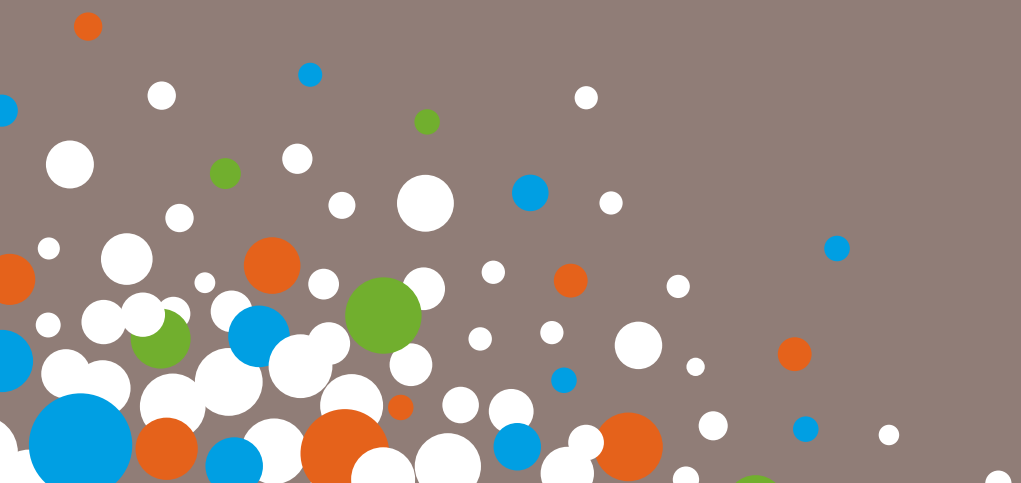
Orygen

The National Centre of Excellence in Youth Mental Health

Youth mental health service models and approaches

Considerations for primary care



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Introduction

The task of commissioning health services can be challenging, but also rewarding as it provides a real opportunity to improve lives. This is particularly pertinent in youth mental health where quality services and interventions help support young people's recovery and reduce their chances of long-term mental ill-health.

Considerations for primary care has been developed to support Primary Health Network (PHN) staff to commission appropriate, high-quality, youth mental health services. It is a tool to assist PHNs as they work to design evidence-based solutions that meet the needs of local young people experiencing mental health challenges – particularly those with severe and complex mental illness.

The document provides a 'framework for thinking' about youth mental health services and programs and poses various considerations for PHNs. Examples of good practice are included throughout, as well as background information on a range of relevant topics and links to additional information and resources.

Background

Youth mental health

Throughout this document the term 'youth' is used to describe young people aged 12 to 25 years. It includes the stages of adolescence and emerging adulthood, which are times of great change for all young people as they establish their identities, seek greater independence and transition into adulthood, often whilst dealing with pressures from school and social environments. Youth is also the peak age of onset for many mental health disorders [1,2].

Mental health problems are common in adolescence and early adulthood. In Australia one in four young people aged 16-24 years have experienced a mental health disorder in the past 12 months[3]. Disturbingly, around 80% of young males and 70% of young females with mental health issues don't seek help[4].

While youth can be a particularly challenging time for young people, it is importantly also a period in which there is great potential to increase protective factors associated with mental wellbeing and reduce the risk factors associated with mental illness.

Youth mental health is an emerging field. The evidence-base for particular approaches and interventions is building, but is still in its early stages. However, there is wide consensus, particularly in the early pschosis field, that early, specialist intervention can reduce the severity and duration of young people's mental ill-health[5].

Youth mental health services within primary care

The increasing role of primary care in responding to mental health concerns has been recognised and supported by Australian Government initiatives.

The provision of youth mental health services within primary care has the potential to massively increase the numbers of young people who can receive help and achieve improved outcomes. Locating services within primary care has the advantage of being less stigmatising, more accessible and more recovery-focused than the state-based tertiary, or specialised care settings, that often deal with the more acutely unwell and highly at-risk young people needing mental health care.

The role of PHNs

The mental health of young people is a priority for all PHNs as they work to:

- improve clinical outcomes and quality of life;
- develop locally-appropriate, evidence-based models of care;
- support integrated and equitable services; and
- improve care coordination at the local level.

PHNs are required to commission primary mental health care services for children and young people with, or at risk of, mental illness that is being managed in primary care. The Primary Mental Health Care Flexible Funding Pool is for services that cover a broad continuum of care, from mild illness to more severe disorders requiring more acute and longer-term intensive care. Services must also cater for Aboriginal and Torres Strait Islander young people with mental illness and include suicide prevention programs. PHNs' management of local **headspace** contracts is an important part of youth mental health service provision. Many PHNs also focus on prevention activities.

Any youth mental health service model requires a flexible approach, where young people can enter and exit, re-enter and receive treatment that best meets their needs in a timely manner. In developing responsive service systems, PHNs must manage the challenges of understanding local needs, defining the type of care required, developing and maintaining a sufficiently trained mental health workforce, enabling appropriate service provision within their service systems, and of addressing the stigma associated with mental ill-health. These challenges are present for all age groups, but are particularly relevant in youth mental health.

The commissioning cycle

Under the Australian Government's requirements, all mental health programs that include contracted service delivery must move through a commissioning cycle as a model of competitive service provision.

As shown in Figure 1, the process of commissioning involves a continuous cycle of [6]:

1. **Assessing needs** – understanding what local communities need and working out the local priorities that can be addressed based on this information
2. **Designing solutions** – working with others to identify the most efficient and effective ways to address the identified priorities
3. **Implementing solutions** – procuring quality health services and initiatives and proactively working with providers to monitor performance and progress towards agreed outcomes
4. **Evaluating outcomes** – assessing the efficiency and effectiveness of services and initiatives (including value for both health gains and money) against outcomes and informing priorities for future investment in successive commissioning cycles.

The engagement of local stakeholders (including young people) and the building of positive relationships with service providers are key to the success of the commissioning cycle.

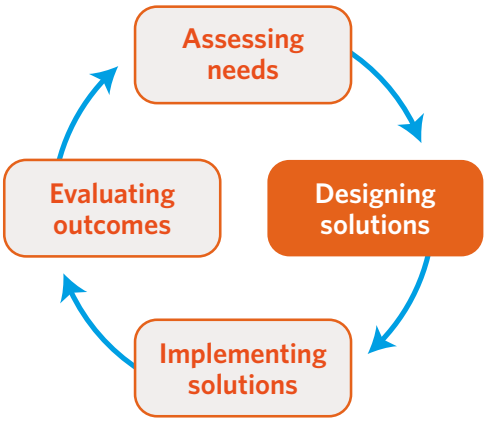

FIGURE 1 – THE COMMISSIONING CYCLE

Best use of this document

This document focusses on the **designing solutions** step of the commissioning cycle. Assuming PHNs have completed their Local Needs Assessments, the document provides considerations and advice for:

a. developing inclusive, youth-friendly services;

b. determing local priorities;

c. designing a service or program model; and

d. undertaking collaborative design processes.

The document does not profess to have all the answers, and will evolve as new evidence and best practice models arise, but should be a useful tool to help PHNs consider and address the most critical issues for procurement of quality youth mental health services. It will be useful for PHNs that are determining how best to address the results of their Local Needs Assessments and for staff in the youth mental health sector as a general reference.

Ideally, the document should be read in conjunction with the *Orygen PHN Briefing Paper - Models of Youth Mental Health* produced for PHNs for the purpose of the Youth Severe initiative (available from August 2018 on PHN Sharepoint).

Considerations for primary care reminds us of the importance of using a 'youth lens' when designing and procuring youth mental health services, and of putting young people, and their particular needs, at the centre of decision-making in relation to their mental health care.

Developing inclusive, youth-friendly services

Seeking help for mental health problems is not easy, and may be especially difficult for young people. How inclusive and youth-friendly a service or program is will have a considerable impact on young people's engagement and willingness to use, or continue to use, the service.

When designing youth mental health services, as distinct from adult services, a good starting point is to revisit the foundational principles of youth mental health care and the steps that are required to create inclusive, youth-friendly services.

Youth mental health principles

The following principles should underpin any service design and may be useful inclusions in service specifications or selection criteria.

A youth friendly service and focus – steps are taken to ensure that the organisational setting and the attitudes and behaviour of staff are welcoming to young people.

Early intervention – there are strategies to support the early detection of mental ill-health and to identify and address risk factors.

Expert care is easily accessible – service structures and clinical referral pathways are responsive in providing easy access and streamlined care, so that young people can be seen quickly and easily without having to contact multiple services.

Hopeful and optimistic approach – a spirit of hope and optimism is embedded within the service and there is a clear ambition to assist young people to return to their usual or improved developmental trajectories.

Holistic, person-centred care – an integrated approach is taken and care is provided for the young person as a 'whole' - not simply their symptoms or mental health condition but their overall functioning. The young person's needs and wishes are at the centre of everything that is done with and for them.

Comprehensive, flexible and integrated service approach – a range of interventions are available for young people and their families, and selected according to young people's needs.

Evidence-based/informed clinical practice – interventions are in accord with evidence-based best practice; or, where a youth-specific evidence base does not exist, are informed by evidence from related fields, such as adult studies.

Family-friendly and inclusive – where appropriate, friends and family are involved collaboratively in all aspects of treatment and care. Services cater for the needs of young people and their families from specific groups, including Aboriginal and Torres Strait Islander young people, young people who identify as LGBTQIA+, young people with disabilities, those experiencing homelessness and those from culturally and linguistically diverse backgrounds.

Continuum of care – mild, moderate and severe ill-health can be addressed within an integrated service system.

Care coordination – there is an identified central or lead worker (e.g. case manager) who coordinates the care provided within and across agencies.

Community awareness and education – education and awareness-raising strategies are in place to reduce stigma and promote access to services.

Youth participation and peer work – young people are involved in service design, continuous evaluation and governance. Peer worker programs are available.

Engaging with young people

Engagement with young people is the cornerstone of effective youth mental health programs or interventions. Mental health service providers need to do everything they can to create a positive experience for young people and their families[A], from the minute they walk in the door or contact the service, through to experiences during their treatment and support. Additional steps may be needed to create a 'culturally safe' and welcoming environment for young people from vulnerable groups.

PHNs have a unique opportunity to encourage inclusive, youth-friendly services by setting expectations through the commissioning cycle. When commissioning youth mental health services, PHNs should encourage services to:

- provide a positive, inclusive and welcoming environment appropriate for all young people;
- provide communications that are appropriately pitched to young people, and delivered in accessible formats;
- clearly communicate their privacy and confidentiality protocols;
- ensure staff are trained in engaging and working with young people and their families;
- commit to genuine youth participation and embed youth engagement strategies into service design, delivery and evaluation practices.
- ensure they are easily accessible for young people and can support an active outreach component; and
- ensure their hours of operation meet the needs of young people.

Advice from young people[B]

'Services should consult with young people, particularly those who might be in contact or impacted by the services they're working with (e.g. clients, friends, community members). Especially with young people and the community, they will have valuable information that services and staff just won't know.'

Inclusive, culturally appropriate service provision

Some groups of young people have particular needs and face additional barriers to accessing mental health support. They include Aboriginal and Torres Strait Islander young people, young people who identify as LGBTQIA+, young people with disabilities, those experiencing homelessness and those from culturally and linguistically diverse backgrounds.

To promote inclusive, culturally appropriate service provision, PHNs should encourage (or require) commissioned service providers to:

- be culturally sensitive and create a 'culturally safe' and welcoming space that is appropriate for the demographics of their local community (e.g. observe celebrations such as NAIDOC Week, offer a prayer room, etc.);
- use interpreters and provide written materials in locally appropriate languages;
- address the access and communication requirements of young people with disabilities;
- provide family and friend-inclusive practice;
- create a supportive environment for LGBTIQA+ young people (e.g. ensure staff use gender-neutral language that does not assume a young person's gender identity, sexual identity or sexuality);
- ensure staff have received cultural awareness training;
- assign staff to be 'champions' to advocate for, and lead, activities that promote cultural awareness and inclusive, culturally sensitive practice, both within the service and across the mental health system;
- develop partnerships with key organisations that can provide expert consultations on culturally appropriate work with young people; and
- encourage a diverse group of young people to participate in service design, development and evaluation, possibly through Youth Advisory Groups. Address any barriers to their participation.

A 'Family' may encompass a range of relationships, including immediate family, extended family, partners, children, close friends, housemates, and other guardians or supports.
B Provided by a member of Orygen's Youth Advisory Council

Further considerations

These ideas and considerations may help you to develop and encourage inclusive, youth-friendly services:

- include the Youth Mental Health Principles within your selection criteria;
- fund and/or provide workforce development opportunities, such as cultural awareness training;
- be specific about the need for a youth-friendly environment that includes easy access to the service (e.g. close to public transport), has a welcoming reception area and is a place where young people can feel safe and comfortable;
- ensure the specific needs of young people from vulnerable groups have been considered and addressed;
- learn from others -
  - gain the support of local community leaders who have experience in this area of work;
  - establish partnerships with appropriate experts;
  - draw on the expertise of state and national peak bodies;
- lead by example -
  - be flexible to changing processes to meet cultural needs;
  - work with Reconciliation Australia to develop a Reconciliation Action Plan for your PHN.

Good practice example

Headspace has used a wide range of strategies to create welcoming, youth-friendly centres. The 'youth-friendliness' of all aspects of their business has been considered, from the colours and décor of their reception areas and the language used in their communications, through to the involvement of young people in program development.

Headspace is committed to recruiting staff with expertise and interest in working with young people, and in many centres, young people are involved in the recruitment process.

Young people are actively involved in the functioning of headspace centres. All headspace centres have a Youth Advisory Group and many also have a LGBTQ Advisory Group. Peer education is increasingly provided as part of the headspace service model.

Resources and further reading

- MindOUT – National LGBTI Mental Health and Suicide Prevention Project
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023
- Australian Indigenous Health InfoNet – Social and Emotional Wellbeing – includes publications, policies and resources
- Framework for Cultural Competence - Centre for Cultural Ethnicity and Health
- Children and Young People With Disabilities Australia – national peak body
- Tips for providing a youth-friendly reception service – Orygen Toolkit

Designing youth mental health services and programs

A PHN's choices on how to structure its youth mental health services will be influenced by:

- their identified local priorities;
- Australian Government recommendations;
- evidence (including emerging evidence) of service models that have, or are likely to, produce successful outcomes for young people and recognised best practice within the mental health sector;
- alignment with Youth Mental Health Principles; and
- the feasibility of different approaches within the local setting.

Determining local priorities

By analysing available data on both health and service needs, PHNs identify opportunities, priorities and alternative options for a local service response that fits into the wider service system.

In many instances there will be a diverse range of competing needs across a PHN region. PHNs must use their judgement to determine their local priorities and how best to apportion their flexible funding. In doing so, they may need to gather additional data and/or futher consult with local stakeholders, either formally or informally (see page 23 for information on working with others to design a service model or program).

Local priorities should reflect:

- the results of the Local Needs Assessment, including any gaps identified through service mapping;
- the PHN's Strategic Plan, Mental Health Activity Work Plan and Regional Mental Health and Suicide Prevention Plan; and
- the Australian Government's eight key priority areas for mental health[7]:
  - achieving integrated regional planning and service delivery;
  - suicide prevention;
  - coordinating treatment and supports for people with severe and complex mental illness;
  - improving Aboriginal and Torres Strait Islander mental health and suicide prevention;
  - improving the physical health of people living with mental illness and reducing early mortality;
  - reducing stigma and discrimination;
  - making safety and quality central to mental health service delivery; and
  - ensuring that the enablers of effective system performance and system improvement are in place.

In recent commissioning cycles, PHNs have identified a wide range of youth mental health priorities. They included: managing self-harm and suicide; drug and alcohol issues; school refusal; family violence, sexual abuse and trauma and the associated impact on levels of depression; and anxiety and self worth.

Further considerations

- Gather more information if required -
  - request additional data or conduct further analysis to help answer questions or to decide between competing options;
  - undertake further consultations to gain different perspectives.
- Narrow the list of priority options -
  - which priorities are supported by evidence and/or policy?
  - which are likely to get the best buy-in from stakeholders?
  - which help address service gaps?
- Draw on the ideas and support of others -
  - what issues have other PHNs prioritised and why?
  - talk through your ideas with Orygen's National Programs team. They will be able to work through priority options with you and provide advice.

Good practice example

The South East Melbourne PHN identified several areas of concern in their needs assessment for their region, including self-harm and suicidal behaviour, as well as school refusal. Looking into these areas, school refusal was seen as a potential priority issue after a review of the headspace 'evidence maps' around school refusal behaviour and discovering there was limited data available. Further consultations were undertaken with school wellbeing teams who reported they were finding school refusal more difficult to manage than self-harming or suicidal intentions.

The RISE (Recovery, Improve, Support, Empower) Program was developed to reduce school refusal for those aged 12-16 years. The program, still in the pilot phase, offers treatment designed to address young people with severe anxiety and/or depression that is having a significant impact on their school engagement. RISE works not only with the young person, but also their family and school, and uses a coordinated and complementary range of strategies including care coordination, family therapy, family peer support, evidence-based psychological interventions and psychiatric support.

RISE provides assertive outreach services from a headspace centre, with referrals typically coming from schools. It employs two full-time senior clinicians as well as a 0.8 EFT family therapist and a family peer support worker. The team caseload is approximately 40 young people at any one time. Early data appears to be very promising, with more than half of the young people re-engaging with school.

The following advice was offered to other PHNs:

- be prepared to do further investigation following your needs assessment to determine your priorities;
- consider school refusal – it could be a target area that you may not have thought about;
- ensure services maintain strong links with schools – they are vital partners in the care of young people experiencing mental ill-health and can assist with the prevention of further illness; and
- engage families as early as possible in treatment as there are often complex family issues.

Resources and further reading

- PHN Needs Assessment Guide – includes suggested data sources for health and service needs analysis (page 8)
- Guidance for commissioners of child and adolescent mental health services - although this is a UK resource, there is much to be learnt from other contexts.

Youth mental health service design

Once a PHN has established its local priorities, the next step is to design the best service or program model to address those priorities.

Challenges include:

- choosing/developing a service or program model;
- working within funding structures and set timelines; and
- getting the investment balance right - low intensity vs high intensity, reactive vs proactive services, one location vs another, etc.

When designing a youth mental health service, PHNs will need to make decisions about the service model, the key elements of care and service specifications.

Stepped care as the basis for service model design

The stepped care model (Figure 2) is recommended by the Australian Government as part of its mental health reform. It provides the foundation for service design upon which PHNs will develop their service models and programs.

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. Although there are multiple levels within a stepped care approach, they do not operate in isolation or in a single direction of increasing care, but rather offer a spectrum of service interventions to meet needs at different levels of illness severity[8].

Within the stepped care model there is a commitment to a '**continuum of care'** approach, where young people receive services that respond to their mental health needs or diagnosis at any particular point in time - based on their level of need. It involves an integrated system of care that guides and tracks young people over time through a comprehensive array of health services spanning all levels of intensity of care[9]. However, this is not to say that a young person starts at one point and continues up the steps, say from mild to severe mental ill health. This may occur but it can also be the reverse, or a young person may 'dip into' a service getting treatment at whatever level is required for however long is required, and then move out of care.

Well population	At risk groups (early symptoms previous illness)	Mild mental illness	Moderate mental illness	Severe mental illness
What do we need to achieve?				
Focus on promotion and prevention by providing access to information, advice and self-help resources	Increase early intervention through access to lower cost, evidence-based alternatives to face-to-face psychological theray services	Provide and promote access to lower cost, lower intensity services	Increase service access rates maximising the number of people receiving evidence-based intervention	Improve access to adequate level of primary mental health care intervention to maximise recovery and prevent escalation Provide wrap-around coordinated care for people with complex needs
What services are relevant				
Mainly publically available information and self-help resources	Mainly self-help resources, including digital mental health	Mix of self-help resources, including digital mental health and low density face-to-face services Psychological services for those who require them	Mainly face-to-face clinical services through primary care, backed up by psychiatrists where required Self-help resources, clinician-assisted digital mental health services and other low intensive services for a minority	Face-to-face clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health Coordinated multi agency services for those with severe and complex mental illness

FIGURE 2 – STEPPED MENTAL HEALTH CARE

Source: The Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (2015)

The '**clinical staging'** model (Figure 3) complements stepped care. It provides a framework to help determine what interventions are needed for each young person. The framework guides treatment selection across the range of mental health difficulties that a young person might present with, including early, mild symptoms which do not yet fit within a diagnostic category. This makes the model particularly useful for young people who often present with symptoms that are below the threshold for a mental disorder, but who nevertheless may experience high levels of distress and impairment in their functioning.

The clinical staging model uses a combination of help-seeking, symptoms and functioning information to categorise a person's mental health into one of six potential stages, ranging from Stage 0 ('No illness or symptoms') to Stage 4 ('Ongoing and unremitting illness') (See Figure 3 on page X). For young people with severe and complex presentations in the primary care setting, most would be expected to fall within Stage 1b ('At risk for disorder') or Stage 2 ('First episode of severe disorder').

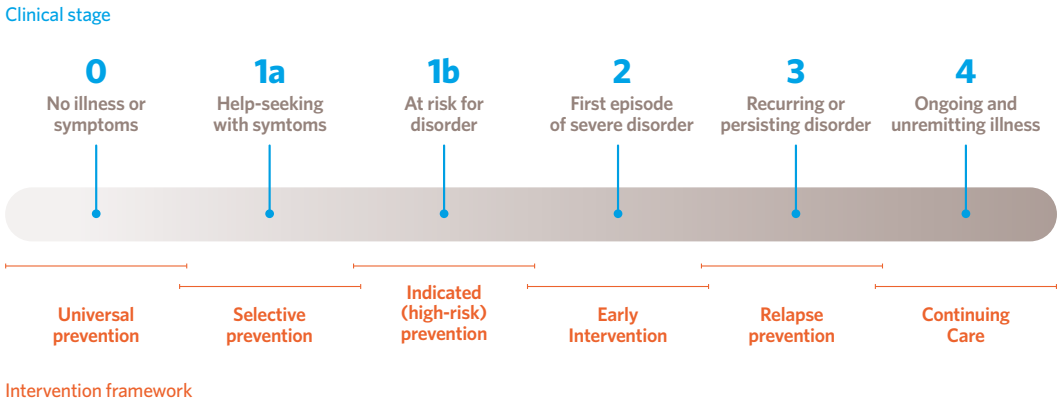

FIGURE 3 – CLINICAL STAGING MODEL

Elements of care

There are several elements of care that should be considered and, where appropriate, embedded into youth mental health service designs. As there is no 'one size fits all' service model appropriate for all regions and circumstances, flexibility is required in how the elements of care are adapted.

Assessment

A broad, comprehensive, biopsychosocial assessment process should be used to determine the severity and complexity of young people's needs and, in turn, to help develop case formulations and appropriate care plans:

- Who will undertake assessments?
- What assessment tools will be used?
- How will the service ensure assessments are an engaging experience for the young person?
- Is there a low threshold for assessment so that young people have ease of access to care and do not face a barrier to treatment?
- Is there assistance available after the assessment process for supported or 'warm referrals' to other programs that may be more suitable for the young person?

Workforce

Youth mental health services and programs typically require a multi-disciplinary workforce, ideally with outreach capacity.

- What roles, qualifications and skills are required for the proposed service model?
- Is recruitment feasible given the current local workforce, or is flexibility required?
- Is there a multi-disciplinary team to support individual case managers in care planning and review? In rural or remote areas, is technology being used (e.g. video-conferencing) to facilitate multi-disciplinary team meetings or mental health consultations?
- Are peer workers part of the workforce? (Peer workers are generally young people with a lived experience of mental ill-health. They receive specific training to be able to provide information and support to other young people.)
- Does the PHN support workforce development strategies? Are funds allocated within service contracts for professional development? How can PHNs best support training, including on-line training? Are there enticement options for increasing the workforce in a given area?
- Are services flexible with when, where and how they contact and connect with young people?
- How will be local service providers involved in the referral pathway (e.g. GPs, nurses, allied health workers etc.) be supported to feel confident in referring young people to the service?

Good practice example

The Western Queensland PHN (WQPHN) is planning a long-term, multifaceted strategy to manage mental health workforce challenges across its remote region. Key to the PHN's workforce model is the funding of mental health nurses who act as clinical care coordinators. Where possible, credentialed mental health nurses have been appointed, with some roles currently filled by Registered Nurses and Certificate IV Workers in Mental Health. WQPHN has funded a stepped care approach by combining funds from the Primary Mental Health Care for People with Severe Mental Illness and the Youth Severe funding pools.

Across the region, general practice is promoted as the 'health care home'. Young people experiencing mental health challenges are encouraged to see a general practitioner (GP) and to book a long appointment. They are then typically referred to a mental health nurse who undertakes an assessment and works with the young person to develop a Mental Health Treatment Plan. Mentoring and supervision of the nurses and mental health workers is provided centrally by the PHN, where indicated and required.

Treatment options for low intensity patients include the evidence-based New Access program, developed by Beyond Blue, which uses trained coaches who deliver Cognitive Behaviour Therapy (CBT) sessions. Coaches are currently only trained to deliver the program to people over the age of 18, but there are plans to expand services to include the adolescent program, and to engage Aboriginal Social and Emotional Wellbeing Workers (SEWB) as coaches. Another treatment resource being rolled out in the region through the Aboriginal and Torres Strait Islander Mental Health Services funding stream, is the Menzies Institute's Stay Strong App: a structured mental health and substance misuse intervention tool using Indigenous-specific content.

WQPHN's workforce strategy includes a commitment to professional development. Training packages are being developed by Orygen, based on a consultation and needs assessment process, to support each decision point in the referral pathways, including schools. Commissioning includes funding for training, including Stay Strong training, Mental Health First Aid (ATSI), motivational interviewing etc. It also supports 'proof of concept' activities which encourage practices to clean patient data, develop patient registers and stratify patients against stepped care categories.

The following insights were offered to other PHNs:

- Workforce development takes a long-term commitment. Our preference has been to develop our existing workforce, over supporting fly-in, fly-out workers from other areas.
- Local services have been receptive to the credible, evidence-based programs we were able to offer, such as New Access.
- We found that young people had much better engagement with tele-health if a practitioner guided them through an introduction.

Comprehensive care and case managment

Services should provide, or facilitate access to, a range of different care options for young people with complex or multiple issues. A case management approach should support the coordination of holistic, person-centred care. Care should be available for all mental health issues, including eating disorders, early psychosis, anxiety, depression, personality issues etc. Services should also have strategies to support the functional recovery of young people who may be experiencing homelessness, disengagement with education, unemployment, drug and/or alcohol use, family issues etc. Access to specialist mental health care should be facilitated when required.

- What support options are available for young people at different stages of the stepped-care model?
- How does the service ensure linkages between mental health care (primary, secondary and tertiary) and local services such as general practice, allied health, education, employment and community services?
- Is a holistic approach taken to supporting young people's health, including their physical health needs? Are young people supported to return or remain at school or work?
- Are young people able to easily enter, exit and re-enter the service?

Psychological interventions for young people with complex needs

Services should expect to see young people with a wide range of mental health concerns, including anxiety disorders, eating disorders, mood disorders, personality disorders, psychotic disorders and substance use disorders, as well as young people who self-harm or have suicidal ideation.

Low intensity services will need referral pathways for the care of young people with complex needs. Within services catering for young people with moderate to severe mental illness there should be clinical staff able to provide evidence-based, best practice, psychological care, such as cognitive behaviour therapy (CBT), interpersonal psychotherapy, family therapy and family-based interventions and psychoeducation[10].

Functional recovery

Care should include a focus on functional recovery and supporting a young person's overall physical, social and vocational functioning. This may include direct work with the young person, group work, family work and working with other services e.g. schools, workplaces etc.

Families and other supports

Where appropriate, involvement of family members and other supports can add considerable value to a young person's care.

- How will the service model support the engagement of families and other supports?
- Is funding available to support family engagement?

Medical treatment

Support and advice from medical practitioners will be important for young people with complex problems, especially those requiring psychotropic medications. GPs are often the main providers of medication and services should consider how to support them to provide the best evidence-based care to young people with mental health issues. This could involve developing partnerships or networks including GPs, psychiatric services and private psychiatry providers.

Tele-psychiatry and secondary consultation can be important components of care. Referral pathways for tertiary level psychiatric care when required should be established. Services should establish who will provide specialist psychiatric care (e.g. a consultant psychiatrist, registrar with supervision etc.) and how care will be arranged (e.g. as part of a multi-disciplinary care team, via secondary consultations or telepsychiatry etc.).

The involvement of GPs and allied health workers will help ensure other health problems, such as concerns with diet or physical activity, are managed.

Outreach services

Outreach services, with the option of care provision in a non-clinical location where the young person feels comfortable, can greatly increase their engagement with mental health services and mental health treatment.

- Does the service model include an outreach component?
- Is assertive outreach undertaken, with the service having a presence at locations where young people gather e.g. schools, community centres etc.?

Insights from young people[C]

'Meeting my case manager outside of (the service) makes it feel more like we're equals so it's just not "I'm your case manager now". It makes me feel more comfortable and relaxed. You (a young person) don't feel that your case manager is intimidating. It makes it more casual and breaks that formality.'

'Not having a thousand people with you (when you are being seen) would be great … so would having a choice of having a different gendered person in the room.'

'It's nice when they get to know you, when they get to know your interests and hobbies.'

Service specifications

The following practical considerations will help determine how care is organised.

Eligibility criteria

Service/program eligibility criteria should be based on a sound rationale and clearly articulated. It may encompass a young person's age, type of mental health issue, mental health history, referral point, location etc.

- Do the proposed eligibility criteria help address local priorities?
- Do the criteria enable access for young people with severe and complex mental health issues?
- Use eligibility criteria to model the likely demand for services. How might changes in the criteria affect demand? For example, how many young people would be likely to use the service if there was an open-referral system compared to only GP or psychologist referrals? How might this affect workforce requirements?
- Be open to modifying eligibility criteria, if required, after a trial period.
- Are there strategies for managing young people who are not eligible for a service and may need to be referred to other providers? Are 'warm referrals' standard practice? (i.e. where the young person being referred is introduced to the other service and information about their situation and care is shared.)

Clinical pathway

- What is the service model's clinical pathway?
- How will the model support early intervention?
- How will the service ensure young people experiencing mental ill-health are seen quickly?
- Will the service use individual case management, peer work, youth work or other options? Or a combination of methods?
- If case management, who will deliver the case management? e.g. nurses, mental health nurses or allied health professionals with the specific skills and competencies to fulfil the role, etc.

Capacity and demand management

- How might different referral pathways affect potential referral numbers? – referrals from GPs, community workers, self-referrals, open referrals vs selected referrals, etc.
- How will the service ensure caseloads are workable? Are caseloads capped to ensure young people receive the best care possible?
- Will services have review meetings to consider the flow management of cases concerning intake, discharge to assist in demand managment?
- Does the service have strategies for managing fluctuations in demand?
- What is the best location for the service or program? Is location choice based on existing demand for services or an area of potentially high needs, or both?

Duration of care

Thought should been given to how long a young person may need to be treated. Duration will differ depending on the young person and the severity of their illness. For example, the duration of care may range from six to 12 months or longer. Flexibility is needed to cater for changing needs.

C Provided by young people from Orygen's Youth Health Clinical Program

Service integration

Service integration is central to the government's reforms for primary and mental health care.

Often, the mental health care needs of young people cannot be met within one service or program but require input from several professionals, services or organisations. Relationships and networks should be built with a variety of partners, not only those delivering PHN-funded services. With the aim of providing comprehensive clinical care across the stepped care continuum, networks should include tertiary mental health services.

Key partners may include social care, housing and non-government organisations as well as employers and the education system, all of which can play an important role in relation to mental health.

Tele-health

Tele-health or tele-psychiatry can be used to adapt collaborative care models to make them more feasible in rural and remote areas that have limited access to onsite mental health specialists. Tele-psychiatry uses information and communications technologies (e.g. phone, web-based or smart phone audio visual) to deliver mental health services and transmit health information over both long and short distances. It includes diagnosis, treatment and preventive (educational) aspects of healthcare services. This facility might be offered by the local GP or another local healthcare provider.

Monitoring and evaluation

Monitoring and evaluation plans should be considered during the design process and finalised shortly after program onset. Orygen's Program Evaluation – Laying the Right Foundations provides background information and advice on the different types of program evaluation and when to use each type. It includes information on the steps to take when scoping an evaluation.

Also consider:

- Have clearly articulated realistic service/ program aims and objectives been established?
- Is the service design supported by a logic model? Could the logic model be co-designed with stakeholders once the model is identified and prior to going to tender? (See NSW Ministry of Health Developing and Using Program Logic: A Guide www.health.nsw.gov.au/research/Publications/developingprogram-logic.pdf)
- Are providers required to develop an evaluation framework?
- What are the desired outcomes?
- How will outcomes be measured?
- What monitoring and evaluation tools will be used?
- What data will be required by the PHN?
- How will feedback from young people be captured?

Further considerations

The various elements of mental health services described above provide PHNs with flexibility in designing service models to meet local needs and priorities. Once PHNs have potential service/program models in mind, these further considerations and advice may help to develop and refine service design ideas:

- How can existing services be adapted to cater for young people, or are new services needed?
- How can services improve their networking to increase collaboration and provide integrated care for youth mental health?
- Which service design options make the best use of existing service structures? Are there any current youth mental health platforms the service could be provided from?
- Which service models make best use of the funding provided?
- Which service models have the potential to be scaled-up over time?
- Are Youth Mental Health Principles embedded in the service design?
- Set short-term and longer-term goals - Is there a service response/s that could be trialled and evaluated within a reasonable time-frame? What steps may be needed to help you reach long-term goals? Is there data to support the goals and planning process?
- Don't feel you always need to be 'innovative' – build the foundations of your service models on tried and tested approaches - innovation can be added when addressing local issues.
- In areas with complex workforce challenges, consider investing in tele-communication, including tele-psychiatry.
- Use the PHN network - consider what other PHNs are doing or have done, talk to PHN colleagues and use them as a sounding board for ideas.
- Seek advice from Orygen - staff from Orygen's National Programs team are available to talk through ideas and approaches and support PHNs in relation to any youth mental health issue.

Good practice example

The Gold Coast PHN (GCPHN) is establishing a new mental health service called **Plus Social.** It is designed to meet priorities identified through GCPHN's 2016 needs assessment and associated consultations, that included limited after-hours services, a need for better care coordination and more services for those at the higher end of the stepped-care continuum.

Plus Social will provide two streams of care: i) care for young people aged 12-18 years with, or at risk of, severe mental ill-health, and ii) care for adults with severe mental ill-health. It will be predominantly an outreach service, with after-hours, community-based care available via a 'safe space' where activities and support will be available until 11pm.

The service model will be GP centric, with all referrals into the program coming from GPs or private psychiatrists.

GCPHN staff offered the following advice to other PHNs:

- Try to carry and stay true to your identified priorities across all steps of the commissioning cycle – things can move at any time;
- It's easier to start with a restricted referral system and add additional referral pathways later if desired; and
- Establish your evaluation process from the start – it would be good to include evaluation in your selection criteria.

Good practice example

Commissioned by Sydney North PHN, Karrikin[D] is a mobile, assertive outreach mental health treatment service for young people aged 12-25 who are experiencing, or are at risk of, severe mental illness. It is managed by Paramatta Mission.

The Karrikin program was developed to help address the needs of the 'missing middle' – young people whose mental health problems are beyond the headspace remit, but do not require Local Health District (LHD) services.

The mobile service provides support for young people wherever they feel most comfortable, with visits occurring in schools, cafes, young people's homes or at the service base at Chatswood. The assertive outreach program is well integrated within the community and has a regular presence at various schools and youth-based programs. Staff work closely with the local headspace to ensure smooth transitions of care.

There is an ease of access referral system that includes self-referrals, as well as referrals from all other sources, including family, friends and service providers (teachers, youth workers, GPs, headspace, LHDs etc).

A key feature of the service model is the psychiatrist-led, multi-disciplinary team, with the psychiatrist ultimately responsible for all young people's care. They sign off on all assessments and are present at all clinical reviews.

The service operates Monday to Friday between the hours of 9am and 8pm, with after-hours support provided by On the Line: a national online and telephone counselling service. There are plans to implement on-call service with the current staffing profile in the future.

Karrikin continues to scale up its activity after commencing the service in September 2017. Staff offered the following insights to PHNs:

- Having a psychiatrist-led, multi-disciplinary team has enabled the program to:
  - provide holistic care and to manage young people's complex issues in a safe way.
  - ensure comprehensive evidence-based psychiatric care that accounts for all aspects of the young person's life.
  - build capacity across the multi-disciplinary team through clinical case review.
- Having peer workers as part of the staffing profile has assisted us in engaging young people as they take a 'walk alongside' approach and can demonstrate hope for recovery through their own recovery journey.

D Karrikin is an Aboriginal name for 'seed growth after bushfires' or rejuvenation

Good practice example

The Tern Program[4] was developed to provide young people aged 12-25 with access to long-term trauma-informed care in a safe, youth-friendly and inclusive environment. The program was commissioned by the NQPHN in July 2017 following a needs analysis identifying a service gap for young people who are affected by trauma and are not adequately treated through existing services.

The Tern Program has been embedded within Northern Australia Primary Health Limited's (NAPHL) headspace centres in Mackay and Townsville and offers young people and their families quality, evidenced-based, trauma-informed care via a multi-disciplinary team. The program provides young people with a comprehensive care package based on individual needs and includes psychological therapy, psychiatry, physical health, alcohol and other drug treatment and vocational and educational support. Additionally, the program offers care coordination and practical support in areas such as housing, activities of daily living, finance and social recovery, to ensure a holistic approach to treatment. Service delivery is flexible and includes face-to-face, phone and video counselling to facilitate engagement. The program targets young people with severe psychological symptoms including anxiety, depression, PTSD and complex trauma symptoms, and those with vulnerable personality structure (e.g. borderline personality).

The program employs the equivalent of two full-time clinicians and is supported by the core components of the headspace model as well as NAPHL's integrated model of care (ITC, Allied Health).

NAPHL perceives trauma-informed care to be a community approach and the Tern Program aims to increase knowledge and awareness of trauma-informed care within the Townsville and Mackay communities via cross-sector collaboration (workshops, shared PD opportunities, case conferencing etc.).

E Named after the tern bird

Resources and further reading

- PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance – Stepped Care
- National Mental Health Service Planning Framework – a tool designed to help plan, coordinate and resource mental health services to meet population needs.
- Planning in a Commissioning Environment – a Guide – outlines some of the characteristics that may be particular to planning by PHNs in a commissioning environment
- Orygen National Centre of Excellence in Youth Mental Health. 2016. Australian Clinical Guidelines for Early Psychosis. Second edition Updated. Available from: https://www.orygen.org.au/Campus/Expert-Network/Resources/Free/Clinical-Practice/Australian-Clinical-Guidelines-for-Early-Psychosis/Australian-Clinical-Guidelines-for-Early-Psychosis.aspx?ext
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Working with others to design a service model or program

Ideally, a range of local stakeholders with differing perspectives and expertise will be involved in the design of youth mental health programs or models of care. There are various strategies for gathering stakeholder input, including consultations, the formation of Advisory Groups and commitments to co-design.

A PHN's decision on who to engage in the development stage, and how to engage them, will be influenced by:

- timeframes;
- the interest, capacity and availability of local stakeholders;
- the potential scope of the program;
- the PHN's overall strategic approach to meeting the mental health needs of young people in the community; and
- the PHN's commitment to collaboration/co-design.

Co-design

Co-design is increasingly being used by governments, health and the community sector to describe a range of activities and processes used in the design of services and programs that involve people who use or may be impacted upon by that service or program.

Co-design requires a commitment to working in partnership with others to discover new ways of understanding an issue, and then jointly developing and testing possible solutions. It is a method that is applied differently in different situations and is much more than a consultation process. The results are never pre-determined. Everyone is seen as an expert in their area and, as such, has something to offer in the design of programs and solutions. There is no step-by-step guide to co-design, although the principles below will help inform the approach.

PHNs may find the co-design process useful for developing cross-region solutions involving multiple stakeholders, including young people and their families.

Principles of co-design[11]

Inclusive – the process includes representatives from critical stakeholder groups who are involved in the co-design project from framing the issue to developing and testing solutions. It uses feedback, advice and decisions from people with lived or work experience, and the knowledge, experience and skills of experts in the field.

Respectful – all participants are seen as experts and their input is valued and has equal standing. Strategies are used to remove potential or perceived inequality. Partners manage their own and others' feelings in the interest of the process. Co-design requires everyone to negotiate personal and practical understandings at the expense of differences.

Participative – the process itself is open, empathetic and responsive. Co-design uses a series of conversations and activities where dialogue and engagement generate new, shared meanings based on expert knowledge and lived experience. Major themes can be extracted and used as the basis for co-designed solutions. All participants are responsible for the effectiveness of the process.

Iterative – ideas and solutions are continually tested and evaluated with the participants. Changes and adaptations are a natural part of the process, trialling possibilities and insights as they emerge, taking risks and allowing for failure. This process is also used to fine-tune potential outcomes or solutions as it reaches fruition and can later be used to evaluate its effectiveness.

Outcomes focused – the process can be used to create, redesign or evaluate services, systems or products. It is designed to achieve an outcome or

series of outcomes, where the potential solutions can be rapidly tested, effectiveness measured and where the spreading or scaling of these solutions can be developed with stakeholders and in context.

Involving young people in service development

For youth mental health, a commitment to co-design means a commitment to involving young people in service development.

Providing opportunities for young people to use their experiences and skills to actively participate in mental health service design, improvement and delivery has significant benefits for funders, service providers and young people. Importantly, youth participation helps to ensure that services are relevant and appropriate, and improves the youth-centeredness and youth-friendliness of services.

There are many different ways to engage young people and their families in service design. Some organisations, such as headspace, will have established Youth Advisory Groups, others will draw young people and/or family members together to help address particular issues.

Whichever method is chosen, it is important that youth participation is managed respectfully and is not a token gesture. Young people should be supported to contribute, and given a genuine opportunity to influence outcomes. An inclusive approach would encourage engagement regardless of background, culture, location, gender or sexuality.

Advice from young people[F]

'My advice would be that in developing health services, organisations should include young people as much as possible, every step of the way. This way that service is actively shaped by the perspective of young people throughout the whole process.'

Further considerations

Working with others to design youth mental health programs requires time and commitment. There can be challenges, particularly in a competitive-tendering environment, and it is not always easy to achieve genuine, respectful engagement with young people that is not tokenistic. Determining the best roles for young people, particularly when working at a regional level, can also be difficult.

However, the rewards of co-design outweigh the challenges. Harnessing and respecting the input of others, including young people with a lived experience of mental health concerns, will help ensure program models are appropriate and relevant - services that are designed by and for young people.

The following suggestions for co-design may also be helpful. There are further suggestions in the example below.

- Take a flexible approach to design - the concept and principles of co-design represent good practice, however PHNs may need to adapt their approach to meet tight timeframes. In some contexts, one-off stakeholder consultations may be appropriate, although it is advisable that PHNs work towards increasing stakeholder engagement and involvement, and to collaborative, co-design approaches.
- Draw on existing structures - if your PHN does not have a Youth Advisory Group (or similar), consider using a group established by another organisation, such as headspace. Members are likely to have received training on making contributions to committees/groups and will have an interest in mental health.
- Only establish a Youth Advisory Group if you have an organisational commitment and resources to use and nurture the group over time.

F Provided by a member of Orygen's Youth Advisory Council

Good practice example

Hunter New England Central Coast PHN (HNECC PHN) used co-design principles when developing its service model for young people with complex mental health needs.

HNECC PHN's Mental Health and Suicide Prevention Needs Assessment and health planning data assisted to identify the four highest areas of need in the region. To develop their service model, the PHN hosted a workshop in each area. The process was seen as a 'journey', with stakeholders partnering to design a locally appropriate service model. A wide range of stakeholders were invited, including: mental health service providers; GPs; allied health providers; community-based organisations; school principals; representatives from the local health districts; youth mental health services; young people (from headspace Youth Reference Groups and the local area); parents; and carers.

The workshops attracted between 20-90 attendees and were facilitated by Orygen, to add national expertise, credibility and transparency to the process. Participants received a discussion paper before the workshop, outlining background information and key questions.

Discussions on the day were highly collaborative, with all participants recognised as having valuable expertise. Mixed groups of stakeholders debated a range of issues and helped to balance perspectives, which resulted in very useful recommendations for service design.

HNECC PHN used these recommendations to develop service specifications and to determine the weighting of the tender's selection criteria. For example, there was a strong recommendation from the workshops for service providers to demonstrate established local networks, linkages, MOUs etc. Applicants also needed to demonstrate service access for rural and remote areas, and describe the collaborative and integrated clinical mental health care model which they would provide to clients.

HNECC PHN has since put its youth severe service model out to tender and included a young person on the tender evaluation team, along with the senior clinician from the local health district as an independent subject matter expert. They intend to adopt co-design principles in all future mental health service funding opportunities.

HNECC PHN offered the following advice to other PHNs:

- work towards co-design. Although it may seem daunting at first, there are clear benefits, both in terms of service outcomes and in building partnerships with the local community.
- make sure you allow plenty of time to do co-design justice.
- keep an open mind about the ideas that will come from others. When you involve young people and parents you'll have completely different conversations.
- draw on the expertise of Orygen. Without them we wouldn't have achieved such a high degree of local buy-in.

Resources and further reading

- How to Partner with Young People – recommendations and key issues
- James AM. 2007. Principles of Youth Participation in Mental Health Services. *Med J Aust*. 187 (7 Suppl): S57. Available from: https://www.mja.com.au/journal/2007/187/7/principles-youth-participation-mental-health-services
- Mental Health Experience Co-design Toolkit – developed by the Victorian Mental Illness Awareness Council and Tandem

Conclusion

PHNs play an important role in identifying the youth mental health challenges in their regions and in developing locally appropriate strategies to address these challenges. With youth mental health being a relatively new field, there is still much to learn about the approaches and models that work best in different settings. What is clear, however, is that services need to be youth-friendly, responsive, flexible and well-designed.

When it comes to service design, PHNs have much to consider. With the stepped-care model providing a foundation, design decisions will need to cover the general approach to care, the elements of care and detailed service specifications. These decisions must be considered within the context of the local health service environment, whilst addressing local and Government priorities. Resulting service models should be well integrated with local services that can help meet the diverse and holistic needs of young people experiencing mental ill-health.

We encourage PHNs to embrace the design process and to recognise the benefits of co-design, and of working closely with local stakeholders and young people, to develop robust, locally-appropriate service models. There is much to be learnt from others, both in Australia and in international settings, and a willingness within the sector to share ideas and experiences.

We hope the considerations raised in this document have been useful in supporting PHNs to develop service models that they are proud to commission – services that will provide the care needed to intervene early and support young people people experiencing mental ill-health to recover and to thrive.

Additional information

- Orygen, the National Centre of Excellence in Youth Mental Health – Evidence finder - a tool for searching published studies of treatment and prevention strategies for mental health and substance use issues in young people.
- headspace website – provides resources for clinical and non-clinical staff
- Improving the mental health of children and adolescents in Australia, position paper of the Australian Infant, Child, Adolescent and Family Mental Health Association. Includes the principles of effective care for children and young people.
- Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. – Latest Australian Government report on the national Young Minds Matter survey.
- Engagement and Assessment in Youth Mental Health – on-line training module offered by Orygen.

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