Government of **Western Australia**
Department of **Health**

A Better Deal for Youth Mental Health: Prevention Meets Recovery

A Collaborative Approach to Development of a Youth Mental Health Service in Western Australia

August 2011

Delivering a **Healthy WA**

Contents

1. Executive Summary

Remit

The Youth Mental Health Planning Working Party was formed at the request of Chief Executives from Adult and Child, Adolescent Mental Health Services (CAMHS). This was in the context of the integration of Child, Adolescent Mental Health Services into a single service within Child, Adolescent Health Services (CAHS).

The purpose of the group is to provide the State Health Executive Forum (SHEF) with options regarding the delivery of mental health services to Youth. The Terms of Reference outline the following objectives;

1. To determine a shared understanding of the definition of Youth for the purposes of WA Mental Health Service development.
2. To develop a position statement as to whether Department of Health Specialist Mental Health Youth services should be comprehensive or limited to specific diagnostic groups.
3. To develop a model of care, either comprehensive or specific, across tiers and services.
4. To outline the benefits and disadvantages of various service delivery models.
5. Recommend a service delivery model.

Membership of the Youth Mental Health Planning Working Party as follows:

- Co-chair- Dr. Caroline Goossens- CAHS CAMHS Clinical Lead
- Co-chair- Dr. Nathan Gibson- Program Director, North Metropolitan Adult Mental Health
- Dr. Gordon Shymko- Clinical Director, Peel and Rockingham Kwinana Mental Health Service
- Dr. Gosia Wojnarowska- Bentley Adolescent Unit Clinical Head of Service
- Anthony Collier- Program Manager YouthReach South
- Denise Follett- Director YouthLink
- Dr. Cathy Nottage- Child Adolescent Psychiatrist
- Shelley Tamatoa- Community Mental Health Nurse, Rockingham Kwinana CAMHS
- Dr. Edward Petch- Director State Forensic Mental Health Services
- Tracey Harrison- Clinical Psychologist, Bentley Mental Health Service
- Sue Pratt- Community Mental Health Professional Bunbury CAMHS.
- Casey McNab- Project Officer

Process

The Youth Mental Health Planning Working Party commenced on the 22 March, 2011, and met fortnightly and concluded on the 5th July 2011. Resources informing this process were gathered from key recent, local interstate and international service planning reports and guidelines. Consultation occurred with local specialist service providers. For this initial document, direct consumer and carer consultation was acknowledged as limited. However the literature used to underpin this report, both Australian and international, had significant consumer and carer focus and input.

Summary

It was noted by the group that notwithstanding the significant impact of the Orygen model and the success of headspace, outcomes remain either developmental or in some cases unaudited. Currently there are a number of interesting and potentially useful Youth models but as yet there has been no single generalisable best practice model fully defined. The challenge of the group was to identify the option that suits the topography of the WA health and demographic landscape, and that will be sustainable into the future.

It was recognised that there is no single definition of Youth in the WA context defining Youth as 16-25 gave greatest inter-sector cohesion and made a deliverable service model more likely and sustainable.

The group identified that the following principles should be embedded in, and underpin, all future developments within mental health services for Youth, which was identified as 16-25 year old group:

- Developmentally informed care
- Delivering holistic biopsychosocial interventions
- Engagement as appropriate with all systems in young person's life, including family, relationships, education, work and leisure
- In a culturally sensitive and informed framework
- Focusing on collaborative partnerships across all tiers of care in government and non-government organisations
- Delivered in a youth-friendly environment

The Working Group acknowledged that it would be preferable to plan a comprehensive mental health service for Youth, but noted that this would entail a far more detailed and extensive planning process as well as significant resources. The following recommendations are based on a pragmatic plan to build a new service in stages, with an emphasis on building a critical mass of clinical expertise that will facilitate program fidelity and future sustainability.

Summary of All Recommendations

Establish a Youth Specific Lead

Recommendation 1: A dedicated position for Youth Mental Health Lead is created to coordinate and lead the design of a supra-regional Youth Specialist Mental Health Stream (Page 28).

Establish a Youth Specialist Mental Health Stream

Recommendation 2: Create Specialist Youth Mental Health Stream as a discretely governed supra-regional stream within Adult Mental Health to ensure program fidelity (Page 29).

Recommendation 3: The concepts of both Secondary Prevention and Recovery to inform delivery of care (Page 12).

Recommendation 4: Transition existing assertive outreach programs YouthReach South and YouthLink to Youth Mental Health Stream (Page 13).

Recommendation 5: Youth Mental Health Stream to commit to future evidence-based planning for identified "gap" areas including services targeting emerging personality disorders, co-morbidities with ADHD, Intellectual Disability and Pervasive Developmental Disorders and Young people exiting the care of the Department of Child Protection (Page 18).

Recommendation 6: Develop a training Framework that encompasses developmental systems, trauma, emerging personality disorders, psychosis, alcohol and other drug and cultural sensitivity (Page 32).

Establish EPPIC programs

Recommendation 7: Early Intervention in Psychosis (EIP) is seen as a natural first step in the development of a Youth Stream. The State Government match the funding that the Federal Government has allocated to the

development of EIP programs as a first step in the development of a WA Specialist Youth Mental Health Stream (Page 30).

There was not consensus around the model. From a broader system perspective the majority of the group perceived better capacity to build clinical expertise and maintain fidelity in having one overarching Youth stream manage a specialist EIP program. However, it has been identified that some well developed local services have clear capacity to maintain program integrity embedded at a local level and this was the strongly preferred approach of some group participants. The further finalisation of this model would be a role for the Youth Lead.

It is identified that pursuing the announced Federal funding may require action prior to the establishment or functionality of a Youth Stream.

Recommendation 8: That the initial Youth Stream focus be EIP and existing Youth services-clients aged 16-18 that do not meet the eligibility criteria for EIP, YouthReach South and YouthLink will continue to have services provided by CAMHS, whilst clients aged 18-25 will continue to have services provided by Adult Mental Health Services (Page 30).

Recommendation 9: Provision of dedicated Consultant Psychiatrist support for YouthLink and YouthReach South from within Specialist Youth Mental Health Stream (Page 13).

Care Coordination

Recommendation 10: Planning transitions for Youth is essential and structured transition planning needs to be a standard part of care (Page 22).

Recommendation 11: Care-coordination is the recommended framework for shared care between all specialist mental health services, public sector agencies and Non-government organisations. Formal care-coordination must be implemented at the outset of Youth Stream development (Page 21).

Recommendation 12: Implement the goals that Victorian Youth Specialist Mental Health Services propose for 16-24 year olds in Western Australia (noting change to age range) (Page 25).

Create and Strengthen collaborative Partnerships with NGOs

Recommendation 13: Form collaborative partnerships with NGOs, with specialist mental health maintaining responsibility and leadership in clinical governance, to optimise and strengthen quality of care delivered to Youth with complex mental health issues (Page 32).

Recommendation 14: Maintain and strengthen links between Youth specialist mental health services, headspace and Youth Focus (Page 24).

Recommendation 15: Embed vocational training into EPPIC as part of a Functional Recovery approach (Page 31).

Enhance WACHS Youth Mental Health

Recommendation 16: Enhance and seed new initiatives for Youth mental health in rural and remote areas (Page 29).

Development of a Youth specific inpatient unit, Youth-friendly Emergency Department and specialised Eating Disorders unit

Recommendation 17: Develop a new Youth Inpatient Unit(s) on a teaching hospital site with access to a youth-friendly emergency department, and specialist medical care, prior to the shift in Bentley Adolescent Unit beds to the New Children's Hospital, 2015 (Page 32).

Recommendation 18: Establish a youth-friendly area in the associated emergency dept depending on the site of Youth Inpatient Unit (Page 32)**.**

Recommendation 19: Develop a specific inpatient unit for treatment of severe Eating Disorders for 16-25 year olds due to the highly specialised medical and psychological treatments required (Page 33).

Recommendation 20: Increase in supported crisis accommodation services for Youth to be incorporated in future planning (Page 33).

Planning for Forensic Services for adolescents and Youth should be established as a separate planning process

Recommendation 21: That children and young people appearing before the children's court of Western Australia have access to appropriate, comprehensive mental health assessment, and referral and treatment services (Page 16).

Recommendation 22: That a dedicated forensic mental health unit for children and young people be established (Page 16).

Aboriginal Youth Services

Recommendation 23: That culturally inclusive models and pathways for Aboriginal Youth be developed in association with SAMHS (Page 15).

Recommendation 24: That there is a close collaborative relationship between a Youth Lead/Stream and SAMHS to maximise synergies in the development of Aboriginal Youth Mental Health Services (Page 15).

Youth ADHD

Recommendation 25: The development of a comprehensive Youth Stream requires the establishment of a public sector Adult ADHD structure with appropriate youth transition options (Page 17).

2. Youth in a Snapshot

"Mental illnesses are the chronic diseases of the young"[1]

Mental illness and substance abuse disorders are the key health issues for young people in their adolescent years and early 20's. The literature identifies two major definitions for the Youth cohort; ages 12-25 versus 16-25. There is not a consistent single national or international demarcation for Youth by age. The Working Group identified that a 12-24 or 12-25 definition of Youth for the purposes of service development would create a risk of fragmentation in the Western Australian context of broader inter-sectorial service delivery- it does not fit well. It was noted by the group that there are enormously different developmental tasks and needs for adolescents aged 12-15 compared with Youth aged 16-25, which impacts significantly on service design, planning and implementation. The Working Group has adopted the definition of Youth as age 16-25, to describe the period of late adolescence and early adulthood. This distinction is compatible with existing service transitions, particularly with other community and inpatient Child and Adolescent health services in Western Australia. Specialist Child and Adolescent Mental Health Services within the New Children's Hospital planned for completion in 2015 will cater for 0-16 year olds. Thus, there is a natural demarcation for definition of the Youth cohort to be 16-25 in Western Australia. [2][3]

Adolescence is an intense period of change and challenge for young people. Severe mental health problems such as psychosis or eating disorders can emerge in the pivotal ages of 16-17, and difficulties already present can become more complex or severe. Increases in risk-taking with this age group also increase the risk of mental health difficulties, and co-morbidity is often prevalent among young people aged 16-25 years old. [4]

Epidemiology

Whilst age 16-25 fits with existing health demarcations national population census data clumps ages 15-24 yrs together. According to the 2006 ABS census data, young people aged 15 to 24 years represented 14% of the total population of Australia.[5] In 2006, it was estimated that within Western Australia young people aged 15-24 years represented 14% of people living in metropolitan areas, 11% of people living in rural areas and 14% of people living in remote areas. In metropolitan areas Indigenous young people represented 2% of all 15-24 year olds. In rural areas this percentage was 8% and in remote areas, 31%.[6] Western Australia's population of 15-24 year olds is expected to rise from 330,432, in 2010 to 423,683 by 2020, which has significant implications for service planning.

[1] Insel T.R., Fenton W.S. (2005). Psychiatric epidemiology: it's not just about counting anymore. *Arch Gen Psychiatry*; 62: 590-592.
[2] Department of Health, Western Australia (2009). *Paediatric Chronic Diseases Transition Framework.* Perth: Health Networks Branch, Department of Health, Western Australia
[3] Brodie, I., Goldman, R., Clapton, J. (2011). *Mental Health Service Transitions for Young People*. UK: Social Care Institute for Excellence.
[4] Brodie, I., Goldman, R., Clapton, J. (2011). *Mental Health Service Transitions for Young People*. UK: Social Care Institute for Excellence.
[5] Australian Bureau Statistics
[6] DOHWA Epidemiology and GIS Branch, 2010

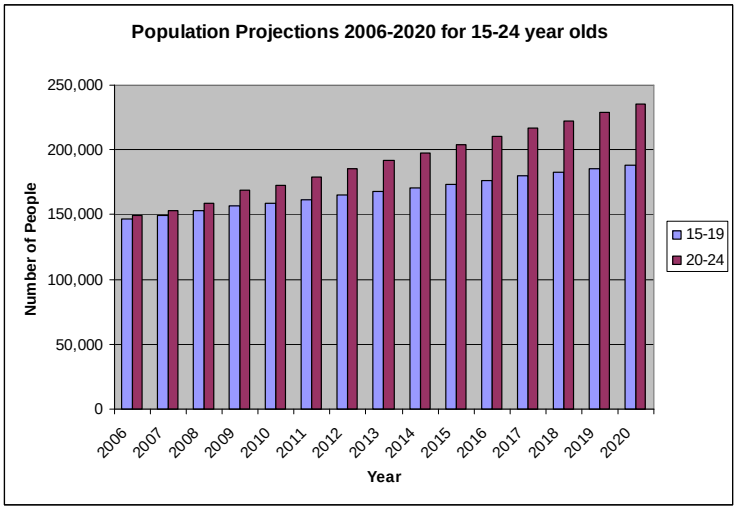

Figure 1. Population Projections for 15-24 year olds in WA, 2009-2020
Source: DoHWA Epidemiology and GIS Branch, 2010

In 2010, 8074 young people aged 16-25 were seen by specialist mental health services. This accounts for approximately **2.4%** of the population for this age group based on population projection data.

Figure 2 outlines the increase in occasions of service for 16-25 year olds attending specialist mental health services in Western Australia.

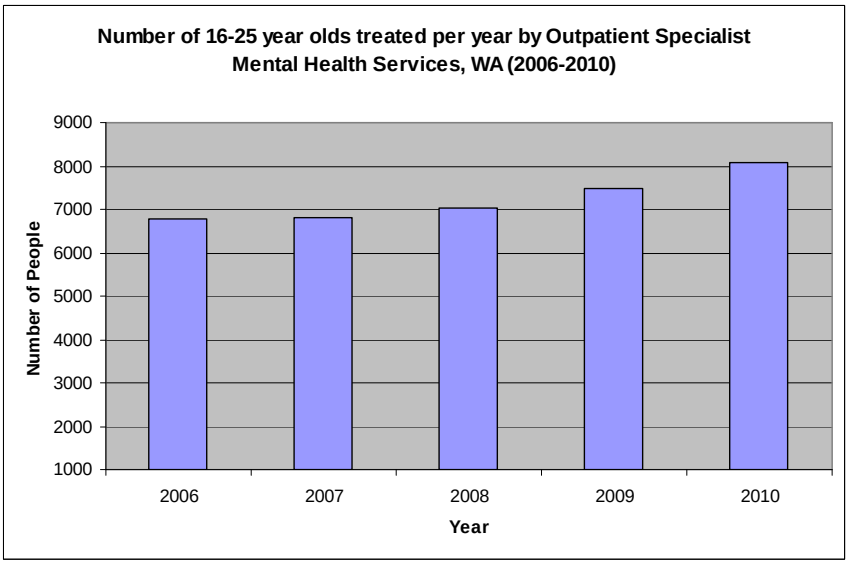

Figure 2. Number of Persons Treated by Specialist Mental Health Services aged 16-25 in WA (2006-2010)
Source: DoHWA Epidemiology and GIS Branch, 2010

The prevalence of mental illness varies by age. In children, it is estimated that between 7% and 14% experience mental health concerns, this rises to 19% in adolescents aged 13-17 years and peaks to 27% among young adults aged 18-24.[7] Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have experienced its onset by 24 years of age, with the onset for most of these disorders falling into a relatively discrete time band from the early teens to the mid 20's, and peaking in the mid 20's. This is the highest prevalence and incidence for such disorders across the whole lifespan.

Burden of Disease

Mental illness is the largest single cause of disability among Australians aged 15-24.

[7] McGorry, P.D., Purchell, R., Hickie, I.B. & Jorm, A.F. (2007). Investing in Youth Mental Health is a best buy. *Medical Journal of Australia, 187*, S5-S7.

Burden of disease data, supplied by the Australian Institute of Health and Welfare, use the disability-adjusted life years (DALYs) measure which combines information on the impact of premature death (years of lost life, YLL) as well as non-fatal health outcomes (years of 'healthy' life lost, YLD). Mental disorder now accounts for 49% of the burden of disease, measured as both death and disability (and 61% of the non-fatal burden) in this age range.[8] This is by far the biggest contribution and well ahead of the next highest important contributor, injuries, at 18%.

Figure 3 indicates that mental disorders account for 70% of the disability burden in young people aged 15-24; this is significantly higher than any other age cohort.

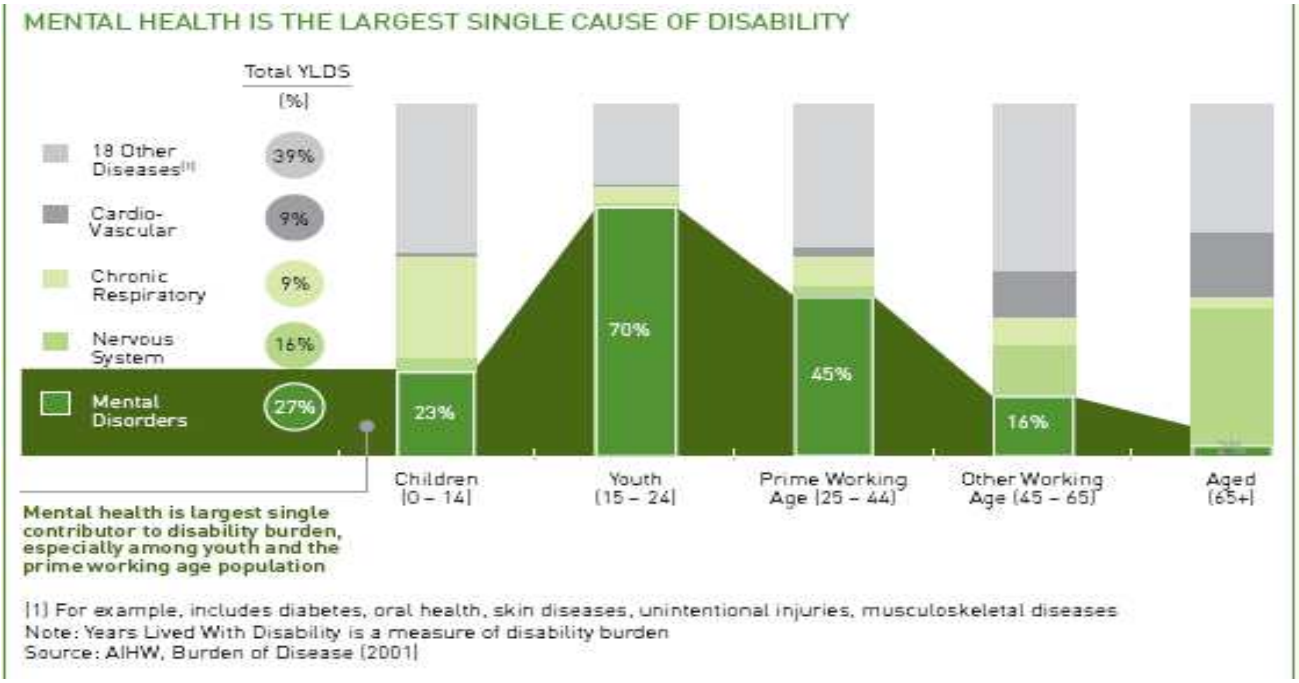

Figure 3. Cause of Disability in the Australian Population (2001)
Source: AIHW, Burden of Disease (2001)

With regard to specific cause, anxiety and depression accounted for the majority of the burden of disease and injury for this age group, accounting for 17% of the male burden and 32% of the female burden. The third and fourth leading causes of burden of disease and injury for young males were schizophrenia (10%) and suicide and self inflicted injuries (7%). For young females, schizophrenia was the fifth leading cause of DALYs followed by personality disorders at seventh.[9]

Eating disorders are associated with high rates of morbidity, mortality and burden. Bulimia and Anorexia Nervosa are the 8th and 10th leading causes of burden of disease and injury in females aged 15-24 in Australia.[10] One in seven (15.5%) Australian women will experience an eating disorder in their lifetime and mortality rates are 12 times higher than the annual death rate from all causes in females aged 15-24 with up to 10% of those affected dying as a result of their disorder. Eating disorders are associated with high rates of co-morbidity with other psychiatric illnesses such as depression, anxiety disorders, substance abuse issues and trauma and neglect. Approximately 45% to 86% of people with Eating Disorders have co-morbid depression and approximately 64% have co-morbid anxiety disorder.

[8] Australian Institute of Health and Welfare (2007). *Young Australians: their health and wellbeing 2007*. Cat. no. PHE 87. Canberra: AIHW.
[9] Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L.., Lopez, A.D. (2007). *The Burden of Disease and injury in Australia 2003*. AIHW PHE 82, April. Canberra.
[10] The National Eating Disorders Collaboration (2010).*Eating Disorders, Prevention, Treatment and Management*: An Evidence Review. The Butterfly Foundation.

Personality Disorders are also associated with severe functional impairments, high rates of co-morbid mental disorders, high rates of suicide, intensive use of treatment and high costs to society.[11] [12] In clinical populations, borderline personality disorder is most common personality disorder, with a prevalence of 10% of all psychiatric outpatients and between 15-25% of inpatients.[13] [14] The mortality rate from suicide is between 8-10%, which is 50 times higher than the general population.[15] [16] 84.5% of patients with borderline personality disorder met criteria for having one or more 12 month Axis 1 disorders. Borderline Personality Disorder is most frequently associated with Mood Disorders, Post-Traumatic Stress Disorder, and disorders associated with substance misuse.[17]

Suicide

In 2008, suicide accounted for 17.8% of all deaths for people aged 15-19 and 24.6% for those aged 20-24.[18]

Figure 4 outlines total number of deaths by suicide from 1998 to 2008 for ages 15-24.

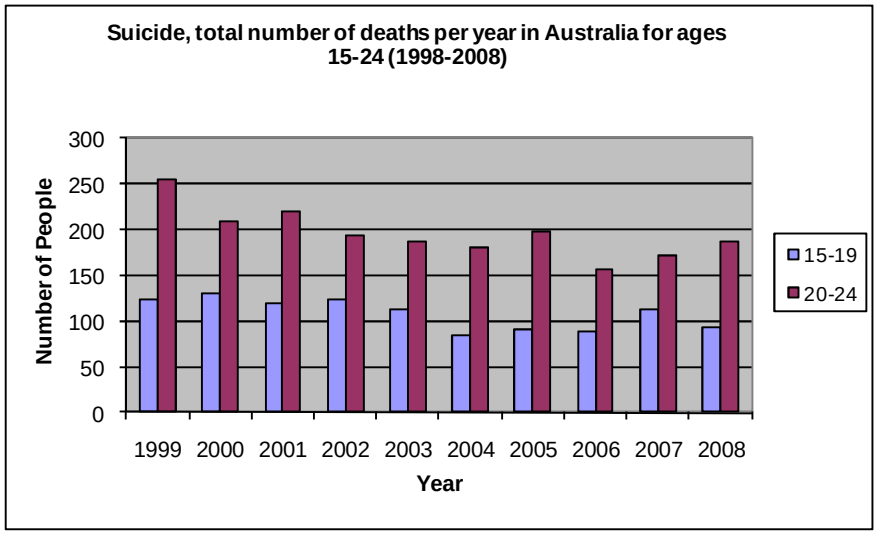

Figure 4. Suicide, total number of deaths per year between 1995-2005 for ages 15-24

Deaths from suicide accounted for 2,191 people in Australia, 2008. Of those deaths 281 people were between the ages of 15-24, representing 12.8% of suicide deaths in Australia, 2008. Suicide is ranked as the 14th leading cause of deaths registered in Australia, 2008. Of this figure, 78% were males, indicating suicide as the 10th leading cause of death for males. Suicide deaths encompass a much higher proportion of total deaths in younger age groups compared with older age groups.[19]

3. WHY A YOUTH SPECIFIC SERVICE?

3.1 What Youth Want from a Service

There is remarkable consistency across multiple reports in what young people say that they want from a mental health service. Young people want a service that provides an environment that is informal, easily accessible, and

[11] Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. (2011). Borderline Personality Disorder. *Lancet* 377:74-84.
[12] National Institute for Health and Clinical Excellence (January 2009). *The guidelines manual*. London: National Institute for Health and Clinical Excellence.
[13] Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. (2011). Borderline Personality Disorder. *Lancet* 377:74-84.
[14] National Institute for Health and Clinical Excellence (January 2009). *The guidelines manual*. London: National Institute for Health and Clinical Excellence.
[15] Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. (2011). Borderline Personality Disorder. *Lancet* 377:74-84.
[16] National Institute for Health and Clinical Excellence (January 2009). *The guidelines manual*. London: National Institute for Health and Clinical Excellence.
[17] Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. (2011). Borderline Personality Disorder. *Lancet* 377:74-84.
[18] Australian Bureau of Statistics (2010). *Causes of Death, Australia, 2008.* 3303.0, Australia: Canberra
[19] Australian Bureau of Statistics (2010). *Causes of Death, Australia, 2008.* 3303.0, Australia: Canberra

provides a balance between confidential health, support services and family involvement. They want the service to be designed in an age appropriate, attractive manner that diminishes stigma and facilitates access. Services with single or easy points of access that are staffed by experienced clinicians who can build solid relationships with the young person and assist with all aspects of their lives are preferred. Youth want assistance with relationships, education, vocation, leisure activities, housing, substance use and issues relating to their sexuality. Youth have expressed a preference for their own involvement and participation in service design and development.

Youth-friendly services provide direct service provision such as treatment, support, group work, referral, rehabilitation, as well as working towards the prevention of ill-health. Effective Youth services are often characterised by using a co-location model; integrating a number of different services in one location.[20] This is consistent with findings from multiple reports and frameworks within key local, national and international organisations, for example;

- World Health Organisation (WHO) Framework[21]
- Social Care Institute for Excellence, UK
- Burdekin Report, Australian Government (1993)[22]
- WA Commissioner for Children and Young People (CCYP) Report, 2011
- Youth Affairs Council of Western Australia (YACWA)
- Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMA) Youth Participation[23]

What does youth-friendly mean?

The following is a list of what is meant by 'youth friendly' taken from a variety of sources*

- ⇒ Fostering a warm and welcome environment
- ⇒ Respecting Youth as individuals
- ⇒ Developmentally appropriate
- ⇒ Youth and their families/carers are active contributors in design, development and implementation of a program
- ⇒ Recognising the importance of accessibility
- ⇒ Providing flexible hours of operation
- ⇒ Seeking feedback about what is working and what needs improvement
- ⇒ Youth participation at varying levels within the organisation
- ⇒ Provide treatment, support, group work, referrals and rehabilitation
  - Balance of family involvement with individual confidentiality
  - Youth-specific, safe community and inpatient services
- ⇒ Working towards the prevention of ill-health
- ⇒ Using a co-location model, integrating a number of different services
- ⇒ Experiencing continuity of care
- ⇒ Experiencing well planned, smooth transition
- ⇒ Using non-judgemental collaborative interventions
- ⇒ Holistic approach i.e. peers, relationships, education/vocation, leisure, sexuality, housing, substance use

*This list is not exhaustive of what is required for a youth friendly service. [24] [25] [26] [27] [28]

[20] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

[21] World Health Organisation (2005). *Mental Health Policy and Service Guidance Package: Child, Adolescent Mental Health Policies and Plans.* World Health Organisation.

[22] Burdekin, B., Rose, S., Jenkin, R. (1993). *The Burdekin Report: human rights and mental illness: report of the National Inquiry into the Human Rights of People with Mental Illness.* NSW: Parliamentary Library.

[23] Australian Infant, Child, Adolescent and Family Mental Health Association (2008). *National Youth Participation Strategy Scoping Project Report.* Australian Infant, Child, Adolescent and Family Mental Health Association.

[24] Appleton, S., Pugh, K. (2011). *Planning Mental Health Services for Young Adults-Improving Transition: A Resource for Health and Social Care Commissioners.* United Kingdom: National Mental Health Development Unit.

[25] Brodie, I., Goldman, R., Clapton, J. (2011). Mental Health Service Transitions for Young People. UK: Social Care Institute for Excellence.

[26] Pereira, N. (2007). *Ready…Set…Engage: Building Effective Youth/Adult Partnerships for a Stronger Child and Youth Mental Health System*. Toronto: Children's Mental Health Ontario & Ottawa: The provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

[27] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

[28] NSW Centre for the Advancement of Adolescent Health (2010). *The NSW Youth Health Policy: Healthy Bodies, healthy minds, vibrant futures, 2010-2015.* Sydney: NSW Department of Health.

3.2 What Youth Do Not Want from a Service

Young people have been equally clear about what **they do not want** from a service. They do not want services with a narrow illness-focussed approach with multiple barriers to access. They do not want shared facilities with adults that suffer enduring and severe mental illness, as it engenders feelings of hopelessness and can be traumatising, leading to an experience of services, especially inpatient units, as unsafe. Equally, they would like their age and stage recognised and do not want to share facilities with small children.[29] [30] [31] [32] [33]

Feedback from service providers in WA, who are working with Youth suffering severe, complex and co-morbid mental health disorders state that their experience is that this cohort is more likely to:

- ⇒ Access a Youth specific service and are likely to feel less comfortable accessing a service with a significant child focus or significant adult focus
- ⇒ Be particularly sensitive to stigma associated with both mental health and drug and alcohol issues
- ⇒ Have unstable accommodation
- ⇒ Have had negative experiences with help seeking in the past

The sensitivity of this cohort to service design and delivery highlights the need for more assertive outreach and creative ways of engaging young people, which ought to be built into the culture and practises of a Youth-specific mental health stream. This is in line with recognition of effective ways to work in CAMHS services in the UK and other states in Australia.

In Western Australia, the Mental Health Commission actively endorses the Recovery paradigm within Mental Health Services-in short, the focus on hope and services supporting individual empowerment in the achievement of personal goals. A Youth stream requires an additional focus on minimisation of the impact of an evolving disorder on all aspects of the young person's life, and involvement and strengthening of family support and functioning. This is endorsed within youth mental health literature and is encompassed by the term Secondary Prevention-in short, mitigating the effects of an emerging illness. A Recovery paradigm alone may not necessarily give sufficient emphasis to the important developmental approach around prevention in the care of young people and their families.

Recommendation 3: The concepts of both Secondary Prevention and Recovery to inform delivery of care.

3.3 Current Services in Western Australia

To deliver a best quality service targeting the above disorders in the 16-25 year old age range it is recognised that both CAMHS and Adult Mental Health Service (AMHS) expertise is required. It was acknowledged by the Working Group that AMHS have more experience and expertise in managing psychosis and severe affective disorders, whereas CAMHS have more expertise in managing severe anxiety, complex trauma and attachment disruption, emerging personality disorder and the complex systemic interventions that these require. Members of the Working Group acknowledged that neither program could best manage the needs of Youth without the input of the other.

[29] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

[30] Appleton, S., Pugh, K. (2011). *Planning Mental Health Services for Young Adults-Improving Transition: A Resource for Health and Social Care Commissioners.* United Kingdom: National Mental Health Development Unit.

[31] Brodie, I., Goldman, R., Clapton, J. (2011). Mental Health Service Transitions for Young People. UK: Social Care Institute for Excellence.

[32] Pereira, N. (2007). *Ready…Set…Engage: Building Effective Youth/Adult Partnerships for a Stronger Child and Youth Mental Health System*. Toronto: Children's Mental Health Ontario & Ottawa: The provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

[33] NSW Centre for the Advancement of Adolescent Health (2010). *The NSW Youth Health Policy: Healthy Bodies, healthy minds, vibrant futures, 2010-2015.* Sydney: NSW Department of Health.

It was also acknowledged that neither program is currently delivering adequate services to young people who are in or are exiting the care of the Department for Child Protection or Corrective Services, or those with co-morbid complex developmental disorders such as Autism or Intellectual Disability.

Current Tier 3 and 4 (See Figure 5) CAMHS treat severe and complex mental illnesses that are often characterised by co-morbidities;

- ⇒ Severe emotional, relational, and behavioural difficulties, deliberate self-harm, suicidality
- ⇒ Range of disorders e.g. severe anxiety, refusal, somatoform, affective, sequelae trauma/abuse/neglect, early psychosis, emerging personality disorders
- ⇒ Co-morbid developmental disorders including learning, speech, intellectual, PDD, ADHD

Current Tier 3 and 4 Adult Mental Health Services treat severe and enduring mental illness;

- ⇒ Predominantly psychosis, severe affective, severe personality disorders, organic overlap
- ⇒ Co-morbidities frequent especially AOD

3.4 Current Specialist Youth Specific Mental Health Services

YouthReach South and YouthLink are intensive outreach programs for homeless Youth or those who experience major barriers in accessing mainstream mental health services. As specialist Tier 4 services they provide assessments, ongoing interventions with an extremely vulnerable population, many of whom have chronic patterns of self harm, suicidal behaviour, and serious and enduring mental health problems.

YouthReach South and YouthLink currently provide services for those clients between the ages of 13-24, although the bulk of their clients are over the age of 15. Both services have gaps in their current staffing to provide these comprehensive services. These gaps include lack of dedicated Consultant Psychiatrist resources at YouthLink and YouthReach South and specialist nursing service at both services. Currently, clinical staff at both YouthLink and YouthReach South continue to broker the services of Psychiatrists from the relevant catchment based services. This arrangement is less than optimal, and can result in undue risk, poor communication and lack of integration of care plans.

Staff at YouthLink and Youth Reach South have extensive clinical experience and expertise at engaging high risk Youth and providing youth-friendly services, which should be utilised and built upon in future service planning.

Recommendation 4: Transition existing assertive outreach programs YouthReach South and YouthLink to Youth Mental Health Stream.

Recommendation 9: Provision of dedicated Consultant Psychiatrist support for YouthLink and YouthReach South from within Specialist Youth Mental Health Stream.

3.5 Major Gaps in Current Service Delivery

3.5.1 Aboriginal Youth Mental Health Service Delivery:

Overrepresentation of disadvantage is apparent in many indices for Aboriginal people; physical illness, education, poverty, mental health and involvement with the justice system.[34] Education is a primary issue. The interface for Aboriginal Youth between the education and mental health systems are a key factor in transition.

The Telethon Institute for Child Health Research's survey on Aboriginal Child Health found that just over 1 in 5 Aboriginal children were living in families where 7 or more life stress events such as; physical illness, hospitalisation or death of a close family member, family break-up, incarceration, job loss and financial difficulties, vicarious trauma (loss, grief, family separation, loss of culture), trauma and abuse, domestic violence or substance misuse had occurred in the preceding 12 months.[35] [36] [37] In addition, the survey found that Aboriginal children were five and a half times more likely to be at a high risk of clinically significant emotional or behavioural difficulties.[38]

For young Aboriginal Australians males aged 12-24 years in 2004/05 Schizophrenia was the main mental health disorder leading to hospitalisation (35%), followed by psychoactive substance abuse (32%), and reaction to severe stress and adjustment disorder (9%). For young Aboriginal females leading disorders that led to hospitalisation were psychoactive substance use (25%), reaction to severe stress and adjustment disorder (16%), and schizophrenia (15%).[39] Substance use and misdiagnosis are major issues in managing Aboriginal Youth with psychosis.

The rate of suicide in the Aboriginal population is three times greater than that of the non-aboriginal population (3.7% compared to 1.3%)[40].Between the years 2001-2005, Aboriginal females under 25 years old completed suicide approximately five times the rate of non-aboriginal females and male Aboriginal Australian suicides averaged five to six deaths to one Aboriginal female suicide.[41]

The recent "Doing Time-Time for Doing" report released June (2011) by the Parliamentary Committee states that Aboriginal Youth are 28 times (397 per 100,000) more likely to be in detention facilities compared to non-aboriginal Youth (14 per 100,000). [42] A NSW study reviewing the health of young people in custody reported that Aboriginal young people were more likely than non-aboriginal young people to have an attention or behavioural disorder (75% compared with 65%) or an alcohol or substance use disorder (69% compared with 58%). Availability and access to counselling and health professionals in detention centres is limited, particularly in regional areas and often the environment of detention facilities compounds existing trauma[43]

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[34] Editors: Purdie, N., Dudgeon, P. & Walker, R. (2010). *Working Together: Aboriginal and Torres Strait Islander Mental health and Wellbeing Principles and Practice.* Commonwealth of Australia.

[35] Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J. *et al*(2005). *The West Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people.* Perth: Curtain University of Technology and Telethon Institute for Child Health Research.

[36] Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J. *et al*(2005). *The West Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people.* Perth: Curtain University of Technology and Telethon Institute for Child Health Research.

[37] Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J. *et al*(2005). *The West Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people.* Perth: Curtain University of Technology and Telethon Institute for Child Health Research.

[38] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

[39] Australian Institute of Health and Welfare (2007). *Young Australians: their health and wellbeing 2007.* Cat. no. PHE 87. Canberra: AIHW.

[40] Editors: Purdie, N., Dudgeon, P. & Walker, R. (2010). *Working Together: Aboriginal and Torres Strait Islander Mental health and Wellbeing Principles and Practice.* Commonwealth of Australia. book

[41]Editors: Purdie, N., Dudgeon, P. & Walker, R. (2010). *Working Together: Aboriginal and Torres Strait Islander Mental health and Wellbeing Principles and Practice.* Commonwealth of Australia. book

[42] House of Representatives: Standing Committee on Aboriginal and Torres Strait Islander Affairs (2011). *Doing Time-Time for Doing: Indigenous Youth in the Criminal Justice System.* Commonwealth of Australia.

[43] House of Representatives: Standing Committee on Aboriginal and Torres Strait Islander Affairs (2011). *Doing Time-Time for Doing: Indigenous Youth in the Criminal Justice System.* Commonwealth of Australia.

The Ways Forward Report (1997) describes Aboriginal perspectives of health and mental health as being holistic, encompassing spiritual, social, emotional, cultural, physical and mental wellbeing.[44] Barriers to accessing services for Aboriginal people are; engagement issues, stigma and discrimination, distrust of services, logistical issues for rural and remote areas and for some, transport issues within metropolitan areas and services. Overall, organisations and services that are unresponsive and inappropriate to the cultural needs of Aboriginal individuals, families and communities are barriers to service delivery to Aboriginal people.

Culturally appropriate and safe practice is essential in service delivery to Aboriginal Youth experiencing mental health problems that encompass the values of reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity.[45] Specific frameworks should be provided to ensure development of education programs for those working in the field of Aboriginal Mental Health. Educational strategies must include identification of current workforce and need in all health professions. In relation to the disproportionate numbers of young people in the juvenile justice system; policy elements need to include education and early intervention of behaviour problems aimed at prevention.[46]

Understanding kinship networks is an essential part of affirming identity and preventing disconnection for Aboriginal Youth.

The State-wide Aboriginal Mental Health Service (SAMHS) has a lifespan remit. The clinical modelling with recently boosted funding for SAMHS has been completed, with key recruitments occurring. It would be envisaged as essential that a Youth Lead would work closely with the Director of SAMHS to ensure the models were synergistic. This is important for a culturally-responsive Youth Stream and to prevent marginalisation of Aboriginal Youth**.**

Professor Helen Milroy has been appointed to SAMHS and will have a primary role in Youth service development within SAMHS.

Recommendation 23: That culturally inclusive models and pathways for Aboriginal Youth be developed in association with SAMHS.

Recommendation 24: That there is a close collaborative relationship between a Youth Lead/Stream and SAMHS to maximise synergies in the development of Aboriginal Youth Mental Health Services.

3.5.2 Forensic Services:

A separate planning process is required in the development of a Forensic Adolescent, Youth Mental Health Service. The requirement of a secure forensic psychiatric facility for adolescents in WA has long been recognised by forensic services and more recently articulated by other agencies.[47] [48]

Studies of the prevalence of mental health problems in juvenile justice populations are limited in number and are difficult to undertake.[49] Rates of mental disorder are particularly high in children and teenagers who offend.

[44] Swan, P & Raphael, B. (1995). *Ways Forward: National Aboriginal and Torres Strait Islander mental health policy: National Consultancy Report.* Canberra: AGPS.
[45] Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J. *et al*(2005). *The West Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people.* Perth: Curtain University of Technology and Telethon Institute for Child Health Research.
[46]Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J. *et al*(2005). *The West Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people.* Perth: Curtain University of Technology and Telethon Institute for Child Health Research.
[47]Psychiatrically disturbed adolescent offenders working party (1999). Business Case for Young offenders Inpatient Unit.
[48]Department of Corrective services (2010). *Making a positive difference in the lives of Young people in Youth Custodial Services*. Department for Corrective Services, WA.
[49]Vermeiren, R., Clippele, A. & Deboutte, D. (2000). *A descriptive study of Flemish delinquent adolescents*. Journal of Adolescence, 23, 277-285

Aboriginal and non-Aboriginal adolescents on remand experience poorer physical and mental health, higher rates of suicidal ideation and behaviour, greater family adversity, poorer school attendance and worse health related quality of life than those in the community.[50] Adolescents on remand therefore experience a wide range of health, educational and social problems, 50% cease living with their parents and no longer attend school. It is clear that there is substantial continuity of psychiatric problems from childhood to adulthood, with conduct disorder being most significant. This group should be considered a high priority if the path towards later problem behaviours and psychiatric problems in adulthood is to be averted.[51]

Overall the domains of mental disorder most relevant to juvenile justice populations are:

- Mood disorders, including major depression and bipolar disorders
- Anxiety disorders and post-traumatic stress disorder
- Substance-related disorders
- Disruptive behaviour disorders such as attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder
- Psychoses such as schizophrenia (also including adolescent precursors of psychotic conditions that can include a prodromal stage featuring many of the symptoms of other disorders)

"*Despite the high prevalence of mental illness in young people entering the justice system, and despite the extremely complex needs of many children and young people facing court, there is no comprehensive mental health service attached to the Children's Court, or any comprehensive process for the identification or assessment of children and young people with underlying mental health problems."* [52]

Recommendation 21: That children and young people appearing before the children's court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services. (Taken from *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia* p.80 Recommendation 19).

There needs to be a move towards better access to health, education, housing and social care, substance misuse services, and forensic mental health care for those who offend or who are at risk of offending. Current gaps in the workforce contribute substantially to inadequate responses to the alienation, marginalisation, and social exclusion arising from mental disorder in this challenging set of young people.

Recommendation 22: That a dedicated forensic mental health unit for children and young people be established. (Taken from *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia* p.83 Recommendation 20).

3.5.3. Attention Deficit Hyperactivity Disorders (ADHD) and Related Disorders:

Services for ADHD are a complex planning issue in their own right and highlight the disparity between CAMHS and Adult Services. The Western Australian Stimulant Regulatory Scheme overseen by the Pharmaceutical Services branch of the Department of Health currently defines clear parameters for the prescription of stimulants and requires specialist medical involvement as part of this. Prevalence figures for ADHD are variable depending on source and criteria but in one context are reliably defined by stimulant prescription. For WA in 2009, 18.2 per 1000 15-17 year olds were treated with stimulants for ADHD, 12.0 per 1000 for 18-19 year olds and 11.4 per 1000 for 20-29 year olds.[53]

[50] Sawyer, M.G., Guidolin, M., Schulz, K.L., McGinnes, B., Zubrick, S.R., Baghurst, P.A. (2010). The mental health and well-being of adolescents on remand in Australia. *Australian and New Zealand Journal of Psychiatry 44:*551 559.
[51] Kim-Cohen, J., Caspi, A., Moffitt ,T.E., et al. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Arch Gen Psychiatry **60**:709– 17.
[52] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP
[53] Pharmaceutical Services Branch (2009). *Western Australian Stimulant Regulatory Scheme 2009 Annual Report.* WA, Department of Health.

Services for up to and including 17 year olds are consistently provided both privately by paediatricians and publically within CAMHS and more broadly CAHS services, which also include the tertiary specialist Complex Attention and Hyperactivity Disorder Services in North and South Metro (providing linkages for WACHS). GPs co-prescribe in this model. Service for adults predominantly rests in the private sector with private psychiatrists who work closely with co-prescribing GPs. There is an Adult ADHD Service Planning Committee (commissioned by the MHORC) currently drafting a framework for public Adult ADHD services. This framework will need to address both the local access as well as tertiary specialist needs for individuals with ADHD as adults.

ADHD fits very well within a Youth model as an indicative and illustrative disorder, with the associated often complex co-morbidities and given that it bridges across childhood into adult life. Transition processes between CAMHS and public Adult Mental Health services for the ongoing management of ADHD and related disorders are currently non-existent. A comprehensive Youth Service would require the priority clarification of public sector transition options within Adult Mental Health Services for individuals with ADHD.

Recommendation 25: The development of a comprehensive Youth Stream requires the establishment of a public sector Adult ADHD structure with appropriate youth transition options.

3.5.4 Eating Disorders:

While there are some well-established state-wide services for eating disorders, there is not a comprehensive framework.

Princess Margaret Hospital (PMH) is a state-wide, in-home and community, outpatients, day treatment and inpatient care setting that includes a state-wide training and education centre. These services provide multi-disciplinary care for 8-18 years old, however they do not accept new referrals over the age of 16. In 2010, 49% of patients seen were between 16 and 18 years.

The Centre for Clinical Interventions (CCI) Eating Disorders programme is a public sector specialist outpatient service for individuals with an eating disorder for 16 years and over. Currently CCI is the only public sector provider of specialist services for 18-24yo youth with an eating disorder. CCI provides an outpatient evidence-based treatment for adolescents with anorexia nervosa: Family-Based Therapy; and evidenced-based individual treatment, Enhanced Cognitive Behaviour Therapy, for youth and adults. 62**%** of all referrals into the CCI programme are for youth (16-24yo).There is no public specialist inpatient unit or day program for CCI to refer youth to, when their needs are too complex or severe for outpatient management.

Individuals aged 18 and over can receive treatment for eating disorders through Adult Community Mental Health services. It is very uncommon for individuals with eating disorders to access these services , thus there is little capacity for those services to maintain expertise in this context, and this is a self-perpetuating fragmentation of service to that cohort.

There are eating disorder specialist services within the Private psychiatric sector who do cater for Youth, but there is no formal collaboration with the broader public sector.

The Australian and New Zealand Academy for Eating Disorders (ANZAED) (2007) state that, “treatment of a severe eating disorder is complex and requires multidisciplinary specialist medical, nutritional, nursing and psychological care.” [54] [55]

[54] Australia & New Zealand Academy for Eating Disorders (2007). Position Statement: Inpatient Services for Eating Disorders.
[55] Australia & New Zealand Academy for Eating Disorders (2007). Position Statement: Inpatient Services for Eating Disorders.

The ANZAED endorses the following principle:

The inpatient ward environment is very important to a successful outcome. Patients (and their families) may suffer psychological trauma when treated in inappropriate settings. There are well-recognised problems and risks with:

⇒ Managing patients in high security psychiatric units where the medical difficulties of eating disorders can be overlooked and where their needs may be placed at a lower priority than patients who have greater behavioural disturbance

⇒ Mixing adolescents with adults suffering acute psychosis, the latter who may have severe behavioural disturbance

⇒ Management by professionals unfamiliar with current management and/or the potential for adverse effects of excessively punitive and coercive approaches

3.5.5 Emerging Personality Disorders:

Young people with emerging Personality Disorders struggle to access the care they need from specialist mental health services. Their acute presentations, marked by poor impulse control, deliberate self harm, suicidality and aggression to others are experienced as burdensome in general psychiatric settings. The American Psychiatric Association's evidence-based practice guidelines recommend psychotherapy as the main treatment of Borderline Personality Disorder with pharmacotherapy as an adjunctive component to target symptoms in periods of acute decompensation.[56] This is also reflected In the N.I.C.E guidelines for Borderline and Antisocial Personality Disorders which recommends the establishment of Personality Disorder Services working along psychotherapeutic guidelines.[57]

There have been 24 randomised control trials following Cochrane criteria which establish the efficacy of psychotherapy, with best evidence base for Dialetical Behavioural Therapy, Mentalisation-based psychodynamic therapy, Transference focussed therapy and Schema focussed therapy. There is a significant overlap between treatment models, and considerable agreement exists regarding the principles that should underpin service delivery. Key elements of successful community based personality disorder services include active engagement of young person in their therapy, adherence to an explicit and consistent model of therapy delivered by well trained and supervised staff, with recognition of need for open communication and explicit boundaries. [58] [59]

Recommendation 5: Youth Mental Health Stream to commit to future evidence-based planning for identified "gap" areas including services targeting emerging personality disorders, co-morbidities with ADHD, Intellectual Disability and Pervasive Developmental Disorders and Young people exiting the care of the Department of Child Protection.

3.5.6 Appropriate inpatient beds for Youth:

Professional views internationally have stated that adult inpatient wards are inappropriate for young people particularly in regards to activities, education and training. Often young people report that placement in an adult facility feels isolating and boring, information provided is confusing and often lacks content, staff lack

[56] National Institute for Health and Clinical Excellence (January 2009). *The guidelines manual.* London: National Institute for Health and Clinical Excellence.
[57] American Psychiatric Association Guidelines
[57]Australia & New Zealand Academy for Eating Disorders (2007). Position Statement: Inpatient Services for Eating Disorders.
[57]Australia & New Zealand Academy for Eating Disorders (2007). Position Statement: Inpatient Services for Eating Disorders.
[57] National Institute for Health and Clinical Excellence (January 2009). *The guidelines manual.* London: National Institute for Health and Clinical Excellence.
[57] American Psychiatric Association (2006). *American Psychiatric Association Practice Guidelines for the treatment of psychiatric disorders : Compendium 2006.* American Psychiatric Association.
[58] Gunderson, J.G. (2011). Borderline Personality Disorder. *The New England Journal of Medicine, 364,* 2037-2047.
[59] American Psychiatric Association (2006). *American Psychiatric Association Practice Guidelines for the treatment of psychiatric disorders : Compendium 2006.* American Psychiatric Association.

understanding of the developmental stage, discharge is disorganised and a lack of safety, in some cases physical and sexual abuse has occurred.[60]

In 2010, Western Australia saw 3761 young people aged 16-25 admitted to all (i.e. BAU and Adult) inpatient facilities. This figure does not include multiple admissions by the same individual. Table 1 describes the increase in number of 16-25 year olds, aboriginal/TSI and non-aboriginal, admitted into inpatient facilities from 2006-2010.

Table 1. Number of persons treated in an inpatient facility and total separations for 16-25 year olds, 2006-2010.

	2006	2007	2008	2009	2010
Number of people	3160	3171	3337	3445	3761
Total Separations	5985	5989	5855	5827	5645

Source: Mental Health Information System, Data Integrity Directorate, DOH WA

Total separations describe the number of admissions to inpatient facilities; often this could be the same individual being admitted more than once. Table 2 describes the number of 16-25 year olds treated in an inpatient facility by region between the years 2006-2010.

Table 2. Number of 16-25 year olds treated in an inpatient facility by region, 2006-2010.

	2006	2007	2008	2009	2010
North Metro	1195	1261	1278	1287	1404
South Metro	951	939	1032	1102	1252
South West	244	235	239	249	251
Goldfields	121	108	135	130	117
Great Southern	106	104	110	144	134
Kimberley	140	130	123	183	111
Midwest	111	123	98	117	125
Pilbara	90	66	118	102	109
Wheatbelt	115	117	112	97	138
Other	87	88	92	82	120

Source: Mental Health Information System, Data Integrity Directorate, DOH WA.

Over the last five years there has been a steady increase in young people aged 16-25 being admitted into an inpatient facility. Currently there are limited facilities in WA for those requiring acute inpatient care and more than likely they will be admitted into a facility that does not have a corresponding emergency department nearby. Table 3 describes the average number of public mental health beds occupied and length of stay per year for young people aged 17-24 in Western Australia, by unit name for years 2008 and 2009.

Table 3. Average number of public mental health beds occupied in Adult inpatient units and length of stay for persons aged 17-24 by unit and year 2008 and 2009.

	2008		2009	
	Beds occupied	**Mean LOS**	**Beds occupied**	**Mean LOS**
Swan Valley Centre	3	17	2	11
RPH Ward 2K	3	12	2	10
SCGH Ward D20	4	9	4	8
Armadale Adult Acute MH Unit	5	17	3	12
Joondalup Health Campus Mental Health Unit	6	20	8	18
Mills St Centre Bentley	7	26	10	25
Alma St Centre Fremantle	8	21	9	25
Graylands Hospital	34	47	20	30
Sub Total	**70**	N/A	**58**	N/A

Source: Mental Health Information System, Data Integrity Directorate, DOH WA.

[60] Brodie, I., Goldman, R., Clapton, J. (2011). *Mental Health Service Transitions for Young People*. Social Care Institute for Excellence.

The average length of stay in Western Australia for CAMHS Inpatient Units is approximately 10 days and 11-14 days in Adult Inpatient Units, depending on the type of inpatient unit; the length of stay is usually longer in rehabilitation inpatient services. Approximately 70, 16-24 year olds at any time will be occupying an inpatient bed. This figure also includes the occupancy of CAMHS inpatient beds.

3.5.7 Children in or Exiting DCP Care:

In 2010, there were 3,276 children and young people between the ages of 0-17, in the care of the chief Executive Officer in Western Australia, 45% were Aboriginal. Growth in numbers of children in care is to be expected, with an annual increase of 6.8% since 1998.[61]

Up to 70% of children and young people in care have complex mental health needs, frequently due to the traumatising environments they have experienced. The main factors that are associated the need for out of home care, which also predict significant mental health disturbance, are domestic violence, physical abuse and parental substance abuse. These children and young people have higher rates of multiple and severe disturbances that are often poorly understood; conduct problems, disorganised attachment and disturbance, attention deficit/hyperactivity, trauma-related anxiety which drive them to engage in risk-taking behaviour that require specialist mental health interventions. Children and young people require timely and responsive access to coordinated and holistic services where there is multimodal mental health assessment; access to culturally appropriate interventions from multidisciplinary teams, coordinated health care and service pathways that facilitate equitable access and participation.[62]

Unfortunately, children and young people in care experience significant barriers in accessing effective health care provision, due either to a lack of recognition of mental health difficulties, not meeting eligibility criteria for services or ineffective co-ordination of services. There has been an attempt to redress this by the implementation of health screening for all young children coming into care, with creation of a health plan to be reviewed annually. This includes mental health screening with notion that problems identified will result in referral to DCP psychological service and subsequently as required to CAMHS. The implementation of an across-government Rapid Response framework, has recommended that Rapid Response should include priority access to specific mental health services for children and young people. If implemented effectively, this has huge resource implications, as it will result in large extra demand on an already stretched Child and Adolescent Mental Health Service. If a Youth Mental Health Service is developed, it will also have significant resourcing implications in the future, which will require careful planning.[63]

In addition to the barriers to access and resourcing implications, the age cut-off of 18 for CAMHS and DCP leaves many young people exiting DCP with little or no emotional support for mental health concerns as they would not be eligible for Adult Mental Health Services. This leaves a huge gap in continuity of care for some of Australia's most vulnerable young people.[64] [65]

Collaboration between agencies is required. Information sharing, referral and service pathways and having a shared clinical framework is essential with an emphasis on an integrated holistic service model and developing 'standardised care coordination protocols' between key agencies.[66]

[61] Department for Child Protection (2010). *Department for Child Protection Annual Report 2009-2010.* Government of Western Australia.
[62] Ford , P. (2007). *Review of the Department for Community Development: Review Report.* Department for Community Development.
[63] Ford , P. (2007). *Review of the Department for Community Development: Review Report.* Department for Community Development.
[64] Crawford M (2006). Health of children in out-of-home care: Can we do better? *Journal of Paediatrics and Child Health 42:* 77-78.
[65] Ford , P. (2007). *Review of the Department for Community Development: Review Report.* Department for Community Development.
[66] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

3.5.8 Effective Transition Planning:

Transitions always occur, whether between CAMHS & Youth, CAMHS and Adult or Youth and Adult. Recent UK reports state that only **4%** of transitions are successful for young people transitioning to Adult Mental Health Services, due to differences in intake criteria, service design and difficulties with engagement with a subsequent and unfamiliar service[67] [68]

The National Mental Health Development Unit (2011) published a document outlining recommendations for the transitions of young adults receiving specialist mental health services from CAMHS to AMHS, in the United Kingdom. The focus is on the 16-19 cohort, stating that currently the transition process from CAMHS to Adult Mental Health is poorly planned and managed, resulting in this age group either not receiving appropriate services or falling through the gaps. [69] [70] The *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia* from the Commissioner for Children and Young People (CCYP) 2011, states that, the transitional process in Western Australia is not adequate in meeting the needs of young people, often transitions are abrupt, particularly where the treatment cut-off point is around age rather than developmental need or readiness.[71] The report stipulates that a stronger focus is required on developmental pathways across the age continuum when looking at transitions between services. Table 4 outlines eligibility for specialist mental health services according to age in Western Australia.

Table 4: Eligibility for Mental Health Services according to age.

Service	Age
Infant, Child, Adolescent and Youth Mental Health Community	In most cases to 18 years old
Complex Attention and Hyperactivity Disorder Service	To 18 years
Bentley Adolescent Inpatient Unit and Transition Unit	To 18 years
Ward 4H Princess Margaret Hospital	To 16 years
Assertive Community Intervention Team	To 16 years
Eating Disorders Program PMH (Outpatient and Inpatient)	To 16 years

Source: Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia (2011).

It appears that nationally and internationally CAMHS services face the same issues in transition for Youth aged 16 to 25: rates of drop out of services and ineligibility for a service. When planning for transitions CAMHS, Adult Mental Health Services and service providers, including NGO sectors, must come together. Currently, there is a lack of service coordination and continuity of care between all sectors regarding the 16-25 age group. The CCYP Report states that transition frameworks are particularly important to those young people with complex needs and those who are vulnerable without strong family support networks, such as young people in the care of the Department of Child Protection (DCP) who have mental health issues.[72]

Key **barriers to transition** are;

- ⇒ There are different inclusion/exclusion criteria between Adult Mental Health Services and CAMHS. Often young people that CAMHS would consider requiring on-going therapeutic input, do not always meet the criteria for Adult services and so have reduced access to a full range of therapeutic options. For example, ADHD.
- ⇒ There are often no clear agreed procedures or therapeutic approaches to transition for young people moving between CAMHS and Adult Services.
- ⇒ The Adult clinical model focuses less on development and systems and more on individuals. This has

[67] Appleton, S., Pugh, K. (2011). *Planning Mental Health Services for Young Adults-Improving Transition: A Resource for Health and Social Care Commissioners.* United Kingdom: National Mental Health Development Unit.
[68] Brodie, I., Goldman, R., Clapton, J. (2011). Mental Health Service Transitions for Young People. UK: Social Care Institute for Excellence.
[69] Appleton, S., Pugh, K. (2011). *Planning Mental Health Services for Young Adults-Improving Transition: A Resource for Health and Social Care Commissioners.* United Kingdom: National Mental Health Development Unit.
[70] Brodie, I., Goldman, R., Clapton, J. (2011). Mental Health Service Transitions for Young People. UK: Social Care Institute for Excellence.
[71] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP
[72] Commissioner for Children and Young People (2011). *Report of the Inquiry into the Mental Health and Well-being of Children and Young People In Western Australia.* Western Australia: CCYP

implications for treatment effectiveness in Youth.

⇒ Young people require outreach and assertive community follow-up and liaison with other youth services. Clinic-based intervention is not always most therapeutic for this age group.

⇒ Financial factors/difficulty in accessing resources.

⇒ Varying, sometimes conflicting views of needs among young people, families and providers.

⇒ Poor intra-agency coordination.

⇒ Lack of planning and lack of appropriate adult specialists with Youth training.[73]

Recommendation 11: Care-coordination is the recommended framework for shared care between all specialist mental health services, public sector agencies and Non-government organisations. Formal Care Coordination must be implemented at the outset of Youth Stream development.

A number of transition models are available and no one model has been researched for its long term effectiveness. Table 5 describes models outlined in the National Mental Health Development Unit (2011).

Table 5: Models for Transition as outlined in the National Mental Health Development Unit Document, 2011.

Model Type	Model Features
Specific Transition Services	At least one or a combination of; - A designated transition service. - A designated transition team within a service. - Designated staff trained in adolescent work seconded to Adult teams.
Designated Liaison/Link Posts and Teams	Comprise at least two clinicians, often community psychiatric nurses with expertise in adolescents, who carry out assessments and face to face work. They work jointly across CAMHS and Adult MHS
Age Appropriateness and flexibility of Service Access	Maintain flexibility around age boundaries. Services are age appropriate.
Disorder specific services	Services that span adolescence to adulthood, covering the divide between CAMHS and Adult MHS. For example; Early Episode Psychosis.
Whole System Approach to wellbeing, recovery and partnership	Young people have access to a range of services to enhance their lives Commissioners establish partnerships with a range of statutory and non-statutory agencies in order to provide a range of cost-effective services.
Improving transition for young people who do not meet the criteria for Adult Mental Health services but for whom there is still a need for graduated support.	- Extending Tier 3 service provision to young people past the age of 18 to 25 years. This allows professionals to continue service provision to young people on their case load up to 25 years. This may use an assertive outreach style of engagement.

Source: National Mental Health Development Unit (2011).

Recommendation 10: Planning transitions for Youth is essential and structured transition planning needs to be a standard part of care.

4. Service Delivery Framework

4.1 Roles of Tier Services

NGO's and private services, particularly General Practitioners provide Tier one and Tier Two mental health services in Western Australia, and are an essential part of services responding to the mental health needs of Youth.

[73] Appleton, S., Pugh, K. (2011). Planning Mental Health Services for Young Adults-Improving Transition: A Resource for Health and Social Care Commissioners. United Kingdom. National Mental Health Development Unit

Figure 5. Outline key roles, responsibilities and service providers associated with Tier 1, 2, 3 and 4.

Tier One

Services at this level are provided by non mental health specialists who are in a position to:

- Provide developmental opportunities that promote mental health and wellbeing
- Initiate prevention strategies
- Identifying mental health problems and disorders early
- Refer children with symptoms of mental health problems and disorders for assessment
- Offer general advice
- In certain cases provide treatment
- Manage cases

Types of services and service providers can include:

- Childcare
- Pre schools
- Schools
- General practice
- Paediatric services
- Community health services (incorporating a range of health professionals)
- Youth services
- Department for Community Development
- Disability Services Commission
- Juvenile justice services
- Accommodation services
- Other non government services

Tier Two

Key roles and responsibilities can include:

- Identification of children with mental health problems and disorders
- Assessment of less complex, severe and persistent cases.
- Provision of treatment for problems not complicated by co-morbidity or serious risk factors
- Case management
- Training and secondary consultation to tier 1 personnel
- Outreach services to identify severe or complex needs which require more specialist intervention but where specialist services are not accessible
- Counselling, liaison and advocacy
- Screening and referral to tier 3 and 4 services

Types of services and service providers can include:

- Paediatricians
- Mental health practitioners
- Educational services
- Adult mental health services
- General practitioners with specific skills
- Department for Community Development
- Disability Services Commission
- Juvenile Justice Services

Tier Three

Key roles and responsibilities can include:

- Provision of emergency services
- Assessment and provision of some aspects of treatment for complex, persistent and more severe cases
- Case management of multi-modal service provision
- Screening and referral to tier 4
- Training and consultation with personnel in tier 1 and 2 services
- Under taking research and development programs

Types of services and service providers can include:

- A multidisciplinary team working in a community clinic or outpatient service
- Child and Adolescent Mental Health Services
- Specialised paediatric services
- Educational psychological services
- Emergency services
- Adult Mental Health Services
- Other specialists as required

Tier Four

Key roles and responsibilities can include:

- Complex assessment
- Treatment of the most complex, persistent or severe cases
- Contribution to services, training and consultation at tiers 1,2 and 3
- Undertaking research and development programs

Types of services can include:

- Highly specialised community teams.
- Specialist treatment programs.
- Inpatient services for older children and young people who are severely ill or suicidal.

Source: Infancy to Young Adulthood: A Mental Health Policy for Western Australia (2001).

Two well established youth mental health specific Tier 1 and Tier 2 services are headspace and Youth focus.

4.1.2 headspace

There are currently three operational headspace sites in WA (Fremantle, Albany and Broome) with a fourth site recently announced that is to be based in the North Metropolitan Region of Perth. Tier one and Tier two services are the primary referral pathways into specialist mental health services.

headspace is funded by the Australian Government and the Department of Health and Ageing under the Youth Mental Health Initiative Program. It provides early intervention care and services for a range of mental health issues to 12-25 year olds. However Headspace is designed to deliver services for mild to moderate mental health issues and requires specialist mental health service support for those young people with serious mental health issues. The aim of headspace is to intervene and prevent long-term adverse effects, by providing face to face services and a gateway to specialist care. [74] Currently, headspace has 30 centres operating nationally and from July 2009-June 2010 provided services to 23,000 young people with 154,237 individual occasions of service.

The Federal Government has allocated from 2011, $197 million over five years to 30 new headspace centres, bringing the total number of sites to 90 and achieving national coverage. Once these sites are established headspace is expected to aid up to 72,000 young people annually. [75]

The headspace model endorses that all of the consortia adopt standard clinical practices and documentation. If the public sector is providing services in conjunction with them, the lead headspace agency in the consortium becomes lead agency in these public-NGO collaborations.

4.1.3 Youth Focus

Youth Focus has been allocated $1.2 million by the WA state government to provide more counsellors to meet increased demand of their service. Youth Focus provides a variety of prevention and early intervention services that focus on supporting young people and their families to overcome the issues that are associated with suicide, depression and self harm.[76] Similarly to headspace, Youth Focus requires clearly identified referral pathways to specialist mental health services for Youth suffering with mental health issues.

Recommendation 14: Maintain and strengthen links between Youth Specialist Mental Health Services, Headspace and Youth Focus.

4.2 Geographical Issues

An important challenging factor that needs to be considered in terms of planning for services to Youth in Western Australia is the wide urban sprawl, relative lack of population density in metropolitan areas and huge distances and scarcity of resources in regional and remote Western Australia. It was recognised in the Youth Mental Health Working Group that specialist Youth mental health services should ultimately be developed in each district health service to maximise potential for access by youth. However it was also acknowledged that to respond to the clearly identified needs of Youth, and create a fundamental cultural shift in the model of service delivery to this age group, it was important to pragmatically plan to build a new service in stages, which may necessitate initially more centralised services.

[74] headspace National Youth Mental Health foundation Ltd (2010). *headspace Annual Report 2010.* Australian Government Department of Health and Aging.
[75] Commonwealth of Australia (2011). Budget 2011-2012: *Delivering better hospitals, mental health and health services*. ACT: Australian Government.
[76] Government of Western Australia (2011). *Budget Overview 2011-12: Supporting our Community, Building our State.* Government of Western Australia.

It was recognised that a major challenge in major service delivery reform is the need to build a critical mass of clinical expertise to create a sustainable model, with a commitment to program fidelity and limiting of clinical variation.

The outcome of the tension between access, creating centres of clinical excellence and the maintenance of program fidelity will in part be determined by the funding available and the purchasing intentions of the Mental Health Commission.

4.3 Service Models

There are multiple models of mental health service delivery for youth across Australia. Among the senior clinicians in the Youth Mental Health Working Group, a diverse range of opinions were expressed regarding the best model and process for achieving best outcomes for Youth. There is no single agreed best practice model identified nationally or internationally. It is worthy of note that in Victoria alone, depending on the Area Health Service, there are four different models of service delivery;

- EPPIC/Orygen Western Melbourne which co-exists with CAMHS 0-18
- Two CAMHS demonstration sites for 0-25 year olds: tendered successfully by the Grampians and Alfred Health services, which have recently been established with planning for evaluation
- Melbourne Southern Health Area Health Service has recently reconfigured with the development of Early in Life Program: Perinatal to 25 year olds service supported by a youth specialist inpatient unit (reconfigured Adult inpatient unit)
- Eastern Health Services; Adult Programs providing Early Episode Psychosis (EEP) Services and CAMHS providing services to all other mental health disorders to ages 0-25

It is important to note that the CAMHS demonstration sites have not yet been evaluated and that Orygen are not as yet capturing all disorders.

The Victorian Strategy Implementation Plan 2009-2011 outlines preparation for the reform of Child and Youth mental health services to provide services to ages 0-25. Recommendations for young people aged 12-25 years old are: key target areas of early intervention and identification, mental health support to specific groups of highly vulnerable young people and strengthening support for families where there is risk related to mental health and drug and alcohol problems.[77]

Goals for the Victorian Youth Specialist Mental Health Services:*

- Reduced prevalence and severity of mental health problems, and associated disability and disadvantage in young people aged 12-25 years
- Improved mental health outcomes for youth justice clients with emerging or existing mental health problems by intervening earlier
- Improved mental health outcomes for children and young people with autism spectrum disorder and co-occurring mental health problems
- Reduced long-term impact of eating disorders on young people
- Improved outcomes for young people with mental health problems experiencing homelessness, including those with co-occurring mental health and alcohol or drug issues (dual-diagnosis)

** Source: Victorian Mental Health Reform Strategy 2009-2017: Implementation Plan 2009-2011.*

Recommendation 12: Implement the goals that Victorian Youth Specialist Mental Health Services propose for 16-24 year olds in Western Australia (noting change to age range).

[77] Department of Human Services (2010).*Victorian Mental Health Reform Strategy 2009-2017: Implementation Plan 2009-2011*. Mental Health and Drugs Division, Department of Human Services. Melbourne

5. Current Funding Environment

In the 2011-2012 Commonwealth budget, the Federal Government is allocating $481 million to significantly expand effective models of mental health care that are appropriate to young people who are not always comfortable with accessing mainstream services.[78] Table 6 outlines the areas of mental health that will be receiving funding over the next four years.

Table 6. 2011-2012 Commonwealth budget for children, families and youth mental health over the next four years.

Strengthening the focus on the mental health needs of children, families and youth						
Summary of measures	**2011-12 $m**	**2012-13 $m**	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**5 Year total (from 2011-12) $m**
Early Psychosis Prevention and Intervention Centre Model-further expansion	2.9	23	44.9	70.8	80.8	222.4
Expansion of Youth Mental Health	13.5	22.5	34.9	61.4	65	197.3
Expanding community mental Health Services-40 additional Family Mental Health Services	2.3	8.9	13.3	18	18.5	61
Health and wellbeing checks for three year olds	1	6.7	0.9	1.3	1.1	11
Subtotal	**19.7**	**61**	**94**	**151.6**	**165.5**	**491.7**

Source: Commonwealth of Australia (2011). *Budget 2011-2012: Delivering better hospitals, mental health and health services*. Australian Government

The 2011-2012 Commonwealth Budget has allocated $222 million over five years to enable the opening of up to 12 youth psychosis sites in Australia, based on the Early Psychosis Prevention and Intervention Centre (EPPIC) Model. This will bring the total number of sites up to 16 and an estimated additional 11,000 young people in Australia will receive intervention per year.[79] The EPPIC model is described further in 5.1.

The 2011-12 State Budget for Western Australia has allocated funding to the Mental Health Commission to resource:

- ⇒ The Mental Health 2020 Strategic Policy to guide planning and implementation of priority mental health reforms over the next 10 years. This will emphasise the importance of person centred services and supports, connected whole-of-government and community approaches, and provide balanced investment in areas such as early intervention and community support. The commission observes the requirement for targeted investment in areas such a planning, workforce and quality
- ⇒ Ongoing implementation of the Western Australian Suicide Prevention Strategy 2009-2013
- ⇒ Funding for Youth Focus to enable them to meet increasing demand for service
- ⇒ $500,000 to Lifeline WA to increase telephone counsellors by at least 50% over the next 12 months[80]

5.1 The EPPIC Model

The EPPIC model was developed by Professor Pat McGorry's team and Orygen Youth Health for young people aged 12-25 with emerging severe mental illnesses. Orygen is Melbourne-based. Since the model's establishment in 1992, EPPIC has become a best practice model of care for early psychosis.

EPPIC provides three core functions:

- ⇒ **Early Detection** of young people with emerging severe mental illness
- ⇒ **Acute Care** following a crisis episode of emerging severe mental illness and expert multimodal interventions

[78] Commonwealth of Australia (2011). *Budget 2011-2012: Delivering better hospitals, mental health and health services*. Australian Government
[79] Commonwealth of Australia (2011). *Budget 2011-2012: Delivering better hospitals, mental health and health services*. Australian Government
[80] Government of Western Australia (2011). *Budget Overview 2011-12: Supporting our Community, Building our State.* Government of Western Australia.

⇒ **Recovery** to enable a young person to regain their social, academic and career trajectory during the "critical period" of the early years following the first onset of illness [81]

The minimum features required of an EPPIC service are:

⇒ Provision of specialist early psychosis expertise that combines community awareness
⇒ Screening and prevention programs
⇒ Youth participation and peer support
⇒ Family programs and peer support
⇒ Case management
⇒ Medical treatments
⇒ Psychological treatments
⇒ Social recovery programs
⇒ Home based care and assessment
⇒ Mobile outreach
⇒ Streamed youth-friendly inpatient care

Orygen offers additional services to the above; providing specialist expertise in mood, personality and substance use disorders, and community residential facilities to offer young clients "step up/down" beds to reduce the risk of homelessness.[82]

McGorry (2010) recommends that if a new EPPIC service would be delivered to the same standard as Orygen the average annual budget per service once fully operational is $20 million. McGorry (2010) recommends a four year period is required for an EPPIC service to be fully operational. In this first four years an operational budget of $49 million is identified. In addition, each EPPIC centre should allow for a dedicated inpatient unit which requires a capital allocation of $19 million. Therefore, over the first four years approximately $68 million is required to fund each EPPIC program.[83] In Western Australia a centralised EPPIC service such as this would also require additional funding for transport and family accommodation.

It was noted by rural representation in the Youth MH Working Group that if a centralised EPPIC model were to be responsive to rural needs it would:

⇒ Require a broad focus (i.e. criteria not too restrictive)
⇒ Require a senior rural transition/ Consultation Liaison role within the staffing make-up
⇒ Consideration of prioritising approximately 25% beds for rural admissions
⇒ Include family accommodation or funding for this
⇒ Ensure PATS guidelines enable multiple family members to travel to the central hub
⇒ Require access to specialised after-hours advice
⇒ Ongoing training using video conference consistent with the State-wide Clinical Services Enhancement Program (SCSEP) model

[81] http://www.patmcgorry.com.au/sites/all/files/EPPICchecklist.pdf
[82] http://www.patmcgorry.com.au/sites/all/files/EPPICchecklist.pdf
[83] http://www.patmcgorry.com.au/sites/all/files/EPPICcostingNov_1.pdf

6. Youth Mental Health Stream for Western Australia

This section draws together those specific key recommendations noted above relating to the development steps for a Youth Mental Health Stream.

These recommendations from the Working Group evolved from guidelines in international and national literature, the current funding environment, the current topography of the WA Mental Health landscape, and consideration of pragmatic steps which could result in a functional Youth Mental Health Stream.

It is recognised that as part of all of the recommended strategies, establishment of culturally secure practice for Aboriginal young people is included. This will require benchmarking of Aboriginal Youth mental health workers to be employed in each service area.

6.1 Establish a Youth Mental Health Lead

Recommendation 1: A dedicated position for Youth Mental Health Lead is created to coordinate and lead the design of a supra-regional Youth Specialist Mental Health Stream.

The establishment of the Youth Mental Health Lead is an essential first step to allow dedicated time for effective future planning for a Youth Mental Health Stream. The sole reliance on a working group will not provide the resource and traction required for the major challenge of Youth Stream development.

A Youth MH Lead and Stream should be supra-regional. Creating a single supra-regional stream will assist in ensuring the development of program fidelity and limiting clinical variation. A major risk in a Youth mental health stream being governed by district or area mental health services is the evolution of different clinical models of practice and culture. It is acknowledged that some mature local services have very good model fidelity but this is difficult to generalise. Whilst the clinical governance would sit with the Stream and the clinical remit state-wide, the Stream itself might initially be corporately overseen by one Area Health Service.

The Youth Mental Health Lead would require administrative and project officer support to function optimally. This position should facilitate engagement of clinicians and key management positions (government and other non-government organisations) in service planning and drive the development of specific training necessary for capacity building in staff.

It is recognised that a new model of service delivery will require strong leadership to be successful, with a considerable shift in service culture, enhancement and reorganisation of resources to create a viable, sustainable Youth-specific mental health service, which is built on and has ongoing capacity to forge strong links with both CAMHS and Adult MHS. This position will drive the delivery of equitable and responsive care for Youth in WACHS. The Youth Mental Health Lead would have a strong collaborative relationship with the Director of SAMHS.

6.2 Establish a Specialist Youth Mental Health Stream

Figure 6 outlines the recommended features for a Youth specialist mental health stream as discussed in the Youth Mental Health Working Group.

Figure 6. Recommended features for a Youth Specific Stream

Recommended features for a Youth Specific Stream

- Recognises the important balance among a developmentally informed, systemic and individually focussed model of service delivery
- Staffed by both CAMHS and Adult Mental Health Service clinicians that have a specific interest in youth
- Staff are equipped with clinical skills to treat all emerging severe mental health disorders affecting this cohort, including those with dual diagnosis
- Management clearly aligned with principles of Secondary Prevention and Recovery
- Dedicated, purpose built inpatient facilities
- Largely community-based care, including an outpatient and day program
- Specialist outreach programs and emergency response teams
- Youth residential accommodation options
- A close relationship with the Forensic community and inpatient mental health services
- Integration with all agencies with youth, including local government, government and non-government services

The question of governance of the Youth Mental Health Stream was discussed at length in the Youth Mental Health Working Group. All felt that it was a significant opportunity for service re-design and reform. The current resources and capacity of CAMHS and Adult MHS were considered in forming the recommendation that Adult Mental Health Services assume the governance for a Youth Mental Health Stream, which would firstly focus on providing enhanced services for Youth with early psychosis.

Recommendation 2: Create Specialist Youth Mental Health Stream as a discretely governed supra - regional stream within Adult Mental Health to ensure program fidelity.

YouthLink and Youth-Reach South, successful functioning Tier 4 specialist mental health services, should be brought into the stream as assertive outreach teams. These teams have valuable clinical experience and expertise at engaging high risk youth and providing youth-friendly services, which can be incorporated and built upon in Youth Mental Health Stream.

If Youth Stream and Early Intervention Psychosis teams are successfully established, further planning may be considered regarding the optimal management of other disorders in the 16-24 cohort in the metropolitan, rural and remote areas. This would require a longer-term planning process.

Rural and Remote service enhancement requires:

⇒ Additional funds to enhance and standardise youth counsellor program. (Consider Peel model for template for standardisation)
⇒ All programs to have two youth counsellors, one of which is an indigenous position
⇒ All positions to have dual –diagnosis skill set as part of role
⇒ Youth Counsellor Program to be established in all seven of the WACHS regions

Recommendation 16: **Enhance and seed new initiatives for Youth mental health in rural and remote areas.**

6.3 Early Intervention in Psychosis (EIP) Enhancement

To enhance EIP services in Western Australia it is recommended that the State match the Federal funding initiative announced in the 2011-12 budget. It is envisaged this would allow the establishment of two comprehensive EPPIC services in the metropolitan area, placed to maximise access by Youth, close to other youth-friendly services. Each of these would have formal links with identified Rural and Remote Districts, with use of tele-psychiatry to facilitate support, consultation and co-management.

As stated the geography and low population density of Western Australia pose specific challenges in designing services that are economically sustainable yet facilitate access. The central EPPIC teams would provide centres of excellence with training, supervision, consultation and joint models of care with NGOs. The clinical model of care needs further development in consultation with the sector by the Youth Mental Health Lead, informed by the funding available and the purchasing intentions of the Mental Health Commission.

Recommendation 7: Early Intervention in Psychosis (EIP) is seen as a natural first step in the development of a Youth Stream. The State Government match the funding that the Federal Government has allocated to the development of EIP programs as a first step in the development of a WA Specialist Youth Mental Health Stream.

Recommendation 8: That the initial Youth Stream focus be EIP and existing Youth services-clients aged 16-18 that do not meet the eligibility criteria for EIP, YouthReach South and YouthLink will continue to have services provided by CAMHS, whilst clients aged 18-25 will continue to have services provided by Adult Mental Health Services.

There was not consensus around the model. From a broader system perspective the majority of the group perceived better capacity to build clinical expertise and maintain fidelity in having one overarching Youth stream manage a specialist EIP program. However, it has been identified that some well developed local services have clear capacity to maintain program integrity embedded at a local level and this was the strongly preferred approach of some group participants. The further finalisation of this model would be a role for the Youth Lead.

It is identified that pursuing the announced Federal funding may require action prior to the establishment or functionality of a Youth Stream.

Existing clients aged 16-18 that are not eligible for access to Early Intervention Psychosis, YouthReach South and YouthLink will be required to remain with CAMHS. Those clients over the age of 18 will be required to remain in Adult Mental Health Services.

All 16-18 year olds presenting with possible First Episode Psychosis should receive a joint mental health assessment from CAMHS and EPPIC to ensure best quality of service to clients and their families.

Functional aspects are essential to the long term recovery of a young person experiencing any mental illness but particularly Youth experiencing their first episode of psychosis.[84] Psychosis seriously impacts an individuals ability to maintain their usual commitments to employment or study due to loss of functioning for the individual and their family. Absence from employment and other functional roles are likely to contribute to exacerbation of disability suffered and be a risk factor for relapse.[85] 90% of Youth attending EPPIC in Victoria make symptomatic recoveries however, only half make a functional recovery.[86]

[84] Fraser, R., Berger, G., Killackey, E., McGorry, P (2006). Emerging psychosis in young people-Part 3: Key issues for prolonged recovery. *Australian Family Physician, 35,* 329-333

[85] Fraser, R., Berger, G., Killackey, E., McGorry, P (2006). Emerging psychosis in young people-Part 3: Key issues for prolonged recovery. *Australian Family Physician, 35,* 329-333

[86] Fraser, R., Berger, G., Killackey, E., McGorry, P (2006). Emerging psychosis in young people-Part 3: Key issues for prolonged recovery. *Australian Family Physician, 35,* 329-333

Inclusion of education and vocational interventions to promote functional recovery is essential within EIP. One prominent model that supports the reintegration into vocational or educational activities is the Individual Placement and Support (IPS) Model. This focuses on helping people return to competitive employment opposed to sheltered work and is community-based rather than being based at a mental health service.[87] Supported employment requires a mental health worker dedicated to vocational recovery that will work with clients that would like to return to work or education.[88] [89] EPPIC services in Victoria are currently trialling an Employment Program that is embedded within their service and encompasses the IPS Model. There is a full time Youth Employment Consultant who works with clients for a period of 6 months to place them into employment or educational activities. This position also provides intensive post-placement support to assist the young person in maintaining employment.[90] In the case where services cannot fund an employment consultant, working collaboratively with NGOs that can provide this service is essential for the functional aspects of recovery.[91]

Recommendation 15: Embed vocational training into EPPIC as part of a Functional Recovery approach.

6.4 Partnerships with NGOs

Collaboration and care coordination partnerships between the public sector and Non-government Organisations are integral components for a Youth specialist mental health service. Non-Government Organisations enhance mental health services. They are a primary referral source, gateway services and services to which clients are discharged and play a key role in the recovery model. Both the public sector and NGOs have a range of skills that they can provide each other. The public sector brings specialist skills to the community, providing a comprehensive capacity to assess a client's difficulties and what a client requires, and have an obligation to work within partnerships that support capacity building and develop clinical pathways. In partnership, we need to focus on the whole life span and services need to be integrated to enhance lives.

With certain conditions, the public sector and NGOs can deliver services as fully integrated partners. For example, Peel and Rockingham Kwinana (PaRK) Early Episode Psychosis works with a NGO where both services have the capacity to carry out certain roles in common: carrying out mental state examinations and basic cognitive assessments. It is clear in this partnership that the public service is the lead in clinical governance. In other situations where NGOs may not be as able to have an equal partnership, it is recommended that the NGO focuses on the psycho-social aspects of treatment and the specialist mental health service focuses on assessment and clinical treatment. Currently, it is the experience of public mental health services working with Youth in WA that the majority of NGOs express a need for assistance with assessment and acute response from the public sector.

One suggested model is for both public sector and NGOs to be under the same governance structure. In this model the public sector would provide supervision, training and capacity building in a targeted way. It is recognised that to establish fully integrated level of partnership, such as the PaRK model, there would need to be significant support from the public sector. There is a risk that if only the traditional model continues; where NGOs and specialist mental health services provide different set of services, then the benefits of an integrated model will be lost. Such partnerships require careful negotiation.

Another indicated model is the system of care model as identified in the WA Infancy to Young Adulthood Policy. In this approach, specialist mental health services focus on clinical aspects and NGOs provide supportive psycho-

[87] http://www.eppic.org.au/functional-recovery
[88] http://www.eppic.org.au/functional-recovery
[89] Fraser, R., Berger, G., Killackey, E., McGorry, P (2006). Emerging psychosis in young people-Part 3: Key issues for prolonged recovery. *Australian Family Physician, 35,* 329-333
[90] http://www.eppic.org.au/employment-program
[91] Fraser, R., Berger, G., Killackey, E., McGorry, P (2006). Emerging psychosis in young people-Part 3: Key issues for prolonged recovery. *Australian Family Physician, 35,* 329-333

social services. This model is strongly indicated for young people suffering complex trauma as their primary presentation. In this case it is important to build in care co-ordination, and it is recommended the specialist mental health service work in partnership with NGOs with Health taking the lead in clinical governance. [92] An example similar to this is the Milwaukee Model where the Youth Mental Health Service would be the responsible governing body and then might broker out case management. This would allow for partnership with private psychologists, psychiatrists and social workers.

Recommendation 13: Form collaborative partnerships with NGOs, with specialist mental health maintaining responsibility and leadership in clinical governance, to optimise and strengthen quality of care delivered to youth with complex mental health issues.

6.5 Training

The Youth Lead will be responsible for driving the process of development and implementation of a youth-specific training program that focuses on a holistic, developmentally appropriate systemic model of care. This would involve families and carers, with the goal of secondary prevention. There would need to be an identified cohort of existing staff from Adult and CAMHS to train, creating a critical mass of Youth Mental Health Clinicians, commencing with Early Episode Psychosis. Clinicians require competencies including dealing with trauma, alcohol and other drugs, psychosis, cultural sensitivity, emerging personality disorders and developmental systems.

Recommendation 6: Develop a training Framework that encompasses developmental systems, trauma, emerging personality disorders, psychosis, alcohol and other drug, and cultural sensitivity.

6.6 Youth Specific Inpatient Unit

Western Australia needs to commence planning for a Youth Specific Inpatient Unit to support EPPIC hubs.

Recommendation 17: Develop a new Youth Inpatient Unit(s) on a teaching hospital site(s) with access to a youth-friendly emergency department, and specialist medical care, prior to the shift in Bentley Adolescent Unit beds to the New Children's Hospital, 2015.

Royal Perth Hospital Emergency Department recommends that a designated area/ward for young people awaiting assessment/admission is created. Often emergency departments are adult domains; occupied by authority figures and expose young people to unpredictable, inappropriate and sometimes violent behaviours from adult patients. There is an absence of youth positions that focus on young people and a lack of supervision in waiting rooms; young people are often left alone to wait in the main waiting room once triaged. This is a highly unpredictable environment often occupied by predatory and aggressive patients that causes additional fear and stress to young people and their families when presenting to the Emergency Department.

Recommendation 18: Establish a youth friendly area in the associated emergency dept depending on the site of Youth Inpatient Unit.

Specialised Eating Disorder services for Youth need to be developed as presently there are limited services for those over the age of 16. Princess Margaret Hospital (PMH) psychological medicine Eating Disorder Program

[92] Mental Health Division (2001). *Infancy to Young Adulthood: A Mental Health Policy for Western Australia.* Department of Health: Western Australia.

provides inpatient care for patients under 16 on medical wards with in-reach from a specialist multi-disciplinary team and will provide service up until 18 years of age to existing patients. Hollywood Private Hospital provides inpatient care for ages 16 and above and all Mental Health Units provide general psychiatric care with medical support for young people suffering eating disorders, however, these services are ill-equipped to persevere with treatment resistant anorexia nervosa and it's medical complications.

Recommendation 19: Develop a specific inpatient unit for treatment of severe Eating Disorders for 16-25 year olds due to the highly specialised medical and psychological treatments required.

In addition to a youth specific inpatient unit, enhancement of emergency departments and an eating disorders ward, an increase in supported crisis accommodation services for young people with mental health issues is required. There is immense difficulty in placing young people with mental health issues requiring supported accommodation. This can precipitate a psychiatric admission which would not have been required had youth supported accommodation been available.

Recommendation 20: Increase in supported crisis accommodation services for Youth to be incorporated in future planning.


Delivering a Healthy WA