Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF JASON TRETHOWAN

I, Jason Trethowan, Chief Executive Officer at headspace, of 485 La Trobe St, Melbourne Victoria, say as follows:

Background

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 I am providing evidence to the Royal Commission into Victoria's Mental Health System in my capacity as CEO of headspace.

Overview of my experience

3 My upbringing was in rural and regional communities in Victoria including towns such as Murtoa, Horsham, Robinvale, Mildura and Ballarat. In 2000 I moved to Geelong where my wife and I live with three teenagers. My professional career started as a Health Information Manager in 1996 at Ballarat Base Hospital at a time when Lakeside Hospital was decommissioned in the same year. At that time, I had limited understanding of the significance this had on the Ballarat community and those experiencing mental illness.

4 My six years at Barwon Health involved working across all parts of the health system including the acute and community mental health systems. In 2007 I commenced working as a CEO of an Australian Division of General Practice – The General Practitioners Association of Geelong (now Western Victoria Primary Health Network). This organisation led one of the first headspace centres to be established in 2007. This service for young people experiencing mental health and wellbeing challenges was developed following a 10 year local service called Clockwork which had a similar culture of engaging and supporting young people.

5 Over the next ten years in CEO roles of Barwon Medicare Local and Western Victoria Primary Health Network, I was proud to be part of implementing new service models such as Kardinia Health GP Super Clinic, Primary Mental Health Partners in collaboration with Deakin University and Barwon Health, and commissioning mental health services across Western Victoria.

6 In January 2017 I commenced my new position at headspace as the national organisation's CEO.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

7 Attached to this statement and marked 'JT-1' is a copy of my Curriculum Vitae.

My role at headspace

8 I am the CEO of headspace, the National Youth Mental Health Foundation. The position reports to a skills-based Board and two Youth Advisors. I have a team of executives who develop and implement a diverse range of direct services for young people and a series of programs supporting the network of 112 headspace centres, and digital services in local communities. The executive team also provides active support to primary and secondary schools.

9 As CEO, I have learned from young people about their experiences overcoming stigma linked to mental health and their help seeking journeys for mental health support. I have observed the benefits of youth specific approaches for helping young people, their families and friends in areas such as general health, alcohol and other drugs, mental health and work and study.

10 My role involves working in a complex yet rewarding stakeholder environment with governments, NGOs, businesses, national and local media, education systems and broader community representatives passionate about the mental health and wellbeing of young people.

About headspace

11 headspace provides young Victorians with access to a choice of face-to-face, online or phone services across a range of settings relevant to young people. headspace was originally conceived to provide early intervention for young people (12–25 years old) experiencing mild to moderate mental health issues. Over time, as trust in the headspace brand has increased, headspace has become a soft entry point for young people into the mental health system; we are now supporting an increasing number of young people with more complex and severe mental health issues, which is where headspace support can intersect with tertiary mental health services.

12 headspace partners with state mental health services and local service providers to support young people. For example, the consortia model of headspace centres encourages Child and Adolescent Mental Health Services (CAHMS) to be part of the consortia, and headspace centres are encouraged to have Memorandums of Understanding and Service Level Agreements that define the thresholds for transfer of care between centres and CAHMS. Although headspace centres have a referral

pathway in and out of tertiary services, only those centres with youth enhanced funding[1] are well-placed to support and maintain these pathways. headspace National programs (such as eheadspace, headspace Work and Study, and headspace Schools) also have referral pathways in and out of tertiary services.

13 headspace provides a range of supports across four core streams (mental health, physical health [including sexual health], alcohol and other drugs, and work and study) aligned to the stepped care model, including:

(a) Face-to-face support at centres.

(b) Digital and online support services including information and resources for self-help, chat groups led by headspace clinicians or peers, and 1:1 counselling.

(c) Group programs, both online and in-person.

(d) Youth and family and friends participation and engagement support.[2]

(e) Work and study support, including career planning, resume-building, career mentoring, mock-interviewing and study assistance.

(f) Schools support, including regional telephone service (headspace Enhancing Mental Health Support in Schools initiative) in Victoria, as well as schools suicide prevention activities, Be You (a national initiative run by Beyond Blue) and postvention support.

(g) Community engagement to build mental health literacy and reduce stigma.

(h) Support for early psychosis, including care planning, psychological therapy, family work, crisis response and medical interventions.

(i) Skills training, including psycho-education, social and communication skills and anger management.

(j) Psychological interventions, including Cognitive Behaviour Therapy, Acceptance and Commitment Therapy, relaxation strategies and mindfulness-based therapies.

(k) Support for family-inclusive practices, including Single Session Family Consultation and Tuning in to Teens.

(l) Access to a psychiatrist through headspace Telepsychiatry.

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[1] Youth enhanced funding is part of PHNs' flexible funding pool and requires PHNs to develop and commission new early intervention services to meet the needs of young people with, or at risk of, severe mental illness who can be appropriately managed in the primary care setting. It is at the discretion of a PHN whether it allocates this funding to headspace centres.

[2] headspace uses the term 'family and friends' rather than 'carers'. This is in response to advice from its National Family and Friends Reference Group. headspace believes the use of this term encourages all people involved in a caring role to engage with the service and seek advice and support.

The headspace model

14 Unlike other parts of the mental health system, headspace is not a clinical service model that is focused solely on the provision of mental health services by clinicians. The headspace model aims to remove barriers to service access and increase help-seeking by young people. The model is designed to provide accessible, appropriate and effective services to young people within a sustainable service system.

15 The headspace centre model comprises 16 components, 10 of which are core service provision components and six of which are enabling system components.

16 The core service provision components of the headspace model are:[3]

(a) **Youth participation**: Youth participation occurs at three levels. The first level is the young person's treatment plan, whereby young people are enabled to participate in their own care. This is supported by a comprehensive orientation process, resources for young people, and policies and procedures to involve them in decisions about their care at all points in their care pathway, including a collaborative treatment plan. The second level is the engagement of young people in ongoing service development, particularly through the operation of a centre-specific Youth Reference Group. This group provides input into service design, delivery and evaluation. The third level is at the highest level of governance, through attendance at governance meetings and input to strategic and operational planning.

(b) **Family and friends' participation:** Family and friends' participation is also at the three levels. At the first level of a young person's individual care, the critical role of the family is recognised and prioritised. Centre staff emphasise engaging family and friends in supporting the young person in their mental healthcare and encourage family inclusive practice. The inclusion of family and friends is negotiated with the young person with due regard to choice, confidentiality and privacy. At the second level, family and friends have a role in service development and evaluation. This can be achieved through a Family and Friends' Reference Group, or other mechanisms that include the views of young people's significant others in service development. At the third level, family and friends' input is required in governance of the centre. This is achieved through involving family and friends in centre governance processes and strategic planning.

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[3] , Debra Rickwood et al. "Australia's innovation in youth mental health care: the headspace centre model." *Early intervention in psychiatry* 13.1 (2019): 159-166.

(c) **Community awareness:** Building community awareness about the local headspace centre is a primary focus. headspace centres dedicate a proportion of their staffing resources to a community awareness and engagement position and have an annual plan of activities to build community knowledge and support. Awareness for the community is further supported by national campaigns run by headspace National.

(d) **Enhanced access:** headspace Centres are expected to have a "no wrong door" policy so that young people can present with any issue, meaning they and their families do not have to navigate a complex care system on their own. Centres are also expected to provide a timely response to young people, operate out of normal business hours, and provide the choice for drop-in sessions. Service access is facilitated by ensuring that the centre has a welcoming environment, in both its physical setting, and a non-judgemental and personalised staff response and orientation process. The service must be youth-friendly, and socially and culturally inclusive. Centres are expected to be easily accessible, but provide some privacy to entry and adhere to design and branding requirements to ensure that the centre is identifiable as a headspace centre.

(e) **Early intervention:** headspace is oriented to allow access to services as early as possible in the development of a mental health problem. In contrast to traditional service approaches, young people are able to access headspace centres long before an acute or crisis situation arises, or before a problem or disorder becomes chronic. Young people at risk of developing a mental health problem through exposure to risk factors and those showing early symptoms and sub-syndromal mental disorder are expected to be prioritised.

(f) **Appropriate care:** Appropriate care is developmentally and culturally tailored, and proportional to the stage of illness, stage of life and complexity of presenting issues.

(g) **Evidence-informed practice**: headspace centres deliver services based on the best current evidence by employing staff who are appropriately trained and credentialed, and additionally trained through headspace orientation.

(h) **Four core streams:** headspace centres are an enhanced primary care platform providing four core service streams - mental health, physical and sexual health, alcohol and other drug (AOD), and work and study - that match the needs of young people in adolescence and young adulthood. The main health need for this age range is mental health, however, so this comprises the largest service focus.

(i) **Service integration:** On-site and off-site service integration are necessary to coordinate and provide appropriate clinical governance for the four core streams and any other services provided through the headspace centre. After the holistic needs of each young person are identified, they are met through an integrated care pathway with a coordinated approach to the mix of services required.

(j) **Supported transitions:** Supported transitions proactively and personally link young people with external services when a headspace centre is not able to meet their needs. This ensures those who are at risk of disengagement do not fall through the gaps during transitions. Again, strong collaborative partnerships, established referral pathways and warm referrals are the techniques used to support effective service transitions. For young people who need more intensive, longer-term or complex-care management than the headspace primary care approach can provide, supported transitions are required with secondary and tertiary services.

17 The six enabling system components of the headspace model are:

(a) **National network:** The headspace national network currently comprises 112 centres along with the coordinating support of headspace National. The network enables innovation and shared learning to develop best practice and continually improve service quality. The network supports and strengthens individual centres, helps achieve national consistency with appropriate local customisation, and provides opportunities for inter-centre knowledge transfer. headspace has a strong and consistent national brand that clearly identifies and promotes its services and is also a trusted and credible source of information.

(b) **Lead agency governance:** Independent Lead Agencies are commissioned to operate each headspace centre, although some agencies operate multiple centres. There are currently 64 different Lead Agencies operating the centres. Lead Agencies provide the infrastructure, employ staff, develop partnerships with other agencies and are responsible for corporate and clinical governance.

(c) **Consortia:** Governance of a headspace centre is provided by a Consortium of local service providers that collaborate with the Lead Agency to give strategic direction, additional capacity through in-kind contributions and local planning oversight. The Consortia approach enables local community investment in and support for the centre and ensures that the centre meets community needs through planning and appropriate collaboration. It provides a formal structure for the creation and maintenance of partnerships that increase the reach and continuity of care of headspace services.

(d) **Multidisciplinary workforce:** Centres are staffed by multidisciplinary teams that can address the holistic needs of young people. This comprises both clinical and non-clinical staff with a minimum staffing mix that includes a centre manager, clinical coordinator, community engagement and intake workers, and reception staff.

(e) **Blended funding:** Multiple funding streams are combined to support a headspace centre. This ensures that services can be provided to young people at no or low cost. The headspace centre grant, which comes from the Australian Government Department of Health, provides core funding which covers infrastructure and salaries for essential staff positions. Health and mental health service provision is supported by access to the Australian Government's Medical Benefits Scheme, which rebates medical and allied health staff for designated health services. In-kind contributions are expected from Consortium member organisations and from other local partner organisations to provide the full range of services. Fundraising and donations are encouraged. Some centres are enhanced by funding from additional state/territory government funding. headspace National helps to address some workforce capacity issues; for example, by providing telepsychiatry to eligible rural centres. Centres, and their Lead Agencies, are expected to be proactive in investigating and taking advantage of all appropriate funding opportunities, and ongoing advocacy from headspace National and the entire network promotes greater resourcing of youth mental health.

(f) **Monitoring and evaluation:** All centres must contribute to the national minimum data set through the headspace data collection system. Analytics are routinely provided through dashboard reports to service providers, centre managers, Lead Agencies and their commissioning agents (regional Primary Health Networks (PHNs)) about the characteristics and outcomes of young people accessing the centres and the level and types of service activity.

Measuring the impact of headspace

18 There are a number of metrics we use to measure and report on the impact of headspace support for young people, including:

(a) **Access**:

(1) 116,228 services provided to 27,233 young Victorians across Victorian headspace centres in FY2019.

(2) 23,222 eheadspace sessions provided to 9,028 young Victorians in FY2019.

(3) 2,174 headspace Work and Study sessions provided to 112 young Victorians in FY2019.

(4) 695 young Victorians have been supported through the headspace Early Psychosis program in FY2019.

(5) Since January, headspace Schools supported school communities impacted by 12 suicides and 8 suicide attempts across Victoria.[4]

(b) **Outcomes:**

(1) **reduced psychological distress and increased functioning:** 60.4% of young people accessing headspace services between 2015 and 2019 reported improvement in their psychological distress and/levels or in their social and occupational functioning, as measured by K-10 and/or Social and Occupational Functioning Assessment Scale (SOFAS)[5]. Additional headspace analysis, shows this increases to 68% for those who attended five or six sessions at headspace.[6]

(2) **further positive improvement after exiting headspace services**: up to two years after leaving headspace, young people have shown continued improvement in clinical and wellbeing outcomes.[7]

(3) **improved mental health literacy, wellbeing and vocational functioning:** as a result of headspace services.[8]

(4) **improved quality of life outcomes across five domains important to young people:** general wellbeing, day to day activities, relationships with friends, relationships with family, and general coping. These outcomes are maintained up to two years after leaving headspace.[9]

(5) **increased engagement with work and study**: headspace data indicates that more young people are employed, and employed young people are able to work productively on more days, as a result of headspace services.[10]

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[4] The headspace postvention service supports whole school communities who have been impacted by suicide (including school leaders, staff, educators, students and parents). This is done through guiding and partnering with school leadership groups, principals, wellbeing teams, and sector representatives, and walking them through evidenced-based response and recovery strategies in the short, medium and long term.
[5] Deloitte Access Economics (2020) "The Economic and Social Value of headspace" Unpublished.
[6] headspace unpublished service data, 2013-2018.
[7] headspace (2019) headspace centre young person follow up study.
[8] Ibid.
[9] Ibid.
[10] Ibid.

(c) **Choice** of a range of services (face-to-face, online and phone) for young people, enabling them to choose headspace rather than a tertiary mental health service.

(d) **Satisfaction**: Young people have high levels of general satisfaction with all headspace programs: eheadspace (83%); headspace centres (86%); headspace Early Psychosis (94%).[11]

(e) **Brand Recognition**: 77% of young Australians recognise headspace as a youth-specific mental health organisation.[12]

(f) **Campaigns:** Increased mental health literacy and stigma reduction through community engagement and campaigns.

(g) **Community impact**: In a recent survey on the impact of headspace in the community and schools, Lead Agencies and local headspace consortia members agreed that their local headspace centre:

(1) provides a trusted service that has led to increased and easier access mental health services for young people; and

(2) provides a vital community service; reduced stigma; and improved coordination of local services[13].

19 headspace centres have the capacity for intake processes to identify young people presenting with complex health needs.[14] These assessment processes ensure that all components of complexity are considered for a young person who is identified as 'complex', as well as ensuring that a young person's strengths and resources are also identified. These processes ensure that support allocated to young people is the most appropriate 'level' of care or 'supported transition' to another service.

20 Youth mental health services should align with individual needs. The headspace appropriate care approach seeks to align a young person's unique set of circumstances, needs and preferences to an appropriate, evidence-based intervention. This approach advocates for concurrent support for identified physical health, alcohol and other drugs, education/vocation, and risk of harm needs. Appropriate care is about matching the right type and degree of care or intervention to a young person's changing needs and unique preferences[15].

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[11] headspace (2019). Annual Report 2018–2019.
[12] Colmar Brunton (2018). Australian youth mental health & well-being survey 2018. Unpublished.
[13] Colmar Brunton (2020). headspace Community Impact Research. Unpublished.
[14] headspace National Youth Mental Health Foundation (2020) Practice Principle Complexity.
[15] Ibid.

21 headspace seeks to ensure that there is 'no wrong door' for young people when seeking help. This means that all young people – regardless of complexity - should be able to receive support from a headspace centre that meets their needs. If the young person's needs may be better supported by a different service, then the headspace centre staff will support the young person to access that service with a warm referral. Where the young person can be supported directly at the headspace centre – due to additional funding streams such as Youth Enhanced Services, a strong and established link with the tertiary mental health system, or clinical staff having the qualifications, experience, scope of practice and supporting structures and processes to provide appropriate care – then this could be provided.

22 The 'no wrong door' approach relies on enhanced investment in specialist and primary care services, improved resourcing for tertiary mental health services and integration, and a strengthened headspace centre model.

Referral to and from headspace in Victoria

23 In Victoria, approximately 45% of young people self-refer to headspace,[16] as headspace is trusted by young people and is seen as a safe place to seek help. Further, just under half of all young people (44.58%) who commence their first episode of care with headspace at a Victorian headspace centre do not have a written referral. We believe that this demonstrates the ease of access provided by headspace, as many young people and their families are able to self-refer to access headspace services rather than requiring a formal referral.

24 Other than self-referral, the most common referral source into Victorian headspace centres is from a GP (18.4%), followed by school-based service referrals (10.3%).[17]

25 The majority (85.01%) of services provided to young people in Victorian headspace centres do not result in a formal referral out.[18] During the financial year ending in 2019, the most common referral out of a Victorian headspace centre was to an external specialist health service (for physical health including inpatient admission) (8.23%), followed by external mental health service (CAHMS, Adult Mental Health Services, psychiatrist or inpatient admission) (4.54%).[19]

26 I also acknowledge the role parents, carers, families and those in regular contact with young people play in supporting young people to seek help through headspace as a safe place to engage with.

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[16] headspace unpublished service data, 2018-19 Financial Year.
[17] Ibid.
[18] Ibid.
[19] Ibid.

Adherence to the headspace model

27 The headspace model is a set of principles of accountabilities that would be expected of any service that encompasses mental health services, primary care, vocational support and alcohol and other drug services. The model aims to create a primary care platform that is accountable to the headspace brand, provides a safe place for young people, and provides appropriate responses to their challenges.

28 headspace centres and Lead Agencies are required to maintain fidelity to the headspace model. Adherence to the model is evaluated based on how it is applied in a particular local setting and involves:

(a) Centre self-assessments.

(b) Independent assessments conducted by headspace National.

(c) Benchmarking against headspace's national minimum data set to evaluate service activity and outcomes. This data set is gathered from headspace clients and service providers by headspace National.

(d) Seeking feedback and critique from youth reference groups and family and friends reference groups.

29 Where a centre is not meeting a requirement of the model, headspace National will work with the Lead Agency and commissioning agent to address the issue. The goal is quality improvement; we will provide examples of best-practice from other centres across the network and then assist the centre to apply them, taking into account the particular local circumstances of that centre.

The uniformity of headspace centres

30 The headspace model allows for appropriate customisation to support localisation of services to meet local community needs. The headspace Model Integrity Framework (hMIF) provides for a minimum standard and framework, whilst also enabling Lead Agencies operating these services to localise aspects to meet their community's needs.

31 The hMIF has national standards for best practice youth mental health service delivery, but enables flexibility and localisation to meet the needs of local communities and the young people and families in those areas. A key way that this is achieved is through the requirement that all headspace centres have a consortia of local agencies who play an important ongoing role in strategic planning and local stakeholder and interagency relationships. Consortia member organisations are required to commit ongoing in-kind resources to the headspace centre.

32 The consortia model ensures that headspace centres are localised and embedded in local communities and service system, and service providers, influencers and community members come together to guide and nurture their headspace centre. This ensures strong engagement and referral pathways with local services and better support for young people. Appointment of an Independent Chair (usually an influencer from the local community) supports leadership and champions the service and consortium partners.

33 While headspace centres must adhere to the model, the model allows (and requires) each centre to deliver care and services that are appropriately adapted to their local community. For example:

(a) headspace Bondi, whose consortia provide access to a family therapist.

(b) headspace Launceston, which has created crucial partnerships with employment services on its consortium to address high youth unemployment rates in the city.

(c) The headspace Pilbara Trial uses outreach, technological and novel approaches to engaging and supporting young people, particularly Aboriginal young people in the region. Youth wellbeing workers deliver mental health services where young people feel comfortable, which may include in young people's homes, or in public places such as on country, the beach, or in coffee shops. The Pilbara Trial is not associated with a physical headspace centre, but rather headspace National works closely with the Lead Agency and PHN to ensure that the service aligns with the evidence requirements of the hMIF and provides a safe quality service for young people.

(d) headspace Wollongong recognised the high level of mental health issues among transgender and gender diverse young people as well as the lack of support for this cohort in the region. To address this, the centre partnered with local parents to form the Parents of Transgender and Gender Diverse Children Group, which provides health, legal and social support for parents. headspace Wollongong has also expanded its services to include specialist support for transgender and gender diverse young people.

(e) headspace Grafton was established after a number of youth suicides in 2015 and is now an integral component of Our Healthy Clarence (a vital Clarence Valley community-driven wellbeing initiative). headspace Grafton receives support from headspace Schools as the community moves away from the recovery phase.

(f) headspace Darwin harnesses the passion of Australian Rules in the Northern Territory and recognises the important role that football clubs have in

developing social networks. headspace Darwin partnered with AFLNT to develop the Wellbeing Champions program, where young people receive mental health training to then deliver mental health presentations to teammates and promote referral pathways for local services.

34 In addition to accountabilities under the headspace model, each headspace centre will also be accountable to its Lead Agency and commissioning agent. These differing accountabilities can sometimes create issues for headspace centres, which include the difficulty engaging local services that are already over-stretched, lack of systems for services to share, and lack of financial incentives for services to integrate and share.

International evidence

35 Globally, headspace is recognised as an exemplary evidence-based example of community-based youth mental health services,[20] and organisations from Ireland, Canada, Denmark, Israel, USA and Iceland have partnered with headspace to develop similar approaches to approaches to integrated youth services.

36 Jigsaw, the National Centre for Youth Mental Health in Ireland, was founded in 2006 and provides free mental health support service for young people aged 12–25 years in 13 local communities across Ireland and through online supports. Recent data shows that:

(a) Since inception, Jigsaw has supported over 28,000 young people. In 2018, Jigsaw supported 6,356 young people (which represents a 45% increase on the prior year).

(b) Jigsaw has provided mental health awareness and literacy workshops to 27,000 parents, teachers, GPs and young people.

(c) 71% of 17–25 year olds and 51% of 12–16 year olds who had a brief intervention had a reliable reduction in psychological distress after accessing support from Jigsaw.

(d) 92% of young people and 96% of parents/guardians reported satisfaction with the quality of support they received from Jigsaw.

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[20] World Economic Forum & Orygen (2020) 'Global Framework for Youth Mental Health', available at https://www.orygen.org.au/Policy/World-Economic-Forum-partnership/Files/Orygen-WEF-global-framework-for-youth-mental-healt.aspx [accessed 31 July 2020].
McGorry P, Trethowan J and Rickwood D (2019) 'Creating headspace for Integrated Youth Mental Health Care', *World Psychiatry*, 18(2): 140–141.McGorry P, Bates T and Birchwood M (2013) 'Designing Youth Mental Health Services for the 21st Century: Examples from Australia, Ireland and the UK', *British Journal of Psychiatry*, 202(54): S30–35.Rickwood D, Paraskakis M, Quin D,et al (2019), 'Australia's innovation in youth mental health care: The headspace centre model', *Early Intervention in Psychiatry*, 13:159–166.

37 Foundry was founded in 2015 and provides free mental health support service for young people aged 12–24 years in 11 local communities across British Colombia, Canada. Recent data shows that:

(a) 99% of those surveyed across centres agreed or strongly agreed that they felt comfortable and welcomed at Foundry.

(b) Integrated care partners are highly satisfied with the initiative at 75–85%

38 In late 2019, the three organisations agreed to establish the headspace–Foundry–Jigsaw Collaboration to leverage the expertise, experience and capabilities of the organisations and to form a peer support for common challenges. The collaboration will also serve to better understand emerging issues for young people, approaches to service improvement, service evaluation and knowledge transfer.

Trends in demand for headspace services

39 As for the changing needs of young Australians, a number of important observations can be made at a population level:

(a) Nearly one in three (32%) young Australians (12 to 25 year olds) are reporting high or very high levels of psychological distress – more than treble the rate in 2007 (9%).[21]

(b) 18 to 21 year olds are reporting the highest levels of psychological distress (38% compared to 20% of 12 to 14 year olds).[22]

(c) Nearly two thirds of young Australians (62%) say that the mental health of young people is getting worse, with 37 per cent of respondents saying that social media is one of the leading contributors.[23]

40 Social media and digital technology have undoubtedly had an impact on the mental health and wellbeing of young people, and may have contributed to the elevation of the levels of psychological distress in the cohort.

41 In light of these changes in young people's mental health and wellbeing, we are unsurprisingly seeing an increasing number of young people seeking help from headspace.

42 In Victorian headspace centres, the average wait time for a young person to have an intake session is 10.5 days, 25.5 days for first therapy session, and 12.2 days for

[21] headspace National Youth Mental Health and Wellbeing Survey (2018) 'K10 Psychological Distress Score'; ABS (2007) 'National Survey of Mental Health and Wellbeing'.
[22] Ibid.
[23] headspace National, National Youth Mental Health Survey (2018).

subsequent therapy session. The average wait time for a young person to access eheadspace support is 25 minutes.

43 Young people accessing support from headspace are also presenting with higher levels of complexity and acuity. 14.5% of young Victorians who sought support from headspace centres reported having suicidal behaviour or thoughts in 2018–19. This reflects an increase in young Victorians who sought support from headspace centres reporting having suicidal behaviour or thoughts from 12.9% of young Victorians in 2017–18 and 9.6% of young Victorians in 2016–17.[24]

The impact of COVID-19 on headspace and its clients

44 Psychological distress remains at already-high levels among young people and COVID-19 is now a new factor that will have a long-term mental health impact on their lives.

45 We recently commissioned a research study to investigate the impacts of COVID-19 on young people and parents in Australia[25], and some of its key findings include:

(a) 97% of young people feel they have been personally impacted by COVID-19.

(b) 51% of young people feel that their mental health has suffered.

(c) 40% of young people feel that COVID-19 has impacted their confidence to achieve their future goals.

(d) Over half of young people feel that COVID-19 has negatively impacted their interactions with friends (56%) and their study situation (53%). Just under half report that their routine (48%), their work situation (48%) and their mood (47%) has been negatively impacted; and

(e) In some instances, parents perceive that COVID-19 has had a greater negative impact on several aspects of their children's lives than young people do themselves. Significantly more parents than young people themselves feel that the young person's participation in sport (62% vs. 46%), exercise and physical activity (49% vs. 38%) and general routine (58% vs. 48%) has been negatively impacted by COVID-19.

46 The sharp rise in unemployment and added uncertainty associated with the impacts of COVID-19 for young people will negatively impact their mental health and wellbeing. This will particularly be the case for those young people who have pre-existing mental health challenges.

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[24] headspace unpublished service data, 2018–19 Financial Year. 2017–18 Financial Year. 2016–17 Financial Year.

[25] Colmar Brunton (2020)'The early impacts of the COVID-19 pandemic on Australian young people', Unpublished.

47 Before the pandemic, 1 in 4 young people (aged between 17 and 25 years) who came to a headspace centre were not engaged in work or study. Our challenge will be to ensure that headspace can remain accessible for these people when they do contact us. Importantly, a positive in reaching young people disengaged with work and study is to provide a combination of centre based and digital services to provide choice for young people to engage in services.

Involvement of young people, their families, carers and friends

48 As I outline above, the headspace model requires youth participation at three levels for headspace centres.

(a) At the level of the young person's treatment plan, youth participation is achieved through rapport-building, active engagement and shared decision-making in a young person's care.

(b) At the service development and implementation level, each centre has a Youth Reference Group. These groups provide feedback to the headspace centre about the design, delivery and evaluation of services. headspace has support structures in place to support young people to tell their stories and share their experiences.

(c) At the governance level, young people attend centre consortium meetings and provide high-level feedback about government, service planning, service delivery, and continuous improvement.

49 Young people are also involved at every level of headspace National's governance. Two young people are Board Youth Advisors. The headspace Youth National Reference Group is involved in service planning, brand marketing, service delivery, evaluation and continuous improvement. We continuously engage young people on a range of projects to ensure that our work is informed by the voices of young people.

50 Similarly, every centre is required to engage with family and friends. At the individual service level, headspace centre staff seek to engage family and friends when providing support and will provide family-inclusive services unless it is unsafe to do so. In Victoria, each headspace centre also has funding to deliver Tuning in to Teens, a six-session program designed to help parents teach their teenage children to control, understand and express their emotions in healthy and positive ways.

51 headspace National has had varying degrees of success in establishing family and friends participation and only recently created the National Family and Friends Reference Group. In late 2019, headspace National funded a two-year project exploring

the best models for family and friends participation, as well as the creation of resources for all headspace centres to improve the participation of family and friends.

52 Furthermore, a key component of the hMIF is Family Participation, which requires headspace centres to work towards the inclusion of family and friends at the governance level, at the service level and by ensuring family-inclusive practice occurs in the care of young people engaged with the service (unless specifically clinically indicated).

53 As is the case for most of the mental health sector, family participation in headspace is not as advanced as youth participation. There are still relatively low levels of family involvement with headspace centres and at the end December 2019, only 24% of centres across the headspace network have an active family reference group. Our National Family and Friends Reference Group is not as embedded and sophisticated as our National Youth National Reference Group, and we have further work to do to identify the right model that best engages families. We would welcome the opportunity to work with carers' organisations and the whole sector in developing the right approach.

54 Family and carer participation at headspace is limited by the following factors:

(a) Family work is not properly funded at headspace centres. The blended funding model for headspace centres provides for a small salaried intake and assessment team. The bulk of treatment provided by headspace in Victoria is performed by private practitioners, who are paid according to the items funded on the Medicare Benefits Schedule (MBS). Before recent changes, MBS items were not conducive to providing family inclusive treatment which often require longer sessions and multiple clinicians to be present in the room.

(b) The work performed by headspace is normally episodic in nature, meaning that a young person, on average, will access three to four sessions. This may make it difficult to engage and maintain a connection with a young person's family and friends to facilitate the contribution of family and friends into service design, development and delivery. For this reason, family-inclusive models that work in the treatment of psychosis (which involve funded family work and more longer-term care) are not easily adapted to headspace.

(c) From its inception, headspace was publicly designated as a youth-oriented service. For this reason, many people assumed that headspace was not family-inclusive. Over the past four to five years, the whole organisation has taken steps to reorient the organisation to providing more family-inclusive practices. Two key examples of service models implemented by headspace to develop family engagement are:

(1) **Single Session Family Consultation** (SSFC) is a collaborative approach between a headspace clinician, family and friends and the young person. Each session collectively defines and addresses the most salient concern of the young person. It is an effective approach for the young person as well as their family and friends to receive the help they most want. The approach is effective for headspace services because it supports and improves demand management. In 2016 to 2017, headspace National coordinated a roll-out of SSFC across 48 headspace centres using a train-the-implementer model where SSFC 'champions' received face to face training and online supervision from experienced family practitioners at the Bouverie Centre, Victoria's Family Centre at La Trobe University. Champions then trained headspace centre staff, who in turn provided SSFC services to young people and their families and friends. Each centre determined how it introduced SSFC into its care pathway. Alongside this work a range of other initiatives occurred including the creation and dissemination of a poster to be displayed in every headspace centre stating that headspace is a family-inclusive service, and the development and dissemination of a range of supporting resources to help centres move toward greater family-inclusive practice. Many headspace centres use SSFC with promising results[26]. headspace National will continue to support the implementation of SSFC across all headspace centres.

(2) **Tuning in to Teens** (TINT) is an evidence-based 6 week group parenting program which teaches parents the skills of emotion coaching, including how to recognise and respond to their own and their child's emotions. The successful pilot of TINT in Victoria received overwhelmingly positive results from both facilitators and parents who completed the program. The program worked well because it is evidence-based, easy to implement, practical, and the group-work component of the course allows parents to connect and learn from one another.

55 Some of the key lessons that headspace has learnt from supporting partnerships with young people and families and friends are:

(a) True partnerships occur when young people and family and friends and service providers hold an equal level of decision-making power.

[26] headspace (2018) 'Single session family consultation project evaluation report'. Unpublished.

(b) Facilitating good participation requires a strong authorising environment and leadership from governance groups and across all levels of management, and needs to be structurally embedded within organisations.

(c) Engagement must be non-tokenistic and meaningful.

(d) Young people and family and friends are experts in their own lives and experiences.

(e) Young people and family and friends need to be compensated for their time.

(f) There needs to be appropriate and clinically-endorsed support structures to support young people and family and friends at all stages in the engagement process.

(g) Different and culturally-appropriate supports are needed for engagement with Aboriginal and Torres Strait Islander young people, Elders, family and communities.

56 As for what skills and capabilities are needed of a workforce to better engage with young people and family and friends, clinicians and non-clinicians alike should be trained and have the skills to empower young people to speak up and then be able to listen and enact change based on their lived experience. All mental health disciplines (including psychology, social work, occupational therapy and nursing) should be trained in collaborative care planning and formulation inclusive of young people and family and friends, as well as training in family inclusive practice as a core practice component.

57 Future mental health workforce strategies should incorporate training and orientation to youth participation and family and friends participation. Moreover, Executives, CEOs and those responsible for organisational governance should be advocates and champions for non-tokenistic youth participation and family and friends participation.

Community model of care

Delivering community-based mental health services to young people

58 At the time headspace was created, it was identified that young people needed friendly, accessible, low cost and convenient mental health services. Recent data collected by headspace shows that these needs have not changed significantly. In a 2020 survey, young people reported that the following things are important to them when engaging with headspace:[27]

(a) Knowing they won't be turned away (92%).

[27] Colmar Brunton, 'headspace Community Impact Research' (2020). Unpublished.

(b) Welcoming and safe space (91%).

(c) Free or low cost (90%).

(d) Knowing service was youth friendly (87%)

(e) Easy to get to (84%).

(f) Being able to be connected to other services if needed (84%).

(g) Having all needs met is one location (83%).

59 Young people aren't unlike other age cohorts that also want timely and accessible care provided close to home and outside of overtly clinical settings. We make great efforts to ensure that each headspace centre is welcoming; the moment when a young person walks in the door is an important one. It is also an important opportunity to demonstrate to that young person that there is a place for them in the mental health system.

60 Many young people, and particularly Aboriginal and Torres Strait Islander young people, want mental health care that is culturally safe and secure. headspace aims to provide cultural safety by employing an Aboriginal and Torres Strait Islander workforce and fostering strong links with local communities. This includes close partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs).

61 Young people require services that match their needs (or sometimes, multiple complex and competing needs) and don't want to be turned away from a service because that service doesn't have the right skillsets or capacities. The language of stepped and staged models of care is often discussed in the context of commissioning and funding youth mental health services. However, young people who present to headspace do not present as "step one or step three", but instead they present as a person with a series of needs that may or may not be understood in their initial conversation with us. Sometimes, we may only get to the root of their issues after several conversations.

62 Ensuring that young people are comfortable accessing primary mental health care, and are not discouraged by other barriers such as cost and environment, is very important to Victoria's mental health system. The evidence is clear that if young people don't address mental health challenges early in life, these challenges will be exacerbated.[28]

[28] Birchwood, M., Singh, S. P., Mcgorry, P., Stallard, P., & Buck, R. (2013). 'Youth mental health: appropriate service response to emerging evidence'. *The British Journal of Psychiatry: the Journal of Mental Science*.Rickwood, D., Van Dyke, N., & Telford, N. (2013). 'Innovation in youth mental health services in Australia: common characteristics across the first headspace centres'. *Early Intervention in Psychiatry*, *9*(1), 29–37. Rickwood, D. J., Telford, N. R., Parker, A. G., Tanti, C. J., & Mcgorry, P. D. (2014). 'headspace - Australia's innovation in youth mental health: who are the clients and why are they presenting?' *200*(2), 108–111. Scott, E. M., Hermens, D. F., Glozier, N., Naismith, S. L., Guastella, A. J., & Hickie, I. B. (2012). Targeted primary care-based mental health services for young Australians. *The Medical Journal of Australia*, *196*(2), 136–140. McGorry, P. D., Tanti, C., Stokes, R., Hickie, I. B., Carnell, K.,

This becomes a problem for the future waiting rooms and emergency departments of the state's health system.

63 headspace could play an increased and critical role in Victoria's future community-based mental health system. To do this, headspace could be funded to undertake a range of activities, including:

(a) Continuing the delivery of services to young people.

(b) Undertaking care coordination and service integration between headspace, tertiary mental health and other relevant services.

(c) Being better equipped to help moderate and more complex young people, where appropriate and based on the young person's choice and continuity of care.

(d) Delivery of family-inclusive practices by having a family worker in every headspace centre.

(e) Providing assertive follow-up support post-discharge after a suicide attempt.

(f) Expanding Individual Placement Support (IPS) in all Victorian headspace centres and expanding access to the Digital Work and Study Service (DWSS) to young Victorians.

(g) Partnering with culturally and linguistically diverse young people and communities to develop and co-design tailored approaches which enable culturally and linguistically diverse young people and families to engage with providers and services.

(h) Collaborating with ACCHOs to co-design culturally safe services and supports, and strategies for improving engagement with Aboriginal communities including young people, Elders and families.

(i) Growing digital services and online supports that complement in-person supports.

(j) Increasing community engagement efforts to improve mental health literacy, reduce stigma and increase help-seeking behaviour of young Victorians, including priority populations.

(k) Use headspace as a platform or an integrated model to build structured links into services to meet the needs of young people with health care needs of a higher acuity.

Littlefield, L. K., & Moran, J. (2007). 'headspace: Australia's National Youth Mental Health Foundation--where young minds come first'. *The Medical Journal of Australia*, *187*(7 Suppl), S68–70.

64 From a youth mental health policy and reform perspective, headspace could support young people and family and friends to be engaged at all levels of Victorian mental health reform, including the design and implementation of changes, and support the Victorian youth mental health sector to implement best-practice participation. We can also be involved in the development of a youth mental health workforce strategy, as well as involved in the development of a model to address mental health issues in primary school-aged children.

65 All providers of social services should have a sufficient understanding of a young person's mental health difficulties and be able to access a primary, secondary or tertiary consultation with a relevant mental health service. Social services could consider exploring local co-location and service integration with headspace centres.

66 Specific types of care and services delivered by general health services to support young people could include youth-specific beds in acute mental health settings (supported by specialist staff with a youth mental health speciality), and an increased number of alcohol and other drug specialists.

67 The housing support sector should provide services that are flexible and allow for self-referrals and walk-in appointments and cater for young people who do not have contact options. Young people also need to be provided with a range of access supports, such as transport.

68 The employment sector can provide a number of services to help support improved mental health outcomes for young people, including:

(a) Training employment service providers in youth mental health first aid.

(b) Ensuring mental health clinicians are available in all employment services.

(c) Appropriately reviewing young people in employment services for mental health challenges prior to actioning an activity breach.

(d) Carrying out research to understand the ongoing impacts of a compliance-based system on young people living with mental health challenges and the impact this has on their future trajectory in the system.

69 As for the school sector, specific types of care and services could include:

(a) Better access to clinical services for young people in areas of most need, particularly in rural and regional areas.

(b) Access for school leaders and educators to systemic and consistent support in the identification, response and direct referral of vulnerable and at-risk students.

(c) Better access to postvention suicide services.

(d) Improved communication channels between key stakeholders (such as schools and mental health services) to help respond to serious mental health concerns, including, for example, suicide attempts.

(e) Inclusion of practical youth mental health skills training for educators across all career stages, and development of pre-service training standards for TAFE and university.

70 As for the tertiary education sector, specific types of care and services could include:

(a) Access to mental health services (on-site, off-site or digital services), and a more flexible approach for student access to mental health support.

(b) Mandatory mental health and wellbeing strategies for every tertiary institution, which includes a suicide postvention framework and support plan.

(c) Mental health literacy skill-based training for all staff (including teaching staff, librarians, executive staff).

(d) Mental health literacy campaigns.

(e) Improved data collection on university student mental health.

(f) Collaborations and linkages between mental health services and tertiary education institutions.

(g) Strategic responses to heightened risk in specific student groups, including Aboriginal and Torres Strait Islander students and those from low socio-economic backgrounds or rural areas.

71 There are a number of arrangements that could be put in place to ensure better integration between mental health and other social services and improved health outcomes for young people, such as:

(a) Increased funding and incentivisation for improved service integration.

(b) Provision of sufficient resources to enable clinical staff to undertake care coordination.

(c) Co-location of services to support service integration and collaboration. For example, co-location of general practice and mental health services could enhance the provision and experience of care for young people.

(d) Formal requirements that services liaise between services.

(e) Funding for approaches and innovations that address known service gaps.

(f) Investment in digital technologies and services that complement in-person services and coordinate care.

Information and service delivery through digital platforms

Demand in digital services during COVID-19

72 Not unlike other mental health services providers, we have seen a significant decrease in the number of people accessing our physical centres since the onset of COVID-19. headspace centres have had to change service delivery from face-to-face services to online and telephone telehealth services. The net effect of these changes in demand is that we are seeing similar levels of access by young people from across Australia.

73 As much as possible, we are trying to ensure that young people do not become disconnected from our services in this transition.

74 Our own survey of 1,348 young people accessing headspace services in early May 2020 shows the increased and successful uptake of telehealth support among young people:

(a) 94% of clients who received a telehealth service agreed or strongly agreed that they had a positive experience with headspace.

(b) 78% agreed or strongly agreed that the mode of service they received was suitable for their needs.

(c) 89% of clients who received a telehealth service agreed or strongly agreed that they felt able to build a connection with the headspace staff member who was helping them.

(d) Half of all clients surveyed indicated that they would like to use telehealth in the future. Clients who had received support by telehealth were significantly more likely to say they would do so again.

75 The uptake of telehealth has demonstrated that it can be provided anywhere across the country and young people find it helpful, and we are now more likely to deliver services in this way in the future.

76 We don't believe that telephone and video consultation is a perfect substitute for the face-to-face provision of care. Hopefully, we are now in a position to offer young people the choice to interact with our clinicians in the way they would like. Many young people living in regional and remote areas may prefer video and telephone consultation because of the barriers of distance and transport. Other young people, including those with experiences of social anxiety, may just feel more comfortable interacting with us through text, phone or video. The continued provision of headspace services online will hopefully allow us to better engage with these cohorts of young people.

headspace digital platforms

77 Digital technologies allow young people to access support wherever they are and whenever they want – services delivered digitally can be less confronting and more accessible than in-person services.,

78 Self-stigma and low mental health literacy can delay help-seeking, and digital services can offer low-intensity resources and support, including information on mental health, self-help resources, and provision of peer support and web-based counselling services.

79 This means that digital options can be an important part of reducing wait times and increasing support options for young people with more complex needs.

80 To support people to manage their mental health, it is crucial that digital services are integrated with face-to-face service delivery (where appropriate), and that online technologies are part of a stepped care approach that allows young people to access higher intensity support when needed.

81 Online services and in-person services can be put together as part of a comprehensive package of care options for young people, by offering interim online support while waiting for an in-person service, and by improving the level of a young person's engagement. Digital technologies can also enable collaborative care planning by sharing outcome measures between mental healthcare practitioners, General Practitioners and allied health professionals involved with a young person.

82 On our eheadspace platform, the overwhelming number of consultations or interactions are via a web chat with a mental health clinician. The platform allows clinicians to provide real-time links to services available in a young person's local community, including their headspace centre or a GP where there isn't a centre in the community.

83 The headspace platform employs a stepped approach. An early help-seeker may be accessing a social media platform where headspace has placed paid advertising that directs them towards the headspace website. The help-seeker will then be able to access specific information related to their particular needs (e.g. a relationship breakdown, feeling stressed, or concerns about alcohol and drugs). They then might be directed to a group chat facilitated by a headspace clinician with people experiencing similar problems. If that is not sufficient, the young person could then have a one-on-one chat with the clinician. For over 60% of young people who do proceed to this stage

and commence a new episode of care, it is the first time they have ever spoken to a mental health professional about their issues.[29]

84 Access to the eheadspace platform is on the user's terms. For example, the platform can be accessed outside of ordinary business hours, which mirrors when demand rises sharply.

85 eheadspace is a dynamic digital platform. Gone are the days where a mental health service could merely post fact sheets online that identify the common symptoms of mental health disorders. While this could be helpful, it could also be confusing for young people who ask 'do I see myself in that list of symptoms or am I experiencing something different?' or who have individual and family circumstances that generic information does not engage with. The eheadspace platform allows young people to be provided with relevant information and advice.

86 Using the trusted headspace brand in innovative ways, our online presence has significant flow-on effects for our mental health system. We think that eheadspace and our other digital offerings have the potential to detect and manage mental health problems in young people before they are exacerbated. Along with the headspace centres, our digital capabilities are aimed at providing young people the tools to manage mental health challenges at an early stage.

87 headspace's online presence also allows us to provide complementary digital support for our work and study support programs. We provide online mentoring services which, for example, allows a young person in Mildura to be connected with a bank executive who can provide advice and support for that young person's wellbeing.

88 headspace has recently undertaken work to explore the potential to apply behaviour change principles to our digital resources. These principles are ordinarily engaged in face-to-face cognitive behaviour therapy to treat and manage depression and anxiety. Hopefully, this will allow our users to make small changes in their own lives and perhaps avoid the need to access any additional mental health services.

89 One of the biggest obstacles we continue to address is the need to maintain connection between our digital and face-to-face services. In an ideal world, a young help-seeker would be able to access services both online and in-person, and headspace would have a complete record of both. This would better ensure continuity of service delivery by headspace clinicians.

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[29] headspace unpublished service data, 2018-19 Financial Year.

90 There are a number of barriers that prevent young people from accessing digital support which can be overcome with improved resourcing and funding:

(a) Limited internet access and data can be overcome with improved internet access in regional and rural areas and by providing young people with data top-ups.

(b) Culturally inappropriate digital resources can be overcome by tailoring digital resources and supports for a range of cultures.

(c) Digital illiteracy can be overcome by ensuring that digital resources are developed for low literacy needs, such as with the use of simple language, pictures, and easy-to-digest video content.

(d) Lack of awareness of the digital supports that are available can be overcome with increased and targeted community awareness and marketing of available services and that ensuring mental health brands (such as headspace, Beyond Blue and Reach Out) cross-promote resources and supports.

(e) Concern about whether digital supports and resources are being delivered from known and trusted services can be overcome by ensuring that trusted mental health brands are delivering and communicating resources for their audiences.

Service integration

91 We see that our role is to be an advocate for young people who may have to move from one part of the health system to another. We seek to ensure that young people transition seamlessly to different services and teams if necessary, by requiring that headspace centres undertake warm referrals to support effective service transitions.

Challenges in providing services integrated with Victoria's CAHMS

92 A key element of the headspace model is the role that state mental health services play in headspace consortia. These services are key partners for headspace centres as they provide advice and client pathways.

93 There are a range of issues that we have observed with integration with the Victoria state mental health services. Primary care providers including headspace do not receive the funding required to adequately link young people from its centres to secondary or tertiary mental health services. In circumstances where the Victorian public system predominantly cares for acutely unwell people, effectively transitioning a young person from primary care or headspace requires significant resources. The referring service needs to be able to provide a warm referral or supported transition to the secondary service and ensure that they receive treatment from the secondary service. Given the importance of supporting transition of care arrangements, I strongly encourage care

coordination support for practitioners remunerated by the MBS (i.e. bulk billed) to ensure that maximum time is allocated for partnering with CAMHS at the patient level. The same should be said in support of the CAMHS, so that they too have the capacity to respond.

94 Moreover, many GPs in headspace centres find it difficult to obtain a second opinion from a psychiatrist in the public system. Access to a second opinion can allow a headspace GP to manage a young person's care in a primary care setting rather than referring them to a specialist service for treatment. This ultimately reduces the pressure on specialist public health services, as well as means that the young person is treated in a more appropriate setting. Regional based commissioning and service models should consider access to Psychiatrists as essential.

95 Many Victorian headspace centres also report that they have limited options when it comes to referring young people to public mental health services. This is because many public mental health services will only accept the most acutely unwell young people, rather than those young people who could benefit from the service. While headspace centres are able to continue to care for these young people, they would often be better served by other parts of the mental health system.

96 When headspace centres aren't able to transition young people to the most appropriate service, their capacity to accept new young people is restricted. This means that many young people's access to a headspace centre is delayed, and this is an indirect effect of the withdrawal over time of accessible community-based supports from the Victorian system.

97 Both headspace and the state mental health system are presently missing opportunities to form effective partnerships. It is not just that the public system that needs to do a better job, headspace also needs to be able to provide the right supports so that no young person falls through the gaps between primary and secondary care.

98 headspace would need to be appropriately resourced for integrated care and to undertake care coordination and service integration between headspace, tertiary mental health and other relevant services. The investment in improving the system for the community requires investment in collaboration and sustainable pathways of care.

99 There also needs to be better linkages between CAHMS with headspace in rural settings, and in particular in towns where there is limited access to specialist mental health services. Possible solutions include the increased provision of telehealth or adopting new workforce models that increase access to state services.

100 In some instances, local public health services are the Lead Agencies for headspace centres. headspace National has observed some significant benefits of tertiary mental health services being Lead Agencies for centres, including:

(a) Stronger links between headspace and tertiary mental health services which can facilitate the transition of young people's care.

(b) Greater access to psychiatry.

(c) Access to tertiary mental health services' existing clinical governance structures and processes which can greatly benefit the headspace centre.

101 Other Lead Agencies across the country have been able to establish strong relationships with local tertiary mental health services and other local services. Like any system, models of care will be only as effective as relationships and the people involved.

Better integrating primary and secondary health providers

102 At present, transitioning young people between services is relationship-dependent. This means that a successful transition will often depend on one clinician knowing another clinician. Whilst memorandums of understanding may be entered into by primary and secondary care providers, in practice, these relationship documents may cease to operate when key personnel leave one of the providers.

103 The task of sustaining mutually-accountable partnerships is difficult and requires structural rather than relationship-based responses. Some of the best examples we have seen have occurred where organisations have both committed not to let any young people fall between their services Some headspace services have managed to facilitate better integration by building relationships with local tertiary mental health services, but these relationships are often person-dependant. Other examples across headspace where this integration works better is when PHNs have provided headspace centres with funding for positions that work with young people with higher acuity. This adds to the multi-disciplinary team in a very positive way.

104 A number of the components of the headspace model seek to effectively transition young people between the primary care platform and other service providers. These include:

(a) The requirement that the public mental health service in the same region as the headspace centre is a part of the headspace consortium, which creates a sense of investment in the headspace centre by the health service.

(b) headspace National is able to share best-practice examples of collaboration across all of the network, including by providing template memorandums of

understanding, written models and presentations on the negotiation of service partnerships by experienced staff.

(c) The co-location of primary care clinicians and other services in one location. Whilst the majority of Victorian headspace centres receive visits from public health service workers, there are a few stand-out examples of effective integration and co-location. One example is the headspace Early Psychosis program, where headspace provides a safe front door to psychosis care provided by public mental health services. We think that it would be beneficial to investigate the use of this comprehensive approach to treat conditions other than psychosis.

(d) Linkages with community services, through both co-location and involvement in consortia. In Victoria, headspace has implemented a model of Individual Placement Support which integrates vocational and clinical services for young people who have disengaged from work and study. In the context of COVID-19 and the resulting economic downturn, the importance of this model may increase. Some headspace centres also provide legal support and sexual health services with the goal of supporting wellbeing in young people. Salarying staff, including GPs and allied health professionals, to facilitate case coordination between services will play a crucial role in achieving a more integrated service for all young Victorians.

105 Based on our experience, we can also say that:

(a) The direction and purpose of funds also influences behaviour. Funding models for Victorian public health services should include clear accountabilities for engagement with the primary care system (i.e. GP clinics, ACCHOs and headspace centres).

(b) There needs to be a more deliberate approach to co-locating and integrating services, including through the sharing of electronic records, meetings and intakes. Ensuring that all service providers and clinicians are on the same page is particularly important for high risk young people who are more likely to be provided 'stepped-up' or specialist services outside of primary care settings.[30]

(c) Similarly, different services need to employ a shared language to describe the same concepts and risks. This could reduce the instances of tertiary mental health services reassessing young people who have already been assessed in a headspace centre.

[30] These young people might also be provided with specialist treatment within a primary care setting such as headspace when it is decided that their needs could be managed more appropriately that way.

(d) As well as greater accountability, leadership is important because effective partnerships require cultural change within organisations. An absence of leadership or leadership fatigue is a barrier to cultural change.

(e) Sharing of information and resources between services is important, as well as engaging people to coordinate care and build partnerships between services.

(f) In constrained funding environments, there is a tendency for clinicians and service providers to retreat back from partnerships to their own 'core business'. The result is often time-poor partnerships where referrals occur less frequently.

106 It is important to remember that when a young person presents to a service with complex needs or difficulties, it is not the young person that is complex. Rather, the complexity lies in the interaction of services and skills and experience of the clinician.[31]

107 We propose a number of mechanisms and structures for better integrating community-based and acute mental health services, including:

(a) Increasing the scope of MBS payments to include case coordination within and between services.

(b) Developing a coordinated plan or platform for young people who fit the 'missing middle' criteria.

(c) Shared commitments between services to ensure young people do not fall between the gap of primary care and tertiary care services. This commitment should be enacted through a memorandum of understanding between services that is supported by regular meetings and reviews.

(d) Sharing staff between primary care and tertiary care services – including, for example, psychiatrists.

108 Co-investment and blended funding models between Commonwealth and State governments will allow for the creation of pathways for people between primary care and other services.

109 Other innovative examples include:

(a) The Health Care Homes program[32] coordinates care for people with chronic and complex conditions and is an example of where the system works best for the client and not just the funder.

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[31] headspace National Youth Mental Health Foundation (2020) Practice Principle Complexity.
[32] See https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes [Accessed 31 July 2020].

(b) Beyond Blue's Way Back Program provides assertive aftercare following a suicide attempt and demonstrates strong integration between hospitals and community care.

(c) The headspace Brief Intervention Clinic provides evidence-based psychological interventions as an alternative service model for young people with mild to moderate difficulties to reduce the need for more intensive, longer-term treatment.

Service design

Roles and responsibilities of the Victorian and Commonwealth governments in responding to the 'missing middle'

110 headspace is major point of entry for young people into the Victorian mental health system. For this reason, it is important that headspace is not viewed solely as a Commonwealth responsibility.

111 The approach of the Victorian State Government to date has been to decide on a region-by-region basis whether the state mental health system will partner with headspace.

112 The Victorian Government should instead consider entering into a partnership with headspace at the State (rather than regional) policy level. This partnership need not be exclusive, but it would build off the trusted brand of headspace, possibly involve co-locations of services in bigger buildings, and permit joint decision-making about client pathways at a more systemic level.

113 To allow effective integration of headspace and state mental health services, additional capital contributions by the Victorian State Government will be required for headspace centres in larger buildings. Larger centres are required to accommodate a wider range of services under one roof.

114 As for the respective roles and responsibilities of Commonwealth and State Governments for youth mental health services:

(a) Blended funding will be best for young people, their family and friends and communities.

(b) Commonwealth and State Governments should commit to ensuring that no-one falls through the gaps

(c) State funding should be provided to national programs to integrate and coordinate with state youth mental health services.

(d) State Governments could create central hubs of community-based mental health care for people with moderate to complex mental ill-health, which could be trialled as a 'proof of concept' to address the 'missing middle'.

Ways to strengthen the primary care response to young people's mental health needs

115 It is crucial that the primary care system is strengthened to support all groups of young people through appropriate funding for youth mental health as part of the broader mental health system inclusive of the three stages, and funding for care coordination and service integration for each group.

116 As for young people at risk of developing mental health issues, the primary care system can be strengthened by:

(a) Community engagement to promote mental health literacy and help-seeking.

(b) Investment in digital technologies to promote mental health literacy.

(c) Development of resources and supports to enable young people to maintain their mental health.

117 The primary care system can be strengthened to better support young people living with mental health issues by:

(a) More flexible funding to support integration and care coordination which links young people with complex needs to appropriate higher-intensity services.

(b) Integrating digital supports with face-to-face service delivery.

118 As for young people experiencing suicidal ideation and at risk of suicide, the primary care system can be strengthened by:

(a) Assertive after-care following a suicide or self-harm attempt that is specifically designed for young people.

(b) Increased mental health literacy about crisis points and when to reach out and seek help.

(c) Multiple entry pathways into services and supports.

119 System-wide improvements that could be implemented to meet the physical and mental health needs of young Victorians include:

(a) Ensuring that services are free or low cost so that cost barriers do not preclude young people from accessing help. We know that twice as many 15 to 24 year-

olds with a mental health condition do not see a GP because of cost barriers compared with those without a mental health condition.[33]

(b) Having a salaried GP in every Victorian headspace centre.

(c) Sharing GPs between primary services and tertiary services.

(d) Mandating appropriate mental health training of all health clinicians.

120 Examples of best practice models for ensuring physical and mental health needs are met include:

(a) The headspace Early Psychosis program has a salaried GP component to address physical and mental health issues as an integrated part of the model.

(b) headspace Bondi Junction facilitates service delivery and stronger referral pathways for visiting primary health service providers such as supporting a number of regular bulk-billed GP services, a funded exercise physiologist, and monthly dentists and dental nurses for non-invasive therapy.

(c) headspace Launceston partners with the Tasmanian Government's Youth Health Services team, which provides a nurse two days per week for young people to receive health assessments and STI checks.

Engaging people from culturally and linguistically diverse communities

121 The main barriers to engaging people from culturally and linguistically diverse (CALD) communities in mental health services include:

(a) Use of language, both for mental health literacy and concepts of mental health.

(b) Staff training, competence and confidence.

(c) Lack of partnerships and focus on community engagement of CALD communities.

(d) Lack of appropriate engagement of family and friends using a CALD community specific approach.

(e) Lack of resources, especially for workforce to engage with CALD young people and family and friends.

(f) Lack of meaningful support for lived experience representatives and reference group members.

122 These challenges can be overcome with:

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[33] Productivity Commission (2019) 'Report on Government Services 2019: Mental Health Management', Table 13A.19. =

(a) Better access to interpreters.

(b) Support for youth ambassadors to act as leaders in local communities to create links and raise awareness.

(c) Funding for CALD family and friends work.

(d) Development and co-design of tailored approaches which enable CALD young people and families to engage with providers and services.

(e) Incentivising services to work closely with CALD communities to understand their needs and priorities as well as identify and address cultural and language barriers.

123 Staff training can also help to overcome some of the barriers, especially training on culturally-responsive practices, engaging with CALD young people and communities, working with interpreters, partnering with local multicultural organisations, and gathering settlement and population data to understand local CALD communities.

124 headspace works best for young people when there is strong engagement with both young people and different sections of the community, including CALD communities.

125 headspace recognises the need for community mental health services to be agile and inclusive in the way that they serve CALD communities. This requires maintaining a dialogue with members of the relevant community to:

(a) Understand their needs and priorities.

(b) Identify and address cultural and language barriers to accessing services.

(c) Solicit feedback about what can be done better.

(d) Co-design and tailor service approaches to the community.

(e) Promote and inform community members about the services available.

126 headspace has recently undertaken a project to improve its engagement with CALD young people and communities. In order to better understand the challenges and opportunities that headspace centres experience when working with CALD young people and communities, headspace National held a workshop with representatives from different headspace centres. The purpose of the workshop was to identify how centres were working to meet the needs of CALD young people and identify how headspace National could best support the centres. The following key themes were identified, and these will be addressed with short- and long-term projects and initiatives:

(a) Language barriers.

(b) Partnerships and community engagement.

(c) Staff development and capacity-building.

(d) Intersectionality.

(e) Communication.

(f) Workforce.

(g) Resources.

(h) Family work.

(i) Marketing.

(j) Changing mental health language and using a new model of care.

127 headspace National is also collaborating with Orygen on its 'Supporting the wellbeing of culturally and linguistically diverse young people' project, and with the Centre for Multicultural Youth on its 'Reverb' project.

Suicide prevention

Trends in suicidal behaviour among young Victorians that seek help from headspace

128 Suicide is the leading cause of death for Australian young people aged 15–24,[34] and rates of self-harm and suicide among young Australians are increasing.

129 Expertise from the headspace Schools team in partnership with the Be You team highlights that Victoria has one of the highest rates of suicide risk for young people.[35] The age range for suicide risk has lowered over the years, and the risk is more heightened in years 9, 10 and 11 but most acute in the first year after school. Historically, young women have used less fatal methods for suicide which resulted in a lower suicide rate amongst young women, however, young women are now choosing more fatal means as opposed to 10 years ago.

130 The goal of headspace, as a primary care platform, is to address the risk factors for suicide in a young person as early as possible. We recognise that suicide is extremely complex and there is no sole or leading risk factor. However, we want to eliminate as many risk factors as possible. We seek to do this by:

(a) Remaining an open and accessible service where young people feel comfortable to talk about their needs, both in-person and online.

[34] Australian Institute of Health and Welfare (2018). 'Australia's health 2018. Australia's health series no. 16.
[35] In-house expertise from headspace Schools team (2020). Unpublished data.

(b) Ensuring that young people are not lost in the transition from primary to secondary care.

(c) Partnering with community organisations and schools to identify, assess and refer at-risk young people to appropriate care.[36]

131 14.5% of young Victorians who have accessed support from headspace expressed suicidality or suicide ideation. Usually this was not their primary reason for going to headspace.[37]

132 We are aware that there have been significant increases in the number of young people who present at emergency departments after having self-harmed or attempted suicide[38]. Notwithstanding the great work that emergency departments do, they are not necessarily the most appropriate service to provide ongoing support to people who are risk of further self-harm.

133 We think that there is potential for headspace to provide (or partner with other services to provide) additional assertive outreach support for young people at risk of suicide and self-harm. This could be done in a more timely and integrated manner than currently is been done.

Challenges of current suicide prevention approaches

134 Research shows that most people who die by suicide reach out to the health system in the six weeks prior to their death.[39] The health system has failed to save these people.

135 There is a lack of system integration across organisations that have some responsibility for youth suicide prevention (e.g. schools, emergency departments, and primary care). There is no one centralised resource for schools, workplaces and parents to access when they come to believe a particular person is a suicide risk. Even if contact is made with headspace or a GP, there is no centralised register that records the details of people who are considered at-risk of suicide. Because of the inadequate surveillance of suicide risk, both at the state and national level, services like headspace cannot easily identify people and communities at risk and provide them with the necessary supports. This stands in sharp contrast to the way the community has responded to COVID-19

[36] The headspace school support program, a suicide postvention program assisting Australian school communities to prepare for, respond to and recover from the death of a student by suicide, is now rolled into Beyond Blue's 'Be You'.
[37] headspace unpublished service data, 2018-19 Financial Year.
[38] Hiscock, H, Neely RJ, Lei S, Freed G (2008) 'Paediatric mental and physical health presentations to emergency departments, Victoria' *Med J Aust* 2018; 208: 343-348.
[39] Orygen analysis of 2018 Causes of Death ABS data, accessible at https://www.orygen.org.au/About/News-And-Events/2019/Rates-of-suicide-continue-to-increase-for-young-Au [Accessed 31 July 2020].

where we are now quickly able to identify clusters of the virus and then provide intensive support to affected individuals, organisations and communities.

136 Where the need for support is identified to address suicide risk in a particular community or organisation, local action groups are needed to provide these supports, which can be health and non-health oriented. A report by the Casey Cardinia Suicide Project showed that while some pilot programs have brought small communities together, these successes have not been implemented at the regional and State levels.[40]

137 Another challenge for youth suicide prevention is the separate operation of suicide prevention sector from mental health services. Young people who experience suicidal ideation or engage in suicidal behaviours require safe and effective services with an emphasis on continuity of care, assertive follow-up, and a focus on continual improvement. The fragmentation and lack of integration in the sector means that these things are difficult to ensure for young people. For example, a consistent application of a shared framework for suicide assessment should be nationally implemented. Additionally, the interface between the suicide prevention sector and the mental health sector needs some serious attention.

138 Further challenges for youth suicide prevention include the lack of focus on young people in existing programs (e.g. assertive follow-up care), data sharing and data capture around suicide, and family and friends not being integrated into support services.

Translating suicide prevention and postvention research into practice

139 There is an absence of a youth focused and co-designed suicide prevention and postvention program that operates at a broader systems level. We would like to see successful programs such as Beyond Blue's Way Back program strengthened with youth-specific approaches that account for the nuances in youth engagement with mental health services. It is important that any new programs work with people who have lived experience of suicide attempts, as well as friends and families who have lost loved ones to suicide.

140 Moreover, aftercare support for young people should be based on risk formulation and treatment needs (which is client focussed), rather than risk stratification (i.e., low, medium or high).

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[40] headspace National Youth Mental Health Foundation (2016) 'Final evaluation report: Casey Cardinia Suicide Project. A headspace suicide recover project'.

141 New youth suicide prevention initiatives should promote place-based and context-specific suicide prevention strategies for young people, such as having peer support workers join paramedics when supporting a young person, and more outreach and mobile home treatment services as alternatives to Emergency Departments.

142 The trust and expertise of services that already have a strong reach into youth populations should also be leveraged. For example, headspace has a strong youth brand and is well placed to scale up efforts to reduce suicides and suicidal behaviour for young Victorians. However, it is equally essential that all parts of the system such as CAMHS, ACCHOs, General Practice and school mental health systems are coordinated and working in an organised collaborative approach.

143 Governments and service providers responsible for suicide prevention should form mutually-accountable partnerships (including information-sharing guidelines, better linkages and referral pathway supports), and agreements that no young person will fall through the gaps of service. This could be formalised via a National Mental Health and Suicide Prevention Agreement and a National Suicide Prevention Strategy which is specific to the unique experiences of young people and developed in partnership with young people and family and friends, and includes a whole of community focus (with identified responsibilities for all levels of government (i.e. federal, state and local) and clear directions for the non-government sector). Partnerships could include emergency departments, CAMHS, General Practitioners, headspace, ACCHOs, police, ambulance and schools. All service providers should be provided suicide prevention training, including Psychological First Aid and suicide gatekeeper training.

144 Real-time monitoring and surveillance will allow us to understand suicide behaviour in young people, what works, and why some interventions help divert young people from suicidal behaviour.

145 Based on local advice, the State and Commonwealth should consider who is best placed to lead and operate coordinated approaches to preventing youth suicide.

Commissioning

146 headspace National was responsible for the commissioning of headspace centres across Australia up until 1 July 2016, after which PHNs became responsible for the regional commissioning of new centres. At this time, there were 97 headspace services operating nationally, and 21 in Victoria. Since 1 July 2016, 50 new centres and satellites have been announced, of which 18 have been established. In Victoria, there have been 14 new services announced since this time, of which six are currently operational.

147 The current regional approach to commissioning is based on the identification of local needs and circumstances. This ensures that young people have the continued choice to access headspace centres in their local communities in addition to the other avenues for service available for young people.

148 National commissioning in respect to headspace was a key enabler of:

(a) Consistency in quality and safety, clinical governance, and service design.

(b) Good governance and standard approaches to tendering and procurement.

(c) Leverage of a national brand, community awareness initiatives and help-seeking campaigns that can be developed nationally for economies of scale and adapted locally.

(d) Attraction of local partnerships, fundraising and media.

(e) Sharing lessons learnt across the network – for example, benchmarking and communities of practice.

(f) Larger scale of innovative trials with greater support for evaluation and roll-out.

(g) The ability to attract workforce and provide opportunities across a large network, along with strong clinical governance and opportunities to learn.

(h) The ability to integrate local headspace centres with national digital services.

(i) The ability to set minimum standards and ensure quality, ensuring evidence-based safe service delivery for young people.

149 Commissioning approaches can support new care models by allowing for innovative trials with longer trial timelines (greater than the usual 1 to 2 years) and appropriate program logic and evaluation, providing time to design, establish, test and adapt new care models.

150 Commissioning approaches can respond to the preferences and needs of consumers by ensuring participation of consumers in all aspects of the service through paid participation. Youth participation is at the foundation of headspace and, in our opinion, it is the reason for our long-term success. headspace National has youth advisers to the Board and governance committees, along with the headspace Youth National Reference Group. This is replicated locally through headspace centres who are required to maintain an active Youth Reference Group who are involved in the design of the centre and play an important ongoing role in service design, local governance and community engagement activities.

151 The commissioning approach of headspace has helped to incentivise early intervention approaches by: ensuring that the headspace model is developed within an evidence-

based framework with appropriate KPIs and supports; requiring that services are welcoming, stigma-free and that the community is aware of them; and limiting the entry assessment criteria.

152 The commissioning approach of headspace has encouraged the provision of treatment, care and support to people with complex needs by requiring primary care services to partner with tertiary mental health services, and requiring that headspace centres undertake warm referrals, support transitions and, where clinically indicated, provide direct support. Commissioning needs to recognise that the complexity of young people's presentations is not static – it will go up and down. That is, commissioning needs to allow for continuity of care by employing salaried staff for longer periods that have appropriate qualifications to support young people presenting with complex needs.

153 We disagree that the headspace model is inflexible or not adaptive to different local communities.[41] Further, by opting out of the headspace model, PHNs forgo the following benefits:

(a) The headspace network is also a learning network which allows clinicians and staff to learn best practice from one another.

(b) Integration with the headspace digital platform.

(c) Access to national and state data capture.

(d) A brand that is trusted by young people and is recognised from an early age.

(e) An established and wide-ranging social media presence.

(f) School programs designed to combat stigma and improve mental health literacy.

Workforce

154 A workforce working specifically with young people and family and friends in mental health should be young person-centred, recovery-focussed, strengths-based and adept at evidence-based practice. The workforce should also be based on the commitment to work collaboratively with young people and family and friends, and respond to the needs and unique circumstances of priority groups, such as Aboriginal and Torres Strait Islander young people, CALD young people, and young people who identify as LGBTIQA+. The recognition of a peer workforce as a legitimate modality to support and enhance traditional treatments is also crucial.

[41] See my discussion of the flexibility of the headspace model above at 30 to 34.

155 As for the clinical workforce, there is currently no youth mental health clinician specialty. Such a specialty will need to be developed with minimum standards and skillsets and facilitated by credentialed training.

156 Many of the principles outlined above for a youth mental health clinician come from non-clinical modalities. For example, the peer workforce provides clinical outcomes but without clinical training, as there is no formal definition or training for peer workforce.

157 There is a significant proportion of young people under 12 years who are developing mental health issues (including anxiety and developmental disorders)[42], and there is a need to recognise child mental health as a specialty.

Prevention and health promotion

headspace campaigns to promote awareness of mental health and address community attitudes

158 headspace's multifaceted mental health literacy campaigns span traditional media, social media and community engagement activities and are highly effective and targeted at young people and high priority groups, such as Aboriginal and Torres Strait Islander people and parents and carers of young people.

159 headspace campaigns build community understanding of mental illness, and reduce stigma, which increases mental health literacy and builds the capacity of people to understand and look after their own mental health, and to recognise and respond to changes in the mental health of their family, friends and colleagues.

160 Improving mental health literacy for young people means that:

(a) Young people can better understand their own mental health, and the mental health of their peers and friends. This includes knowing where, when and how to seek help if needed.

(b) Young people's family, teachers and colleagues recognise when something isn't right, know how to start a conversation, respond supportively and when to suggest a young people seeks help.

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[42] Simone Darling and Frank Oberklaid (2019). 'Child mental health: building a shared language'. *Insight website*. Accessible at https://insightplus.mja.com.au/2019/36/child-mental-health-building-a-shared-language/ [Accessed 31 July 2020].
Rhodes A, Sciberras E, Oberklaid F, South M, Davies S, Efron D. Unmet developmental, behavioral, and psychosocial needs in children attending pediatric outpatient clinics. Journal of Developmental and Behavioral Pediatrics. 2012;33:469-478.
Oberklaid, F., Baird, G., Blair, M., Melhuish, E., & Hall, D. (2013). Children's health and development: approaches to early identification and intervention. *Archives of Disease in Childhood*, *98*(12), 1008–1011.

161 The manner in which headspace seeks to promote mental health literacy and help-seeking opportunities is continuously adapting so that our message remains relevant to young people. Our campaigns are always developed in consultation with the target cohort.

162 We have learnt a lot about what works for engaging with young people and communities through community campaigns, including:

(a) Approaches have to be multifaceted, systematic and integrated.

(b) Approaches must be co-designed across campaign strategy, concept development, campaign roll-out and associated community engagement efforts.

(c) Awareness-raising leads to service demand, so it is crucial that campaigns also increase mental health literacy to build skills in self-care, recognition of warning signs and starting conversations.

(d) Association with the headspace brand can strengthen campaign messaging aimed at improving mental health and wellbeing in young people. The power of our brand, and its perception of 'safety-ness' in young people, is a necessary complement for local community initiatives.

(e) Clinicians need to be equipped with resources and skills to deliver effective psycho-education to young people and family and friends that is aligned with the campaign.

(f) Centres and services (like eheadspace) need to be aware of the campaign and able to manage increased service demand.

(g) Community awareness campaigns can help those who are supporting young people (parents and friends) to develop skills and use resources to support young people who are struggling.

(h) Campaigns and community engagement efforts should consider a range of settings where young people are, including school, workplaces and sporting clubs.

(i) It is crucial to target efforts for priority populations who have lower mental health literacy, and who can benefit from tailored messages, engagement approaches and calls to action, such as Aboriginal and Torres Strait Islander young people, CALD young people, young people who identify as LGBTIQA+, young men, and young people living in rural and regional areas.[43]

[43] Productivity Commission (2019). Mental Health, Draft Report Volume II. Commonwealth of Australia. Pg. 121.

(j) Information must be practical and easy-to-understand. For example, the headspace '7 tips for a healthy headspace' are simple, everyday things that people can do.[44]

(k) Community engagement activities must be localised and tailored to a community.

(l) A mix of ambassadors to share and amplify mental health literacy tips and stories should be included, such as:

(1) high profile ambassadors across a range of industries relevant to young people (sport, art, music, celebrity, business); and

(2) real life 'young people' who identify with the issues that most young people experience across a range of ages, genders, sexualities, cultures, locations (metro, regional and rural).

(m) Partners can be leveraged to amplify campaigns and boost reach and engagement of the campaign messages. For example, headspace partners with the NRL and GWS Giants to tailor messages specifically to young men who can be hard to reach.

(n) Media must be selected to ensure the right message is tailored to the audience of young people and family and friends. This includes a mix of broadcast, streaming, radio, digital and press media.

163 For example:

(a) Our consultation with young males aged 18–25 years highlighted that they strongly look up to role models who are able to speak about their lived experience of mental health. Based on this, headspace developed the 'head coach' campaign with young men and engaged prominent sporting people to speak about their views on and experiences of mental health and wellbeing. The first iteration of the campaign launched in July 2018 with a full suite of advertising including TV, digital, social media, transit media, and stadium advertising at sporting matches. The sporting personalities included in the campaign were: Tom Boyd (AFL), Dale Thomas (AFL), James Tedesco (NRL), Usman Khawaja (Cricket), Daniel Arzani (soccer), Kurtley Beale (Rugby Union) and Brandon Defina (e-sports). Just over 1 in 4 young men aged 15–25 years saw the campaign and 64% took action as a result of seeing it.[45] The second phase of the campaign launched in March 2019 with the same personalities (with the exception of Kurtley Beale) and with TV, digital advertising and social

[44] See https://headspace.org.au/young-people/tips-for-a-healthy-headspace/ [Accessed 31 July 2020].
[45] headspace (2018). headcoach Campaign Evaluation. Unpublished.

media. The campaign reached 30% of young men in Australia, and 72% who saw the campaign took action to better their mental health.[46] Moreover, 88% of parents who saw the campaign also took action to better the mental health of themselves or their young person.[47]

(b) Our 'Life isn't always glitter and rainbows' campaign targeted young people identifying as LGBTIQA+. The content for the campaign was developed from insights of young people in this community and data showing that LGBTIQA+ young people are two times more likely to experience mental health issues than non-LGBTIQA+ young people. The campaign first launched in the lead up to Mardi Gras 2019, and was a social media led content series that involved a small paid advertising effort across social medial channels. The campaign yielded strong digital engagement (including a click-through rate on the videos that is double the industry average).[48] We ran a second iteration of the campaign in early 2020 with similar messaging and a new series of videos.

164 Our fathers campaigns in 2016 and 2017 encouraged fathers, especially fathers of sons, to speak to their children about mental health. The key aims were to promote awareness about mental health issues in young people, encourage fathers to start conversations with their children about mental health, help identify warning signs, and provide information about services available to them to support family and friends including headspace. One third of parents (30%) took action after seeing the campaign, including speaking to their child about mental health, visiting the headspace website, or speaking to a friend or family member about mental health).[49]

165 To further support the work that we do, headspace could be funded to roll-out large-scale community awareness campaigns to improve mental health literacy, reduce stigma and increase help-seeking of young Victorians and family and friends. These campaigns could target engagement efforts to priority populations.

166 To support the roll out of campaigns that focus on parents of young people, it would be useful to fund a family therapist in each headspace centre who is able to work with families to address key issues.

Supporting recovery from trauma

167 We have come to understand that headspace lacks a coherent trauma framework across Victorian headspace centres.

[46] headspace (2019). headcoach Campaign Evaluation. Unpublished.
[47] headspace (2019). headcoach Campaign Evaluation. Unpublished.
[48] headspace (2019). 'Life isn't always glitter and rainbows' Campaign Evaluation. Unpublished.
[49] headspace (2017). Fathers Campaign Evaluation. Unpublished.

168 During the bushfires in early 2020 we made the following observations regarding young people and trauma that are equally applicable to the current COVID-19 pandemic:

(a) People have different responses at different times to traumatic events.

(b) People affected by trauma don't always present to headspace centres and explicitly acknowledge the source of any trauma by saying, for example, "I'm here because of the fires". This underscores the need to embed trauma-informed practice into the whole mental health sector.

(c) Often in the aftermath of natural disasters, young people are not always the first cohort that is provided support. During the recent bushfires we saw that when families entered recovery centres it was the parents, rather than children, who were first approached.

169 However, some young people who seek support from headspace are referred to trauma-specific services such as the Centre Against Sexual Assault, the Australian Childhood Foundation or to public mental health services (however, these services are highly specialised and have very tight inclusion criteria).

170 One of the main challenges that headspace faces when supporting young people who have experienced trauma is MBS funding and eligibility constraints. The MBS-funded ten sessions are not sufficient for a lot of young people, especially those with experiences of trauma who have:

(a) Complex co-morbidity or more severe mental health difficulties, including depression, anxiety, eating difficulties and interpersonal difficulties.

(b) Post-traumatic stress disorder which requires specific evidence-based treatment.

(c) Trust issues which means they need therapeutic contact with a clinician prior to the start of formal treatment.

(d) Social challenges due to their trauma and require case management for issues such as housing instability, justice issues, educational and vocational challenges.

171 Mental health professional training programmes are not mandated to include trauma-informed care, meaning that many professionals working at headspace have no training in the specific needs of trauma-exposed young people.

172 Overall, the youth service sector lacks a systemic approach for trauma-exposed young people. This results in a lack of communication between the services involved such as justice, acute mental health, primary health and education, which undermines best quality care for young people.

sign here ▶ 

print name **Jason Trethowan**

date 3 August 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JT-1

This is the attachment marked 'JT-1' referred to in the witness statement of Jason Trethowan dated 3 August 2020.

Jason Andrew Trethowan

Career Objectives	To create public value by connecting people, their professions, their businesses and their customers. To be the best possible leader in a complex environment. To be known as a respected, credible and effective leader both locally and nationally
Current Employment	**Chief Executive Officer** **headspace** National Youth Mental Health Foundation January 2017 - Current
Work History	**Chief Executive Officer** Western Victoria Primary Health Network (PHN) June 2015 – January 2017 **Chief Executive Officer** Barwon Medicare Local (BML), Geelong Victoria September 2011 – June 2015 **February 2007- September 2011** Chief Executive Officer), General Practitioner's Association of Geelong. **September 2006- February 2007** Strategic Planner, Ambulatory Services (reporting to CEO), Barwon Health, Geelong **March 2003- August 2006** Manager, Health Information Services/ Acting Executive Director Information Services, Barwon Health, Geelong, **November 2000- March 2003** Project Manager, Clinical Systems, Barwon Health, Geelong **July 1999- November 2000** Project Manager, Clinical Information Systems, Ballarat Health Services, Ballarat **January 1997- June 1999** Data Manager/ Casemix Analyst, Ballarat Health Services, Ballarat **January 1996- January 1997** Health Information Manager, Ballarat Health Services, Ballarat
Education	Masters of Business Administration (MBA) Deakin University Geelong, 2006 Graduate Certificate in Health Informatics Monash University Melbourne, 2000 Bachelor of Health Information Management La Trobe University Melbourne, 1995
Professional & Community Membership	Member of Ministerial Mental Health Advisory Committee – Victorian government appointed by Minister Martin Foley. Member AFL Industry Mental Health Steering Committee

Jason Trethowan

Company Director Positions	Director Barwon Health (1 July 2016 – current) - Chair, Community Advisory Committee - Member, Primary Care & Population Health Committee Director Professionals with Alzheimer's Limited (2016 - current) Director, headspace Services Limited (2017 – current) Director G21 Geelong Region Alliance 2011 – 207 (includes 2 years as Deputy Chair) Director Glastonbury Community Services 2008-2011 Director Committee for Geelong 2009 – 2013
References	Available on request.