Safeguards Child and Adolescent Mental Health Response Teams ('Safeguards Teams')

Service Guiding Principles

Document reference number: H21/159055

Contents

Introduction

The Safeguard Service Guiding Principles provide an overarching framework for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) implementing Safeguards Child and Adolescent Mental Health Response Teams ('Safeguards Teams'). The Guiding Principles have been informed by *Investing in our Children* (RANZCP NSW Branch CAMHS, 2020) and developed in consultation with all LHDs/SHNs and other stakeholders. The Guiding Principles are a living document that will evolve over time with experience and as new evidence emerges.

The Guiding Principles outline 'service imperatives' - the non-negotiable service elements that are central to the model. Fidelity to these elements will ensure that this enhancement reaches the intended target population and that there is a consistent, evidence-based approach across the State. Balanced with this is a recognition that each District and Network will need to develop their own specific service model that will build on current resources and service models and will address local constraints and opportunities. There will be support available from the Mental Health Branch to achieve this through consultations and focussed working groups.

Background

Demand for NSW specialist mental health services for children and adolescents has been increasing disproportionately to other age groups over the last decade. Indicators such as psychological distress, intentional self-harm and suicide in young people have been steadily increasing well beyond population growth. Concerningly, some of the greatest increases are for younger adolescents, aged 10 to 14 years. Demand analysis highlights the impact of recent challenges including drought, bushfires, floods and COVID-19, with an increase in numbers of children and adolescents presenting with high levels of acuity and complexity.

The Trace Data for 2020 shows an overall significant increase in presentation of young people to mental health services with higher levels of acuity and complexity. Compared to 2019 figures:

- An increase in MH presentations
    - by 5% among children aged 0 to 11 years
    - 21% for adolescents aged 12 to17 years (with one LHD having a 39% increase)
- An increase in suicidal ideation or self-harm presentations
    - by 15% for children aged 0 to 11 years
    - 25% for adolescents aged 12 to17 years (with one LHD increasing by 53%)

In 2020 the NSW Branch Royal Australian and New Zealand College of Psychiatrists (RANZCP), in consultation with Child and Adolescent Psychiatrists in NSW, developed the *Investing in Children* proposal advocating the urgent need to increase specialist child and adolescent acute response mental health teams to complement investments in schools supporting wellbeing and primary mental health support such as headspace. The proposal identified the gap of acute community care and the need to provide an alternative to care in emergency departments or inpatient units. The Ministry of Health, in consultation with key stakeholders across NSW, provided additional considerations related to the service capacity to provide equitable and effective responses to support children, adolescents and their families, as well as the existing Health sector.

An enhanced service proposal was supported by the NSW Government in the 2021 State Budget with an investment of $109.5 million over four years to establish 25 Safeguards Teams across NSW. This included $18 million in 2021-22 to establish an initial 11 Safeguard teams, with further staged increases to the full number of teams in year 4.

The Safeguards Teams enhancement aligns with key strategic priorities and directions

The Safeguards Teams deliver against the Premier's Priorities:

- Towards Zero Suicides – Reduce the rate of suicide deaths in NSW by 20% by 2023
- Improving outpatient and community care - Reduce preventable visits to hospital by 5% through to 2023 by caring for people in the community

Implementation of the Safeguards Teams also supports NSW Mental Health Reform, including the five strategic directions (*NSW Health Strategic Framework and Workforce Plan for Mental Health 2018-22)*:

1. Strengthening prevention and early intervention (with a stronger focus on services for children and young people)
2. Supporting a greater focus on community-based care
3. Developing a more responsive system
4. Working together to deliver person-centred care
5. Building a better system

The Safeguards investment reflects the need for community-based care across the life span, and opportunities to improve early access and navigation across the sector, as highlighted in the *Living Well* and *Living Well in Focus* reports (Mental Health Commission of NSW). It is in line with the *NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework* and contributes to the objectives of the *First 2000 Days Framework*.

The need for additional CAMHS specialist clinicians is recognised in the *NSW Health Strategic Framework and Workforce Plan for Mental Health*, the *NSW Health Psychiatry Workforce Development Plan*, and the Australian Government *Productivity Commission Report into Mental Health*.

The Guiding Principles are informed by the *NSW Health Commissioning for Better Value Strategy 2021-24* which is aimed at moving the health system to a value-based healthcare approach. Key elements of the Strategy are to: analyse service needs and identify desired outcomes; design evidence-based service models; implement the selected service model; and review and evaluate outcomes for continuous improvement.

Crisis Interventions in CAMHS

Increasing numbers of children and young people presenting to Emergency Departments with acute mental health presentations has led to attempts internationally to find alternative interventions to manage crises within the community setting whenever possible. Crisis interventions for young people have drawn on the experience of teams that respond to adults with a mental health crisis. The evidence ranges from expert panel recommendations, through formal enquiries that seek input from both experts and people with lived experience, to pilot data and systematic reviews. Approaches vary between specific interventions, such as Multisystemic Therapy for behaviour disorders, Assertive Community Treatment for high-risk and difficult to engage adolescents who have severe mental illness, and 'one-stop shops' that aim to cater for all psychosocial, educational, physical and mental health needs in an early intervention model. Commonalities between approaches include the need for services to be easily accessible and available outside of usual business hours, ability to provide outreach into the community, providing individually-tailored care that is specific for the child and family's needs, and ensuring that referrals are in place to support the young person after the crisis intervention is complete. Common therapeutic approaches include cognitive-behavioural approaches, problem-solving, safety planning, supportive psychotherapy, and medications, delivered by a multidisciplinary team. There is agreement that consistency of service approach and model fidelity are needed to ensure positive outcomes, in addition to strong service

evaluation to demonstrate clinical effectiveness and ongoing service improvement. Inclusion of the views of people with lived experience in the design, implementation and review of services is essential to ensure that services are in line with the community's needs.

Increasing presentations to Emergency Departments

Internationally, there has been increasing focus on children and young people who present to the Emergency Department (ED) seeking help for mental health problems. The research includes the reasons for such presentations and predictors of repeated ED presentations, aiming to explore the drivers of presentations and how to address the issue. For example, a survey of 241 adolescents and their caregivers in Canada (Cloutier, et al., 2010) asked young people and their parents the reasons for crisis presentation to the ED and their expectations for the visit. Youths and parents presented to ED mainly because of risk (suicide ideation, attempt, self-injury) and emotional distress (mood and anxiety). There was a high level of concordance between the young people and their parents around the risk issues, but less concordance between clinicians and consumers on the need for immediate help. The main stresses identified by young people were school, issues with parents and problems with friends. There was an overall lack of understanding amongst consumers and carers about what mental health services are available and how to access help, suggesting the need for system navigation and community education.

Predictors of repeated presentations to ED may help to identify those children and adolescents who may benefit from more intensive intervention. Cloutier conducted a large prospective cohort study (Cloutier, et al., 2017) to examine the predictors of repeat presentations to the ED by children and adolescents aged under 18 years over a 5-year period, including 4080 presentations by 2900 patients. Almost half (45.8%) of the ED visits were repeat, from 23.8% of the consumers. The researchers identified a higher likelihood of repeat visits in females, those with a previous psychiatric admission, those who were on psychotropic medication, living in a metropolitan area, in child protection services' care, and those with a diagnosis of clinically significant depression or bipolar disorder. When the researchers controlled for demographic, service use and clinical variables, suicide risk and deliberate self-harm were not significant predictors of repeat ED visits, contrary to previous research. They note other research has shown that a lack of availability from primary care services on weekends and evenings, and those who are dissatisfied with primary care, are more likely to go to ED. This research is useful in identifying those who may be at particular risk and the need for community education about other available services and how to get help. The researchers also noted the need for better integration of care between child protection agencies, hospitals and MH professionals.

Expert opinion on management of acute mental health problems in children and young people

Various principles of care have been developed in Australia to manage children and young people presenting in crisis, based on expert advice. For example, expert opinion from Victoria's Orygen service (Hughes, Hebel, Badcock, & Parker, 2018) makes 10 recommendations: 1. Acknowledge and incorporate the full continuum of service response; 2. Employ evidence-informed practice; 3. Ensure smooth pathways and ease of access into services; 4. Embody a 'youth-friendly' ethos; 5. Facilitate youth empowerment, agency and self-determination; 6. Take into account the developmental stage of the young person; 7. Prioritize youth 'at-risk' of, or experiencing, severe mental ill-health; 8. Collaborate with other services in the treatment system; 9. Provide family-sensitive practices; and 10. Take an integrated, holistic approach with a recovery focus. In addition, the Royal Commission into Victoria's Mental Health System recommends redesigning services for infants, children (aged 0 – 11 years) and families to include a balanced approach to emotional wellbeing, behavioural and developmental challenges and MH, where eligibility is not based on diagnosable mental illness.

Developmentally and relationally informed treatment, care and support, including working with the attachment relationships, a focus on early intervention no matter which part of the service stream the individual is being managed and working collaboratively with the many systems that support infant and child mental health and well-being (State of Victoria, 2021). Others internationally have also drawn attention to the need for better integration of care between child protection agencies, hospitals and MH professionals (Cloutier, et al., 2017).

Consumer and carers' views

Consumers and carers' views have also been sought to inform service design. Sands conducted a qualitative survey of 75 adults who contacted a Mental Health Triage Telephone Line in Australia about their perceptions of the service (Sands, Elsom, Keppich-Arnold, Henderson, & Thomas, 2016). Although this was a telephone-based crisis intake line and conducted with adults in crisis rather than children and adolescents, the principles identified are valuable. People in crisis valued ease of access and timeliness of response. There can be differences in opinion between consumers and counsellors about what is a 'significant' crisis, which requires sensitivity to ensure that consumers feel heard and understood. Being provided with choices was important for many people, but some found being given choices difficult when in crisis. Consumers valued feeling cared for, listened to and being given reassurance. They also valued receiving follow up and were positive that crisis intervention was able to prevent the need for hospital admission.

In a qualitative study of caregivers' perspectives on trauma-informed care for suicide prevention in adolescents (Inscoe, et al., 2021), 92% of the participants emphasised the need for caregiver involvement across the care continuum. They emphasised the need for being given practical assistance, psychoeducation, referrals and care navigation as well as emotional support for caregivers. Therapist characteristics of authenticity, genuineness and warmth, being nonjudgmental, empathic and validating were all seen as important. The caregivers noted that clinicians need to be educated about trauma and the impact of traumatic stress on suicide risk in young people. The ED and inpatient environment can be traumatising and lack of clinician competence in recognising and responding to trauma was a negative experience. Barriers to care include system navigation and cost.

Community-based crisis intervention models in children and young people

A recent scoping review of Integrated Community-Based Youth Service Hubs (Settipani, et al., 2019) examined the evidence for 'one stop shops' for youth (12 – 25 in general). In general, such hubs cater for both physical and mental health care needs and include examples such as headspace and Orygen Youth Health. The emphasis of such models includes the need for strong collaboration, integration of services, early intervention, and the need for evidence-based intervention. The review found limited information provided by the models to allow replication or evaluation, demonstrating the need demonstration of clinical outcomes directly related to the model employed.

A literature review (Lamb, 2009) explored alternatives to inpatient care for young people requiring intensive treatment. Multi-Systemic Therapy (MST) and Assertive Community Treatment (ACT) have the strongest evidence base and ACT has been shown to reduce the need for inpatient care. The reviewers noted the need for a variety of complementary models of intensive MH care, including intensive outreach, crisis intervention, day- and inpatient, but the lack of evidence about which model is best for which young people. There is also a need for more evidence on the therapeutic content of interventions. The review recommended that intensive community treatment works best for children with severe and complex needs when a range of treatment modalities is available, including inpatient psychiatric care.

Schley and colleagues reported on the Victorian Intensive Mobile Youth Outreach Service (Schley, Yuen, Fletcher, & Radovini, 2012). This Australian study retrospectively studied 44 high-risk, difficult to engage young people (aged 14 – 25 years) and demonstrated that a community-based collaborative approach that is timely and individually tailored is associated with positive treatment outcomes and engagement even in young people who have been at high risk to themselves or others and who have not been able to engage with other treatment services.

Assertive Community Treatment for youth who have severe mental illness and who are difficult to reach has been shown to have positive effects in terms of psychiatric symptom improvement and reduced frequency and duration of psychiatric hospitalisation (Vijverberg, Ferdinand, Beekman, & van Meijel, 2017). Effect sizes varied between the 13 studies included in this systematic review, indicating the importance of model fidelity. The approach may be useful for this subset of young people who present in crisis.

Fendrich (Fendrich, et al., 2019) studied a model of rapid response crisis stabilization for children and adolescents aged 3 – 17 years. The model provided short term intervention up to 45 days and included support, screening and assessment, suicide assessment and prevention, brief solution-focused intervention, and referral and linkage to ongoing care. The researchers compared 2532 children and adolescents who were provided mobile crisis team intervention with a control group of 3961 children who were not offered crisis team involvement. They found a statistically significant 25% reduction in risk for subsequent ED visit in those receiving the mobile crisis service compared with the control group and a 22% reduction in ED visits.

Similarly, Mantzouranis and colleagues in Switzerland (Mantzouranis, Baier, Holzer, Urben, & Villard, 2019) studied 179 adolescents and found Assertive Community Treatment led to statistically and clinically significant improvement in HONOSCA and GAF scores. The approach enabled appropriate referral to other services for those who did not respond to the crisis model.

In Western Australia, a pilot program for youth in transition to adult MH services (ages 16 – 24), Youth Community Assessment and Treatment Team (YCATT) is reported by Goel and colleagues (Goel, et al., 2021). This pilot service aims to bridge inpatient and community services. Participants are offered comprehensive follow up care, urgent community assessments and interventions by a multidisciplinary team. The approach includes medical review and use of medications in addition to cognitive behaviour therapy, problem solving, motivational interviewing, supportive psychotherapy and crisis support. In addition, broader psychosocial needs are provided such as accommodation support, referral to the National Disability Insurance Scheme (NDIS) and child protection, education support and psychoeducation. In a retrospective evaluation that included 308 young people who had no established public sector mental health service involvement the researchers showed significant improvement in HONOS and K10 scores in a median intervention of 49 days. Hospital admission was averted in 93% of cases and in 61 young people who had been specifically referred to prevent hospitalisation, 90% were diverted from either ED admission or direct psychiatric admission. Discharge from the service was to GP (37%), community (23%) and ongoing support from mental health services including both public and private (46%).

Another pilot of Intensive Crisis Intervention (McBee-Strayer, et al., 2019), a CBT-based, family-centred model that includes crisis admission to a short-term inpatient unit (average length of stay of 3 days), showed positive outcomes for 50 suicidal adolescents. The improvement in suicidality was significant and sustained for 3 months (large Effect Size of 2.2) and the adolescents also reported improved functioning that was sustained for 3 months (medium ES of -0.5).

Summary

There is a range of evidence demonstrating the effectiveness of crisis interventions for children and adolescents who are in acute mental health distress. Crisis interventions can reduce ED presentations and hospital admissions, thus maintaining children and adolescents in the community and minimising psychosocial disruption. There is a need for consistency in approach and model fidelity for interventions to be effective. Successful models include elements of outreach, individually tailored assessment and management, and collaborative care. Demonstration of treatment outcomes is important for ongoing service development as well as contributing to the evidence base with the aim of further delineating the successful elements of interventions and their application.

The Safeguards Teams

Overview

The Safeguards Teams are a new dedicated CAMHS resource designed to provide innovative and best practice care to children and adolescents aged 0-17 years experiencing acute mental health distress

The Teams are community based and will provide rapid, mobile, intensive and flexible short-term delivery of skilled evidence-based interventions to resolve mental health crisis. They will provide extended hours mental health services and partner with relevant health services to ensure 24/7 support to young people and families while in crisis.

The Teams will respond to young people in their schools, homes and communities and in hospital-based settings (EDs/Wards), through face to face, phone and telehealth appointments. This flexible model will be adapted to work across rural, regional and metropolitan locations and be tailored to meet local cultural and diversity needs. Within a stepped care approach[1], the Safeguards Teams provide a more intensive acute service component on the spectrum of care supporting the work of community-based child and adolescent mental health services and the tertiary acute child and adolescent inpatient units.

Teams will be multidisciplinary and comprised of psychiatry, nursing and allied health professionals with the clinical expertise to deliver crisis assessment, specialist clinical care and short-term therapeutic interventions for young people with high and complex mental health needs and their families/carers. Teams will incorporate psychiatry registrar training positions which will grow a much-needed sustainable child and adolescent psychiatry workforce and support the expansion and professional development of a skilled multidisciplinary child and adolescent workforce.

Service imperatives (non-negotiable service elements)

The Mental Health Branch will provide supports and processes to assist LHD/SHNs to implement the Safeguards Teams program. This will include a Model of Care Working Group that will further develop and refine the overarching Safeguards framework for the state. At a local level, it is expected that LHD/SHNs will develop a local service model that will ensure integration of the new Safeguards Teams into the existing CAMH service structures and will reflect local challenges and opportunities. The development of local service models should utilise regional planning processes (including the Primary Health Network) and incorporate co-design and co-production with consumers, carers, staff and other stakeholders.

[1] Stepped care is defined as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs' (PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance 2019)

The Mental Health Branch has identified service elements that central to the model and must be incorporated into local service models.

Safeguards Teams must:

- be embedded within and additional to existing Child and Adolescent Mental Health Services (CAMHS). Governance of services must sit within the CAMHS service structures
- be comprised of skilled multidisciplinary clinicians able to provide a range of evidence-based therapeutic interventions. Immediate recruitment to a project officer position will be needed to support establishment and initial operationalisation of the model.
- adhere to the overall principles (below) and intent of the Safeguards Teams model
- work within an assertive outreach model and deliver specialist assessment, care coordination, clinical care and therapeutic interventions.
- provide care across the 0-17 age range
- ensure that access to care is based on level of acuity, risk, complexity and distress, and is not limited by diagnosis or co-morbidities such as developmental disability, Eating Disorders, children in out of home care and younger children. Availability of other supports and alternative care options may be considered. (Further guidance about what is meant by 'crisis' will be developed by the Model of Care Working Group)

Values

The Safeguards Teams reflect the NSW Health CORE Values:

- Collaboration
- Openness
- Respect
- Empowerment

Principles

The following key principles support the delivery of holistic, high quality mental health care:

1. Rapid, accessible, inclusive
2. Any child or adolescent with a mental health crisis regardless of diagnosis or sociodemographic status
3. Child and young person-centred, family/carer-centred
4. Developmentally appropriate
5. Recovery-oriented, strengths-based, culturally safe and trauma informed
6. Collaborative, integrated care, navigation
7. Draws on and contributes to existing evidence, continually improving

Aims

Primary Aim

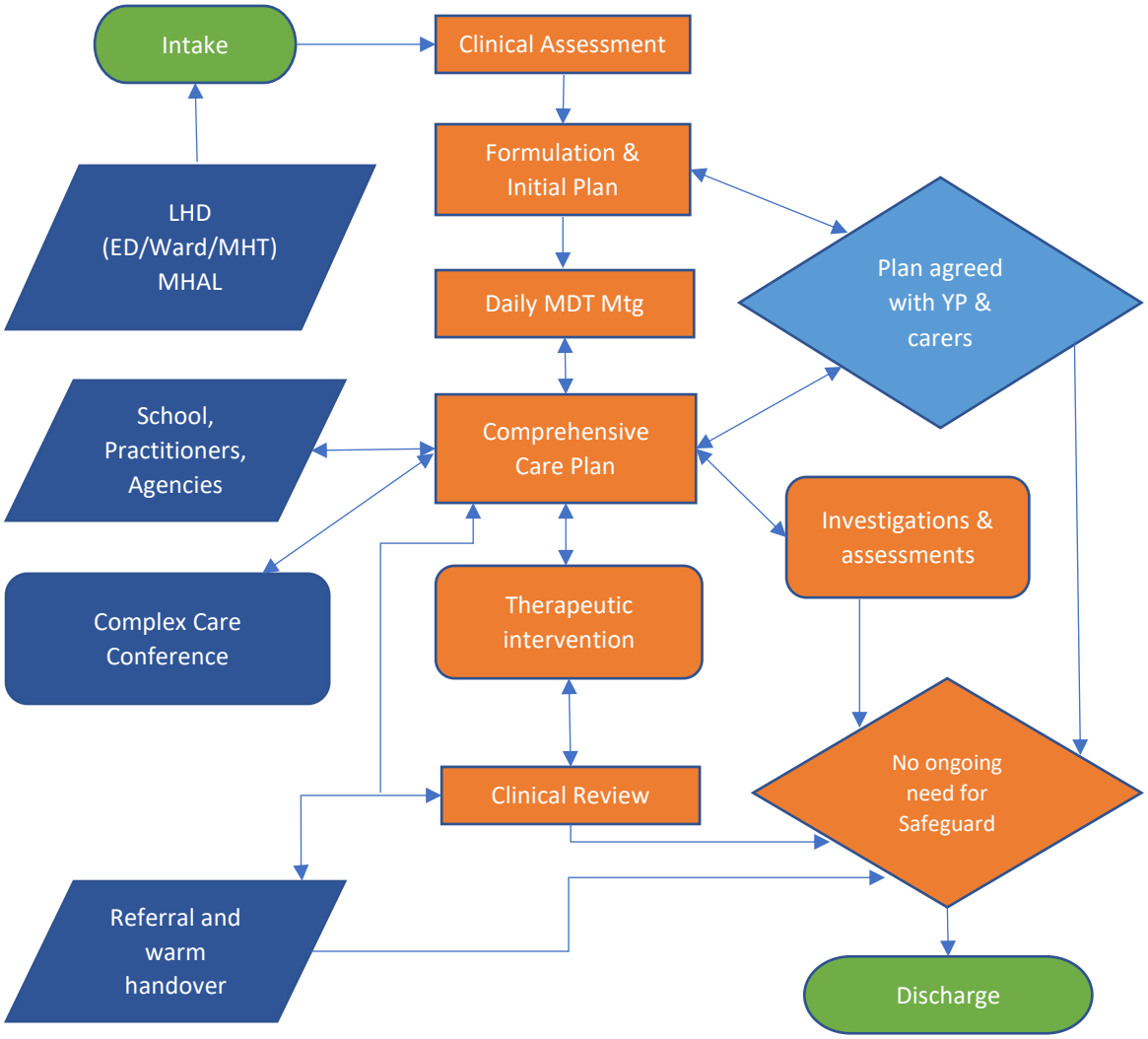
- To improve access to timely, evidence-based, recovery-focused and trauma-informed assessment and brief treatment intervention for children, young people affected by acute mental health concerns and their families

Additional Aims

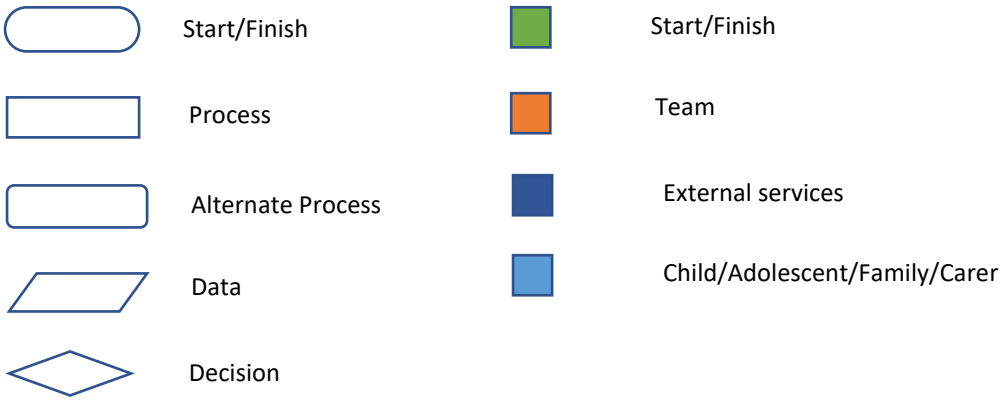
- Intervene early and prevent deterioration
- Promote well-being, resilience and coping skills in children, adolescents and their families/carers

- Ensure individualised comprehensive follow up is in place
- Provide an integrated experience of mental health care that encourages engagement, particularly for hard-to-reach young people and families
- Prevent avoidable hospital admissions
- Prevent avoidable ED presentations
- Facilitate early discharge from hospital

Safeguards Team Flow Diagram



KEY:



Inclusion Criteria

- Ages 0 – 17 years inclusive (> 17 if still in school)
- Likely/known Mental Health diagnosis
- Acute Mental Health Crisis
- Can be managed safely out of hospital

Exclusion Criteria

- Child or adolescent is already actively in treatment AND their usual treating practitioner/team is available to see them
- Acute intoxication
- Primary placement problem

Intake

No Wrong Door approach.

Broad intake including:

- LHD/SHN-based:
    - Emergency Department
    - Hospital inpatient unit (Acute Psychiatric Inpatient Unit, PECC, Paediatric Ward)
    - Community CAMHS/CYMHS Team
- External Referrals via MHTAL:
    - General Practitioners
    - Private Mental Health Practitioners
    - Headspace/NGO
    - School
    - Self/family referral

What Care is Provided?

- Comprehensive multidisciplinary team assessment and management
- Bio-psycho-socio-cultural formulation
- Crisis intervention
    - Approach to be determined by individual child/adolescent/family/carer need
    - Evidence-based approaches, including individual, parent/carer, family, Single Session, psychotherapeutic approaches, psychoeducation, problem-solving skills, pharmacotherapy
    - Safety planning
- Comprehensive care planning
    - Collaborative with child, adolescent, family/carer
    - Inter- and intra-agency collaboration and integration
    - Include physical health care needs
    - Include psychosocial care needs
    - Include educational care needs
    - Include family/carer needs
    - Collaborative discharge planning
- Care coordination
    - Support system navigation
    - Ensure all involved/required agencies are provided appropriate information

- Provide ‘warm handover’ ie: ensure relevant information is provided to services that the person is referred to; ensure the person has engaged with the new service; provide alternative services if required

Where is Care Provided?

Flexible care provision, based on child/adolescent/family need

- Community based
  - Home
  - School
  - Community CAMHS/CYMHS Centre
  - Elsewhere if appropriate
- Hospital based
  - Hospital outpatients
  - Emergency Department (in-reach to facilitate transfer of care)
  - Hospital Ward (Acute MH Ward, Paediatrics) (in-reach to facilitate transfer of care)
- Flexible access
  - Face to face
  - Video-link
  - Telephone

When is Care Provided?

Flexible care provision, based on child/adolescent/family need

Service provided 7 days per week, extended hours

- Next day appointment (or same day if indicated)
- Extended hours (including evenings and weekends)
- Daily contact if needed
- Care continues until child or adolescent can be safely managed by lower intensity community-based services (usually up to 6 weeks)

Team Staffing

A total indicative staffing of 8.0 FTE per team. The Core Team is to consist of the positions identified below, with additional staffing recruited according to local skill mix requirements.

Position gradings recommended by NSW Health and should be advertised in line with the grading.

Safeguard Teams are to be embedded and managed within CAMHS governance structures.

All staff members must have professional reporting lines in place within the LHD/SHN.

Core Team (6.0 FTE):

- Child and Adolescent Psychiatrist (up to Senior Staff Specialist) - 0.5 FTE
- Psychiatry Registrar Year 4 (Stage 3 Child and Adolescent Psychiatry Trainee) - 1.0 FTE
- CNS2/CNC1 - 1.0 FTE
- Clinical Psychologist or Psychologist with extensive post-graduate experience - 1.0 FTE
- Social Worker Level 3 - 1.0 FTE
- Occupational Therapist Level 3 - 1.0 FTE

- NOTE: Team Leader to be taken from above core nursing/allied health staffing, at senior grading (CNC2 or Senior Psychologist or Clinical Psychologist or Social Worker Level 4 or OT Level 4)
- Administrative Officer Level 3 - 0.5 FTE

Additional Clinical Staff (2.0 FTE):

Discipline to be recruited according to local need and availability. Can include Nursing, Clinical Psychologist, Psychologist, Social Worker, Occupational Therapist on above grades.

Can also include other Allied Health staff who have appropriate skills and experience, for example Speech Pathologist Level 3, Aboriginal Health Practitioner/Principal Aboriginal Health Worker

Staffing Considerations:

Consider flexible staffing arrangements to ensure availability of staff, eg part-time, casual, sessional.

Consider cross-team work arrangements to ensure staff well-being, eg staff working part-time in Safeguards Team and part-time in community CAMHS/CYMHS team.

Sample Staff Roster:

	08.30 – 17.00	**09:30 – 18.00**	**12.00 – 20.30**
Monday	Psychiatrist Registrar Team Leader x 1 Admin Officer	CNS/CNC/AH x 1	CNS/CNC/AH x 2
Tuesday	Registrar Team Leader x 1	CNS/CNC/AH x 1	CNS/CNC/AH x 2
Wednesday	Psychiatrist **08.30 – 12.30** Registrar Team Leader x 1Admin Officer **08.30 – 12.30**	CNS/CNC/AH x 1	CNS/CNC/AH x 2
Thursday	Registrar Team Leader x 1	CNS/CNC/AH x1	CNS/CNC/AH x 2
Friday	Psychiatrist Registrar Team Leader x 1Admin Officer	CNS/CNC/AH x 1	CNS/CNC/AH x 2
Saturday	Not staffed	CNS/CNC/AH x 2	Not staffed
Sunday	Not staffed	CNS/CNC/AH x 2	Not staffed

NOTES:

- Shift times are indicative only and may be changed to suit local service usage patterns
- Psychiatrist on call back up cover after hours and when Safeguard psychiatrist not on duty to be provided from usual LHD/SHN on call rosters
- Psychiatry Registrar after hours on call/leave relief to be provided from usual LHD/SHN on call rosters
- Management after hours support to be provided via usual LHD/SHN systems and on call rosters
- Administrative Officer back up during working hours for urgent matters when Safeguard Admin not on duty to be provided from existing LHD/SHN staffing

Key Partnerships

Key partnerships listed below are indicative, not exhaustive. Local partnerships may vary.

Children, Adolescents and Families/Carers:

People who use the service are key partners in their care. All efforts should be made to work collaboratively with consumers and families/carers, and to include their social supports whenever possible.

CAMHS/CYMHS:

- Safeguards Teams are based in and complement existing CAMHS/CYMHS services within the LHD/SHN
- Safeguards Teams have access to and build on existing CAMHS/CYMHS resources including
    - Peer Workers
    - Suicide Prevention Teams (Alternatives to ED, Safe Havens, SPOT)
    - Case Managers

Hospital-Based Health Services:

- Emergency Department
- Inpatient Wards (Acute Psychiatry, General Paediatrics)
- Hospital Outpatients (Mental Health, Violence Abuse Neglect Services)

Community-Based Health Services:

- General Practitioners/PHN
- Private Specialist Mental Health Providers
    - Psychiatrists
    - Psychologists
    - Other
- Commonwealth/PHN-funded Mental Health Providers
    - Headspace
    - Youth Enhanced Services
    - Other
- Other Health Providers
    - Paediatricians
    - Youth Health
    - Drug and Alcohol Services
    - Justice Health/Forensic MH
    - Child and Family Health
    - PIMH
    - Transcultural MH

Government Agencies

- Department of Education
- Department of Communities and Justice
- NSW Police Force, Probation and Parole
- Ambulance Service of NSW
- National Disability Insurance Scheme

Community Managed Organisations:

- Aboriginal Community Controlled Health Organisations
- NDIS commissioned services
- Carer Gateway providers
- Family and MH Carer Program NGO providers
- Diversity providers

Continuing Service Development

Staff Training:

Staff must be given an orientation program that outlines the team roles and functions prior to commencing in the team. This must include training in the use of the clinical and service measures.

Staff must be provided with regular clinical supervision to ensure they continually develop their clinical skills and to ensure well-being.

Staff training should include training in brief models of assessment and therapy, for example single session therapy and gold card clinic brief intervention model, as determined in clinical Model of Care.

Service Development and Evaluation:

A service evaluation plan is being developed. It will include measures to evaluate the implementation and ongoing functioning of the clinical service, consumer/carer evaluations of experience and outcomes, and clinician rated consumer outcomes measures. Key Performance Indicators will also be developed.

Staff must complete all required measures routinely. Processes must be in place to ensure that this requirement is adhered to and that reports are provided as required to the Mental Health Branch.

Capacity building:

Capacity-building is a key element of the Safeguards Teams. This includes providing training and consultation to build capacity in key stakeholder groups including:

- Child, adolescent and family/carers
- Within Safeguards team
- With service partners/stakeholders

Local Considerations

The overall principles must be adhered to. Agreed therapeutic approaches to be developed by the Model of Care Working Group must also be adhered to.

The Safeguards program can be adapted by LHDs/SHNs through a co-design process with consumers, carers, staff and partners to ensure it meets the local needs of Child and Adolescent consumers with acute mental health needs. For example:

- Extended hours may include early morning or later in the evening, but services are to be provided 7 days per week
- An Aboriginal Health Practitioner or a practitioner with specific clinical experience (Out of Home Care, Eating Disorders, Developmental Disability, younger children) may be required
- Flexibility of working arrangements may be required (fly-in fly out, video-conferencing, sessional staff)

- Subspecialist support for other LHDs/SHNs may be required
- Local escalation pathways will need to be developed
- Clarity of roles between the Safeguard Team and existing services within LHD/SHN to be determined
- Collaboration with local external stakeholders to be negotiated and formalised
- Some LHDs/SHNs may rotate staff between Safeguards and other CAMHS teams, others may have specific staff separately allocated to each team within the service
- An Aboriginal health impact statement will need to be completed in each LHD/SHN

Abbreviations

ACT	Assertive Community Treatment
AH	Allied Health
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
COVID-19	Coronavirus Disease of 2019
CYMHS	Child and Youth Mental Health Services
ED	Emergency Department
GAF	Global Assessment of Functioning
GP	General Practitioner
K10	Kessler Psychological Distress Scale
HONOS	Health of the Nation Outcome Scale
HONOSCA	Health of the Nation Outcome Scales for Children and Adolescents
LHD	Local Health District
MHTAL	Mental Health Triage Access Line
MH	Mental Health
MST	Multi-Systemic Therapy
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
OT	Occupational Therapy/Therapist
PECC	Psychiatric Emergency Care Centre
PHN	Primary Health Network
PIMH	Perinatal and Infant Mental Health
RANZCP	Royal Australian and New Zealand College of Psychiatrists

SHN Specialty Health Network

SPOT Suicide Prevention Outreach Team

YCATT Youth Community Assessment and Treatment Team

References

Cloutier, P., Kennedy, A., Maysenhoelder, H., Glennie, E. J., Cappelli, M., & Gray, C. (2010, February). Pediatric Mental Health Concerns in the Emergency Department: Caregiver and youth Perceptions and Expectations. *Pediatric Emergency Care, 26*(2), 99-106.

Cloutier, P., Thibedeau, N., Barrowman, N., Gray, C., Kennedy, A., Leon, S. L., . . . Cappelli, M. (2017). Predictors of Repeated Visits to a Pediatric Emergency Department Crisis Intervention Program. *Canadian Journal of Emergency Medicine, 19*(2), 122-130.

Fendrich, M., Ives, M., Kurz, B., Becker, J., Vanderploeg, J., Bory, C., . . . Plant, R. (2019). Impact of Mobile Crisis Services on Emergency Department Use Among Youths with Behavioral Health Service Needs. *Psychiatric Services, 70*, 881-887.

Goel, C., Shafi, R. M., Conner, A. J., Waters, F., Croarkin, P. E., & McGorry, P. (2021). A Retrospective Evaluation of a Pilot Youth Community Assessment and Treatment Service. *Psychiatric Services, 72*, 415-420.

Hughes, F., Hebel, L., Badcock, P., & Parker, A. G. (2018). Ten Guiding Principles for Youth Mental Health Services. *Early Intervention in Psychiatry, 12*, 513-519.

Inscoe, A. B., Donisch, K., Cheek, S., Stokes, C., Goldston, D. B., & Asarnow, J. R. (2021). Trauma-Informed Care for Youth Suicide Prevention: A Qualitative Analysis of Caregivers' Perspectives. *Psychological Trauma: Theory, Research, Practice, and Policy*. Retrieved 07 20, 2021, from https://doi.org/10.1037/tra0001054

Lamb, C. E. (2009). Alternatives to Admission for Children and Adolescents: Providing Intensive Mental Healthcare Services at Home and in Communities: What Works? *Current Opinion in Psychiatry, 22*, 345-350.

Mantzouranis, G., Baier, V., Holzer, L., Urben, S., & Villard, E. (2019). Clinical Significance of Assertive Community Treatment Among Adolescents. *Social Psychiatry and Psychiatric Epidemiology, 54*, 445-453.

McBee-Strayer, S. M., Thomas, G. V., Bruns, E. M., Heck, K. M., Alexy, E. R., & Bridge, J. A. (2019). Innovations in Practice: Intensive Crisis Intervention for Adolescent Suicidal Ideation and Behavior - an open trial. *Child and Adolescent Mental Health, 24*(4), 345-349.

Sands, N., Elsom, S., Keppich-Arnold, S., Henderson, K., & Thomas, P. A. (2016). Perceptions of Crisis Care in Populations Who Self-Referred to a Telephone-Based Mental Health Triage Service. *International Journal of Mental Health Nursing, 25*, 136-143.

Schley, C., Yuen, K., Fletcher, K., & Radovini, A. (2012). Does Engagement with an Intensive Outreach Service Predict Better Treatment Outcomes in 'High-Risk' Youth? *Early Intervention in Psychiatry, 6*, 176-184.

Settipani, C. A., Hawke, L. D., Cleverley, K., Chaim, G., Cheung, A., Mehra, K., . . . Henderson, J. (2019). Key Attributes of Integrated Community-Based Youth Service Hubs for Mental Health: A Scoping Review. *International Journal of Mental Health Systems, 13*, 52.

State of Victoria. (2021). *Royal Commission into Victoria's Mental Health System, Final Report.* Parl Paper No. 202, Session 2018-21. Retrieved from www.rcvmhs.vic.gov.au

Vijverberg, R., Ferdinand, R., Beekman, A., & van Meijel, B. (2017). The Effect of youth Assertive Community Treatment: A Systematic PRISMA Review. *BMC Psychiatry, 17*, 284.

Reports and Websites

Australian Government Department of Health (2019). *PHN Mental Health Flexible Funding Pool Programme Guidance: Stepped Care*, Canberra: Australian Government Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.pdf

Mental Health Commission of NSW (2014) *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* https://www.nswmentalhealthcommission.com.au/content/living-well-plan-and-report

Mental Health Commission of NSW (2020). *Living Well in Focus: 2020-2024* https://www.nswmentalhealthcommission.com.au/report/living-well-focus-2020-2024

NSW Health. CORE values https://www.health.nsw.gov.au/careers/ministry/Pages/CORE-values.aspx

NSW Health (2018). *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022: A Framework and Workforce Plan for NSW Health Services* https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mh-strategic-framework.aspx

NSW Health (2019). *NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework. https://www.health.nsw.gov.au/parvan/Pages/iparvan-framework.aspx*

NSW Health (2019). The First 2000 Days Framework. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf

NSW Health (2021). *NSW Health Commissioning for Better Value Strategy 2021-24. https://www.health.nsw.gov.au/Value/Pages/cbv-strategy.aspx#:~:text=This%20strategy%20provides%20guidance%20to,services%20that%20support%20patient%20care*.

NSW Health (2021). Psychiatry Workforce Plan 2020-2025. https://www.health.nsw.gov.au/workforce/medical/Pages/psychiatry-workforce-plan-2020-2025.aspx

NSW Premier's Priorities https://www.nsw.gov.au/premiers-priorities

Productivity Commission (2020). *Mental Health*, Report no. 95, Canberra. https://www.pc.gov.au/inquiries/completed/mental-health/report

RANZCP NSW Branch CAMHS (2021). *Investing in our Children: RANZCP NSW CAMHS 2020-21 Pre-budget submission*