Submission to the ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

July 2019

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1.0 ABOUT THIS SUBMISSION

This submission puts forward practical solutions for immediate improvements to Victoria's mental health system. Our focus is on the improvements required to better address the mental health related needs of young people aged between 10 and 25 years of age, however aspects of our recommendations could also be applied across all age groups.

Our commentary, critique and recommendations have been informed by:

- Conversations with the young people who we are privileged to work with and who have direct experience of the system.
- Consultation with our service provision workforce who regularly interact with the system.
- A review of the evidence on the characteristics of effective service and systems responses for young people with complex mental health related needs.

Our submission provides the Commission with a deeper understanding of how young people experience the mental health system and how they are impacted by the system breakages and failures we observe.

We have taken an evidence informed approach to our commentary and recommendations, drawing on the lived experience of our client group and staff. We highlight new approaches or system modifications that are achievable and implementable in the short term but that would result in long term improvements to young people's access to effective mental health care.

2.0 EXECUTIVE SUMMARY

This submission provides commentary and critique of Victoria's mental health system that is focused on the needs and experiences of young people and families. Our aim is to provide the Commission with a deeper understanding of how young people encounter the mental health system and how they are impacted.

There are multiple system breakages and service failures apparent in Victoria's mental health service system that are, today, materialising for young people, as significant and often insurmountable barriers to accessing essential mental health support. Young people across Victoria are unable to access appropriate and adequate specialist mental health interventions when they need them most.

Drawing on our experience of supporting thousands of young people experiencing disadvantage over our 21-year history, and feedback from consultation with workers and young people undertaken for this submission, YSAS has identified the major contributors to mental health service system failure for young people in Victoria.

We believe that State clinical mental health services are too illness/condition focused and fail to address the issues that exacerbate and perpetuate mental health problems, which creates:

1. **System fragmentation and barriers to continuous care;**
2. **Uncoordinated and disjointed care planning;**
3. **The dangerous practice of transferring risk and accountability for client care to community-based; youth services that are without sufficient capacity to respond effectively;**
4. **Conditions that exclude family members and helpful others; and**
5. **A lack of effective mental health support for young people from diverse backgrounds.**

These features mean that much of the care for young people experiencing mental health problems is provided outside of the tertiary service system. Young people with moderate to severe mental health needs who are unable to access tertiary mental healthcare, have been supported by an under resourced community sector. As a result, the client cohort supported by community services such as YSAS has multifaceted service requirements and a complex set of needs to meet.

Consequently, community-based programs must cater to a far more diverse client cohort and take on more risk, which without additional investment, has impacts for service quality, safety (of young people, staff and the community) and the financial sustainability of providers.

If not addressed, these challenges will continue to have substantial, detrimental impacts on the health and life outcomes of young people in Victoria who are dealing with mental illness and other underlying issues. In turn, this will create costs that will impact on the Victorian economy over time.

This submission puts forward practical solutions for immediate improvements to Victoria's mental health system.

Our focus is on the improvements required to better address the mental health related needs of young people aged between 10 and 25 years of age but there are aspects of our recommendations that could be applied across all age groups.

We have taken an evidence informed approach to our commentary and recommendations, drawing on the lived experience of our client group and staff. We highlight new approaches or system modifications that are achievable and implementable in the short term but that would result in long term improvements to young people's access to effective mental health care.

RECOMMENDATIONS

RECOMMENDATION 1.0:

Ensure system reform and service design are informed by and commit to the **ten characteristics of a more effective 'youth' mental health service system**:

Characteristic 1	*Capacity for effective early intervention*
Characteristic 2	*Holistic, person-centred care that integrates effective specialist clinical intervention*
Characteristic 3	*Service system responses geared to level of client vulnerability and complexity rather than illness or behavior*
Characteristic 4	*Engagement and retention in continuing care – a developmental pathways approach to treatment*
Characteristic 5	*Strong focus on the psychosocial stability of clients*
Characteristic 6	*Formal mechanisms to ensure the effective integration with other Service Systems*
Characteristic 7	*Address the specific needs of diverse populations - Cultural competency*
Characteristic 8	*Specific responses to ensure that young people and Families in Rural regions and/or remote communities have access to the care they require*
Characteristic 9	*A competent workforce that is adequately supported*
Characteristic 10	*Proactive service system planning that involves service users*

RECOMMENDATION 2.0

Achieve immediate improvements to Victoria's mental health system by:

Recommendation 2.1	*Integrating a system navigation and continuing care coordination function for young people and families within the youth mental health service system; and*
Recommendation 2.2	*Enhancing Youth AOD Residential Withdrawal and Rehabilitation to provide additional service offering within the Mental Health Service System.*

Whilst there is substantial work required to bridge the gap for young people between the mental health system they have, and the mental health system they need, the foundations for success are evident. Speaking from our perspective, the youth Alcohol and Other Drug (AOD) sector is supported by a workforce that provides daily demonstrations of their ability to connect with and deliver results for young people in their care. The young people trust that these workers have their best interests at heart. We observe similar commitment and drive across other sectors we interact with.

Whilst the efforts of our workforces and services are admirable and essential for growth, we must work towards achieving a system that does not rely so heavily on the preparedness of community services staff to respond to unmet need and the extraordinarily resilience of young people who continue to seek help despite the many setbacks thrown at them by our imperfect system.

System failures can be addressed and overcome if we adopt a shared commitment to changing the 'personality traits' or characteristics of our system to those that place a much higher value on genuinely integrated, holistic and person-centred care that is delivered in the best interests of young people and families.

3.0 ABOUT YSAS

Youth Support and Advocacy Service (YSAS) is a leading youth health not-for-profit agency that enables young people experiencing serious disadvantage to access the resources and support they require to lead healthy and fulfilling lives. YSAS has supported thousands of young people and families over the 21 years it has been in existence.

YSAS employs more than 350 skilled staff across 19 sites in metropolitan and regional Victoria.

Through its health and welfare services, YSAS enables young people and families to overcome challenges associated with substance use, mental health and behaviours such as offending and self-harm. YSAS provides practical support and evidence-based clinical services for young people experiencing serious problems, but also intervenes as early as possible to prevent these problems from escalating and becoming entrenched.

All services delivered by YSAS are client centered, resilience based and recovery focused, family inclusive and trauma informed. In particular, YSAS has a demonstrated track record of engaging the following special needs populations:

- Young people in Out of Home Care
- Young people engaged with the Criminal Justice System
- Young people from Aboriginal and Torres Strait Islander backgrounds
- Young people from Pacific Island and Maori backgrounds
- African young people and others from CALD backgrounds
- Young people who are refugees and unaccompanied minors
- Young women
- Lesbian, gay, bi, trans, intersex and queer young people
- Young parents

The broad appeal of YSAS programs and services for disadvantaged groups or those with special needs is reflected in the significant representation across our programs.

YSAS Services

Alcohol and Other Drug (AOD)

Residential 'Youth AOD' Treatment Services

- Youth residential AOD rehabilitation in Eltham (Birribi) with a state-wide remit.
- Bunjilwarra Koori AOD Healing Service in partnership with the Victorian Aboriginal Health Service in Hastings, with a state-wide remit.
- Youth residential AOD withdrawal services, operating in Glen Iris, Fitzroy and Geelong, constituting 19 beds.
- Youth AOD supported accommodation in northern metropolitan Melbourne.

Community based 'Youth AOD' Programs in Eight placed-based programs across Melbourne, in Gippsland and the Loddon Mallee regions that incorporate:

- Youth AOD Outreach
- Home Based Withdrawal and Primary Health Services
- Medical Practitioners and a Youth Dual Diagnosis Nurse Practitioner
- Non-residential 'Therapeutic Day Programs' in the Dandenong and Abbotsford
- Youth AOD Principle Practitioner for the Eastern Division.
- YoDAA (Youth Drug and Alcohol Advice) - online content, a phone line, live webchat and email services all of which contribute to a more accessible, coordinated and navigable Youth AOD service system in Victoria.

Mental Health

- Lead agency for headspace Collingwood and Frankston
- Enhancing Mental Health Support in Schools (Collingwood and Frankston)
- Youth Mental Health Bounce Back (Frankston) and Youth Enhanced (Collingwood) Programs - intensive casework and care coordination for young people with moderate to severe mental health problems
- Aboriginal Mental Health support service (through DDACL)
- Doctors in Secondary Schools McClelland and Mornington

Justice and crime prevention

- Youth Support Service – diversion and intensive early intervention for young people after first contact with Police (Metropolitan Melbourne and Gippsland)
- Embedded Youth Outreach Program – Youth workers and police officers will target and prevent youth offending in Melbourne's the Cities of Wyndam and Greater Dandenong as part of a 12-month pilot
- Pivot – Crime prevention through intensive casework and restorative justice work with high volume offenders in the Melbourne's south east corridor and Frankston

Adolescent Primary Health

Primary Health services in Secure Welfare Service (SWS): YSAS is contracted by DHHS to provide the primary health service for all clients in Victoria's SWS. These includes addressing AOD issues. These young people are all in the care of the State.

Generation and implementation of evidence-based practice

YSAS has a dedicated research program, collaborating with academic partners to increase knowledge of youth AOD issues nationally.

In 2012, with the support of the Victorian Department of Health, YSAS published the seminal evidence-based Therapeutic Framework for Youth AOD Practice.[1] This framework informs systematic AOD assessment and care planning and articulates how key therapeutic interventions are linked to positive outcomes for young people and families. The framework also identified the ten Characteristics of Effective Practice and can be used to inform the development of youth focused approaches across other disciplines such as mental health.

YSAS also auspices the Centre for Youth AOD Practice Development, an institution that brings together expert practitioners and researchers to develop practical and effective responses to the needs of young people affected by alcohol and other drug problems. The material is also relevant for practitioners in mental health designing service approaches for young people. The centre creates practical and evidence-informed resources, that is accessible to the Commission including:

- **The Youth AOD Tool Box** (http://yodaa.org.au/toolbox), which is an online resource for practitioners that integrates the best available evidence with direct practice experience to provide a practical and comprehensive guide to working with young people affected by drug and alcohol related problems.
- **The Youth AOD Learning Hub**, an online, self-paced, learning program that provides practitioners with structured, guided courses incorporating the skills and knowledge necessary to be effective in youth AOD practice. Clinical supervisors can use the hub through the 'Reflective Practice Guides for Supervisors' provided with each course.
- **The Out of Home Care Tool Box** (http://oohctoolbox.org.au), a resource for residential care workers and foster carers that contains information and guidance on responding to common issues faced by young people in OoHC, including substance use, self-injury, sexualised behaviours and mental health concerns.
- **The Young Parents' Tool Box** (http://www.youngparentsaod.org.au/about), created using our evidence- based knowledge about what works with young people experiencing problematic substance use.

[1] YSAS Background paper (Bruun and Mitchell, 2012).

- In collaboration with Deakin University's 'Centre for Social and Early Emotional Development (SEED)', YSAS helped produce the evidence-based tool **'ERIC'**, a trans-diagnostic modular intervention that addresses emotion regulation difficulties in young people with substance use and mental health issues.

4.0 OUR APPROACH

YSAS considers a young person's mental health as a resource for life. To create the conditions that nurture and protect this resource, YSAS adopts a resilience-based practice approach.

Resilience Based Practice is geared toward young people developing the capacity to face, overcome and even be strengthened by life's adversities. All young people can develop their capacity to be resilient given the right conditions. This demonstrates that resilience depends not only the development of individual qualities but also the capacity environment to provide access to health-enhancing resources in culturally relevant ways.[2] Resilience Based Practice emphasises young people's social and emotional well-being and synthesises lines of evidence from both resilience and developmental health research. The aims of Resilience Based Intervention, and the central assumptions on which it is based, are aligned philosophically with the harm reduction and health promotion movements. This represents a major departure from deficit-focused models that dominated earlier approaches in adolescent health.[3]

The focus is on creating the conditions that support young people and those involved in their care to gain as much control as possible over mental health and associated behavioural problems that impact on them.

YSAS practitioners frame positive goals for their work with young people. This does not mean that risks, symptoms, vulnerabilities, and disorders are ignored but rather that assets and strengths are assessed and strategies are aimed at reducing risk, increasing resources, and/or mobilising adaptive systems. Practitioners hold a focus is on "…the present as well as the young person as a future adult."[4] This means working with young people to address immediate issues while all the time considering the impact of interventions and experiences on their long-term development and future prospects.

5.0 ADOLESCENCE AND MENTAL HEALTH

Adolescent Development: Adolescence is a time of immense change in a young person's life as they transition from childhood to young adulthood. Rather than a universal domain of 'development' a wide range of behaviours and biological functions are co-occurring, making each young person's experience of adolescence individual. Some of the core changes that occur during adolescence to allow maturation include physical changes (maturation, puberty and sexual development), psychological (increasing desire for autonomy, evolving identity and value system), cognitive (moving from concrete to abstract and complex thought), emotional (changes in affect and mood, moving from being self-focused to empathizing with others and seeing bigger picture) and social (identifying and integrating with peer groups, forming intimate relationships, developing reciprocity and considering vocation, cultural adjustment and identity).

The trajectory and outcomes of each adolescent's development come about through the unique combination of these factors alongside the impacts of external social determinants and internal factors including resilience. Through reducing barriers to external supports and change and increasing young people's sense of internal resilience, YSAS intervene early to guide young people back on course in relation to their development. A guide to developmentally sensitive practice is included with this submission in Section 10.0 Appendices.

Social Determinants: When considering a majority of health issues (including mental health) estimates indicate that around 25% of the contributors to health outcomes are the direct result of genetics, biology and health behaviours.[5] In contrast, the other 75% are attributable to social determinants of health.
Evidence indicates that adolescence is the period of the greatest change and challenge in relation to social determinants as the young person is increasingly exposed to different world views and is forming their own

[2] Ungar, M. (2005a). Resilience among children in child welfare, corrections, mental health and educational settings: recommendations for service. Child and Youth Health Forum, 34(6), 445-464.
[3] Masten, A. (2009) Ordinary magic: Lessons from research on resilience in human development.
[4] Hamilton, M., & Redmond, G. (2010). Conceptualisation of social and emotional wellbeing for children and young people, and policy implications. Melbourne: A research report for the Australian Research Alliance and for Children and Youth and the Australian Institute of Health and Welfare, p5
[5] Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B.,Viner, R. M. Our future: a Lancet commission on adolescent health and wellbeing. Lancet, 387(10036), 2423–2478. doi:10.1016/S0140-6736(16)00579-1.2016

internal concepts based on this exposure. Young people growing up in contemporary society differ in fundamental ways from those of past generations[6] in the social determinants they interface with. Key among these differences are changes in the structure and function of families, greater engagement with education, and greater exposure to media influences. Each influence can function as an important enabling and protective system for health.

Social determinants of health are economic and social conditions that influence the health of individuals and communities (Commission on Social Determinants of Health, 2008). Essentially, they are the conditions under which we are born, grow, develop, live, work, age and eventually die.

Importantly, social determinants can be positive or negative for young people. Notably, the family plays a central role in development and there is now extensive evidence to indicate that positive experiences of family in childhood and adolescence are protective factors and linked to increased self-worth and self-esteem (McPherson et al., 2014). In contrast, negative family experience (including family violence) are associated with negative outcomes for young people.[7] These data indicate that the importance of families remains strong, although family relationships require change in line with adolescents' greater capacity and desire for autonomy. At the other end of the continuum, evidence indicates that societal values and norms around gender, ethnicity, and sexual orientation lead to inequality and poorer outcomes for many young people.[8]

Without addressing social determinants of mental health issues and substance use, systems continue to place the burden for recovery or wellbeing on the individual and their immediate family or carers.

Social determinants may be addressed at government policy, community, local, and informal levels. Difficulties in adolescent development can be viewed as a mismatch between the developmental needs of the adolescent and the opportunities afforded to them by their social environment (Eccles et al., 1993). Whilst appropriate, achievable developmental challenge combined with resilience allow young people to thrive, significant social determinants such as family violence or chronic disability may not be changeable for young people who then experiences distress, helplessness and or hopelessness, depression, anxiety and/or anger and are placed in the position where these may play out through mental ill health, substance use or destructive behaviour.

Data on Adolescent Mental health: The World Economic Forum found that mental ill-health accounted for 35% of the global economic burden of non-communicable diseases, which is more than cancer, diabetes and heart disease[9]. Children and young people aged 10-24 years bear the major burden for onset and impact of mental illness across the whole lifespan. For this age group, mental ill-health is the leading cause of disability, contributing 45% of the overall burden of disease[10].

On November 1st 2016, workers from 35 government funded Victorian Youth Alcohol and Drug treatment services completed a comprehensive survey on each of the young people in their care. Data returned from 857 young people forms The Youth Needs Census (ThYNC).

Half of all mental ill-health onsets before the aged of 14 years and three-quarters by 24 years. 26% of young Australians aged 18-24 years will have experienced a mental health condition (including substance-use disorders) in any given year[11] and suicide remains the leading cause of death for young people aged 15 and 24 years.[12] The rate of young people in Australia experiencing high or very high levels of psychological stress has tripled since 2017, which now represents almost a third of all young people (32%).[13]

The 2016 Victorian Youth Needs Census (ThYNC) found that 35% of young people in the survey sample had a current mental health diagnosis; 39% self-injured; and 20% had attempted suicide in the past.

[6] Institute of Medicine (IOM) and National Research Council (NRC) of the National Academies. *Toward and integrated science of research on families: workshop report.* Washington, DC: National Academies Press. 2011
[7] Volpe JS. Effects of domestic violence on children and adolescents: an overview. 1996; http://www.aaets.org/article8.htm (accessed 28-05-2019).
[8] Viner RM, Ozer EM, Denny S, et al. Adolescence and the social determinants of health. Lancet 2012; 379: 1641–52
[9] Bloom DE, Cafi ero ET, Jane-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The global Economic Burden of non-communicable disease. Geneva: World Economic Forum; 2011.
[10] Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet (London, England). 2011;377(9783):2093-102
[11] ABS. National Survey of Mental Health and Wellbeing: Summary of Results, 4326.0, 2007. Canberra: Australian Bureau of Statistics; 2009.
[12] ABS. 3303.0 Causes of Death, Australia, 2017: Table 11.1 International self-harm, Number of deaths, 5 year age groups by sex 2008-2017. In ABS, editor.2018.
[13] Colmar Brunton & headspace National. headspace National Youth Mental Health and Wellbeing Survey, 2018. 2019.

It is known that 'the timing of first onset in adolescence and early adulthood means that mental disorders have a significant social and economic impact and must, therefore, be a priority focus. It is at this age and stage in life that young people are:

- engaged in education that will be formative in their social connections and future pathways to employment;
- experiencing major life transitions including moving between levels of education, from education to employment, and away from their families or caregivers into independent living arrangements; and
- developing and navigating new social connections and interpersonal relationships.'

'The experience and impact of mental illness during adolescence can derail key developmental milestones and significantly increase the risk of poor health, social, education and employment outcomes. The human and economic impact then lasts for decades, through what should be the prime years of productivity and economic participation.'[14]

6.0 COMMENTARY AND CRITIQUE OF VICTORIA'S MENTAL HEALTH SYSTEM

This section provides commentary and critique of Victoria's mental health system that is focused on the needs and experiences of young people and families. Our aim is to provide the Commission with a deeper understanding of how young people encounter the mental health system and how they are impacted.

There are multiple system breakages and service failures apparent in Victoria's mental health service system that are, today, materialising for young people, as significant and often insurmountable barriers to accessing essential mental health support. Young people across Victoria are unable to access appropriate and adequate specialist mental health interventions when they need them most.

Drawing on our experience of supporting thousands of young people experiencing disadvantage over our 21-year history, and feedback from consultation with workers and young people undertaken for this submission, YSAS has identified the major contributors to mental health service system failure for young people in Victoria.

We believe that State clinical mental health services are too illness/condition focused and fail to address the issues that exacerbate and perpetuate mental health problems, which creates:

1. **System fragmentation and barriers to continuous care;**
2. **Uncoordinated and disjointed care planning;**
3. **The dangerous practice of transferring risk and accountability for client care to community-based;**

   youth services that are without sufficient capacity to respond effectively;
4. **Conditions that exclude family members and helpful others; and**
5. **A lack of effective mental health support for young people from diverse backgrounds.**

These features or conditions of the current system, have contributed to a substantial service shift for youth mental healthcare, from the tertiary service system to community health settings in recent years. More than ever, young people with moderate to severe mental health needs who are unable to access tertiary mental healthcare for the reasons outlined above, have had to seek support in the community sector.

As a result, the client cohort supported by community services such as YSAS has a more multifaceted and complex set of needs than ever before which means holding and managing more risk. Without additional investment this has tangible impacts for service quality, safety (of young people, staff and the community), risk management capacity and the financial viability of community service providers.

[14] Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation: Submission to the Productivity Commission's Inquiry into Mental Health. April 2019, p 3

If not addressed, these challenges will continue to have substantial, detrimental impacts on the health and life outcomes of young people in Victoria dealing with mental illness and other underlying issues, with substantial impacts for the individual and broader Victorian community.

6.1 System fragmentation and barriers to continuous care

System fragmentation is observed across many government service systems in Victoria, Australia and internationally. The mental health service system is not immune and its effectiveness for clients is severely impacted by entrenched fragmentation of the mental health system and related services. There are a number of factors that create this fragmentation and impact on the ability of the system to provide effective continuous care in mental health including:

- *There are multiple mental health providers servicing clients in Victoria*: The Commonwealth and State Governments, and community and private health sectors are providers of mental health services for young people and each sector has their own service frameworks, operating theories and cultures, some of which are incompatible or in conflict.

- *The service systems are not integrated*: Systems and structures to support or encourage information sharing, collaboration or service coordination across sectors and services are not in place.

- *Service and program funding structures are siloed*: Services are predominantly delivered along discrete funding and program lines, with very limited flexibility (particularly at the tertiary end) to offer service packages that cross portfolio, policy or geographic boundaries. This structural rigidity acts as a disincentive to the provision of continuing care for clients that is geared towards treatment of the issues that exacerbate and perpetuate mental health problems.

- *Mental health services have not been designed around the youth client experience*: Service models are not informed by proven youth work approaches or adolescent development and as a result are often unsuitable and ineffective for young people, particularly those with complex needs and who require ongoing care.

Complexity of service navigation

Fragmentation results in a system that is complex, rigid and extraordinarily difficult to navigate, particularly for young people with multiple, complex needs. YSAS workers report service navigation as being one of the greatest challenges in supporting young people with mental health issues.

'I had to call four Emergency Departments across three regions to fill the gaps in Kyla's case history. It took me five hours to find the right people to talk to.' YSAS Worker

Service navigation was regarded as almost impossible for young people and families to undertake alone and YSAS workers remarked on the significant drain case investigation and service navigation had on their time. It is not uncommon for YSAS workers to spend hours on the phone on any given day just to get basic client history in order to broker additional service. As 'service navigation' hours are not resourced or factored into 'occasions of care', they are by default absorbed by organisations and workers and have the effect of diverting workers' time away from other critical tasks such as case planning, therapeutic interventions and program delivery.

Service siloes

Funding, policy and area siloes are entrenched within the mental health service system and impact on the ability of services to share information and coordinate care. YSAS workers report that collaboration or shared care planning is uncommon across hospitals in different geographic catchment areas and can also be limited within different units of the same hospital. As a result, services are generally unable to provide clients with joined up service provision, which for young people, can often result in a frustrating service experience. Joined up service provision is important for all clients; however, it is a critical necessity for young people who are less proactive in seeking treatment or support and have a high risk of disengaging.

Further, geographic service restrictions severely impact access for highly vulnerable young people including those who may experience periods of homelessness or are forced to transition across area boundaries to secure

stable housing. Geographic catchment arrangements across the mental health system are complex and made more difficult to navigate as they are not always aligned with the catchments that other government services use. Young people are required to attend services located in the catchment area they live in, unless they require a specialised service that is not provided or available in their own catchment. YSAS workers provided numerous cases of young people who were unable to access service on geographic grounds or lost access to service when they were forced to move house. Several studies have also found that homeless young people have very high rates of substance abuse and mental disorders, but very low rates of access to these services relative to need.[15] *[See 'Scout' Case Study].*

'I was kicked out of home and I wasn't eligible for the services I needed without an address. But I needed those services to get stable enough so Mum would let me come home.' Young person

Diagnostic focussed assessments and service thresholds

Eligibility for access to area mental health services and emergency departments are too strongly determined by the extent to which a young person meets the diagnostic criteria for a particular illness or condition. This prevents access to mental health services for young people who could be distressed and at risk but don't make the threshold for eligibility. It is then extraordinarily difficult for young people to be provided with effective continuous care. A commitment to working with young people over the longer term is an essential element in the provision of continuing care, however the mental health service frameworks are geared toward discrete interactions rather than the development of long-term care relationships.[16] Further, mental health services are not informed by, or responsive to changing developmental needs of young people. As a result, young people who require on-going care and support are very commonly underserviced or unable to access support at all. *[Refer Tamlin Video Case Study].*

'When I was told I was too complex to be helped by the mental health service, but not unwell enough to access inpatient care. It just felt like another rejection.' Young person

Young people with moderate to severe mental health problems need more specialised, intensive and extended care than is currently available within the community sector, however, they are not ill enough to reach the high threshold for access to state funded acute and continuing care. Young people presenting with moderate to severe mental health concerns at Emergency Departments are routinely discharged to community-based services despite the severity of their illness, due to lack of available youth focussed step down facilities.

YSAS workers also report that mental health assessments can be weighted toward presentations that suit bed or service availability (i.e., emphasising AOD issues in order to secure a YSAS residential placement, when AOD abuse may be only one of multiple issues being experienced by the young person). This adds additional pressure and risk for YSAS when accepting these young people as their referral is not based on the full picture of that young person's needs or a comprehensive risk assessment.

Youth and trauma informed crisis support

A lack of trauma informed, youth focussed crisis support is also a major challenge for the system. When young people experience psychotic episodes, crisis support is provided by the Crisis Assessment and Treatment Team (CATT) with support from paramedics and the police if required. There is high demand for crisis support and the CATT team are often unavailable or refuse to attend due to safety concerns. In such instances, police are brought in to attend.

The presence of police can be highly problematic for young people, especially those from Aboriginal Torres Strait Islander or other backgrounds who have traumatic associations with police. When police attend it is often a trigger for further escalation of the young person. Workers and young people both considered police responses as being too regularly excessive and out of step with the real threat posed by the young person or the needs of a particular situation. *[See 'Jessica' Case Study and 'Tamlin' Video Case Study].* Similarly, young people felt there was an over reliance on restraints in the hospital system, with one young

'I am a young girl of 50kg. I don't understand why they needed 22 big men to restrain me.' Young person

[15] Busen, N. H., & Engebretson, J. C. (2008). Facilitating risk reduction among homeless and street-involved youth. Journal of the American Academy of Nurse Practitioners, 20, 567-575

[16] Bruun, A., & Hynan, C. (2006). Where to from here? Guiding for mental health for young people with complex needs. Youth Studies Australia, 25(1), 19-27.

person recounting a story where she was so heavily medicated she was unable to move, but was still restrained to her hospital bed. Consideration should be given to additional training and development for tertiary mental health professionals, police and paramedics to enable them to take a more person centred, developmentally appropriate approach to engaging with young people, particularly during periods of crisis and when drugs and alcohol are involved.

'[When I was an in an inpatient mental health unit], it felt like they were trying to correct me rather than help me.' Young person

When service navigation is treated as a dedicated and resourced activity, system breakages and failures can be overcome. The Advanced Care Coordinator pilot is an example of how the application of qualified and experienced service navigators can transform the service experience for young people. Effective service navigators have both mental health and youth work training and utilise evidenced based youth engagement methods to inform their approaches, which are heavily reliant on assertive outreach. The have a depth of system expertise that enables service packages to be provided in a joined-up way and essentially operate as a glue to fill the wide gaps that exist between mental services and other sectors. *[See 'Phoebe' Case Study]*

Young people often gravitate to community settings due to the person centred and holistic approach employed, that is focussed on building trust and rapport with the young person and funnelling engagement through trusted networks. Additional supports (when available) can then be scaffolded around the young person to build resilience and promote recovery. As a consequence, the community sector would provide a valid alternative treatment setting for young people dealing with more advanced mental illness, if there was greater access to wraparound support services. Combining a 'youth friendly' person centred approach with specialised interventions delivered into community settings would reduce the burden on tertiary mental health services and arguably lead to a better client experience for young people.

'PHOEBE'

Phoebe was referred by youth justice to headspace who assessed her as having multiple, complex needs and additional layers of disadvantage including hearing impairment, housing instability, family violence and autism. The headspace model was not able to meet all her needs so she was then referred to four different services for additional support. Normally Phoebe would be required to navigate her interaction with all of the different services independently. Phoebe had no family support and invariably, Phoebe would be lost to follow up due to her inability to attend appointments or engage in the service model that was offered.

*Phoebe however, was lucky. She was appointed an advanced care coordinator. Her advanced care coordinator, Jane got involved once Phoebe's multiple complexities were identified and the need for advanced service navigation and advocacy. *Jane has both youth work and clinical experience. Jane met with Phoebe at a local shopping centre as that's where Phoebe liked to hang out. Jane was able to quickly build trust and rapport with Phoebe and undertake developmental engagement sessions and assessments over a number of weeks in a way that Phoebe responded to and at a pace that suited her. Phoebe never responded well to intensive assessments or tick box checklists.*

In the background Jane was working to coordinate services for the spectrum of Phoebe's needs. This included accessing homelessness supports and accompanying Phoebe to Centrelink to seek financial aid. Jane also made sure all the services working with Phoebe had her full background and case history. With Phoebe's consent, Jane also starting working with Phoebe's family, and they began to feel more confident they could support Phoebe at home.

**Jane (not her real name) is an Advanced Care Coordinator, her role is part of a joint initiative of the North West Primary Health Care Network Pilot, YSAS and Headspace Collingwood and Frankston.*

6.2 Uncoordinated and disjointed care planning

Young peoples' journey through the mental health system (as observed by workers and young people) is often disjointed and uncoordinated. The rigidity of funding arrangements in mental health do not support person-centred care and make it difficult to tailor and deliver integrated packages of support. Young people are often forced to navigate multiple services to meet their range of needs and the funding structures encourage short-term interventions that can be crisis driven and un-coordinated, rather than focused on long term outcomes.

Illness/ condition focus

Young people are often delivered services as discrete interventions based on isolated or selective diagnoses. When assessment and diagnosis are compartmentalised, it prevents health professionals from taking a holistic view of the young person's needs and developing care plans accordingly.

'The acute system said I needed continuous counseling, but I was assessed as not 'severe' enough to warrant continuous counseling.' Young person

A specific illness focus does not allow time for the young person's underlying issues to be properly understood and therefore often result in the young person being referred back to community services without ongoing access to specialist interventions or effective continuing care. For young people who have multiple, complex needs and experience serious disadvantage, this approach can be particularly ineffective and significantly impact their chance at recovery. For example, evidence suggests young people have increased risk of poor treatment outcomes and social disadvantage as a result of having comorbid alcohol and drug issues and mental health conditions. Their particular emotional, cognitive, psychosocial development, demands a distinct developmentally geared treatment approach that is not available in the current service system.[17]

There is no clear process or pathway that workers in the community sector can draw on when a young person's mental health deteriorates and becomes severe to acute. Appropriate step up or step-down facilities are regularly unavailable when young people need them. Young people are often 'bounced' around the system from service to service based on availability or isolated diagnosis and workers are forced to 'cobble together' a package of supports in an attempt to maintain the young person's engagement in service, and avoid escalation or crisis.

'I needed not to need rehab to get into rehab.' Young Person

Further, there are multiple prerequisites to access tertiary mental health support, such as stable AOD use, permanent housing and an ability to engage proactively in services (i.e., attend appointments), many of which young people are unable to meet. The strict diagnostic criteria and thresholds, often do not acknowledge the impact of trauma or adolescent developmental stages. Even when a young person has needs that are severe enough to be accepted into inpatient care, there is limited access to services at points of transfer and discharge from hospital, including access to residential care, home outreach, and outpatient clinics. These are critical services at particularly high points of suicide and self-harm risk for young people with severe and complex mental health conditions.

Many YSAS workers also noted the numbers of young people who are excluded from mental health services based on 'behavioural' diagnoses. As public inpatient units are usually full to overflowing, practitioners prioritise people with acute serious mental illness and the accompanying psychotic symptoms. This often means that distressed young people who act out their anxieties or impulses, may not be admitted due to their 'Personality Disorder or Axis 2' characteristics. While these categorisations are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and ICD Classification of Mental and Behavioural Disorders, they can also represent moral evaluations of the individuals that negatively impact on young people's ability to access specialised care. Many have serious and intense self-harm or suicidal impulses but are not floridly psychotic and therefore do not meet the required criteria for admission despite the seriousness of their mental ill-health.

Unsupported transitions and lack of shared care planning

Unsupported transitions between services contribute to the disjointed service experience for young people. Following a period of inpatient mental health care, a young person is often discharged to a community-based service in their home catchment for continuing care. YSAS workers report a norm of patients being discharged from tertiary mental health services without case discussion, a care plan, nor any agreement to support the young person's referral with additional wraparound supports. Siloes and structural rigidity act as a disincentive to the sort of regular and routine information sharing and engagement across sectors that could embed a culture of communication and collaboration regarding care coordination.

'I have to go to multiple places to receive support I need and I get assessed over and over again.' Young Person

'I feel like I'm being bounced around a pin ball machine from service to service, and no one really can help me.' Young Person

[17] AIHW. Australian Burden of Disease Study: impact and causes of illness and death in Australia. 2011. Australian Burden of Disease Study series no.3. Cat. No.BOD 4. Canberra: Australian Institute of Health and Welfare; 2011.

Whilst YSAS workers report there is a willingness to share information when sought, proactive information sharing from mental health services to the community sector is not prioritised. Further when dealing with mental health, the acute and community sectors do not currently have adequate structures in place, nor a cultural foundation to encourage collaboration, build engagement and partnerships and facilitate communities of practice.

The disjointed and uncoordinated nature of the mental health service experience for young people is exacerbated by the fact that mental health professionals are invariably overstretched and under resourced. Hospital reporting and performance frameworks that don't acknowledge or place a tangible and recordable value on shared care planning activities are also to blame.

Emergency Departments as the front door to acute services

As the only door to accessing acute mental health support, young people are forced to present at emergency departments as a first stop to receiving acute care. It is not uncommon for a young person to present at multiple emergency departments across their journey, and the inability of the system to share information and coordinate care means they are often forced to start from scratch with health professionals at each intervention. This not only impacts on the young person's experience, it also leads to duplication and waste as assessments and testing are often repeated at each intervention. When service continuity is broken for young people, critical background information can be missed, the young person's engagement levels are invariably diminished and valuable treatment momentum is lost. YSAS workers recall numerous stories of young people becoming disillusioned with their service experience, disengaging and subsequently being lost to the system. In many instances this sequence of events has had catastrophic outcomes. *[Refer 'Scout' Case Study].*

'We had jointly developed an effective plan for a supported transition from Area Mental Health with the registrar. All was going well until the shift changed, handover apparently didn't happen and the agreed plan was forgotten. Jane was discharged without support and an hour later arrived at our door.' YSAS Worker

YSAS workers also reported that in most hospital EDs they engage with, no initial triaging assessment is undertaken when a young person arrives at the ED. This means that regularly the young person (and often support worker or family member accompanying them) wait in excess of five hours before receiving any medical intervention. In a stable state this is a significant challenge for adolescents, but is made even more difficult when the young person is in a heightened state. The result is often that workers cannot keep the young person at the ED and a valuable intervention opportunity is lost. Young people (15-24 age group) present to emergency departments for mental health related reasons at a higher rate per population than any other age group. More than one quarter of mental health related emergency department presentations in 2016-17 were for people aged 25 years and under.[18] However, the triage and assessment model of EDs make it very difficult for young people to stay engaged in the process of seeking help.

'SCOUT'

The YSAS worker was working with Scout for months. He had experienced significant trauma in his life. Two of his best friends had committed suicide. He was the one to find them. His father was in jail for murder. His mother was experiencing drug abuse.

While engaged with YSAS, regularly Scout would escalate and become very unwell, experiencing psychotic episodes. He was taken to the ED numerous times (sometimes up to three or four times a week) but was churned out and never received a comprehensive mental health assessment. He regularly threatened violence against others including his grandmother who was his primary carer. YSAS tried to refer him to every available mental health service but he repeatedly didn't meet diagnostic thresholds for admission. YSAS finally secured a mental assessment for Scout but then referrals weren't accepted as his address fell between catchments. Multiple area mental health services used his location to exclude Scout from service.

YSAS workers sat in meetings having explored every avenue but were left with no options for ongoing specialist mental health support for Scout.

Inevitably Scout escalated again. This time he seriously beat his grandmother. Scout was charged and is now facing a very lengthy jail term and his grandmother has been left with serious permanent injury.

[18] AIWH. Mental Health Services in Australia: Services provided in public hospital emergency departments. Table ED.6: Mental Health-related emergency department presentations in public hospitals, by patient demographic characteristics, 2016-17. Canberra: Australian Institute of Health and Welfare; 2018.

6.3 The practice of transferring risk and accountability for client care to community-based youth services that are without sufficient capacity respond effectively

'If a young person is discharged without adequate support and ends up in a community service, who is responsible when something goes wrong?' YSAS Worker

Increasing complexity of clients being supported by community services
Increasing demand for service across the spectrum of interventions, but particularly for young people suffering from moderate to severe and acute mental illness has resulted in a gradual, but significant service shift from acute hospital services to the community services sector. The increasing acuity of patients seeking support in the hospital system has had flow on affects for the complexity of patients being pushed out to community settings and consequently, the client profile supported by the community health sector has evolved to become increasingly complex with higher risk, broader change readiness and more diverse care needs than ever before.

In acute and other inpatient mental health services there is no expectation that shared care planning will be undertaken when referring, transitioning or discharging patients. This means young people are often transitioned out of acute settings without the support they need. Increases in mental health funding in response to rapid population growth and demand increases has been largely focused on more acute and hospital-based care, or in managing emergency department presentations, leaving a considerable gap in specialist, community-based youth mental health services. Given the shortage of step-down facilities available for young people, community services such as YSAS are regularly being referred young people with needs far more complex than those YSAS programs are designed to support.

'I feel like I have to get sicker to get help.' Young Person

Approaches to managing duty of care for young people in the mental health system are unsophisticated. Who holds accountability for young people as they traverse the mental health system and transition across service sectors is not clearly understood or well documented. There are no protocols or agreed and enforced practices around referral, discharge and transition, which means that there is no documented continuity in terms of duty of care for a young person. There is no accountability placed on referring organisations to ensure referrals are appropriate or accepted prior to discharge. This often means that YSAS is forced to accept high risk young people with complex care needs, as the young person's only alternative. Otherwise, they would be left without any support and/or homeless.

For example, YSAS now support an increasing number of young people with highly complex mental health needs that coexist with other issues and challenging behaviours, in the absence of other available treatment options. Many of these young people also have extensive previous involvement with mental health and other social support services. YSAS wants to work with these young people but they require specialised wraparound supports delivered into their community and residential settings. Such services are extraordinarily hard to access for all but the most severe clients. Workforces in the community sector do not ordinarily have sufficient training or experience to respond effectively to the breadth of clinical issues complex clients bring and as such, there are impacts on the quality of care that can be provided to young people. Too often, young people are forced to reach crisis point before they can access necessary specialist support.

Risk transfer to community services
As a result of this service shift, YSAS and other community sector organisations are now taking on substantially higher levels of risk. The risk manifests in a number of ways but is consistently poorly understood and unacknowledged by tertiary mental health organisations, who are responsible for transferring the risk when they discharge and refer patients to the community health sector. Risk is commonly transferred from one service to another without adequate, or any, consideration of the implications for the young person, other clients, staff or the organisation that is left with the risk.

'It is common for us to receive a cold referral via fax without any prior discussion or agreement.' YSAS Worker

Supporting clients with complex care needs, without adequate funding for specialised wraparound supports means that YSAS are unable to provide young people with the intensity of support required to match their needs. Without intensive specialist interventions, a young person's underlying issues may not be treated and their condition is likely to deteriorate. There is an obvious risk to the young person's health and safety of worsening

mental health, but there are also tangible risks to workers, families and the broader community when young people's mental health remains untreated or undertreated. Complex, high needs clients bring with them high levels of risk that community sector organisations are not yet fully equipped to manage or mitigate. As such, this puts pressure on the community sector to take on the responsibility and risk for severely unwell, highly complex young people.

'It can feel like duty of care for a young person is treated like a hot potato.' YSAS Worker

The risk also manifests in a workforce that is being put under ever increasing pressure. This has significant implications for their health, wellbeing and safety and makes it increasingly difficult for organisations to attract and retain high quality staff. Furthermore, competitive grant based, time limited funding arrangements impact on the ability of organisations like YSAS to provide their workforces with the certainty and conditions that could help counter the difficult working conditions and attract high quality staff.

Young people with multifaceted and complex needs can be successfully supported in community settings, but only if they and the workforces have access to additional specialist, wraparound supports for the young person. There is a critical lack of availability and subsequent reluctance to provide these services for transitioning young people putting excessive on community workers to 'make do'.

'BILLIE'

Billie was an intelligent teenager from a supportive middle-class family. Whilst she has experienced mental health difficulties throughout her childhood, she had managed to maintain engagement in education and was studying science at university.

Her parents had sought and accessed private mental health support for Billie over a number of years, however Billie's mental health continued to deteriorate and she began abusing drugs and alcohol at which time she was referred from headspace to YSAS. As her issues escalated and Billie experienced suicide ideation and self-harm attempts, she had numerous admissions to Emergency Departments.

At one point she laid down on train tracks and narrowly escaped being run over. After each admission she was assessed as having a 'behavioural' issue and referred back to YSAS. She was engaged in and comfortable at YSAS settings but needed more specialised care that YSAS could not access for her.

She once again presented in a heightened state at YSAS who called the CATT team. She was stabilised but not admitted to inpatient care. She had plans to spend the night with her younger sister.

24 hours later she went to her local train station and again laid down on the tracks. This time the train ran over her.

Miraculously she survived but was kept in a coma for five days and stayed in hospital for months. She now has access to long-term inpatient mental health care.

In order to get the help she needed, Billie had to come far too close to death.

6.4 Conditions that exclude family members and helpful others

The mental health system's illness focus or specific condition diagnosis often ignores the benefits of involving family and helpful others in the young person recovery journey and in doing so rules out an essential resource to enhance young people's chance at recovery.

For the most disadvantaged and vulnerable young people, families are almost universally both a key source of stress and risk, and the most important source of protective resources. Whether or not families are functioning poorly, many possess under-utilised and under-recognised resources that can be helpful for young people.

Outcomes for young people are optimised when networks of care and support are built and maintained, and families are included in all parts of the client journey, including inviting families to hold shared responsibility for care planning. Even in the presence of troubling family histories, where safe to do so, family members, kinship figures and safe adult mentors can provide an enduring source of comfort, challenge and belongingness to young people long after our service involvement finishes.

Across YSAS services we seek to collaborate with families and carers on the common goals of protecting their child's safety, health and wellbeing and future prospects. The goals of family focused interventions are to:

- Engage families in the care and support process as far as possible
- Motivate family members as supporters of their young person
- Build the capacity of family members to provide emotional and practical support that assists the young person along a positive developmental pathway.

There is emerging evidence that specially designed, culturally sensitive strategies can achieve high rates of family engagement and better outcomes for highly marginalised and vulnerable young people. The Youth Cohort Study found that "domestic instability and family conflict are the factors most strongly predictive of intractable substance related and wider life problems".[19]

Families that are invested in the young person's recovery are a critical protective influence. When workers actively involve families in their young person's journey, better navigation of service system and less distress is often the result. Constructive family experiences and environments contribute toward building resilience in young people and thus family engagement should be a central feature of any therapeutic intervention.

6.5 Lack of effective mental health support for young people from diverse backgrounds

The system finds it particularly difficult to coordinate care for young people from diverse background including, young people from CALD or Aboriginal and Torres Strait Islander backgrounds and LGBTQI young people.

'We were working with a young man from a CALD background. Both he and his mother has limited English but they refused to use an interpreter as the interpreters are part of their community and they were worried about their community finding out what was happening. It made it much harder to effectively support the young person.' YSAS Worker

The Centre for Multicultural Youth in Victoria identified that young people from migrant and refugee backgrounds accessed mental health services at a much lower rate than other Australian-born young people.[20] Many culturally and linguistically diverse (CALD) young people who had mental health issues were found to be less likely to access community state-based services than Australian-born young people, but had proportionately higher admission rates to inpatient units, suggesting they experienced significant barriers to accessing mental health care until their illness had become acutely severe.[21]

YSAS workers agreed that accessing culturally appropriate, safe and effective mental health care for young people from CALD backgrounds was challenging. Stigma around mental health and alcohol and drug use also made engagement with the young person and family even more difficult than normal and affected the quality of care they could provide for young people.

Workers also highlighted the increasing need for targeted interventions for young people from LGBTQI backgrounds, with gender diverse young people presenting at higher rates than ever before for mental health support. Some workers reported feeling underprepared to support young people from LGBTQI backgrounds, particularly transgender youth.

Despite much higher rates of psychological distress and suicide (which sits at 3.3 times higher among Aboriginal and Torres Strait Islander young people aged 15-24 than non-Indigenous people), Aboriginal and Torres Strait Islander young people use of mental health services at considerably lower rates than non-Indigenous young people indicating higher barriers to access for this group. Orygen and headspace suggest some of the key barriers for young Aboriginal and Torres Strait Islander people accessing mental health services are stigma and shame, cultural appropriateness, inflexible intake processes and limitations to western clinical approaches and

[19] Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet (London, England). 2011;377(9783):2093-102
[20] Welfare AIoHa. Young Australians: their health and wellbeing 2011. Canberra; 2011.
[21] Centre for Multicultural Youth. Mind Matters: The mental health and wellbeing of young people from diverse cultural backgrounds. Melbourne, Victoria; CMY; 2014. De Anstiss H, Ziaian T, Procter N, Warland J, Baghurst P. Help-seeking for mental health problems in young refugees: a review of the literature with implications for policy, practice, and research. Transcult Psychiatry. 2009;46(4):584-607.

mainstream assessment tools which do not necessarily identify the presence or impact of trauma and intergenerational trauma[22].

The lack of culturally appropriate care also places higher stress on the services that do exist as they are required to accept young people with a broader range of needs and states of change due to the absence of alternative service options. For example, YSAS operates Bunjilwarra Koori Youth Healing Service in partnership with the Victorian Aboriginal Health Service (VAHS). Bunjilwarra is the only service of its type that provides an integrated cultural/clinical service mix specifically for Aboriginal young people. The service has experienced success, however faces challenges in managing demand and transitions to and from the service as there are no other culturally specific stepped care facilities available. This puts additional pressure on Bunjilwarra to cater to clients in a much broader state of change, which has impacts for program quality and client experience.

'JESSICA'

Jessica is an 18 year old aboriginal young person. She has suffered from mental health concerns over a long period and has had inpatient stays in mental health for severe mental health concerns. Jessica was transitioned to a YSAS drug and alcohol rehabilitation unit and whilst there attempted suicide. Staff tried to ring the CATT team however the number was diverted and no response was forthcoming. With no other options, emergency services were called. Paramedics and 15 police officers presented at the YSAS unit.

Jessica became immediately distressed by the presence of so many police and her behaviour escalated and she became aggressive and physically threatening at which time she was sedated.

The incident was extremely traumatic for Jessica and the workers who had successfully contained and comforted her following her suicide attempt and Jessica experiences ongoing trauma from the event.

[22] Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation: Submission to the Productivity Commission's Inquiry into Mental Health. April 2019, p 31

7.0 RECOMMENDATIONS

Building on the commentary and critique of Victoria's mental health system outlined in Section 6.0, our recommendations explained in Section 7.0 highlight what YSAS observe as the ten characteristics that are key to an effective youth mental health system.

When embedded in a service system, **these ten essential characteristics** work in unison to create a service experience for young people (and other clients) that is integrated, person-centred and holistic and will help achieve a much more effective youth mental health system.

Our recommendations also identify two practical strategies that if implemented, would improve Victoria's youth mental health system and result in immediate benefits for clients.

Action is urgently required to address the increasing mental health complexity of young people seeking support in the community sector. Providing young people and families with enhanced service system navigation and continuing care coordination has been proven to be able to successfully bridge service and sector gaps that are a feature of Victoria's fragmented mental health system.

YSAS proposes a multi-systemic therapeutic approach that draws on the ecology of the client as well as existing community resources to empower young people in achieving long-lasting, positive mental health outcomes. Further, enhancing the capacity of youth AOD residential services to more effectively support young people with complex mental and other health needs by embedding more specialist mental health expertise within services will reduce the demand for acute service and ensure young people have better access to more effective integrated and continuous care.

Dedicated and experienced system level navigators embedded into the mental health system would operate as the glue that is needed to bridge the gaps that are a persistent feature of the current fragmented Victorian mental health system. These roles would exist to guide young people, families (and other workers) through their recovery journey, helping them find a path that suits them and to stay on track. They would be able to workaround and overcome system and service deficiencies by creating linkages and coordinating services where there are none, and developing enduring relationship with high risk young people who need continuous care over the longer term. The enhanced service system navigation function would focus on reducing barriers to engagement and would provide flexible responses including outreach support and care coordination to effectively engage young people with more complex needs in appropriate services they would otherwise not access. The function would conduct comprehensive assessments, care planning and co-design appropriate interventions to enable young to access supports.

Enhancing Youth AOD Residential Withdrawal and Rehabilitation services to provide an additional service offering within the Mental Health Service system will enable young people with multifaceted and complex needs to be successfully supported in community settings. When workforces have access to additional specialist, wraparound supports for the young person and the facilities can act as genuine 'step down' facilities for young people transitioning to and from acute care. Young people often gravitate to community health settings due to the youth informed approaches employed by organisations such as YSAS. As a consequence, the community sector provides a valid alternative treatment setting for young people dealing with more advanced mental illness, if there was greater access to wraparound support services. Combining the person centred approach of YSAS with specialised interventions delivered into community settings would reduce the burden on tertiary mental health services and arguably lead to a better client experience for young people.

RECOMMENDATION 1.0

Ensure system reform and service design are informed by and commit to the Ten characteristics of a more effective 'youth' mental health service system

The ten characteristics of an effective 'youth' mental health system are summarised in the figure below. A further explanation of the characteristics is also provided which includes supporting evidence highlighting the importance of the essential characteristics and the impact they can have on a system's effectiveness and client service experience.

Ten Characteristics of an effective 'youth' mental health service system

1	*Service system responses geared to level of client vulnerability and complexity rather than illness or behavior*
2	*Holistic, person-centred care that integrates effective specialist clinical intervention*
3	*Capacity for effective early intervention*
4	*Engagement and retention in continuing care – a developmental pathways approach to treatment*
5	*Strong focus on the psychosocial stability of clients*
6	*Formal mechanisms to ensure the effective integration with other Service Systems*
7	*Address the specific needs of diverse populations - Cultural competency*
8	*Specific responses to ensure that young people and Families in Rural regions and/or remote communities have access to the care they require*
9	*A competent workforce that is adequately supported*
10	*Proactive service system planning that involves service users*

1.1 Service system responses geared to level of client vulnerability and complexity rather than illness or behaviour

A range of biological, psychological and social factors interact to determine for each individual the severity, frequency and even the onset of Mental illness and mental health problems. In many cases these factors when not properly addressed are also the determinants of problems such as substance misuse, antisocial and self-harming behaviour. As such, these behaviours and diminished mental health are often co-occurring and interrelated.

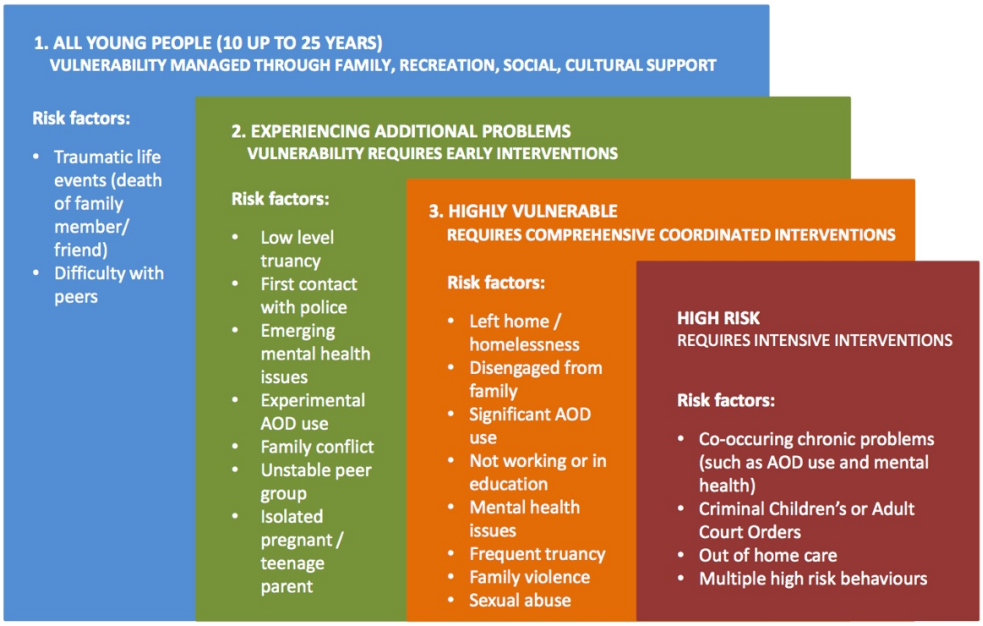
These common determinants are also known as risk factors that influence the degree to which a young person is vulnerable to developing mental health problems and related health compromising behaviours. Prevention scientists and epidemiologists have also been able to identify factors that are protective, both mitigating risk and nurturing positive development.

A young person's level of vulnerability is then determined by the number of risk factors and how influential they are combined with the degree to which they are moderated by the influence of protective factors. In 2008, the Victorian State Labor Government developed a Vulnerable Youth Framework that made a young person's level of vulnerability the focus of intervention. This stands in direct contrast to the current circumstance where service systems are built around responding to isolated health behaviours and issues. This siloed approach creates the conditions for the unnecessary duplication of effort, wasted finances, difficulties for young people and families in accessing the right services and serious disadvantage resulting from unmet need.

The authors of the Vulnerable Youth Framework drew on substantial evidence to demonstrate that all young people are vulnerable to disruptions and challenges that at times make developmental tasks difficult to achieve. Even so, for the bulk of Victorian young people, vulnerability "…is managed through family, recreational, social

and cultural support". [23] When a young person is adequately supported and resourced, exposure to threats or challenges can be an opportunity for learning and personal growth.[24] Alternatively, it is most often the children and young people who contend with the greatest adversities that do not have the protections offered by adequate resources and social 'scaffolding' capable of regulating their exposure to risk.[25]

Layers of Vulnerability



"Vulnerability becomes problematic when negative behaviours or experiences multiply and there are few or no supports in place to assist young people [who….] confront issues that they do not have the skills, knowledge or support to get through".[26]

The Vulnerable Youth Framework identifies four layers or levels of vulnerability (see Figure 2.1). While no consideration is given to the moderating influence of protective factors, the framework could again be a useful conceptual tool for enabling policy makers and service providers to craft responses that target vulnerability and the factors that perpetuate and exacerbate mental health and behaviour problems.
The Centre for Mental Health at the University of Melbourne's School of Population and Global Health (the 'Centre') identifies that multiple sectors with a common interest in young people's health and development need to work together to identify priority populations or cohorts and common risk and protective factors that can be targeted in collaborative intervention programs.[27]5

1.2Holistic, person-centred care that integrates effective specialist clinical intervention

Specialist treatment and interventions based on a sound assessment and diagnosis are incorporated within a holistic and client centred approach.

Client-centred care involves tailoring interventions as much as possible to fit with the unique needs and experiences of each client. Although all of our clients share many experiences and issues, they also differ from each other along many socio-demographic variables such as cultural background, religion, age, gender, sexuality, and particular sub-cultural affiliations. There is also wide variability among our clients according to

[23] Vulnerable Youth Framework, 2008, p12
[24] Fleming, J. & Ledogar, R.J. (2008). Resilience, an Evolving Concept: A Review of Literature Relevant to Aboriginal Research. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 6(2)
[25] Masten, A. S. (2001). Ordinary magic: Resilience over the lifespan: Developmental perspectives on resistance, recover, and transformation. In J.W. Reich, A.J. Zautra & J.S. Hall (Eds), Handbook of adult resilience (pp213-237). New York: Guilford Press.
[26] Ibid, p12
[27] Mitchell, P.F. (2014) Victoria's most disadvantaged and vulnerable young people: a fresh look at needs for health and social care services. The Centre for Mental Health: Melbourne School of Population and Global Health, University of Melbourne.

developmental stage or maturity, and the strengths and other resources that they bring with them. Our staff do their best to ensure that the care young people receive is appropriately nuanced according to these variables.

Holistic care involves recognition that a wide range of biological, psychological and social factors impact upon the client and the issues they bring to a particular service, recognising that these factors and issues are connected with each other, and ensuring that these factors are taken into consideration in the design and implementation of the client's care.

A term that is widely used in the literature to denote a combination of client centred and holistic care is 'needs-led' care. Treatment services often profess that their services are needs-led but the content of the program has usually already been determined before the client seeks admission. In contrast to this genuine client-centred care involves ensuring that interventions (i.e. the contents) are selected, adapted, and delivered in ways that are consistent with the individual needs of the client.[28] An orientation that "responds to what our patients require from us rather than our deciding what they need in advance" and "incorporat[ing] the services of the program into their lives rather than having them adjust to us".[29]

In most real-life practice settings the question of how or if a particular type of intervention or treatment can be customised is rarely considered from an intervention or illness-centred perspective. In contrast to this, a client-centred and holistic approach is concerned with understanding the variety of different interventions that may be appropriate to the range of issues experienced by a particular client (including their problems and their strengths), and when and how these different interventions can be most profitably introduced and configured. In this way clients and their carers can be included into an active and collaborative process of solution-finding.[30]

1.3 Capacity for effective early intervention

Early intervention refers to strategies targeting people displaying the early or emerging signs and symptoms of developing mental health problems. This requires the early identification of young people at risk so that a timely and effective response can be made to either resolve the problem before it progresses and becomes entrenched or reduces the impact of the problem over time.

YSAS endorses the headspace model as an effective, place based early intervention option for young people but the Federal Government Department of Health report, that the effectiveness of early intervention is poorly recognised in the current system. They note that for adolescents, mental illness is a significant risk factor for not completing secondary school and subsequent study or employment. It is also a risk factor for longer term mental and physical health outcomes, as well as impacting on their families, friends and others around them.

The Centre for Mental Health at the University of Melbourne's School of Population and Global Health (the 'Centre') identifies that early intervention is necessary and that all sectors need to work together to identify priority populations and common risk and protective factors that will be targeted in collaborative intervention programs31.

YSAS supports the view of the Centre's view that early intervention be targeted toward:

- Young people who have disconnected or are at risk of disconnecting from school, and provide supports that retain or reconnect them with education or supported employment.
- Identifying and supporting families under pressure.
- Victoria's most disadvantaged and vulnerable young people such as those in out-of-home care and Youth Justice settings.

headspace Centres are ideally positioned to work within local communities to engage these populations and provide a targeted early intervention response. Interventions and programs need to be timely and attractive to young people who could be resistant to treatment.

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[28] Pichot, T. (2001). Co-creating solutions for substance abuse. Journal of Systemic Therapies, 20(2), 1-23.
[29] Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.
[30] Munford, R., & Sanders, J. (2008). Drawing out strengths and building capacity in social work with troubled young women. Child and Family Social Work, 13(1), 2-11.
[31] Mitchell, P.F. (2014) Victoria's most disadvantaged and vulnerable young people: a fresh look at needs for health and social care services. The Centre for Mental Health: Melbourne School of Population and Global Health, University of Melbourne.

This intervention should be conducted by practitioners that are mobile, expert at engaging young people and qualified to work with and families.

1.4 Engagement and retention in continuing care – a developmental pathways approach to treatment

Treatment and early intervention services can only be effective if young people and families can be engaged and retained in treatment. Young people who remain in treatment do better than those who drop out, regardless of the level of impairment.[32] This means that focused engagement and retention strategies are a key characteristic of treatment programs.[33] This is critical as young people are less proactive than adults in seeking treatment in particular those with substance and mental health problems[34]

Barriers to help seeking and service access for young people include:

- Complex and impersonal intake processes
- Not perceiving a need for treatment
- Lacking knowledge of what assistance is available or how to find what they need
- Inadequate help seeking support and limited personal power or confidence to negotiate for services in a system they struggle to understand
- General mistrust of adults and professionals
- Treatment providers not being equipped or prepared to understand and respond to their unique circumstances

The youth mental health service system would be enhanced by ensuring that:

- There are multiple access points for young people and families seeking or requiring help a capacity to respond to the issues of most pressing concern to clients at intake.
- Complex and impersonal intake systems and processes are limited
- Assessment where possible can be conducted over an extended period of time at a pace dictated by the young person
- Services have capacity to use outreach and/or offer treatment and intervention in attractive, youth-friendly spaces that are accessible[35] [36]
- There are mechanisms for young people and families to access help when they determine it is needed
- Services are inclusive, seeking to minimise the impact of any stigma, and do not make young people feel different from their peers[37]
- Strong referral networks and collaborative links exist with gateway service systems (such as Youth Justice, mental health, child welfare, school counselling and homeless support, AOD services)[38].

Further, young people with complex needs frequently attend services intermittently and in brief bursts were a very intensive 'Solution Focused' service response is required.[39] For young people experiencing instability in their lives, a space that is physically and emotionally safe and provides respite from violence at home or the dangers of street life is a critical starting point[40] [41]. Feeling safe and secure is an important prerequisite for resolving AOD problems[42]. Further, enabling access to services for highly marginalised young people often requires support through crisis and providing for basic needs such as clothing, food, washing facilities, accommodation and

[32] Gilvarry, E. (2000). Substance abuse in young people. Journal of Clinical Child & Adolescent Psychiatry, 41(1), 55-80.
[33] Henderson, C. E., Young, D. W., Jainchil, N., Hawke, J., Farkas, S., & Davis, R. M. (2007). Program use of effective drug abuse treatment practices for juvenile offenders. Journal of Substance Abuse Treatment, 32, 279-290.
[34] Sawyer, M., & Patton, G.. Unmet need in mental health service delivery: children and adolescents. In G. Andrews & S. Henderson (Eds.), Unmet need in psychiatry: Problems, resources, responses (pp. 330-344). Cambridge: Cambridge University Press. 2000
[35] Barry, P. L., Ensign, J., & Lippek, S. L. Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.2002
[36] Crago, A., Wigg, C., & Stacey, K. Youth-friendly practice in mental health work. Youth Studies Australia, 23(2), 38-45. 2004
[37] Statham, J. (2004). Effective services to support children in special circumstances. Child: Care, Health & Development, 30(6), 589-598.
[38] Ozechowski, T. J., & Waldron, H. B. (2010). Assertive outreach strategies for narrowing the adolescent substance abuse treatment gap: implications for research, practice and policy. The Journal of Behavioral Health Services & Research, 37(1), 40-63.
[39] Perkins, R. (2006). The effectiveness of one session of therapy using a single session therapy approach for children and adolescents with mental health problems. Psychology and Psychotherapy: Theory, Research and Practice, 79, 215-227.
[40] Karabanow, J., & Clement, P. (2004). Interventions with street youth: a commentary on the practice-based research literature. Brief Treatment and Crisis Intervention, 4(1), 93-108.
[41] Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. The Journal of Psychology, 136(4), 449-463.
[42] Bruun, A. (2008). Effective Practice for Young People Experiencing Alcohol and Other Drug-Related Harm. In D. Moore & P. Dietze (Eds.), Drugs and Public Health: Australian Perspectives on Policy and Practice. Melbourne: Oxford University Press.

practical help.[43] [44] Assertive Outreach or mobile services in a wide variety of settings where vulnerable youth may be found, facilitates better access to services[45] [46] as does providing a variety of different services in a single location[47].

The development and maintenance of a strong, trusting relationship between young person and practitioner within the service or system is fundamental to promotes engagement and retention in care.

Developmental pathways

Adopting a developmental pathways approach involves protecting and nurturing a young person's capacity to recover and be resilient by altering exposure to risk, influencing the experience of risk, averting chain reactions of negative experience and fostering healthy adaptation.[48] Well-timed interventions geared to respond at critical moments have the potential to disrupt negative cascading effects or initiate healthy developmental processes and positive adaptation.[49] It has been well demonstrated that "…critical or fateful moments" can become turning points for a young person.[50] The mental health service system should be designed to respond immediately when these critical moments present and offer a viable treatment pathway.

1.5 Strong focus on the psychosocial stability of clients

Some degree of stability in life circumstances is a precondition to being able to gain control over the range of mental health problems and a range of health compromising issues and behaviours.

The experience of stability creates a sense of coherence whereby a young person might come to trust in the reliability of people and the availability of resources and life opportunities. Acute mental health problems and the social drift associated with long term ill health undermines that sense of coherence and reliability. This is exacerbated by a fragmented mental health service system in Victoria.

Only when basic needs are met are people free to pursue their goals and achieve their potential.[51] Research has found that "…often health is not considered a priority in a chaotic life where survival takes precedence".[52] Many clients have experienced homelessness and extended periods of instability.

Creating psychosocial stability involves working to ensure that young people and those involved in their care have access to sufficient resources to address basic needs and both the skills and motivation to use in their own interests. Each young person (and/or their carers) requires access to adequate income, housing, nutrition, clothing, information technology and transportation. These resources enable young people to participate in constructive, socially valued activity and are essential for dealing effectively with a range of health and behavioural issues. Inequalities in income and material resources, coupled with the resulting social exclusion and marginalisation, are linked to poor health.[53]

Young people's family and social network also have a crucial role in creating psychosocial stability, particularly when they are minors. Where these protective relationships are not available, mental health and other services have a role in collaborating to establish stable conditions. Also, young people and their carers can learn how to predict and prevent crisis. Planning and preparation can reduce the number of crises and the degree of harm experienced by clients.[54]

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[43] Karabanow, J., & Clement, P. (2004). Interventions with street youth: a commentary on the practice-based research literature. Brief Treatment and Crisis Intervention, 4(1), 93-108.
[44] Statham, J. (2004). Effective services to support children in special circumstances. Child: Care, Health & Development, 30(6), 589-598.
[45] Busen, N. H., & Engebretson, J. C. (2008). Facilitating risk reduction among homeless and street-involved youth. Journal of the American Academy of Nurse Practitioners, 20, 567-575.
[46] Ozechowski, T. J., & Waldron, H. B. (2010). Assertive outreach strategies for narrowing the adolescent substance abuse treatment gap: implications for research, practice and policy. The Journal of Behavioral Health Services & Research, 37(1), 40-63.
[47] Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. The Journal of Psychology, 136(4), 449-463.
[48] Ungar, M. (2011). Counseling in challenging contexts: Working with individuals and families across clinical and community settings. Belmont: Brooks/Cole.
[49] Masten, A. (2009) Ordinary magic: Lessons from research on resilience in human development.
[50] Thomson, R., Bell, R., Holland, J., Henderson, S., McGrellis, S., & Sharpe, S. (2002). Critical Moments: Choice, Chance and Opportunity in Young People's Narratives of Transition. Sociology, p350
[51] Naidoo, J., & Wills, J. (2000). Health Promotion: Foundations for Practice (Second ed.) London: Bailliere Tindall.
[52] Rowe, J. (2005). Access health: Providing primary care to vulnerable and marginalized populations. Australian Journal of Primary Health, 11(2), p32
[53] Spooner, C., Hall, W., & Lynskey, M. (2001). Structural determinants of youth drug use: A report prepared by the National Drug and Alcohol Research Centre. Woden: Australian National Council on Drugs.
[54] Robinson, E & Miller, R. (2010). Adolescents and their families: Best interests case practice model specialist practice resource. Victorian Government Department of Human Services.

1.6 Formal mechanisms to ensure the effective integration with other Service Systems

Many young people who are clients of the mental health service system experience co-occurring behavioural issues and a variety of psychosocial disturbances, creating life complexity[55]. Despite their clients having multiple co-occurring and integrated health and social issues to deal with, the services they need have tended to be delivered from within discrete silos. As such there are multiple service systems either duplicating services, delivering interventions targeting the same issue in totally different ways or leaving certain critical issues completely unaddressed.

This creates the conditions for fragmentation and uncoordinated care planning. It has often been practitioners at the frontline, collaborating according to local arrangements that have been able to create viable cross sector collaboration and properly coordinated care for young people and families.

In order to enable clients to respond effectively to the range of issues and risks they are contending with, the mental health service system needs to be integrated with other youth and health service systems including youth AOD, youth homelessness, youth justice, child protection and out of home care, education, primary health and sexual health.

YSAS strongly believe that service collaborations and integrated care is best to be configured to target young people's level of vulnerability (see 1.1) not an isolated problem. This should be guided by public policy

Within current service system architecture, integrated care can be achieved when services reorient their processes, methods and practice tools to be person-centred. Integration with other systems and effective collaboration and care co-ordination can be better facilitated by:

- The responsiveness of an outreach model.
- Dedication of some time to care coordination or case management is critical for young people with complex needs.[56]
- System and organizational leaders authorising and formally supporting the building of collaborative shared care arrangement relationships.
- Overarching co-ordination at the systems level and within peak bodies and service networks to provide the opportunity for grassroots collaboration to succeed.
- Organisations and services clearly understanding and communicating their unique contribution developing formal mechanisms for collaboration with other services within the broader system.

1.7 Address the specific needs of diverse populations - Cultural competency

Clients using the mental Health service system are a heterogeneous group. They differ according to:

- Maturity and developmental stage
- Gender
- Ethnicity and cultural identity
- Religious affiliations
- Socio-economic status and access to income
- Place of residence
- Legal status

[55] Kutin, J., Bruun, A., Mitchell, P., Daley, K., & Best, D. (2014). Snapshot: SYNC Results: Young people in AOD services in Victoria. Summary Data and Key Findings. Youth Support + Advocacy Service: Melbourne, Australia.
[56] Schuetz, S., & Berry, M. (2009). Review of best practice around behaviour change in young offenders with alcohol and other drug issues. Melbourne: Caraniche for Australian Community Support Organisation.

- Sexual identity
- Identification with particular youth sub-cultures

Each of these differences can influence how mental health needs are expressed and best responded to. In short, a specialised early intervention and treatment response is required and those delivering services require cultural competence. The following special needs populations clearly require a more effective response from youth mental health service system:

- Young people from ATSI backgrounds
- Young people from Pacific Island and Maori backgrounds
- Young people who are refugees and unaccompanied minors
- Young women
- Lesbian, gay, bi, trans, intersex and queer young people
- Young parents
- Young people in Out of Home Care

A client-centred, needs led practice approach lends itself to shaping the service provision response to unique needs of clients. However, a system should be instituted for identifying emerging needs and influences impacting on special needs populations. The systematic practice responses to the identified need can be identified and incorporated into the practices and programming of youth mental health services and collaborators. Any new practices should be evaluated and the findings disseminated to further build service system capacity to respond to special needs populations. This would require regular workforce development and appropriate resourcing.

1.8 Specific responses to ensure that young people and Families in Rural regions and/or remote communities have access to the care they require

Specific responses are needed to ensure that young people and Families in Rural regions and/or remote communities have access to the care they require. Lifeline identifies that rural regions and/or remote communities lack the same coverage of local services and professionals (e.g. doctors, mental health professionals, government agencies) that are commonly expected to be available in metropolitan Melbourne. They highlight that support services are also regularly too far away or too expensive. To a lesser extent, the same issues beset those young people and families in newly established communities on Melbourne's urban fringe.

Prevalence rates for mental health problems are evenly spread across the state so the lack of service coverage and treatment options is bound to be a problem. It is unsurprising that the SYNC study57 clearly found that young people from rural and regional Victoria were found to have significantly more unmet treatment need, particularly in the areas of mental health and housing.

For young people in rural regions and/or remote communities and on Melbourne's urban fringe, the youth mental health service system requires:

- An allocation of resources per head of population and for the provision of particular service types that exceeds the allocation for services provided for metropolitan services
- Enhanced investment in innovative approaches that reduce the tyranny of distance, including through the incorporation of Information Communication Technology (ICT) solutions.

1.9 A competent workforce that is adequately supported

An inclusive, responsive, relationship-based service demands a great deal from its practitioners. They require the physical, psychological and emotional energy to invest in both the care and support of clients and initiatives to improve programs and services. For this reason, organisations need to invest in employee wellbeing.

[57] Kutin, Jozica., Bruun, Andrew., Mitchell, Penny., Daley, Kathryn., & Best, David. 2014. Snapshot: SYNC Results: Young people in AOD services in Victoria. Summary Data and Key Findings. Youth Support + Advocacy Service: Melbourne, Australia.

Like young people, practitioners are more resilient when they know that they are not isolated and have some way of making sense of their experiences. High quality, regular supervision, mentoring and collegiate support can enable practitioners to reflect on the complex nature of their work and feel personally supported.

Organisations routinely confirm their support for frontline staff by:

- Ensuring responsibilities are clear and that all staff in new to roles have access to adequate induction
- Ensuring staff have adequate back up and emergency assistance when required
- Providing formal debriefing in response to incidents and respite where required
- Putting in place policies that support self care including a formal Employee Assistance Program (EAP)
- Investing in their professional development.

Perhaps most important is instituting and maintaining a supportive psychological climate where practitioners and service managers feel comfortable discussing issues in their lives that may potentially impact on their work.

Research conducted on psychological climate in child welfare services supports the notion that the characteristics of the way staff is treated are reflected in the ways that workers treat clients.[58] The suggestion is that by providing emotional and practical support around personal issues, practitioners feel comfortable to bring up a wide range of issues, including difficult issues that may affect or involve their work life. This contributes to a broader climate of honesty that facilitates learning and evolving at a professional, as well as a personal level.

A viable career pathway should intentionally be carved out for practitioners within the youth mental health workforce and collaborating workforces from other sectors.

Given that the youth mental health service system is likely to undergo some reform or modification, workforce development should be:

- Geared toward creating alignment with changes; and
- Ensuring that practitioners with specific roles within the new system have the capability to fulfil requirements effectively.

1.10 Proactive service system planning that involves service users

Young people and families have a right to be involved in decisions that affect them, ranging from treatment planning through to program improvement and service design. Participation empowers young people through:

- Building self-confidence that supports an active role in their own health management
- Providing a sense of meaning, control and connectedness
- Improving health care available by making services that are more accessible and efficient.

In order to meaningfully engage a young person and their family, dedicated resources ranging from specific program funding, staff time and participation as well as specific space and equipment are required.

A clear participation framework that is enshrined in organisational policy and supported by endorsed procedures should include:

- Systematic engagement of client feedback and mechanisms for a prompt response
- Training and development for young people in their participation role

[58] Glisson, C., & Hemmelgarn, A. The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. Child Abuse and Neglect, 22(5), 401-421; 1998.

- Systems to monitor and evaluate youth participation strategies and outcomes
- A clear communications mechanism to ensure young people, staff and stakeholders are aware of youth participation outcomes.

There has been some effort and success on the part of the Department of Health and Human Services (DHHS) in developing consumer participation practices within the sector, but much more can be done.

Shaping the future: The Victorian AOD Quality Framework states: "…a client-centred system has been defined as one that meaningfully engages clients in planning, implementation, delivery and evaluation of interventions and services"[59]

DHHS should lead the sector to:

- Establish minimum standards and best practice guidelines for client participation (including young people and families).
- Build the capacity of practitioners in the sector to facilitate the participation of clients at least to meet minimum standards.
- Establish and maintain a system for the management and monitoring of client participation activities.
- Institute a system for engaging clients in policy development and broader service planning and development and system review.

[59] Victorian Government Department of Human Services (2008). Shaping the future: The Victorian AOD Quality Framework

RECOMMENDATION 2.0

Achieve immediate improvements to Victoria's mental health system by:

Recommendation 2.1 *Integrating a system navigation and continuing care coordination function for young people and families within the youth mental health service system; and*

Recommendation 2.2 *Enhancing Youth AOD Residential Withdrawal and Rehabilitation to provide additional service offering within the Mental Health Service System.*

RECOMMENDATION 2.1

Integrate a system navigation and continuing care coordination function for young people and families within the youth mental health service system.

Providing young people and families with enhanced service system navigation and continuing care coordination has been proven to be able to successfully bridge service and sector gaps that have been a feature of Victoria's fragmented mental health system.

To be effective this function must:

- Be provided by community service organisations with a track record of engaging and retaining vulnerable young people in care and working with their families
- Be available throughout the entire treatment pathway but particularly at critical moments where young people increased support and timely intervention
- Incorporate the capacity for outreach and flexible, client centred service delivery
- Integrate with other functions provided within the Mental Health System in the best interests of young people and families
- Be provided by qualified, experienced professionals and subject to rigorous clinical governance

RECOMMENDED SERVICE MODEL

ENHANCED SERVICE SYSTEM NAVIGATION AND CONTINUING CARE COORDINATION

YSAS proposes a tested multi-systemic service model that provides:

- A flexible, responsive and intensive support service for vulnerable young people with complex mental health and psychosocial issues.
- Timely access to high quality, evidence based treatment and collaborative clinical care at critical momments.
- Support to specialist and acute care services within the mental health system to empower young people in achieving long-lasting mental health and developmental outcomes.

Dedicated, community based practitioners with capacity for outreach, work collaboratively with an adjunct Psychiatrist (generally part time) to address the presenting mental health needs of vulnerable young people. The provision of an adjunct Psychiatrist is in line with a stepped care approach to mental health support, and contributes to the provision of holistic, person centred care with capability and capacity to respond to severe or complex mental health issues as they arise. This includes Implementing safety planning to minimise and manage the potential for self-harm, suicidal ideation and other risky behaviours.

A holistic and person centred approach is adopted for assessment and the development of care plans that are applied flexibly to suit each young person's needs. Skilled professionals provide a clinical pathway for young people 12-25 whose complex needs are otherwise unaddressed by tertiary services due to access or eligibility barriers. A youth friendly "advantaged thinking" approach that is strengths based and builds on the young person's story and their hopes for the future

The enhanced service system navigation function would focus on reducing barriers to engagement and would provide flexible responses including outreach support and care coordination to effectively engage young people with more complex needs in appropriate services they would otherwise not access or not make the most of. Comprehensive assessments, care planning and co-design ensures that appropriate interventions are arranged and delivered to enable young to access supports. Further, families and carers are included and supported through:

- Education on how to best make the system work for them and their child
- Appropriately engagement in care planning
- Guidance for how and when to they can access additional support for themselves

The approach results in:

- Minimised disruption in the young person's life due to undressed and escalating mental health problems
- Reduced duration and impact of untreated illness
- Reduced wait times.
- Improved engagement in treatment for young people across the spectrum of mental health services
- A better experience of mental health services for young people and families
- Improved mental health literacy for young people and families
- Improved staff engagement and wellbeing.
- Clinical capacity building within the workforce through support and professional development provided by a Lead Psychiatrist

RECOMMENDATION 2.2

Enhance Youth AOD Residential Withdrawal and Rehabilitation to provide an additional service offering within the Mental Health Service system.

The youth residential AOD withdrawal and rehabilitation services across Victoria can be enhanced to provide step down care for young people dealing with more severe and complex mental health issues.

Current funding limitations essentially prescribe a staffing profile in residential services that is heavily weighted toward youth workers, with little capacity to employ mental health specialists to work within services or across the system.
As the residential services are already in place, the delivery of an enhanced care model would be reliant on:

- Embedded mental health clinicians within programs

- Workforce development to build mental health capability of existing workforces
- Clear protocols with other step up and down options in the mental health system regarding discharge, referral and transition supports
- Flexibility in the staffing roster to reduce staff to client ratios depending on the complexity of resident's cases and their safety needs
- Enhanced clinical governance.

RECOMMENDED SERVICE MODEL

ENHANCED YOUTH AOD RESIDENTIAL WITHDRAWAL AND REHABILITATION TO PROVIDE ADDITIONAL SERVICE OFFERING WITHIN THE MENTAL HEALTH SYSTEM

YSAS proposes an enhancement to the youth AOD residential service model to provide viable step down care for young people dealing with more severe and complex mental health issues. This would result in:

- A reduction in young people needing to 'step up' to tertiary care or being in contact with the mental health system as they could receive more effective mental health inventions in the stable residential setting that are more in line with those available in acute settings;
- The residential AOD workforce having the capability to support young people through their mental health issues; and
- More seamless service transitions from and to acute settings due to the benefits of discipline-to-discipline communications and planning.

The mental health specialists embedded within programs required to deliver an enhanced care model would include*:

Access to new specialist capacity:

- **Senior Psychiatric Nurse:** The Senior Psychiatric Nurse provides back up expert consultation for nursing and youth work staff regarding management, advice or deterioration of mental health of young people in the service. (1.0 FTE)
- **Consultant Psychiatrist:** This role provides back up expert consultation for GPs and nursing staff regarding medication prescriptions and management. (0.2 FTE)
- **Youth mental health psychologists:** This role provides specialist 1:1 counseling for young people who have identified the readiness to undertake more in depth therapeutic work. (0.4 FTE).

Access to additional capacity in existing roles (including after hours):

- **General Practitioner**: The GP provides young people with access to essential GP services. Supports and services may include review of medications, including pharmacotherapies, general medical consultation and check-up, vaccinations, sexual health and blood borne virus screening, assessment, referral and co-management of mental health presentations.
- **Nurse:** The nurse conducts thorough health assessments of young people accessing services and coordinate and monitor health plans, ensure appropriate referrals and follow-up with community based health providers.

*FTE allocations are estimates based on YSAS's experience in residential services management and the need may vary across services. Efficiencies can also be found by sharing specialist clinicians across a number of residential units.

8.0 MESSAGES FROM YOUNG PEOPLE WHO ARE YSAS CLIENTS

[redacted]

[redacted]

8.2 Written Messages

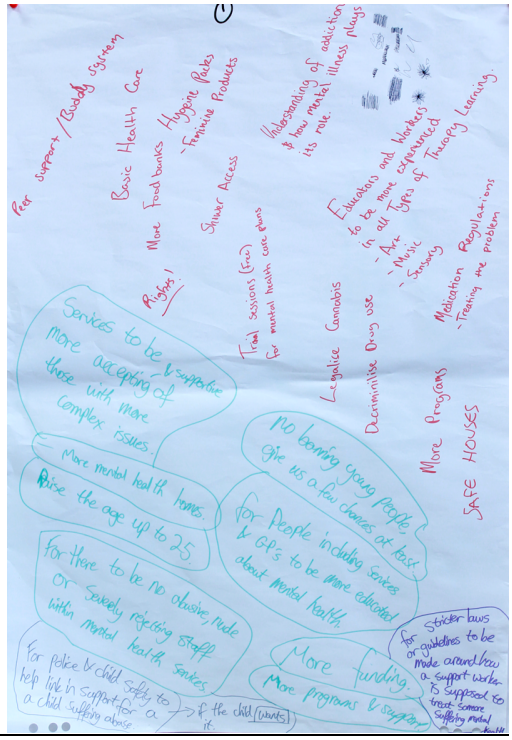


Image 1

- Peer support / buddy system
- Basic Health Care
- Rights!
- More Food banks
- Hygeine Packs – feminine products
- Shower Access
- Trial sessions (free) for mental health care plans
- Understanding of addiction and how mental illness plays its role
- Legalise Cannabis
- Decriminilise Drug use
- More Programs
- SAFE HOUSES
- Educators and Workers to be more experienced in all Types Therapy Learning:
    - Art
    - Music
    - Sensory
- Medication Regulations:
    - Treating the problem
- Services to be more accepting and supportive of those with more complex issues.
- More mental health homes
- Raise the age up to 25
- No banning young people, give us a few chances at least
- For People including Services and GP's to be more educated about mental health
- More funding
- More programs and support
- For there to be no abusive, nude or severely rejecting staff within mental health services
- For police and child safety to help link in support for a child suffering abuse if the child wants it

For stricter laws or guidelines to be made around how a support worker is supposed to treat someone suffering mental health

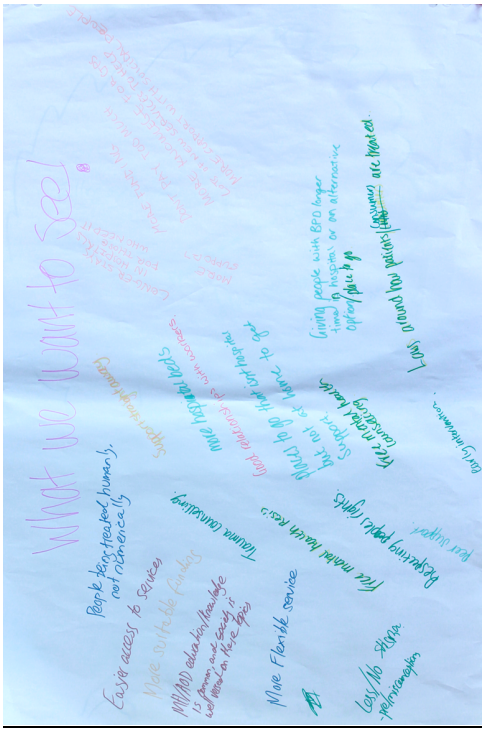


Image 2

- People being treated humanely, not numerically
- Easier access to services
- More suitable funding
- MH/AOD education/knowledge is common, and society is well versed on these topics
- More Flexible service
- Less/no SHSBA – pre/misconception
- Trauma counselling
- Free mental health resi's
- Respecting people's rights
- Peer support
- Support straight away
- More hospital beds
- Good relationships with workers
- Places to go that isn't hospital but not at home to get support
- Free mental health counselling
- Early intervention
- Longer hospitals stays for those who need it
- More support
- More funding
- Don't pay too much
- More knowledge for GPs
- Lots of new services to help
- More support with suicidal people
- Giving people with BPD longer time in hospital or an alternative option/place to go
- Laws around how patients / consumers are treated

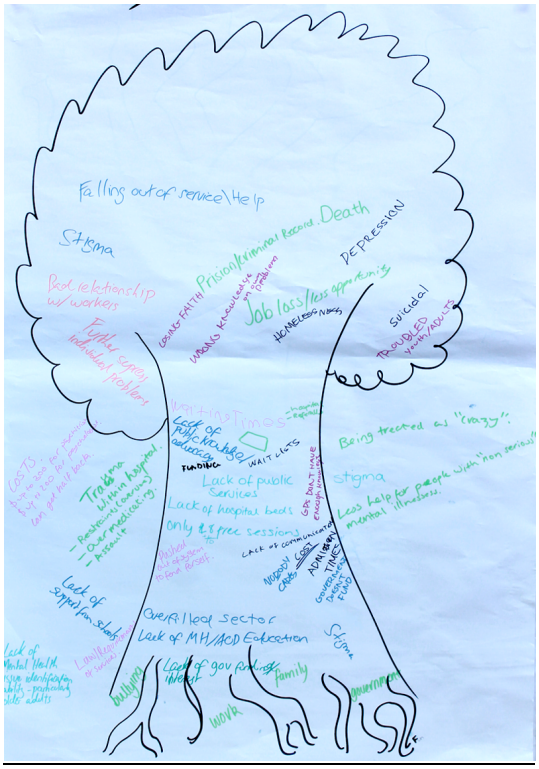


Image 3 – What we want to see

- Falling out of service / help
- Stigma
- Bad relationships w/workers
- Prison/criminal record. Death
- Losing faith
- DEPRESSION
- Wrong knowledge on own problem
- Job loss/less opportunity
- Homelessness
- Suicidal
- Further supress individual problems
- Troubled youth/adults
- Costs:
    - Up to $300 for psychiatrist
    - Up to $200 for psychologist
    - Can get half back
- Trauma within hospital:
    - Restraints (over use)
    - Over medicating
    - Assault
- Waiting times – hospital – referrals
- Lack of public knowledge / advocacy
- Wait lists
- Funding
- Lack of public services
- Lack of hospital beds
- Only 8 free session
- GPs don't have enough knowledge
- Lack of communication
- Pushed out of system to fend for self
- Being treated as ''crazy''
- Less help for people with ''non serious'' mental illnesses
- Lack of support from schools
- Lack of Mental Health issue identification ability – particularly older adults
- Law/requirements of services
- Overfilled sector
- Lack of MH/AOD Education
- Bullying
- Lack of gov funding interest
- Work
- Family
- Government

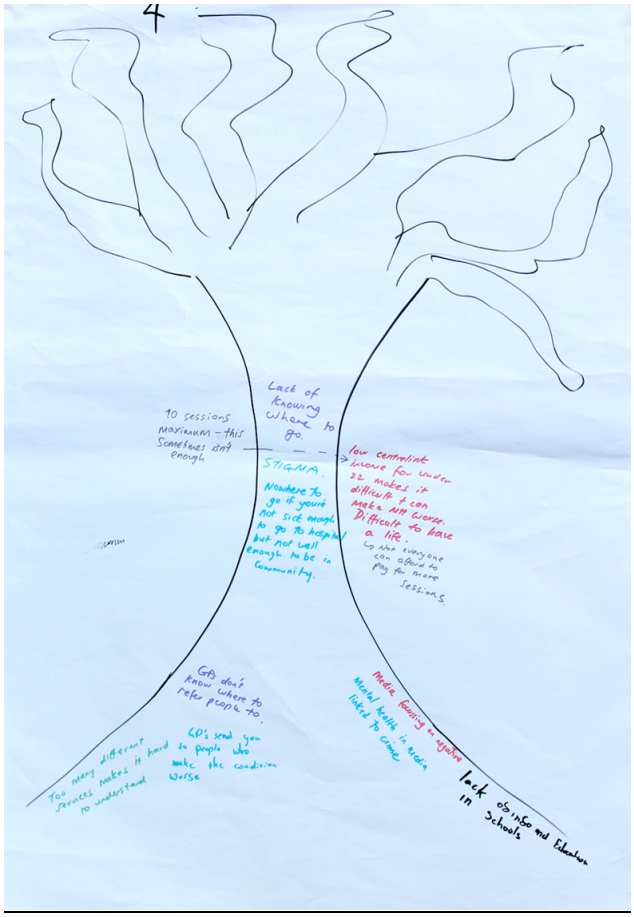


Image 4

- Lack of knowing where to go
- 10 sessions maximum – this sometimes isn't enough
    - Low centrelink income for under 22 makes it difficult and can make it worse. Difficult to have a life:
        - Not everyone can afford to pay for more sessions
- Stigma:
    - Nowhere to go if you're not sick enough to go to hospital but not well enough to be in community
- GPs don't know where to refer people to
- Too many different services makes it hard to understand
- GPs send you to people who make the condition worse
- Media focussing on negative
- Mental health in media linked to crime
- Lack of info and Education in schools

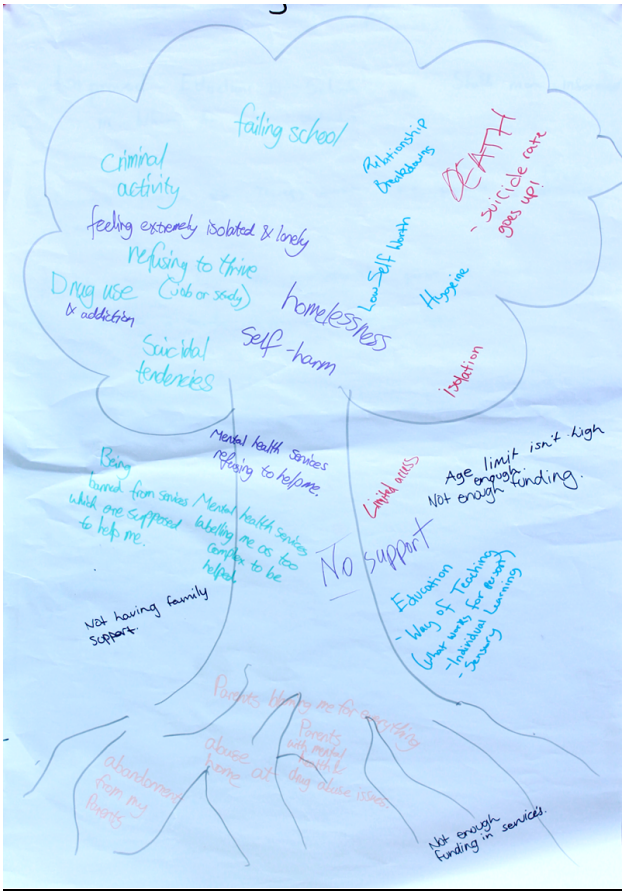
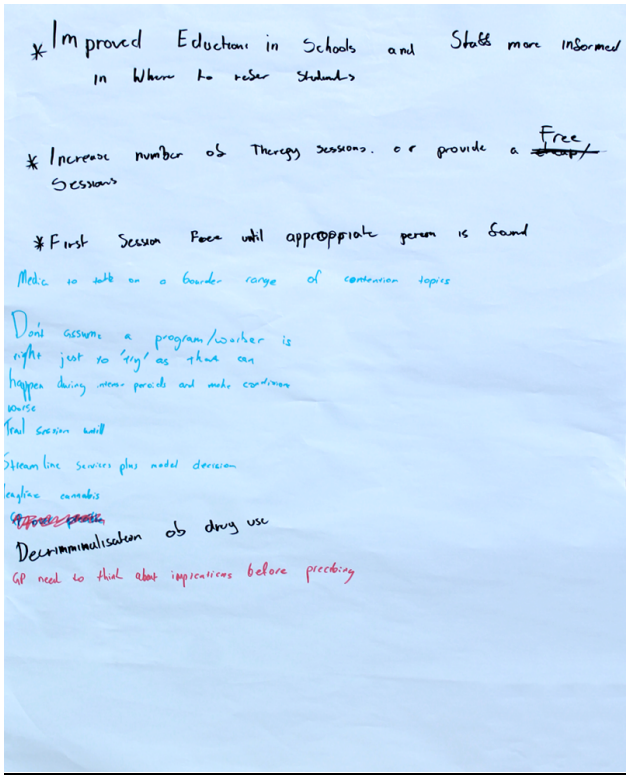


Image 5

- Failing school
- Criminal activity
- Relationships breakdowns
- Death – suicide rate goes up!
- Feeling extremely isolated and lonely
- Refusing to thrive (job or study)
- Drug use and addiction
- Suicidal tendencies
- Homelessness self – harm
- Low self worth
- Hygeine
- Isolation
- Being banned from services which are supposed to help me
- Mental health services refusing to help me
- Not having family support
- Mental health services labelling me as too complex to be helped
- No support
- Limited access
- Age limit isn't high enough
- Not enough funding
- Education:
    - Way of Teaching (what works for person:
        - Individual learning
        - Sensory
- Parents blaming me for everything
- Abandonment from my parents
- Abuse at home
- Parents with mental health and drug abuse issues

Not enough funding in services



Tree 6

- Improved Educations in schools and staff more informed in where to refer students
- Increase number of therapy sessions or provide a free session
- First session free until appropriate person is found
- Media to talk on a broader range of contention topics
- Don't assume a program/worker is right as that can happen during intense periods and make conditions worse
- Trial session until
- Streamline services plus model decision
- Legalise cannabis
- Decriminilisation of drug use
- GP need to think about implications before prescribing

9.0 REFERENCES

1. ABS. National Survey of Mental Health and Wellbeing: Summary of Results, 4326.0, 2007. Canberra: Australian Bureau of Statistics; 2009.
2. ABS. 3303.0 Causes of Death, Australia, 2017: Table 11.1 International self-harm, Number of deaths, 5 year age groups by sex 2008-2017. In ABS, editor.2018.
3. AIWH. Mental Health Services in Australia: Services provided in public hospital emergency departments. Table ED.6: Mental Health-related emergency department presentations in public hospitals, by patient demographic characteristics, 2016-17. Canberra: Australian Institute of Health and Welfare; 2018.
4. AIHW. Australian Burden of Disease Study: impact and causes of illness and death in Australia. 2011. Australian Burden of Disease Study series no.3. Cat. No.BOD 4. Canberra: Australian Institute of Health
5. Aronowitz, T. (2005). The role of "envisioning the future" in the development of resilience among at-risk youth. Public Health Nursing, 22(3), 200-208.\
6. Barry, P. L., Ensign, J., & Lippek, S. L. Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.2002 and Welfare; 2011.
7. Bloom DE, Cafi ero ET, Jane-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The global Economic Burden of non-communicable disease. Geneva: World Economic Forum; 2011.
8. Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. The quality of highly regarded adolescent substance abuse treatment programs. Archives of Pediatric and Adolescent Medicine, 158, 904-909. 2004.
9. Bruun, A., & Hynan, C. (2006). Where to from here? Guiding for mental health for young people with complex needs. Youth Studies Australia, 25(1), 19-27.
10. Busen, N. H., & Engebretson, J. C. (2008). Facilitating risk reduction among homeless and street-involved youth. Journal of the American Academy of Nurse Practitioners, 20, 567-575.
11. Catalano, R.F., Hawkins, J.D. (1996). The social development model: A theory of antisocial behaviour. In Hawkins, J.D. (Ed.), Delinquency and crime: Current theories (pp149-197), Cambridge University Press, New York.
12. Centre for Multicultural Youth. Mind Matters: The mental health and wellbeing of young people from diverse cultural backgrounds. Melbourne, Victoria; CMY; 2014.
13. Coleman, J., & Hendry, L. (1990). The nature of adolescence. London: Routledge.
14. Colmar Brunton & headspace National. headspace National Youth Mental Health and Wellbeing Survey, 2018. 2019.
15. Crago, A., Wigg, C., & Stacey, K. Youth-friendly practice in mental health work. Youth Studies Australia, 23(2), 38-45. 2004
16. De Anstiss H, Ziaian T, Procter N, Warland J, Baghurst P. Help-seeking for mental health problems in young refugees: a review of the literature with implications for policy, practice, and research. Transcult Psychiatry. 2009;46(4):584-607.
17. De Rosa, C. J., Montgomery, S. B., Kipke, M. D., Iverson, E., Ma, J. L., & Unger, J. B. (1999). Service utilisation among homeless and runaway youth in Los Angeles, California: Rates and reasons. Journal of Adolescent Health, 24, 449-458.
18. Dworsky, A., & Courtney, M. (2009). Addressing the mental health service needs of foster youth during the transition to adulthood: How big is the problem and what can states do? Journal of Adolescent Health, 44, 1-2.
19. Ensign, J., & Gittlelsohn, J. (1998). Health and access to care: perspectives of homeless youth in Baltimore City, USA. Social Science and Medicine, 47(12), 2087-2099.
20. Evans, R., & Pinnock, K. Promoting resilience and protective factors in the children's fund. *Journal of Children and Poverty, 13*: 21-36, DOI: 10.1080/10796120601171211; 2007.
21. Fleming, J. & Ledogar, R.J. (2008). Resilience, an Evolving Concept: A Review of Literature Relevant to Aboriginal Research. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 6(2)
22. Gilligan, R. (2008). Promoting resilience in young people in long-term care – the relevance of roles and relationships in the domains of recreation and work. Journal of Social Work Practice, 22(1)

23. Glisson, C., & Hemmelgarn, A. The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. Child Abuse and Neglect, 22(5), 401-421; 1998.

24. Gilvarry, E. (2000). Substance abuse in young people. Journal of Clinical Child & Adolescent Psychiatry, 41(1), 55-80.

25. Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet (London, England). 2011;377(9783):2093-102.

26. Hamilton, M., & Redmond, G. (2010). Conceptualisation of social and emotional wellbeing for children and young people, and policy implications. Melbourne: A research report for the Australian Research Alliance and for Children and Youth and the Australian Institute of Health and Welfare, p5

27. Henderson, C. E., Young, D. W., Jainchil, N., Hawke, J., Farkas, S., & Davis, R. M. . Program use of effective drug abuse treatment practices for juvenile offenders. Journal of Substance Abuse Treatment, 32, 279-290. 2007

28. Henderson, C. E., Taxman, F. S., & Young, D. W. (2008). A Rasch model analysis of evidence-based treatment practices used in the criminal justice system. Drug and Alcohol Dependence, 93(1-2), 163-175.

29. Institute of Medicine (IOM) and National Research Council (NRC) of the National Academies. *Toward and integrated science of research on families: workshop report.* Washington, DC: National Academies Press. 2011.

30. Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. Brief Treatment and Crisis Intervention, 4(1), 93-108.

31. Kutin, Jozica., Bruun, Andrew., Mitchell, Penny., Daley, Kathryn., & Best, David. 2014. Snapshot: SYNC Results: Young people in AOD services in Victoria. Summary Data and Key Findings. Youth Support + Advocacy Service: Melbourne, Australia.

32. Masten, A. (2009) Ordinary magic: Lessons from research on resilience in human development.

33. Masten, A. S. (2001). Ordinary magic: Resilience over the lifespan: Developmental perspectives on resistance, recover, and transformation. In J.W. Reich, A.J. Zautra & J.S. Hall (Eds), Handbook of adult resilience (pp213-237). New York: Guilford Press.

34. Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. The Journal of Psychology, 136(4), 449-463.

35. McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. Journal of Adolescent Health, 44, 7-13.

36. Mitchell, P.F. Victoria's most disadvantaged and vulnerable young people: a fresh look at needs for health and social care services. The Centre for Mental Health: Melbourne School of Population and Global Health, University of Melbourne; 2014.

37. Munford, R., & Sanders, J. (2008). Drawing out strengths and building capacity in social work with troubled young women. Child and Family Social Work, 13(1), 2-11.

38. Naidoo, J., & Wills, J. (2000). Health Promotion: Foundations for Practice (Second ed.) London: Bailliere Tindall.

39. Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation: Submission to the Productivity Commission's Inquiry into Mental Health. April 2019

40. Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., … Viner, R. M. Our future: a Lancet commission on adolescent health and wellbeing. Lancet, 387(10036), 2423–2478. doi:10.1016/S0140-6736(16)00579-1. 2016.

41. Perkins, R. (2006). The effectiveness of one session of therapy using a single session therapy approach for children and adolescents with mental health problems. Psychology and Psychotherapy: Theory, Research and Practice, 79, 215-227.

42. Pichot, T. (2001). Co-creating solutions for substance abuse. Journal of Systemic Therapies, 20(2), 1-23.

43. Robinson, E & Miller, R. (2010). Adolescents and their families: Best interests case practice model specialist practice resource. Victorian Government Department of Human Services.

44. Rosenthal, D., Mallett, S., Milburn, N., & Rotheram-Borus, M. J. (2008). Drug use among homeless young people in Los Angeles and Melbourne. Journal of Adolescent Health, 43, 296-305.

45. Rowe, J. (2005). Access health: Providing primary care to vulnerable and marginalized populations. Australian Journal of Primary Health, 11(2), p32

46. Spooner, C., Hall, W., & Lynskey, M. (2001). Structural determinants of youth drug use: A report prepared by the National Drug and Alcohol Research Centre. Woden: Australian National Council on Drugs.

47. Sawyer, M., & Patton, G.. Unmet need in mental health service delivery: children and adolescents. In G. Andrews & S. Henderson (Eds.), Unmet need in psychiatry: Problems, resources, responses (pp. 330-344). Cambridge: Cambridge University Press. 2000

48. Statham, J. (2004). Effective services to support children in special circumstances. Child: Care, Health & Development, 30(6), 589-598.

49. Tarlov, A.R. Public Policy Frameworks for Improving Population Health. *Annals of the New York Academy of Sciences, 896*: 281-293. 1999.

50. Thomson, R., Bell, R., Holland, J., Henderson, S., McGrellis, S., & Sharpe, S. (2002). Critical Moments: Choice, Chance and Opportunity in Young People's Narratives of Transition. Sociology, p350

51. Ungar, M. (2011). Counseling in challenging contexts: Working with individuals and families across clinical and community settings. Belmont: Brooks/Cole.

52. Ungar, M. (2005a). Resilience among children in child welfare, corrections, mental health and educational settings: recommendations for service. Child and Youth Health Forum, 34(6), 445-464.

53. Welfare AIoHa. Young Australians: their health and wellbeing 2011. Canberra; 2011.

54. Williams, J., Toumbourou, J., Williamson, E., Hemphill, S., & Patton, G. (2009) Violent and antisocial behavious among young adolescents in Australian communities: an analysis of risk and protective factors. Australian Research Alliance for Children and Youth, Canberra.

55. Viner RM, Ozer EM, Denny S, et al. Adolescence and the social determinants of health. Lancet 2012; 379: 1641–52.

56. Volpe JS. Effects of domestic violence on children and adolescents: an overview. 1996; http://www.aaets.org/article8.htm (accessed 28-05-2019).

10.0 APPENDICES

Effective developmentally sensitive practice with young people

All clients of youth services are making the transition through adolescence from childhood to young adulthood. Adolescents with psychosocial difficulties are best served by services that are developmentally appropriate.[60] [61] [62] [63]

Developmentally appropriate practice is sensitive to the ways in which the needs of young people in adolescence vary from those of children and adults, and the ways these needs change over time as development progresses. In addition to the developmental experiences shared with all adolescents and young adults, some young people experience absences and disruptions in social processes that drive development. This includes experiences within the family and in the education system. This can result in delays and distortions in these young people's developmental pathway when compared to those on a more typical developmental trajectory. Given that many clients have had to fend for themselves and negotiate complex relationships and business transactions while procuring substances, in some areas their development will be accelerated. Developmentally conducive practice aims to

[60] Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.
[61] Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. (2004). The quality of highly regarded adolescent substance abuse treatment programs. Archives of Pediatric and Adolescent Medicine, 158, 904-909.
[62] Henderson, C. E., Taxman, F. S., & Young, D. W. (2008). A Rasch model analysis of evidence-based treatment practices used in the criminal justice system. Drug and Alcohol Dependence, 93(1-2), 163-175.
[63] Henderson, C. E., Young, D. W., Jainchil, N., Hawke, J., Farkas, S., & Davis, R. M. (2007). Program use of effective drug abuse treatment practices for juvenile offenders. Journal of Substance Abuse Treatment, 32, 279-290.

- Provide alternative experiences that help young people catch up in, or reshape areas of development that have been delayed or distorted
- Enable young people who have developed competencies for surviving and negotiating life in marginalised contexts to recognise and employ them in pursuit of their goals in mainstream environments

Developmentally appropriate services and programs are designed to meet the unique developmental needs of children or adolescents. Merely being 'adolescent specific' does not guarantee developmentally appropriate service provision. A sophisticated approach demands the deliberate use of strategies that are tailored to the requirements of young people at particular developmental stages.
The following analysis describes several broad guiding principles that need to be applied across all areas of work with young people who are adolescents, as well as several very specific implications for practice.

a. Sensitivity to the developmental challenges and changes faced by all adolescents

Clients span a wide age range, they are as young as 10 or as old as 25 years old. Developmentally appropriate services are sensitive to the developmental tasks and challenges faced by young people making the transition through adolescence.

The adolescent transition is not linear and consistent, rather, individuals move back and forth between orientations towards childhood and adulthood. As such, working with young people demands a high level of flexibility and adaptability from practitioners.

Like all young people, those who experience problems with mental health, alcohol and other drug use and/or offending are working toward achieving a range of developmental tasks including:

- Identity formation,
- Value clarification,
- Cognitive skill development,
- Learning consequential thinking and responsible decision-making,
- Identifying and understanding vocational strengths and inclinations,
- Forming relationships outside of the family

Developmentally appropriate services are sensitive to the fact that most adolescents are concentrated on these tasks and experience considerable anxiety around their achievement. The capacity of service providers to understand and be sensitive to these general themes, as well as the specific concerns of individual adolescents, will influence the ability to successfully engage and retain young people in treatment and support programs. [64] [65] This is likely to be equally true for prevention and early intervention programs.

An example of ways in which health and social care needs of adolescents consistently differ from most adults is with respect to the **capacity for health autonomy**. Adults are expected to assume responsibility for identifying potential health concerns, bringing these concerns to the attention of a health professional, securing and interpreting advice, and following advice according to their values and preferences. In contrast, young people may not yet have acquired the knowledge or experience to confidently take personal responsibility for these health care tasks.

A developmentally appropriate health service is proactive in helping young people earn and practice the skills required to achieve developmental tasks until they are able to exercise them independently. Cognitive and emotional development also plays a strong role in shaping the ability of adolescents to understand risks and make informed decisions on the basis of those risks. In this way, developmentally appropriate practice is sensitive to differential maturity.

Certain legal restrictions and statutory requirements pertain to young people who are legally considered to be minors. Many clients develop **survival skills** as a result of periods of poor supervision, disconnection from family, and exposure to unsafe environments. The coping methods of employed by these are not always socially acceptable and at times come with unwanted consequences. The challenge is to enable the young person to recognise these strengths and channel them in more socially acceptable directions towards the achievement of their goals.

[64] Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.
[65] Bruun, A. (2008). Effective practice for young people experiencing alcohol and other drug-related harm. In D. Moore & P. Dietze (Eds.), Drugs and public health: Australian perspectives on policy and practice (pp. 115-126). South Melbourne: Oxford University Press.

Many young people who are struggling with health and behavioural issues have had adverse developmental experiences such as:

- Parenting that is insufficiently attentive, unpredictable, overly harsh or neglectful
- Family conflict
- Becoming parentified at an early age (taking responsibility for parents who can't cope and possibly protecting and caring for siblings)
- Lack of responsible adult role modelling
- Frequent physical relocations
- Lack of a stable and structured learning environment at home
- Exposure to substance abuse and other behavioural issues in the family

Each of these issues (and others) cause substantial disruptions in the bio-psycho-social processes that drive development. Young people require structure and guided experience. Those that have no control over the pace of change and transition are highly susceptible to developmental problems occurring'.[66] Without the necessary experiences, young people's development can become out of step with those on a more typical developmental pathway. To catch up or to get one's development back in step with most other young people, some clients require an opportunity to develop the personal and social resources needed to move through adolescence to adulthood.

Many young people who develop problems during adolescence either have not had, or don't currently have, anyone in their lives to provide the sense of structure and support that the effective limit setting and caring role offers. Because many clients have experienced significant periods of poor supervision, disconnection from family, and exposure to unsafe environments, they can learn methods of coping and surviving that are unusual and not always socially acceptable. When a young person's experiences are not adequately regulated, the task can fall to professional services and carers. The setting of limits linked with fair consequences provides structure and a sense of containment as well as a clear set of rules that young people can test out and use to develop a sense of their own identity. Experiences believed to compromise the safety, health and the future prospects of the young person need to be regulated but not eliminated. Young people still need to be challenged to learn problem solving and decision making skills.

In particular youth service types such as residential rehabilitation, or where clients have long-term involvement with a practitioner or service a form of substitute parenting can be required. This involves compensating and catching up on the guidance and role modelling that healthy parenting normally provides.

b. Creating attractive, welcoming spaces for young people

Young people have been shown to prefer attractive, youth-friendly spaces in accessible central locations.[67] [68] [69] Overly formal, clinical settings and cumbersome intake and assessment processes can be experienced by young people and families as impersonal and can act as a barrier to engagement[70].

Young people are sensitive to the potential for stigmatisation, so it is important that services are inclusive and do not make young people feel different from their peers.[71] Also, most clients, particularly those who are experiencing instability in their lives, prefer and often require a space that is physically and emotionally safe that can provide respite from violence at home or the dangers of street life.[72] [73] [74]

[66] Coleman, J., & Hendry, L. (1990). The nature of adolescence. London: Routledge.

[67] Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.
[68] Crago, A., Wigg, C., & Stacey, K. (2004). Youth-friendly practice in mental health work. Youth Studies Australia, 23(2), 38-45.
[69] Ensign, J., & Gittlelsohn, J. (1998). Health and access to care: perspectives of homeless youth in Baltimore City, USA. Social Science and Medicine, 47(12), 2087-2099.
[70] Bruun, A. (2008). Effective practice for young people experiencing alcohol and other drug-related harm. In D. Moore & P. Dietze (Eds.), Drugs and public health: Australian perspectives on policy and practice (pp. 115-126). South Melbourne: Oxford University Press.
[71] Statham, J. (2004). Effective services to support children in special circumstances. Child: Care, Health & Development, 30(6), 589-598.
[72] Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. Journal of Transcultural Nursing, 13(2), 145-152.
[73] Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. Brief Treatment and Crisis Intervention, 4(1), 93-108.
[74] Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. The Journal of Psychology, 136(4), 449-463.

Harsh exclusion policies for disruptive behaviour[75], focusing too much on the past, and assigning blame have also been found to act as barriers to engagement.[76]

c. Create the conditions that promote positive developmental pathways

Given favourable conditions, even small changes in how a young person functions can create a ripple effect, possibly generating momentum for further change and development across a range of life domains [77]

Young people in the process of **forming an identity** learn from experience and appreciate opportunities to both express themselves and be recognised for their contribution. Therapeutic work that engenders self-acceptance and freedom from stigma while helping young people identify their values and interests increases their motivation to invest in self-care and constructive action towards achieving longer-term goals. Racism, homophobia and sexism can all have a pernicious effect on young people's identity as it develops. The formation of a strong positive relationship between a young person and a worker of is one of the key therapeutic strategies employed to correct damage done to identity through experiences of distorted relationships and rejection.

The Australian Research Alliance for Children and Youth[78] draws on the Social Development Model[79] to outline the dynamics by which young people adopt pro-social attitudes and behaviours. First, young people require opportunities to engage in pro-social activity and experience pro-social interactions. Through understanding that participation will be positively rewarded, young people become motivated to develop the emotional, cognitive, and behavioural skills that allow him or her to continue earning, perceiving and experiencing positive reinforcement. In this way, new, more productive ways of dealing with life can be substituted for behaviours that served as coping mechanisms but led to further social dislocation and poor development outcomes.

Another key developmental task for all adolescents is learning **consequential thinking** and the **decision-making** skills necessary to become adults. Most adolescents acquire these cognitive skills gradually over a long period through talking and reflecting on experience with trusted adults that have in an interest in their development. Building on the foundation of the trusting relationship, practitioners can spend a lot of time helping young people to reflect on their experiences, understand why things happen and develop insight into how their actions may influence outcomes. Through this relationship young people can be offered constructive feedback and guidance that enables them to learn from their experience.

d. Continuous assessment of capacity

The needs of adolescents can change rapidly over time as they develop. The salience of particular risk and protective factors may subtly change as certain developmental tasks come into focus at different developmental stages. There is a need for continuous assessment of client capacity. Young people going through adolescence can make marked developmental gains in relatively short periods of time.

Practitioners need to be cognisant of young peoples' emerging developmental capacity and continually revise their assessment of clients' ability to cope with stressors in life, and effectively calculate and respond to risks. At the same time practitioners need to take care not assume that older adolescents necessarily have accurate information, knowledge and the skills required for coping and age appropriate participation in community life. It is important to be aware that many young people send the message to others that they are 'in-control', competent and mature even when this is not the case. Efforts to conscientiously assess young peoples' capacity to cope with stressors and make appropriate decisions will facilitate awareness of, and assist in managing, several tensions that frequently arises when striving for developmentally appropriate practice.

One key tension involves striking an appropriate balance between promoting a young person's autonomy or self-determination against the need to minimise risk. Promoting empowerment and self-determination for young people is a key commitment in youth AOD work that needs to be tempered by consideration each young person's ability to estimate risk and make responsible judgements about how it will be managed. Generally, stronger emphasis on autonomy is appropriate for more mature older adolescents, while stronger emphasis on risk

[75] Busen, N. H., & Engebretson, J. C. (2008). Facilitating risk reduction among homeless and street-involved youth. Journal of the American Academy of Nurse Practitioners, 20, 567-575.
[76] Arnold, E. M., & Rotherham-Borus, M. J. (2009). Comparisons of prevention programs for homeless youth. Prevention Science, 10, 76-86.
[77] Gilligan, R. (2008). Promoting resilience in young people in long-term care – the relevance of roles and relationships in the domains of recreation and work. Journal of Social Work Practice, 22(1)
[78] Williams, J., Toumbourou, J., Williamson, E., Hemphill, S., & Patton, G. (2009) Violent and antisocial behavious among young adolescents in Australian communities: an analysis of risk and protective factors. Australian Research Alliance for Children and Youth, Canberra.
[79] Catalano, R.F., Hawkins, J.D. (1996). The social development model: A theory of antisocial behaviour. In Hawkins, J.D. (Ed.), Delinquency and crime: Current theories (pp149-197), Cambridge University Press, New York.

reduction and firm guidance is appropriate for less mature adolescents.

e. Expectations matched to the developmental stage of clients

As young people develop and become more competent and mature they will naturally be subject to higher expectations from society and the significant others in their lives. In general young people require a consistent, reliable service that is uncomplicated and simple to understand. Adolescents require certainty and are very sensitive to injustice and being let down by adults, particularly when they have been exposed to inconsistent parenting.

Early stage adolescents are more amenable to direction and in the main require more structured programming. Middle stage adolescents are expected to benefit from structure but become very sensitive about direction from adults. Practitioners need to take care to ensure the young person feels they are in the 'drivers seat'. As this group moves into late adolescence young people need to be allowed progressively more agency in managing their own circumstances.

f. Duty of care and confidentiality

Adolescent clients are expected to be sensitive about their privacy. As such, clients need to be made aware that the service respects their right to confidentiality. Information held should only be released with client consent. The only exception would be when the health and safety of clients or others would be comprised should relevant information be withheld.

Young people in the early and middle adolescent stages are legally considered to be minors. This requires adults in professional roles to be mindful of threats to their safety, health and ongoing development. This requires suitable, developmentally attuned risk assessment processes and relevant policies pertaining to engaging other health and community services.

Again, balancing a commitment to self-determination with a young person's right and need to be protected is crucial. The individual's level of maturity needs to be considered when making choices such as encouraging independent decision-making versus providing more direction and even containment. This balance is particularly pertinent to harm reduction in relation to substance use. Good quality relationship based practice positions practitioners in the lives of clients in a way that allows for an accurate assessment to be made of their exposure to risk and capacity for adaptive coping. Such 'unobtrusive monitoring'[80] has been shown to have a strong protective effect.

g. Guided experience

Young people, particularly early and middle stage adolescents, are most likely to learn through direct experience. For this purpose, behaviourally-oriented interventions focused on development of skills are most effective. Whenever appropriate young people should be encouraged to 'do' for themselves. The degree to which practitioners undertake tasks on behalf of young people should be determined through continuous assessment of their capacity to manage (see above).

Practitioners work alongside clients in real world setting not solely in clinics or counselling rooms. This facilitates direct, real-time feedback that recognises pro-social participation and interaction with others. This approach also enables workers to identify, highlight and facilitate naturally occurring rewards for pro-social interactions that occur in the lives of clients. Through guided experience clients can develop the emotional, cognitive, and behavioural skills that reinforce healthy development and promote pro-social behaviour.

h. Family and systems-focused interventions

Some form of family involvement is important when considering their critical role in caring for young people and having a strong influence on their behaviour. In particular, early and middle-stage adolescents tend to be reliant on care-givers for resources, thus securing care-giver involvement, or at least support, may often be essential to

[80]Aronowitz, T. (2005). The role of "envisioning the future" in the development of resilience among at-risk youth. Public Health Nursing, 22(3), 200-208.

the task of engaging younger adolescents in health and social care services.

Assessment and intervention planning with young people needs to be family inclusive or at least family sensitive in the sense of considering whether and how the family system as a whole, or unilateral relationships between the adolescent and particular family members may be shaped and strengthened to diversify and enrich the social supports available to the adolescent.

If immediate family members are unavailable, the potential contribution of other significant adults should be considered. Whether or not families are involved or supportive, other social systems such as schools, alternative education organisations, sports clubs and other social institutions are also vitally important to building a viable network of social supports around adolescents.

A critical role for care-givers (most often parents) is to regulate the experiences of the young people in their care through the application of appropriate boundaries (limit setting). This is of central importance for early and middle stage adolescents but still applies for clients in late adolescence. Enhancing the capacity of parents and caregivers to fulfil this parental role of regulating the experiences of their adolescents, or to contribute to this role in some way, is a key goal of family-focused interventions, particularly family therapy. Practitioners might help a family identify one or more forms of support that they can provide to support that enables the young person in their care to move away from problematic behaviours.

As clients begin to take on more responsibility for their own health and well-being they also have more agency regarding the nature and degree of the contact they have with families and significant others. Practitioners need to assist clients to work through these decisions.

i. Transition planning

Transition points are ideal opportunities for effective intervention because individuals tend to be more open to advice and learning that will assist them.[81] Key transition points for all young people are from primary school to high school and then out of high school. These are also important periods of change for young people that can influence substance using behaviour.

Youth services and practitioners are also sensitive to the risks and opportunities inherent in key transitions created by service systems. In relation to treatment of persistent AOD and mental health problems for example, developmentally appropriate programs will incorporate careful transition planning for young people moving from youth specific services to the adult system.

Another service system transition occurs when young people who are child protection clients leave care. Research has shown that many young people lose access to services such as mental health care when they exit child protection.[82] [83] For vulnerable young people who are beginning to develop mental health and or substance use problems a sudden loss of support at this transition point can be devastating.

For young people exposed to multiple risk factors, such as neglect, abuse and poor connection to school, the transitions out of school and out of the Child Protection system may be particularly important windows of opportunity for delivery of early intervention programs.

[81] Spooner, C., Hall, W., & Lynskey, M. (2001). Structural determinants of youth drug use: A report prepared by the National Drug and Alcohol Research Centre. Woden: Australian National Council on Drugs.
[82] Dworsky, A., & Courtney, M. (2009). Addressing the mental health service needs of foster youth during the transition to adulthood: How big is the problem and what can states do? Journal of Adolescent Health, 44, 1-2.
[83] McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. Journal of Adolescent Health, 44, 7-13.