Mental Health Council OF TASMANIA

Tasmanian youth-mental health forum

# Briefing Paper

Mental Health Council of Tasmania

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# 1. Background

The Mental Health Council of Tasmania (MHCT) partnered with Primary Health Tasmania (PHT) and the Tasmanian Department of Health to deliver the *Tasmanian Youth Mental Health Forum: Exploring Integration and Innovation* on 6-7 November 2019.

In a complex policy context including current work by the State Government's Southern Mental Health Integration Taskforce and the development of a joint State and Federal Government Mental Health and Suicide Prevention Plan, this Forum was arranged for the Tasmanian mental health sector to facilitate meaningful engagement in, and consideration of, recent trends identified in youth mental health including:

- Lack of awareness of appropriate services and support available;
- Increased demand for and on youth mental health services;
- Young people presenting more acutely unwell; and
- Increased funding and services for young people.[1]

# 2. Forum participants: key partners in co-design

The Forum brought together key decision makers, policy makers, practitioners and service providers in youth mental health. In an invitation-only structure, MHCT prioritised attendance of leaders and decision-makers across the breadth of the Tasmanian mental health sector, including leading representatives from the public, community-managed and private mental health sectors as well as state and federal government agencies. A full list of participants is available from MHCT.[2]

Forum participants were actively engaged in knowledge-sharing and capacity-building at the Forum. Their views, informed by their significant knowledge and expertise, were central to ten of the eighteen Forum sessions. Forum presenters held the floor for eight sessions while Forum participants led and shaped discussion during six Q&As, two co-design sessions and two co-design presentation sessions. Forum participants' voices were critical in guiding, framing and informing Forum discussions and suggested outcomes.

MHCT used technology to increase participation beyond its usual limits. The use of the online platform Slido enabled all participants to upload questions to presenters at any time. Once uploaded, these were public; others could 'up-vote' a question to indicate a 'seconder'. Some questions attracted numerous up-votes, which pushed them to the top of the Slido list. This enabled the Forum facilitator to prioritise questions of interest to the most participants. The use of Slido was a useful counter to common participation barriers,[3] and Q&A sessions were lengthened to allow the greatest possible opportunity to engage presenters on relevant themes and elucidate specific points of interest.

In relation to co-design sessions, MHCT carefully curated each co-design group to include a diversity of voices. This provided strong structural support for balanced, non-partisan approach that resulted inclusive, considered work that was well-integrated across different sectoral streams.

In short, Forum participants comprised skilled and experienced leaders in the Tasmanian youth mental health sector. Informed by the expert knowledge of presenters, participants effectively shaped the Forum's discussions with the help of mechanisms that were intentionally used to strengthen engagement. This ensured the strongest possible sectoral ownership of outputs from the Forum.

[1] As identified and discussed in the Tasmanian Youth Mental Health Forum *Booklet* (Mental Health Council of Tasmania, Primary Health Tasmania, Government of Tasmania, October 2019.

[2] Please contact MHCT for further information.

[3] Participation barriers commonly encountered at conferences and fora are timing issues (attendees think of a question *during* a presentation, but cannot recall their question *after* the presentation, when questions are sought) or shyness (attendees want to ask a question but feel embarrassed speaking in from of the entire audience).

## 3. Presenters and Panel Discussions

The following table lists presenters, panellists and topics of presentations and discussions at the Forum:

| Session | Presenter/ panellist | Topic |
|---|---|---|
| Session 1 | Ms Leanne McLean, Tasmanian Commissioner for Children and Young People | Commissioner's key findings for 2019 |
| Session 2 | Dr Kelly Shaw, Primary Health Tasmania | Young people in Tasmania: what does data tell us? |
| Session 3 | Mr Matthew Etherington and Ms Hannah Godfrey | Lived experience of young people |
| Session 4 | Dr Joanna Henderson, Executive Director, YWHO, Ontario | YWHO: an approach to integration |
| Session 5 | Mr Jeremy Harbottle, Department of Health (Tas)<br>Mr Grant Akesson, Primary Health Tasmania<br>Dr Aaron Groves, Tasmanian Chief Psychiatrist | Working together toward integration |
| Session 6 | PANEL:<br>Dr Clare Smith, GP, Kingston<br>Prof Jane Burns, Swinburne University<br>Ms Tania Hunt, CEO, YNOT<br>Ms Connie Digolis, CEO, MHCT<br>Dr Joanna Henderson, ED, YWHO, Ontario<br>Mr Matthew Etherington, lived experience speaker<br>Dr Kelly Shaw, Primary Health Tasmania | Reflections on integration |
| Session 7 | Participant co-design session | Identifying integration challenges and opportunities |
| Session 8 | Dr Catherine Spiller, Primary Health Tasmania | The *HealthPathways* Project |
| Session 9 | Prof Jane Burns, Swinburne University | Innovation, technology and youth mental health |
| Session 10 | George Scott and Angus McMaster, student mental health contact officers, The Hutchins School, Hobart | How peer models complement an integrated approach |
| Session 11 | Dr Joanna Henderson, Executive Director, YWHO, Ontario | The YWHO Ontario youth peer support model |
| Session 12 | PANEL:<br>George Scott and Angus McMaster, student mental health contact officers, The Hutchins School, Hobart<br>Mr Matt Magnus, School Counsellor, The Hutchins School, Hobart<br>Dr Joanna Henderson, YWHO, Ontario<br>Ms Tania Hunt, YNOT | Peer models |
| Session 13 | Participant co-design session | Development of Priority Actions from Forum |

Brief summaries of presenters, topics and key points are provided for reference at Appendix 1.

## 4. Key Themes

Several key themes emerged through forum presentations, Q&A sessions and participant workshops. These are listed as themes 1 – 6 below, which combine to create a vision of a successful, integrated youth mental health system, as discussed below.

### Theme 1: System integration – focus on common goals

Key points for consideration in building an integrated youth mental health system include mandated data flows that have consistent datasets across the sector (Shaw). To aid system integration, existing relationships between organisations and individuals should be leveraged, as these are central to a collaborative approach (Henderson). Partners in integrated systems may experience clashes of organisational culture or may be resistant to change. The key to overcoming these issues is to agree on a shared intent and build a set of common goals. In this way, if clashes arise, the focus can return to the shared intent and common goals, which are more important than divergences between partners (Henderson).

It is important to include current organisations and services that are working well in any new integrated model; there is no need to 'reinvent the wheel' (Henderson). Tasmania could usefully draw upon working integrated youth mental health system models in other jurisdictions, for instance, in Ontario, Canada (Henderson). Integration should build on existing strengths and add new ones to compound the benefits. Other aspects of an integrated system that were agreed between all presenters, panellists and participant groups were the importance of the system being holistic (treating the whole person, rather than focusing solely on mental ill-health) and integrally connected to and embedded within the community, with a focus on re-establishing community connections where these were missing.

## Theme 2: The need for a 'one-door' or 'every door is the right door' approach

Presenters, panellists and participant groups all identified easy accessibility (preferably through a 'one door' or 'every door is the right door' approach) as critical to an integrated youth mental health system. Presenters agreed it was critical to design simpler pathways for young people to navigate youth mental health services. It was also critical that better navigational pathways be provided to help GPs, primary health workers and families so that they could provide better support for young people. There is an urgent need to provide a service to assist Tasmanian GPs, to support appropriate referrals and to provide specific service information (Smith). PHT's *HealthPathways* tool (which includes all health services, not just mental health) is a model of a 'curated' online portal that reduces the complexity of the overcrowded service market by using subject matter experts to assess a wide range of tools and supports and recommends 'handpicked' services (Spiller). In this way it gives consumers some surety around quality and appropriateness of services. MHCT's proposed model for a Centralised Mental Health Access Service, co-designed by MHCT members, is also an example of how a 'one-door' approach might be achieved in the youth mental health system (Digolis).[4]

New Zealand has introduced a one-call service in which a single provider has been contracted by the government to aggregate all 'helpline' services; the company uses artificial intelligence (AI) to help its phone operators navigate the complex web of services in real time and provide consumers with one-call assistance (Burns).


*L – R: Angus McMaster, George Scott, Hutchins School student mental health contact officers*

[4] Please refer to MHCT's *Submission to the Tasmanian Government Review of the Statewide Mental Health Helpline and CATTs*, 2019.

## Theme 3: Importance of peer workers in youth mental health care

While MHCT has a standard definition of the term 'peer worker'[5], it was clear during Forum presentations that this term meant different things to different people:

- A person with lived experience of mental illness and recovery *(Etherington, Godfrey, Henderson, Digolis) who is a:*
    - Paid mental health worker *(Henderson)*
    - Paid or unpaid mental health worker *(other speakers)*
- A person of the same age as the person seeking mental health assistance, not necessarily with lived experience of mental illness and recovery *(Scott, McMaster, Magnus, Hunt).*

Peer workers were considered centrally important to an integrated youth mental health system. The Ontario model (Henderson) uses peer workers over the age of 18 as a central means of communicating with and providing appropriate services for their clients (Henderson). Generally, Forum presenters were highly supportive of the role of peer workers, both in providing empathic support and in modelling recovery models.

Additionally, 'age peers' (young people the same age as the person seeking mental health assistance, who have Mental Health First Aid training but may not have lived experience of mental illness) can be extremely beneficial within a school environment, where they are seen as a more approachable, 'safer' alternative when help-seeking than asking a teacher or other adult for help (Scott, McMaster). The Hutchins model of age-peer, student-led mental health assistance was received with great positivity by Forum speakers and participants, leading participants to use it as a model for one of the Forum's Priority Actions (see Section 5 of this Paper).

## Theme 4: Listening to and involving young people in system design, planning and operation

Presenters, panellists and participant groups all identified youth co-design and continued involvement as a critical part of designing an integrated youth mental health system.

Many speakers stressed the importance of direct consultation with young people in planning an integrated youth mental health service. It was critical to have young people 'in the room' to determine exactly what their needs were (McLean). In relation to design, implementation and operation of an integrated youth mental health system, it is critically important that young people are involved at every stage and at every level of the system, including the planning, design and construction of any new facilities, and the planning, design and rollout of programs and services (Henderson). Youth advisory boards should be established to guide project decisions at regional and local levels.

Young people should also be employed in paid roles and seeded through all developmental stages and delivery levels of an integrated youth mental health system where they are respected for their first-hand knowledge and experience of 'being a young person engaging with mental health services' (Henderson). It was also important to include a diversity of voices from young people.

During the Forum, it was clear that the word 'youth' meant different things to different people. It was variously defined as:

- People aged between 0 and 18 years *(McLean)*
- People aged between 16 and 24 years *(Shaw)*
- People aged between 18 and 24 years *(Shaw)*
- People aged between 12 and 25 years *(Henderson)*

## Theme 5: Importance of meaningful communication, greater choice and autonomy

Young people and older people often failed to understand each other to the extent that it sometimes felt like they were different species (Etherington). We need to enhance effective listening and communication between young people and older people (Etherington). Older people including teachers and parents have a responsibility to actively encourage and engage in effective communication with young people, and to plan for and provide appropriate space and time for this to happen. It is not enough to assume that a young person will speak about mental health issues;

[5] Peer Workforce Development Strategy, Mental Health Council of Tasmania, November 2019, p. 10

young people are inexperienced at help-seeking and are often deterred from help-seeking if a first communication attempt is unsuccessful (Etherington).


*L-R: Hannah Godfrey, Matthew Etherington*

Young people with mental ill-health often are not given opportunities to learn about and self-manage their mental health. When this happens, their right to exercise autonomy and choice in mental health care is reduced. Parents and/or carers may become over-involved in decision-making on behalf of young people; this can limit the young person's capacity to self-manage their own recovery. It is important to provide young people with enough information and support to enable them to actively participate in decisions to do with their care. Enabling them to do this is likely to increase their confidence and sense of autonomy (Godfrey).

## Theme 6: Importance of the first 1000 days of life: a prevention/early intervention approach

There is a growing volume of international evidence to support the view that experiences gained in the first 1000 days of a person's life (i.e., from birth to about three years old) are critical in shaping a person's lifetime risk of mental illness. This view has been firmly established within Australian mental health policy through the Productivity Commission's recent *Inquiry into Mental Health Draft Report*. While parents and caregivers could usefully be given more information and offered skill-building (Burns), it should be acknowledged that the rights of parents and carers of young children sometimes conflict with the rights of the child, which must be the primary and central focus of any 'first 1000 days' program (McLean). The sector must gear itself toward developing interventive mental health screening, assessment, care and support for very young children, potentially with reference to Early Learning Centres and Child and Family Health Centres (McLean, Burns).

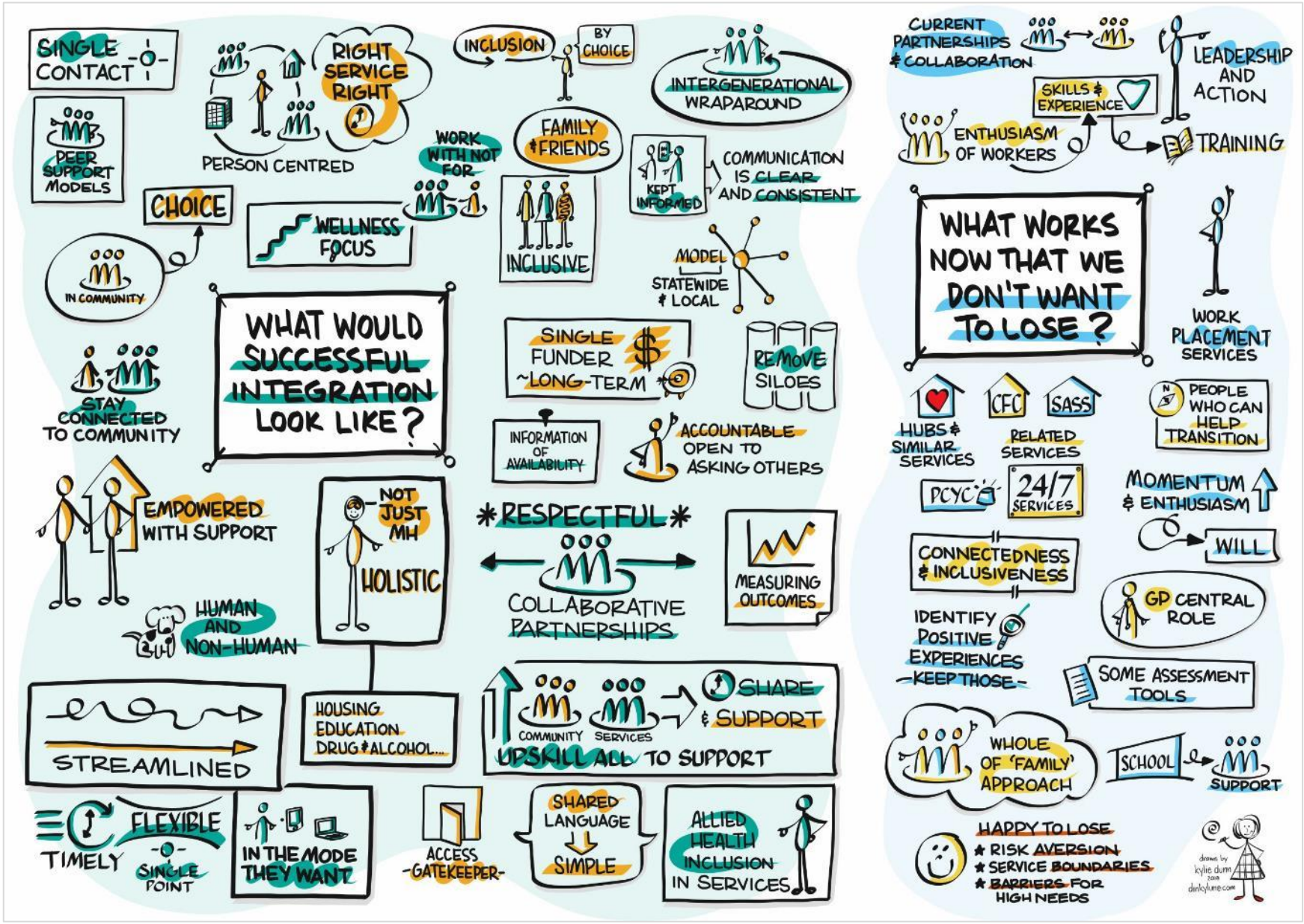
## Summary of Themes 1-6: A vision for a successful, integrated youth mental health system

Discussion during presentations and panel sessions at the Forum elicited that a successful, integrated youth mental health system would:

- **Be co-designed and planned with young people**, ensuring that their voices were heard (Digolis), and this approach should be used to design services and programs as well as physical spaces like hubs (Henderson)
- **Be easy to access**, with an 'every door is the right door' approach (Smith); it was noted the Centralised Access Service concept recently proposed by MHCT is a model for a 'one-door' entry into the system (Digolis)
- **Be equally accessible regardless of geographic location** (Smith)
- **Be holistic** and focused on 'wellness' rather than 'mental illness' (Henderson)

- **Include peer workers and culturally-specific services** at every level of the system (Digolis, Henderson)
- **Be integrally connected to the community** and should not separate young people from their communities. Rather, it should **address causal issues of isolation and lack of connection** (Burns)
- **Leverage existing physical spaces and health hubs in the community**, for instance, TheLink and YFCC (Hunt)
- **Be flexible enough to provide the right support** (or, person-centred support) including different support options, at the right time (Digolis), not just for different people but for the same person over time - noting that needs will change (Henderson)
- **Invest in young people**, viewing them as a valuable resource (Henderson)
- **Be creative** enough to encompass young peoples' ideas of new ways of delivering age-appropriate support (Henderson)
- **Provide more training and resources for general practitioners** to help them take a more active role in assisting young people. Young people often found the first disclosure of their mental health issues overwhelming; GPs could receive more training in how to manage such disclosures sensitively (Etherington) GPs should also be provided with a list of referral contacts for local, affordable programs for young people to provide more referral options than a Mental Health Plan (Smith)
- **Use innovative technology** to decrease administrative burden, improve data management and link people to services (Burns)
- **Use existing online platforms and train health professionals to use them effectively**, rather than creating new ones from scratch (Burns); for instance, the MeetUp app could be engaged to provide mental health support through community engagement (Smith)
- **Consider aggregating public initiatives upward**, so that (for instance) all stigma reduction campaigns join forces to create one clearly branded message. This would strengthen mental health messaging and mitigate the risk of 'white noise' (Burns).

*L – R: Connie Digolis, Jurek Stopczyski at the Youth Forum*




*Kylie Dunn, Visual Mapping of participant co-design session: Integration Challenges and Opportunities*

## 5. Priority Actions

Active participation by all attendees in Forum workshop sessions, together with strong attendee engagement in Q&A sections and in the framing and shaping of debate between and among the Forum speakers, resulted in the creation of 19 Priority Actions.

Participants were asked to consider and prioritise actions that:

- Have capacity to immediately improve young peoples' experiences of Tasmanian mental health care, and contribute to improved mental health outcomes for young Tasmanians;
- Could reasonably be implemented within 12 – 24 months;
- Could reasonably be implemented without significant net negative financial implications (although they may require remodelling of existing arrangements)
- Would support a central long-term goal of broader and deeper integration within and around Tasmania's youth mental health system.

*Wayne Frost, Forum participant*

The groups developed and discussed their ideas separately, then presented their top three 'draft actions' to the Forum. This resulted in 21 actions (three each from eight groups) which were condensed to remove duplications. This resulted in a list of 19 Priority Actions:[6]

### Actions 1 – 4: Tools and Resources

1. Commit to one set of assessment documents across the sector (online and paper-based) to be shared across services that integrates common language

2. Implement effective screening/assessment/triage tool to address waitlists – must incorporate regional community needs and services but have state-wide reach

3. All sector services to ensure their information is on PHT's *HealthPathways* and is kept updated.

4. Require funding contracts to include co-design, peer workforce involvement and multi-agency collaboration across health, housing, schools, welfare etc.

[6] Participants present at the time of voting were asked to nominate their top 5 actions. Actions 5 (59%), 6 (47%), 1 (38%), 7 (35%) and 12 (35%) gained the greatest proportion of votes.

### Actions 5 – 11: Programs and Initiatives

5. Trial and evaluate a school-based mental health support program which includes student mental health contact officers with Mental Health First Aid Training. Leverage Department of Education's Wellbeing Framework to trial a program in Tasmanian public and independent schools.

6. Centralised one-call service supported by a multidisciplinary team that helps consumers, families and service providers to navigate the range of mental health services (including an online option)

7. BE BRAVE - Trial Ontario model using existing successful services and hubs i.e Community Family Health Centres. Young people to drive the trial.

8. Education and childcare systems to lead increased focus on wellbeing including perinatal support (first 1000 days of life)

9. Guaranteed post-discharge follow up for mental health admission discharges AND emergency department presentations

10. Introduce funding for "care coordinators" to walk alongside a young person to help navigate a mental health pathway (consider peer workers)

11. Create a stronger focus on wellbeing as a core component of the Tasmanian community

### Actions 12 - 16: Partnerships and Collaboration

12. Collect input from young people – what do they want from mental health services and how do we know the service is effective? Use existing services and incorporate youth feedback.

13. Establish a community of practice with to inform and further develop ideas around the integration of youth mental health services, with the first action to be co-designing a Youth Forum to gain input from young people

14. Broker an agreed framework for progress with a shared vision, definitions and language, supported by a "backbone" organisation to guide this process.

15. Coordinate/aggregate youth mental health professional development, networking, learning and co-design events and opportunities (integrate existing activities)

16. Find Tasmanian youth who have experienced mental illness. Ask them to use their stories across services and youth spaces to highlight youth mental health.

### Actions 17 – 19: Research and Evaluation

17. Service mapping and evaluation to see what is working and where integration works well

18. Explore emerging technologies that support mental health and increase their use in mental health services

19. Create a survey for parents to better understand what they need to support their kids' mental health

## 6. Next steps

### Mental Health Sector Survey

As an outcome of the Tasmanian Youth Mental Health Forum, MHCT and PHT will partner to publish the *Tasmanian Youth Mental Health Integration Planning Survey*, to be distributed broadly through the Tasmanian youth mental

health sector in December 2019 with the support of Forum participants. This Briefing Paper will be made available to survey respondents to provide context for the survey questions.

It is expected that survey respondents will include (but are not limited to) private practitioners, public mental health service staff, government agency staff, community service organisation staff, GPs and clients.

Survey results will be collated, analysed and will contribute to the development of Tasmania's joing mental health and suicide prevention planning process[7], with the resulting Plan due for completion in 2020. The Plan will provide a strategy for the integration of Tasmania's mental health system.

### Community Sessions

As an outcome of the Tasmanian Youth Mental Health Forum, MHCT will deliver a comprehensive round of consultations in regional and rural Tasmanian communities that will work with Tasmanians to discuss youth mental health needs. These community sessions will take place in early 2020. These will include specific consultations with young people in line with a central tenet of Forum discussions, that young peoples' voices be heard, and that the views and ideas of young people are central to the development of an integrated youth mental health system.

Views raised during the Community Sessions will be used to inform the implementation of the actions in *Tasmania's Joint Mental Health and Suicide Prevention Plan.*

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## Appendix 1: presentations, panel discussions and co-design group work

### Leanne McLean, Tasmanian Commissioner for Children and Young People

Commissioner McLean raised the following key issues:

- Her brief included young people aged 0 – 18 years
- In order to plan mental health care delivery for young people, we need to have them 'in the room' (direct consultation)
- The importance of 'the first 1000 days of life' in shaping lifetime mental illness risk. Growing international evidence supports this and it was recently referenced in the Productivity Commission's draft Report. Understanding the significance of early-in-life mental health risk factors highlights the need to develop better interventive supports for very young children.

### Dr Kelly Shaw, Primary Health Tasmania

Dr Shaw presented data on young people aged 18-24, making the following key points:

- Data cannot be collected on people who do not present for treatment, therefore those people who do not present are not reflected in any datasets
- A survey completed by young mental health service users indicated that 20% of those users said their needs had not been met, with a further 22% saying their needs were 'partially' met. This was a disturbing finding and appeared to warrant more research into why services were not meeting the needs of that group.

### Matthew Etherington and Hannah Godfrey: Personal perspectives and lived experiences

Matthew and Hannah presented their lived experience as young people (aged 18-24) who had experienced mental ill-health. Key points included:

- Young people and older people often failed to understand each other to the extent that it sometimes felt like they were different species; a 'soundboard' approach was needed to facilitate effective listening and communication between younger and older people.

[7] Please refer to PHT's Factsheet.

- It is the role of older people, including teachers and parents, to use and foster effective communication and to actively involve themselves in assisting young people to speak about mental health issues. It is not enough to assume that a young person will speak up if they want to. Young people are inexperienced at help-seeking. This should be acknowledged and the onus for facilitating effective communication placed upon older people, who have the benefit of additional life experiences and skills.
- Young people with mental ill-health often lack opportunities to learn about and self-manage their own mental health. The right to autonomy and choice may be overlooked or not a feature of youth mental health care.
- Parents may be over-involved in decision-making on behalf of young people. This can limit the young person's capacity to self-manage recovery and actively participate in decisions around their mental health care.
- It is critical to listen to young people and to encourage them to articulate their views freely and in their own words, even if this is challenging to hear. Older people need to assume responsibility for enabling young peoples' views to shape decisions in planning and delivery of youth mental health care.

## Dr Joanna Henderson, Executive Director, YWHO, Ontario: An approach to integration

Dr Henderson described the development, trial and implementation in Toronto and three other Ontario jurisdictions of an integrated mental health system for young people aged 12 -25. Key features of the system included:

- Initial development of a shared intent between public, private and community-sector service providers, that included a set of common goals in relation to system integration and outlined the roles of all parties;
- Identifying key existing issues by asking young people about their experiences (strong service user pre-planning). Issues included discharge-related and age-related 'cliffs' (gaps in care), siloed mental health and substance use services and inappropriate care for individuals' age (i.e., 20-year-olds in child-oriented spaces full of Lego, or 18 to 25-year-olds placed in treatment centres filled with long-term service users who modelled recovery poorly).
- Asking young people what they wanted and needed from mental health care (strong service user planning). There was a strong desire for services to:
    - Be able to demonstrate success rates of specific treatments
    - Adapt service hours to meet the needs of young people
    - Introduce 'single-session solutions' as a walk-in service designed to assist a young person with an urgent, immediate problem
    - Have a separate needs-assessment process leading into longer-term care options
    - Co-locate wraparound services.
- During implementation, young people were centrally involved through:
    - Local and national youth advisory boards guiding project implementation decisions
    - Hiring young people as paid staffers and seeding them through all stages and roles (planning, design, policy, capital construction, programs, services).
- Youth peer workers (18 to 25-year-olds with lived experience of mental illness and recovery) with a significant role in multi-disciplinary practice. It was not considered appropriate to involve people under the age of 18 in peer work. All peer workers in the Ontario model have paid positions.

## Jeremy Harbottle (Tasmanian Department of Health), Grant Akesson (Primary Health Tasmania) and Dr Aaron Groves (Tasmanian Chief Psychiatrist): Working together toward integration

- To establish the current relative quantum of state and federal youth mental health funding, Grant noted that 35% of all PHT funding is currently directed into youth mental health services, while Jeremy referenced the Department of Health's flexible funding for the Child and Adolescent Mental Health Service (CAMHS) and specific funding provided to non-government service for young people as part of mental health services in the state.

- Policy drivers were the *Fifth National Mental Health and Suicide Prevention Plan*, the Tasmanian Government's *Rethink* Plan, the Tasmanian Government's Mental Health Integration Taskforce Report and the recently released *Draft Report* from the Productivity Commission's Inquiry into Mental Health.
- Grant described the work being undertaken in the Mental Health and Suicide Prevention planning process. The Steering Group is acutely aware of the work of *Rethink*, which will provide a strong base. They will also take into account more recent developments such as the creation of PHT, the work of the Integration Taskforce, and the upcoming evaluation of the Tasmanian Suicide Prevention Trial Sites. The intended outcome will reflect the combined priorities of both levels of government and provide a vision of systemic integration as a major new component.
- Dr Aaron Groves discussed the work of the Mental Health Integration Taskforce during 2018-19. The Taskforce had a brief to do what was possible within existing resources, although Dr Groves noted additional capital expenditure budget commitments and other resources that could be used to fund aspects of implementation. The Taskforce had recommended integration of the mental health system along both vertical (linkages with allied health care systems) and horizontal (linkages with other community sectors, i.e., housing, employment) axes. Other recommendations included an 'every door is the right door' approach; better collaboration between primary care and specialist care systems and services; and an integrated 'service hub' approach for Southern Tasmania. Support for the 'hub' approach was reflected in the Federal Minister for Health's announcement of the introduction of 100 integrated mental health hubs around Australia the weekend prior to the Forum. However, Dr Groves cautioned that 'total' integration is not achievable ("you can't integrate everything for everybody all of the time"), and that funding is needed to properly integrate services and processes.


*L – R: Jane Longhurst (facilitator), Kylie Dunn (visual note-taker), Dr Aaron Groves, Grant Akesson, Jeremy Harbottle*

## Panel Discussion: Reflections on Integration

Panel members:

- Ms Connie Digolis, CEO, Mental Health Council of Tasmania
- Mr Matthew Etherington, youth lived experience speaker, Tasmania
- Dr Joanna Henderson, Executive Director, YWHO, Ontario
- Ms Tania Hunt, CEO, YNOT? Tasmania
- Professor Jane Burns, Swinburne University, Victoria
- Dr Clare Smith, General Practitioner, Kingston, Tasmania
- Dr Kelly Shaw, Primary Health Tasmania

Panellists were initially posed the question "*In a perfect world, what would successful integration look like*?" Their dresponses demonstrated agreement on key tenets. A successful, integrated youth mental health system would:

- **Be co-designed and planned with young people**, ensuring that their voices were heard (Hunt, Digolis), and this approach should be used to design services and programs as well as physical spaces like hubs (Henderson)
- **Be easy to access**, with an 'every door is the right door' approach (Smith); it was noted the Centralised Access Service concept recently proposed by MHCT is a model for a 'one-door' entry into the system (Digolis)
- **Be equally accessible regardless of geographic location** (Smith)
- **Be holistic** and focused on 'wellness' rather than 'mental illness' (Henderson)
- **Include peer workers and culturally-specific services** at every level of the system (Digolis, Henderson)
- **Be integrally connected to the community** and should not separate young people from their communities. Rather, it should **address causal issues of isolation and lack of connection** (Burns)
- **Leverage existing physical spaces and health hubs in the community**, for instance, TheLink and YFCC (Hunt)
- **Be flexible enough to provide the right support** (or, person-centred support) including different support options, at the right time (Digolis), not just for different people but for the same person over time - noting that needs will change (Henderson)
- **Invest in young people**, viewing them as a valuable resource (Henderson)
- **Be creative** enough to encompass young peoples' ideas of new ways of delivering age-appropriate support (Henderson)
- **Provide more training and resources for general practitioners** to help them take a more active role in assisting young people. Young people often found the first disclosure of their mental health issues overwhelming; GPs could receive more training in how to manage such disclosures sensitively (Etherington) GPs should also be provided with a list of referral contacts for local, affordable programs for young people to provide more referral options than a Mental Health Plan (Smith)
- **Use innovative technology** to decrease administrative burden, improve data management and link people to services (Burns)
- **Use existing online platforms and train health professionals to use them effectively**, rather than creating new ones from scratch (Burns); for instance, the MeetUp app could be engaged to provide mental health support through community engagement (Smith)
- **Consider aggregating public initiatives upward**, so that (for instance) all stigma reduction campaigns join forces to create one clearly branded message. This would strengthen mental health messaging and mitigate the risk of 'white noise' (Burns).


*L-R: Jane Longhurst (facilitator), Clare Smith, Jane Burns, Tania Hunt, Connie Digolis, Joanna Henderson, Matthew Etherington, Kelly Shaw*

The Panel was asked, *"What services outside of the mental health sector should be part of an integrated youth mental health system?"*

- **Housing, drug and alcohol, and education services** should be primary targets for horizontal integration (Digolis, Burns, Henderson, Smith)
- **'Employment' should be understood as purposeful, focused life activity, and was critical** in this sense. This could include supported employment, establishment and staffing of social enterprises, study and other activities (Burns)
- **LGBTIQA+ community services** should also be considered for integration, as this community faced specific challenges of stigma and discrimination and showed demonstrably high need for services (Etherington).

The Panel was asked, *"What role does sport and recreation play, and how can people with a disability access these?"*

- **Sport is a central feature of Australian culture**; sportsgrounds are places where kids form core beliefs and values (Etherington)
- **Engaging with sport and recreation programs was critical** to provide ways for young people with mental ill-health to engage with others and to socialise
- **The YMCA is a great community resource**, readily available to users with various disabilities; the mental health sector should think about how to engage with community sporting organisations (Burns).

## Workshop session: Identifying Integration Challenges and Opportunities

Forum participants considered the questions, *"What would successful integration look like for (a) clients/patients; (b) families and friends; and (c) service providers/practitioners?"* and *"What is currently working that we would not want to lose?"*

Group responses have been collated, condensed and appear below underneath the respective questions.[8]

**What would successful integration look like for clients / patients?**

- Statewide model of care, but with regional needs considered
- Co-designed system and service/s
- One contact point, multiple service options - 'hub and spoke' network of interconnected services; a range of ways to access the contact point (hotline, app, face to face). For hotline, could use 'Strong Families Safe Kids' model
- System is responsive, timely, highly attuned to need
- System is holistic - treats the whole person
- Services listen and are flexible
- Services use shared language, so people understand what is happening, when and why
- Provide a list of horizontally integrated services available (housing, employment, education, etc.)
- 24-hour model with multiple workers and services
- Consumers stay connected to their communities with services available in the community
- Include peer workers ('someone to hold your hand during system navigation')
- Include pet-centred and/or animal-centred support
- Intergenerational wraparound services – upskilling families and community services
- System dynamics (relationships, partnerships) would mirror healthy interpersonal environments (the systems would model healthy family dynamics)
- Services are accountable for actions and outcomes.

**What would successful integration look like for families and friends?**

- Stepped model focused on keeping people well
- Inclusiveness for family/partners, but respecting consumers' rights to confidentiality/choice

[8] In several cases, several groups separately identified the same or a very similar point. Where this occurred, the point appears only once on the above list, so that duplications are eliminated.

- Services are well-matched to need, available when needed

**What would successful integration look like for service providers?**

- Single plan for mental health and wellbeing with a single funding base and longer-term funding agreements
- Service providers to be less 'siloed' and have better access to shared information
- Willingness to be curious
- Shared language between organisations
- Peer workers to be integrated into and across services; different peer models to be clarified
- Multi-disciplinary teams
- Partnerships with clarity on what, where, when and how things will be done, and by whom
- Respectful communication in relationships/partnerships
- Adequate tools/resources

**What would successful integration look like for communities**?

- Diverse needs of different communities are recognised
- Foster inclusiveness by strengthening culturally appropriate support
- Ongoing system engagement, co-design and feedback loops for the community
- Flexible system that adapts and responds to feedback
- Increased knowledge about services and greater service availability – community is educated to provide better support for the consumer
- Community understands service limitations (Tasmania's low population density, poor economy of scale, etc)
- System outcomes are measured at state level

**What is currently working that we would not want to lose?**

- Political will/appetite for change
- Youth engagement
- Local knowledge
- Sectoral commitment to achieve better outcomes
- Existing sectoral leadership and collaboration
- Current opportunities to work together
- Current training opportunities – invest in increasing these
- Workers' enthusiasm, passion, skills, experience
- Existing successful partnership models, connectedness
- Existing, effective community services (PCYC, TheLink, Lifeline), co-located service hubs, child services and programs, online resources, 'pockets of amazing work', positive outcomes in current system
- Whole-of-family approach to youth mental health services
- Multidisciplinary team approach
- Existing shared language and inclusiveness
- Capacity of current orgs with breadth of service provision to easily transition youth into adult services
- Existing, effective assessment tools

Some groups elected to answer the following question in addition:

**What do we need to lose?**

- Risk aversion
- Service boundaries
- Barriers for people with extreme disadvantage - 'below the cut-off' (lack of service responses due to other service non-responses – the example was given of a homeless person who could not access one service due to being homeless but could not be accepted into a housing assistance program because his mental health was too unstable)

## Dr Catherine Spiller, Primary Health Tasmania: The HealthPathways Project

Dr Spiller introduced PHT's HealthPathways Project, which has been operational since 2014. Key points included:

- Healthpathways is an online tool developed by PHT. It includes a website and online portal designed to be used by GPs and other primary health professionals. It must be localised and constantly updated to provide an effective and reliable resource.
- HealthPathways facilitates collaborative communication between primary health care workers and other people involved in a person's care, with the aim of creating better holistic care outcomes. It could be inclusive of mental health services but is mostly used to facilitate person-centred care in preparing a patient-centred, holistic hospital workup.
- It includes public, private, community-sector health providers and PHT-commissioned services but is not exhaustive (it does not list every single service on the market). Rather, it is a 'curated' presentation or 'field guide', put together by subject matter experts who determine the most useful and important resources to list. The 'curated' approach combats the issue of complexity. A User Guide is available.

## Professor Jane Burns, Swinburne University, Victoria: Innovation, Technology & Youth Mental Health

Professor Burns discussed her long involvement with Victorian youth social enterprise, Streat, and veterans' group, Open Arms, to contextualise her research into youth mental health.

Professor Burns' key points included:

- Australia's considerable investment in community awareness-raising mental health activities has helped to identify people at risk but has not changed methods of service delivery
- The sector should consider *"what does it mean to be brave? What does it mean to do things differently?"*
- Emerging technology provides significant capacity to deliver effective mental health support. Examples of technology-assisted mental health service delivery include:
    - *Appli,* a skill-building tool for young people to assist them to manage difficult emotions and situations
    - *MindRazr,* which links co-design with technology to encourage people interested in music to engage with mental health and wellbeing programs
    - *Young and Well,* a collaborative research project involving 75 partner organisations, 19 universities and young people with lived experience with the aim of translating emerging research into practice to create an evidence base.
- Emerging technologies can provide mental health support by matching people with health professionals and providing integrated platforms which support people to practice cognitive behavioural therapy (CBT) and emerging, evidence-based alternatives such as mindfulness. However, CBT was not always useful for people; many found the skills difficult to learn and people experiencing an episode of acute mental ill-health were unlikely to be able to use CBT skills.
- (In response to a question around online versus face-to-face care) As human beings, we like to connect personally –an initial face-to-face treatment session could be used to 'ground' a series of follow-up appointments so that a meaningful treatment relationship can be created, even in remote areas where access is difficult.
- (In response to a question on whether it was possible for the entire Tasmanian mental health web of services to use one information system) Yes – the work of Stuart Robert is a useful example. The technology exists to enable it. The real challenge is to convince organisations and systems to surrender 'legacy' systems, and be prepared to embrace change.

## George Scott and Angus McMaster: How peer models complement an integrated approach

George Scott and Angus McMaster, Year 12 students at Hutchins School, jointly presented a model of student-run peer mental health support developed at the Hutchins School, referencing their own roles as Mental Health Contact Officers. Key points included:

- The 'Hutchins model' is a student-initiated, student-led mental health student support service, in which

students with mental health concerns can approach and speak confidentially to Mental Health Contact Officers who are easily identifiable via a green ribbon pinned to their lapels.

- The model originated in a student survey that was conducted at Hutchins at the end of 2018. When asked *"If you were struggling [with a mental health issue], who would you feel most comfortable talking to?"* students overwhelmingly answered *"friends"* (as opposed to parents, family, teachers). This prompted George Scott, a Prefect with responsibility for the school's Mental Health portfolio, to ask the school to provide Mental Health First Aid training for himself and other students who volunteered. The program commenced with the support of Hutchins' school counsellor, Matt Magnus.
- Mental Health Contact Officers are student volunteers who have completed Mental Health First Aid training. They use their training to sensitively listen to and manage difficult conversations and encourage further help-seeking where needed. They also initiate approaches, using their training to inform decisions about whether to approach someone, why, and how.
- In addition to being available on an ad hoc basis, Mental Health Contact Officers also have a weekly lunchtime casual 'drop in' session (an engagement activity that provides a 'safe place' and counters bullying and social exclusion).
- Mental Health Contact Officers also have regular group debriefing sessions (equivalent to clinical supervision) with school counsellors in which they can bring up any issues and ask for advice.
- A recent student survey 'tested' the program. 66% of students said they would feel comfortable to approach a Mental Health Contact Officer and over 80% of students said that Contact Officers were a good idea, showing very high support for the model.
- In referencing 'peer support', the Hutchins model uses 'peer' to describe a fellow student (someone of the same age) who has training in mental health first aid. This is different from the usual understanding of 'peer support' in the mental health sector (a person with lived experience of mental illness and recovery).

## Dr Joanna Henderson, Executive Director, YWHO, Ontario: The Ontario Youth Peer Support Model

Dr Henderson expanded on her previous presentation to explain the specific role of peer workers in Ontario's integrated youth mental health system.

Key points included:

- There is emerging international evidence that engaging peer workers in mental health care increases positive consumer outcomes.
- It was critically important to approach youth peer worker planning and delivery in a thoughtful and highly intentional way, with particular attention paid to potential impacts of peer work on youth peer workers
- In Ontario's model, youth peer workers are young people between the ages of 18 and 25 with lived experience of mental illness and recovery. People under the age of 18 are not employed as peer workers.
- All youth peer workers have paid roles (it is not thought appropriate to ask peer workers to work voluntarily)
- It was necessary to provide youth peer workers with strong support and supervisory mechanisms, preferably including opportunities to continually increase their skills, training and self-awareness. 'Shadowing' training, where a trainee accompanies an experienced youth peer worker and learns 'on the job', is an important part of peer worker training. It was also important to give youth peer workers a strong grounding in self-care.
- Issues of stigma, discrimination and compensation liability present potential challenges that can be successfully mitigated by paying attention to the workplace into which peer workers will be introduced and addressing any negative attitudes from existing staff. This must be undertaken *prior* to the introduction of any peer workers.

## Peer Models: Panel Discussion

Peer Models Panellists:

- Mr George Scott, Mental Health Contact Officer, Hutchins School, Hobart
- Mr Angus McMaster, Mental Health Contact Officer, Hutchins School, Hobart
- Mr Matt Magnus, School Counsellor, Hutchins School, Hobart
- Dr Joanna Henderson, Executive Director, YWHO, Ontario
- Ms Tania Hunt, YNOT? Tasmania

Question to Matt Magnus: *"What could replicate your model at other schools?"*

- The weekly meetings between leaders and fortnightly meetings with all contact officers – this creates the basic supervisory support structure around which the model is built.

Question to Angus McMaster: *"What would prompt you to approach a person who you think needs support?"*

- With friends I notice things that are unusual. I might start a casual conversation with them. Mental Health First Aid Training was critical to know what to say to someone disclosing a mental health issue.

Questions to Dr Henderson: *"How do you determine if a young person is ready to take on a peer support role? Who provides peer training and what does that look like?"*

- They need lived experience of mental illness and they need to identify that they are in a state of recovery. They also need formal training and supervision and need to be supported by a policy framework.
- For a service provider – you don't need to start by considering your own clients for peer work roles. That could become an issue in that, if they relapse, their position as a peer worker within the organisation may be a barrier to re-entering the service as a consumer.
- All our peer workers are paid, we approach this from an equity perspective. We also ensure that young people who contribute their expertise to co-design groups and consultations are paid or receive a payment equivalent.
- A mix of clinicians, peer workers and other mental health workers deliver our youth peer worker training. In that way, the training curriculum is informed by a diversity of experiences. We do stress that it's important for peer workers to understand that, while 'lived experience' is common to consumers and peer workers, each person's experience is unique and different – they must remember that everyone's experiences are not the same as their own.

# References

Tasmanian Youth Mental Health Forum Booklet, 2019

Leanne McLean, Tasmanian Commissioner for Children and Young People, Session One Powerpoint Presentation

Dr Kelly Shaw, *Session Two Powerpoint Presentation: Young People in Tasmania*

Dr Joanna Henderson, Executive Director, YWHO, Ontario, Session Four: Youth Wellness Hubs Ontario Powerpoint Presentation

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Grant Akesson (Primary Health Tasmania), Jeremy Harbottle (Tasmanian Department of Health) and Dr Aaron Groves (Tasmanian Chief Psychiatrist), Session Five Powerpoint Presentation

Dr Catherine Spiller, Primary Health Tasmania, Session Nine: HealthPathways Powerpoint Presentation

Prof Jane Burns, Swinburne University, Session Ten: Twenty-first Century Models of Care, Powerpoint Presentation

Dr Joanna Henderson, Session Eleven: Youth Peer Support in a Mental Health Context, Powerpoint Presentation

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*Dr Astrid Wootton*
*MHCT, November 2019, Tasmanian Youth Mental Health Forum: Briefing Paper*
*<web link>*