Government of Western Australia
North Metropolitan Health Service
Mental Health, Public Health and Dental Services

Youth Mental Health

YouthLink and YouthReach South

MODEL OF CARE

Endorsed on 31 March 2020 by:

YMH Steering Committee
Version 2.0 FINAL

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Contents

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This Model of Care will be formally reviewed 12 months from endorsement. Comments and feedback can be made at any time to the Director of Youth Mental Health and Youth Mental Health Steering Committee.

Summary

YouthLink and YouthReach South provide specialist mental health services to young people:

- aged 13-24 years
- with complex, and/or persistent and/or severe mental health difficulties, or experiencing significant symptoms and at-risk of developing a long term mental illness
- who require Tier 4 youth mental health services and are experiencing significant barriers in accessing other mental health services appropriate to need, such as homelessness, transience, and/or limited support networks.
- who are help accepting and consenting to mental health treatment and support
- primarily residing in the Perth metropolitan area.

Youth Mental Health recognises that young people aged 13-15 who are not homeless or transient, and those with Tier 3 mental health difficulties, are most appropriately serviced by Child and Adolescent Mental Health Services (CAMHS).

Youth Mental Health recognises that marginalised groups commonly experience complex psychosocial problems and are at higher risk of developing a mental illness. These may include but are not exclusive to ATSI, LGBTI, CaLD refugee, and homeless young people. Homelessness includes primary, secondary or tertiary homelessness, and is inclusive of those young people who are unsafe and at-risk within their current living situation.
YouthLink and YouthReach South provide a welcoming, trauma-informed, flexible approach with assertive case management and community outreach to support the engagement and retention of young people in the assessment and treatment of their mental health problems. The services aim to improve the functioning and quality of life for young people with complex mental health needs.

YouthLink and YouthReach South operate Monday to Friday 8:30am–4:30pm. Outside these hours, incoming callers are provided with names and contact numbers for emergency services. YouthLink and YouthReach South do not provide acute or urgent responses to unknown clients in crisis. Young people who are not known to the service who require acute mental health services will be directed to other appropriate services.

YouthLink is located at 223 James Street, Northbridge. YouthReach South is located within the Cockburn Youth Centre, Level 3, 25 Wentworth Parade, Cockburn. Referrals and inquiries can be made by phone to 1300 362 569. Clinical services are delivered in a variety of settings to best support the young person's needs and/or stage of engagement, including home, community organisations, inpatient settings, the services' offices.

YouthLink and YouthReach South have a capped capacity for client services within their target population. On occasions the services may operate with a waitlist.

Whilst the composition of each team varies, both YouthLink and YouthReach South are staffed and supported by a multidisciplinary team, consisting of clinical psychologists, social workers, clinical nurse specialists, Aboriginal Mental Health Professionals and psychiatrists.

Length of treatment is dependent on the young person's need and capacity to use the service appropriately and effectively to effect change. Longer term psychotherapy is indicated for many

young people to address complex trauma histories, and to effect changes in personality organisation and core internal schemas. For other young people, shorter term treatments can be effective in providing stabilisation, reduction in symptoms or positive experience of help-seeking. Discharge will be by mutual agreement when treatment goals have been achieved or where the young person indicates they no longer require services. Transfer of care will occur when the young person reaches 25 years or when their care needs can be more appropriately met by other services or support agencies.

YouthLink and YouthReach South are governed through Youth Mental Health, Mental Health, Public Health and Dental Services, North Metropolitan Health Service.

CAMHS 0-17 years and adult community mental health services 18 plus, provide Tier 3 community mental health services to young people apart from YCATT, Youth Axis, YouthReach South, YouthLink, CCI for 16 plus and Forensic Services.

Introduction

Youth Mental Health

Youth Mental Health comprises four specialist mental health services

- Youth Axis
- YouthLink
- YouthReach South
- Youth Hospital in The Home

These services work collaboratively to provide a range of services to improve the mental health and wellbeing of young people across metropolitan Perth.

Youth Mental Health aims to reduce the incidence, prevalence and impact of mental health and psycho-social problems on young people, in consultation and collaboration with other service providers and the broader communities in which young people reside and find themselves connected.

Youth Mental Health is based on the *National Framework for Recovery Orientated Mental Health Services (2013)*[1], trauma-informed care and practice[2], youth–friendly service delivery principles[3] and culturally appropriate service delivery models[4]. Youth Mental Health aligns with the objectives of the *International Declaration on Youth Mental Health*[5] (Appendix 1).

Youth Mental Health embraces a commitment to evidence based continuous quality improvement, the *National Standards for Mental Health Services (2010)*[6], the *WA Mental Health Act 2014*[7] and the *National Safety and Quality Health Service Standards 2nd Edition (2017)*[8]. The model of care supports good corporate and clinical governance and is guided by the priorities and principles of the North Metropolitan Health Service, Mental Health Public Health and Dental Services (NMHS MHPHDS) , WA Department of Health, Office of Chief Psychiatrist, and the WA Mental Health Commission.

YouthLink and YouthReach South

YouthLink and YouthReach South are specialist youth mental health services providing Tier 4 mental health treatment to young people with significant mental health problems or at significant risk of developing significant mental health problems. Tier 4 is defined as a highly specialised treatment program for complex, severe or persistent problems[3]. Both services target marginalised young people aged 13 to 24 years, who are homeless or experiencing other significant barriers in accessing mainstream mental health services. Such barriers typically include transience, limited support networks, cultural barriers including Aboriginal or Torres Strait Islander identity, marginalisation due to diverse sexuality and gender, and previous negative treatment experiences.

Both services provide a welcoming, trauma-informed, flexible approach with assertive case management and community outreach to support the engagement and retention of young people in the assessment and treatment of their mental health problems. YouthLink and YouthReach South aim to improve the functioning and quality of life for young people with complex mental health needs.

Philosophy, Principles and Objectives of Care

Philosophy

The model of care gives value to seven key concepts that support the delivery of holistic, high quality mental health care and treatment for young people accessing the service:

- person centred care
- youth participation and consultation
- trauma-informed care
- recovery orientation
- systemic care
- managing barriers
- welcome and responsiveness to diversity.

The philosophy of care is reflected graphically below and further articulated in Appendices 2-9.

Principles

YouthLink and YouthReach South reflect a commitment to best practice mental health care and contemporary human rights legislation which focuses on:

- Timely, responsive and quality care across the continuum from triage to discharge, including where necessary facilitating access to acute and subacute admissions
- Care provision consistent with relevant legislation including:
  - WA Mental Health Act 2014
  - WA Children and Community Services Act 2004
  - Health Services Bill 2016
  - WA Health Services Quality Improvement Act 1994
  - WA Carers Recognition Act 2004
  - WA Occupational Health and Safety Act 1984
  - WA Equal Opportunity Act 1984
  - Australian Human Rights Commission Act 1986
  - Australian Disability Discrimination Act 1992
  - Australian Racial Discrimination Act 1975
- Effective care coordination is optimised by the allocation of a case manager (where possible) at the point of acceptance to service, adherence to care coordination protocols and frameworks, effective multidisciplinary team functioning and for young people of Aboriginal and Torres Strait Islander descent, access to cultural consultation for both non-indigenous staff providing their care and treatment, and for the young person themselves
- Delivering mental health care within the principles of least restrictive options: this requires staff to prioritise client autonomy and only utilise the Mental Health Act when risks cannot be contained in a less restrictive way
- Utilising standardised documentation (assessment and communication tools) to optimise care standards and communication with the multidisciplinary team and other partners in care
- Ensuring the principles of clinical risk management are adopted and that issues of concern or risk are appropriately discussed within the governance structures of the respective teams
- Supporting informed consent by young people that respects the young person's autonomy, confidentiality and human rights
- Supporting access to treatment for young people under the age of 18 without parental consent where it can be reasonably assessed that the young person meets the criteria of a mature minor.

These principles are consistent with the Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia (2012)[9].

Key Objectives

- Provide safe, high quality assessment and treatment that is recovery orientated and evidence based for young people with complex mental health and psycho-social needs
- Involve consumers and where appropriate carers in all phases of care, and support them through the mental health and other agencies systems with an emphasis on building sustained and consistent relationships
- Provide preventative help, assertive response and support to manage emerging crisis situations, including assisting the young person to access extended hours services through effective liaison with appropriate after hours crisis services
- Communicate and liaise with other case managers, teams, inpatient services and community managed organisations to facilitate seamless care and ensure continuity and consistency of service delivery
- Develop a treatment, support and discharge plan with the young person based on and responsive to individual needs
- Provide education and consultative advice and support to the young person, carers, family members and other support services
- Engage, develop and maintain effective collaborative partnerships with other health services, teams, GPs and government and non-government service providers
- Work with other organisations to increase capacity of the community to meet the mental health needs of young people across the spectrum of interventions

Clinical Model

Target population and intake criteria

YouthLink and YouthReach South provide specialist mental health services to young people:

- aged 13-24 years
- with complex and/or severe mental illness or experiencing significant symptoms and at-risk of developing a long term mental illness
- who require Tier 4 youth mental health services and are experiencing significant barriers in accessing other mental health services appropriate to need, such as homelessness, transience, and /or limited support networks.
- who are help accepting and consenting to mental health treatment and support
- who are primarily residing in the Perth metropolitan area.

All young people meeting these criteria will be considered for acceptance to the service. However, where the young person's needs may be more appropriately met by another service, the young person and the referrer will be provided with advice and support to access other services. For young people aged 13 -15 years, acceptance is typically based on the criterion of homelessness or transience, as the majority of young people within this age group are more appropriately seen by Child and Adolescent Mental Health Services (CAMHS).

Similarly, young people whose mental health difficulties can be treated by Tier 3 services are more appropriately seen by CAMHS or adult mental health services.
Youth Mental Health does not provide comprehensive services to the youth population. Specifically, it does not provide acute or urgent responses to unknown clients in crisis. Young people who are not known to the service who require acute mental health services will be directed to other appropriate services.

YouthLink and YouthReach South have a capped capacity for client services within their target population. On occasions services may operate with a waitlist.

Key elements of service

The key elements of clinical service delivery are:

1. Person centred care, youth participation and consultation
2. Working with other service providers / partnering
3. Access and entry
4. Assessment and activation
5. Care and treatment
6. Multidisciplinary team reviews
7. Inpatient admission
8. Continuity of care
9. Transfer and discharge
10. Research and education
11. Community capacity building

These are described in the following tables.

Service element 1: Person centred care, youth participation and consultation

The WA Mental Health Commission identifies person centred supports and services as one of the three key directions of its ten year strategic policy Mental Health 2020: Making it personal and everybody's business (2010)[10]. The principle of a young person's right to self-determination and to make choices and decisions about their care is also consistent with the philosophy of person centred care and recovery orientation.

YouthLink and YouthReach South respect young persons as partners in decisions about their mental health care, ensure young people are fully informed about their rights, and provide the necessary information, support and access to alternative services that will enable them to make informed decisions. For young persons under the age of 18, these rights will be afforded under the provisions of criteria for a mature minor. If a young person under 18 years does not meet the criteria for mature minor, parental or guardian consent will be required.

Involvement of consumers in the planning, development, review and evaluation of mental health services is reflected in the National Standards for Mental Health Services (2010)[6], the Mental Health Act 2014[7] and the National Safety and Quality in Health Service Standards 2nd Edition (2017)[8].

Tasks / Strategies	**Performance Indicators**
Co-creation and co-signing a treatment, support and discharge plans	• % of treatment, support and discharge plans signed by young person
Feedback informed therapy: active engagement of all young persons in evaluating treatment progress and engagement, For example, this can be evaluated using the Experience of Service Questionnaire (ESQ)	• % of young people completing feedback informed measures such as the ESQ
Consumer consultations, co-design activities and other forms of participation through the Youth Reference Group. See Appendix 15 for Youth Reference Group Terms of Reference.	• # of YRG meetings, consultations, co-design processes and other activities conducted annually • # of young people engaged in youth participation through the YRG, or other mechanisms such as client surveys.

Service element 2: Working with other service providers / partnering

It is recognised that strong and respectful partnerships with other service providers, developed and maintained through an understanding of common purpose and goals and clear communication processes and protocols, will improve the quality of care and support provided to young people. Partnering will also allow YouthLink and YouthReach South to support the capacity of the community and other organisations to meet the mental health needs of all young people across the spectrum of interventions.

Tasks / Strategies	Performance Indicators
Each young person accepted to service will be allocated a mental health clinician as case manager. The case manager will have primary responsibility for developing a therapeutic relationship with the young person and undertaking a thorough assessment, diagnosis and formulation of the young person's presenting problems. This is documented in a treatment, support and discharge plan (refer to element 5). The case manager's role will be supported by the multidisciplinary team (refer to element 6) and clinical / organisational supervision. Case managers are responsible for: • Maintaining regular and clear communication with all persons / agencies within the young person's system of care • Developing the treatment, support and discharge plan with involvement of the young person and other service providers, such that responsibilities of each service provider are articulated • Where indicated providing a copy of the treatment, support and discharge plan to other service providers as per the signed Release of Information form • Attempting to link the young person with a General Practitioner (GP) and liaising regularly with any identified GP • Liaison with private psychiatrists and other medical specialists involved in young person's care	• % of clients with a treatment, support and discharge plan on PSOLIS • %of clients with overdue a treatment, support and discharge plans • % of clients with identified GP • Where GP identified, % of medical records that evidence regular communication with GP • NMHS MH documentation and clinical pathway audit • NMHS MH General Practitioner communication audit

• Where multiple agencies are involved, case managers can facilitate care coordination by encouraging the system of care to appoint a lead agency • Develop clear protocols and processes for interim clinical care in the absence of the primary case manager eg. leave • Where multiple service providers are providing services to young people, case managers are expected to convene or participate in case conferences on a regular basis to ensure an integrated system of care	
Maintenance of Portfolio Framework as outlined in the Youth Mental Health Team Based Service Delivery Policy[11]	• Evidence of annual Action Plans for identified portfolios • Regular reporting and accountability on Action Plans

Service element 3: Access and entry

Youth Mental Health will maintain an Integrated Triage Service to facilitate effective, quality, safe and timely processes and pathways for access and entry to the service, consistent with NMHS MHPHDS Admission Policy[12], National Safety and Quality in Healthcare Standards 2nd Edition 2017 [8]and National Standards for Mental Health Services (Standard 10)[6].

The Integrated Triage Service is a critical part of the clinical care pathway whereby the mental health problem/s, unmet need and level of risk are identified for the young person and/or family and/or community. A core function of the triage officer is to link the young person and/or community member to the best service to meet their need. When a young person meets the criteria for YouthLink and YouthReach South, it is the responsibility of the triage officer to establish the young person's informed consent to progress the referral and to access information from the referrer, the young person and collateral sources for presentation to the multidisciplinary team.

The Integrated Triage Service will operate Monday to Friday 8:30am – 4:30pm. Referrals will be received from a variety of sources including self and family, community members, community managed organisations, mental health services, General Practitioners, Emergency Departments and private practitioners. All referrals will be recorded in the triage function of PSOLIS and all other documentation will be integrated into the medical record when the young person is activated to the service. The triage process can be supported by face-to-face assessments by the triage officer where indicated.

Referrals to YouthLink of Aboriginal and Torres Strait islander young people can be made by direct contact with the Aboriginal Mental Health Practitioners employed at YouthLink. Within YouthLink the triage officer is expected to seek cultural consultation from Aboriginal Mental Health Practitioners in relation to any Aboriginal and Torres Strait Islander young person referred to the service.

The young person and referrer are provided with prompt feedback regarding the acceptance of the referral following multidisciplinary team consideration and decision making. If YouthLink and YouthReach South are operating at capacity, the young person will be placed on a waitlist and managed within the protocols of the Youth Mental Health Program Waitlist Management Policy[13]. Consistent with the Roadmap for National Mental Health Reform 2012-2022[14] and a focus on person-centred care, the Youth Mental Health Program operates a "no wrong door" policy'. If YouthLink and YouthReach South are not able to provide the needed service, the triage officers will assist referrers to navigate their way to other appropriate services.

Tasks / Strategies	**Performance Indicators**
Obtaining informed consent for referral	• Evidence of consent during triage process
Maintenance, review and ongoing quality improvement of Integrated Triage Service	• Average length of time between referral and presentation to multidisciplinary team • Monthly number of referrals • Monthly occasions of service by triage officer • Monthly face-to-face assessments conducted • Regular surveys of referrers

Service element 4: Assessment and activation

At acceptance to service, a case manager is allocated as soon as possible, dependent on capacity and waitlist demand. Best practice requires the allocated case manager to establish contact with the young person and the referrer within two working days and to offer an initial assessment appointment within seven working days. If there are difficulties in making contact or establishing initial assessment with the young person, the case manager is expected to make assertive efforts to contact and encourage engagement with assessment process under the guidance of the multidisciplinary team. The initial assessment should attempt to be comprehensive while working within the young person's capacity and tolerance, and be sensitive to engagement and rapport. It should include the following domains:

- History of presenting problems
- Risk assessment
- Mental State Examination
- Mental health history
- Medical history
- Current and past medications
- Developmental, family and social history
- Cultural identity and background
- Sexuality and gender
- Abuse and trauma history
- Education and work history
- Alcohol and drug use (past and current)
- Psychiatric illness in family
- Forensic history
- Social and family relationships
- Current psycho-social stresses and needs

At minimum, case managers are expected to undertake a Mental State Examination and risk assessment as comprehensively as possible. Where a young person is resistant to providing information or this is contra-indicated, the limitations of information gathered should be noted on the assessment form.

The initial assessment is documented within the Standardised Clinical Form SMHMR902. On completion, case managers are required to present their initial assessment report: treatment, support and discharge plan and Risk Assessment to the multidisciplinary team for endorsement.

Tasks / Strategies	**Performance Indicators**
Timely and assertive attempts to establish first contact	• Documented evidence of attempts to establish contact within two working days • Length of time between allocation and first offered appointment
Timely completion of initial assessment and presentation to multidisciplinary team	• Average time between allocation and presentation of initial assessment to multidisciplinary team
Assertive case management (see Appendix 6) with services being provided in treatment setting of young person's choice	• Documented evidence of assertive outreach being offered to young person indicating unwillingness / inability to attend centre based appointments

Service element 5: Care and treatment

Clinical interventions, review and follow-up will be delivered through a variety of methods and treatment settings to address changing clinical care needs and to optimise safety. Interventions could include telephone contact, written correspondence, home visits and office-based appointments and may be delivered by Youth Mental Health staff, other specialist mental health services or staff from other organisations. The site of service delivery will be negotiated with the young person to best facilitate their engagement and retention in treatment, whilst giving regard to safety. The extent and type of intervention will align with the treatment, support and discharge plan, clinical need and acuity levels. Interventions will be guided by recovery principles and young people will be supported to access a range of biopsychosocial interventions which address their individual needs.

Consistent with assertive case management, case managers are expected to deliver as much of the mental health interventions as possible. Mental health interventions include:

- Psycho-education to young persons and carers (eg. information about mental health disorders, stress vulnerability model, risk management, relapse prevention, treatment and support options, accessing other mental health and support services, alcohol and drug use, physical health care)
- Supportive counselling
- Collaborative safety planning
- Crisis interventions
- Evidence-based psychological interventions (eg. cognitive behavioural therapy, dialectical behaviour therapy, mindfulness, motivational interviewing, schema focussed therapy, acceptance and commitment therapy, integrative treatment for complex trauma)
- Assessment and management of alcohol and drug use within the concept of co-occurring capacity

Discipline specific skills can be accessed for specific mental health interventions that are not within the competency of the case manager (eg. cognitive assessments, projective and personality assessments, medical and physical examinations, evaluation by consultant psychiatrist for specialist opinion and pharmacological interventions, consultative advice and support to GPs regarding pharmacological interventions and medical monitoring)

Throughout the episode of care, case managers are expected to make significant effort to link young people with GPs and other medical specialists to address physical, sexual and dental health care needs.

Where staff members of YouthLink and YouthReach South are involved with the prescribing or administration of medications, all prescribing, dispensing or administration of medicines will be compliant with the WA Poisons Act 1964 and WA Health policies, guidelines and standards. Appropriate consumer information will be provided to support informed consent, adherence and monitoring of side effects. Evidence-based clinical treatment guidelines will support prescribing regardless of consumer's personal goals for medication.

Within Youth Mental Health teams, case managers are expected to actively seek the advice and support of the Aboriginal Mental Health Practitioners in developing the treatment, support and discharge plan for Aboriginal and Torres Strait Islander young people. Where appropriate staff may also consult with relevant portfolio holders in regards to treatment.

Within Youth Mental Health teams, case managers are expected to operate within the principles of family sensitive practice. At referral and admission to service, case managers are expected to clarify the young person's definition of their family system, their current and historical relatedness and connectedness to this system, and their attitudes and beliefs about family involvement and inclusion in their care. Throughout the episode of care, and at minimum each clinical review period, the clinician should review the young person's current relationship with their family and the potential for family involvement. Within the young person's consent, family interventions should be reflected within the treatment, support and discharge plan. Such interventions might include psycho-education, referral to family support groups, family counselling options, interagency collaboration and consultation.

Length of treatment is variable dependent on the young person's need and capacity to use the service appropriately and effectively to effect change, and may extend beyond reduction in symptomatology and stabilisation. Longer term psychotherapy is indicated for many young people to address complex trauma histories, and to effect changes in personality organisation and core internal schemas.

The level and nature of the care and treatment is made explicit in the treatment, support and discharge plan and where indicated the crisis management plan which are endorsed by multidisciplinary team.

Case managers within both teams are expected to write interim treatment, support and discharge plans to support any planned personal leave as per each team's practices / guidelines to ensure continuity of care and effective handover.

Tasks / Strategies	**Performance Indicators**
Development of treatment, support and discharge plans in collaboration with the young person Recovery orientation, evidence-based care and frequency of contact outlined within the treatment, support and discharge plan are tailored to the young person based on their clinical need and acuity.	• % of treatment, support and discharge plans signed by young person • % of clients with current treatment, support and discharge plan • % of clients with identified GP • Evidence of attempts to link with GP in medical record audits
Completion of interim treatment, support and discharge plans	• NMHS MH Documentation and Clinical Pathway Audit

Service element 6: Multidisciplinary team reviews

Multidisciplinary team review meetings will occur weekly, chaired by the Director / Team Leader, or senior clinical staff as delegated by the Director / Team Leader. Meetings are to be scheduled when all clinicians can attend, and all staff are expected to attend regularly. The multidisciplinary team will provide a forum to:

- Review and provide advice and support to case managers regarding the progress of assessing and activating clients on entry to service
- Ensure the periodic review of the client every 3 months from activation throughout the episode of care. At reviews the case manager and relevant staff present current National Outcome Casemix Collection (NOCC) assessments, current risk assessments, outcome of previous treatment, support and discharge plan, revised treatment, support and discharge plan, and where indicated crisis management plan and PSOLIS alerts. All multidisciplinary team reviews are documented in the medical record and PSOLIS
- Facilitate ad hoc clinical discussions in the context of emerging complex issues, crisis presentations, clinical instability and following critical incidents where other forums (eg. clinical supervision, organisational supervision, triadic supervision between case manager, clinical supervisor, organisational supervisor) cannot occur in a timely manner or where multidisciplinary discussion is recommended
- Discharge and transfer involve the case manager presenting current NOCC assessments, current risk assessment, outcome of previous treatment, support and discharge plan, revised treatment, , and where indicated crisis management plan and PSOLIS alerts.

Tasks / Strategies	**Performance Indicators**
Effective processes and protocols for the management of multidisciplinary clinical review meetings on a weekly basis Systems for ensuring that clinicians are aware of due dates for multidisciplinary review and that each client is reviewed every three months. Case manager develops treatment, support and discharge plan in collaboration with the young person and presents to multidisciplinary team for review and endorsement at initial assessment, at three month intervals throughout episode of care and at discharge.	• % of clients with overdue treatment, support and discharge plans • NMHS MH documentation and clinical pathway audit

Service element 7: Inpatient admission

In the context of the principles of person centred care, least restrictive practice and an understanding of the potential iatrogenic effects of hospitalisation, each service / case manager will work with the young person, other mental health services, other support agencies and persons to prevent hospitalisations. This may include increased frequency of contact, referral to acute response services to provide additional support, referral to Hospital In The Home, referral to sub-acute facilities and engaging family and community supports.

Where inpatient admission is indicated, the case manager, wherever possible, assumes responsibility for facilitating admission, encouraging the young person to accept voluntary admission and liaising with acute services and bed flow managers.

When voluntary admission is not possible, the case manager, wherever possible, assumes responsibility for explaining the use of the Mental Health Act 2014 to the young person and carer/s and liaises with appropriate agencies / Youth Mental Health Authorised Mental Health Practitioner to support the use of the Mental Health Act to have young person referred for assessment.

In the absence of the case manager, each service will have a process for identifying an appropriate person to assume these responsibilities.

Case managers will take an active role in providing clinical handover to acute services and inpatient treatment teams regarding the young person's current and past presentations, diagnosis, formulations, treatment, support and discharge plans and crisis management plans, including a formulation of the meaning and value of current admission. Case managers, in negotiation with inpatient treatment teams and where clinically indicated, will maintain contact and continue to engage the young person during admission. Case managers or their representative will attend inpatient team reviews or request case conferences to participate in the development of an inpatient discharge plan. Where the young person's presentation is resulting in repeated admissions, the case manager will attempt to negotiate an agreed crisis management plan with the young person, inpatient unit and acute mental health services that is appropriately communicated with others.

Tasks / Strategies	**Performance Indicators**
Effective verbal and written clinical handover in accordance with ISOBAR	• NMHS MH Documentation and Clinical Pathway Audit

Service element 8: Continuity of care

Clear information is provided to young people, carers, and other support persons to ensure knowledge of how to contact mental health services across a 24 hour seven day period. Case managers will encourage young persons to identify a GP or medical centre to manage their physical health needs. The young person's GP and other service providers will be identified in the medical record and PSOLIS and contact details will be regularly updated. Case managers will maintain regular communication with identified GP and other service providers through documented phone calls, letter and email communication, care planning meetings and case conferences.

Tasks / Strategies	**Performance Indicators**
Provision of emergency services contact details on entry to service	• NMHS MH Documentation and Clinical Pathway Audit
Relevant contact details in medical record and on PSOLIS	• NMHS MH Documentation and Clinical Pathway Audit
Identification of GP	• NMHS MH Documentation and Clinical Pathway Audit
Evidence of communication with GP eg. identification of GP, liaison at least at each review highlighting current treatment plan and risk issues	• GP Communication Audit

Service element 9: Transfer and discharge

Transfer of care will occur when young person reaches 25 years or when their care needs can be more optimally or more appropriately met by other services or support agencies. Transfer plans, including the time period for transfer of care, will be developed with the young person and the receiving agencies to facilitate a seamless transfer of care. Where possible young people will not be transferred during crises, nor prior to initial contact and assessment of young person with the current responsible clinical team. A timely written handover is provided on each transfer occasion. The SSCD Care Transfer Summary is the minimum documentation to be completed for all transfers of care (including hospital admissions). Wherever possible a verbal clinical handover should complement clinical documentation with every transfer process.

Optimally, discharge from service will be by mutual agreement when treatment goals have been achieved or where the young person indicates they no longer require services. Planned discharges of this nature provide much greater opportunity to liaise and handover to other service providers, to develop relapse prevention plans and to ensure young person, carers and other support services are aware of processes to re-engage with youth mental health services, or other service providers. Effective discharge planning is supported by clear discussion from the time of first presentation and throughout the episode of care. Planned discharges will be supported by:

- attempts to engage young person in relapse prevention strategies
- clearly articulated understanding that young person can re-enter the service, if appropriate
- comprehensive liaison and handover with all other services providers who will contribute to ongoing care
- comprehensive discharge documentation indicating diagnosis, treatment provided, progress of care, recommendations for ongoing care and procedures for re-referral and at minimum supported by PSOLIS treatment, support and discharge plan. Risk assessment and risk management information to be included where clinically indicated.

Wherever possible young people and support persons will be involved in discharge planning and young people will be actively encouraged to sign their discharge plan.

Where young persons are lost to follow-up, there will be documented evidence of attempts to contact consumers, where appropriate family/carer and other service providers. Discharge should occur no later than three months after last contact, unless endorsed by the multidisciplinary team. At times young people may be discharged if they are not engaging in or benefitting from treatment. In these cases they will be given instructions about how to re-engage in treatment in the future.

All transfer plans and discharge plans are to be endorsed by the multidisciplinary team. Case managers are responsible for promptly preparing all documentation for presentation to the multidisciplinary team.

Tasks / Strategies	**Performance Indicators**
Development and documentation of transfer and discharge plan (SSCD Care Transfer Summary)	• NMHS MH Documentation and Clinical Pathway Audit
Development of discharge plan in PSOLIS	• NMHS MH Documentation and Clinical Pathway Audit
Liaison and handover to other service providers and GP if identified	• NMHS MH Documentation and Clinical Pathway Audit
Presentation to multidisciplinary team	• NMHS MH Documentation and Clinical Pathway Audit

Service element 10: Research and education Youth Mental Health is committed to engaging in research and evaluation, to achieve a better understanding of the needs and outcomes of clients, measure change and clinical progress, and plan services that can make a difference at the individual and clinical population level. This objective is being achieved with the development of clinical outcome monitoring systems and engagement in clinical research projects.	
Tasks / Strategies	**Performance Indicators**
The creation of standardised clinical monitoring forms	• Routine completion of clinical monitoring form
Development of a database to collect and extract data with a dashboard to visually display activity data and client flow.	• Accessible and visual dashboard to support performance, or regular PSOLIS reports.
Protocol to collect additional routine clinical data on young people and their outcomes	• % of young people providing consent for access to routine data for research and evaluation • % of young people completing additional routine outcome measures
Securing institutional and ethics approvals to support quality improvement and research projects	• # of registered quality improvement and research projects undertaken
Creation and maintenance of a research database	

Service element 11: Community capacity building

YouthLink and YouthReach South accept the responsibility to work with other youth service organisations and agencies to increase the capacity of community and other organisations to meet the mental health needs of all young people across the spectrum of interventions. This responsibility is enacted in a variety of ways.

YouthLink and YouthReach South provide training to other organisations to increase the confidence and competence of their workforce in recognising and responding to mental health problems in young people. This is primarily delivered through training workshops to meet identified needs of stakeholder organisations. Workshops can be provided on a variety of youth mental health issues including working with Aboriginal young people, working with young people with diverse gender and sexuality, depression, deliberate self-harm, personality disorders, and trauma. The majority of these workshops are directed to staff of NMHS and community managed organisations who work in support roles, and staff who are providing counselling and therapeutic interventions. In addition, YouthLink can tailor specific training packages to meet the identified needs of organisations by negotiation and within capacity.
In addition, YouthLink and YouthReach South provide clinical staff to participate in the clinical review processes of each of the metropolitan headspace centres. This facilitates the provision of consultative advice and support to inform clinical decision making, determining most appropriate clinical pathways and treatment planning. Consultative advice and support is also provided through regular inreach to specific youth services eg. accommodation services, Ngatti (see next section for further details), PICYS, Passages and Street Connect, and may be provided to services on request.

Within capacity, YouthLink and YouthReach South will:

- consult, liaise and support other health and community service providers regarding the assessment, management and treatment of youth with mental health problems and the family / support systems
- assist and support the development of universal, selective and indicated prevention strategies which have the objectives of enhancing the social and emotional wellbeing of youth in partnership with other health and community agencies
- assist and support the development of treatment and support services which have the objectives of enhancing the social and emotional wellbeing of youth in partnership with other health and community agencies.

Tasks / Strategies	**Performance Indicators**
Development and delivery of training workshops.	• # of workshops • # of training participants • training evaluations
Development and delivery of specifically tailored lectures, workshops, presentations	• # of workshops • # of training participants • training evaluations
Passages / PICYS / Ngatti activities	
Headspace attendance	• Number of headspace centres where there is regular attendance

Youth Accommodation Liaison Clinical Nurse Specialists (YAL CNS)

YouthLink and YouthReach South each have a Clinical Nurse Specialist working in partnership with youth crisis accommodation services. The aim is to provide an integrated service model to support homeless young people with mental health issues and co- occurring drug and alcohol issues. The YAL CNS's function as members of the MDT of each team, and provide the following services to the youth crisis accommodation agencies:

- **Triage -** Most Referrals are made by direct contact with the clinicians whilst attending the accommodation provider services. A face to face assessment is offered to most referrals.
- **Assessment (including risk)**
- **Brief intervention (BI) -** Once accepted to service the YAL CNS will provide short term mental health interventions for up to 12 weeks from the first contact.
- **All linkages (including Transition) -** Within short term case management, all significant supports and stakeholders in the young person's life will be identified in order to plan transition and linkage at the final stages of case management.
- **Training** - Provide training opportunities to enhance the knowledge and skills of all staff in the sector.

The YAL CNS positions are described more fully in Appendix 9.

Gender Pathways Service (GPS)

The Gender Pathways Service (GPS) is a State-wide service administered through YouthLink. The GPS provides specialist gender diversity consultation, training, community development, referral information, and assessment for suitability and readiness for gender affirming medical treatment (hormones and /or surgery). Specialist assessments for gender affirming treatment are provided to young people aged 17 -24 years with complex mental health/ neurodevelopmental disorders, and/or significant barriers to accessing gender affirming care. The GPS is administered through YouthLink, and is staffed by a Clinical Psychologist, who practices as part of the YouthLink MDT. The GPS is described more fully in Appendix 10.

Youth and Adult Complex Attentional Disorders Service (YACADS)

YACADS is a separately funded State-wide service administered within YouthLink, which provides specialist ADHD assessment services to 18 - 64 year olds with ADHD and co-occurring conditions. YACADS is staffed by a Consultant Psychiatrist, Clinical Neuropsychologist and Clerical Officer. Eligibility criteria include either an established diagnosis of ADHD and/ or a significant history of moderately or severely debilitating attentional difficulties and hyperactivity consistent with ADHD, with complex presentations, and a co-occurring Axis 1 or Axis 2 diagnosed mental illness. People referred to YACADS must also be case managed by Youth or Adult Community Mental Health Service providers, as YACADS does not provide continuing stimulant prescription or other treatments. Further description of YACADS is in Appendix 11.

YouthReach South Clinical Inreach to Ngatti House

YouthReach South provides clinical inreach to Ngatti House, the State-wide homeless youth facility in Fremantle. Ngatti House offers a residential recovery-focussed program providing medium term accommodation (up to 12 months) in a shared living environment. Ngatti House provides up to 16 beds and is staffed 24 hours per day seven days a week by community managed organisation Life Without Barriers (LWB).

Ngatti House provides services to young people who:

- are aged between 17 and 22 years, however current residents will not be excluded on turning 23
- are homeless or at risk of long term homelessness

have a diagnosed mental illness or are at risk of developing a long term mental illness require medium to high level support

Ngatti House provides a transitional support and rehabilitation program, working from a strengths and recovery based framework that is culturally appropriate, flexible, and provides support based upon the individual needs of the young person, their families and/or carers. Individual needs are determined during the development of individualised care plans that are person centred and holistic, with a strong focus on enhancing social inclusion, recovery and the capacity for young people to achieve their desired goals and live successfully in the community.

YouthReach South is responsible for triage and assessment of all referrals to Ngatti House. There is a joint intake process between Youth Mental Health and LWB. Where a person is already engaged with another mental health service, a period of transition may occur, with care arrangements outlined in the management plan. YRS allocate a case manager to all resident young people and this may include shared care arrangements with other mental health services.

YouthReach South and LWB work in partnership to ensure that each young person utilising the service has the right mix of clinical support, individualised case management / care coordination and life skills services.
YouthReach South and LWB have a Service Level Agreement which specifies the care coordination / partnership model. This is available from: W:\Mental Health\NM-Youth Program\Management\06_PARTNERSHIPS & PORTFOLIOS\SLA\Endorsed\Ngatti\2019.01.25 Ngatti House Service Level Agreement between LWB and YR.pdf
Roles and Responsibilities at Ngatti House are described in Appendix 12.

Operational Model

Hours of operation

YouthLink and YouthReach South operate Monday to Friday 8:30am–4:30pm. Outside these hours, incoming callers are provided with names and contact numbers for emergency services. All marketing material indicates hours of operation.

Service settings

YouthLink is located at 223 James Street, Northbridge.

YouthReach South is located within the Cockburn Youth Centre, Level 2, 25 Wentworth Parade, Cockburn.

Clinical services are delivered in a variety of settings to best support the young person's needs, including the services' offices, clients' homes, public spaces, community organisations, and inpatient settings.

Clinical documentation

All documentation will be consistent with the "Triage to Discharge" Statewide Standardised Clinical Documentation Framework and with NMHS-MH clinical documentation policies and practices.

All interventions and communications will be recorded in the young person's medical record.

Service events, outcomes measures, risk assessments, alerts, individual treatment, support and discharge plans and crisis management plans will be completed on PSOLIS.

All young people where possible are to be involved in the development of their treatment, support and discharge plan, to be offered the opportunity to co-sign their treatment, support and discharge plan and to receive copies of their treatment, support and discharge plan.

Caseload

Individual clinicians are expected to carry a caseload of a minimum of 12 to 15young people , for full time equivalent .
The Director / Team Leader regularly reports to YMH Executive on team and individual caseloads.

Length of treatment

The length of treatment is flexible and responsive to the individual clinical needs of the young person and their capacity to effectively use the services offered to make changes. These may include the areas of mental health symptomatology, psychosocial circumstances, co-morbid alcohol and substance use, reduction in impact of past trauma, changes in personality organisation, core maladaptive schema and coping strategies.

It is acknowledged that early in the episode of care, young people may be ambivalent about treatment, and have significant difficulty in forming a strong therapeutic alliance that effects significant change. In early stages of treatment, therapeutic goals are focussed on establishing regular and consistent contact with young person, establishing mutually agreed foci of treatment, stabilising psycho–social circumstances, reducing significant risk and reducing therapeutic interfering behaviours.

Within this period, there is much greater tolerance for ambivalent engagement with the service that might be enacted in many different ways. Beyond reduction in mental health symptoms, stabilisation of psycho-social circumstances, and psycho-social recovery evidenced by improved functioning, consideration will be given to extension of treatment to address unresolved trauma and personality organisation dependent on the young person's willingness and capacity to work on these goals.

It is recognised that these capacities may vary at times. In some cases treatment may involve discrete episodes of care that occur at different points in the young person's life. This episodic care will be facilitated by service processes that allow an "easy-in, easy-out" service delivery model. That is, it is made as easy as possible for young people to be seen for timely treatment and it is easy for young people to exit from treatment if needed.

Workforce

Multidisciplinary team

Whilst the composition of each service has variance, each team will be staffed and supported by the skills of clinical psychologists, social workers, nurses, Aboriginal Mental Health Practitioners, and Psychiatrists.. Appendix 12 details the staffing establishment for each team.

The majority of staff will assume the role of case manager for a dedicated caseload, and consistent with assertive case management will deliver as much of the mental health interventions as possible. In some instances a secondary case manager will be allocated, and work in collaboration with the primary case manager, to provide additional support as required.

Discipline or role specific skills can be accessed for specific interventions that are not within the competency or scope of practice of the case manager eg. cultural consultation, cognitive assessments, projective and personality assessments, psychiatric assessment, pharmacotherapy, consultative advice and support to GPs re pharmacological interventions and medical monitoring.

Mandatory training

All new staff employed within YouthLink and YouthReach South will be provided with site specific orientation and required to attend NMHS MH orientation. All staff are expected to comply with mandatory training requirements of NMHS and NMHS MH as required for their role and function. Each service is expected to report on compliance rates for staff completion of mandatory training.

Core competencies

Preliminary work has identified the following core competencies for the workforce employed within YouthLink and YouthReach South:

- Mental State Examination, diagnostic and formulation skills
- Understanding of common mental health presentations and their treatment in young people
- Understanding and responding to suicide risk (including risk assessment)
- Understanding and responding to risk of harm to or from others (including risk assessment)
- Understanding the normative development of adolescents and young adults
- Understanding principles and practices of assertive case management
- Responding to psychiatric emergencies
- Understanding principles and practices of Mental Health Act 2014
- Administration and interpretation of National Outcome Casemix Collection (NOCC) measures
- Assessment and management of co-occurring alcohol and drug problems
- Motivational interviewing
- Clinical skills in providing evidence-based interventions
- Culturally sensitive practice

- Working with Aboriginal young people
- Competency in delivering mental health services to lesbian, gay, bisexual, transgender and intersex (LGBTI) young people
- Understanding pharmacotherapies for mental health, alcohol and other drug issues
- Supportive counselling
- Therapeutic case management, including managing engagement and therapeutic relationship
- Family sensitive practice
- Collaborative care planning within recovery orientated principles
- Trauma-informed care

Specialist competencies

- Advanced skills in the assessment, diagnosis and formulation of mental health problems
- Advanced clinical skills in providing evidence-based interventions
- Competency to assess and treat complex trauma, attachment difficulties and personality disorganisation
- Advanced clinical skills in the assessment and management of co-occurring alcohol and drug problems
- Capacity to provide supervision
- Research and evaluation skills

Professional development

Youth Mental Health recognises the challenges of building, sustaining and retaining a skilled and competent mental health workforce. Whilst quality practice is built on sound evidence, the primary therapeutic tools are the knowledge, skills, attitudes and personal qualities that staff bring to the job and develop through work experience and professional development. Youth Mental Health is therefore committed to ensuring that all staff have access to high quality professional development opportunities, to support and maintain professional registration and association membership/s and to extend their skills and competencies appropriate to role.

Youth Mental Health staff will be encouraged and supported to extend their professional and personal competencies, and to meet professional registration requirements through training needs identified within the individual performance and review process and clinical supervision.

All staff will be supported by access to clinical and organisational supervision.

All training supported by Youth Mental Health will be based on best practice principles and evidence-based treatment guidelines.

YouthLink and YouthReach South acknowledge key strategic documents that delineate the practice domains, key competencies and capabilities required of mental health practitioners to function within the principles of recovery orientated practice, including the National Framework

for Recovery–Orientated Mental Health Services Guide for Practitioners and Providers[1] and the National Practice Standards for the Mental Health Workforce (2013).[16]

The development and maintenance of these key competencies can be supported by:

- A range of NMHS MH education and staff development courses which can be accessed via the NMHS MH intranet site
- Access to the Mental Health Professional Online Development (MHPOD). This is an online resource developed to support the implementation of the National Practice Standards for the Mental Health Workforce[16] with staff accessing modules relevant to their scope of practice and target audience.

Student placements

YouthLink and YouthReach South support the teaching and training of undergraduate and postgraduate students in relevant disciplines to assist future workforce recruitment and development.

Lead Seniors will take a facilitative role in liaising with relevant university departments and organisations to support student practicums, and to facilitate teaching within undergraduate and postgraduate programs. Staff are encouraged to take up these roles when ready to do so.

Workforce development

Youth Mental Health recognises the strategic priority of a workforce development program which includes:

- Ongoing monitoring of current workforce
- Forecasting future workforce needs based on model of care
- Identifying current and future gaps between workforce supply and demand
- Developing a competency based framework to support the model of care.

Governance

YouthLink and YouthReach South are governed through the organisational structure of the NMHS MHPHDS Youth Mental Health. The Director / Team Leader of each service reports to the Director, Youth Mental Health. Each is responsible for the clinical and operational governance of their respective service, and providing leadership to each team to:

- promote, develop and deliver evidence-based standards specific to youth
- review and monitor standards of care
- review and monitor performance
- effect continuous quality improvement
- maintain a competent and healthy workforce
- promote, develop and maintain an organisational culture that promotes openness, transparency, learning, and innovation.

The governance of both teams is supported by representation of the Director / Team Leader on the Youth Mental Health Steering Committee and the Youth Mental Health Safety, Quality and Risk Management Committee.

Organisational structure

The organisational structure of Youth Mental Health, YouthLink and YouthReach South is shown in Appendix 13.

Lead seniors

Youth Mental Health has appointed three roles as lead seniors for the professions of clinical psychology, nursing and social work. The broad role and function of the lead seniors is to support the Director / Team Leader and professional staff in the maintenance of professional standards and competencies. The lead senior role is consultative only and executive, clinical and corporate governance responsibilities remain with line managers, Director and Head of Service (Clinical).

Performance, Evaluation and Data Collection

Development and monitoring of key performance indicators (KPIs) is an essential process in clinical governance and evaluation.

To meet the requirements for measuring and identifying outcomes as a baseline, Youth Mental Health has adopted the KPIs for Australian Public Mental Health Services[17] which set the benchmark for quality care across nine domains:

- Effective
- Appropriate
- Efficient
- Acceptable
- Continuous
- Responsive
- Capable
- Safe
- Sustainable

Youth Mental Health complies with Commonwealth requirements for reporting KPIs which are reported via the Mental Health Commission.

Youth Mental Health also utilises a suite of non-mandatory KPIs to supplement the Commonwealth suite.

To support performance monitoring and evaluation, statistical data is captured via a number of databases:

- WEBPAS and PSOLIS. These two statewide data collection systems collate and store patient information which includes demographics, admission and discharge dates, referral source, length of stay, diagnosis, outcome measures (including NOCC), treatment, support and discharge plans and discharge / follow up arrangements.
- Research and Evaluation Clinical Outcome Measures
- Clinical Incident and Management System (Datix CIMS)

Youth Mental Health will be compliant with the completion of all relevant NMHS MHPHDS audits in the annual quality calendar managed through the MHPHDS Safety, Quality and Performance Unit, and implementing action plans to address identified issues.

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Appendix 1: International Declaration of Youth Mental Health

The International Declaration on Youth Mental Health

A shared vision, principles and action plan for mental health service provision for young people aged 12–25 years

IAMH YOUTH MENTAL HEALTH

Imagine a world where...

- **Every young person** has a meaningful life and can fulfil their hopes and dreams
- All young people are respected, valued and supported by their families, friends and communities
- Young people feel empowered to exercise their right to participate in decisions that affect them
- Young people with mental ill-health get the support and care they need when and where they need it
- No young person with mental ill-health has to endure stigma, prejudice and discrimination
- The role of family and friends in supporting young people is valued and encouraged

Ten-year targets

1. Suicide rates for young people aged 12–25 years will have reduced by a minimum of 50% over the next ten years. This minimum target means that we do not accept that the death of any young person by suicide is inevitable.
2. Every young person will be educated in ways to stay mentally healthy, will be able to recognise signs of mental health difficulties and will know how to access mental health support if they need it
3. Youth mental health training will be a standard curriculum component of all health, youth and social care training programmes
4. All primary care services will use youth mental health assessment and intervention protocols
5. All young people and their families or carers will be able to access specialist mental health assessment and intervention in youth-friendly locations
6. Specialist assessment and intervention will be immediately accessible to every young person who urgently needs them
7. All young people aged 12–25 years who require specialist intervention will experience continuity of care as they move through the phases of adolescence and emerging adulthood. Transitions from one service to another will always involve a formal face-to-face transfer of care meeting involving the young person, his or her family/carers and each service involved in his or her care.
8. Two years after accessing specialist mental health support, 90% of young people will report being engaged in meaningful educational, vocational or social activity
9. Every newly developed specialist youth mental health service will demonstrate evidence of youth participation in the process of planning and developing those services
10. A minimum of 80% of young people will report satisfaction with their experience of mental health service provision
11. A minimum of 80% of families will report satisfaction that they felt respected and included as partners in care

Why an International Declaration on Youth Mental Health?

"International declarations that articulate core values, goals and standards have played an important role in enhancing the quality of care in a number of areas of medicine"
(Bertolote & McGorry 2005)

The World Health Organisation (2011) recognises mental health as one of the main health issues affecting young people around the world today. At any one time up to one in four young people aged 12–25 years will be going through a period of mental ill-health and three-quarters of adults with mental health difficulties are likely to have developed those difficulties by the age of 24 *(Kessler et al 2005)*.

The International Declaration on Youth Mental Health (2011) articulates core principles and targets for youth mental health service provision. The declaration aims to influence how people think about and respond to young people's mental health needs. It will be used to leverage support for the development of timely and appropriate youth mental health services internationally.

Appendix 2: Person Centred Care

The WA Mental Health Commission identifies person centred supports and services as one of the three key directions of its ten year strategic policy: Mental Health 2020: Making it Personal and Everybody's Business. The principle of a young person's right to self-determination and to make choices and decisions about their care is also consistent with the philosophy of person centred care and recovery orientation.

YouthLink and YouthReach South respect young persons as partners in decisions about their mental health care, ensure young people are fully informed about their rights, and provide the necessary information, support and access to alternative services that will enable them to make informed decisions. For young persons under the age of 18, these rights will be afforded under the provisions of criteria for a mature minor.

The elements of a person centred approach are:

- being recognised as an individual with their unique background, experience, interests, likes, dislikes and aspirations
- having a voice to make their ideas and wishes known and have important people in their lives - family, friends, cultural and community leaders, teachers ,doctors, employees, psychiatrists – listen, consider and respond
- shaping the essential supports and services that support their recovery
- having choice, flexibility and control in the services they receive and the ability to navigate the right mix of supports and services.

Similarly, the Victoria Department of Health Guide to Implementing Person Centred Practice (2008) identifies the following elements as critical to person centred care:

- Getting to know the consumer as a person. This focuses on building a *relationship* between the clinician and the consumer and carers. Health professionals need to get to know the person and appreciate their key life experiences, relationships and achievements. This builds trust and understanding and supports collaborative care planning and individualised care.
- Sharing of power and responsibility. This focuses on respecting preferences. It includes treating consumers as partners when setting goals, planning care and making decisions about care, treatment or outcomes.
- Accessibility and flexibility. This reflects the importance of meeting the consumer's individual needs by being sensitive to values, preference and expressed needs. It also focuses on giving the consumer choice by providing timely, complete and accurate information in a manner they can understand, so they can make choices about their care.
- Coordination and integration. This is about teamwork and communication. It includes working within effective multidisciplinary teams (and with referring agencies and external service providers to minimise duplication and providing each consumer with a key contact at the health agency. It also involves service providers and systems working 'seamlessly' behind the scenes to maximise consumer outcomes and provide them with a positive experience.

- Environments. The environment refers to both the physical and the organisational / cultural environment. This is focused on having an environment that enables staff to be person centred in the way they work.

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Appendix 3: Engagement and Therapeutic Relationship

Research has consistently shown that the single most important predictor of treatment outcome that is under the control of clinicians is the therapeutic alliance. This is even more important than what specific treatment approach is used (Karver, Handelsman, Fields and Bickman, 2006; Lambert and Barley, 2001; Shirk and Karver, 2003).

These findings are even more important in the population of young people who are seen at YouthLink and YouthReach South. These young people often have the following experiences that interfere with engaging and benefitting from treatment:

- belong to marginalised / high risk groups (eg. Aboriginal and Torres Strait Islander, gender diverse young people)
- poor past experiences of treatment or engaging with systems of care
- poor or unstable relationships with others and difficulty with forming and maintaining relationships
- trauma, often at the hands of trusted adults (eg. parents)
- transience and/or homelessness.

These difficulties can have long-lasting and major impacts on people's ability to form relationships, maintain them, trust others, and experience safety in relationships. Unfortunately these are also the core elements required to engage with and benefit from psychotherapy. Without an understanding of these difficulties there is a much greater chance that the therapy will either terminate early, not be effective, or may even be re-traumatising / iatrogenic (Briere and Lanktree, 2011).

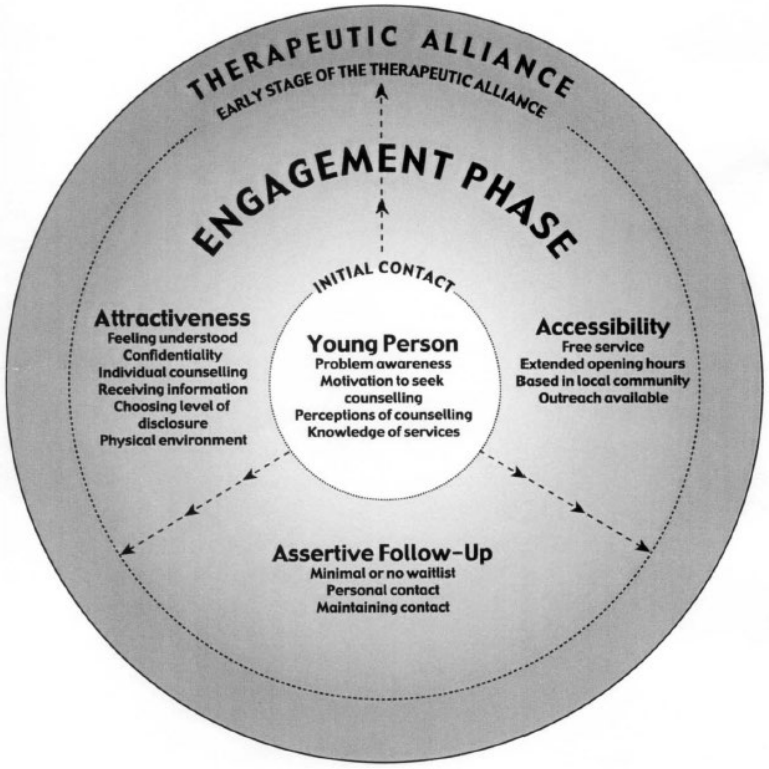

FIGURE 1. Model illustrating the influences on the engagement process from the perspective of at-risk youth. As shown, the thematic categories that emerged from the interviews were Young Person, Attractiveness, Accessibility and Assertive Follow-Up. Arrows represent the time from initial contact with the service to the early stage of the therapeutic alliance.

Given these difficulties, it is important that services are presented in ways that are easily accessed by young people. Research with YouthLink consumers illustrates some of these engagement processes, (see Figure 1, from French, Reardon and Smith 2003, p535). A positive therapeutic alliance is associated with less premature drop-out and improved outcomes. This is a relationship where the young person feels understood, respected, is working on issues

important to them, and in a way that suits them. It is important that clinicians actively foster these elements of the relationship and monitor these throughout treatment.
In addition people need to experience benefit from treatment and may drop out of therapy early if they do not experience positive changes. As a result it is important to also monitor treatment outcomes. YouthLink and YouthReach South undertake treatment monitoring primarily through the NOCCs collected and reported on for each client, at three- month review periods.

In summary services need to focus on the relationship with the young person and working flexibly to deliver services and treatments that fit the young person, rather than trying to force the young person to fit the service model and way of working.

Implications for service delivery

1. Focus on welcoming services that work flexibly to develop good engagement and positive therapeutic relationships
2. Clinicians get ongoing feedback from consumers about their experience of the relationship and therapeutic change on an ongoing basis throughout treatment
3. Understanding that the therapeutic relationship can repeat past negative relationships as well as heal from these
4. Need for trauma-informed understanding of relationships
5. Acknowledgment that for some clients it will be hard to develop good positive relationships and that this can be an important goal of therapy
6. Focus on transitions and endings of relationship and sensitivity to the impact this can have on clients
7. Need for continuity of care and longer term treatment with the same clinician for a number of clients with early relational trauma or neglect.

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Appendix 4: Trauma-Informed Care

Trauma-informed care has emerged in response to the recognition that a large percentage of people accessing mental health services have a history of psychologically traumatic experience which significantly impacts on their mental health presentations and has implications for their management and care needs.

Psychologically traumatic experiences are usually interpersonal in nature and include sexual and physical abuse, neglect and extreme invalidation. These experiences often occur over time and for the young person attending YouthLink and YouthReach South have usually begun very early in childhood or adolescence.

For the target population of YouthLink and YouthReach South, rates of experiences of trauma are consistently high: 35-70% for psychosis (Morrison, Frame and Larkin, 2003) and 40-80% for borderline personality disorder (Lieb, Zanarini, Schmahl, Linehan and Bohus, 2004). In order to best support and not re-traumatise young people, the Youth Mental Health Program operates in a trauma-informed manner.

Experiencing complex trauma can have a profound effect on an individual's life. Common effects include:

- development of mental health disorders
- an inability to manage emotions and impulses
- an altered sense of self and others
- a lack of ability to have a stable and satisfying relationship
- a lack of sense of safety in the world.

In order to provide an effective service to individuals who have been traumatised, services and all staff within them need to take into account the impact of trauma and take measures to not re-traumatise the individual.

> *"Trauma-informed" refers to all of the ways in which a service system is influenced by having an understanding of trauma, and the ways in which it is modified to be responsive to the impact of traumatic stress. A program that is "trauma-informed" operates within a model or framework that incorporates an understanding of the ways in which trauma impacts an individual's socio-emotional health. This framework should, theoretically, decrease the risk of re-traumatisation, as well as contribute more generally to recovery from traumatic stress." (Harris and Fallot, 2001)*

In a trauma-informed system, trauma is viewed not as a single, discrete event, but rather as a defining and organising experience that forms the core of an individual's identity (Harris and Fallot, 2001).

There is evidence from a large scale, multi-site study to suggest that trauma-informed services are more effective in improving trauma and mental health symptoms than those that are not trauma-informed (Morrissey et al, 2005).

Key Principles of Trauma-Informed Care

Trauma Awareness

Trauma-informed services are those in which all members of the organisation share an understanding of the profound neurobiological, biological, psychological and social effects of trauma and violence on the individual human being. This shared understanding is used as a platform to assess and modify every part of the organisation's management and service delivery system to be more supportive of the individual seeking treatment and to avoid traumatisation. This may include establishing a philosophical shift, with the overall system taking a different perspective on the meaning of symptoms and behaviours. Staff training, consultation, and supervision are important aspects of organisational change to incorporate trauma awareness. Practices within the agency should also reflect an awareness of the impact of trauma, including changes such as screening for trauma history and increasing access to trauma-specific services and staff self-care to reduce the impact of vicarious trauma

Emphasis on Safety

Because trauma survivors are often sensitised to potential danger, trauma-informed service systems work towards building physical and emotional safety for young people and clinicians. The system should be aware of potential triggers for young people and strive to avoid re-traumatisation. Because interpersonal trauma often involves boundary violations and abuse of power, systems that are aware of trauma dynamics establish clear roles and boundaries developed within a collaborative decision-making process. Privacy, confidentiality, and mutual respect are also important aspects of developing an emotionally safe atmosphere. Diversity is accepted and respected within trauma-informed settings, including differences in gender, ethnicity, culture, and sexual orientation.

Opportunities to Rebuild Control and Empowerment

Because control is often taken away in traumatic situations, trauma-informed service settings emphasise the importance of choice and empowerment for young people. They create predictable environments that allow young people to re-build a sense of efficacy and personal control over their lives. This includes involving young people in the design and evaluation of services.

Strengths-Based Approach

Trauma-informed systems are strengths-based, rather than punitive or pathology driven. This type of system assists young people in identifying their own strengths and developing coping skills. Trauma-informed systems are future focused and utilise skill building to develop resilience.

References

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Morrison AP, Frame L and Larkin W (2003). Relationships between trauma and psychosis: a review and integration. *British Journal of Clinical Psychology*, 42(4), 331-53.

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Appendix 5: Recovery Orientation

The National Standards for Mental Health Services 2010 state in its principles of recovery oriented mental health practice that:

> *From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.*

Recovery principles incorporate:

- Uniqueness of the individual
- Real choices
- Attitudes and rights
- Dignity and respect
- Partnership and communication
- Evaluating recovery

For the professional, the recovery approach implies a fundamental shift from "doing for" to "doing with". Through this, service providers work in a manner that stimulates wellness and focuses on strengths rather than concentrating on symptoms and deficits. Recovery-oriented practice encapsulates mental health care that:

- Embraces the possibility of recovery and wellbeing created by the inherent strength and capacity of all people who experience mental health issues
- Maximises self-determination and self-management of mental health and wellbeing and involves, person centred, strengths-based and evidence-informed treatment, rehabilitation and support
- Acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture and families as well as people's unique strengths, circumstances, needs, preferences and beliefs
- Addresses a range of factors and social determinants such as housing, education, employment, income, geography, relationships, social connectedness, personal safety, trauma, stigma, discrimination and socioeconomic hardship that impact on the wellbeing and social inclusion of people experiencing mental health issues and their families
- Helps families or supports people to understand their family member's experiences and recovery processes and how they can assist in their recovery, while also helping them with their own needs for counselling, therapy, education, training, guidance, support services, peer support and advocacy
- Understands that people who have lived experience of unresolved trauma struggle to feel safe, considers the possibility of unresolved trauma in all service settings and incorporates the core principles of trauma-informed care into service provision.

YouthLink and YouthReach South aligns with recovery oriented practice in their delivery of evidence-informed treatment, therapy and psychosocial support centred on the individual's unique care needs with a focal objective of achieving the best outcomes for the young person's mental health, physical health, wellbeing and social and occupational functioning.

References

A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers. Commonwealth of Australia, 2013. Available from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-recovgde

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Appendix 6: Systemic Care, Care Coordination and Assertive Case Management

Case management is a clinical process which aims to reduce fragmentation of service delivery and to ensure care provided from different professionals / agencies is coordinated. It aims to strengthen the collaborative relationships between service providers and with consumers their families and carers. This ensures that consumers who potentially have difficulty engaging with more than one service are supported and assisted through assessment, treatment, psycho-social support and recovery (Rapp and Goscha, 2004).

A case manager is the identified clinician who has the responsibility of coordinating the care and ongoing assessment, treatment and support to an individual consumer, and their carers or significant other where appropriate, from admission into the service until their discharge.

Assertive case management involves:

- low patient to staff ratio
- most services provided in the community
- assignment of patients to a dedicated case manager
- time unlimited service
- most services provided by the case manager
- 24 hour care (Meuser et al, 1998)

Preston and Fazio (2000) demonstrated that assertive case management has the potential to reduce inpatient admissions in chronically ill mental health patients over normal case management.

Rapp and Goscha (2004) comprehensively reviewed the literature on evidence-based case management and extracted 10 ‘ingredients’ of effective case management (note that these include the elements of assertive case management above):

1. Case managers should deliver as much of the "help" or service as possible, rather than making referrals to multiple formal services
2. Natural community resources are the primary partners
3. Work is in the community
4. Individual and team case management works
5. Case managers have primary responsibility for a person's services
6. Case managers can be paraprofessionals. Supervisors should be experienced and fully credentialed.
7. Caseload size should be small enough to allow for a relatively high frequency of contact
8. Case managers should foster choice
9. Case management service should be time unlimited
10. People need access to familiar persons 24 hours a day, seven days a week

Within YouthLink and YouthReach South, case managers provide care consistent with the North Metropolitan Health Service Mental Health Care Coordination Framework Tier 3 Assertive Case Management (Nizich, 2011).

Case managers will work collaboratively with community agencies, primary care providers, general health services, private practitioners and community managed organisations in supporting young people. Working effectively in partnership with other practitioners and organisations involves all parties identifying a lead agency or practitioner, having a strong commitment to a common purpose and goals, and engaging in clear communication and processes. Case managers will support the system around the young person to provide a clear, coherent, contained system of care. Services will be delivered in a systemic manner, helping the young person to operate effectively in the world in which they live.

Coordinated interventions can include multi-agency care meetings, regular liaison meetings; person centred joint care planning, joint case reviews and joint reporting of agreed outcome measures. For young people from Aboriginal, Torres Strait Islander or culturally and linguistically diverse backgrounds, coordinated interventions that include internal cultural consultation, relevant specialist services providers and community networks will be considered important. Case managers will be the primary point of contact for consumer, carers and any agencies involved in care.

References

Meuser KT, Bond GR, Drake RE and Resnick S (1998). Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin, 24(1), 37-73.

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Appendix 7: Managing Barriers and Delivering Youth-Friendly Services

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 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 services such as treatment, support, group work, referral and 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. This is consistent with findings from multiple reports and frameworks within key local, national and international organisations:

- WA Commissioner for Children and Young People (www.ccyp.wa.gov.au)
- Youth Affairs Council WA (www.yacwa.org.au)
- Australian Infant, Child, Adolescent and Family Mental Health Association (www.emergingminds.com.au)
- Burdekin Report (1993)
- World Health Organisation (www.who.int/mental_health/en/)
- Social Care Institute for Excellence, UK (www.scie.org.uk)

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, including co-design, and the maintenance of an inclusive Youth Reference Group
- Provide treatment, support, group work, referrals and rehabilitation
- Balance of family involvement with individual confidentiality
- Youth-specific, safe community and impatient services
- Working towards the prevention of ill health
- Using a co-location model, integrating a number of different services

- Experiencing a continuity of care
- Experiencing well planned, smooth transition
- Using non-judgemental collaborative interventions
- Holistic approach ie. peers, relationships, education / vocation, leisure, sexuality, housing, substance use

YouthLink and YouthReach South also recognise that the serious history of abuse and disordered attachment patterns in many of their clients, their particular difficulties with homelessness, lack of support and past treatment failures create significant additional barriers in them accepting help, establishing therapeutic relationships and maintaining regular attendance that need to be managed in very sensitive and flexible ways that are attentive and responsive to the individual client. This might include:

- Negotiating preferred and safest location for service delivery
- High tolerance for missed appointments particularly early in the treatment relationship and episode of care
- Assertive attempts to contact clients who have missed appointments or are lost to follow up
- Trauma-informed practice and attachment-informed formulations
- Significant focus on therapeutic relationship and reflected / considered practice in response to therapeutic mistakes / ruptures
- Significant attention to transitions, breaks and endings
- Continuity of care
- Extended treatment to address underlying trauma, core schema, personality organisation and attachment difficulties
- Therapeutic case management targeting both imminent / critical psycho-social needs whilst addressing underlying factors that perpetuate these difficulties.
- Minimising wait-time for treatment where possible

References

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Appendix 8: Acceptance and Responsiveness to Diversity

There is widespread evidence to indicate that mental health difficulties are more prevalent among particular groups within broader populations, and that these groups also experience greater barriers to receiving mental health treatment. The Report of the National Review of Mental Health Programmes and Services (2014) identified Aboriginal and Torres Strait Islander (ATSI) people, and those of diverse sexuality or gender (DSG) or cultural and linguistic background (CALD), among people who experience disadvantages both in terms of prevalence of mental health disorders and access to appropriate mental health treatment. The difficulties are even more pronounced within young people from these groups. It is therefore important to deliver mental health services for young people which recognise, accept and respond to the diversity of their needs.

There are a number of key Acts of Parliament and other documents which inform the approach to diversity of YouthLink and YouthReach South. The relevant Acts include:

- Australian Racial Discrimination Act 1975
- Australian Sex Discrimination Act 1984
- Australian Human Rights Commission Act 1986
- WA Equal Opportunity Act 1984.

The National Standards for Mental Health Services 2010 Standard 4 Diversity Responsiveness states that:

> *"The Mental Health Service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care."*

Diverse groups are identified within Standard 4 as inclusive of people of ATSI descent, CALD people, and those of diverse religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status that access the service.

The criteria presented within the Standard also emphasise that the Mental Health Service:

- utilises available and reliable data to document and review needs of its community
- plans and delivers services with responsiveness to diverse needs
- maintains awareness of, consults and partners with, other organisations with diversity expertise
- trains staff to provide services appropriate to diverse communities
- ensures that staff deliver services within non-discriminatory practice, and maintain equitable access to services.

The National Standards principle of recovery-oriented mental health practice "acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture and families as well as people's unique strengths, circumstances, needs, preferences and beliefs". The implementation guidelines from the National Standards state that the Mental Health Service should also have documented evidence to show their consultations

and partnerships relating to diversity, their engagement in whole of service training in the diversity needs of the target population and culturally competent service delivery, management of complaints and grievances around diversity factors, and the engagement of interpreters.

Further, the WA Mental Health Commission ten year strategic policy Mental Health 2020 identifies diversity as one of its five key principles, stating that

> *"The unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or from culturally and linguistically diverse backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs."*

YouthLink and YouthReach South align with and uphold the standards, principles and practices of acceptance and responsiveness to diversity in the planning and implementation of services. Both services target marginalised young people aged 13 to 24 years, with significant barriers to service including cultural barriers and issues related to diverse sexuality and gender.

Within YouthLink and YouthReach South, these principles are operationalised through a variety of processes and practices including:

1. Adherence to the Youth Mental Health Team Based Service Delivery Policy and the portfolio framework embedded in this policy. Portfolio Coordinators have been appointed to each of the following specialist areas: ATSI, CALD, DSG. Portfolio Coordinators have the responsibility to develop annual actions plans to ensure sound contemporary knowledge of evidence-based practice and community resources within each area of specialisation, to take leadership for ongoing quality improvement in these domains and to provide leadership to ensure effective partnerships with other service providers.
2. Development and maintenance of policies and procedural documents on diversity responsiveness.
3. Staff profiles that support the recruitment and retention into dedicated Section 50D positions in which Aboriginal and Torres Strait Islander descent is a genuine occupational qualification. There are currently three ATSI Mental Health Practitioners employed across YouthLink and YouthReach South, the Moorditj Wirn ("Solid Spirit") team, who provide direct clinical services to ATSI young people, act as cultural consultants to non-ATSI clinicians working with ATSI young people, and provide a community triage function to support culturally sensitive community based referral processes for ATSI young people.
4. Ensuring capacity to provide clear and unambiguous welcome and appropriate service delivery to LGBTQI+ young people. Within YouthLink this has been informed through the conduct of external audits ("Opening Closets") of the service. These audits have informed actions such as display of welcoming posters and other materials in the waiting area, gender neutral toilet facilities and changes to administrative and clinical processes (including assessment) to accommodate diversity in gender. Both YouthLink and YouthReach South focus on providing a welcoming and responsive service with a focus on sound engagement and positive therapeutic relationship that is inclusive of sexuality and gender. Youth Mental Health's capacity to deliver services to LGBTQI+ young people has also been informed through membership of the National LGBTI Health Alliance, and the involvement of the DSG Portfolio Coordinator in the LGBTI Mental Health

Champions project which has the broad aim of enhancing the capacity of mental health services to deliver inclusive and welcoming services to persons with diverse sexuality and gender.

5. Adoption of trauma-informed care principles, which promotes an atmosphere of acceptance and responsiveness to diversity, including ethnicity, cultural and linguistic and sexuality and gender.
6. Ensuring an informed and competent workforce. Cultural capability in delivering service to LGBTQI+ young people is seen as a core competency for all staff employed within Youth Mental Health. This is supported by training opportunities, and competencies in these domains of practice are assessed in recruitment and selection processes and in performance development cycles.
7. Engagement in consumer surveys and consumer participation events which examine and respond to client (and broader target group) perceptions and experiences of the service, including factors related to acceptance and responsiveness to diversity.

References

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Mental Health 2020: Making it Personal and Everybody's Business. Mental Health Commission, WA (2012). Available from https://www.mhc.wa.gov.au/media/1316/mhc-strategic-plan.pdf

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Appendix 9: Youth Accommodation Liaison Clinical Nurse Specialists (YAL CNS) Clinical Framework

Service

The Youth Accommodation Liaison Clinical Nurse Specialists (YAL CNS) will provide leadership and direction in the establishment and maintenance of effective partnerships between Youth Mental Health and youth accommodation providers. Areas of accountability will include:

- Provision of clinical assessment, risk assessment and brief treatment for young people who are classified as homeless or have had a recent history of homelessness who are residing at youth accommodation services.
- Facilitate access to specialist mental health services as appropriate for young people, with complex mental health issues and associated behavioural manifestations.
- Deliver consultative advice, education and support to crisis accommodation providers.
- Provide a flexible response to meet young people's needs.
- Facilitate an integrated approach between specialist accommodation services, mainstream mental health providers and primary care providers.
- The two YAL CNS positions will be based at YouthLink and YouthReach South respectively.

Mission

- The Youth Accommodation Liaison Clinical Nurse Specialists will work in partnership with youth crisis accommodation services and aim to provide an integrated service model to support homeless young people with mental health issues and co-occurring drug and alcohol issues.

Key Objectives

- Young people who access the services will be:
    - Provided with a comprehensive assessment and treatment package that will address presenting mental health symptomatology and substance misuse issues;
    - Supported to access existing mental health services, including community support services and clinical services; and
    - Supported access to other mainstream health services.

- Upskill the youth accommodation services in managing young people with mental health and co-occurring Alcohol and Other Drug (AOD) issues.
- Provide youth accommodation services a link to main stream mental health services in order to better inform their practice and there by improve outcomes of the young people who reside at their facilities.

Services Provided

The YAL CNS will be an outreach program and deliver evidence based, developmentally and culturally appropriate, trauma informed mental health services.

The clinician will engage young people through flexible, inclusive and responsive practices including assertive outreach.

The Model will provide:

Consultation

The YAL CNS will provide specialist advice and information in relation to young people's mental health issues who are residing in crisis/transitional accommodation. Provide guidance on the implementation of strength based care plans, risk assessment and crisis management. Act as a resource/point of contact for navigating pathways within mental health services. Promote understanding of mental health issues whilst maintaining a respectful approach and acknowledgement of accommodation providers existing knowledge, training and experience.

Referrals

The YAL CNS's will accept referrals from the youth crisis accommodation providers in Perth:

- Armadale YAS (Parkerville)
- Calvary Youth Accommodation
- Carlow House (MercyCare)
- Ebenezer House (Aboriginal Evangelical Church)
- Indigo Junction (formerly - Swan Emergency Accommodation)
- Tinoca (Joondalup Youth Services / Youth Places)
- Victoria Park YAS (Mission Australia)
- YSHAC – Rockingham / Spearwood (Anglicare)

Service provision to young people in adult SAAP services and transitional accommodation providers, such as Horizon House and Foyer, will be considered.

Triage

It is recommended that a face to face assessment is offered to all referrals from the youth crisis accommodation providers. Referrals to YAL CNS can be made by direct contact with the clinicians whilst attending the crisis accommodation provider services. Otherwise the usual clinical pathway / route into Youth Mental Health will be observed.
Youth integrated triage, including the YAL CNS, will undertake the following tasks:

- Request referrer contact details.
- Log the information on PSOLIS as "Information only".
- If preferred by the referrer, referral information can be taken over the phone.
- The Triage Officer then informs relevant YAL CNS of referral, forwards, together with any additional information to the designated Triage Officer inbox and informs the YAL CNS by phone or email.

- The YAL CNS will be responsible for the work up of the referral from this point on. All referrals will be logged onto PSOLIS under the individual YAL CNS. It is the responsibility of the YAL CNS to present the completed referral to the Youth Integrated Intake Meeting.

Assessment (including Risk)

Standardised documentation will be adhered to, which includes:

- Assessment report
- NOCCs (HoNOS, K10, LSP-16)
- Brief Risk Assessment Form
- PSOLIS Management Plan
- PSOLIS Crisis Management Plan (if required)

All assessment documentation will be completed within two weeks after activation of the young person.

Brief Intervention (BI)

Once accepted to service the YAL CNS will provide short term mental health interventions for up to twelve weeks from the first contact.

Using a strength-based case management model the YAL CNS will link participants to resources within the community. The clinical service will be a partnership model between the young person, the accommodation provider, YAL CNS and significant others where appropriate.

The focus of care will be:

1. mental health care, including alcohol /drug use intervention;
2. housing needs;
3. legal issues;
4. employment / occupation / education.

The care will be defined in a case management plan which will be shared by all relevant parties with consent from the young person.

Review

The YAL CNS will present:

- All assessments to the YouthReach South / YouthLink multidisciplinary team (MDT) within two weeks of activation for review.
- All transitions / closures will be presented to the YouthReach South / YouthLink MDT review meeting two weeks prior to completing BI.

All Linkages (including Transition)

Within short term case management (C/M), all stakeholders in the young person's life will be identified in order to plan transition and linkage at the final stages of C/M.
Transition will include:

- negotiating service options with the young person, significant others where appropriate and support services;
- selecting the most suitable service option and ensuring its availability;

- development of plans – these need to be formalised and documented highlighting any special needs of the young person;
- in advance of the transition, introducing the young person to the receiving service or care arrangement and their key contact.

Training

YAL CNS and youth crisis accommodation providers work collaboratively to provide training opportunities to enhance the knowledge and skills of all staff in the sector. Training topics will include suicidal and self-harming behaviours, anger and crisis management, setting boundaries and mental health disorders.

Admission Criteria

Young people who are homeless, residing in youth crisis accommodation services (secondary homeless), that have signs or symptoms of having a mental illness and may have co-occurring substance misuse issues.

Exclusion Criteria

Youth who do not meet the above criteria.

Operational Model

- Outreach model.
- Hours of operation: Monday to Friday, 8.30am to 4.30pm.
- Each YAL CNS will manage incoming referrals and case manage ten young people for Brief Intervention.
- Brief Intervention will be up to twelve weeks.

Staffing

Nursing staff

- Two Clinical Nurse Specialists.

Benefits to North Metropolitan Health Service, MHPHDS

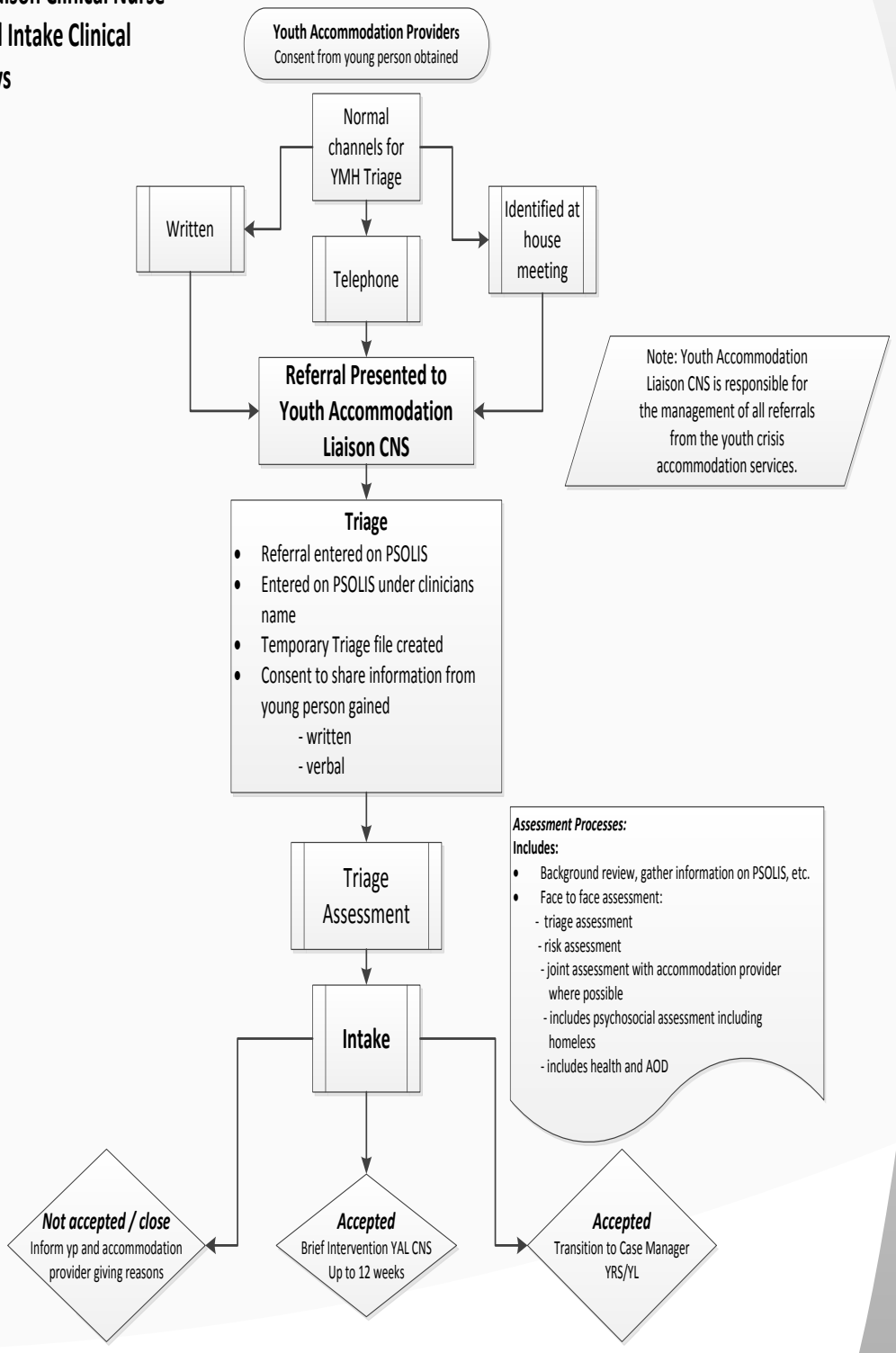
- Improved access to specialised comprehensive assessment, observation and treatment in Youth Mental Health.
- Improved clinical outcomes for mental health consumers and families.
- Improved referral and access to mental health, AOD and other support services.

Evaluation

The monitoring and evaluation plan will address the following, with the data to be reported on after six months of operation:

- **Number of referrals** received from the identified youth crisis accommodation providers. This will be compared to the number of referrals received prior to the service being commenced.
- **Service-related information** regarding: Admission numbers, Referral source, reasons for non-admission, discharge destination, length of stay. Data to be retrieved from R&R database and Psolis, as per usual clinical practice
- **Client characteristics**: Homelessness code, parental code, LGBTI, ATSI, history of trauma and substance abuse. Data to be retrieved from Psolis, as per usual clinical practice.
- **Outcome measures**: HoNOS, K10, LSP at activation and discharge, to be retrieved from Psolis.
- **Consumer Survey** to be conducted at the fourth week of treatment (Experience of Service Questionnaire - ESQ)
- **Stakeholder Survey** to be conducted at a six month interval.

Youth Accommodation Liaison Clinical Nurse Specialist Referral and Intake Clinical Pathways



Appendix 10: The Gender Pathways Service (GPS)

The Gender Pathways Service (GPS) within YouthLink can be accessed state-wide and provides specialist gender diversity consultation, training, community development, referral information, and assessment for suitability and readiness for gender affirming medical treatment (hormones and/or surgery).

Transgender and gender diverse youth are at elevated risk of suicide, self-harm, homelessness, and other mental health and psychosocial difficulties. This service aims to improve the mental, social, and physical health outcomes for gender diverse youth by increasing capacity within services to provide gender affirming care and to facilitate access to medical interventions to address gender dysphoria through specialist assessment.

The Gender Pathways Service will provide:

- Specialist assessments to ascertain diagnosis and suitability for gender affirming medical interventions for gender diverse youth, aged between 17 and 24 years old presenting with;
    - complex mental health/neurodevelopmental disorders
      AND/OR
    - having experienced significant barriers to accessing gender affirming care
- Referral for ongoing mental health and psychosocial support for youth with gender issues
- Consultation to mental health providers, professional bodies, and organisations around issues relating to gender diverse youth
- Education and training in the youth sector to increase inclusive and gender affirming practices
- Peer consultation and education to develop capacity to complete assessment for readiness for gender affirming medical interventions
- Peer education and consultation to mental health service staff to support the management of young people with gender issues who also present with mental health and/or neurodevelopmental disorders
- Development of psychoeducational resources/support materials related to social and medical gender transition.

Note: The GPS will not provide ongoing mental health support or case management. A referral to a youth mental health program, in addition to a referral to the GPS, would be advised if the young person is likely to require ongoing mental health support and meets criteria for YouthLink, YouthReach South, or Youth Axis. Assessment follows the standards of care guidelines set forth by the World Professional Association for Transgender Health.

The GPS is provided by a clinical psychologist 0.5 FTE and is not a comprehensive service.

Admission criteria for assessment

- 17-24 years old (inclusive);
- Gender questioning/ gender diverse identity;
- Seeking assessment to determine suitability for readiness for medical intervention/s (hormones/surgery) to address gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between an individual's experienced or expressed gender and their sex assigned at birth;
- Presenting with co-occurring complex mental health and/or neurodevelopmental concerns;

AND/OR

- Experiencing heightened distress due to facing significant barriers to accessing assessment needed to pursue gender affirming medical interventions;
- Must be experiencing significant barriers in accessing these assessments elsewhere.

Exclusion criteria for assessment

- A current client of YouthLink, YouthReach South, or Youth Axis (the current case manager can seek consultation and/or joint assessment if needed). Current clients of Youth HITH can be referred for assessment due to the time limited nature of the service
- Is eligible for/a current client of the Gender Diversity Service at PMH
- Has capacity to/is accessing private psychiatry/mental health services that are able to complete assessment
- Currently accessing gender affirming hormone therapy (not applicable if the young person is seeking assessment for surgery).

Referrals

Referrals for assessment can be made by completing the Gender Pathways Service (GPS) referral form and emailing this to youthmhtriage@health.wa.gov.au or contacting the Youth Mental Health triage line on 1300 362 569.

For current Youth Mental Health employees, requests for consultation and/or joint assessments for medical interventions can be made directly with the Senior Clinical Psychologist at the Gender Pathways Service located at YouthLink.

Appendix 11: Youth and Adult Complex Attentional Disorders Service (YACADS)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by a persistent pattern of inattention and/or hyperactivity, as well as forgetfulness, poor impulse control or impulsivity, and distractibility.

ADHD is generally considered a persistent and chronic condition, although medication and other therapies may effectively treat symptoms.

ADHD may adversely affect learning, socio-emotional development and overall functioning.

Note: To be considered for acceptance to YACADS, referred individuals must be current patients of Youth or Adult Community Mental Health Services.

Youth and Adult Complex Attentional Disorders Service (YACADS)

YACADS will provide specialist ADHD assessment and treatment services to respond to the needs of 18-64 year olds with ADHD and co-occurring conditions. The YACADS includes:

- 0.2FTE Consultant Psychiatrist
- 0.3FTE Senior Clinical Neuropsychologist
- 0.2FTE Administrative assistant

YACADS will provide:

- Assessment
- Advice to inform care-planning
- Treatment and prescribing (in cases where stimulant medication is indicated)

Attendance at case conferences

- Peer consultation
- Consultation liaison
- Peer education to mental health service staff within community health care settings to support the management of young people and adults with mental health conditions who also have ADHD.

Individuals admitted to YACADS will be reviewed by the mental health service every 12 months. Those who no longer meet intake criteria or who are now able to access services through a privately practising Psychiatrist, or other specialist, will be discharged. 2

Admission criteria

- 18-65 years old with an established diagnosis of ADHD and/or a significant history of moderately or severely debilitating attentional difficulties and hyperactivity consistent with ADHD, with complex presentations;

AND

- A co-occurring Axis 1 or Axis 2 diagnosed mental illness, which is being case managed by Youth and Adult Public Mental Health Service providers. Eligible conditions include but are not exclusive to:
    - Depression
    - Anxiety
    - Psychotic disorders
    - Personality disorders

Assessment Process

Once referrals have been accepted an appointment will be offered to the individual; community case managers are encouraged to attend the initial appointment (usually with the Consultant Psychiatrist) as well. Case managers may be contacted prior to the appointment and asked to provide further collateral which will be useful in determining an ADHD diagnosis. The assessment process may take several appointments over weeks; it is important to attend all of the appointments.

Neuropsychology testing may be necessary to confirm an ADHD diagnosis, which YACADS will provide. These tests may need to be spread out over several appointments; the individual will be advised of this during the assessment process. Please let YACADS know if there are any special requirements we need to consider when making these appointments. After the assessment process the individual will be informed of the outcome and case managers are invited to participate in care-planning.

Appendix 12: Roles and Responsibilities at Ngatti House

YouthReach South provides clinical inreach to Ngatti House, the State-wide homeless youth facility in Fremantle. Ngatti House is a residential recovery service providing medium term accommodation (up to 12 months) in a shared living environment. Ngatti House provides up to 16 beds (8 male / 8 female) and is staffed 24 hours per day, seven days a week by community managed organisation Life Without Barriers (LWB).

Ngatti House provides services to young people who:

- are aged between 17 and 22 years, however current residents will not be excluded on turning 23
- are homeless or at risk of long term homelessness
- have a diagnosed mental illness or are at risk of developing a long term mental illness
- require medium to high level support.

YRS is responsible for triage and assessment of all referrals to Ngatti House. There is a joint intake process between YRS and LWB. Where a person is already engaged with another mental health service, a period of transition may occur, with care arrangements outlined in the management plan. Shared care with other professional staff can also be accommodated.

YRS and LWB work in partnership to ensure that each young person utilising the service has the right mix of clinical support, individualised care coordination / case management and life skills services.

Care Coordination

YRS and LWB have a Service Level Agreement which specifies the care coordination model. The purpose of care coordination is to coordinate and support young people to access a range of clinical and community support services which are tailored to meet individual needs and to assist the young person to live a meaningful life in the community.

Care coordination aims to:

- engage the young person
- provide a single point of contact and a single management plan for Ngatti residents
- promote access to a range of clinical and non-clinical services
- coordinate the respective roles and responsibilities of each agency
- review overall progress and the young person's individualised outcomes.

The guiding principles of care coordination are:

- person centred and consumer driven
- carer and family inclusive
- rehabilitation orientated, in a recovery framework
- trauma sensitive

- socially inclusive
- tailored to individual young person's needs.

There will be two care coordinators for each young person:

- the clinical care coordinator, referred to as the Case Manager YRS
- the community support coordinator, referred to as the Key Worker LWB

Role and Responsibilities of the Case Manager YRS

- Focus on individualised, one to one, targeted therapeutic interventions, emotion regulation and medication management, including monitoring for efficacy and potential adverse effects
- Facilitate psychiatry review for assessment and medication prescribing
- Facilitate medication dispensing by Fremantle Mental Health Service pharmacy, ensuring that all medications are prepared in Webster packs (requirement for all Ngatti residents)
- Additional symptom management, including Dialectical Behaviour Therapy (DBT) skills training and self-monitoring of mood
- Ongoing specialist, multidisciplinary youth mental health care planning and review
- Specialist youth mental health assessment, risk assessment and monitoring of National Outcomes and Casemix Collection (NOCC) and self-reported outcome measures
- Facilitation of access to additional appropriate support services eg. mental health group program, mental health after hours support
- Physical health care of young people at Ngatti House. The Case Manager YRS is responsible to:
    - ensure that the young person is registered with a GP (preferably local)
    - facilitate physical health examination and screening by a GP (including metabolic screening if required)
    - coordinate healthcare appointments, together with the young person
    - accompany the young person to appointments, where indicated, to act as advocate, relay mental health treatment and other relevant information and to support discussion of issues and needs of the young person
    - explore dental health needs of the young person and support access to dental care
    - assess for alcohol and drug use and if appropriate offer treatment and support and/or facilitate access to specialist youth alcohol and drug services
    - negotiate with Key Worker LWB as some of these responsibilities may be appropriate for LWB staff to provide (agreed responsibilities will be clearly defined in the management plan).

Roles and Responsibilities of the Key Worker LWB

- Support and promote independence with daily living skills, such as:
    - budgeting;
    - shopping
    - personal care

    - meaningful activities
    - cooking
    - general planning, organising and goal setting.

- Support development of social and interpersonal skills, in order to assist the young person to manage day to day interactions and daily demands of life. This may include:
    - recreational and social roles in the house and in the wider community
    - support with emotion and behaviour management
    - focus on enhancement of the young person's self esteem
    - support to access and maintain engagement in training, education and/or employment
    - sharing of household chores
    - one to one targeted individualised support.

- Reporting of mental health concerns to the Case Manager YRS

Joint Roles and Responsibilities of the Case Manager YRS and Key Worker LWB

The Case Manager YRS and Key Worker LWB in partnership are responsible for:

- establishing rapport and close contact with the young person and significant others
- reporting, communicating and supporting all partners in care
- the Case Manager YRS will assist LWB staff in delivering person centred daily living (domestic, vocational and social) support
- behaviour management, identification of clear treatment goals and how best to achieve them are the joint responsibility of the Case Manager YRS, Key Worker LWB and the young person and should be clearly identified in the management plan.

Roles and Responsibilities of the Young Person

Planning for exit from Ngatti House is the responsibility of the young person. YRS and LWB will assist the young person to explore options and plan for long term independent living.

Care coordination reviews will determine roles and responsibilities in the following areas:

- investigating independent living options
- supporting the young person with applying for future accommodation
- developing saving plans
- transitioning back to the general community.

Appendix 13: Staffing Establishment

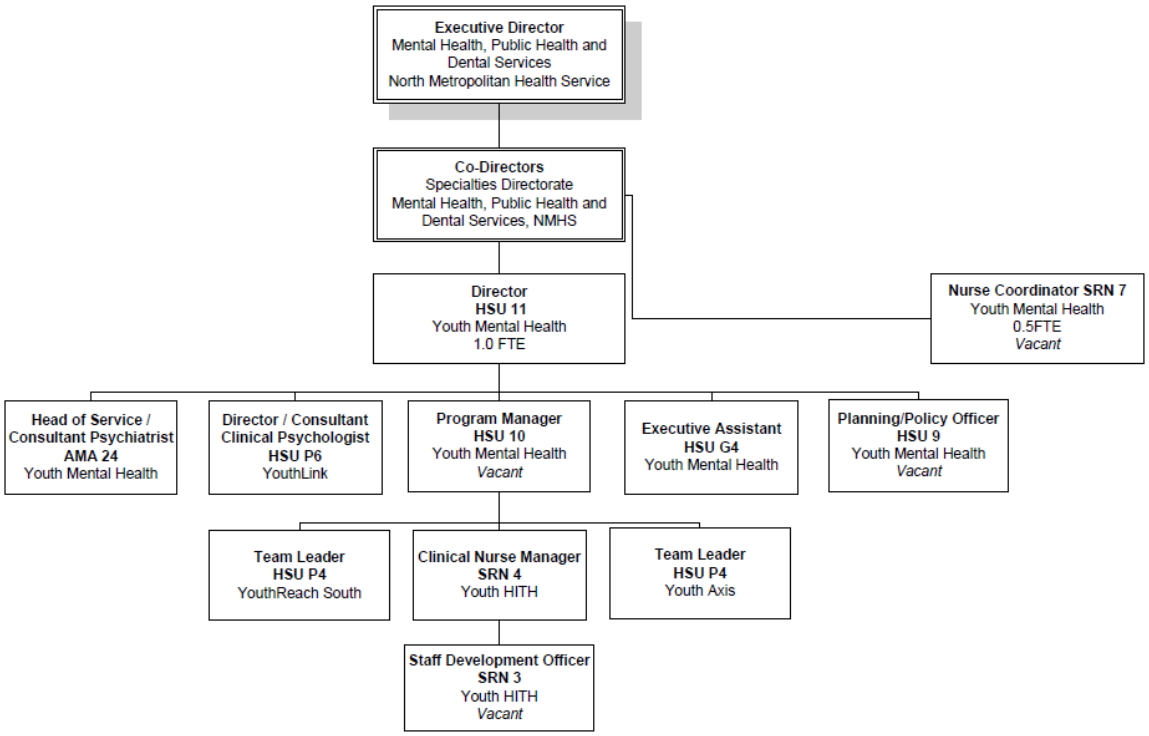
Current at July 2020

YouthLink: Position Title	FTE
Director / Consultant Clinical Psychologist	1.0
Senior Clinical Psychologist	2.7 (3 positions)
Clinical Psychologist Grade 2	1.8 (2 positions)
Clinical Psychologist Grade 1	0.8
Senior Clinical Psychologist GPS	0.5
Senior Clinical Neuropsychologist YACADS	0.3
Aboriginal Mental Health Professional	1.0
Senior Social Worker / Youth Counsellor	1.0
Senior Social Worker	0.8
Social Worker	2.0
Senior Aboriginal Mental Health Practitioner	1.0
Clinical Nurse Specialist Triage Officer	0.8
Clinical Nurse Specialist YAL	1.0
Consultant Psychiatrist	0.6
Consultant Psychiatrist YACADS	0.2
Secretary	1.0
Clerical Officer	0.4
Clerical Officer YACADS	0.2
Total	**17.1**

YouthReach South: Position Title	FTE
Team Leader	1.0
Clinical Service Coordinator	1.0
Clinical Nurse Specialist Triage Officer	1.0
Clinical Nurse Specialist YAL	1.0
Clinical Nurse Specialist	1.0
Senior Social Worker	2.0
Social Worker	2.0
Clinical Psychologist	1.0
Clinical Psychologist Registrar	1.0
Consultant Psychiatrist	0.6
Aboriginal Mental Health Officer	1.0
Administrative Assistant	1.0
Clerical Officer	0.4
Total	**14.0**

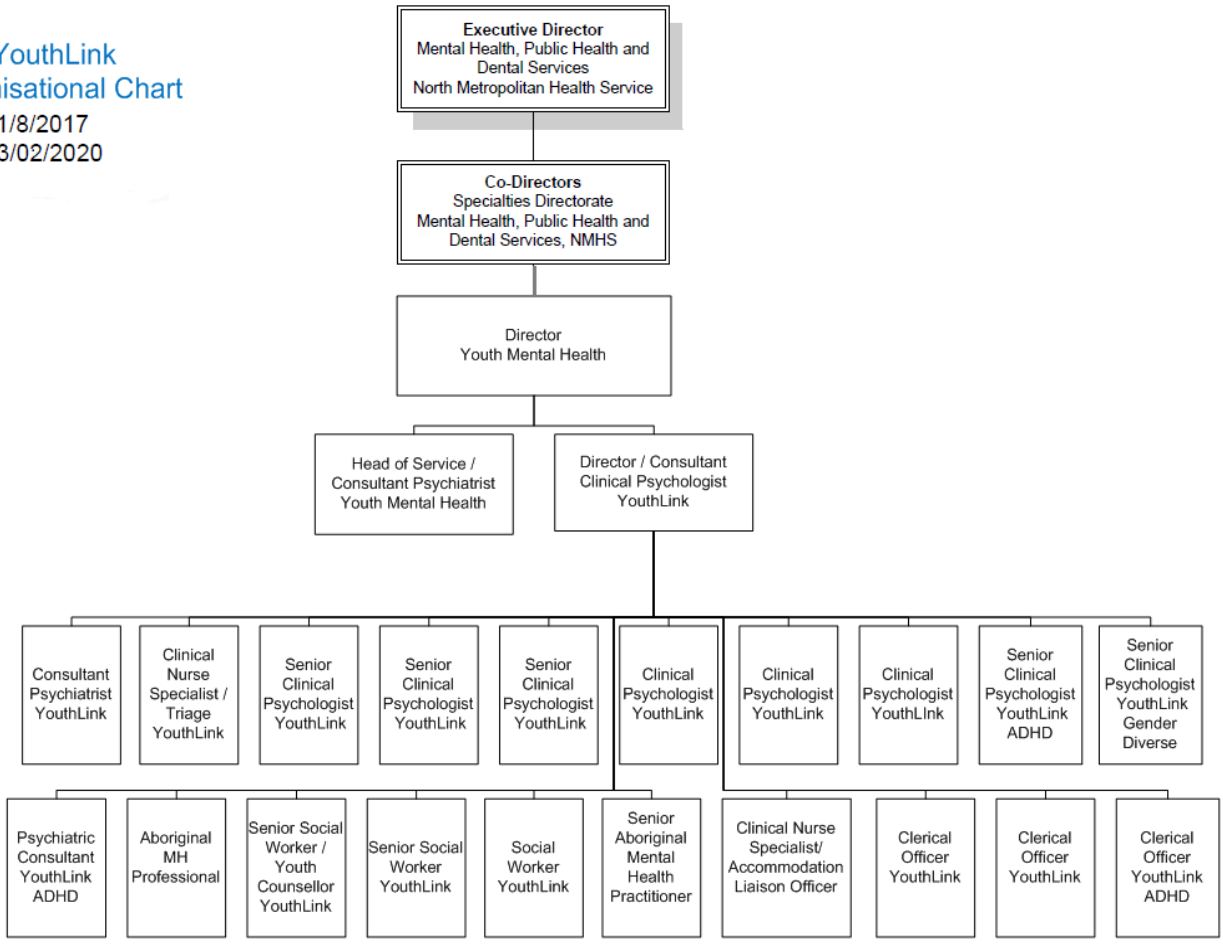
Appendix 14: Organisational Structure

Youth Mental Health
Organisational Chart
21/8/2017
r 03/02/2020

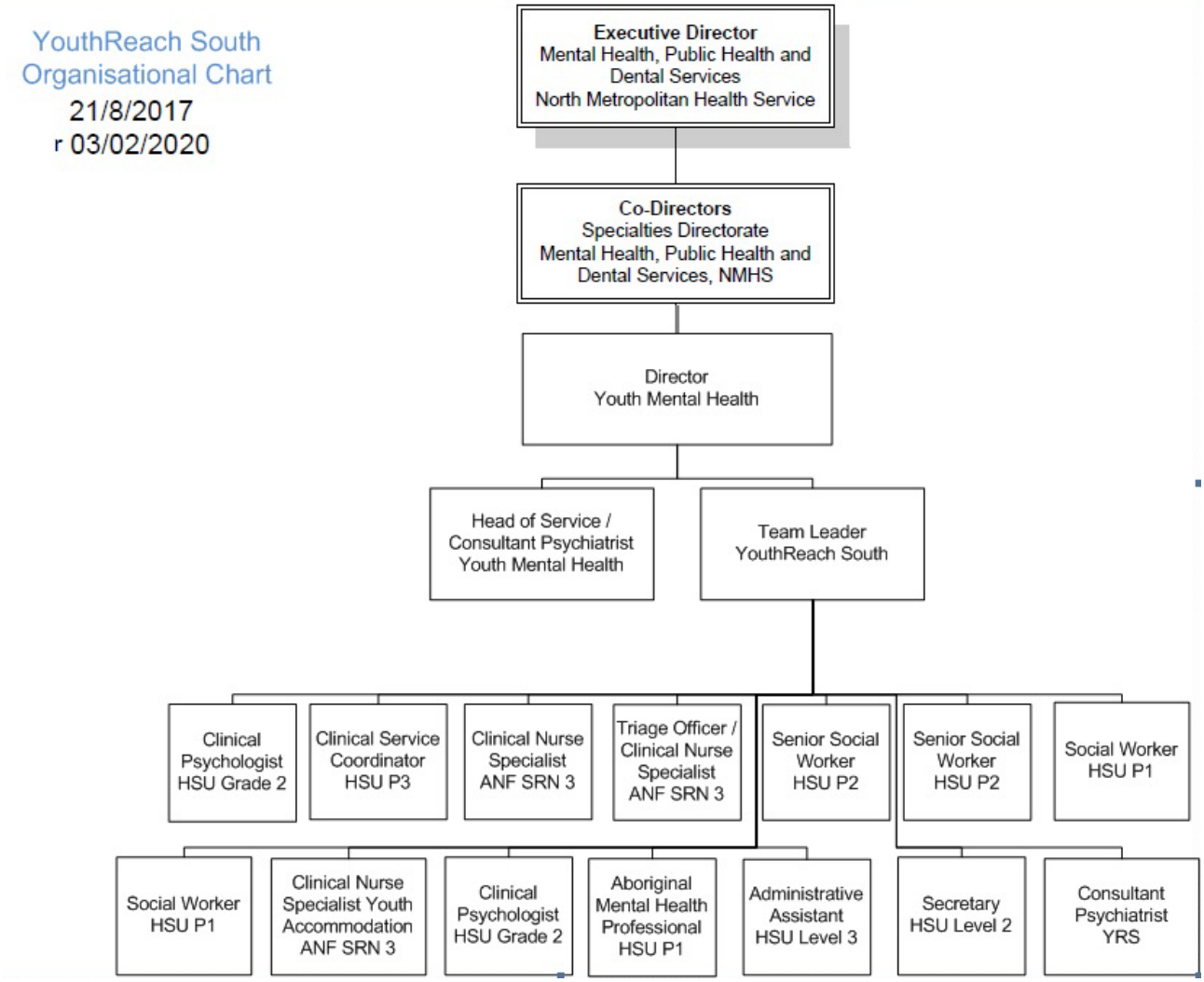


YouthLink Organisational Chart

21/8/2017
r 03/02/2020



YouthReach South
Organisational Chart
21/8/2017
r 03/02/2020



Appendix 15: Youth Reference Group Terms of Reference

Youth Mental Health
Youth Reference Group

Terms of Reference

1. Purpose

The purpose of the Youth Reference Group (YRG) is to ensure that Youth Mental Health (YMH) provides services that are youth friendly and relevant to young people. The YRG provides direction and input into the development, service provision and evaluation of Youth Mental Health services. The YRG also develops, promotes and collaborates in youth participation activities and community awareness events.

YRG members will be invited to participate in community forums, surveys and events which are relevant to youth mental health at local, State and National levels. The purpose and activities of the YRG are aligned with the National Safety and Quality Health Service (NSQHS) Standard 2, Partnering with Consumers, in particular Criterion 4: Partnering with Consumers in Organisational Design and Governance.

The YRG will meet 4-6 times per year for the purposes of contributing to service development, design and evaluation, and developing and implementing projects which promote and enhance youth participation in mental health-related activities.

The impact on patient, staff and organisational safety will be considered when undertaking business decisions.

2. Functions and Responsibility

2.1 The aim is to engage current and recent past (two years) users of Youth Mental Health services in an open group which allows participation in any or all activities of the YRG. There is no obligation on participants in the YRG to attend either the formal meetings or the projects and activities.

2.2 Key Performance Indicators

2.2.1 A minimum of four formal meetings of the YRG to be held annually.

2.2.2 The YRG is engaged in providing input and responses to investigation or to design, development and evaluation processes as identified through the Youth Mental Health Executive.

2.2.3 A minimum of one youth mental health promotion activity is conducted each calendar year, with selection, design and implementation of each activity being undertaken through engagement with the YRG.

Attainments against Key Performance Indicators are to be recorded throughout the year and reported at monthly Youth Mental Health Steering Committee meetings.
The activities of the YRG will be recorded and reported on electronically, and stored on the Youth Mental Health shared drive.

3. Accountability

3.1 Reporting Lines

This committee receives reports from:

Report	By Whom	Frequency	Process
Youth Mental Health Steering Committee	Director of Youth Mental Health	Quarterly	Issues forwarded to Chair prior to meeting, added to agenda as appropriate.

This committee provides reports as follows:

Report	To	By Whom	Frequency	Process
Youth Mental Health Steering Committee	Director of Youth Mental Health	Chair	Monthly	Progress update provided within Youth Mental Health Steering Committee

4. Membership

4.1 Permanent Membership

- Director YouthLink (Chair)
- Member of Youth Participation Portfolio (Deputy Chair)
- Youth Reference Group members

4.2 Apologies and Proxy Members

If a member is to be absent then an apology should be notified to the Convenor of Meetings. Where possible this should be given at least 24 hours prior to the scheduled meeting. Permanent members are required to provide a proxy representative when not in attendance.

5. ExOfficio

Secretarial support (as required)

6. Operating Procedure

6.1 Convenor of Meetings

Meetings will be convened by the Chair.

6.2 Quorum

Meetings are open to any Youth Mental Health service user who has nominated themselves to be added to the Youth Reference Group electronic mailing list. All YRG members are advised through the YRG email group of forthcoming meetings. RSVPs are required, but attendance is not mandatory to any meeting or activity.

The minimum number of YRG members required to endorse a decision at a meeting is four.

6.3 Administration

Minutes detailing action statements will be recorded by the Chairperson Secretary and distributed within five working days of the meeting. All in attendance, along with non-attending members of the YRG (via emailing list) will receive the minutes.

Annual Reports will not be compiled but summaries of activities and achievements will be provided to YMH Executive through the YMH Steering Committee.

Copies of the minutes will be stored on the W:Drive at W:\Mental Health\NM-Youth Program\Staff\02_PARTNERSHIPS AND PORTFOLIOS\Consumer Participation\Youth Reference Group.

6.4 Meeting Frequency

Formal Meetings will be held at least quarterly at YouthLink (Northbridge). Additional meetings will be convened as required to progress activities or for the purposes of consultations with the Health Service or external organisations.

6.5 Special Meetings

Special meetings maybe convened at the discretion of the Chairperson. The purpose of these is to provide YRG input to identified consultation processes which may be internal or external to North Metropolitan Health Service, Mental Health Public Health and Dental Services, or to progress specific YRG activities promoting mental health.

6.6 Conduct of Meeting

The Chairperson will ensure that the meeting is run with procedure and order. Decisions of the committee shall be by the majority.

6.7 Agenda Items

Standing agenda items will include:

- Welcome and Acknowledgement of Country
- Ground Rules and Safety
- Orientation to the YRG
- Purpose of Meeting
- Review of previous Minutes (where applicable)
- Actions from previous Minutes (where applicable)
- Standing Items (where applicable)
- New Business (where applicable)

Additional items for the agenda need to be provided to the Chairperson at least five working days prior to the next meeting. The Chairperson will compile the agenda and circulate it to members at least four working days prior to the next meeting.

6.8 Communication

Communication to the YRG will be from the Chairperson to YRG members via electronic mail. Responses are to be invited via electronic mail from YRG members directly to the Chairperson.

6.9 Confidentiality

The members of the Committee are obliged to maintain the confidentiality of details of any discussion relating to the proceedings of the meeting where stipulated by the Chairperson. Otherwise once action statements/minutes are approved they will be made available for distribution.

6.10 Conflict of Interest

Where a member has a pecuniary interest in a matter, which is before the meeting for discussion, that member should not take part in the discussion or vote on the issue unless the Chairperson of the meeting is satisfied that the interest is so trivial as to be unlikely to affect the member's judgement in the matter. This interest must be declared to the Chairperson and recorded in the minutes.

6.11 Substantive Equality

This Committee shall act in accordance with the State Government's Policy Framework for Substantive Equality (2004), in recognition that the equal or same application of policy, processes and actions to people of Aboriginal and/or Culturally and Linguistically Diverse (CaLD) backgrounds may result in unequal outcomes.

Where Committee membership, co-option expertise and/or agenda topics, includes participation by community members, particularly Aboriginal people and people from CaLD backgrounds, systems and supports to assist in their full participation must be outlined.

7 Adoption and amendment of Terms of Reference

The Terms of Reference shall be endorsed by the Committee and reviewed annually.

These Terms of Reference were first adopted by the Director of Youth Mental Health and the Youth Mental Health Steering Committee on 26 February 2019.

8 Document Review

The Youth Reference Group will complete an annual evaluation. This self-assessment is intended to evaluate the effectiveness, function, membership, attendance, purpose and outcomes of the YRG, including membership satisfaction with the activities of the committee, and the review of the Terms of Reference.

Next review date:

9 Approval

Changes to these Terms of Reference must be approved by Director Youth Mental Health.

This document can be made available in alternative formats on request for a person with a disability.