such things as commemorating birthdays and going out for dinner for the socialisation component. The use of food as part of the groups gets them there, acts as a socialiser, and decreases anxiety. In summer activities are run outside the centre where possible, and at other times there may be guest speakers on health / mental health issues.

**Conduct Disorder Group**
The Conduct Disorder Group builds on the relationship between staff and the young people within the group, as well as dealing with anger management. In the younger age the groups are single gender.

**Staffing**
There is one facilitator per group mostly, however 2 when there is a need for extra support (ie: conduct disorder and HIV groups). The program enlists staff from across programmes, and now 35 staff run 20 - 30 groups. All social work staff are expected to run at least one group.

**Supervision**
There is a strong emphasis on the use of and participation in supervision on a formal level as part of individual supervision, and on a peer level in the weekly supervision groups. This has created a culture of support and cross fertilisation of expertise and ideas that has fuelled much of the enthusiasm and energy around the innovative and expansive program development that has occurred. It also has promoted a strong sense of accountability to the service and the young people by making the work as transparent as possible.

## 2. SINAI PEERS ENCOURAGING EMPOWERMENT THROUGH KNOWLEDGE S.P.E.E.K

Although not specifically a mental health program, Sinai Peers Encouraging Empowerment through Knowledge (SPEEK), is a wonderful example of young people / consumer involvement, empowerment, early intervention and advocacy.

The program works with a diverse group of youth, aged 15 – 20 years old, who are recruited from out patients and trained to be peer educators. To date, the SPEEK program has trained over 100 adolescents to provide HIV/AIDS, STD, and pregnancy prevention outreach and education, and who advise AHC on program activities, needs assessment tools, and educational and outreach materials. In addition SPEEK staff provide workshops for over 4000 adolescents annually, as well as providing individual and group educational sessions.

Peer educators utilize interactive exercises to lead pregnancy prevention and HIV / AIDS workshops at schools, community centres and the Adolescent Health Centre. These workshops aim to build self-esteem, offer options and provide skills to help young people reduce their risk for HIV infection, Sexually Transmitted Illnesses and unplanned pregnancy.

**Aims**
The goal is to empower young people to make healthier decisions and to become their own health advocates. Adolescents are offered positive learning experiences so they can apply their newly gained skills to their personal lives and their career. Since peers have the ability to affect each other's lives, the hope is to create the opportunity for positive peer influences.

**History**
**1987** First HIV+ case in clinic was a young woman. There were concerns about what could be done to support her and the subsequent young people presenting, which lead to a pilot program of a support group.

**1988** Three groups ran for 10 sessions, with Pre, and post test evaluations. From this the young people were supported to continue an idea of peer education. Ten young people were recruited to do training of 78hrs (38 x 2hr sessions with a Graduation Ceremony and Certificates) during the summer. The training involved:

1. Getting to know you
2. Knowledge
3. Self-esteem
4. Range of subjects eg: STD, pregnancy
5. Decision making
6. Communication

It was very experiential and had them actively learning facilitation skills. Peer educators then became mentors to new young people. Most have now been in the program 1 – 2 years.

Peer educators now do a range of activities with staff regarding support and recruitment of other young people.

**Numbers referred**
There are over 150 applications per year. They are predominantly females however more recently there have been an increase in male applicants (still 2:1 ratio).

**Process (for recruitment, summary)**

1. Interview
2. Orientation / training
3. Regular groups
4. 5 page contract drawn up
5. 3-hour sessions per week with educators on Fridays ie: resume writing, topics of their choice.
6. Every year the peer educators go on a retreat to a new place for 2-3 days to promote group bonding in a challenge situation ie: ropes courses, climbing

**Process**
After reviewing applications and interviewing potential candidates, the staff select a small group of youth to attend a 60-hour training on various issues including values clarification, HIV, pregnancy prevention, anatomy, Sexually Transmitted Illnesses (STI's), decision-making, communication and group facilitation. Peer educators are trained and supervised by health educators to lead a range of activities including running workshops, conducting outreach and participating in special projects such as the development of a quarterly newsletter (Refer below).

**Supervision**
The group meet every week for 2 hours. Mentors arrive earlier and leave later for pre – post supervision. There is always a staff person scheduled between 10.00am – 7.00pm (divided between 3 staff) to cover any support needs of the educators

**Roles of S.P.E.E.K staff and Peer Educators: Prevention and Education**

**Mentoring Program**
This intense program pairs youth from the community with young adult role models to emphasise the importance of education and encourage healthy behaviour. Ten young people pair up with ten College students over three months for 12 – 14 sessions that include tutoring, workshops, and small group work.

**Community Outreach and Education**
Outreach efforts provide prevention and education to clients of youth serving agencies, schools and community agencies in New York City with special emphasis on the East Harlem community. Health educators and trained peer educators provide workshops for youth on HIV prevention, pregnancy prevention, STD's, anatomy, safe sex, condom negotiation, relationships, decision-making and communication. Workshops for parents are provided as well. Educational messages are in various mediums – posters, t-shirts, videos, and the Webb.

**Education Groups at AHC**
Waiting room groups and other educational groups are provided on a regular basis
The peer educators and a staff member go to the waiting room in the Adolescent Medical Centre at peak hours daily (usually about 3.30pm). There they run workshops, videos, and an informal RAP group.

**Street Outreach**
Risk reduction education and counselling are provided to youth on the streets, local parks and neighbourhood hangouts of the East Harlem community. Referrals for services are provided as needed. Literature and condoms are available.

**Other projects peer educators plan and implement**
**Newsletter:** Quarterly newsletters including astrology, updates of clinical services, community events, games and articles. HIV and pregnancy prevention are emphasised.

**Pamphlets:** Peer educators are involved in the development of health education pamphlets.

**Multiple Interventions:** A series of workshops to the same groups of adolescents over a period of time.

**Videos:** Peer Educators are involved in the creation of health education videos

**Conference:** Youth from the community are invited to participate in an all day fun and information conference. Over 50 young people usually attend.

**Health Fairs:** Information on health and clinical services is provided. Literature is distributed.

**Clinic tours:** Information about the clinic services is provided to individuals or groups.

**Youth Fest:** This is a community event to provide youth with positive health messages and to celebrate youth involvement. Over 150 young people from 13-19 years old attend.

**Condom Availability:** Available via outreach workers and the clinic.

**Technical Assistance and Training:** Staff training or technical assistance is available to individuals or groups in youth serving agencies on adolescent health issues, sexuality, and peer education program development.

**Problems / challenges**

Getting the balance between consistent limits and working where the individual "is at". Young people may go on probation if they have issues going on that may be affecting their ability to do the job. They get strongly encouraged / supported to see one of the Social Workers to assist them. Also some internal relational dynamics at times need to be managed, ie conflict and competitiveness.

**Outcomes**

The program gets a diverse group of young people who come in with ability and skills that had not been developed and now are; staff look for and build on specific skills ie: verbal, writing and leadership. They also build extremely positive relationships by their commitment and availability.

**Why a success?** Key features that make this program a success are that it is accessible, flexible, youth friendly, has direct links to and from the clinics that facilitate easy contact, and uses a learning model that always builds on and gives concrete outcomes, i.e. things the young person can finish. This means they have tangible things to show for attending.

## 3. VIOLENCE PREVENTION & INTERVENTION

**Funding:** Grant funded by Dept of Health. State of New York.

**Back Ground data**

In the United States, a woman is raped every two minutes. Half of all rape victims are under the age of 18 years old. One in every three adolescents will experience

relationship violence. Relationship violence happens in same-sex relationships at about the same rate as in heterosexual relationships. Eighty to ninety percent of sexual abuse offenders are known to their victims. As many as 38% of females and 16% of males are survivors of sexual abuse. Every year in America, nearly three million cases of child abuse are reported.

## SERVICES OFFERED

### Counselling/ therapy

Ongoing Individual Therapy and Support, Psycho Educational Groups, Family Counselling, Psychiatric Consultation and Psychological Testing for survivors. The service also provides crisis intervention, and is on-call to attend emergency and outpatient medical departments.

### Medical

Medical intervention includes HIV prophylaxes, comprehensive medical care including reproductive and gynaecological health care, health education and HIV pre and post test counselling.

### Legal

Police and criminal justice system advocacy,

### Prevention through education

Adolescent Health Centre clinicians provide educational workshops on the prevention of relationship abuse, sexual abuse and assault, as well as the prevalence and impact of child and adolescent sexual abuse and violence on survivors. The workshops are for adolescents (in area schools) and for professionals (in community based organisations, teachers, nurses, doctors and other service providers).

**Age:** 14 - 21years old for the group work (but will see 12year olds individually).

**Referrals:** An intake meeting occurs every Friday morning, however direct referrals are taken from teams, Emergency Medical Department (EMD), and Adult program Sexual Assault Violence Intervention (SAVI).

**Rate:** One rape from Emergency (EMD) per fortnight at least. There are a lot of date and acquaintance rape referrals.

**Process:** Safety must be assessed first, as the service is mandated per Social Services*. The young person is then seen twice per week initially, then once per week.

* Young people are usually agreeable to this although they may be angry at first; they usually feel safer once it is done as they were crying out for help. Often it is found that they have a past record with Social Services.

**Groups:** There are 2 types of groups run; one for Rape Survivors, and one for Sexual Abuse Survivors. The groups run for 12 weeks and are semi-structured (They have ground rules on time and confidentiality). The groups are also divided into two age brackets, 14 – 16 years old and 17 – 21 year olds, as 14 and 21year olds are not put together due to their very different needs and developmental levels.

**Supervision:** Supervision is seen as essential. One hour per week is given to cover cases and management.

**Challenges:** Lots of rape cases drop out, therefor there is a high turn over, and the pathology of the young person presenting is intense.

**Outcome measures:** If the young people engage and come it is seen as a huge achievement. Other areas where there have been improvement noted in the young people who attend, are school performance, better choices of relationships, protecting themselves more effectively ie: safe sex, and generally taking care of themselves better.

## 4. MNT SINAI RESEARCH UNIT

The Mnt Sinai Research unit was established 3 years ago as a vehicle for Practice Based Research. It arose from the staff wanting to know what they were doing and if what they were doing was actually working. Mnt Sinai was also recognised for delivering really great services, but no one knew about it on a National level. The service had no formal recognition and therefore needed a Research Unit to create a National profile.

**Staffing**
The staff consists of a Research co-ordinator who holds this portfolio in addition to their clinical role, a Physician researcher in Adolescent Mental Health, a Health Economist, 2 Program Assistants (a secretary and research assistant specifically to formats grants) and 2 Research assistants for pure research.

**Process**
The process for implementing a research project is that there is an initial meeting with the research co-ordinator to set up a research proposal, and clarify and pull ideas together. Prof Irwin Epstein is also part of this meeting and helps to pull it together from an ethics perspective. The project is then presented to peers and staff to ensure there is a broad knowledge of and involvement in the research activities within the service. This is done by holding staff breakfasts and in-services.

**Projects**
The projects that are currently in progress are as below:

1. Risk factors in Adolescents – School based
2. Loss in the Community
3. Attitudinal change to sex education

**Challenges**
The challenges have been that staff taking on projects can feel pulled in both directions between direct clinical work and research, and to have projects acceptable to both Mental Health and Health. It was also noted that Mental Health could be protective of patients regarding access to researchers.

**Benefits**
There have been a number of real benefits for the staff members and the service as a whole. It has given people the opportunity to work together in ways they may not have previously, and most have found meeting with other peers in the research forums

really supportive. The training in use the of research tools has been beneficial, staff have also found the overall process has made them reflect on the work they are doing and as a result this has encouraged them to keep themselves sharp clinically.

It was found that having students around keeps the organization grounded, prevents being blind to their own system, and also brings in new information from the universities. There is a conscious attempt to get students from different training programs to ensure multimodal interventions.

All of this promotes a Learning Organisation with the focus of success off the client group solely. The client group is 60 – 65% High-Risk population, which is stressful for the therapist. These other things help therapists by diversifying their focus and by giving them support in their practice.

**Outcomes**
The program is doing extremely well, with a majority of the staff either actively involved in research projects, or contributing by attending the research breakfasts and giving support where they can. Beyond this the program recently got a grant to develop a research program for Adolescent Health Fellows. The program also links in closely with The Centre for Excellence, which has provided a rich cross fertilisation between clinical practice and research / academia (Refer below).

## 5. THE CENTRE FOR EXCELLENCE

The Center for Excellence (CfE), is a division of Mount Sinai Adolescent Health Center committed to building the capacity of service providers and community-based organizations to work with young people by providing technical assistance and training in the areas of Adolescent risk and resilience, best practices in promoting positive youth development, building on strengths of young people and communities, collaboration and partnership among service providers and communities, practice-based research, strategic planning and staff development.

It was established in 2000 through The New York State Department of Health's ACT for Youth (Assets Coming Together for Youth) initiative, which uses a youth development approach to pursue the goals of reduced violence, abuse, and sexual risk among young people ages 10-19 in New York State. The ACT for Youth initiative funded the development of eleven Community Development Partnerships (CDPs) and two academic-based Centers for Excellence, of which CfE is one. The initiative also funded an Upstate Center for Excellence, which is a collaboration among Cornell Family Life Development Center, University of Rochester Division of Adolescent Medicine, and New York State Center for School Safety.

The CDPs are made up of community-based organizations, young people and community members, and public agencies coming together to work toward the common goal of positive youth development. The youth development perspective looks at both the influence of young people on their environments and the influence of the environment on the healthy development of young people. Good youth development work focuses on helping young people reach their full potential by working with them directly AND on improving the environments young people spend their time in.

**Principles**
In order to build these healthier environments within communities, the ACT model calls for the CDPs to build six things; a focus on positive youth outcomes, facilitating youth engagement and a youth voice, inclusiveness, long-term involvement, community involvement and collaboration.

**Desired Outcomes**
ACT communities use the above six principles in different ways and to varying degrees, but desired outcomes include; increased opportunities, services, and supports for young people, increased youth engagement, organizational change, and community policy change.

As part of the work on the ACT for Youth initiative, Cfe provides the CDPs with technical assistance, informational resources, training, and help with evaluation to support their work.

**Staffing**

The staff consist of a Ph.D. Coordinator, an Evaluation and Policy Researcher, a Training & Resource Specialist, a Program Evaluator, a Consultant Professor, and 2 Program Assistants.

## DISCUSSION

**The SPEEK Peer Educator Program**
The SPEEK program was a wonderful example of how the service targets young people and makes it accessible to them in an adolescent sensitive way. The program empowered young people by giving them training that was relevant to them and a role beyond the training that gave them value and purpose. The young people I met were extremely proud of themselves and their success, as well as what they did in the peer educator roles for the service.

They obviously had a very respectful two-way relationship with the staff. The staff met were also extremely enthusiastic and proud of the program and the young people, given the backgrounds that many of the young people had come from and the circumstances they had to overcome to get to the program.

The work delivered to the other young people in the community by the peer educators and staff was a continuation of the service being accessible, youth friendly and relevant to the specific young people who the service was targeting, for example the street outreach health education and promotion work.

**The Group Program**
The group program was also a good example of how the service developed based on client needs, and the flexibility and youth sensitivity around the groups. The fact that young people were accepted based on need and not on diagnosis exemplified this, as did the topics for the groups, the location and the support structures around them, ie. the fact that there were ongoing low key education groups run in the waiting room to be accessible to those who may drift in via that avenue, and that in the more formal groups food and special occasions were used to create a sense of nurturing and celebration, both of which were an important way of engaging difficult to engage young people.

**Violence Prevention and Intervention**
This program further demonstrated a number of the principles that informed service development within the AHC. These included program development based on client need that was delivered in a flexible and adolescent sensitive manner, that integrated a range of treatment modalities from both the primary and mental health fields, and that were accessible to the young people via the one program / point of contact.

**The Centre for Excellence**
The Centre for Excellence took the adolescent sensitive philosophy to the next level in a way that was truly impressive, in that it moved into advocating for young people on a State and National / International policy level. It was also a level that I have become increasingly aware of as a gap both in my own experience and awareness, and as something that is often missing in services, where true advocacy for young people tends to get lost in management issues and organizational, funding and political dilemmas. However it is something I have come to appreciate as essential if there is any real difference going to be made in the quality of services funded and therefor what is available to young people and those who wish to support them.

Another aspect of note in relation to the Center for Excellence and it's link to the research program was a theme that has been consistent throughout this report, that is the promotion of clinically driven research that has direct application to enhance service delivery, with the aim of making research available and inclusive of clinicians; ideals that again reflect a Learning Organisation approach.

**Integration with Primary Health**
The AHC demonstrated how Mental Health and Primary Health could be integrated in a meaningful way, and in a way that preserved the integrity and respected the specialist areas of each. Both aspects of the service appeared to really appreciate the expertise of the other and what both areas contributed to the service, the young people and each other. There was no real evidence of the "us" and "them" division that can often exist between the two areas. The combination of the two made holistic care quite accessible to the young person, who felt welcomed into the service and could get a range of needs met within the one service rather than having to negotiate their way through a complex network of separate services and intake systems.

**Summary:** The Adolescent Health Centre (AHC) was quite a unique service and has a leading role in providing health services to adolescents both locally and further a field, within an area that borders the poorest and the richest areas of New York. It was the first primary care program in New York specifically designed for the health needs of adolescents and stands as the nations largest provider of health care services to adolescents. It is the only program of its kind in the country, and is used as a model for effective healthcare programs for urban adolescents.

The breadth of the services offered and how they have evolved to be responsive to the needs of the population and delivered within a solid adolescent philosophy was quite remarkable. It also demonstrated how different models could be integrated yet specialist areas and skills protected (particularly in how Mental Health and Primary Health had been integrated). Along with the other services reviewed, it further demonstrated the integration of theory and research with practice and program development in a way that involved and inspired staff.

## 9. OVERALL DISCUSSION RE SCHOLARSHIP

The material presented above is an indication of the richness of the experience and the caliber of the programs seen when traveling on this scholarship. The initial seduction to see and do as many things as possible, reinforced by the evolution and expansion of my professional role, led to having contact with a huge amount of services, attending a number of conferences, and to delivering and attending a number of training seminars.

This led to the choice to present 4 services in depth, to both reflect the depth of involvement and knowledge gained, and to represent some of the range of what was seen and experienced. However whilst representing different domains, there were a number of things most of the services had in common in both the challenges they experienced and some of their key features or strengths on a clinical and organizational level, which will be discussed here. Those more unique to the individual program have been discussed under each section above, however certain important aspects will be reiterated in the discussion below.

### CHALLENGES

The challenges tended to be experienced on or originate from 3 main areas or levels; these were Socio-Political, Organizational and Clinical.

### SOCIO-POLITICAL CONTEXT

Whilst undertaking this study tour, it quickly became apparent the profound influence the Socio- Political context had on all levels, from the macro to the micro, in relation to the mental health and well being of children and families and on the services established to support them. As stated by Crisp (1996), "notions of mental health and the sociological influence on problems, effects how programs are developed and what their place is relative to other services. Together with historical precursors, this has contributed to the diversity of program types and how they are applied"(p3).

Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie & Hamilton (1997), develop this further by saying, "It is important to recognise that the introduction of new treatment approaches is often hampered by social and political agendas" (p639). They emphasise the reality of working with the larger social and political structure, as a significant component of programme development needs to be acknowledged, as it is within this context that programme development takes place. They go on to say, "Mediating the impact of the complex forces that impinge on programme delivery requires skill and political sophistication that challenge even the most experienced practitioners" (p640).

The work of Moretti, et al, and two reports from the United Kingdom, The Big Picture report (1999) and Together We Stand (Jan 1993- Feb 1995), were utilised in Section 6 to highlight the impact of the socio-political issues. The reports from the United Kingdom explored in-depth the broader social and political context and the impact this has on the mental health of children and young people within the United Kingdom, as well as the impact this has on the structure and delivery of Child and Adolescent Mental Health Services. Many of the issues covered were common to other countries visited, and have particular relevance to Australia; therefore they have been outlined in detail. (The relevance to the Australian context is be explored in

detail in the discussion at the end of Section 6 and at the end of this discussion under Major Lessons Learnt).

**Social context**
The reports referred to a time of rapid change on the social, economic, political and managerial levels, in which people have to cope with increasing complexity, instability, diversity and conflict in both their personal and working lives. Many of these changes are occurring on many levels in Australia and other countries, leading to similar dilemmas and challenges for young people, families, services and governments; particularly those relating to changes in social structure with the move to economic individualism, competition and the erosion of mechanisms for maintaining social cohesion. The interplay between these factors has had a profound effect on both the structure and function of the family and of the role of children within our society.

As stated within the Big Picture and also evident in Australia, the impact of parental separation and the fragmentation of the extended family networks have increased the sense of isolation of both families and children. The fact that children have become viewed in terms of economic commodities by governments, with more and more the sole responsibility for their social, emotional, physical and financial well being placed within the nuclear family adds further stress to the family unit, that is making it "increasingly difficult for vulnerable parents to meet their children's needs" (The Big Picture, p10).

The shifts in the labour market, with the greater social differentiation and income inequity, the emphasis on competition, academic achievement and the diminution of unskilled employment has become more and more evident in Australia and other countries, with now 2nd and 3rd generation unemployment, and has far reaching effects on the circumstances our children and young people are growing up within and the opportunities open to them.

As stated in The Big Picture, "The myths and priorities of the late 20th century life have separated many children from their wider communities and it is therefore small wonder that some feel little sense of involvement with or responsibility to the society around them and vice versa. Our acquisitive society tends to see children as the sole property and responsibility of their parents rather than also members of a community or even as citizens" (p5).

**Adolescence**
The report recognized that adolescence is now a longer, more complex and less predictable transition from childhood to adulthood, where some young people may lose their way, that there has been an increased emphasis in the education system on academic attainment and an increase in school exclusions, juvenile crime and adolescent suicide/self harm rates.

**Incidence of Mental Health Problems**
The Big Picture report noted that in increasing numbers children and young people are failing to thrive emotionally, are less able to cope with the ups and downs of life, and increasing numbers of them are going to develop severe and enduring mental health problems. The difficulties were seen to already manifest in the growing

numbers of families experiencing multiple problems, school exclusions, juvenile crime and the worrying suicide and self-harm rates among young people as mentioned above.

Statistics given regarding the incidence of mental health problems highlighted that fifteen million children and young people less than 20 years old in UK (25% population) will experience some form of mental illness in their lives, and that at any one time 20% of the population experiences mentally ill health (1:5), which is similar to that of Australia and the other countries visited. In addition to this the report stated there has been a clear increase in psychosocial disorders in youth since World War II in nearly all developed countries.

The report stated that theses problems, “are causing immense distress to the individuals and their families, limiting the potential of future generations and yet we, adult society, are largely blind to the problems. But it is a blindness of the ostrich. We do not want to see it because it’s too uncomfortable, because to recognise the need in others we would have to confront too many painful facts about our own emotional and mental vulnerabilities.” (The Big Picture, 1999, p4).

**Political**

These societal pressures influence and are influenced by the political climates and agendas of the country within which they exist. There were areas of difference that were politically and culturally based, however what stood out was some of the similarities.

The Big Picture report highlighted that although there is a broad political consensus that supporting families is the best way society has devised so far to raise children, many of the changes in society are making this more difficult, especially as the role of the State, Government and Public Services in supporting families has in recent years been reduced or changed in this area, and their ability to solve social problems has been questioned. This has placed additional stresses on the family and contributed to the difficulty mentioned earlier for parents to meet their children's needs.

In addition to the above, Moretti, et al, (1997), give specific examples of the influence of political agendas on program selection and funding. They highlighted the fact that "during the past decade, public outcry regarding youth crime has prompted politicians to implement programmes that respond to concerns regarding public safety and restitution that are often designed to appease public demands rather than to implement new programmes based on research" (p647). They cite the example of programs for Conduct disorder within Canada, stating that, “Despite the fact that conduct disorder is extraordinarily costly and that early intervention strategies are well foundered in research and promise effective returns, prevention programmes are rarely considered. This again likely reflects the short-term political agendas that focus on appearing to solve current problems and demands rather than long-term investment in preventing future ones" (p647). This is to gain immediate favour from the voters (i.e. for the term of their political office).

The Big Picture report also stated there is a tendency that no government will invest in long-term programs that will not yield results in their lifetime, however it saw the government as beginning to acknowledge the need for government departments to

work together to address at least some of these issues, but that inconsistencies were still evident. It stated that successive recent government proposals on children and families * are a great improvement on what has gone before, "nevertheless still fail to address the fundamental fact that the root cause of so much dysfunction in individuals, families, in schools, organizations and in society as a whole is poor mental and emotional health and that as a result can only be partially successful" (p5).

*Recent government proposals include the aim to reduce social exclusion, to support those who are vulnerable, to strengthen the family, and to promote joint solutions to complex problems.

Again, as in the United Kingdom, more recently there has begun to be a shift in focus toward Child and Adolescent services generally, however there is still a long way to go in both the support of exiting services and in effective service development. Some of the recommendations outlined within the United Kingdom reports therefore, have major relevance to Australia on a broader social and structural level, as well as on the more specific service level, and are summarized as part of the recommendations below (Refer to Section 7 for a more detailed outline of recommendations made within these reports).

**Impact on CAMHS Service provision**

The Big Picture report outlines that work relating to the mental health of children and young people – like most work on modern social issues – involves a continuous process of reconciliation between different conflicting pressures. These include the conflict between personal freedom and public protection, diversity and uniformity, local discretion and central control, open access and targeted provision, equity in process and effectiveness in outcome, risk and safety, and inclusion and exclusion.

Further to this, the report goes on to say that these tensions can arise in the formulation of policy and legislation, in the development of professional practice, and in the management of organisations, and that such pressures tend to underpin and reverberate across the many tiers of influence from the political decisions made down to the conflicting pressures experienced by clinicians in delivering their day-to-day service.

However, whilst in any work with children and young people the conflicting social pressures outlined are operative, there are additional conflicting pressures on a service delivery level in a culture where on a ministerial and policy level, services are not thought about and are ill defined.

Moretti, et al, (1997), emphasized that, "when services are not integrated with a common goal, a common paradigm for understanding the social problem, a common language of how to work together, families and children fall prey to fragmented services and interagency debates about mandates and responsibilities" (p646).

**Current Situation CAMHS Services**

This is reinforced by the findings outlined within The Big Picture regarding the current situation in Child and Adolescent Mental Health Services in the United Kingdom. It reported that specialist services are patchy, under-funded and plagued by lack of co-ordination and discontinuity's between agencies. Similarly, vital universal

and early intervention services are piecemeal, subject to short-term funding and unintegrated, and that a major difficulty facing these institutions is whether they can work within the present labyrinthine structures, guidance, legislation and funding regimes.

It also stated that mental health services for children and young people are starved of resources, and that other recent reports, most notably the Health Select Committee report, have also highlighted the lack of services, funding and priority given to services for children with mental health problems. (The issues specific to Child and Adolescent Mental Health Services are outlined in more detail in the summary of the report Together We Stand, et al, in Section 7).

In addition to this, services cited that the policy of community based services and deinstitutionalisation that began in the 1960's, has put increasing strain on families and support services, as the resources did not follow out into the community. The sequelae to this has been a breakdown in social supports and long waiting lists, which was seen to often have contributed to the delay in young people with mental health problems being detected and receiving treatment. This in turn has often exacerbated their illness and negatively affected their prognosis.

Other funding arrangements such as mainstreaming psychiatry into the general public hospital system have often created financial difficulties in obtaining the designated funding from the parent hospital in some countries, particularly New York and here in Australia in many instances, and the dependence on grants in New York, where there is very narrow specifications about what service can be provided and to whom, can limit the provision of holistic and generally accessible care.

The combination of all of the above has had fear reaching effects on government policy and funding priorities and the structure of service systems. As in the United Kingdom, with the exception of Norway, in the countries visited there has been a lack of priority given to services for children with mental health problems. This has led to a general lack of focus or funding to these services, and an overall lack of support, direction or resources. In keeping with the situation outlined in the United Kingdom, mental health service for children and adolescents in Australia have been starved of resources, and, as stated by Moretti, et al, when they describe the similar situation in Canada, "clinicians struggle to implement the best strategies they can within these parameters." (P 646).

## ORGANIZATIONAL

### Fragmentation

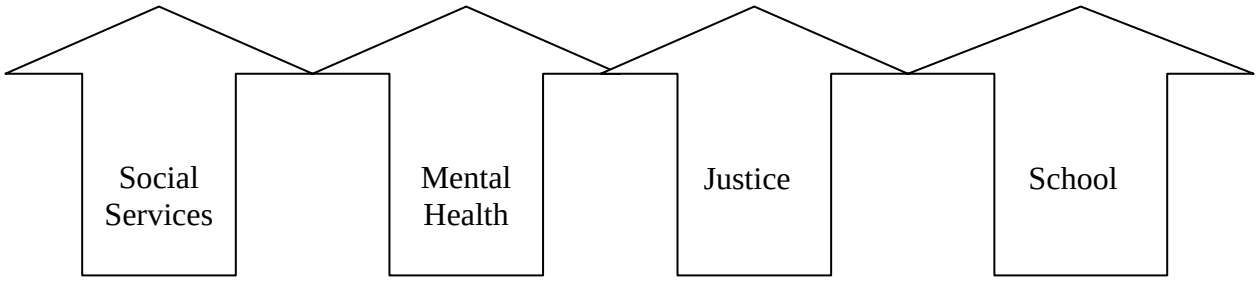
Further to the above, because service development has been driven by Political pressures, they have grown as a "hot potch". This has led to the provision of services for youth and families being fragmented so that co-ordination of services is extremely difficult. This often results in a situation where providers attempt to define service requests as outside their mandate in order to preserve limited resources

### Silos

The fragmentation of services and interagency debates about mandates and responsibilities, as outlined above by Moretti, et al, 1997, is often referred to as the Silo affect. The diagram below represents how services are often separated by the

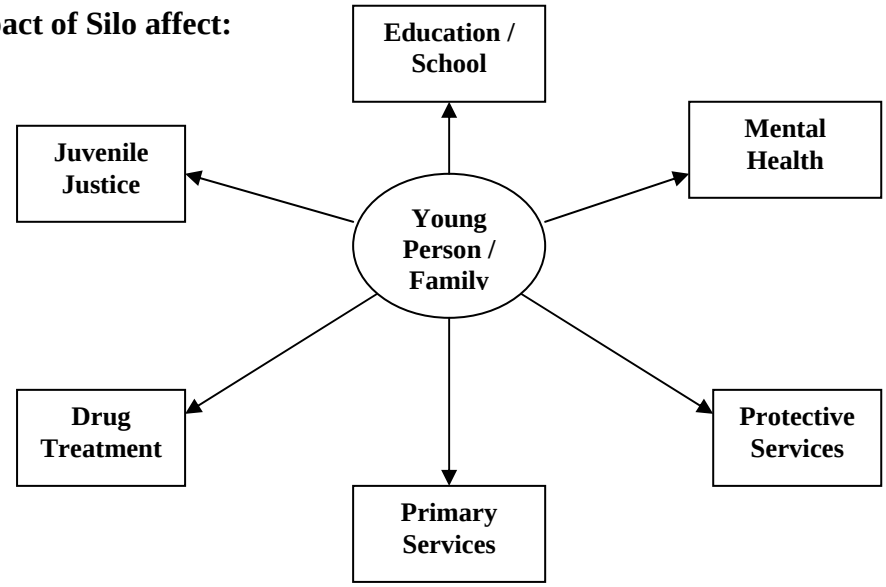
mandates they work within, and where there are major communication problems between and across services.

**SILO EFFECT**




The impact this has on young people and families seeking help, or being involved with a number of services that do not communicate nor integrate their approaches can be devastating, and is one of the major criticisms of Multisystemic interventions. These have included concern that the interventions may fail to identify and target underlying systemic problems in families and communities that contribute to the maintenance of the problem; that the interventions may not coherently 'hold together' and make sense to family members, mental health practitioners and others involved in supporting the family, and finally that the interventions may work at cross purposes and end up increasing the likelihood of splitting between the family, mental health providers and the service system at large.

**Impact of Silo affect:**




**Managing Change**

Services were constantly evolving because of changes in policy, funding, legislation, and client population, which created both challenges and opportunities for most of the services visited. This required effective change management processes that were evident in the programs outlined above, but are often mismanaged or absent in many organisations. The effects of this are destructive for staff and clients and add to or accentuate the fragmentation and pressures outlined above.

In addition to this**,** developing new models of practice takes time and energy on many levels; creating cultural change, getting people to refer initially, integration to the rest of the hospital/service and the challenge to maintain the integrity of the program and ensure all the components are covered were some that were common to each of the services. The practicalities of the intensive time involved and the cost of delivering the service was also a theme.

## CLINICAL

### Increasing complexity of client

Each service highlighted the increasing complexity of their clients. The profile of client was extremely challenging with complex family and psychosocial issues that gave rise to multiple needs – social, educational, mental health problems and for the need for multi-service involvement. In light of the above challenges outlined regarding fragmentation and the Silo affect, the consistent challenge shared by the services seen worldwide, was how to integrate care that crossed a number of service sectors.

### Managing minimal resources and the pressure on service provision

Each service, with the exception of Rogaland Psychiatric in Norway, was struggling to obtain adequate funding and resources for the services required. Despite the increasing complexity of the client presenting, and the shared recognition that attachment is important for children, services still often experienced a pressure to provide short term interventions to manage through put or demand with minimal resources. This was often reinforced by the political agendas and funding models as outlined above.

### Difficulties getting enough trained staff in the child and adolescent area

This was a universal problem that is experienced Australia and in each country visited, particularly in the disciplines of child psychiatry and psychiatric nursing.

## KEY FEATURES COMMON TO THE SERVICES REVIEWED

Despite being very different services with different mandates, there were fundamental underpinnings on political, organizational and clinical levels that made them stand out as dynamic and effective services.

## Political

Recognizing the impact of political policy and direction on both service delivery and ultimately the opportunities and options for young people, each of the services saw lobbying on a State and National level for young people as an important component of their work; some to the extent of having a specific portfolio or program within the service to do this, for example the Mnt Sinai Centre for Excellence.

## Organizational

### Program Development

There were a number of key elements that made program development within these services extremely comprehensive that are closely linked to and reflect the learning organization principles in practice.

These included having a service with an over arching framework with a strong philosophical, theoretical and practice base; this was evident in each of the services, particularly the Maples and Mnt Sinai. Having a management structure and change management process that were congruent to this framework was seen as an important aspect to compliment and support the principles aspired to; again this was seen in each service and highlighted within the Maples.

The process of service development was seen as equally important as the outcome. This process was where a need was identified, research was undertaken into the best practice in relation to that need, followed by community consultation and involvement. From this data a pilot program was designed and run followed by an evaluation, which informed the evolution and refinement of that program. Finally the important elements and processes of the program were documented and outcomes were published and disseminated.

**Practice Based Research**

Research and evaluation were seen as a fundamental part of program development, not as a possible adjunct, and were built into the structure and processes of the programs seen. In each of the services discussed, programs were based on well-researched local need and were therefore client centered and meaningful. This exemplified the final aspect of having evidenced based practiced that linked theory and research with real practice and thus reflected the learning organization philosophies as outlined below.

**Learning Organizations**

The principles of a learning organization that were consistently reflected within the service models were such things as a shared vision and goals based on a theoretical underpinning, having a philosophy of enquiry, that promoted reflection and evaluation, using an all staff approach that included ongoing training and professional development, having structures built in to facilitate these processes and having strong links to universities and academic institutions.

The integration of theory and research with practice and program development was done in a way that inspired and involved staff. The combination of this promoted a culture of life long learning and continuous professional development within each of the services reviewed.

**Community Collaboration and Integration**

Whilst having slightly different strategies for approaching the problem, each service recognised the need for innovative ways to overcome beaureacratic "Silos" with broad and practice based partnerships, and acknowledged that service provision had to occur within a multi-agency partnership at both the strategic and operational level in order to meet children's complex and inter-related mental health developmental, educational and social needs. The model of joint health and social care or Joint Commissioning in the United Kingdom and the Community Care Plans of the Maples centre were particularly effective and dynamic examples of this.

**Clinical (General)**

**1. Linking theory and practice**

Theory and Philosophy that translated into practice and linked with research to inform and evaluate practice was seen as essential and was integrated into the program structure and service delivery. This was enhanced by the specialist team based structure where the program was specifically tailored to meet a researched client need (Refer below). The promotion of learning organization principles further enhanced this, where staff built up specialist skills and were actively involved in the research and evaluation process.

**2. Systemic thinking / Community Integration**

There was recognition of systemic and environmental issues and influences that led to a range of specific structures and processes within the programs to address these. In addition to the importance of the community and collaborative projects as discussed above, other initiatives such as community based services, outreach services, community care plans and making training and education accessible to the community, all helped to keep the young person connected to their community and supported the multi-modal multi-dimensional interventions that were needed to address the needs of an increasingly complex client group.

**3. Youth Specific Services**

In each service there was a strong focus on youth specific services that were accessible, developmentally sensitive and adolescent friendly. Such features as long-term flexible treatment that was supportive of families and other social connections were examples of how the specific program managed to successfully engage young people.

**4. Primary Mental Health**

The interface with the primary health and other services and the role of dedicated mental health workers within that was something that featured highly in each service, particularly Leicester CAMHS and Mnt Sinai Adolescent Health Centre. It was seen as essential to link Child and Adolescent Mental Health Services with the continuum of services to ensure they did not operate in isolation and that the expertise across services could be shared to best support the young person and their family in a more community centered, less fragmented way. The importance of streamlining services where possible to a single point of entry to prevent individual referrals to multiple services was particularly important for the high-risk categories.

**5. Team Based Specialist Services**

Each service utilized a specialist program based structure, where practitioners became part of developing a specialist team and were both supported and expected to develop specialist skills on both the clinical and research level. This created a focus and a space in which to build a solid philosophical and practice framework. On the practitioner level, this promoted a strong sense of ownership of the program and very much linked with the goal of supporting continuous professional development and creating a "Culture of life long learning" across all clinical areas. On the clinical level the client benefited in having a specialist program based on an identified client need, in which specific skill and expertise was then developed to meet that need.

**6. Specific Clinical Interventions**
The clinical interventions that were specific to each service are outlined in-depth under the relevant sections. These included working with conduct disordered young people using an Attachment Theory model and Community Care Plans at The Maples in Canada; A comprehensive model for working with young people experiencing first episode Psychosis, with multi- family group work as a feature in the TIPS program, Norway, Integration of Mental Health with Primary Health and use of a strong adolescent philosophy in Mnt Sinai Adolescent Health Centre, New York, and a range of programs working with primary health in Leicestershire and Rutland CAMHS, the United Kingdom.

**7. High Risk**
What is important to note is that whilst specific programs for high risk youth were visited, all the key features discussed in this report are equally essential and relevant, if not more so, to work with this target group, as without the solid structures to support the clinician and the community it makes it almost impossible to effectively support the young person.

The programs seen that specifically targeted High Risk Youth demonstrated this clearly. Each service emphasized the need to have a common vision, paradigm, and language and working agreement, both within and across services. This highlighted the need for Collaborative, Multi-agency, and Multi-interventions that were delivered in strong partnerships and supported by clear collaborative structures that had a solid pragmatic application in day-to-day practice.

The range of interventions on the direct clinical level and on a more consultative and advocacy level included the in-patient and residential work of the Maples and Rogaland, the role of Primary Mental Health, particularly in Leicestershire and Mnt Sinai, extensive group work and consumer participation within Mnt Sinai, and the Consultation, Training and Outreach work of each of the services (refer to individual service sections for detailed outlines and discussions).

However despite different approaches utelised, the importance of long-term work with this client group and the importance of relationships, in particular the active use of the therapeutic relationship was consistently emphasized and supported (A more detailed framework is outlined within the recommendation section that follows).

**SUMMARY**
The services seen were all exceptional services on many domains, and demonstrated a wonderful mix of sophisticated program development, innovative and comprehensive clinical work, and reflective practice based research within the context of a very grounded and pragmatic approach to the client and their needs.

The combination of the above with the integration of a range of theories and models into practice provided a strong and cohesive framework for the programs to develop within. This created a structure that held the services accountable to young people, the community, and the staff, for what service was provided and how it was provided.

The outcome was a solid service culture that promoted professionalism, a strong commitment to client needs, positive and enthusiastic staff who took pride in owning

the work they did and the programs they had helped develop, and very much created the culture of life long learning that was valued. All of these elements were reflected in the sophistication of the direct clinical work and the innovative programs that were developed.

On a specific service delivery level this translated into practice that utelised multi-modal interventions and a comprehensive range of therapeutic approaches (for example, psychodynamic, systemic, psycho-educative multi-family group work model, mixed with pragmatic approaches such as social coping, and building networks of supports for the client and their family).

Overall, the programs seen and the people met were impressive in the level of professionalism that was demonstrated, and the enthusiastic pride the staff had in their service reflected the fact that they were well supported and encouraged.

**Addressing the Original Research Questions and areas of Enquiry**

In revisiting the original research questions and areas of enquiry for this scholarship study, it was clear that the programs seen and data obtained has given an incredible amount of information that is of relevance and can have direct application to the Australian context.

Topics such as the challenges faced, what has or hasn't worked, program models and treatment methods, and how theory was translated into practice were discussed in depth on both the clinical and organizational level which has gone a long way to embellishing my understanding of what is really needed for young people, clinicians and service systems.

Finally, the strength of the research models seen that were well integrated into practice and inclusive of the staff within the service, demonstrated how programs can be informed by and linked with research in a user friendly and accessible way.

**In Conclusion**

The scholarship was a rich and rewarding experience on both a personal and professional level. It has begun an enquiry rather than completed one, and given the nature of the recommendations and strategies planned, will function as a platform for sparking even further enquiry beyond those that have already emerged. Therefore it will continue to have a huge influence on my endeavors to truly make a difference for young people and the community for a long time to come.

## MAJOR LESSON LEARNT

In addition to the above discussion, it is important to highlight one of the major lessons learnt from my experiences during this study tour that has prompted the next level of enquiry beyond this scholarship; that is the need to know and understand the impact of the Socio-Political context as fundamental to any enquiry about services such as those visited on the study tour and in general.

The Socio – Political context has a profound impact on all levels in relation to the mental health and well-being of children and families and the services established to support them. This was evident in each of the countries visited, and is equally as powerful within Australia. The influence on the macro to the micro levels cannot be ignored, as Moretti, et al (1997) state, "It is important to recognise that the introduction of new treatment approaches is often hampered by social and political agendas" (p639). As they emphasise, "The reality of working with the larger social and political structure as a significant component of programme development needs to be acknowledged, as it is within this context that programme development takes place"(p640). This is something that as a manager and practitioner I had always been aware of on a local level, however I became increasingly aware of the universality of just how profound an impact the permutations from the Socio-Political context have.

As highlighted within this report, it has been and continues to be a time of rapid change on the social, economic, political and managerial levels, in which people have to cope with increasing complexity, instability, diversity and conflict in both their personal and working lives. Many of the shifts and changes were common to Australia and other countries, leading to similar dilemmas and challenges for young people, families, services and governments. Of particular relevance were those relating to changes in social structure with the move to economic individualism, the shifts in the labour market with the greater social differentiation and income inequity, the emphasis on competition, academic achievement and the diminution of unskilled employment, and the increased sense of isolation of both families and children from the impact of parental separation, the fragmentation of the extended family networks and the erosion of mechanisms for maintaining social cohesion (Refer Socio-Political section 6 for more detailed discussion).

Linked closely to this is, as stated within (The Big Picture, p10), “the fact that children have become viewed in terms of economic commodities by governments, with more and more the sole responsibility for their social, emotional, physical and financial well being placed within the nuclear family adds further stress to the family unit, is making it increasingly difficult for vulnerable parents to meet their children’s needs”

The interplay between these factors has had a profound effect on both the structure and function of the family and of the role of children within our society and has far reaching effects on the circumstances our children and young people are growing up within and the opportunities open to them.

If we do not become more aware of the impact of this and only focus on specific programs, despite being examples of exceptional practice, we will continue to treat the symptoms and not the cause and define broader social problems as mental health

problems in individual children or families. Rather than identifying and treating the broader social problem, we will continue to feed and in fact influence, the short term political agendas highlighted above, and similarly as in the United Kingdom, " fail to address the underlying systemic issues that maintain the problems, and the fundamental fact that the root cause of so much dysfunction in individuals, families, in schools, organizations and in society as a whole is poor mental and emotional health and as a result can only be partially successful"(The Big Picture, 1999,p5).

As stated by Moretti, et al, 1997, "unless and until the public is convinced of the need for long-term intervention strategies for social problems (of conduct disorder), politicians will be seduced by the lure of appearing to "do something" about it with short-term, quick-fix programmes (p647) to gain immediate favour from the voters. (ie: for the term of their political office).

In some ways it is easier to have a short term, narrow focus, that is largely blind to the problems, however as stated in the Big Picture report, 1999, "it is a blindness of the ostrich. We do not want to see it because it's too uncomfortable, because to recognize the need in others we would have to confront too many painful facts about our own emotional and mental vulnerabilities"(p4).

Further to the above as highlighted within this report, because service development has been driven by political pressures, they have grown as a "hot potch". The current situation is where mental health services for children and young people are starved of resources, and where specialist services are patchy, under-funded and plagued by lack of co-ordination and discontinuity's between agencies. Similarly, vital universal and early intervention services are piecemeal, subject to short-term funding and unintegrated. This compounds a major difficulty facing these institutions of trying to work within the present labyrinthine structures, guidance, legislation and funding regimes. This often results in a situation where providers attempt to define service requests as outside their mandate in order to preserve limited resources, (or what has been referred to as the Silo effect).

The subsequent impact on young people and their families are that the interventions may not coherently 'hold together' and make sense to family members, mental health practitioners and others involved in supporting the family, and may work at cross purposes and end up increasing the likelihood of splitting between the family, mental health providers and the service system at large.

This begs the question as to what priority is given to our children and challenges the local rhetoric "that Children are our future". As stated within the Big Picture report, (p5), "The myths and priorities of the late 20$^{th}$ century life have separated many children from their wider communities and it is therefore small wonder that some feel little sense of involvement with or responsibility to the society around them and vice versa. Our acquisitive society tends to see children as the sole property and responsibility of their parents rather than also members of a community or even as citizens." It is little wonder that, as highlighted within The Big Picture, "some feel little sense of involvement with or responsibility to the society around them and vice versa," when, as in the United Kingdom, "we claim to be a child-centered but in reality there is little evidence that we are" (p4).

As in United Kingdom and elsewhere, here in Australia the possible sequelae to this are evident in the increasing numbers of children and young people who are failing to thrive. The ratio of (1:5) cited within the United Kingdom of those who will experience some form of mental illness in their lives at any one time is similar to that within Australia and each of the countries visited and there is also evidence that there are a growing number of families experiencing multiple problems and young people presenting to services with increasingly complex problems. Perhaps it is no accident that there has been a clear increase in the incidence of psychosocial disorders in youth since World War II.

In addition to this, despite the WHO has cited that by the year 2020, Depression alone will constitute one of the greatest health problem worldwide, what is perhaps most disturbing for us here in Australia is the increasing suicide and self-harm rates, and the fact that we have one of the highest suicide rate in the world. This sheds a significant shadow on the myth of Australia as the lucky country; perhaps the question is for whom?

Brian Mitchell, et al, states, "As a people we are poor performers in cherishing our children and valuing them as our most precious national resource. With one in five Australian children in poverty and our children being the largest single group among the nations poor, our sense of national justice remains under developed" (p66).

Whilst the roles of government and public services in this area have been changing and their ability to solve social problems has been questioned, it is not just "The Governments" problem. It is very easy to leave the onus and therefore the responsibility to 'the other', however for social problems, there needs to be a social solution, which means us all taking responsibility for what is happening around us to the children and young people, of Australia and internationally.

As stated by Brian Mitchell, 1987, "With Australia's poverty and social problems following on the heels of the American experience, it is clear that the numbers of excluded families in our community is going to increase, perhaps dramatically. Left untreated the problem that these families present will be at great social and economic costs to all Australian people. Entrenched in our 'I'm all right, Jack' attitudes, it is time we started to care about other peoples' children".

It is equally true for Australia that, “Unless as a society we can overcome our discomfort with the very notion that we are all mental beings and that our mental health and that of our children is a fragile and precious commodity, fundamental to societies’ well being and something that needs nurturing, protecting and investing in, the evidence clearly indicates that the consequences for all our futures will be very worrying indeed. If we are to change things, action is needed now" (The Big Picture, 1999,p5).

## 10. OVERALL RECOMMENDATIONS

The recommendations below were drawn directly from the key elements outlined in the discussions above. Most of these elements were common to each of the organisations, and are fundamental to good service delivery regardless of the nature of the client, while others were more specifically targeting high-risk youth.

### POLITICAL

Throughout this report, the need to acknowledge the reality of working with the larger social and political structure as a significant component of programme development has been highlighted. This translates into the issues and recommendations below:

**1. Changes on a Political and Social level**

To reiterate again the points emphasized above within The Big Picture, 1999, rather than being like the ostrich, as a society we need to address the fundamental fact that the root cause of so much dysfunction in individuals, families, in schools, organizations and in society as a whole is poor mental and emotional health. To do so we need to overcome our discomfort with the very notion that we are all mental beings, and to recognize and acknowledge that our mental health and that of our children is a fragile and precious commodity, fundamental to societies' well being and something that needs nurturing, protecting and investing in

This means as a society we need to think about children, young people and families and their position within our society, and to review such things as the structure and function of families and the pressures upon them, and the role of children within our society and opportunities open to them.

Linked closely to this us the need to review whose responsibility it is to promote and maintain the social and emotional health of our children and society generally and with this review the role of Government, State and Public Services and their ability to solve social problems. The application of the notion of shared responsibility on all levels, Ministerial / Government, Communities and parents, is an important aspect within this to promote joint ownership as a "Society" rather than place the responsibility exclusively on the shoulders of elected political parties. The flow on from this is to influence governments to not respond with the short-term solutions to appease voter's demands, and promote the implementation of more holistic, long-term solutions.

Closely linked to this is the need to recapture the value of the "humanness" and the whole person, and what this means in practice in how we nurture, protect and invest in children, young people and families as fundamental components of our society. The dehumanizing concepts underlying economic rationalism need to be challenged, where worth is measured in monetary terms and within this our children and families valued as economic commodities rather than for their inherent worth as human beings; something that cannot be measured against these values. Specific strategies that can begin to address this are outlined in the recommendations to follow.

**2. Promote the application of Qualitative as well as Quantitative measures when valuing and evaluating Mental Health and other Social Services**
While we continue to measure human / social services against purely economic and quantitative measures we will continue to miss the essential and holistic needs of the human beings that the services are meant to be addressing. As a result this will perpetuate the fragmentation of humans into their component parts and with it the problems that cannot be dealt with in such a fragmented manner.

**3. Identify and target Underlying Systemic and Social Problems that contribute to the Maintenance of Mental and Emotional Problems**

Review the current research and promote further research into the above factors and promote the use of this in determining further policy and service development.

**4.Early Intervention and Opportunities for Children, Young People and Families.**
Further to the above utilize risk and resilience factors to identify main factors and recommend effective interventions at the level of the individual child, the child within the family, and in the wider social context.

Promote child emotional well being by focusing on family, friends and informal networks, and by promoting the importance given to universal community responses to promoting children's well being.

Promote broader spectrum opportunities for young people beyond the emphasis on academic excellence / achievement and promote a revaluing of a range of skills and talents within our education and broader social systems.

**5. Advocate for Children, and Young People on a State and National Level.**
Lobby for appropriate resources, support structures and policy directions (refer below) for children and young people, emphasising the impact on services, service delivery and the cost to clients and society generally of the current situation in social, economic and emotional terms.

**6. Increased Resources**
Clearly without the input of resources at both a primary care and specialist level, it will not be possible to develop the range of services needed at a local and national level for children and young people experiencing mental health problems. "Evidence suggests that child and adolescent mental health needs a greater share of an expanded health budget" (The Big Picture, 1999, p14).

**7. Further Enquiry**
Given that politics and policy has such a major impact service development and delivery, there is a need to be informed of the current policies and directions to be able to identify and lobby strategically for sensitive service development. Further information is required before more detailed or informed discussion is possible (which is the next phase of this scholarship project currently underway).

**STRUCTURAL**

**1a). The need to develop National Frameworks of Legislation, Standards and Funding Mechanisms**

The message which emerged consistently was that plans and programs relating to the mental health of children and young people should be locally owned and delivered, within a national framework of legislation, standards and funding mechanisms, and that there should be a structure of accountability for ensuring that they are provided on the scale and to the quality that are required.

This also needs to flow further down to ensure that CAMHS services are well supported and managed on all levels, as (outlined below) in the context of a sensitive, appropriate and clear approach to philosophy, and a clear grasp of the work of the services and the professional constraints.

**b) The appointment of an Effective Hierarchy with an Identified Leader.** To facilitate the above, there needs to be a dedicated portfolio for both strategic planning and operational management for Child and Adolescent Mental Health to fill the void that exists currently under the present structure, where CAMHS is a minor portfolio that gets lost under a management responsible for a range of other areas that traditionally have overshadowed child and adolescent issues.

**c). The creation of a Single Ministry for Children and Young People** In an attempt to address this problem, the Province of BC has created a single ministry for children. The development of a central agency to co-ordinate and integrate services is critical to the implementation of multi model intervention strategies.

**2. Application of the model of Joint Health and Social Care (Joint Commissioning)**

Good structural organization is essential to the delivery of multimodal programmes that cut across domains (eg, Family Services, Mental Health, and Education) that traditionally have been represented by separate ministries or government agencies.

In order to meet children's complex and inter-related mental health developmental, educational and social needs, and to facilitate dynamic collaboration at every level of service management and delivery within and across services, it is recommended that the model of service provision within a multi-agency partnership at both the strategic and operational level is utilized. This promotes true collaboration that is structured from the top down within a broad range of partnerships. Such measures ensure the partnerships are community owned and integrated into all aspects of service development and delivery, and are sensitive to the needs of the local population.

**ORGANISATIONAL**

**1. Program Development Package: Promotion of effective and comprehensive program development and change management as demonstrated by the services reviewed.**

There were a number of key elements that made program development within these services extremely comprehensive that are closely linked to and reflect the learning organization principles in practice.

These included having a service with an over arching framework with a strong service philosophical, theoretical and practice base and having a management structure and change management process that were congruent to this framework.

The process of service development was seen as equally important as the outcome, with a clearly defined process that has 6 stages: **1.** Identified need, **2.** Research best Practice, **3.** Community Consultation and Involvement, **4.** Pilot and evaluation, **5.** Evolution, refinement**, 6.** Documentation: policies and procedures and published outcomes.

Research and evaluation were seen as a fundamental part of program development, and therefore the model included evidence-based practice linking theory with real practice, based on local client centred need.

The combination of the above promotes some of the essential elements for strong team performance, these being a common vision, a common paradigm, a common language and a common working agreement.

**2. Learning Organisation Philosophy and Approach.** Promotion and application of a Learning Organization Philosophy and approach that promotes a philosophy of enquiry, reflection and evaluation, has a theoretical underpinning, uses an all staff approach and has structure to facilitate this, and has strong links with Universities and academic institutions. The combination of this promotes a culture of life long learning and continuous professional development.

**3. Adolescent Sensitive Philosophies and Specific Advocate Portfolio**
The promotion of an Adolescent Sensitive Philosophy that underpins the service and informs both service development and day-to-day practice, and the creation of a specific adolescent portfolio within services to advocate for young people on a State and National level.

**4. Systemic Thinking / Community Integration**
There was recognition of systemic and environmental issues and influences that led to a range of specific structures and processes within the programs to address these. Whilst having slightly different strategies for approaching the problem, each service recognised the need for innovative ways to overcome beaureacratic "Silos" with broad and practice based partnerships, and acknowledged that service provision had to occur within a multi-agency partnership at both the strategic and operational level in order to meet children's complex and inter-related mental health developmental, educational and social needs. The model of joint health and social care or Joint Commissioning in the United Kingdom and the Community Care Plans of the Maples centre were particularly effective and dynamic examples of this.

**5. Tiered structure**
The adoption of a coordinated, tiered, strategic approach to the commissioning and delivery of Child and Adolescent Mental Health Services. In addition to this, adopting the stages of developing the tiered approach as outlined within the Together We Stand report, as an integral part of this process.

**6. Managing CAMHS**

Within the Big Picture report one recommendation that is important to highlight is the need for improved leadership, communications, management, and performance monitoring within the specialist provider services for the effective management of a Child and Adolescent Mental Health Services.

This needs to include a cohesive and coherent strategic plan, clear service specifications and supporting information, a sensitive, appropriate and clear approach to philosophy, a clear and credible operational management structure, a clear grasp of the work of the services and of the professional constraints, a view about the gaps in provision of the present service, a view of the opportunities for service development and of the way the capacity of the current services is developing.

## SPECIFIC CLINICAL PROGRAM AREAS

**1. Appropriate Components of the Services**

Finally, the components of CAMHS services as outlined in Together We Stand report (Jan 1993-Feb 1995), are those that should be seen as fundamental to all CAMHS services. However clear funding and resources needs to be put in to support these functions rather than what occurs currently, where an ever increasing / expanding range of comprehensive functions are expected from an already over extended service system.

The full range of child and adolescent mental health services should include:

- Assessment services, which would include testing, investigation and diagnostic services.
- Specialist reporting services, including those for the Courts.
- Advice and short-term interventions, including the recognition and containment of concern and anxiety about children's welfare, education and health
- Management and treatments of a range of differing styles, including those for individuals, groups, parents, and families.
- Management and treatment of different types, including counselling, dynamic psychotherapy, psycho-analytic psychotherapy, play therapies, behavioural and cognitive therapies, social skills training and activity-based and creative therapies, prescription of medication (including psychotropic drugs), and marital therapies for parents.
- The ability to advise families and other agencies.
- Referral to other sources of expertise, investigation, diagnosis and management.
- Collaborative work, including advice to agencies, involvement in case conferences and statutory proceedings.
- Liaison and consultation services.
- Training
- Research.

Specialist focus on the development of care packages geared to each individual's particular problems and exploring integrated care pathways.

**2. Creation of Youth Mental Health Services**

Promote a strong focus on youth specific services that are accessible, developmentally sensitive and adolescent friendly.

**3. Primary Mental Health**.
Further emphasis of the role of staff at primary level and the creation of a Primary Mental Health Worker integrated into the tier system and formally linked with CAMHS as first contact for primary level professionals. This is to ensure clear boundaries for the service yet facilitate linkages between CAMHS and other levels of the service system, community and client. This then acts as an essential to link Child and Adolescent Mental Health Services with the continuum of services to ensure they do not operate in isolation and that the expertise across services is shared to best support the young person and their family in a more community centered, less fragmented way.

**4. Specialist Team Based Structure within CAMHS**
Utilize a specialist program based structure, where practitioners become part of developing a specialist team based on an identified client need, and are both supported and expected to develop specialist skills on both the clinical and research level.

This creates a focus and a space in which to build a solid philosophical and practice framework. On the practitioner level, this promotes a strong sense of ownership of the program and links with the goal of supporting continuous professional development and creating a "Culture of life long learning" across all clinical areas. While on a clinical level the client benefited in having a specialist program in which specific skill and expertise was then developed to meet that need.

**5. Early Psychosis**
Promote the TIPS package use in total, not just aspects of it i.e. Education / Marketing, the Treatment package, including, medication, multi-family psycho-education groups and family work, supportive psychotherapy (especially the long term, more comprehensive work with clients and families with a psychodynamic and systemic focus), the research model and the staff training and education.

**6**. **Milieu Therapy**
Promote a revisiting of the focused use of Milieu Therapy and the principles of therapeutic community in residential settings, and explore the relevance to the proposed retreat and training centre (Refer under implementation and dissemination section).

**7. Attachment Theory**
Whilst the Attachment Theory model as developed by the Maples Centre has specific relevance to the High Risk population, which was their specific target group, the fundamental principles also have a broader application to work with young people generally. Therefor it is suggested that the recommendations put forward by C Baxter, (1999) and outlined below be applied to both sectors.

**a).** Support the conceptual framework of Attachment Theory being disseminated across the spectrum of service providers in Victoria, to provide a common perspective from which to work with (high-risk) young people.
**b).** Use of the Attachment Model for interpreting and responding to what is being communicated and use of the attachment profiles as tools to monitor interventions.

**c).** This would require a significant educational component, hence I would advocate for discussion and / or direct training with staff from the Maples Treatment Centre.
**d).** Implement a principle based model of practice (7 attachment principles).
**e).** Further research, re attachment theory application and ongoing liaison with The Maples to stay abreast with the developments in their research

**8. Community Collaboration and Integration**
In addition to the importance of the community and collaborative projects as discussed above, other initiatives such as community based services, outreach services, community care plans and making training and education accessible to the community, all helped to keep the young person connected to their community and supported the multi-modal multi-dimensional interventions that were needed to address the needs of an increasingly complex client group.

**9. The use of Community Care Plans**
Care Plans that consider all aspects of Young Person and family need, are based on an extremely comprehensive Assessment, are owned by the young person, their parents and the community, and are transparent and accessible.

**10. High Risk Youth**
Application of some essential components for service delivery to High Risk young people as outlined below.

These included recommendations made by C Baxter (1999) that on an Intervention level, an understanding is required that **a).** Problems are multi-factored, and multi-determined that require long-term intervention **b).** Interventions must address the bio-psychosocial domains of the youth **c).** Community based interventions are optimal **d).** Interventions should be guided by a single over-arching philosophy of care for optimal impact and sustainability, and that **e).** Interventions require a program of support and clinical consultation for optimal impact and sustainability.

On an Organisational level, in keeping with the model of program development outlined above, essential elements were a Common Vision, Paradigm, Language and Working Agreement.

What was of major importance in all the services in relation to working with High Risk youth was the need for Collaborative, Multi-agency, and Multi-interventions that were delivered in strong partnerships and supported by clear collaborative structures as described above.

The importance of streamlining services where possible to a single point of entry to prevent individual referrals to multiple services was particularly important for the high-risk categories

Finally despite different paradigms utelised the importance of long term work with this client group, as well as the importance and therapeutic use of relationships (in particular the active use of the therapeutic relationship) was consistently emphasized and supported.

**11. Consumer Involvement**
Promote the SPEEK peer education program as a model of adolescent consumer involvement and empowerment.

**12. Training**
There is a need to develop multidisciplinary, shared training alongside uni-disciplinary staff development. Examples of this were the structures community-training schedule provided by Leicester and Rutland CAMHS, that was available in an ongoing manner, the joint training provided by the TIPS Program in Norway to a range of disciplines and services, and the teleconference training provided by the Maples Centre.

**13. Group Work**
Promotion of a comprehensive and flexible and client needs driven group work program for adolescents, based on the Mnt Sinai group work model.

## 11. IMPLEMENTATION OF STRATEGIES

There are 6 main headings under which are a range of strategies for the dissemination and implementation of the findings and recommendations of this scholarship. These are Clinical, Organizational, A combination of Clinical and Organizational, Political, Community and Documentation.

### 1. CLINICAL

**a). Further study and training in Attachment Theory.**

To enhance my ability to work therapeutically in direct clinical work within this paradigm.

**b). Run training seminars and lectures**

These will be and will include Attachment Specific training, Crisis and risk Management and Understanding High Risk Youth, to a range of services in both Rural and Metropolitan areas. Among these will be CAMHS services on a regional, State wide and National level (In patient, Out patient, Outreach and Intake / Triage Teams); The Royal Children's Hospital (Registrars and consultant training, Wards and Accident and Emergency); The Department Of Human Services (Protective services, Placement and Support, Disability services), Non Government Organisations (Particularly those working with High Risk youth), Schools and Primary Health Services (Doctors, Counselors).

**c). Project Involvement**

Directly related to clinical work that may promote the trial and / or implementation of working within an Attachment Paradigm, as well as being able to integrate some of the other clinical best practice findings such as the TIPS package of work with first episode psychosis.

**d). Offering mentoring relationships**

To assist the community professionals in developing expertise and competence, either with myself as mentor or by facilitating links with relevant professionals from the services visited.

### 2. ORGANIZATIONAL/ PROGRAM DEVELOPMENT

**a). Feedback to CAMHS Managers** the key findings from the in-depth analysis in this scholarship report.

**b). Review current Organizational / Management Structures**

Set up formal meetings with other managers within the specific service currently employed in, to discuss ways the Key Organizational elements outlined within the report may be applied in current service delivery and future service development.

**c). Secondary and Tertiary Consultation**

Act as a consultant to services working with adolescents and young people, such as Non Government Hostels and Treatment settings, Secure Welfare, and Acute Services.

**d). Committee of Management and Advisory Boards**

**3. COMBINATION OF CLINICAL AND ORGANIZATIONAL**

**a). Develop a Service Model**

Develop a service model that incorporates the best practice elements on both the Clinical and the Organizational level and apply it to the proposed **Retreat and Training Centre for Homeless and High Risk Youth.**

**b). Research**

Undertake further specific research in Attachment issues in High Risk Adolescents and the application of attachment theory in addressing theses issues, to be utelised to inform specific clinical practice and service development.

**4. GOVERNMENT / POLITICAL**

**a).** Participate in **reviews / Audits** of service systems as a specialist in the field.

**b).** Participate in specific **liaison and advisory** groups to the Mental Health Branch

**c). Feedback Scholarship findings.** Provide expert presentations to the Mental Health Branch and other significant bodies / organisations, ie: The Health and Community Services Union, that provides research documenting the impact of these programs and highlights the compatibility of the programs reviewed within this report, with more recent policy changes to enlist support.

**d). Further research projects** written up as papers, that will refer to and incorporate / build on the Churchill Fellowship. The first two being the Master's Thesis and the In-depth political analysis as outlined within the recommendations above.

**5. COMMUNITY**

**a).** Public Lectures outside of the Care Professions, ie: Rotary Clubs

**b).** Projects that involve awareness raising about Adolescent Mental Health

**6. DOCUMENTATION**

**a).** Report dissemination, hard copy and Webb site access

**b).** Training and education material

**c).** Further research projects written up as papers, that will refer to and incorporate / build on the Churchill Fellowship report; the first two being the Master's Thesis and the In-depth political analysis.

**d).** A Book in progress will further expand on the above

## DETAILED OUTLINE OF ACHIEVEMENTS TO DATE

**AWARDS**

**2001 -** Fellow in Psychotherapy Royal Children's Hospital

- Honorary Fellowship in Psychiatry Melbourne University

**2000 -** Hon Governess of Victoria, Lady Lynn Landy, Recognition of 10 years of Voluntary work with Homeless and at Risk Youth in Victoria, and particularly with The Lighthouse Foundation.

- Certificate of Appreciation: International Year of Volunteers -In Recognition of Voluntary Service to the Community, from the Hon Steve Bracks, MP (Premier of Victoria) and the Hon Christine Campbell, MP (Minister for Community Services)

## COMMENDATIONS

**2000 (Specific)** Policy and Procedure Development
Suicide Risk Assessment Tool
Go West Adventure based Therapy Program Development
**2000 (General)** Customer Focus
Improvement Demonstrated
Measurement of Outcome
Best Practice/Investigated/Demonstrated Team Work

## CLINICAL

**a). Further Study and Training**

Applied for and was appointed into the sole Victorian Internship in Child and Adolescent Psychotherapy at Royal Children's Hospital as part of Master's in Child and Adolescent Psychoanalytical Psychotherapy (Preliminary to Doctoral Studies), in the field of Disrupted Attachment in High Risk Youth.

**b). Direct Clinical**

Improved clinical input to young people as result of the development of my own clinical practice in conjunction with the training and input provided to other workers and areas. This has also contributed to improved support to practitioners from various organisations.

## TRAINING SEMINARS, LECTURES AND PRESENTATIONS

**2000 Academic Presentations (Overseas) - Winston Churchill Scholarship**

**(United Kingdom)**
Trust for the Study of Adolescents -Eddie Piper, Brighton
Interagency Project for Young People with Complex needs -Michael Maher, Surrey

**(Canada, Vancouver)**
Ministry for Children and Families, Province of British Columbia: Ministerial Working Party into Secure Care
Dr Marlene Moretti (Attachment) Orinoco Research Project, Maples Centre.

**(Seattle)**
Mayors Working Party on Drug Abuse and Mental Health Issues in Adolescents

**(New York)**
Mount Sinai Adolescent Health Centre, New York
New York University: Social Work Department

**Academic Presentations Australia**

**2001**
**Adventure Therapy: Making Models Work**

**Collage of Continents: An International Review of Adolescent Services**
Victorian Child Psychiatry Training Department

**Prevention and Treatment of Depression in Teenagers**
Clockwork Community Forum, Geelong, Co-Presenter: Prof Bruce Tonge

**Mental Health Issues in Adolescence**
Regional Parenting Resource Centre, Geelong / Drysdale

**Developmental Stages of Growing Up**
Eduction Week for Adults, Mt Duneed Primary School

## Training and Education Provided

**2000 / 2001**
**Treatment of Personality disorder in young People**
Clockwork Lecture Series for General Practitioner, Co-Presenter: Dr T Callaly, Director of Clinical Services, Barwon Health

**Mental Health Issues in Adolescents;** Juvenile Justice: Barwon Region

**Attachment and it's implications with High Risk Youth**
Working Together Strategy, Department Of Human Services, Melbourne

**'Creating Systems that work with "At Risk Youth": The application of Attachment, Systems and Crisis Theory.'**
Seminar Series, Department of Child Psychotherapy,

**Depression and Anxiety in High Risk Youth**. Working Together Strategy, DHS

**Working with High Risk Youth: Translating Theory into Practice**
State wide Child Psychiatry Training Department –: Post Graduate Child Psychiatry Training Dept, University of Melbourne and Monash University

**A Child Reacting to Separation/Separation Issues**
State-wide Child Psychiatry Training, Developmental Psychiatry Course Post Graduate Child Psychiatry Training Dept, University of Melbourne and Monash University

**Conduct Disorder and its Management: New Aspects.**
Barwon Paediatric Association

**Crisis Assessment and Management:** Gordon TAFE (Certificate 4: Youth Work)
Co-Presenter: Mr W Fallon

**Managing' At Risk' Adolescents: A Local and International Perspective**
Gippsland CAMHS

**Child and Adolescent Mental Health**
Tutorials -Medical Officers Barwon Health (annually)

**Video Series on: Diagnostic Categories and General Management of Adolescents Psychiatric Emergencies** / Training Program/Modules Development
HW3 Paediatric In-Patient Unit: Barwon Health

**Management of Young People with At Risk Behaviours**:
Victorian Child Psychiatry Training

**Attachment and its Implication for Understanding and Treatment of Emerging Borderline Personality Disorders:** Grampians Region

**Engagement, Assessment and Crisis Management: A Developmental / Systemic Perspective,** Royal Children's Hospital

**Problem Substance Use and Mental Health / Dual diagnosis training**
Barwon Region

**The Systems We Work in and the Impact on Regional Service Delivery to Adolescents,** Department of Human Services, Barwon Region

**Depression in Young People:** Clockwork, Community Forum: Co-Presenter: Dr T Callaly D

**Evidence Based Medicine: Adolescent Mental Health Approaches to Crisis Management and Treatment**

**Management in the Community of Challenging Behaviours in Adolescents.** Paediatrics one day Symposium: Barwon Region. Annual Paediatric Meeting: 30 Year Celebration

**Train the Trainer: Crisis Management** RCH/ MH SKY

**Specialist Assessments**. Introductory Course in Child Psychiatry: Post Graduate Child Psychiatry Training Department, Melbourne University Assessment and Mental Status Workshop: Travancore/RCH

**'Filling the Gap -Working with High Risk Adolescents and Developing New Models of Practice'** -Second National Conference on Child and Adolescent Mental Health, Melbourne.

**Facilitated National Youth Forum** -Young Peoples Experience of Mental Health System (as part of above conference)

**2. ORGANIZATIONAL**

**a). Feedback to CAMHS managers**

Statewide Presentation of Scholarship at Friday forum of the Victorian Child Psychiatry Training Department, linked to rural services via video linkup

**b). Specific Program Development**

Adolescent Mental Health (Barwon Health)
-Barwon Health, Youth Service Co-Location of Drug Treatment/Community Health
-Centralised Triage and Brief Intervention Program
-IMYOS: Integration of High Risk Program
-Community Out patient Treatment and Satellite Clinic, Colac
-Secondary Consultation Program

-Go West Adventure Based Therapy Program jointly:
- Joint Go West/YEP therapeutic day program DHS, McKillop, Barwon Health

**c). Project Involvement**
- Department of Human Services Working Together Strategy
- Barwon Region Human Services Training and Development Review Committee
- Compass Project
- Beyond Blue Depression Research

**d). Secondary and Tertiary Consultation**
- Youth Connect Adolescent Placement Program
- Lighthouse Foundation Long-term Accommodation to Homeless Youth
- Police and Ambulance Liaison
- McKillop Family Services Carers Selection panel.
- Range of other services / organisations working with young people.

**e). Committee, Boards, Advisory Committees**
- Mental Health branch Primary Mental Health Initiative
- CAMHS Statewide Forum Chairperson
- HACSU State wide Psychiatric Nursing Professional Issues Committee (advising
- HACSU Health Minister) -General Working Party
-Supervision Sub Committee
- Barwon Region Youth Council: Advisory to Minister of Youth Affairs and Local Members of Parliament
- Development of High Risk Adolescent Reference Group.
- Involvement in formal review of DHS High Risk Program and Sibling Group Placement Programs
- Committee of Management -St John of God Lighthouse Foundation, Geelong

**3. COMBINATION OF CLINICAL AND PROGRAM DEVELOPMENT**
- Program Model for retreat and training centre being developed

**4. POLITICAL: LIAISON, REVIEWS AND ADVISORY BOARDS**

**a). Reviews**
- Statutory Clients Response Reviews (2) 13 – 3rd in the state
- Mental Health Branch Service Improvement Initiative-
- CAMHS State wide Executive

**b). Advisory**
- State-wide CAMHS Clinical Directors advisory body to Mental Health Branch
- Rural Management Consultation Group to Mental Health Branch
- Working Together Strategy (1997 and ongoing)
- CAMHS State wide Forum Chairperson

**5. COMMUNITY**
- Rotary Club presentation
- Lighthouse Foundation

## 6. DOCUMENTATION

**Publications**

**2001** Contribution overseas publication Turned Upside Down: Developing Community based crisis services for 16-25 year olds experiencing a Mental Health Crisis. The Mental Health Foundation, 2001, Karen Smith and Lucy Leon.

**December 1999** New Paradigm: p 11-17: Therapeutic Holding and Containment: Creating Systems that Work with "At Risk" Youth.

**October 1999** V.A.F.T News, Vo121, No.5: pp 5-12: The application of Attachment Systems and Crisis Theory in Working with "At Risk" Young People.

**Unpublished Training Manuals**

1. AMHS Service
2. Developmental Stages
3. Risk Assessments and Crisis Management
4. At Risk Youth: Understanding and Managing
5. Depression and Psychosis
6. Conduct Disorder, Personality Disorder
7. Attachment and Separation
8. Assessment and Mental Health issues in Adolescents: Mental Health
9. Managing Challenging Behaviours in Adolescence :In Patient, Out Patient, and Community
10. Best Practice Examples from Overseas Agencies visited on Winston Churchill Scholarship

**Specific Protocols**

1. AMHS Policy and Procedure
2. AMHS Orientation Program/Manual
3. DHS/Barwon health
4. Rape Crisis Centre/Barwon Health
5. Banksia Admissions and Liaison
6. Risk Assessment Tool (now Barwon Health wide)
7. Quality Improvement and Accreditation Manual, Adolescent Mental Health

## APPENDIX: ISSUES OF INTEREST; SEMI- STRUCTURED INTERVIEW

### General

- How your service was established?
- Organisational Structures that support the program
  - Management level
  - Fit with the broader programs in the organization
- On costs / running costs.
- Funding sources
- Staffing – profile, qualifications, training, gender mix, age, previous experience
- Job descriptions / Roles / Responsibilities
- Physical layout / design of the service
- Policies and Procedures

### Admission Criteria

- Profiles of young people, particularly mental Health characteristics / diagnostic presentations
- Clients excluded
- Referral processes

### Programs

- Types of programs offered, ie Outreach, day programs, etc
- How characteristics / needs of young people addressed
- What are the anticipated benefits / outcomes.
- Is it a suitable program for the homeless / at risk client group
- Problems encountered and how they were overcome
- Ongoing challenges
- Interface with other programs, ie professionals (government / non government) and the broader community (what, where, how, when)
- Community involvement / ownership and consumer participation.

### Models of the program

- Philosophies
- Therapeutic approaches informing practice.
- Assessment, Treatment, Case management, Individual service plans, Review.
- Integration back into mainstream services ie Inpatient, out patient.
- Crisis Intervention / Management
- Discharge planning and long-term follow up.

### Research and Evaluation

- Quality Assurance, performance indicators
- Qualitative / Quantitative research projects (current / planned)
- Future Service Direction

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**NEW YORK: MNT SINAI**

*Revised Adquest; (In Print)* Chapter Titles and Authors June 2003

Dianne Ciro, MSW, Michael Surko, PhD, Kalpana Bhandarkar, BA, Nora Helfgott, MSW, Ken Peake, DSW, and Irwin Epstein, PhD; Chapter 12. Gay, Lesbian, Bisexual Sexual-orientation Questioning Adolescents Seeking Mental Health Services: Risk Factors, Worries, and Desire to Talk About Them

Angela Diaz, MD, Ken Peake, DSW, Michael Surko, PhD, and Kalpana Bhandarkar, BA ; Chapter 1.Including "At-Risk" Adolescents In Their Own Health And Mental Health Care: A Youth Development Perspective

Elizabeth Diaz-Cruz, BA, Daniel Medeiros, MD, Michael Surko, PhD, Ruth Hoffman, MSW, and Irwin Epstein, PhD; Chapter 6. Adolescents' Need to Talk About School and Work in Mental Health Treatment

Jennifer Elliott, MSW, Michael Nembhard, MSW, Vincent Giannone, PsyD, Michael Surko, PhD, Daniel Medeiros, MD, and Ken Peake, DSW; Chapter 5.Clinical Uses Of An Adolescent Intake Questionnaire: Adquest As A Bridge To Engagement

Vincent Giannone, PsyD, Daniel Medeiros, MD, Jennifer Elliot, MSW, Caroline Perez, MSW, Erika Carlson, BA, and Irwin Epstein, PhD; Chapter 11. Adolescents' Self-Reported Risk Factors and Desire to Talk About Family and Friends: Implications for Practice and Research

Nyanda Labor, MPH, Daniel Medeiros, MD, Erika Carlson, BA, Nancimarie Pullo, MSW, Mavis Seehaus, MSW, MPH, Ken Peake, DSW, and Irwin Epstein, PhD; Chapter 9. Adolescents' Need to Talk About Sex and Sexuality In an Urban Mental Health Setting

Daniel Medeiros, MD, Erika Carlson, BA, Michael Surko, PhD, Nicole Munoz, MSW, Monique Castillo, MSW, and Irwin Epstein, PhD Chapter 10. Adolescents' Self-Reported Substance Risks and Their Need to Talk About Them in Mental Health Counselling

Daniel Medeiros, MD, Leah Kramnick, MSW, Elizabeth Diaz-Cruz, BA, Michael Surko, PhD, and Angela Diaz, MD, MPH; Chapter 8. Adolescents Seeking Mental Health Services: Self-Reported Health Risks and the Need To Talk

Ken Peake, DSW, and Irwin Epstein, PhD; Chapter 2.Theoretical and Practical Imperatives for Reflective Social Work Organizations in Health and Mental Health: The Place of Practice-Based Research

Ken Peake, DSW, Irwin Epstein, PhD, Diane Mirabito, DSW, and Michael Surko, PhD; Chapter 4. Development and Utilization of a Practice-Based, Adolescent Intake Questionnaire (Adquest): What Clinicians Need to Ask About

Ken Peake, DSW, Diane Mirabito, DSW, Irwin Epstein, PhD, Vincent Giannone, PsyD, and Ruth Hoffman, CSW; Chapter 3. Creating and Sustaining a Practice-Based Research Group In an Urban Adolescent Mental Health Program

Ken Peake DSW, Michael Surko, PhD, Daniel Medeiros, MD, Jennifer Elliott, MSW, and Irwin Epstein, PhD; Chapter 14. Multiple Risks, Multiple Worries and the Need to Talk

Ken Peake, DSW, Michael Surko, PhD, Daniel Medeiros, MD, and Irwin Epstein, PhD; Chapter 15. The Future of Clinical and Program Development Tools in Practice Settings: Adquest and Beyond

Michael Surko, PhD, Dianne Ciro, MSW, Carol Blackwood, CSW, Michael Nembhard, MSW, and Ken Peake, DSW; Chapter 13. Racism as a Predictor of Developmental and Health Outcomes Among Urban Adolescent Mental Health

Michael Surko, PhD, Dianne Ciro, MSW, Erika Carlson, BA, Nyanda Labor, MPH, Vincent Giannone, PsyD, Elizabeth Diaz-Cruz, BA, Ken Peake, DSW, and Irwin Epstein, PhD; Chapter 7. Which Adolescents Need to Talk About Safety and Violence?