The open mind

Reaching Out:

Changing Service Models for Youth

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During the past decade, there has been increasing recognition of the need to provide less traditional treatment interventions in child and adolescent mental health beyond in-patient and clinic-based outpatient services.

Less traditional approaches have included intensive home as well as community-based interventions, which differ in many ways, but share some common principles and practices. These practices include a multifaceted, eclectic approach focused on the needs of the patient and family, they are multisystemic and potentially intervene in all significant aspects of the young person's life (*i.e.*, school, home and family). Strategies are individualized and focused on strengths and on maintaining social and community connections for the individual and his/her family.

This article describes a program that includes all of the above aspects of community-based care that is also linked with an in-patient and day-treatment program allowing a continuum of care between various components.

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About the program...

The Adolescent Outreach program consists of a core team of three highly skilled psychiatric nurses, combined with an intake worker, psychiatrist and social worker. The latter three professionals are shared with the in-patient and partial hospitalization components of the entire adolescent program.

The team has established a model of care that successfully integrates these relatively independent fields of practice and creates a fiscally responsible program responding to the needs of this vulnerable population.

Since the program's inception nine years ago, care provided has become increasingly responsive and proactive with the youth as an active participant in informed decisions and problem-solving strategies.

How do I differentiate "normal" adolescent behaviour from mental health problems?

While moodiness and defiance are expected, particularly in early and mid-adolescence, more sustained symptoms, such as intense irritability, mood changes and sleep disturbance warrant assessment.

Target population

These nontraditional services are provided for youth aged 13 to 18 within a county population base of 403,000. Contacts with the youth are based on patient preference and appointments may be at their home, at school or in the community.

Presenting problems are varied and may include mood and anxiety disorders, psychotic disorders, attention deficit hyperactivity disorder (particularly with complex presentation and comorbidity) and parent/child conflict in the presence of a mental illness. Suicide and self-harm are common in the served population.

Based on the acuity of the presentation and the need and/or maturity of the patient, individual meetings may be scheduled from twice a week to once monthly. In addition, flexibility of support may range from a single assessment to a year or more of involvement.

The clinician is available to the patient and/or his/her family primarily via scheduled meetings; however, they may make contact through e-mail, pager or phone. At the nurse clinician's request, the patient may be seen for psychiatric consultation and/or be referred to the team social worker for family therapy. Group therapeutic approaches are utilized (*e.g.*, for youth with anxiety disorders and poor social skills).

Opportunities for consultation

The Outreach clinicians have weekly supervision with the team psychiatrist who also provides face-to-face consultation and medication reviews for patient. Family members may be included in the treatment process including psychoeducation, parent support and family therapy.

Clinicians also draw on the expertise of other disciplines associated with the in-patient program and can access more intensive services as required. For example, a patient may be referred for a short in-patient stay or partial hospitalization. Both include school programs and a variety of therapeutic groups. Program partnerships with community schools, community agencies and services often include collaboration of client care, educational presentations, group facilitation and consultations.

? What is the best therapeutic approach with adolescents?

Adolescents have a preference for active (not intrusive or lecturing) therapists. Cognitive behaviour therapy and interpersonal therapy are effective evidenced-based approaches for adolescents.

? With the recent controversy about psychotropic medications in youth under 18 years (especially SSRIs and NSRIs and more recently, amphetamine and dextroamphetamine), should I prescribe these agents?

If used when indicated, they can be effective, but careful monitoring (*e.g.*, agitation, suicidal ideation [SSRIs] and cardiac parameters [stimulants]) should be performed and documented.

? What is the relationship between substance abuse and mental disorder in adolescence?

Youth with emergent disorders may use substances to self-medicate (especially depression); substances may mask a predisposition to mental illness, especially psychotic disorder.

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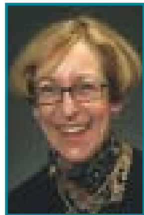

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Program philosophy and model of care

The youth is central to the intervention and is actively involved in the referral. With this approach, from the point of intake, the developmental tasks of the patient are facilitated by encouraging autonomy and the level of commitment of the youth is increased.

The therapeutic approach is eclectic utilizing components of nursing theory combined with cognitive behaviour therapy, dialectical behaviour therapy and psychosocial support. Medication is prescribed and monitored where indicated. Standardized assessments are completed at baseline, allowing a measure of outcomes.

Benefits and challenges

Benefits

- Provides alternatives to hospitalization that are cost-effective and delivered in the environment of the young person. When hospitalization is necessary, length of stay can be significantly reduced with pre-admission intervention and aftercare services.
- The caseload of the psychiatrist and utilization of the hospital program can be expanded without impacting program resources.
- Care is delivered in a client-centred way with the youth having input into treatment goals and the treatment process.
- The recognition of the early onset of serious mental illness may allow the youth to reach developmentally appropriate milestones through early intervention.

Challenges

- The realities of clinician travel.
- The inevitable waiting list (currently three to four months); urgent cases and discharges from in-patient care are prioritized.
- The need to further expand the program to include more rural communities is difficult within current program resources.

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