A Submission to the Royal Commission into Victoria's Mental Health System

Breaking the cycle of dysfunction, disadvantage and death related to youth mental health through the provision of specialised mental health services for complex and hard-to-engage young people.

- **Summary:**

Victoria is currently entrenched in a youth mental health crisis. Suicide ranked as the leading cause of death in 2018 for young Australians between 15 - 24 years of age, and emergency departments are seeing unprecedented youth mental health presentations. Victoria's current mental health system is critically under resourced and lacks the capacity to meet the needs of young people with mental ill health, particularly those who present with complex needs or are hard to engage. The Victorian government has a responsibility to acknowledge that these impacts are preventable, and immediate action is vital, to prevent the further loss of life, dysfunction and disadvantage which results from depriving young people of the appropriate and timely mental health supports they require. Access to services should be centred around need, not competition for limited resources. It is strongly recommended that swift and sustained investment in appropriate and specialised youth mental health supports begin immediately.

- **Recommendations:**

Recommendation 1- Invest in and expand upon an existing Assertive Outreach model such as Orygen's Intensive Mobile Outreach Service.

Recommendation 2- Invest in and expand upon current Child and Adolescent Mental Health Service's (CAMHS) Intensive Mobile Outreach Service. This will require reforming the upper age limit to 25.

Recommendation 3- The Victorian Government advocates for increasing the capacity for Headspace to support complex and hard-to-engage young people through the Coalition of Australian Governments (COAG).

- **Costings/Resourcing and Impact:**

Recommendation 1-This recommendation will provide specialist state wide mental health supports for 2500 hard to reach or complex needs young people. This option will expand on Orygen's Intensive Mobile Outreach Service (IMYOS) model, requiring a total of 65 IMYOS state wide. The teams will require office space and the potential to co-locate with Headspace offices could be explored.

Recommendation 2- This option will provide specialist state wide mental health supports for 2500 hard-to-reach or complex needs young people. This option will expand on Child and Adolescent Mental Health Service's (CAMHS) Intensive Mobile Outreach Service's. Similarly requiring a total of 65 IMYOS state wide. CAMHS will experience the additional impact of a required restructure, extending the adolescent arm of their IMYOS and increasing the upper age limit to 25 years. There is the potential the new teams could co-locate with existing IMYOS teams.

Recommendation 3- Minimal resourcing is required for this recommendation as Headspace is a federal program, accordingly this option is unlikely to have any significant impact in the immediate future.

- **Conclusion:**

This submission puts forward recommendation one as the suggested policy action, expanding Orygen's IMYOS teams to provide mental health supports to 2,500 complex needs and/or hard to engage young people.

Acronyms

COAG- Coalition of Australian Governments

AO- Assertive outreach

IMYOS- Intensive Mobile Youth Outreach Service

CAMHS- Child and Adolescent Mental Health Service

AMHS- Adult Mental Health Service

Who

I write this submission from my position as an individual in my penultimate year of becoming a qualified and accredited Social Worker. I also write this submission from my experience working in the youth homelessness sector. I am offering insight gained from my employment as a youth refuge worker in a crisis accommodation context, where I provided intensive case management and support for 16 – 25 year olds experiencing homelessness. I also write from experience gained in my current position as an Initial Assessment Plan worker at a homelessness Access Point, where I work with young people who experience mental ill health on a daily basis. My academic training and work in direct practice has gifted me a unique insight into the challenges and barriers, as well as the lack of available and timely supports, encountered by young people who live with experiences of mental ill health and homelessness.

Policy position

Immediate action needs to be taken to prevent further loss of life, dysfunction and disadvantage which results from depriving young people of the appropriate and timely mental health supports they require[1]. This submission addresses the lack of capacity Victoria's current mental health system has to meet the needs of young people with mental ill health[2], particularly those who are hard to engage or present with complex needs[3]. This submission supports the Australian Medical Associations[4] position that access to services should be centred around need, not competition for limited resources. Further to this, it endorses Mental Health Victoria's [5] counsel recommending swift and sustained investment in appropriate and specialised youth mental health supports to immediately begin addressing this critical issue.

---

[1] Purcell, R, Goldstone, S, Moran J, Albiston, D, Edwards, J, Pennell, K & McGorry, P 2011, 'Toward a Twenty-First Century Approach to Youth Mental Health Care', *International Journal of Mental Health*, vol. 40, no.2, pp. 72-87.

[2] McGorry, P 2007, 'The specialist youth mental health model: strengthening the weakest link in the public health system', *Medical Journal of Australia*, vol. 187, no. 7, pp. 53-56.

[3] Schley, C, Radovini, A, Halperin, S, Fletcher, K 2011, 'Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'', Children and Youth Services Review, vol. 33, pp. 1506-1514.

[4] Australian Medical Association 2018, *Position Statement: Mental Health-2018*, Australian Medical Association, accessed on 22 April 2019.

[5] Mental Health Victoria 2018, *Saving lives, saving money: a case for better investment in Victorian mental health*, Mental Health Victoria.

Background & Issues

High Rates of Youth Mental Illness

Victoria is currently entrenched in a youth mental health crisis. Suicide ranked as the leading cause of death in 2018 for young Australians between 15 - 24 years of age[6] and emergency departments are seeing unprecedented youth mental health presentations[7].

> "Mental ill health in young people is all too often associated with ongoing disability, including impaired social functioning, poor educational achievement, unemployment, substance abuse, and violence, leading to a cycle of dysfunction and disadvantage that is difficult to break"[8].

Mental illness is the primary cause of disability in 12 - 25 year olds [9] and forms 55 percent of the overall disease burden affecting 15 - 24 year olds[10] and most psychiatric disorders onset in adolescence and early adulthood, reaching their peak in the early 20's [11].

Mental Illness and Youth Homelessness

From my experience on the front line, in the youth homelessness sector, I witness the immense impact of mental ill health on my clients lives on a daily basis. We, as social workers are privy to the volatile, unpredictable and traumatic nature of homelessness, which acts as a trigger for a range of mental health presentations, from anxiety to full psychosis. Emerging disorders and mental ill health adds another extremely distressing barrier for a young person, who is already trying to cope with one of the most challenging times of their lives. The link between homelessness and mental ill health is widely documented both locally and internationally with homeless young people experiencing mental illnesses and disorders at roughly twice the rate of the average population[12]. A

---

[6] Australian Institute of Health and Welfare 2018, *Deaths in Australia*, Australian Institute of Health and Welfare, accessed on the 22 April 2019.
[7] Hiscock, H, Neely, R, Lei, S & Freed, G 2018, 'Paediatric mental and physical health presentations to emergency departments, Victoria, 2008–15', *Medical Journal Australia*, vol. 208, no. 8, pp. 343-348.
[8] Purcell et al., op. cit,. p. 24.
[9] Mental Health Victoria 2018, op cit.
[10] Mental Health Council of Australia 2009, *Home Truths: Mental Health, Housing and Homelessness in Australia*, Mental Health Council of Australia.
[11] McGorry, P, Purcell,P, Hickie, I & Jorm, A 2007, 'Investing in youth mental health is a best buy', *Medical Journal of Australia*, vol. 187, no.7, pp. 5 – 7.
[12] Kamieniecki, G 2001, 'Prevalence of Psychological Distress and Psychiatric Disorders Among Homeless Youth in Australia: A Comparative Review', *Australian and New Zealand Journal of Psychiatry,* vol. 35, no. 3

report by the Mental Health Commission of NSW found that 50 - 75 percent of homeless young people in Australia have some experience of mental illness [13].

Further to this, young people experiencing homelessness often present with 'complex needs', which refers to the interplay of multiple factors such as mental illness, drug and alcohol use, behavioural challenges, developmental disorders and the influence of historical and environmental aspects[14]. These 'complex' factors act in concert, impacting on an individual's daily life and functioning, which can result in complex needs young people requiring specialised support and engagement opportunities that mainstream mental health services struggle to provide[15]. In my experience it can also be very challenging to house a young person who presents as complex, or has a more severe mental illness, as many refuges are unwilling or unable to cater to the needs of this cohort. This ultimately means that complex young people are further removed from receiving support and are vulnerable to entering into a cycle of chronic homelessness that can last their life time.

Inadequate Service Availability

There are few things more distressing in my role as a youth worker, than witnessing a young person actively reaching out for mental health supports, and being unable to link them in with the support they are seeking. Unfortunately, this is has become a common place experience as most clients I work with struggle with untreated mental health challenges. Due to lack of service availability, catchment limitations, or their presentation not meeting the program criteria, few of my clients ever receive the holistic and assertive support they require. When a young person does make it on a waitlist, they still face a minimum 8-10 to weeks wait. To a homeless young person who doesn't know where they will be tomorrow, ten weeks may as well be a lifetime. Another challenge I frequently encounter in my role as a refuge worker, is a young person who has been linked into mental health supports being dropped when they are placed in crisis accommodation outside of their previous catchment area. This begins the whole cycle of support seeking anew, with the added barrier of relationship and attachment breakdown, being added to a new waitlist and having to go through the trauma of another assessment and intake. Our inability to fulfil this basic support need fosters mistrust of services on a broader level, and prevents young people for reaching out for help again in the future.

Victoria is subject to the lowest per capita spending on mental health services in Australia, with access to services being 40 percent lower than the national average[16]. The provision of specialist adolescent mental health services designed for 16 - 25 year olds remains

[13] Costello, L, Thomson, M, Jones, K 2013, *Mental Health and Homelessness – Final Report*, Mental Health Commission of NSW.
[14] ibid.
[15] ibid.
[16] Mental Health Victoria 2018, op. cit.

inadequately-resourced and poorly distributed[17]. Homeless young people, or individuals with complex needs and severe mental disorders are often hard-to-reach and engage due to insecure tenancy and transience (frequently leaving catchment areas), financial barriers, stigmatisation, mistrust of services, lack of service responsiveness, long waitlists and presentations that are too 'complex' for services to support [18] [19] [20]. A decade of chronic underfunding combined with the role out of the NDIS, which saw a transfer of funding from mental health services[21], has resulted in a significant gap in the availability of clinical and community health supports for young people [22]. This deficit has resulted in consumers competing for limited resources with 2 out of 3 young Victorians who seek a service, being left stranded without appropriate support [23].

Exacerbating this already gaping chasm in service delivery is the divide between specialist paediatric services (CAMHS) and adult mental health services (AMHS) [24]. CAMHS discontinues service provision at age 18, transferring young people into an underfunded adult system which is poorly equipped to cater for their unique developmental and cultural requirements [25]. Accordingly, as the pattern of peak onset and burden of mental disorders are manifesting continuity of care is disrupted [26], the public mental health system being at its weakest, when it should be strongest [27]. While it may be argued that Headspace is supposed to be the service filling this gap, in my experience it has been extremely challenging to gain the required support from headspace. It has been being cited to me that the client is either too complex for the service, or the waitlist is over ten weeks, at which point my service period has generally ended for clients or they have moved on. Headspace's inability to support clients presenting with complexity or more severe diagnosis is not a problem I struggle with alone and has been broadly critiqued [28] [29] [30]. Accordingly, this cohort require a youth specific model to fill the sizeable gap in service delivery that is responsive to

[17] Purcell, R, Goldstone, S, Moran J, Albiston, D, Edwards, J, Pennell, K & McGorry, P 2011, 'Toward a Twenty-First Century Approach to Youth Mental Health Care', *International Journal of Mental Health*, vol. 40, no.2, pp. 72-87.
[18] Mission Australia 2017, op. cit.
[19] Robinson J, McCutcheon L, Browne V, Witt K, 2016, *Looking the other way: Young people and self-harm,* Orygen the National Centre of Excellence in Youth Mental Health, Melbourne.
[20] Mental Health Council of Australia 2009, op. cit.
[21] Australian Association of Social Workers 2019, Submission to the Productivity Commission Re: The Social and Economic Benefits of Improving Mental Health, Productivity Commission.
[22] Mental Health Victoria 2018, op. cit.
[23] ibid.
[24] Purcell et al., op. cit.
[25] McGorry, P 2007, 'The specialist youth mental health model: strengthening the weakest link in the public health system', *Medical Journal of Australia*, vol. 187, no. 7, pp. 53-56
[26] ibid.
[27] ibid.
[28] Patulny, R, Muir, K, Powell, A, Flaxman, S, Opera, I & McDermott, S 2013, 'Are we reaching them yet? Service access patterns amongst attendees at the headspace youth mental health initiative', *Child and Adolescent Mental Health*, vol. 18, no. 2, pp. 95-102.
[29] Allison S, Bastiampillai, T, Goldney, R 2016,' Australia's national youth mental health initiative: Is *headspace* underachieving?', *Australian & New Zealand Journal of Psychiatry,* vol. 50, no. 2, pp. 111–112.
[30] Allott, K, Van-Der-El, K, Bryce S, Hamilton, M, Adams, S, Burgat, L, Killackey, E, Rickwood, D 2018, *'*Need for clinical neuropsychological assessment in headspace youth mental health services: A national survey of providers'*, Australian Journal of Psychology*, vol. 1, no. 9.

their help-seeking behaviours and needs, as well as culturally appropriate and sensitive to their unique life-stage challenges[31].

Recommendations

This submission notes that experiences of homelessness and mental ill health are inextricably linked, and a 'housing first' policy action is required to holistically address these interconnected issues[32]. It is acknowledged that a housing first policy response is outside of the scope of this Royal Commission**.** This submission also acknowledges that young people with disabilities, Aboriginal and Torres Strait Islander, LGBTIQ+ and culturally and linguistically diverse communities are peoples who often require additional, sensitive and appropriate responses that are not specifically addressed in this submission.

Recommendation 1- Expansion of Pre-existing Assertive Outreach Models

In line with this suggestion, the primary policy option proposed and recommended by this submission is to invest in and expand upon an existing Assertive Outreach model (AO). AO models have a substantial evidence base attesting to their effectiveness in supporting adults experiencing a severe mental illness and homelessness[33] [34], with expanding literature on the model's efficacy with young people [35] [36] [37]. An existing Victorian AO program that could be expanded is Orygen's Intensive Mobile Outreach Service (IMYOS). Orygen's IMYOS has been in operation since 1998 and utilises a multidisciplinary team-based approach to provide flexible, intensive outreach and community treatment aimed to meet the needs of complex needs and hard to engage youth[38]. IMYOS teams manage the impact of emerging mental disorders on the individual's life, identity and their functioning with a focus on actively engaging young people within the setting they feel comfortable[39]. IMYOS teams are characterised by a low client/staff case load to ensure young people receive holistic, rather

[31] McGorry 2007, op. cit.
[32] Mental Health Council of Australia 2009, *Home Truths: Mental Health, Housing and Homelessness in Australia*, Mental Health Council of Australia.
[33] Bond, G, Drake, R, Mueser, K & Latimer, E 2001, 'Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients', *Dis Manage Health Outcomes*, vol. 9, no. 3, pp. 141-159.
[34] Vijverberg, R, Ferdinand, R, Beekman, A, Meijel, B 2017, 'The effect of youth assertive community treatment: a systematic PRISMA review', *BMC Psychiatry*, vol. 17, no, 284.
[35] ibid.
[36] Assan, B, Chia, A, Coffey, C, Floreani, S, Weir, J & Woods, B 2008, 'Intensive Management Team: An Intensive Outreach Mental Health Service for High-Risk Adolescents', *Australasian Psychiatry*, vol. *16*, no. 6, pp. 423–427.
[37] Schley, C , Ryall, V, Crothers, L , Radovini S, Fletcher, K, Marriage, K, Nudds, S, Groufsky, C & Hok Pan Yuen 2008, 'Early intervention with difficult to engage 'high risk' youth: Evaluating an intensive outreach approach in youth mental health', *Early Intervention in Psychiatry,* vol. 2, pp. 153-175.
[38] Ryall 2008, op. cit.
[39] Schley, C, Radovini, A, Halperin, S, Fletcher, K 2011, 'Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'', *Children and Youth Services Review*, vol. 33, pp. 1506-1514.

than tokenistic, support for the treatment they desperately require[40]. Orygen's IMYOS programs could be reproduced or expanded into regions that are currently underserviced, while incorporating some flexibility with catchment limitations to meet the needs of transient young people.

The limitation of this approach is the cost, due to the intensity and multidisciplinary nature of the model it will require a significant and sustained fiscal investment. However, there is strong economic argument for the feasibility of IMYOS programs when examining the efficacy of comparable Assertive Community Treatment models, in particular attending to the fiscal savings attained through the significant reduction hospitalisations[41]. Importantly, continuing to deny early intervention services also comes at the cost of the increasing number of youth suicides, lifelong disabilities and forced dependence on adult services[42] [43].

Recommendation 2 - Extend the Age Range and Capacity of CAMHS

The second policy recommendation could be to expand on current IMYOS team run by Child and Adolescent Mental Health Services (CAMHS). The CAMHS IMYOS model is comparable to Orygen's model, with the added limitation of only servicing up to the age of 18 years [44]. For this recommendation to be feasible in filling the young adult service gap CAMHS would be required to restructure through extending the adolescent arm of their IMYOS and increasing the upper age limit to 25 years[45]. This would allow for a differentiation of the adolescent and young adult component from the current focus CAMHS has on children[46]. The limitations of this approach being the challenge of increasing the upper age limit and the fiscal costs associated with expanding the service. Once more, obstacles and expenses that pale in comparison to the cost of human life that will continue unabated as a result of inadequate service provision.

Recommendation 3- Evaluation and Oversight of Headspace

Finally, this submission suggests that if Headspace is going to continue as a major policy initiative, the programs capacity to support complex and higher needs young people should be developed and outcome measures implemented[47] [48]. It is understood that this

[40] Ryall, V, Radovini, S, Crothers, L, Schley, C, Fletcher, K, Simon Nudds, & Groufsky, C 2008, 'Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention', Social Work in Mental Health, vol. 7, no. 1-3, pp. 153-175.
[41] Bond 2001, op. cit.
[42] Purcell et al. 2011, op. cit.
[43] Mental Health Victoria 2018, op. cit.
[44] Assan 2008, op. cit.
[45] McGorry, P 2007, 'The specialist youth mental health model: strengthening the weakest link in the public health system', *Medical Journal of Australia*, vol. 187, no. 7, pp. 53-56
[46] ibid.
[47] Allison S, Bastiampillai, T, Goldney, R 2016,' Australia's national youth mental health initiative: Is *headspace* underachieving?', *Australian & New Zealand Journal of Psychiatry,* vol. 50, no. 2, pp. 111–112.
[48] Allott, K, Van-Der-El, K, Bryce S, Hamilton, M, Adams, S, Burgat, L, Killackey, E, Rickwood, D 2018, 'Need for clinical neuropsychological assessment in headspace youth mental health services: A national survey of providers', *Australian Journal of Psychology*, vol. 1, no. 9.

recommendation is outside the scope of the Commission, however, it is encouraged that oversight into Headspace is advocated for by the state government through COAG. It is noted that this suggestion is in an addition to the recommendation one, as advocacy to reform headspace is unlikely to bear fruit in the immediate future. Youth mental health is a problem that cannot wait for national reform and the Victorian government is urged to act in such a manner that reflects the seriousness of the challenge facing our young people by developing appropriate supports as quickly as possible.

Resourcing

Recommendation 1

The IMYOS program will require funding reflective of the level of demand and outputs of service delivery. On census night, 39 percent of homeless persons counted were under 25, which equates to almost 10,000 homeless young people in Victoria alone[49] [50]. Even by the most conservative projection of 50 percent, 5000 of these young people are likely to experience mental ill health and homelessness[51]. Halving this amount once, more by assuming that not all of the 5000 have complex needs or a severe mental illness, this still leaves 2500 young people who require intensive specialised mental health supports. Due to the large number of young people requiring support and the multidisciplinary nature of the IMYOS model, the primary resourcing cost will be in staff. Adhering to the Orygen IMYOS model [52] each team has a capacity for 35 clients, accordingly an estimated 65 IMYOS teams, state-wide, will be required to meet the current demand. This equates to employing 65 occupational therapists, 65 psychiatric nurses, 130 psychologists, 130 social workers and one consultant psychiatrist per team, two days per week. Ideally teams will co-locate with other mental health services, such as Headspace, to provide maximum impact, however office space represents an additional cost.

Recommendation 2

The IMYOS teams run through CAMHS are likely to vary slightly from hospital to hospital, however, generally employ similar staff/client ratios to Orygen's IMYOS[53]. Accordingly, the resourcing projections are the same as above. The positive impacts of this recommendation being that CAMHS is already located in strategic positions across Victoria, which may provide the opportunity for expanded IMYOS teams to co-locate with pre-existing teams.

---

[49] Australian Bureau of Statistics 2016, *Census of Population and Housing: Estimating Homelessness 2016*, Australian Bureau of Statistics.
[50] Council to Homeless Persons 2018, *Facts about homelessness*, Council to Homeless Persons.
[51] Costello, L, Thomson, M, Jones, K 2013, *Mental Health and Homelessness – Final Report*, Mental Health Commission of NSW.
[52] Ryall at al. 2008, op. cit.
[53] Assan, B, Chia, A, Coffey, C, Floreani, S, Weir, J & Woods, B 2008, 'Intensive Management Team: An Intensive Outreach Mental Health Service for High-Risk Adolescents', *Australasian Psychiatry*, vol. *16*, no. 6, pp. 423–427.

The additional challenge faced by CAMHS will be attending to the impact of reforming the upper age limit of their service to 25. While this reform will be of benefit to service users, the politics of reform for CAMHS may be more problematic requiring some adjustment and restructuring. CAMHS will also be required to expand their capacity to respond beyond pre-pubescent disorders and become better equipped to work with adult type mental health disorders which typically begin to onset in the late teens and early twenties[54].

Recommendation 3

Minimal resourcing is required for this recommendation as Headspace is a federal program, accordingly this recommendation is unlikely to have any significant impact in the immediate future.

Impact

A growing body of research speaks to the impact IMYOS programs have in terms of excellent client retention rates**,** capacity building[55] and success in reducing hospitalisations, suicidal ideation, self-harm and inpatient stays[56]. When I worked in crisis accommodation we were forced to routinely send young people to hospital to address mental health challenges, as we continuously came up against a lack of responsiveness from CAMHS and Crisis Assessment and Treatment Teams, and lacked any other alternatives. Young people were often sent back, after a lengthy wait in the emergency department, often representing to our service just as distressed as when they left. Accordingly, policy action on this matter would present opportunities to both preserve and improve young lives[57], as well as economise the fiscal dollar as emergency services and inpatient stays are both time and resource intensive[58].

There will always be obstacles to overcome and money to be invested in the rollout of services, however, the loss of life and potential for long-term disability and adverse life impacts[59] if the status quo continues is inexcusable. Inaction on this issue could also have detrimental political impacts as polls demonstrate that a majority of Australians think that

[54] McGorry, P 2007, 'The specialist youth mental health model: strengthening the weakest link in the public health system', *Medical Journal of Australia*, vol. 187, no. 7, pp. 53-56
[55] Assan 2008, op. cit.
[56] Schley, C , Ryall, V, Crothers, L , Radovini S, Fletcher, K, Marriage, K, Nudds, S, Groufsky, C & Hok Pan Yuen 2008, 'Early intervention with difficult to engage 'high risk' youth: Evaluating an intensive outreach approach in youth mental health', *Early Intervention in Psychiatry,* vol. 2, pp. 153-175.
[57] Ibid.
[58] Australian College of Emergency Medicine 2018, *A state of crisis: Data shows blow outs for mental health care*, Australian College of Emergency Medicine.
[59] Purcell et al. 2011, op. cit.

youth mental health should be a top priority, with 90% of voters agreeing that young people should have access to early intervention rather than waiting to present at hospital in crisis[60].

Implementation

As Orygen's IMYOS program has successfully operated since 1998[61], expanding on the model should be relatively straight forward through the inheritance of a functioning template from which to base future programs off. Despite this advantage working out systems and processes relating to the parameters of the program such as operational protocols, geographic coverage, referral pathways and criteria will still be required. An evaluation of the implementation of a similar program found that the provision of external supervision from a child and adolescent clinician, and the secondment of experienced senior clinicians from pre-existing teams was important to the success of the program within the initial 18 months[62]. Adequate time will be required to recruit appropriate and qualified staff, find suitable work spaces, or co-locate with existing mental health services. Accordingly, it is suggested that the program should be an iterative process implemented through pilot projects. This allows for agility and flexibility in initial stages so the model can adapt to local contexts before rolling out broader operations[63].

Conclusion

Victoria is currently witness to the devastating impacts caused by the critical shortage of specialist and effective mental health services for hard-to-reach or complex needs young people. This includes suicide, life-long disability and preventable dysfunction and disadvantage. Strengthening and investing in dedicated and age-appropriate specialist services, such as IMYOS programs, at the acute and complex end of the mental health system provides an opportunity to greatly improve and save young lives. IMYOS programs offer scope to complement current public mental health services and redirect young people from inappropriate and resource intensive responses, such as Emergency Departments and inpatient units, with the added bonus of saving on the fiscal dollar.

---

[60] Galaxy YouGov 2019*, Australians Attitudes to Youth Mental Health*, Orygen the National Centre of Excellence in Youth Mental Health.

[61] Schley et al. 2008, op. cit.

[62] Jones, A, Eastman, C, Katz, I 2014, *Evaluation of the Assertive Community Child and Adolescent Mental Health Servic Pilot in New South Wales*, Mental Health and Drug and Alcohol Office NSW Health.

[63] ibid.

References

Allison S, Bastiampillai, T, Goldney, R 2016,' Australia's national youth mental health initiative: Is *headspace* underachieving?', *Australian & New Zealand Journal of Psychiatry,* vol. 50, no. 2, pp. 111–112.

Allott, K, Van-Der-El, K, Bryce S, Hamilton, M, Adams, S, Burgat, L, Killackey, E, Rickwood, D 2018, 'Need for clinical neuropsychological assessment in headspace youth mental health services: A national survey of providers', *Australian Journal of Psychology*, vol. 1, no. 9.

Assan, B, Chia, A, Coffey, C, Floreani, S, Weir, J & Woods, B 2008, 'Intensive Management Team: An Intensive Outreach Mental Health Service for High-Risk Adolescents', *Australasian Psychiatry*, vol. *16*, no. 6, pp. 423–427.

Australian Association of Social Workers 2019, Submission to the Productivity Commission Re: The Social and Economic Benefits of Improving Mental Health, Productivity Commission, accessed 9 June 2019, < https://www.pc.gov.au/inquiries/current/mental-health/submissions>.

Australian College of Emergency Medicine 2018, *A state of crisis: Data shows blow outs for mental health care*, Australian College of Emergency Medicine, accessed 22 April 2019, https://acem.org.au/News/Oct-2018/A-state-of-crisis%E2%80%9D-Data-shows-blow-outs-for-ment

Australian Bureau of Statistics 2016, *Census of Population and Housing: Estimating Homelessness 2016*, Australian Bureau of Statistics, accessed on 22 May 2019, < https://www.abs.gov.au/ausstats/abs@.nsf/mf/2049.0>

Australian Institute of Health and Welfare 2018, *Deaths in Australia*, Australian Institute of Health and Welfare, accessed on the 22 April 2019**,** **<**https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death>.

Australian Medical Association 2018, *Position Statement: Mental Health-2018*, Australian Medical Association, accessed on 22 April 2019, <https://ama.com.au/position-statement/mental-health-2018>.

Bond, G, Drake, R, Mueser, K & Latimer, E 2001, 'Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients', *Dis Manage Health Outcomes*, vol. 9, no. 3, pp. 141-159.

Costello, L, Thomson, M, Jones, K 2013, *Mental Health and Homelessness – Final Report*, Mental Health Commission of NSW.

Council to Homeless Persons 2018, *Facts about homelessness*, Council to Homeless Persons, accessed on 22/4/2019 < http://chp.org.au/homelessness/>.

Galaxy YouGov 2019*, Australians Attitudes to Youth Mental Health*, Orygen the National Centre of Excellence in Youth Mental Health.

Hiscock, H, Neely, R, Lei, S & Freed, G 2018, 'Paediatric mental and physical health presentations to emergency departments, Victoria, 2008–15'*, Medical Journal Australia*, vol. 208, no. 8, pp. 343-348.

Jones, A, Eastman, C, Katz, I 2014, *Evaluation of the Assertive Community Child and Adolescent Mental Health Service Pilot in New South Wales*, Mental Health and Drug and Alcohol Office NSW Health.

Kamieniecki, G 2001, 'Prevalence of Psychological Distress and Psychiatric Disorders Among Homeless Youth in Australia: A Comparative Review', *Australian and New Zealand Journal of Psychiatry,* vol. 35, no. 3.

McGorry, P 2007, 'The specialist youth model mental health: strengthening the weakest link in the public health system', *Medical Journal of Australia*, vol. 187, no. 7, pp. 53-56.

McGorry, P, Purcell,P, Hickie, I & Jorm, A 2007, 'Investing in youth mental health is a best buy', *Medical Journal of Australia*, vol. 187, no.7, pp. 5 – 7.

Mental Health Council of Australia 2009, *Home Truths: Mental Health, Housing and Homelessness in Australia*, Mental Health Council of Australia.

Mental Health Victoria 2018, *Saving lives, saving money: a case for better investment in Victorian mental health*, Mental Health Victoria.

Mission Australia 2017, *Youth Mental Health and Homelessness Report*, Mission Australia, accessed 22 April 2019, < Mission Australia 2017, *Youth Mental Health and Homelessness Report*, Mission Australia>.

National Youth Commission (NYC) report into Australia's Homeless Youth (2008)
Purcell, R, Goldstone, S, Moran J, Albiston, D, Edwards, J, Pennell, K & McGorry, P 2011, 'Toward a Twenty-First Century Approach to Youth Mental Health Care', *International Journal of Mental Health*, vol. 40, no.2, pp. 72-87.

Ryall, V, Radovini, S, Crothers, L, Schley, C, Fletcher, K, Simon Nudds, & Groufsky, C 2008, 'Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention', Social Work in Mental Health, vol. 7, no. 1-3, pp. 153-175.

Schley, C , Ryall, V, Crothers, L , Radovini S, Fletcher, K, Marriage, K, Nudds, S, Groufsky, C & Hok Pan Yuen 2008, 'Early intervention with difficult to engage 'high risk' youth: Evaluating an intensive outreach approach in youth mental health', *Early Intervention in Psychiatry,* vol. 2, pp. 153-175.

Schley, C, Radovini, A, Halperin, S, Fletcher, K 2011, 'Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'', Children and Youth Services Review, vol. 33, pp. 1506-1514.

Vijverberg, R, Ferdinand, R, Beekman, A, & Meijel, B 2017, 'The effect of youth assertive community treatment: a systemic PRISM review', *BMC psychiatry*, vol. 17, no. 248.