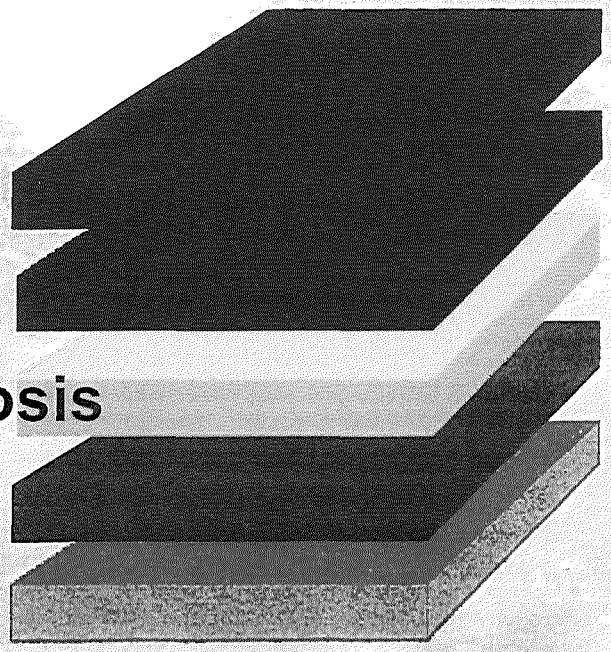
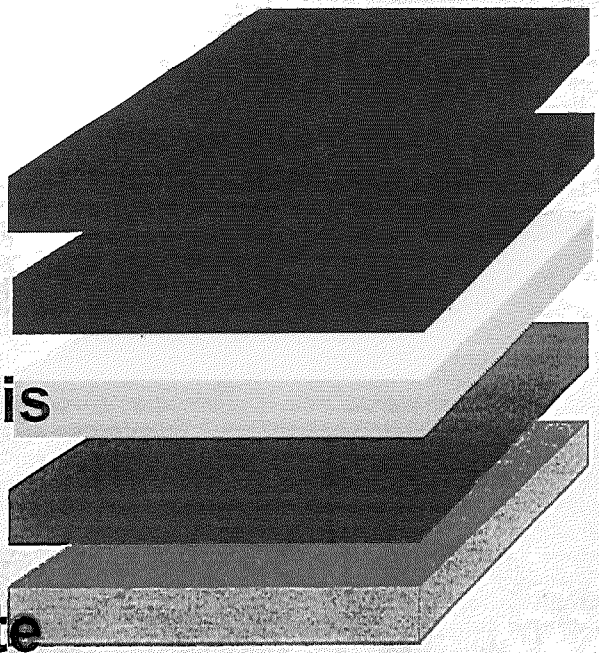
Levels of Assessment

End Point - The Diagnosis



- DSM-IV a starting point for many treatment protocols
- Problems with diagnostic specificity in adolescence
- Usually present with co-morbid diagnoses
- Often irrelevant in the absence of a developmental history

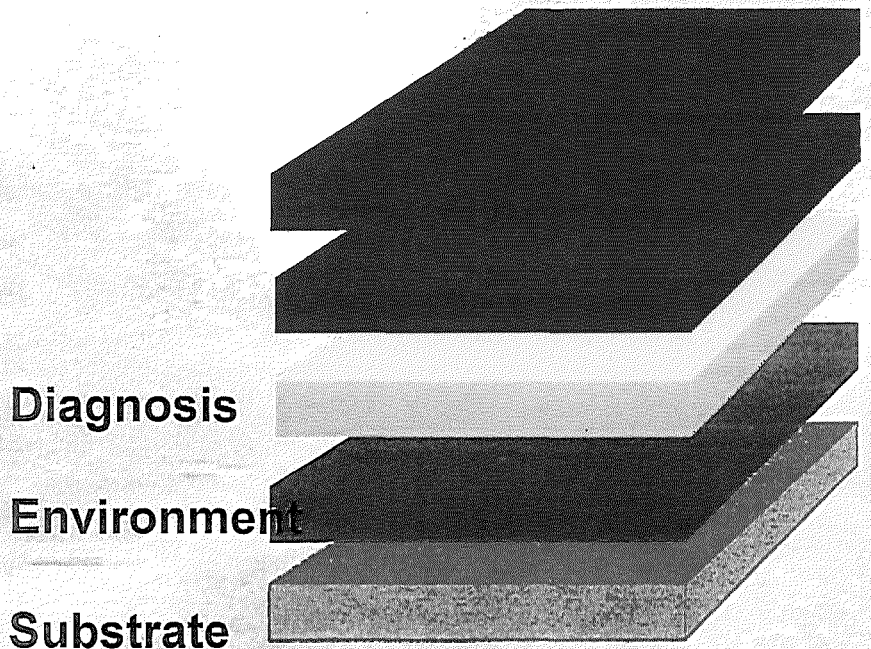
Levels of Assessment



Predisposing - Inherent biological (substrate) issues

- Temperament
- Attachment style
- Sociability
- Language delays
- Attention delays
- Impulsivity issues
- Learning delays
- Motor delays
- Perceptuo-sensory sensitivities

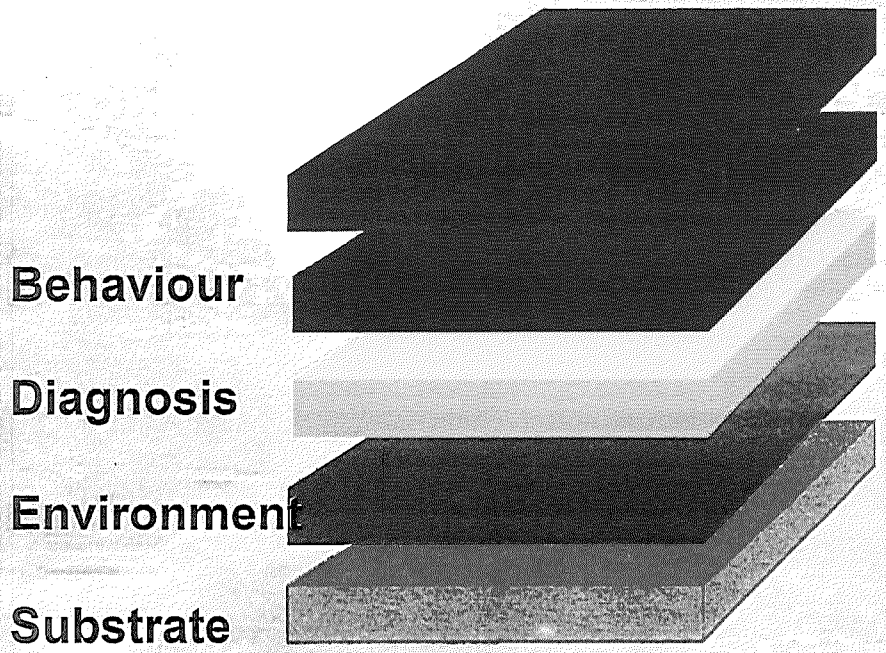
Levels of Assessment



Predisposing - Effects of Environment

- Family environment
  - Structure
  - Parenting style
  - Mental health history
  - History of abuse
  - Family supports
  - Socio-economic
- School environment
  - School stability
  - Achievement / failure history
  - Teacher variables
  - Peer variables

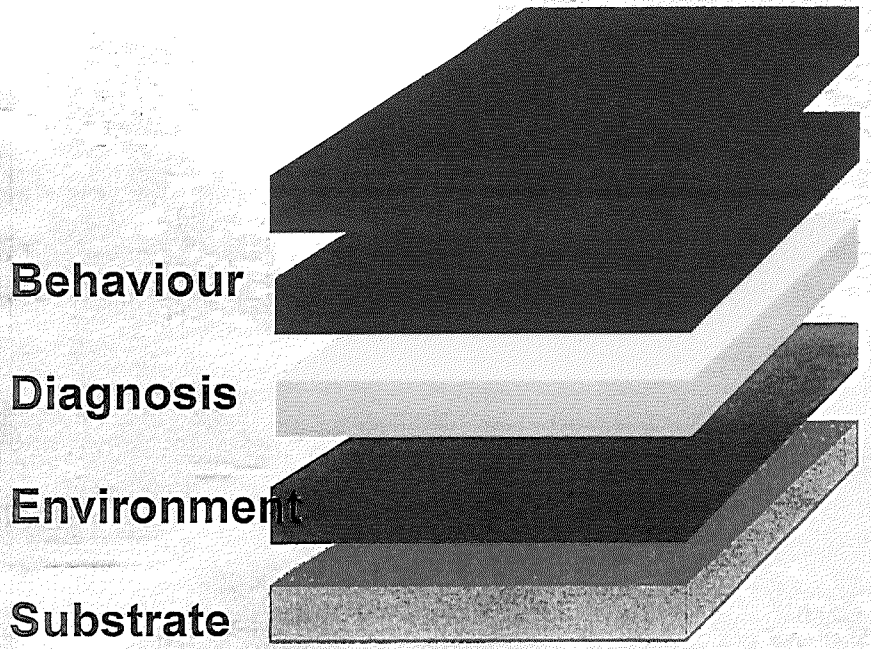
Levels of Assessment



Analysis of Behavioural Changes

- What exactly is the behaviour?
- To what extent does it occur?
- Where does it occur?
- How often does it occur?
- What brings it on?
- How long does it last?
- What other behaviours are associated with this behaviour?
- What other symptoms are associated with this behaviour?
- What intensifies this behaviour?
- What eases the behaviour?
- How does it finally resolve?

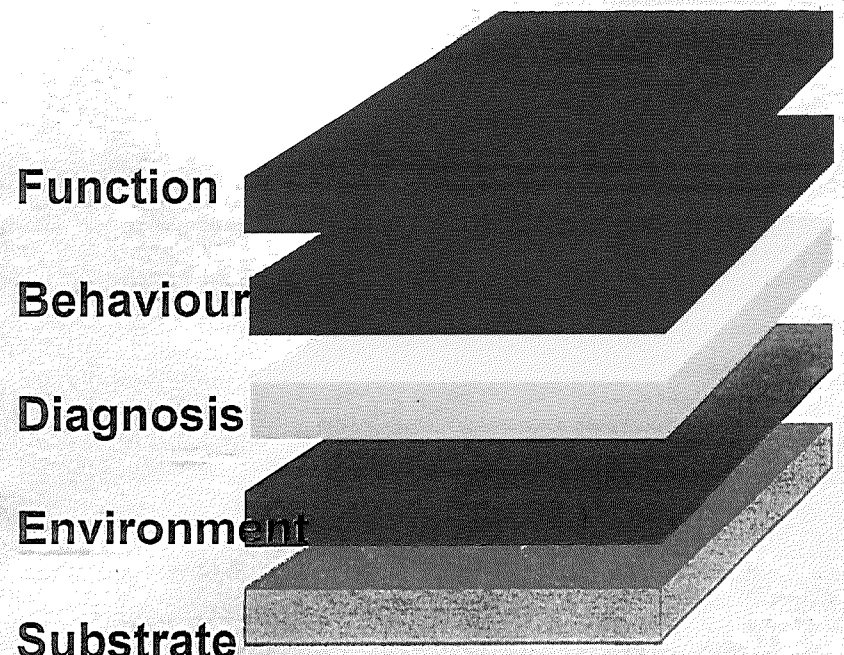
Levels of Assessment



Sequelae - Behavioural Changes

- Has the behavioural change had an impact on the family?
- Has the family's behaviour towards the adolescent changed?
- Has the family's behaviour towards other family members changed?

Levels of Assessment



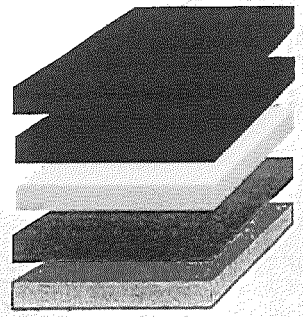
Sequelae - Changes in Function

- Has the adolescent served a function within the family?
- Does the illness serve a function for the adolescent?
- Do the behavioural changes serve a function for the family or the adolescent?
- Does the illness or behaviour serve a function for the adolescent in relation to peers or society?
- Beware of speculation about function.

The Developmental Tasks of Adolescence

- Cope with physical changes

Function
Behaviours
Diagnosis
Environment
Substrate

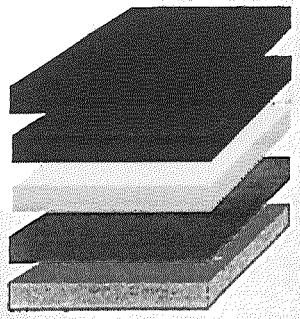


- Early puberty
- Delayed puberty
- Effects on identity
- Effects on emotions
- Effects on behaviour
- Effects on cognitions
- Define sexuality

The Developmental Tasks of Adolescence

- Cope with physical changes
- Develop cognitive maturity

Function
Behaviours
Diagnosis
Environment
Substrate

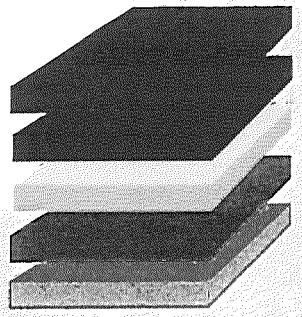


- Develop formal thought
- Develop problem solving
- Develop a healthy cognitive style
- Develop organisational skills
- Cognitive adequacy

The Developmental Tasks of Adolescence

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school

Function
Behaviours
Diagnosis
Environment
Substrate

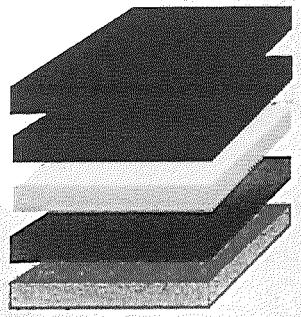


- Academic competency
- Other competencies
- Peer relationships
- Teacher variables
- Family attitudes
- Levels of support
- Review suitability of schooling
- Assist transition to work

The Developmental Tasks of Adolescence

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time

Function
Behaviours
Diagnosis
Environment
Substrate

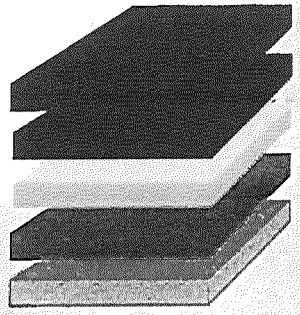


- Range of competencies
- Peer interactions
- Planning
- Tolerance of being alone
- Moral development - effects on choice
- Emotional overlay - effects on choice, risk taking

The Developmental Tasks of Adolescence

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self

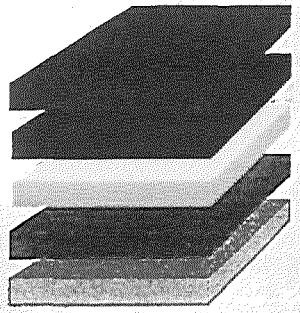
Function
Behaviours
Diagnosis
Environment
Substrate



- Self protection skills
- Self care skills
- Health behaviours
- Control issue
- Assessment of risk behaviours
- Substrate influences
- Mood influences
- Family influences

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

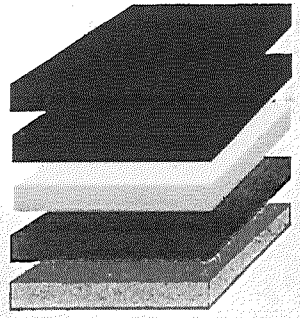


- Identify emotions
- Recognise emotions
- Identify correct emotions
- Express emotions appropriately
- Regulate emotions

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

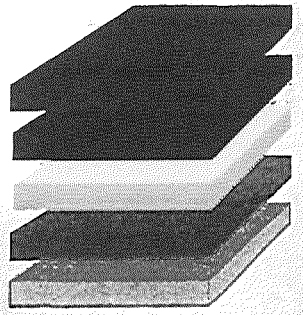


- Boundaries for self
- Boundaries within the family
- Control issues
- Peer boundaries
- Recognition of boundaries
- Boundary style
- Boundary negotiation
- Boundary violations

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

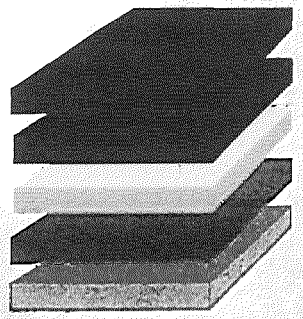


- Opportunities to have peer relationships
- Appropriate social skills
- Minimal concomitant developmental delays (e.g. language, impulsivity)
- Peer consonance
- Peer acceptance

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

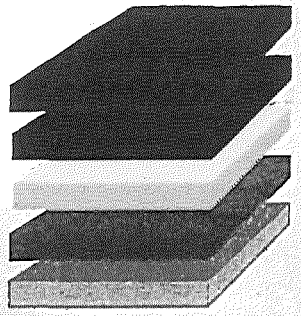


- Stages of moral development
- Cognitive influences
- Family influences
- Peer influences
- Media influences
- Morals in practice
- Spiritual, cultural factors

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

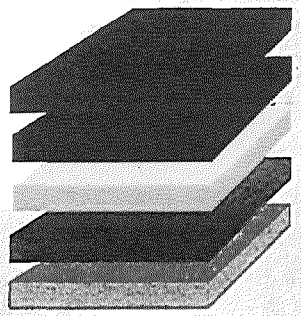


- Cognitive abilities
- Physical abilities
- Premature independence
- Overprotection / enmeshment
- Control issues
- Oppositional behaviours

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

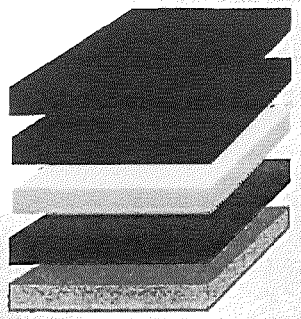


- Incorporate sense of family and culture
- Strength of teen-parent relationship
- Nature of teen-parent relationship
- Articulated values
- Review of childhood

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

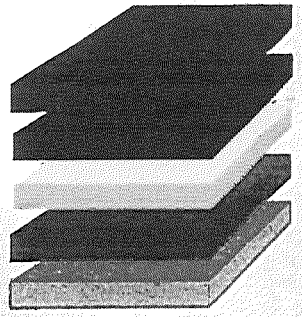


- Identify concepts and styles
- Self concepts
- Self esteem
- Assaults on identity
- Behaviour and identity
- Function and identity

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity

The Developmental Tasks of Adolescence

Function
Behaviours
Diagnosis
Environment
Substrate

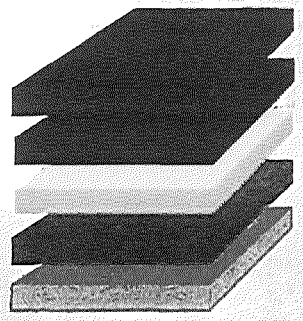


- Cause-effect relationships
- Attributions
- Re-evaluate childhood
- Schemas about social interactions
- Schemas of society
- Relevance of altruism and prosocial values

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity
- Develop life schemas

The Developmental Tasks of Adolescence

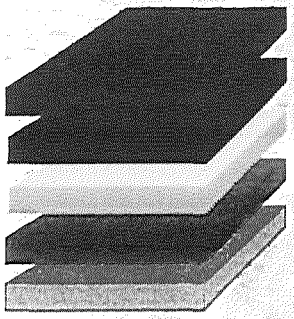
Function
Behaviours
Diagnosis
Environment
Substrate



- Planning ability
- Levels of motivation
- Goal definition
- Family influences
- Mood impediments
- Skill-goal consonance
- Vocational goals

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity
- Develop life schemas
- Develop a sense of the future

Function
Behaviours
Diagnosis
Environment
Substrate



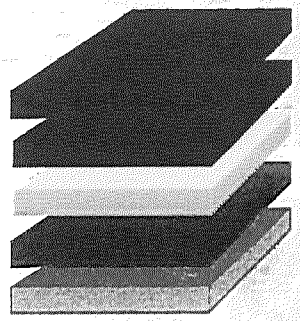
The Tasks of Parenting

- Level of commitment
- Adequacy of nurturance
- Bonding styles
- Met dependency needs
- Met protection needs
- Levels of consistency, supervision, monitoring
- Correction styles

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity
- Develop life schemas
- Develop a sense of the future

towards recovery

Function
Behaviours
Diagnosis
Environment
Substrate

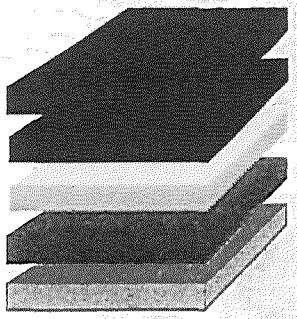


The Tasks of Parenting

- Development of competencies
- Communication of schemas, values
- Adequate boundaries
- Emotional containment
- Capacity to facilitate transitions
- Capacity to understand
- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity
- Develop life schemas
- Develop a sense of the future

Integrating Assessment, Development and Parenting

Function
Behaviours
Diagnosis
Environment
Substrate



- Level of commitment
- Adequacy of nurturance
- Bonding styles
- Met dependency needs
- Met protection needs
- Levels of consistency,
- supervision, monitoring
- Correction styles
- Communication of schemas, values
- Adequate boundaries
- Emotional containment
- Capacity to facilitate transitions
- Capacity to understand

- Cope with physical changes
- Develop cognitive maturity
- Negotiate school
- Occupy leisure time
- Care for the self
- Develop emotional maturity
- Establish boundaries
- Negotiate peer relationships
- Establish moral maturity
- Develop competencies to become independent
- Individuate
- Develop identity
- Develop life schemas
- Develop a sense of the future

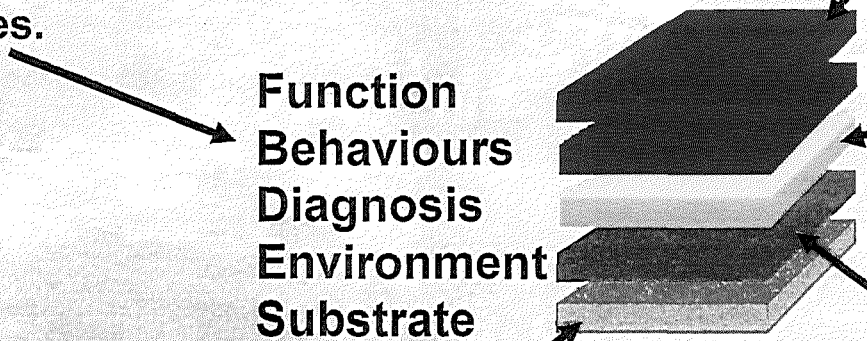
Understanding Recurrent Self Harm in Adolescents with Complex Trauma

Part 1 – A Basic Model for Interventions

Levels of Assessment 1

Most adolescent disorders are associated not only with emotional changes, but also behavioural changes which impact on their development and/or on the family and others. Examples of behaviours include social withdrawal, restricted eating, self harm etc. A detailed examination and assessment of the behaviours is important to indicate management strategies.

Occasionally behaviours persist because they come to serve a function for the adolescent. The evidence for this must be carefully evaluated.



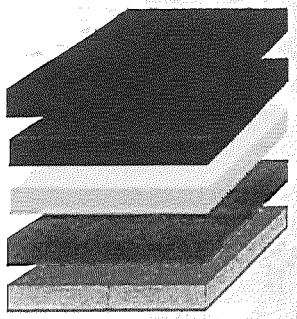
Standard ICD -10 or DSM-IVTR diagnoses including co-morbidities.

Family, school and neighbourhood environments both from the perspective of coping with substrate issues and also any direct contribution to the diagnosed disorder and associated behaviours

Substrate factors are inborn biological factors e.g. temperament, communication potential (presence of receptive - expressive language disorder), learning difficulties, sensory preferences, motor skills, social skills and attention and impulse control. These have the capacity to influence severity and degree of impairment of any disorders.

Levels of Assessment 2 – Developmental Tasks

Function
Behaviours
Diagnosis
Environment
Substrate



Developmental tasks are often impaired due to the behaviours associated with mental illness. For example a depressed adolescent may have sleep changes, do less schoolwork secondary to concentration and motivation difficulties, self harm and experience social withdrawal. These can impact schooling, peer relationships, self care, leisure and if prolonged, competencies for independence in some areas. These then have secondary impacts on identity and individuation. Elements of developmental tasks may need to be addressed to assist improvements in mood.

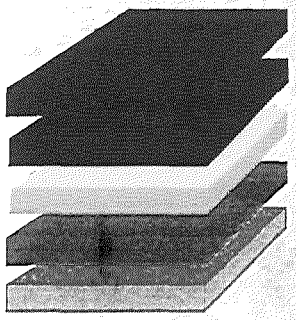
Elements of developmental tasks can be addressed in community, inpatient or residential settings with input from various sectors

Developmental Tasks of Adolescence

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

Levels of Assessment 3 – Family Environment

Function
Behaviours
Diagnosis
Environment
Substrate



The Tasks of Parenting

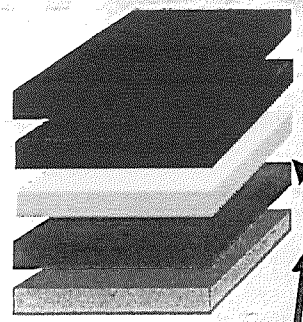
Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

These tasks of parenting can be extracted from large longitudinal population studies of children and adolescents in Australia, NZ, UK, Canada and the USA. They are also identified in ancient documents from other cultures, and smaller cross-cultural studies.

The greater the adequacy in the tasks of parenting, the greater the chances of good adjustment in young adult life.

Adolescents from families where multiple tasks of parenting have been inadequately filled can experience levels of care in clinical environments which range from contrasting to mirroring the care environment of the home e.g. follow up phone calls reflect commitment, taking steps to ensure safety after self harm a suicide attempt are protective measures by the clinician. Consistency, supervision and monitoring are not typically roles of community clinicians, but are important in residential settings.

Function
Behaviours
Diagnosis
Environment
Substrate



The Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

Developmental Tasks of Adolescence

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

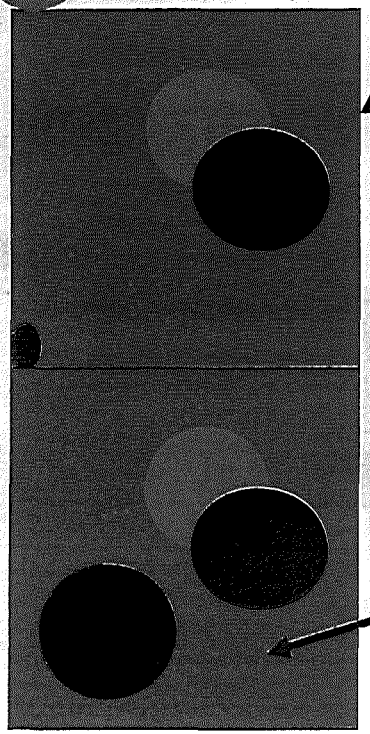
The final analysis is how these varying domains impact on each other, identify interventions for change in various domains and their potential impact on other domains, and identify elements in a domain unlikely to change and compensatory interventions.

Part 2 – Stages of Change for Adolescents who Self Harm in the Context of Trauma

Trauma

Emotion

Behaviour



An adolescent presents after an episode of self harm, often in the context of depression. There are no indicators which differentiate the different groups of adolescents with this picture after an initial presentation. Adolescents who have been abused (often several years before) do not reveal the abuse, because although they know it happened, actively try not to remember it. There is nothing in their minds which connects the abuse with the current mood or associated behaviours. This is so even after several episodes of self harm or suicide attempts.

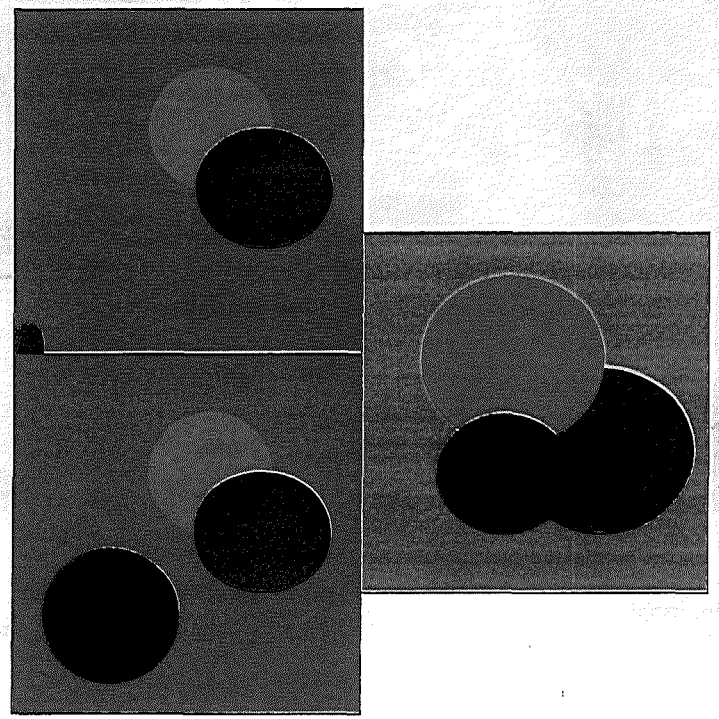
Adolescents with known histories of abuse with similar presentations (depression and suicide attempt or self harm) often do not relate the abuse to the current mood or behaviour. It is just an event that happened in their life.

Pre-connection Phase

Trauma

Emotion

Behaviour



Pre-connection Awareness Phase

For adolescents without known histories of abuse, this stage is in two parts. The first is a deterioration in mood and an escalation of suicidal/self harm behaviours. These need to be assessed each time with respect to the intent, precipitants, context of emotions and effects of self harm on the adolescent and others.

This stage can last for months

The second part is an awareness of the impact of the abuse – recurrent nightmares, dissociation, flashbacks, hallucinoses etc. There are often precipitating external stimuli which trigger off the awareness of the abuse, and its association with the depression and the self harm.

The first stage is often much shorter for adolescents about whom the abuse is known. Those who have lived in situations of high risk (e.g. being homeless) describe the "adrenalin rush" from such a life style. They identify the onset of trauma related symptoms in a place of extended safety.

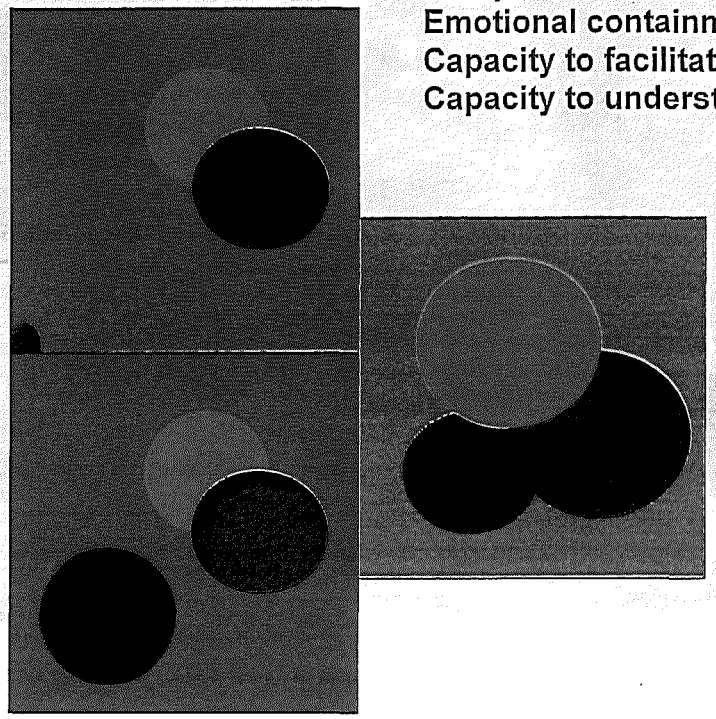
towards recovery

Trauma

Emotion

Behaviour

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand



From observation, the Awareness phase can only develop when the adolescent is in a stable care situation (if in care) and when there are stable clinical relationships either with individual clinicians within a system.

If care is across levels of settings e.g. community and inpatient, the adolescent benefits if they perceive that clinicians are integrated in their treatment e.g. consistent model, good communication, opportunity for the community therapist to visit them in an inpatient setting, and the inpatient setting provides some of the after hours crisis intervention if not available in the community

This stage is more distressing for the adolescent, who may prefer to be in the pre-connection stage. Their attendance may be sporadic, they may use substances to self sooth.

Pre-connection Awareness Phase

The awareness phase is problematic for clinicians. The escalation in self harm or suicidal behaviours can variously be seen as care eliciting, manipulative, or an indication of developing Borderline Personality. Evidence from adult treatments of the person with Borderline Personality Disorder is often applied. Inpatient admission is frequently short.

For adolescents with complex trauma, their admission results in a brief period of safety, which allows some experiencing of traumatic symptoms. Their discharge into unsafe or unstable home or care situations together with these emerging trauma symptoms can precipitate further self harm behaviour.

Every episode of self harm requires a careful assessment of its precipitants and its phenomenology, especially the adolescent's description of the effect it had on them e.g. presence or absence of pain, the reasons for the self harm, what they thought would happen to themselves or others. It is only as this information is collected over time that an assessment can be made whether this is a way of coping with potential or known trauma, whether it is a form of care eliciting behaviour or communication of some other needs, or a mixture of these reasons.

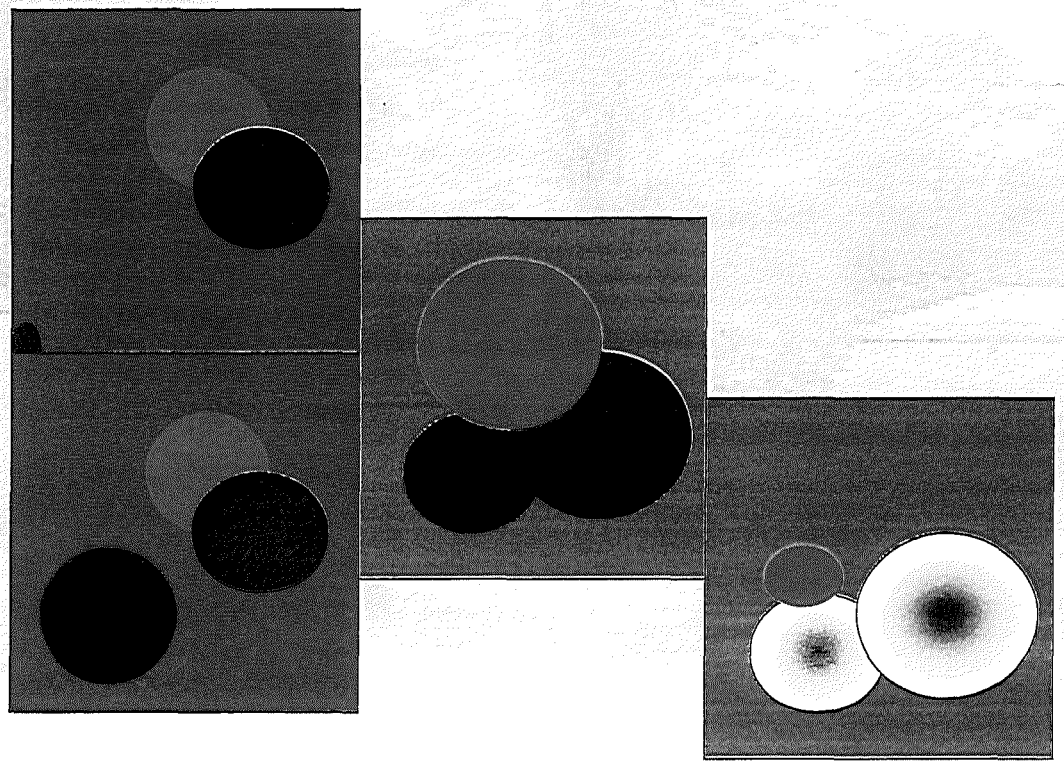
Because the self harm behaviour has the potential to arouse strong emotions in staff (e.g. anger, anxiety) there is a need for staff to be educated on the conceptual issues, trained in a behavioural assessment of the self harm and provided with support and supervision. Special liaison between CAMHS and Emergency Departments is beneficial.

Trauma

Emotion

Behaviour

A number of treatments (Dialectical Behaviour Therapy, Cognitive Analytic Therapy (and in a RCT structured Good Clinical Care – Chanen et al) have demonstrated reductions in self harm behaviours, decreased intrusiveness of the phenomena associated with trauma, and some improvements in mood, although there are frequently reports of continuing dysthymia. Generally there are improvements in associated functioning.



Pre-connection Awareness Working through Phase

Although these treatments differ in fundamental specifics, they have in common periods of regular therapy sessions over periods of six months or more, structured to semi-structured therapy and therapist supervision.

All of these lessen therapist anxiety, decrease the potential for therapist disengagement and creates a safe and containing environment for the adolescent.

Specific issues of the abuse are often not addressed.

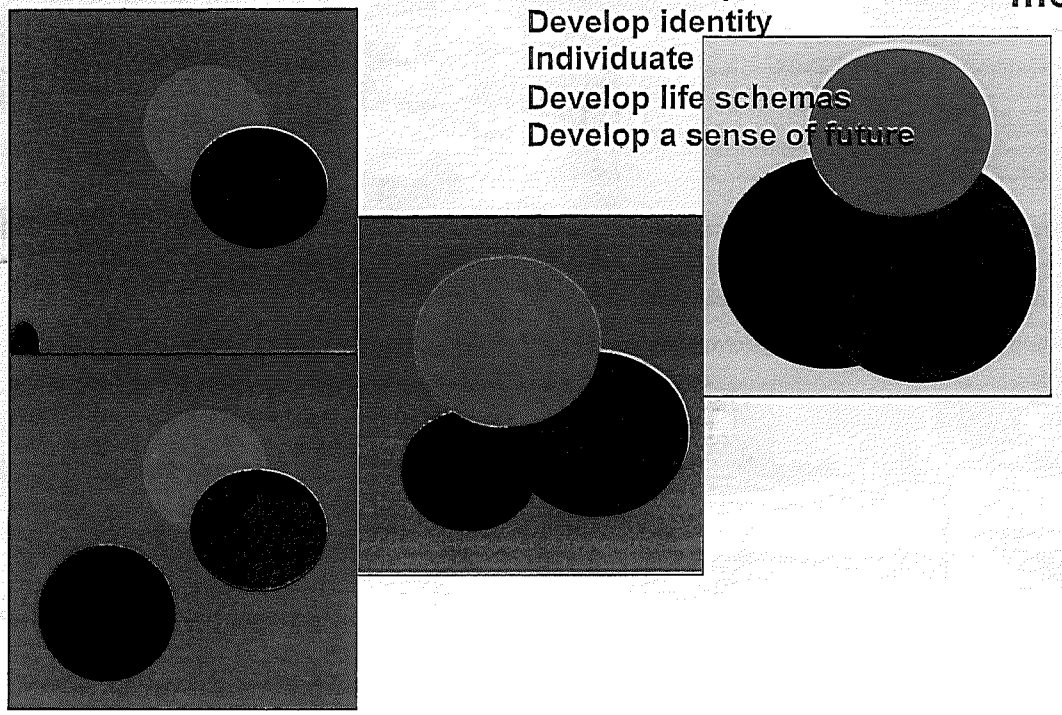
Trauma

Emotion

Behaviour

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

There is often a moratorium on developmental tasks in the Awareness phase. Systemic interventions which addresses both symptom amelioration and developmental tasks in the context of good care enable adolescents to move on with developmental tasks.



However the intrusiveness of the trauma symptoms prevents their successful attention to developmental tasks. They then make a decision to work through the trauma. This is often difficult as there is increased re-experiencing of the trauma memories. It often requires the containment only available in an inpatient unit.

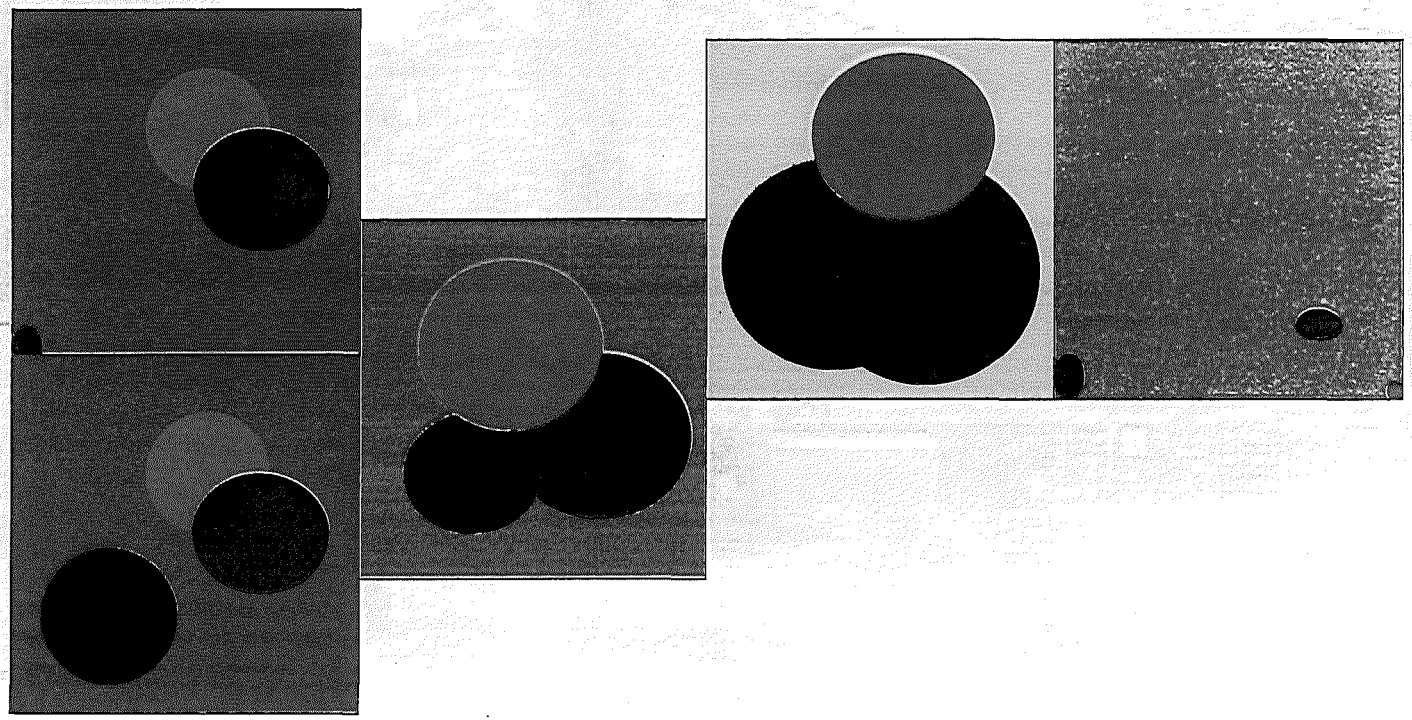
Pre-connection Awareness Working through Phase

Trauma

Emotion

Behaviour

Adolescents who can successfully work through their abuse who are now in their 20's and 30's report a good sense of well being, minimal to no impact of the trauma on their lives and little if any self harm.



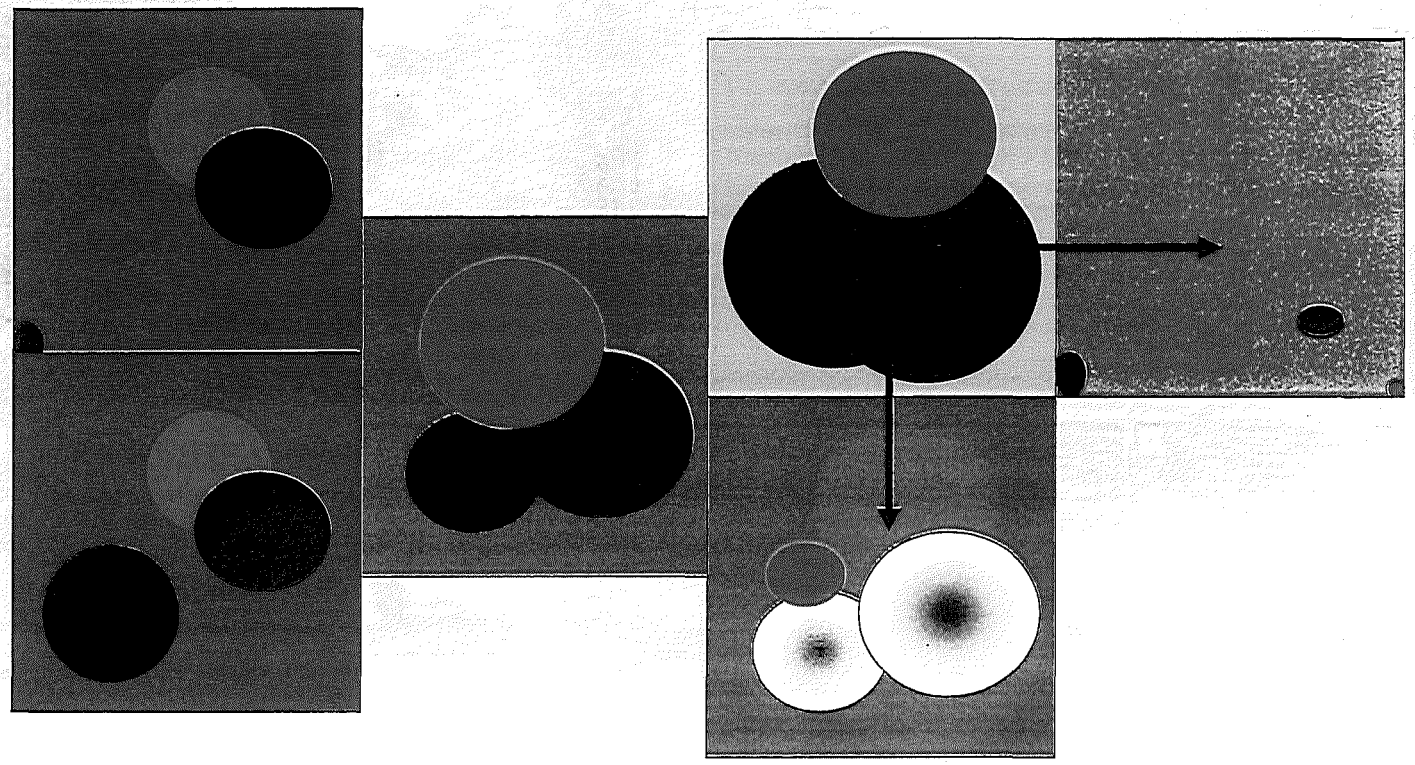
Pre-connection **Awareness** **Working through** **Recovery Phase**

Trauma

Emotion

Behaviour

Some adolescents find the increased symptoms of the Working through Phase to be too difficult initially. They try to "numb out the symptoms", but cannot sustain this. Eventually they work through and on to recovery.



Pre-connection Awareness Working through Recovery

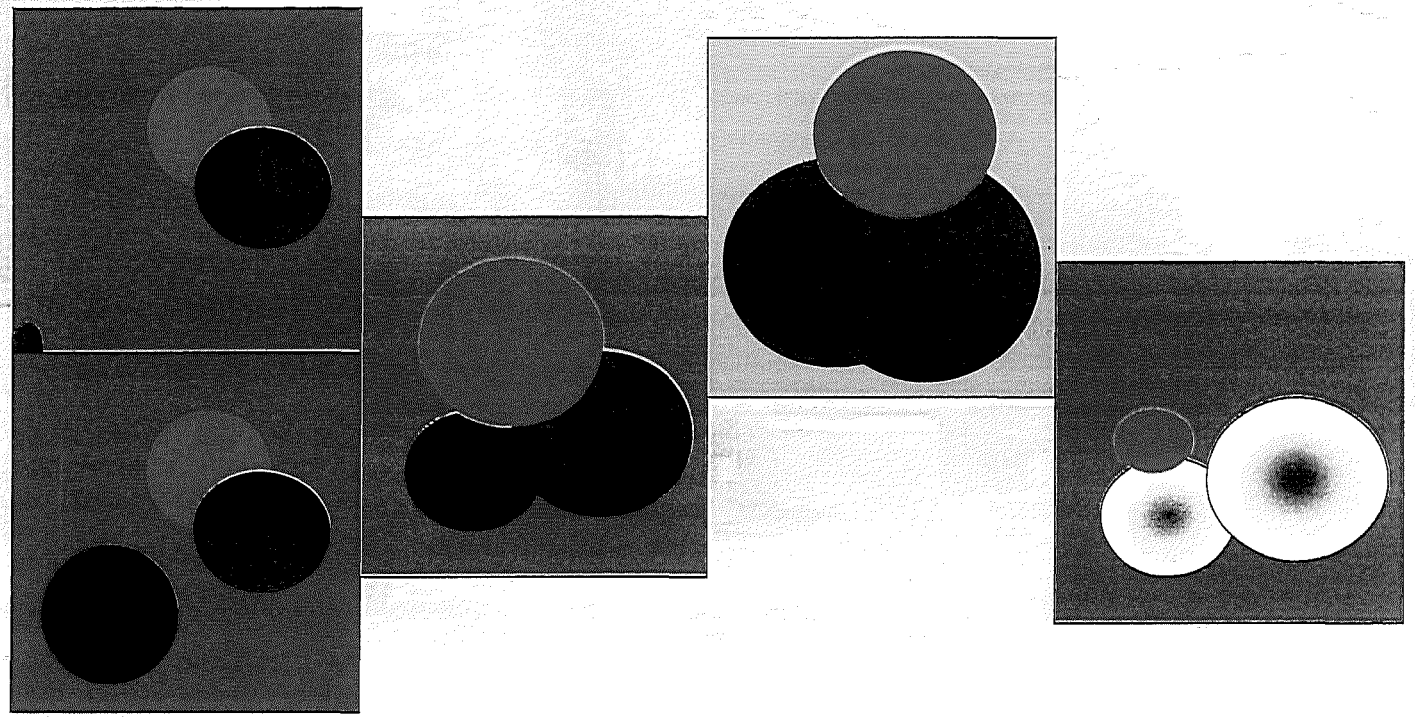
towards recovery

Trauma

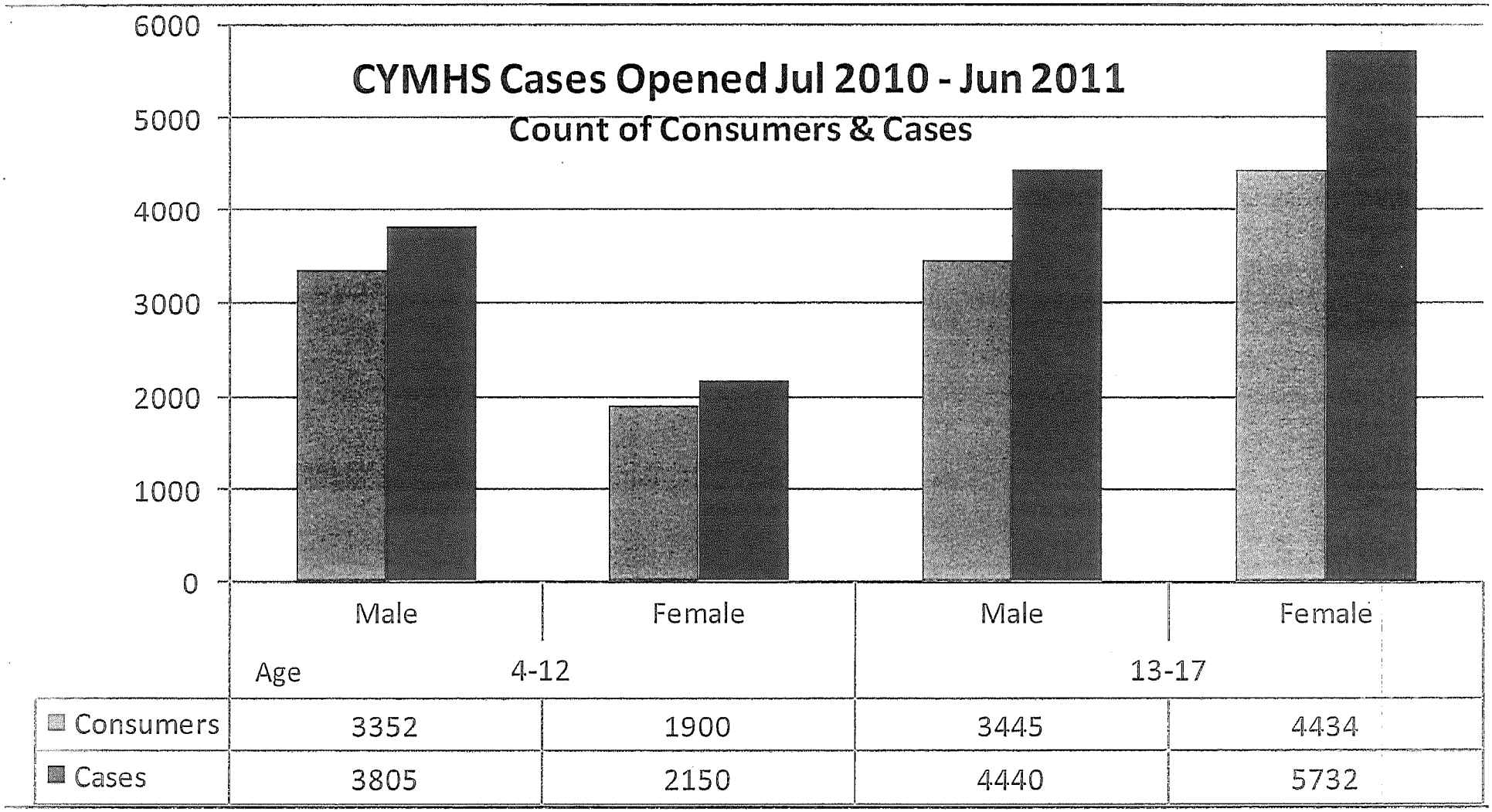
Emotion

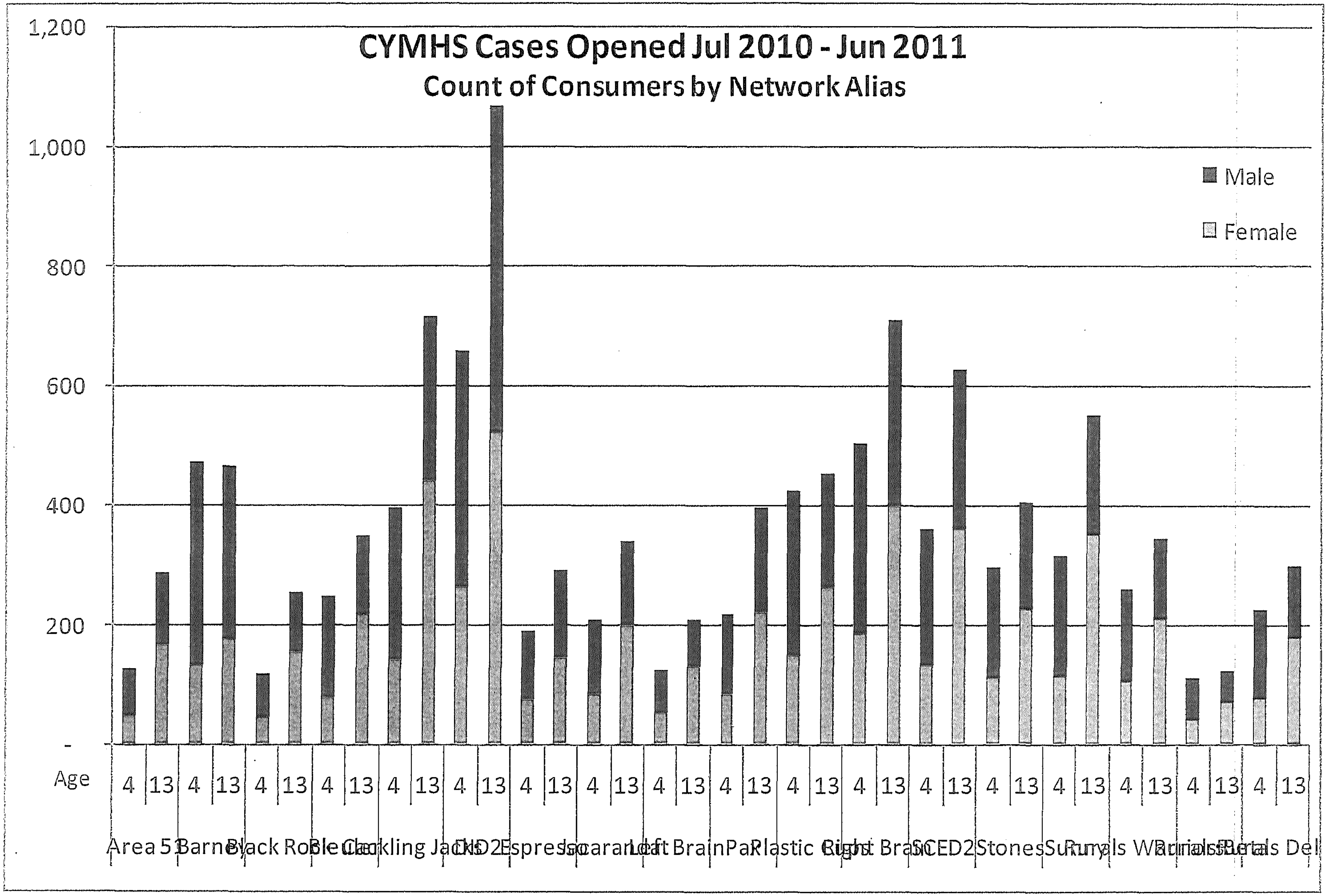
Behaviour

Some adolescents find the re-experiencing phenomena of working through the issues of abuse too difficult, and find that the most they are able to do is accommodate the abuse and reduce the self harm. This enable them to at least begin again to move on with developmental tasks



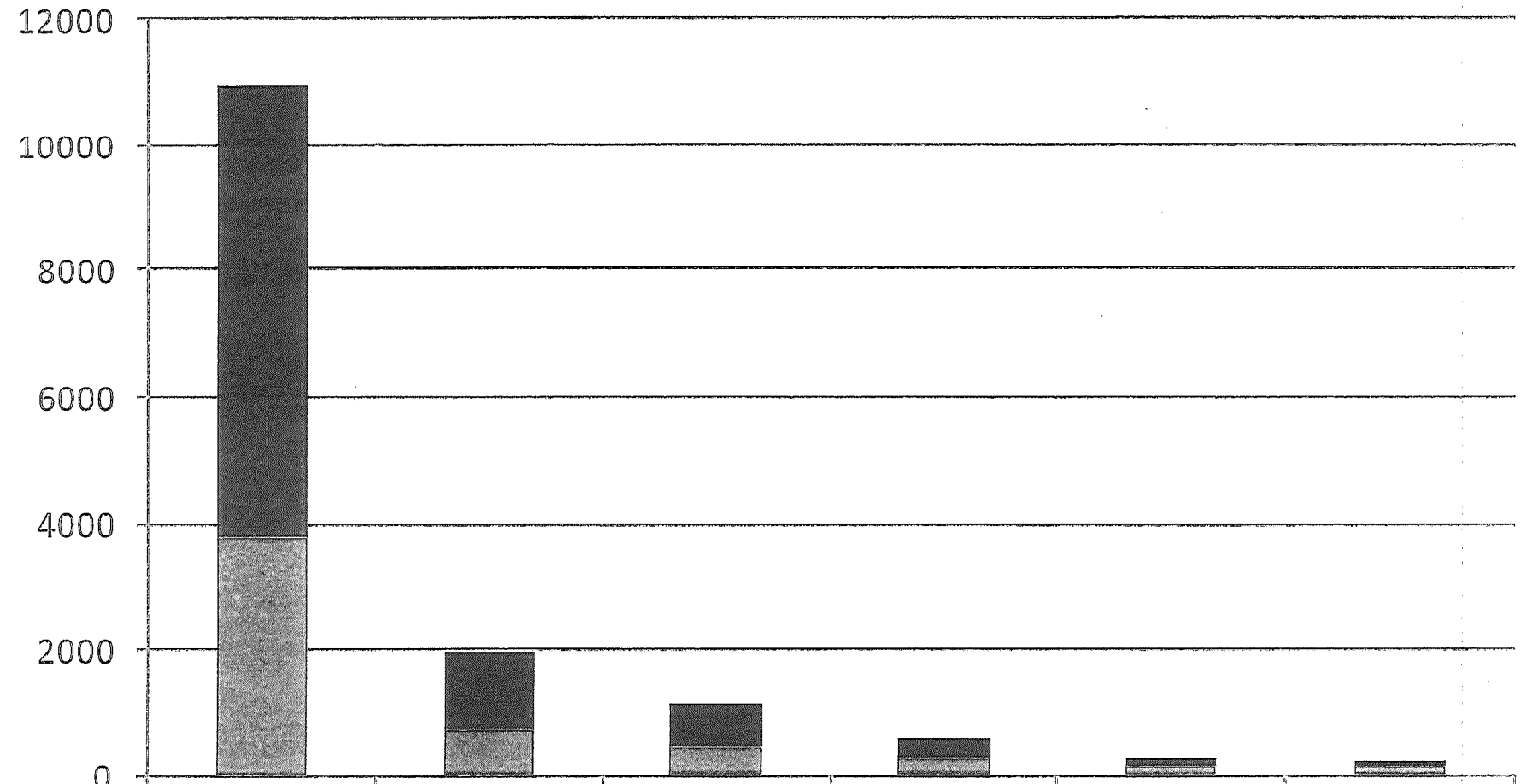
Pre-connection Awareness Working through Accommodation Phase


CYMHS Cases Opened Jul 2010 - Jun 2011
Count of Consumers & Cases
6000
5000
4000
3000
2000
1000
0
Male
Female
Male
Female
Age
4-12
13-17
Consumers
3352
1900
3445
4434
Cases
3805
2150
4440
5732


CYMHS Cases Opened Jul 2010 - Jun 2011
Count of Consumers by Network Alias
Male
Female
1,200
1,000
800
600
400
200
-
Age
4
13

CYMHS Cases Opened Jul 2010 - Jun 2011

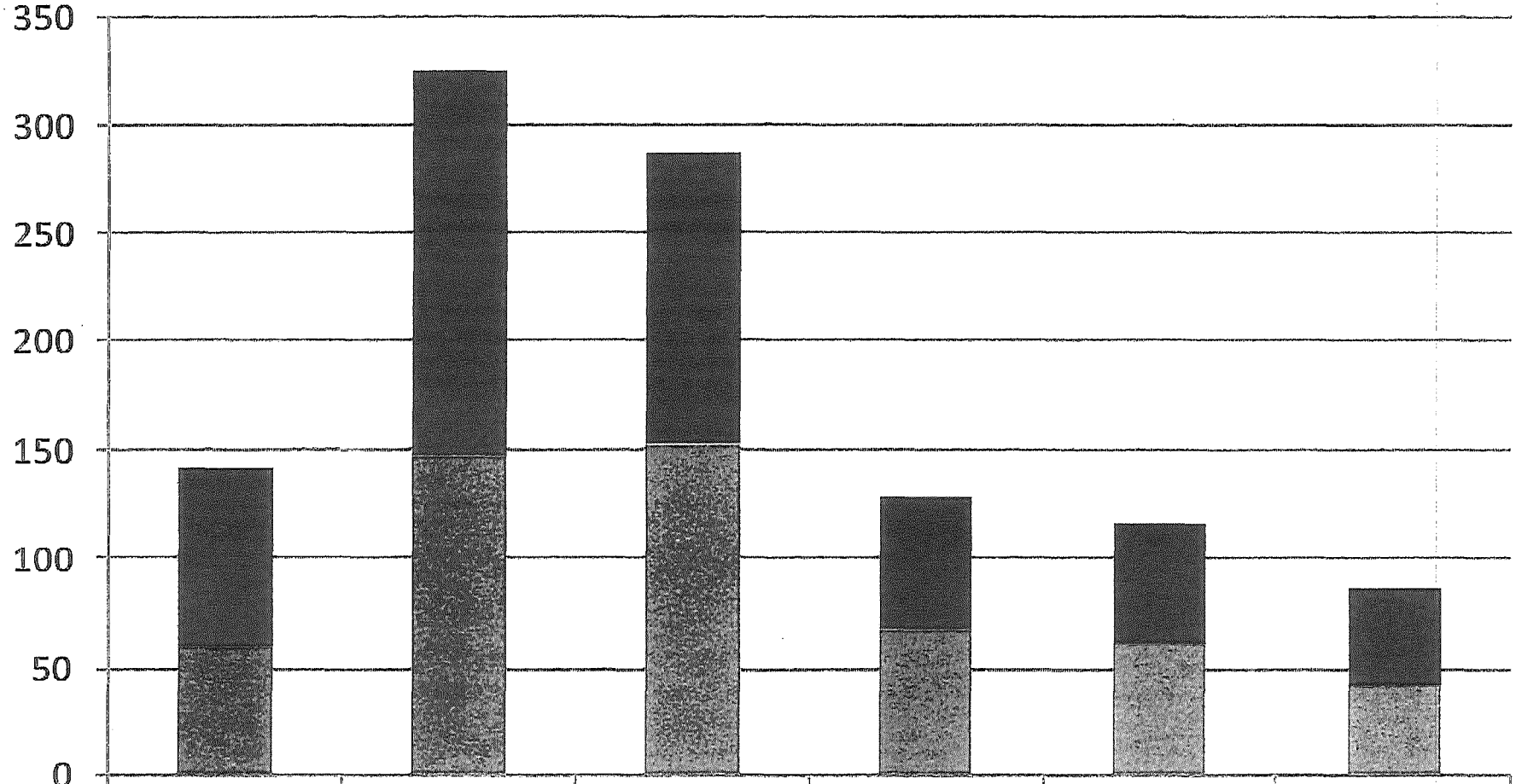
Closed Cases @ 31/12/2011 by LOS Weeks



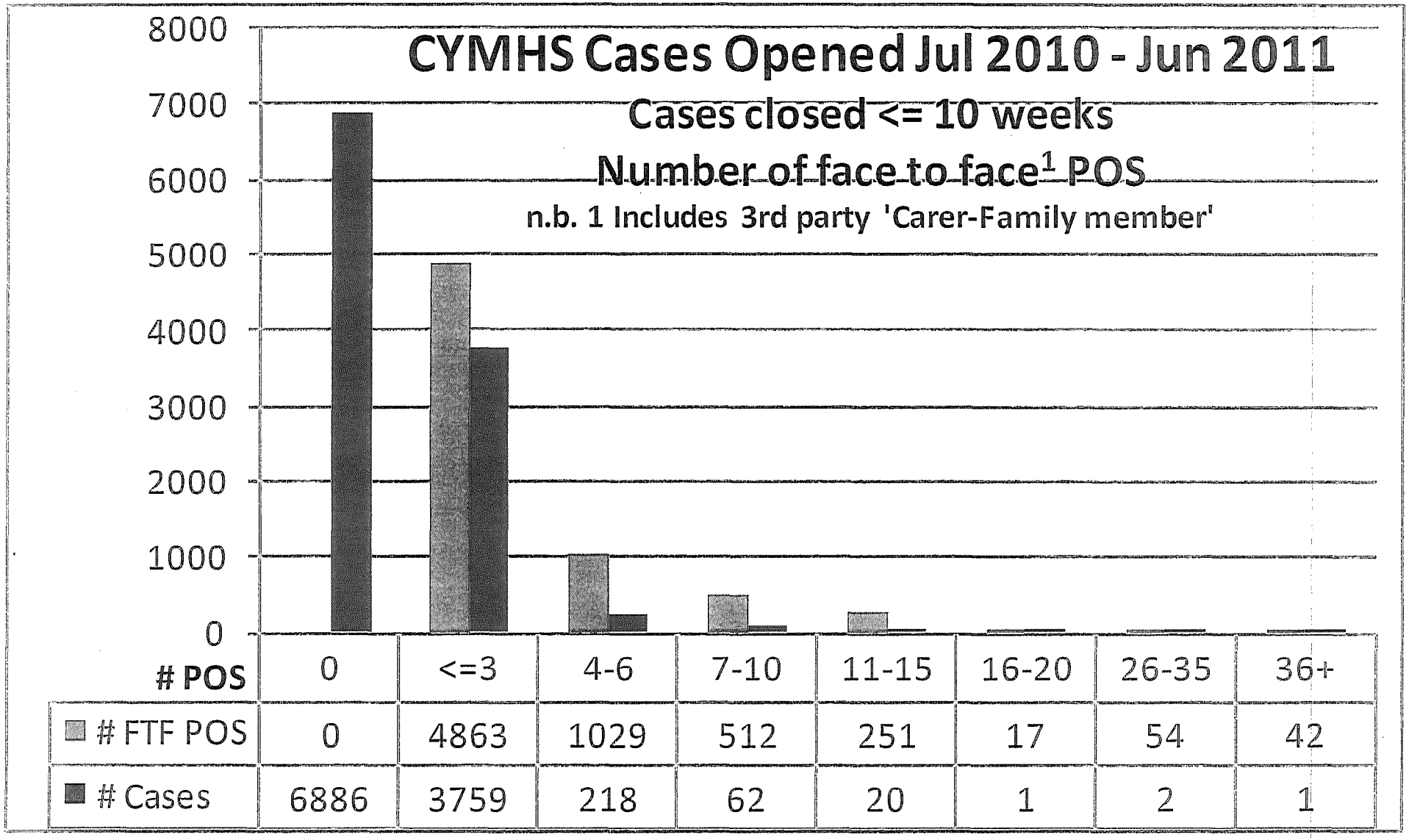
Weeks	1-10	11-20	21-30	31-40	41-50	>51
13-17	7174	1211	634	320	156	123
4-12	3775	706	455	255	116	118

CYMHS Cases Opened Jul 2010 - Jun 2011

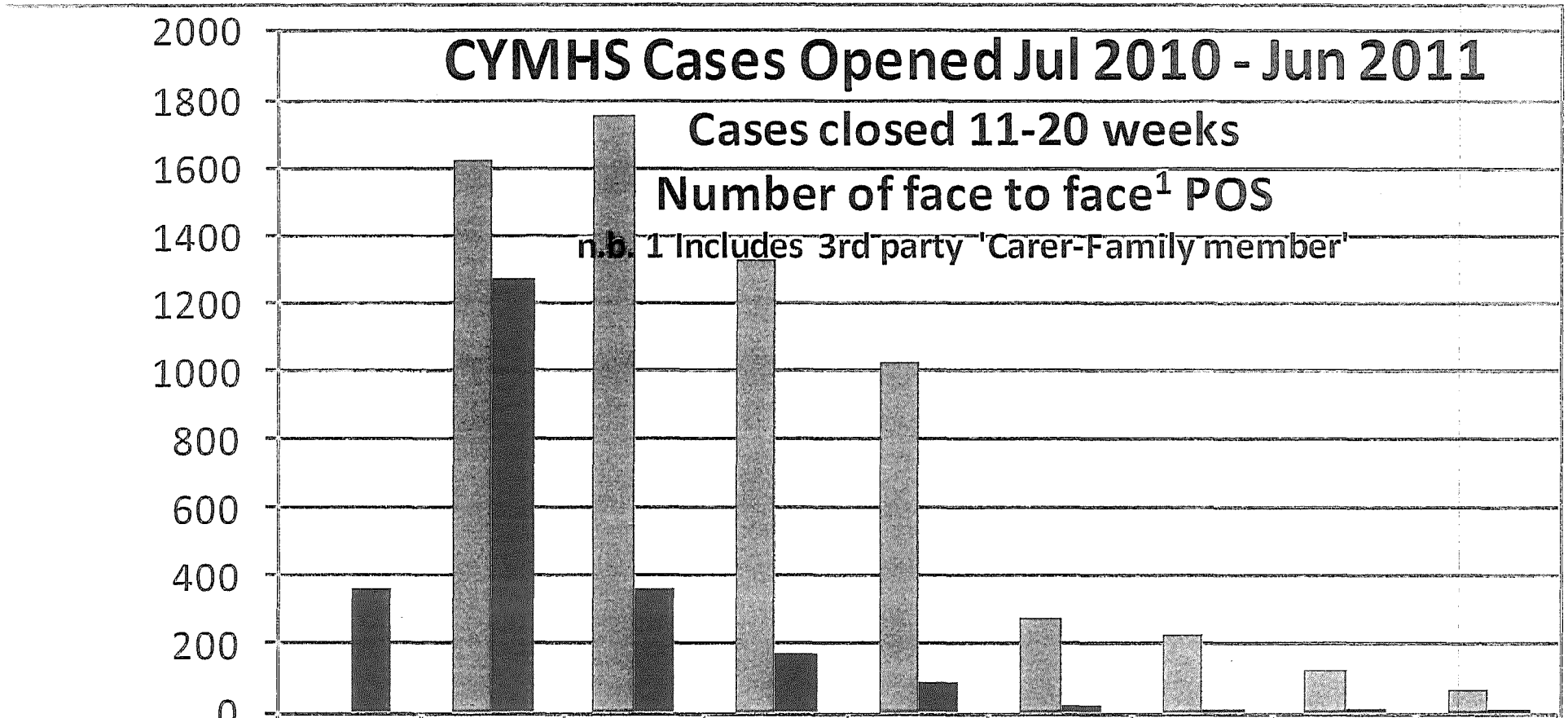
Open Cases @31/12/2011 by LOS Weeks



Week	26-30	31-40	41-50	51-60	61-70	> 70
13-17	81	178	134	61	55	45
4-12	60	147	153	67	61	42



# POS	0	<=3	4-6	7-10	11-15	16-20	26-35	36+
# FTF POS	0	4863	1029	512	251	17	54	42
# Cases	6886	3759	218	62	20	1	2	1



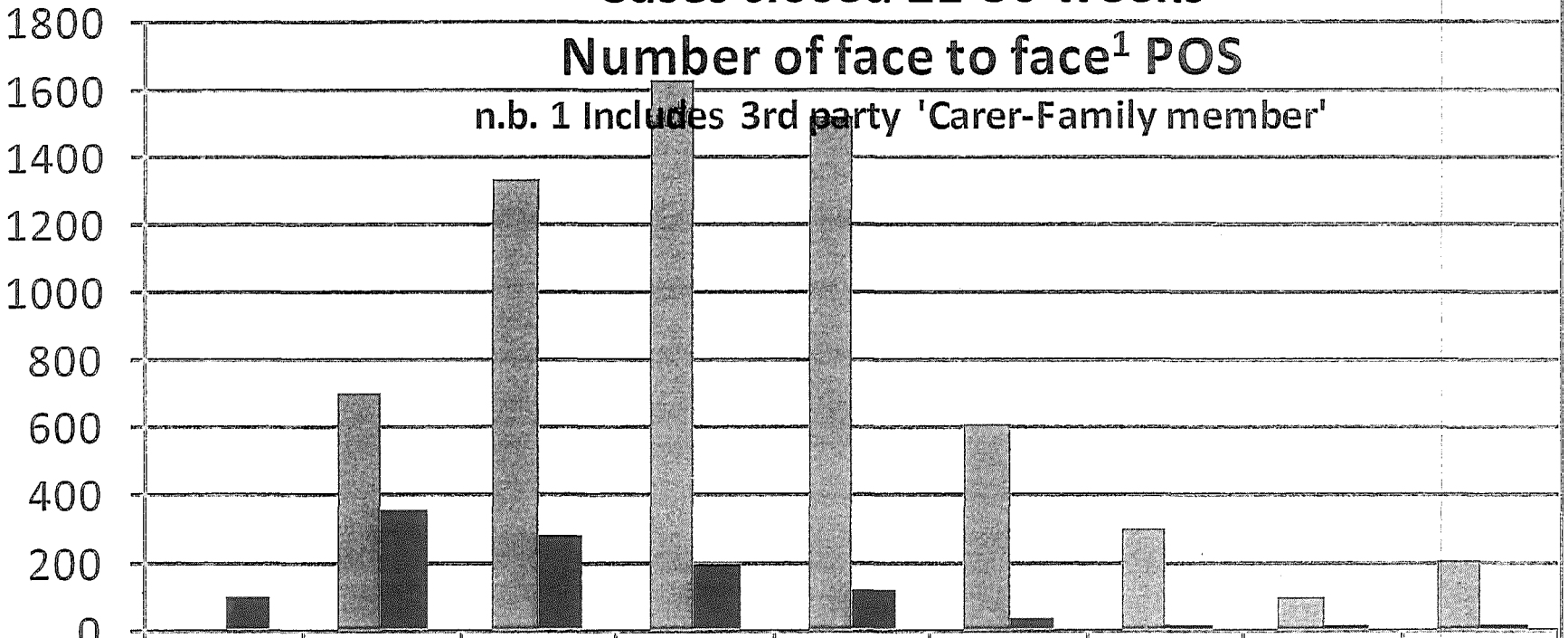
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	1619	1755	1328	1027	271	228	122	71
# Cases	365	1272	365	167	83	15	10	4	1

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases closed 21-30 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



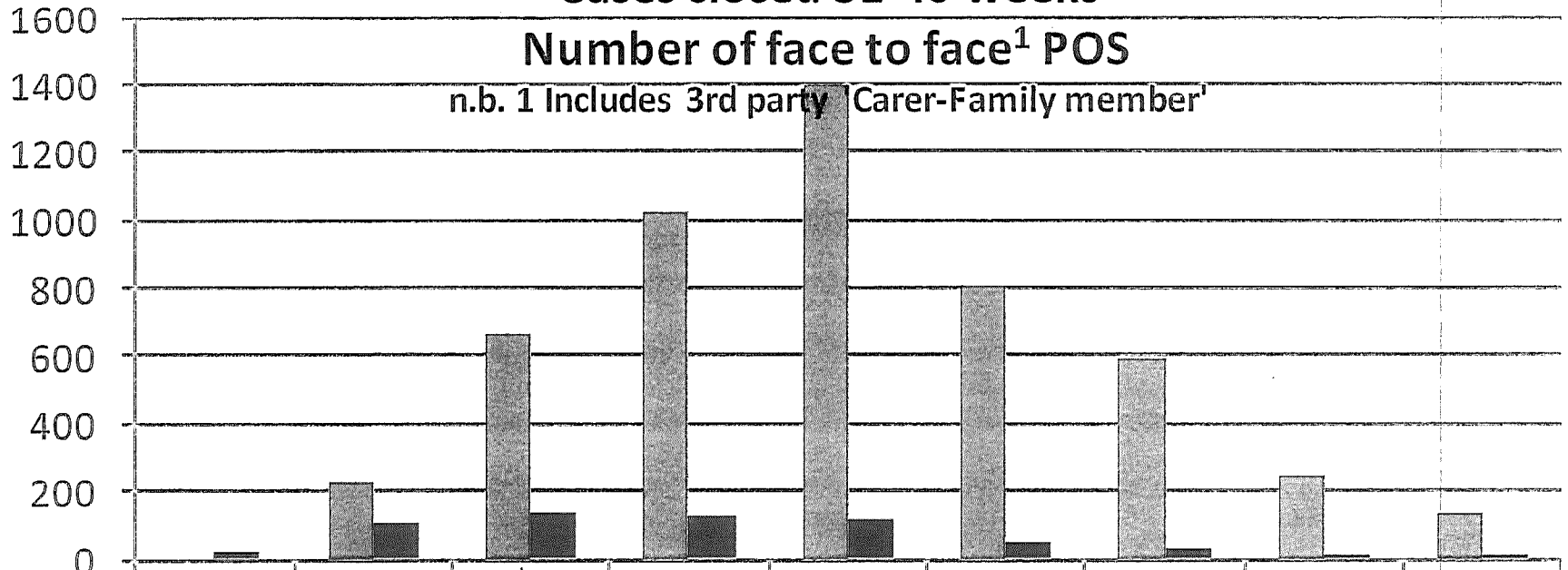
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	699	1324	1618	1519	597	297	91	200
# Cases	95	353	271	195	120	34	13	3	5

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases closed 31-40 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party Carer-Family member'



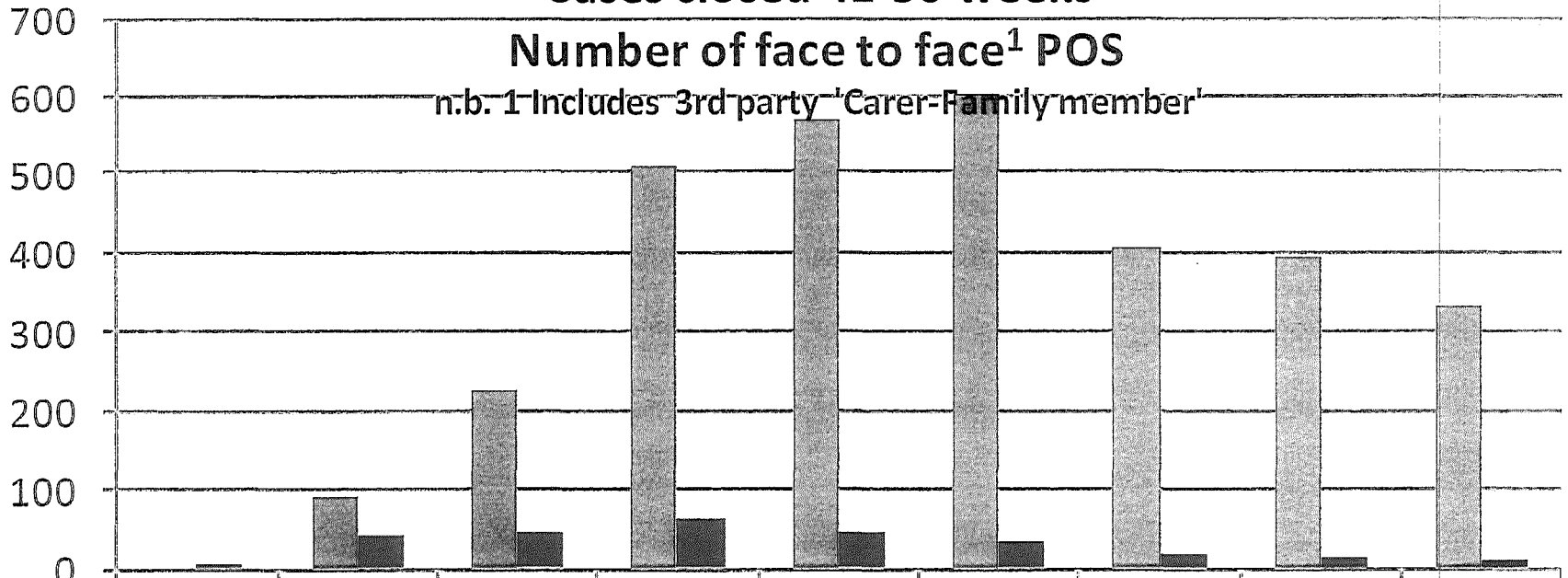
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	224	668	1023	1395	802	588	245	128
# Cases	19	107	134	121	112	45	26	8	3

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases closed 41-50 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



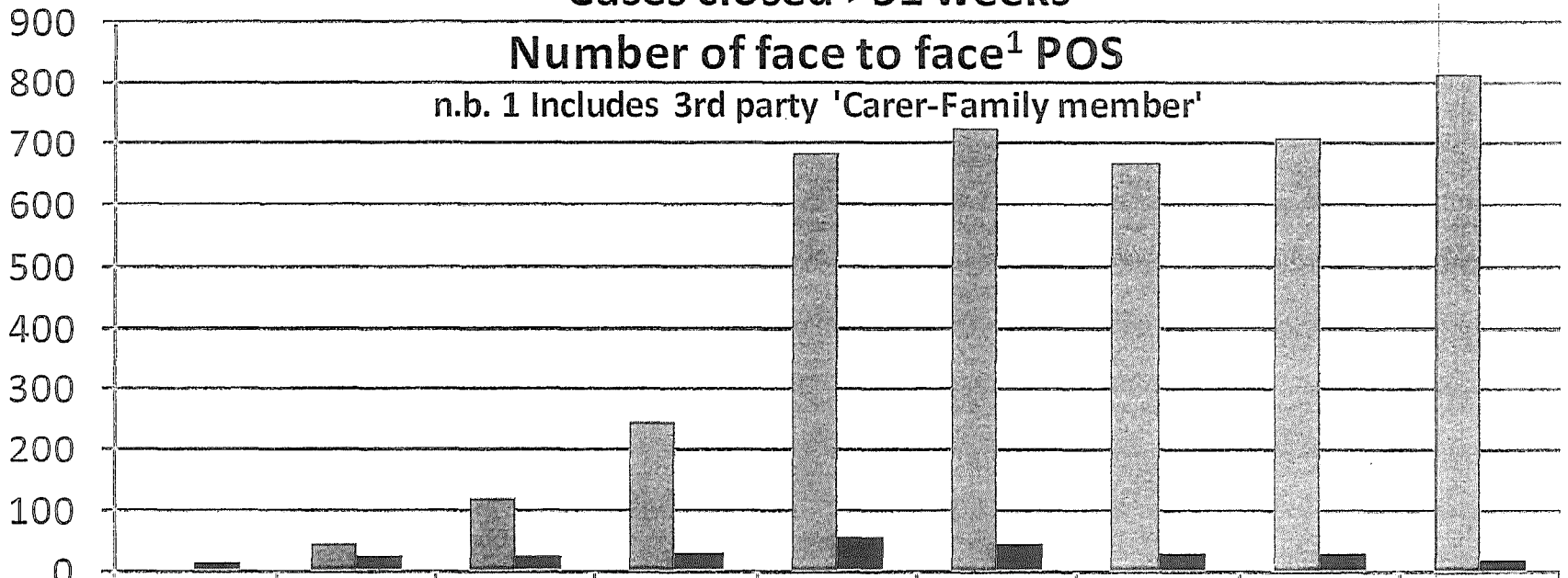
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	89	226	509	570	602	407	392	331
# Cases	6	43	46	60	44	34	18	14	7

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases closed >51 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



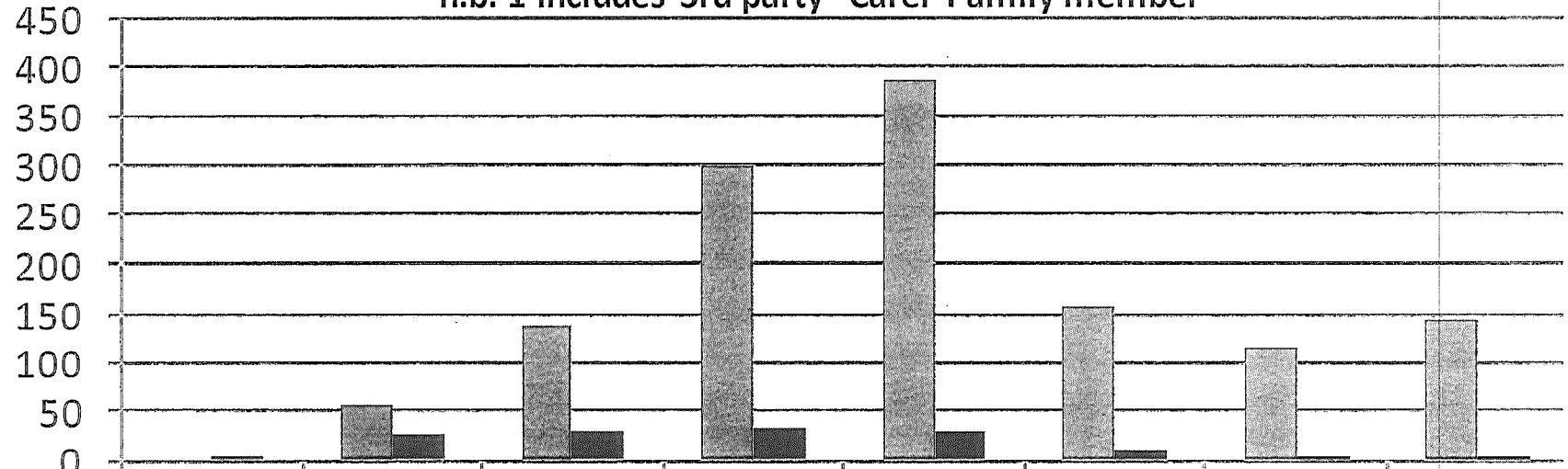
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	44	115	243	679	722	664	705	813
# Cases	9	19	23	28	53	40	29	24	16

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases open 26-30 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



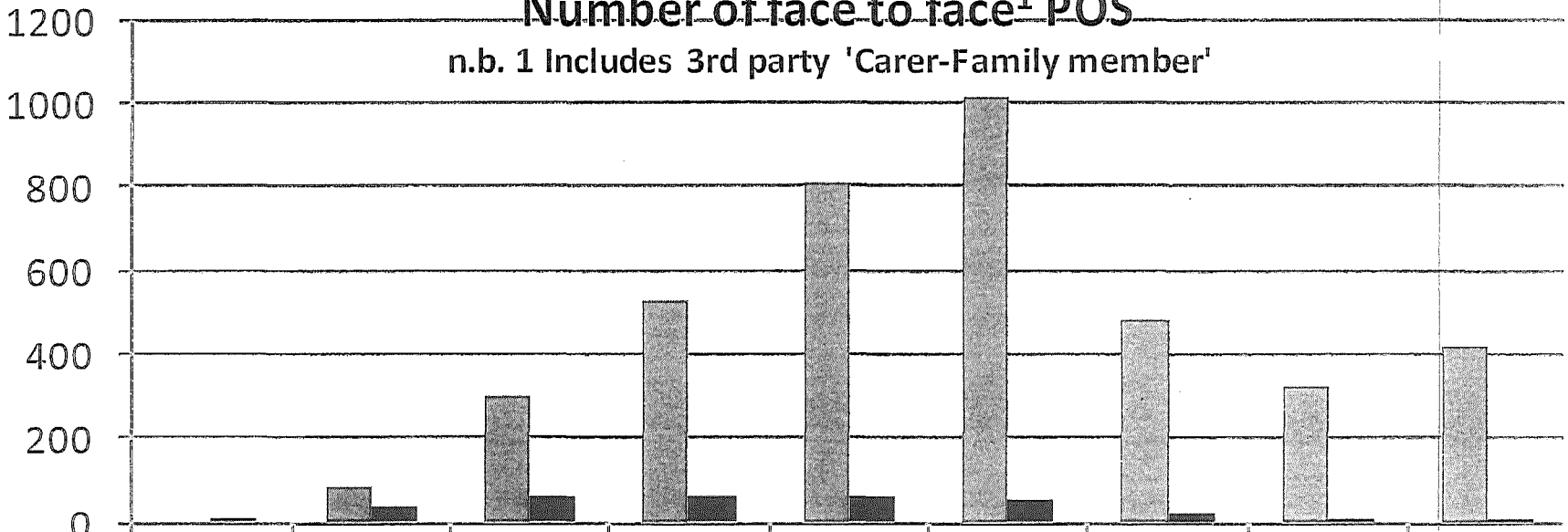
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35
# FTF POS	0	56	138	297	386	156	115	144
# Cases	3	25	29	34	31	9	5	5

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases open 31-40 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



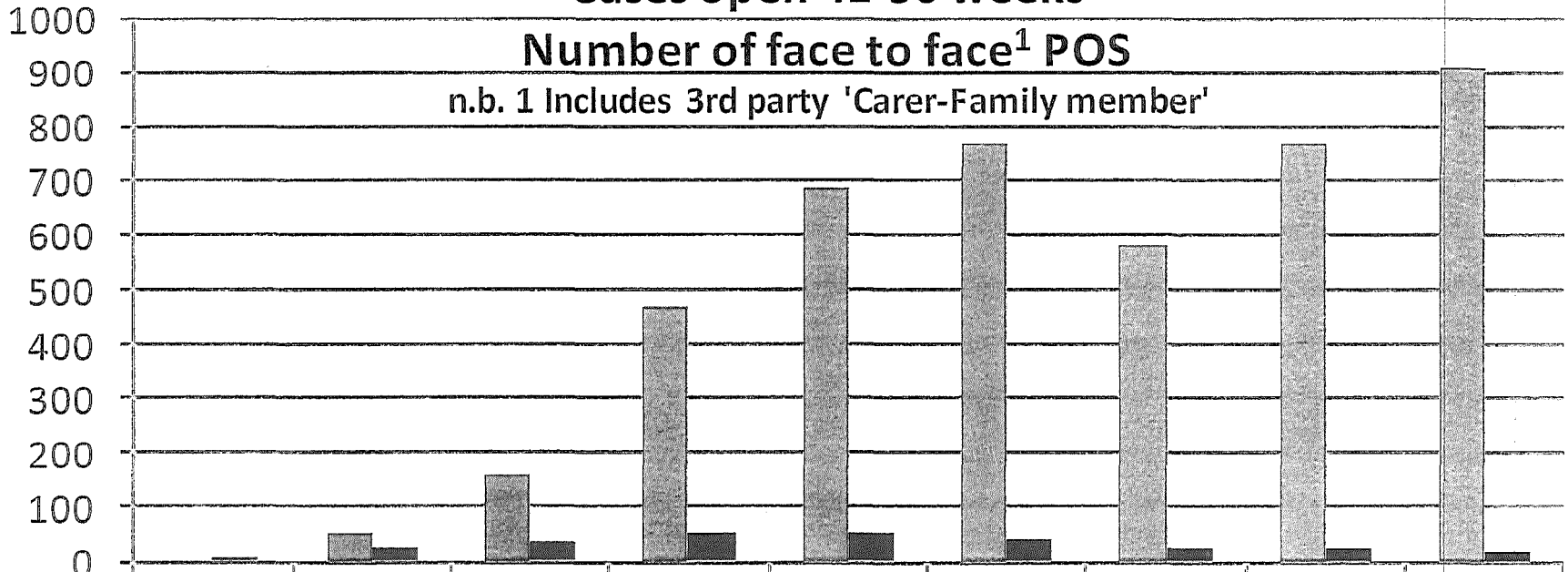
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	83	300	528	808	1010	483	321	417
# Cases	3	41	61	62	63	56	21	11	7

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases open 41-50 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'



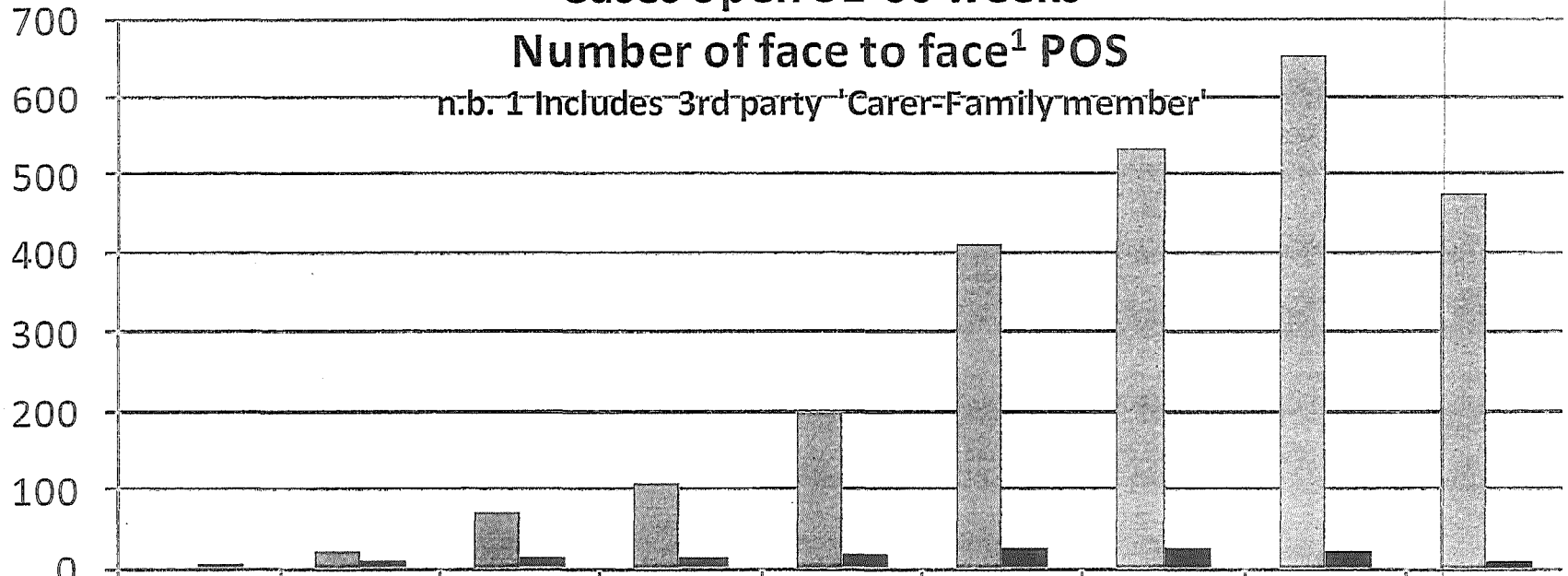
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	51	160	471	687	764	578	766	905
# Cases	6	26	33	54	53	43	26	26	20

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases open 51-60 weeks

Number of face to face[1] POS

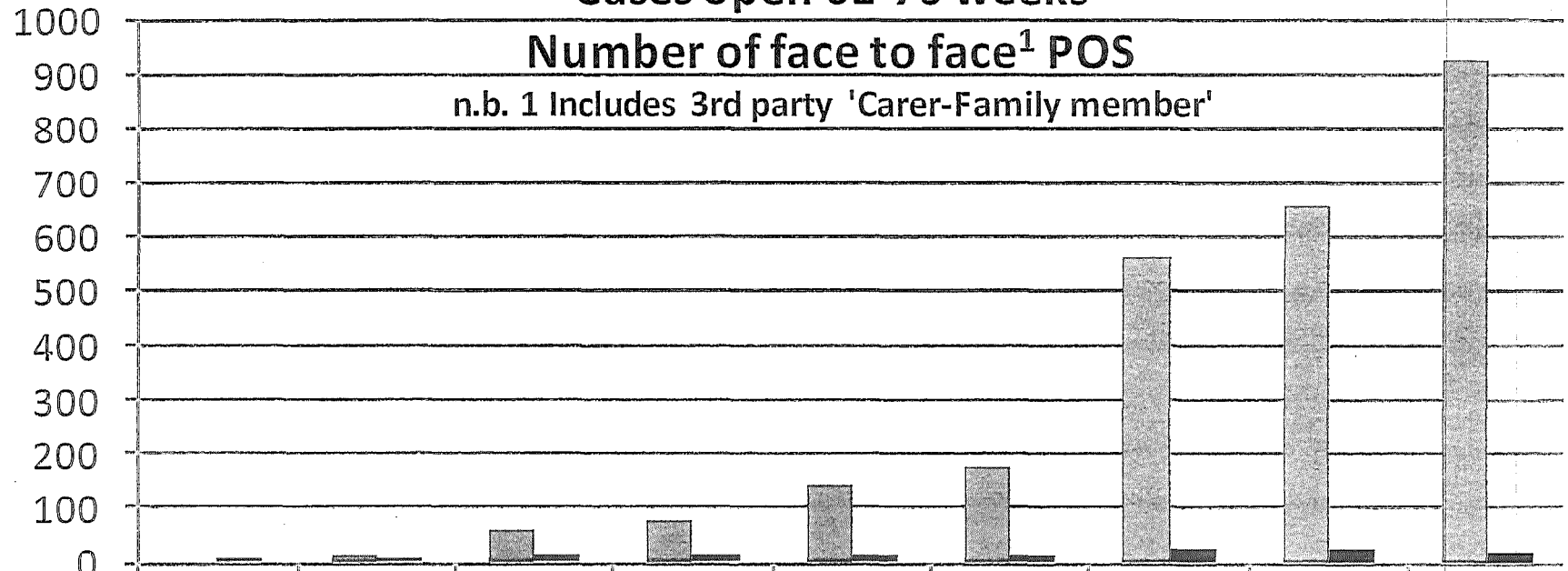
n.b. 1 Includes 3rd party 'Carer-Family member'



# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	19	69	107	198	408	532	653	476
# Cases	1	7	14	13	15	23	23	22	10

CYMHS Cases Opened Jul 2010 - Jun 2011

Cases open 61-70 weeks



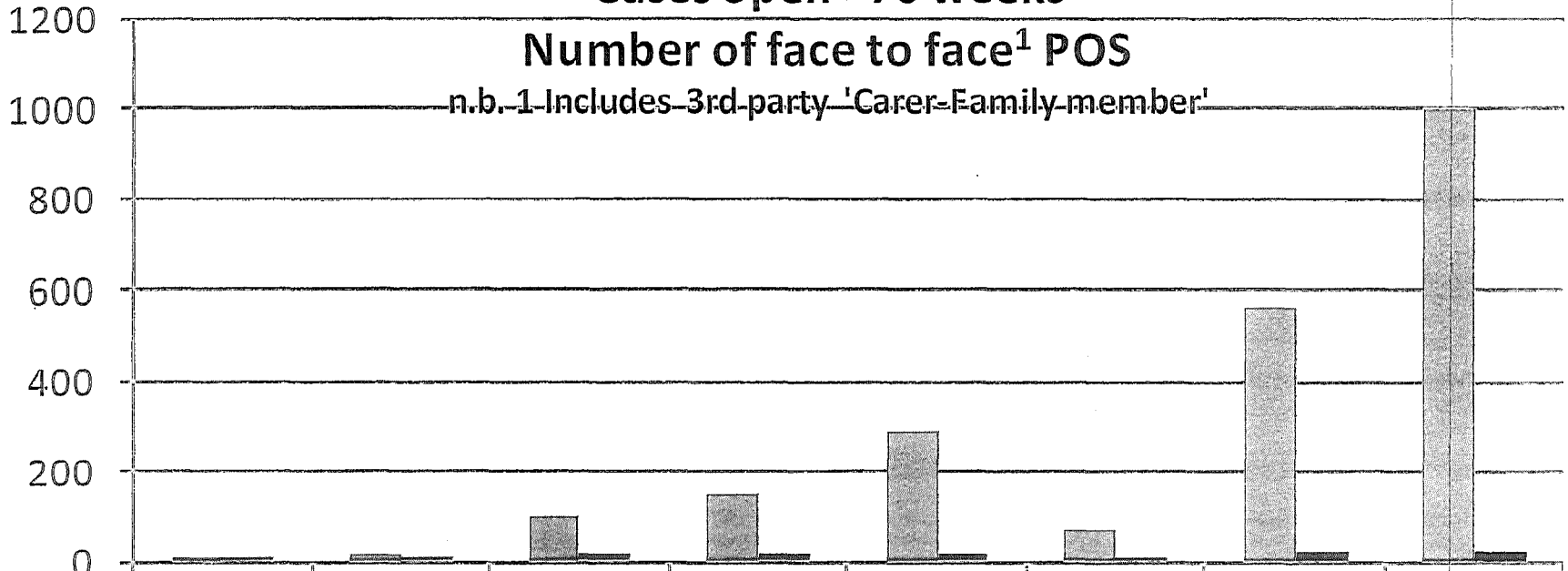
# POS	0	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	0	14	60	78	141	174	561	658	925
# Cases	1	7	12	10	11	10	24	22	19

CYMHS Cases Opened Jul 2010 - Jun 2011

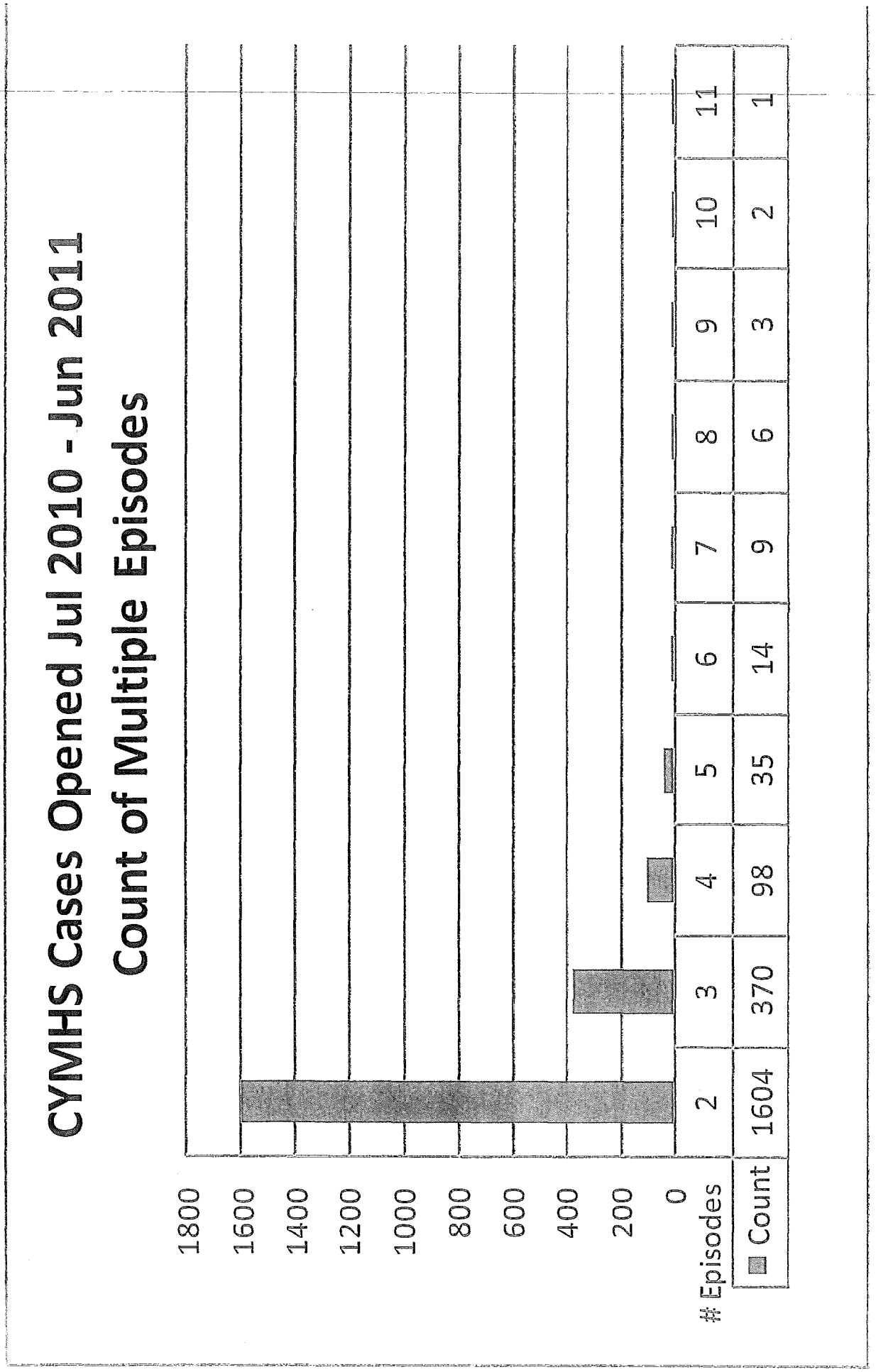
Cases open >70 weeks

Number of face to face[1] POS

n.b. 1 Includes 3rd party 'Carer-Family member'

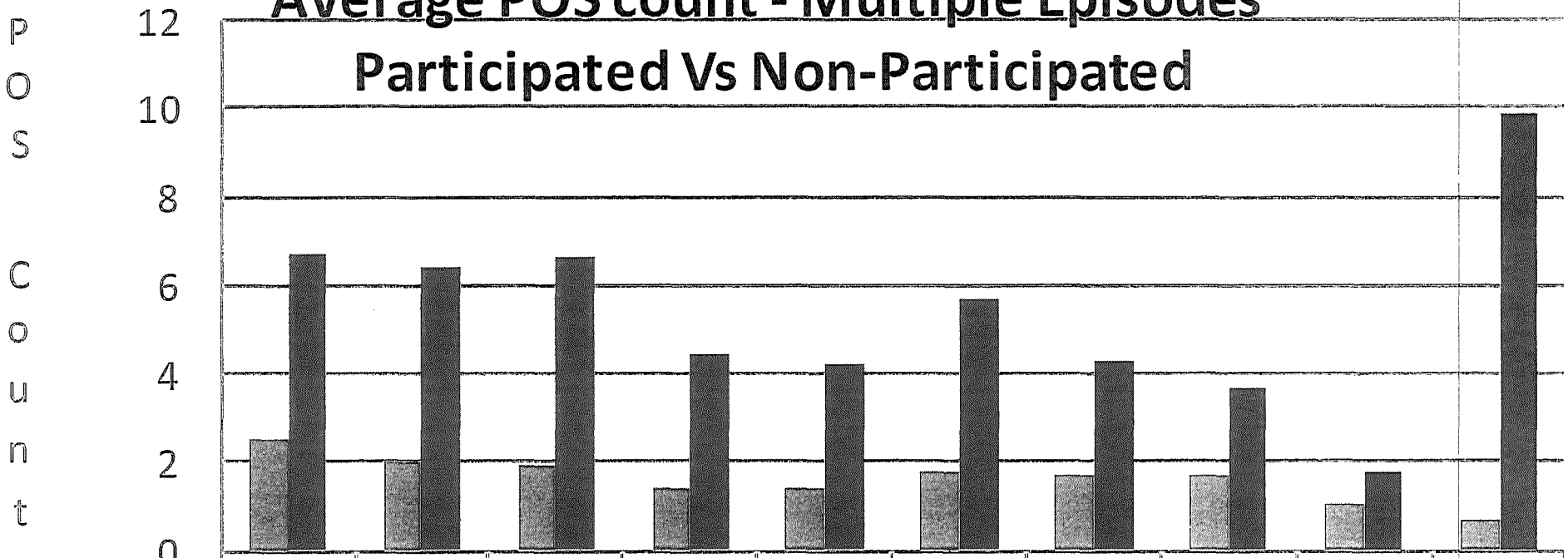


# POS	<=3	4-6	7-10	11-15	16-20	21-25	26-35	36+
# FTF POS	8	11	100	149	286	69	559	998
# Cases	4	2	11	12	16	3	18	21


CYMHS Cases Opened Jul 2010 - Jun 2011
Count of Multiple Episodes
1800
1600
1400
1200
1000
800
600
400
200
0
Episodes
Count
2
3
4
5
6
7
8
9
10
11
1604
370
98
35
14
9
6
3
2
1

CYMHS Cases Opened Jul 2010 - Jun 2011

Average POS count - Multiple Episodes Participated Vs Non-Participated

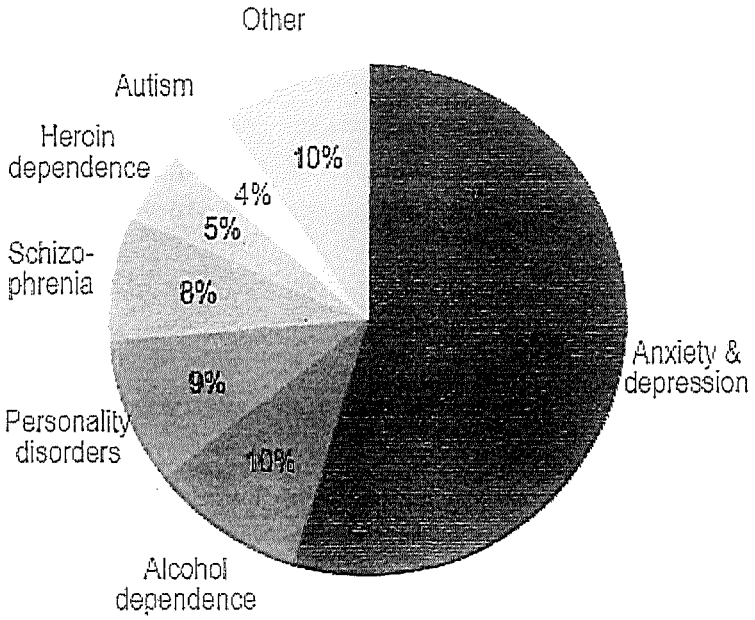


# Episodes	2	3	4	5	6	7	8	9	10	11
Part	2.5	2.0	1.9	1.4	1.4	1.8	1.7	1.7	1.0	0.6
NotPart	6.7	6.4	6.6	4.4	4.2	5.7	4.3	3.7	1.8	9.8

Built Environment and the Adolescent Extended Treatment Centre Model of Care

Rationale

Contribution of Various Illness to Mental Health Burden



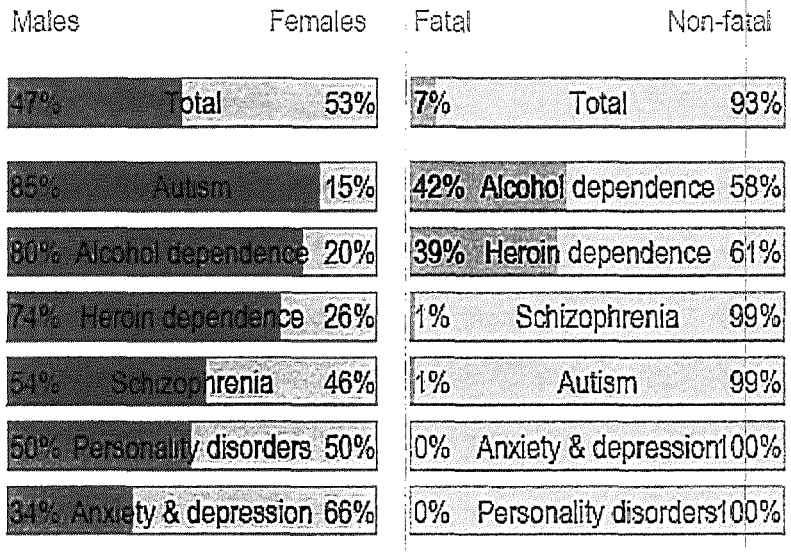


Figure 3.17: Mental disorder burden (DALYs) by specific cause expressed as: (a) proportions of total, (b) proportions by sex, and (c) proportions due to fatal and non-fatal outcomes, Australia, 2003

The Burden of Disease and Injury in Australia 2003 AIHW 2007 Begg, Vos, Barker, Stevenson, Stanley, Lopez

Age at Which First Incidence of Disease has an Impact

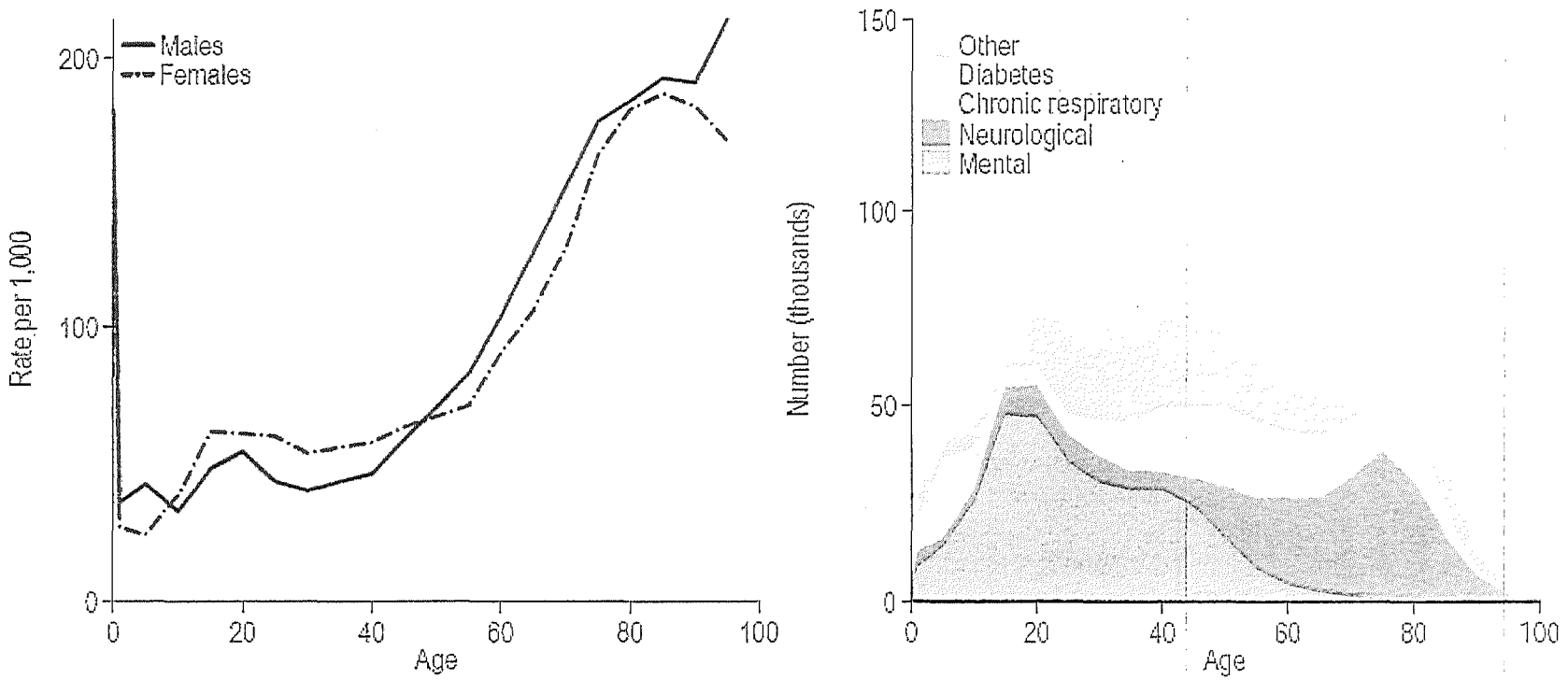


Figure 3.6: Incident non-fatal burden (YLD) by age expressed as: (a) rates by sex, and (b) numbers by broad cause group, Australia, 2003

The Burden of Disease and Injury in Australia 2003 AIHW 2007 Begg, Vos, Barker, Stevenson, Stanley, Lopez

Duration of Burden of Disease over the Life Span

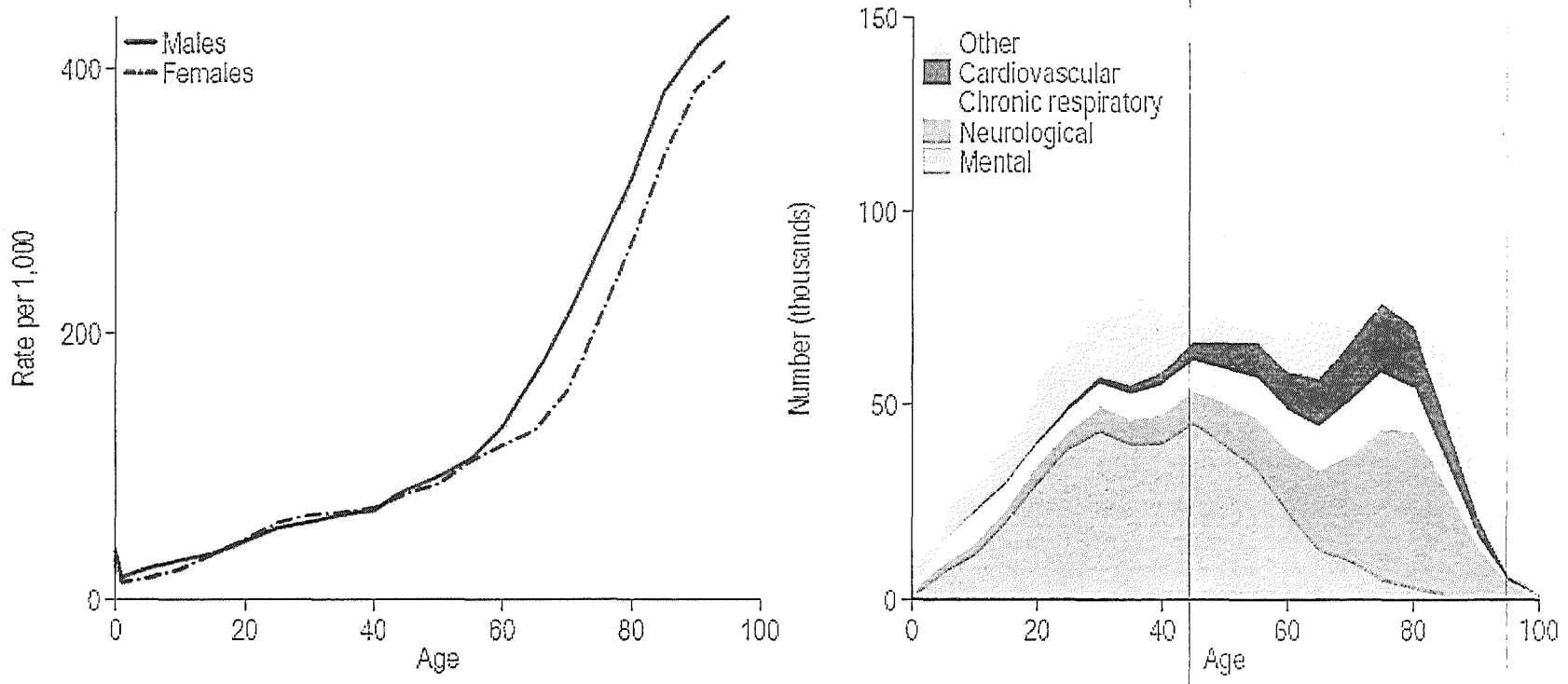


Figure 3.7: Prevalent non-fatal burden (PYLD) by age expressed as: (a) rates by sex, and (b) numbers by broad cause group, Australia, 2003

The Burden of Disease and Injury in Australia 2003 AIHW 2007 Begg, Vos, Barker, Stevenson, Stanley, Lopez

Number Burdened by Various Mental Health Burdens by Age

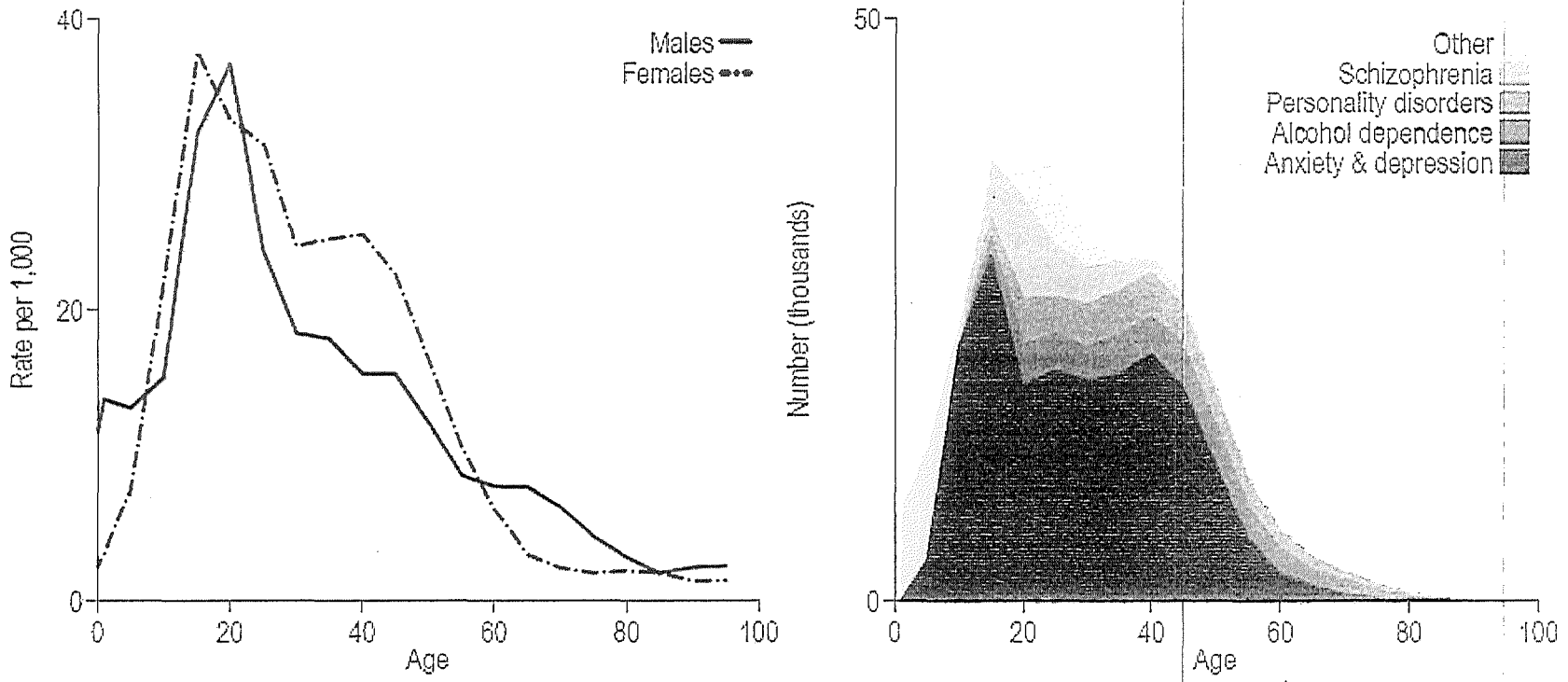
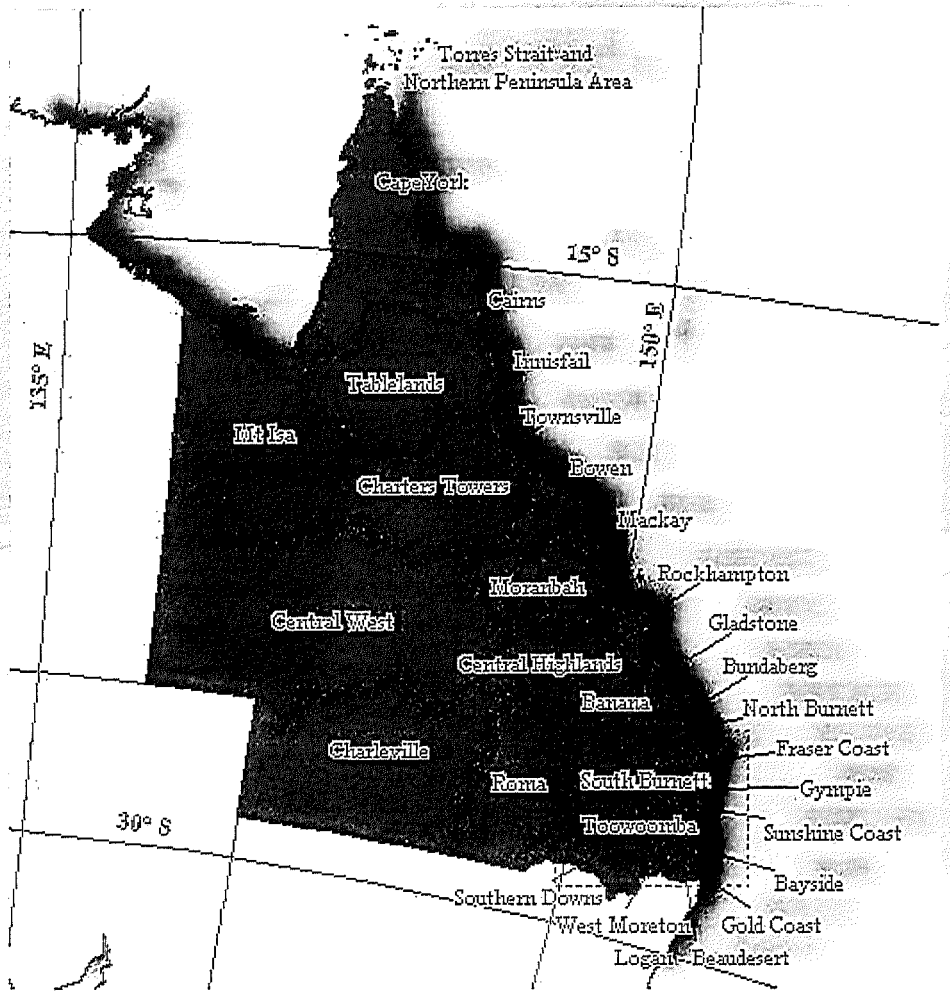


Figure 3.18: Mental disorder burden (DALYs) by age expressed as: (a) rates by sex, and (b) numbers by specific cause, Australia, 2003

The Burden of Disease and Injury in Australia 2003 AIHW 2007 Begg, Vos, Barker, Stevenson, Stanley, Lopez

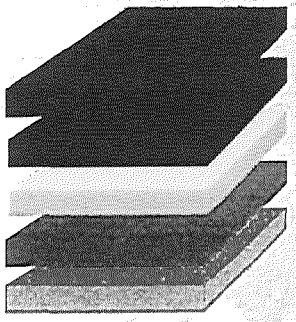
Referrals and Recovery

Barrett Adolescent Centre – An Integral Part of Queensland CYMHS



- Cairns 3
- Townsville 12
- Mt Isa 1
- Mackay 1
- Rockhampton 5
- Bundaberg 3
- Sunshine Coast 10
- Redcliffe- Caboolture 13
- Toowoomba 9
- West Moreton 18
- South West 1
- Gold Coast 14
- Logan – Redlands 18
- Mater 24
- RBH – RCH 27
- Darwin 2
- Private Psychiatrist 15

Function
Behaviours
Diagnosis
Environment
Substrate



The Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

Developmental Tasks of Adolescence

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

Adolescent Extended Treatment Centre, Diagnostic Profile

Diagnostic Group	Percentage
Social Anxiety Disorders	52%
OCD and other Anxiety Disorders	24%
Eating Disorders	27%
Depression and Dysthymic Disorders	62%
Post Traumatic Symptoms	25%
Schizophrenia	6%
Pervasive Developmental Disorders	20%
Receptive-Expressive Language Disorders	53%
Other Developmental Disorders	52%
Oppositional Defiant Disorder	51%
Substance Abuse	9%
Disorders of Organic Origin	4%
Parent Child Relational Disorders	84%

Characteristics of Adolescents Admitted to BAC with Social Anxiety Disorder

Major Problems

- Developmental moratoriums
- Social isolation
- Restricted range of interests
- "Passive" adolescent
- Parent directed aggression
- Pre-contemplative phase of change
- Poor emotional recognition

Confounding Problems

- Language Disorders
- Disorders of Attention and Learning
- Sleep reversals
- Limited life skills

Characteristics of Adolescents Admitted to BAC with a History of Recurrent Self Harm

Major Problems

- Variable histories of abuse on admission
- History of repeated suicide attempts, recurrent self harm
- Often significant family dysfunction
- Ambivalent attachments common
- Variable symptoms of trauma
- Oscillate Major Depression to Dysthymia
- Variable levels of aggression
- Variable emotional expression
- Variable temperament
- Developmental moratoriums
- Cognitive deterioration

Confounding Problems

- Sensory integration difficulties
- Isolated from peers
- Few in care of DChS

towards recovery

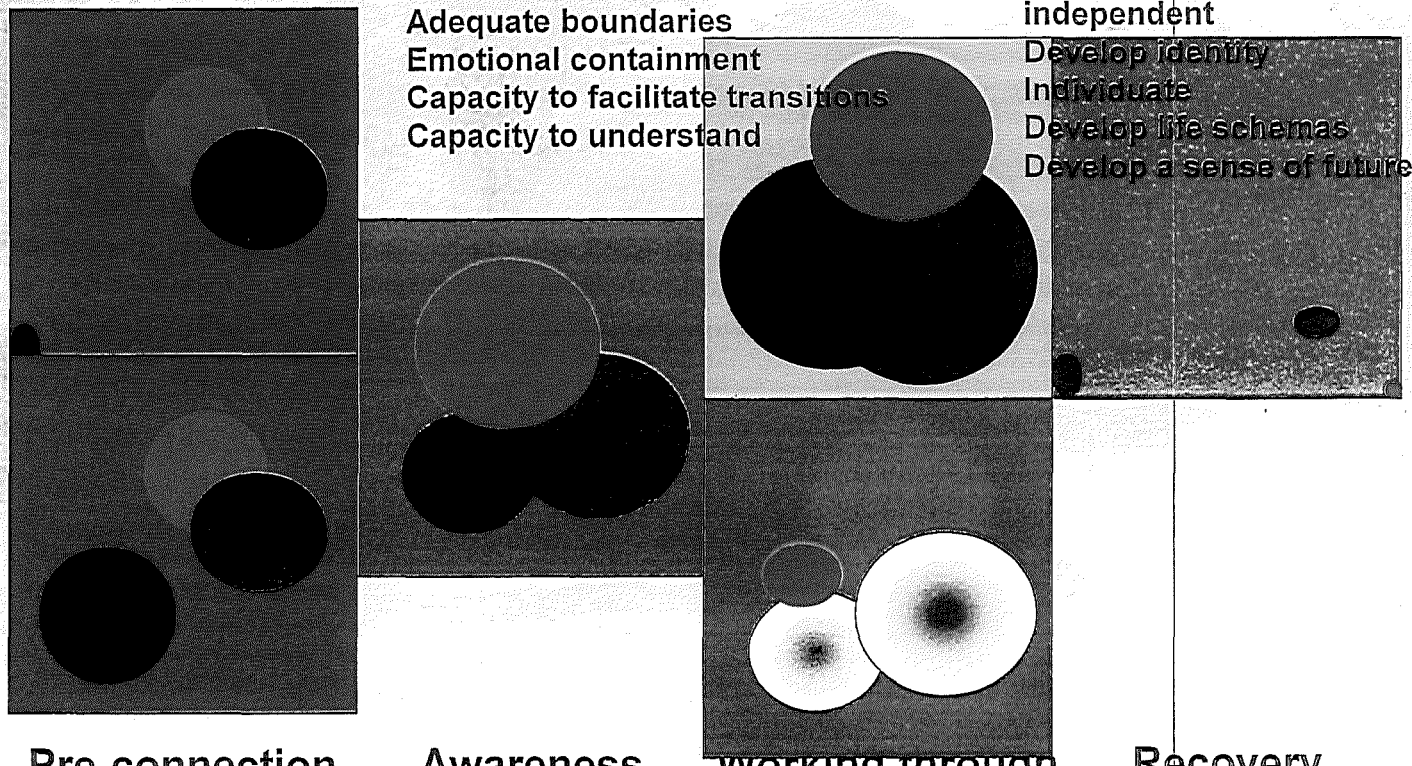
Trauma

Emotion

Behaviour

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future



Pre-connection Awareness Working through Recovery

Barrett Adolescent Centre

Characteristics of Adolescents Admitted to BAC with an Eating Disorder

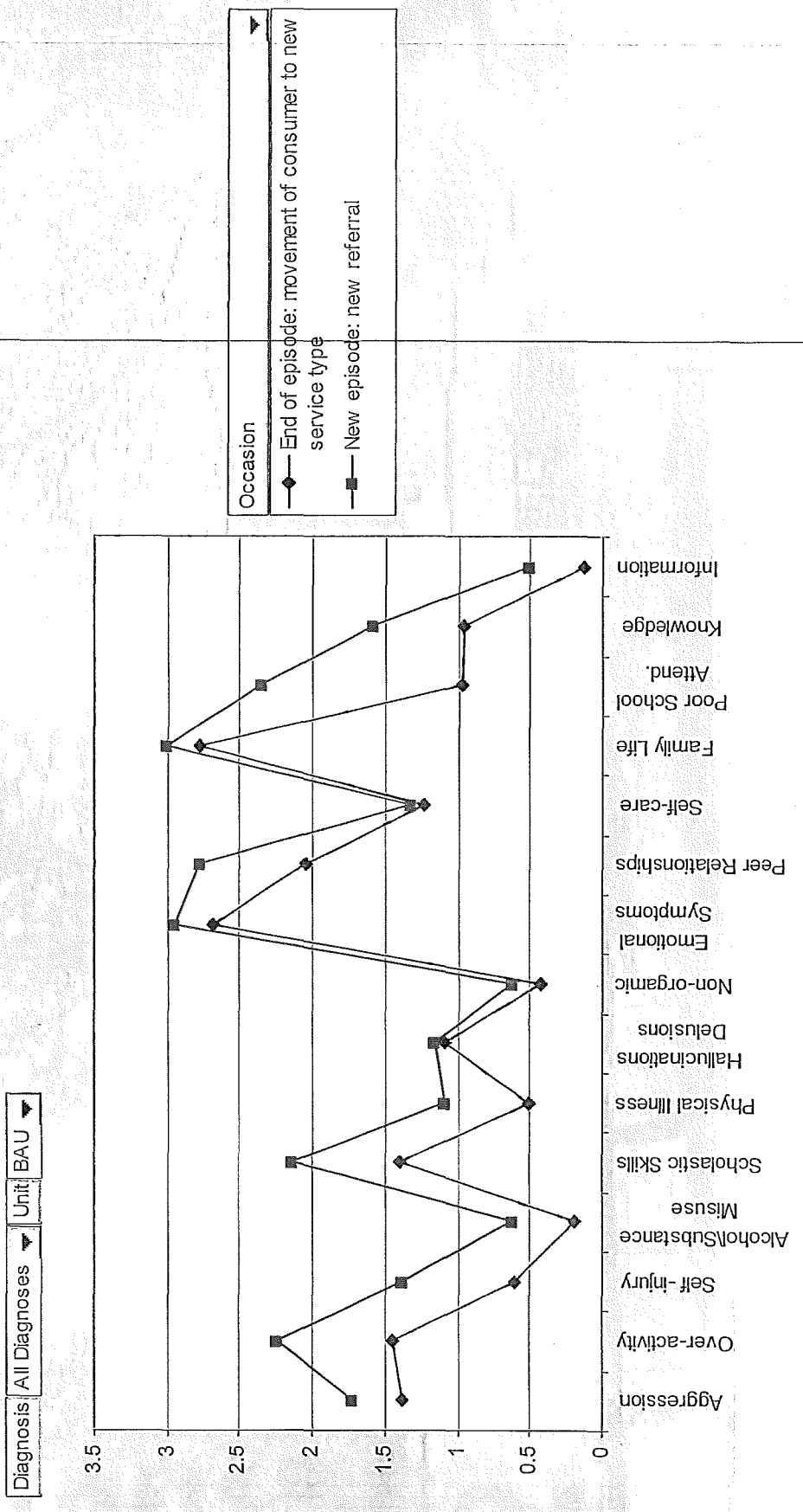
Major Problems

- Eating Disorder of 2 years or more
- Significant physical problems
- Significant developmental moratoriums hospitalisations
- Co-morbid Social Anxiety Disorder
- High rates of abuse histories
- Most are in the pre-contemplative stage of change

Confounding Problems

- Language Disorders
- Parent-child difficulties common

HoNOSCA Scores at Admission and Discharge to BAC



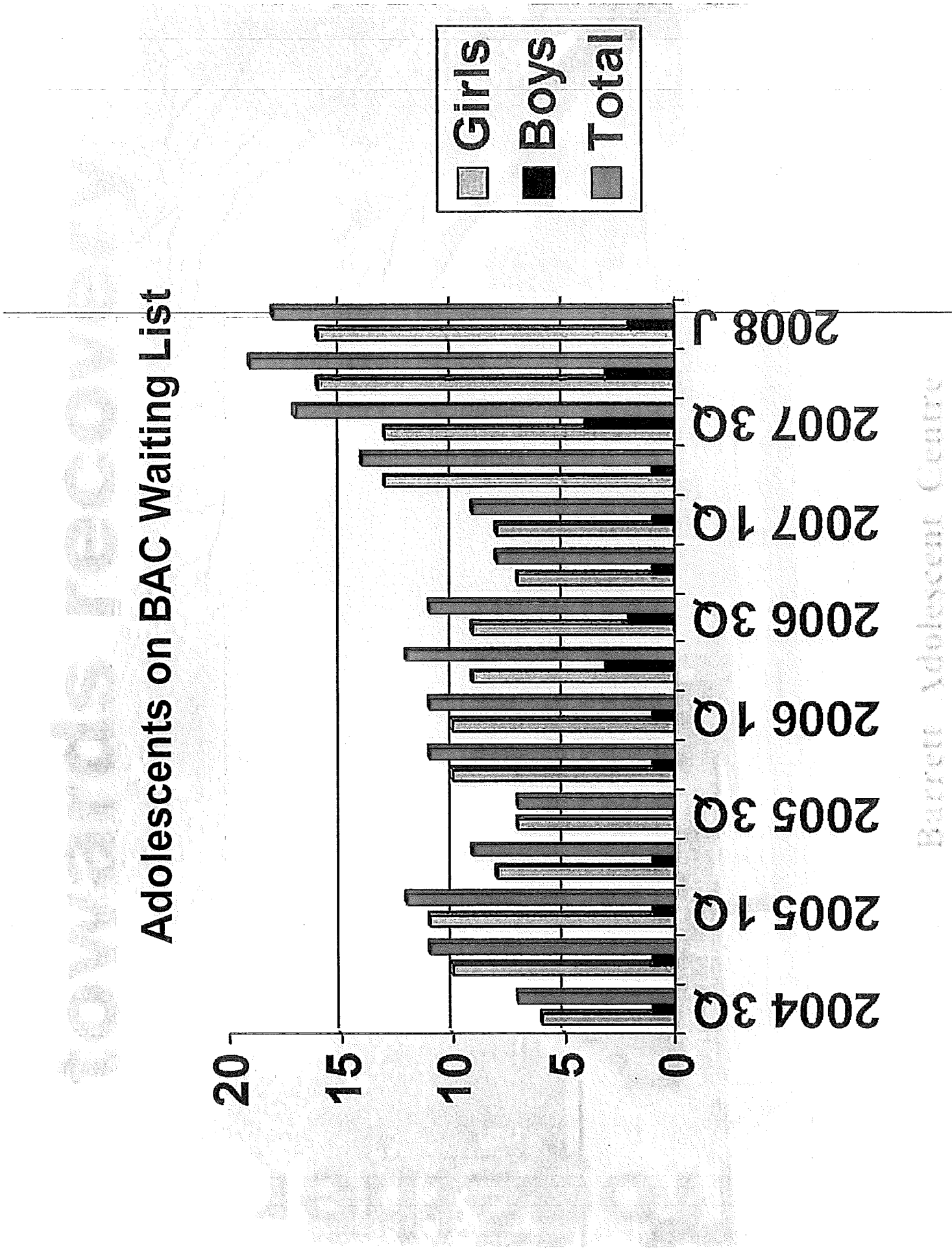
Principles of Operation of an Integrated Treatment and Rehabilitation Adolescent Unit

- State wide facility within a strong network of community clinics and acute inpatient units – Queensland demographics
- Tertiary referral only
- Linkages with family and community essential - day patient, partial hospitalisation, family stay units, transport access
- Risks must be managed – height of building, high dependency unit, open spaces, buffer zone
- Meticulous attention to development tasks is a *sine qua non* of the unit – school, life skills, community access etc
- A range of tailored psychosocial interventions are more important than medication – adequate spaces and staffing for a range of psychosocial interventions
- *Level of care provided = level of care required*
- *The unit should bear some resemblance to an adolescent environment*

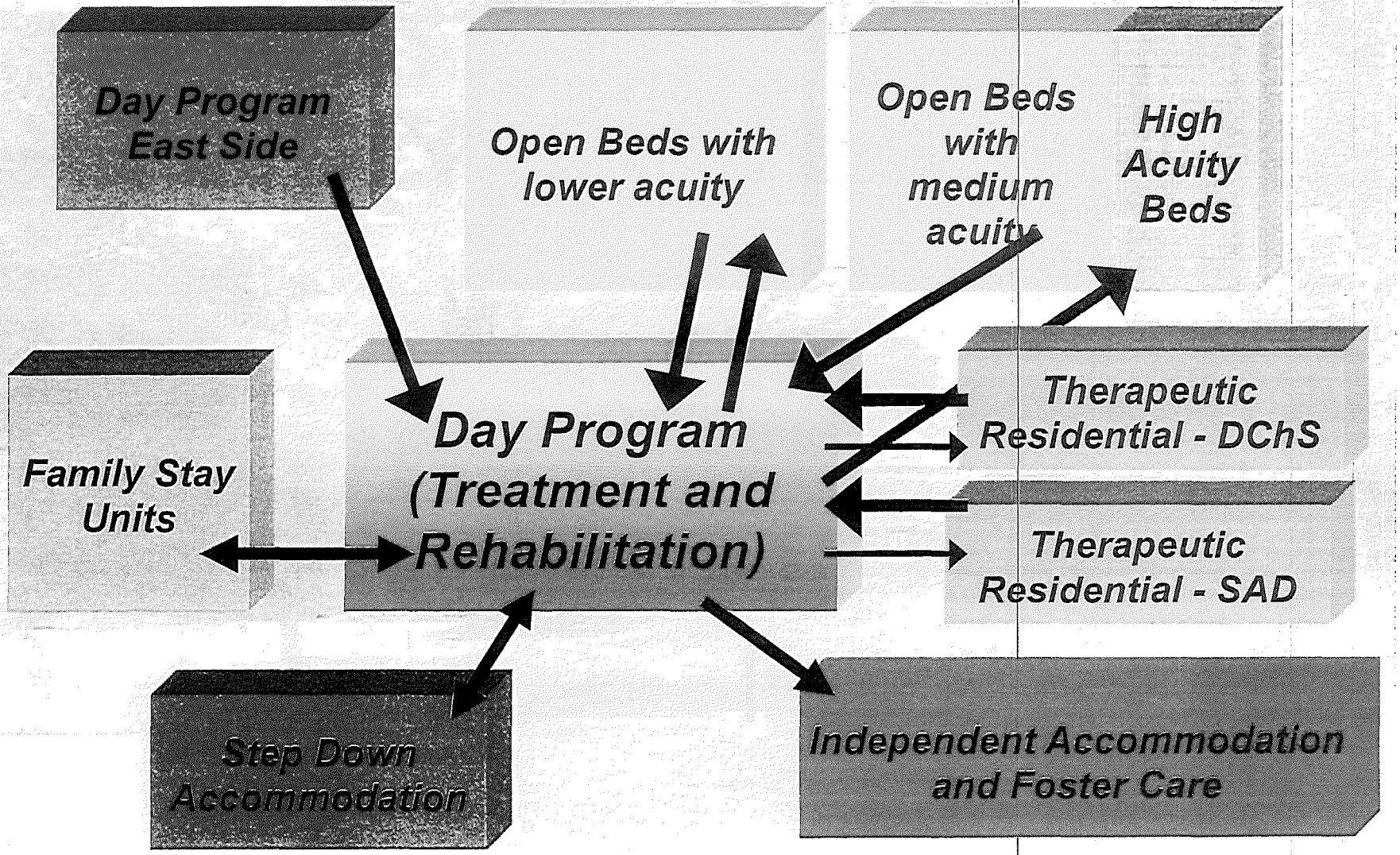
Trends 1988 - 2008

- Education Queensland provides a considerable resource for partnership with Queensland Health to promote recovery.
- Inherent factors in adolescents and their families are the major rate limiting factor to change.
- Lack of a range of interventions often impedes the rate of change.
- Most adolescents are at a pre-contemplative stage of change.
- Evidence based approaches lacking
- Severity of impairment has increased
- Acuity has increased
- Trend towards older age on admission
- Adolescents now stay beyond 18 years

Referrals to BAC 2004 - 2007
40
30
20
10
0
2004
2005
2006
2007
Referrals


Girls
Boys
Total
Adolescents on BAC Waiting List
20
15
10
5
0
2004 3Q
2005 1Q
2005 3Q
2006 1Q
2006 3Q
2007 1Q
2007 3Q
2008 J

Model of Essential Components of the Rebuilt Facility



Day Program 9 – 5/5.30

Developmental assessments

School – classrooms, TAFE equipment, library,

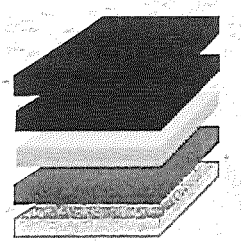
Life skill assessments and interventions – cooking, community access

Therapy areas – rooms and outdoor areas for IT, sand play, art, dance, music

Outdoor adventure – storage, facilities

Areas for social interactions – eating, play, talking

Function
Behaviours
Diagnosis
Environment
Substrate



Developmental Tasks of Adolescence

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

Residential

High acuity

Medium acuity

Low acuity (on site and therapeutic residential)

Parent/family

Transition/step-down

Determined by

- **Levels of acuity**
- **Skill levels**
- **Need for containment**
- **Need for processing emotions at various times**

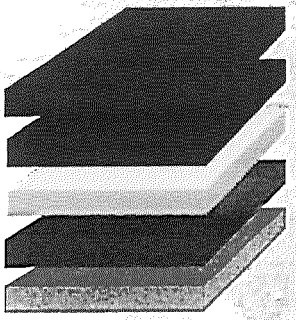
Attention to Developmental tasks

Provide for transitions

Provide for space away from unit

Facilities for family interventions

Function
Behaviours
Diagnosis
Environment
Substrate



Diagnosis, Behaviours

- Medication room
- Clinic
- Mandometer

Substrate issues

- Assessment rooms for Psych, SP, OT, Exercise Physiologist
- Student room
- Storage for tests
- Access to kitchen, laundry
- Sensory room
- Physical assessment area

Non-risk behaviours

Sleep – sleep studies room

Eating – differing dining areas

Developmental Tasks – Develop Emotional Maturity

- Individual therapy/assessment rooms (day area)
- Interview rooms (Residential areas)
- Quiet rooms (Day and residential areas)
- Multi-sensory room (Day and inpatient areas)
- Time out room (Day and residential areas)
- Expressive therapies (Sand play room, art room) (Day and inpatient areas)
- Expressive therapies (Dance room, music room) (Day area – shared with school)
- Group therapy rooms (Day area)
- Access to adventure areas
- Hydrotherapy pool
- Outdoor recreational spaces, equipment
- Adequate storage for the above

Developmental Tasks – Negotiate School

- Adequate number of classrooms for size of facility
- Principal and administration offices (x3)
- Reception area
- Shared gym
- Shared home economics/kitchen
- Performance area (shared with professional development etc.)
- Storage areas and equipment (including computer servers)
- Multi-media room
- Library
- Outdoor recreational area
- Outdoor area for TAFE programs

Developmental Tasks – Self Care Skills/Competencies for Independence, Developing Leisure Options, Social Skills

- Kitchens in residential areas
- Kitchen in day (school home economic) areas
- Dining areas (day and inpatient areas)
- Laundry, and drying facilities
- Bathrooms
- Access to public transport
- Bedroom spaces/storage
- Office for specific skills e.g. driving, employment
- Community access
- Television, lounge areas (residential)
- Recreational area (day area)
- Adequate range of outdoor activities
- Links with community activities
- Adequate storage