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Youth Mental Health Services for South Australia

Model of
Care
SA Health
Final 2023



Government
of South Australia

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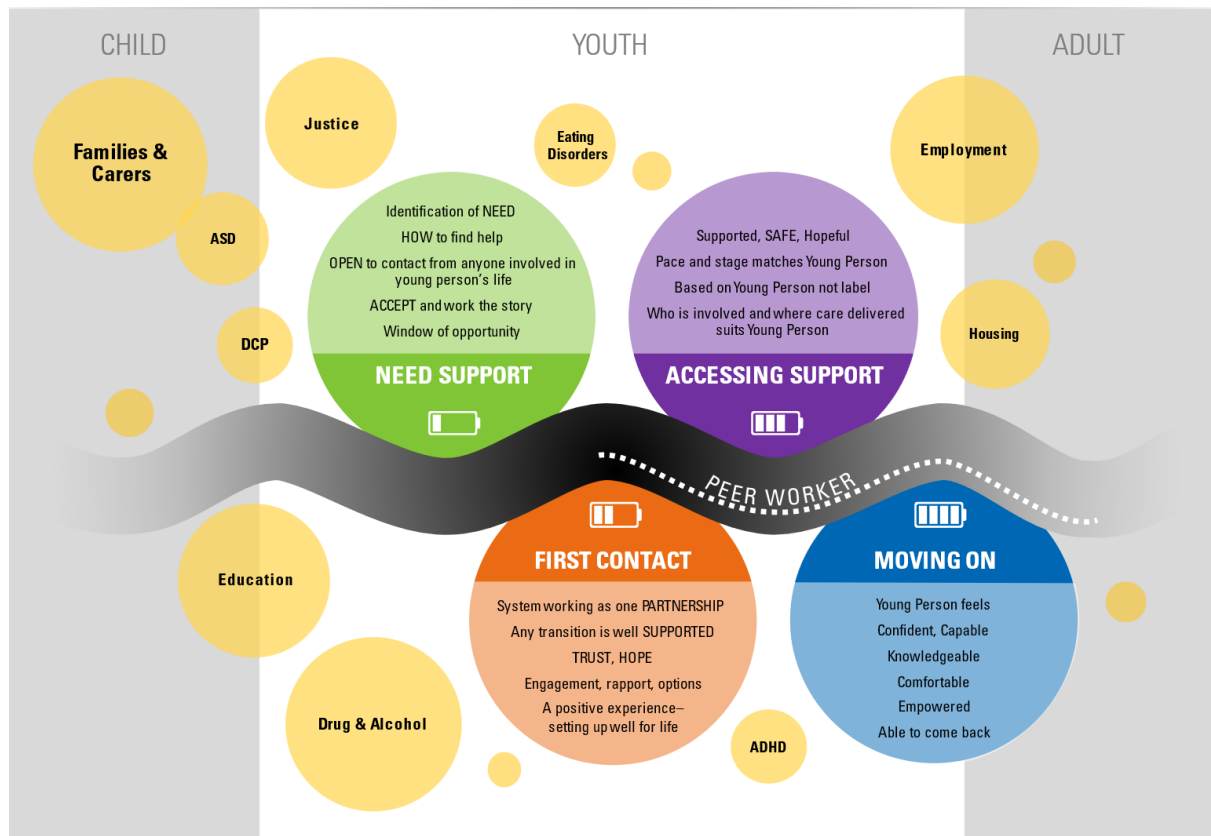
Acknowledgements

Mental Health Strategy and Planning would like to thank the many people who have contributed to the development of the Youth Model of Care, in particular people with lived/living experience, but also the many staff for whom seeing strong mental health services for young people is a passion.

This document builds on the previous work undertaken to establish a system of care for youth mental health in South Australia.

Traditional Owners

We acknowledge Aboriginal people as the first Australians, traditional owners of South Australia, and we respect their ongoing living and spiritual relationship with the land and sea. We respect and celebrate the many Aboriginal peoples and lands across the state of South Australia.



Introduction

South Australia faces a challenge in providing mental health services to young people across the state which are accessible, timely and focused on the young person and their support networks. Mental health workers do their best in a system which is fragmented, complex and difficult for young people, their families and supports to navigate. There is no single answer to these challenges, however this model provides a way forward.

We cannot design a better system without listening to and walking alongside the people who are part of the system and who need care and support. Essentially, our problem is a 'human' problem, not a technical one and so people need to be a part of the solution.

Model of Care for Youth Mental Health Service Design

This Model of Care has been developed with young people, their families, carers, and organisational partners. It outlines an approach for improving youth mental health care across South Australian tertiary mental health settings.

The **purpose** of this Model of Care is to provide direction for local delivery of a consistent approach to care for all young people (16 – 25 years) who enter SA Health mental health services across each stage of the young person's journey, including from when the young person recognises they need support, first contact with the mental health system, accessing and tailoring services and supports and leaving or transitioning to other services.

This Model of Care is recommended as the first phase in the further design, implementation, and evaluation of robust, evidence based and person-centred youth mental health services. Once endorsed, it is recommended that Local Health Networks (LHNs) undertake the subsequent phases of locally tailored development, implementation, and evaluation of their youth mental health services. This Model of Care will ensure the essential components of care are incorporated into service improvements and that local policies and procedures are consistent with this Model of Care.

Mental health is fundamental to wellbeing, physical health, and quality of life. For children and young people, mental health is vitally important at all developmental stages as it will impact on a person's wellbeing later in life. Mental health enhances people's resilience, capacity to be optimistic, ability to build positive relationships with others and be socially included.

The years 16 – 25 are a time of general good health and wellbeing for a substantial proportion of the population but it is also a critical time in the emergence of mental health problems, with 75% of mental disorders occurring for the first time before the age of 25 years (McGorry et al. 2022). Indeed, mental health struggles often begin in childhood with around 13.6% of Australian children aged 4-11 experiencing a mental health disorder. There is convincing evidence that mental disorders in childhood and adolescence predict mental illness in adulthood (WHO 2014b; Lahey 2015; NMHC (National Mental Health Commission) 2019a). Improving mental wellbeing of young people is of paramount concern in the immediate and longer term to create better outcomes across the lifespan. It is also integral in terms of the overall health of our communities and society due to our aging society placing greater dependency on the health and productivity of young people (McGorry et al. 2022).

The negative impact of Covid-19 has amplified the already disproportionately poor mental

health outcomes of young people.

According to the Australian Institute of Health and Wellness,

Covid-19 has emerged as a major health threat to young people in Australia. While Covid-19 affects people in different ways, the social and economic impacts on young people have been substantial. In the initial months following the emergence of Covid-19 in Australia, young people experienced greater levels of psychological distress, loneliness, educational disruption, unemployment, housing stress and domestic violence, compared with pre-pandemic levels. The full impact of Covid-19 is complex and further monitoring is required to understand the longer-term impacts on young people's wellbeing (AIHW 2021d).

In 2022 a study undertaken by the Australian National University Centre for Social Research and Methods identified that young Australians, whose mental health and wellbeing were hit hardest by the pandemic, are improving in measures of life satisfaction, psychological distress, and loneliness. Young Australians still, however, have the most elevated level of psychological distress compared to pre-Covid (Biddle et.al. 2022).

A global meta review conducted by Bower et.al. (2023), synthesised the longitudinal mental health impacts of the pandemic. Findings show that probable depression and anxiety were significantly higher than pre Covid-19, and provide evidence that certain population groups, including adolescents, experienced heightened adverse mental health.

This Model of Care acknowledges the diversity of experience of young people, their families, and carers.

How Did We Get Here?

Background and drivers for change

In 2012 a system of care was developed for youth mental health, with implementation occurring during 2014-2015. Operationalisation of the 'system' was undertaken differently in each of the LHNs depending on history, resourcing, and geography.

A review of youth mental health was undertaken by Dr Sandra Radovini in 2018 under the delegation of the Chief Psychiatrist. The following key findings were made:

1. **A Youth Model of Mental Health Service Provision has not been implemented in South Australia.** What is being provided is extremely variable with widely varying degrees of satisfaction/dissatisfaction with the various models. Service providers were reported as having a varying range of skills, training, confidence, and desire to work with this age group. Transition points are challenging. Continuity of care was difficult to achieve and transition points at all levels were described as difficult. Some services also did not seem to have a way of satisfactorily resolving disputes. There are variable relationships with state-run and NGO (Non-Government Organisations) services resulting in a lack of continuity of care with escalating need, and a lack of integrated care. *To put this another way what is often currently being provided to young people and their families is fragmented care.*
2. **A passionate and committed workforce is doing its best.** There are many examples of passionate and committed clinicians doing their best to provide good care for young people. There are many examples of innovative solutions to demand

and build capacity, and examples of strong local partnerships. Some services have embraced a youth model of care.

3. **There is significant workforce dissatisfaction with current arrangements.** There is significant workforce dissatisfaction with what is perceived as poorly implemented and/or integrated attempts at a youth model of service delivery in South Australia.
4. **There is a lack of ongoing training and issues with workforce recruitment and retention.** It was reported that no systematic ongoing training has been provided to build capacity in the youth mental health workforce. Services experience ongoing problems of recruitment and retention of skilled staff. Initial training was provided by Orygen Youth Health to youth mental health clinicians, many of whom were described as having left the service and hence that expertise has been lost. Where there is not critical mass of 'youth clinicians' this not only impacted on service delivery but also on 'on-the-job' professional development opportunities within some services.

(Office of the Chief Psychiatrist SA 2021)

Following the review, a clinical working group was established which had three main aims:

- To review and update training for youth mental health
- To develop a Model of Care
- To consider the development of a single point of entry for youth mental health services

The group met consistently for two years, reporting to the Mental Health Leadership Group. The group determined that a facilitator should be engaged to assist with the work on the Model of Care (previously system of care).

Current service provision

Local Health Networks

Youth mental health services are offered across all South Australian Local Health Networks (LHNs). LHNs have adopted differing approaches to the provision of youth mental health services with individual operational models and service plans. Regional settings have had fewer resources available with service delivery spread over a large geographical area.

- > Women's and Children's Health Network (WCHN) includes Child and Adolescent Mental Health Services (CAMHS) which offers services to children and young people 0-18 years. New referrals are routinely accepted to age 16 but can be accepted up to the age of 18 depending on location and clinical need. CAMHS also operates the sole inpatient unit for young people aged up to 18 years (Mallee Ward at Women's and Children's Hospital (WCH)), a mental health service in the WCH paediatric emergency department, and a forensic service for young offenders. Other areas where CAMHS offers services past the age of 16 are for vulnerable groups where a transition to adult services is not deemed to be conducive to care. Depending on individual circumstance, this may include Aboriginal young people, children under guardianship and those with a co-morbid disability.
- > In other LHNs, young people are offered care in a variety of different operational structures including a specialist youth team, specialist clinicians within adult community mental health teams, and consultation liaison approaches.
- > Referrals are accepted for young people from the age of 16 by:
 - Southern Adelaide Local Health Network (SALHN),

- Central Adelaide Local Health Network (CALHN),
 - Barossa Hills Fleurieu Local Health Network (BHFLHN),
 - Limestone Coast Local Health Network (LCLHN),
 - Riverland Mallee Coorong Local Health Network (RMCLHN),
 - Flinders and Upper North Local Health Network (FUNLHN),
 - Yorke and Northern Local Health Network (YNLHN),
 - Eyre and Far North Local Health Network (EFNLHN)
- > Northern Adelaide Local Health Network (NALHN) accepts referrals for young people from the age of 18 years

Commonwealth Funded Services

Commonwealth funded services are critical in the provision of a complete response to mental health concerns in the community. Adelaide and Country Primary Health Networks commission a wide range of mental health services within South Australia with crucial links within General Practitioner (GP) clinics, and the non-government sector.

GPs are often the first point of contact for both physical and mental health issues and provide a pathway to a range of psychological programs funded by the Commonwealth Government such as Better Outcomes in Mental Health Care and Better Access to psychological services by allied health professionals through the Medicare Benefits Schedule and Access to Allied Psychological Services (ATAPS). Medicare Better Access provides referral pathways to other allied health disciplines such as occupational therapy and social work.

Enhanced primary care services such as the Commonwealth Government's headspace centres and services (including online and phone counselling) are a key entry point for young people aged 12-25. Headspace provides mental health and wellbeing information, advice, support, and evidence-based interventions in a youth friendly environment. South Australia currently has 12 headspace centres situated in a range of locations across the state.

The Primary Health Networks (PHNs) model for Better Outcomes for Chronic and Complex Health Conditions aims to provide appropriate and effective care to people who would benefit from intensive support. The PHN model assists the individual and service providers or systems involved in care by improving support integration through a personalised care plan.

Young people with a mental illness make up a relatively smaller number of the population supported through NDIS (National Disability Insurance Scheme) psychosocial disability funded support, primarily due to the need to evidence lifelong disability. However, a considerable number of young people also access NDIS funded support for primary physical, cognitive, or behavioural issues with secondary or co-existing mental health concerns.

Why Do Young People Need a Different Service?

Multiple factors affect mental health, and there are unique issues and pressures shaping young people's mental health today in the context of social, political, economic, environmental, and digital change.

The more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Factors that can contribute to stress during adolescence include exposure to adversity, pressure to conform with peers, exploration of identity and the impact of intersectionality on a young person's mental health. Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future. Other important determinants include the quality of their home life and relationships with peers. Violence (especially sexual violence and bullying), harsh parenting and severe socioeconomic problems are recognized risks to mental health.

Issues specific to young people include:

Transition points: Occur at various developmental physical, psychological, and educational stages of a person's life. This includes education, employment, leaving home or care situations, and transition between numerous services and clinicians.

Transition between services, including from child services into youth services and then from youth services into adult services can be frustrating and difficult for young people and their families (Anderson et al 2022). Discontinuation of care during transition periods can leave young people vulnerable to adverse mental health outcomes (Cleverley et al 2020). Proactive collaboration with services such as CAMHS, schools and education providers, primary care providers, NGOs, and adult mental health services for example, are critical at these junctures.

Families: Can have a varied understanding of mental health issues and support needs and are varied themselves in terms of make-up and support able to be offered. Families can face difficulties in balancing mental health support needs and attempting to mitigate potential risks whilst allowing usual developmental growth that includes establishing a level of autonomy and self-exploration.

Families and carers, when involved in appropriate and meaningful ways, can be an important part of the young person's care and recovery. Collaborative approaches to understanding the young person's difficulties, information about the service, treatment modalities, psychoeducation and contact at key points can assist families and carers to feel confident in their skills and ability to support the young person (Rice et al 2016).

Peers: Developmental trajectory may differ from friends when coping with mental health issues. Young people with mental health issues may engage in comparisons with peers and feel judged due to perceived differences. Peers are sometimes the first who may notice emotional changes and are also in a unique position to offer support.

Education and Employment: Economic developments and advances in technology mean that the future job market will emphasize employment of skilled labour. This has a flow on effect within the education system with greater pressure on completion of pre-tertiary and tertiary or diploma studies. Compared to their peers, young people with a mental illness are almost twice as likely not to be in education (O'Dea 2014 in McGorry 2022).

Emerging illness: Includes first onset of symptoms and the period referred to conceptually as the 'at risk mental state.' Recognising potential symptoms, help seeking and early intervention during this period can make a significant difference to long term outcomes (Collizzi et al. 2020; Iorfino et al. 2021). This can be an extremely confronting time for a young person and their family, carers, or peers.

Substance use: It is not unusual for young people to experiment with alcohol or other substances. The combination of substance use, and mental ill-health may make it difficult to manage symptoms whilst also attending to other responsibilities (Headspace 2022).

Developing brain: Adolescence is a time of significant growth and development. The early years are a critical time for brain development, but the brain still needs a lot of re-modelling before it can function as an adult brain. Research is supportive of the hypothesis that the adolescent brain is structurally and functionally vulnerable to environmental stress, risky behaviour, drug addiction, impaired driving, and unprotected sex (Arain et al. 2013). Brain re-modelling happens intensively during adolescence, continuing until a young person is in their mid-20s (Arain et al. 2013).

Adolescent development: Adolescence is a crucial period for developing social and emotional habits important for mental health and well-being. These include adopting healthy sleep patterns; exercising regularly; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Protective and supportive environments in the family, at school and in the wider community are important.

Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, autism spectrum disorder, an intellectual disability or other neurological condition; pregnant adolescents, adolescent parents, or those in early or forced marriages; orphans; and adolescents from minority ethnic or sexual backgrounds or other discriminated groups (WHO (World Health Organization) Nov 2021).

What Does the Mental Health Services Plan Tell Us?

The Mental Health Services Plan 2020-2025 identified three high level goals that were to be applied to services commissioned by the Department for Health and Wellbeing. During the stakeholder workshops these goals were reviewed and expanded to underpin the delivery of youth mental health services.

Personalised Care (page 61 Mental Health Services Plan)

Respect the needs and preferences of the individual and support them to actively participate in all care and treatment decisions.

- > Needs-based, not diagnosis-based
- > Enables different, individualised trajectories - with young person enabled to exercise agency/choice
- > Developmentally attuned and family-oriented
- > Young person is actively involved, at the centre of their care
- > Able to hold lifelong conditions and 'let go' of cure when appropriate – shifting definitions of success

Integrated Care (page 74 Mental Health Services Plan)

Support a holistic service approach that focuses on the whole person, recognising and supporting their mental health, physical health and social needs through improved partnerships, collaborative care planning and continuity of care.

- > Genuinely joined up services with partnerships working towards aligned outcomes
- > Enable peer connections
- > Multi-modal and accessible

Safe and High-Quality Care (page 83 Mental Health Services Plan)

Ensure services are planned and delivered to the highest quality, and are safe, respectful and protect the rights of all who utilise services.

- > Culturally sensitive and responsive
- > Early intervention and built on hope and optimism
- > Future focused to offer support for what lies ahead

In addition, key elements relating to young people outlined in the plan are:

- > Increased access to services for young people identified as developmentally vulnerable
- > Increased access to community-based options to support young people
- > A reduction in deaths by suicide for young people aged 12-24 years
- > Improved rates for mental health follow-up post attempted suicide or self-harm
- > Increased proportion of young people recovering from mental illness supported into or resuming employment and/or education
- > Reducing waiting lists for young people being connected with a service

Establishment of a youth sub-acute inpatient service will be considered in the medium term

Human Rights

The Plan aims to significantly reduce the use of community treatment orders and inpatient treatment orders, while maintaining consumer and community safety. This includes promoting the following principles derived from the Convention on the Rights of Persons with Disabilities (United Nations 2006)

- > Respect for individual autonomy including the freedom to make one's own choices, and be independent
- > Inherent dignity of the person
- > Accessibility of services and resources
- > Equality of opportunity
- > Full and effective participation in society
- > Non-discrimination
- > Acceptance of persons with disabilities as part of human diversity
- > Gender equality
- > Respect for the evolving capacities of children with disabilities
- > Respect for the right of children with disabilities to maintain their identities

Human rights are inter-related and inter-dependent. An integrated approach across health, education, employment, housing, human services, and other sectors is essential (page 19 Mental Health Services Plan).

Appendix Seven provides a list of Human Rights Provisions in South Australian Legislation with implications for the mental health sector.

Methodology for the design of the Model of Care

To lead the development of the Model of Care two cross sector workshops were held on 30 September and 21 October 2021. The purpose of the workshops was to engage with a broad range of young people, carers, service providers to co-design a youth-centred model of care. The Model of Care reflects the voice of the participants from the workshops.

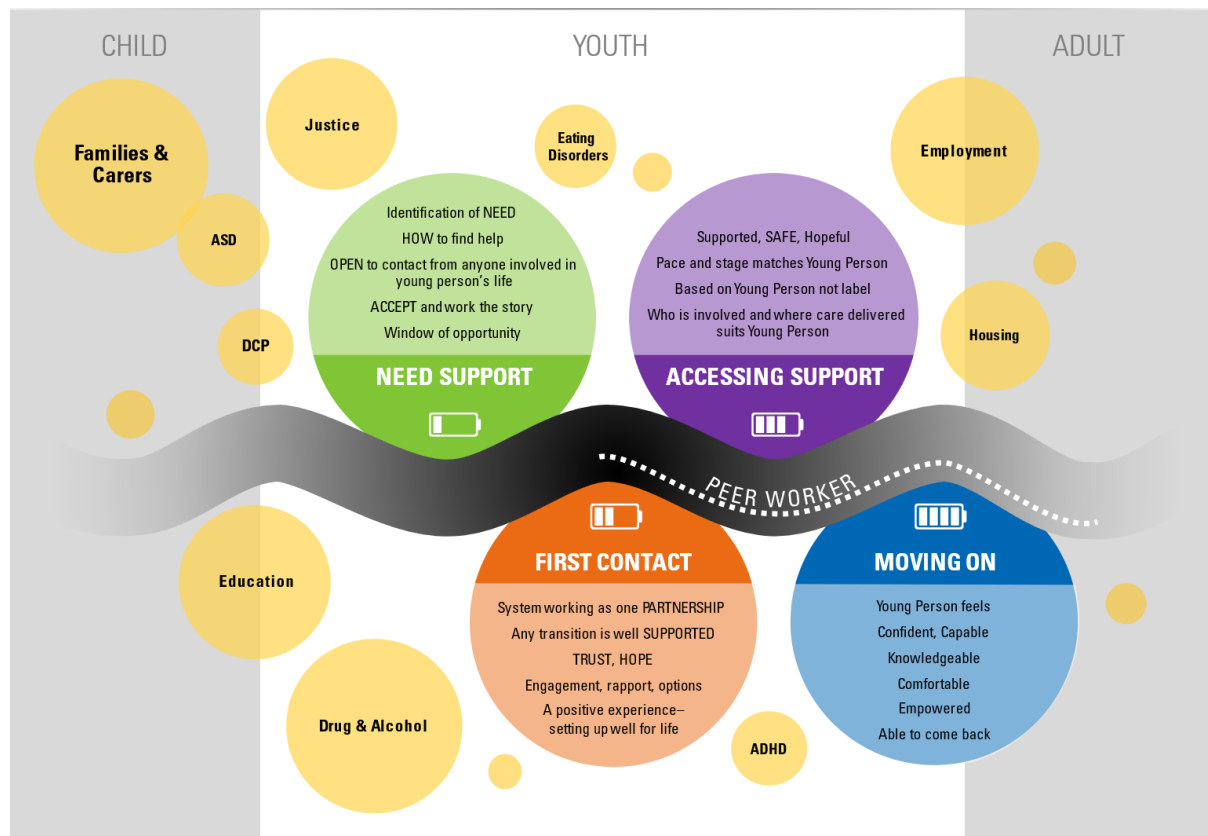
The workshops took an interactive *human centred approach*, to answer a series of 'How might we....' questions that need to be answered in designing the Model of Care to ensure it is fit for purpose and young-person centric.

The first workshop engaged participants to describe the vision for thriving youth mental health, the threats and supports to youth mental health and rapid ideation of the system of the future.

The second workshop focused on developing design principles for the new Model of Care and rapid design elements of a new model.

Information from the workshops has been used to guide and inform this Model of Care. (See **Appendix One** for further information on the attendee list).

What Does Our Model Look Like?



The visual representation of the model reflects the many elements of comprehensive support and care for a young person requiring a tertiary mental health service. It depicts a landscape with a range of agencies and organisations with whom a young person may engage, from

the years between childhood and adulthood. Engagement may occur at any point and so the image is not designed to be a fixed linear process, rather a young person may journey in ways unique to their needs. Central to the model is the peer worker, in acknowledgement of the significant role they play in helping young people with their journey through services and live with or recover from mental health challenges. Individuals, agencies, and organisations across the community will work in partnership to ensure high quality and timely care.

Who Is the Model for?

The model informs and guides mental health services for young people between the ages of 16 and 25 delivered by LHNs. As of 30 June 2021, the Australian Bureau of Statistics indicated that this age range included 211,446 young people in SA. Approximately 25% of these young people experienced some level of mental health issue in any 12-month period (ABS 2021).

There are notable differences across the 16–25-year developmental period. Developmental level is a critical factor related to where a young person best receives services. A 16-year-old may present as much younger or much older, and services need to consider this when determining 'best fit' for service delivery. Developmental level should also be taken into consideration when a young person is transitioning between services and stages as this presents as a key risk point.

While the need for extra services is acknowledged, the experience in other states demonstrates that more can be achieved when youth is a priority objective (page 7 Mental Health Services Plan).

Special considerations for adolescents

Care of an adolescent (aged 16-18) who is seeking health care or is a consumer or inpatient of a SA Health service must be undertaken according to SA Health policy directives/policy guidelines and resources.

The Vision for Thriving Young People

The **vision** is for thriving through youth mental health, where:

- > Young people
 - Are achieving their maximum potential
 - Are genuinely connected, with a strong sense of belonging and inclusion
 - Have high levels of mental health literacy
 - Have key support at critical points in their development and their journey e.g., transition points
 - Are seen holistically and can see themselves holistically
- > Mental health
 - Is normalised and there is no stigma attached to seeking support
 - Services are designed as a wellbeing rather than clinical model

Key elements of youth mental health services

- > Needs-based, not diagnosis-based
- > Enables different individualised trajectories – with the young person enabled to exercise agency and choice
- > Developmentally attuned and family-oriented

- > The young person is actively involved, at the centre
- > Able to hold lifelong conditions and 'let go' of cure when appropriate – shifting definitions of success
- > Multi-modal and accessible
- > Culturally sensitive and responsive
- > Early intervention and built on hope and optimism
- > Future focused to offer support for what lies ahead
- > Enable peer connections
- > Genuinely joined up services with partnerships working towards aligned outcomes

Key Enablers

Working in Partnership

Why this is important

The space is complex

Youth mental health services offered by state mental health services operate in a complex space which can be confusing for young people and those who support them. Youth mental health services need to be undertaken in partnership with all services in the field including headspace centres and other state and Commonwealth funded service providers. Local partnership arrangements will need to be developed and agreed to, with the aim of ensuring ease of access, and that the young person gets the right service level as and when required.

The young person is at the centre of care

Strong connections and partnerships ensure a holistic approach, with the understanding that mental health concerns cannot be treated in isolation from the young person's past and present context/ lived experience. This includes the impact of issues which coincide with mental health distress, including intergenerational unemployment, poverty, homelessness, trauma, racism, bullying, loss and grief, settlement experience and stigma. In keeping with the principle of the young person at the centre of care, agencies will need to work together to ensure that a seamless service is delivered to the young person. In practice, this may require shared documentation, shared agreement processes, common training, shared staffing, and service delivery locations.

Collaborative partnerships enable the best journey of care

The development of clear, collaborative partnership arrangements between *headspace* centres, other primary care service providers, non-government (including youth) organisations and youth specific mental health services at the local level are pivotal for the delivery of integrated services to young people. Shared youth specific mental health assessment will ensure early identification, assessment, and management of young people with mental health issues, ensuring that these partnerships communicate effectively and prioritise service experience and expediency to meet young peoples' needs when and where required.

Barriers to accessing services by Aboriginal young people need to be resolved

Initiatives between youth specific mental health services, Aboriginal youth services and health organisations which break down the barriers that currently exist for Aboriginal youth in accessing primary health care will be supported. The role of a Traditional Healer is an option some Aboriginal people want available to choose as a form of treatment in conjunction with western clinical practices.

Peer Workers

Why this is important

Peer workers play a valuable role within the care team and provide a collaborative adjunct to clinical treatment. Peer workers should be matched for experience and personal priorities of the young person. There has been limited research to date on the impact of peer work practice within youth mental health, however there are transferrable benefits from research and subsequent implementation of peer work models within adult mental health services (Ibrahim et al. 2020). Building hope for young people and contributing to their support network cannot be underestimated during their journey through services.

Some of the challenges for organisations in implementing successful peer worker models are role clarity and defining scope of practice for peer workers, developing organisation culture supportive of peer worker/lived experience skills, and providing sufficient training, supervision, and supportive processes. Orygen (orygen.org.au) have developed guidelines for implementing peer work within various youth mental health settings.

The Care Pathway

The Care Pathway for a young person's journey is not a fixed linear process. The elements of the Care Pathway, which aim to improve mental health care within tertiary mental health are outlined below.

Phrases included under the sections “key elements for service design” include quotes from the workshop report in italics.

What Happens When Mental Health Care Is Needed?

The Young Person Recognises Their Need for Support

What we heard

A young person experiences mental distress. They may or may not recognise this as distress, but all is not OK. They may or may not have support to reach out for help, or know where or how to get help, not even if help is required, with potential to discount their experiences as ‘normal.’

Why this is important

Accessing the right support at the right time is critical for young people. There is often a small window where help may be sought and a positive and helpful response from mental health services is essential. This will ensure that an appropriate therapeutic and trusting relationship is established. The setting where a young person is when they experience distress needs to be supportive and make it easier to recognise the need for help and reach out for it, or for that support to be offered.

Key Qualities of the Service:

- > Warm and approachable
- > Normalising mental health questions and concerns

- > Sense of safety
- > Integrated with other services

Key Elements for the Service Design:

Multi-channel outreach - including easy to access online information and pathways.

The Model of Care needs to lessen distress and pressure from the first point of contact – including outreach materials and messaging conveyed by other partners outside the direct mental health system.

Connections with other agencies and supports in a young person's life - consent to share information across the integrated system of providers will be established at first contact with the young person. This will build a level of trust in the system working collaboratively, decrease the need for re-telling stories and reduce the potential for re-traumatisation. Transition and continuity of care are key issues for young people, especially in the 15–17-year age group where there is a high incidence of emerging serious mental health problems.

Strong community presence

Education and promotion in early years and in other settings to improve prevention and early intervention.

Discreet access to information and advice, including online, 24 hour and early years to focus on normalising mental health. Focus on developing peer literacy on emerging mental health needs to ensure support is sought early.

Consistent language and approaches to assessment and clear pathways through the service systems will be established to address the need of the young person. It is recommended that an assessment of need and direction of referral will be based on a consistent tool across the service agencies. An example of an evidence-based assessment tool that could be implemented is the Initial Assessment and Referral Decision Support Tool (v1.05 Commonwealth of Australia 2021). The IAR DST would enable a standardised approach to assessment interpretation across agencies. The assessment considers severity of symptoms across eight domains with a recommended level of care then made relating to the intensity of service need. An Integrated Referral Assessment Process will provide direction of the referral based on the identified intensity of service need.

The Young Person's First Contact with the Mental Health System

What we heard

There is a sense of collaboration and connection between all the key players, with young people able to find the right place and get the information they need. Young people and/or family supports feel glad they reached out and understand what the options are for them to get support.

Why this is important

When a young person, their family or supports reach out for support they want to be heard, validated, given hope and guidance. Not all young people experiencing a mental disorder will access professional help. This suggests there are barriers around the accessibility and design of mental health services for young people. Collaboration and partnership building enable the identification of and solutions to barriers.

This first interaction should be positive and welcoming for the young person and set up a clear expectation for all parties of how the system can support the young person and their family or carers. The focus should be on engagement and development of trust in the services provided. The young person should feel confident in understanding how the service will work for them.

When a young person, their family or supports reach out for support they want to be heard, validated, given hope and guidance. Services should be quick to respond to the needs of the young person. There should be a sense of collaborative connection between all the key stakeholders. Young people and their supports should feel glad to have reached out and understand what options are available and how to access them. This Model of Care strongly recommends the use of peer workers to walk alongside a young person to help ensure continuity of care.

Key Qualities of the Service:

- > Providing affirmation of young person making contact
- > Offering hope and reassurance
- > Open door - to come in and go out
- > Empathetic and non-judgemental

Key Elements for the Service Design:

Highly-skilled professionals available at front-end / first point of contact

Within the Tertiary Mental Health Service people with the appropriate level of mental health expertise will be available for young people at the front end and first point of contact.

Staged assessment - minimal upfront

Assess, as needed. Consider how much is required up front and co-design treatment plan and pathway with the young person

Ability to capture people's stories and details effectively

Offer opportunity for conversation alone with clinician, without parents, or with

*support, according to young person's needs and preferences.
Story is captured and checked back with the young person, with informed consent given to share it to provide joined up support and avoid retelling.*

Visible & realistic pathways and options

Multiple access channels to meet varying needs and preferences – phone, social media, in-person, schools/community outreach. Walk-in options that do not require an appointment.

Pathways and options are described and documented and given to the young person in written/visual form for future reference and for ease of navigation.

Young person defines who their key supports are and that is respected by the system, whilst supporting other key players who may also be experiencing distress (e.g., parents/caregivers).

First point of contact priority for follow-up / keeping young person connected

Provide a sense of hope and reassurance that there is support available. Clear information about how to stay connected, take next steps and who will support them.

Options for self-referral

Opportunities for self-referral, without need to disclose to support people to seek support.

Multiple access channels to meet varying needs and preferences – phone, social media, in-person, schools/community outreach. Walk-in options that do not require an appointment.

Peer supports

Options for and easy access to peer supports from the very first contact.

Young person as active co-designer of care and pathways

Clearly documented decisions are signed off by the young person who has autonomy to say no to a particular pathway without that closing off support.

Ensure that there is affirmation that every step forward is the right step, a clearly articulated outcome to every interaction and a supported pathway to the next step.

The Young Person is Accessing and Tailoring Services

What we heard

Accessing services helps young people feel safe in the present and hopeful for the future. The service enables workers to keep listening to the young person and building on their story incrementally to provide tailored support appropriate to their age, stage, previous pathway, and future goals. Key players collaborate so the wealth of knowledge can be accessed to support better therapeutic pathways. There is an acknowledgement that therapy and recovery are not linear, and the service enables options, recognising that the right support is more important than diagnosis.

Why this is important

Services help a young person to feel psychologically and physically safe in the present and hopeful for their future. Workers continue listening to the young person and building on their story incrementally. Tailored, compassionate support and intervention are provided which are appropriate to age, stage, previous service experiences and future goals. People key in the young person's life and care collaborate are involved (where appropriate) so the wealth of knowledge can be accessed to support better therapeutic pathways and outcomes. Therapy and recovery are non-linear. The right support at the right time is often more important than a diagnosis in many cases. The focus is on a transdiagnostic approach, has a focus on strengths, and considers improving function as the primary goal. Services will engage in care planning via a variety of mediums that are accessible, youth friendly, sustainable and maximise the young person's self-determination and self-management of recovery. The young person could engage in aspects of care planning and therapy via online platforms, better enabling personalised care to fit their lifestyle and needs.

Key Qualities of the Service:

- > Culturally responsive and attuned
- > Empathetic and non-judgemental
- > Listening and responsive
- > Tailored and dynamic
- > Sense of belonging and safety
- > Consistency of services and staff

Key Elements of the Service Design:

Peer supports

Peer supports sit alongside clinical staff and offer consistency.

Peer support is available for family/carers/support people as well as for young person if desired.

Intentional design of service transition points to ensure warm transition, not cold transfer – service transition points are designed to maximise ease of transition and support for young people.

Supported exits or flexible criteria rather than being turned away or losing services because the young person does not meet the criteria.

Information transfer to reduce need for retelling of story

Design service to minimise need for unnecessary reassessment; at new service entry points take an incremental approach to assessment, building on current knowledge to refine holistic picture of young person. Leveraging existing health supports where they exist as a pathway to proactive outreach and intervention.

Step up and step-down service options

Timely responses and immediate options for increased support. Regular early check-ins to confirm service suitability to young person's perceived need. System allows young person to 'ease in' to support services.

Co-located and collaborative services

Co-location of services minimises handovers and silo-ed approaches to maintain consistent support for the young person.

GPs are integrated into treating team and involved appropriately throughout the young person's journey.

True partnership approach and multi-disciplinary teams.

The Young Person Transitions Between Systems or Leaves the System

What we heard

Reduce repetition of storytelling to reduce risk of re-traumatising. Key players collaborate so the wealth of knowledge can be accessed to support better therapeutic pathways. There is an acknowledgement that therapy and recovery are not linear, and care needs to enable options, recognising that the right support is more important than diagnosis.

Why this is important

The young person is supported to transition between or out of the system. Care is not simply transferred, and existing supports walk alongside the young person until newer supports are established. When the time comes for a young person to leave or transition to a new service they are supported and have a framework in place to: feel *confident* and *capable* of tackling their next steps; feel *knowledgeable* and *comfortable* about their needs, service options and transition processes; and feel satisfied and *positive* about their path thus far and *empowered* to continue their pathway in the direction of their choosing.

The young person can re-enter services if required with an understanding that their information and story is known within the system. Goals of transitioning from services will be based on individual needs with a focus on improving skills to self-manage mental health, development of social connections and therapeutic relationships in the community, establishing a stable housing base and engaging in employment and education opportunities.

Key Qualities of the Service:

- > Empathetic and non-judgemental
- > Compassionate & honouring of long-term relationships and supports
- > Empowering & enabling
- > Connected

Key Elements of the Service Design:

Robust information handover systems

Exits and transitions are co-designed with the young person, with appropriate supports. Celebration of successes and achievements.

Soft exits, with possibility of re-engagement

Intentional design of exit processes paying attention to long-term relationships of trust and reassurance of possibility to return. Key contacts are made with the young person to continue their support or re-engage as required.

Clear pathways & options beyond the youth mental health service system

Clear exit process that includes full disclosure and control of information and treatment plans by young person. Care promotes informed decision making to empower young person to leave service when they feel ready. Clear pathways ahead beyond current service provision.

Co-designed pathways with young person-

Exit process is tailored and modified to suit each person, co-designed with them.

What Services May Be Offered to the Young Person?**Importance of Engagement and Person-centred Care Planning**

Engagement with a young person is a critical first step to development of a therapeutic relationship. Level of engagement will assist in undertaking a meaningful assessment and provide a sense of ownership for a young person in their treatment. It is essential for young people to feel listened to, respected, safe, to have a sense of autonomy and perceive that their clinician is trustworthy, kind, and caring when seeking help for mental health issues, otherwise there can be no benefit. In other words, young people must be engaged in the process of help-seeking. It often takes a longer period working consistently with a young person to create an environment of comfort, safety, and trust to promote engagement prior to making therapeutic gains. To build engagement, it is particularly important to:

- > build strong therapeutic relationships
- > address confidentiality issues and concerns
- > involve caregivers if possible, taking into consideration the young person's age, stage of development, wishes and circumstances. (Adapted from Orygen 2017 Clinical practice guide Treating depression in young people Guidance, resources and tools for assessment and management)

Therapeutic engagement and personalised care are central to care planning. Ensuring every therapeutic encounter that people have with mental health services are meaningful, engaging, and effective is a key focus of the Mental Health Services Plan, 2020-2025. Care planning is led by the young person and based on the principles outlined in the draft mental health treatment and care plan guideline to accompany the Chief Psychiatrist standard (Office of the Chief Psychiatrist 2022):

- > Care planning is led by the individuals engaged in care
- > Care planning is recovery-oriented and strengths-focused
- > Care planning upholds the rights of a person to personal dignity and freedom
- > Autonomy and choice in treatment and care is valued
- > The importance of facilitating people to lead their own recovery is valued
- > The plan is based on a therapeutic discussion between people with mental health issues, their support network and care providers
- > Care planning is sensitive to the background, circumstances, and particular needs of people, including those who have experienced trauma
- > Care planning is undertaken in the least restrictive manner and in an environment that produces the best outcomes for the individual
- > Language and concepts used in care planning must be understandable. This includes use of interpreters, as well as visual options for people who work best in this way
- > Social and cultural diversity are part of being human and form the lens through which mental health care is planned and delivered

Evidence Based Practice forms the basis for the treatments and therapies used for working clinically with young people. A shared approach to decisions regarding therapeutic interventions will assist engagement and ownership of mental health.

Psychological Interventions

The National Institute for Health and Care Excellence (NICE) offers guidelines for best practice in providing clinical care to young people (accessible at www.nice.org.uk). The most current clinical practice guidelines will vary for each diagnosis depending on relevant recent research. Examples of psychological therapies clinically indicated include:

- > Cognitive Behaviour Therapy (CBT)
- > Family Based Therapy (FBT)
- > Dialectical Behaviour Therapy (DBT)
- > Guided Self-Help
- > Psychotherapy

The Australian Clinical Guidelines for Early Psychosis were developed in response to growing research and clinical interest in a model of psychosis that challenged the pessimism prevailing at the time regarding the prognosis of people with psychosis. The second edition (updated 2016) is available from the Orygen website: <https://www.orygen.org.au>

A broad range of other evidence-based resources are available on the Orygen website including, but not exclusively: Brief Interventions in youth mental health; cultural diversity and mental wellbeing; peer work; self-harm and suicide prevention; depression; anxiety; trans and gender diverse young people; trauma; clinical complexity; borderline personality disorder.

Headspace provides access to a clinical research database with published studies of treatment and prevention strategies for mental health and substance use problems in young people. The data base includes research published from 1980 with new research added annually. www.headspace.org.au

Trauma Informed Care

While there is no universally accepted definition of trauma informed care, the most widely cited definition within the youth healthcare literature is based on the definition of trauma-informed approaches provided by Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA, which states: 'A program, organization, or system that is trauma-informed:

- > Realizes the widespread impact of trauma and understands potential paths for recovery.
- > Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- > Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
- > Seeks to actively resist re-traumatization.'

Trauma Informed Care should be embedded into practice within youth mental health services. Corresponding training should be provided across all aspects of organisations involved in care for young people. Improvements can be made in the assessment and treatment of trauma-related disorders within youth mental health services. 'In particular, there is a need for youth mental health services to stop conceptualising 'trauma' and 'mental health' as distinct and different treatment approaches and services (Bendall et al. 2018)'.

Medications

The Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines (accessible at www.ranzcp.org) provides current best-practice guidelines for managing mental illness in Australian settings and includes recommendations for adolescents and young adults. The most current clinical practice guidelines will vary for each diagnosis depending on relevant recent research.

Digital mental health

As more young people can now access technology and the internet, the opportunity for people to access 24/7 online mental health help and support is increasing. In 2016-17, 87% of people aged 15 years and over in Australia were active internet users. Young people aged between 15 and 17 years had the highest proportion of use (98%) ABS (Australian Bureau of Statistics, 2018). Recent technology development through applications (apps) via the internet and accessible through mobile devices has made access even easier for young people.

E-mental health can include:

- > Blended care – e.g., a combination of face-to face interactions alongside online or tasks using technology. Online platforms can work as an adjunct to face-to-face therapies and can for example be utilised whilst young people are waiting to receive services. Youth involved in a workshop at Orygen felt that technology should only be used as an addition to treatment rather than a replacement, and that the therapeutic relationship was the biggest predictor of successful treatment rather than specific interventions.
- > There is a need for flexibility within this area of care delivery into the future and considerations for commissioning the use of appropriate sustainable platforms should be made.
- > E-therapies – e.g., programs that use the internet or devices to deliver interactive interventions, such as telepsychiatry.
- > Online information - technology can help young people and their parents access a variety of resources including mental health promotion, screening, prevention, early intervention, and referral options. Young people can also access information about a variety of topics such as respectful relationships, violence, bullying, emotional abuse, physical activity, nutrition, sexual health, smoking, alcohol, and other drugs. There are ways in which better use of technology could improve timely access to, and engagement with, mental health services for young South Australians.
- > Online self-help programs – e.g., the Centre of Clinical Interventions or MoodGym, which deliver mental health information and self-help activities (Orygen 2019).

How Do We Communicate?

Communication is part of an individual's culture. To engage with young people, the right message through the right channel at the right place and time among the right people must occur.

Use of Technology

Communication via current modes of technology including the use of mobile phone text message functions is an effective medium for engaging young people. There is potential for misunderstandings or interpretations with use of text messaging, so clear strategies need to be implemented around the function of this mode of contact both individually with the young person and as organisations. Young people need to be aware of and agreeable with help seeking during an emergency through more appropriate modes of contact.

Technology forms a component of the personalisation agenda of the MHSP (2020-25). Common elements across all age groups include app-based models that provide resources to consumers, and communication with clinicians and support workers.

Use Of Research and Innovative Practice

The youth mental health model of care aims to achieve positive mental health and wellbeing outcomes for young people. This will require effective detection and intervention methodologies and optimal management of mental health issues/disorders to enhance resilience and capacity and maximise wellbeing and quality of life at this very important stage of a young person's life. The collation of young peoples' experiences of care, therapeutic interventions and other service delivery modalities will be essential in informing service development and improvement.

Youth mental health services will have a strong emphasis on embedding innovative youth-oriented research approaches into practice and building a youth-oriented learning culture. The research, which will include a range of professional disciplines and groups, will involve collaborations with all major SA universities as well as expert collaborations from Australia and overseas.

Training and Development

Apart from discipline specific skills and ongoing training relevant to registration requirements, it will be an expectation that staff working at a tertiary level will be required to complete further core competency training to support best practice for working with young people, bearing in mind recognition of prior learning. The approach will encompass continuing development and professional supervision for all clinicians, both new and more experienced. Youth focused training packages will be aimed at developing a basic applied understanding of the diversity of mental health needs for young people, including young people with lived or living experience of eating disorders, LGBTQIA+ and gender identity complexities, trauma backgrounds, Aboriginal and CALD (Culturally and Linguistically Diverse) backgrounds. The development of core competencies for clinical practice will not take the place of specialist services, however, will provide interim support whilst awaiting further specific therapy input and assist in collaborative work alongside specialist services once a therapeutic relationship has been established.

Core components of training within the workforce development program will also include:

- > Resilience and recovery;
- > Building therapeutic relationships with young people at different developmental stages;
- > Cultural understanding and awareness;
- > Information, education, and training in relation to drug and alcohol use;
- > Lived experience of young people and their families in managing mental health and wellbeing;
- > Mental Health and Human Rights
- > Working with vulnerable individuals or groups
- > Engaging interpreters effectively, including the use of sign language
- > Suicide safety training

Clinical And Operational Governance

LHNs providing mental health services to young people have clinical and operational governance responsibility for clinical protocols, procedures, major budgetary decisions, research, quality improvement and operational matters. There is an expectation of agreed inter-service collaboration, consistent language and processes, and human based design involving the community in this model which holds services to account.

In line with the National Safety and Quality Health Service (NSQHS) Standards, there will also be an expectation that young people will be embedded in quality improvement and feedback processes (ACSQHC 2018) The LHN will include young people with a lived experience at all levels of youth mental health services. This includes service design, delivery, measurement and evaluation of care, operational governance, recruitment, and individual care. Furthermore, it is recommended that in the review and development of operational guidelines a human rights analysis occurs to ensure consistency with this approach.

Understanding the experiences of young people and their carers provides a critical opportunity for safety and quality improvement. The Carer Experience Survey (CES) can provide a baseline to advance in monitoring the improvement of the experience of carers who have contact with SA Health mental health services ([accessible at What Carers say about their Experience of South Australian Mental Health Services 2021](#)).

Governance structures will be dependent on resourcing within the particular LHN, however some variation of the following functions would aid in the provision of an integrated, high-quality service:

- > Interagency partnership development and support to manage partnerships and shared procedures, documentation, decision making
- > Interagency clinical operations focusing on clinical care at system and at individual level
- > An interagency Youth Mental Health advisory group to provide feedback, input, and guidance for service development and to ensure ongoing accountability of services regarding the quality of service provided.

How To Use This Model of Care

This Model of Care for design of youth mental services used the principles of human centred design in its creation. Likewise, the application of the Model of Care in the design of local youth mental health services needs to ensure there is diverse representation from young people with lived experience. This Model of Care is recommended as the first phase in the further localised design, implementation, and evaluation of robust, evidence based and person-centred youth mental health services.

What is human-centred design?

Human-centred design is an approach to problem-solving that puts the people we are designing for at the heart of the process. It is an iterative process aimed at developing solutions that meet the needs of the people who are most affected by the problem. It deals with complex problems by generating, validating, refining, and improving design solutions. In this sense, with young people at the heart of youth mental health services, design and delivery will evolve over time. It begins with empathy for the people we are designing for (Victorian Government 2022).

Key Design Principles to Guide Design of Your LHN Youth Mental Health Service

The suggested questions should be considered indicative, as an example of how questions can be used to hold the design of youth mental health services true to the principles in an iterative way, rather than designing services first to retrospectively check against the principles.

1. Young people's needs at the centre of the service (model), before everything else

Does our service (model) draft

- Enable us to hear and understand the young person's needs?
- Give greater priority to anything else, over the young person's needs?
- Keep the young person's needs at the centre, throughout the journey and at different transition points?
- Provide mechanisms to 'course correct' if the young person's needs are no longer at the centre?

2. Young person-led and clinician-guided

Does our service (model) draft

- Enable the young person to voice their preferences for next steps?
- Increase the young person's sense of agency over decision-making?
- Support a positive relationship and partnership between young person and clinician?
- Provide mechanisms to resolve if the young person's wishes and the clinician's advice conflict?

3. Transition, not transfer

Does our service (model) draft

- Ensure no young person is 'dropped' at a transition point?
- Ensure the young person has consistent and continuous connection to a known person in the Mental Health System?
- Support the building of new positive relationships between young person and clinician as their journey progresses?

4. Prioritise the young person's aspiration

Does our service (model) draft

- Enable a young person to voice their aspirations, and refine them over time?
- Support the dignity of risk in enabling the young person to make informed choices about their direction and aspiration?
- Provide easy, positive pathways back into support if required?

5. Draw on the past to help us move forward

Does our service (model) draft

- Build on what we know is working well?
- Address the key challenges we can see in the current system?
- Draw on the voice of lived experience in how the system has helped and hindered young people in the past?
- Keep us stretching towards our vision?

6. Enable collaboration and agility in service models and staff practice

Does our service (model) draft

- Make it easier to work across agencies for the benefit of the young person?
- Make it easier to work in multi-disciplinary teams for the benefit of the young person?
- Make it easier to deliver timely services and respond quickly to the young person's needs?
- Pay attention to points of handover and transition to ensure a smooth pathway for the young person?

Appendix One – Acknowledgements

Workshop attendees are acknowledged and thanked for contributing their insights, knowledge, and experience to the design of the Model of Care:

- > People with a lived experience: young people, parents, and carers.
- > Clinical staff from Metropolitan and Country Local Health Networks with a range of disciplines (medical, allied health and nursing) represented.
- > Staff from the Office of the Chief Psychiatrist of South Australia.
- > Representatives from the Mental Health Commission of South Australia.
- > Staff from Adelaide and Country Primary Health Networks.

Thank you to the members of the **Youth Mental Health Working Group** for your passion and commitment for improving mental health services for young people.

We would also like to particularly acknowledge NALHN youth mental health services. NALHN has pursued and committed to providing a contemporary and person centred mental health service to young people in collaboration with local partners. Their innovative ideas and approaches have been included in this model. We thank them for their generosity in sharing.

Appendix Two – Acronyms

Acronym	Meaning
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
BHFLHN	Barossa Hills Fleurieu Local Health Network
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CAMHS	Child and Adolescent Mental Health Service
DHS	Department of Human Services
EFNLHN	Eyre and Far North Local Health Network
FUNLHN	Flinders and Upper North Local Health Network
GP	General Practitioner
LCLHN	Limestone Coast Local Health Network
LGBTIQA+	Lesbian Gay Bisexual Trans Intersex Queer Asexual
LHN	Local Health Network
MHS	Mental Health Service/s
MHSP	Mental Health Service Plan
MOC	Model of Care
MOU	Memorandum of Understanding
NALHN	Northern Adelaide Local Health Network
NSQHSS	National Safety and Quality Health Service Standards
NMHSPF	National Mental Health Service Planning Framework
OCP	Office of the Chief Psychiatrist
PHN	Primary Health Network
RMCLHN	Riverland Mallee Coorong Local Health Network
SALHN	Southern Adelaide Local Health Network
WCH	Women's and Children's Hospital
YNLHN	Yorke and Northern Local Health Network

Appendix Three – Glossary / Language

Word/phrase	Meaning
Agency	Agency in the context of recovery from mental illness involves a range of discrete and more synthetic activities in which people are actively making meaning in their lives. To be an agent in a life with (or without) mental illness can mean deciding to do a particular thing (e.g., return to work) or to assert basic rights while facing injustice. To recapture agency can also, however, refer to regaining a larger experience of ownership and authorship of one's thoughts, feelings, and actions. (Lysaker & Leonhardt 2012)
Carer	A person who cares for or otherwise supports a person living with mental illness. A carer has a close relationship with the person living with mental illness and may be a family member, friend, neighbour, or member of a broader community.
Diverse/diversity	Diversity is linked to the human right to equality and non-discrimination and is about recognising, respecting, and valuing other people's differences.
Early intervention	The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity, and impact of mental illness.
Empowerment	Empowerment is an important element of human development. It is the process of taking control and responsibility for actions that have the intent and potential to lead to fulfillment of capacity. This incorporates four dimensions: 1. self-reliance 2. participation in decisions 3. dignity and respect 4. belonging and contributing to a wider community (WHO, 2010)
Evolving capacities	According to UNICEF, the evolving capacities of children need to be understood and examined through three conceptual frameworks: 1. As a developmental concept, recognising the extent to which children's development, competence and emerging personal autonomy are promoted through the realisation of the Convention rights. In this sense it imposes obligation on State parties to fulfill these rights 2. As a participatory or emancipatory concept emphasizing the rights of children to respect their capacities and transferring rights from adults to the child in accordance with their level of competence. It imposes obligations on State parties to respect these rights. 3. As a protective concept, which acknowledges that because children's capacities are still evolving, they have rights to protection on the part of both parents and the State from participation in or exposure to activities likely to cause them

	harm, although the levels of protection they require will diminish in accordance with their evolving capacities. It imposes obligations on States parties to protect these rights (UNICEF, 2005)
Intersectionality	Intersectionality describes how multiple social aspects of identity, such as gender, race, and sexuality, intersect with or interact with each other. Intersectionality is about seeing a person as a whole and encourages thinking beyond discrete labels that make up someone's identity and experience in the world (Orygen, 2021).
Lived/living experience	People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness.
Mental health	A state of wellbeing where an individual has the capacity skills and resources to work through adversity, meet their needs and find meaning and purpose in their life.
Mental health issues or concerns/mental ill health	Thoughts, feelings, or behaviours which can impact on a person's mental health and wellbeing and lead to distress and disruption to their lives. Mental health issues can occur with or without diagnosed mental illness.
Mental illness/disorder	A clinically diagnosable disorder that impacts on a person's cognitive, functional, emotional, or social abilities. Mental illness is diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) or the International Classification of Diseases (ICD-10) (WHO, 2011). There are various types of mental illness, including anxiety disorders, depressive disorders, bipolar disorder, eating disorders and schizophrenia. Mental illnesses can have different levels of impact and severity.
Mental health literacy	The knowledge and beliefs about mental health problems that aid their recognition, management, or prevention. https://emergingminds.com.au/resources/child-mental-health-literacy-what-is-it-and-why-is-it-important/
Peer worker	Workers who have a lived experience of mental illness and who provide valuable contributions by sharing their experience of mental illness and recovery with others. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering educational programs, providing support for housing and employment, coaching, and running groups and activities

Person/patient/consumer	This document uses the term ‘person with lived experience’ or person. In contemporary recovery-oriented mental health services the term ‘patient’ is no longer used. Terms are retained where the term ‘patient’ is used as part of a service, such as outpatient, inpatient, and day patient.
Recovery	There is no single definition of recovery because recovery is different for everyone. Central to all recovery are paradigms of hope, self-determination, self-management, empowerment, and advocacy. Also, key is a person’s right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. (Commonwealth of Australia, 2013, cited in Australian Commission on Safety and Quality in Health Care, 2018)
Recovery-oriented practice	Recovery-oriented practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. (ibid)
Sub-acute health care	The delivery of services to address a person’s functional status and quality of life rather than the underlying medical diagnosis
Trauma-informed care	Trauma-informed care is an organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological, and emotional safety for people who have experienced trauma, their families and carers, and service providers. (Commonwealth of Australia, 2017). At a service/organisational level, this means ensuring well trained staff are aware of the impact of trauma and taking steps to avoid re-traumatisation

Appendix Four – Levels of Care

- > Level 1 (self-management) Services at this level of care are designed to prevent the onset of illness and are mostly focussed on supporting the person to self-manage any distress or symptoms. This level of care generally involves evidence-based digital therapies and other forms of self-help.
- > Level 2 (low intensity services) are designed to be accessed quickly (without the need for a formal referral e.g., through a third-party service or provider) easily (through a range of modalities including face-to-face, group work, telephone and digital interventions) and typically involve few or short sessions.
- > Level 3 (moderate intensity services) generally provide structured, reasonably frequent, and intensive interventions (e.g., a defined number of psychological sessions delivered regularly).
- > Level 4 (high intensity services) including periods of intensive intervention that may involve multidisciplinary support. Usually supporting people experiencing severe mental illness, significant functional impairment and/or risk factors.
- > Level 5 (acute and specialist community mental health services) usually includes intensive team-based specialist assessment and intervention (typically state/territory mental health services) with involvement from a range of different types of mental health professionals, including case managers, psychiatrists, social workers, occupational therapists, psychologists and drug and alcohol workers. This level also often includes more intensive care provided by GPs.
 - (Commonwealth of Australia, 2022, <https://strategic-data-pty-ltd-docsiar-dstoneonline.readthedocs-hosted.com/en/latest/level-of-care/index.html>)

Appendix Five - Key Partners

The model of care must consider partners in service delivery, the agencies delivering key components in a young person's life and their critical touch points.

Effective partnerships mean partners benefit from shared knowledge, skills and resources which enable the coproduction of outcomes that meet both partners' and the community's expectations and needs. Importantly, working in partnership can extend the reach, impact, and sustainability of health outcomes (Commission on Excellence and Innovation in Health 2023 page 1)

Key partners play a vital role across all areas of mental health for young people, from early detection, to support and ensuring the delivery of comprehensive services, as well as determining next best steps when mental health issues have settled. Key partners must work together with the young person at the centre to offer coordinated and evidence informed care in a timely manner.

Schools

School is one of the first places where an indication of mental health issues might be identified. Links to the services providing mental health response is critical. Access points for education staff should be clear, with the availability of mental health staff to talk through a potential issue and to work on the best way forward for the young person. A range of programs exist within the school system that focus on educating students, teachers and other staff, and families on mental health and wellbeing and building resilience. With the Department for Education planning to pilot additional mental health practitioners within sites, it is an important time for improving connection between education and primary and specialised youth mental health services. Partnership between education, headspace, CAMHS and state funded youth mental health services should be a focus alongside the evolving youth mental health services that will be available within schools in the future.

Child Protection

The Department for Child Protection (DCP) works in partnership with families, government and non-government organisations, carers, and the community to care for and protect vulnerable children and young people by addressing harm and keeping them safe. The DCP Practice Approach provides an integrated and contemporary approach to practice that supports the vision that all children and young people grow up safe, happy, healthy, and nurtured to reach their full potential (Government of South Australia, Department of Child Protection ND).

Children and young people in care, and those who have left care may be eligible for priority access to services under the *Investing in their future* initiative, available at [Priority access to services | Department for Child Protection](#).

Children and young people in care receive priority access to the Child and Adolescent Mental Health Service (CAMHS). Depending on their needs, children and young people in care may also be eligible to receive priority access to a range of in-patient services.

Youth services

A number of youth services and initiatives relevant to mental health are also provided through the Department of Human Services (DHS) and other non-government organisations.

Youth Justice

Youth Justice is a division of the DHS. The programs and services within Youth Justice aim to support young people to: Desist from offending; recognise the impact of their crime on victims; and access opportunities to participate safely and productively in the community (Department of Human Services 2022).

Public Advocate

The Office of the Public Advocate (OPA) advocates for and safeguards the rights and interests of people with impaired decision-making capacity. The OPA can sometimes become involved in the life of someone during the critical transition period from youth to adulthood.

Aboriginal communities and agencies

Improving linkages to culturally appropriate services for first nation's young people and their families is key to better health outcomes within the Aboriginal and Torres Strait Islander populations in South Australia. Integrating care with SA Health primary health care services such as Muna Paendi, Maringga Turtpandi and Kanggawodli and non-government service providers such as Nunkuwarrin Yunti assists by addressing mental and physical health needs through delivery of contemporary culturally based health and social and emotional wellbeing services (Nunkuwarrin Yunti of South Australia 2015). DHS funded Metropolitan Aboriginal Youth and Family Services (MAYFS) is a dedicated Aboriginal service with a focus on diverting young people away from the justice system and toward improved life outcomes. MAYFS can support referrals to mental health services for Aboriginal young people who have had contact with the youth justice system in metropolitan Adelaide (Department of Human Services 2021). Country PHN provides linkages to several Aboriginal mental health services in rural and regional settings.

Drug and alcohol services

Support for young people experiencing issues related to drug and alcohol use can be sourced through government services such as Drug and Alcohol Services South Australia (DASSA) or through a range of non-government organisations in metropolitan or country South Australia. The available support, programs, and therapies offered will differ depending on the provider.

Communities and agencies relating to other vulnerable groups

Multicultural Youth South Australia (MYSA) provide community support for mental health through case management and other services aimed at supporting young people from a variety of ethnic backgrounds. Support also extends to English language development, employment, education, housing, independent living and other health, recreation, and social skill goals.

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) employ specialist child and youth counsellor/advocates to deliver holistic services for children and young people both onsite and through outreach in the community, working closely with the young person and key people in their life. STTARS work alongside family and carers, schools, mental health services and youth services to provide counselling and support from both a culturally sensitive and trauma focused lens. Safe, collaborative, and non-judgmental support structures for young people from the LGBTQIA+ community are vital when providing personalised and integrated care. Linking a young person to local services such as ShineSA or Bfriend, or national counselling supports such as Qlife can assist when tailoring care needs.

Appendix Six - Diagnoses

Distress, self-identification of issues or identification of issues by other people in the young person's life such as parents, friends, teachers may lead to identification of the need for services. Access to appropriate services in a timely fashion is critical for preliminary and ongoing engagement. With respect to young people, a diagnosis is not always immediately evident, and should not be a defining factor for receiving a youth mental health service.

Having made the comments above, there are however some critical diagnoses and presentations which should be carefully considered in young people.

Anxiety and depression

Anxiety disorders are the most prevalent in this age group and are more common among older than among younger adolescents. The ABS (2018) indicated increasing rates of both depression and anxiety, compared with 2014-15 data.

Anxiety and depressive disorders can profoundly affect functioning and capacity to attend to education, employment, and activities of daily living. Social withdrawal can exacerbate isolation and decrease access to support (McGorry et al. 2007).

Depression is the leading contributor to the burden of disease and injury in females aged 10-24 years, and the second leading contributor for males of the same age (AIHW 2018).

Behavioural disorders

Attention deficit hyperactivity disorder (ADHD), characterized by difficulty paying attention, excessive activity and acting without regard to consequences, occurs among 2.4% of 15–19-year-olds. Disruptive Behavioural Disturbances (involving symptoms of destructive or challenging behaviour) occurs among 3.6% of 10–14-year-olds and 2.4% of 15–19-year-olds.

Autism Spectrum Disorder (ASD) affects 2.8% of people aged 15 to 19 and 1.2% of people aged 20 to 24 (ABS 2018). A young person with ASD will often require additional support to engage in education, will be less likely to obtain educational qualifications beyond school and may face greater barriers in entering the workforce. Other mental health diagnoses may occur comorbidly to ASD, further impacting on wellbeing and capacity to engage socially and independently within society.

Eating disorders

Eating disorders commonly emerge during adolescence and young adulthood. Eating disorders involve abnormal eating behaviour and preoccupation with food, accompanied in most instances by concerns about body weight and shape. Primarily affecting females, 15 per cent of Australian females under the age of 20 have experienced an eating disorder (Fairweather-Schmidt & Wade 2014) with a further 25 per cent of Australian women aged 22 to 27 years having experienced a form of disordered eating within the past 12-month period. Eating disorders can lead to premature death, often due to medical complications or suicide, and within the 15- to 24-year-old cohort has higher mortality than many other serious health conditions (Hoang, Goldacre & James 2014).

Psychosis

Conditions that include symptoms of psychosis most commonly emerge in late adolescence

or early adulthood and can include hallucinations or delusions. These experiences can impact on a young person's ability to participate in daily life, education, and employment.

Suicide and self-harm

In 2020, suicide accounted for two in five deaths among people aged 15-17 years (40 per cent) and more than one in three among those aged 18-24 years (36 per cent). Risk factors for suicide are multifaceted, and include harmful use of alcohol, trauma in childhood, reluctance to seek help, barriers to accessing care and access to means of suicide.

Risk-taking behaviours

Many risk-taking behaviours for health, such as substance use or sexual risk-taking, start during adolescence. Risk-taking behaviours can be a strategy to cope with emotional difficulties and can severely impact an adolescent's mental and physical well-being.

Substance use

Among young Australians, trends for alcohol and illicit substance initiation of use and recency of use have increased, indicating that young people are beginning use or experimentation later in life on average and potentially with less frequency of use. Of concern is the amount of single occasion use for substances and the impact this may have on health, particularly on the developing brain, and in terms of potential increased risk through misadventure (Australian Institute of Health and Welfare 2022).

Complex post-traumatic stress disorder

A disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (WHO ICD-11 2023).

Developmental Trauma Disorder (DTD)

DTD has been proposed to describe the biopsychosocial sequelae of exposure to interpersonal victimisation in childhood that extend beyond the symptoms of post-traumatic stress disorder. Comorbidities that are unique to DTD or not associated with PTSD (Post Traumatic Stress Disorder) include panic, separation anxiety, and disruptive behaviour disorders (van Der Kolk, Ford & Spinazzola 2019).

Appendix Seven – Human Rights Provision in South Australian Legislation with implications for the mental health sector.

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LEGISLATION	HUMAN RIGHTS	LEGISLATIVE PROTECTION
Advance Care Directives Act 2013	The right Equal recognition before the law when decision-making capacity is fluctuating.	An Act to enable a person to make decisions and give directions in relation to their future health care, residential and accommodation arrangements and personal affairs; to provide for the appointment of substitute decision-makers to make such decisions on behalf of the person; to ensure that health care is delivered to the person in a manner consistent with their wishes and instructions; to facilitate the resolution of disputes relating to advance care directives; to provide protections for health practitioners and other persons giving effect to an advance care directive; and for other purposes.
Health and Community Services Complaints Act 2004	Everyone has the right to enjoy the highest attainable physical and mental health standard.	Contained in Part 3 of the Act, the Charter of Health and Community Services Rights protects: the right to access health and community services; the right to be safe from abuse; the right to high-quality services; the right to be treated with respect; the right to be informed; right to actively participate; right to privacy and confidentiality; right to comment or complain see s22.
Children and Young People (Safety) Act 2017	Every child has the right, without discrimination, to such protection as is in the child's best interests and is needed by the child by reason of being a child.	This Act commits to upholding and promoting a set of outcomes for children, which they expect all state members to safeguard and comply with. This Act addresses these outcomes as “rights” for children and young people.

Mental Health Act 2009	Everyone has the right to enjoy the highest attainable physical and mental health standard.	This Act protects members of the state who suffer from mental health issues and ensures they receive comprehensive treatment to encourage their recovery and they retain their freedoms and dignity. The Act does not categorically state these safeguards are “rights”; however, it does infer the importance of upholding this standard and imposes penalties on those who breach it.
Disability Inclusion Act 2018	The right not to be discriminated against in public life, including employment, education, getting or using services, renting or buying a home or accessing public places because of disability.	This Act promotes the social inclusion and protection of state members with a disability. It provides safeguards for supporting and representing those with a disability and informs the government about their disability policies. The object of the Act is to support the United Nations Convention on the Rights of Persons with Disabilities and acknowledge that people with disabilities have the same human rights as other community members. Therefore, the Act does specifically state that its provisions are “rights”.
Electoral Act 1985	Every eligible person has the right, and is to have the opportunity, without discrimination— (a) to vote and be elected at periodic State and municipal elections that guarantee the free expression of the will of the electors;	This Act protects the rights of South Australians to vote in State Elections. The Act does explicitly say that all members of the state have a “right” to vote in a state election if they have enrolled.
Police Act 1998	A person must not be subjected to arbitrary arrest or detention. A person must not be deprived of their liberty except on grounds, and in accordance with procedures, established by law. A person who is arrested or detained must be informed at the time of arrest or detention of the reason for the arrest or detention and must be promptly informed about	This Act helps to govern the power of the Police in our society. One of its aims is to protect the public’s civil freedoms by protecting them from subjection to arbitrary police power. The protections found in the Act are not specified as being “rights” however the Act does insinuate the importance of these protections and imposes a penalty if they are not upheld.

	any proceedings to be brought against the person.	
Education and Children's Services Act 2019	Every person has the right to education.	This recently created Act firstly establishes a legislative framework to ensure that education given to children across the state is of a high standard. Secondly, the Act helps to enforce the legal requirement that all children of legal age must be enrolled in school. The Act specifically states that every child has the "right" to education.
Equal Opportunity Act 1984	Every person is equal before the law and is entitled to equal protection of the law without discrimination and has the right to equal and effective protection against discrimination.	This Act is one of the most important South Australian pieces of legislation that protects the civil liberties of individuals living in the state. The purpose of the Act is to prevent South Australians from being discriminated against based on their sex, race, disability, age, sexual orientation, or other common grounds. The Act also creates a Commissioner and Tribunal to ensure enforcement of the legislation. The Act surprisingly does not make any overarching comment that its protections are "rights". However, it does insinuate through the language used that its protections are important legal privileges that South Australians must be granted.
Racial Vilification Act 1996	All persons with a particular cultural, religious, racial or linguistic background must not be denied the right, in a community with other persons of that background, to enjoy their culture, declare and practise their religion, and use their language.	This Act prevents South Australians from racial vilification of any kind by organisations or natural persons. It does this by stating that by law any behaviour of this kind is an offence and therefore those who engage in this activity will be punished. This Act does not explicitly state that protection from racial vilification is a "right", however, it insinuates that this is a protection that all South Australians should have.
Public Health Act 2011	Every person has the right to the enjoyment of the highest attainable standard of physical and mental health.	This Act is the main South Australian legislative support that ensures those who receive medical treatment receive the highest quality care through the creation of governing bodies, individuals and policies.

		The Act does not specifically state that all of the protections found in the Act are “rights”. However, it does insinuate through its guiding principles and objects that members of the state should benefit from the promotion of its specified principles.
Guardianship and Administration act 1993	The decision or order made must be the one that is the least restrictive of the person's rights and personal autonomy as is consistent with his or her proper care and protection.	An Act to provide for the guardianship of persons unable to look after their own health, safety or welfare or to manage their own affairs and for the management of the estates of such persons; and for other purposes.

Appendix Eight- References

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