Mental Health Advocacy Service: Young People Priority Framework

What works? What doesn't work?

Information provided to the Mental Health Commission : 15 September 2020

NOTE: The following information is based on positive feedback from consumers and their carers regarding what they have told Advocates works and what isn't working. The exclusion of programs from this list does not indicate they do or don't work. MHAS is forwarding information based only on consumer feedback and it has not done any independent study or inquiry.

WHAT WORKS ACCORDING TO FEEDBACK FROM CONSUMERS, FAMILIES AND CARERS:

1. *Hollywood Hospital Youth/adult therapeutic Day Program for Eating Disorders*

Cohort: youth to adults 16+ with eating disorder. Referral criteria includes: must be a voluntary patient, BMI 16+, have private health insurance or fully self-funded

https://www.hollywoodclinic.com.au/Programs-and-Therapies/Eating-Disorder-Programs/Eating-Disorder-Day-Patient

Intensive therapeutic support once discharged from hospital or whilst accessing services in the community to prevent admissions. Positive feedback from consumers but with waitlist. Consumers must be voluntary and have adequate private health insurance to enter the program. This program excludes patients on a Community Treatment Order or without private health insurance.

2. *Touchstone Program (run by the Child and Adolescent Mental Health Service (CAMHS)) - providing intervention for EUPD and self-harm behaviours*

Cohort – Adolescents (13-17yo); Referral from- Community CAMHS clinics

The full therapy program consists of case management, individual, group and family therapy as well as occupational therapy, community outings and creative therapies. Young people attend for at least three days of the week for six months, with onsite school sessions as part of the programme. Currently Long waiting lists and some patients must travel considerable distances to attend the program based in Bentley.

3. *72-HR Crisis admissions at Fiona Stanley Hospital (FSH) Youth Unit and East Metropolitan Youth Unit (EMYU)*

Fiona Stanley Hospital Youth Unit- Patient Controlled Crisis Admission Plan (PCAP).

Cohort 16-24yo; Referral criteria: via Emergency Departments, planned admissions via Community Mental Health services

Admission Criteria: EUPD, EUPD traits, accessing Community Mental Health Services, history of extended hospital admissions with dependency on admissions for care needs. Often utilised to support young people to manage escalating feelings of self-harm and suicidal ideation.

Access to 72-Hr crisis admissions is viewed positively by youth consumers and can contain a youth during a crisis but is also long enough to allow for engagement with the therapeutic team, individual

therapy sessions (which establishes over the course of multiple crisis admissions) and to attend some inpatient groups / activities.

[Note PCH currently offers 48 hrs crisis admissions)

East Metropolitan Youth Unit- 72-HR Crisis Admissions

Cohort 16-24yo; Referral criteria: via Emergency Departments, planned admissions via Community Mental Health services

Admission Criteria: EUPD, EUPD traits, accessing Community Mental Health Services, history of extended hospital admissions with dependency on admissions for care needs.

Access to 72-Hr crisis admissions is viewed positively by youth consumers and can contain a youth during a crisis but is also long enough to allow for engagement with the therapeutic team, individual therapy sessions (which establishes over the course of multiple crisis admissions) and to attend some inpatient groups / activities.

4. ***Youth Community Assessment and Treatment Team (YCATT)***

Cohort: 16-24 in South Metropolitan Service catchment; Referrals: self-referral, GP referral, referral by a Community Managed Organisation via a school, preferably by the school nurse or psychologist.

Exclusion criteria: Youth already active with government mental health services (CAMHS, Youth Axis, Youth Reach South, Youthlink, local government adult mental health services).

Community outreach, client centred, recovery focussed service. Services include, assessment, case management, a range of interventions, school liaison and community mental health liaison.

5. *Youth HITH*

Cohort: 16-24y residing in North Metropolitan Health Service catchment who are mentally unwell and are willing to be treated at home rather than in hospital. Individuals should have stable accommodation.

Referrals: Community Mental Health Clinic, Emergency Department or an Inpatient unit.

http://www.nmahsmh.health.wa.gov.au/services/youth_yhith.cfm

The Youth Hospital in the Home (YHITH) provides care in the patient's home that would otherwise be delivered within a hospital as an inpatient. YHITH provides clinical services and actively facilitates access to additional community services. YHITH clinicians work in partnership with the individual and their families or carers for around 14 days to provide intensive support, education and guidance to all parties. Where possible, clinicians work with the patient's general practitioner (GP) to enable maximum communication and continuity of care

6. *EEP programs / Early Intervention Psychosis Service /programs*

Early Episode Psychosis (EEP) Programs are in the adult and youth space. Currently children in CAMHS with Early Episode Psychosis receive treatment as part of the regular program.

Cohort: 16-35yo in health service catchment (North, South and East Metropolitan Services)

EIPS / EEP focus on providing individualised, comprehensive care for young people with psychosis and their families. The service promotes recovery and self-sufficiency and facilitates the uptake of social, educational and employment opportunities.

7. *Multi-Systemic Therapy- (Specialised CAMHS)*

Cohort -11-16yo; Referral- Community CAMHS clinics, Specialised CAMHS services and CAMHS Inpatient Unit.

Multisystemic therapy (MST) is an intensive four to five-month intervention helping families with young people aged 11 to 16 years experiencing serious behavioural and mental health problems, who are at risk of:

- chronic mental illness including substance abuse
- out of home placements due to family conflicts
- expelled from school due to violence or truancy
- involvement with the police and juvenile justice system

Clinicians meet with parents and carers in their home about three times per week, including after normal work hours to ensure parents are engaged with the process. MST provides families with communication and problem-solving skills they need to better manage their own problems. Typical family goals include keeping the young person in school, not breaking laws, and living at home with less conflict

8. ACIT/ART

Acute Community Intervention Team (ACIT) provided 6-8 weeks of intensive care in the community and Acute Response Team (ART) provided support in emergency departments (EDs).

The services were devolved in 2016. See the 'Post- implementation Review : Integration of Acute Response Team (ART) and Acute Community Intervention Team (ACIT) into Community CAMHS' -

https://healthywa.wa.gov.au/~/media/Files/Corporate/general%20documents/CAMHS/ARTACITReport_May19.pdf

Cohort: <18yrs

Both these programs with devolved and services distributed to local Community CAMHS in 2016. We understand there were various drivers for these services ceasing but consumer and clinician feedback to MHAS has been that ACIT and ART were valued services by consumers that provided follow-up and intensive support following Emergency Department presentation until the Community CAMHS could provide appointments. One of the recommendations of the post-implementation review (see link) is that CAMHS seek additional funding to deliver an intensive and assertive assessment and intervention service, including after-hours support for those children and young people who need more care than it is usually possible to provide within the CAMHS settings.

9. YPECN – Young People with Exceptionally Complex Needs (Department of Communities Program)

Cohort: child (usually 10-18 yrs) with a complex presentation, usually disability, mental health and child protection matters.

Based in the Department of Communities. This service provides case management process to coordinates services across multiple sectors for Young People with Exceptionally Complex Needs (YPECN). This model has improved significantly since its inception and MHAS has observed YPECN coordinators facilitate highly effective collaboration between services including community mental health services, acute inpatient services, disability services, child protection and accommodation service providers. Due to the increase in demand and referrals to YPECN (and their limited capacity), the Department of Community established the *Other Young People for Discussion Committee. This committee* can provide case specific advice and recommendations to services in lieu of not begin able to access YPECN.

10. DBT – Dialectal Behaviour Therapy

Cohort: varies depending on service providing DBT; Referral: varies depending on service providing DBT. DBT Teen is self-referral or GP. Services in HSP's typically require referral from Community Mental Health Service.

DBT is evidenced based and most Health Service Providers run this program but there are too few running with long waiting lists. DBT-Teen is also run out of LifeLine WA and Hollywood clinic.

11. Centre Clinical Interventions (CCI)

Cohort: >16yo; Self-referral, GP, Community mental health services or acute mental health services.
https://www.cci.health.wa.gov.au/

This service is said by consumers to work well and is highly regarded but is underfunded which reduces it scope and consequently has long waiting lists. Evidenced based treatments included CBT and FBT.

WHAT DOESN'T WORK ACCORDING TO CONSUMER, FAMILY AND CARER FEEDBACK

1. *Transitions from inpatient admissions to community mental health services*

Inpatient admissions include admissions to mental health units, medical wards and Emergency Departments. Consumers and carers frequently feedback that following discharged from hospital, they may need to wait many weeks for a follow-up Community CAMHS appointment. The lengthy wait for an appointment often results in the young person re-presenting to Emergency Departments, as the young people seek support for their mental health. Consumers frequently report cycles of fragmented care between Emergency Departments, inpatient admissions and community services.

2. *Emergency Departments' capacity to support people in crisis presenting with suicidal intent / ideation and EUPD (EUPD traits)*

Increasing numbers of children are presenting to ED's seeking an inpatient admission to PCH, FSH Youth Unit or East Metro Youth Unit. Most days there are waiting lists for children to be admitted to all these inpatient units, with some children waiting many days in ED before a bed is available. ED capacity issues include:

- Holding children for extended periods in ED's creates risk, as EDs are not secure nor therapeutic environments; in fact they are highly stressful, busy, environments that can worsen a child's presentation. It is not uncommon for children to abscond from the ED whist waiting for admission to an inpatient bed.
- Lack of knowledge and skills in managing acute suicidal risk and people with EUPD (and EUPD traits).
- If discharged from ED, due to lack of inpatient beds, there is often a wait for the follow-up Community CAMHS appointment.

3. Services for people with EUPD

No early intervention program for emerging EUPD to prevent and redirect trajectory. Currently these consumers are accessing Community Mental Health Services but there is variable expertise with this group of young people. Current management is inconsistent and access to DBT is variable. They often end up in ED's because there is nowhere else to go and face issues of stigma and lack of understanding and training by ED staff.

4. *Community CAMHS*

Community CAMHS is underfunded, overstretched, with long wait lists and delays for appointments and variable capacity to provide ongoing long-term intervention for some children/youth need.

- CAMHS has reduced capacity to provide ongoing therapeutic treatment for young people with more chronic needs.
- CAMHS will frequently discharge children if they won't 'buy-in' to therapy. Consumers report that CAMHS need to reconsider its approach with children who experience challenges with engagement. These children may take longer to engage, and an individualised approach needs to be considered in understanding underlying factors contributing to poor engagement.
- Consumers and carers have reported that some CAMHS need to improve engagement of children who have developmental challenges, trauma history, attachment difficulties or loss of trust in services / systems.
- Limited early intervention services as Community CAMHS primarily focus on acute community patients, due to risk. The limited focus on early intervention and prevention results in children developing more entrenched, chronic mental health problems that become more difficult to treat.
- CAMHS needs to support clinicians to develop knowledge and skills to support children / youth with co-morbid presentation such as developmental challenges and emerging mental health issues.

5. *Services for children/youth with dual diagnosis*

Co-morbidity of developmental disability and mental health presentation. Next to no capacity for inpatient services to conduct differential diagnosis of children/youth with developmental disability and mental health presentations. Often discharge with lack of clarity regarding dual diagnosis and required to wait many months for referral to community services for assessment. Poor access to neuropsychiatrists in the child/youth sector for Further Opinions. Often there are dividing opinions between services regarding the basis of the child's presentation which impedes collaboration.

6. *Children with child protection needs and mental health issues*

There is inconsistent and at times poor collaboration across Department of Communities and Health (CAMHS, EMYU and FSH Youth Unit) with clear silos and significant challenges in collaborating or providing wrap-around approached for high risk complex children. MHAS Advocates can verify consumer and family/carer feedback in this regard. Youth Advocates spend a considerable amount of time facilitating engagement between the different services. Sometimes the family just needs Department of Communities support for a while but this can be hard to get; arguments between the agencies with each saying the other is responsible are not uncommon.

7. *Care for young people in regional areas*

There are significant challenges in providing equivalent care in the regions and often a lack of coordinated discharge planning involving local community mental health services in the regional areas.

8. *Prolonged admissions to acute inpatient units due to inadequate accommodation*

Examples include:

- When crisis accommodation is needed (usually an inappropriate option for children and youth who have just had an acute mental health admission) however it is often all that is available especially if Child Protection Services have refused involvement.

- Where accommodation is dependent on NDIS funding
- It is agreed that the child requires intensive 24-hour supported accommodation however the length of time to outsource and set up accommodation can prolong inpatient admissions if there is no safe option in the community.
- young people with no discharge address or comorbid issues (drug and alcohol) – the only specialised youth mental health service (NGATTI) has such restrictions as do the step up/step down services.

9. Services for young people with eating disorders

There are massive gaps in services for young people with eating disorders; readmissions to hospital are high but fraught with long delays as the youth units limit the number they will take. Currently there are limited mental health beds for youth (16-24yos) with eating disorders (4-beds State-wide: 2x at FHS and 2x at EMYU)

There is significant lack of specialised community services in the public sector.

10. Family and carer support and involvement

There is a lack of a holistic approach involving young people and their families / carers. Too often services do not demonstrate regard for the views of parents and carers as required by the Mental Health Act 2014 and do not include them in collaboratively planning processes. At the same time they often expect too much of them including organising family meetings at the last minute and without regard to parents/carers' other responsibilities such as work and caring for other children.

11. Treatment, Support and Discharge Planning (TSDP).

Lack of collaboration with the young person and their carers regarding TSDP during admission and at discharge. TSDP needs to be completed in collaboration with the young person (as it's their plan) and their family/carers (who have to deal with the discharge) but often this is driven by the clinician and treatment team. Safety plans are also often poor and done at the last minute or sent after discharge.