

Evaluation report on the Targeted Youth Support Service 2010-2015

Ann MacRae B. Soc. Sci (Psych)

Executive summary

The Targeted Youth Support Service (TYSS) as delivered by Bapcare in the South West region of Tasmania commenced in October 2010 and has recently achieved 5 years of service delivery to youth at risk in the Glenorchy, Hobart, Kingborough and Huon Valley areas. TYSS utilises a trauma informed therapeutic and complex case management approach to working with highly disengaged young people between the ages of 10 and 18 who are experiencing multiple and complex issues which without intervention place them on a trajectory to entering the statutory services of Child Protection and Youth Justice. TYSS utilises a key worker model and client centred approach to addressing complex issues which impact on the young person's functioning, identity and role in the community. A multimodal therapeutic approach combined with practical support provides clients with a unique medium to long term support program with the aim of improving long term outcomes for clients who have experienced significant trauma and are at risk of future disadvantage. Data collected since the commencement of the program demonstrates substantially improved outcomes for young people who engage with the program, leading to reduction in future risk and cost to the community as a whole. The data illustrates trends of particular risk issues for these young people and demonstrates gaps in service availability which could inform the allocation of resources for services to young people. The program also demonstrates possibility for improvement in how service delivery to young people could be included in future youth at risk strategies.

TYSS – a complex case management and therapeutic model of service to youth at risk

The Targeted Youth Support Service (TYSS) is a program aimed at providing key worker intensive case management for young people who are highly disengaged, have multiple and complex needs and without intervention are likely to enter the statutory services of Child Protection or Youth Justice. TYSS operates geographically across the State and is provided through partnership between Bapcare and Mission Australia in the South East and South West, with Anglicare providing a similar service in the North and North West (Supported Youth Program). TYSS is funded in all areas through the Department of Health and Human Services Youth at Risk Strategy. This funding provides for service delivery to 70 young people in the Southern regions per year.

Referrals to TYSS are received through the Gateway service and are accepted from professionals, community and young people wishing to access the service. The majority of referrals for TYSS are received from Child Protection, Police and School Social Workers.

TYSS provides medium to long term support and is targeted at young people aged 10-18 years old requiring significant support concerning often complex and multiple needs. These needs may be, but are not limited to, risk taking behaviours, history of trauma, mental health and safety concerns and disengagement from family, school and community. They may also have limited to no support or protective factors. In addition, young people may be faced with multiple risk factors spanning across their individual, family, social, community and school lives.

The program objectives are to work towards improving the developmental outcomes, wellbeing and safety of young people, while reducing risk factors contributing to a pathway into statutory intervention, accommodation breakdown and personal or social disconnection.

TYSS workers practice within a trauma informed and evidence based framework, utilising varied therapeutic interventions which are tailored to the needs of the young person. TYSS workers highly value the therapeutic relationships they develop with young people, and see

this as a key aspect for being able to provide successful and holistic support. The therapeutic relationship which underpins the service promotes an aspect of healing in order to facilitate positive change. Interventions are tailored to the needs of the young person and based on their interests and strengths. For example, facilitating a session with a client which involves pampering and beauty activities, in order to assist self-confidence and identity or engaging the client in equine assisted therapy in order to support emotional regulation and impulse control.

TYSS workers employ the key practice principles of person-centred, self-directed, family, carer and network inclusive, collaborative practice and partnership approach, evidence based and continuous improvement in their day to day work.

TYSS worker will meet clients at their home, in the community, support young people to attend appointments with other services and engage with the young person in spaces they feel comfortable. Clients are welcome to but are not required to meet with workers in an office based environment.

TYSS workers actively promote and work towards engaging young people with their communities and linking them into supports. In order to do this, TYSS workers engage with community organisations collaboratively and work in partnership with the young person to decrease their risk factors across a broad area. TYSS does not target one area, instead meeting the multiple needs and goals of the young person by completing assessments and case plans which are comprehensive and holistic. TYSS workers recognise that young people are not singular, and endeavour to see the young person as an individual within their contexts.

Key Practice values employed by TYSS worker include:

- Empowerment – Valuing choice, participation, responsibility
- Strengths-based – building on existing skills, abilities and opportunities
- Social Justice – Upholding human rights and inclusivity
- Solutions-focus – holistic approach to finding solutions
- Early intervention support – in order to increase opportunities to enable people to achieve their goals, identification of needs and implementing strategies at the earliest point is necessary.

Leading innovation

Historically, youth services much like adult services in Tasmania have been siloed according to area of need. These areas of need include homelessness and housing services, drug and alcohol services, mental health services, education services, and health services. However the TYSS program is innovative and unique in its recognition that none of these issues commonly occur in isolation but rather clients present with complexity and have multiple concurrent areas of need. Whilst other services may recognise the multiple and complex needs of their clients, their service delivery models restrict focus on a particular area of need which does not directly address the complexity. TYSS is unique in that clients are not expected to fit the service model, rather the service model is flexible and adapted to the client's specific needs and addresses any or all of the presenting complexities and areas of need. This service model allows for more specific, targeted intervention at the root cause level rather than addressing symptoms and is unique in Tasmania.

The TYSS model may also be unique worldwide in its approach and lack of targeted intervention. Similar programs exist in the US (Becker, Greenwald, & Mitchell, 2011), UK (Callaghan, Pace, Young, & Vostanis, 2003) and in Australia (Schley, Radovini, Halperin, & Fletcher, 2011) however are either centre based or focused on specific and singular risk areas such as mental health and youth offending. Although the TYSS program does target interventions to address these issues, it is not specifically a youth mental health or offending program but it incorporates these interventions as and when needed. This implies a unique service which holistically addresses youth at risk issues without relying on targeted funding or outcomes.

TYSS provides an outreach model as opposed to many other youth services which are centre based. Although there are some youth services in Tasmania which work to an outreach model, TYSS is unique in that it provides not only practical support but a therapeutic component. Traditionally, therapeutic youth services in Tasmania have been centre based and siloed which does not cater to highly disengaged youth with multiple and complex needs who are unlikely to access such services and outreach based models in Tasmania provide mainly practical support or recreational support.

Theoretical basis

One of the program's unique features is its multimodal approach to therapeutic intervention. Despite being suitably skilled and qualified to be undertaking intensive youth work, TYSS workers are not expected to be highly skilled in all modes of therapy, to be all things to all people so to speak. TYSS workers undertake professional development and coaching to assimilate and apply to their practice the basic principles of various therapeutic approaches to specific client areas of need and to support referrals to specialist therapeutic services where appropriate. This approach is based on the understanding that there is not one single therapeutic approach that is clinically indicated for all clients or for all areas of need. TYSS workers undertake thorough assessment of client need and other factors such as the therapeutic relationship, the client's level of literacy and communication skills, the client's areas of interest and strengths in order to inform the most appropriate therapeutic intervention for that client. The intervention may be based on one or multiple mainstream and alternative therapeutic approaches as a "best fit" for that client.

The following therapeutic approaches and theoretical influences is not an exhaustive list of approaches used but provides an overview of the kinds of specific therapeutic interventions utilised by TYSS workers. An evidence base for each intervention is also provided to demonstrate the use of best practice principles.

Therapeutic approaches:

- The Neurosequential Model of Therapeutics (NMT)

The Neurosequential Model of Therapeutics (NMT) is based on the premise that as the brain develops sequentially from the bottom up, developmental trauma also needs to be addressed using a bottom up approach, targeting the symptoms that align with four areas of the brain: the brainstem, the midbrain, the limbic system and the cortex (Perry, 1997). NMT is not a therapeutic intervention but rather a framework in order to model appropriate therapeutic interventions to resolve clinical problems (Perry & Dobson, 2013). Perry and Dobson (2013) propose that until basic brainstem functions are adequately addressed, the more executive and higher functioning areas of the brain will not respond adequately to therapeutic intervention.

Bruce Perry is a leading expert in the area of developmental trauma and asserts that in order for positive developmental educational and therapeutic experiences to be beneficial, 6 R's need to be established (Perry, 2015).

- Relationship applies to the establishment of safety for the young person.
- Relevance ensures that the interventions are matched to the young person's developmental stage which may not be at the same level as their chronological age.
- Repetition provides patterned input which ensures consistency and predictability leading to assimilation of the experience
- Reward provides pleasure to the experience ensuring maximum investment from the young person
- Rhythm is essential for resonating with the biology of the young person
- Respect incorporates sensitivity to the young person and their family and culture.

Activities that work in line with the principles of NMT are utilised with young people in order to establish the 6 R's. Significant input is made to develop a safe therapeutic relationship between the young person and the worker leading to a level of safety and trust in which

the young person may disclose significant trauma and their primary concerns for support. This also allows for the worker to challenge the young person in aspects of their behaviour and cognition in order to facilitate change. Assessments take into account the young person's age and developmental stage, bearing in mind that the two may not be in line and therefore language, challenges and interventions are targeted to developmental levels rather than chronological age (Perry & Dobson, 2013). Repetition and rhythm are also maintained to ensure the maximum therapeutic advantage. A young person may be exposed to the same experience on multiple occasions thus imprinting a pattern of positive exposure. Activities incorporating rhythm such as playing basketball, swinging on swing sets or drumming are utilised to establish biological synchronicity and regulation such as mimicking heartbeat and stabilising respiration. Activities are also developed to elicit pleasure for the young person, taking into account the young person's interests such as music, art, photography in applying therapeutic interventions. Workers apply the principle of respect in all their activities, being guided by the young person and their family's cultural context.

- Cognitive Behaviour Therapy (CBT)

Mash and Wolfe (2012) describe the underlying principles of Cognitive Behaviour Therapy (CBT) as addressing psychological disturbances as a result of faulty thought patterns through disrupted learning and environmental experiences. Meichenbaum (1977) proposes that the way children and adults think about their environment determines how they will react to it. Mash and Wolfe (2012) state the major goals of CBT to be the identification of maladaptive cognitions and replacement with adaptive ones with a focus on the client being able to regulate their own responses.

Research identifies that CBT is indicated for such problems as depression (Kaufman, Rohde, Seeley, Clarke, & Stice, 2005; Kendall, 1993; Mash & Wolfe, 2012), conduct disorder (Kaufman et al., 2005; Mash & Wolfe, 2012), aggression (Kendall, 1993) ADHD (Kendall, 1993) and anxiety disorders (Kendall, 1993; Kendall & Southam-Gerow, 1996; Mash & Wolfe, 2012; Seligman & Ollendick, 2011). Kendall and Southam-Gerow (1996) and Armelius and Andreassen (2007) also state that CBT is effective in the treatment of adolescent offending behaviours and the reduction of recidivism rates where young people have the opportunity to practice new skills in non-residential setting. (Stice, Rohde, Seeley, & Gau, 2008) state that CBT can also be used as a preventative intervention for young people at risk of developing mental health issues or behavioural issues due to their exposure to risk factors.

CBT is proposed to be the most effective intervention for treating young people living with anxiety (Prins & Ollendick, 2003), trauma (specifically sexual abuse) (Saywitz, Mannarino, Berliner, & Cohen, 2000; Springer & Misurell, 2012) and depression (Kaslow & Thompson, 1998; Reinecke, Ryan, & DuBOIS, 1998). There is limited application for CBT in the treatment of eating disorders such as bulimia (Stice et al., 2008).

Acceptance and Commitment Therapy is a derivative of behavioural therapy based on relational frame theory (Harris, 2009). Like CBT, ACT has clinical applications in such disorders as depression and anxiety. ACT involves the present awareness and thought processes of the client, accepting the painful emotions that come with traumatic events rather than eliminating them, and taking action to live a full life according to the client's value base (Harris, 2009). ACT however requires the client to have the capacity to be present and engage in mindfulness without emotional dysregulation and to have the cognitive capacity to deconstruct thought processes and identify values and therefore this approach is most appropriate following the successful application of therapeutic interventions that target the basic functions of cognition, affect and behaviour.

TYSS workers utilise the principles of CBT through strategies such as identifying and challenging maladaptive thought processes and supporting clients to reframe their thoughts (cognitive restructuring) through positive self talk, increasing social and emotional skills, increasing engagement with pleasant activities including recreation

and personal interests, addressing behavioural issues through analysing the thought processes that precipitate the behaviours, problem solving and positive conflict resolution skills (Cohen, Mannarino, Berliner, & Deblinger, 2000; Kaufman et al., 2005). Game based CBT (Springer & Misurell, 2012) has demonstrated efficacy of adapting CBT principles into activity based interventions which are easily adapted to a non-clinical setting and TYSS workers will often interweave CBT interventions into ordinary activities which increases engagement and application which would not be able to be achieved in an office based environment with highly disengaged young people.

- Trauma Focused Cognitive Behaviour Therapy (TF-CBT)

Trauma Focused Cognitive Behaviour Therapy (TF-CBT) takes the principles of CBT and applies them in specific intervals throughout the process of transforming trauma. Saxe and Ellis (2012) propose 5 phases of trauma processing which include Surviving, Stabilising, Enduring, Understanding and Transcending. CBT is often regarded inappropriate for the treatment of people who have ongoing exposure to trauma (Cohen, Mannarino, & Murray, 2011). However in the stages of understanding and transcending, TF-CBT is helpful for the development of emotional regulation skills and managing the processing of trauma-related cognitions (Saxe & Ellis, 2012). For example, the application of cognitive strategies support identification and regulation of emotion in order to increase emotional vocabulary and therefore the capacity to externalise emotions in a cognitive fashion. Strategies such as thought stopping and reframing cognitions are not appropriate for a traumatised person who has not been able to yet successfully regulate emotion (Saxe & Ellis, 2012). Therefore, TF-CBT utilizes specific CBT principles only where clinically indicated.

The elements of TF-CBT can be summarised in the acronym PRACTICE (Cohen et al., 2011):

- P – Psychoeducation
- P- Parenting skills
- R – Relaxation skills
- A – Affective modulation skills
- C – Cognitive coping skills
- T – Trauma narration and processing
- I – In vivo mastery of trauma reminders
- C – Conjoint child – parent sessions
- E – Enhancing safety

Ideally, TF-CBT is delivered in a structured format, in an office based environment with both the young person and the primary caregiver receiving therapeutic support in individual and conjoint sessions. However, as many TYSS clients do not have a protective or supportive caregiver, the young person receives individual therapeutic support often in community based settings through a conversational model of delivery. Becker et al. (2011) demonstrates the appropriateness and efficacy of delivery of trauma based CBT in community settings and states that this is beneficial when appropriately adapted and presented. The elements of TF-CBT that are utilised with these young people therefore are psychoeducation, relaxation skills, affective modulation skills (emotional regulation), cognitive coping skills, trauma narration and processing (only if the young person is amenable and it is clinically appropriate), in vivo mastery of trauma reminders and enhancing safety. These elements of TF-CBT are often delivered in conjunction with other therapeutic techniques such as exposure therapy (in vivo mastery of trauma reminders), narrative therapy (trauma narration and processing) and mindfulness and meditation (relaxation and affective modulation skills).

TF-CBT can be used with young people who continue to be exposed to trauma (Cohen et al., 2011; Murray, Cohen, & Mannarino, 2013)

and may support the improved management of future trauma through skill development. This also supports the enhancement of safety strategies.

- Mindfulness and relaxation

Emotional dysregulation is a common presentation in TYSS clients due to chronic exposure to trauma and maladaptive coping strategies. Due to the bottom up development of the brain, young people with severe emotional dysregulation are unable to balance cognitive and emotional states and therefore cognitive therapies are not beneficial. In order to efficiently utilise cognitive strategies, emotional regulation must be addressed first. Mindfulness, meditation and other relaxation interventions are useful in the stabilising of emotion and building emotional regulatory skills.

There is a growing body of evidence based support for the use of mindfulness as a complimentary approach to therapeutic interventions such as CBT (Dimidjian & Segal, 2015), TF-CBT (Cohen et al., 2000; Cohen, Mannarino, Kliethermes, & Murray, 2012), exposure therapy (Cohen et al., 2000), narrative therapy (Cohen et al., 2012) and targeted interventions for families, adults, adolescents and children (Coatsworth et al., 2015; Cohen et al., 2000; Mermelstein & Garske, 2014). There is also evidence that mindfulness can be used as an effective brief intervention to reduce risk taking behaviours and improve emotional regulation, emotional awareness and resilience (Mermelstein & Garske, 2014; Watford & Stafford, 2015).

Mindfulness derives from Eastern meditative traditions and involves the practice of attending to, being fully aware of and in touch with the present moment from an objective, non-evaluative and non-judgemental perspective of one's inner experiences (Cohen et al., 2012; Hülshager, Alberts, Feinholdt, & Lang, 2013; Watford & Stafford, 2015). Although it is not specifically a relaxation, it can assist in the ability to engage in relaxation strategies in order to reduce stress and improve emotional wellbeing through the interruption of automatic responses to emotions and thoughts (Hülshager et al., 2013; Watford & Stafford, 2015).

Relaxation and meditation strategies also have an evidence base in the treatment of complex trauma in children and adolescents due to the impact of developing adaptive responses to stress resulting in increased coping and resilience (Cohen et al., 2000). Cohen et al. (2000) state that the development of muscle relaxation and controlled breathing techniques reduces anxiety and hypervigilance in children who have been traumatised. This can assist in basic functional areas such as sleep and concentration but can also be helpful in preparing the child or adolescent to engage in therapeutic work which may elicit physical or emotional tension (Cohen et al., 2000).

TYSS workers apply the principles of relaxation and meditation with clients who have clear presentation of emotional dysregulation which poses a barrier to engaging in cognitive based therapeutic interventions. These principles can be applied to activity based interventions such as colouring and using play equipment with a rhythmic component (swings, see-saws) etc. During these activities the workers can engage in conversation with the young person in a less confrontational manner which requires eye contact and by doing so can reduce the physical and emotional tensions that can arise from purely talk based activities. More sophisticated interventions such as the practice of controlled breathing and the use of biofeedback instruments can be utilised with young people who have some ability to emotionally regulate in order to be exposed to relaxation in a controlled environment. Young people who have the demonstrated ability to engage in some relaxation can then be coached in more structured relaxation through the use of meditation techniques. And finally, mindfulness can be introduced to young people who are able to engage in relaxation without attunement and attention eliciting stress responses.

TYSS workers develop therapeutic plans to address relaxation and emotional regulation based on the young person's capacity and level of dysregulation alongside activities that are pleasurable and do not elicit extreme stress responses. This allows the young person to have

a level of control in the activity they engage in and also allows the worker to introduce enjoyment and relaxation experience subtly. The desired outcome from meditation, relaxation and mindfulness exercises is twofold. The first outcome is to create an emotional environment which feels safe for the young person to engage in more challenging therapeutic exercises and to expose the young person to pleasurable experience which does not result in reinforcement of traumatic experience (as often children exposed to trauma associate pleasure with pain). The second outcome is the development of adaptive emotional responses to stress, leading to improved resilience and emotional wellbeing which then can support the reduction of maladaptive post-traumatic stress responses to ongoing trauma.

- Narrative Therapy

Narrative therapy has many clinical applications to support clients to develop and articulate a narrative around their experience and to support clinicians to identify themes and problematic cognitions. Narrative therapy is most commonly used in a traditional counselling setting however there is opportunity for creative application in outreach and youth work settings.

Narrative therapy is specifically indicated for clients who have experienced traumatic events and can be a powerful tool to process not only the trauma but the client's responses to the trauma. Through narrative, clients can develop a trauma vocabulary through non-verbal mechanisms as well as written and verbal techniques. This not only provides developmental benefit to the client but also allows the practitioner to develop an understanding of the client's trauma experience from the client's perspective and therefore provide essential empathy and validation toward the client's experience. The benefit of narrative therapy is that it revolves around a trauma theme rather than a specific traumatic event thus reducing the risk of retraumatisation that can occur in revisiting an unresolved event. Narrative approaches assist clients to make meaning from events and engage in discourses which realign attributed causation to external rather than internal factors (Toolis & Hammack, 2015). This can assist in reducing internalised emotions such as guilt and shame as a result of complex trauma being attributed by the client to themselves rather than the actions of others. For example, a young person may commence therapeutic intervention following a sexual assault with a narrative that states they were assaulted because they deserved it and result in a narrative which states that they are worth being treated with respect and the offender is solely responsible for their behaviours. Specific experiences related to the trauma such as cognitions, behaviours, and feelings are woven into the core theme (Cohen et al., 2012). Cohen et al. (2012) states that due to the fragmented nature of traumatic memory, narrative therapy can provide a means to integrate memory, emotions, thoughts and behaviours into a linear story.

TYSS workers have adapted narrative approaches in their work through such approaches as life story work and journaling. Life story work can take the form of drawings, photographs, collages and written media to externally express a traumatic theme or event. Journaling can be used as an expressive tool to allow clients to put into words their thoughts and feelings without the perceived judgement or misunderstanding that can be a barrier to traditional talk therapies. The client may choose to share some or all of what they write with their worker or others however they have the power to keep their writing private. Clients who have experienced trauma often have difficulties with trust and therefore doing this can reduce the physical and emotional stress that internalisation of these thoughts and feelings or sharing their story with others can cause (Cohen et al., 2012). Journaling and life story work can also provide the benefit of reflection on events once an event has been processed or cognitively restructured so that a client can then identify the progress they have made. Journaling has a strong evidence base as an effective complimentary therapy for traumatised clients when used alongside CBT and TF-CBT as the only alternative intervention which successfully reduces depressive symptoms (Stice et al., 2008).

The advantage of creatively applying narrative approaches into outreach work is that clients and workers can add to the narrative at

their own pace without the pressure of having to achieve intensive outcomes within a clinical therapeutic session. Pleasurable activities that tie into the client's own interests can also be utilised to apply this approach (such as photography, scrapbooking, art, music etc.) (Cohen et al., 2012).

- Exposure therapy

Exposure therapy is most commonly clinically indicated in the treatment of Post-Traumatic Stress Disorder (PTSD) (Cohen et al., 2000; Foa, Gillihan, & Bryant, 2013) but can also be used to treat specific phobias and anxiety (Mash & Wolfe, 2012). It is usually delivered in a clinical setting however the principles of exposure therapy can be utilised in non-traditional therapeutic settings as part of an overall trauma focused therapeutic intervention (Cohen et al., 2000). Exposure therapy falls under the category of Behaviour Therapy and is targeted specifically at phobias and anxiety as a result of trauma through exposing the client to what frightens them whilst providing adaptive coping skills rather than avoidance and escape (Mash & Wolfe, 2012). The process of exposure is gradual with exposure stimuli graded from least to most anxiety producing (Mash & Wolfe, 2012). As a client becomes able to tolerate a stimulus using adaptive coping techniques provided through TF-CBT, the exposure is then moved to the next stimulus up the list until the most anxiety producing stimulus no longer provokes an anxiety response. Exposure therapy is cited to be more effective than non-trauma-focused therapies (Foa et al., 2013) and is often used in conjunction with TF-CBT (Cohen et al., 2000; Foa et al., 2013). Exposure therapy differs from systematic desensitization and flooding as it is more gently applied and neither of these approaches are indicated for complex trauma but more generalised anxieties and phobias (Mash & Wolfe, 2012).

Careful assessment and significant relationship building occurs between the TYSS worker and the young person prior to attempting any exposure based therapy. It is not routinely used with TYSS clients who have not established a level of emotion regulation. It is important to note that before exposure therapy can be considered as appropriate, the young person needs to have demonstrated the ability to utilise adaptive coping strategies in stressful situations that do not involve trauma triggers. Cohen et al. (2000) however states that through the process of repeated exposure, reminders of the initial trauma become less emotion laden over time which results in an unpairing of thoughts about the trauma and overwhelming negative emotions.

A useful aspect of exposure therapy is that it does not require the young person to revisit the traumatic event per se but can have a deleterious effect with trauma triggers. Caution is taken in regard to possibly being exposed to retraumatisation, although Foa et al. (2013) states that there is no evidence of adverse side effects from exposure therapies. TYSS workers liaise closely with the young person around their list of stimuli, ensuring that the client is empowered to determine the levels at which they are willing to be exposed and have the ultimate say in whether to go ahead. This choice and control ensures that the young person feels ready to face their fears at their own pace and the very act of taking control can be a powerful one for these young people who have had little control over many aspects of their lives to date.

- Pro-social modelling

Pro-social modelling refers to the way in which workers model pro-social values and behaviours in their interactions with clients (Trotter, McIvor, & Raynor, 2007). Children who are developmentally supported in their family naturally assimilate the social values their family members model however children and young people who have experienced adverse events or are exposed to chronic pro-criminal or anti-social behaviours and values tend to assimilate these into their attitudes and behaviours. Pro-social modelling provides an opportunity for these young people to be exposed to positive and pro-social behaviours as an exception to their norm and due to the novelty and under repeated exposure combined with positive reinforcement, they are more likely to take on pro-social behaviours themselves.

Cherry (2005) states that the worker's behaviours and attitudes in their interactions with the client promote prosocial behaviour whilst discouraging antisocial behaviour and attitudes.

Due to the intensive nature of the TYSS role, workers are provided with extended opportunity to model prosocial behaviours both in their interactions with the client but also during interactions with others whilst the client is present. TYSS workers are mindful of their own values and behaviours whilst accompanying a client and can utilise naturally occurring situations and interactions to model these behaviours. For example, supporting a client to interact with a Centrelink worker may involve role play and rehearsal of positive interaction which is then reinforced through a positive outcome in that real life interaction as opposed to the client's known experience of conflict in such an interaction.

Prosocial modelling also provides the opportunity for workers to explore with the client what their value base is and what "pushes their buttons" in order to cognitively restructure attitudes that often result in conflict, antisocial behaviour and negative outcomes for the client. The use of prosocial modelling also provides opportunity for workers to support the young person to develop their communication skills such as being able to articulate their wants and needs in a verbal way rather than using sometimes maladaptive behaviours.

- Recreational and physical activity

Although TYSS is not specifically a recreational program, the workers do recognise the important role that recreation and physical activity can play in working with young people who have multiple and complex needs. Recreational and physical activities deviate from the traditional talk based therapies in clinical settings in which the young person would be expected to engage in direct eye contact and conversation for extended periods. Young people with behavioural and emotional regulation issues find this extremely difficult and therefore it is likely to be ineffective or sustainable. Diversions such as activities can incorporate some talk based interventions simultaneous to the activity, increasing the likelihood of engagement but also providing a physical outlet for emotional distress which is constructive. Physical activity also has the benefit of releasing endorphins which increased feelings of self efficacy and wellbeing (Doucette, 2004). Doucette (2004) states that combining the counselling process with mild aerobic exercise is an effective intervention for behaviourally challenged youth, particularly between the ages of 9 and 13. Evidence presented by (Doucette, 2004) indicates that combining talk based therapies with physical activity supports young people to explore alternative behavioural and increased prosocial choices and learn new coping strategies and life skills.

Common activities that TYSS workers engage in with young people include fishing, playing basketball or soccer, martial arts, swimming and gym based activities. Brokerage is often used to support clients to engage in recreational activities outside of the therapeutic relationship given the health and wellbeing benefits of such activities and the diversional role they can play in restricting opportunity for antisocial and pro-criminal behaviours.

Theoretical influences

- Attachment theory

Attachment theory was developed by John Bowlby and Mary Ainsworth in the 1950's, combining influences from ethology, cybernetics, information processing, developmental psychology and Freudian psychoanalysis (Bretherton, 1992) The underlying premise of attachment theory is that a child who forms an enduring social-emotional relationship to an adult (usually the mother) is more likely to survive (Kail & Cavanaugh, 2000). Since this time, attachment theory has seen further development and application in the clinical setting. Kail and Cavanaugh (2000) identify four primary types of attachment relationships:

- Secure attachment:
- Avoidant attachment

- Resistant (ambivalent) attachment
- Disorganised (disoriented) attachment

Secure attachment is considered to be the result of healthy interactions and bonding between adult and child. Disruptions to this process can result in avoidance, ambivalence or disorientation which present in multiple maladaptive ways. Patterns of attachment have been linked to specific psychological and behavioural presentations such as depression (Jakobsen, Horwood, & Fergusson, 2012), anxiety (Brumariu & Kerns, 2010; Esbjørn, Bender, Reinholdt-Dunne, Munck, & Ollendick, 2012; Jakobsen et al., 2012; van Eijck, Branje, Hale III, & Meeus, 2012), phobias (Brumariu & Kerns, 2010), emotional regulation (Brumariu & Kerns, 2013; Esbjørn et al., 2012), adolescent behavioural problems (Daubs, 2013) and peer competence (Brumariu & Kerns, 2013). Secure attachment is considered to be instrumental in the development of positive interpersonal relationships throughout the life span (Kail & Cavanaugh, 2000). Evidence supporting the linkages between insecure attachments has formed the basis for the classification of specific disorders such as reactive attachment disorder and separation anxiety disorder for inclusion in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) and International Classification of Diseases (World Health Organization, 1992).

Attachment theory has formed the basis of specific structured therapeutic interventions, particularly aimed at early intervention approaches with mothers and babies and children who have experienced disruption in their attachment. The focus of attachment focused therapies is to establish a secure base to which the client can return for comfort and reassurance in times of distress (Cooper & Hoffman, 2011; Hughes, 2007). The therapeutic relationship can be considered to model secure attachment given the inherent safety that is established between therapist and client which may not be present in other relationships (Hughes, 2007).

- Maslow's hierarchy of needs

Maslow's hierarchy of needs is a graphical representation of one's physical, emotional and spiritual needs which must be met in order for one to achieve fulfilment, referred to as self-actualisation (Maslow, Frager, Fadiman, McReynolds, & Cox, 1970). The hierarchy forms a bottom up approach to fulfilment with the most basic needs forming the foundation for which more executive needs such as social and emotional fulfilment can be built upon.



Figure 1 - Maslow's hierarchy of needs

TYSS applies therapeutic principles alongside Maslow's hierarchy of needs (Maslow et al., 1970) to establish baseline stability and increasing the level of complexity of therapeutic intervention according to the young person's level of functioning and therapeutic needs. For example if the young person's basic care and biological needs are not being met (such as food, housing and clothing) then the next step of meeting their emotional needs cannot be adequately

addressed. Likewise if their emotional needs are not being met and their limbic system is in stress response cognitive strategies will continue to be ineffective. TYSS workers focus on a linear approach of establishing relationship, addressing basic needs, safety, then building emotional regulation followed by more executive therapeutic approaches culminating in adaptive coping strategies and resilience. This approach is in line with TF-CBT which states that establishing safety is the first step in any effective therapeutic intervention (Cohen et al., 2012) and the NMT approach (Perry & Dobson, 2013).

- Stages of Development

There are multiple theories which have been developed in order to explain the stages of development across the lifespan. These include the psychodynamic theory (Erikson, 1980), Learning theory based on behaviourism (Skinner, 1938; Watson, 1928) and social learning theory (Bandura & McClelland, 1977), Cognitive theory (Kohlberg, 1976; Piaget, 1964), Ecological systems theory (Bronfenbrenner, 1994) and Life cycle theory (Duvall & Miller, 1985). Each theory proposes a view of the stages of development however in terms of developmental theory, the biological view is the one most referred to when assessing the developmental stage of a child or adolescent (such as meeting milestones). However it is well established that adverse events and trauma causes detrimental effects to physiological, psychosocial and emotional development.

In the context of working with children and adolescents who have experienced trauma, it is important to assess all aspects of development with a trauma-informed lens. That is, taking into account the age and stage of development, being aware of typical developmental trends in children and young people and utilising knowledge based on brain development and the impacts of childhood abuse and neglect in neurodevelopment (American Academy of Child and Adolescent Psychiatry, 2008). Examples of neurotypical versus trauma-informed development can be found in resources such as the Every Child, Every Chance Child Development and Trauma Guide (Victorian Government, 2007) and Facts for Families Guide (American Academy of Child and Adolescent Psychiatry, 2016).

- Neurobiology of complex trauma

Everyone experiences some degree of trauma throughout their lives whether it be grief or loss, assault or accident, or natural disaster such as flood, fire or earthquake. These events are identified as simple trauma and whilst they can be extremely distressing and can result in psychopathology there is a simple cause and effect relationship due to an isolated but real and imminent threat to life and safety. Complex trauma is chronic exposure to adverse events and threat to life or safety and involves a relational component. This includes experiences such as chronic sexual abuse, exposure to family violence, repeated physical abuse and chronic neglect. The repeated nature of these events across multiple time periods can have significant detrimental effects on the developing brain (Perry, 2006; Van der Kolk, 1996) and therefore complex trauma is often referred to as developmental trauma.

A basic understanding of the neurobiology behind emotional regulation can provide invaluable insight into behaviours that are considered to be problematic. Callaghan et al. (2003) describes oppositional behaviours and defiance to be related to emotional problems, self harm, peer and family relationship difficulties and school non-attendance. Ollendick and Benoit (2012) further explains that oppositional behaviours can present when the child or adolescent is trying to avoid anxiety producing situations. These examples illustrate the inextricable link between emotional regulation and behaviours in traumatised children and adolescents.

Under normal stress conditions, the sympathetic nervous system is activated in order for the body to respond in a life preserving manner. This is often known as the fight or flight response (Jansen, Van Nguyen, Karpitskiy, Mettenleiter, & Loewy, 1995). Perry, Pollard, Blakley, Baker, and Vigilante (1995) expands on this concept by including the freeze and faint response to stress. The fight and flight responses are a hyperarousal response to the stressful stimuli in which

the body prepares for action whereas the freeze and faint responses are hypoarousal responses in which the body “plays dead” or “plays possum” in order to divert the threat. During this sympathetic response, energy is focused on basic brainstem functions such as respiration and heart rate and functions such as cognition and emotion are inhibited. This is followed by a release of adrenaline and a parasympathetic response which returns the body to a state of homeostasis once the threat has passed.

As a result of chronic exposure to stressful stimuli such as repeated, chronic abuse and trauma, the brain does not quickly return to homeostasis as the threat is ever present and this results in prolonged states of hyper or hypoarousal. This can be likened to a smoke alarm which is hypersensitive and is triggered by air movement not just the presence of smoke. Every time the alarm goes off, the body responds as though there is imminent threat. Siegel (2010) illustrates this phenomenon with the Window of Tolerance (Figure 2).

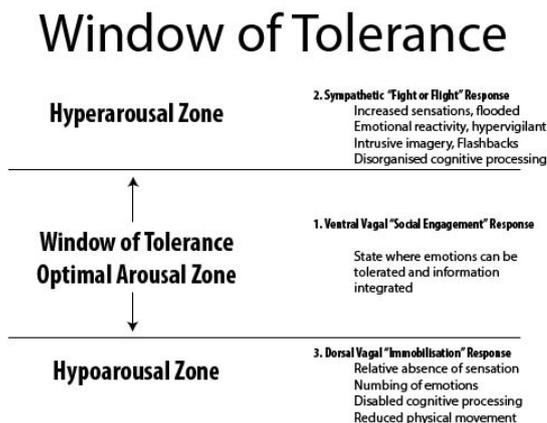


Figure 2: The window of tolerance (Dahlitz, 2015)

Children and adolescents who are exposed to chronic trauma have a very narrow window of tolerance in which they are able to be open to experience and function within neurotypical parameters. When the window is very narrow, hyper or hypoarousal can be triggered by the smallest of stimuli which activate traumatic memory, during which challenging behaviours can present (Dahlitz, 2015). An example of a hyperarousal response would be oppositional (fight) or defiant (flight) behaviour. Hypoarousal may present as dissociation. Either response is a reflexive reaction and is not premeditated (Dahlitz, 2015; Siegel, 2010). Understanding these responses to stress is vital in preparing trauma-informed responses and therapeutic interventions to problematic behaviours and emotional dysregulation.

A wealth of research based evidence is now available which demonstrates the direct linkages between exposure to developmental trauma and problematic presentations in children and adolescents, even after the exposure has ceased and safety has been established (Anda et al., 2006). Complex trauma results in the loss of core capacities for self-regulation and interpersonal relatedness (Cook et al., 2005). Reading (2006) states that psychosocial stress in childhood has profound effects on brain chemistry and morphology which are long lasting and permanent. Cook et al. (2005) further states that exposure to complex trauma often results in lifelong problems that increases vulnerability to further trauma across the lifespan.

The following is a very brief summary of some of the evidence based effects of exposure to complex trauma:

- Chronic exposure to violence and poverty leads to rage, distrust and hopelessness (Greene, 1993)
- Chronic, cumulative trauma impairs the establishment of interpersonal trust (Greene, 1993)
- Childhood maltreatment has been linked to a variety of changes in brain structure and function, impacting on health and emotional wellbeing (Anda et al., 2006)

- Young people who have experienced sexual abuse, physical abuse and parental mental health issues have increased dissociative symptoms (Tyler, Cauce, & Whitbeck, 2004)
- Insecure attachment to the mother significantly increases the development of externalising behaviours in adolescents exposed to family violence (Daubs, 2013)
- Parental alcohol problems leading to neglect predict early adolescent drinking and risk taking behaviours including other substance use (McMorris, Tyler, Whitbeck, & Hoyt, 2002)
- Children who experience coercive and abusive behaviours within their family are at high risk of being rejected by their peers, often resulting in association with nonconventional peers (Tyler, Whitbeck, Hoyt, & Yoder, 2000)
- Adolescents who have experienced family abuse are more likely to become homeless at an early age and spend time on the street (Tyler & Cauce, 2002; Tyler et al., 2000)
- Many adolescents who become homeless have experienced physical and sexual abuse and have dysfunctional families with little social support (Tyler et al., 2000; Whitbeck, Hoyt, & Ackley, 1997)
- Adolescents who become homeless as a result of dysfunctional home environments continue on trajectories that lead to participation in health compromising activities (Tyler et al., 2000)
- The amount of time that youth live on the street is positively correlated with deviant subsistence strategies and behaviours such as substance abuse and risky sexual behaviours (Thrane, Hoyt, Whitbeck, & Yoder, 2006; Tyler et al., 2000)
- *Working in relationships* – between professionals and families in order to find the best outcomes for vulnerable children and young people;
- *Munro's Maximum: Thinking Critically and fostering a stance of inquiry* – being open to other possible ways of knowing and resisting the attempt to treat one view as 'the truth';
- *Landing grand aspirations in everyday thinking*- Ensuring constructive outcomes by documenting client and practitioner experiences of what good practice looks like.

SOS utilises a range of tools such as SOS Mapping Sheets, Three Houses, wizards and fairies, aimed at different client contexts, age groups and purposes (Stanley, McGee, & Lincoln, 2012). There is a considerable amount of data supporting the use of SOS in the context of child welfare work, relating to increased job satisfaction, increased service recipient satisfaction, and better case management and workplace culture (Scerra, 2012).

Although the SOS approach was designed to work within a statutory context and with children and families, the TYSS program has made some practical applications of some of the aspects of the framework in the development of the assessment and intervention case planning tool. In particular, the scaling question on the mapping tool has been incorporated into the case plan to support clients to map their progress over their engagement with TYSS. Appreciative enquiry style questions are used in all stages of assessment and intervention with TYSS clients. For younger clients, the three houses and wizard and fairy tools have been useful in supporting clients to identify their wants, needs and deficits. The mapping tool is also used in cases where Child Protection becomes involved in order to assess the worries and what is working well for the child in the context of their family.

- Strengths based interventions

Strengths based approaches are widely utilised across a diverse range of interventions. The strengths perspective and strengths-based approaches offer service providers ways of working that focus on strengths, abilities and potential rather than problems, deficits and pathologies (Chapin, 1995; Early & GlenMaye, 2000; Saleebey, 1996; Weick, Rapp, Sullivan, & Kisthardt, 1989). Strengths Based Approaches recognise that every person, child, family has strengths, abilities and resources which can be used to facilitate positive change. Solutions are found through exploring exceptions to the bad and supporting clients to recognise their capabilities.

Scerra (2012) and Hammond (2010) describe the underlying principles of strengths based practice which are summarised as:

- Every person and community has strengths and potential and the focus is on these strengths rather than limitations
- Capacity building is a process and a goal
- Interventions are based on client self-determination. That is the client is the expert in their own life.
- Collaboration and authentic relationship are essential
- Change is inevitable and all people have the capacity to learn, grow and change.

TYSS workers operate under the principles of strengths based approaches. For many young people, their experience of interactions with people and the community has resulted in negative language, blame and pathologising. The strengths based approach allows workers to draw on the inherent capacity, capabilities and resilience demonstrated by the young person to work towards positive change.

- Client centred practice and Client centred case planning

Client centred practice stems from the work of Carl Rogers who states that if certain conditions are present in the worker-client relationship such as congruence, positive regard and empathic understanding, then growthful change will occur with the client (Zastrow, 2003). Client centred practice places the person at the centre of the therapeutic relationship, demonstrating genuineness and sensitivity, and promoting the idea that the client is the 'expert of their own lives'. A core principle underlying client centred approaches is that change is

Best practice intervention models

From a quality perspective, the program places a strong focus on practice based on research and best practice models of intervention. Key elements of the program are measured against a research base in order to demonstrate that the program is in line with current best practice models and to identify any areas of potential improvement.

Greene (1993) suggests 9 key elements of successful youth intervention programs. These elements are:

- street outreach and referral
- needs and interests assessments
- provisions for supportive, personal relationships with adults
- availability of role models
- peer group discussions
- family interventions
- neighbourhood projects
- education and job preparedness training
- program objectives.

Greene (1993) also asserts that youth programs should utilise young people in the program planning and operations to ensure relevance to the cohort.

The TYSS program utilises principles from a variety of best practice based approaches. The following is an overview of the best practice influences within the program.

- Signs of Safety

Signs of Safety (SOS) is a practice framework which has widespread use locally and internationally and was developed in Australia by Andrew Turnell and Steve Edwards (Turnell & Edwards, 1999). SOS utilises a strengths based approach and appreciative enquiry which enables families, children and young people to discover their goals, responsibilities and strengths (Turnell & Edwards, 1999). SOS is a collaborative approach which was initially developed to target Child Protection services and is aimed at enhancing practitioner competence across the child welfare and family and community sectors, in order to reduce historical practices considered paternalistic (Turnell, 1998). SOS utilises three core practice principles (Pecora, Chahine, & Graham, 2013):

more likely to occur if it is driven and directed by the client rather than imposed by outside influences. Rogers believed that our basic nature is inherently good and if a person can be free from outside influence attempts then that person can become sociable, cooperative, creative and self-directed (Zastrow, 2003). Connolly and Joly (2012) state that the overwhelming use of client centred practice in youth work is a key element of success in outreach based youth work.

Client centred case planning draws on the principles of the strength based and client centred approaches by focusing on the client's identified goals rather than the practitioner's or other's problem focused objectives. Case planning in the TYSS program involves the practitioner undertaking a risk assessment and developing therapeutic plans for the client but the goals are set solely by the client. The worker supports the client to develop key steps to achieving their goal. The worker utilises the strengths assessment components of the targeted assessment tool in order to inform the core capacities of the client that will support achievement of these goals.

- Complex Case management

Case management involves the processes of assessment, planning, advocacy and referral. Zastrow (2003) describes the role of a case manager as linking clients to needed resources and orchestration of timely service delivery as well as functioning as brokers, facilitators, linkers, mediators and advocates. Zastrow (2003) further states that case managers must have an extensive knowledge of community resources, client rights, policy and procedure, taking on the primary responsibility for the client.

Complex case management is required when a client has multiple complex issues and barriers to accessing services and is often identified through high levels of disengagement. Due to the eligibility criteria of having multiple and complex needs and being highly disengaged, TYSS clients fall under the category of requiring complex case management.

Central to the role of complex case management is the ability to develop a strong therapeutic relationship with the young person in order to facilitate other aspects of the case management role. The therapeutic relationship is considered to be crucial for the successful treatment of traumatised adults and children as a change mechanism (Ormhaug, Jensen, Wentzel-Larsen, & Shirk, 2014; Seligman & Ollendick, 2011) and can be defined as agreement on goals, task collaboration and an emotional bond (Bordin, 1979). Evidence suggests that the single factor of a positive therapeutic relationship is directly linked with client outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011; Seligman & Ollendick, 2011) and therefore the relationship can be considered as therapeutic in itself. A foremost reason for this is that the experience of trauma alters core assumptions around the safety of the world and the trustworthiness of people (Ormhaug et al., 2014) and the exposure to a positive relationship in the therapeutic alliance challenges these assumptions. Establishing a trusting relationship is essential for developing a sense of safety (Cohen et al., 2012; Schley et al., 2011) Secondly, due to the experience of trauma, the client may be hesitant to engage and the ability to overcome this reluctance can be critical to therapeutic outcomes (Ormhaug et al., 2014; Perry, 2006; Seligman & Ollendick, 2011). Subsequent to this, further examination of the relationship between worker and client can empower them to take steps toward accessing further services (Connolly & Joly, 2012).

TYSS workers invest a significant amount of time in establishing and then strengthening the therapeutic relationship with clients prior to commencing any further therapeutic work. During this initial phase, some case management support may be required to establish safety and ensure basic needs are met however these practical supports also assist in hastening the development of the therapeutic alliance. Workers provide the young people opportunity to "test" the therapeutic relationship and in doing so establish trust and safety which provides the cornerstone for the therapeutic interventions to follow.

Further aspects of complex case management TYSS workers engage in include advocacy for young people in times that they require support to articulate their needs, facilitated and supported referrals including "warm handovers", establishment of care teams and involvement in case conferencing, and client centred case planning.

- Trauma informed practice

Trauma-informed practice takes trauma into account within a comprehensive treatment approach that can be applied to a range of presenting problems (Becker et al., 2011). Given the high number of trauma affected clients in the TYSS program, a key best practice approach in service delivery is trauma informed practice. The use of a trauma informed approach with all clients ensures the best possible service delivery regardless of whether a trauma history is known. The multiple and complex needs of clients alongside the numerous risk factors indicate that a trauma history is likely. Evidence suggests that hard to reach disenfranchised urban children can benefit from trauma informed treatment when it is appropriately adapted and presented (Becker et al., 2011).

Principles of trauma-informed practice include (Mahoney, Ford, Ko, & Siegfried, 2004):

- Emotion identification, processing and regulation
- Anxiety management
- Identification and alteration of maladaptive cognitions
- Interpersonal communication and social problem solving

TYSS operations and practice are based on the Best Interests Case Practice Model (Miller, 2010) which provides a trauma informed framework and summary of developmental indicators of exposure to trauma. This provides TYSS workers with a developmental and trauma informed approach to meeting the young person's need based on their presentation rather than chronological age-associated factors (Perry & Dobson, 2013).

- Key worker and Outreach based youth programs

Key worker models and outreach based youth programs are increasing in commonality both locally and overseas. Greene (1993) states that young people need ongoing exposure to adults with whom they can identify and for many young people, a youth worker is the only positive adult role model in their lives. (Greene, 1993) further states that given the chaos that surrounds at risk youth, a youth worker can instil a faith that adulthood can be ok. This supports the use of key worker models in which one trusted professional adult is the key liaison between services and young people, acting as both a buffer and an advocate.

Connolly and Joly (2012) state that outreach involves locating youth in their own environment with the goal of connecting them with services that meet their needs. Outreach reduces the barrier of the requirement for the young person to keep appointments in an office based setting. Successful outreach can be measured by the development of rapport through which the client's needs are met and by empowerment of the young person to take further steps in accessing services (Connolly & Joly, 2012).

However, many youth programs that involve a key worker and outreach component are targeted at a specific risk cohort of young people. In the UK, primary mental health workers perform the key worker role in an outreach based service targeting young offenders (Callaghan et al., 2003). Youth Offending Teams (YOTS) take a mental health approach to the reduction and prevention of youth offending, attempting to link young people in with Child and Adolescent Mental Health Services with the underlying premise that young offenders have extensive mental health needs which are largely unmet by traditional services (Callaghan et al., 2003). In the US, a community outreach service targeted disenfranchised youth in an urban area utilising a trauma-informed treatment program (Becker et al., 2011). The focus of this program was to reduce the presence of post-traumatic stress symptoms within a culturally diverse area. In Australia, the Intensive Outreach Mental Healthcare (IOMHC) service provides assertive community treatment, assertive outreach and

intensive case management with a focus on mental health within the difficult to engage and high risk youth cohort (Schley et al., 2011). These service models illustrate the effectiveness of community outreach based service delivery and the outcomes demonstrate effective use of key worker models in siloed mental health and youth offending services. It is likely that the specific targets of these programs is due to the funding streams they are delivered through.

The TYSS program utilises a key worker and outreach model of practice without focusing on a specific target group. Due to the funding agreement covering such departmental areas as Education, Housing, Youth Justice and Child Protection, TYSS workers are able to work in a more holistic manner with young people who may fall into one or more of these categories thus enabling them to address multiple and complex needs. The key worker approach provides the young person with some ownership over the therapeutic relationship and the outreach component addresses the hard to reach and highly disengaged components whilst building service awareness through word of mouth amongst the peer group of the young person. A comprehensive review of the literature on key worker and outreach models was unable to identify a similar holistic approach such as the TYSS program.

- Culturally sensitive practice

TYSS has received very few referrals for culturally and linguistically diverse young people. No referrals have been received for non-English speaking young people and the majority of CALD clients have been of aboriginal descent. For many of these aboriginal clients, their aboriginality may not have been identified until later in the assessment stage (Post-Gateway), meaning that their CALD status has not been recorded in the data. The migrant resource centre provides specialist youth services for the CALD community and this may account for the majority of cases which might have been referred to TYSS. Additionally, IFSS may have received referrals for the CALD community which included adolescents but did not require the level of support that TYSS provides. A study by Connolly and Joly (2012) indicates that low uptake of culturally diverse youth is a common factor in youth outreach services.

Having said this, TYSS workers engage in cultural sensitive practice development opportunities and training and cultural issues are a key component of the initial and targeted assessment and ongoing case planning approaches. Regardless of whether cultural diversity is known during assessment, TYSS workers work in a manner which supports culturally sensitive practice. The elements of client centred practice and client centred case planning take into account the client's needs in their specific cultural context, taking into account factors such as cultural identity, personal identity, connection to community, gender diversity and spiritual beliefs.

- Ethics in youth work

There are multiple ethical frameworks that apply to TYSS practice. Some TYSS workers have a degree in Social Work and therefore are subject to the Social Work Code of Ethics (Workers, 2002). There are also reference resources which detail desired ethical frameworks for youth workers (Banks, 2004, 2012; Sercombe, 2010).

Youth workers however did not have a national standard of ethics as this was determined by state. In 2012, the Youth Network of Tasmania responded to this gap and issued a consultation process on developing a Youth Ethics Framework for Tasmania (Gaynor, 2012). TYSS staff were involved in the consultation process which resulted in an ethics framework which was adopted state-wide (Youth Network of Tasmania, 2013). The key ethical areas covered in the framework are:

- The youth is the primary client
- Ecological and structural influences
- Equity
- Empowerment
- Duty of Care

- Anti-corruption
- Transparency
- Confidentiality
- Co-operation
- Knowledge
- Self awareness
- Boundaries
- Self care
- Professional awareness

Clearly, the framework is comprehensive in its coverage and although it is not a prescribed framework, the areas covered by the framework complement and consist of key elements of effective youth work practice described above. TYSS workers have engaged in forums and professional development around the framework and ethics is also a regular topic of conversation in individual and group supervision to ensure that best practice is continually applied.

Evolution of the program

The TYSS program has seen several changes since it was piloted in 2010. Initially, two full time TYSS workers were employed with a capacity caseload of 10 clients each, allowing for half a day per client of intensive support. In 2011, additional funding was obtained to increase the number of employees to 2.6 FTE which increased our capacity from 20 to 26 clients at any given point. Despite the increase in capacity, the program was regularly at capacity and at multiple points in time, referrals have been declined at the intake stage due to no capacity which indicates that the need far outweighs the capacity of the program to work with all clients who would meet eligibility for the program.

It was decided in the early stages of the program rollout that due to the high level of risk and disengagement, Bapcare would not hold wait lists for TYSS clients. In order to manage capacity restrictions, referrals that exceeded capacity were prioritised based on level of risk, level of disengagement and the level of family support. The rationale for this was the immediacy of need and that alternative referrals were preferable to clients waiting for a service. Clients who were still residing within the family unit were considered for the Integrated Family Support Service in the interim until capacity became available. Other services such as Save the Children (where bail orders were present) and Reconnect were utilised with strong collaboration between the two services. Prior to funding dissolution, specialist case management services such as Youth Connections were considered for clients who were highly disengaged from school but were lower in risk in other areas. Mentoring services such as Whitelion were also considered for clients who were lower in risk however changes to the operations of this program, many clients over the past 2 years were ineligible for this service due to a lack of Child Protection involvement. Due to the need to investigate other points of referral, the TYSS program has been able to report back to government on identified gaps in service delivery resulting from cessation of services and changes to operations.

Part of the TYSS role has included involvement in youth networking meetings and key youth events. The TYSS program has developed a strong working relationship with the Glenorchy City Council and is a regular sitting member of the Youth Action Network of Glenorchy. Given the high number of referrals coming from the Glenorchy municipality, this networking has provided opportunity for access to additional support for young people in the area. The TYSS team have also had regular involvement in youth networking events such as Gig in the Gardens, National Youth week, Mental Health week, Drug and Alcohol week, Youth Homelessness Matters day in which marketing of the program to other services and youth alike has increased program awareness in the community and amongst young people. Other key collaborations have been with the Hobart City Council (Youth Action Priorities meetings), the Huon Valley Council (Youth Inclusion Network), Kingborough Council (Youth Action Network of Kingborough) and the Youth Network of Tasmania. TYSS has been represented at State-wide Youth Conferences in Hobart and Launceston holding stalls in collaboration with Mission Australia.

As part of providing wraparound service to clients, TYSS workers engage in collaborative practice with other services. Reconnect provide a 2 worker model and in the instance where TYSS was already working with a young person, Reconnect provided a worker for the family whilst the TYSS worker continued work with the client as part of this model. This prevented a double up in service and continuity of care for the client. TYSS has also established a strong working relationship with Pulse Youth Health Centre who provide additional supports to TYSS clients through their programs and who also refer to the TYSS program. TYSS also worked strongly with the Kingborough Council facility YSpace before this service ceased. TYSS workers also have a positive working relationship with the various Early Intervention police officers in Hobart and Glenorchy as well as alternative education providers at Huonville, Cosgrove, Kingston and Montrose Bay High Schools. The establishment of care team meetings for particularly complex cases has become standard practice, with the TYSS workers playing a key role in the decisions around supports to the young person. TYSS workers have also established a positive working relationship with Clare House and access not only assessments for clients but utilise their facility for secondary consultation where clients do not meet the eligibility for CAMHS.

In early 2015, the TYSS program introduced a pilot of a Therapeutic iPad. The iPad is loaded with psychoeducation, therapeutic, creative and educational apps in order to increase client participation in targeted therapeutic interventions such as CBT, mindfulness, DBT, ACT, meditation, life story work and neurobiology. The pilot has not yet been evaluated however feedback so far has been positive in that the iPad provides an alternative to talk or paper based activities when outdoor activities are not weather permitting or when the young person requires some down time to self-regulate. It is anticipated that further iPad's will be purchased so that each worker has access to this at all times for circumstantial and planned work with their clients.

Additional resources have also been obtained in order support the work that TYSS does on a daily basis. Fidget packs have been provided to each worker which contain sensory fidget tools for clients to use to support emotional regulation in such instances as long car rides, waiting in court or in waiting rooms to prevent disruptive behaviours. TYSS workers also have access to fishing rods, soccer, basket and footballs and games for use with clients as recreation and pro-social skill building. Over time, the number of resources available to workers has increased and has been based on feedback from workers around what would work well with clients. These resources have been funded through donations to the program, Baptcare funding resources and some use of brokerage (when client specific).

In addition to static resources, consumables such as food packs have been purchased in order to reduce the practice of purchasing fast food and drinks for clients. Although this does still happen occasionally (usually in the case of celebrating key events and goal accomplishment), the food packs are utilised in irregular instances where clients have not had access to regular meals and are unable to access emergency relief. The food packs consist of snack foods that are of reasonable nutritional value such as rice crackers, muesli bars, fruit boxes and water. TYSS workers regularly access dry goods hampers from SecondBite to support more planned meal relief for homeless clients.

In 2014, Baptcare funded the position of a Complex Case Management and Therapeutic Practice Project Officer in the Hobart office. This resource provided TYSS workers with access to structured peer supervision and secondary consultation additional to the Team Leader support. This position was a state-wide but Hobart based position until mid-2015 when a Launceston based worker assumed the role. This role is due to end in mid-2016 however given the benefits to workers in terms of improved trauma-informed practice, self-care and supervision benefits there will be strong advocacy for this to continue.

There have been ongoing attempts to build strong working relationships with the TYSS team in the South East (delivered by Mission Australia) and at times this has been quite successful, particularly in the development of the TYSS case plan which has undergone 2 reviews during the life of the program. However due to high staff turnover within the team and management at Mission Australia, this relationship building has been somewhat clunky at times. Efforts are ongoing to work collaboratively and to ensure consistency of program delivery across both regions.

TYSS have utilised case planning tools since the commencement of the program in 2010. The initial case planning tool was based on a holistic needs assessment and had a simple goal and task framework. In 2011, in consultation with Mission Australia, a more comprehensive case planning tool was developed that was in line with the targeted assessment tool. In early 2015, further development of the case planning tool was conducted to include a more therapeutic focus, the signs of safety framework and incorporating the risk matrix used to collect the data presented below.

The targeted assessment tool has also been used for the entirety of the program. The initial screening tool component of the CAF tool underwent some changes mid program however the targeted assessment component of the new CAF tool did not include specific youth at risk assessment criteria and therefore the original Targeted Assessment tool was retained.

Finally, a significant change to the program occurred in 2013 in regard to the eligibility criteria of not being on Child Protection or Youth Justice orders. As the program is intended to prevent escalation into the statutory services, young people who were subject to orders at the time of referral were ineligible for the service. However due to the development of trust with workers resulting in increased disclosures and notifications to Child Protection and the presentation in court on charges obtained prior to referral, a number of young people became subject to orders after their acceptance to the program. In keeping with the eligibility criteria in the funding agreement and bearing in mind potential duplication of service, these clients were closed out of the program. In 2013, a review of this practice resulted in some flexibility where it was determined that involvement with TYSS despite being moved onto orders would provide ongoing benefit, clients were reviewed on a case by case basis to determine continued TYSS support. This resulted in a larger number of clients being closed due to completion of support rather than the arbitrary imposition of statutory orders.

Retention Rates

In terms of staff turnover, the TYSS team has been relatively stable across the 5 year period with one team leader and 7 staff occupying 3 positions. Staff turnover has been largely due to maternity leave resulting in one resignation and 2 short term contracts, with one staff member dismissed during probation and one moving to another program. This has resulted in stable continuity of care for longer term case management of TYSS clients.

The program has seen a variety of engagement timeframes with clients, represented in the chart below (Figure 3).

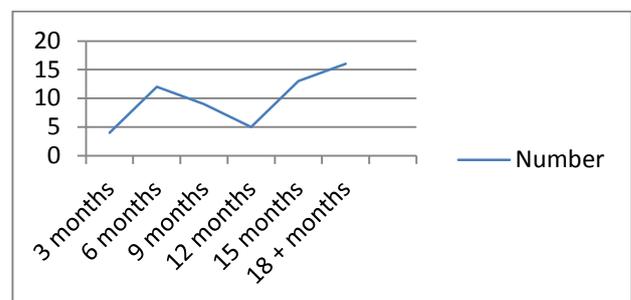


Figure 3: Time intervals at closure

The chart shows that the largest number of closures was at the 18 + month period (n=16 or 27%), 15 months (n= 13 or 22%) and 6 months

(n=12 or 20%). This represents 57% (n=34) of clients engaging for 12 months or longer and 44% (n=26) engaging between 6 and 12 months. For comparative purposes, in a similar outreach based youth program in the US, Becker et al. (2011) reported that their retention rate of 87% is excellent for any mental health treatment program. Given that TYSS is a medium to long term service and works with highly disengaged youth, a result of 93% (n=55) engaging for more than 6 months is a pleasing result given that the first 6 months of work is focused on the core work of therapeutic relationship building and establishment of safety.

Represented in these closures are 10 clients who were closed due to being placed on Child Protection orders or Youth Justice orders (including detention). However these closures are only represented in the cases referred prior to 2013 when a change in practice allowed for flexibility in remaining involved with clients on orders who had already established a positive working relationship with TYSS.

Demographic data analysis

Data included in the sample set includes cases that have completed casework with a minimum of 3 months engagement with the program. Data from 2010 is limited as the program commenced in October 2010. Data from 2014 is also limited as several cases referred during 2014 are still open and have not been included in the data set.

Data presented below consists of age and area at the time of referral and is analysed using male and female groups.

Figure 4 represents the number of young people referred at various ages within the catchment cohort of 10-17. The age range at referral is for males has been 11-17 and 12-17 for females. The median age at referral is 14 for males and 15 for females. The highest number of referrals for males was at age 13 (n=7) and 15 (n=6). For females this was age 15 (n=12). This data indicates a vast number of referrals are made at specific developmental and transitional stages for young people. In particular age 13 is the age of entry to High School. Age 15 is mid to late pubescence and is typically the age at which development of identity and desire for independence emerges.

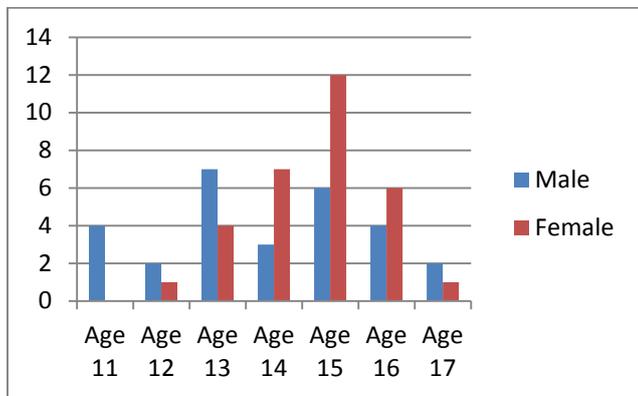


Figure 4: Age at referral

Figure 5 represents the average age at the time of referral across the 5 years of the program. Boys referred have consistently been younger than girls with a consistent average of around 14 years of age. Girls referred showed a dip in age between 2011 and 2013 and accounting for small numbers included in the data set for 2010 (due to restricted date range) and 2014 (due to cases still on active casework) it could be deducted from this data that both boys and girls are showing a trend in younger age at referral.

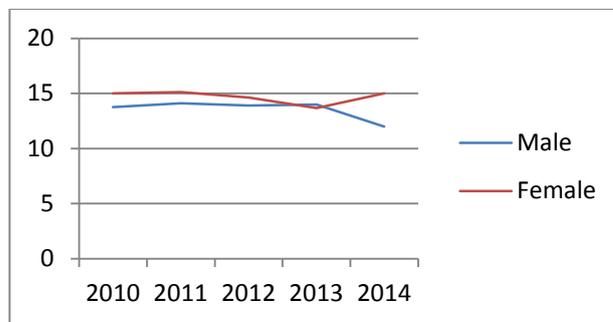


Figure 5: Average age at referral by year

Figure 6 breaks down the number of referrals each year by gender. 2010 only counts from October (commencement of the program) to December. 2015 is not included as all referrals moved to casework are still open. A number of referrals from 2014 moved to casework are also not included as they are still open. Data from 2011 to 2013 suggests a shift from male dominated referrals to female dominated referrals.

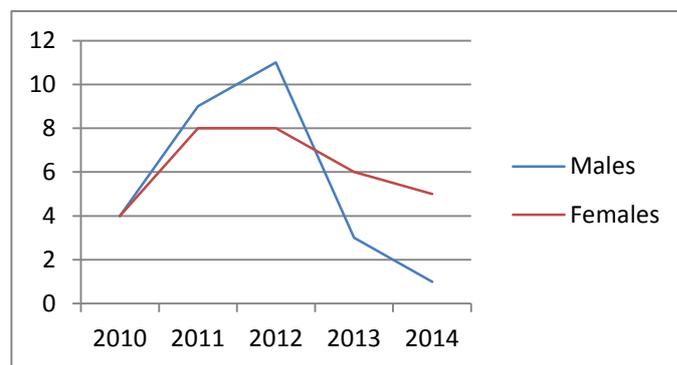


Figure 6: Number of males and female referrals each year

The previous three analyses indicates that projections for future young people referred to the program will include a younger cohort and a higher number of females.

The following data analyses the young people engaged with the program by suburb and local government area. TYSS as delivered by Baptcare is funded to service the Hobart, Glenorchy, Kingborough and Huon Valley regions.

Figure 7 represents the number of young people referred according to suburb and gender. The highest rate of referrals are from Geeveston, Glenorchy, Huonville and Kingston. The highest referral rate is from Kingston for Males (n=4) and females (n=5).

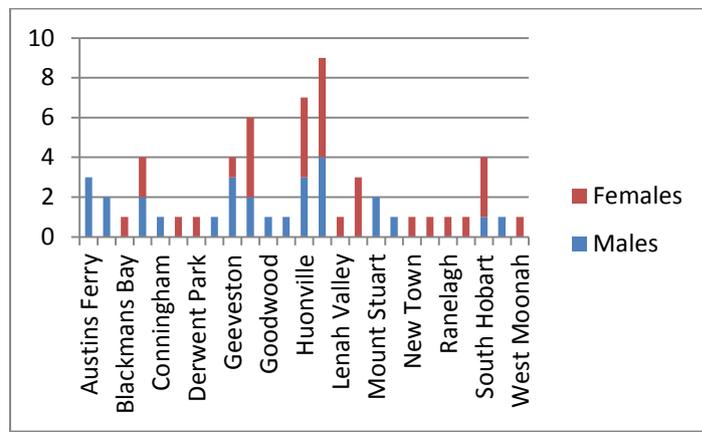


Figure 7: Referral by suburb

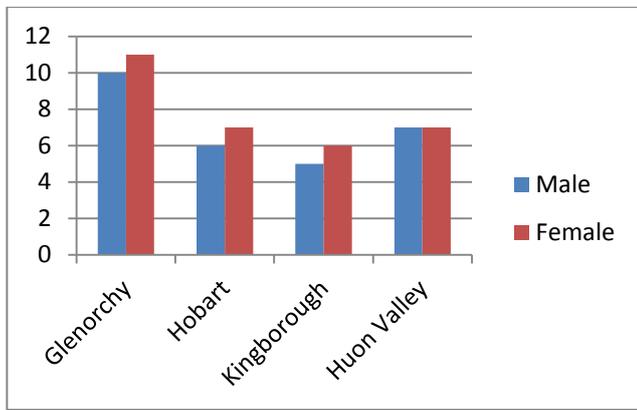


Figure 8: Referrals by Local Government Area

When grouped into Local Government Areas (Figure 8) for both males and females, the highest number of referrals came from the Glenorchy LGA with fairly even numbers of referrals from the Hobart, Kingborough and Huon Valley regions. This indicates that although by suburb the highest number of referrals are from the three main population centres of Huonville, Kingborough and Glenorchy, the majority of referrals overall are coming from other areas within the LGA.

Analysis of referrals over the first 5 years of the program (Figure 9) demonstrates significant community engagement activities in the Glenorchy area throughout the life of the program and focus on the Huon Valley area since 2011 have resulted in an increase in referrals for young people living in these areas.

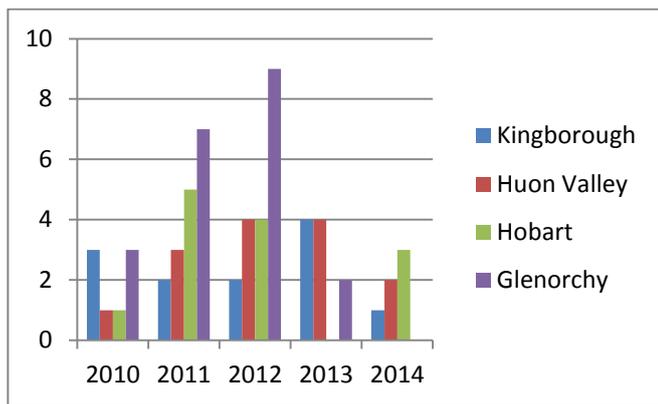


Figure 9: Number of referrals per year for each LGA

Outcomes based thematic analysis

Data has been collected for each client according to 20 areas of need at intervals of three months from intake to closure. The areas of need are based on the DHHS prescribed reporting tool. It was determined early in the life of the program that the reporting tool had some limitations in regard to tracking of outcomes and therefore the data collection tool was developed by Baptcare in order to provide more in depth outcomes based statistical data. Figure 10 describes each area of need and outcome indicators associated with each area.

Figure 11 is the risk assessment matrix used to determine each client's area of need at each interval, providing each area with a numerical value for statistical analysis purposes. The categorisations provided in the table below are a guide only. Whilst there may be some variation in the categorisation guide for some clients, all scores have been allocated a number based on the no concerns, limited concerns, some concerns and serious concerns criteria.

Each client included in the data has been rated against all 20 criteria, meaning that where there is no need in a particular area, the client would score 0 for that criteria. For the purposes of tracking outcomes and data analysis, a score of 2 or more is classified as having clinical significance in that the young person would benefit from targeted therapeutic support in that area.

The risk scores have a range of 8-40 at intake and 10-42 at 3 months. The average total risk score for all clients at intake is 25.81 and at 3 months the average score is 27.84. The median risk score at intake is 25 and at 3 months is 27 which indicates that the average scores have been marginally impacted by outliers. A risk score of 25-27 indicates that the client has rated 2 or 3 in approximately 10 areas demonstrating the complexity of needs identified early in engagement with clients. The variation in the risk scores indicate an increase in risk between intake and the first 3 months. This can be explained through various considerations.

The information collected at intake is limited to the information the referrer has at the time the referral is made. It is also only collected on the basis of determining eligibility for the client to be referred for targeted assessment. At 3 months, the targeted assessment has been completed by the worker. The targeted assessment has more youth at risk specific questions and provides additional information which then informs the risk scoring at 3 months for each client. In the first 3 months, the TYSS worker also focuses on building relationship and rapport with the young person which allows for greater depth of information to be gained for the targeted assessment but also increases the disclosure rate of the young person once trust has been established. Therefore the score increase between intake and 3 months cannot necessarily be an indicator of an increase in risk but should rather be interpreted as a more accurate assessment of the client's risk status. Therefore, the initial risk for each client is recalculated as an average between their intake and 3 month assessment score to more accurately reflect a baseline score for each client. The average baseline score is 26.8 and the median baseline score is 26.5.

The risk scores at closure have a range of 5-35, an average risk score of 18.49 and a median risk score of 18. The range of difference in risk scores from baseline to closure is -7.5 (escalation) to 25 (improvement) with a median difference of 10 (improvement).

This data clearly demonstrates a significant overall reduction in risk scores at point of closure compared to baseline with 22% of clients (n=13) exiting the service with an increased risk score compared with baseline.

There are several possible reasons for the escalation in risk score from baseline to closure for the 13 clients.

If clients who were closed prior to 6 months of engagement are excluded from the sample, the number of clients with an increased risk score at closure reduces to 16% (n=10). This indicates that a number of the clients who were closed with increased risk scores were not effectively engaged with the program and did not receive adequate therapeutic benefit, or they were exited due to being placed on Youth Justice or Child Protection orders prior to establishment of relationship which made them ineligible for continued service. For example, 11 clients included in the sample were closed with active Child Protection or Youth Justice order in place, 4 of which had an increased risk score at closure. It should be noted that all 11 of these cases occurred prior to 2013 when a change in practice introduced more flexibility around continuity of service to clients who had an established engagement with their TYSS worker at the time of entry into statutory services.

If clients who were closed prior to 9 months of engagement are also excluded, this reduces the number of clients with an increased risk score at closure to 11.8% (n=7). This indicates that there is a correlation between the length of engagement with the service and the likelihood of a reduced risk score which may be an indicator of therapeutic effect.

As TYSS is a client directed service, there have also been instances where a client has scored highly at risk on a particular area of need but does not identify this need or does not wish to address this area of need. This is most common in cases where there is drug or alcohol use or mental health issues. This may impact escalation in risk scores at closure.

There are several reasons for premature closure with clients who have not completed their therapeutic service plan. Clients may also have experienced a crisis which has led to disengagement from the service during this crisis point, resulting in an increased risk score at closure. Although assertive outreach measures are utilised, due to the highly chaotic environments and the impacts of trauma, some clients become impossible to locate during and some time after periods of crisis.

A further reason for closure when there has been an escalation in risk scores is that a client may have left the area, resulting in closure or

transfer to another agency. In this instance, the risk score does not adequately capture the therapeutic effect of the service as engagement has been disrupted.

Therefore, although the aim of the program is to achieve outcomes in all areas of need, an escalation in score cannot be attributed solely to failure of the service nor is it reasonable to expect a complete absence

Area of need	Descriptor
Access to services	The young person's involvement in or ability to access services including knowledge of what services are available.
Social Supports	The young person's access to positive social connections including family and friends
Alcohol abuse	The young person's level of alcohol use
Cultural and personal identity	Factors such as confidence, self-esteem, self-worth, cultural identity and emotional attunement
Disability	The young person's level of disability and access to specialised disability services
Drug abuse	The young person's level and type of drug use.
Education / Training	The young person's enrolment and attendance status with mainstream or alternative education.
Experience of trauma	The young person's trauma history and level of presenting trauma symptoms
Housing	The young person's housing status and risk of homelessness including access to shelters, couch surfing and primary homelessness
Mental health	The young person's mental health presentation including any diagnoses or access to mental health supports / medication
Money Management / financial	The young person's level of financial independence and access to basic material needs
Offending behaviour	The level of young person's offending behaviours including whether they are known to police or involved in the court system
Referral to Youth Justice or Child Protection	The young person's Child Protection and Youth Justice history including any current involvement, notifications or orders.
Parent / Guardian	The capacity and effectiveness of the young person's parent or guardian and whether the young person is functionally independent.
Parenting / caring	The young person's parenting or caring responsibilities.
Personal safety and wellbeing	Physical and emotional safety factors including risks from own and other's behaviours.
Physical health and self care	The young person's health status, access to medical care and ability to perform basic self-care tasks
Self harm / attempted suicide	The young person's self harm and suicidal ideation history as well as any current concerns
Violence	The young person's level of exposure to and involvement in physical violence
Other	Any other risk factors not adequately included in the above areas of need: these have included such things as bullying, sexual harm and grief and loss.

Figure 10: Area of need descriptors

Scoring of risk	0 (No concerns)	1 (limited concerns)	2 (some concerns)	3 (serious concerns)
Accessing Services	Well informed and demonstrated capacity to access services	Some knowledge and capacity to access services	lack of knowledge and concerns around capacity to access services	Lack of knowledge and significant limitations in capacity to access services.
Accessing Social Supports	Strong social support network	Some social supports	Very few or inappropriate social supports	No social supports
Alcohol Abuse	Not engaging in alcohol use	Occasional or recreational alcohol use	Regular alcohol use	Significant alcohol use / dependency
Cultural and Personal Identity	No concerns with cultural or personal identity	Some concerns with cultural or personal identity however supports in place	Significant concern with cultural or personal identity however supports in place.	Significant concerns related to cultural or personal identity with no supports in place
Disability	No disability	Mild disability, not eligible for disability services	Significant disability but receiving disability support	Significant disability / Not receiving disability support.
Drug Use	Does not engage in drug use	Occasional or recreational drug use	Regular drug use	Significant drug use / dependency
Education/Training	Enrolled and attending mainstream education	Enrolled and attending mainstream education or alternative education most of the time	Enrolled but not attending mainstream or alternative education regularly	Not enrolled and not attending any education
Experience of Trauma	No identified trauma history or symptoms	Trauma history identified but no identified symptoms	Trauma history and symptoms identified but managed	Significant history of trauma and presentation of trauma symptoms

Housing	Secure and stable accommodation	periods of instability in accommodation (primarily at home but occasionally in shelters or couch surfing)	Accommodation is insecure and unstable (i.e.: in a shelter or couch surfing)	Primary homeless (No accommodation options)
Mental Health	No mental health symptoms or concerns	some mental health symptoms but no diagnoses	Significant mental health concerns but no diagnoses	Significant mental health symptoms and diagnoses
Money Management/Financial	Sufficient income or financial support to enable self sufficiency	Accessing income which covers basic needs	Accessing income which is inadequate to meet basic needs	No income or financial support
Offending behaviour	No offending behaviour	Offending behaviour but not known to police	Offending behaviour and known to police	Significant offending behaviour and currently involved in the court system
Referral to Youth Justice or CPS	No involvement with Youth Justice or CPS	History of YJ or CPS but no current concerns	Notifications / Referrals made to YJ or CPS	On youth justice or CPS orders
Parent/Guardian	Effective guardian / carer	Unstable relationship with guardian / carer	Significant concerns around relationship with guardian / carer	No effective guardian / carer
Parenting/Caring	Not in a parenting / caring role	providing some guardianship or care to a minor but with significant support.	In a parenting or caring role with some concerns and little support	In a parenting / caring role with significant concerns and no support.
Personal Safety & Wellbeing	No safety or wellbeing concerns	some threats to safety and wellbeing but adequate supports in place	Some threats to safety and wellbeing and no supports in place	Significant threats and concerns to safety and wellbeing and no supports in place
Physical Health & Self care	No physical health or self-care concerns	Minor physical health or self-care concerns and supports in place	Physical health or self-care concerns but some supports in place	Significant physical health concerns or concerns in regard to self-care capacity
Self harm/attempted suicide	No self harm or suicidal ideation	History of self harm / suicidal ideation but not currently present	some self harm, suicidal ideation but no current plans or intent	Significant self harm, current suicidal ideation / plans and intent
Violence	Not engaging in or exposed to violence	Not engaging in but exposed to violence	Engaging in or exposed to some violence	Engaging in or exposed to a high level of violence
Other	No other risks or concerns	Some other risks or concerns but support in place	Some other risks or concerns in place and little or no supports	Significant other risks or concerns and no supports in place

Figure 11: Scoring of risk matrix

of escalated risk scores given the client cohort as this could be attributed to multiple extraneous causal factors.

Of the clients who experienced an improvement in risk score between baseline and closure, 50% achieved a risk score improvement of 10-25 which indicates a significant improvement in at least 4 and up to 8 areas of need. This is explored further in the specific area of need outcomes analysis.

Engagement and relationships

As part of the highly disengaged criteria for entry to and eligibility for case work, engagement and relationships analysis comprises of the access to services, social supports and parent / guardian assessment scores. This covers the young person's connection or disengagement from community, services, family and friends. Although disengagement from education is also considered during the eligibility assessment, for the purposes of this report, education is treated as a separate matter due to the significant representation of young people who are referred to the TYSS program and have substantial disengagement from education and the practice of limited acceptance of referrals for young people who are not significantly disengaged from education.

As part of the capacity building component of TYSS, significant focus is placed on information provision to young people around what services are available to them, supporting them to develop confidence to approach and engage with services autonomously, and developing positive and prosocial relationships with peers and family members with the ultimate goal of increased connection to community.

Figure 12 indicates that on all three measures, the average risk score decreases over the support period with a significant improvement shown in the parent / guardian category. At closure, many clients are either aged out of the service or are demonstrating functional independence and this is reflected in the parent / guardian score (2.08 to 0.22). This score is based on the capacity of the parent or guardian to provide care, protection and supervision to the young person and does not relate to the quality of interpersonal relationship which is accounted for under social supports. For example, a client may enter the service at age 16 with an ineffective guardian however at age 18 or at closure may be living independently with no need for a parent or guardian for support and this is taken into consideration when scoring at closure.

The access to social supports and access to services categories demonstrate and overall average risk score falling from the some concerns (a score of 2) to the limited concerns (a score of 1) range. A score of 1 is an indicator that the client no longer requires support in that specific area.

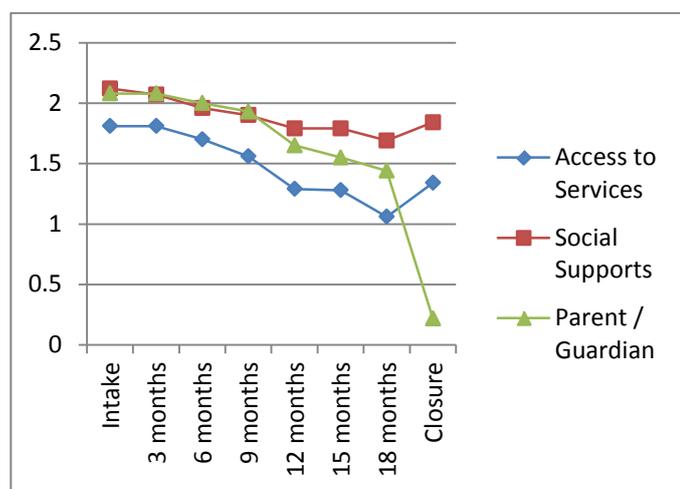


Figure 12: Average risk scores on engagement and relationship measures

Access to services

Access to services data was assessed by the level of knowledge about available services and the capacity to access these services without

support. For example, clients may have had a good knowledge of available services but lacked the capacity to access these without support due to factors such as geographical area, mental health and socialisation issues, confidence, communication skills or influences that posed a barrier to access (such as peer attitudes, previous negative experiences etc.). Alternatively, clients may have had a capacity to access services but were uninformed of what was available to them. Engagement with TYSS was also considered as part of assessment of engagement with services.

At intake, 67.8% of clients (n=40) scored at the some or significant concerns in regard to their level of knowledge of and ability to access services. 44% of clients (n=26) rated as having some concerns and 23% (n=14) as having significant concerns.

At 3 months, 71% of clients (n=42) scored at the some or significant concerns in this area, 52% (n=31) rated at some concerns and 18% (n=11) rated as significant concerns.

At closure, 25.4% of clients (n=15) scored at the some or significant concerns in this area, 18.6% (n=11) rated at some concerns and 6.8% (n=4) rated as significant concerns.

Of the 4 clients who exited the program with significant concerns in accessing services, 2 were closed at the 6 month point and 2 at the 9 month point. 3 of the 4 had overall equal or higher risk scores between intake and closure indicating that they had received little therapeutic benefit during their short engagement. All four clients were closed prior to 2013. This indicates that the level of disengagement these clients presented with at intake influenced their level of engagement with TYSS and also indicates that development of the program over the first 2 years of the pilot impacted positively on engagement rates and improvement in access to services.

This data suggests that engagement with the TYSS program has had a significant positive impact on both knowledge and capacity to access services without support with just under 75% of clients having a good knowledge and capacity to access services.

Social supports

Social supports refers to the micro and mesosystems for the young person (Duerden & Witt, 2010) or the young person's immediate relationships with family, peers and other associated persons including the TYSS worker. The assessment of social supports considered the number of supports the young person has, the quality of the relationship with these supports and any negative or pro-criminal associations, particularly peers associations.

At intake, 89.8% of clients (n=53) scored at the some or significant concerns in regard to their number and quality of positive and prosocial family and peers. 64% of clients (n=38) rated as having some concerns and 25% (n=15) as having significant concerns.

At 3 months, 91.5% of clients (n=54) scored at the some or significant concerns in this area, 76% (n=45) rated at some concerns and 15% (n=9) rated as significant concerns.

At closure, 50.8% of clients (n=30) scored at the some or significant concerns in this area, 45.7% (n=27) rated at some concerns and 5% (n=3) rated as significant concerns.

Considering the importance of connections and interpersonal relationships, these are positive results in terms of the quality of relationships at closure. Many clients who engage with the TYSS program have few to no positive family supports and form relationships with "like-minded" peers who display similar interpersonal relationships and pro-criminal behaviours. Of the 3 clients who scored as having significant concerns at closure, 2 were exited on CPS or YJ orders. All three clients were closed prior to 2013. The data demonstrates significant reduction in risk across all levels of need with an overall 41% decrease in some and significant concerns. This appears to support the positive change that can occur through the provision of pro-social modelling and building on the therapeutic relationship, particularly in regard to improvement in relationships and positive decision making in terms of peer

associations. Systems theory based interventions such as improving the quality of connections with family and peers may also have impacted positively on this result.

Parent / guardian

Assessment of the parent / guardian relationship takes into consideration the assessment of attachment, conflict, supervision, provision of care and quality of relationship with the primary caregiver. Young people who were homeless or had no effective guardian prior to the age of 16 were assessed as having significant concerns however young people over the age of 16 who were not homeless but had no effective guardian were considered to be independent and scored as no or limited concerns depending on the presence or absence of conflict and negative relationship impacts with their parent or guardian.

At intake, 83% of clients (n=49) scored at the some or significant concerns in regard to their parent or guardian's level of capacity to provide care, protection and supervision of the young person. 56% of clients (n=33) rated as having some concerns and 27% (n=16) as having significant concerns.

At 3 months, 76% of clients (n=45) scored at the some or significant concerns in this area, 45.7% (n=27) rated at some concerns and 30.5% (n=18) rated as significant concerns.

At closure, 37% of clients (n=22) scored at the some or significant concerns in this area, 20% (n=12) rated at some concerns and 17% (n=10) rated as significant concerns.

This data represents an overall 50% improvement in the young person's relationship with the parent / carer or their capacity to be independent. Considering the TYSS program works with the young person and is not a family support focused program, these findings are significant. Some work is done directly with parents and carers of the young people in the program however this is an extraneous rather than targeted effect of working with the young person.

Of the 10 clients who were closed with significant concerns, 3 were closed at the 3 month point and 3 were closed at the 6 month point indicating that there was insufficient time for therapeutic benefit to impact on their parent / guardian relationship. Only 2 clients who scored significant concerns at closure had been part of the program for more than 18 months. Both of these clients came from a family with a significant history of parenting concerns and ongoing CPS involvement, indicating that TYSS support was unlikely to be of benefit due to the concerns being related solely to parenting capacity. Both clients were subject to CPS orders as result of these concerns.

Drug and alcohol use

Risk scores on the client's drug and alcohol use is based on the level of usage or dependency. A score of 1 indicates only occasional use, which is of concern given the age cohort however given the degree of impact compared with regular use or dependency a low score is given. A score of 2 indicates regular use or occasional but heavy use such as binge drinking. A score of 3 indicates daily use and dependency.

Figure 13 demonstrates an overall average decrease in risk for clients using drugs and alcohol.

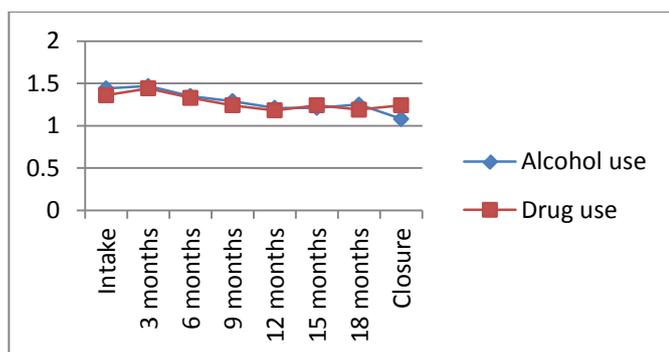


Figure 13: Average risk scores on drug and alcohol abuse measures

Alcohol abuse

At intake, 54% of clients (n=32) scored at the some or significant concerns in regard to their alcohol use. 49% of clients (n=29) rated as having some concerns and 5% (n=3) as having significant concerns.

At 3 months, 56% of clients (n=33) scored at the some or significant concerns in this area, 50.8% (n=30) rated at some concerns and 5% (n=3) rated as significant concerns.

At closure, 23.7% of clients (n=14) scored at the some or significant concerns in this area, 22% (n=13) rated at some concerns and 1.7% (n=1) rated as significant concerns.

The 3 clients identified as having significant alcohol use concerns were all males aged 15 and 16. The young person who scored as significant at closure was included in these clients and was exited from the program at the 6 month point, indicating possible lack of engagement or lack of acknowledgement of the concerns and willingness to address this.

Of greater concern is the number of young people who were assessed as engaging in some alcohol use (that is regular, recreational use) was significantly high at 56%. Girls were strongly overrepresented in this category, with 66% (n=20) of the clients being female. The average age of girls scoring in the some category is 14.55 years, the youngest being 4 females aged 13. For boys the average age is 14.1 years and the youngest being 1 boy aged 11 years.

The results demonstrate that over half of the young people using alcohol at 3 months had either ceased use or were only engaging in occasional use. This is a positive result as TYSS is not an alcohol rehabilitation program and rarely is alcohol use addressed directly with clients unless they identify this as a concern however a comparison study between the reduction in alcohol use and the reduction in other risk scores indicates that this improvement is likely to be a result of increased personal skills (confidence to resist peer influence) and decreased maladaptive coping strategies (self-medicating) due to therapeutic intervention.

Drug use

At intake, 44% of clients (n=26) scored at the some or significant concerns in regard to their drug use. 30.5% of clients (n=18) rated as having some concerns and 13.5% (n=8) as having significant concerns.

At 3 months, 47.5% of clients (n=28) scored at the some or significant concerns in this area, 35.6% (n=21) rated at some concerns and 12% (n=7) rated as significant concerns.

At closure, 33.8% of clients (n=20) scored at the some or significant concerns in this area, 27% (n=16) rated at some concerns and 6.8% (n=4) rated as significant concerns.

The reductions in drug use are not as significant as those for alcohol use however there is a reduction overall. Males are slightly overrepresented in drug use at the 3 month mark (57%, n=16) and are substantially overrepresented at the closure mark (70%, n=14). Of the 7 clients scoring significant concerns at the 3 month mark, all but 2 had reduced their usage and the other 2 clients scoring significant concerns at closure had increased their usage from the 3 month mark, one from limited concerns (occasional use) and the other from some concerns (regular use). Of the clients who reduced their usage, despite referral to specialist drug and alcohol services, none engaged with these services and only reduced their usage with the support of the TYSS worker.

Cannabis appears to be the drug of choice for clients in the TYSS program with 89% (n=25) reporting cannabis use at the 3 month point. Other drugs that were being used by young people at the 3 month mark were opioids (n=2), amphetamines (n=5) and chroming (n=2) with one user not specifying around their usage. Males were overrepresented in the other drug usage, with only 1 female using a drug other than cannabis (speed and ecstasy). Drug usage was not

area specific with relatively even distribution of clients across all four local government areas.

Drugs and Alcohol combined

Analysis of the data demonstrates significant comorbidity across drug and alcohol use. At the 3 month mark, 72% (n=44) of clients were engaging in both drug and alcohol use (including limited, some and significant concerns) and 34% (n=20) were using both drugs and alcohol at the some and significant concern levels, 3 of whom were using both drugs and alcohol at the significant concern level. At closure, 56% (n=33) of clients were engaging in both drug and alcohol use (including limited, some and significant concerns) and only 20% (n=12) using both drugs and alcohol at the some and significant concern levels, 1 of whom was using both drugs and alcohol at the significant concern level. This young person was included in the 3 clients at the 3 month mark and was exited from the program at 6 months. This particular young person was referred to Holyoake but identified he was not interested in making changes around his drug and alcohol use.

Overall reductions in drug and alcohol use, both in isolation and combined, indicates therapeutic benefit is gained from engagement with the TYSS program, particularly with clients who engage for longer and who identify a desire to change their usage patterns.

Personal safety

Personal safety demonstrates areas of need in regard to the young person's physical safety from others and their own behaviours. Safety incorporates risks and protections involved in the young person's own risk taking behaviours, exposure to violence and engagement in perpetrating violence against others, and statutory risk involving notification or placement of care and protection orders by Child Protection. Figure 14 outlines the outcomes trajectories for child protection, physical safety and violence.

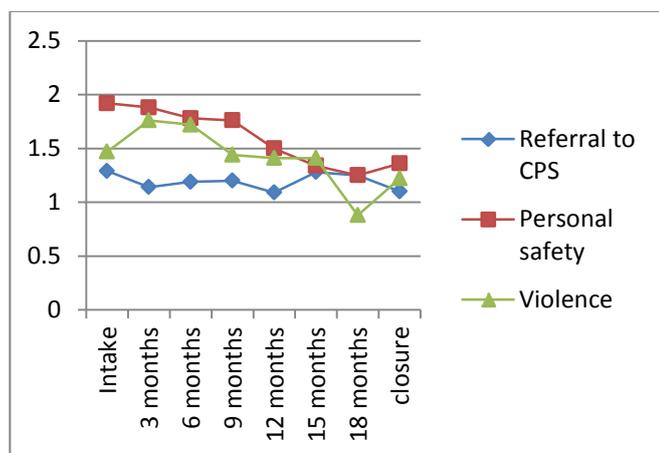


Figure 14: Average risk scores on safety measures

Child protection involvement

At intake, 47.5% of clients (n=28) scored at the some or significant concerns in regard to child protection involvement. 44% of clients (n=26) rated as having some concerns and 3.4% (n=2) as having significant concerns.

At 3 months, 32% of clients (n=19) scored at some concerns in this area, and 0% (n=0) rated as significant concerns.

At closure, 18.6% of clients (n=11) scored at the some or significant concerns in this area, 8.5% (n=5) rated at some concerns and 10.1% (n=6) rated as significant concerns.

The reduction in CPS involvement between intake and 3 months can be accounted for by considering notifications that may have been open at intake and closed by the 3 month mark due to TYSS involvement. At 3 months, 19 clients had open notifications with CPS however no young people were on CPS orders at this point. At closure, 5 clients had open notifications with CPS and 6 clients were subject to CPS

orders. As one of the key outcomes of the TYSS program is to prevent escalation into the CPS system a result of 90% of clients not proceeding onto orders is an excellent result.

Of the 6 clients who were subject to CPS orders at closure, 1 client was moved onto orders at the post-3 month mark as a result of notifications that were already open at the time of intake. This young person remained on CPS orders for the remainder of their involvement with TYSS (15 months). 2 clients were moved onto CPS orders at the post 6 month mark. Both these clients had significant CPS history prior to intake (over 65 previous notifications) and the orders related to further disclosures and ongoing risk assessed by the TYSS workers leading to further notifications. Without the therapeutic relationship between the TYSS workers and these clients, the evidence required to establish safety may not have been able to be obtained, implied by the multiple notifications prior to TYSS involvement. One client was subject to orders as part of a sibling group however continued to reside in the family home and was supported by TYSS despite the orders for 2 years. The other 2 clients who became subject to orders also had a strong history of notifications to CPS and both had primary caregivers who had significant capacity issues in regard to their parenting, one as a result of an intellectual disability and the other as a result of chronic alcoholism. TYSS support resulted in overall reduced risk scores for both of these clients however was unable to address the parenting capacity issues.

Safety

At intake, 79.6% of clients (n=47) scored at the some or significant concerns in regard to their personal safety and wellbeing. 57.6% of clients (n=34) rated as having some concerns and 22% (n=13) as having significant concerns.

At 3 months, 71% of clients (n=42) scored at the some or significant concerns in this area, 49% (n=29) rated at some concerns and 22% (n=13) rated as significant concerns.

At closure, 37% of clients (n=22) scored at the some or significant concerns in this area, 33.8% (n=20) rated at some concerns and 3.4% (n=2) rated as significant concerns.

This data demonstrates a significant reduction in risk to safety as a result of the client's own or other's behaviours. In particular, the reduction from 22% at 3 months to 3.4% at closure on significant concerns indicates that the focus on establishing safety as a key aspect of therapeutic work has been highly beneficial. The two clients who rated as having significant concerns were at risk due to significant mental health issues (referred for specialist support) and ongoing threats of suicide and exposure to a sexual abuse perpetrator whilst subject to CPS orders which was notified to CPS at the time of closure. All other clients who rated as having significant concerns demonstrated a reduced risk to some or limited concerns as a result of safety planning and harm minimisation strategies put in place with the TYSS worker.

Of the 20 clients rating at some concerns at closure, almost half (45%, n=9) had relatively short engagement with TYSS (less than 6 months). Of the clients who rated as some or significant concerns at the 3 month mark and engaged with the TYSS program for over 12 months (n=10), 4 demonstrated a reduction in risk by at least one category, 5 remained in the same category and only one client increased in risk (from limited to some concerns). No clients who engaged with the program for more than 12 months fell into the significant concerns category.

Thematic analysis indicates that the threats to safety and wellbeing for TYSS clients included risks associated with their own behaviours (including risky sexual behaviours, association with pro-criminal peers and adults, night time absconding), lack of supports, mental health impacts, exposure to previously known perpetrators (sexual and physical abuse) and exposure to violence by others.

Violence

At intake, 59% of clients (n=35) scored at the some or significant concerns in regard to their exposure to and engagement in violence.

44% of clients (n=26) rated as having some concerns and 15% (n=9) as having significant concerns.

At 3 months, 69.5% of clients (n=41) scored at the some or significant concerns in this area, 45.7% (n=27) rated at some concerns and 23.7% (n=14) rated as significant concerns.

At closure, 33.9% of clients (n=20) scored at the some or significant concerns in this area, 23.7% (n=14) rated at some concerns and 10.2% (n=6) rated as significant concerns.

These figures represent a significant improvement in exposure to and engagement in violence with 42% (n=15) reducing their risk scores to the limited or no concerns category. Of the remaining 20 clients with ongoing concerns at closure, 7 clients experienced an increase in risk, 5 clients experienced a decrease in risk and 8 clients remained in the same risk category. Of the 7 clients who experienced an increase in risk, 2 clients did not assess as having any concerns around violence at the 3 month mark, 4 experienced an overall increase in risk at closure, 5 were subject to CPS or YJ orders at closure and 2 had relatively short engagement with TYSS (less than 6 months).

Of the 20 clients scoring as some or significant concerns at closure, 60% (n=12) are male. 45% (n=9) were deemed at risk from their own violent behaviours, 20% (n=4) were at risk from violence by others and the remaining 35% (n=7) were at risk from a combination of their own and other's violent behaviours. Of those clients at risk due to their own violence, 87.5% are male (n=8). Those clients at risk from the exposure to violence by others were all female. Of the clients at risk due to a combination of their own and other's behaviours, males and females were relatively equally represented with males representing 57% (n=4) and females 43% (n=3).

Mental health and trauma

Although many mental health disorders are unable to be formally diagnosed until after the age of 18, it is important to recognise emerging mental health issues in young people in order for early intervention to be effective. Mental health issues often coincide with the incidence of trauma and as can be seen below, a large number of young people working with the TYSS program have a significant history of trauma which displays as trauma informed symptoms. Although self harm and suicidal ideation and attempts are not considered to be indicative of mental health disorders, they are included under this category due to the level of distress and emotional turmoil they indicate for the young person. Figure 15 demonstrates the outcomes in regard to client's experience of trauma, mental health symptoms and self harm / suicidality. It is interesting to note that on all three categories, the risk score increases between intake and the 3 month point. This is likely to be due to the lack of information around trauma symptoms, mental health concerns and self harming behaviours which are often internalised and not easy to assess outside of a trusting relationship.

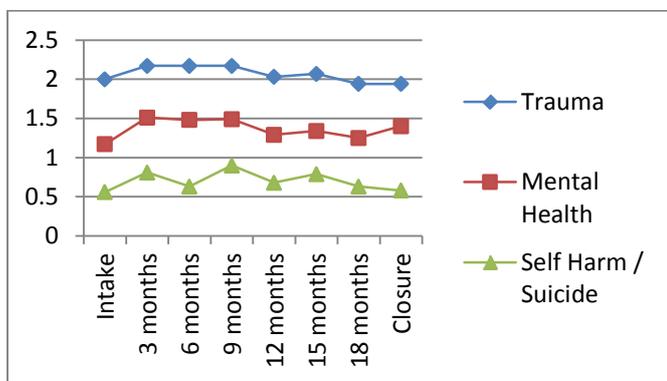


Figure 15: Average risk scores on Trauma, mental health and self harm measures

Trauma

At intake, 66% of clients (n=39) scored at the some or significant concerns in regard to their experience of trauma. 13.5% of clients

(n=8) rated as having some concerns and 52.5% (n=31) as having significant concerns.

At 3 months, 71% of clients (n=42) scored at the some or significant concerns in this area, 20% (n=12) rated at some concerns and 50.8% (n=30) rated as significant concerns.

At closure, 56% of clients (n=33) scored at the some or significant concerns in this area, 38.9% (n=23) rated at some concerns and 16.9% (n=10) rated as significant concerns.

The trauma category does not focus specifically on the historical or current experience of trauma but is more specifically assessing trauma-related symptomatology and the impact this is having on client functioning. This may have negatively impacted on the periodical scoring as trauma symptoms may have presented as difficulties which were assessed under other categories (such as mental health, violence, safety and wellbeing and child protection history) and therefore the number of young people presenting with trauma-related symptoms is likely to be underrepresented. Therefore, the number of young people scoring as having some or significant concerns at the 3 month mark is considerably noteworthy, particularly given the high percentage of significant concerns assessable at a very early stage in the relationship with the TYSS worker.

Also of note is the reduction in imposing symptomatology at closure. Two thirds of clients presenting as having significant concerns at the 3 month mark were able to move into the some concerns category or lower. This reduction in significant concerns has had an inverse impact on the clients presenting as having some concerns, with this almost doubling. However overall the number of clients presenting as having some or significant concerns is clearly reduced and represents the benefits of a trauma-informed therapeutic approach employed by TYSS workers.

Of those clients presenting with some or significant concerns at 3 months and who engaged with the TYSS program for 18 months or more (n=15), none were assessed as having significant concerns at closure, 46% (n=7) moved from significant to some concerns, 26% (n=4) moved from significant to limited concerns, one client remained at some concerns across both assessment points and 20% (n=3) moved from some concerns to limited concerns. Of these clients, none demonstrated an increase in trauma symptoms between 3 months and closure.

Of those clients presenting with some or significant concerns at 3 months and who engaged with the program for less than 9 months (n=13), 38% (n=5) were assessed as having significant concerns at closure, 23% (n=3) moved from significant to some concerns and 7% (n=1) moved from significant to limited concerns. Of those clients in this group who were assessed as having some concerns at 3 months (n=4) there was no improvement at closure.

This comparison indicates that the improvement in trauma symptoms occurs over a long period of time and those clients who received the most benefit had engaged with the program for 12 months or more.

Mental health

At intake, 44% of clients (n=26) scored at the some or significant concerns in regard to mental health symptoms. 30.5% of clients (n=18) rated as having some concerns and 13.5% (n=8) as having significant concerns.

At 3 months, 57.6% of clients (n=34) scored at the some or significant concerns in this area, 49% (n=29) rated at some concerns and 8.5% (n=5) rated as significant concerns.

At closure, 28.8% of clients (n=17) scored at the some or significant concerns in this area, 23.7% (n=14) rated at some concerns and 5.1% (n=3) rated as significant concerns.

The results around the mental health data are of concern, with over 50% of clients presenting to the TYSS program having some or significant mental health concerns. However the results at closure are promising with over half of these clients moving out of the some or

significant concerns categories into the lower risk categories of limited or no concerns. Of the 5 clients who presented with significant mental health issues at 3 months, only 2 remained as having significant concerns at closure. Of the 3 clients with significant concerns at closure, one experienced depression and suicidal ideation and disengaged at the 3 month mark, one experienced PTSD and auditory hallucinations and disengaged at the 9 month mark, and the other was diagnosed with chronic mental health issues including a personality disorder and was linked in with Clare House and Partners in Recovery at closure at the 15 month mark.

Thematic analysis of the presenting mental health issues at the 3 month mark indicate anxiety (38%, n=13) and depression (53%, n=18) were the most common presentations. Other presentations included PTSD (8%, n=3), attachment disorders (6%, n=2), ADHD (12%, n=4), anger management concerns (18%, n=6), dissociation (6%, n=2), OCD (3%, n=1), personality disorders (3%, n=1), conduct disorder (3%, n=1) and 18% (n=6) were unspecified in the assessment.

Self harm / suicide

At intake, 20.3% of clients (n=12) scored at the some or significant concerns in regard to self harm, suicidal ideation and attempts. 8.5% of clients (n=5) rated as having some concerns and 11.8% (n=7) as having significant concerns.

At 3 months, 27% of clients (n=16) scored at the some or significant concerns in this area, 15% (n=9) rated at some concerns and 11.8% (n=7) rated as significant concerns.

At closure, 6.8% of clients (n=4) scored at the some or significant concerns in this area, 1.7% (n=1) rated at some concerns and 5.1% (n=3) rated as significant concerns.

The reduction in suicide and self harm risk is significant. The some concerns category assesses suicidal ideation or a recent history of self harm or attempts. All 9 young people scoring some risk at the 3 month mark reduced to limited or no concerns by closure, indicating a significant improvement in hope and safety for these young people. The one client who scored at some concerns at closure was an escalation from the 3 month mark. This young person was subject to CPS orders at the time of closure.

At the 3 month mark, 7 young people were assessed as having a significant risk due to ideation, plan or attempted suicide. Of these 7 young people, only 1 was assessed as having significant risk at closure (this particular young person was on CPS orders at closure). Of the other 2 clients scoring as significant risk at closure, these were escalations from the 3 month mark where neither of these young people were assessed with a risk of suicide or self harm. One of these young people disengaged at the 3 month mark and the other was closed at the 15 month mark after referral to case management through mental health services due to significant mental health concerns.

Overall, the outcomes in regard to self harm and suicide demonstrate significant improvement in the mental health and emotional wellbeing of the young people. Of those few who experienced an escalation, an analysis of the other complex risk issues present for these young people demonstrate that the risk of self harm and suicide is a direct result of ongoing and chronic exposure to trauma requiring statutory or mental health intervention.

Offending

As part of the eligibility criteria for TYSS, young people who were subject to youth justice orders were deemed ineligible. However, if the orders were due to lapse, they may be accepted to the program. Similarly, once a young person was placed on youth justice orders during engagement, case management was transferred to youth justice and the case closed early in the life of the program. However, through the evolution of the program it was deemed appropriate in some instances for TYSS to remain involved when youth justice orders were put in place. Closure however was unavoidable in the instance

that the young person was detained at Ashley Youth Detention Centre (which is only 1 young person in this data set who was detained due to charges obtained prior to referral to the TYSS program).

Many young people were engaging in criminal activity with various levels of involvement from police and the courts. The focus of TYSS was to reduce the risk of escalation within these systems. The data clearly demonstrates a downward trajectory of offending behaviours the longer the young person is engaged with the program.

Figure 16 demonstrates the measures on offending behaviours and youth Justice involvement.

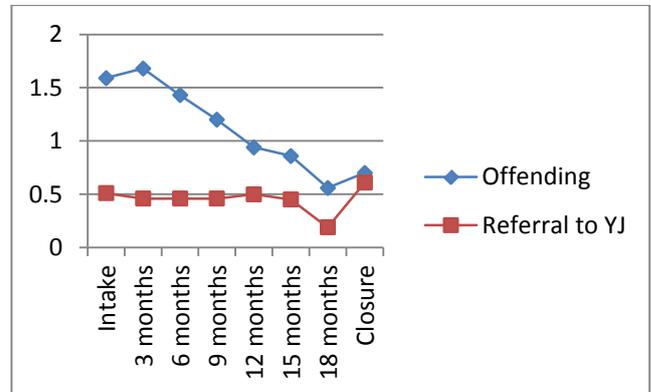


Figure 16: Average risk scores on offending measures

Offending

At intake, 59% of clients (n=35) scored at the some or significant concerns in regard to offending. 39% of clients (n=23) rated as having some concerns and 20% (n=12) as having significant concerns.

The results were exactly the same at the 3 month interval.

At closure, 10% of clients (n=6) scored at the some or significant concerns in this area, 5% (n=3) rated at some concerns and 5% (n=3) rated as significant concerns.

The some category relates to clients assessed as having been known to police in that 3 month period or charged with an offence. The significant concerns category relates to young people with court matters pending or occurring during that period. Due to the length in time that it takes for some matters to proceed to court or be resolved through the court systems, outcomes in this category may take longer to resolve however the outcomes speak strongly of reduction in offending, charges being laid and court matters arising from these. A reduction of 35 clients to 6 clients being known to police or charged is a significant reduction. The reduction of 12 clients to 3 clients having court matters outstanding demonstrates natural resolution of outstanding matters as well as a reduction represented by the number of young people coming to police attention and being charged. It should also be noted that the lack of reduction in the period from intake to 3 months reflects the time delay in the justice system processes and does not indicate any escalation from those pre-existing matters during this time.

Of the 35 clients who were assessed as having some or significant offending behaviours at 3 months, 3 were closed at the 3 month mark, all with reductions in their offending behaviours to limited (n=1) or no concerns (n=2), 9 were closed at the 6 month mark, 5 of whom demonstrated reductions to limited (n=3) or no concerns (n=2) and 4 demonstrating equal (n=3) risk scores and one client escalating from some to significant concerns. The graphical representation indicates a slight upwards trajectory at closure however this may be explained by those young people who engaged for a short period of time (less than 12 months) and technically escalated due to court appearances which were due to charges laid prior to or early on in their engagement with TYSS. Therefore, this represents a false result and the overall downward trajectory over the entire time period gives a more accurate representation of the reduction of concerns over time. That is, it is clear from the data that the longer a young person was involved with

the TYSS program, the lower their risk score was in regard to offending behaviour. This is due to the completion of the justice process combined with therapeutic benefit over time.

Of the 35 clients rating some or significant concerns at intake, 17 clients ceased offending altogether by the time of closure.

Youth justice involvement

At intake, 20.3% of clients (n=12) scored at the some or significant concerns in regard to their enrolment and engagement with education. 15.2% of clients (n=9) rated as having some concerns and 5.1% (n=3) as having significant concerns.

At 3 months, 16.9% of clients (n=10) scored at the some or significant concerns in this area, 13.6% (n=8) rated at some concerns and 3.4% (n=2) rated as significant concerns.

At closure, 13.6% of clients (n=8) scored at the some or significant concerns in this area, 5.1% (n=3) rated at some concerns and 8.5% (n=5) rated as significant concerns.

It should be noted that of the 5 young people who rated at significant concerns upon closure, only 1 was engaged with the program for longer than 6 months and this client was placed on a community service order due to charges laid prior to referral. 1 client was detained at Ashley youth detention centre 3 months after engagement due to matters pending ruling prior to referral. All of the clients who engaged for longer than 6 months either reduced in risk or completely exited the youth justice system. This is important to note given that due to the timeframes around court appearances and legal processes, often it takes longer than 6 months for matters to be heard and therefore there appears to be an escalation in risk presented in this data however the risk at closure for these 5 clients had not increased but was due to matters outstanding from point of intake. None of the clients referred to TYSS escalated from no concerns to being placed on orders during their engagement with TYSS.

Education

Disengagement from education is one of the factors for consideration in determining eligibility for the service. Most clients referred are disengaged completely with only few attending regularly. At closure, the figures incorporate clients who have aged out of the education system or have moved into the employment space, indicated by a score of 0 or 1. Clients scoring a 2 were enrolled but not attending regularly and a score of 3 indicates the client not being enrolled or not having attended for over 12 months. Data suggests a significant improvement in educational outcomes for clients over time, with clients who engage with the program longer having more improved educational outcomes.

Figure 17 demonstrates the outcomes in regard to disengagement from education.

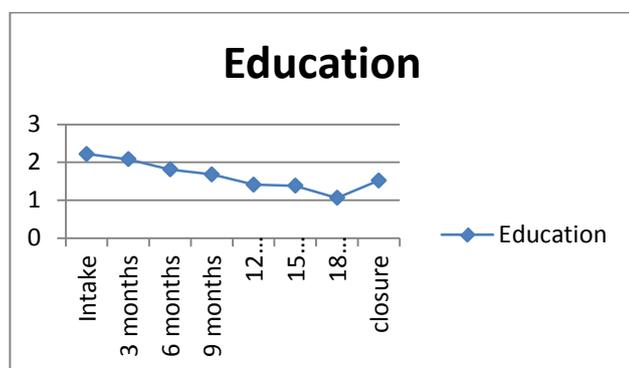


Figure 17: Average risk scores on education measures

Education

At intake, 91.5% of clients (n=54) scored at the some or significant concerns in regard to their enrolment and engagement with education. 64.4% of clients (n=38) rated as having some concerns and 27.1% (n=16) as having significant concerns.

At 3 months, 85% of clients (n=50) scored at the some or significant concerns in this area, 61% (n=36) rated at some concerns and 23.7% (n=14) rated as significant concerns.

At closure, 40.6% of clients (n=24) scored at the some or significant concerns in this area, 30.5% (n=18) rated at some concerns and 10.1% (n=6) rated as significant concerns.

The number of clients in the program who were highly disengaged at intake is significantly high however given the relationship with eligibility criteria, it is unsurprising that this is the case. The number of young people highly disengaged from education at closure also appears to be high at 40% however this does also indicate a significant improvement. In particular, the reduction of the number of clients either not enrolled or not attending for over 12 months reduced from 16 at intake to 6 at closure and this is an excellent result considering TYSS workers do not actively focus on school attendance unless the client indicates this as an area of focus (that is, TYSS workers are not truancy officers and are more concerned with identifying and resolving barriers to the young person attending school).

Of the 6 clients rating with significant concerns at closure, 2 were closed at the 6 month period indicating that they had not engaged long enough for therapeutic benefit, and only one of these clients indicated an interest in working on attending school. All of these clients had significant barriers to accessing education such as mental health issues, experience of trauma, homelessness and alternative education options had been investigated.

It should also be noted that over the time period covered by this report, several alternative education options (U-turn, Youth Connections, Yspace, FLIP, Yconnect), ceased operation reducing the referral points for highly disengaged young people who were not suitable for mainstream education (the most common reason for this being emotional dysregulation issues as a result of trauma). Out of 59 clients, a result of 5 clients presenting as school refusing after therapeutic service provision is an excellent result.

Personal issues

Cultural and personal identity is a factor which was able to be assessed more thoroughly over time and incorporates factors such as cultural and linguistic or aboriginal backgrounds, personal traits such as confidence, self-esteem and sense of identity.

Very few clients referred to the service and accepted had identified disabilities. This factor was taken into account early in the eligibility process in order to determine the client's capacity to engage with a therapeutic service. Those who had significantly limited capacity to engage in a therapeutic service were supported with alternative referrals such as to disability services and in the latter part of the time period, the National Disability Insurance Scheme. Those young people who identified as having a disability and were accepted into the program tended to be restricted to mild intellectual disabilities or learning disorders.

Figure 18 demonstrates outcomes in regard to cultural and personal identity, health and self-care and disability measures.

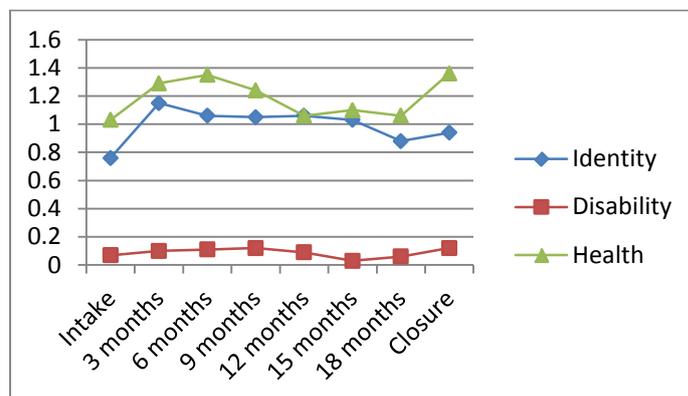


Figure 18: Average risk scores on Identity, disability and health measures

Cultural and personal identity

At intake, 23.7% of clients (n=14) scored at the some or significant concerns in regard to their cultural and personal identity. 18.6% of clients (n=11) rated as having some concerns and 5% (n=3) as having significant concerns.

At 3 months, 32% of clients (n=19) scored at the some or significant concerns in this area, 23.7% (n=14) rated at some concerns and 8.5% (n=5) rated as significant concerns.

At closure, 11.8% of clients (n=7) scored at the some or significant concerns in this area, 8.5% (n=5) rated at some concerns and 3.4% (n=2) rated as significant concerns.

Cultural and personal identity was one area of need which assessed very low numbers of young people needing significant support in this area. Thematic analysis of the clients with some or significant concerns demonstrates that the most common concerns related to emotional regulation and awareness, confidence, self-esteem and communication skills.

The large spike between intake and 3 months indicates the inherent nature of assessing personal traits which are often not able to be identified during initial assessments and become more apparent over time in which the therapeutic relationship is established. The upward trajectory at closure once again can be explained by those clients who disengaged early on in the program. Of the 7 clients who demonstrated some or significant concerns at closure, 2 were closed at 6 months, 1 demonstrated no improvement, remaining as significant from intake to closure, 1 reduced from significant to some concerns and only 1 experienced an escalation from limited concerns to significant concerns (this young person had significant trauma related symptomology and was subject to CPS orders at closure).

Overall, the data shows a relatively stable distribution of scores between the 6 and 15 month period with the slight dip at 18 months demonstrating marked improvement tended to occur over a long period of support. The data also demonstrates overall improvement in cultural and personal identity across the board.

Disability

At intake, 1.7% of clients (n=1) scored at the some or significant concerns in regard to disability. 1.7% of clients (n=1) rated as having some concerns and 0% (n=0) as having significant concerns.

The same results were returned at the 3 month interval and at closure.

3 clients were referred and accepted to the TYSS program that had an identified disability. Only one client had some disability related concerns which were persistent throughout their engagement with TYSS. This client had sensory processing disorder, memory issues, a mild Intellectual disability and a queried diagnosis of Autism Spectrum Disorder and the concerns were in regard to his lack of acknowledgement of any intellectual or learning difficulties.

The data set for this area of need is too small for any further thematic or data analysis.

Health and self care

At intake, 40.7% of clients (n=24) scored at the some or significant concerns in regard to their physical health and self-care skills. 35.6% of clients (n=21) rated as having some concerns and 5% (n=3) as having significant concerns.

At 3 months, 50.8% of clients (n=30) scored at the some or significant concerns in this area, 49% (n=29) rated at some concerns and 1.7% (n=1) rated as significant concerns.

At closure, 20% of clients (n=12) scored at the some or significant concerns in this area, 18.6% (n=11) rated at some concerns and 1.7% (n=1) rated as significant concerns.

The data indicates an upward trajectory between intake and 6 months (which is essentially the assessment period) and a downward trajectory, reducing the concerns over the next 12 month time periods.

This is consistent with the development of the therapeutic relationship in which young people are more likely to disclose concerns of a personal nature.

Thematic analysis of the nature of health care concerns demonstrates that the most common concern at the commencement of engagement with TYSS is in regard to general hygiene and self-care. Of the 30 clients who scored at some or significant concerns at the 3 month period, 50% (n=15) demonstrated some or significant concerns related to general hygiene, 27% (n=8) demonstrated concerns around eating behaviours and lack of nutrition, 23% (n=7) had poor sleep hygiene, 16% (n=5) had sustained a serious injury, 20% (n=6) had general health concerns or infections, 16% (n=5) had sexual health concerns, 6% (n=2) had multiple miscarriages or abortions, 6% (n=2) had suspected pregnancies, 6% (n=2) were smoking with a diagnosis of asthma and 3% (n=1) had a sexually transmitted infection.

At closure of the 12 clients who had some or significant concerns at closure, 50% (n=6) had general health concerns or infections, 33% (n=4) demonstrated some or significant concerns related to general hygiene, 25% (n=3) demonstrated concerns around eating behaviours and lack of nutrition, 25% (n=3) had sexual health concerns, 8% (n=1) had poor sleep hygiene, 8% (n=1) had sustained a serious injury, 8% (n=1) was smoking with a diagnosis of asthma and 3% (n=1) had a sexually transmitted infection.

The significant reduction in risk between 3 months and closure appears to be as a result of improved self-care skills.

Basic needs

In terms of establishing safety, basic needs are one of the first areas of focus for TYSS workers, particularly in the areas of safe and stable accommodation and access to food and clothing. Figure 19 demonstrates the outcome measures in regard to the young person's basic needs of accommodation and adequate access to financial resources to meet basic needs.

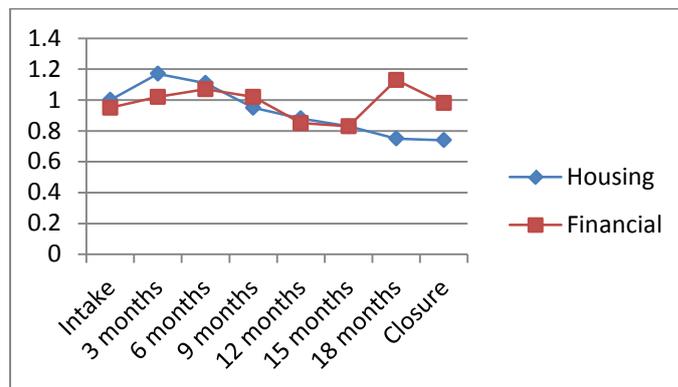


Figure 19: Average risk scores on housing and financial measures

Housing

At intake, 25.4% of clients (n=15) scored at the some or significant concerns in regard to their accommodation. 23.7% of clients (n=14) rated as having some concerns and 1.7% (n=1) as having significant concerns.

At 3 months, 32% of clients (n=19) scored at the some or significant concerns in this area, 28.8% (n=17) rated at some concerns and 3.4% (n=2) rated as significant concerns.

At closure, 16.9% of clients (n=10) scored at the some or significant concerns in this area, 15.2% (n=9) rated at some concerns and 1.7% (n=1) rated as significant concerns.

The data shows an overall decline in concerns around housing across the 6 month to closure period. Of the 2 clients who were primary homeless at the 3 month period, one moved to some concerns (shelter accommodation) and one to limited concerns (relatively stable accommodation) at the point of closure. Of the 17 clients who rated as some concerns at the 3 month mark, 7 moved to limited concerns

and 7 moved to no concerns by closure with only 3 remaining at the some concerns level and one escalating to primary homelessness. The one young person who was primary homeless at closure disengaged from the service at 3 months.

Many young people who engage with the TYSS program have very few appropriate family supports and for many, the family home is not a safe environment for them to return to. For example, of the 10 clients scoring as some or significant concerns in accommodation at closure, 5 had significant concerns with their parent / carer relationship and 2 had some concerns. None of these young people were subject to CPS orders and therefore it is unlikely that sufficient evidence was available to statutory services to indicate the level of risk to the young person if they returned home. The ages of these 10 young people ranges from 13-16 which is a problematic age group for CPS to obtain out of home care placements for, with shelters at times being utilised by Child Protection to accommodate young people in this age cohort (Pryor, 2014).

Given the lack of housing options, particularly for young people under the age of 16 who are ineligible for Housing Support Services (8 of the 10 young people with concerns at closure were under the age of 16), many young people are forced to cycle in and out of short term accommodation (such as Annie Kenney and Youthcare) and few are able to access and maintain medium term accommodation (such as Mara House and Launch). It is these young people who demonstrate significant initiative in resourcing accommodation through couch surfing or living with unrelated adults. Although this is not a stable option (leaving many clients in the limited or some concerns category at closure), TYSS supports the young people to engage in this resourcing due to the lack of other suitable alternatives. That so few clients are in unstable accommodation at closure demonstrates significant support that has taken place to provide any increase in stability at all.

Money / financial

Many young people engaged with the TYSS program do not have access to an independent income. Money and financial management assessment incorporates access to income and whether this is sufficient to meet their basic needs or whether the young person has access to basic needs through a third party such as family.

At intake, 30.5% of clients (n=18) scored at the some or significant concerns in regard to their access to sufficient income to cover basic needs. 16.9% of clients (n=10) rated as having some concerns and 13.5% (n=8) as having significant concerns.

At 3 months, 33.8% of clients (n=20) scored at the some or significant concerns in this area, 20.3% (n=12) rated at some concerns and 13.6% (n=8) rated as significant concerns.

At closure, 23.7% of clients (n=14) scored at the some or significant concerns in this area, 13.6% (n=8) rated at some concerns and 10.1% (n=6) rated as significant concerns.

Overall there was little change in the access to basic needs between intake, 3 months and closure however there was a slight decline in concerns over time. The number of young people unable to access basic needs at the some and significant concerns level is of concern. It demonstrates the difficulties that young people who have little support from family or friends face in being able to meet the basic needs that are required in order to function, let alone engage in therapeutic services. That is, it is very difficult to have a therapeutic conversation of benefit when the young person has not eaten in 3 days. TYSS workers have accessed brokerage support in the form of purchasing meals, providing food packs and have accessed services such as SecondBite and ER agencies for food support however none of these options are sustainable over time. Even those clients who have been able to access independent income through Centrelink either struggle to maintain this due to the requirement that they engage regularly in education and many of these young people do not have stable accommodation (it cannot reasonably be expected for a homeless young person to prioritise going to school over their basic

needs) or the income received is insufficient to support them to live independently.

Of the 20 clients who demonstrated some or significant concerns in this area at the 3 month mark, 2 were aged 13 years and 4 were aged 14 years, both of which age groups are ineligible for income support, all 6 of these young people had some or significant concerns with their parent / carer despite living at home and therefore it can be determined that the lack of access to basic care needs represents a systemic family issue. Of the 14 young people in the older age cohort (15-17 years), 5 were in shelters or primary homeless, all had some or significant concerns with their parent / carer and all had some or significant concerns accessing social supports, 12 of 14 having some or significant concerns accessing services. This represents the significant impact that the level of disengagement and lack of social support has on the basic care of young people. The situation of these 20 young people at closure demonstrates some improvement with 13 clients scoring limited or no concerns at the closure point. Comparative analysis demonstrates that of these 13 clients, 10 had significantly improved relationships with their parent / carer scoring at limited or no concerns, 7 had improved access to social supports scoring at limited or no concerns and all 13 having improved access to services scoring at limited or no concerns. This demonstrates a direct correlation between strengthening supports around the young person and access to basic care.

Of the 14 clients who demonstrated some or significant concerns in regard to money and financial management at closure, a strong theme of early disengagement from the program is apparent with 4 clients disengaged at the 3 month point, 4 at the 6 month point, 2 at the 9 month point and only 3 clients engaging for over 12 months. This also supports the correlation between therapeutic support building social supports and the access to basic care needs. Of these 12 clients, 2 rated limited or no concerns with their parent / carer, 5 had limited concerns with their access to social support and 8 had limited or no concerns with accessing services. 5 young people were living in shelters or primary homeless at the point of closure. This supports the assertion that when young people have limited social support and insufficient income, accessing services to support their basic needs is insufficient and highlights a gap in service to clients in this cohort.

Other

Figure 20 demonstrates outcomes on parenting or caring responsibilities of the young person and any other concerns not assessed under other categories.

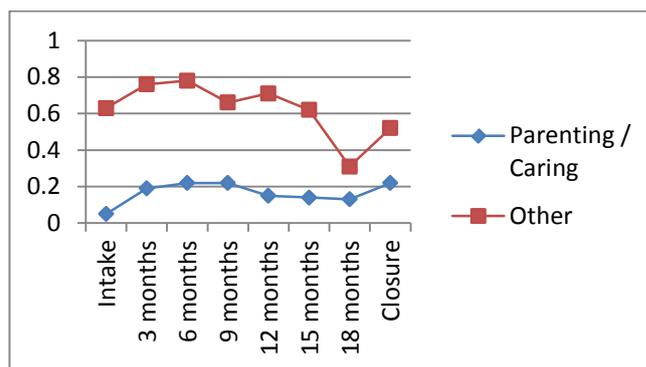


Figure 20: Average risk scores on parenting / caring and other risks measures

Parenting / caring

Parenting / caring relates to the responsibility of the young person to provide a caring role to another person who may be a parent, sibling or other relative and to young people who are pregnant or have a child and their capacity to fulfil this caring role.

At intake, no clients scored at the some or significant concerns in regard to their parenting or caring responsibilities.

At 3 months, 3.4% of clients (n=2) scored at the some or significant concerns in this area, 3.4% (n=2) rated at some concerns and 0% (n=0) rated as significant concerns.

At closure, 1.7% of clients (n=1) scored at the some or significant concerns in this area, 1.7% (n=1) rated at some concerns and 0% (n=0) rated as significant concerns.

At 3 months, 9 young people were identified as being in a parenting or caring role. 7 of these demonstrated limited concerns and these related to the responsibility of taking on this role as a young person. The ages of these young carers ranged from 11-17 years. The 2 clients who scored as some concerns at this point were both females aged 13 and 15. The 13 year old identified as a carer for her mother who had early onset dementia. This client was referred to CPS due to other concerns and was closed at the 3 month mark and is the one client represented as having some concerns at closure. The 15 year old was taking responsibility for the care of her siblings due to her mother's lack of parenting capacity. This client demonstrated an improvement in concerns by closure.

At closure, 10 young people were identified as being in a parenting or caring role and 9 of these demonstrated only limited concerns. Of these young people, 3 clients were in a caring role with their siblings and 1 with their mother. 4 young people were pregnant and 2 had babies. These 6 young people who were either pregnant or had babies were aged 14 (n=1), 16 (n=2) and 17 (n=3) at closure with only one of these babies subject to Child Protection involvement.

Other

The other category relates to any other issues that a young person engaged with the TYSS program may face that impacts on their functioning and that is not adequately covered by any of the other categories. This includes issues such as grief and loss (n=5), underage sex (either under age 15 or with a much older partner >20) (n=4), problem sexualised behaviours (n=3), parental issues such as mental health, conflict or mental health (n=4), bullying (n=3) and exposure to sexual predators (n=2). The issues included in the other category are often not picked up at assessment without voluntary disclosure by the client.

At intake, 23.7% of clients (n=14) scored at the some or significant concerns in regard to any other concerns not assessed through other criteria. 15.2% of clients (n=9) rated as having some concerns and 8.5% (n=5) as having significant concerns.

At 3 months, 27% of clients (n=16) scored at the some or significant concerns in this area, 18.6% (n=11) rated at some concerns and 8.5% (n=5) rated as significant concerns.

At closure, 10% of clients (n=6) scored at the some or significant concerns in this area, 6.8% (n=4) rated at some concerns and 3.4% (n=2) rated as significant concerns.

The data shows a spike between the intake and 6 month period and this is likely related to an increase in disclosure as the therapeutic relationship developed between TYSS worker and the young person. There is a decline in concerns between the 9 and 18 month period consistent with effective therapeutic intervention. The spike at closure is likely to be impacted by a number of young people who did not engage with the service past the 6 month mark (n=4) and therefore there was insufficient time for therapeutic benefit to be evident in this category. Of those young people who engaged with the service for 12 months or more and scored some or significant concerns at 3 months (n=11), 8 demonstrated a decline in risk scores to the limited or no concerns level, 1 reduced from significant to some concerns, 1 remained at some concerns and 1 remained at significant concerns (this young person demonstrated an overall increase in risk and was closed due to referral to specialist mental health services).

Discussion

Young people who engage with the TYSS program demonstrate multiple risks and vulnerabilities however, as this report has shown, with appropriately applied therapeutic support and the development of

positive social supports these can be overcome. The TYSS program works in an evidence based manner, utilising client-centred approaches, incorporating developmental understanding, a caring relationship, variety and flexibility, youth centric practice and cultural sensitivity which Connolly and Joly (2012) state are crucial for programmatic success in working with disengaged youth. Connolly and Joly (2012) also stress the importance for funding bodies to be aware of the absolute necessity of outreach work with this cohort, an element of the TYSS program which has single-handedly ensured the engagement with young people who would not have engaged with a centre-based program and to support young people to access services they either were unaware of or unable to access without support.

Research demonstrates that the risk of suicide, substance use, mental health problems, violence, prostitution, malnutrition and respiratory illness is significantly higher for young people on the streets (Connolly & Joly, 2012) and the data in this report supports the presence of these issues in a high proportion of the young people engaged in the program. Without effective intervention, all of these issues have the potential to impose high economic and social costs to the community and early intervention to address these risks makes fiscal sense.

Overwhelmingly, the young people represented in this report have experienced adversity and challenges which have negatively impacted their functioning. Not the least of these experiences are the relationships with family and exposure to trauma. Whilst most of the young people had had some contact with Child Protection at some point in their childhood, the level of risk to them in their home environment had not been deemed sufficient for statutory intervention but this does not reduce the level of impact these experiences have had on their development and ultimately their exposure to further risk.

Furthermore, Forrest and Edwards (2015) state the inextricable link between early childhood adverse experiences and the risk of developing young offending behaviours and associated problems such as unemployment, financial difficulties, substance dependence, mental and physical illness, difficult interpersonal relationships, criminal victimisation and family violence which is also evident in the data presented in this report. Callaghan et al. (2003) demonstrates the link between young offenders and oppositional / aggressive behaviours, increased emotional problems, self harm, peer and family relationship difficulties, school non-attendance which is supported by the data in this report. Forrest and Edwards (2015) further state that intervention between late childhood and early adolescence is effective and work toward the prevention of life-course persistent problems including offending. The need and benefit of early intervention is strongly represented in the literature (Tyler & Cauce, 2002) and the outcomes in this report demonstrate that change is possible.

The strong evidence toward the presence of family relationship breakdown in high risk youth also identifies the need for early intervention family support services to address the risk factors present in families in order to prevent the escalation of concerns in adolescence. Although there are many options in terms of family support services for families with young children, these are voluntary services and many families either do not recognise the need for early intervention support or have such complex needs that prevent them from engaging with these services. Intensive family support services, particularly as early intervention support for young families is a significant gap in service in Tasmania, with most services providing a reactive rather than preventative approach to family support. Factors such as substance use, family violence, punitive parenting practices, teenage motherhood and socioeconomic constraints within the family all place children at greater risk of developing risk taking and antisocial behaviours as adolescents (Forrest & Edwards, 2015).

The issue of youth homelessness continues to be a predominant social concern in Tasmania and is highlighted in this report as a significant issue impacting on multiple domains of the young person's functioning. Many factors contribute to young people leaving the family home at an early age such as physical abuse, sexual abuse, neglect, parental substance use and parental rejection (McMorris et

al., 2002; Thrane et al., 2006; Tyler & Cauce, 2002; Tyler et al., 2004) and that once they become homeless their risks increase due to deviant subsistence strategies and street victimisation (Thrane et al., 2006). Research indicates that young people do not exaggerate the reasons for them leaving the family home and the difference between youth and parent's reports vary in degree but not content (Whitbeck et al., 1997). So exploitation and victimisation within the family leads to youth homelessness (Tyler & Cauce, 2002) leaving them to face very few accommodation options (Pryor, 2014) and significantly increased risk of substance use, victimisation, sexual violation and prostitution, dissociative mental health issues and pro-criminal behaviours (Thrane et al., 2006; Tyler et al., 2004). This catch 22 situation requires strategic focus in both the early intervention and crisis service delivery space in order to break the cycle of adverse childhood experiences leading to "safety" strategies which pose different risks to the young person. Without the capacity to provide youth with the safety, stability and basic care needs they require, their projected outcomes are unlikely to improve, with significant impact to the community as a whole.

The impacts of violence is also a key issue highlighted in this report, both in regard to young people's exposure to violence, their engagement in violence and the links to poor mental health outcomes and suicide risk. Evans, Marte, Betts, and Silliman (2001) report a strong link between peer related violence and the risk of suicide among youths and the data in this report supports the link. With over 70% (n=44) of young people in this data set presenting with exposure to or engagement in some or a significant level of violence and over 50% (n=23) of them displaying varying degrees of self harm or suicidality during their engagement with TYSS, this is a key issue in both risk taking behaviours and establishment of safety for young people.

Drug use is clearly a key issue for young people engaged with the TYSS program, particularly cannabis use. In a 2007 report, Bruno, Ong, and De Graaff (2007) stated that prevalence rates for cannabis use in the over 14 population in Tasmania is 11% and within the 14-24 age group is 22% whereas the TYSS cohort reported cannabis use at assessment as over 42% (n=25) which is also likely to be an underrepresentation of the true usage rates. This represents both an indication of exposure to adverse experiences (self-medication) and an increased risk for drug related adverse experiences. Although there are some dedicated drug and alcohol services available to young people, there are also barriers to engagement and outreach services are very limited in this area. Support in this area however has been focused on adaptive coping mechanisms which appears to have had good efficacy overall in the reduction of illicit substances among TYSS clients, treating the root cause rather than the symptoms so to speak.

This report has demonstrated the use of best practice models for youth intervention with evidence of efficacy across all 20 areas of need. The use of TF-CBT remains the most evidence based intervention and as has been demonstrated in the literature review and outcomes focused thematic analysis, this therapeutic approach has demonstrated that this is both appropriate and effective. There are no other known programs that use this evidence based approach to addressing significant risks for vulnerable young people who have multiple and complex needs and in this fact, TYSS is a unique program and has demonstrated both its worth and its potential for further development.

Limitations

As this study is an evaluation of the TYSS program as delivered by Bapcare, data and outcomes for the program delivered in the South West, North and North West of the state are unavailable and not included in this study.

For the purposes of establishing baseline and outcomes risk scores, only young people who remained in the program for 3 months or longer have been included in this study. Although this may impact on some data, those who engaged for less than 3 months would not be expected to have demonstrated any therapeutic effect and therefore would not be considered clinically significant for the purposes of this

study. Additionally, young people who engaged with the program short term (less than 12 months) have been included in the data set however this may have skewed some outcomes data due to the limited therapeutic benefit of their shorter engagement.

Conclusion and recommendations

The data demonstrates that the TYSS program provides therapeutic benefit across all outcome areas. Analysis indicates that the level of therapeutic benefit is directly correlated with the length of time that the young person engages in the program and that medium to long term support results in overall therapeutic benefit whilst short term engagement results in limited therapeutic benefit. The cost of the TYSS program is approximately \$250 per client per week based on the current funding and service delivery of half a day's support per client per week. This is a relatively costly service however given the extensive number of areas in which the client receives benefit, the underlying therapeutic change agency and the reduced level of risk of the clients accessing high level services into the future, the benefit to the client, community and reduction in health, justice and community service reliance far outweighs the initial cost. It is therefore the strong recommendation of this evaluation that the service continues to operate and the following additional recommendations should be considered to enhance the high quality service and address identified gaps in services.

- Increase in community engagement and relationship building between the TYSS program and services in the Glenorchy and Huon Valley areas has indicated an increase in referrals from these areas. It is recommended that community engagement and relationship building in Kingborough and Hobart areas be areas of focus in future along with continued networking with the Glenorchy and Huon Valley service providers.
- It is recommended that the age parameters be amended to allow for more of a case by case based eligibility for younger children. This would allow for earlier intervention and therapeutic support for children displaying extremely challenging behaviours at an earlier age could result in prevention of escalation into youth justice at age 10.
- An ecological systems theory approach which incorporates a whole of system intervention, including access to an intensive family support worker to build on family supports and interpersonal relationships (this is outside of the scope of IFSS) and reduce the systems issues that contribute to the re-emergence of behavioural issues in adolescence.
- Early intervention evidence suggests we should be acting sooner and with younger children to prevent escalation. TYSS funding restricts service to the most high risk and therefore early intervention is more reactive than proactive. There are no services funded to do early intervention with at risk youths who are disengaged from family. Therefore it is recommended that funding bodies and program development within government and non-government have more of an early intervention approach and move away from the reactive services that are currently the only option for youth and families.
- It is the strong recommendation from this report that further investment and service be instated to address outreach models for youth mental health and drug and alcohol services and a review of youth homelessness and accommodation options be undertaken.
- Extension to existing or establishment of a new mentoring service for young people by young people as a transition option for young people exiting the TYSS program to have access to a positive peer network of support to ensure longer term outcomes.
- Longitudinal research through follow up with young people at regular intervals (such as yearly) post-discharge from the TYSS program would enable the ability to measure longer term outcomes of therapeutic support and provide an additional evidence base for the model.

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