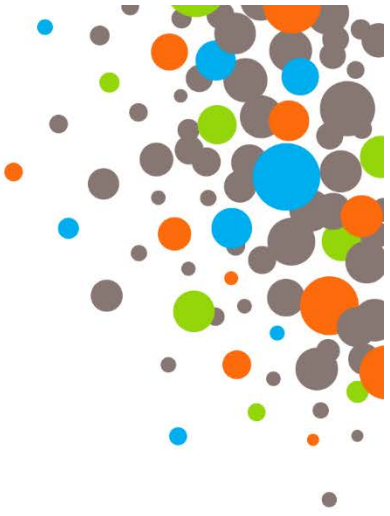


Orygen
The National Centre of Excellence in Youth Mental Health

Orygen, The National Centre of Excellence in Youth Mental Health

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

July 2019

Contents

Executive Summary

Orygen, The National Centre of Excellence in Youth Mental Health (Orygen) welcomes the opportunity to provide a submission to the Royal Commission into Victoria's Mental Health System. This Royal Commission presents an enormous opportunity to drive the reforms needed to address issues of access, safety and quality of mental health care in Victoria. Reforms that will not only improve the lives of people experiencing mental ill-health, but will save lives that are being cut unnecessarily short by these entirely treatable and even preventable conditions.

I feel like they're doing a lot even just by having the Royal Commission…. I definitely don't have the solution of how to fix all the problems and all the issues, but someone definitely will, and something is going to come out of this Royal Commission that is definitely going to help a lot of people. I think I'm very optimistic about what's coming out of it." Young person

Young people aged 10-24 years bear the major burden for onset and impact of mental ill-health across the whole lifespan. Mental ill-health is the leading cause of disability in young people aged 10–24 years, contributing 45% of the overall burden of disease.(1) 50% of mental ill-health onsets before the aged of 15 years, 75% by 24 years.(2)

Victoria and Australia have been at the forefront of developments in youth mental health research, service and system design that is shifting the paradigm nationally and globally toward recognising the importance and benefits (individually, socially and economically) of targeting evidence-based, appropriate, acceptable and effective services for this age group.

This is particularly evident through the Australian Government's commitment to a Productivity Commission's inquiry on the Social and Economic Benefits of Mental Health, while at a global level, Orygen is the lead partner on the World Economic Forum's (WEF) Youth Mental Health Interventions project, one of four initial projects under the WEF's mental health portfolio in 2019. This project has the potential to transform the design and delivery of models of mental health care for young people worldwide.

In Australia, the critical foundation for a youth mental health system at the primary care level has been laid with over 110 headspace centres operating across the country, improving access to mental health services and resources that are acceptable and effective for young people. However, challenges continue. There remains serious underinvestment in direct, and in particular, specialist community-based youth mental health care, stifling innovation to enhance the scaffolding that does exist and provide early intervention across all stages of life and mental ill-health.

This situation is particularly evident in Victoria, where it is estimated that, while approximately 3% of Victorians experience severe mental illness, the Victorian state-funded mental health system is only able to provide care for 1% of the state's population.

In the North West of Melbourne, Orygen Youth Health is currently only resourced to provide a service to one in four young people who are referred and even then, the service offering is time-limited through a two year tenure of care. In 2016-17, 89% of clients in Victoria's child and youth mental

health services (CYMHS)[1] had a Strengths and Difficulties Questionnaire (SDQ) impact score over three, putting them in the highest range of the most unwell 5% of the population.(3)

In addition, young people with more moderate to serious/complex mental health issues are slipping through the gaps between primary care and tertiary specialist care. This group, now often referred to as the 'missing middle' need more specialised, intensive and extend care than is currently available within primary care, however, they are not yet acutely or severely ill enough to reach the high threshold for access to state-funded acute and continuing care.

> ***"Not providing that middle service is not just detrimental to functioning. It's losing lives. I've lost friends because they can't access services. Cause they, like me, they're too severe for one but not severe enough for the other and I can't afford private. It's not as simple as just walking up to a service and saying,"hey, I need help", which is what everyone markets themselves as." Young person***

The result has been that for too many young people, their illnesses remain untreated, or undertreated, escalating in severity until they present to emergency departments at crisis point, or they come into contact with police and ambulance services.

The recent Victorian Auditor-General's Office (VAGO) Report into Child and Youth Mental Health (3) accurately reflected the nature and extent of the issues in the provision of youth mental health care in Victoria. These included:

A lack of strategic direction and framework: There has been no progress made on earlier Victorian Government policy to prioritise and develop a framework for the provision of child and youth mental health services. There also appears to be limited focus on child and youth mental health service delivery within the Department of Health and Human Services (DHHS) and no rationale, specifications, accountability structures or guidelines for the current programs and services it funds.

A lack of oversight and monitoring: There are no effective governance or monitoring arrangements through which the DHHS can provide oversight of CYMHS, which restricts the Department's ability to advise on the CYMHS system's performance, its resourcing needs or the challenges patients and health services face in engaging other services.

Funding models: While the rest of the system has begun to move toward activity-based funding, CYMHS remain on a block funding model and the community-based funding does not contain any specifications, guidance, targets or realistic outcome-focused Key Performance Indicators (KPIs) on how it should be spent. Unsurprisingly, services confirmed that they 'cross-subsidise' from their community CYMHS funding to cover the costs of meeting demand for their inpatient beds (which are underfunded). The block funding approach has also resulted in disparities in per capita funding across different regions, with the North West receiving $57.94 per young person in the population (lowest) compared to $79.87 per young person in the population in the North East of the state.

Inconsistency in geographic access due to catchments: Children and young people currently receive different services and access to different types of evidence-based treatments and care based on the

[1] For the purposes of this submission the use of the term Child and Youth Mental Health Services (CYMHS) refers to all clinical services that the Victorian Government funds to support children, adolescents and youth aged 0–25 years with mental health issues (including services named CAMHS) in line with the VAGO Child and Youth Mental Health report definition.

catchment they live in. This has led to inequity in mental health service provision and discontinuous, fragmented care. In large part, this is the result of a lack of service specifications and guidance from the DHHS on what treatments and services should and must be provided by CYMHS.

A failure to provide services for the most vulnerable young people in Victoria: Over three years the five services audited by the VAGO showed that the rates of vulnerable client groups accessing CYMHS to be low compared to less vulnerable groups.

The VAGO analysis of Victoria's child and youth mental health system resonated with Orygen. We believe the report provides an accurate reflection of the impact of routine neglect in regards to policy, funding, governance and performance monitoring, and the need for wide-ranging system reforms.

Orygen strongly supports a move towards a more transparent and accountable mental health system with: a) clear KPIs that are based on clinical outcomes and linked to the delivery of effective evidence-based treatments within a robust model of care; and b) reporting on the use of public mental health funding in line with the findings from the VAGO report.

"It's just when you're diagnosed with a mental health condition, you don't see that that creates opportunities. You just see what it takes away." Young person

Recommendations

As described in the body of this submission, there is a growing body of international evidence that targeting preventive measures and effective early interventions to young people presents the best opportunity to reduce the economic burden of mental ill-health over the lifespan. Economic evaluations and international expert consensus position early intervention, particularly for ultra-high risk and first episode psychosis and extending to other mental health conditions such as depression, as an unequalled model of care to reduce symptoms, distress and economic burden.

In this submission Orygen presents a view of what the mental health service system in Victoria should deliver for young people[2], and recommendations that we believe will be effective at moving the system from its current position into one which provides optimal, evidence-based and effective care for young Victorians. The recommendations are summarised below, with additional detail provided within the body of this submission.

A state-wide system that provides evidence-based, effective and seamless mental health services for 12-25 year olds across all stages of ill-health.

1. Develop and implement a state-wide Youth Mental Health Services (12-25 years) model of care that is built upon and integrated with the headspace platform at a regional level.
2. Reform the governance and accountability mechanisms associated with all aspects of state-funded youth mental health care beyond bed-based services.
3. Remove eligibility for services based on catchment areas for community-based clinical services provided to young people aged 12-25 years.

[2] Orygen defines 'young people' and/or 'youth' as the age range of 12 to 25 years, inclusive of the youngest and oldest year of age.

4. Review the current availability of dedicated youth inpatient and Youth Prevention and Recovery Centre (YPARC) beds across the state and instigate a capital program focused on meeting current and future needs. This includes:

    a) Developing specific 'fit for purpose' design guidelines for youth inpatient and YPARC facilities to better meet the diversity of requirements across the age group and across diagnostic and therapeutic needs.

    b) A state-wide review of the YPARC model, including eligibility criteria for age and opportunities to extend referrals beyond Victorian public patients and include young people engaged in primary care services such as headspace.

5. Increase funding across the mental health system with a new financial and governance model to ensure it has the capacity to meet the needs of the 3% of the population experiencing severe mental illness, as well as, a proportion of those with moderate/complex conditions. The Victorian Government should also:

    a) Prioritise and explore more accountable and effective models of clinical community-based youth mental health funding, such as activity based funding and packages of care.

    b) Direct clinical community-based youth mental health funding to agencies that can scale up their existing enhanced primary youth mental health care offerings (e.g. headspace centres).

6. Develop a time-limited and targeted mental health workforce plan with clear KPIs for the Victorian Government to grow the mental health workforce through:

    a) Building the workforce pipeline, including supporting and funding as required the number of clinical placement opportunities, particularly within community settings.

    b) Creating more employment incentives and addressing current disincentives, including the job insecurity and poor pay and conditions.

    c) Attract and empower expert and respected clinical leaders especially clinical academic psychiatrists to model the same successful approaches which have worked in oncology, neurology and cardiovascular medicine.

A system that provides a fully integrated response for co-presenting substance use issues, physical and sexual health and family support into standard youth mental health care.

To fully integrate a response to substance use into the delivery of youth mental health care:

7. Increase: a) funding for quality treatment of comorbid drug and alcohol presentations in youth mental health services and b) the number of specialists in addiction medicine or addiction psychiatry[3] who are working directly in youth mental health services and have expertise in providing evidence-based treatment to address co-occurring substance use and mental health issues.

8. Provide training in the screening, assessment and initial treatment of mental health symptoms for all disciplines working in alcohol and other drug use services and vice-versa for mental health services.

[3] Addiction medicine specialist or addiction psychiatrists who are qualified and recognised sub-specialists in medicine who are trained to provide prevention, screening, interventions and treatment of substance use and addiction.

To fully integrate a response to physical and sexual health into the delivery of youth mental health care:

9. Provide dedicated funding to mental health services to employ GPs, exercise physiologists, dieticians, general nurses and sexual health nurses so that services can incorporate support for diet, exercise, smoking cessation and sexual health as standard care.
10. Provide ongoing professional development of the mental health workforce so that they can understand and incorporate responses to physical and sexual health within their approach to providing care, including developing strong working relationships with primary health providers.

To better support families and family engagement within youth mental health service delivery:

11. Provide targeted funding to ensure family-inclusive practice is appropriately implemented rather than these funds being taken from block funding for therapeutic services.
12. Develop best practice guidelines and a funded implementation plan supported by reportable KPIs for working with young people and their siblings.

A system that responds to complexities among vulnerable and specific youth populations in Victoria.

To better respond to young people with experiences of trauma and/or trauma-related mental health conditions:

13. Invest in the development and implementation of a trauma-informed, youth-specific screening tool to assess the presence and impact of trauma in young people aged 12–25 years who are engaged in clinical services.
14. Develop an overarching framework for implementing trauma-informed care (TIC) and evidence-based trauma therapy in Victoria across mental health service delivery.

To better respond to the mental health needs of young people who are at risk of offending or who are in contact with the justice system:

15. Develop and deliver a state-wide comprehensive forensic mental health service for young people both in custody and in the community.
16. Provide the broader mental health and justice workforce with training for a basic accreditation for working with justice-connected young people who are experiencing mental ill-health. Support from academic institutions to provide specialist training in these areas is required.
17. Fund evidence-based interventions and strategies to engage with specific youth populations overrepresented in justice system contacts to prevent offending or minimise the risk of reoffending.

To better respond to young people who are in out of home care, are experiencing housing insecurity or homelessness and other vulnerable populations.

18. Progress recommendations from the VAGO *Child and Youth Mental Health* report which relate to improving, and prioritising, access to mental health services and supports for young people experiencing specific complexity and vulnerabilities.

A system that ensures that young people experiencing mental ill-health are not disadvantaged in their educational and vocational pathways.

19. Develop and implement education settings-based approaches that focus on building capacity for enhanced case detection, help-seeking support and access to services.
20. Enhance the capacity of mental health services to provide transitional support for young people to reengage in school and university study.
21. Consider a review of the schools currently funded by Department of Education and Training (DET) to provide education services to mental health clients.
22. Provide investment into the Individual Placement Support (IPS) model for young people in youth mental health services and implement and evaluate enhancements to this model by incorporating peer work and integration with technology into its delivery.

A system that responds urgently and effectively to increased risk of self-harm and suicide-related behaviours among young people.

23. Develop an evidence-based youth-specific suicide and self-harm prevention strategy which includes a clear and measurable implementation plan.
24. Invest in enhancing current mental health services and system design to deliver high-quality responses for young people with suicide-related behaviours or self-harm presentations and seamless pathways to appropriate care in the community.
25. Provide systematic, curriculum-based approaches to training and high-quality protocols for responding to self-harm and suicide-related behaviours for staff working in emergency departments and hospitals.
26. Invest in linking data systems and a standardised, robust and real-time surveillance system for suicide-related behaviours and self-harm presentations to Victorian hospitals and mental health services with immediate community level responses.

A system that prioritises research and its translation into service improvement and innovation.

27. Provide equity for mental health research through: infrastructure support for Mental Health Medical Research Institutes (MRIs); a direct (not just 'indirect') financial response to the current lack of investment in mental health research organisations; and a commitment to new investments such as dedicated funding for a Mental Health Research Scheme in Victoria.
28. A refocus and redeployment of current Victorian mental health research investments, such as the clinical academic posts.
29. Invest in a new round of Mental Health Research Fellowships with a priority focus on applied and translatable research which can support the attraction and retention of mental health research talent.

Just make it as easy as possible for young people to seek help. There's already so many barriers around it, actually getting a young person to a service. Once they're in that service, it should just be the easiest thing in the world. Like that service shouldn't be putting another thousand barriers in their way. I think that's all it is." Young person

About Orygen, The National Centre of Excellence in Youth Mental Health

Orygen, The National Centre of Excellence in Youth Mental Health (Orygen), is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. The organisation has a translational research capacity spanning discovery, novel treatments, clinical, health services, health economics and practice improvement research.

This capacity is further enhanced by the organisation's role in running clinical services (four headspace centres), supporting the professional development of the youth mental health workforce and providing policy advice to the Australian Government relating to young people's mental health.

As a National Centre of Excellence, Orygen has been contracted by the Australian Government, through the Department of Health, to assist, support and guide the development of services that target young people with, or at risk of, severe mental illness. In particular Orygen provides guidance, support and expert advice to Primary Health Networks (PHNs) on their planning and commissioning of youth mental health services. This includes:

- headspace Youth Early Psychosis Program (hYEPP) to support the continued scaling up of operations and fidelity to the Early Psychosis Prevention and Intervention Centre model;
- supporting PHNs to commission 'Youth Enhanced' services for young people with moderate to severe mental illness, including the three PHN lead sites (ACT, SE Melbourne and Tasmania) that are developing and testing regional models of care for this group of young people; and
- the development of relevant resources and supporting evaluation activities. Orygen has hosted several national workshops to build this partnership, bringing together staff from PHNs and service providers from across the country.

Orygen's youth mental health economics work aims to inform and guide innovation in youth mental health services and systems and includes: conducting economic evaluations of youth mental health interventions, service models and supporting programs; developing and validating economic models and simulations utilising the evidence base in youth mental health; and exploring the potential long-term costs and benefits of prevention, early intervention and treatment in youth mental health.

Orygen's current research strengths include early psychosis, personality disorders, functional recovery and neurobiology. Other areas of notable research activity include: health science implementation, emerging mental disorders, mood disorders, online interventions, substance use, trauma and suicide prevention.

Orygen's work has created a new, more positive approach to the prevention and treatment of mental disorders, and has developed new models of care for young people with emerging disorders. This work has been translated into a worldwide shift in services and treatments to include a primary focus on getting well and staying well, and health care models that include partnership with young people and families.

Orygen is a not-for-profit company limited by guarantee. It is a charitable entity with Deductible Gift Recipient Status and is an approved research institute. The Company has three Members: the Colonial Foundation, The University of Melbourne and Melbourne Health.

About this submission

This submission will focus on the challenges and future opportunities in providing young Victorians (aged 12-25 years) with accessible, appropriate, effective and evidence-based mental health care and treatment.

Experts across a range of research areas and clinical service delivery were consulted in the development of this submission, along with a number of young people and their families who have had a lived experience with mental ill-health and contact with the service system in Victoria. They have been de-identified in this submission to protect their privacy, however we would like to acknowledge their time in talking to us and sharing their experiences with us.

We acknowledge that the response to mental health must be delivered across a continuum of prevention, early intervention, treatment and recovery services and programs and that there are a number of other service systems and settings through which we can embed improved responses to supporting mental health and wellbeing and address a range of risk factors for poor mental health.

However, Orygen's submission will focus primarily on **early intervention, treatment and recovery** for young people experiencing mental ill-health and the opportunities for improvements in those aspects of system design, development, service delivery and evaluation that are considered primarily the remit of the Victorian Government to fund and deliver.

Given the strong community and sector engagement in this Royal Commission, we believe there will be numerous submissions from organisations better positioned to respond to the broad ranging issues and intersecting social determinants of mental health and wellbeing, including mentally healthy workplaces, homelessness supports, child and family welfare services and mental health for other age groups including those under the age of 12 years and over the age of 25.

Orygen and headspace National Office also jointly provided a submission to the Productivity Commission's Inquiry into Mental Health in April this year. This submission contains detailed information and recommendations focused heavily on the youth primary mental health care system and in particular the national headspace platforms. We would invite the Royal Commission into Victoria's Mental Health System to access this submission here as a complementary document to this submission.

Orygen has also undertaken a comprehensive range of policy analysis since 2014/15. Recommendations have focused on opportunities to improve the effectiveness and efficiency of youth mental health service delivery across a range of areas including: workforce development; trials and pilots to test evidence-based interventions or trial new initiatives in service delivery; funding models to ensure services are provided to specific populations or mental health conditions; Medicare Benefits Schedule (MBS) reforms; priorities for future youth mental health research; and improvements in datasets. This has been used to inform the development of this submission, however a full list of Orygen's policy recommendations can be provided on request.

Youth mental health in Victoria

Profile of young Victorians

Victoria's population is projected to be almost 6.4 million at June 30, 2019, with approximately 1.1 million young people aged between 12-25 years. The population of young Victorians is projected to increase by 6.78% between 2019-24.(4)

Some characteristics of the youth population in Victoria include:

- a 20% increase in Aboriginal population aged 24 and under since 2011 (making up half of Victoria's total Aboriginal population and 1.3% of the total youth population in the state);
- culturally diverse, with one in six young Victorians born outside Australia and an increasing population of young refugees;
- 8,000 children and young people in out of home care;
- largely urban population, with 75% of young people living in the greater Melbourne region; and
- nearly one in five young people have a special health care need – and require more extensive health and related services than other young people.(5)

Mental health is a significant area of interest and concern among young Victorians. In the most recent Mission Australia youth survey:

- over four in 10 young people from Victoria (43.1%) identified mental health as an important issue in Australia today;
- nearly three-quarters of young people from Victoria placed a high value upon mental health (extremely important: 43%; very important: 31.9%);
- 45% of young Victorians were either extremely concerned about coping with stress or very concerned; and
- 32.8% of young Victorians were either extremely concerned or very concerned about mental health.(6)

The 2014 Mission Australia Youth Survey found that 19.1% of Victorian young people (aged 15-17) had probable serious mental ill-health, close to the national average of 20%.(7) Nationally 26% of young Australians (18-24 years of age) experience a mental health condition (including substance use disorders) in any given year, the highest of any age group.(8)

The recent ABS Causes of Death data indicated that Victoria had the lowest suicide rate in 2017 compared to other states and territories. However, the data also indicated that, nationally, suicide remained the leading cause of death among young people and it is in this age group that the largest increase in suicide rates was indicated.(9) This increase was particularly marked for young women aged 12-17 and 18-25 years of age.

Victoria's mental health clinical services and young people

"We hear that a lot "just ask for help" … When people do ask for help, a lot of the time the help isn't available. I think that's sometimes where the issue is in Victoria and Australia. I think we're working really hard on the stigma and telling people to reach out, but if the services aren't there and they're not accessible, I don't know how helpful telling people to ask for help is." Young person

Over the past two decades there has been a steady fall in Victorian Government funding (in real terms) for clinical mental health service delivery. Along with significant population growth, this has resulted in a mental health system that is now inadequate and unable to respond to demand.

Twenty years ago Victoria spent more per capita in mental health specialist care (including public psychiatric hospitals, community mental health care services, residential services and grants to Non-Government Organisations (NGOs)) than any other state or territory in Australia. In 2016-17, Victoria spent the least and provided specialist clinical care to the lowest rate of population nationally. The current situation (with a focus on young people where possible) is described in more detail below.

Proportion of population accessing care: Across all ages, Victoria has had the lowest proportion of the population receiving clinical mental health care of all states and territories. Although 3% of the population experiences severe mental ill-health, only 1.1% of Victorians received state-funded specialist clinical mental health care in 2016-17.(10)

Rates of young Victorians in state-funded mental health services almost half the national average: Across all ages the national average rate of community mental health care patients is 17.2 per 1,000 population, almost doubling Victoria's rate of 10.7. The comparative rate (per 1,000) is even lower across age groups of children and young people:

- 5-11 year olds patient rate of 4.6 (compared to a national average of 9.3),
- 12-17 year olds at 15.4 (compared to a national average of 30.3),
- 18-24 year olds at 14.2 (compared to a national average of 25.4).(11)

(AIHW notes this data may have been impacted by industrial action in Victoria).

Expenditure into specialised mental health care: In 2016-17, Victoria's recurrent expenditure per capita on specialised mental health services was 12.83%, below the national average and the lowest of all states and territories.(11) Additionally, while the preceding five year period saw a national average annual change of 1.5% at constant prices, Victoria increased expenditure by an annual change of 0.9% over the same period (*Fig 1*).(11) A failure to plan for and respond to relentless population growth, particularly in key urban growth corridors, has amplified the funding issue. Victoria's population has grown by more than half a million in the past six years, consistently outpacing the national average with a mean growth rate of 1.85 % per annum.(12)

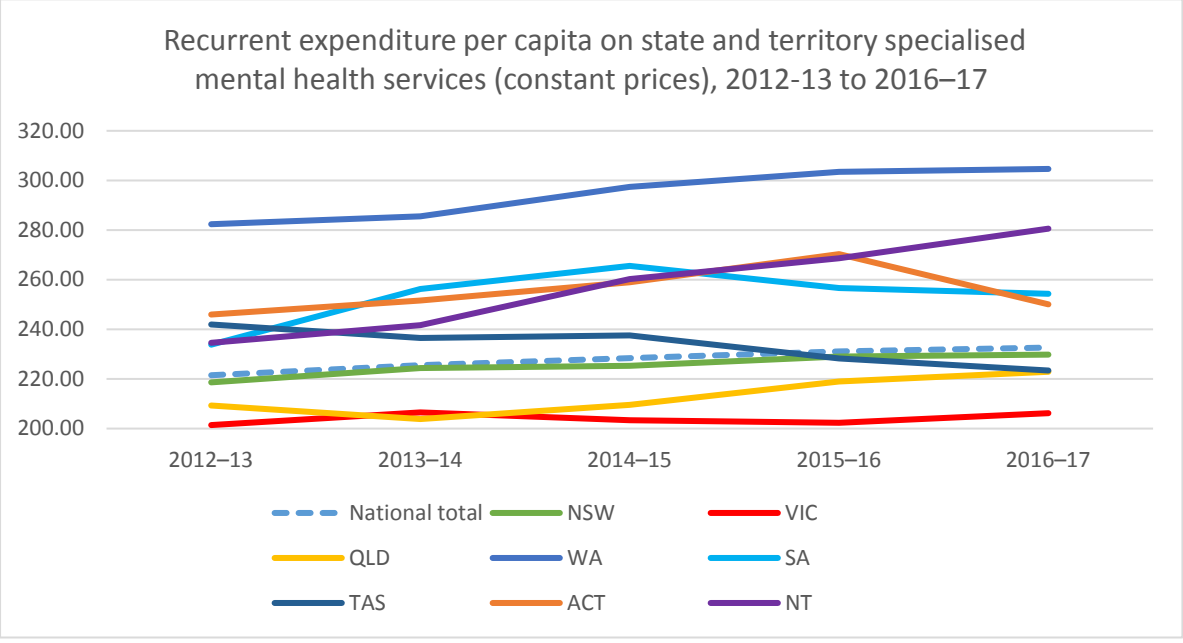


Figure 1: Recurrent expenditure per capita on specialised mental health services (Source AIHW)

Staff profile per population: Of all states, Victoria has the lowest number of FTE staff per 100,000 population in state and territory specialised mental health care facilities.(13)

While not specific to young people, the *Targeting Zero, review of hospital safety and quality assurance in Victoria* report raised a red flag for acute mental health services, highlighting that in 2013–14 Victoria had:

- the lowest proportion of new clients to all clients, indicating failure or inability to discharge (36.8% compared to a national average of 41.7%); and
  the highest proportion of patients readmitted within 28 days of discharge (14.7% compared to a national average of 14.3%).

This report also found that in Victoria the average patient is now both sicker on admission and discharge than they were five years ago.[13]

Safety and satisfaction in Victoria's child and youth mental health services: At 8.8 seclusion episodes per 1,000 occupied bed days in Victorian child and youth programs, 2017-18 seclusion rates in Victoria were the highest they had been in five years.(14) In the same year, the rate of bodily restraint episodes in Victoria were twice as high for children and youth programs than they were for adults.(14)

Data from Victoria, New South Wales and Queensland in 2016-17 show that young Victorians aged 18-25 have the lowest number of positive experiences with admitted and ambulatory care among these states.(11, 15)

Emergency department mental health presentations: For each year between 2012-13 and 2017-18, Victoria had the lowest rate per population of mental health-related emergency department presentations in public hospitals compared to other states.(10) However, the Victorian rate, particularly among children and young people is rising. In 2017-18, 24.77% of mental health emergency department presentations (or approximately 14,251) were by young people (12-24 years old).(13) Between 2008-09 and 2014-15, among children and adolescents, the number of mental health presentations to emergency departments rose by 6.5%, three times that of physical health presentations. In particular, the rates of presentations for self-harm, stress-related, mood, and behavioural and emotional disorders each increased markedly over that period.(16)

The importance of early intervention and youth mental health

Improving the response to mental and neurological ill-health is one of the core health challenges facing the world now and into the future. These conditions pose the greatest threat to worldwide economic growth of all non-communicable diseases, including cancer and cardiovascular disease (see *Fig 2*).(17) In Australia, mental and substance use disorders were responsible for an estimated 14.6% of the total disease burden in Australia.(18)

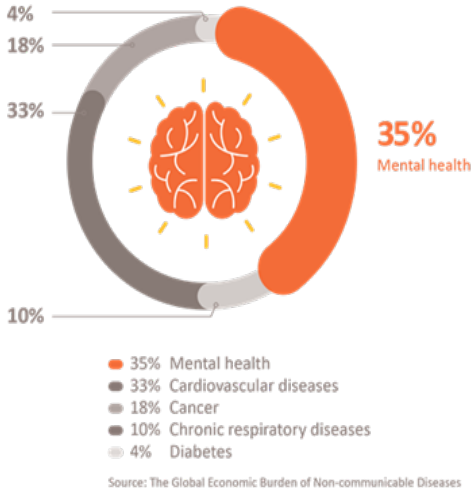


Figure 1: Global Burden NCDs

The timing of first onset in adolescence and early adulthood is a primary reason why mental disorders have such a significant social and economic impact. Fifty per cent of mental ill-health onsets before the age of 15 years, 75% by 24 years.(2)

Mental ill-health is the **leading cause of disability** in young people aged 10–24 years, contributing 45% of the overall burden of disease in this age group (1) (*Fig 3*). Compared to other non-communicable diseases, mental illness begins at the precipice of independence and adulthood. It's a time when young people will further their educations, forge career pathways, enter the workplace, move away from home and establish key relationships.

Left untreated, the trajectory and lifelong impacts of mental ill-health are borne by the individual, their families, their communities and governments. These include: un/underemployment, social exclusion, poor physical health, substance abuse and premature mortality.(19, 20) Suicide remains the leading cause of death among young people in Australia (21) for which mental ill-health is a well-documented risk factor.(22)

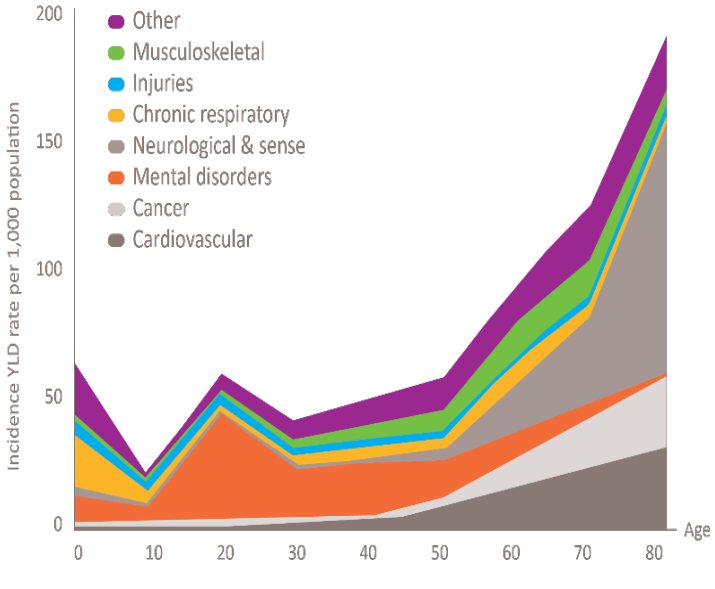


Figure 2: Burden of disease by age

In addition to the huge costs to the individual of experiencing mental ill-health, the society that they are a part of also plays a price for the lack of an early, sustained and recovery focused response to the onset of mental ill-health. Society loses the social and economic contribution that the individual may have made if they were well. There is also the cost of delayed care, coming too late in the trajectory of ill-health. This care can be harder to access, take longer, is more likely to be delivered in hospital and, as such, is more costly to provide. Then there are the other related costs of untreated or poorly treated mental ill-health such as imprisonment, confinement, taxes foregone and benefits paid.

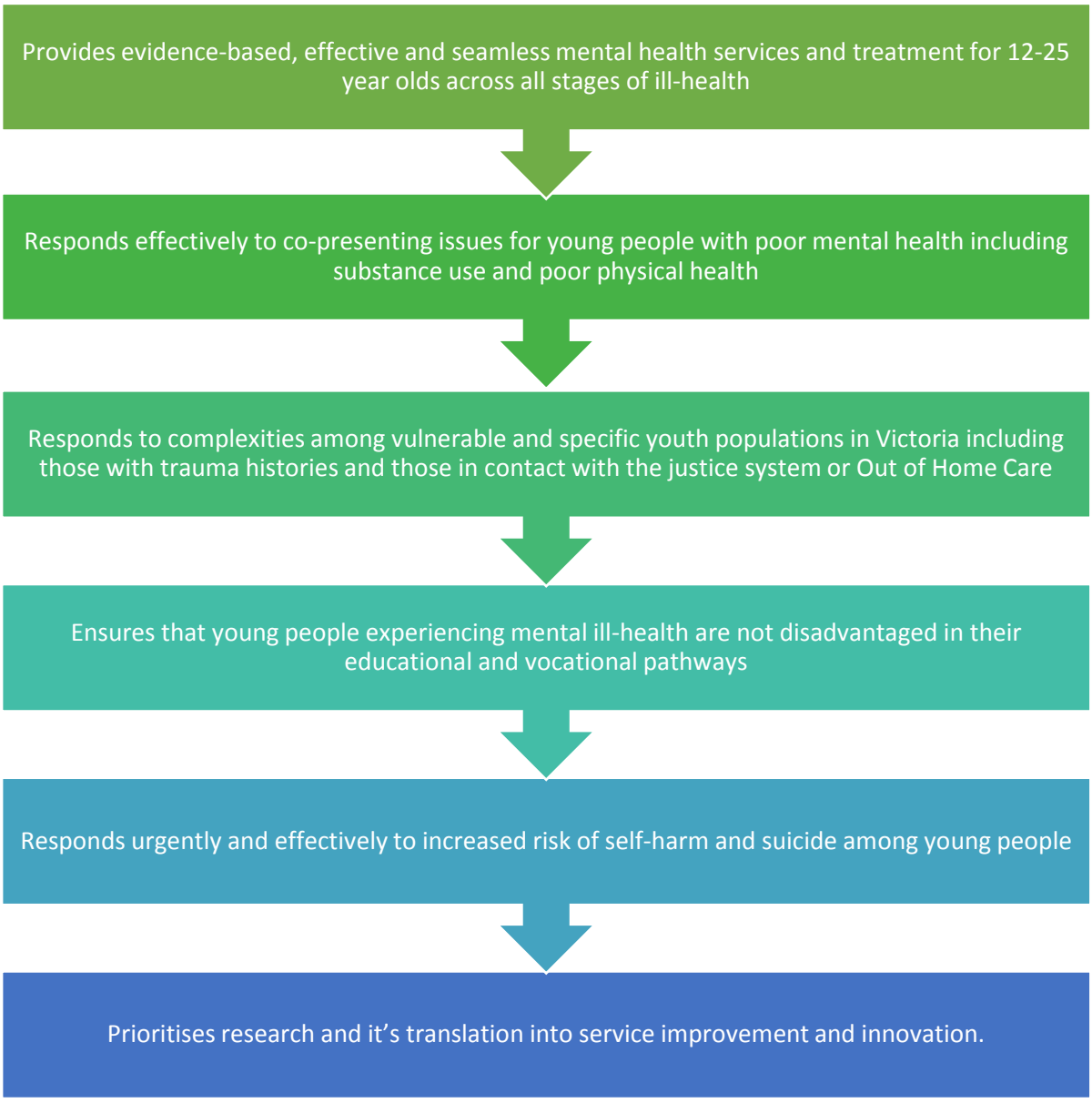
There is a growing body of international evidence that targeting preventive measures and effective early interventions to young people presents the best opportunity to reduce the economic burden of mental ill-health over the lifespan. In particular, there is strong evidence for the cost-effectiveness of prevention and treatment of mental disorders, particularly among young people relating to psychotic disorders. Economic evaluations and international expert consensus position early intervention in psychosis as an unequalled care model to reduce distress and economic burden. (27, 28)

It is now well established that the benefits of early intervention in youth mental health extend beyond early psychosis and mental health systems and into other areas of economic productivity. A Deloitte Access Economics report in 2009 found the financial cost of mental illness in people aged 12-25 in that year was $10.6 billion, of which $7.5 billion was productivity lost due to lower employment, absenteeism and premature death of young people with mental illness, and $1.4 billion was direct health system expenditure. The return on investment in early intervention was found to be approximately $6.19 for every dollar spent.(23)

Key priority areas for improving mental health services and systems for young Victorians

Victoria is home to international youth mental health experts and a skilled workforce that can provide evidence-based, high-quality mental health care. There is enormous potential in this state to elevate it once more to a world-leading position in the development, design, implementation, evaluation and research of youth mental health models of care. However, this potential has continued to be stifled by the shortfalls in service funding, the lack of policy direction and governance, poor data collection, oversight and monitoring, and an insufficient investment and focus on research and translation to drive innovation and service improvements.

Orygen believes there is an urgent need for these issues to be addressed and for the system to be redesigned to better respond to mental health issues among the youth population. The goal is for a state-wide system of youth mental health care that:



Provide evidence-based, effective and seamless mental health services for 12-25 year olds

Vision:

That the Victorian youth mental health system is designed and structured, with greatly expanded investment required, to ensure that:

- appropriate treatment can be provided across the stages of mental ill-health for the full age range 12- 25 years (in alignment with headspace) for as long as it is needed;
- community-based care and treatment is prioritised and recognised as providing the most acceptable, effective and safe setting for youth-focused services; and
- serious and life-threatening gaps in mental health services (resulting from service age transition points and tenures of care) are addressed.

Youth mental health system design

Significant gains have been made in Australia over the past decade in responding to the 'youth mental health imperative' and the development of a primary platform of mental health care that is effective at meeting the clinical, social and vocational needs of young people aged 12-25 years. Across Victoria, headspace centres are now improving access to enhanced primary mental health care that is highly acceptable and effective for young people.

In contrast, to access more specialised and acute care, young Victorian's must navigate a disparate number of services demarcated by various age limits. These include: community-based, outpatient and acute inpatient services that work with children and adolescents aged 0-18 years (CAMHS), services that work with children and young people aged 0-25 years (CYMHS), as well as, adult mental health services (AMHS) that work with young people aged 16 years and over. There is also a specific youth model in the North West of Melbourne for young people aged 15-24 years.

> ***"So throughout that whole year, I was kind of seeing all these new psychologists and I have to build up everything again. Tell them the same story. Like what I'm telling now, over and over again to these psychologists. I just want to be with someone and be in that kind of recovery not have to move on from place to place because I've already seen so many psychologists before and it kind of got tedious." Young person***

In addition there are three Youth Prevention and Recovery Centres (YPARCs) in Victoria, in Frankston, Dandenong and Bendigo, with a fourth to be built in the North West region of Melbourne. These centres provide short-term, sub-acute residential care with a focus on recovery for young people aged 16-25 years. They provide a valuable step-up and step-down service from inpatient care, but are only available for young people who are Victorian public mental health system patients.

Not only has this inconsistency in age eligibility created significant service confusion and inequity across the state, it has also resulted in significant gaps in care and a dangerous discontinuity of service provision for young people aged 12-25 years as they move between service models and catchments.

In particular, CAMHS services withdraw at a point of significant transitional vulnerability for young people (18 years of age). Even within the North West Melbourne youth-specific service for young people up to 24 years (Orygen Youth Health), under-resourcing and service design has restricted the

tenure of care for Orygen Youth Health (OYH) patients to a maximum of two years or up to 18 years of age. The impact of these limitations on tenure of care have been described in the case study below (Spotlight 1).

Spotlight 1: Tenure of care

Young person A:

"That was rough because (the program), it always said to me that I'd have approximately six months (of care).. So it kind of stops you wanting to form that relationship with the clinician, knowing that you're going to have to walk out of here and that that. So my case manager and the psychiatrist were pushing me to kind of go private. I'm a Uni student, I can't afford private…

It's just frustrating that you've made that connection with one person, but because the service is under so much pressure, you've got to go elsewhere."

Young person B:

"I kept telling them that I don't feel ready to leave and I need more time for that fell on deaf ears. They said that usually the people stay for six months, but we do give exceptions and things like that to people who we think are in need of it, but they didn't think I was in need of it.

And then having all that, then just suddenly having no support at all and not being able to go to the groups or anything that..I felt I was back at square one again. Yeah it (tenure of care) plays a big part, even if it's not directly, but plays a big part in patients' recovery… because that limits them with what they can do and what services they can access."

Although theoretically eligible for entry to the adult mental health system, most young people often find themselves 'not unwell enough' to access care, or the care on offer is alienating and inappropriate as adult services are ill–equipped to provide the youth-focused care required. Inpatient care is particularly concerning with young people placed in wards with adults or with individuals who can be experiencing specific mental health conditions and symptom severity that can be confronting, distressing or remove a sense of hope for many young people for whom this is their first inpatient admission and experience of a severe episode of poor mental health. In this system, young patients fail to engage and exit care resulting in poor outcomes and dangerous consequences.

Research has highlighted that the assumption that transition from CAMHS to AMHS is easy for adolescents and their families is incorrect. Evidence from Australia, Canada, the UK, and the United States has consistently confirmed that it is very difficult to provide coordinated/integrated youth mental health services during this period of transition.(24)

"Being in an adult psychiatric unit as a 16 year old was not a good experience. I felt my recovery would have been a lot more effective if I had been somewhere that was youth-specific with other young people facing the things that I was facing." Young person

The recent VAGO report into Child and Youth Mental Health Services identified successive failures of the Victorian Government to articulate a framework for child and youth mental health services.(3) In 2009, the Victorian Government's mental health policy articulated a direction toward elevating the transition age to adult services to 25 years as part of a 0-25 year old system of care. A limited amount of funding was provided to a number of projects to progress this reform strategy, including the child and youth mental health service redesign demonstration projects, however this strategy ceased after

four years in 2013 and there has been no introduction of a replacement policy agenda since. As a result, additional inconsistencies have been introduced into the system with individual services progressing with their own modifications to service design and delivery in lieu of any guidance or direction from the Victorian Government.

The Government's most recent 10 year plan does not provide direction on youth mental health. As the VAGO report (3) highlighted: 'DHHS formed the Mental Health Expert Taskforce to advise on the 10-year plan... The taskforce identified child and youth mental health as one of the highest priority areas for action; however, no plan was developed on what that action should be' p25. In contrast, Orygen has continued to develop specifications for a regional model of youth mental health care that could be rolled out state-wide. Our organisation has documented and costed this model (see Spotlight 2) for implementation in both metropolitan and regional locations and can provide this upon request.

Spotlight 2: Regional model of youth mental health care

Orygen has advanced the development of a regional model of youth mental health care. This new model of care would:

- provide a service for **all** young people who need a service;
- provide comprehensive, evidence-based stepped care proportionate to need and complexity, with the ability to monitor and adjust as required to suit the young person;
- deliver an innovative system navigator approach which will facilitate seamless care across a suite of expert intervention options which could include, but is not limited to: case management, medical treatments, psychological interventions, mobile outreach, peer support and access to inpatient or sub-acute care;
- embed new technologies across the service experience, from initial online engagement and triage through to the delivery of interventions and follow up support;
- work collaboratively with the acute care sector, including state-funded specialist community-based services, to ensure young people with complex and extremely severe mental health presentations are able to access early intervention; and
- partner with young people and their families across all elements of the model's design, implementation and evaluation.

Central to the model is a single entrance point, building on a regional cluster of expanded headspace platforms. It will be welcoming and accessible to young people, accepting of all presentations across all stages of illness (mild, moderate and severe) and is supported by online services and evidence-based interventions. Through this entry point young people and their families will access treatment and interventions matched seamlessly to their needs. This includes:

- **enhanced primary care** (mental health, alcohol and other drugs, employment/educational, specialist psychiatric assessment, psychosocial recovery) suitable for those young people with mild to moderate mental ill-health;
- **home-based assertive outreach/acute care** provided seven days per week, for young people with complex needs who struggle to engage with clinic-based services;
- **specialist care** (including vocational/psychosocial/clinical/physical and sexual health) for severe and/or relapsing mental illness and incomplete recovery (including for a range of serious/complex mental disorders, such as personality disorders, eating disorders, psychosis, mood disorders, alcohol and other drugs, and neurodevelopmental disorders such as autism);
- **around-the-clock specialist care** including extended hours, assertive outreach and crisis responses.

- **warm referral and active engagement** support to acute inpatient mental health care and other external providers; and
- specialist expertise, supervision, and technology assisted care.

Addressing the missing middle

Orygen has previously estimated that of the 26% of young people in any given year with mental ill-health, almost half will be experiencing a more moderate to severe and complex mental health issue and may be missing out on clinical expert care.(25) The National Child and Adolescent Mental Health and Wellbeing Survey found that 27.5% of young people with moderate to severe mental health problems had not accessed *any services* – including those provided through schools, telephone or online help-lines or general practitioners(26), let alone specialist care.

Orygen defines these young people as the 'missing middle'. They are too unwell to be provided effective services through the primary mental health system but are not acutely unwell enough to access state-funded services.

"It's frustrating because you're too severe for one service, that you're not severe enough for the other, which is so confusing." Young person

The missing middle may be even larger in Victoria as the level of acuity that needs to be reached to access this level of care has increased in recent years as services struggle to meet demand under significant resource constraints. In a letter to VAGO in response to the *Child and Youth Mental Health report*, Eastern Health described that the profile of their commencing CYMHS clients is substantially more severe in symptom intensity and impact compared to national averages.

This is also evident at Orygen Youth Health (OYH) in North West Melbourne. Only 1,000 young people with the most acute and urgent needs succeed in accessing OYH each year, while another 3,000 young people are not accepted into the service. This has placed the headspace centres in the North West of Melbourne under considerable pressure as they are responding to an increasing proportion of young people with complex, high-risk presentations (including self-harm and suicide risk). This has also compromised their ability to provide timely care for young people presenting with mild-moderate mental health issues who are left on waiting lists which can reach 6-8 weeks. This issue is being experienced across the headspace centre network and is described in considerable detail in the Orygen and headspace National Office Productivity Commission Submission.(25)

"The headspace team member has very bluntly said "The staff I have here at the moment would not be able to manage kind of, all of the symptoms, there is a risk because they're not experienced in that field or they're not experienced with this, that or the other". Young person

In addition, the impact of Victoria transferring its Psychiatric Disability and Rehabilitation Support Services and Mental Health Community Support Services over to the National Disability Insurance Scheme (NDIS) has, and will continue to, resulted in a significant depletion of community mental health support for young people with more complex and serious mental health issues. In the March 2017 NDIS dashboard data, it appeared only approximately 200-300 young people aged 15-24 years were active participants with an approved plan primarily for a psychosocial disability (or around 2% of all young people in this age group on approved plans).(27) This suggests that, while the NDIS individualised supports can be provided to young people with mental illness,

these are being applied sparsely (compared with the more than 20% of people aged 25 years and over on approved plans primarily for psychosocial disabilities).

Spotlight 3: Regional and rural service delivery

Young people living in regional and rural areas may be exposed to a unique set of structural, economic and social factors that result in poorer mental health outcomes.(70) The Young Minds Matter report shows that 12 – 17 year olds outside greater capital cities who had experienced a major depressive disorder showed higher rates for suicide ideation, suicide planning, and attempting suicide than for those living in greater capital cities.(5)

Yet regional and rural young people experience much greater difficulty accessing any primary mental health services, let alone youth mental health-specific care, as Medicare-subsidised mental health services per population decrease significantly with rurality.(71) A review of headspace centres found most young people attended a headspace within 10kms of where they live. As few as 1% of young people in remote Australia live within a 30-km radius of a centre.(37) For young people with more severe mental ill-health, admission into specialist, inpatient care will often require periods of relocation to metropolitan areas for young people and their families due to a limited number of available beds, outreach or expertise in regional health services.

"These kids are in [town] and their nearest headspace is in [suburb]. But to get to [suburb] is not a direct line. They have to get on a bus. Or if they want to go to [town], they have to go on a train, and it's an hour on the train and a 10 minute walk down there. And we have all these tiny little regional communities, like [town], which is a 20 minute drive from the nearest train station. And you can't walk that or ride a bike. There's no bus cause the road's too small. So how's a kid that lives there supposed to go and get access to these resources? They'd have to lie to their parents and say "yeah I'm going to see some friends" and it's such a journey and if this person is going through stuff that's really serious, to do that alone is brutal." Young person.

<u>Telehealth/eHealth</u>

Digital and online services are increasingly being adopted as a way to expand service delivery and especially to reach young people in rural/regional areas or for young people who have other barriers to accessing face-to-face care. They are also highly acceptable to young people.

However, as Orygen and headspace described in their Productivity Commission submission (25) they should be viewed as a "key component of a stepped care continuum, providing the first point of contact for mental health problems, as well as an adjunct support to face-to-face interventions… Where possible access to services such as telehealth and face-to-face support should be provided conjunctly, particularly in rural, remote and high risk settings."p 53

"I think the online stuff is great. I think it's amazing. I think it's really, really fantastic. But I'd be remiss if I didn't say that face-to-face interaction is always going to be better." Young person

"I hate the idea that they're using phones and online services to say "oh, now we've got the regional people covered". I think they're great, but I don't think they should be used instead of face-to-face services." Young person

Catchments

In Victoria, people are restricted to accessing state-funded mental health services based on their place of residence. These geographic catchment areas were defined in the 1990s and do not align with other health, human and social service catchments (including the Australian Government's PHN catchments or with Local Government Area boundaries). The VAGO report on Access to Mental Health Services highlighted the multitude of ways that the current catchment arrangements hinder service access and service coordination.(28)

The VAGO *Child and Youth Mental Health* report also highlighted the issues with complex catchment arrangements across the child and youth mental health system in Victoria.(3) Given the variability in child and youth mental health service delivery and availability across: age eligibility, regional per capita funding allocation and specific mental health disorders specialisation, there has been rising concern for the current inequity in youth mental health care provision that has developed from a system designed around 'postcode' eligibility. Further, it has resulted in a discontinuity of treatment and services should a young person move into a new catchment area where they may only be eligible for adult services, or where specialist capacity related to specific diagnoses is no longer available.

> ***"I think yes, as a whole broad general thing, across all the kind of services, is if people had more choice and more freedom to choose what kind of support they get and how it's run that will be very helpful as well. Young person***

While there have been recommendations to reconfigure and redistribute catchment boundaries, Orygen would suggest that, in clinical community-based youth mental health at least, catchments be removed altogether. In primary youth mental health care, the headspace centre network has been established without catchment restrictions and young people are free to access whichever headspace centre is their preference. Although for most young people this will be determined by their ability to physically access the service, in metropolitan regions this may still enable them the choice of a number of centres.

Funding

While the past two Victorian Government budgets have provided growth funding to address the service shortfall that has resulted from years of under-expenditure in mental health, mental health service providers in Victoria have admitted much of this new funding has been used to redress the difference between actual costs of service delivery and the price DHHS pays (DHHS only funds 65% of the costs of mental health beds, whereas it meets 80% of the actual costs of inpatient care provided by other health services). The funding has, therefore, not been used to provide additional services to people.(3, 28)

The VAGO *Child and Youth Mental Health* report (3) also highlighted the redirection of specific funding for community youth mental health care to plug funding holes in other areas of service delivery: 'Audited health services confirmed that they 'cross-subsidise' from their community CYMHS funding to cover the costs of meeting demand for their inpatient beds'. p28

This has in part been allowed to occur based on:

- the outdated, inefficient and ineffective approach of block funding arrangements. DHHS has begun to implement funding reform in the adult system by moving to 'packages of care' attached to clients, however as VAGO reported, this has not translated into the child and

youth system, where there has been no progress toward implementing activity-based funding;

- a lack of oversight or monitoring attached to the funding provided; and
- an apparent lack of population and demand-based modelling to calculate funding ratios across catchment areas. This is evident in the substantial variation in funding distribution per head *(Fig 4*) with North Western region funded at $57.34 per young person in the population compared to $79.87 per young person in the North Eastern region of the state and $77.41 per young person in the South Eastern region.(3)

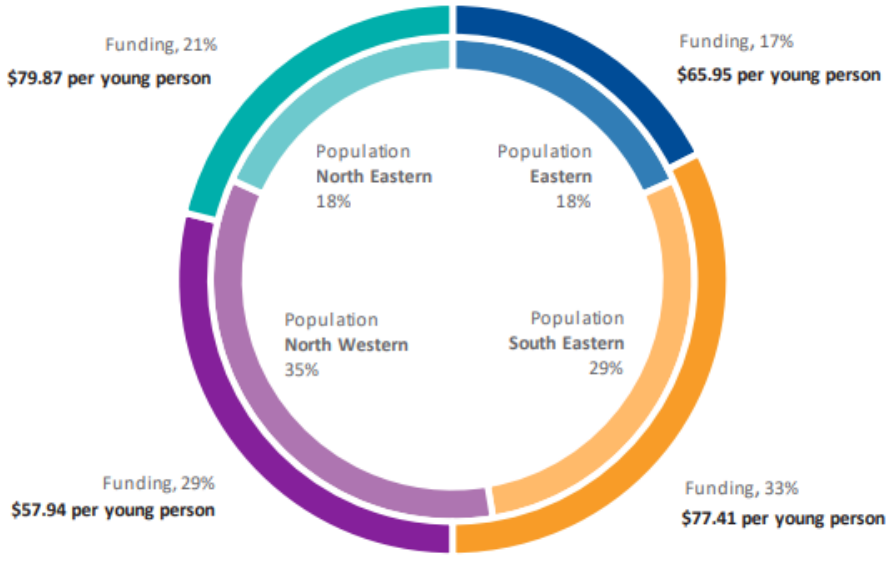


Figure 4: Geographic distribution of 2018-19 CYMHS funding compared to population of 0-24 year olds Source: VAGO Child and Youth Mental Health report

Even for those young people unwell enough to be accepted into inpatient care, the lack of funding for community-based services means there is limited access to services at points of transfer and discharge from hospital, including access to residential care (such as Youth Prevention and Recovery Centres in Victoria); assertive home outreach; and outpatient clinics. These are critical services at particularly high points of suicide and self-harm risk for young people with severe and complex mental health conditions. In addition, failure to provide adequate levels of funding to youth mental health services has resulted in cuts to a number of other service offerings which fall outside what would be considered standard clinical care, but which have a significant benefit to the engagement, experience and outcomes for many young people experiencing serious ill-health. These include social and group programs and family inclusive practice (discussed later in this document).

"They're shutting down all the groups..they've shut down so many groups and they only have two or three. I was part of all those groups and that was probably one of the main things that helped me start my kind of whole proper recovery journey. Yeah, the therapy was kind of helpful, but for me personally, it was the groups that helped the most." Young person

Governance

Governance issues exist right across service provision, service coordination, monitoring and oversight of Victoria's mental health system. VAGO's report highlighted, in particular, the lack of a governance structure responsible for oversight or monitoring of performance across the Victorian CYMHS system.

Successive state governments have failed to design, maintain and resource a system of the shape, design and balance required to meet the need. It is also clear that Local Hospital Networks, with a focus on acute health settings, have failed to protect even the inadequate level of funding that governments did allocate to community mental health care. There has been a serious failure to develop appropriate governance models to support essential community-based mental health care.

At a regional level, new mechanisms for commissioning and delivering dynamic, responsive and innovative models of community-based mental health care that integrate with primary mental health services (such as headspace) are critical. Orygen believes this will require a redesign of the governance arrangements for these services. Given the evidenced redirection of funding tagged to community-based care into other hospital-based services (3, 28), Orygen believes community mental health service delivery should be provided under new governance arrangements, outside of those in existing state hospital and health structures.

Workforce

There are well documented issues with attracting and retaining both a sustainable mental health workforce and a more specialised youth mental health workforce.(25, 29)

Although there are 5,000 people working in mental health in Victoria (28) across psychiatry, psychology, social work, occupational therapy and peer/consumer work, services continue to report difficulties attracting, retaining and managing the workforce. In particular there are issues with:

- workforce shortages in rural areas;
- differences in remuneration and incentives between the private and public system;
- getting the right skill set for community-based care compared to hospital acute care; and
- inadequate training and lack of development and promotional opportunities.(28)

> ***"I mean I went through three case managers, maybe four or five psychiatrists. That's not a very long time to form our working relationship"***
> ***Young person***

In this field there are also currently perceived/actual risks to the personal safety of the workforce and their general wellbeing. All of this has contributed to workforce personnel and skill shortages across the state. Opportunities to address this include:

Developing new funding models and increase funding in public mental health services: so as to improve working conditions, reduce burnout and stress which, together, make it difficult to attract and retain the workforce. In particular, the Victorian Government must provide the levels of funding required to fully meet conditions in Enterprise Bargaining Agreements (EBAs) which it currently does not do. The current perversity in the system has led to a disaffected workforce with poor morale and mental health and wellbeing. The result has been greater losses from the workforce than would be expected, further compounding the workforce recruitment and retention issues.

Build the peer workforce: The peer workforce has become integral to an effective youth mental health system and has been shown to deliver clear social, clinical and economic outcomes for individuals, families and mental health services.(30) For example, this workforce has been shown to improve social functioning, as well as reduce admission rates and longer community tenure.(31) In

the first three months of an Australian mental health peer support service, one study found that 300 bed days were saved, equating to $93,150 saved after project costs of approximately $19,850.(32)

Training and development: Along with more pre-service youth mental health training across a broad range of related professional disciplines, there is a need to embed and incentivise training within the workforce. If this is coordinated and delivered alongside regular duties, this can have a beneficial effect of providing the ongoing support and mentoring necessary to embed the skills and competencies developed from training.

"I think mental health education should be a right. It should be part of the curriculum. I think that kind of stuff would be incredible. Really, really beneficial because this stuff does save lives and even if it's just little stuff.." Young person

Building workforce capacity for shared decision-making with young people: Shared decision-making (33) is an approach to healthcare that can help to ensure each and every young person is supported to make informed decisions about their own treatment and care. It is the final step in evidence-based practice (34), whereby all available and relevant information about the potential benefits and harms of suitable treatment options are conveyed to the young person by their treating clinician in a way that is readily understandable. The young person then explores and communicates their personal preferences and values about these potential outcomes so that they can make a decision based on both evidence and what is right for them personally. Shared decision-making is feasible in youth mental health and in the case of depression can result in young people making a decision that is more in line with the evidence-based clinical practice guidelines.(35)

Recommendations

To build a state-wide youth mental health system that provides evidence-based, effective and seamless mental health services for 12-25 year olds across all stages of ill-health:

1. Develop and implement a state-wide Youth Mental Health (12-25 years) model of care underpinned by a clear and consistent guidelines and service specifications developed by leaders in youth mental health alongside the Department of Health and Human Services. This model should build on and integrate with the headspace platform at a regional level.

2. Reform the governance and accountability mechanisms associated with all aspects of state-funded youth mental health care beyond bed based services. This includes:
   a) moving the clinical and operational/corporate governance out of the hospital system and into community-based organisations/consortia;
   b) development of clear and consistent service specifications and KPIs; and
   c) reviewing the Mental Health Act to consider how it is able to support the preferences of patients in where and how they receive mental health care in the overall system (including the primary care system) and take account of proposed changes in governance.

3. Remove eligibility for services based on catchment areas for community-based clinical services provided to young people aged 12-25 years. Consideration should be given to the:
   a) alignment of state-funded clinical service delivery to primary youth mental health care providers (e.g. headspace centres) operating within PHN regions; and

b) Development of formal relationships between state-funded services and primary mental health care providers and other key regional stakeholders.

4. Funding should be increased across the mental health system with a new financial and governance model to ensure it has the capacity to meet the needs of the 3% of the population experiencing severe mental illness, as well as, a proportion of those with moderate/complex conditions. The Victorian Government should also:
   a) prioritise and explore more accountable and effective models of clinical community-based youth mental health funding, such as activity based funding and packages of care to deliver evidence-based treatment and tenure of care for young people with more severe and complex conditions; and
   b) direct clinical community-based youth mental health funding to agencies that can scale up their existing enhanced primary youth mental health care offerings. Priority should be given to contracting non-government organisations and not-for-profits with demonstrated capability in running youth mental health services, for example those that currently operate a well performing headspace centre.

5. Review the current availability of dedicated youth inpatient and YPARC beds across the state and instigate a capital program focused on meeting current and future needs. This includes:
   a) developing specific 'fit for purpose' design guidelines for youth inpatient and YPARC facilities to better meet the diversity of requirements across the age group and across diagnostic needs. This should occur using principles of inclusive design and co design with young people in all phases; and
   b) a review of the YPARC model to a) expand the age range to better align with the youth construct b) have a clear model of therapeutic care consistent with evidence for this cohort; and c) open referrals and access to non-Victorian public patients creating an open access referral pathway that enables primary care, private providers and services, such as headspace, to refer and work with the YPARC in providing care and support for young patients without the need to sever or fragment existing care arrangements.

6. Develop a time-limited and targeted mental health workforce plan with clear KPIs for the Victorian Government to grow the mental health workforce through:
   a) building the workforce pipeline, which would include supporting and funding as required clinical placement opportunities and peer workforce positions particularly within community settings; and
   b) creating more employment incentives and addressing current disincentives, including job insecurity and poor pay and conditions. As a priority, the Victorian Government must pay the actual costs of mental health care and review the underfunding of EBAs which, cumulatively, results in an indirect cut to the capacity to provide clinical services in an already overstretched system.
   c) Attract and empower expert and respected clinical leaders especially clinical academic psychiatrists to model the same successful approaches which have worked in oncology, neurology and cardiovascular medicine

A system that provides an integrated response to co-presenting issues

Vision:

Young people who present to mental health services for care and support are often also experiencing a number of interrelated personal, family and social issues along with other health-related comorbidities that can have a significant impact on their symptom presentations, severity, and complexity and can impact on their response to treatment.

Victoria's mental health system should deliver services that provide a comprehensive response to the young person in the context of their broader psychological, physical, social and cultural needs. This includes a system that can provide mental health care alongside evidence-based interventions for:

- drug and alcohol use;
- physical and sexual health;
- family inclusive practice; and
- vocational support (discussed in separate section)

Drug and alcohol use

Young people experiencing mental ill-health are more likely to use alcohol and other drugs. Either health issue can lead to or exacerbate the other, and once established, they are difficult to disentangle.

Divisions in the health sector between mental health and alcohol/other drug use services present barriers to access. The integration of services and treatment provides an opportunity to achieve improved outcomes for young people and service efficiencies. Joint treatment for young people requires workforce training, service integration (or coordination) and a workforce **skilled** in providing evidence-based early interventions for young people.

Early intervention

First time exposure to alcohol/other drugs between the ages of 12 and 24 years and the increased likelihood of use among young people experiencing mental ill-health requires a specific service focus for young people. Early intervention models face implementation barriers as young people do not always see the value of an intervention until substance use problems become severe. Orygen is currently conducting studies aimed at improving the evidence base for implementation of early intervention approaches for substance use, both with and without other mental illness.

Continuous professional development is required of all disciplines to ensure health practitioners engaging young people are aware of the latest approaches to assessing mental health and alcohol/other drug use. Continuous assessment is required for young people receiving treatment as rates and patterns of alcohol/other drug use often changes over time.

Although the headspace model was established to provide both mental health and alcohol/other drug use services it is popularly perceived and promoted as a mental health service. Only a small proportion (1.7%) of young people attending headspace present for alcohol and other drug use alone.(36) This suggests that more can be done to optimise the treatment of substance use problems at headspace, including providing more seamless integration of alcohol and other drug use treatment with mental health care.

Workforce training

Regardless of the point at which a young person connects with the health system, staff need to be skilled and resourced to provide dual care. Mental health and primary care workforces need training in how to screen, assess or treat alcohol/other drug use effectively and in a non-judgemental manner.

Workforce training needs to be embedded in pre-service training, not delivered through a few hours of video content. Training needs to be comprehensive and cover experimental and polysubstance use by young people and harm minimisation strategies.

The transition to joint treatment will require broadening workforce capacity away from narrow specialisation. This change will be required in both mental health and alcohol/other drug use services.

Service integration

Service integration is required to enable joint treatment. However, currently alcohol/other drug use service systems and mental health service systems are very different.

An integrated approach has been identified as best practice by Australian governments and health departments. Available clinical research evidence suggests that integrated treatments offer the best method of encouraging the client to better understand the links between their conditions, and to make improvements across multiple domains. Integrated treatment is also associated with higher levels of engagement and retention. Young people do not want to see two clinicians.

Specialist clinical services for severe comorbid disorders, with case management and evidence-based medication are required.

Although there is international evidence for the translation of comorbidity treatment approaches into clinical settings they have not been widely tested in Australia.(37) Available evidence supports longer treatment for people with comorbid mental health and alcohol/other drug use issues. Longer treatment was found to have an additional impact on functioning and depression among people with alcohol, psychosis or depression-related comorbidity and greater reductions in cannabis use in psychotic populations.(38-40)

Recommendations

To fully integrate a response to substance use into the delivery of youth mental health services:

1. Increase the number of specialists in addiction medicine or addiction psychiatry and psychology[4] who are directly working in youth mental health services and have expertise in providing evidence-based treatment to address co-occurring substance use and mental health issues.

2. Provide training in the screening, assessment and initial treatment of mental health symptoms for all disciplines working in alcohol and other drug use services and vice versa for clinicians working in mental health services. Specific training modules are required for both primary health and specialist services.

[4] Addiction medicine specialist or addiction psychiatrists who are qualified and recognised sub-specialists in medicine who are trained to provide prevention, screening, interventions and treatment of substance use and addiction.

3. Increase funding for mental health services to provide clinical treatment, assertive outreach and the duration of care needed dependent on complexity and severity for young people presenting with comorbid mental health and alcohol/other drug use issues.

Physical and sexual health

Young people experiencing mental ill-health are also at greater risk of experiencing poor physical and sexual health.(41, 42) They are more likely to smoke, be less active, partake in risky sexual behaviours and have poor diets.(41) Young people who experience psychosis, in particular, are at greatest risk of poor physical health. These include complications from psychotropic medication and polypharmacy that can cause rapid weight gain and cardiovascular disease combined with other lifestyle factors.(42) The physical health complications that arise during the early phase of illness can extend into adulthood and ultimately reduce lifespan.(43)

"Choosing medications that are low on the propensity to increase weight gain or other metabolic changes should be standard practice." Psychiatrist working with young people

Youth mental health services are positioned in a way that physical health issues could also be addressed as a part of a holistic care package. This indeed is the intention of the headspace model. Yet, presently, there is a singular focus for treatment of the mental illness in most youth mental health settings despite young people with mental ill-health having poorer physical health. In most secondary and tertiary youth mental health services, the scope does not reach beyond addressing mental health.(44) This is in part due to the workload and time capacity of the workforce providing care to young people. But is also due to workers' perceptions and the services' perceptions of their requirement to provide care beyond mental health intervention.(44)

Monitoring of physical health

Psychiatrists and mental health nurses are a pre-existing workforce that are ideally placed to engage young people in physical and sexual health monitoring while they are in the care of the mental health service.(44) Metabolic monitoring as a standard practice would enable the identification of early signs of metabolic disturbances in order to identify areas needed for intervention for young people in treatment. This is particularly important when commencing a young person on psychotropic medication.(42) Additionally, sexual health testing would ensure early signs of sexual health complications would be addressed in-house which would delay the progression of certain disorders into more serious ones.(41)

Evidence-based interventions

Monitoring and identifying need for intervention, however, is insufficient in improving the physical health outcomes of young people experiencing mental ill-health. Services need to be resourced such that when physical health difficulties are identified, intervention can be provided within that service. The success of interventions such as using exercise physiologists, nutritionists and addressing smoking cessation in-house is indicated through clinical research. Research investigating the efficacy of targeted interventions to reduce weight gain in young people experiencing psychosis demonstrates the benefits of providing physical health interventions within a mental health service.(42) This program included a clinical nurse, dietician, exercise physiologist and youth peer wellness coach. The authors recommend implementing lifestyle and life

"It is too easy to say well that isn't our role, that is the GP's problem… "Having dedicated staff to do the physical health checks make it more likely to happen." Psychiatrist working with young people

skill interventions from the initiation of treatment in a first episode psychosis service as a part of routine clinical care.(42)

> ***"Any kind of exercise really helped. I still do that to this day and that's really what's kind of helped me keep going on and not falling back into that depressive state because they now I have actual goals to work to" Young person***

Interventions such as these are effective and improve not only the current physical health profile of a young person but provide the opportunity to prevent further physical health complications and difficulties later on into adulthood. This type of intervention could also extend beyond young people who experience psychosis but also those experiencing mental ill-health, who have similar physical health risks.(42) Unfortunately, research into sexual health interventions for young people experiencing mental ill-health is incredibly limited. Dedicated funding is required to ensure optimal interventions can be developed and supported by research.

Recommendations

To fully integrate a response to physical and sexual health into the delivery of youth mental health services:

1. Provide dedicated funding to mental health services to employ GPs, exercise physiologists, dietician, general nurses and sexual health nurses so that services can incorporate support for diet, exercise, smoking cessation and sexual health as standard care.

2. Provide ongoing professional development of the mental health workforce so that they can:
   a) understand and incorporate responses to physical and sexual health within their approach to providing care;
   b) develop effective working relationships with GPs and other primary health providers working with the young person within the wider primary care system; and
   c) Build in KPIs requiring regular, timely and clinically necessary communication with all other health care providers working with a young person to mitigate fragmentation of care, ensure role clarity and effective understanding of clinical responsibility. This includes communication at point of referral, regular review points, symptom exacerbation, medication changes, changes in personnel, transfer of care to another service and or discharge.

Family inclusive practice

Family involvement in the care and treatment of young people experiencing mental ill-health is core to their initial and ongoing recovery.(45) The definition of family extends beyond the typical family model and should be considered to encompass all diverse families, including single parent families, siblings, single sex parents and other non-biological family who the young person considers to be family in their life.(46)

Service design and funding

Involving family in a young person's treatment is successful in improving recovery however, the actual process of doing this in treatment can often be perceived as tokenistic. This is mostly due to the lack of dedicated funding in services for family involvement in a young person's treatment which does not allow for adequate family inclusive practice.(46) In addition, lack of training for clinicians on how best

"There are current aspects of involving families that are working well but not in terms of systemically or not in any way in terms of how the system is set up… Families are an afterthought." Clinician working with families and young people

to engage and work with the families is a key issue that impacts the success and function of family inclusive practice in mental health services. The current system is not designed in such a way that families have a key part in a young person's treatment.(46) Orygen believes the six partnership standards developed by Mind Australia should be implemented across all mental health services for young people regardless of whether they are state or federally funded. There are resources developed with the support of the Commonwealth Department of Health which are available to support implementation, including an app.(45)

Workforce development

In order to better involve families in a young person's treatment, services should be trained to view the young person's mental ill-health as a part of a whole family system and experience. Particularly, the function of involving families in care should not just be to brief them on their young person, but also to consult and work together with the family to promote overall recovery.(45) As such there is a need to build the skills of the mental health workforce in family inclusive practice so that they can better incorporate considerations of the young person's family and family context into the care and treatment provided. The employment of specialised and skilled family clinicians and family peer workers (46) is critical in the future development of the youth mental health workforce.

"We don't attend to how acceptable some types of treatment are for some families. Then months later we realise it's not how their family does things. Understanding family and family involvement and how that helps is key to this." Clinician working with families and young people

Siblings

Siblings of young people who experience mental illness are also not often formally perceived as care-givers by themselves or service, despite many sharing this role with their parents. Siblings can play a key role in their own sibling's recovery.(47) They can also be at risk of developing mental ill-health particularly, after the stress of being involved in their sibling's treatment and care.(47) There is currently very little research and literature in the area of siblings of young people who experience of mental ill-health and the unique perspective and experience they may bring to theirs and their sibling's experience.

Recommendations

To better support families and family engagement within youth mental health service delivery:

1. Provide targeted funding to ensure family inclusive practice is appropriately implemented rather than these funds being taken from block funding for therapeutic services. This funding should be linked to a satisfaction and experience evaluation by family members, as well as, young people to ensure its ongoing success and validity. Dedicated funding is also required for family peer support workers to ensure they have secure and recognised positions.

2. Develop best practice guidelines and a funded implementation plan supported by reportable KPIs for working with young people and their siblings.

Deliver services that respond to vulnerable and/or specific youth populations

Vision:

The risk and experience of mental health problems increases considerably in the context of other aspects of disadvantage and vulnerability. These include experiences of trauma (including childhood neglect and abuse), displacement as a refugee, homelessness and contact with the justice system.

Victoria's mental health system should provide wrap around and coordinated services and supports that respond to the complexities and need of specific vulnerable youth population groups including:

- young people with experiences of trauma;
- young people in contact with the justice system;
- young people who have arrived as refugees;
- young people who are homeless; and
- young people in out of home care.

Trauma

Trauma is beginning to be considered essential to understanding the mental ill-health experiences of many young people. Between 57-75% of all Australians will be exposed to a potentially traumatic event, and international studies suggest that half to two-thirds of young people are exposed to at least one traumatic event before 16 years of age.(48-51)

Although treatment for Posttraumatic Stress Disorder (PTSD) is important, the relationship between trauma and mental ill-health is more extensive, and PTSD does not sufficiently cover the experiences, the needs or the complexities of young people with experiences of trauma.(52) With or without PTSD symptoms, childhood trauma increases the risk of mental ill-health later in life, and has been associated with anxiety, depression, psychosis, personality disorders, self-harm and suicide-related behaviour and eating disorders.(52) Additionally, experiences of trauma increase the risk of onset, illness duration, complexity and severity, and can impact treatment responses.(53)

Current responses to trauma

Despite the prevalence of trauma experiences, and its impact on mental ill-health, trauma is often poorly understood and treated by the current mental health system. It is under-identified in clinical assessments. Some clinicians avoid assessing for trauma exposure and mental health effects for fear of opening 'Pandora's Box' or concerns about re-traumatisation. In addition there is a lack of age-relevant assessment tools (or resources to train in them) and a belief that trauma requires separate, specialist care.(54)

There are currently a number of significant barriers to providing effective treatment for trauma. These include: inadequate diagnostic frameworks for young people with complex trauma experiences, a limited number of appropriate mental health practitioners who are skilled in trauma treatment approaches, or supervising staff who are working with traumatised young people.

When clinicians are trained and experienced in trauma-informed approaches, the 10 Better Access initiative sessions are not sufficient to provide trauma-related treatment responses to young people. Treatment guidelines suggests that for PTSD up to 16 sessions are required (55) and for complex trauma presentations, the number can be significantly more.(56)

Trauma-informed care

Trauma-informed care describes a service response that understands trauma; promotes safety, shared power and autonomy; and recovery-focused care.(52) It focusses on the physical, psychological and emotional safety of the client and clinician, and aims to prevent re-traumatisation by the service or system.(56) A trauma-informed system aims to reduce re-traumatisation, and trauma-informed approaches are instrumental in reducing experiences of restraint and seclusion.

Trauma-informed care isn't a checklist or an intervention, but a system or service-wide culture shift that will support clinicians to screen for trauma and its effects and provide appropriate treatment. Trauma-informed care in youth-specific mental health settings requires implementation initiatives that include senior leadership commitment, support staff, amplifying the voices of young people and their families, aligning policies and programs to trauma-informed approaches, and incorporating a focus on data and evaluation.(57)

Trauma-informed care is often inadequately implemented in services, with a focus on single training sessions rather than the necessary system-wide implementation and policies needed to permeate care with a trauma-informed response. Additionally, there is a need for clarity, shared definitions of trauma, and evidence-informed approaches when trauma-informed care is implemented.

Recommendations

To better respond to young people with experiences of trauma and/or trauma-related mental health conditions:

1. Invest in a research project to develop and trial a trauma-informed, youth-specific screening tool to assess the presence and impact of trauma in young people aged 12–25 years who are engaged in clinical services.

2. Develop an overarching framework for implementing trauma-informed care (TIC) in Victoria across mental health service delivery which includes:
   a) a clear and consistent definition of TIC and service specifications for these settings; and
   b) investment in workforce development and accreditation to ensure that service managers, clinicians and the broader youth mental health workforce provide consistent responses to trauma across the system.

Juvenile Justice and Forensic Youth Mental Health

Young people who are connected to the justice system are often from a range of disadvantaged backgrounds, are more likely to have experienced childhood trauma and, for those who are in custody, are overrepresented by certain cultural groups. (58) There is immense scope for the improvement of the forensic system in order to better support and improve the mental health of young people who are justice-connected. Service improvement should focus on the areas below.

"There are numbers of the young people that haven't hit the (mental health) system at all. Where are they? Where were they before they reach custody or the forensic system?" Clinician working with young people in custody

Expanded service model

A key issue in supporting justice-connected young people experiencing mental ill-health is that mental health intervention does not often occur until they reach the forensic system.

Although it is acknowledged that Victoria was recently provided with funding to set up the forensic community care program for young people in custody, this funding is not adequate to reach the demand of young people experiencing mental ill-health in custody.

> ***"Once people have contact with forensics it is usually only one of the complex issues they have".***
> ***Clinician working with young people in custody***

Of the young people who are in custody, 80% experience at least one mental illness.(58) These difficulties are present long before they reach custody yet funding for mental health intervention is currently aimed toward the population of young people in custodial settings. Being in custody itself also has an impact on young people's mental health. Young people are being placed in a custodial environment which further exacerbates their mental ill-health and ultimately, can result in their degree of criminality worsening.(58)

Earlier intervention should focus on a stepped care model that ensures the right level of treatment is provided at all stages of engagement with the justice system.(59) In particular:

- children who display complex behaviours that increase the likelihood of criminal offending later on require service support and intervention;
- treatment specifically focused on young people with intellectual disabilities or who are on the Autism Diagnostic Spectrum and are displaying problem behaviours;
- outreach services for young people who are justice-connected but not yet in custodial settings;
- treatment following the completion of a supervision order through integration into community-based mental health services to support a young person's transition;(59)
- A trauma-informed approach to all stages of treatment and intervention to ensure that contact with the justice system is not further traumatising for young people; (58) and finally
- treatment for young people in custody.

Workforce development

Broadening the scope of youth justice services should also include a focus on workforce development. The success of further service expansion is highly dependent on a trained and capable workforce. Justice workers who work specifically with justice-connected young people do not receive standard basic training regarding mental ill-health support and treatment. They themselves also not do not receive enough support in working with this complex population.(58)

For clinicians working specifically with justice-connected young people there is limited training around the needs of this group and specifically in navigating the complexities of the forensic system.(58) Within the adult forensic system, forensic clinical specialist roles exist however, these roles have not been implemented for clinicians working with young people in this area. Workers such as these are needed so that extra training, support and supervision is provided to justice-connected young people who experience mental ill-health.

Cultural competency

There is an overrepresentation of Aboriginal and Torres Strait Islanders, Maori and Pacific Islanders, and Sudanese, who make up 40% of young people in detention or on parole.(58) This data indicates the ongoing levels of social disadvantage among young people who are justice-connected and indicates intervention and greater support for these groups needs to be implemented much earlier before they reach the justice system.

Recommendations

To better respond to the mental health needs of young people who are at risk of offending or who are in contact with the justice system:

1. Develop and deliver a state-wide comprehensive forensic mental health service for young people both in custody and in the community. This should include: a focus on early intervention, integration of specialised mental health treatment with interventions that address offending behaviours; and Youth Forensic Clinical Specialists for youth justice clients (12-21 years).

2. Provide the broader mental health and justice workforce with training for a basic accreditation for working with justice connected young people who are experiencing mental ill-health. Support from academic institutions to provide specialist training in these areas is required.

3. Fund evidence-based interventions and strategies to engage with specific youth populations overrepresented in justice system contacts to prevent offending or minimise the risk of reoffending. The workforce engaged in these programs should be provided with targeted training in working with these populations in their unique cultural context.

Young people who are homeless, in out of home care or from refugee backgrounds

Out of home care

The number of young people in out of home care (OoHC) in Victoria is approximately 8,000 (one-third are aged between 12-17 years)(5) and each week in around 60 young people are placed in out of home care. Across Australia the number of young people living in OoHC care doubled between 2001 and 2013-14 with 10 times more Aboriginal and Torres Strait Islanders than non-Aboriginal young people.

These children and young people often experience significant disadvantage and early childhood trauma and have multiple and complex needs. They display four times the levels of emotional and behavioural difficulties than their age-matched peers in the community and international data suggest they are four to five times more likely to be hospitalised following a suicide attempt than their peers in the general community.(60)

As such there is a need for integrated service models to better connect OoHC and mental health services within a trauma-informed framework. As described in Orygen and headspace National's response to the Productivity Commission, a program being trialled in Victoria, the Ripple project, shows that strengthening the therapeutic capacity of carers and implementing complex mental health intervention across sectors is potentially feasible and cost-effective, and likely to provide essential supports to improve the mental health and wellbeing of young people in out of home care' p32.(61)

Refugee and newly arrived populations

For young people arriving from other countries, and particularly those who are seeking asylum and refugee status in Australia there are a range of risk factors which impact on their mental health and wellbeing. Many of these young people and their families will be traumatised through personal or witnessed experiences of violence and/or deaths. They may have been separated from family members and had distressing, if not terrifying, experiences as they move through temporary accommodation, refugee settlements and detention centres on their way to resettlement in Australia.(54)

Their experience, even once they have arrive, can increase their risk of poor mental health and psychological distress including isolation, social exclusion, cultural shock and discrimination, not to mention, early housing insecurity, unemployment and financial stress.(62)

Young people from migrant and refugee backgrounds access mental health services at a much lower rate than other Australian born young people. Many CALD young people who had mental health issues were found to be less likely to access community state-based services than Australian-born young people but had proportionately higher admission rates to inpatient units, suggesting they experience significant barriers to accessing mental health care until their illness had become acutely severe.(63, 64) A report from CMY found work is especially needed in the areas of mental health and housing – with housing instability and poor mental health shown to have the most significant adverse impact on settlement outcomes.(65)

Homeless young people

More than 26,000 young people aged 12-24 years are estimated to be homeless in Australia.(66) In 2017-18, at least 30% of those aged 10 and over who sought help from a specialist homelessness service in Australia reported a diagnosed mental health issue. This incidence is far higher than the 18.2% of Australians who have a mental health condition. Research has also demonstrated that housing insecurity both causes and prolongs mental ill-health, with a major Victorian study finding that just 15% of people accessing specialist homelessness services had mental health issues prior to experiencing homelessness, while another 16% only developed mental ill-health after their experience of homelessness commenced.

In addition, trauma has been found to be an important factor in young peoples' pathway to homelessness. 97% of homeless participants in one Australian study were found to have experienced more than four traumatic events.(54)

Many people experiencing mental ill-health, including those experiencing homelessness alongside complex mental illnesses, will require intermittent multidisciplinary support, with very flexible case period lengths. A greater focus on integrated programs is required – programs that include professionals from a range of disciplines as part of a service delivery team.

"I wanted a better connection between some of these services. Like, my counsellor didn't suggest any of the things that would help my family with financial issues or stuff like that. Like, all the things that were causing me so much stress and anxiety that I was needing to see a counsellor. It was very "let's fix the symptoms", not "let's do some primary prevention and let's fix what is actually causing these issues." Young person

Recommendation

To better respond to young people who are in Out of Home care or are experiencing housing insecurity or homelessness

1. Progress recommendations from the VAGO Child and Youth Mental Health report which relate to improving, and prioritising, access to mental health services and supports for young people experiencing specific complexity and vulnerabilities.

Ensure young people experiencing mental ill-health are supported to participate in education and employment

Vision:

Young people experiencing mental ill-health have the same aspirations as other young people to engage in study, enter the workforce and have successful and fulfilling careers. The Victorian mental health system should be designed with a focus on recovery, which includes supporting young people to achieve these goals. This includes:

- providing effective supports to young people experiencing mental ill-health in both schools and in tertiary education;
- including evidence-based supports for educational and vocational recovery within mental health services and treatment; and
- including evidence-based supports for social and community participation within mental health services.

Young people with mental ill-health tend to have large gaps in their employment history, interrupted learning resulting in lower literacy and numeracy levels, lack employment references, and lack confidence to apply for jobs or enrol in further study. They also tend to lack social skills, be socially isolated and are disconnected from their community.

> ***"I think probably the biggest thing I was missing at school was that there was no one that was willing to kind of be "this kid's just dropped from As to Ds. Maybe something has happened" more so than "he's just stuffing around." Young person***

High school completion rates of young people experiencing mental illness varies between 32-62% compared to the general population's completion rate of 78%.(67) In vocational education and training, students with an identified mental illness have low subject completion rates and the lowest award rate of all the major disability groups. (68, 69)

In universities, 86% of students experiencing severe mental illness withdraw from their course (70) and the annual Student Experience Survey has shown year-on-year increases in the numbers of undergraduate university students considering an early course exit for health and stress-related reasons, which peaked in the most recent survey in 2017 at 45%.(71)

Building the capacity of schools to support students experiencing poor mental health has been a focus for the Australian and Victorian Governments over a number of years. Most recently, the Australian Government has funded Beyond Blue to deliver a national education initiative called Be You to support early childhood educators, primary and secondary schools to identify and respond to mental health issues more effectively.

The Victorian Government is also about to commence roll out of their mental health workers in schools initiative, which aims to increase the workforce with mental health expertise within all secondary schools in Victoria. In addition, there are Department of Education Secondary School Services provided for young people accessing public mental health clinical services, which are offered in partnership with the clinical team to assist young people to remain in education or facilitate return to education.

"We had great wellbeing staff at [regional school], they were fantastic… you could go down there and if you were really, really struggling, you could have a nap in one of the rooms. They were fantastic. They were really, really caring… I think a direct line between wellbeing staff at schools and general practitioners and the hospitals around the area would be incredible. And also services like headspace and stuff having direct communication lines would be fantastic." Young person

Responses to suicide, suicide-related behaviours and self-harm needs to occur in settings where young people are engaged, such as schools. Be You (formally headspace School Support) offers postvention to schools affected by suicide. It provides immediate and ongoing support to secondary schools to assist them to respond to and recover from suicide, as well as suicide prevention and responding to suicide risks. Across Australia, Be You has responded to 4-5 deaths every week, with an increase in requests from primary schools.(25) Between 2012-2018, the service was notified of 1,194 suicides and 714 suicide attempts.(25)

In addition the Victorian Government has partnered with headspace to provide schools and school communities with support to respond specifically to mild mood disorders (e.g., depression and anxiety) and self-harm. headspace School Support has reported that the uptake was significant, possibly evidence in itself of the high need in schools for support to respond to these presentations, and that the program was well received, with other states and territories also indicating interest.(60)

Universities across Victoria provide counselling and psychological support services for students although these services often report high demand, long waiting lists and difficulties in referring out into community-based mental health services. Some universities also have developed, or are beginning to develop, mental health strategies to embed whole of university responses to mental health and wellbeing. Orygen is currently developing a National University Mental Health Framework to support universities nationally to respond to these issues.

However, despite this work, the experience of accessing support within educational settings is highly variable as highlighted in the quotes from young people we interviewed for this submission in Spotlight 4:

Spotlight 4: Experiences of accessing mental health support at school	
Young person A: We didn't actually have a school psychologist at the time even though the was a whole support service setup but eventually I got one and then I was only with them for six months, but then they left to go to a different job. So, I'll just kind of left mid-recovery with them so I had to get a new one but they left two months in then I got another one and they left a week in. I told the school what was going on (with my mental health) and well, they were less than helpful. So yeah, I was just kind of expelled from school and didn't really get to do anything when	**Young person B:** Yeah. School was great. I mean I could go down to first aid and sleep, whatever I wanted. They were really accommodating… I mean the school was incredible. I'd gone to another school up until year 10 and then 11, 12 I was at that school and I have no doubt that I wouldn't have finished year 12 if I been at that other school… But they (school) were very well linked in with who I was seeing so that they could figure out what the best things to do where, I mean, I had my safety plan, I had all of those kinds of things.

that happened. I felt so hopeless like I'm so screwed… If the school was actually properly supportive and j even if I ended up still not passing school and getting no score, if I still had gotten that constant support it would have made recovery a lot easier because it just made me feel so much more hopeless when getting expelled and getting no support at all	Yeah. But yet teachers were aware. I had a contact teacher that knew my situation best and new the people around me at school…

Employment

"I mean work had no clue what the hell was going on. All of a sudden I just dropped off the face of the earth." Young person

37.6% of all people with a mental illness (or 67.3% with severe mental illness) are unemployed or not in the labour force, compared to 22.3% of people without mental health conditions.(30) For young people with mental illness who wish to seek work there are a number of barriers that make this more difficult. Many feel uncomfortable disclosing their illness and may cycle in and out of employment frequently, missing out on services and assistance to support them into and during employment or education. Orygen Youth Health data reinforces the relationship between poor mental health and poor vocational outcomes, with approximately 40% of young people presenting at Orygen Youth Health clinics being not in education, employment or training.

Employment services for young people experiencing mental illness are fragmented and rarely coordinated with or integrated into mental health service delivery. Instead young people with mental ill-health are directed toward employment services targeted at the general community which apply a generic approach to employment support and do not have the understanding or expertise to properly support young people with specific needs related to their mental health.

Access to effective psychological care

In primary mental health care there is evidence that providing good quality psychological care and support early in the onset of mental ill-health can improve educational and vocational outcomes for young people. For example, an evaluation of headspace in 2015 found improvements in young people's mental health had positive benefits on their social and economic participation, with days out of role (in study or work) decreasing from 7.6 to 3.1 days per month.(72) An earlier evaluation found 50% of headspace clients believed that headspace had improved their ability to go to school, TAFE or university, or to work or find work – largely attributed to the psychological care they received rather than specific and targeted vocational support. (73)

Individual Placement and Support

Individual Placement and Support (IPS) is an evidence- based employment services model for people with mental illness, developed in the US. The model has eight core principles: 1. Competitive employment. 2. Eligibility based on client choice. 3. Integration of employment services and mental health services. 4. Attention to client preferences. 5. Personalised benefits counselling. 6. Rapid job search. 7. Systematic job development. 8. Time unlimited and individualised support.(74)

A 2014 report by Orygen presented strong evidence for the IPS employment services model, shown to be an effective and cost-effective way to increase workforce participation among young people experiencing mental ill-health, and divert them from the disability support pension.(74)

A recent international meta-analysis of randomised controlled trials found better vocational outcomes for participants in IPS compared to usual treatment conditions, (75) while another systematic review and meta-analysis in 2016 found that IPS was more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation.(76)

The Australian Government has now funded IPS for young people within 24 headspace centres nationally (expanding the original 14 trial sites by another 10 in the 2019-20 budget).

The Victorian Government has also invested in an employment support program for young people experiencing mental health issues who are engaged in Orygen services. Orygen has tried to fit IPS into the JVEN funding model however there are elements of the funding criteria and reporting requirements that work against some of the key principles of IPS. For example young people in the JVEN IPS program must be able to work a minimum of 15 hours per week, every week for 26 weeks, for this to be considered a sustained employment outcome (this goes against the fidelity points that all people who want help getting work, regardless how many hours per week, are eligible for IPS). While this works for some in the program, many of the more disadvantaged young people that need a graded entry to work or want to study and work at the same time.

There are opportunities to expand and further develop the IPS model for young people to maximise and expand the benefits to a larger number of young people. This includes:

- **Adapting the IPS model to include support into education**: A recent study by the Orygen research team evaluating the feasibility and effectiveness of adapting the IPS model to focus on education found that 95% of participants who completed the intervention achieved positive education results.(77)
- **Employment of youth vocational peer workers**: This has been trialled in Orygen's IPS program funded through the Victorian Government. These positions work collaboratively with IPS workers and clinicians to provide emotional and social support to others with whom they share a common experience. In the employment and education context, this can include supports such as talking to participants about disclosing their mental health with employers or developing strategies with young people to manage their mental health when balancing life and work or study. Peer workers can also provide ongoing post-placement support, supplementing the role of the IPS worker.

  Benefits of peer work programs include the creation of entry level career opportunities for people experiencing long term unemployment or for people with limited work experience, and increased uptake and program participation as peer workers can improve engagement with support services.
- **Online augmentation:** Orygen has also commenced development and trials of the Youth Online Training and Employment System (YOTES). This is a comprehensive web-based employment support package for Victorian young people aged 15-24 who are experiencing barriers to obtaining and remaining in work due to mental ill-health. It features moderated social interaction with other young people and targeted career support provided by online vocational specialists and peer motivators in real-time.

Recommendations

To ensure young people experiencing mental ill-health are supported to participate in education, employment and in their community.

1. Develop and implement education settings-based approaches (across secondary schools but with an additional focus on vocational education and training providers and universities) that focus on building capacity for: enhanced case detection, help-seeking support and access to services.
2. Enhance the capacity of mental health services to provide transitional support for young people to reengage in schools and university study.
3. Consider a review of the schools currently funded by DET to provide education services to mental health clients and consider if the current model: a) reflects an evidence-based approach and is operating consistently across the state b) may be at risk of duplication with new initiatives including Meath Health PR actioners in Schools and c) is integrated sufficiently with existing educational settings young people are engaged.
4. Provide investment into the IPS model for young people in youth mental health services and ensure that the reporting and minimum activity requirements are appropriate to meet IPS model fidelity. There is also a need to implement and evaluate enhancements to this model by incorporating peer work and integration with technology into its delivery.

Respond urgently and effectively to self-harm and suicide-related behaviours

Vision:

That young people in Victoria who have engaged in self-harming or suicide-related behaviours, and/or who are at increased risk of future self-harm, suicide attempt or suicide, are:

- identified early;
- provided with prompt access into high-quality, evidence-based and young person-appropriate mental health services and seamless pathways between services;
- provided with an empathic, caring and helpful response at the points they have presented to for help (including emergency departments and first responders); and
- followed up after discharge from clinical care and services at points of increased risk.

Suicide is the leading cause of death for young Australians.(9) In 2017, almost 33% of Victorian deaths in those aged 15-24 were due to suicide. (9)

In Australia, the total economic loss due to youth suicide (15-24 years old) is estimated to be $511 million a year.(78) While the direct costs and the costs of bereavement account for almost 0.02% of the total cost (ambulance costs, coronial inquiry, policing costs and funeral expenses), most is accounted for by lost productivity.(78)

Suicide attempts and self-harm occur much more frequently than suicide, and represent two of the primary risk factors for future suicide. Likely underestimated, approximately 10-20% of young Australians have engaged in self-harming behaviour, and young people disproportionately present to hospitals with self-harm compared to other age groups.(60) While only accounting for a portion of total costs, the annual hospital cost of self-harm in young people (15-29 years old) is estimated at $55 million.(79)

For two decades, suicide prevention policies and programs have been delivered across Australia. However, suicide remains the leading cause of death for Australians aged 15-29, and rates among young people account for the largest increases in suicide rates across the age range.(9) Although suicide rates are higher among men, the number of suicides for women aged under 25 has increased by 76% in the past 10 years.(80)

Although more research is needed, specific youth suicide prevention interventions in clinical and educational settings can be effective at reducing self-harm and suicidal ideation, and multi-faceted, place-based approaches in community settings can have an impact on suicide and self-harm rates.(81)

The Victorian Government has recently invested in a number of place-based trials, providing the funding through the PHNs. However, it is important these trial sites include a focus on youth-specific suicide and self-harm interventions, even if regional suicide rates are higher in other age groups. National, state and regional suicide prevention efforts need to respond to the disproportionate level of individual and societal burden of suicides among this age group, and to meet the unique needs and preferences of young people.

Gaps in clinical care

Experiences of mental ill-health are one of the largest risk factors for suicide and suicide-related behaviour. Access to evidence-based, high-quality clinical care is essential to reducing suicide and suicide-related behaviour, however young Victorians are often unable to access timely specialist services. As described earlier in this submission, underfunding and poor governance in Victoria has

resulted in a splintered and fragmented youth mental health system, leaving young people with limited access to expert mental health care even when they are experiencing serious, complex mental ill-health or suicide and suicide-related behaviours.

In the current system, young people are often discharged from services, emergency departments or hospitals without follow up, despite the elevated risk of suicide post-discharge.(82)

For young people who are at increased risk of self-harm or suicide, community youth mental health services should be resourced to provide or triage immediate access to the mental health system for ongoing and specialist care when needed.

In addition, community mental health services must be resourced to reduce waitlists and improve service access, as evidence shows that improving access to evidence-based treatments for depression could halve rates of suicide-related behaviour in young people.(83) Although not all young people will seek help for suicide or suicide-related behaviour, the young Victorians who seek support require a system that responds to them when they do.

The capacity of current youth mental health services should be augmented to increase their outreach capacity within schools and emergency departments. Enhanced Care Coordinators (ECCs) have been an important step toward providing responsive care to people with severe or complex mental ill-health, or for young people at risk of self-harm or suicide (see Spotlight 5). ECCs are senior clinicians who act as an interface between different teams; liaise between primary, secondary and tertiary services; provide outreach; and supplement existing care. They also work in emergency departments to help young people to access appropriate service pathways and facilitate coordinated care. As this approach appears to be bridging the gap in services and allowing smooth referral processes, these positions should be scaled up across the state.

Spotlight 5: Orygen enhanced care model (extract from news article on Orygen website)

The enhanced care model piloted at Orygen's four headspace centres in Melbourne's North West in 2017 has had its funding extended following successful results in its first year. The model is centred on ECCs who provide a vital role in addressing gaps in mental health care for young people with severe and complex health issues, and better identifying those young people at risk of suicide.

The funding from the North West Melbourne PHN supports the four ECCs who have been recruited across Orygen's headspace sites in Craigieburn, Glenroy, Sunshine and Werribee.

ECCs were the interface between the headspace access/intake teams, medical staff and private clinicians, as well as the liaison point between primary, secondary and tertiary services. Providing this flexible and responsive service to young people supports their engagement with mental health services and may involve:

- addressing poor functioning or psychological barriers to treatment;
- outreach to support initial engagement or assessment;
- supplementing existing care provided by allied health providers;
- providing timely support to clients presenting in crisis to emergency departments;
- assisting families and carers in supporting an ambivalent young person to seek help; and
- coordination, consultation, and the training/coaching of staff and external agencies.

Technology

As technology is increasingly recognised as appropriate to young people and an important adjunct to clinical face-to-face responses, technology should be considered in youth suicide and self-harm prevention and intervention. Further research is needed, as there is currently limited published evidence on youth-specific technology-based suicide prevention interventions and their cost-effectiveness.(84) Regardless, technology will likely have utility in training, decision aids, safety planning, provision of treatment and mood monitoring and can be used across settings i.e. in schools and also clinical settings and as a soft entry point into services and to help bridge cracks in services.

Emergency departments

Where possible, young people are best supported by community services. However, increasingly young people are presenting to emergency departments in crisis, often because they have not been able to access support elsewhere. This means emergency departments need to have the skills to assess young people presenting after self-harm or a suicide attempt and respond in a manner that is empathic, caring and causes no additional harm. Given the elevated risk of suicide at post-discharge(82), resources are required for assertive follow up at points of discharge and dedicated resources for enhanced care coordination.

While Victorian and national guidelines for emergency departments exist, Orygen's report into young people and self-harm found emergency department staff have reported feeling as though they may not be best-placed to assist young people presenting with self-harm and suicide-related behaviours, due to time-constraints and the need for suicide-specific training. Additionally, some nursing and medical staff have reported feeling uncomfortable to start conversations relating to suicide/ self-harm, and are unsure about whether it involves taking on a greater level of risk.(85) These factors cause some young people with suicide-related behaviours to experience suboptimal, non-guideline-concordant care in emergency departments, making them hesitant to present to an emergency department in future.

As seen in other areas of health, staff require systematic, regular and evidence-based training in youth suicide and self-harm presentations, and protocols need to be developed and implemented to ensure high-quality care and effective post-discharge support, which includes comprehensive and supported referral processes.

Surveillance data

Suicide and self-harm data collection and surveillance is necessary to improve targeted and timely responses, and to evaluate relevant policies and programs. Suicide death statistics are collected through the National Coronial Information System and reported by the ABS annually. The delays in coronial inquiries and deaths by suicide that aren't identified have led to available data being incomplete and delayed by up to two years. Currently, the most robust self-harm prevalence data (that includes people who do not present to the public health system) is the Child and Adolescent Mental Health and Wellbeing Survey, last conducted in 2015, but restricted to the population 17 years and younger.

Through partnership with hospitals in North West Melbourne, Orygen has developed systems for monitoring self-harm presentations to emergency departments. With additional funding from the DHHS this project is also being implemented in four other sites across the state. At a relatively low-cost, a full state-wide rollout would develop a dataset for self-harm presentation prevalence, associated characteristics, and information relating to suicide-related behaviour (Spotlight 6).

Spotlight 6: Emergency department self-harm monitoring

To understand the prevalence, rates of representation, and demographic, clinical and treatment characteristics for all people aged nine years and older presenting to Victorian emergency departments following self-harm, Orygen's Suicide Prevention Team are developing a self-harm surveillance system that will allow for ongoing and timely monitoring of all self-harm presentations using routinely recorded clinical, triage, and administrative data. This system will also be able to detect changes in self-harm trends across Victoria e.g. use of different methods of self-harm or emergence of clusters, and will inform the development of evidence-informed interventions that can be delivered at scale and robustly evaluated.

Real-time surveillance of suicide, suicide-related behaviour and self-harm would increase the capacity for the health system to prevent further deaths, provide appropriate and timely support, and allow Victoria to accurately track progress against state-wide strategies to reduce suicide rates. This should collect data from state coroners, police, ambulance and hospital emergency departments, and it should be connected to an immediate, coordinated response at the community level.

Recommendations

1. Develop an evidence-based youth-specific suicide and self-harm prevention and implementation plan, or dedicated youth-specific strategies in future suicide and self-harm prevention plans.
2. Invest in enhancing current services and improving system design to improve the access, quality and duration of care. This would include a focus on delivering high-quality responses for young people with suicide-related behaviours or self-harm presentations, and provide seamless pathways to appropriate care in the community.
3. The provision of systematic, curriculum-based approaches to training and high-quality protocols for responding to self-harm and suicide-related behaviours for staff working in emergency departments and hospitals.
4. Invest in linking data systems and a standardised, robust and real-time surveillance system for suicide-related behaviours and self-harm presentations to Victorian hospitals and mental health services with immediate community level responses.

Prioritise research and its translation into service innovation and improvement

Vision:

That Victoria continues to lead the world in research into early intervention and treatment of mental ill-health in young people through:

- the provision of a strong profile and parity for mental health research, in line with the investments and support provided to other areas of medical research;
- the development, support and retention of Victorian clinical academic expertise in youth mental health; and
- the rapid translation of research evidence developed in Victoria into local, national and global clinical service improvements and policy reforms to improve the mental health of young people.

Mental health research priorities

Early intervention in mental health is increasingly recognised as an essential component of government strategies to contain the growing burden on developed economies worldwide of non-communicable chronic illnesses. In particular, Orygen believes the greatest opportunity for mental health research to have a sizable economic and social impact is through building the evidence for early interventions in young people which can reduce the risk of lifelong illness.

As mental ill-health is most likely to onset in adolescence and early adulthood, young people aged 12-25 years are an important population to target mental health research and translation into evidence-based service and treatment models.

Orygen believes the priorities for the Victorian Government's investment into mental health research should be focused on:

- supporting the development of accessible, effective, equitable and sustainable service responses to improve the mental health of young people;
- providing supporting infrastructure and workforce strategy to allow the development of a youth mental health research program that continues to provide leadership within Victoria and which can inform an Australian and international youth mental health research agenda; and
- designing research projects so that they fit into clinical settings and complement their activities without causing disruption or placing unduly onerous requirements on clinical staff or young people.

6.2 Funding

Victoria has mental health research institutes that possess the critical mass to transform care if properly resourced and linked to expanded clinical services. However, without redesign and expanded and strategic state-funded research investments, there is a risk that the potential of this infrastructure and expertise will not be fully realised.

Funding for mental health research has received a recent boost at a national level through the Australian Government's Million Minds Mental Health Research Mission which aims to develop new approaches to prevent, detect, diagnose and treat mental illness. The recipients of the first round of

funding, which focused on child and youth mental health, Aboriginal and Torres Strait Islander mental health, and eating disorders, have been announced.

However, mental health continues to be proportionately underfunded in medical research grants and investment globally. Despite these conditions posing the greatest threat to worldwide economic growth of all non-communicable diseases, including cancer and cardiovascular disease, in 2015 only 8.6% of National Health and Medical Research Council (NHMRC) funding across all health categories went to mental health research, a reduction on 9.5% of total health research funding from the NHMRC in 2009.(86)

Along with research study funding, infrastructure funding in mental health is also lagging far behind parity with other areas of health research. In 2015-16 the Victorian Government provided $25 million to 10 medical research institutes (MRIs), yet Orygen, Australia's largest MRI in mental health does not receive a share of this funding for infrastructure.

Building and supporting clinical academic expertise and leadership

Joint clinical academic leadership positions make an invaluable contribution to improvements in mental health care. Alongside the potential career benefits of having research experience is the benefit of expanding cross-over between research and practice that would aid the broader strategy of translating research evidence into clinical services. Victoria was a leader in this area in the 1990s, but the academic leadership model has since fallen into disrepair.

In particular, there is a need to restructure and redeploy current investments, such as the clinical leadership academic posts. Many of these postings are employed in small isolated units or in services without the infrastructure and support for research and knowledge translation. Consequently they are unproductive academically and translationally.

Supporting new and talented mental health researchers, especially research psychiatrists and psychologists, will strengthen the Victorian mental health and medical research workforce. Funds to create career pathways and address disincentives such as lower pay, lack of job security and reliance on the difficult task of obtaining research funding are needed. This should include a focus on entry-level positions to ensure a skilled workforce in the future.

The career development of clinical researchers should be enhanced. Options include:

- providing specific fellowship programs;
- establishing more mid-career posts;
- prioritising joint research/clinical positions; and
  training pathways in the health sector that include research and clinical components.

Academic institutions and research centres need to combine new and old avenues for promoting early career researchers. In addition to traditional pathways (peer-reviewed publications and presentations at conferences), increased engagement with health service providers would provide increased recognition and the opportunity to initiate the translation of new research into practice.

For established researchers, a fellowship provides recognition and the opportunity to focus on research. For early career researchers, scholarships provide additional or complementary support that make careers in research financially and professionally more attractive.

Involving young people in research

Involving young people and their families in all areas of youth mental health is essential to ensure that mental healthcare, policy and research are relevant to, and meets the needs of, young people and their families.

Youth partnerships in research: In order to ensure that the mental healthcare system is responsive to the unique needs of young people and their families, it is essential to involve a diverse range of consumers and caregivers throughout all stages of the research ('knowledge to action') cycle.(87) This includes when setting priorities for research funding and focus areas; conceiving and designing research studies; conducting the research; analysis, interpretation, and dissemination of data; and the synthesis, translation and implementation of the overall evidence base.(88) Involving people with lived experience of mental ill-health improves the quality and significance of research, including its relevance(89); feasibility, such as recruitment rates (90, 91); allows for additional insights into data analysis(92), improves the dissemination of findings (93); increases the efficacy and sustainability of outcomes(94), and ensures that the language of interventions is appropriate and "youth friendly". (95)

Recommendations

To build a system that prioritises research and its translation into service improvement and innovation.

1. Provide equity for mental health research through infrastructure support for Mental Health Medical Research Institutes (MRIs); a direct (not just 'indirect') financial response to the current lack of investment in mental health research organisations; and a commitment to new investments such as dedicated funding for a Mental Health Research Scheme in Victoria.
2. A refocus and redeployment of current Victorian mental health research investments, such as the clinical academic posts. At least three existing positions, or three new positions, should focus on youth mental health and be strategically located in youth mental health service platforms.
3. Invest in a new round of Mental Health Research Fellowships with a priority focus on applied and translatable research which can support the attraction and retention of mental health research talent and strengthening the translation of mental health research outcomes through youth partnerships in research

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