# YOUTH ENHANCED SERVICE MODEL

## CORE COMPONENTS AND UNDERPINNING PRINCIPLES

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**Orygen acknowledges** the Traditional Owners of the lands we are on and pays respect to their Elders past and present. Orygen recognises and respects their cultural heritage, beliefs and relationships to Country, which continue to be important to First Nations people living today.

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# INTRODUCTION

Mental health is a major health issue for young people globally. 75 per cent of mental health issues have their onset before the age of 25, and experiencing mental ill-health during this phase of life can then have a substantial impact on a young person's development and capacity to participate and contribute economically and socially. If young people experiencing the early stages of mental ill-health are connected to appropriate, accessible and effective supports via mental health services, programs and clinical treatment, they stand a far greater chance of recovering from a mental illness.

The increasing role of primary care in responding to mental health concerns has been recognised and supported by Federal Government initiatives. The provision of youth mental health services within primary care has the potential to massively increase the numbers of young people who can receive help and achieve improved outcomes. Locating services within primary care has the advantage of being less stigmatising, more accessible and more recovery-focused than the state-based tertiary, or specialised care settings, that often deal with the more acutely unwell and highly at-risk young people needing mental health care. While headspace has enhanced young people's access to, and engagement with, mental health services, many young Australians with more complex presentations do not receive the care that they need.

## YOUTH ENHANCED SERVICES

Through its Policy Strengthening Mental Health in Australia, the Australian Government outlined a package of commitments targeting youth mental health with a particular emphasis on severe mental illness to address this issue. Since 2016/17 Primary Health Networks (PHNs) have been funded to develop regional service models for young people presenting with severe and complex mental health issues, known as Youth Enhanced Services (YES), and Orygen has been funded to provide expert advice and guidance to PHNs to support this work.

As youth mental health is an emerging field, the evidence-base for particular approaches and interventions is building and this includes best practice models for young people presenting with complex mental health issues. Over the past few years Orygen has provided PHNs with a range of guidance, which has been continually updated and adapted as the evidence builds.

# PURPOSE OF THIS DOCUMENT

This document is the next iteration of this guidance, incorporating what we have learnt over the past three years. It builds on the 16 early psychosis (EPPIC) model core components, literature reviews, surveys of PHNs about core components in their YES services, and testing of ideas with service providers across Australia, including in the YES Implementation Lab. This document acknowledges that there currently is no ideal model for a YES program, but there is clear consensus on the core components and underpinning principles.

The purpose of this document is to provide further guidance to PHNs and youth mental health services for designing, improving, modifying and reviewing their YES programs. The document does not provide definitive answers, and YES programs will need to evolve as new evidence and best practice models arise and take into consideration their local context.

# WHO ARE YOUTH ENHANCED SERVICES FOR?

The original guidance provided to PHNs by the Department of Health (and supplemented with guidance from Orygen) was that funding was allocated to design services for young people with severe and complex mental health needs and that severe mental illness is often defined by its duration and the level of disability it produces. Severe illnesses can include psychosis, major depression, severe anxiety, eating disorders and personality disorders. Severity can also relate to the level of risk that a person presents with as a result of their illness, in combination with any number of external factors or circumstances such as homelessness, family violence, poor social supports etc.

With such a broad definition, PHNs and services have grappled with defining target groups and eligibility for YES. For different areas and different services this cohort of young people can look different depending on service gaps in the area, socio-economic issues and the level of funding provided. Some services have focused on disorder specific criteria (for example, psychosis) or presenting problem (for example school refusal).

## CASE STUDIES FROM YES PROGRAMS

The following two case studies demonstrate the complexity in which young people present. They are based on real case reviews from YES programs engaged in secondary consultations with Orygen.

### JANE

Jane is a 16-year old female currently living with her mother, although she was in foster care for a short period of time several years ago. When Jane was 10, she was the victim of a sexual assault from her mother's then partner.

In the past six months, Jane has ceased attending school due to frequent panic attacks and fears she will run into her perpetrator, after she believes she saw him while on a school excursion. She has also recently started engaging in self harm and consuming alcohol to relax. She experiences low mood and suicidal ideation but denies intent.

Jane's mother is keen for her to receive support, but has failed to follow through with a safety plan due to fears that it would exacerbate conflict between the two of them. Jane herself has not engaged any further than consenting for her mother to be involved, and refuses to speak to her clinician.

Jane has been diagnosed with moderate PTSD, major depressive disorder and foetal alcohol syndrome.

Jane's goals are to feel less anxious and to stop fighting with her mum. Her mum additionally wants Jane to return to school, to stop drinking, and to overcome her trauma.

### PAUL

Paul is a 20-year-old male living with his father. He was diagnosed with autism spectrum disorder at the age of 7. His intellectual skills were assessed as normal but his self-care and daily living activities are limited. Paul's father is concerned about him developing type 2 diabetes due to his poor diet and genetic predisposition. Paul also consumes cannabis on a daily basis.

Two years ago, Paul was travelling on a bus that was involved in a minor accident. Since then, he has developed a fear of the bus which has prevented him from attending meetings with his employment agency.

Recently, Paul has also started experiencing anxiety about migraines which he believes might indicate a brain tumour. He has been told by doctors that they are nothing to be concerned about, but he continues to worry that there is something wrong with his brain.

Conflict between Paul and his father has recently escalated. After conflict, he experiences hopelessness and suicidal ideation. Following an episode three months ago, Paul overdosed on paracetamol with the intention to die. He had a brief stay in hospital for monitoring.

Paul's goals are to find a job and to feel less anxious.

# EXPLORING CLINICAL STAGING, COMPLEXITY AND THE MISSING MIDDLE

Clinical staging, the complexity model and the 'missing middle' can help to conceptualise this group of young people.

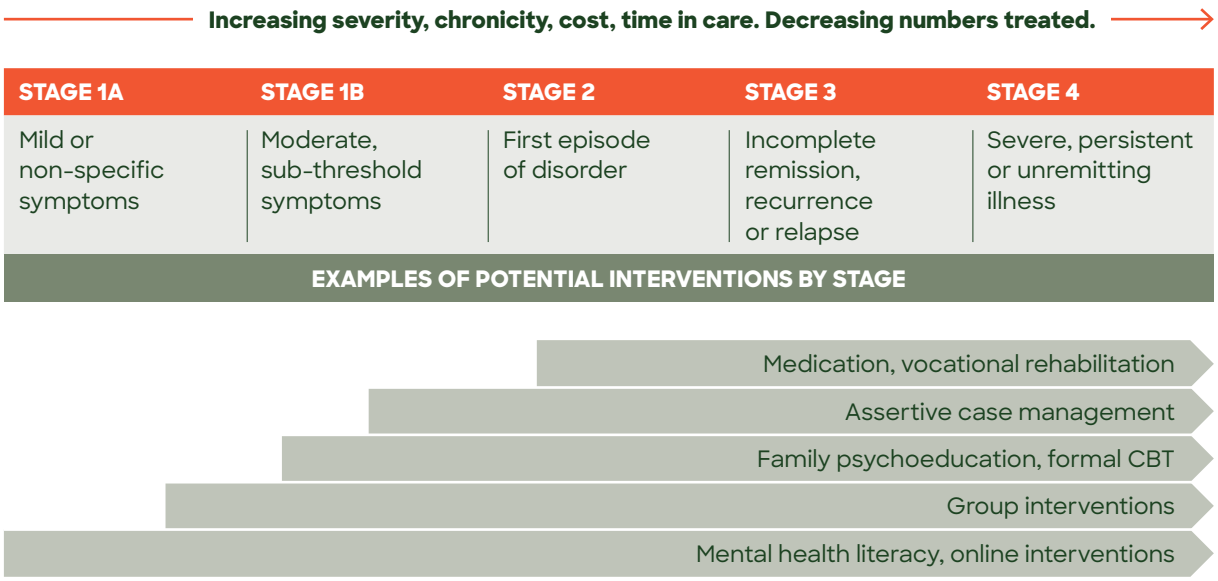
## Clinical staging

Clinical staging is a framework that has been developed to describe the extent of progression of a mental illness and assist accordingly in the identification of appropriate interventions. Originally utilised in other areas of medicine such as cancer and cardiovascular disease, clinical staging has been more recently applied to youth mental health in an attempt to guide treatment selection across the range of mental health difficulties that a young person might present with, including early, mild symptoms which do not yet fit within a diagnostic category. This makes the model particularly useful for young people who present with symptoms that are below the threshold for a mental disorder, but who nevertheless may experience high levels of distress and impairment in their functioning. This is in contrast to stepped care models which categorise individuals based on the severity of a *diagnosable* illness. The clinical staging model uses a combination of help-seeking, symptomatology and functioning information to categorise a mental health problem into one of six potential stages, ranging from Stage 0 ("at risk but no symptoms") to Stage 4 ("severe, persistent or unremitting illness") (Figure 1). For young people with severe and complex presentations in the primary care setting, most would be expected to fall within Stage 1b ("subthreshold symptoms") or Stage 2 ("first episode of severe disorder"). The rationale used for the focus on Stages 1b and 2 is that these stages represent a period of potential overlap and transition between primary care and specialist services in which, at least for non-psychotic disorders, there is a need for more clearly elaborated and evidence-based descriptions of optimal service provision.

Determining the clinical stage of a young person allows better matching of the intensity of the intervention with the level of need. This improves safety and efficiency by ensuring that lower-risk and less time- or resource-intensive interventions are offered before more intensive, invasive and costly interventions. Clinical staging can be used alongside the stepped care model to provide comprehensive guidance on which interventions should be provided to young people at what time and in what way.

Clinical staging adds to the stepped care model by allowing the matching of needs of young people experiencing potentially significant levels of distress and functional impairment, but who don't meet the threshold for a mental disorder, with appropriate interventions aimed at both the presenting problems and at preventing progression towards a more serious illness. Figure 1 provides examples of the types of interventions that might be matched to each clinical stage.

**CLINICAL STAGING MODEL**




Adapted from Cross SPM, Hickie I. Transdiagnostic stepped care in mental health. Public Health Res Pract. 2017;27(2):e2721712.

## Complexity

Some services have found it important to factor in complexity. Complexity can relate to the level of risk that a person presents with as a result of their illness, but also considers further factors that incorporate social, economic and health areas that are likely to influence a young person's wellbeing, functioning, responsiveness to services and overall recovery. Some common examples may be psychosocial stressors such as homelessness, family violence or limited social supports. Complexity describes and acknowledges the combination and interaction of many stressors and the range of services that a young person is engaging with, and is likely to be interpreted and understood differently between individual young people, clinicians and services.

Another possible way to understand complexity is to see it as an interaction between three areas: system factors; client presentation and workforce factors (see Table 2). It is possible to use this model of complexity to identify needs across the domains and develop a service plan that considers the workforce and system needs, in addition to the young person's clinical needs. A service that chooses to focus on reducing the complexity in young people's lives may use a service navigator model to coordinate care from other services who can provide support in line with the young person's individual needs.

| SYSTEM FACTORS | CLIENT PRESENTATION | WORKFORCE FACTORS |
|---|---|---|
| • Involvement with child protection<br>• Disability services<br>• Multiple healthcare providers<br>• Educational disengagement<br>• Unemployment<br>• Family difficulties/parental mental health<br>• Foster care<br>• Involvement with the criminal justice system | • Severity<br>• Impairment across multiple domains<br>• Co-morbidity<br>• Chronicity<br>• Clinical stage<br>• Suicidality/self-harm<br>• Impulsive externalising behaviours<br>• Low engagement<br>• Complex presentations (e.g. complex trauma, dual diagnosis) | • Clinician competencies<br>• Clinician confidence<br>• Service-level supports (e.g. availability of outreach, supervision and team support)<br>• Workforce shortages |

## Missing middle

Another term that is often referred to is the 'missing middle'. The 'missing middle' is an emerging definition used to describe people whose needs are not met by current mental health services. They are often too unwell or their needs are too complex for primary care, but not unwell enough for state-based services. We know from speaking to PHNs and services that there are a few different interpretations of this term and perhaps there is more than one 'missing middle' – that is, there are multiple groups of young people who fit into this service gap but for different reasons. The term 'missing middle' can describe young people who:

- are not receiving any services for their mental health needs;
- are currently accessing primary care services, but are underserved as they require more specialist care and expertise, particularly for specific diagnoses and complex psychosocial needs;
- are on long waiting lists for services;
- have seen a GP but do not or cannot follow through with a Mental Health Treatment Plan to see allied health (often because they cannot leave the home or get to the appointment, or they are unable to engage with a private psychologist due to a range of reasons including unaffordable gap payments);
- have accessed inpatient/community-based state-funded care but are discharged too early, with these services not able to deliver the duration, or intensity of care needed due to demand pressures; and/or
- have presented to emergency departments due to mental health issues. Presentations which: a) could have been avoided with adequate care in the community and b) often leave the emergency department without adequate and assertive follow up.

At the time of writing, there is a Delphi study in progress to develop a consensus definition of the missing middle.

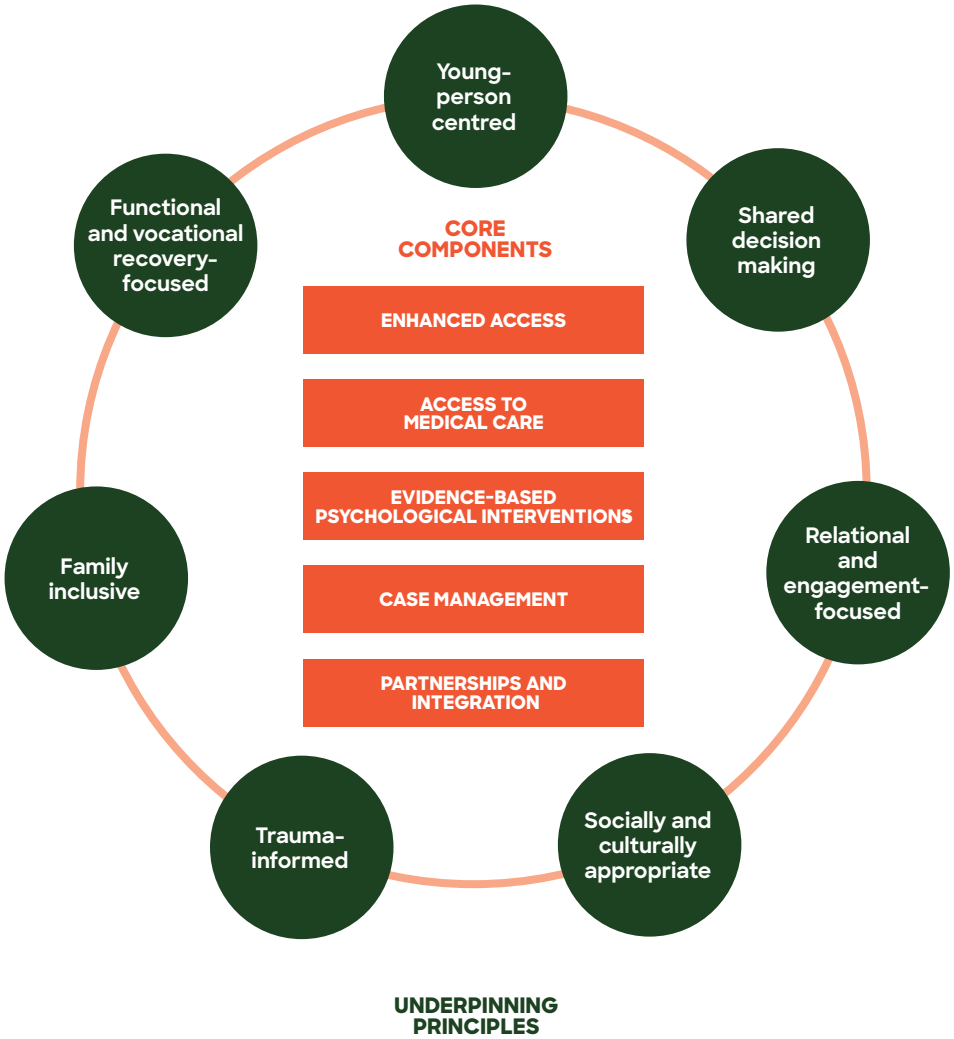
Clinical staging, complexity and the missing middle are not mutually exclusive and there are overlaps. However, they can help frame discussions around the unmet needs of local young people and determining the YES target population. These frameworks can also help the service design process: are you designing for severity of illness, complexity of presentations, or a combination of both? This will also be impacted by the level of funding and skill mix in the available workforce. Finally, it is important to acknowledge that one service will not be able to meet the needs of all the missing middle and thus it is important to conceptualise who will be prioritised.

# MODEL OVERVIEW: YOUTH ENHANCED SERVICES

YES is an emergent space and evidence about effective YES models is in its early stages. However, we know that any youth mental health service model for young people presenting with severe and complex mental health issues requires a flexible approach, in which young people receive appropriate treatment at a time and place which suits them, and allows them to exit and re-enter the service when needed.

To aid the design and implementation of YES programs across the country, Orygen have developed a YES model based on both our knowledge of developing youth mental health services, and the knowledge of the PHNs and YES providers we have worked with over the past few years. The YES model (see Figure 2) consists of five core service components, which are underpinned by seven principles.

**FIGURE 2: THE YES MODEL**



## A model responsive to context

The healthcare system is complex and there are range of contexts in which YES programs operate. Contextual factors which the model may need to respond to include:

- the needs and preferences of local young people;
- local population density and local infrastructure;
- local social-cultural characteristics;
- local pre-existing support models and mental health (and other service) infrastructure availability;
- workforce supply issues in different geographical areas which may result in variations in skill and discipline mix; and
- the amount of PHN funding allocated to YES programs.

A strong understanding of these factors is needed to ensure that YES programs 'fit' the local context. Contextually relevant modelling and data analysis should inform planning, and co-design should be the rule, not the exception. Local program designers should involve local young people in a meaningful way (see figure 3 taken from 'Co-designing with young people: the fundamentals'). It will likely also be beneficial to collaborate with people who have previously developed, researched, and evaluated youth mental health programs and interventions in other contexts.

To facilitate the planning and implementation of contextually 'fit' YES programs, the model has been informed by complex systems theory and developments in implementation science. The model is designed so that it can be adapted to local contexts whilst retaining integrity of its core components. This also allows the model to continue to evolve as new evidence emerges. To ensure the programs remain effective over time, YES providers and PHNs will need to continually refine their models based on ongoing assessment of performance, continual learning, capacity building, and problem solving.

**FIGURE 3: CO-DESIGNING WITH YOUNG PEOPLE IN THE PHN COMMISSIONING CYCLE**
(Co-designing with young people: the fundamentals)


**YOUNG PEOPLE CAN**

- Provide perspectives on their health care needs during a needs assessment.
- Help to develop priorities and population outcomes during annual planning.

**YOUNG PEOPLE CAN**

- Assist in identifying what should be monitored and measured.
- Inform continuous improvement in service delivery by helping to review data (e.g. service feedback forms) and identify ways that services can be improved upon.
- Contribute to evaluation during its design (e.g. setting of priority questions), interpreting data, making recommendations and helping to communicate the findings in an accessible way. (See 'Program evaluation: Laying the Right Foundations' in Useful resources).

**YOUNG PEOPLE CAN**

- Shape design goals during the design of services and strategies.
- Generate, test and refine ideas.
- Design service specifications.
- Review tender applications.
- Sit on interview panels.
- Develop service outcomes and Key Performance Indicators (KPIs).

# CORE SERVICE COMPONENTS

The following table provides guidance about each of the five core YES components. When designing YES programs, it is important to consider each of the components and how they can be operationalised best within the local context. Alongside the rationale for each component, we provide examples of how the model could be operationalised at a 'minimum' level and 'extended' level. While the form that each component takes will differ, the components' essential functions are maintained.

| COMPONENT | RATIONALE | MINIMUM LEVEL | EXTENDED LEVEL |
|---|---|---|---|
| **ENHANCED ACCESS** | Enhanced access allows young people to receive support in a time, location and format that suits them.<br><br>This is particularly important for young people who have a history of poor engagement with physical-based services. Outreach services, with the option of care provision in a non-clinical location where the young person feels comfortable, can greatly increase their engagement with mental health services and with their mental health treatment.<br><br>Enhanced access will vary based on geographic size, number of cases and an estimate of the likely number of young people who will drop out of case management or clinic based appointments and need intensive mobile outreach. | At a minimum, YES programs should provide:<br>• Extended hours (outside of office hours, weekends)<br>• Assertive engagement<br>• Telehealth appointments to provide access to young people who have poor engagement with clinic-based appointments | In addition, YES programs should ideally provide care to young people in non-office based settings, such as:<br>• Community outreach to places where the young person feels comfortable, e.g. local park, shopping centre<br>• Home-based care<br><br>This may require after-hours work and involve assessment, treatment or a crisis response.<br><br>It also requires strong support for clinical supervision and risk management strategies.<br><br>Barriers to delivering this level can include limited funding for infrastructure supports e.g. vehicles, phones, staff ratios, and the geographic reach of the service. |

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| COMPONENT | RATIONALE | MINIMUM LEVEL | EXTENDED LEVEL |
|---|---|---|---|
| **EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS** | YES programs should expect to see young people with a wide range of mental health concerns, including anxiety disorders, trauma, eating disorders, mood disorders, personality disorders, psychotic disorders and substance use disorders, as well as young people who self-harm or have suicidal ideation. Access to evidence-based psychological interventions is crucial to the young person's recovery.<br><br>Interventions offered must be based on relevant clinical guidelines and evidence based literature for psychological interventions including therapeutic approaches that work to engage and support this client group.<br><br>A comprehensive biopsychosocial assessment is required to determine a young person's most immediate needs. This will assist in the determination of severity and will consider individual morbidity, current functioning, the number and type of comorbid presentations and level of risk to self and others and help develop case formulations and appropriate care plans .it will also assist determining appropriate dose and duration of interventions required to address complexity and severity of mental ill-health. | At a minimum, YES programs should facilitate access for young people to psychological interventions after a comprehensive biopsychosocial assessment. This may be to:<br>• Private practitioners<br>• Other services, e.g. a local headspace<br>• In doing this, the following should be in place:<br>• Clear referral pathways<br>• Clinical governance frameworks to manage risk | At an ideal level, the service itself will employ clinical staff to deliver evidence-based, best practice, psychological interventions internally, such as:<br>• Cognitive behaviour therapy (CBT)<br>• Interpersonal therapy<br>• Family therapy and family-based interventions<br>• Psychoeducation<br><br>Additionally, the service should have:<br>• A longer duration of care (6-12 months)<br>• Multi-disciplinary team (including peer workers)<br>• Caseloads of 15 to 20 per full-time clinician<br><br>Barriers to delivering this l level include funding to employ accredited staff, local workforce shortages, and access to training in evidence-based therapies. |

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| COMPONENT | RATIONALE | MINIMUM LEVEL | EXTENDED LEVEL |
|---|---|---|---|
| **CASE MANAGEMENT** | Young people often present with a range of practical issues, aside from any mental health symptoms, which can impact their overall functioning. These can include: unstable accommodation, drug and alcohol use, family discord, unemployment or disengagement from education and physical health concerns. Assistance with these issues can involve direct work by a case manager to address the concern, or linking to appropriate support services and advocating on the young person's behalf. Case management provides a strong foundation for care that is person-centred, culturally appropriate, and improves a clients' quality of life. It has been shown to be effective for high risk young people with limited contact with mental health services. | At a minimum, YES programs should employ service navigators (sometimes known as a brokerage model or care coordination).<br>The service navigator:<br>• Can be a non-specialist or early career mental health worker<br>• Coordinates care provided by other clinicians and services (e.g. medical treatment, legal services, and accommodation services)<br>• Facilitates access to other supports | At an ideal level, the YES program should employ case managers who are responsible for a number of tasks:<br>• Acting as the primary treating clinician and providing formulation-driven psychological therapy aimed at recovery, maximal psychosocial functioning and with minimal risk of relapse<br>• Coordinating care to other supports and services<br>• Facilitating medication management<br>The case manager should be appropriately qualified to provide psychological interventions and provide outreach services.<br>Barriers to the ideal level include challenges recruiting suitably qualified staff to deliver psychological interventions, and lack of funding available. |

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| COMPONENT | RATIONALE | MINIMUM LEVEL | EXTENDED LEVEL |
|---|---|---|---|
| **ACCESS TO SPECIALIST MEDICAL CARE** | Severe and complex disorders can be challenging to address and often require oversight from a medical professional e.g. GP or Consultant Psychiatrist as well as appropriate medical management regarding medications and any physical health issues. Medical treatments are one of the key clinical interventions in any mental health service. These interventions are wide-ranging and include coordinating medical screening and psychiatric assessment as well as evidence-based pharmacotherapy to ameliorate symptoms and distress associated with psychosis, mood disturbances, anxiety and substance misuse. Having other doctors available is important for treating any physical health problems and for prescribing medicines.<br><br>Tele-psychiatry and secondary consultation can be important components of care. Referral pathways for tertiary level psychiatric care when required should be established. Services should establish who will provide specialist psychiatric care (e.g. a Consultant Psychiatrist, Registrar with supervision etc.) and how care will be arranged (e.g. as part of a multi-disciplinary care team, via secondary consultations or tele-psychiatry etc.). The involvement of GPs and allied health workers will help ensure other health problems, such as concerns with diet or physical activity, are managed. | At a minimum, YES programs should facilitate access to general practitioners for management of medication and physical health. This should include:<br>• Developing partnerships with local GPs to facilitate smooth referrals<br>• Developing networks including GPs, psychiatric services and private psychiatry providers.<br>• Providing clinical updates to referring GP<br><br>Services should also consider how to support GPs by building their capacity to provide best evidence-based care to young people with mental health issues. | Ideally, the service should employ sessional psychiatry for assessment, diagnostic clarity and treatment planning to guide purposeful therapeutic work.<br><br>Barriers to implementing the ideal level include limited access to psychiatry in the region and lack of funding to employ a psychiatrist.<br><br>Access to telehealth, both primary and secondary, is a viable alternative when employment of a sessional psychiatrist is not feasible. |

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| COMPONENT | RATIONALE | MINIMUM LEVEL | EXTENDED LEVEL |
|---|---|---|---|
| **PARTNERSHIPS AND INTEGRATION** | Often, the mental health care needs of young people cannot be met within one service or program but require input from several professionals, services or organisations. Relationships and networks should be built with a variety of partners, not only those delivering PHN-funded services. With the aim of providing comprehensive clinical care across the stepped care continuum, networks should include tertiary mental health services and headspace or other mild to moderate mental health services. Other key partners may include social care, housing and non-government organisations as well as employers and the education system, all of which can play an important role in relation to mental health.<br><br>Integration can happen at different levels and through different mechanisms. It exists on a continuum from formalised agreements and arrangements between services, such as services using the same referral and assessment processes or sharing administrative processes, medical records and team meetings, to collaborative care approaches and dedicated multidisciplinary onsite teams with a common culture of care.<br><br>Effective, strong partnerships enable team-based care, which is critical in ensuring young people have access to the range of disciplines and supports that may be relevant to their needs. | At a minimum, YES programs should facilitate partnerships and integration with relevant other local service providers, through:<br>• MOUs<br>• Attending multi-agency meetings<br>• Establishing clear referral pathways<br>• Providing supported transitions/warm referrals<br>• Establishing consultation-liaison processes | At an ideal level, YES programs will have stronger and closer relationships with other service providers, through:<br>• Co-location<br>• Team-based care<br>• Collaborative care approaches<br>• Dedicated multidisciplinary onsite teams with a common culture of care<br>• Peer workforce and volunteers<br><br>Barriers to implementing the ideal level include limited time to build relationships, finding suitable facilities to co-locate, and funding structures that foster competition not collaboration. |

# UNDERPINNING PRINCIPLES

**There are seven (7) principles underpinning the YES model. These are:**

## PRINCIPLE 1
## YOUNG PERSON-CENTRED

Person-centred care is widely recognised as a foundation to safe, high-quality healthcare and is a fundamental principle for youth mental health services. It is care that is respectful of, and responsive to, the preferences, needs and values of the individual young person. It involves seeking out, and understanding what is important to the young person and their family, understanding their development phase and history, fostering trust, establishing mutual respect and working together to share decisions and plan care.

## PRINCIPLE 2
## SHARED DECISION MAKING

Shared decision making is an approach to treatment decision making that involves collaboration between a clinician and a young person, their families, and other professionals. It promotes treatment choices that are based on both the best available evidence, as well as, the preferences of the young person. Shared decision making has been shown to improve engagement with and satisfaction with treatment, and to lead to improved outcomes (see Shared Decision Making for Mental Health, What is the evidence).

## PRINCIPLE 3
## RELATIONAL AND ENGAGEMENT FOCUSED

The YES model recognises the strong available evidence that engagement and the formation of a strong therapeutic alliance between clinicians and young people improves attendance, adherence with biological and psychological interventions and results in improvements in symptomatic and functional outcomes. Furthermore, engagement and the quality of the therapeutic alliance improves information gathering, increases clinicians' contextual and aetiological understanding of the young person's presentation, assists the young person to seek help in the future, aids collaboration with family and support agencies and is experienced by all involved as a more congenial way to interact (see Working with clinical complexity and challenges in engagement).

## PRINCIPLE 4
## SOCIALLY INCLUSIVE AND CULTURALLY ACCESSIBLE

The model recognises that young Australians are diverse, with a range of cultural identities and backgrounds, religious beliefs, gender identity, sexual orientation and indigeneity and that distress and wellbeing are experienced within cultural, social and historical contexts. Therefore, young people require services that are inclusive and culturally accessible, services that include consideration of human rights, language, written resources, engaging community and family, and understanding intersectionality. A transcultural and inclusive approach to care is reflective of, and seeks to explore, a person-centred perspective within the individual's socio-cultural context (see Designing mental health services for young people from migrant and refugee backgrounds).

## PRINCIPLE 5
## TRAUMA INFORMED

The model is underpinned by a recognition of the impact that past and present trauma can have on the onset, complexity and severity of a young person's experience of mental ill-health. The model also recognises that recovery from mental ill-health can be compromised should experiences of trauma not be identified and effectively responded within mental health care and treatment.

The model incorporates a trauma informed care approach which: a) realises the widespread impact of trauma; b) recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; c) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and d) seeks to actively resist re-traumatisation. However, the model also recognises that an effective youth mental health service response must also include trauma assessment and appropriate treatment and consideration of the broader trauma-informed system where there is good trauma-awareness amongst all partnering agencies (see Trauma and young people Moving toward trauma informed services and systems).

**OTHER RESOURCES**

Trauma informed toolkit for organisations.:

A Systematic Review and Synthesis of Trauma-Informed Care Within Outpatient and Counselling Health Settings for Young People, Bendall S et al (2020), Child Maltreatment.

## PRINCIPLE 6
## FAMILY INCLUSIVE

The model recognises the scaffolding families provide in a young person's recovery, including after they turn eighteen years of age. As such, the model promotes family inclusive practice, the requirements of which will vary for each young person and their families. The level of illness, prior experience with a service and the service context, will all shape how family inclusive practice is delivered. The expectations of a family and their own need for support is also an important consideration. Family inclusive practice needs to recognise that family does not simply mean parents but can include siblings, partners and other support people (see We're in this together; Family Inclusive Practice in Mental Health Services).

## PRINCIPLE 7
## FUNCTIONAL AND VOCATIONAL RECOVERY FOCUSED

Severe and complex mental health disorders can impact and disrupt young people's social, educational and employment opportunities or associated activities. Preventing loss of functioning and promoting functional recovery is important. This can be achieved via direct work, group work, family work and partnerships with other agencies.

Activities within functional recovery aim to restore or maintain the normal functional trajectory of the young person from the employment, educational and social perspectives, recognising that these perspectives are interlinked. Educational recovery is linked to an improvement in the chances of employment. Educational and employment activities are likely to improve social recovery given that work and education or work environments are usually the source of social networking and friendship development and employment provides the financial means for social and leisure activities.

It is important to be guided by a young person's individual goals (see Keeping on track and Working it out).

# CONCLUSION

There is a well-established need for services to support young people with, or at risk of, severe and complex mental ill-health, who would otherwise fall through the gaps. Best-practice evidence for service delivery in this space is limited, but emerging. Furthermore, YES programs vary in the level of resourcing and operate in vastly different contexts. They must therefore be adaptable to the local context and flexible to the needs of individual young people.

This document builds on previous Orygen guidance and what we have learnt over the last three years of supporting PHNs and their YES programs. By describing key components and underpinning principles, it ensures that programs are based on evidence while providing room for local adaptation. The operationalisation of each component will vary depending on these contextual and resourcing factors, but the function of each component is retained. As the evidence continues to grow, service models must continually adapt and improve to ensure the highest quality care is provided to young people.

# EXAMPLES OF YES

## YOUTH ENHANCED SUPPORT SERVICE

YESS YOUTH ENHANCED SUPPORT SERVICE — Parramatta Mission

### ELIGIBILITY CRITERIA

- 12-25
- Requiring more support than what primary mental health care can provide
- Priorities:
  - Unable or unwilling to attend centre-based appointments
  - Unable to afford private services

**KEY PRESENTING ISSUES**

- Comorbidity
- Developmental trauma
- Social disadvantage

- SELF OR FAMILY REFERRAL
- PRIMARY CARE PROVIDERS
- YOUTH SERVICES
- CYMHS

**TRIAGED AT TEAM MEETING**

### YOUTH ENHANCED SUPPORT SERVICE NORTHERN SYDNEY (YESS)

**Parramatta Mission**
Chatswood, Sydney

**STAFFING PROFILE**

- 0.6 FTE psychiatrist
- 5.0 FTE mental health clinicians
- 1.0 FTE youth peer workers
- 0.4 FTE GP
- 0.25 FTE administration
- 0.58 FTE managers

**PSYCHOLOGICAL INTERVENTIONS**

- CBT, DBT, ACT, EMDR, Narrative therapy

**COMPREHENSIVE, HOLISTIC ASSESSMENT**

- By clinician, psychiatrist, GP and peer worker

**CASE MANAGEMENT**

- Delivered by interdisciplinary team

**ENHANCED ACCESS**

- Extended opening hours by appointment
- Outreach, home visits, telehealth

**ACCESS TO MEDICAL CARE**

- Psychiatrist as clinical lead
- Onsite GP

**FAMILY SUPPORT**

- Family therapy
- Access to Family and Carer Mental Health Program

**PARTNERSHIPS AND INTEGRATION**

- Employment provider
- headspace
- Lifeline H2H
- Northern Sydney LHD
- GPs

**AVERAGE 12-MONTH DURATION OF CARE: AVERAGE SESSIONS ARE WEEKLY**

**CASELOADS**

- 15-20 per clinician

**GROUP PROGRAMS**

- Social group
- Dungeons and Dragons
- Parents group
- Study skills (with headspace)
- DBT group (with Lifeline H2H)

- +/- PRIVATE MENTAL HEALTH PROVIDER
- +/- SUPPORT SERVICES

**CAPACITY BUILDING FOR LOCAL GPS**

- Ongoing dialogue during young person's care
- Information about social prescribing and community programs

**REGULAR PROGRESS MONITORING**

- Outcomes Star
- Focus on functioning, relationships, values, hopes and goals, as well as symptoms

**DISCHARGE TO GP**

**GOALS**

- Individual goals set using Outcomes Star tool

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# ENHANCED CARE PROGRAM

headspace Darwin AnglicareNT

## ELIGIBILITY CRITERIA

- 12-25
- Emerging complex mental health difficulties
- Circumstances that may lead to vulnerability to mental health challenges

**KEY PRESENTING ISSUES**

- Trauma
- AOD
- Domestic/family violence
- Emerging personality disorders
- Depressive disorders
- Anxiety disorders

- SELF-REFERRAL
- OTHER HEADSPACE TEAMS
- SERVICE PROVIDERS

**INTAKE ASSESSMENT WITH ACCESS TEAM**

## ENHANCED CARE PROGRAM

**headspace Darwin**
Anglicare NT

**60-70%**
of young people identify as Aboriginal or Torres Strait Islander

**PSYCHOLOGICAL INTERVENTIONS**

- Trauma-informed counselling, CBT, DBT, narrative therapy

**INITIAL FOCUS ON ENGAGEMENT AND RAPPORT-BUILDING AND THE YOUNG PERSON'S GOALS**

**ACCESS TO MEDICAL CARE**

- Onsite GP
- Telepsychiatry via headspace National

**CASELOADS**

- 10-20 depending on complexity

**CASE MANAGEMENT**

- Flexible, assertive, therapeutic approach
- Strengths-based and culturally informed

**ENHANCED ACCESS**

- Extended opening hours
- Outreach, home-visits and office-based care

**12-MONTH DURATION OF CARE: AVERAGE WEEKLY SESSIONS**

**STAFFING PROFILE**

- 1.0 FTE Senior Enhanced Care Coordinator
- 1.0 FTE Aboriginal Wellbeing Worker
- 1.0 FTE Team Leader
- 0.6 FTE Administration

**FLEXIBLE STRUCTURE: NO 'ONE-SIZE FITS ALL'**

**PARTNERSHIPS AND INTEGRATION**

- Danila Dilba Health Service
- Tertiary mental health services

- CAN RE-REFER AT ANY TIME
- ONWARD REFERRAL IF REQUIRED

**SUPPORTED CLOSURE**

## PROGRESS MONITORING

- Based on individual needs and preferences
- 3-monthly review
- hAPI
- Recovery Star
- Stay Strong App

## GOALS

- To support young people who are often seen as 'hard to engage'
- Collaboratively-set individual goals

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