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WORKING WITH COMPLEXITY IN YOUTH MENTAL HEALTH

A NEW MODEL TO ENCOURAGE REFLECTION

INTRODUCTION

'Complexity' is a term that is regularly used in clinical mental health services but has, to date, been narrowly defined. Traditional definitions of complexity have often focused on the young person alone. This can include the level of risk that a young person presents with as a result of their illness, but may also consider psychosocial factors (e.g. homelessness, family violence or limited social supports).(1) Although these factors are likely to impact a young person's wellbeing, functioning, responsiveness to services and overall recovery,(1) attributing complexity based on a young person's presentation alone can be unhelpful. This is because it may:

- Perpetuate unhelpful beliefs (e.g. the young person being labelled as 'difficult' or a 'burden'), especially depending on how this is communicated and then internalised by the young person.
- Impact on therapeutic relationships between young people and services. If services perceive the young person as "too complex" it may cause relational dynamics in which staff feel stuck or hopeless, and consequently become more controlling or rejecting in their response.
- Mask problems in the system e.g. workforce issues, service capacity, and service and sector demand.

In contrast to traditional definitions, we propose that complexity relates to more than just young people's presenting issues, and that it also incorporates other factors including workforce issues and the influence of the broader service system.(2) Furthermore, working with complexity requires us to consider and celebrate the strengths and capacities of young people, families, mental health staff and service systems.

AIMS OF THIS RESOURCE:

This resource aims to:

- Propose a model of complexity which comprises of three domains (young person, workforce and service systems)
- Encourage self- reflective practice and adaptive learning for individuals, teams and organisations as a way to explore and respond to complexity;
- Identify approaches for clinical practice around complexity, including recommendations for how clinicians, teams and services can respond to complexity (based on feedback from services doing this work); and
- Provide case examples of what reflecting, exploring, formulating and responding to complexity might look like in practice.

EXPLORING A MODEL OF COMPLEXITY: THE THREE DOMAINS

To support clinicians, teams and organisations to approach complexity in their work, we propose a model of complexity which comprises of three domains:

- young person
- workforce
- service systems

It is the interplay of these three domains that contribute to complexity.

Further, each of these domains may hold multiple different factors, and thus several interactions may be occurring simultaneously within or between these domains. It is helpful to understand these interactions or, at the very least, be aware of their potential to occur.

For example, when discussing identity (which is a factor under the domain of 'young person'), it may be useful to recognise that people can often hold multiple and shifting identities, meaning identity in of itself may lend to a case being understood as complex.

Therefore, a holistic approach to formulating, understanding and approaching factors that span across (and live within) the three domains is needed. This is in line with adaptations to clinical approaches that increasingly understand the role that formulation holds to synthesize multiple factors and acknowledge the meaning or influence of these interactions. (2)

Table 1 describes how the model translates into practice and possible factors that could contribute to each domain.

FIGURE 1: A MODEL OF COMPLEXITY -

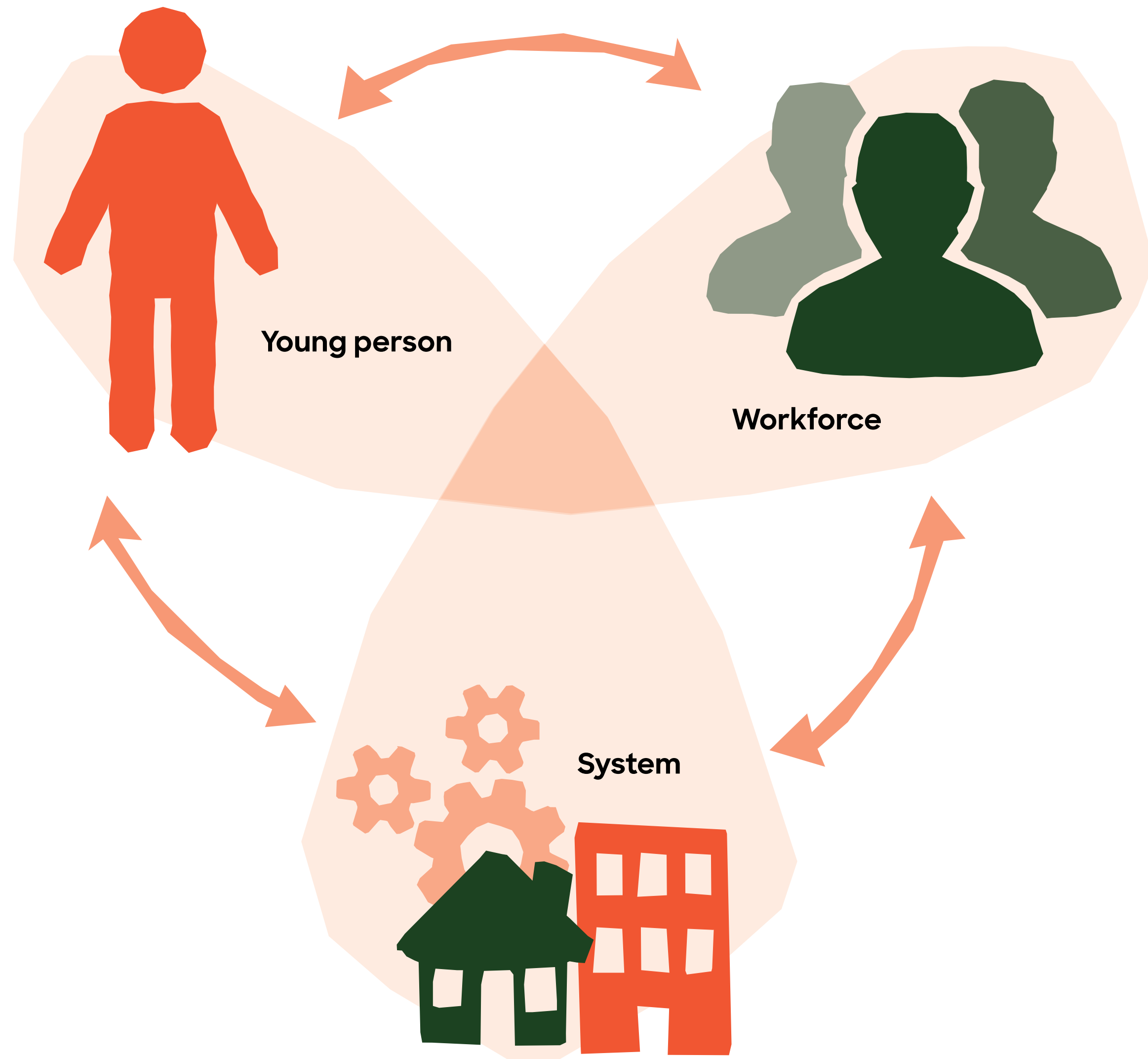

TABLE 1: THREE DOMAINS OF COMPLEXITY

DOMAIN	DESCRIPTION	ASSOCIATED FACTORS
Young person	Recognises the complexity of people's lives and experiences in general.(3) Of particular importance is the role of identity which, in itself, can be multi-layered, complex and changing- and be both personally and collectively understood. In this we recognise the importance of young people being able to self- identify in regards to their identity, however recognise also the impacts of other people (as well as intuitions and systems) in how they perceive and respond to a person's identity. These associated factors listed may include the young person's presenting mental ill-health, as well as stressors or experiences that may intersect, influence or be influenced by their presenting mental ill-health. Some of these factors may be understood to be either vulnerabilities or protective factors depending on the context and young person's perspective. Some factors may be considered vulnerabilities only in the way in which they interact and are affected by larger systems or institutions (to include workforce and systems factors).	**Clinical:** • Clinical stage of illness/severity and prognosis • Type of mental illness • Illness history (longstanding vs state based) including aspects of untreated illness • Level of clarity around presenting mental health needs and required treatment approach • Level of distress • Co- morbidity (including AOD) • Functioning • Risk (including vulnerability) **Experiences:** • Developmental trauma /adverse childhood life experiences • Developmental delays, neurodiversity, cognitive difficulties or disability/chronic health issues • Psychosocial stressors (e.g. homelessness, financial stressors, educational experiences) • Social disadvantage (e.g. educational, income, stigma, discrimination, isolation, poor mental health literacy) • Experiences of previous treatment (and consequent thoughts on helpfulness of treatment), including experience in other systems (e.g. education, justice) • Individual (and personal) experiences of recovery • Stigma (experienced or perceived) of mental ill health and accessing mental health services • Access to supports and social networks **Identity:** • Cultural identity (including language) • Religion and spirituality • Sexuality • Gender identity • Disability and ability • Personality • Class • Recovery journey (including how various factors interact with goals, hopes, development, dreams, self-esteem and identity). **Family:** • Individual family needs & whole family system needs (including mental health, transgenerational patterns and trauma, parenting, life events, developmental stage, disadvantage, discrimination, strengths and protective factors) • Supports available, access to supports, mental health literacy and stigma • Past experiences with services and service system • Grief, loss, role adaption and caring duties • Experiences of culture, language and identity

DOMAIN	DESCRIPTION	ASSOCIATED FACTORS
Workforce	Recognises that the workforce is influenced by multiple systems (e.g. team, organisation, service system) as well as clinical experience and individual factors (e.g. background, identity, personal approach). This domain refers to both the individual clinician, and the whole team system. Ideally, practice can be considered in a whole team approach so that a broad range of skills can be utilized and shared.	• Clinician competence • Clinician confidence • Clinical experience (and access to expertise in team or sector) • Cultural responsiveness skills and attributes (and access to cultural navigators or workers with cultural expertise) • Youth friendly skills and knowledge • Personality style • Influence of own identity (including cultural background) • Engagement skills • Access & use of supervision • Ability to work in a team • Team functioning- including culture, shared values, access to varied workforce (eg. Peer work, cultural leaders) with interdisciplinary functioning • Therapeutic stance used • Model of care for the service (including service design and contract expectations) • Staff wellbeing (including ability to manage work stressors or sit with unpredictability, levels of burn out) • Organisational leadership, governance, accountability, processes and quality improvement
System	Recognises the influence and intersection of other systems (e.g. education, employment, healthcare, justice, and broader society) on young people, the workforce/service, and the broader system. This can include communication between systems (or lack of). All systems are influenced by broader socio-cultural and political systems.	• Sector and service demand (including case load demands on workforce) • Relationships and partnerships within the local mental health service system (e.g. between primary and tertiary mental health services) • Relationships and partnerships between sectors/systems (eg. broader healthcare, education, justice, employment, housing, centrelink services). • Referral pathways, options for care and flexibility of support available • Resource allocation • Multiple service involvement in providing care (inc clear role clarity and communication) • Local demographics - representation & needs of the community • Mental health systems culture (including western approaches to healthcare and historic influences)

CONSIDERATIONS FOR HOW WE RESPOND TO COMPLEXITY

Responding to complexity requires team and organisational approaches, not just individual approaches. We should encourage multiple perspectives and collective reflection on how to respond. While there may not be a clear right or wrong answer, an ability to openly discuss the different influencing factors, opinions and potential courses of action is an integral part of our work.

Just as we may develop a clinical biopsychosocial formulation to develop an understanding of a young person's needs to guide treatment planning, we may similarly use formulation skills to identify a composite of needs across the three complexity domains. From this, it is possible to develop a plan that addresses clinical, workforce and system factors.

The questions in Table 2 are designed to stimulate reflection and discussion on how we understand and respond to complexity. We encourage that the dialogue occurs in self- reflective practice, in supervision, in discussion within teams and organisations, and when possible, within local systems of care, as this in itself may act as an intervention.

TABLE 2: QUESTIONS TO ENCOURAGE REFLECTION

REFLECTING ON A CASE	REFLECTING ON OUR INDIVIDUAL PRACTICE	REFLECTING ON THE TEAM
• What factors might be driving complexity? How do they interact together and what influence do they have on the young person? • What needs to change for the young person to support the young person's goals and needs? • What needs to change for us as clinicians to support the young person's goals and needs? • What needs to change for us as a team/system to support the young person's goals and needs? • What is within our control? What can we do, using the resources that we have? This includes the young person and their network, the workforce (including us) as well as the larger system. • Who is most concerned about the complexity (young person, family, clinician, organisation)? What is driving our current response or plan?	• What is complex to me? Why? How does this present in day to day practice? • How might this differ or intersect with other influencing factors, such as severity? How might we distinguish these overlapping factors? • How do I respond to something that is perceived as complex? What might be helpful or unhelpful about this? • Are there aspects of complexity (across domains of young person, workforce and system) that might often be neglected in my formulation? Why? • Who (or what) helps me to think about complexity in my practice? • If this document has brought up questions I haven't had a chance to think about before, how might I carve out time to think about these things? (eg. supervision)	• How might we create processes and space that allow us to effectively respond to complexity? Are there ways we can approach complexity more helpfully and proactively? • How can we review our own (and our teams) models for complexity? How might we review and learn from our mistakes? How can we be flexible and continue to explore new ways of approaching complexity? What is sustainable? • How might we be able to learn to sit with complexity and uncertainty (and recognise this as part of the work) while having useful and planned approaches to how we respond to it? • How might we be pushed or pulled to respond? Are there competing needs or conflicting priorities across domains? How do we work within certain constraints? • Are there others in the system who we can bring in to explore and discuss complexity with?

CASE EXAMPLES OF COMPLEXITY

We have included two case examples ('Franky' and 'Jane') that represent how complexity can be thought about and formulated using the three domains (young person, workforce, system) of the complexity model. It may be useful to reflect on how you may have addressed the complexity of each case within your own context.

'FRANKY'

Franky is a 13-year-old girl living with her parents. Franky has multiple physical health difficulties which have caused fecal incontinence throughout her life and has required multiple appointments with specialists and hospital services over the years. This has resulted in generalised anxiety and difficulties in school attendance, with secondary social anxiety in relation to interaction with peers which has increased over the past six months. Franky's goals relate to addressing social anxiety and increasing her self-esteem.

Franky's developmental history, suggests longstanding difficulties in relation to her social skills and interactions with her peer network. Franky's case manager also wondered if she may present with undiagnosed autism-spectrum disorder. Franky is vulnerable in interactions with her peers and although she does not present with overt risks to self or others (with some vague suicidal ideation with no history of attempts), she does present with significant developmental risks.

Due to her health, Franky has often struggled to attend appointments in person and has disengaged from therapeutic support in the past. Franky's school has also queried whether home schooling may be a more viable option, as they are unsure of how best to support her, given the number of absences Franky has had from class and her difficulties in completing coursework outside of school hours.

Franky has supports via a contact teacher at school, GP, specialist health services and her current mental health case manager. Of note, Franky and her parents have described themes of feeling dismissed and invalidated by healthcare professionals, and while Franky's parents are very supportive, they are experiencing multiple stressors as a family unit.

Despite these challenges Franky presents as a thoughtful young person who is keen to get support and has developed a good relationship with her case manager despite the many barriers.

HOW COMPLEXITY COULD BE UNDERSTOOD?

- **Young person**: the stressors of her chronic health issues, her ability to engage in developmental tasks with peers and school, the worsening of her anxiety and the barriers to her engagement in mental health support.
- **Workforce**: the clinician's experience and confidence working with Franky due to Franky's age, confidence working in an engaging and continued/purposeful manner over telehealth, the lack of clarity around the young person's ASD diagnosis to guide the direction of care, and perceived pressure from the school to find an alternate option for Franky's education
- **System**: the involvement of multiple services, with lack of a clear consensus or formulation to understand Franky's current stressors; potential replication of relational patterns across services that may contribute to feelings of dismissal from Franky and her family; and limited access to ASD assessment in the local area.

HOW WAS COMPLEXITY ADDRESSED?

- The clinician did some research in relation to sensory modulation strategies to assist with therapeutic responses;
- a telepsychiatry appointment to discuss the possible ASD diagnosis and support the clinician with treatment planning and accessing further assessment to guide treatment, as well as a general plan that could take potential ASD traits into consideration;
- advocacy with the school in order to access a formal ASD assessment for Franky and to support discussion between the clinician, young person, parents and school around appropriate schooling options;
- liaison via case conferences and a joint formulation (including diagnostic clarity) shared between physical health services, mental health services, the school, and the young person and family. This identified previous patterns of family feeling dismissed by the system (and minimised this being repeated), ensured there were clear role and responsibilities between workers in supporting Franky and her family, and determined key priorities (to guide therapeutic planning) for everyone involved.

'JANE'

Jane is a 15-year-old female living in the granny flat of her family home. She resides with her mother and two younger siblings. There is a history of domestic violence in the family (perpetrated by her step-father) to include emotional neglect, physical and sexual abuse to both Jane and her siblings. Jane's step-father has recently been incarcerated and all family members describe a period of recovery from this, including Jane's mother who reports her own current mental health challenges.

Child protection remain actively involved. Historically there has been brief and sporadic involvement from mental health services. While Jane has been well engaged with our service (due to outreach and a high focus on relationship building) there is some caution from the family unit around trusting services. The family appear hesitant to share information for fear of how services might respond, potentially due to fears that this might involve police, child protection or further involvement of mental health services, given that previous contact has felt intrusive or controlling.

Jane has been disengaged from education for one year and describes difficulty leaving her granny flat due to anxiety. Jane has considerable strengths, including protectiveness of her younger siblings, likeable personality, and motivation to work on goals around improving relationships with family and returning to school.

Jane presents with a mix of symptoms, many that appear to be present since early adolescence, including: disordered eating, poor sleep, low mood, anxiety, occasional auditory hallucinations (a male voice, derogatory in nature) and dissociative-like symptoms. Jane reports poor self-esteem, often having felt dismissed by family and others regarding her mental health, and presents with a critical relationship with herself. Jane has longstanding self-harming behaviours and suicidal ideation, often talking at length about suicide plans, and one previous suicide attempt one year ago that required admission to hospital.

Jane is pending an assessment with the tertiary CAMHS team, however it is unclear whether they will be able to remain involved, and if they do it would require Jane to attend the clinic for appointments. Jane has also presented with a recent escalation in risk-taking behavior (along with some behavioral changes) and it has been queried whether this could indicate an emerging manic episode.

HOW COULD COMPLEXITY BE UNDERSTOOD?

- **Young person**: longstanding and recent trauma and life stressors; functional (education, relationships, basic care) and case management needs; Jane's sense of self and wellbeing; the needs of the whole family unit.
- **Workforce**: the pressure to respond to multiple demands and needs; concern for developmental trajectory versus providing therapeutic support at Jane's pace; lack of diagnostic clarity which can cause challenges in treatment planning; and risk of vicarious trauma given nature of Jane's trauma.
- **System**: the number of services involved (and risk of role diffusion), risk of apathy to risk given previous (high) threshold for responding to abuse in both family and service system; challenges of system meeting Jane's needs given her difficulties getting into the clinic; whether YES are the best service to meet this young person's needs and if so, how this can be shared within the team and broader system.

HOW WAS COMPLEXITY ADDRESSED?

- a team approach to supporting Jane's needs and responding to risk (physical health, risk to self, vulnerability risk) within the team between key workers and medical officer;
- collaborative goal setting (short term and long term) between the service and Jane, which included short term goals around anxiety management & exposure to support functional ability to attend clinic appointments;
- secondary consultation between clinician and trauma specialist in the team about how to approach trauma in this case;
- thorough handover prior to assessment with CAMHS service;
- discussion within the team to determine potential system challenges with thought to what YES team could offer in role and how this may fit within broader system, as well as how this can be effectively communicated with others;
- case conferences and communication with child protection team to ascertain supports they could provide for family as well as handover concerns for vulnerability;
- secondary consultation with psychiatrist which highlighted concerns for manic episode secondary to antidepressant, with ways to monitor and assess this along with some thoughts to therapeutic approach;
- discussion in team and in supervision around relational dynamics between clinician and Jane, with thought to providing appropriate therapeutic care while also not colluding with themes around minimising needs versus controlling behavior.

APPROACHES TO RESPONDING TO COMPLEXITY

"Cookie cutter therapy works well if your clients are cookies but most of our clients are soup. The beauty of our program is our capacity to adapt the mode of therapy, issue to be focused on, who to involve, extent of systems work, time required etc to the client rather than expecting them to squeeze into a model that is not working for them... This constant assessment and adaptation (within reason) takes time and expertise from the therapist."

(YOUTH MENTAL HEALTH SERVICE CLINICIAN)

Youth mental health services are often responding to broad (and multiple) needs of young people, which may include a particular focus on severity of mental health and/or complexity.

What one service deems as complex will depend on a number of factors. This includes the focus of the service, the type of clinical and personal experience of clinicians, the model and structures of support available within the team or network, and staff members' ability to learn new ways of working.

The ability to work flexibly is central to the work of youth mental health services. This is important for engagement, particularly when working with 'hard to reach' young people, as well as for working with young people who may not have benefited from other therapeutic interventions or previous clinical settings, where thorough assessment and adaptation to clinical practice is essential.

Similarly, it requires flexibility in working with the service system in relation to how the model is enacted (through processes like co- location or outreach) as well as an ability to navigate the mental health eco-system (through relationship building, understanding the system and how services fit within it, as well as an ability to work with multiple organisations to provide care to young people).

As part of the development of this document, a number of youth mental health services were consulted to provide suggestions on individual approaches and service wide structures and processes which have helped them to respond to complexity effectively. These are described in Table 3.

TABLE 3: TEAM APPROACHES TO RESPONDING TO COMPLEXITY

APPROACH	WHY THIS IS HELPFUL & WHAT THIS LOOKS LIKE IN PRACTICE
Focus on the role of the therapeutic relationship (and resources to allow clinicians to generate this)	Staff reflected that their core business was to work with young people who may have been traditionally seen as difficult to engage- or who may be "floaters" in the system. Extra focus and resource was required to support the therapeutic relationship and, at times, baseline (or consistent) engagement between young person and worker was cause for significant celebration. Staff identified skills such as being youth friendly, empathetic, tolerant and flexible as key. It was noted that peer workers and family peer workers often provided a unique role in supporting engagement between young people, families and services.
Workers are a bridge to other services (and the importance of discharge planning)	Staff also saw it as their responsibility to also act as a 'bridge' that extended engagement to other workers in the system. This was seen to be important during care, but especially in relation to discharge planning. It was noted that many young people may achieve therapeutic goals during a period of care, however may have ongoing mental health or psychosocial needs post discharge that require longer term consideration. This highlighted the importance of workers connecting young people to a General Practitioner (GP) who can carry on coordinating care long term. As well as connecting young people with community services or groups that fit the young person's interests. In this way workers valued the roles of others working within the system, supported young people to understand ways to access supports should they need in the future, and considered not just current but future needs for young people in discharge planning. It may also suggest the importance of naming the episodic nature of the work early to ensure that time is given to supporting young people with other relationships within the system.
Purposeful but flexible care	This related to having a clear direction clinically (to be episodic based, with clear assessment of presenting issues, and a treatment plan that was diagnostically and clinically driven) but which remained flexible enough to address the needs and wants of the young person.
Self-reflective practice and access to specialised consultation	Self-reflective practice was identified as a core clinical skill, and this (along with access to consultation) helped clinicians to feel that they were 'on track' and to seek support around their clinical work, but also reduced unrealistic expectations that they had to know everything. It provided better clinical care, allowed for collective recognition of the influence of the system in the work, supported staff wellbeing and sustainability with the work, and supported connections within the team and the sector.
Ability to be stuck or not know (and know where and who to ask).	Importantly, the feedback from staff suggested that it was not that they did not feel or get 'stuck' in their clinical work, but rather that they felt confident to identify when they were, and to know how to navigate the system themselves in order to get appropriate feedback or guidance (either from their team directly or elsewhere). This often provided an opportunity for reflective practice as well as feedback from colleagues with advice on a new approach that could be tried. Workplace culture and psychological safety were therefore seen as influential in staff feeling comfortable to acknowledge the challenges they were facing, and which often lead to improved quality of care with young people. Therapeutic optimism was also seen as a key skill so that staff could still hold joy and hope when confronted with themes of hopelessness (both in the work but at times, in their own confidence in their abilities as well). This included an openness to working with young people with complexity (or with young people who may have experienced challenges in contact with other services) in recognition that refusing service entry to young people (and having young people bounce between multiple services) was, in of itself, a factor that could lead to further complexity.

APPROACH	WHY THIS IS HELPFUL & WHAT THIS LOOKS LIKE IN PRACTICE
A clear model with clear purposes and aims	It was identified as important for staff working in YES services to have a good sense of the model they were working to, and the purpose or focus of their support. This was due to the breadth of young people that could be serviced under the label of 'complexity' or 'missing middle'. This requires clear service aims, eligibility criteria and ongoing review/evaluation of the model. In some cases, extensive consultation and co-design were completed with young people and services in the sector prior to the development of YES programs. At other times this was developed, refined and adapted over time in consultation with primary health networks.
Resources, confidence and support to provide case management and advocacy	It was identified that therapeutic skills alone were often not adequate, and as such it was important for staff to have resources in order to effectively implement case management, particularly within a youth lens that often involved family and others in care. This required reasonable expectations in relation to case load, considering direct contact with young people and families (including time for outreach and travel, as well as care coordination) but also supports outside of direct clinical care to include documentation and staff meeting times. It was also recognized that staff saw advocacy for young people and families as a key aspect of their role, which might often get forgotten under labels of case management and therapeutic support.
Interdisciplinary approaches	It was identified that team approaches were necessary to sharing clinical needs and knowledge, complexity, risk and treatment planning as a team. This also suggested the importance of space for reflective practice, both individually and as a team, and opportunities for the team to share their individual knowledge and develop a cohesive approach to the model. This included processes such as shared intake meetings, case review discussions, shared reviews with clinical staff and/or psychiatrist, and team building days.
Access to psychiatry	Psychiatry can provide some confidence around diagnostic clarity, formulation, and treatment planning (with thought to how this might apply for a local system), which can guide purposeful therapeutic work for young people, clinicians, referrers and services as a whole. It should be noted that this does not solely rely on medication and diagnostic labels, but can include broader approaches to care. This may be accessed through primary and/or secondary consultation. Staff often used this feedback not just in direct contact with young people and families, but also with other services in the system, which helped provide a consistent systemic approach.
Good clinical governance and leadership	It is important for staff to have clear processes to escalate concerns to more senior staff so that risk concerns are adequately shared within a team. Both proactive and reactive forms of monitoring, evaluation, debriefing, structures of support, processes, incident reporting and supervision were identified. This assisted staff in feeling able to respond to complexity as a team rather than needing to have all the answers as individuals.
Team functioning, psychological safety and staff wellbeing	The complexity (and impact) of the work was highlighted as a core feature that required some consideration. This included spaces to debrief, the complexity of the work to be acknowledged openly within the team and for staff to feel comfortable enough to name its impacts. Connection between team members, respect for the contributions of individual staff and a focus from senior leadership around staff wellbeing were highlighted as crucial, as well as a general dialogue within the team as service pressures or impacts changed.

APPROACH	WHY THIS IS HELPFUL & WHAT THIS LOOKS LIKE IN PRACTICE
Organisational learning, brainstorming & development	Staff identified that they had been surprised about how much they had learned in their role, even coming from other youth or case management roles. Team members took onus to identify areas of need or learning within the team, and discussions were had about whether training or support could be accessed internally or externally. While specific training or secondary consultation was made available, the learning environment was clearly represented in the availability of senior staff sharing their knowledge with more junior staff. This was represented through reflective team spaces where staff could brainstorm or learn together as a team (eg. case reviews, group supervision or secondary consultation processes), as well as significant support in line supervision to support staff growth and professional development. Staff and teams felt comfortable to learn if there was an organisational structure that valued and created space for people to discuss complexity, be open and learn together.
Monitoring and evaluation	Monitoring and evaluation refers to both regular processes identified in clinical work (such as completing outcome measures and 3 monthly clinical reviews) that assist with quality and safety of care, as well as the way in which the teams evaluate their program expectations and outcomes (in regards to service development). While seen as core part of the role, staff surprisingly described these review processes as emotionally containing, especially given the unpredictability of the work and when there may be service growth also contributing to significant change. It was seen as important for all staff to be given the opportunity to provide feedback on monitoring and evaluation tools to leadership, to be given feedback on why senior leadership may choose particular methods or evaluation tools, and to have the time (and support) to implement monitoring and evaluation tools effectively in their work schedules. The importance of effective outcome measures which highlighted the level of complexity and intervention that services were working with (for reporting) was also highlighted as important by senior staff.
Time and resources to build relationships with the sector	YES services can have a particular role in linking between services as well as serve a function as the 'top end' of the primary care sector. This can both define what YES services can offer that is different from the rest of the primary care sector (e.g. ability to engage in outreach with 'hard to reach' young people). This supports capacity building of others in the primary care sector, and also provides opportunity to benefit from receiving support and capacity building via the tertiary sector. In this way YES services can also provide a unique insight and advocacy role in relation to systemic needs. This two-way communication process between YES services and other services in the sector can ensure that there is a shared understanding and communication between services, and help reduce potential gaps or ruptures that can occur between services or in the care of young people. This has been identified as a key priority for structural change more broadly in the health sector. Relationship building could include service meet ups with multiple agencies in the system, shared intake meetings, shared assessment or care arrangements, secondary consultation and co- location.

FURTHER RESOURCES

As we've discussed, there are often multiple ways in which you may consider approaching complexity, which will be further molded by your local context.

We have included a brief list of resources that relate to core clinical skills that support you to think about complexity. These in particular relate to supervision and relational skills.

This is not an exhaustive list. We recommend that you consider a range of resources that guide your work individually and in your teams, and recommend a broad understanding of the content of resources that may be valuable in your thinking about your work in complexity.

- Orygen resources on complexity- **Clinical practice points - Orygen, Revolution in Mind**
- 'When the doctor – patient divide is a chasm' by Alexander Blount: **When the Doctor-Patient Divide Is a Chasm | SpringerLink**
- 'Reformulating Suicide Risk Formulation' by Anthony Pisani, Daniel Murrie and Morton Silverman - **Reformulating Suicide Risk Formulation: From Prediction to Prevention | SpringerLink**
- 'Exploring the new world: practical insights for funding, commissioning and managing complexity' by Toby Lowe and Dawn Plimmer - **Exploring-the-New-World-Report_MAIN.pdf (collaboratei.com)**
- 'The 4 Ps model: A Cognitive Analytic Therapy derived tool to assist individuals and staff groups in their everyday clinical practice with people with complex presentations by Phyllis Annesley and Lindsay Jones- **The 4P's model: A Cognitive Analytic Therapy (CAT) derived tool to assist individuals and staff groups in their everyday clinical practice with people with complex presentations (acat.me.uk)**
- The seven eyed model of supervision: Hawkins, P., Shohet, R. (2012). *Supervision in the helping professions (supervision in context).* Open University Press. A description of this model (and an adapted version) is also available here by Jurai Darongkamas, Christopher John and Mark James Walker- **An eight-eyed version of Hawkins and Shohet's clinical supervision model: the addition of the cognitive analytic therapy concept of the 'observing eye/I' as the 'observing us': British Journal of Guidance & Counselling: Vol 42, No 3 (tandfonline.com)**

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