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GLOBAL CONSULTATIONS WITH YOUTH MENTAL HEALTH SERVICES

SUMMARY REPORT

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The project team would like to sincerely thank each organisation for their time and commitment to being interviewed for the project and sharing their wisdom, sage advice and learnings from implementing youth mental health programs across many different countries.

This information has played a pivotal role in shaping the global youth mental health framework that has been developed as part of this important collaboration. The information collected will be important in supporting the development and implementation of new youth mental health programs into the future.

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GLOBAL CONSULTATIONS WITH YOUTH MENTAL HEALTH SERVICES: SUMMARY REPORT

Over the past 15 years several integrated youth mental health services have been established across 14 different countries. Each service has their own unique characteristics that are particular to the country in which they have been established, which vary according to available resourcing, the overarching model or approach identified to work best locally, local leadership, current policy settings and the co-design process involving young people.

To date some services have been evaluated, usually in relation to program implementation or utilisation and acceptability by young people. Building on the work of Hetrick and colleagues[1], the development of a global model for youth mental health provides an opportunity to further consult with models established to date and understand what has informed their development and for some, further expansion of their program.

The global youth mental health partnership between Orygen and the World Economic Forum has facilitated a unique opportunity to consult with existing youth mental health services internationally, which has contributed to the development of a global framework for youth mental health.

ESTABLISHED PROGRAMS

Many of these programs have evolved from the initial headspace model that was developed in Australia where the first centre opened in 2007. Since that time, headspace has undergone significant expansion across Australia with 145 centres to be established by the end of 2019. The core tenant of many of these programs is the notion of a one stop shop or hub and spoke model (in more rural settings) where young people can access a range of primary mental health related services. In some programs this includes sexual health, alcohol and other drug services, vocational supports and access to primary care physicians. Some variations have emerged according to country of implementation and their preferred approach, these include:

- utilisation of paid clinical staff versus use of volunteers as counsellors;
- specific models targeting indigenous or First Nations people;
- capacity to provide services and supports online;
- co-location of other service providers versus site specific employees;
- capacity for outreach and service provision offsite;
- use of young people as peer mentors; and
- programs delivered through health providers versus not-for-profits.

CONSULTATION PROCESS

Given the number of programs established internationally, the process was never intended to be exhaustive, rather, the aim was to consult each service with a specific focus on the learnings and critical success factors, particularly for those more mature programs. For those recently established, the focus was on understanding their approach and model of care and what may have informed their approach.

As a result, the following method was used to undertake the consultations with youth mental health programs internationally:

- Undertake in-depth interviews with key leadership staff to ascertain their views and perspectives on program establishment, implementation and learnings to date.
- Key informant interviews, particularly in those services with multiple sites, with several service or centre managers (or their equivalent).
- Consultations with clinical staff responsible for provision of clinical services or their equivalent.
- Focus groups with young people affiliated with the service through their youth advisory structure or similar (this information will be dealt with in a separate report).

The project team undertook many in-depth interviews and focus groups with a combination of executive teams (where they were present), program managers, direct service staff and young people. Table 1 below highlights the different programs consulted and the makeup of the different groups who were consulted in each of the organisations.

TABLE 1 – SERVICES CONSULTED

Program	Country	Executive	Service managers	Clinical staff	Young people
Jigsaw Dublin	Ireland	√	√	√	√
headspace	Australia	√	√	X	X
headspace Bat Yam	Israel	X	√	√	X
Access Open Minds, Montreal	Canada	√	√	√	X
Foundry Vancouver	Canada	√	√	√	√
Eskasoni First Nations, Nova Scotia	Canada	√	√	√	√
Te Kurahuna and Te Kuwakawata LeVa (Pasifika) Fraser High School, Hamilton	New Zealand	√	√	X	√
The Junction, Edinburgh	Scotland	√	√	X	√
Forward Thinking Birmingham	England	√	√	X	√
Headspace Copenhagen	Denmark	√	√	X	√
@ Ease Amsterdam Maastricht	Netherlands	√	√	√	X
Maison des Adolescents Paris	France	√	√	√	X

Youth Wellness Hubs Ontario	Canada	√	√	X	X

In all, 13 different programs were consulted across 10 countries. Two new programs, Soulspace in Berlin, Germany and Bergid in Reykjavik, Iceland were still in establishment at the time of consultation.

KEY THEMES

The data obtained from the consultation interviews was routinely summarised from key questions asked. A thematic analysis was undertaken to summarise key themes to emerge and identify the key learnings that were relevant for the development of the global framework.

Further consultations were undertaken with a significant number of young people from around the world and outside of the programs listed here. As a result, an additional report has been developed which focuses solely on the views and perspectives of young people.

The following themes are a summary of what emerged from the consultations undertaken.

PRINCIPLES THAT INFORMED MODEL DEVELOPMENT

Programs were asked to identify key principles or elements which informed their model or service design. In summary they included:

- a focus on early intervention – in many instances this involved engaging the young person before they met the threshold for a diagnosis of a mental illness;
- youth participation and engagement – while not all programs have this as a core practice, they all identified it as a key element of their program;
- multi-disciplinary – with a wide range of disciplines, including peer work, available to young people;
- accessibility, youth friendliness and welcoming environment – all programs had ensured that services were both easily accessible and acceptable with regards to their look, feel, design and flow;
- learning culture – many described the need to ensure the culture within the service was both supportive to those working there and promoted shared learning amongst staff, given for many this was a new way of working;
- engagement, relationship building and continuity of care – many services described this as critical to their way of working given young people often experience poor engagement and continuity of care;
- flexibility – while many programs were part of a broader national initiative such as headspace and Jigsaw, there was a strong statement about the need for the model to be flexible to meet community need and to account for different resourcing capacities; and
- quality improvement (QI) – some of the more established programs stressed the importance of robust data collection that could support their model being funded. There was also a sense that QI should contribute to model development and facilitate change to ensure services were of a high quality that met the needs of young people.

While not expressed as a principle, many programs commented on the need for better engagement with families which many were striving to achieve. Notably, there was only one program which indicated they would not work with the young person unless the family were engaged. Both leadership

staff and program managers identified this as an area of further improvement, however often lacking the necessary resources to support family work.

KEY LEARNINGS TO DATE

All programs highlighted several learnings as part of their implementation. In fact, some programs had learnt from others about some of the critical elements that should be included in their program which again are reflected in the principle's summary.

The following is a synthesis of many of the key learnings that have emerged from implementing youth mental health programs globally:

1. RELATIONSHIP BUILDING

Relationship building was identified as fundamental to any new service being established, specifically in relation to youth mental health and the need to make available different service options and responses for young people whose needs vary. It was also identified that irrespective of the orientation of the program, it would not be possible to meet the clinical and support needs of all young people presenting to the service. Therefore, building key relationships with other mental health services and supports was seen as fundamental and should occur from the outset.

This was identified as particularly important with government funded mental health services who provide both child and adolescent and adult mental health services. There is often a need to refer young people to these services, specifically those who are at extreme risk and cannot be managed in a youth mental health program. Most programs indicated this was often a challenge as it was primarily relationship based.

The need to establish strong relationships with funding bodies was also highlighted, both in terms of funders understanding the program and informing them on program impact and outcomes.

Several programs expressed the need to ensure the service was embedded within the community. While this was the case for all programs, it was especially true for those that were established for indigenous and First Nations people. It was felt that the service or centre should be viewed as a community resource and indeed supported and enabled by the local community. It was also noted that while it may take time to build trust within a community, it was fundamental for the program's survival.

2. YOUTH CENTRED

The desire for the programs to be centred around the needs of young people was paramount to fostering engagement. This includes young people having choice from who they wish to work with to the most appropriate intervention that works for them. In addition, programs highlighted the need to focus on the young person's overall wellbeing rather than illness. While some programs indicated this was hard for some people in practice, the ethos of their programs should be a focus on the young person's strengths and not a deficit model.

Many indicated the key to their success of attracting young people to the service was the way in which centres had been established. They were usually well located, easily accessible, well designed with input from young people and extremely welcoming. There was a wide held view the space should be non-stigmatising and flexible.

3. FLEXIBILITY

The need for service flexibility was seen as fundamental to achieving a successful program. While there were challenges identified for some in having a 'national model', indications point to ensuring local flexibility and adaptability based on community need and resourcing. Programs established for over 10 years had made adaptations to their initial model given maturation of the program and better

understanding the needs of young people locally. For one service this included the provision of outreach in identified locations in order to access young people who were never likely to enter the centre.

Many programs described the youth mental health model as a 'new way of doing business', as such there was a lot of 'learning by doing', meaning they didn't always get it right. Rather the need to be nimble in order to learn from their mistakes was critical.

4. IMPLEMENTATION AND EVALUATION

For some of the more established services, the need to focus on implementation and learn from this was crucial. Utilising an implementation science framework assisted some programs to better understand the implementation challenges and areas they needed to focus their energies. This included better integration of services locally, evolving youth engagement and staff supporting the model and ensuring everyone was on board with data collection and the rationale behind it.

Programs indicated a need to develop evaluation strategies from the outset and not wait for the program to be in a settled state before formulating an evaluation. Ideally, this should be incorporated into the funding model.

For those early adopters, there was a strong indication for a need to document the model from the outset. For some programs the failure to do this has impacted upon implementation and how different sites interpret the model in their context.

5. COMMUNICATIONS AND BRANDING

Communications both internal and external was identified as a critical learning for all programs. Many programs highlighted the importance of communicating what the service is and equally important, is not. There was a view that outside agencies did not always understand the limitations of the youth mental health program, thus resulting in referrals that were often inappropriate, or they were unable to accept.

There was a wide-held view that communication should be ongoing and continually seek to update agencies, young people and families with the program's development. Social media was identified as the most effective and least costly way to achieve this.

Coupled with the communication element is the importance of the program brand. All programs indicated that both young people and local providers had a strong association with the brand and that it was often the best avenue to promote their offerings through word of mouth amongst young people. It was also agreed that the brand must be developed in partnership with the young people.

6. BROAD SKILL-SET REQUIRED

There was a wide-held view that one of the strengths of the youth mental health model was the broad range of skills that had been recruited to the different programs. This included mental health clinicians, medical staff, youth and family peer workers, volunteer counsellors, drug and alcohol specialists and vocational workers. While each program varies as to the breadth of the skills available, it was evident that to provide a comprehensive service response there is a need to extend beyond the traditional mental health workforce.

Adopting a transdisciplinary approach was one way in which programs could be more responsive while being clear about their scope of practice for each of the different disciplines engaged in the service.

Not all programs had youth peer workers. However, those who did highlighted it as a significant strength to their model. The consensus view was ideally all services targeting young people should have youth and family peer workers on board.

Similarly, those programs with volunteer counsellors indicated that as most of their counsellors were also young, it was easy to engage young people with their program.

PROGRAM CHALLENGES

As expected, several program challenges were identified with some suggesting these challenges were part of the learning process that had assisted in changing specific practices to better serve young people. The following summarises the key challenges identified:

1. WORKFORCE AND RETENTION

Recruiting suitably qualified clinical staff was an issue raised by many of the programs. Given the rapid expansion of many services in different countries there has been a need to recruit suitably qualified mental health staff. As there is a shortage of appropriately qualified mental health staff across many countries, this has proven a challenge for many. This is further exacerbated for those programs located in rural or regional areas where it is even more difficult to obtain suitably qualified staff.

Coupled with this is staff retention, as some staff choose to leave after a time to seek out better pay and conditions usually found in government funded mental health programs. Many programs highlighted the difficulty in competing with government funded posts.

To balance this, some programs have worked hard to develop a strong and supportive workplace culture that fosters and nurtures learning and development opportunities to facilitate staff retention.

This leads to the maturity of the sector which is still relatively new and finding its place amongst other programs as some countries have witnessed an expansion in mental health programs.

2. ADAPTING TO A NEW MODEL

For some, the adaptation to a new service model proved a challenge for some staff who were required to learn a new way of working which is very different from traditional mental health services. Those programs changing their existing service structure to a new youth model with limited experience of change management practices have struggled with the impact on staff and their ability to adapt to a new way of working.

3. ENGAGING FAMILIES

While many of the programs indicated their desire to engage families in collaboration with the young person, this has been difficult to achieve for several reasons, including:

- limited skill-set of staff in working with families;
- perception that young people don’t want their family involved;
- few programs have been resourced to work with families; and
- no agreed approach how youth mental health services can engage families.

This is an area where all programs acknowledge they need to do better and will be a fundamental element of youth mental health programs into the future.

4. GOVERNANCE STRUCTURES

The governance structure of many programs has proven quite a challenge. This includes both the organisation governance model, be it a consortium approach with a lead agency and consortia partners or one agency leading the whole initiative. In addition, clinical governance processes have been difficult to navigate for some programs.

There was general agreement that governance processes should ideally be determined before the model is implemented. Some programs experienced poor clinical governance structures developed by lead agencies who do not fully understand clinical service delivery.

Those programs running multiple centres or sites agreed that in order to proceed, all documentation, policies, procedures, etc. should be developed at start-up and be consistent across all sites, with some variation for local factors.

5. PROGRAM ADAPTATION

Managing future trends and incorporating these into existing programs was outlined as a key challenge. The rationale for establishing a new model was existing systems had failed to adapt and change with the needs of their client group. There is a danger that this could well occur with youth mental health programs. Given the dynamic and changing environment, health has often been a laggard with regards to program adaptations and change. Youth mental health programs must remain agile and be willing to change as the needs of young people change into the next decade.

6. TECHNOLOGY

The adaptation of programs to incorporate new technologies which benefit young people was identified as both a necessity and a challenge. Some programs did not incorporate this into their start-up and are only beginning to introduce this now, be it online support or enhanced communication methods. One significant limitation of all programs was their inability to have young people access their service virtually, whereby a young person could engage with a worker online (Skype, FaceTime, etc.) rather in person.

It was evident that all programs are cognisant of the virtues of technology as an adjunct to in person service provision, however there seems little appetite to move in this direction.

CRITICAL SUCCESS FACTORS

All programs were asked to provide advice for future youth mental health programs in addition to the principles and key learnings already described. Several factors were identified and summarised which include:

- Strong leadership is fundamental to implementing new models of care – you need to take people with you and not a ‘top-down’ approach.
- Engaging and working with both schools and universities is important, both from a referral standpoint but also to provide schools with strategies to better manage mental health issues that arise in education settings.
- Where possible, the provision of different access points for young people to better cater to a wider cohort of young people.
- Manage expectations within the community – be realistic about what you can achieve and ensure the community are aware of this.
- Vary the types of services and supports available to young people – include group programs and where possible, online support options and think about cultural relevance of certain programs.

- Use peer workers where possible as the initial engagement with the service – this really helps to connect the young person and provide insights to their situation from a peer perspective.
- Don't always look to supplant a new service or centre in a community, asses what exists locally and ascertain if you can build the capacity of existing resources or re-engineer them in such a way involving young people.
- Do not underestimate local culture and available resources, look to integrate into or connect with existing programs locally.
- A multiple agency approach should be the desired goal, not one single entity.
- Co-design with young people from the outset, not just consultation.
- Be future-focussed, understand trends ahead of time and plan for them.
- Develop learning networks across services so there is capacity to learn from and support one another.
- Find a narrative that fits with the ethos of what it is you are trying to do and make sure that everyone is on board and able to communicate the narrative.
- Identify champions within your community or program who can advocate and inspire.
- Flexibility to utilise volunteers in your program – have great capacity to 'value add' and can be the bedrock of early intervention prior to clinical interventions.

INDIGENOUS PROGRAMS

Two of the programs consulted were specific to the mental health and wellbeing for Maori and Eskasoni First Nations young people. Given the cultural needs of these diverse groups and how they view mental health within their own culture it is important to highlight some of the issues specific to these programs.

For the Eskasoni First Nations Access Open Minds Program the following elements are worth noting:

- The program covers a small population of 4500 people of which 50 per cent are under 25 years of age.
- Community impacted significantly by Residential Schools Policy which was in existence until 1996 where children were removed from their parents – significant trauma was associated with this practice.
- This policy attempted to eradicate their culture and resulted in significant childhood and family trauma and exposed children to sexual and physical abuse. As a result, substance use is high amongst community members.
- The Eskasoni Mental Health Service provides integrated physical, mental and substance use care and reaches out to the whole community.
- The model was developed to provide high quality mental health and addiction services, across the lifespan that are culturally appropriate, community-based and community-led.
- Within the program there is a youth team. The model utilised is called the Fish Net Model which seeks to involve the whole community in a range of health, recreational and wellbeing related activities. It seeks to involve everyone as the client, not an individual focus.

- Community engagement is pivotal to the success of the model and important that young people see the staff as community members and not identified health professionals who they cannot relate to.
- Youth services are provided at the centre which was converted from an old pool hall. This was co-designed with young people and consists of a kitchen, a multi-purpose space, a chill-out mezzanine space and five therapy spaces.
- The service is 24/7 where people can come just to get a tea or coffee, chat with staff – many of whom are ex-clients, which is also an important feature.

The program experiences significant engagement with and ownership by the community. They foster a strengths-based approach and is widely supported by the Chief of the community.

Consultations in New Zealand included Māori leaders and whānau (extended family) in Tairāwhiti (the Gisborne region on the North Island) at Te Kurahuna and Te Kuwakawata, to learn about and experience Māori leadership in the design and delivery of mental health and addiction services. Core components of the services at Te Kuwakawata include:

- a single point of access to all mental health support services (clinical and non-clinical) for all whaiora and their whānau experiencing distress;
- deliberate reinstatement of Mātauranga Māori into services through a partnership with Te Kurahuna and the embedment of Mahi a Atua*; and
- strengthening whānau and increasing community capacity across Tairāwhiti.

*Mahi a Atua draws from Māori creation and custom stories, known as purakau, to understand how Māori ancestors made sense of their realities. The purakau helps Māori understand themselves, their world and their place in it. Through Mahi a Atua they can then shape how they can respond to distress within themselves and their whānau.

The team also spoke to ten Hamilton-based rangatahi (young people) from Fraser High School's Hei Taniwha programme who were supported by Real Waikato program to attend and contribute. The Real Waikato team supports young people's wellbeing through an in-school Māori performing arts program which engages students with kapa haka (Māori performing arts) and cultural practice. The rangatahi demonstrated the how waiata (song) connects them to their history and each other and spoke about how through cultural practice and the importance of the whānau they support each other's wellbeing and mental health.

LIMITATIONS

It should be noted there are some limitations in relation to the consultations undertaken. Most services operate within major metropolitan environments, and therefore the learnings are mostly relevant to that context.

There is still limited information about establishing services in rural and remote locations and low-resource settings with limited or no infrastructure and workforce to support such endeavours.

Also, many of the examples are top-down rather than bottom-up, apart from the indigenous programs. To incorporate learnings from more bottom up approaches would be valuable.

SUMMARY

The consultation process has provided unique insights into new and existing youth mental health programs that have largely been designed around similar principles and practices. Each program is essentially focussed on providing accessible, youth friendly and focussed care in an environment which is acceptable to young people. Coupled with this is the need to meaningfully engage young people in the design and ongoing evolution of the model.

Flexibility is key and while many programs have been established around a national policy or framework, local adaption, community readiness and cultural factors play a big part in determining the look and feel of the program locally.

In thinking about youth mental health programs of the future, consideration must be given to the need for a diverse and expanded workforce who are nimble and agile enough to adapt to the changing needs of young people. This includes the utilisation of volunteers as an initial point of contact for young people who want to talk with someone, not necessarily a professional, about their concerns or issues. Ideally, should this require escalation, clinical staff are part of the overall staff mix to provide youth-specific and evidence-informed interventions.

Similarly, further thought must be given to how technology can enhance service access for young people who may find it difficult to access a physical site or are reluctant to do so. Providing young people with a range of options should be a key feature of youth mental health programs developed into the future.

The information gathered through this consultation process has been an important component in developing the global youth mental health framework. There are several fundamental elements that lend themselves to translation across different settings and cultural contexts that are not dependant on high levels of resourcing. In fact, some of the principles and learnings described may be more easily implemented in settings with fewer impediments or complex health systems.

REFERENCES

Hetrick SE, Bailey AP, Smith KE, Malla A, Mathias S, Singh SP, O'Reilly A, Verma SK, Benoit L, Fleming TM, Moro MR, Rickwood DJ, Duffy J, Eriksen T, Illback R, Fisher CA and McGorry PD. Integrated (one-stop shop) youth health care: best available evidence and future directions. Med J Aust 2017;207(10): S5-S18. doi: 10.5694/mja17.00694