2020

Youth Mental Health Outreach Project

Co-designing a new mental health and wellness service for young people

WAPHA
WA Primary Health Alliance

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

MercyCare

CONTENTS

This report was completed by MercyCare with input from young people (with particular thanks to our Youth Consultation Group), families and carers, service providers and with the support from the WA Primary Health Alliance.

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We would also like to acknowledge our partners, Derbarl Yerrigan and Orygen who have played a key role in this process.

orygen

MercyCare acknowledges the Whadjuk Nyoongar people, traditional custodians of this land. We wish to acknowledge the strength of their continuing culture and offer our respects to Elders past and present.

Introduction

A note on COVID-19

The completion of the formal co-design process for this service coincided with the COVID-19 outbreak and associated lockdowns. This presented a range of challenges for the implementation of an outreach service which had been carefully designed to provide an accessible face-to-face outreach service to young people through youth centres, services, public spaces and even in their own homes.

We have had to rapidly adapt the service delivery mode to being entirely delivered through web-based contact with young people.

We are aware that solely web-based contact may not be ideal for all young people, particularly those with limited access to WIFI or devices during Covid-19 lockdowns.

However we also acknowledge the heightened stressors which Covid-19 is adding to young people who are already experiencing anxiety and distress. We wanted our service to be able to contribute to the sector of hard working counsellors providing support to young people during this crisis, even if we could only provide an imperfect service to a limited number of young people.

All of the insights and principles we uncovered through the co-design about the ways in which young people wanted to engage with a mental health and wellness service still stand. We are still committed to young people having an active, empowered role in their own care, to shared care with other service providers, and opportunities for family/friends to be part of the therapeutic journey.

The modes in which the services and activities are delivered in the short term will be online. We will experiment with different communication platforms, different ways of using validated tools and providing therapeutic care. We will adapt these based on feedback from young people and service users about what works for them.

Thank You

The authors would like to extend their thanks to the young people and families who participated in this project and shared their personal stories. Their willingness to share personal information about their life circumstances proved humbling.

Many of the young people had experienced much adversity and their willingness to share their stories and experiences is a testament to their resilience, bravery and desire to see changes that will benefit others. This project would not have been possible without their engagement, and for this we are grateful.

We would also like to thank our community stakeholders who provided assistance with the recruitment of young people and who also participated in the process.

Your support, insights, experience, guidance and contribution were invaluable to this Project.

We'd like to thank Dr Shane Cross, Dr Danny Rock, Dr Michael Wright, Phil Bartlett, Tiana Culbong, Telethon Kids Institute, Australian Childhood Foundation, Derbarl Yerrigan, Mission Australia, Youth Mental Health and Orygen for your guidance around the model.

Thanks also to those who have supported and added value to the project through your expertise, literature reviews, data sets, governance, advice and guidance.

Finally, we would like to thank our funding body, WA Primary Health Alliance, who enabled this co-design process to occur. It is a rare luxury to have the time to delve into a process of listening and noticing together, and even rarer that a funding body would be so keenly involved in that journey. We know that you took a risk on this project and hope that the process and outcomes provide the impetus for more projects of this kind.

Introduction cont.

For young people with complex or severe mental health needs, it can be difficult to find a suitable service, for many reasons.

Barriers to access can include readiness to seek help, awareness about available options, perceptions about the service, the effort involved with engaging, transport, overly clinical language, disempowering approaches or limited support options, to name a few. Many young people also find that their need falls between the service eligibility cracks of too complex, or not severe enough.

In Perth, several headspace centres have been providing an enhanced service for some of their clients with more complex needs as an add-on, through headspace Plus. These teams have done great work with the available resources, however it was clear there was a need for a dedicated service.

In November 2019, WAPHA commissioned MercyCare to undertake a four-month co-design process to design and deliver a youth mental health outreach service for the Perth's Northern suburbs.

This service would "provide support to young people in the community who are 12-25 years-of-age and are experiencing, or are at risk of developing, severe and/or complex mental health issues".

This Youth Mental Outreach Project Report forms an important component of the design process, documenting our approach to bringing diverse stakeholders together, holding space to listen, capturing key insights and testing of ideas through visual prototypes about how the service might be experienced by a young person with complex mental health needs.

The insights shared in this report combined with those in the attached Literature Review have informed the design of the new Amber Youth Wellness service for young people in Perth's Northern Suburbs.

About MercyCare

MercyCare is one of WA's oldest not-for-profit organisations, working to fulfil its Mission to bring compassion and justice to life and break cycles of significant disadvantage.

We have over 30 services that support children and young people with complex needs, Aboriginal people, asylum seekers, refugees, people with disabilities and families. Our services extend across the Perth Metro area, with additional services in Derby and Broome. We have a strong presence in Perth's North, with service and community hubs in Mirrabooka, Merriwa, Yanchep and Ellenbrook.

Using a person centred approach, we strive to assist individuals and families to overcome challenges, maximise their independence and ultimately to thrive. Our Youth and Homelessness work is underpinned by a Youth Practice Framework, developed in partnership with Australian Childhood Foundation. This trauma-informed model seeks to address toxic stress and deliver cultural strength. It is a youth-centred approach and recognises the importance of family and carers.

Our frontline services are supported by an in-house Service Development and Innovation team, which provides support with strategy, service design and outcomes measurement. This team has led the service co-design aspects of this project.

Our current suite of youth services include:

- **Reconnect:** an outreach support service which provides assistance to young people between the ages of 12-18 years who are having difficulties staying at home, or who have recently become homeless because of family issues.
- **Family Wellbeing Support Service:** provides early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness.
- **Ellenbrook Youth Service:** provides case management services to young people between the ages of 12-20 years who reside, work or take part in activities within the Ellenbrook area.
- **Carlow House:** provides a therapeutic environment for young people in medium term accommodation (up to 12months).
- **Coolock Units:** provides medium term accommodation (up to 6 months) for young mothers between the ages of 16-25 years.
- **Homes for Youth:** provides young people and families between the ages of 16-25 years at risk of homelessness with quality transitional accommodation and individualized support for 6-24months while on their path to personal independence and long term accommodation stability.
- **Youth Support Service:** provides assistance to young people between the ages of 16-25 years to obtain their own accommodation in the private rental market.
- **Housing Support Service:** supports people between the ages of 18-65 years, who are exiting National Affordable Housing Agreement services, to live successfully in the community.

The Project Brief

The proposed service is part of the Commonwealth government's reform agenda to address inadequacies in Australia's current mental health service system and ensure young people's needs are effectively met. This reform agenda has been informed by WAPHA needs assessments, literature reviews, feedback from headspace centres and North Metro Youth Health.

Purpose:

The purpose of this project was to ***design a new youth outreach service to reduce the risk and/or impact of severe and complex mental illness (SMI) amongst 12-25 year olds with or at risk of severe and complex mental illness, whose needs can be effectively managed in primary care, and are not being effectively serviced by existing services.***

And to

Address these young people's health (including mental health) needs through engaging youth mental health professionals and other staff who will work in tandem with existing local youth outreach / community /education services, to reach young people where they already are, outside of a clinic environment, in the context of their existing relationships and familiar environments.

The process:

Our team undertook a four month design process, using a collaborative co-design approach.

Some non-negotiable elements were specified by WAPHA, including:

- Requirement for Staged Care with staging assessment to be developed in partnership with Dr Shane Cross.
- Requirement for a shared care approach involving others providing wellness care.
- Key stakeholders for the co-design process were specified by WAPHA
- Model has to be an outreach model, targeting young people in the Perth North PHN region.
- Therapeutic holistic care to be provided up to and beyond 12 months where needed.
- Final service model and budget subject to approval prior to establishment of the service.

The outcome will inform a service which will officially launch mid 2020.

Scope

It is important to note that this process did not set out to re-design core psychological or therapeutic interventions. These are validated and evidence based and not within the scope of this project.

This process did set out to design the service experience for young people and their families, including how and where they engage with us, how we communicate and involve them, and how we work with others to deliver excellent mental health care. This also included working with mental health experts and young people on an appropriate and youth friendly assessment process.

Summary of Insights

This report provides background to the development of an outreach model for young people in Perth's Northern suburbs with moderate to severe mental health challenges.

Based on the principles of Human-Centred Design, MercyCare has undertaken co-design, consultation and research to uncover important insights for the development of an outreach-based youth mental health service model.

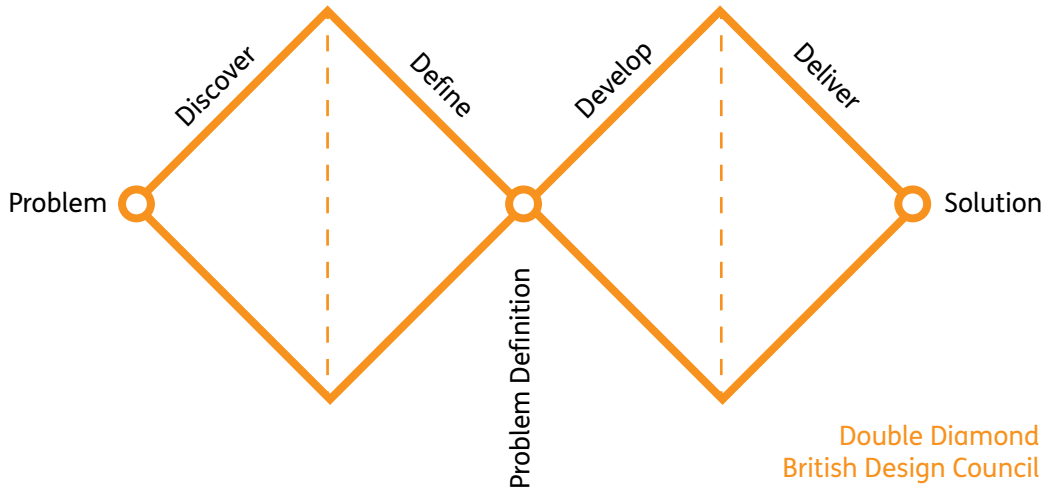
Insights revealed by the discovery and design stages are detailed within this report, including that:

- Young people need clear information/ tools to help them judge when to seek help.
- The effort to connect with the service needs to be lower than the effort to go it alone.
- Young people fear falling between the cracks in the process. They should be kept up to date throughout the onboarding and beyond.
- Young people want the option to have a more active role in their own care planning.
- Young people want the option to have some of their therapeutic conversations in other less formal settings, including outdoors.
- Overly clinical language can contribute to a power imbalance in the therapeutic relationship and be a barrier to formation of a trusting partnership between client and helping professional.
- The first conversation in a therapeutic relationship should be framed around the young person's story, with minimal clarifying questions to fill any gaps. Questionnaires and validated tools can come after a human connection has been made.
- Young people want a service to take confidentiality seriously, and want their wishes for discretion to be respected. Young people generally understand the limits to confidentiality, however they want these to be clearly laid out, and want workers who are not skittish about risk.
- Young people value their natural support networks and often want them to be involved in their care planning. Service should offer options for peer workers, group activities and family/ friends sessions to add value to the process
- Culture is an important dimension of wellness and the service should accommodate different cultural frames on mental wellness.
- Young people have anxiety about being "exited" from a service and want options to step back on their own terms and return if needed.
- The youth/mental health sectors can play a shared role in working with young people to address different aspects of their wellness, of which mental health is one part.

MercyCare's Amber Youth Wellness

Design Methodology

For this process we used the British Design Council Double Diamond model and followed this process over the four months to arrive at the final service model.



Double Diamond
British Design Council

We used an iterative design process, which begins with listening, noticing and empathy. We focused on the experiences of the people who might use the service and drew from a range of expertise, including lived experience, professionals working in the field, data and literature reviews. This enabled better framing of the design problem before diving into ideas about how to design the service model.

Because it was a co-design process, we involved a range of stakeholders along the journey. We not only consulted them about their experiences at the start of the project, but also provided numerous opportunities to contribute input to shape the model during various prototypes and iterations.

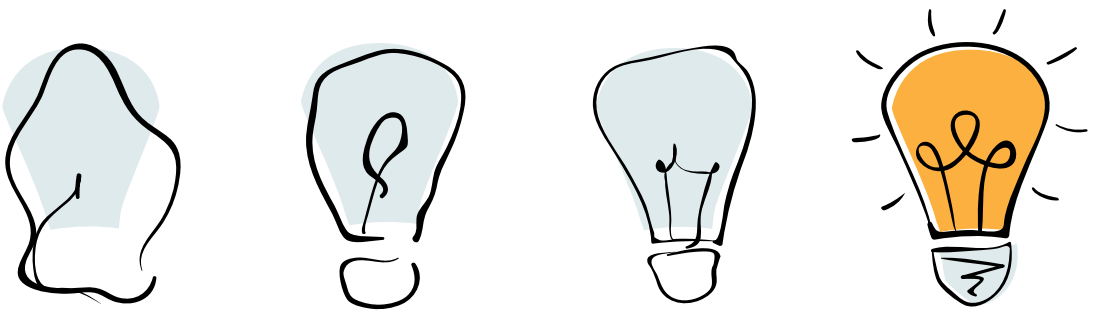
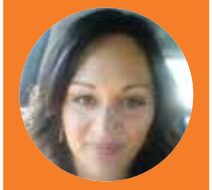


Image source: *reboot.org Implementing Innovation http://implementinginnovation.org*

Co-Design Questions



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The Design Team was initially overseen by Executive Director Lyn Millet and later by her successor, David Holden. Early contributions were made by Kristy Downe, who left the team in December. Additional project support was provided by Isabella Ambrose, who joined the team in March 2020.

The Design Team began by unpacking the parameters of the brief and defining what the co-design process needed to explore.

Design Questions

The following design questions informed the activities over the four month co-design process:

- **How might we design the service to engage with the right young people at the right time in the right way?**
- **Who are the "right" young people for this service?** Explore what definition- "with or at risk of severe mental illness" means. Can the need be met through Primary Care?
- **What barriers are preventing these young people from accessing existing mental health services?** How can we make the service function in a way that works for the target group of young people.
- **How do we best engage young people who... may not recognize their poor mental health or are not willing to engage with existing mental health services?**
- **How can we work with the ecosystem?** How can we know that our service model will not duplicate needs already met through existing services?
- **What is the best mix of professional skill sets for this type of service?**
- **What locations should we focus on to make best use of limited resources?** How will priority coverage be given to identified locations? What partnerships are relevant?
- **How will services be accessible to diverse groups?**
- **How can we balance the flexibility of outreach while ensuring a consistent and supportive team culture?**

Stakeholders

To ensure that we could draw understanding from a range of sources, the design process engaged with a diverse range of stakeholders. The project funder, WA Primary Health Alliance specified some of these stakeholders, however we broadened this to include additional people. The diagram below illustrates the groupings of stakeholders.

A Youth Consultation Group was formed through an Expression of Interest process sent out to the youth sector. Young people with a lived experience of severe mental health challenges were selected for the group which met monthly, in addition to participating in larger group workshops. Young people were paid $35 per hour for their time, plus transport reimbursements with flexible options about how they would like this paid.

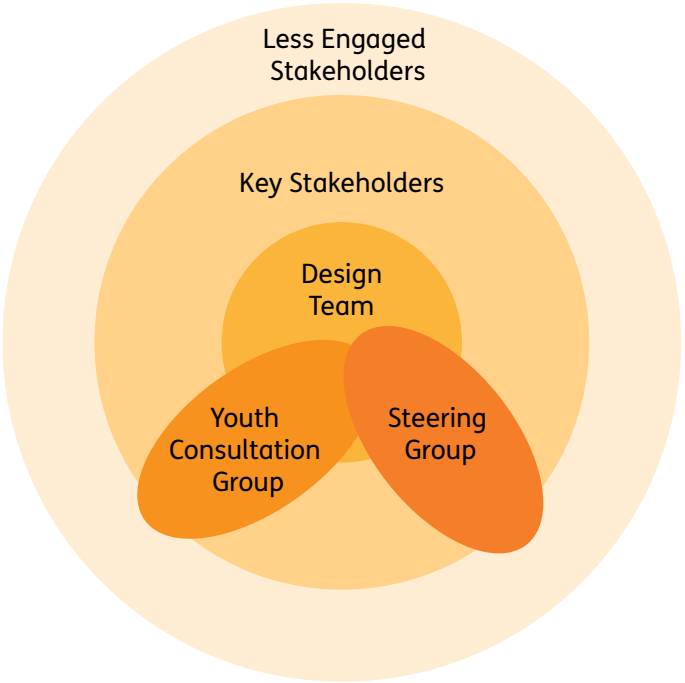
In addition to this group, we ran focus groups and one-on-one interviews with a number of other young people to ensure that we had a range of perspectives.

The Steering Group comprised representatives invited from across the youth and mental health sectors, including two youth representatives selected from the youth consultation group.

The Design Team comprised MercyCare's in-house Project Manager, Service Designer and Outcomes Specialist along with a Project Administrator. Additional team members were contracted into the team based on their skills in Research, Evaluation, Policy, Clinical Governance, Service Design and Peer work.

Key Stakeholders with a direct interest in the project were invited to participate in group co-design workshops, as well as site visits and conversations with the Project Manager about how the new service might interface with their services.

Less engaged stakeholders included services and people with a nominal interest in the project. They were kept informed through a monthly newsletter about the progress of the project and invited to the final co-design workshop.



Practice Visits

MercyCare staff connected with a range of headspace providers to understand the challenges facing young people whose challenges are too serious for mainstream headspace service provision. These included headspace Joondalup, Osborne Park, and Midland.

Interviews and Engagement Meetings

In addition to this, interviews, conversations and site visits were conducted with numerous service providers in the youth/mental health sector in Perth, as well as several site visits with Eastern States organisations providing outreach services and/or providing services to young people facing severe challenges with their mental wellness:

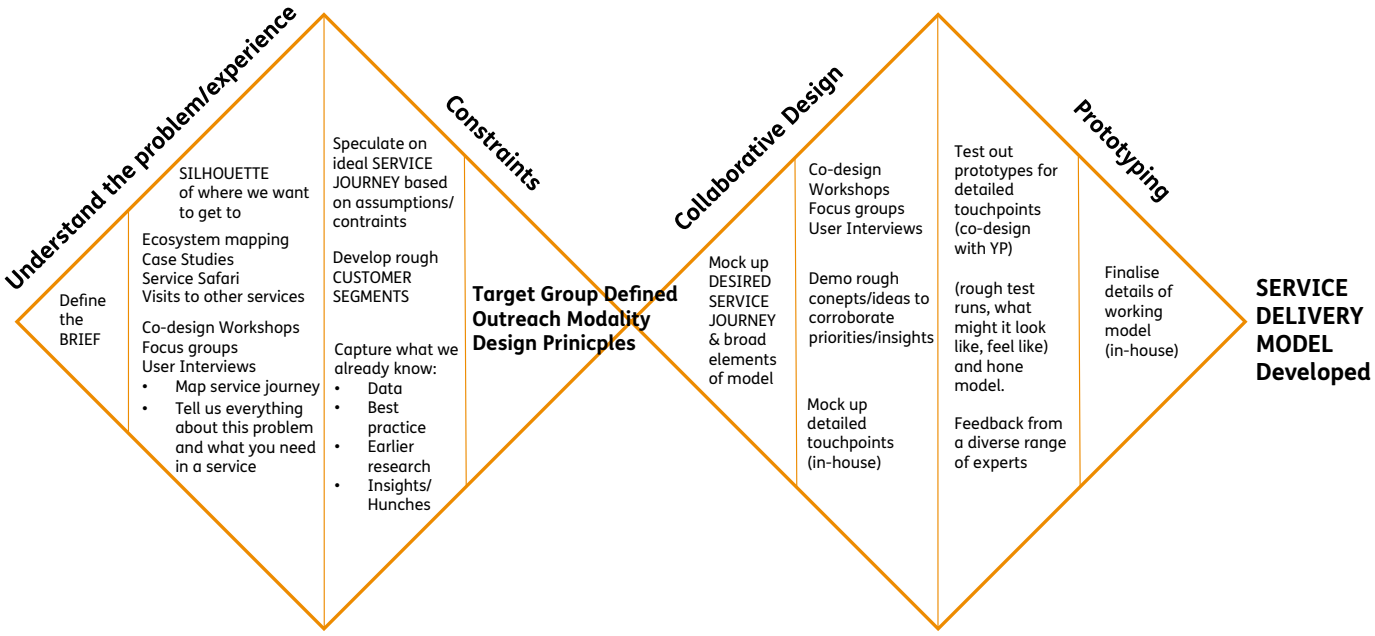
- Passages Youth Service
- North Metro Youth Service
- Indigo Junction
- Perth Inner City Youth Service
- Derbarl Yerrigan
- Headspace Youth Early Psychosis
- Rise Community Support network
- Swan City Youth Services
- YACWA
- Mission Australia
- Holyoake
- Alta-1
- YHITH
- Comet
- Altone Youth Service
- Youth Futures
- Edmund Rice Centre
- Telethon Kids Institute
- Australian Childhood Foundation
- Multicultural Youth Advisory Network
- Orygen
- Dr Shane Cross
- Donald Payne
- 360 Health
- Neami National
- APM Employment
- Key Assets
- Helping Minds
- Edge Employment
- Ngala
- RUAH
- Mental Health Commission
- Specialist Aboriginal Mental Health Service
- Education Department Participation Coordinator

Eastern States Visits

Site visits were also conducted with Eastern States organizations to understand their practice.

- Redcliffe Area Youth Space
- Paramatta Mission - Youth Enhanced Service
- Department of Justice

Co-Design Process



The diagram above captures the spread of activities undertaken across the four month co-design process, allowing for periods of divergent exploration, followed by distillation to focused points.

The timeline below captures some of the key touchpoints with various stakeholder groups over this period.

Nov 2019	December	January	February	March 2020

DISCOVER

Co-Design Discovery Stage

The Discovery stage included a number of activities intended to bring together contemporary research and best practice with the lived experience of young people and insights of service providers.

This stage included:

- Literature Review
- Analysis of demographic data
- Environmental Scan
- Mapping of Ecosystem
- Youth Consultation Group
- Focus groups and interviews
- Co-design workshops

Literature Review

We contracted Telethon Kids Institute to conduct a review of current literature, providing a commentary on the research relating to the following:

- The concept of the 'missing middle'
- Barriers and enablers to accessing mental health services
- Use of Wraparound Services
- Use of Staged Care
- Case studies from around the world for providing mental health support (including outreach support) to young people facing severe challenges
- Principles of care for providing services to young people from diverse groups.
- Use of Trauma Informed Care
- Use of peer and family peer support workers in therapeutic services

It is recommended to read the full literature review in conjunction with this insights report, however some consistent themes which emerged from the literature review included:

- A lack of consensus about what the missing middle is, or even if it is a useful term.
- Intensive outreach models have been found to significantly reduce risk to self and others, and significantly lower admission rates and inpatient days

Young people report social relationships and physical health are more important for their quality of life than symptom reduction.

Common barriers to accessing help include:

- lack of a youth-friendly environment or focus within services
- concerns about confidentiality
- poor coordination between services supporting the same young person
- long wait times or difficulties booking an appointment at a convenient time

Importance of the following elements to a positive outcome:

- self-determination- youth voice and choice within a service.
- engaging young people in programme design and planning, increasing the likelihood that the result would be relevant, non-stigmatising, and accessible
- mental health services designed around the needs of young people as opposed to young people being expected to adapt to the services
- development of a strong therapeutic alliance
- collaboration with treatment
- perceived usefulness of treatment
- culturally informed care, which understands intersectionality, recognises intergenerational effects of trauma and employs workers from similar backgrounds to clients.
- Wellness understood as a holistic, encompassing mental, physical, cultural and spiritual health
- 'no-wrong-door' approach
- strengths based, wraparound, trauma informed
- outreach service is made up of a multidisciplinary and interdisciplinary team (e.g., nurses, clinical psychologists, occupational therapists, social workers), and utilises principles of assertive outreach to engage young people
- service values expertise other than their own, including non-clinical and lived experience
- natural supports (family, friends) incorporated
- peer support and family peer support used
- leveraging digital, mobile connectivity as a value add to face to face outreach.

Environmental Scan

Demographics

Perth North PHN SNAPSHOT	
Total Population (ERP 2016)	1,055,697
Indigenous Population (2016 Census)	14,112
English Proficiency “not at all” or “not well”	2.92%
Population Growth (2012-2016)	5.7%
Area Square Kilometres	2,975

The Perth North PHN region* covers the Northern suburbs of Perth and is home to 1,055,697 people (ERP 2016). The Local Government areas included in the service are the following Local Government areas: City of Swan, Shire of Mundaring, Shire of Kalamunda, City of Stirling, City of Wanneroo, City of Joondalup.

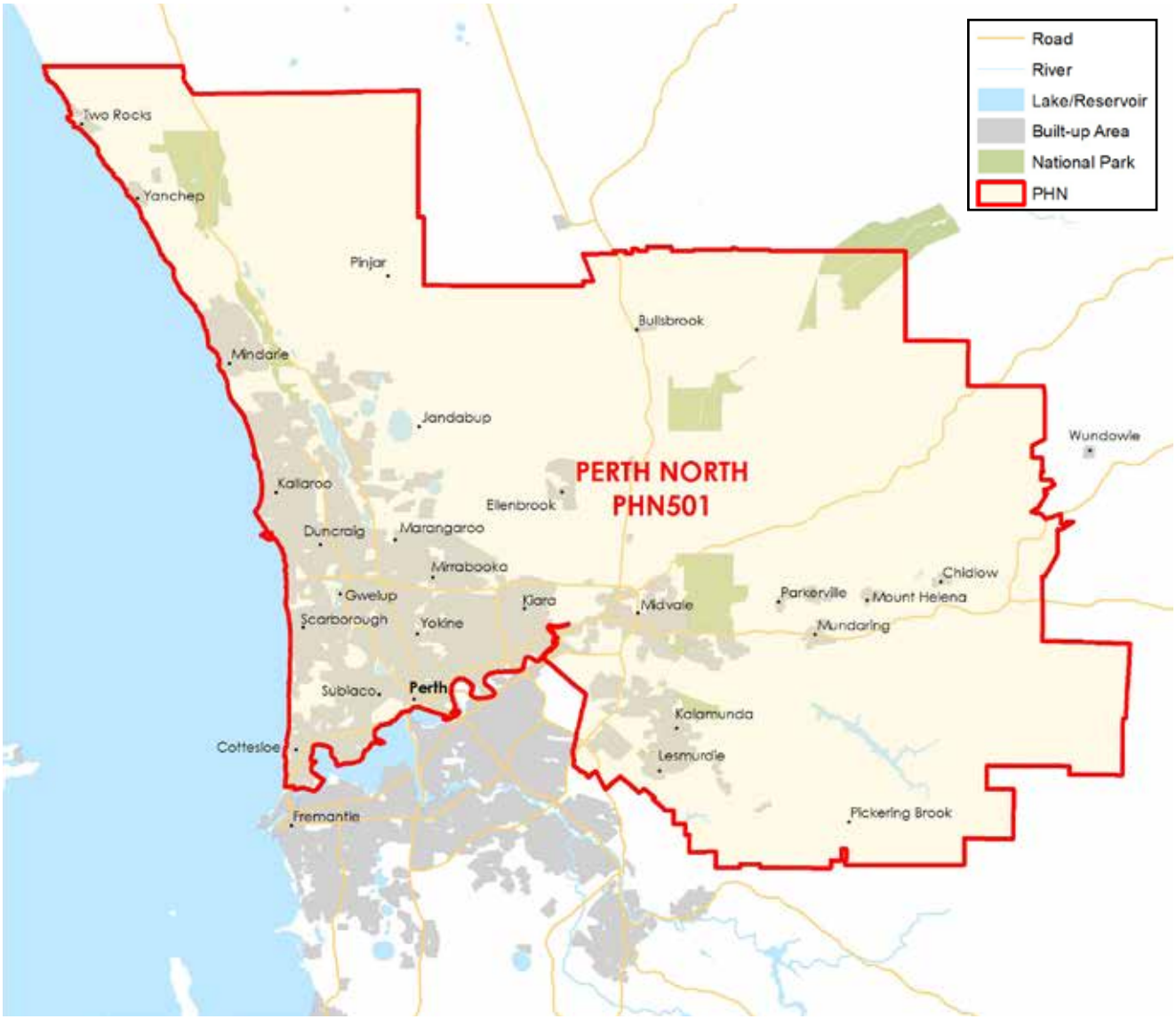


Image Source: *Perth North Primary Health Network (PHN)*

Urban Growth Corridors

Perth North PHN has two main urban growth corridors, both of which would benefit from access to youth mental health outreach:

The North Eastern Urban Growth Corridor, which runs through the northern part of City of Swan from Caversham to Ellenbrook.

The Northern Coastal Growth Corridor which runs along the western edge of City of Wanneroo up to Yanchep.

Challenges and issues faced

Many of the challenges relate to the rapid growth and relative isolation of these Urban Growth Corridors to major metropolitan centres, including:

- Rapidly expanding population and households
- Lack of easy access and availability to services. New developments experience relative isolation from major suburban hubs (e.g. Midland, Ellenbrook) – due to lack of easily accessible and regular public transport
- Community infrastructure which was promised during the establishment of these newer suburbs often fails to materialise.
- Beyond the build and first establishment phase, developers are winding back their community engagement / support
- Housing purchased during housing bubble has lost value, leaving many over-capitalised, locked into mortgages and unable to move.
- There are also significant pockets of small lots and low cost housing throughout the corridor.
- Local Councils report an increase of disadvantage and complex needs in the area
- Lack of social networks and local recreational options in the corridor, especially for young people.
- Community safety concerns
- Lack of local employment and economic development opportunities

However despite this, there is a gradually developing ‘sense of place’, as reflected through the connection of the community with culture, events and activities which take place and the range of place based social media pages and groups which are emerging through these corridors.

MercyCare’s Amber Youth Wellness

North Eastern Urban Growth Corridor

The population is growing rapidly with a population of 15,107 (2018), and forecast to grow to 32,334 by 2036.

Household makeup

There is a much younger median age profile (29) than the national average. Almost 30% of the population is less than 20 years of age and of those, 20% are less than 10 years old.

There are a high proportion of young families (more than 40%), with rapid growth expected in the children and youth cohort in coming years.

Cultural and Language Backgrounds

The urban growth corridor has a significantly higher than average percentage of migrants (44% people born outside Australia), and number of houses where a language is spoken other than English (37%).

The Indigenous community profile is smaller than in other parts of the City of Swan (1.4%), but there is an established Aboriginal community in Caversham.

Training and Work

This corridor has a largely working class, blue collar demographic. The main occupations (17.5%) are "technicians and trades" (compared to National average 13.5%). By comparison, less people work in "professional roles" (compared to National average of 22.2%).

Northern Growth Corridor

The City of Wanneroo is the fastest growing local government in Western Australia. The majority of the City of Wanneroo's population growth will be experienced along the coastal growth corridor, accounting for 73,000 additional people (55% of the City's total growth).

Household makeup

The growth corridor generally has a much younger median age profile than the National median with many young families, including a higher than average percentage of single parent families.

Cultural and Language Backgrounds

This corridor has a higher than average percentage of migrants though many of these are migrants from English speaking countries.

In general, the North Coast Ward has a lower than average percentage of Aboriginal people. Merriwa is the outlier with a higher than average percentage (2.7% compared to Perth average of 1.6%) of Aboriginal people.

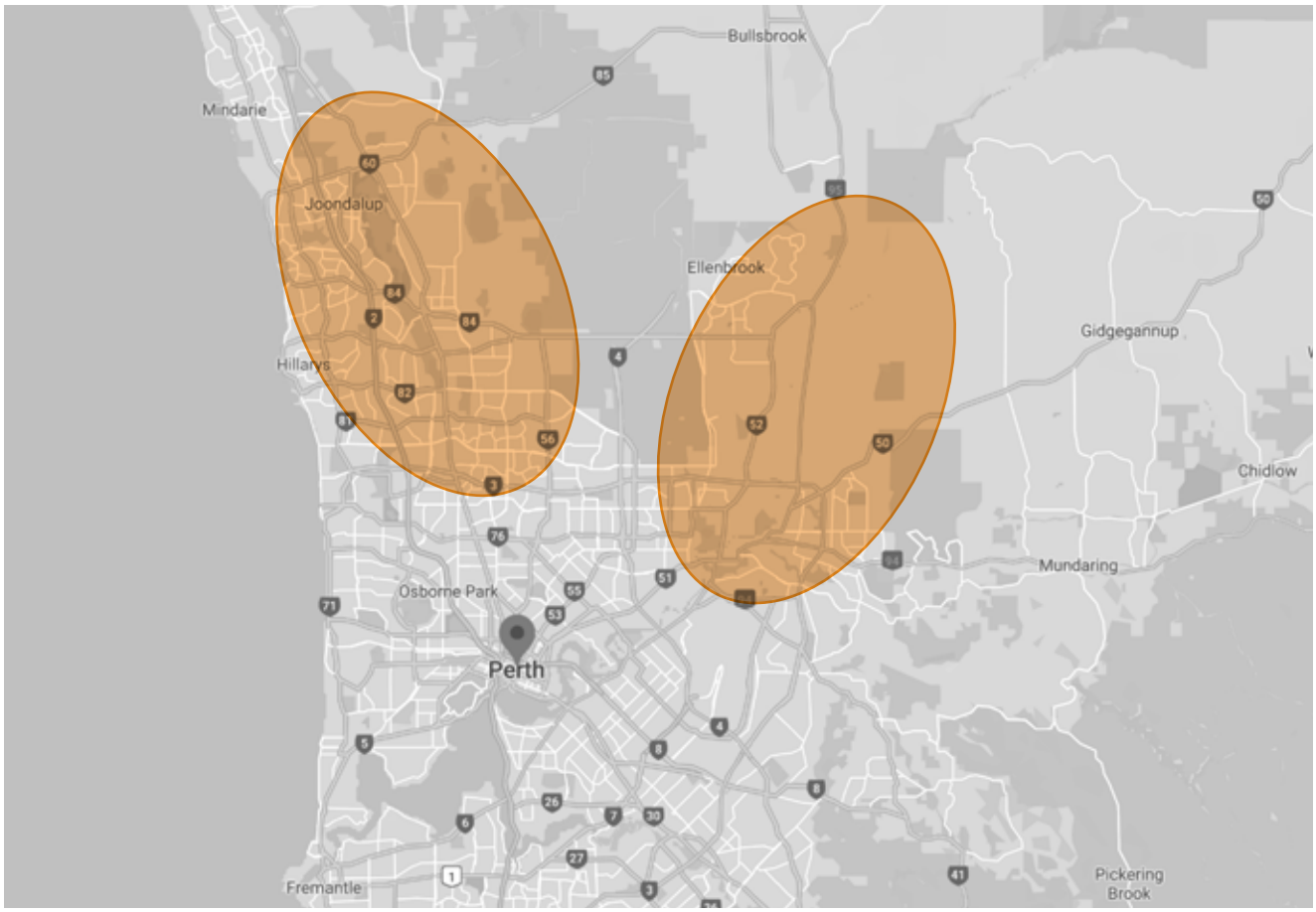
Training and Work

This corridor has a largely working class, blue collar demographic with a high ratio of people with trade certificate qualifications (31.7% compared to National average of 24.6%) and a much lower number of people with university qualifications (12.1% compared to National average of 22%).

The main occupations (20.8%) are "technicians and trades" (compared to National average 13.5%). By comparison, less people (13.9%) work in "professional roles".

(Data sourced from the ABS and https://forecast.id.com.au)

Data and Target Areas



Target Areas

While the new service will cover the whole of Perth North PHN, we identified areas of identified need along the corridor from Midland to Ellenbrook, and the corridor from Stirling to Yanchep. This is informed by data provided by Telethon Kids Institute. Due to limitations in the data format, we were only able to examine datapoints for areas of greatest interest. While this data should be interpreted cautiously, it indicates a level of need in some Northern suburbs:

- **% Deliberate self harm related ED presentations (10-18 year olds)** Suburbs which averaged more than double the WA average between 2007-2016 included Morley, Clarkson, Midland, Joondalup, Middle Swan and Tuart Hill.
- **% Mental Health related ED presentations for 10-18 year olds** Some of the suburbs which had higher (around double) than the WA average between 2007-2016 included Lockridge, Middle Swan, Clarkson, Bassendean, Morley, Joondalup, Midland and Tuart Hill.
- **Mental Illness Diagnosis for 0-18 year olds (per 10,000 persons) (2012-2016)** Suburbs with a higher count of diagnoses per 10,000 persons included Clarkson, Joondalup, Midland, Nollamara, Greenwood and Ballajura.
- **Areas of relative socio-economic disadvantage** All of the following suburbs had SEIFA scores of 1,000 or less (1,000 is the mean): Balga, Midland, Nollamara, Middle Swan, Swan View, Butler/Merriwa, Beechboro, Lockridge, Ballajura, Clarkson, Morley.

Ecosystem Map

To understand where the new service might best fit in the context of the current ecosystem, we mapped the existing services providing youth mental health and wellness support in the North Metro PHN catchment.

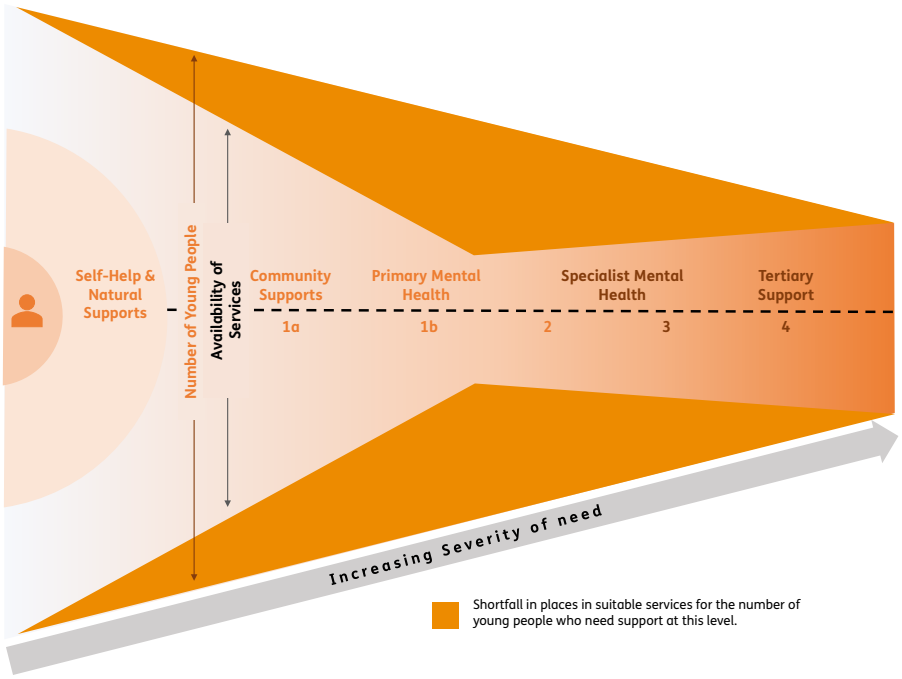
In addition to an audit of service providers, we relied upon anecdotal evidence from young people, service providers and funders about where the gaps exist, including:

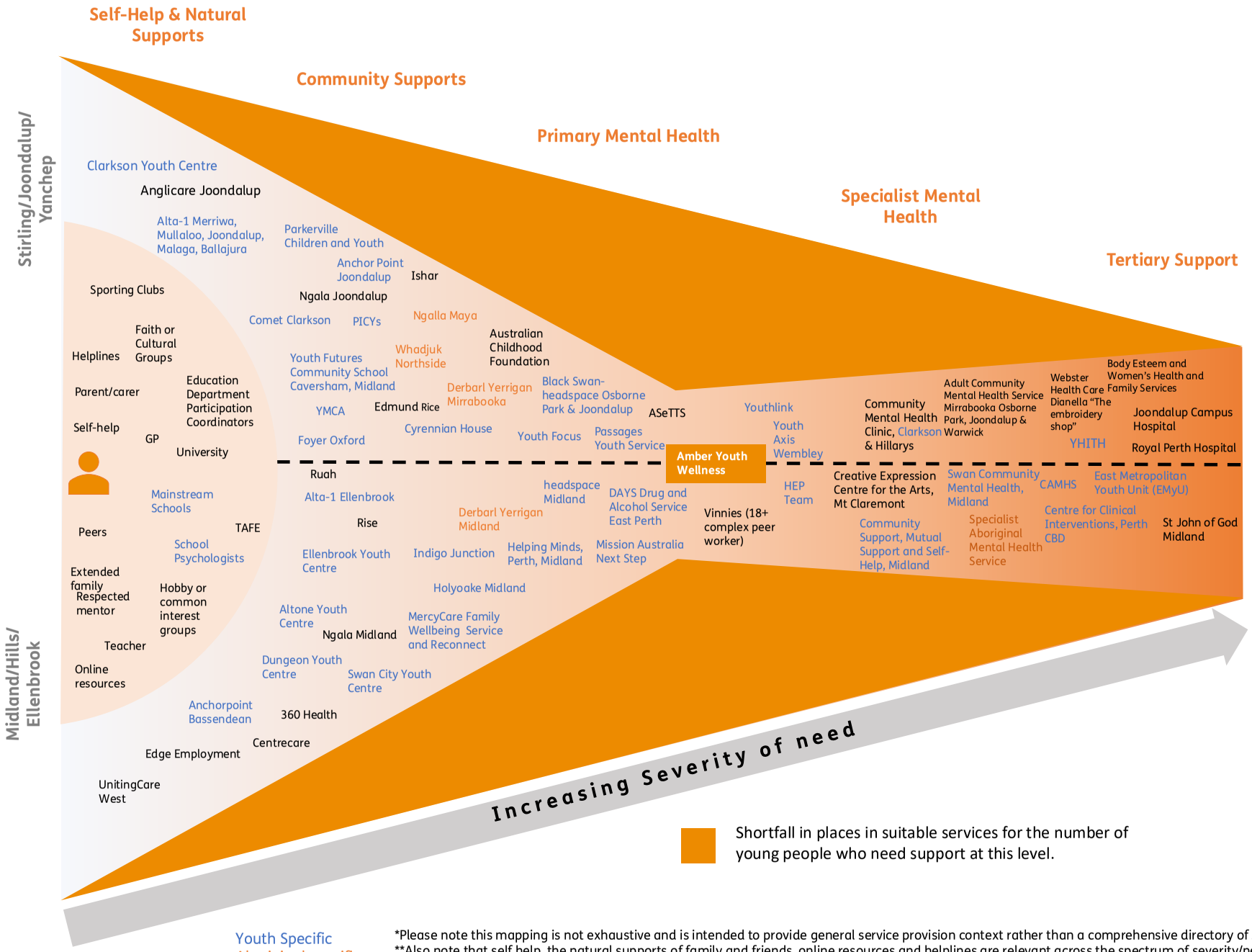
- **Age related gaps-** particularly in the availability of like-for-like services during the transition between CAMHS and Adult services
- **Gaps for severity and illness type-** a lack of suitable services for young people sitting between mild to moderate and more severe mental health challenges, where they would become eligible for Government services. Exclusion criteria sometimes exclude particular mental illnesses from support.
- **Gaps in services for young people with emergent, attenuated symptoms** which do not fit clearly in one diagnosis or another. Without a clear diagnosis young people are not able to easily access more Specialist Mental Health (Tier 3) or Tertiary (Tier 4) services.
- **Gaps in geographic catchments** for many services mean many young people fall between the cracks based on where they live.

The diagram illustrates several dynamics of the current service ecosystem:

1. The funnel of diminishing numbers of young people at each stage of severity of mental health need.
2. The availability of suitable mental health services at each increasing stage of severity. The availability of services does not track to the assumed volume of young people at each stage, with a gap in services at the moderate to severe (stage 1b to 2) part of the funnel. This could be understood as the missing middle services.

The map on the next page captures the spread of services across the North Metro PHN, accessible to either the North Eastern Growth Corridor (Midland/ Hills/Ellenbrook) or to the Northern growth corridor (Stirling through to Yanchep).





*Please note this mapping is not exhaustive and is intended to provide general service provision context rather than a comprehensive directory of services.
**Also note that self help, the natural supports of family and friends, online resources and helplines are relevant across the spectrum of severity/need. Service providers at the less severe end may also maintain support through periods where stepped-up levels of mental health support are needed.

Co-Design

In the first stage of the co-design process, we utilised one-on-one interviews, structured focus groups and larger co-design workshops to listen and gain understanding about the needs and experiences of young people (and other stakeholders) in accessing mental health supports.

We ensured we spoke with a cross section of diverse young people who had faced challenges with their mental health, including:

- Aboriginal young people
- Culturally and Linguistically Diverse young people
- Young people who had experienced homelessness
- Young people who identified as LGBTIQ+
- Young people who had faced challenges with alcohol and other drugs
- Young people who were not currently engaged in education, employment or training.

We utilised the skills of a Service Designer with expertise in peer work, culturally secure approaches and lived experience of overcoming mental health challenges. These qualities enabled greater trust and rapport building with the young people we spoke with.

We utilised the cultural expertise of MercyCare's in-house Aboriginal Consultant and brought in an additional Aboriginal Youth Facilitator to ensure that the perspectives of Aboriginal young people were represented.

We spoke with Aboriginal young people in several sessions, including a dedicated focus group and met with Aboriginal service providers Derbarl Yerrigan and Specialist Aboriginal Mental Health Service. We also drew on the knowledge of Aboriginal Academic Michael Wright on our Steering Group.

We ran a focus group specifically for CaLD young people and met with Multicultural Youth Network, and the organiser of "How's Your Haal" about culturally appropriate mental health supports.

We ran a number of sessions with young people who were accessing homelessness services to listen to them.

We mapped out the journeys of all these different young people in accessing supports, identifying barriers, pain points and positive service experiences.

In addition to this, we liaised with Dr Shane Cross, the Australian Childhood Foundation and the team at Orygen to understand what they had noticed about the needs of young people and what worked for them.

The comprehensive engagement and feedback gathering from stakeholders enabled a greater level of depth and confidence when it came to developing the service plan.

After each co-design session our Design team spent time synthesising and grouping themes which emerged, which were then distilled down into key insights.

Key Insights

There were a number of key insights which emerged from the research and our co-design work with the various stakeholder groups which offer direction for the new service:

Knowing When to Seek Help

Many young people struggled to assess when their mental health was "bad enough" to seek formal support. The biggest barrier was thinking it wasn't bad enough yet. At gradually worsening stages of unwellness, common thoughts were "I can still manage it" or "other people have it worse". There is a window to make contact when mental health is bad but before it gets so bad the young person becomes reclusive. Young people need clear information and tools to help them judge when to seek help and to highlight the benefits of early help-seeking. They need to be able to self-refer. Information about the service needs to be pitched to young people and their natural supports as much as to service providers.

"I'm managing. I'm treading water. When am I sick enough (to get help)? Everyone feels like others had it so much worse."
— Young Person

Not identifying with "mental illness"

For other young people, their barrier was the stigma associated with mental health labels. They did not identify with the clinical ways that symptoms or services are often presented. The service should be framed from their perspective and in ways which they can identify with.

"I knew something was off. I didn't feel right or want to go to school, which wasn't normal."
— Young Person

"I was like I'm not crazy. I'm not seeing no psychiatrist. I don't need no woop woop pills."
— Young Person

The Cost Benefit of Engaging

Some young people described a kind of mental cost/benefit analysis when weighing up whether to seek help during a period of ill mental health. Some said they would rather go it alone through a critical patch than deal with the rigmarole of engaging with mental health supports. The effort to connect with the service needs to be lower than the effort to go it alone.

Engagement preferences

Young people expressed a fear of cold calling a service or receiving calls from unknown numbers, but would happily text or email until they had built up trust to do a voice or video call.

Some young people lacked access to phone credit and preferred the option to contact the service via a messenger service which could be accessed via a free WIFI spot. The cost of streaming video calls was a concern for some young people.

There need to be Text and Messenger options for young people to initiate contact with the service.

Documentation and Paperwork

Some young people, particularly those facing more complex challenges, won't always have the usual paperwork such as Medicare Cards etc. The service needs to find ways to still provide the same timely level of service to these young people, without red-tape bottlenecks or barriers to service. Young people also worry about the cost of a service, so it needs to be clearly communicated early that the service is free.

Summary of Insights

Falling through Cracks

Many young people felt anxious about the period between making contact and waiting for confirmation that they meet the criteria to be accepted as a client into a service. They felt fearful about falling between the cracks in the process and didn't know what to do while waiting. Any initial assessment and decisions about eligibility should be made and communicated as soon as reasonably possible. The young person should be kept up to date throughout the onboarding and beyond.

"Knowing what the worker is thinking at each step helps keep me grounded." — Young Person

Being Done To

Many young people experienced mental health services negatively as something "done to them". Several factors contributed to what they described as an unequal power imbalance and an alienating experience, including:

- Overly clinical language which can emphasise the power of the clinician and can be a barrier to formation of a trusting therapeutic partnership.
- Being given a barrage of surveys and tools as the first step. During the first engagement, the young person is making a decision about whether to come back. They want to be treated as a person, not a diagnosis or a set of symptoms or a risk rating. They want to start by describing their experience in their own words, not in a Leichardt scale.
- Perceived secrecy and a lack of transparency about the different interventions available and the intent of each intervention.
- Young people often described feeling uncomfortable and powerless about other people meeting without them to make decisions which impacted them.

"We don't own their health. We don't own them at all. People live their own lives and they're going to self-manage whether we want them to or not." — Workshop participant

Young people wanted to be given the choice to have a more active role and equal role in their own mental health management and work as partners towards the goal of wellness, including

- To be asked their preferred pronouns and have these used.
- The option to be part of the shared care team with the services supporting them.
- Options to have a Peer Support worker or other support person join them in meetings or sessions for moral support.
- Option to prioritise what needs get addressed first (many young people need their basic needs met before they are ready for counselling).
- Access to view case notes about them or progress charts on request.
- To be able to suggest some questions they want to be asked every session.
- Be partners in the therapeutic journey, have some say about interventions and for the clinician to explain the intention of particular interventions so they can work together towards it.

"If I turn up and just want to talk about something that makes me happy, that's what I want to do, and if I want to talk about something deeper, that should be respected. With that in mind, I'm coming to you because I'm not an expert, and I want your expertise." — Young Person

Even where the young person may not be in a state to take on an active role, being given the choice indicates to them an attempt to level the power imbalance.

"Youth led case management relies on self-realisation. Sometimes you're not in the state to do that." — Workshop participant

Confidentiality, Transparency and Risk

Breaches of confidentiality, or the fear that these would occur are a barrier to young people building trust to open up about what is really going on for them. Young people want a service to take confidentiality seriously. Young people may have good reasons that they do not want their family to know that they are seeking mental health help and want their wishes for discretion to be respected. They generally understand the limits to confidentiality, however they want these to be clearly laid out. They want the service to be transparent with them if they do have to break their confidentiality. They want workers who are robust and not skittish about risk. They want to be seen as an autonomous person not a walking risk and a potential liability to be managed.

Assessing Need Holistically

Many young people indicated they may play up or play down their symptoms for different reasons, including to try and meet eligibility for a service, to appease a worker, or to elude a worker they do not trust. They described over-reliance on narrow diagnostic tools often meant that clinicians missed key information "I wished they would ask me about ... but they never did." Symptoms alone are not sufficient to get a good picture of need. Assessment should take into account a balance of factors (what the young person is experiencing), functioning (how this is affecting their ability to go about their lives) and risk/safety factors, alongside other holistic life factors.

"Behaviour or change in functioning may be the best early indicator of need, rather than diagnosis or symptomology." — Dr Danny Rock

Aim of Intervention

While reduction in symptoms is most important to clinicians, the thing that is most important to young people and their families is improved functioning and improvements to social relationships. The service and associated interventions should be framed from this perspective.

Getting Grounded

Many young people find it hard to feel grounded in a formal clinic environment. Young people want the option to have some of their therapeutic conversations in other less formal settings, including outdoors, while walking, driving, or even playing sport. Going for a walk or shooting some basketball hoops was a way to build up to talking about something difficult rather than diving straight in. The notion of animal therapy was raised numerous times. For some Aboriginal young people, the option to talk in the fresh air, near trees etc. was a feature of a service being culturally secure.

"They say you're supposed to ground yourself. How are you supposed to ground yourself in a clinical office, breathing in unnatural air-conditioned air. Sport brings the good energy back into your body." — Young Person

MercyCare's Amber Youth Wellness

Wellness and Culture

We encountered a range of cultural perspectives on mental health. Culture is an important factor in holistic wellness. The service should be culturally responsive and accommodate different diverse cultural frames on mental wellness, including working with elders and community leaders.

Westerman's work on services for Aboriginal young people highlights the importance of exchanging genealogy (who's your mob) as part of establishing trust and context. In matching a young person with an Aboriginal worker, an understanding of gender/ language/cultural group/family dynamics should inform the match. She also highlights the valuable role of cultural healers and cultural supervision for all staff. Connection to their spirituality, faith and roots is relevant to all young people and this should form part of the holistic approach.

It was also acknowledged that some people may have a mixed feelings about faith or culture, particularly when they are not well, so this should be approached in a way that is affirming and useful for each individual.

Flexibility of Appointments

Due to the challenges they are facing (both internally and in their life contexts), young people in this cohort statistically miss more appointments than those with milder mental health challenges.

The service needs to create easy processes for young people to communicate if they need to change or cancel an appointment, or to reschedule it themselves without judgement or punishment.

Natural Supports

Young people value their natural support networks and found them to be a strong protective factor (even where these relationships were flawed) and often want them to be involved in their care planning. The service should offer options for the young person to include family/ friends in therapeutic sessions to add value to the process.

Some young people wanted to have an ally in the mental health system who had been through something similar and found hope.

The service should create opportunities to utilise peer workers, digital and group activities to add value to the process.

The importance of the existing support ecosystem

A young person referred to a mental health service may already be accessing other supports which contribute to their holistic wellbeing. It is important to respect the work that other organisations and natural supports such as family and friends are already providing.

Young people need a consistent plan of attack to address their challenges, and can usually only focus on a couple of things at a time. It is counterproductive for multiple services to have separate plans in parallel which may contradict one another or confuse/overwhelm the young person.

This service needs a clear approach to Shared Care, which outlines how it will collaborate with other supports to helping the young person achieve their wellness goals.

Impending Dread of Abrupt Exit

Young people felt anxious about the words "exit" and "discharge" and the associated concept of being "exited." While some looked forward to eventually being able to outgrow the service, they could not see it yet. Some said they found it so stressful they had sometimes prolonged their engagement beyond what they felt they needed in order to keep their place open.

Young people want options to step back from formal support on their own terms and return later if needed. Wherever possible, exits should be on their terms, gradually stepped back, in partnership with their natural support networks.

Periods of ill mental health are rarely one-off. Young people may go through multiple periods of needing help. The service should acknowledge the ebbs and flows in mental health mean there will likely be rocky patches ahead, and provide options for young people to easily return for top-up or refresher sessions without having to go back to the very beginning.

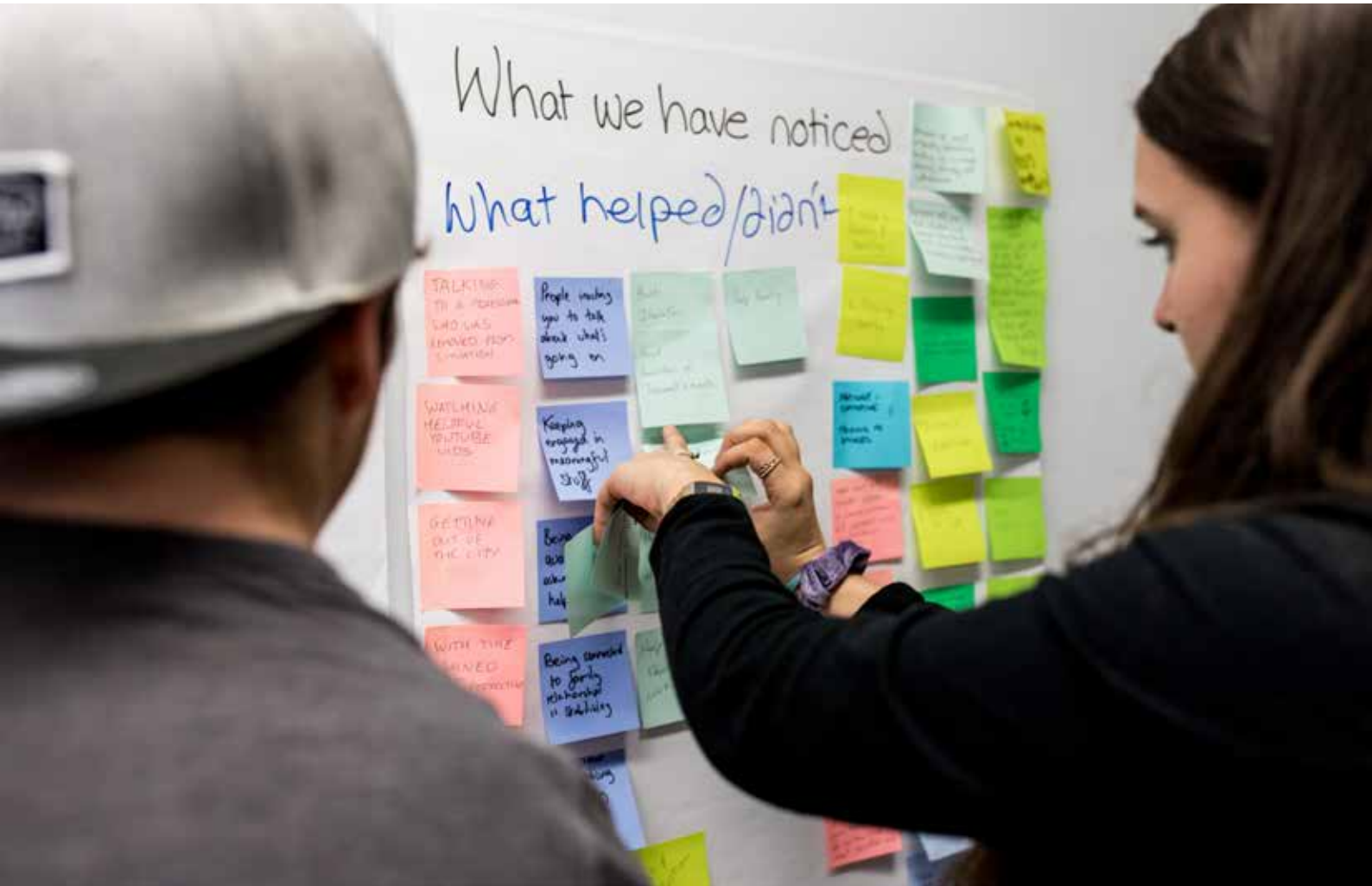
Managing Demand

We anticipate some tensions where demand for the service outstrips available places:

- Managing expectation from services that we can immediately take on all suitable young people.
- Pressure to hurry up young people on the caseload.
- Pressure for staff to take on more young people at a time.

Our stakeholders highlighted the following insights and opportunities:

- Role of other professionals such as youth workers holding the ongoing relationship, and Amber Youth Service being invited bring in specialist mental health support for a period of time, as needed, as part of shared care.
- Opportunity for other sector players to work with young people to address some of their other needs across the holistic domains of wellness, while waiting for a place for formal mental health specific supports.
- Opportunity to support young people to be proactive with their own self -management (such as identifying natural supports and protective factors, social groups and online forums, peer worker, youth/ clinician endorsed apps. etc) while waiting for more formal mental health supports to start.
- There is potential for well-chosen apps to add value to the face to face work. However, it needs to be embedded and endorsed in the mutual narrative about the service. Clinicians need to be champions for these apps and talk with confidence about them.
- There is an emotional dimension to there not being any places available. Feelings of rejection and disappointment. We need to minimise this and create feelings that there is hope.
- Importance of being transparent and communicating to young people what is happening during the time where they are waiting for a place, giving them all the information so that they can make a decision about what they want to do in the meanwhile to look after their mental health.



DEFINE

Definition Stage

Once we had spent time understanding the nature of the challenge from a range of perspectives, we focused in on defining the target group and setting out design principles for the service journey.

Applying evidence based practice and clinical governance in youth friendly ways.

An important decision, based on our understanding of some of the barriers to engagement, was that the entire service journey should be experienced as therapeutic, not just the part of the journey which included discrete psychological interventions.

This service design process has not set out to change or challenge validated clinical interventions or tools. It's focus is to make the service container in which these interventions sit, youth friendly and accessible to young people who may typically disengage from mainstream mental health services.

In this context we broadened the concept of "therapeutic intervention" to ensure that the entire service journey is experienced as therapeutic, from the information provided about the service, to the options to make contact with the service, the way that the first few conversations happen, the appointment booking process, the modes and locations of meeting with clinicians, etc. Clinical interventions sit as one part within this bigger journey.

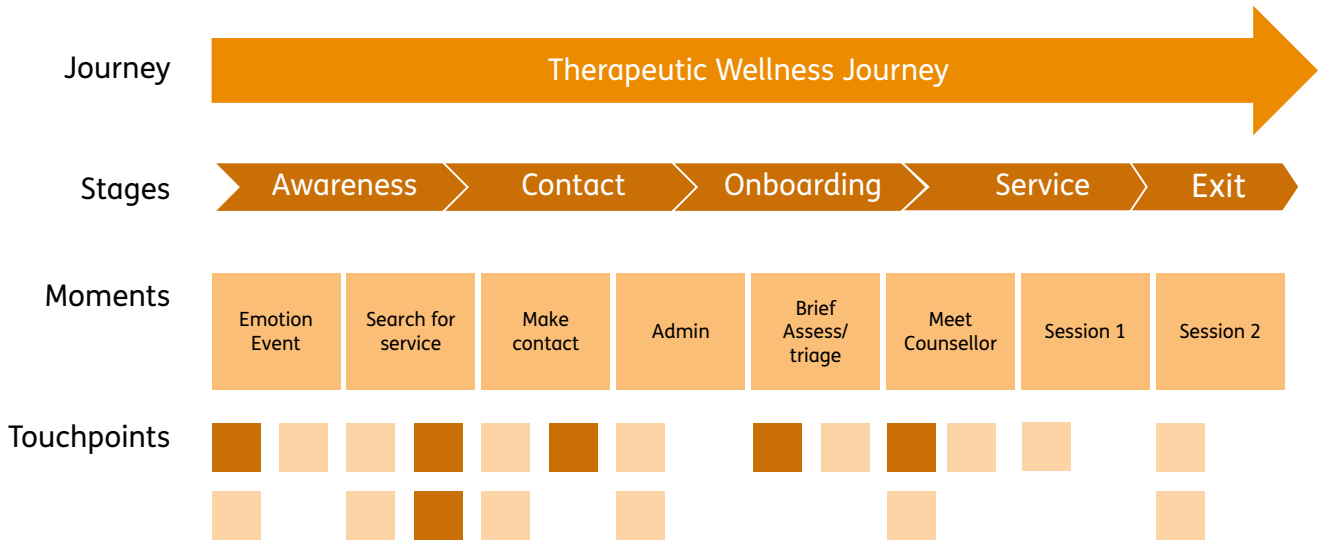
The clinical governance for this service will need to address safety considerations in a way which also works with the person-centred, youth-friendly approach. This will increase the likelihood of young people in the target cohort engaging and remaining engaged for the duration of the process.

To achieve this will require attention to the details of the stages, moments and touchpoints of the service.

The insights about what might be needed at each stage informed a set of design principles (see Design Principles on next page).

Subsequent pages explore the definition of the target group for the service, and some exploration of where the boundaries for that target group might sit.

Designing the Service Journey



Moment Design, 2019, adapted from Risdon & Quattlebaum, Orchestrating Experiences, 2018

Design Principles

Youth Mental Health Service

	Awareness	Contact	Onboarding	Service	Step Back
Design Principles	• Young people need clear information/ tools to help them judge when to seek help • Other services need to know who the services is for and how to refer • Service needs to be promoted through channels which will reach YP/family and friends	• Effort to connect with service needs to be lower than the effort to go it alone • Need an option for young person to self-refer. • Need channels to initiate contact other than cold-call on phone. Email, SMS etc • It should be stated up-front that service is free	• Use non-clinical language. • Ask for preferred pronouns & use them. • Ensure minimal wait times for young people with complex needs. • Provide clear communication about timelines, information about the service and helpful things to do while waiting for first appointment. • Service must accommodate young people who don't have Medicare card/ paperwork	**Use a Staged Care model to assess need and intervention** Trauma informed approach. **Work within the ecosystem:** • Joint assessment with other services. • **Shared care**/case management with other services. YP helps decide lead contact. • Work with elders, family and other supports. **Youth Led - Young people have an active role in their own case management (with parental permission for younger YP):** • Case planning with worker & other supports to prioritise- focus on one thing at a time. • Live visibility of case notes/progress data • YP determines "questions to ask me each session" • Clear parameters around confidentiality • Mutual transparency about types and intent of interventions, YP's symptoms and goals. • Mutual accountability. Ability to see worker calendar and book/cancel appointments. • Choice about where to meet for sessions **Options for less formal settings for therapeutic interventions** including outdoors in nature, walking, driving, video call etc. • **Use of peer supporters, group sessions, apps to increase support networks and good coping.** • **Discretionary brokerage funds** for access to sport/art/ animal therapy as appropriate.	• No abrupt "exit" or "discharge" from service. • Young people step back from service as they feel they are managing better and don't need the formal support. • Service sessions stepped down gradually on young person's terms. • Options to step back in later without going back to the start. • Option for "top-up" or "refresher" sessions without the full process.

Target Group

Addressing "Missing Middle"

The concept of the "missing middle" is slippery and is used to mean many different things, including:

- Young people with or at risk of severe mental illness (WAPHA)
- Young people who need help but do not access it, or who disengage from support services. (Cross, 2019)
- Young people who have ambiguous and evolving symptom profiles and do not easily fit a diagnosis or respond to brief interventions (Cross et al. 2016)
- Young people whose illnesses are too complex, too severe and/or too enduring for primary care alone to be sufficient (whether via standard GP practices or headspace centres) (McGorry, 2019) however, their illnesses do not meet the stringent eligibility criteria to access acute and continuing care despite high levels of distress and functional impairment (Cross & Hickie, 2017), (Orygen & headspace, 2019)
- Young people who are unable to access services after an acute episode of poor mental health, a traumatic experience, or who have episodic mental health needs (Victorian Government, 2019)
- The lack of suitable services for young people with complex needs, the lack of continuity and the fragmentation in the WA mental health system (Western Australian Association for Mental Health (WAAMH), 2018)

These various definition of "Missing Middle" were discussed as part of the co-design and explored through discussions with WAPHA and it was agreed that the term was unhelpful to use in describing our target group and should be discarded.

We came to the following agreement:

- The new service should target young people who are already helpseeking, but also pitch itself so as to engage those who are not (due to various barriers), or who have previously disengaged. The sector can play a role to bridge the engagement of those who are "low help seeking" and connect young people to mental health services like Amber Youth Wellness.
- The new service should include young people who meet Staged Care criteria for stage 1b and some early stage 2 (who don't quite meet the threshold for specialist Government services such as CAMHS).
- We should consider other holistic life circumstances to evaluate complexity.
- Defining criteria for Clinical Need should consider symptoms, functional impairment, suicide risk and complexity of other holistic life factors.
- During the first year of the new service, we should allow for some ambiguity to be open to further discovery about who this cohort is and what its needs are.

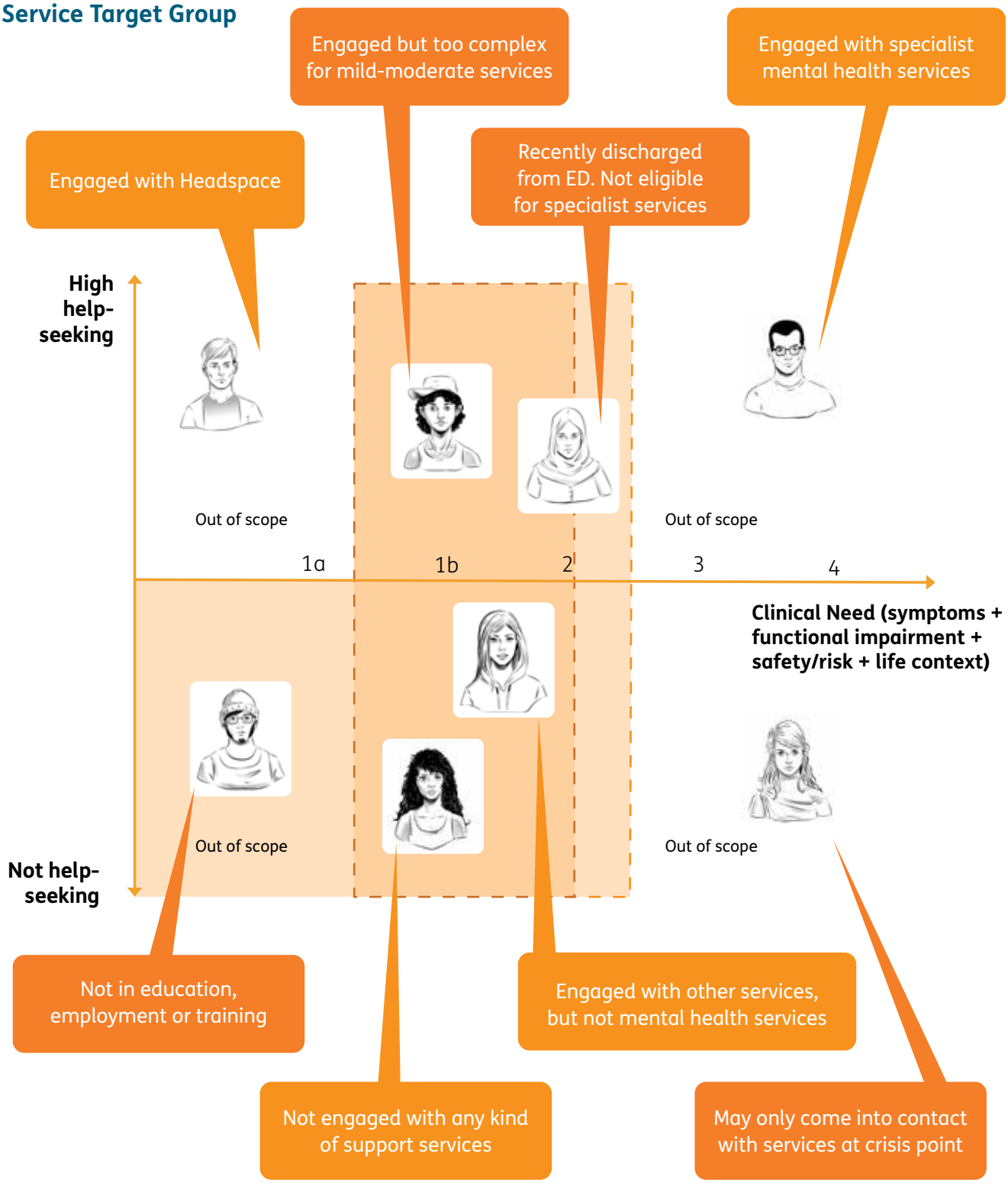
MercyCare's Amber Youth Wellness

TARGET GROUP

The refined definition for the target group for this outreach service is:

- Young people aged 12-25 years old
- Living in Perth's Northern suburbs
- Whose lives are being impacted by moderate to severe mental health challenges
- Who may also have complex life circumstances which are impacting on their wellness.
- Whose needs are not currently able to be met through any existing services.
- And who are seeking mental health support to achieve their wellness goals, which may include:
  - managing symptoms
  - improving their day to day functioning and relationships
  - improving their overall wellness
  - addressing other contributing challenges

Service Target Group

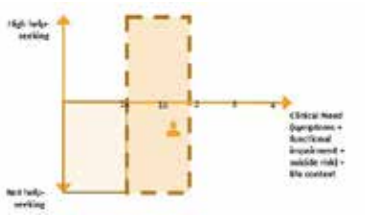


Personas

Judging the boundary between Mild to Moderate and Moderate to Severe need may be challenging. To help us visualise this, we created some personas based on some of the types of experiences and needs which might fall inside our outside our service target group. We ensured we covered a range of mental health challenges, and tried to include examples where the symptoms would not fit neatly in any particular diagnosis. Ultimately we will consider the needs of each young person individually, however use of these personas to segment the service provides a useful tool to conceive of the service and its boundaries.

Ash, Age 18

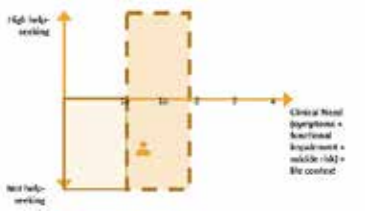
Severe Clinical Need, Medium helpseeking



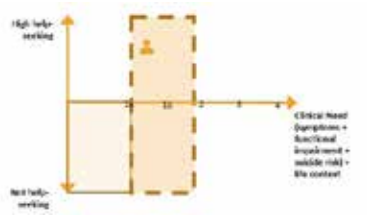
Symptoms	Since she left her partner 6 months ago, she feels paranoid and hears a voice that tells her people are out to get her and that someone is watching her. Feels scared and confused and out of control a lot of the time. Sometimes feel numb, like she is outside her own body.		
Functioning	She was previously in a relationship with a violent partner, which has since ended. She has developed a habit of repeatedly checking the door is locked and feels this is getting worse. She is managing to hold down her part time job but struggles to hide her paranoia and worries her mental health and drug use will soon impact her job.		
Risk Factors	Using drugs and alcohol to cope. Her old friends don't want to hang around when she is like this. She has started hanging around new people she doesn't really trust. Mum struggled with mental health.	Protective	Hesitant but willing to seek help.
Other	She is living in supported accommodation and has a good relationship with the Housing Support worker. She has a part time job at a lunch bar. She has had a previous bad experience with a psychologist who breached her trust without good reason and is mistrustful of the mental health professions. She has also recently started seeing a drug and alcohol counsellor.		

Max, Age 15

Moderate Clinical Need, Low helpseeking



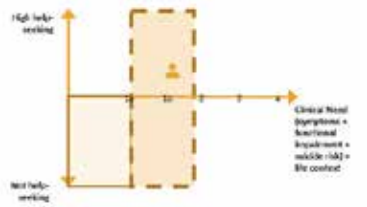
Symptoms	Apathy. Sudden loss of interest in life. Feels sad, empty and bored. Has not been sleeping at night since arriving in Perth. She has been sleeping most of the day.		
Functioning	She has been enrolled in a new school but has hardly attended since arriving in Perth. Usually a keen student. Stays home and watches TV/YouTube/social media. Pulling away from family. She has had cycles of excessive hunger, binge eating a couple of times a week and then feeling guilty.		
Risk Factors	Social isolation- withdrawing. Hopelessness. Recent suicides in the family.	Protective	Positive relationship with Mum.
Other	Mum and Dad divorced recently. She and Mum moved back to Perth to be near Mum's side of the family a few months ago. Dad stayed in Albany. There have been a number of deaths in the extended family, some by suicide. She has attended a lot of funerals in the past few months.		



Lenny, Age 14

Moderate Clinical Need, High helpseeking

Symptoms	Difficulty concentrating, forgetting instructions Talking over the top of others. Easily agitated or frustrated.		
Functioning	Difficulty completing tasks. Affects his ability to achieve at school. Suspensions, detention etc. Often gets into arguments, sometimes even fights. Frequent disagreements with parents. Has been in trouble with police a couple of times for minor offences .		
Risk Factors	Low self esteem.	Protective	Good relationship with youth worker.
Other	Has been sent to the school psych but was considered out of their scope. His behaviour was attributed to a poor attitude rather than mental health. Parents are frustrated at his behaviour and have threatened to kick him out of home if he gets expelled. Plays basketball at the local youth centre and youth worker has discussed (and sought parental permission) possibility of outreach psych appointment at the youth centre.		



Jas, Age 19

Moderate Clinical Need, Medium helpseeking

Symptoms	Feels anxious and jumpy. Has recurring nightmares. Panic attacks at work and university.		
Functioning	Has difficulties forming trusting relationships, particularly with men. She quit her job as she felt she was being triggered by customer service scenarios with any conflict, no matter how small. Increasingly reclusive. Has been pulling back from social situations.		
Risk Factors	Withdrawing from friends. Previous suicide attempt. Hopelessness.	Protective	Positive relationship with Mum. Remorseful and helpseeking.
Other	She is studying at University. Has some childhood trauma- family domestic violence history.		

Staged Care

A requirement from WAPHA was that this new service would use a Staged Care assessment to match treatment to stage.

What is clinical staging?

Clinical staging is used alongside conventional diagnosis to provide context about the severity of clinical need at a specific point in time and to match an appropriate level of intervention for that point in time.

The mantra of **right care at the right time** seeks to match treatment intensity (higher risk/cost) to the stage (severity/need): The aim is to stop progression to more severe stages and promote recovery.

Clinical Staging recognises that many severe disorders have common features at earlier stages; mostly non-specific symptoms of anxiety and depression.

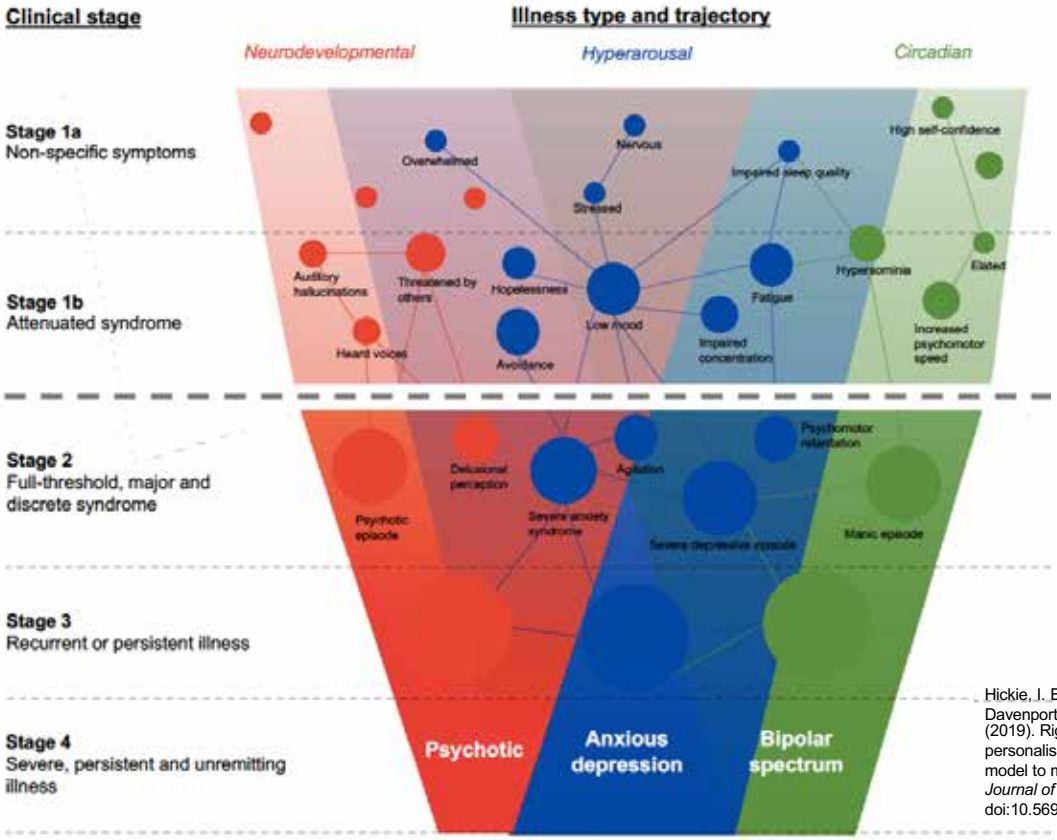
For some, mental disorders are time-limited. For many, mental disorders are chronic, changing conditions. Symptoms often begin to appear in childhood or adolescence and ebb and flow over the course of an individual's life. What the disorder looks like in adolescence is most often not what it looks like in adulthood.

(Hafner, an der Heiden, & Maurer, 2008; Merikangas et al., 2010a; Paus, Giedd, & Keshavan, 2008)

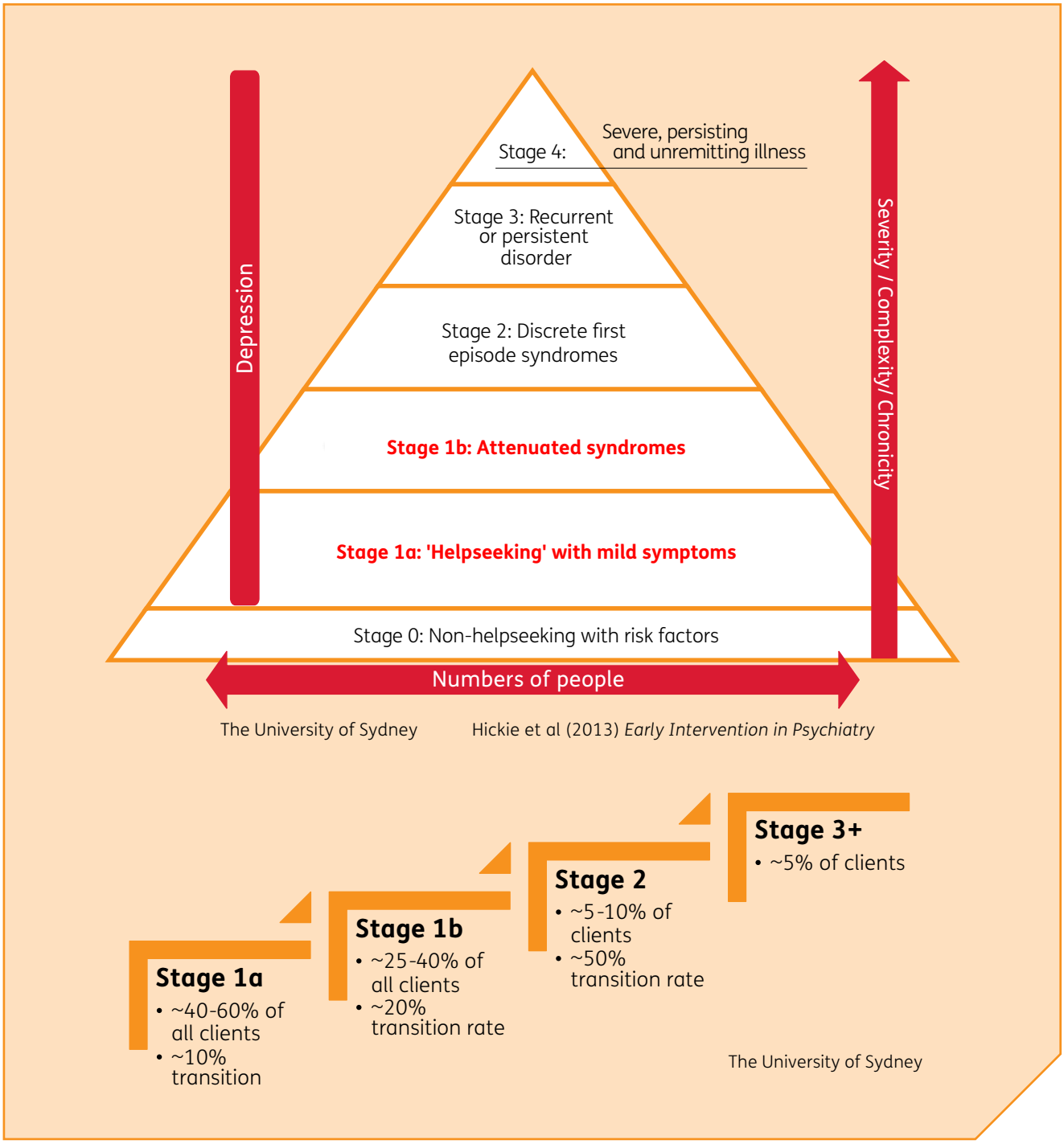
When assessing clinical need and stage, a trained clinician will consider the trifector of symptoms, functional impairment and suicide risk alongside other holistic life factors.

The diagram below highlights some of the characteristics of successive stages. It is intended that this service will mainly focus on young people at Stage 1b who have ambiguous, attenuated or evolving symptom profiles which do not easily fit a diagnosis.

It was acknowledged that there are some limitations to Staged Care for certain types of mental ill health, such as eating disorders and personality disorders that tend to generate some challenges in practice. This service will explore this further in partnership with Dr Shane Cross.



Hickie, I. B., Scott, E. M., Cross, S. P., Iorfino, F., Davenport, T. A., Guastella, A. J., . . . Scott, J. (2019). Right care, first time: a highly personalised and measurement-based care model to manage youth mental health. *Medical Journal of Australia, 211*(S9), S3-S46. doi:10.5694/mja2.50383



Staged Care models assume a funnel of diminishing numbers of young people at each stage of severity, with an anticipated distribution of clients across each stage.

At each stage (as indicated by the diagram at the bottom), a certain percentage of clients will transition to a worsened stage, and notwithstanding the possibility for recovery, clients generally do not move back once they have progressed to the next stage.

For this reason, appropriate early intervention and ongoing outcome monitoring are critical to lessening the likelihood of progression.

If we know a proportion of young people are at risk of progression we need to monitor changes closely and provide more intensive intervention at the first sign of deterioration.

Staged Care Intervention Matching

Staging should ensure appropriate care and avoid over or under treating young people

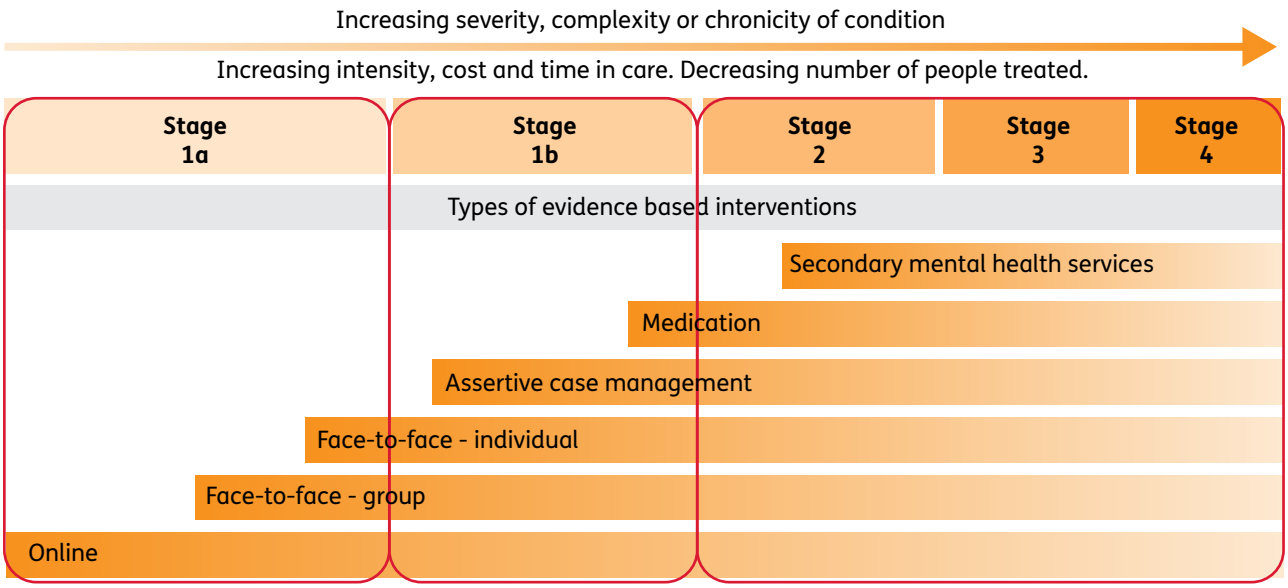
- Risk-to-benefit ratio: Early-stage treatments should carry less risk, and be less time intensive for all involved than later-stage treatments.
- Intensity of Intervention is defined in terms of financial cost (both service level and consumer), consumer requirements to physically attend, the required frequency of attendance, the number of professionals involved, the length of the episode of care and the prescription of psychotropic medication. Shared decision making is key.

Interventions should also address other factors that are linked to poor outcome and worsening mental health, such as:

- Not being in education, employment or training.
- alcohol and other drug use,
- poor physical health and
- social disconnection, relationship and family concerns.

At times, it is appropriate for these domains to be the primary focus of intervention. However it is important to continue to track symptoms, impairment and risk.

Clinical Stage	Description
Stage 0	Non-help-seeking asymptomatic with risk factors
Stage 1a	Help-seeking with presenting symptoms which are distressing, but are not specific to one disorder, are or low to moderate severity and have limited impact on functioning
Stage 1b	Attenuated syndromes of severe mental disorders, with moderate to severe functional impacts
Stage 2	Discrete first episode syndromes with major functional impacts
Stage 3	Recurrent or persistent syndromes with ongoing severe functional impacts
Stage 4	Syndromes which are severe, persistent and unremitting



The University of Sydney

Cross, S. P., & Hickie, I. (2017). Transdiagnostic stepped care in mental health. *Public health research & practice, 27*(2). doi:10.17061/phrp2721712

DEVELOP

Prototype and Test

We used these rich sources of insights, to develop rough prototypes which enabled us to visualise what the new service might look and feel like.

We used these to inform discussions and workshops with our design team, our funder, our Steering Group, our sector stakeholders and young people.

Some of these prototypes dealt with the broader conceptual framework, such as the design components, or the assessment. Others looked at detailed touchpoints for the service (which are sometimes overlooked in the design of services) and how these might provide a more positive service experience for clients.

We used these prototypes to provoke discussion and evoke a response from our various stakeholders, to draw out the tensions and nuances which would need to be addressed in the new service.

We used these additional insights to inform decisions about which elements to discard, which ones to keep and which to further refine.

The following pages provide just a few examples of the many prototypes which were tested throughout the co-design process.

Clinical Language

We prototyped a scenario around switching clinical language for every day language in interactions with young people. We anticipated that there would be a tension between youth friendliness of everyday language and clinicians wanting to use clinical language for psychosocial education or ease of communication between clinicians. There was certainly a space held for the use of clinical language in specific instances, where it would be useful to the young person, however there was a surprising and overwhelming consensus (even from clinicians) that this service should use plain language rather than clinical language in its communication materials, interactions with young people and their families, except where it was specifically requested.

Hello! So I'm going to do a brief psychosocial assessment on you today to look at your symptomology, your functional impairment, your genetic loading and your level of risk. I'd like to look at any previous diagnosis or discharge reports so I know if you're tier 1, 2 or 3, your clinical stage and whether you'll need primary, secondary or tertiary support. Before we look at a care plan and ask about your goals, we'll need to do a safety plan and think about the treatment burden. I'll need to get your informed consent for a release of information for shared care. Before your next appointment we'll also book you in for some transport training.

Google Translate

Hello!

Let's talk about what's been going on for you lately? What have you been experiencing and how has it impacted on your everyday life?

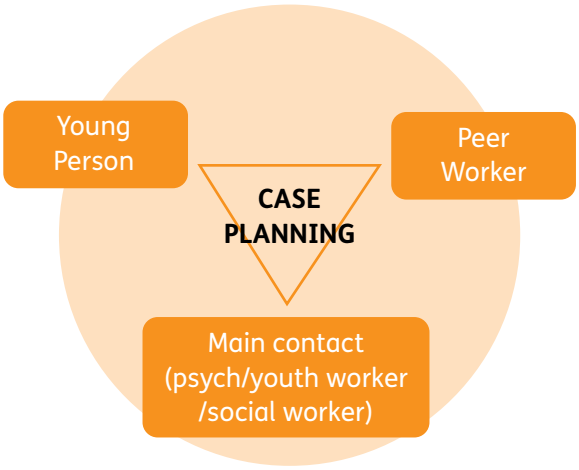
So that we can make sure we can tailor the best support for you, tell me what help you're looking for specifically.

You're an equal partner in this, so we want to be transparent about every step. Let's work out what is the most important thing to work on first which will have the biggest impact for you.

Have you been getting help from anyone else, that it would be helpful for us to speak with?

Can we get your permission to share some of your information with other supports that you want to have involved.

Youth Led/Person Centred



Early on young people brought up the concept of wanting to be an equal partner in their own wellness planning.

The National Health Service in the UK refers to the concept of "patient-led care" in which *"patients are supported to make choices about, and take control of, their health and health care, and services evolve to provide personalised care by listening and responding to patients."* (Fitzpatrick, 2005)

We spent the next few months prototyping with young people and other stakeholders what exactly "Youth-Led Care" might look like.

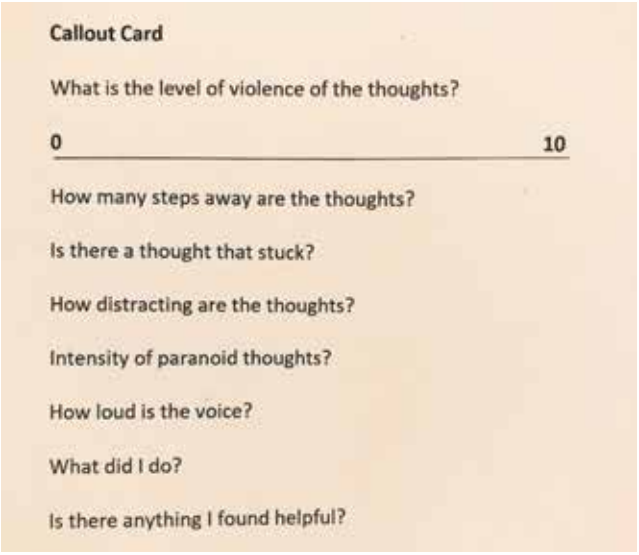
One prototype proposed the idea of replacing the Case Manager role with a team made up of the young person, their main worker and a peer worker who would develop and monitor the care plan together, prioritising what to focus on next (see above).

One of the prototypes developed by one of the young people was a 1 pager of questions for their psychologist to ask them every session. They tested it out with their existing clinician and reported that it was useful. This may have been due to the specific questions or the fact the young person felt empowered to take an active role in their own treatment.

Other prototypes included a 1-pager summary of the young person's mental health history, current key contacts, which they could present or email to a GP or the Emergency Department without having to repeat their story.

Other aspects prototyped included:

- Youth friendly non-clinical language throughout the service.
- Shared transparency about types and intent of interventions.
- A menu of therapeutic services on offer.
- Option to view case notes/progress data.
- Clear parameters around confidentiality.
- Options for best mode of contact (phone, text, in person), good times to contact.
- Access to a calendar to book appointments with clinician ("you can do it with hairdressers so why not?"). Accountable to attend appointments or give worker notice if need to cancel/reschedule.
- Choice about where to meet for sessions
- Get matched with or get choice of a worker who they are likely to get along with.
- Protocols that allow young people (18+/mature minors) to choose whether parents are aware they are receiving service e.g. option to not have mail go to home address, not have parents contacted by phone, put alternate support person as emergency contact.
- Ability to nominate family/support people to come in for family therapy.


Callout Card

What is the level of violence of the thoughts?

0 _____ 10

How many steps away are the thoughts?

Is there a thought that stuck?

How distracting are the thoughts?

Intensity of paranoid thoughts?

How loud is the voice?

What did I do?

Is there anything I found helpful?

Domains for Scaffolding Assessment

In order to understand a young person in their holistic context means having an early conversation with them about the various (interconnected) domains of their life.

This will form part of the formal assessment, but should take the form of a skilfully conducted interview in which the young person experiences it as a warm attentive conversation and the clinician or other worker is mentally compiling a set of insights about the young person's situation.

Rather than following a set of carefully scripted clinical questions, this approach instead uses a set of scaffolded themes, explored conversationally. The scaffolding might contain guidance for workers about "What I ask" and "What I really mean (or what I'm looking for) when I ask that."

This will provide insight about

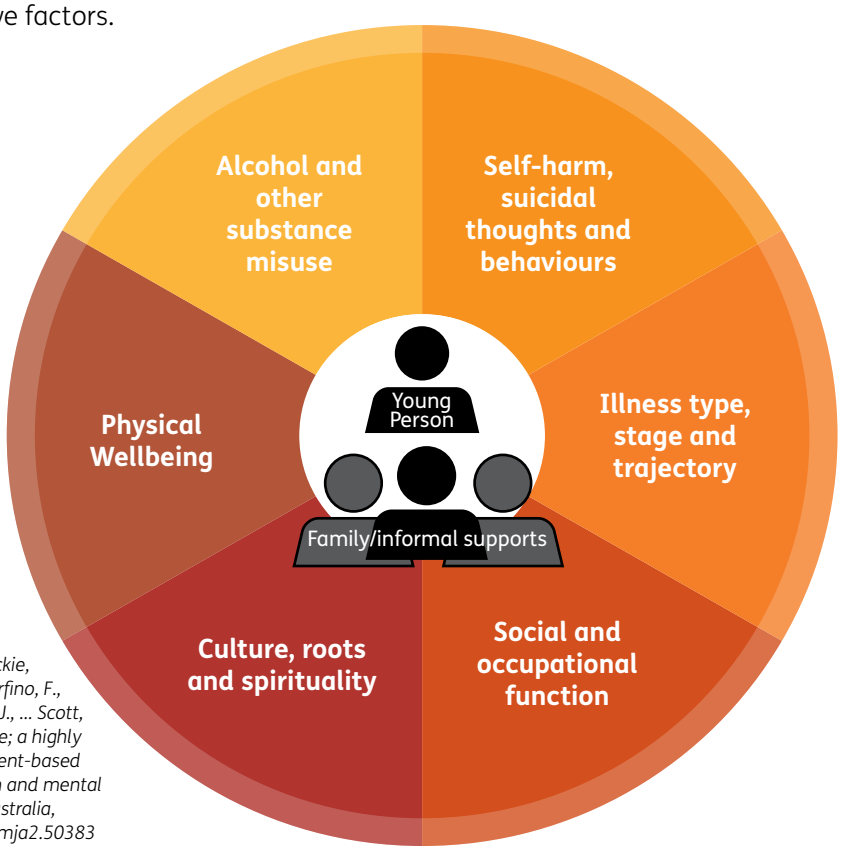
- Areas of strength and weakness for the young person.
- Risk and protective factors.
- The young person's wellness goals and what help they are seeking from this service.
- Other support services (or natural supports such as family, friends, social connections) who are currently helping with other dimensions.

It can inform clinical staging and therefore inform the type and intensity of intervention to proceed with.

It can also uncover possible avenues to pursue validated tools to deepen the assessment in particular dimensions.

We prototyped this concept with the co-design group using domains provided by Dr Shane Cross. An additional domain of culture, roots and spirituality was included as stakeholders felt this was an important part of holistic wellness.

Other sets of domains have been explored including cultural frameworks such as the Maori Te Whare Tapa Whā mode (Durie, HEADSS Psychosocial Assessment and others.



Adapted from domains in Hickie, I.B., Scott, E.M., Cross, S.P., Iorfino, F., Davenport, T.A., Guastella, A.J., ... Scott, J. (2019). Right care, first time; a highly personalised and measurement-based care model to manage youth and mental health. Medical Journal of Australia, 211(S9), S3-46. doi:10.5694/mja2.50383

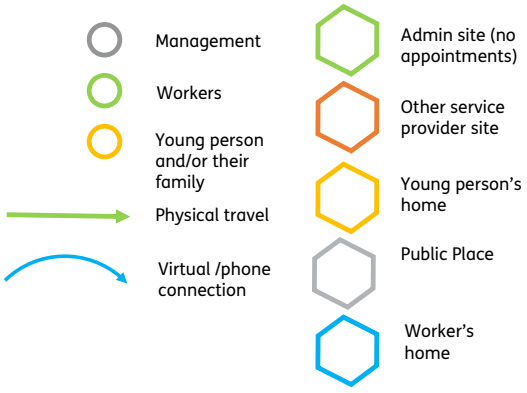
Outreach Modality

We prototyped a variety of models for the outreach modality, to understand the logistics of where we need to put staff so they can be available in the right place and at the right time. This prototype explored the Who/Where/How considerations.

There is a natural pull for any physical building to slip into being a centre based clinic. Outreach is hard and it is convenient for staff to ask young people to come to them in their space. We wanted to keep the fidelity of outreach being into young people's spaces. For this reason, we prototyped admin spaces without clinic rooms. Workers will head out from these admin bases to meet young people at other service provider's sites, public places or where necessary, in the young person's home.

We included two admin bases to cover off the Midland/Hills/Ellenbrook corridor and the Mirrabooka to Yanchep corridor. We also plan to have a worker based out of Derbarl Yerrigan (for cultural expertise). However, staff need a way to stay connected to one another for training, accountability and support. We plan to rotate a weekly staff meeting at each admin site.

The option for virtual/video calls should be a available as a backup to face-to-face. A variety of platforms should be available to choose from, which ensure both usability for the young person's mode of digital access and suitable privacy and security.



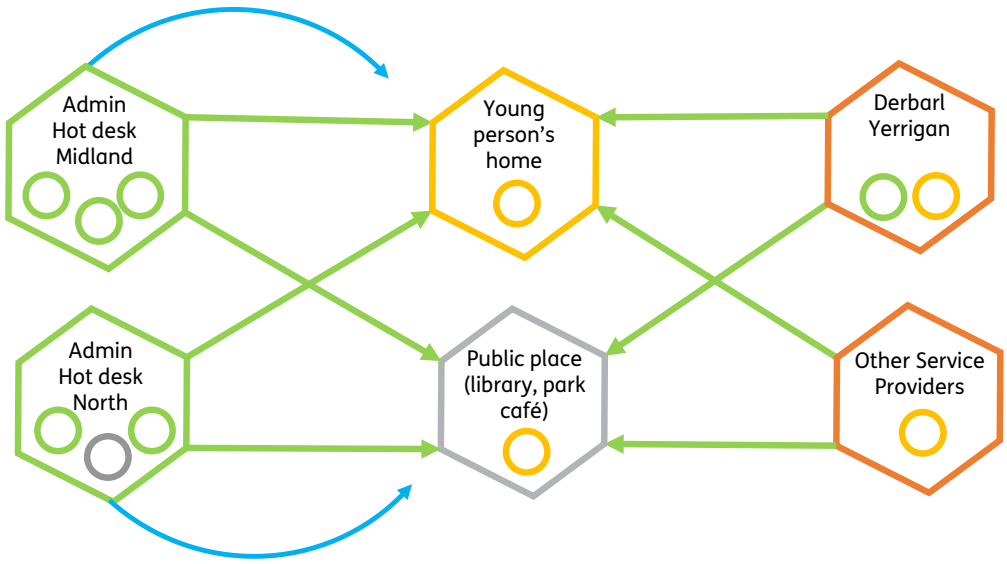


Image adapted from AnglicareWA headspace Pilbara Insights Report, 2018

DELIVER

MercyCare's Amber Youth Wellness

The Final Model

Now that the formal co-design process has concluded, the detail of the model will be firmed up for the implementation phase where the service will be launched and new staff recruited into roles will begin taking on young people to support them with their wellness journey.

The following pages provide a conceptual overview for the service.

The detail of the model will be provided in the Clinical Governance documentation, which include the assessment scaffolding, policies and procedures, etc.

Beyond the launch date, the service itself will become a working prototype for all of the insights and concepts explored in this report.

We will continue to engage with young people, our funder and other stakeholders to reflect on what is working well and which elements may need to be refined or completely re-worked.

We anticipate that this service will continue to iterate and respond to changing circumstances, guided by the underlying understanding and insights of what young people facing significant mental health challenges are looking for in a robust, effective, supportive service.

Introducing Amber Youth Wellness

Concept

The name Amber originated from the idea of a traffic light system- with amber being the middle space between being where you want to be (green) and being in a crisis (red). This name resonated with young people and service providers.

The word wellness reminds us of the holistic focus on the whole person. Orange tones reflect the amber traffic light but also balance youthful energy with earthy warmth.

Finally, the name Amber saved in your mobile phone can appear as a friend, for those who want to be discreet about seeking support with their mental health.

We heard the message that visible branding should be subtle and discreet when going out into communities to outreach. This means minimal branding of vehicles, uniforms etc. so young people can feel safe meeting a worker without everyone knowing about it.

Young people wanted communications such as the web presence, information and welcome packs to use clear but not patronising language, have useful, current information and instil a feeling of hope. They wanted clean, bright graphics and illustrations which celebrate diversity of all kinds.

While we are still working on the broader brand with our Marketing team, here are three visual concepts for Amber Youth Wellness which were prototyped with stakeholders.

Service Components

The service components for Amber Youth Wellness have been captured in the following 9 areas below. These components identify the elements which make this service robust and unique. Further detail is provided on the following page.

MercyCare is a partner in Orygen's Youth Enhanced Services (YES) Implementation Lab, a network of Primary Health Networks and commissioned youth mental health service providers to collaborate and share knowledge.

This partnership with Orygen has provided staff training, consultancy and input into clinical governance which has informed the development of these service components and the detail of the clinical governance.

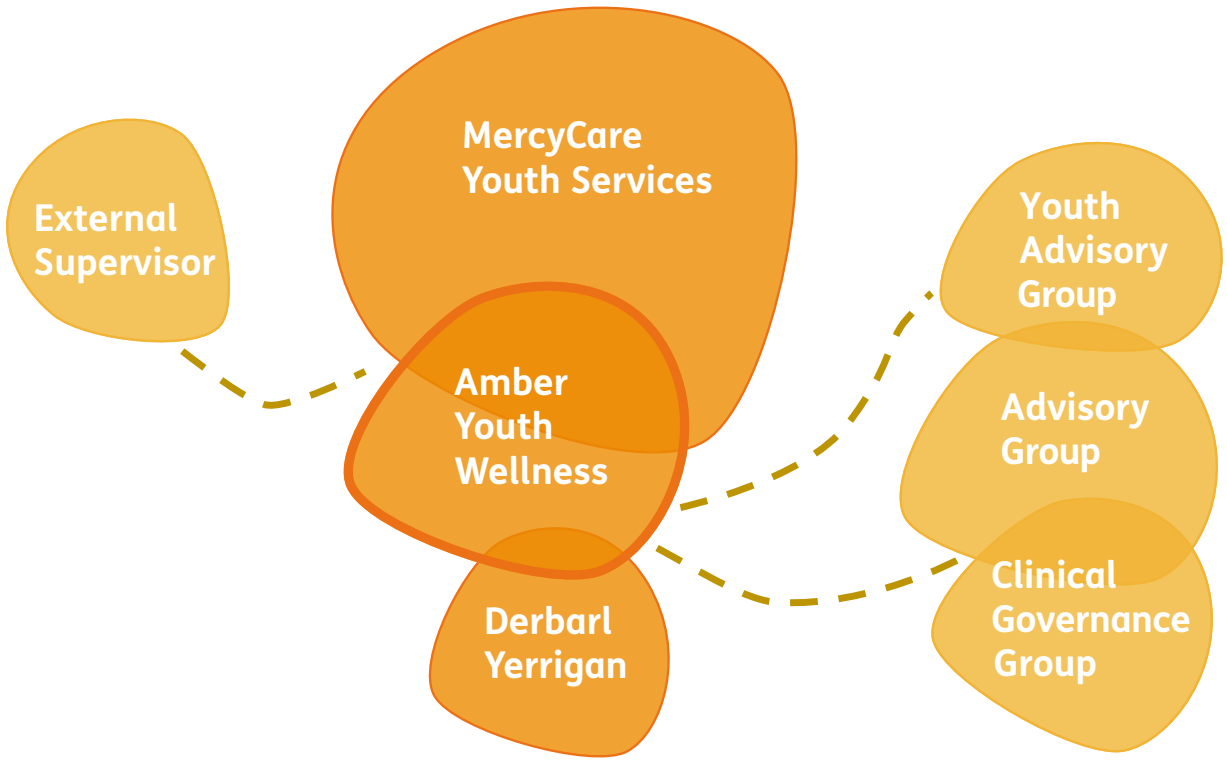
As part of our research, we compared Orygen's guidance on Youth Enhanced Service model components and the World Health Organisation guidance on providing youth mental health services.

Amber Youth Wellness

- Person Centred/ Youth Led Care
- Medical Care
- Ecosystem Approach
- Evidence Informed Practice
- Family Inclusive
- Supported Transitions
- Free, Easy Access, Outreach/In-reach
- Timely Comprehensive Intake & Assessment
- Continuous Improvement

Person Centred/Youth Led Care	Medical Care	Ecosystem Approach
• Shared decision making in care co-ordination and planning • Guidelines for youth practice with consideration of developmental stage • Developmentally appropriate transitions in and out of care • Use of everyday non-clinical language • Culturally secure • Relationship focused • Peer workers in care team • Inclusive, diverse team culture • Utilise youth friendly digital communications	• Evidence informed, individually tailored interventions • Staged Model of care- tailoring support to stage of clinical need • Broad consideration of individual's context • Holistic care including functional recovery. • Addressing social determinants • Risk responsive • Trauma informed	• No referral required • Low physical or geographic barriers • Workers outreach to community settings where YP feels comfortable • No cost barriers • Low stigma setting • Create awareness of services • Mapping of referral pathways • Simple means of contact
Evidence Informed Practice	**Family Inclusive**	**Supported Transitions**
• Defined geographic catchment • Targets all young people at stage 1b and 2 • Development and use of screening tools • Narrative based assessment • Meet in a community setting	• Family and friends involved in care as guided by YP • Family therapy/support sessions and resources • Family peer worker	• Facilitate access to GPs who are youth friendly and mental health aware and who bulk bill. • GP capacity building • Access to sessional psychiatry
Free, Easy Access, Outreach/In-reach	**Timely Comprehensive Intake & Assessment**	**Continuous Improvement**
• Stakeholder mapping and integration • MOUs/ partnerships with other agencies • Clear referral pathways • Consultation-liaison • Collaborative relationships with stakeholders • Supported transitions/warm referrals • Education of referrers • Co-location and in-reach • Shared care protocols • Community education • Liaison with elders, community leaders	• Transition into service works with pre-existing supportive relationships. • Balance of practical and psychological support around key life transitions such as leaving school, leaving home etc. • Service can hold a place during crisis or escalation to hospitalisation etc. and transition back into service if still appropriate. • Gradual, youth-led stepping back process when formal help is no longer needed. • Follow-up post exit • Option to step back into the service later for top-up or refresher sessions if needed.	• Youth reps on Steering Group • YP and other stakeholders involved in co-design and evaluation of service • Routine Outcome Monitoring • Measured based care/ Feedback informed treatment • Workforce development and training • Individual and team/peer supervision • Avenues for youth and family feedback • Clinical governance • Evaluation informing improvement • Utilise technology to improve service offering • Map needs before developing programs

Organisational Model



Amber Youth Wellness will be a partnership between MercyCare, Derbarl Yerrigan and Orygen Youth.

The service will sit under MercyCare's Youth Services area among its other services, however several staff in the Amber Youth Wellness Team will be co-located at our partner Derbarl Yerrigan, who provide cultural expertise.

An Advisory Group comprising a cross section of sector expertise, including Orygen Youth, cultural organisations and other stakeholders as well as a Youth Advisory Group, comprising young people with lived experience of mental health challenges, will meet several times a year to provide oversight of the service.

Within the Advisory Group, a subcommittee Clinical Governance Group will meet quarterly to provide input into clinical governance of the service.

An external supervisor will be provided for the clinical lead. The clinical lead will provide supervision to the clinicians, who will in turn provide supervision for the other non-clinical staff and peer workers.

Staffing Profile

The proposed team will comprise the following staff:

- A clinical lead with a background in Mental Health and Psychology will manage and provide supervision to the team.
- Senior Clinicians (with a mix of professional qualifications in either Psychology, Social Work, Occupational Therapy or Nursing)
- A time-limited Transition Clinician to support the transition of headspace Plus clients to the new service.
- An Aboriginal Cultural Worker will provide cultural expertise and engagement.
- Youth/community workers.
- Either two Peer workers or a Peer Worker and a Family Peer worker.

Young people are involved in the recruitment and interviewing of these staff.

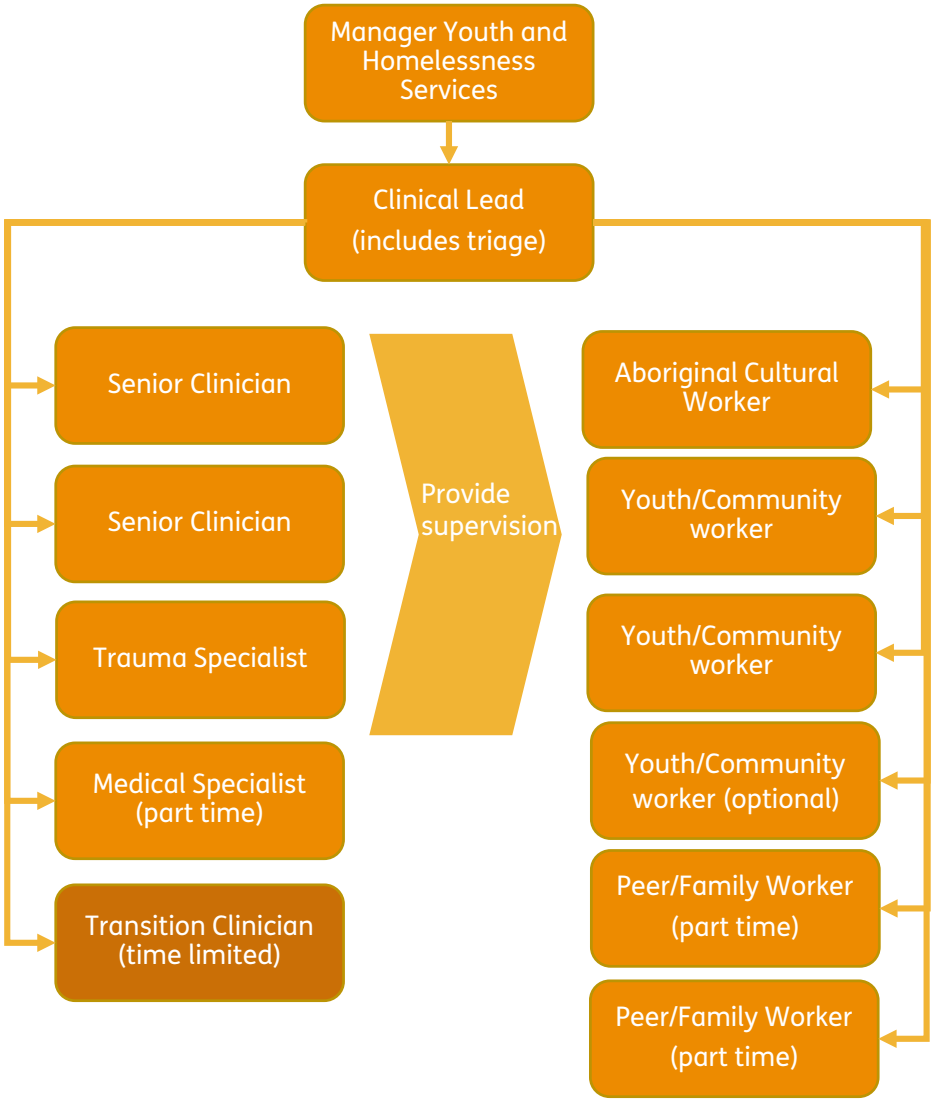
Each worker will carry a caseload of 15-20 young people, allowing for some community education and group-based activities. This will give the service a total caseload of around 100 young people at any given time.

Core team skills should include the following. Training will be provided to fill any gaps:

- Gender diversity
- Autism awareness
- Cultural competency training (ATSI/CaLD)
- Therapeutic Crisis Intervention (TCI)
- Clinical staging
- FASD
- Understanding ADHD/ODD

Across the team there should also be coverage of the following interventions:

- Motivational interviewing
- Cognitive Behaviour Therapy
- Dialectical Behaviour Therapy and other Emotional regulation interventions
- Age appropriate behavioural and cognitive interventions
- Trauma-informed therapy
- Family inclusive therapy



Trauma Informed Framework

The model will incorporate the trauma informed practice model which MercyCare developed in partnership with The Australian Childhood Foundation.

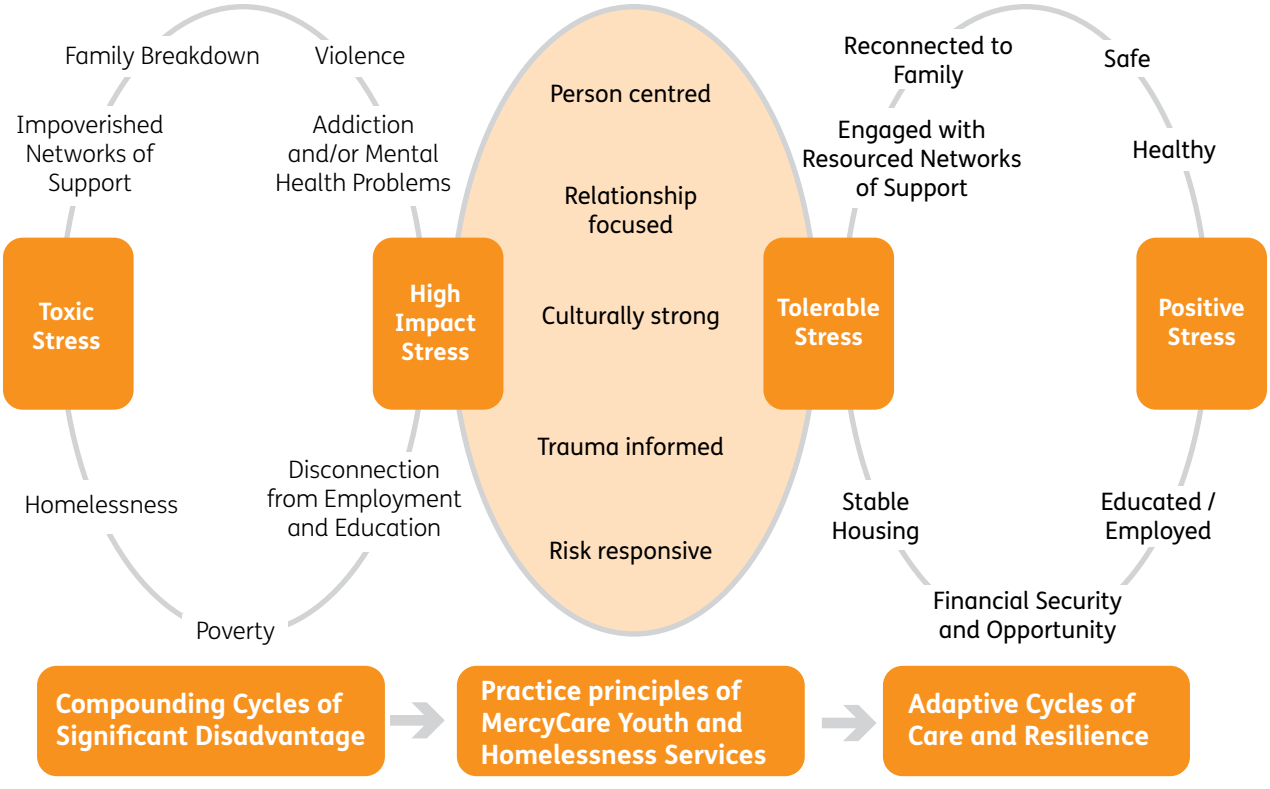
This model considers a young person in their full holistic context and in relation to the stressors which are impacting up on their lives, both through current circumstances, and past traumas which play out in different ways.

Trauma is the emotional, psychological and physiological reactions caused by exposure to experiences of toxic and high impact stress. Young people are very vulnerable to the effects of toxic stress and high impact stress because of their developmental immaturity.

Toxic forms of stress (child abuse, family violence, neglect) and high impact forms of stress (homelessness, parental mental health, high conflict parental relationships, family breakdown, bullying, racism, discrimination) compromise the function of important biological systems and lead to severe limitations in the adaptive capacity of young people.

Our trauma-informed framework for understanding focuses on breaking cycles of disadvantage through resourcing young people in conjunction with their networks of support and care to address the effects of previous and current stressors in their lives. Our aim is to reduce the levels of stress experienced by a young person to either being tolerable or positive.

Conceptual model of practice for MercyCare's Youth and Homelessness Services



AMBER

SERVICE MENU

THERAPEUTIC ONE ON ONE SESSIONS

Depending on where you're at, we have a choice of therapeutic interventions to meet you where you are at.

Don't feel comfortable always meeting in an office? We can walk and talk or meet in a location that feels more safe or comfortable for you. We can also offer virtual sessions by video call. We're a Monday-Friday service but will do our best to find a time that works for you.

GROUP ACTIVITIES

If you'd like to talk with other people who have been through similar things or develop supportive social networks, ask about group activities. One of our peer workers can also come along to any of your sessions as moral support. Just ask.

ACCESS TO A GP/PSYCHIATRIST

If you need a bit extra, such as expert advice about diagnosis or medication, we have access to a youth friendly medical specialist, GP or Psychiatrist. It's not mandatory but the option is there

GROUP SESSIONS FAMILY/FRIENDS

It's your choice whether you want family or another supportive person to accompany you to appointments so that they can support you in your wellness journey*. We also offer group sessions if you want to develop supportive habits and work on wellness as a family.

SUPPORT WITH OTHER WELLNESS DIMENSIONS

Sometimes it's other things going on that can stress you out and push your mental health. When your wellness isn't the best it can throw out other parts of your life. We have youth workers who can help you re-engage with school or work. We can also connect you with other people who can help with whatever is going on.

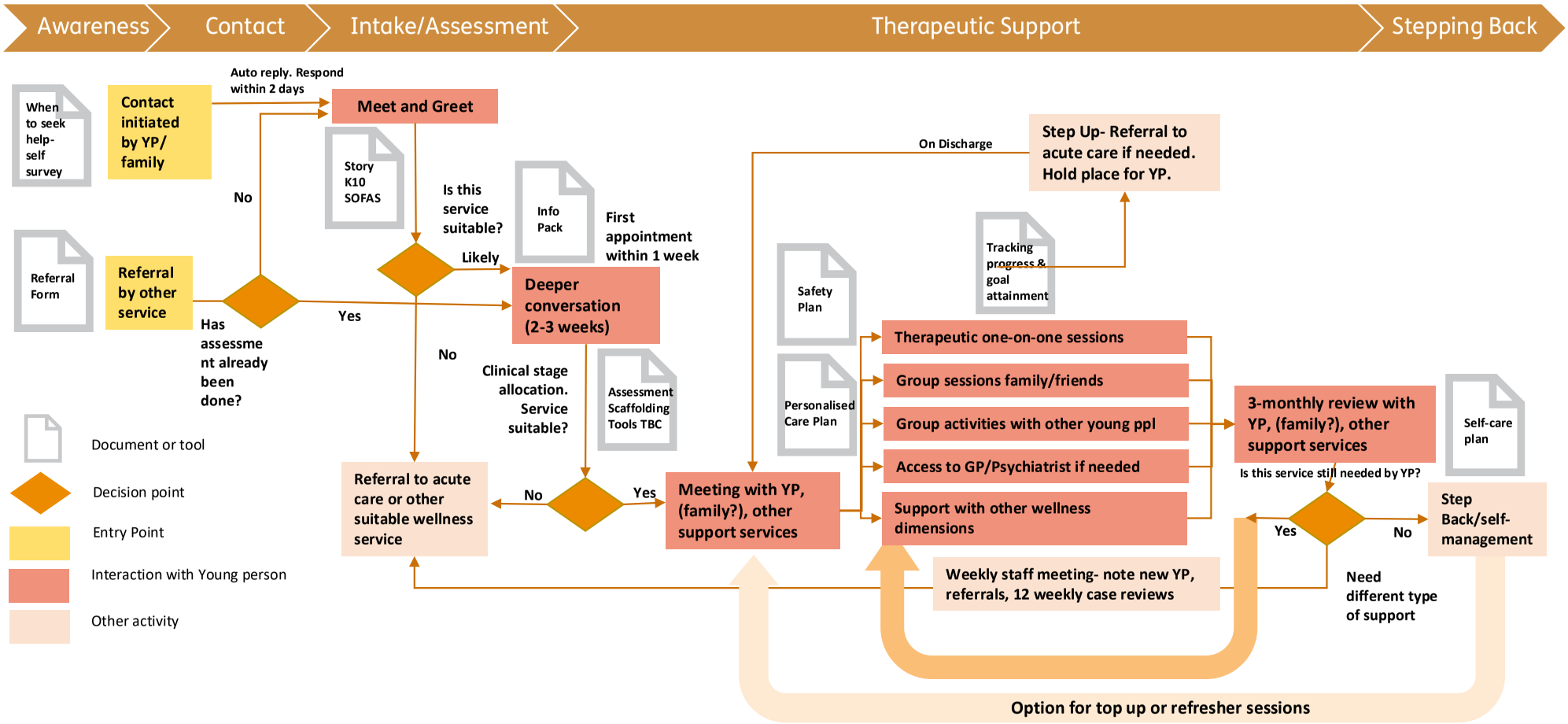
Or allow our wellness professionals to customise something specific to your needs.

The Service Journey

This process maps the journey through the service. Its design has been informed insights gained through the co-design process.

It is designed as an end to end therapeutic experience, partnering with the young person and their other supports to help them improve their own wellness. Innovative elements of this journey map include:

- Elimination of clinical language
- Assessment is flexible to entry mode and accommodates previous assessment work already done.
- Each young person can receive a duration of 12mths+ flexible service provision.
- Option to include family/friends and other services in process.
- Family/friends therapeutic sessions
- Place held in service if young person has to go to hospital in a crisis
- Stepping back (exit) is gradual and on young person's terms
- Opportunity for re-entry into service for refresher/ top-up sessions at a later date


Awareness
Contact
Intake/Assessment
Therapeutic Support
Stepping Back
When to seek help-self survey
Contact initiated by YP/ family
Auto reply. Respond within 2 days
Meet and Greet
Story K10 SOFAS
Is this service suitable?
Info Pack
First appointment within 1 week
Referral Form
Referral by other service
No
Has assessment already been done?
Yes
Likely
Deeper conversation (2-3 weeks)
No
Clinical stage allocation. Service suitable?
Assessment Scaffolding Tools TBC
Referral to acute care or other suitable wellness service
No
Yes
Meeting with YP, (family?), other support services
On Discharge
Step Up- Referral to acute care if needed. Hold place for YP.
Tracking progress & goal attainment
Safety Plan
Personalised Care Plan
Therapeutic one-on-one sessions
Group sessions family/friends
Group activities with other young ppl
Access to GP/Psychiatrist if needed
Support with other wellness dimensions
3-monthly review with YP, (family?), other support services
Is this service still needed by YP?
Yes
No
Need different type of support
Self-care plan
Step Back/self-management
Weekly staff meeting- note new YP, referrals, 12 weekly case reviews
Option for top up or refresher sessions
Document or tool
Decision point
Entry Point
Interaction with Young person
Other activity

Referral Pathway

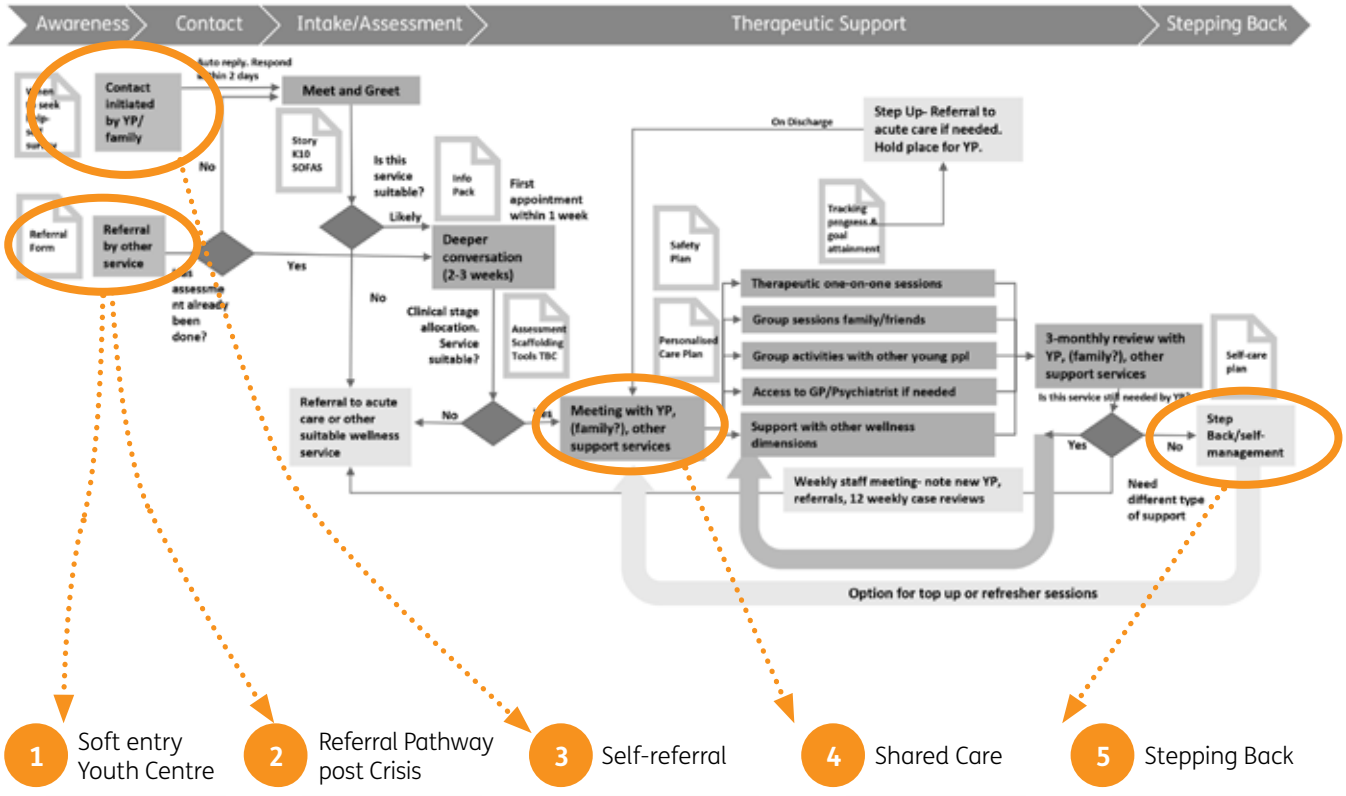
Referral	Who might typically refer this way?	Why might they refer?	Process
Step Up	GP, Headspace, school psychologist, other service suited to mild to moderate mental health support.	Young person may not have responded to brief intervention or it may not be suitable. They recognise the need for more intensive support with complex need.	1. Call intake line for initial chat 2. Fill out referral form with young person 3. Email to service along with any other relevant assessments completed. 4. Support young person to get to meet and greet (backup option for meet and greet over the phone)
Step Down	Emergency Department, HEP.	Following an acute crisis, they may be seeking a suitable service to support young person with moderate to severe need, post-discharge.	1. Call intake line for initial chat 2. Fill out referral form with young person 3. Fax/Email to service along with Discharge Reports and any other relevant assessment 4. Support young person to get to meet and greet (backup option for meet and greet over the phone)
Referral from other service or internal	Youth centre, AOD service, sexual health clinic, homelessness service, employment service, MercyCare's youth services or multicultural services, other social service.	They may be supporting young person with other complex life challenges such as housing, family dynamics, settlement, or other dimension and recognise the need for mental health support in that mix.	1. Call intake line for initial chat 2. Fill out referral form with young person 3. Email to service along with any other relevant assessments completed. 4. Support young person to get to meet and greet (backup option for meet and greet over the phone)
Self-referral	Young person (or their family/carer/support person).	Identify that they are not doing well and that they would like professional help to get back to place of wellness.	1. SMS or call intake line for initial chat/ or Email 2. Support young person to get to meet and greet (backup option for meet and greet over the phone)

Moments and Touchpoints

The Service Journey Map on the previous page offers a good high level process to describe young people's journey however it doesn't provide a feel for the human side of the therapeutic journey.

For this purpose we also developed a series of short comic strips to try to visualise how the service might look and feel and be experienced at the level of key moments in the journey.

These touchpoints are explored in the illustrations in the following pages. They feature some of the personas of young people who we created earlier in the co-design process and the ways in which the service might interact with them.



1 Soft entry Youth Centre

2 Referral Pathway post Crisis

3 Self-referral

4 Shared Care

5 Stepping Back

Lenny, Age 14 | **Jas, Age 19** | **Max, Age 15** | **Ash, Age 18** | **Lenny, Age 14**

1 Soft Entry Youth Centre (Lenny, Age 14)

Lenny is 14. He has difficulty concentrating. He forgets instructions which makes school hard.

He often gets frustrated and gets into arguments which makes it hard to maintain friendships. This effects his self-esteem.

He has been in trouble with the police a couple of times. His Dad is very disappointed, and he feels bad about that.

He loves to play basketball at the local youth centre. Sport offers a way to interact with clear parameters.

The youth worker at the centre notices that Lenny struggles to concentrate and seems to get into a lot of conflicts. They chat about it a bit.

The youth worker asks if Lenny might like to talk to a free mental wellness professional and get their opinion and maybe some help to make his life easier. Lenny agrees.

The youth worker calls Amber Youth Wellness and they fill out the referral form together. They need Lenny's parents' permission. They know Lenny needs help and agree.

The psychologist meets them down at the youth centre for a chat. Lenny asks the youth worker to stay for the chat, for moral support, which gives him the confidence to talk about what is happening for him.

2 Referral Pathway Post Crisis (Jas, Age 19)

Jas is a 19 year old uni student. She has been having nightmares and panic attacks. She quit her job and has been missing classes, withdrawing from social situations.

Jas presented to Emergency Department after an overdose of a low toxicity substance. She was scared and remorseful. They kept her overnight.

The hospital discharge nurse suggests some follow-up mental health support. Jas feels sheepish but thinks it may help. After a quick call, they fill out a referral and send it along with the hospital's assessment paperwork.

Jas gets a text confirming the referral has been received and that someone will be in contact by the next day to follow up.

The next day, Jas gets a text asking if it's a good time to talk and if she's rather talk on the phone or meet in person. She is ready to talk and ok with a call, so she texts back "ok to chat now."

A worker calls and they have a brief chat about what's been happening. They make a time and place to meet up to talk in a bit more depth. They offer a peer worker to come along for the first session and she says yes.

The next week, following a reminder text, Jas shows up at the local library at the agreed time. A friendly young woman (the peer worker) introduces herself and the psychologist. They move to a private meeting room and listen to her story and ask some clarifying questions.

They put together a safety plan and suggest a follow-up to delve into a couple of things over the next 2 weeks. They give her some useful things to take away from the first session, including an info pack and some exercises to do at home.

3 Self-Referral (Max, Age 15)

After her parents breakup, Max and her Mum moved to Perth to be close to Mum's family. Max hasn't been going to school and feels empty, sad and bored. She has been crying for no reason, not sleeping at night and sleeping all day. She binge eats and then feels guilty.

There have been several deaths in her family lately and she has been smoking cannabis to numb the sadness.

Her Mum is worried about her. She isn't sure if this is something serious enough to get help for. Some cousins mention a youth wellness service that has helped them get through a rough time.

She does some googling online. She finds Amber Youth Wellness and does a self-survey. The result suggests she contact the service for a chat.

She feels nervous about phoning the service, so she sends a message. Someone messages back to make a time to chat that afternoon.

The worker calls and asks what's been happening. They listen and take her experiences and feelings seriously. Max asks about what options are available, and if her mum can come with her to an appointment.

The worker thinks the service might be able to help. They make a time/place to meet that works for Max. The worker sends an appointment confirmation text which has details how to reschedule if she needs to.

Max feels relieved having talked to someone and had her feelings taken seriously by a professional. She tells her mum, who is glad she has sought help and agrees to go to the appointment with her.

4 Shared Care (Ash, Age 18)

Ash is 18. After she left her violent boyfriend she has lived in supported housing. She uses alcohol and drugs to cope with the voices she hears, and worries that this will effect her ability to keep her job. She knows she needs help.

With the help of her Housing Support Worker, Ash contacts Amber Youth Wellness to see if she can get some help with her mental health.

They set up a meet and greet, and as part of the conversation, the worker asks if she is getting support from any other services.

Ash tells the worker about the Housing Support Worker and also her Alcohol and Drug Counsellor who is helping her manage her drug and alcohol use.

The worker gets Ash's permission to contact them to work on a shared care plan. She agrees. They offer for her to bring a support person or have a peer worker there for moral support.

On the day of the meeting, Ash brings her older sister for support. Her Housing Support Worker, the Alcohol and Drug Counsellor and the Mental Health Worker are all there.

They ask Ash who she would like to have as her main contact. She chooses the Housing Support Worker because they already have some rapport.

They ask Ash what would be the most useful and important thing she would like to work on first. They all agree who will do what, how they will share information with each other and what approach works for Ash.

5 Stepping Back (Lenny, Age 14)

Lenny has been having sessions with his clinician every fortnight for about 12 months.

Lenny is doing a lot better. His emotional regulation is good. He is taking meds, which is helping. He is doing better at school and his family relationships seem to be getting better.

At their 3-monthly review, the clinician congratulates Lenny on his progress, and checks if he feels the sessions are still needed.

Lenny is feeling positive, feeling much more stable and on top of things. But he feels unsure about stopping the sessions altogether.

The clinician provides options for Lenny to gradually step back. They step back to monthly meetings to work on some last coping strategies. The family come to some sessions to get ready to support the transition and do some self-care planning.

He explains that this isn't an abrupt exit. There are options for refresher sessions or to come back later if Lenny's wellness takes a dive, which is perfectly natural.

He also explains that Lenny can still stay involved in the peer activities if he wants to.

Lenny feels more secure knowing he has the option to come back. He feels a sense of achievement and optimism finishing this period of formal support and is ready to move forward.

Evaluating the Co-Design Process

The co-design process was evaluated by working with an independent evaluation consultant, Dr Rachel Skoss from Telethon Kids Institute/ University of Notre Dame Australia.

Participant surveys were collected and analysed for each of the co-design workshops. This included a total across all three workshops of 66 responses, with 15 from young people, 31 from service providers and 20 from others. (Others include staff from MercyCare, the funder, WAPHA, and Peak Bodies.)

Overall, participants were highly satisfied across all three workshops, with only three participants reporting any negative responses across all 15 rated survey questions.

The way different views were managed received the highest rating with 98.5% of respondents across all cohorts and all three workshops reporting they were satisfied or very satisfied with this.

Not one young person who responded across any one of the three workshops gave a single negative rating to any of the 15 rated survey items and there were only two responses of 'neutral', both being about satisfaction of the workshop location.

Young People gave the highest ratings to the items:

- the environment provided was welcoming (71% strongly agreeing and 29% agreeing)
- the way different views were managed (80% very satisfied and 20% satisfied)

Service Providers who responded across any of the three workshops gave the highest ratings to the following items:

- the explanation for why you at the workshop (70% very satisfied, 27% satisfied)
- the way different views were managed (84% very satisfied, 13% satisfied)
- I felt comfortable sharing my opinions (68% very satisfied, 29% satisfied)

Verbal feedback from the Co-design #3 Workshop included the following comments:

- "I have been surprised by the amount of level playing field dialogue." (young person)
- "Because the service is starting from scratch it has been nice to influence a new build rather than doing renovations to an old building." (young person)
- "MercyCare not being a mental health provider has been an advantage to this process. The process has been infused with the understanding that its about a young person's life, not just their mental health. It can be difficult sometimes for mental health to see itself in the backseat and not the drivers seat." (funder)
- "Having so many different types of people involved has produced such a good quality service and helped shape it and make it inclusive." (young person)
- "We need to be bold and unapologetic about providing a quality service. This needs to be balanced with advocacy for resourcing to increase the number of places." (peak body)
- "This is some of the best co-design happening right now. We need to capture it as a case study and make the case for more co-design of this quality." (other service provider)

MercyCare's Amber Youth Wellness

An evaluation framework was developed by Dr Rachel Skoss, with feedback from both the project design team and project funder. Rachel observed a co-design workshop, conducted interviews with design team and other stakeholders, and reviewed project documentation and communications.

Initial stakeholder engagement was broad within the health, mental health, youth and homelessness services, and targeted engagement occurred with specialist CaLD, ATSI and Carer groups. Many of the young people engaged identified as ATSI, CaLD, and/or LGBTIQ, providing additional insight from these perspectives.

Further targeted engagement during the service implementation phase may be required with service providers, peak bodies and consumer groups in the disability sector given the prevalence of mental health issues in young people with developmental or intellectual disability, to identify core-competencies that may be required to work with this cohort.

The co-design process utilised the existing data and models of 'best-practice' care, together with the insight and experience of multiple stakeholder groups to develop common-understanding and clearly define the boundaries of the process. Activities across the three workshops ensured that assumptions were adequately tested, and that key elements of the model and desired service journey were identified.

Proto-type service models were tested with a mixed stakeholder group. The iterative process allowed key stakeholders to inform the development of the service model, with all perspectives adding value to the decision-making regarding service design. Stakeholders identified the benefit of including the program funder in the co-design process.

The co-design process was undertaken in a collegial environment, and the expected tensions between different stakeholder perspectives were very well managed. There was a high level of energy and optimism from stakeholders involved. Importantly, young people with lived experience of mental health issues were a critical voice in the engagement and were well supported through their involvement.

Rachel will also work with our in-house Outcomes Specialist to develop a process evaluation framework for the new service to support the implementation and embedding of the service and identify potential areas for quality improvement. The framework will also inform program monitoring and outcome reporting.

Opportunities for the Sector

During the co-design process, a number of broader themes emerged which could be useful for the youth mental health sector.

While they were opportunities outside the scope of this project, we did not want them to be lost. These included:

- Opportunity to advocate for a more co-ordinated intake through a centralised point (whether a physical point or a virtual phone/online intake).
- Opportunities for collaborative triage/intake when it is not clear which service will best suit the young person's needs.
- Opportunity for common assessment scaffolding process for services to use.
- Opportunity to be more intentional about forming a shared care team with young people and other services they are working with.
- Opportunities for better protocols and practices for shared care across the sector/s.
- Opportunities to showcase this project as a case study and to advocate for resourcing of further co-design projects.
- Opportunity to advocate for more places and suitable service provision to meet the shortfall for young people experiencing significant mental health challenges in WA.

As a result of this project, both formal and meaningful partnerships have been developed between MercyCare, Derbarl Yerrigan, Orygen, Mission Australia and Australian Childhood Foundation we are excited to develop new partnerships in the near future.

We have also been working closely with Black Swan and Youth Focus' headspace centres to ensure a smooth transition of consenting young people who were working with headspace plus into Amber Youth Wellness.

It was heartening to hear stakeholders referring to the Amber Youth Wellness model as something **we** (collectively) had developed and that **we** (collectively) would be delivering. It is our hope that this sense of shared ownership will carry forward into the implementation. We are committed to being worthy custodians of this model which has been co-designed through the combined expertise of young people, researchers and service providers from all walks of life.

MercyCare's Amber Youth Wellness

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