QCMHR
Queensland Centre for Mental Health Research

A Review of Adolescent Day Programs in Queensland

Summary Report

Dr Zoe Rutherford, Ms Hannah Pocock, Dr Zoe Papinczak, Ms Kate Gadenne & Prof Harvey Whiteford

This review was commissioned in 2023 by the Queensland Department of Health (DoH) and the Department of Education (DoE). This review was conducted by the Mental Health Evaluation Research Stream at the Queensland Centre for Mental Health Research (QCMHR). QCMHR is a research partnership between DoH and The University of Queensland (UQ). Hosted by West Moreton Health, QCMHR is funded to work state-wide in Queensland and contribute to the Australian and global research effort to improve mental health.

For further information and feedback, please contact:
Dr Zoe Rutherford (z.rutherford@uq.edu.au)
Mental Health Evaluation Stream Lead, QCMHR
Senior Research Fellow, School of Public Health, UQ.

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Acronyms

Acronym	Definition
ADP	Adolescent Day Program
CALD	Culturally and Linguistically Diverse
CIMHA	Consumer Integrated Mental Health and Addiction application
COVID-19	Coronavirus Disease 2019
CYMHS	Child and Youth Mental Health Service
DoE	Department of Education
DoH	Department of Health
HHS	Hospital and Health Service
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and other orientations not listed
MoS	Model of Service
QCMHR	Queensland Centre for Mental Health Research
RE-AIM	Reach, Effectiveness, Adoption, Implementation and Maintenance
SDQ	Strengths and Difficulties Questionnaire
UQ	The University of Queensland

1. Background

The most recent National Study of Mental Health and Wellbeing (ABS, 2023) reported that among Australians aged 16 - 85 years, 21.5% experienced mental illness in the previous year, and 42.9% experienced a mental illness during their lifetime. Severe mental disorders often have their onset during adolescence and are associated with considerable impacts upon the individual and their family. Severe mental illness during adolescence can affect educational attainment, employment prospects, social relationships, and long-term physical and mental health (Woody et al., 2019). For over 40 years, Adolescent Day Programs (ADPs) have been operating in the United States, Canada, and the United Kingdom as a service model to provide multi-faceted mental health care for young people with severe and persistent mental illness (Rech et al., 2022). Following their success overseas, ADPs have now been established in Queensland made possible via a partnership between Department of Health and the Department of Education.

1.1 About Adolescent Day Programs

ADPs are multi-disciplinary services providing intensive treatment for young people with severe mental illness who are unable to engage in mainstream schooling. Treatment is provided in a group setting, without the need for an inpatient admission. These services may be staffed by a mix of psychiatrists, psychologists, speech pathologists, occupational therapists, art and music therapists, exercise physiologists, social workers, peer workers and educators; with the ADP's primary goal to facilitate the young person's mental health recovery so that they are able to re-engage with their regular social functioning and schooling/vocational training program. ADPs may operate according to a range of i) theoretical orientations towards therapy, ii) treatment and educational modalities, iii) in a range of settings (e.g. hospitals, community mental health facilities), (iv) formats (e.g., length of time, number of days, school term, etc.), and (v) organisational and team structures (Rech et al., 2022; Milin et al., 2000; Thatte et al., 2013). In practice, ADPs often work with a small cohort of young people (e.g. 8-12 people at a time aged 12-18 years) from a broad range of diagnostic categories over the course of a schooling period (e.g. a school term; or six months).

1.2 Queensland Health's ADP Model of Service

In Queensland, ADPs are operated through a partnership between Queensland Department of Health (DoH) and the Department of Education (DoE), with DoH providing policy oversight of the Model of Service (MoS). Each Hospital and Health Service (HHS) is responsible for the operational delivery of the MoS in partnership with DoE school staff. The ADPs operating in Queensland aim to provide integrated, recovery-focused, mental health treatment and educational support, and are intended to maintain family, educational, social, and community connections within a least restrictive environment. The current MoS was last updated in February 2020 and states that young people aged 13-18 years can access the service through referral from health care providers. To be eligible for referral, young people must demonstrate:

i. Persisting symptoms and functional impairments that are impacting their schooling, despite a history of accessing less restrictive interventions, such as intensive community-based child and youth mental health services;
ii. A need for extended and intensive clinical intervention due to functional impairments that impact schooling but do not need or would not benefit from an acute inpatient admission; and,
iii. A likelihood to substantially benefit from service engagement, as deemed by the referrer and the service.

1.3 Aims and objectives

This project aimed to establish how each of the ADPs in Queensland are implemented and function as a system in practice, given that the MoS emphasises a multi-disciplinary approach to treatment, recovery, and education that prioritises input from young people and their carers, with the partnership arrangement between DoH and DoE being a defining feature.

To that end, this review of six ADPs in Townsville, Toowoomba, Chermside, South Brisbane, Logan, and Gold Coast had three key objectives:

1. To review how the existing ADP MoS aligns with:
    a. the current local service operational guidelines and models of care at each of the six ADPs identified above, and
    b. the implementation and functioning of each of the six ADP services (informed by an empirical investigation of stakeholder views using individual interviews and/or focus groups) (see Section 3.1).
2. To use the findings of this review activity to identify areas of risk (see Section 3.3), opportunities for improvement and future research (see Section 4), followed by recommendations (see Section 4.3).
3. To use the review process to inform the development of an evaluation framework for ADPs in Queensland (see Appendix B).

This summary report will outline the main findings and recommendations at a state-wide level, followed by the program logic and evaluation framework.

2. Methodology

The review of Queensland's ADP's involved a mixed methods approach, incorporating a desktop review of the MoS and program documentation, site visits, and the collection and analysis of primary qualitative data. The framework used to conduct the review was developed in partnership with the funders and is based on the ADPs Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM framework; Glasgow *et al*., 1999) and takes a socio-ecological approach (Bronfenbrenner, 1979). The review was guided by an Advisory Group of Mental Health and Education stakeholders who provided clinical and program expertise.

2.1 Desktop review and site visits

A Program Logic, presented in Appendix A, was developed following a desktop review of the MoS, site program documentation and benchmarking report (from DoH). For the research team to gain a practical understanding of each of the ADP services, site visits were conducted at all six sites between March-April 2023. Site visits included a tour of the facilities and meetings with various Mental Health and Education staff. Field notes were taken and used to inform the desktop review and formulation of the qualitative data collection protocol.

2.2 Qualitative data collection

Semi-structured interviews and focus groups were conducted with young people (*n*=21), their parents/carers (*n*=7), Queensland Health staff (*n*=18) and Education staff (*n*=7) across the six Queensland sites (Townsville, Toowoomba, Chermside, South Brisbane, Logan, and Gold Coast). Ethical approval was received from Children's Health Queensland Human Research Ethics Committee (HREC/23/QCHQ/94527). The method of thematic analysis by Braun and Clarke (2022) guided qualitative data analysis.

3. Findings

3.1 Functioning of the ADP

An analysis of the functioning of the ADPs in Queensland has been conducted with the young person's journey in mind, presenting qualitative data related to the referral process, assessment period, therapies and education provided, transition out of ADP and effectiveness.

3.1.1 Referrals

The referral pathways into ADP are primarily through community and specialist Child Youth Mental Health Services (CYMHS) teams, with a few sites that also accept referrals from Private Psychiatrists, and one site accepting referrals

from school Guidance Officers. The referrals received from CYMHS are often the most appropriate and thoroughly worked up [paperwork], whereas the referrals from Private Psychiatrists tended to be less detailed and appropriate for the service. Differences in the quality and appropriateness of referrals were found to depend largely on the relationships that clinicians had with referrers (CYMHS, private psychiatrists, guidance officer). Staff across the ADP sites highlighted the importance of developing close working relationships with referrers as it helps to communicate and clarify the role and purpose of ADP and what the 'right' referrals would be. Developing and maintaining these relationships takes significant time and resource which is not always factored into staff workload.

Some teams feel their service is only reaching a certain group of young people and may not be reaching all the young people they could be (e.g., Aboriginal and Torres Straight young people, those from culturally and linguistically diverse (CALD) communities and those with more complex diagnoses). A key message from staff is that young people need to be referred to ADP at an earlier point of their school disengagement and refusal, as this length of time may affect their capacity to re-engage and therefore length of stay required. If ADP can intervene early in a young person's journey, the likelihood of recovery and reintegration with education is much higher.

3.1.2 Assessment period and on-boarding

The assessment periods at each ADP differ in length of time, from 3 weeks to 6 weeks. This assessment period is vital to assess and understand the capacity and engagement of the young person and their parent/carer. If the young person and/or their parent/carer doesn't have the capacity or willingness to engage fully in ADP during this period, then they are unlikely to be offered a place at ADP yet. As many staff highlighted during the interviews, if the parent/carer fails to engage fully with their young person's recovery and journey at ADP, then the chances of the young person making meaningful progress can be impacted. The home environment and relationships with siblings and parents/carers are a vital part of a young person's recovery and implementation of long-term positive changes. The young person's and parent/carer goals are also assessed during this time, with these goals needing to include recovery from mental health challenges and also a plan for returning to education after ADP. Staff also highlight that when young people come to the ADP requiring a diagnosis, then the length of the assessment period may not be long enough to establish a functional care and education plan. This can impact the young person's capacity to engage in the program and thus affects the duration of stay required or the effectiveness of the program.

3.1.3 Therapies and Education

The types of therapies offered across the sites were found to be dependent on the cohort of young people; the number, mix and expertise of staff; and capacity to offer them. All sites offer an array of Dialectical Behavioural Therapy (DBT) and Cognitive Behavioural Therapy (CBT) skills, Zones of Regulation and Mindfulness. The group activities that take place also differ across sites, but the most frequently mentioned ones that young people enjoy include art and music therapy, cooking class, community connections (outings) and fun with fear (exposure group therapy). Most sites also offer structured family therapy and support.

Some teachers at ADP spoke of the challenges in teaching a group of 13–16-year-olds who vary in age, educational ability, level of cognition, and level of engagement. Considering this, some teachers spoke of doing individual education sessions with each young person, although this takes a significant amount of time to be able to support each young person in their education journey. Further data is needed before determining if group-based, individual, or mixed learning is the most effective and feasible.

3.1.4 Transfer of skills and transition out of ADP

Both the young people and parents/carers spoke of the skills and techniques they learnt at ADP and observations of these skills being put to use at home or in social situations. For example, parents/carers noticed young people using DBT skills when in conflict with younger siblings, while another young person expressed their increased confidence with making phone calls or orders compared to before ADP when they couldn't leave their home due to anxiety.

The transition phase out of ADP and into an education provider was found to occur at different times depending on where a young person is at in their journey and the length of the program at each site. Typically, around the 6-to-9-month mark is when the transition occurs, with transition planning beginning in the first few weeks of the ADP journey. Once a young person and their parent/carer has decided upon the educational facility, Education staff work with the school or alternative school to enrol the young person and communicate their learning plan and needs. The young person starts tapering attendance at ADP and begins attending school, often starting with half-days and working their way up. Once the transition is complete and the young person is fully attending school they are discharged from ADP.

There is variability in the role and capacity of ADP staff to conduct follow ups with young people when they exit, as there is some difference in which team is responsible for the communication with the next education provider. Additionally, there are governance issues that need to be considered when sharing data with other agencies.

3.1.5 Effectiveness

Conversations with previous consumers who are thriving after ADP, and parents/carers who have seen very positive changes in their young person's mental health and education progress, suggests that the ADP is effective. Staff defined the ADP as being 'effective' when a young person successfully re-engages with education, mental health conditions are managed and being supported appropriately, and improvements are observed in their relationships with family and others. All staff spoke highly of the positive outcomes young people have had following their time at ADP, with anecdotal reports of a large majority of young people successfully transitioning out of ADP and into an education provider. Unfortunately, there are limited quantitative data available that currently align with the Program Logic to explore the short, medium, and long-term outcomes, limiting the ability of this review to determine if the ADP is effective.

3.2 Young People and parent/carer experiences

Overall, all young people and parents/carers were positive about their ADP experience. Many felt that this was their 'last chance' to get back to 'normal' and while they had received an overview of the care they would receive, they were not sure what to expect. One of the barriers young people experienced to adopting a referral was the negative experiences they had previously had in their mental health journey and in their schooling. This was mitigated by having trust that they or their parent/carer had in their referring clinician and then by friendly and welcoming ADP staff from the first point of contact. Indeed, many young people reported that their ADP experience had been their first positive experience of a mental health service.

At the ADP, young people felt listened to, accepted, safe, and among 'people like them'. Staff communication within the mental health staff and between Education staff facilitated this, reducing fatigue by not having to tell their story repeatedly. Being in an environment without stigma (e.g., mental health, LGBTQI+ friendly) was also important in this regard. Young people felt that the ADP services were less intimidating and overwhelming than mainstream school, with fewer young people and less pressure to conform to the 'norm'.

For many parents/carers, the ADP exceeded their expectations as many didn't expect to receive support for themselves or the whole family, they were just happy that their young person was able to get the support they needed. That said, all who responded agreed that family therapies were an important aspect of the success of their ADP experience and saw improvements across the family.

Parents/carers cited that the wrap around service was essential to the success of their ADP journey. They described how having a one-stop-shop for mental health support across allied health disciplines reduced their functional and mental load and that their young people were 'finally' able to get timely support, including diagnoses.

Many parents/carers, particularly in more regional services, were not aware of the alternative education options for their young person and/or did not know how to access them. Working with Education staff helped them to feel confident in pursuing alternative education for their young person. While parent/carers did feel that their young person was working toward their education goals, some commented that getting more feedback on their educational progress would be valuable.

3.3 Risks

There are significant variabilities across ADP sites regarding the following: number of staff, staffing mix (clinical and allied health staff), staff training, physical space and capacity, length of school day and length of program. Considering the variation in delivery of the ADP program across sites and the need for smooth operations between the Health and Education teams, there are some areas of potential risk including:

- The current ADP governance model may not adequately address lack of clarity about Mental Health and Education responsibilities, issues with interoperability between Mental Health and Education systems (particularly around data sharing), or harness capacity for cross working and collaboration.
- There is potential for relationships to impact service functioning if effective connections are not developed between ADP staff and referrers, Mental Health and Education staff within the ADP, ADP staff and young people, parents/carers, and schools/education providers.
- The variability in staffing numbers, staff mix, and training may contribute to inequity in service delivery alongside staff burnout and high turnover.
- The variability in assessment duration across services could mean some services have inadequate time for assessment and diagnosis to inform care planning and education needs.
- The variability in length of the school day could mean some services operating for fewer hours have insufficient time to deliver required interventions.
- The high diversity in classroom mix (in terms of diverse mental health needs, education levels and inclusion of inpatients in the program) may require greater differentiation for group therapy or teaching delivery and more skilled and experienced staff.
- The variability in size, modernity, and comfort of the physical space risks inequity of service and render programs culturally or clinically inappropriate for service users.
- The variability of data collection and quality of clinical assessment/outcome data and the complexities of information sharing between Queensland DoH and the DoE does not support the monitoring and evaluation of outcomes outlined in the Program Logic.

4. Opportunities

The key ingredients of a well-functioning ADP service are identified below, based on the qualitative data gathered from young people attending ADP (and those who transitioned out), their parents/carers, ADP staff and Education staff. Opportunities for future research have also been outlined, followed by other recommendations.

4.1 Key Ingredients

- Specialist staff being appointed to deliver clinical and allied health interventions.
- Lived Experience Workforce being implemented at all sites with adequate supervision and training under a consistent governance structure.
- Re-establishing the state-wide ADP Advisory Group to facilitate shared learning and problem solving across sites, e.g., those with specialist staff to share insights and knowledge.

- Developing and sustaining relationships with external providers such as NDIS and community organisations to support young people continuing their journey after ADP.
- Collaboratively developing care and learning plans with the young person, their parents/carers, and clinicians.

4.2 Future Research

- A deep-dive into the quantitative data collected at ADP to explore the key variables, outcomes and gaps in data collection.
- Identification of young people who are not being reached and why, followed by the development of strategies to reduce barriers and increase awareness of the service.
- Development of a tool to measure functional recovery outcomes in this population of young people.
- Investigate the key factors that underpin strong relationships between staff at ADP, referrers, and external organisations.
- Explore the role and efficacy of specialist staff such as exercise physiologists and music/art therapists on the outcomes and experiences of young people.
- Research into neurodevelopmental disorders and trauma and how this may impact a young person's engagement and response to treatment as part of the ADP.

4.3 Other Recommendations

It is recommended that the ADP MoS be revised in partnership with all stakeholders (including peer workers and those with lived experience of ADP services) to mitigate identified risks and capitalise on opportunities. It is further recommended that the review consider:

- ADP governance (to enhance interoperability and collaboration between Education and Health teams as they reside under different governance structures, clarify the key responsibilities of each team to ensure effective service delivery, and enable sharing of data and joint reporting).
- Clarify the role of ADP and where it fits within the mental health services ecosystem in each HHS area, ensuring the ADP is aligned with the needs of the community and operating within its scope.
- Development of a minimum service delivery threshold (to ensure each ADP is adequately funded and resourced).
- Integration and articulation of the DoE program (to enhance cross-working relationships with staff and development of cross-disciplinary goals for young people).
- Minimum data collection for monitoring and evaluation, and guidance for continuous improvement (a state-wide framework which outlines the minimum data collection required at ADPs that is needed to perform future evaluations).

- Relationship development (to streamline referrals, intake, early intervention, goal setting and implementation, and facilitate sharing of success stories).
- Staffing (number, mix, role clarity, skill, inclusion of key additional support, lived experience and allied health staff).
- Physical space (including sufficient classroom sizes and outdoor, sensory, and self-regulation spaces).
- Data collection (ADP specific service episode on CIMHA, staff data entry training, consent from service users to allow contact for ongoing service monitoring and evaluation, inclusion of surveys and questionnaires, development of a post-discharge survey).

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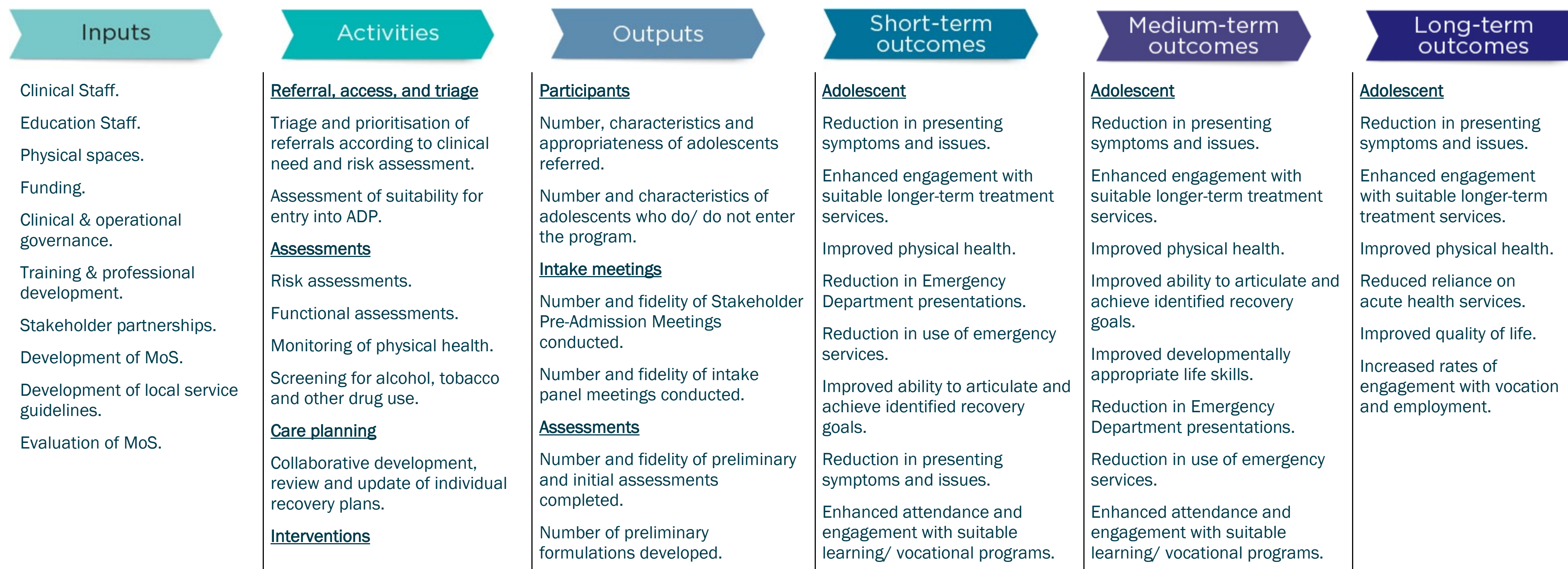
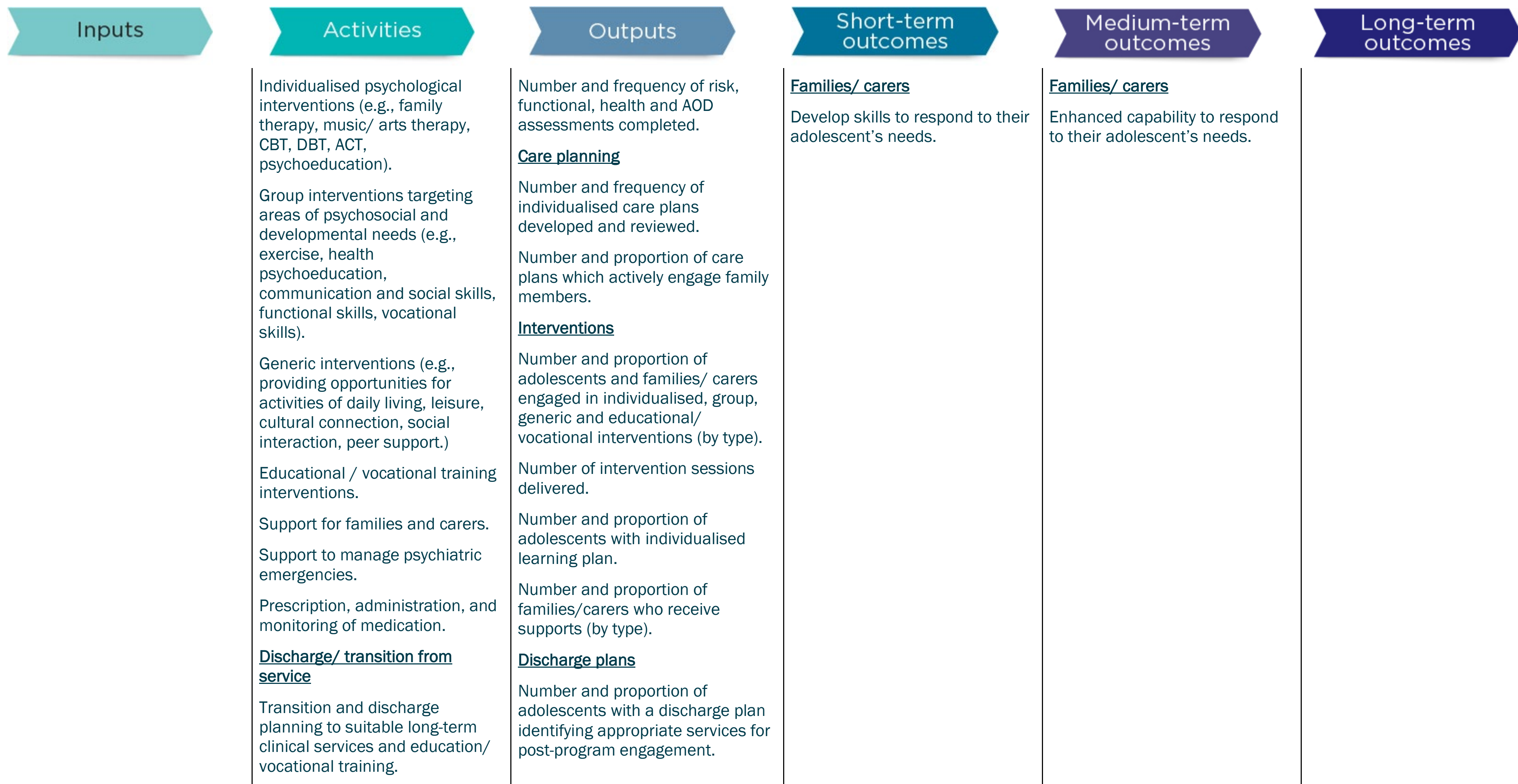
Appendix A

Figure 1. Program logic of the 2020 ADP Model of Service.

The Program Logic outlines the objective, inputs, activities, outputs, impacts and outcomes of the ADPs according to the MoS. The assumptions and external factors that underpin the operationalisation of the Program Logic are also presented and further discussed in relation to how they are experienced by young people, parents/carers, and staff.

Objective: The overall objective of the ADP is to provide integrated recovery-focused mental health treatment and educational support programs to improve functioning in an adolescent's life. This occurs through social, educational, and vocational engagement and individual and group therapies. Practically, services support adolescents to remain living in the community with intensive, wrap-around support services to support their recovery and reintegration to longer-term school/vocational educational options and treatment services.





Inputs	Activities	Outputs	Short-term outcomes	Medium-term outcomes	Long-term outcomes
	Individualised psychological interventions (e.g., family therapy, music/ arts therapy, CBT, DBT, ACT, psychoeducation). Group interventions targeting areas of psychosocial and developmental needs (e.g., exercise, health psychoeducation, communication and social skills, functional skills, vocational skills). Generic interventions (e.g., providing opportunities for activities of daily living, leisure, cultural connection, social interaction, peer support.) Educational / vocational training interventions. Support for families and carers. Support to manage psychiatric emergencies. Prescription, administration, and monitoring of medication. **Discharge/ transition from service** Transition and discharge planning to suitable long-term clinical services and education/ vocational training.	Number and frequency of risk, functional, health and AOD assessments completed. **Care planning** Number and frequency of individualised care plans developed and reviewed. Number and proportion of care plans which actively engage family members. **Interventions** Number and proportion of adolescents and families/ carers engaged in individualised, group, generic and educational/ vocational interventions (by type). Number of intervention sessions delivered. Number and proportion of adolescents with individualised learning plan. Number and proportion of families/carers who receive supports (by type). **Discharge plans** Number and proportion of adolescents with a discharge plan identifying appropriate services for post-program engagement.	**Families/ carers** Develop skills to respond to their adolescent's needs.	**Families/ carers** Enhanced capability to respond to their adolescent's needs.	

The assumptions and external factors that underpin the operationalisation of the Program Logic are presented below.

Assumptions

- Operational and clinical governance arrangements are in place, with clear responsibilities and roles assigned.
- Parents/carers are willing and able to transport the adolescent to and from ADP every day and engage with the adolescent's treating team and treatment plan.
- Adolescents are willing and able to engage with the treatment team and allied health practitioners, commit to returning to mainstream schooling (or equivalent) and abide by ADP rules and regulations.
- Services receive the adequate funding required to provide ADP services outlined in the Model of Service and undertake appropriate professional development activities.
- Clinical assessment measures are completed when required to provide an accurate representation of the adolescent's functioning and improvements during and after ADP.
- The ADP physical infrastructure and environment is conducive to learning and recovery, with a distinction between inpatient units and ADP.
- Activities, spaces, and staff are culturally informed and safe for gender-diverse and neurodiverse adolescents.
- Strong partnerships are developed and in place with other local mental health and mental health service providers, other government agencies, community support services and allied health services.
- Staff receive adequate training and have access to continuing development/educational opportunities, clinician supervision and support mechanisms to ensure clinical competence.

External Factors

- Staff- mix, turnover, and workforce capacity.
- Demographics of area and community needs.
- Number and appropriateness of referrals.
- Mental health severity and complexity i.e., mixes of internalised and externalised presentations of symptoms.
- Parent/carer capacity/engagement.
- Length of time away from school.
- Adolescent's motivation for change and experience of previous interventions.
- COVID-19 guidelines and restrictions.

Appendix B: Evaluation Framework

The RE-AIM framework is an evidence-based example, which provides structure and depth to evaluations by examining the Reach, Efficacy, Adoption, Implementation and Maintenance of interventions, providing a deeper understanding as to whether the programs and models work, and why (not) (Glasgow et al., 1999). The RE-AIM framework can be overlaid against the Program Logic to provide a comprehensive and systematic framework for organising and interpreting both qualitative and quantitative data about the inputs and activities that are intended to lead to the desired outcomes and impacts (Figure 2). The evaluation measures, methods and design are then built to enable assessment of achievement against the elements identified in the program logic map. The following section outlines what data are routinely collected at present, what needs to be collected going forward and the current challenges to data collection that exist.

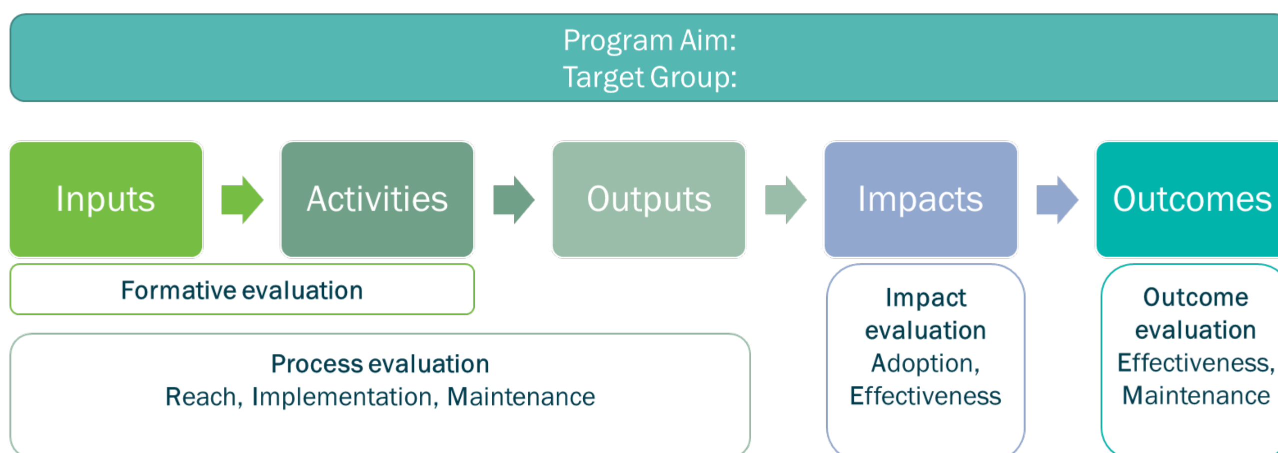


Figure 2. Overlay of the RE-AIM framework, by evaluation type and program logic domain.

Evaluation questions and recommended measures

Upon the conclusion of the ADP review and the knowledge and understanding of the services that was generated, evaluation questions were developed (see Table 1), which align to the Program Logic, the RE-AIM framework, and the Socioecological Model. In future, more questions could be added to address the changes to the MoS and Program Logic, as well as to address specific issues. These questions can be used at a state-wide level and individual services may wish to use them as part of their continuous improvement cycle or to conduct site specific evaluations of their service.

Data collection and measures

As part of any evaluation, the most appropriate data should be collected and analysed, using the most valid and reliable way, to answer the questions posed. The mixed methods approach posed facilitates a comprehensive and robust evaluation within the parameters of the RE-AIM framework. Data should be gathered from a variety of sources (as suggested Tables 1 and 2), which will allow for the triangulation of the data that are analysed.

Quantitative data

As part of the review, an audit of routinely collected data was conducted, although the quality of these data was not assessed. Table 2 outlines the current measures that are captured by the mental health and education teams and where respectively they are held. Some of the outcome measures that are collected, as outlined in the variability table, are not consistent across ADPs, which makes it challenging to assess effectiveness across and between services. The review also identified that there were several output and outcomes that are not currently measured, which means there is not currently quantitative monitoring of some inputs and activities to enable an evaluation at present. Some suggestions have been made for what those measures might be, but the co-design of the full evaluation framework should include a consultation of what these should be, how they are measured and where the data are held.

Table 1: List of evaluation questions by program logic domain.

Program Logic Domain		Evaluation Question	Data	
			Quantitative	Qualitative
Inpu	Clinical Staff	What is the mental health staff profile at this site?	✓	
		Is the mental health staff profile (FTE and mix) adequate to deliver the ADP model as intended? Why?		✓
	Education Staff	What is the education staff profile at this site?	✓	
		Is the education staff profile (FTE and mix) adequate to deliver the ADP model as intended? Why?		✓
	Physical Space	Where is the ADP building situated?	✓	✓
		Is the physical space(s) large enough to deliver the ADP as intended?		
	Funding	Is the level of funding/resourcing adequate to support daily operation and maintenance of the ADP?	✓	✓
	Clinical and Operational Governance	Who is responsible for Clinical and Operational Governance at *site* ADP?	✓	✓
		To what extent is the current governance model effective and how could it be improved?		✓
	Training and professional development	What is the required training for *role* at the ADP?	✓	✓
		How many staff have completed the required training for their role? Are there any barriers to access?	✓	✓
		Have staff been able to access appropriate professional development activities? Why?		✓
	Stakeholder partnerships	What are the stakeholder partnerships and how are they managed? (i.e., between clinicians and referrers, teachers, and schools etc.)	✓	✓
		To what extent are the stakeholder partnerships effective?		✓
		What are the barriers and facilitators to effective partnership working?		✓
	Development of MoS	What was the process for developing the latest MoS? How does that align to best practice?		✓
		Who were the partners/stakeholders involved?		✓

	Development of local service guidelines	What was the process for developing the site service guidelines? How does that align to best practice?		✓
		Who were the partners/stakeholders involved?		✓
		What were the barriers and facilitators to developing the *site* service guidelines?		✓
	Evaluation of MoS	What evaluation activities have been conducted?	✓	✓
		What implementation and translation activities took place and what changes were made as a result?	✓	✓
		What was the impact of the changes?	✓	✓
	Triage and prioritisation of referrals according to clinical need and risk assessment	What is the process for referral/acceptance at an ADP?	✓	✓
		How does this differ by site? Why?	✓	✓
		What is the referral/acceptance (REACH) profile of ADPs?	✓	
	Assessment of suitability for entry into ADP	What criteria is used to assess suitability for ADP?	✓	✓
		How does the existing mix or profile of existing young people impact the decision to accept a referral into the service?		✓
	Risk assessments	What is the function and process for risk assessments?	✓	✓
		How many risk assessments are completed and what is the profile?	✓	
	Functional assessments	What is the function and process for functional assessments?		✓
		Who completes the functional assessments in ADP? (e.g., Occupational Therapist)	✓	✓
		How many functional assessments are completed and what is the profile?	✓	
Acti	Monitoring of physical health	What is the function and process for physical health and metabolic health assessments?		✓
		Who conducts the physical health and metabolic health assessments?	✓	✓
		How many physical health and metabolic health are completed and what is the profile?	✓	
	Screening for alcohol, tobacco, and other drug use	What is the function and process for alcohol, tobacco, and other drug use screening assessments?		✓
		Who conducts the alcohol, tobacco, and other drug use screening assessments?	✓	✓
		How many alcohol, tobacco and other drug use screens are completed and what is the profile?	✓	
	Collaborative development, review and update of individual recovery plans.	What is the function and process for the development and review of a young person's recovery plan?		✓
		Who conducts/collaborates in the development and review of a young person's recovery plan?		✓
		How many recovery plans are completed, reviewed, and updated and what is the profile?	✓	

	Individualised psychological interventions (e.g., family therapy, music/ arts therapy, CBT, DBT, ACT, psychoeducation).	What clinical individual interventions are offered at *site* ADP and which staff role delivers them?	✓	✓
		Are the interventions delivered as intended (i.e., in line with the evidence)		✓
		What is young people's preference/experience of the individual clinical interventions? Why?		✓
		What is the efficacy of the individual clinical interventions?	✓	✓
		What are the barriers and facilitators of the individual clinical interventions?		✓
	Group interventions targeting areas of psychosocial and developmental needs (e.g., exercise, health psychoeducation, communication and social skills, functional skills, vocational skills).	What group interventions are offered at *site* ADP and which staff role delivers them?	✓	✓
		Are the interventions delivered as intended (i.e., in line with the evidence)		✓
		What is young people's preference/experience of the group interventions? Why?		✓
		What is the efficacy of the group interventions?	✓	✓
		What are the barriers and facilitators of the group interventions?		✓
	Generic interventions (e.g., providing opportunities for activities of daily living, leisure, cultural connection, social interaction, peer support.)	What community activities (e.g., excursions), cultural activities or peer support etc., are offered at *site* ADP and which staff role delivers them?	✓	✓
		Are the interventions delivered as intended (i.e. in line with the evidence)		✓
		What are young people's preference/experience of the community activities (e.g., excursions), cultural activities or peer support etc? Why?		✓
		What is the efficacy of the community activities (e.g., excursions), cultural activities or peer support etc.?	✓	✓
		What are the barriers and facilitators of the community activities (e.g., excursions), cultural activities or peer support etc.?		✓
	Educational interventions.	What educational interventions are offered at *site* ADP and which staff role delivers them?	✓	✓
		Are the interventions delivered as intended? (i.e., in line with the evidence)		✓
		What are young people's preference/experience of the educational interventions? Why?		✓
		What is the efficacy of the educational interventions?	✓	✓
		What are the barriers and facilitators of the educational interventions?		✓

	Support for families and carers.	What supports/interventions are offered to parents/carers/families?	✓	✓
		Are the supports/interventions delivered as intended? (i.e. in line with the evidence)		✓
		What families' and carers' preference/experience of the supports/interventions? Why?		✓
		What is the efficacy of the families' and carers' support/ interventions?	✓	✓
		What are the barriers and facilitators of the families' and carers' interventions?		✓
	Support to manage psychiatric emergencies.	What support is there to manage psychiatric emergencies?	✓	✓
		Are the supports delivered as intended? (i.e. in line with the evidence)		✓
		What are the young people's, families' and carers' experience of the supports/interventions? Why?		✓
		What is the efficacy of the support to manage psychiatric emergencies?	✓	✓
		What are the barriers and facilitators to delivering support to manage psychiatric emergencies?		✓
	Prescription, administration, and monitoring of medication.	Who is responsible for the administration, prescription and monitoring of medication for young people?		✓
		Is the process for the administration, prescription and monitoring of medication for young people effective?		✓
	Transition and discharge planning to suitable long-term clinical services and education/ vocational training.	What is the process for transition and discharge planning to suitable long-term clinical services and learning pathway?	✓	✓
		Is the process delivered as intended?		✓
		What are the young people's, families' and carers' experience of the transition and discharge planning to suitable long-term clinical services and learning pathway?	✓	✓
		What are the barriers and facilitators to the successful transition and discharge planning to suitable long-term clinical services and learning pathway?		✓
Outp	Number, characteristics and appropriateness of adolescents referred.	Does the ADP model reach the eligible population? If so how and why? If not, why not?	✓	
	Number and characteristics of adolescents who do/ do not enter the program.	What proportion of eligible consumers are using the service, their demographics and why do/don't they decide to take up the offer?	✓	

	Number and fidelity of Stakeholder Pre-Admission Meetings conducted.	What number of pre-admission meetings were conducted?	✓	
	Number and fidelity of intake panel meetings conducted.	What number of MDT meetings were conducted?	✓	
	Number and fidelity of preliminary and initial assessments completed.	What number and fidelity of preliminary and initial assessments were completed?	✓	
	Number of preliminary formulations developed.	What is the number of care plans that have been completed?	✓	
	Number and frequency of risk, functional, health and AOD assessments completed.	What is the number and frequency of risk, functional, health and AOD assessments completed?	✓	
	Number and frequency of individualised care plans developed and reviewed.	What is the number of valid Treatment Packages?	✓	
	Number and proportion of care plans which actively engage family members.	What is the number and proportion of care plans which actively engage family members?	✓	
	Number and proportion of adolescents and families/ carers engaged in individualised, group, generic and educational/ vocational interventions (by type).	What is the number and proportion of adolescents and families/ carers engaged in individualised, group, generic and educational interventions (by type)?	✓	
	Number of intervention sessions delivered.	What is the frequency and type of intervention sessions being delivered? Are there any differences between groups? E.g., gender, site, age group etc.	✓ ✓	

	Number and proportion of adolescents with a personalised learning record.	What is the number and proportion of adolescents with a personalised learning record? What is the frequency and demographic profile of adolescents with a reviewed personalised learning record? Are there any differences between groups? E.g., gender, site, age group etc.	✓ ✓	
	Number and proportion of families/carers who receive supports (by type).	What is the frequency and demographic profile of adolescents with a discharge plan identifying appropriate services for post-program engagement? Are there any differences between groups? E.g., gender, site, age group etc.	✓ ✓	
	Number and proportion of adolescents with a discharge plan identifying appropriate services for post-program engagement.	What is the frequency and demographic profile of families/carers who receive supports, by type? Are there any differences between groups? E.g., gender, site, age group etc.	✓ ✓	
	Reduction in presenting symptoms and issues.	Has there been a clinically meaningful improvement in the HoNOSCA* scores over the ADP duration? *Or other symptom related outcome measure. Are there any differences in change between groups? E.g. gender, site, age group etc.	✓ ✓	
	Enhanced engagement with suitable longer-term treatment services.	Has the young person/family member(s) engaged with suitable longer-term treatment services? If so, how frequently? Are there any differences in change between groups? E.g., gender, site, age group etc. What are the barriers and facilitators to engaging with suitable longer-term treatment services?	✓ ✓	✓ ✓
	Improved physical health.	Has there been a clinically meaningful improvement in the physical health assessment scores over the ADP duration? Are there any differences in change between groups? E.g., gender, site, age group etc.	✓ ✓	
Sho	Reduction in Emergency Department presentations.	Has there been a reduction in ED presentations since the completion of the ADP? Are there any differences in change between groups? E.g., gender, site, age group etc.	✓ ✓	

	Improved ability to articulate and achieve identified recovery goals.	Have the recovery goals been met?	✓	✓
		To what extent to young people and families believe their recovery goals have been met? How? Why?		✓
		What were the barriers and facilitators to meeting recovery goals?		✓
	Improved developmentally appropriate life skills.	Has there been a clinically meaningful improvement in the Life skills questionnaire or COPM * scores over the ADP duration?	✓	
		*Or other life skill related outcome measure.		
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
	Enhanced attendance and engagement with suitable learning pathway.	Has the young person engaged with a suitable learning pathway? If so, how frequently?	✓	
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
		What are the barriers and facilitators to engaging with suitable learning pathways?		✓
	Families/Carers develop skills and enhance capability to respond to their adolescent's needs.	Families/carers engagement in Family Therapy		✓
	Reduction in presenting symptoms and issues.	Has there been a clinically meaningful improvement in the HoNOSCA* scores over the ADP duration?	✓	
		*Or other symptom related outcome measure.		
		Are there any differences in change between groups? E.g. gender, site, age group etc.	✓	
	Enhanced engagement with suitable longer-term treatment services.	Has the young person/family member(s) engaged with suitable longer-term treatment services? If so, how frequently?	✓	✓
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
		What are the barriers and facilitators to engaging with suitable longer-term treatment services?		✓
Term *Lon*	Improved physical health.	Has there been a clinically meaningful improvement in the physical health assessment scores over the ADP duration?	✓	
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
	Reduced reliance on acute health services.	Has there been a reduction in acute health service usage after completion of the ADP?	✓	
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
	Improved quality of life.	Has there been a clinically meaningful improvement in the quality-of-life scores over the ADP duration?	✓	

		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
	Increased rates of engagement with vocation and employment.	Has the young person engaged with a suitable learning pathway and/or full-time employment? If so, how frequently?	✓	
		Are there any differences in change between groups? E.g., gender, site, age group etc.	✓	
		What are the barriers and facilitators to engaging with learning pathways and/or full-time employment?		✓

Table 2. Outputs and Outcomes measured in line with RE-AIM framework.

RE-AIM Domain	Output/Outcome/Measure	Is it currently being measured? Yes ☑ or No ☒ (if yes - how is it being measured, If no - suggestions for measurement)	Where are the data held?
Reach	Number, characteristics and appropriateness of adolescents referred.	☑ Number of referrals received	CIMHA
Adoption	Number and characteristics of adolescents who do/ do not enter the program.	☑ Number of episodes started and active episodes. Number of episodes ended and end reason, primary diagnosis of service episode	CIMHA
	Number and fidelity of Stakeholder Pre-Admission Meetings conducted.	☒ Number of pre-admission meetings conducted (i.e., with adolescent's referrer)	TBC
	Number and fidelity of intake panel meetings conducted.	☒ Number of MDT meetings conducted	TBC
	Number and fidelity of preliminary and initial assessments completed.	☑ HoNOSCA scores measured at 3 time points – 'proportion of clinicians rated outcomes completed as required' Parent and youth self-assessments 'Proportion of community mental health service episodes with completed consumer self-assessment outcome measures (MHI for adults and SDQ for youth)	CIMHA
Implementation	Number of preliminary formulations developed.	☑ Identified in care plan	CIMHA
	Number and frequency of risk, functional, health and AOD assessments completed.	☑ Physical Health Assessment, Discipline specific assessment (i.e., music therapist, exercise physiologist, occupational therapist)	CIMHA
	Number and frequency of individualised care plans developed and reviewed.	☑ Valid Treatment Packages	CIMHA
	Number and proportion of care plans which actively engage family members.	☑ Family Member/Carer identified	CIMHA

	Number and proportion of adolescents and families/ carers engaged in individualised, group, generic and educational/ vocational interventions (by type).	☑ Average clinician duration per active day (overview of interventions provided by clinicians and how often)	CIMHA
	Number of intervention sessions delivered.	☑ Documented in care plan	CIMHA
	Number and proportion of adolescents with individualised learning plan.	☑ Learning plan developed at start of ADP and during ADP for review	OneSchool
	Number and proportion of families/carers who receive supports (by type).	☑ Number of parents/carers fully engaged in family therapy (if identified in Care Plan)	CIMHA
	Number and proportion of adolescents with a discharge plan identifying appropriate services for post-program engagement.	☑ Documented in care plan	CIMHA
Effectiveness	Reduction in presenting symptoms and issues	☑ Start, case review and post ADP HoNOSCA collected ('proportion of clinician rated outcomes completed as required' and 'change in clinical outcomes')	CIMHA
	Enhanced engagement with suitable longer-term services	☑ Written in Care Plan identifying post ADP services to engage with	CIMHA
	Improved physical health	☑ Physical health assessment completed at start and end of ADP journey	CIMHA
	Reduction in Emergency Department presentations	☒ Number of ED presentations before, during and end of ADP	TBC
	Improved ability to articulate and achieve identified recovery goals	☒ Recovery goals identified in Care Plan	TBC
	Families/carers develop skills to respond to their adolescent's needs	☒ Families/carers engagement in Family Therapy	TBC
	Improved developmentally appropriate life skills	☒ Life skills questionnaire or COPM (Canadian occupational performance measure) before and end of ADP	TBC
	Reduced reliance on acute health services	☒ Number of medical interventions or support needed before and end of ADP	TBC

	Improved quality of life	☒ Quality of life questionnaire before and end of ADP	TBC
Maintenance	Increased rates of engagement with vocation and employment	☒ Post ADP survey to identify vocational/employment prospects	TBC
	Enhanced attendance and engagement with suitable learning/vocational programs	☒ Attendance rates documented by teachers	TBC