Submission to the

Productivity Commission's Inquiry into Mental Health

Prepared by Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation

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Executive Summary

The issue

The World Economic Forum found that mental ill-health accounted for 35% of the global economic burden of non-communicable diseases — more than cancer, diabetes and heart disease (1).

Children and young people aged 10-24 years bear the major burden for onset and impact of mental ill-health across the whole lifespan. For this age group, mental ill-health is the **leading cause of disability**, contributing 45% of the overall burden of disease (2). Half of all mental ill-health onsets before the aged of 14 years, three-quarters by 24 years. 26% of young Australians aged 18-24 years will have experienced a mental health condition (including substance-use disorders in any given year (3)) while, tragically, suicide remains the leading cause of death in people aged between 15 and 24 years (4).

The experience and impact of mental ill-health during this life stage can derail key developmental milestones and significantly increase the risk of poor health, social, education and employment outcomes. The human and economic impact then lasts for decades, **through what should be the prime years of productivity and economic participation.**

The timing of first onset in adolescence and early adulthood means that mental disorders have a significant social and economic impact and must, therefore, be a priority focus. It is at this age and stage in life that young people are:

- engaged in education that will be formative in their social connections and future pathways to employment
- experiencing major life transitions including moving between levels of education, from education to employment, and away from their families or caregivers into independent living arrangements
- developing and navigating new social connections and interpersonal relationships.

Youth mental health in Australia – achievements to date

Australia has pioneered major reforms over the past decade in youth mental health which have: improved service access and delivery; designed novel online and digital supports and interventions; increased levels of mental health awareness and literacy among young people, their families and the broader community; and reduced stigma (a key barrier to early help-seeking). Through the work of headspace and Orygen, a national youth mental health service platform has been developed which now includes (but is not limited to):

- 110 headspace centres nationwide (by 30 June 2019)
- online mental health service delivery through eheadspace, with further work on integrating online and face-to-face care being developed through eOrygen
- specific services for young people experiencing early psychosis in six headspace clusters (14 centres)
- suicide postvention support to schools
- enhanced support for young people experiencing mental ill-health to engage in education, training and employment through the Individual Placement and Support (IPS) model and the online Digital Work and Study Service (DWSS).

Outcomes that have already been achieved through this national service platform include:

- **Greater mental health service awareness:** 76% of young Australians were aware of headspace in 2018 (5)
- **Increased access to services and support:** headspace has supported over 450,000 young people with over 2.5 million services with satisfaction rates of 86% for centres and 83% for eheadspace
- **Online innovation:** 128,686 young people have registered for support through eheadspace

- **Clinical and functional outcomes:** 62% of young people attending headspace for depression and anxiety improve by having either a significant decrease in psychological distress and/or a significant increase in social and vocational functioning
- **Vocational outcomes:** over half the young people participating in the IPS trials and DWSS report a work or study outcome.

Key youth mental health issues

The success of the national headspace network provides the foundation from which the next stage of reforms in youth mental health can be leveraged. There is much more that needs to be done to address growing mental ill-health among young people and need for care. It is now evident that:

- **Young people with more moderate to severe and complex mental health issues are slipping through the gaps in care.** Described as the 'missing middle' these young people need more specialised, intensive and extended care than is currently available within primary care, however, they are not yet acutely or severely ill enough to reach the high threshold for access to state-funded acute and continuing care.
- **There are rising levels of distress among young people**. Just under one-third of Australian young people (32%) are experiencing high or very high levels of psychological stress. This rate is treble the rate reported in 2007 (6).
- **Digital and online services and interventions must be viewed as a key component of a stepped care continuum**, providing a first point of contact for mental health problems right through to an adjunct support for face-to-face interventions.
- **There are significant structural, governance and funding barriers to providing integrated and coordinated mental health supports** both within mental health services and across systems, particularly for young people with additional complexities, including experiences of trauma.
- **There is a need to hasten the expanded delivery of evidence-based programs which specifically support young people with mental illness to find, and remain engaged in, vocational pathways** including education and work.
- **A more effective approach to youth suicide prevention is needed,** including: coordinated support in settings where young people are engaged (schools and community groups); the provision of specialist mental health care and assertive follow-up at points of discharge from these services/hospitals and emergency departments; and urgent improvements to the monitoring and collection of suicide and suicide-related behaviour data.
- **There is a need to build the supply, skills and capacity of clinical and non-clinical professionals in the youth mental health workforce** and address issues that have resulted in an inability for many youth mental health services to attract and retain staff.
- **There remains an inadequate focus and funding commitment to mental health research, data and outcome measurement.** In order to ensure that Australia has the right services, systems and programs in place to improve social and economic outcomes for young people experiencing mental ill-health, we must commit to improving the capture of data, have clear outcomes measures, and fund clinical research to drive continuous improvements in prevention and early intervention, treatments, coordinated and integrated care, and broader system design.

Broader economic goals to address the issues

Despite accounting for 14.6% of total disease burden in Australia (7), mental health related services received only 7.4% of health funding nationally in 2016-17 (8) — about half what is required to be commensurate with the disease burden. This lack of spending on mental health care is then borne

out through costs to other areas of the economy including rising welfare payments, incarceration costs, homelessness costs and costs of suicide.

Much of the burden imposed on individuals, families and the wider Australian community by mental disorders that onset in youth is consequent on poor approaches to financing and organising mental health prevention and treatment service systems. We believe that the Productivity Commission's Inquiry has the potential to identify solutions to these problems.

We have identified a number of high-level economic goals for governments. In particular, these relate to financing and expenditure, which provide the overall context from which the priorities and key recommendations in our submission can be linked. They are:

- dedicate an appropriate and sustainable share of government health expenditure to promoting and supporting the mental health of the Australian population
- achieve more from government expenditure on mental health
- provide equitable and sustainable co-financing of mental health from sectors other than publicly-funded health
- ensure that Australian fiscal policy underpins a mentally healthy population.

These are described in more detail on page 11 and 12 of this submission, which are mapped against our key recommendations in Attachment 1.

Summary of key recommendations

Orygen and headspace have identified **five key priority areas and 17 recommendations** to improve young people's mental health, better support social and economic participation, and enhance productivity and economic growth. Each recommendation is described in more detail in the body of this submission and is supported by:

- the knowledge and experiences of current barriers in providing effective and efficient youth mental services
- the evidence for what youth mental health interventions, service models and characteristics are both cost-effective and deliver improved social and economic outcomes for young people.

Priority area one: Increase access to effective mental health services and supports for young people across all stages of mental ill-health (detailed recommendations p37-39)

Recommendation One

Future youth mental health investment should be directed to strengthen and extend access to headspace, the Australian Government's national platform for youth mental health care.

Recommendation Two

Governments provide greater sustainability and security of funding for youth mental health services, such as the headspace platform, including longer funding cycles and consumer price indexation.

Recommendation Three

Develop and implement a comprehensive and enhanced model of youth mental health care, augmenting the existing headspace platform to provide: a) better care for young people with more severe and complex conditions (the 'missing middle') and b) better respond to local service demand and priority populations such as Aboriginal and Torres Strait Islander young people.

Recommendation Four

Future commissioning of youth mental health services and programs by Primary Health Networks (PHNs) to include oversight by headspace National and Orygen to ensure evidence-based commissioning and to protect the integrity of the headspace platform.

Recommendation Five

Urgently update the Medicare Benefits Schedule (MBS) to provide items that support evidence-based treatment dose and duration for young people aged 12-25 years.

Recommendation Six

Consolidate and further develop the evidence base for the multitude of digital mental health services so that they can be scaled-up and appropriately integrated with face-to-face service provision.

Recommendation Seven

Governments to bolster mental health services and awareness programs targeting key priority populations of young people with an increased risk of mental ill-health and low service engagement. In particular, there should be greater investment to enable mainstream services to engage with Aboriginal and Torres Strait Islander young people and their communities to make it safe and more secure for them to seek help.

Priority area two: Improve education and workforce participation for young people with mental illness (detailed recommendations p48-49)

Recommendation Eight

Increase access to vocational support programs such as Individual Placement and Support (IPS) and Digital Work and Study Service (DWSS) within youth mental health services including in all headspace services.

Recommendation Nine

Develop and fund workplace mental health approaches to increase mental health literacy and promote workplace approaches to supporting ongoing engagement in employment for young people.

Recommendation Ten

Develop and implement education and training settings-based approaches across schools, vocational and tertiary institutions to prevent early exit from education and to enable re-engagement with education for young people experiencing mental ill-health.

Priority area three: Reduce self-harm and suicide-related behaviours in young people (detailed recommendations p54-55)

Recommendation Eleven

Make suicide prevention a focus for all settings and services engaged with young people, including schools, primary care services, mental health services and hospital emergency departments.

Recommendation Twelve

Develop a real-time surveillance system with standardised data collection and reporting for suicide and suicide-related behaviour.

Priority area four: Build a youth mental health workforce to meet the current and future needs (detailed recommendations p60-61)

Recommendation Thirteen

Build the capacity and supply of a youth mental health workforce with the skills and motivation to provide engaging, high quality and evidence-based care to young people.

Recommendation Fourteen

Address barriers, including job insecurity and poor incentive design, for the recruitment and retention of the youth mental health workforce.

Priority area five: Drive improvements through research, data, and outcome monitoring (detailed recommendations p66)

Recommendation Fifteen

Ensure major youth mental health service platforms, like headspace, are harnessed as clinical research platforms to develop and test new prevention, early intervention and treatment modalities and interventions.

Recommendation Sixteen

Regularly collect and report national data, including epidemiological and health service data on the mental health and wellbeing of young people aged 12-25 years in Australia.

Recommendation Seventeen

Invest in economic research in youth mental health to help achieve fairer allocation of the health budget for young people's mental health needs, do more with the allocated budget, co-finance youth mental health supports from sectors beyond health, and inform fiscal policy responses that underpin the mental wellbeing of young people.

Section 1: About our organisations

Orygen, The National Centre of Excellence in Youth Mental Health (Orygen)

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

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

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

- providing a national support network to PHNs and lead agencies with existing headspace Youth Early Psychosis Program (hYEPP) centres to support their continued scaling up of operations and fidelity to the Early Psychosis and Prevention Centre (EPPIC) model
- supporting PHNS to commission early intervention services for young people experiencing or at risk of severe mental illness, including the three PHN lead sites (ACT, South Eastern Melbourne and Tasmania) that are developing and testing regional models of care for this group of young people
- the development of relevant resources and supporting evaluation activities.

Orygen has hosted several national workshops to build this partnership, bringing together staff from PHNs across the country.

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

Orygen's current research strengths include early psychosis, personality disorders, functional recovery and neurobiology. Other areas of notable research activity include emerging mental disorders, mood disorders, online interventions and suicide prevention. Priority research areas for further development include disengaged and vulnerable young people, addiction and eating disorders.

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

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

headspace, the National Youth Mental Health Foundation (headspace)

headspace is the National Youth Mental Health Foundation and is one of the Australian Government's major investments in the area of youth mental health. headspace comprises the largest national network of youth mental health services.

The Department of Health is the principal source of funding for the headspace initiative. This includes funding for headspace National, as well as for the platform of services offered under the headspace brand. headspace National provides national coordination and support for all headspace services, and directly provides some headspace services. Support includes: national community awareness campaigns; national workforce training, education and development; advice and support to PHNs commissioning headspace services; national data collection and evaluation; fidelity assessment and credentialing of headspace centres; facilitating the headspace centre network; monitoring and reporting on services to funders, particularly the Department of Health; and other activities that enable the initiative.

The core of the headspace service offerings is the network of headspace centres (110 by 30 June 2019), contracted through PHNs. Centres have been progressively rolled out across Australia in a series of rounds since the first 10 centres were commissioned in 2006. In 2011, headspace received funding to provide online mental health care through eheadspace, which enabled headspace to extend its reach and reduce the barriers to service access for young people who may not live near a headspace centre, or are not ready or able to access face-to-face care.

The headspace centre network was strengthened in mid-2013 with the integration of specialised services for more complex, low prevalence disorders, specifically early presentations of psychosis. The headspace Youth Early Psychosis Program (hYEPP) is based on the Early Psychosis and Prevention Centre (EPPIC) model developed by Orygen. This program was implemented in six clusters (servicing a national total of 14 centres) using a hub and spoke model and has full service funding committed until 30 June 2021.

headspace received funding from the Department of Jobs and Small Business to pilot the Digital Work and Study Service (DWSS) in July 2016. This service supports the vocational service delivery of headspace centres through the provision of work and study assistance for young people via a digital platform. This program is now funded through the Department of Social Services.

In 2012, headspace School Support became the first service in the world to offer a postvention service to schools affected by suicide. Its purpose was to reduce the impact of suicide on school communities and to ultimately reduce rates of suicide among Australian secondary school students through offering immediate and ongoing services to assist all secondary schools to prepare for, respond to and recover from a death by suicide. headspace School Support has evolved over time to include responses to the risk of suicide, suicide assertive aftercare, suicide attempt and suicide prevention.

headspace is a company limited by guarantee established for the purpose of promoting improved health and mental health outcomes for young people in Australia, including through the funding of early intervention and prevention programs. headspace is classified as a health promotion charity and is endorsed as a deductible gift recipient and tax concession charity. The responsibilities of the board of directors of headspace include corporate governance for headspace and its wholly-owned subsidiary headspace Services Limited. The board has adopted a formal governance charter which sets out the functions and responsibilities of the board and promotes high standards of corporate governance within the headspace group.

Section 2: About this submission

This submission will focus on providing a high level overview of the global and national evidence for the economic and social costs of mental health problems in young Australians, outline a suggested framework for developing economically sustainable solutions for reducing those burdens over the medium to long-term, and recommend a number of directions that are suitable for immediate policy endorsement to strengthen prevention and intervention provided early in age and early in onset.

Our recommendations are focused on five key priority areas:

1. increase access to mental health services and supports for young people across the stages of mental ill-health
2. improve education and workforce participation for young people with mental health issues
3. reduce self-harm and suicide-related behaviours in young people
4. enhance the supply, distribution, capabilities and behaviours of the Australian youth mental health workforce
5. drive innovation and improvements in care through translational research, improved data, and monitoring of outcomes.

We discuss these recommendations in terms of the following broad categories of enablers and barriers: building on and expanding the existing national youth mental health service offerings, infrastructure, funding streams, workforce and research capabilities.

Other submissions to the Inquiry will be better positioned to respond to the broad ranging issues and intersecting social determinants of mental health and wellbeing described in the Issues Paper, including the delivery of social services, mentally healthy workplaces, homelessness supports, and mental health for other age groups, including those under the age of 12 and over the age of 25.

Supplementary information available on request:

headspace would like to bring to the Productivity Commission's attention that we manage the National Minimum Data Set on Youth Mental Health for headspace services, which would be a crucial input for this Inquiry. headspace has been proactive in collecting data on all its programs and putting evaluation processes in place. This is highly unusual for mental health services, but as a result, we now have large data sets related to headspace clients and programs. We have drawn on the substantial data that we have collected from all our programs to provide evidence to support our claims throughout this submission, but we also welcome further requests to access data from the Productivity Commission where appropriate.

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

Section 3: Feedback on the assessment approach

headspace and Orygen commend the Australian Government for undertaking a Productivity Commission Inquiry into Mental Health. While there have been many inquiries into mental health since commencement of mental health reform through the First National Mental Health Plan 1993-1998, the focus of the Productivity Commission on social and economic participation and the clear acknowledgement of the need for better mental health and a better mental health system means that this Inquiry may have some much-needed impact.

The Issues Paper acknowledges that improvements in an individual's mental health have significant flow-on benefits in terms of increased social and economic participation, connection and productivity in employment. The Issues Paper also acknowledges that the onset of mental ill-health often occurs in adolescence and young adulthood and can affect schooling and other factors which strongly impact opportunities and social and economic participation over a lifetime.

The Issues Paper demonstrates a background knowledge of many of the problems plaguing mental health care in Australia. The broad scope, which incorporates many different sectors and settings outside mental health services, appropriately recognises the complex range of factors that impact on mental health, most of which are outside the mental health system. The focus beyond those diagnosed with mental illness – to the mental health and wellbeing of Australia's population generally and those in the early stages of developing mental health problems – is also welcome, because mental health needs to be addressed as a continuum comprising both wellbeing and illness.

Our submission directly addresses the assessment components described in the Issues Paper, particularly in relation to: a) consequences of mental ill-health; b) effectiveness and cost of current programs and supports; and c) gaps in current programs and supports. We would like to comment, however, on a few aspects of the assessment approach that we believe need further emphasis.

A long term economic framework within which to situate the Productivity Commission's work

We welcome the Productivity Commission's Inquiry as a chance to demonstrate the economic and societal value of investment into a robust and effective youth mental health system. Economists have a major role to play in developing strategies that improve the mental health and wellbeing of young people.

As outlined in our Executive Summary, we have identified a number of high-level economic goals for governments, related to financing and expenditure in particular, which provide the overall context to which the priorities and key recommendations in our submission can be linked.

1: Dedicate an appropriate and sustainable share of government health expenditure to promoting and supporting the mental health of the Australian population

To improve allocative efficiency and priority setting within health (spending government health budgets on the optimal mix of programmes, balancing value for money, equity and feasibility considerations), we believe it is necessary to address the inadequate proportion of government health expenditure that is allocated to mental health programmes. In particular, there are a number of areas where new investment in youth mental health care is warranted and which would address unmet or under-met needs within the Australian population.

2: Achieve more from government expenditure on mental health

The technical efficiency of youth mental health services (the health and social benefit achieved with a specified programme budget) can be improved with a combination of implementation, financing and data supports and by aligning the design of provider incentives with the adequate supply and quality provision of care by the youth mental health workforce.

3: Provide equitable and sustainable co-financing of mental health from sectors other than publicly funded health

The benefits of better mental health in young people would be felt across the wider economy. Sectors that benefit from effective prevention, early intervention and treatment in mental health should be better engaged in co-financing these services, in particular to help achieve goals for young people that are typically given inadequate emphasis by the current priority setting framework for government health budgets or which require input from non-health related services.

4: Ensure that Australian fiscal policy underpins a mentally healthy population

Policymakers should have access to better data so that the impact of whole of government policymaking on young people's mental health can be better understood and that potential reforms in regulation, taxation and public subsidies that have scope to enhance the mental wellbeing of young people can be designed and tested.

In light of the importance and scale of the task of developing better understanding of the economics of mental health, we feel that the Productivity Commission Inquiry may have most impact if its final report is framed as the start of a long-term process, with recommendations for immediate action complemented by a framework for future work. Such an approach could help prompt policy reform in a number of areas where the evidence base is already sufficiently strong, and provide a guiding framework for subsequent waves of reform that may require additional analysis and evidence generation that is beyond the scope of this Inquiry. With this in mind, we suggest that the current Inquiry engages with multiple types of economic expertise across some of the key topics relevant to achieving better mental health outcomes for young Australians.

Ideally, micro-economists – working on health, behavioural, education and labour topics, and macro-economists – focused on fiscal policy – could all usefully contribute to developing a high-level economic framework for more efficient and equitable policies to support the mental health of young Australians. Our two organisations are willing to host a roundtable discussion at which Productivity Commission members, other economists with relevant expertise, and expert non-economists explore a number of economic topics relating to policy making and young people's mental health.

Consultation with young people, their families and friends

We encourage the Productivity Commission to fully consult with young people, their families and friends to incorporate their views within the Productivity Commission's final report. We have drawn upon and prioritised their lived experience expertise in this submission, but propose that the Productivity Commission purposely consult with young people, their family and friends as part of the Inquiry. Orygen and headspace could help facilitate this nationally through our existing youth and family engagement networks including hYNRG (the headspace National Youth Reference Group); Orygen's Youth Advisory and Youth Research Councils, the broader network of headspace centre Youth Reference/Advisory Groups, and headspace National's Family and Friends Advisory group.

Recognising that there are some population groups of young people with additional barriers or challenges to their mental health and wellbeing is critical, so we also propose the Productivity Commission make a concerted effort to genuinely consult with:

- **young people who are Aboriginal and Torres Strait Islander** who experience mental health problems, suicide risk and social and economic exclusion at much greater rates than others
- **young people from culturally and linguistically diverse backgrounds, particularly refugees** who have unique and generally unmet needs
- **young people who are LGBTIQ+** who are more likely to experience mental health issues and experience many barriers to their service use and social and economic participation.

Substance use disorders

Alcohol and other drug problems are critical mental health issues (9), and are more likely than not to be comorbid with other mental health problems (10), particularly for young people. While headspace has had a priority focus on alcohol and other drug problems as one of its four core service streams, this has been challenging to progress due to major systemic and structural barriers.

The Issues Paper notes that "previous Australian research indicates that, for some groups of individuals (teenagers and young adults) and some types of mental illness (such as anxiety, affective and substance use disorders [our emphasis]), participation and productivity costs could be much more than twice the cost of healthcare" (p9). Beyond this reference, alcohol and other drug issues are largely absent from the content in the Issues Paper. We believe that the Productivity Commission report will have a major gap and have lost a critical opportunity for much-needed system reform if substance use disorders are not considered within the scope of this Inquiry. By July, we are due to have completed pre-publication versions of a number of simulation-based tools that incorporate this data into economic models that explore the anticipated impact of alternative policy and service design choices in youth mental health. We can also facilitate access by the Productivity Commission to these tools.

Section 4: The social and economic impact of mental ill-health among young people and the cost-effectiveness of early intervention

Preventing and improving treatment of mental and neurological ill-health has been identified as a core health challenge for this century (11). As documented in the Issues Paper, the high costs imposed by mental disorders are now well understood. Orygen and headspace assert that targeting **preventative measures and effective early interventions** to young people presents the best opportunity to reduce these substantial costs, including those relating to unemployment, under-employment, health and welfare spending and premature death, over the lifespan (12).

This section provides a suggested framework for approaching the economics of mental health, a high-level summary of the global and national evidence relating to the socio-economic *costs* of mental ill-health in young people and the *value* to governments of prioritising an early intervention agenda to address youth mental health.

4.1 A framework for considering the economic aspects of mental health

In keeping with the experience of other developed economies, much of the burden associated with mental disorders is avertable with currently available approaches, but these opportunities are missed due to poor approaches to health system financing and organisation (13-21). Addressing the challenges of system financing and organisation is a task well suited to economists, and economic analysis of health and healthcare is a long established and varied field that has grown significantly over the last fifty years (22). The distinctive economic aspects of mental health have also been studied for some time (23).

Our organisations believe that economists have much to contribute to developing strategies to achieve four key goals relating to improving the mental health of Australians, which we outline alongside a non-exhaustive list of relevant economics topics in Table 1.

Table 1: Economics topics to inform strategies to improve the mental health of Australians

Goal	Relevant economic topics
1. Dedicate an appropriate and sustainable share of government health expenditure to promoting and supporting the mental health of the Australian population	• Allocative efficiency and priority setting within publicly funded health (ensuring that the share of the health budget allocated to mental health is both equitable and maximises the benefits to the Australian community achievable by interventions to prevent and treat mental disorders).
2. Achieve more from government expenditure on mental health	• Allocative efficiency and priority setting within public mental health (allocating the public mental health budget to the programmes that will maximise desired outcomes, while also incorporating equity and feasibility considerations). • Technical efficiency (maximising desired outcomes achieved for the specified resource allocation for each youth mental health programme). • Provider incentives and behaviours (ensuring reimbursement systems and choice architecture support appropriate decision making by the youth mental health workforce). • Demand for health and healthcare (eliciting and valuing the preferences of young people and their families for attributes of youth mental health care and ensuring those preferences are incorporated into both the design and economic evaluation of youth mental health services; planning for how

	youth mental health service usage may respond to service fees, service innovation and policy reform).
3. Provide equitable and sustainable co-financing of mental health from sectors other than publicly funded health	• Externalities of prevention and treatment for mental disorders. Externalities are uncompensated impacts of a transaction on individuals who are not party to that transaction. In the context of youth mental health, a focus on externalities can help identify which sectors of the economy bear which costs for mental ill-health in young people, and the extent to which those sectors gain from young people accessing effective prevention and intervention for mental disorders, so that financing of youth mental health care can mobilise resources from those sectors that benefit from it. • Health insurance (are the appropriate number and type of young people being privately insured and does coverage extend to their priority potential mental health care needs).
4. Ensure that Australian fiscal policy underpins a mentally healthy population	• Mental health related externalities of non-mental health transactions (ensuring that positive and negative impact of private transactions in the wider economy [e.g. participation in social media networks] on the mental health of third parties (e.g. young people) is economically valued to inform appropriate regulatory, taxation and public subsidy responses). • Production of health (understanding the socio-economic underpinnings of mental health in young people, so that policymaking in areas beyond healthcare can account for potential impacts on the mental health of young Australians).

4.2 Economic impact of mental ill-health that first onsets in youth

In 2011, the World Economic Forum found mental ill-health **accounted for 35% of the global economic burden of non-communicable diseases: more than cancer, diabetes and heart disease (Fig 1).** Among non-communicable diseases, mental illness is predicted to cause the greatest economic burden to the world by 2030. Between 2011 and 2030, it is estimated that this will cost US$16 trillion in lost economic output worldwide (1). Mental disorders rank among the most substantial causes of death globally.

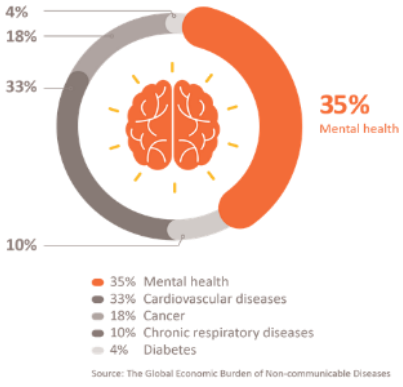

Figure 1: % contribution to global burden of non-communicable diseases.

An estimated **14.3% of deaths worldwide – or approximately 8 million deaths each year – are attributable to mental disorders**. The premature mortality of people with a mental illness is 10 years (24).

Attributing how much of this economic burden relates to mental disorders in young people is difficult because most of the voluminous cost of illness literature in mental health is not age-band specific and adopts prevalence-based rather than incidence-based methodologies. However, as the first onset of mental disorders occurs by the age of 24 years in three out of every four cases, a substantial share of this burden is likely to relate to mental disorders that emerge early in life.

Key global statistics

- 50% of mental disorders develop before the age of 14 years and 75% by age 24 years (25).
- At least 1 in 4-5 young people will experience mental ill-health in any given year (12).

The timing of first onset is one of the key reasons that mental disorders have such a significant economic impact. The **onset of mental illness peaks in adolescence and early adulthood,** which is a critical developmental period for education, employment and interpersonal or relational outcomes. The experience and impact of mental ill-health during this life stage can interfere with the development of skills needed to successfully navigate these social and economic milestones. The persistence of mental ill-health **through the prime years of productivity and economic participation** can significantly increase the lifetime risk of poor health, social, education and employment outcomes. Therefore, the economic impacts of mental disorders in youth can endure well into life-stages at which mental ill-health represents relatively lower proportions of the prevalent health burden.

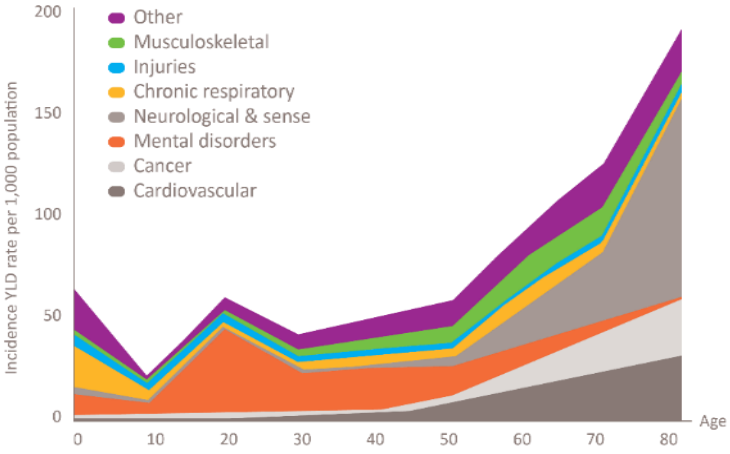

Figure 2: Burden of disease: Non-communicable disease by age.

However, quantifying the economic burden of mental disorders that first emerge in young people is difficult because most cost of illness literature in mental health adopts prevalence-based rather than incidence-based methodologies. In practice this means that this literature typically estimates the economic costs due to mental disorders that accrue over one year across the all-age prevalent population, with the contribution of young people to productivity loss limited by the relatively lower wages earned by this group. Such evidence does little to answer questions about the potential lifetime economic benefits of averting or delaying onset of mental disorders in young people, which would require incidence-based cost of illness study designs.

Furthermore, care is required when interpreting cost of illness evidence, as these analyses can adopt a range of methodologies and cost perspectives that can produce markedly different aggregate results. However, the available evidence is consistent in describing mental disorders as being of major economic significance. As the first onset of mental disorders occurs by the age of 24 in three out of four cases, it is reasonable to conclude that a substantial share of the economic burden of mental disorders relates to disorders that first emerge early in life.

Some Australian studies have attempted to describe some of the economic burden associated with mental disorders in youth. This evidence suggests that the majority of economic costs associated with youth mental health are likely to be imposed outside the health sector. This conclusion is consistent with international evidence (26).

A 2009 study of the economic impact of youth mental health (12-25 year olds) in Australia found that the annual cost was over $10.6 billion nationally ($12.52 billion in 2017 prices)(27). Predominately, these costs were not associated with the healthcare system, as evidenced by:

- **Productivity costs (70.5% of total costs),** including employment impacts, absenteeism, presenteeism, premature death, and search and hiring costs

- **Other costs (13.4% of total costs)**, including carer costs, funeral costs and other costs to society due to economic inefficiencies
- **Health system expenditure (13.4% of total costs)**.

In 2012, the Inspire Foundation and Ernst & Young calculated the cost of mental health for young men in Australia was $3.27 billion ($3.65 billion in 2017 costs) (28). This included:

- **Premature mortality costs (32.3% of total costs)**
- **Employment costs (24.3% of total costs)**, including personal leave, reduced personal income and reduced earnings due to lower education
- **Health costs (17.0% of total costs)**
- **Disability costs (11.4% of total costs)**
- **Justice system costs (8.0% of total costs)**, including direct costs and lost income
- **Unemployment costs (7.0% of total costs)**, including lost income and welfare benefits.

The 2009 study estimated that these costs are largely borne by individuals (61.6%), with governments (31.1%) and employers (7.2%) accounting for the remainder (28).

4.3 Cost-effective prevention and early intervention

In Australia, mental disorders already represent the largest cause of disability. Yet **despite accounting for 14.1% of total disease burden** (7), **mental ill-health receives only 7.4% of health funding nationally in 2016-17** (8). This lack of spending on mental health care has flow-on effects that require high levels of spending in other parts of the economy. These costs include:

- rising welfare payments due to significantly reduced workforce participation among people with mental illness
- prison/juvenile detention costs
- homelessness costs
- suicide costs
- violence/victimisation costs.

The approach to priority-setting in public healthcare expenditure is therefore open to question on at least equity **–** and potentially also efficiency **–** grounds. Furthermore, it should be noted that the priority-setting framework in healthcare adopts a healthcare perspective on costs, which means the substantial productivity and other non-health related costs associated with mental disorders in young people are only indirectly and partially accounted for in the allocation of health budgets. Under Australia's current healthcare priority-setting framework, mitigating these costs remains the responsibility of other parts of government, which have arguably not yet been adequately engaged in the financing of solutions to young people's mental health needs.

There is strong evidence of the cost-effectiveness of prevention and treatment of mental disorders in young people relating to psychotic disorders, where the early intervention in psychiatry paradigm was pioneered, and emerging evidence in other disorders, to which the paradigm has been expanded more recently. Economic evaluations and international expert consensus position early intervention in psychosis as an unequalled care model to reduce distress and economic burden (29, 30). The economic evidence for early intervention in non-psychotic mental disorders is still developing, but is generally supportive (29). It should be noted that most of the economic evaluation evidence considers only the impact on healthcare costs. Given the substantial costs imposed by mental disorders beyond the healthcare sector, the current evidence base is very likely to under-represent the benefits of effective early intervention.

There are significant costs associated with delays in care, inadequate treatment and adverse developmental trajectories. The costs associated with mental health and the potential averted costs are disproportionately higher in youth mental health, as young people are less likely than other age groups to help seek (31), and suicide in younger ages causes greater lost economic output (32).

Within the current paradigm for healthcare priority setting in Australia, it is not a requirement that a healthcare intervention needs to be both more effective and cost-saving (or "dominant"). Instead, the benchmark is that the additional health gain should be of greater economic value than any additional costs associated with delivering that intervention. It is therefore likely that, as with healthcare more generally, a high proportion of cost-effective youth mental health interventions may be both more costly and more effective.

However, there are also likely to be some youth mental health interventions that are dominant. For example, the available evidence suggests that the early psychosis model developed by Orygen is not only cost-effective, but may be dominant. This observation is based on the original Early Psychosis Prevention and Intervention Centre (EPPIC) run by Orygen Youth Health in Melbourne (33) and the international implementations of that model. When converting the results from all economic evaluations of early psychosis services, the annual per-patient healthcare cost was $19,910 for early psychosis services compared to $26,303 for routine care (figures in 2014 Australian dollars). Cost savings to the wider economy could be greater, but as the available evidence base largely adopts a healthcare perspective on costs, such impacts are largely unquantified. However, it has been estimated that 72% of the economic costs of psychosis in Australia are imposed outside of the healthcare sector (34).

In addition, the 2018 *Investing to Save* report by Mental Health Australia and KPMG found that in the provision of Cognitive Behavioural Therapy (CBT) for young people experiencing early onset depressive illnesses, the short term health care savings outweighed the cost of treatment, even before considering longer term savings (32).

An independent evaluation of headspace centres found that an average occasion of service cost $339 and an average treatment of five services per client cost $1,695 (2013/14 dollars) (35). More recent data from headspace National for FY17/18 shows that an average occasion of service costs $264 and an average treatment of five services per client costs $1,320 (2017/18 dollars).

The decrease in average costs since FY13/14 is mostly attributable to a 9% increase in the average number of services provided at each centre and a 14% increase in the average number of young people seen, while the level of funding provided to headspace centres has remained fairly static. Note that the number of centres included in each calculation has increased from 57 in 2013/14 to 100 in 2017/18.

There is no similar program with which to directly compare and benchmark headspace program cost, however this occasion of service cost compares closely to ambulatory services. Ambulatory care services (a form of community based mental health services) are provided by outpatient clinics (hospital or clinic based), mobile assessment and treatment teams, day programs and other services dedicated to assessment, treatment, rehabilitation and mental health care (36). The most recent available data for 2014-15 showed the average recurrent cost per treatment day of ambulatory care was $311.65, with an average 6.9 treatment days per episode of ambulatory care (37).

In addition the headspace costs don't account for the gains made through headspace's community awareness activities which may lead to increased help-seeking and access to treatment at an earlier stage (38).

In a global study of bipolar disorder, community-based interventions were estimated to be more efficient than hospital-based services (39). In the UK, a study of two year outcomes for young people with serious mental ill-health found that youth-specific services decreased hospital admissions, emergency department use and criminal justice system use, and increased employment (40). The potential cost reductions for 20 young people who completed treatment in this service equated to $1,120,990 over two years, which is significantly greater than the estimated $191,527 required to provide the youth-specific service to these young people (figures in 2014 Australian dollars). Another study in the UK found that early intervention in psychosis for young people delivered a cost saving of $8,684 per patient compared to care by Child and Adolescent Mental Health Services (CAMHS), predominately due to the reduced length of hospital admissions (figures in 2014 Australian dollars) (41).

Section 5: Increase access to effective mental health services and supports for young people across all stages of mental ill-health.

KEY ISSUES

- There has been significant growth in the number of young people in Australia seeking support through the headspace centre network and online services.
- While both headspace and eheadspace have shown positive outcomes in reductions of psychological distress and improvements in social and vocational functioning in young people receiving care, the current increase in wait times across these services means that an increasing number of young people are not able to access timely and effective care, early in ill-health, when it would have the greatest impact.
- There is a group of young people with more moderate to severe and complex mental health needs who are falling through the gaps in care between our primary and tertiary mental health systems. These young people are at high risk of:
  - presenting to emergency departments at crisis point, or contact with police and ambulance services. This level is rising rapidly, as documented by AIHW and in the media
  - enduring and chronic ill-health and, as a result, poor social and economic outcomes
  - increased risk of suicide and suicide-related behaviours.
- The current system does not provide for integration and coordination of care for many young people who experience particular complexity or barriers to care including: young people with comorbid drug and alcohol problems, young people from migrant backgrounds, those in contact with the justice system, Aboriginal and Torres Strait Islander young people, and young people living in rural and remote locations.

As outlined in the Issues Paper, an important issue for this Inquiry concerns the opportunities to reduce the prevalence and impact of severe mental health issues through the early identification of mental ill-health, particularly among high risk populations, and the delivery of early intervention as soon as possible after symptoms of illness become apparent (p14).

Given the age of onset of most mental illnesses, the delivery of accessible, appropriate and evidence-based primary mental health care for young people is critical in addressing this issue. The following section describes the:

- current rates of access for young people to existing mental health services across primary and tertiary care and across Commonwealth, State and Territory government and private health providers
- effectiveness of current services at meeting the needs and preferences of young people
- current gaps in care, particularly for those young people with more moderate to severe and complex mental health issues
- priority populations that require a more targeted approach
- structural and funding issues for youth mental health care which need to be addressed to enhance social and economic outcomes for all young people experiencing mental ill-health.

5.1 Current access to mental health services by young people

Increasing numbers of young people are accessing mental health services in Australia. The most recent Australian Child and Adolescent Mental Health and Wellbeing Survey reported a significant increase

in mental health service use by children and adolescents with mental disorders in Australia between 1998 and 2014 (42).

A key factor in access is awareness of a service or brand. headspace has become a prominent, well-recognised brand in the youth mental health field. A large community-based survey undertaken in September-October 2018 revealed that over three quarters of young Australians (76%) recognise headspace as a youth-specific mental health organisation (5). In addition, youth who have high or very high distress have greater awareness of headspace, compared to those with moderate or low distress. Building and leveraging a trusted, youth friendly brand has enabled headspace to engage more young people in mental health services, increased mental health literacy and helped to reduce stigma among young people and their family and friends.

Despite the high level of brand awareness at headspace, stigma and low levels of mental health literacy remain a barrier to many young people accessing supports (43). Media and public awareness campaigns can help reduce stigma, increase mental health literacy, enhance case detection, promote available services and stimulate help-seeking among young people (44).

Targeting community education/awareness campaigns at young people and their family and friends can increase basic mental health literacy skills and help them to access services. This is particularly important because Australian surveys have found that outside of the health system young people with experiences of mental ill-health were most likely to:

- go to both family and friends for help (45)
- receive support through schools (most commonly individual counselling via a welfare officer or school counsellors) (42).

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

Young person

Primary care access

The numbers of young people aged 15-24 years who accessed Medicare-subsidised mental health-related services increased substantially from 280,603 in 2012-13 to 402,220 in 2016-17 (46). GPs provided the majority of these mental health-related MBS services; followed by psychologists, clinical psychologists, psychiatrists and other allied health providers. While service access among those aged 15-24 years was higher than the national average across all age groups (12.6% vs 9.8%, respectively) (46), this still only equates to approximately half of the estimated total population of young people who would have experienced mental ill-health that year.

Help for mental health issues remained the most common reason Australians visited their GP (47). However, young people continue to access GPs for mental health-related reasons at rates lower than other age groups. In 2015-16, there were an estimated 518.5 contacts per 1,000 population for 15-24 year olds, the second lowest rate (after young people aged under 15 years), and less than half that of people aged 55-64 years (48).

headspace

Over 450,000 young people have sought help from headspace since its inception. With close to 110 headspace centres operating in local communities across Australia it has become easier for young people to seek help face-to-face.

Note: the 2015 external evaluation of headspace found that an acceptable return on investment could be found at expansion to 134 centres (38).

Each headspace centre offers multidisciplinary care structured around four core service streams:

- mental health
- alcohol and other drug services
- primary care (general and sexual health)
- vocational support.

Going to therapy [at headspace] and having people who are professionals in this field saying 'that's totally normal', and 'that's totally okay', has helped me be so much more with engaging in the things that help me cope with stresses of everyday life.
Young person

Providing an enhanced primary care platform with four core service streams enables headspace to holistically address the mental health and wellbeing needs of young people and makes access to the service easier as they can come to headspace for multitude of reasons that may or may not be related to their mental health.

Central to the delivery of these services is a multidisciplinary workforce including but not limited to: GPs, allied health (psychologists, social workers, mental health nurses, occupational therapists), other health (Aboriginal health workers, sexual health workers, alcohol and other drug workers) and vocational specialists. The workforce provides integrated team-based care and has the appropriate knowledge, skills and experience to work with young people and their family and friends. The workforce are youth friendly, confidential and non-judgemental, which is key to ensuring young people access services.

Who accesses headspace services?
headspace provided a service to over 120,000 young people in FY2018. It is estimated that headspace provided a service to approximately 13% of Australian young people experiencing a mental health issue in 2018.

Data from 2018 indicate that:

- **The peak age for headspace centre clients was 15-17 years** and the average age was 17.6 years, with 61.5% aged 17 or less and 38.5% aged 18 or older.
- **More young women received mental health services through headspace centres than young men (61.7% vs 36.3%)** with the exception of hYEPP services where there was a higher proportion of young men (58.0%).
- **More than one-third (35.2%) of headspace clients live in regional and remote locations,** which is well above the national population proportion of 26.0%.
- **24.1% of headspace clients identified as LGBTIQA, 7.2% of clients were Aboriginal and Torres Strait Islander young people and 9.2% of clients were from culturally and linguistically diverse backgrounds.**

headspace also provides invaluable national infrastructure from which more specialised or targeted treatments and programs can be developed, trialled and brought to scale where effective. Examples

have included the Individualised Placement and Support (IPS) program for intensive vocational support (**discussed in detail at 5.3**) and the **headspace Youth Early Psychosis Program (hYEPP)**, which now operates in six out of eight state capitals. As described in Section 4, some of the strongest economic cost-benefits evidence exists in the reduced costs of early psychosis services compared to treatment as usual, and the delivery of long-term recovery outcomes (33). The number of young people accessing hYEPPs has increased considerably, having grown by 40% in the 12 months since quarter 1 2017 (n= 1,277 in Q1 2017 to n=1,795 in Q1 2018).

Online and telehealth services (including telepsychiatry)

Digital and online services are seen as key ways to expand service delivery and reach young people. They are particularly important in providing access to support for young people in rural/regional areas, or for young people who have other barriers to accessing face-to-face care. They should be viewed as a key component of a stepped care continuum – providing a first point of contact for mental health problems, as well as an adjunct support to face-to-face interventions.

A significant number of national online platforms and telehealth services are available for young people – including Kids Helpline, Lifeline, ReachOut, Youth Beyond Blue, and many more – that are being funded to provide digital access points to mental health supports off the back of mental health services, community services and even education providers.

One key example of the acceptability of online services is the eheadspace – an online mental health support and counselling service for young Australians aged 12 to 25 years – which was launched in 2011. This service provides free and confidential access to mental health clinicians via web chat, email, and phone from 9am to 1am AEST, seven days per week. It is anticipated that eheadspace will receive close to 37,000 registrations in the 2019 calendar year.

There were 16 headspace centres involved in headspace telepsychiatry in FY17/18, providing 337 bulk-billed services (representing a 21% increase on the previous financial year). Seven more centres are currently starting to access the service (as of Jan–Mar 2019). There has also been interest in this service from other headspace centres that are not located in eligible areas.

Telepsychiatry is bulk-billed (with no gap) under specific MBS telehealth item numbers, providing cost-effective service provision in rural and remote areas that would otherwise have no timely access to senior clinicians like psychiatrists. In June 2018, in an attempt to improve the sustainability of this model, the service was scaled up to provide fee-based services that PHNs and other agencies can purchase. These offerings include primary psychiatry consultations and secondary consultations for workforce supervision and support. In the first six months of the fee-based model, 70 hours of secondary consultations have been available to support the workforce and eight primary consultations have been delivered.

Access to tertiary services funded by state and territory governments

Approximately 3% of young Australians experience a severe mental health condition in any given year. State and territory funded mental health services generally provide tertiary care to those in the population with the greatest severity of illness. For young people, these services are often delivered through Child and Adolescent Mental Health Services (CAMHS) (0-18 years), and in some areas there are extensions to this age range through the provision of Child and Youth Mental Health Services (CYMHS), which can go up to 25 years. The transitional age point into the adult mental health system is one of the significant challenges in delivering youth-appropriate and evidence-based care for young people with more severe conditions.

Community-based care

In 2016-17, the highest rate of state and territory community mental health service use was for people aged 12-17 (30.3 per 1,000 population) and people aged 18-24 years (25.4 per 1,000), while the highest rate of service contacts was for people aged 12-17 years (577.4 per 1,000 population) (49).

However, these figures vary considerably between states and territories. The number of people accessing community mental health care – compared to those who need it – was lowest in Victoria (15,296 12-24 year olds (49) or approximately 50% of the Victorian population in that age group with severe mental health issues).

Residential care

Young people aged 12-17 years had the lowest rates of access to residential mental health care (which provides overnight specialised mental health care in a domestic-like environment, often as a step-down approach from an inpatient stay). This rate increased to 3.8 per 10,000 for 18-24 year olds, which then remained stable across the age groups up to 55 years and over.

Hospital mental health-related care (public and private)

In 2016-17, young people aged 15-24 years had the second highest rates of same-day mental health-related separations in public hospitals with specialised psychiatric care (highest age group was 65+) and without specialised psychiatric care (highest age group was 35-44 years). In private hospitals the rates per 10,000 population were much lower for people aged 15-24, both compared to public hospitals and other age groups. This was potentially due to fewer people in this age group having private health insurance.

Presentations to emergency departments

In 2016-17, Australian mental health-related **ED presentations in public hospitals occurred at a rate of 113.6 per 10,000 population, a significant increase from a rate of 93.2 in 2012-13** (50). Despite not *attending* at a rate more than other age groups, young people aged 15-24 years *presented* to emergency departments for mental health-related reasons at a higher rate per population than any other age group – more than one-quarter (26%) of mental health-related emergency department presentations were for people aged under 25 years (51).

5.2 Effectiveness and cost-effectiveness of current services

What are the attributes of efficient and acceptable youth mental health care?

In 2017, Orygen reviewed the economic evidence relating to the design of mental health services for young people. Based on the type of service responses that have supportive economic evidence and the literature on young people's preferences for mental health services, we identified a framework for efficient and acceptable youth mental health service provision. That framework is summarised in Table 2. Elements within that framework should be targeted based on both the type of mental health problem a young people is experiencing and how well progressed that issue is. headspace developed a best-practice framework, based on learnings from the headspace centre network, identifying similar attributes (52).

Table 2: Attributes of youth mental health care that may be acceptable to young people and potentially cost-effective (29)

Attribute	Implementation
Access	
Affordability and convenience	Fees: low or no out-of-pocket costs to young people Location: face-to-face in-clinic services located near youth activity centres and/or public transport links, and use of satellite clinics; consultations at

	home (or other location determined by the young person) through ehealth or face-to-face mobile outreach Schedule: availability of “walk-in” appointments (including digital walk-ins); opening days/hours outside standard business hours
Helpful information	Education: developing mental health literacy and supporting self-help Signposting: information on appropriate sources of help
Holistic and timely initial assessment	Scope: including mental and physical health, psychosocial risk and protective factors; enhancing detection accuracy through use of multiple tiers of screening Timing: facilitating assessment at earlier stages of risk or illness Tools: using multiple assessment instruments and modalities of data collection and sharing (e.g. digital, pen and paper)
Welcoming environment	Age-appropriateness: availability of youth-specific environments Safety: supportive, youth-friendly staff attitudes; signalling of cultural appropriateness; confidentiality and inclusivity
Care	
Coordinated care	Modality: information exchange, care coordination and case management
Crisis support	Pathways: availability of and linkages between non-acute and acute services, including helplines, youth-specific inpatient beds, youth subacute beds and discharge to outpatient and home-based supports
Family engagement and support	Type: family therapy, education and peer support
Guideline-based care	Decisions: use of decision-support and shared decision making aids Delivery: appropriate provider, format, intensity and tenure of care Monitoring: appropriate frequency, scope and purpose of outcome measurement
Holistic approach	Functioning: support for accommodation, cognitive, education, employment, family and social needs Health: intervention, screening and referral for comorbid mental disorders and physical ill-health
Pre-emptive approach	Prevention: universal, indicated or selected, as appropriate Early intervention: clearly specified intake and referral criteria that prioritise subthreshold and first-episode disorders
Youth peer support	Format: group intervention delivery Support: mentoring and peer support
Capability	
Appropriate financing	Incentives: fee-for-service, salary or outcome-based Sustainability: demand-based, capped or risk-sharing
Attuned, skilled and diverse staff	Competences: evidence-based, developmentally informed and youth-friendly care Profile: diversity (disciplines, personal characteristics) and role flexibility
Automated tools and processes	Client-facing: automated assessment, referral and support Staff-facing: decision support, process optimisation and collaborative tools
Collaborative working	Modality: co-location, information sharing, secondary consultation, shared records and systems, referral networks and partnerships
Quality assurance	Improvement: leadership and processes for continuous improvement Measures: quality indicators, routine data collection and research
Youth participation	Depth: information gathering, consultation, partnership or user control

How effective are current youth mental health services in Australia?

It is difficult to attain data and information on the quality of care and outcomes that have been delivered to young people through Medicare-funded services, private or state/territory-funded services, beyond where we can see an increase in access. In states and territories, it is possible to attain information on outcomes through readmission data, and level of illness on admittance and discharge.

In youth mental health in particular, we can make reasonable assertions (from what we understand of the system and from stories from young people who have attempted to access the system) that state and territory based services (as well as some private services) are not designed to provide youth-appropriate, accessible and acceptable treatment and care (for 12-25 year olds). Structurally, this is demonstrated through CAMHS age limits and transition points into adult care at 18 years, as well as the short tenures of care provided in many state-funded mental health services.

However, we can provide data on outcomes delivered through the headspace platform to date (Table 3).

Table 3: Indicators of the effectiveness of headspace services

Service indicator	Detail
Increased awareness of the service	• A large community-based survey (n=4,065) undertaken in September-October 2018 revealed that over three-quarters of young Australians (77%) recognise headspace as a youth-specific mental health organisation (6). • Importantly, young people with high or very high distress have greater awareness of headspace, compared to those with moderate or low distress.
High levels of service satisfaction	• Young people have high levels of general satisfaction with all headspace programs, **ranging from 83% for eheadspace clients to 92% of clients accessing hYEPP services.** • 81% of families reported that they agreed or strongly agreed that they were satisfied with headspace centre services. • Young people report being very satisfied with eheadspace, in particular the service experience more so than potential outcomes (53). Young people were more satisfied with eheadspace when they had greater engagement, a longer session, a more interactive session with the clinician, and if they had not previously attended a face-to-face session at headspace.
Improved clinical outcomes	62% of young people attending headspace for depression and anxiety improve by having either a significant decrease in psychological distress and/or a significant increase in social and vocational functioning. This proportion increases to over 68% for those who attended 5 or 6 sessions (54).
International influence	headspace has also spearheaded an international movement towards the provision of youth-friendly and accessible models of mental health care. headspace centres have been established in Denmark and Israel and similar models have been, or are being, developed in Ireland (55, 56), UK, Canada, France and the US.

There has been a significant growth in headspace service use over the past five years. By 30 June 2018, headspace had supported over 450,000 young people with over 2.5 million services (120,000 young people during the 2018 financial year) (Fig 3).

eheadspace has also experienced a significant growth in service use between 2011 and 2018. At current projections the service will receive close to 37,000 registrations in the 2019 calendar year. It is important to note that the growth in service use has occurred with no active marketing of the service.

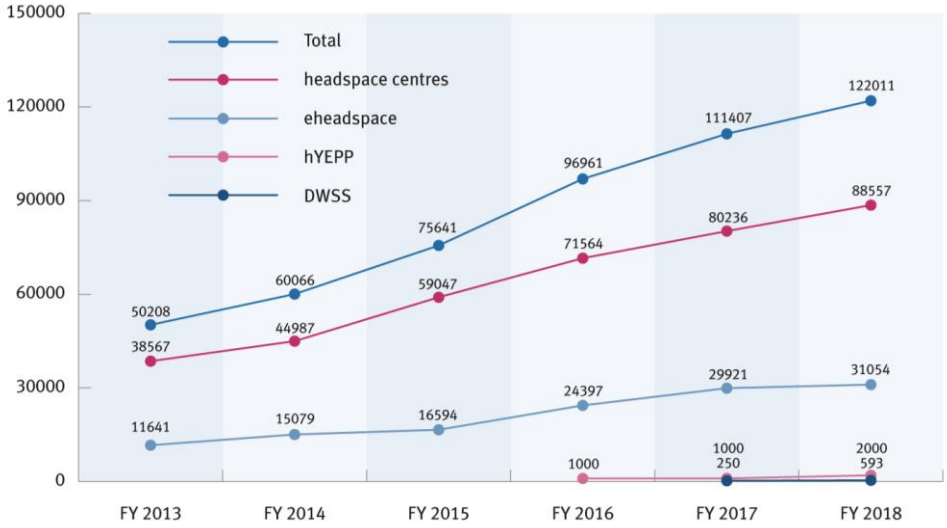

Figure 3: Count of young people receiving services at headspace since 2013.

5.3 Current gaps in care – the 'missing middle'

Orygen and headspace have estimated that of the 26% of young people in any given year with mental ill-health, around 12% are likely to be experiencing a more moderate to severe and complex mental health issue and may be missing out on care.

Generally, these young people are too unwell to be provided effective services through the primary mental health system, but are not acutely unwell enough to access state/territory based care. They have been described as the 'missing middle', a situation well described in Figure 4 (sourced from the Wentwest PHN in NSW as it relates to their broader regional population).

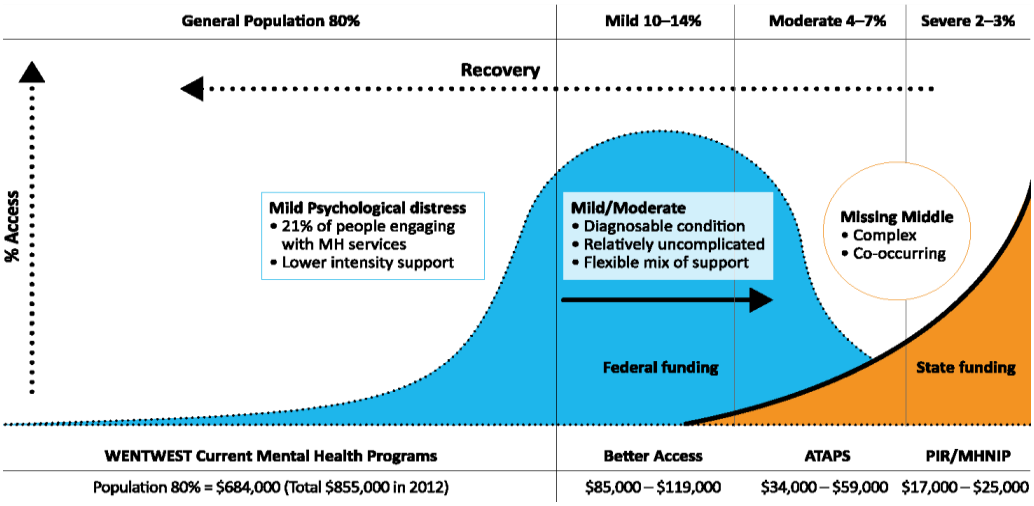

Figure 4: The missing middle of care. Source: WentWest PHN (57).

Both headspace centres and eheadspace are responding to an increasing proportion of young people with complex, high-risk presentations, many of whom have experienced extensive involvement with

mental health and other social support services. This is evident by the high levels of psychological distress that many young people present with, including long-standing mental health challenges, extensive histories of mental health service involvement and high levels of acuity. For headspace centre clients commencing a first-episode in FY 17/18, there were 47.2% (n=45,744) who had high or very high psychological distress on the Kessler 10, indicating they were likely to have a severe mental disorder.

For headspace centre clients commencing a first-episode in FY 17/18, there were 4.2% (n=2,493) who were formally referred outside the headspace service at their first visit. Over one-third of these young people (35.0%, n=873) were referred to community-based mental health services and 11.6% (n=289) were referred to specialist health care (psychiatrist, inpatient).

I think there is still this feeling that if I'm not in a crisis situation, or if I'm not presenting acute mental ill health then there is this barrier you put on yourself to seek help, because you think 'I'm taking up the space of somebody who actually really needs this, I'm not sick enough, or I'm not unwell enough to try get support'.

Young person

There is a question as to whether this level of care is available to the extent it should be. In many states and territories, particularly in states with rapid population growth such as Victoria, mental health funding has been increasingly focused on more acute and hospital-based care, or in managing emergency department presentations, leaving a considerable gap in specialist, community-based youth mental health service for these young people.

Even for those young people unwell enough to be accepted into inpatient care, this lack of funding for community-based services means there is limited access to services at points of transfer and discharge from hospital, including access to residential care (such as Youth Prevention and Recovery Centres (PARCs) in Victoria), assertive home outreach, and outpatient clinics. These are critical services at particularly high points of suicide and self-harm risk for young people with severe and complex mental health conditions. There is also very patchy access for young people to services for more complex presentation, including trauma (58) and eating disorders (59).

In addition, the introduction of the NDIS has led to further gaps in psychosocial disability support for young people with more severe and complex mental health issues. The application of the current eligibility criteria for the NDIS (in particular the need for the condition to be considered 'permanent') is likely to exclude access to important psychosocial supports for a significant majority of young people with severe and potentially enduring mental illness as their primary disability. This appears to be supported by NDIS data. In December the NDIS dashboard (60), indicated only approximately 1,000

Northwest Melbourne case study

Orygen Youth Health (OYH) is the state-funded specialist youth mental health service located in Parkville. Approximately 167,000 young people aged 15-24 years live in OYH's catchment area, a growth corridor of North West Melbourne where the population of young people in this same age group has increased 23% between 2004 and 2014.

Over the past five years the capacity of OYH to provide adequate care and treatment to young people in this catchment has been seriously diminished as a result of a lack of growth funding, failure to fully incorporate EBA increases, and significant population growth.

In real terms, this has restricted access to care for even the most seriously unwell young people, with only one in four young people who are referred to OYH succeeding in accessing the service.

young people aged 15-24 years were active participants with an approved plan primarily for a psychosocial disability (or around 2% of all young people in this age group on approved NDIS plans, compared to approximately 17% of people aged 25 years and over).

What is the social and economic impact?

The 'missing middle' are at high risk and are languishing. Without being able to access the treatment they need their condition will progress and escalate in severity. The resulting outcomes have some of the most sizable impacts on social and economic outcomes including:

- presenting to emergency departments at crisis point, or contact with police and ambulance services. This incidence is rising rapidly as documented by AIHW and in the media
- enduring and chronic ill-health
- increased risk of disengaging with employment and education in the short and long-term
- increased risk of suicide and suicide-related behaviours. For example, the most recent Australian Bureau of Statistics (ABS) suicide data showed that the largest increases in suicide rates were among young people, in particular, the number of suicides of women of aged under 25 increased by 76% over the past 10 years (4).

It is also placing an increasing amount of pressure on primary mental health services to fill the gap, compromising their ability to provide timely and effective care. Along with the general increase in demand for headspace services, the increasing level of complexity and severity of presentations across the network (including responding to young people who present at risk of suicide) is putting the network under considerable strain. In late 2018, headspace National undertook a national survey of headspace centres (total of 103 centres at the time). There were 90% of centres reporting that wait times are a major concern, with average wait times comprising: 10.5 days for intake session, 25.5 days for first therapy session, and 12.2 days for second therapy session.

There has also been a progressive increase in wait times for young people seeking immediate support from online services (Fig 5). Young people with a probable serious mental illness are more likely to go to the internet, online counselling websites and telephone hotlines (45) than young people with no probable serious mental illness. eheadspace data supports this, as 86% of young people accessing this service in 2019 were experiencing high or very high levels of distress, compared to 69% of young people accessing headspace centres and 9% of the general community. Despite this, young people are logging off prior to having an interaction with an eheadspace clinician due to wait times. Out of approximately 17,000 young people contacting during July 1 – Dec 31 2018, nearly 6,000 logged off or exited the website prior to a clinician responding. The service was able to re-contact many of these young people via email or other means, however, there are many who received no support despite their attempt to seek help.

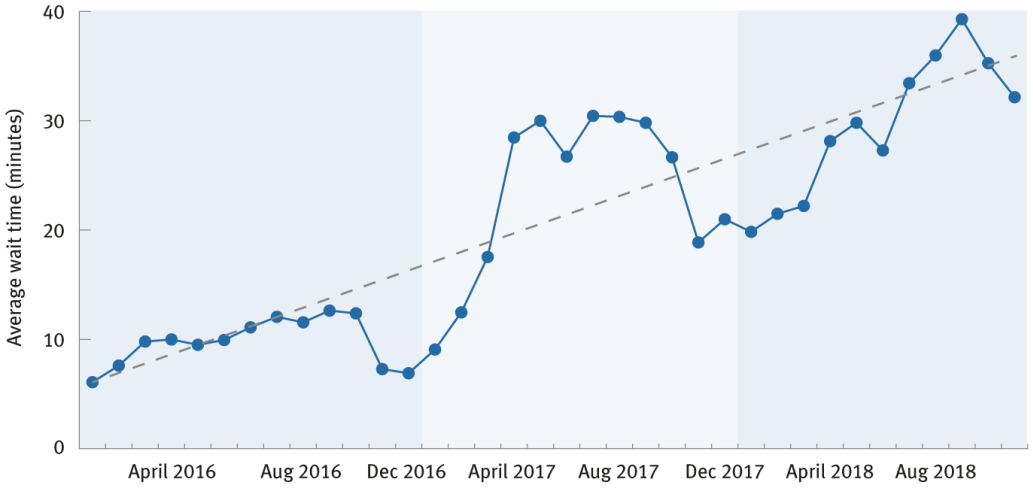

Figure 5: Wait times to respond to eheadspace webchat clients April 2016 – Dec 2018.

5.4 Priority populations that require a more targeted approach

Along with young people experiencing clinical severity, there are also a number of specific groups with more complex needs who are less likely to access services, or who are missing out on evidence-based treatment approaches early in our current youth mental health service system – often only accessing treatment at a point where their mental ill-health has become acute and requires hospitalisation. These include, but are not limited to, those below.

Young people with comorbid alcohol and other drug and mental health issues

For young people aged 10-24 years, alcohol and other drug (AOD) use are the leading causes of the total burden of disease in males (8.2% and 2.0%, respectively), and alcohol and iron deficiency in females (3.4% and 1.0%, respectively) (61). Young people have increased risk of poor treatment outcomes and social disadvantage as a result of having comorbid AOD issues and mental health conditions. They have unique treatment needs, given their emotional, cognitive and psychosocial development and this population group needs distinct evidence-based treatments (62). Stigma around AOD use remains considerably higher than for mental health issues, and lack of understanding about what treatment entails or fear of judgement result in many young people not seeking help or disclosing an AOD issue to a clinician to ensure a timely and effective treatment approach is taken to respond to the comorbidity.

headspace centres have struggled to adequately address AOD issues in young people attending, despite acknowledging the need and this being a core service stream. This is largely due to inadequate funding to specifically support this pillar of the service.

Young people from culturally and linguistically diverse backgrounds

The Centre for Multicultural Youth in Victoria found that young people from migrant and refugee backgrounds accessed mental health services at a much lower rate that other Australian-born young

There has been more of a push for resources in other languages that our parents can actually jump onto improving their mental health literacy. It's a little bit hard when smaller services don't necessarily have the funding to hire a qualified translator to translate the resources and make sure everything is correct.

Young person

people. Many culturally and linguistically diverse (CALD) young people who had mental health issues were found to be less likely to access community state-based services than Australian-born young people, but had proportionately higher admission rates to inpatient units, suggesting they experienced significant barriers to accessing mental health care until their illness had become acutely severe (63, 64). CALD populations have also been found to be underserviced by the headspace network (38).

Aboriginal and Torres Strait Islander young people

Aboriginal and Torres Strait Islander young people face a range of unique stressors including: the impact of colonisation and forced removal from land, family, country and culture; unequal access to the social determinants of good mental health; and higher rates of exposure to life stressors – such as racism and discrimination – than other young people. Research also shows that one in four Aboriginal and Torres Strait Islander young people are exposed to a major life trauma before the age of four which is significantly higher than non-Aboriginal people.

On average, Aboriginal and Torres Strait Islander people have higher levels of psychological distress than non-Indigenous people. The disparity in suicide rates is particularly alarmingly among young people, with suicide rates 3.3 times higher among Aboriginal and Torres Strait Islander young people aged 15–24 than non-Indigenous young people in the same age group.

Despite much higher rates of psychological distress and suicide, Aboriginal and Torres Strait Islander young people's use of mental health services is considerably lower than non-Indigenous youth.

Some of the key personal barriers for Aboriginal and Torres Strait Islander young people accessing headspace services are: stigma and shame, fear, confidentiality, community awareness, and cultural appropriateness, which includes appropriate services and appropriateness of the treatment approach (65). Some of the key structural barriers for Aboriginal and Torres Strait Islander young people accessing youth mental health supports such as headspace services are: physical environment, lack of Indigenous workers, transport and remoteness, inflexible intake processes, and limitations to western clinical approaches and mainstream assessment tools which do not necessarily identify the presence or impact of trauma and intergenerational trauma.

According to the Building Bridges project (WA), the way we think and 'do' engagement with young people in youth mental health services must be expanded to meet the preferences and specific needs of Aboriginal and Torres Strait Islander young people. It is therefore crucial that headspace partners with communities, Elders and young people to design, develop and deliver safe, secure and appropriate service responses.

Case study: Yarnsafe

The headspace Yarnsafe campaign sought to raise awareness about the health and mental health issues impacting Aboriginal and Torres Strait Islander young people, and encouraged these young people to seek help. The campaign involved extensive co-design with Aboriginal and Torres Strait Islander young people and was associated with an increase in the number and proportion of Aboriginal and Torres Strait Islander young people accessing headspace centres.

Young people in contact with the justice system

Young people are at greater risk of experiencing mental ill-health and participating in offending behaviour than any other group in the community. Yet despite this, young people connected with the justice system are less likely to have accessed mental health services (66). There is a need to improve the adequacy and quality of primary and specialist mental health services for young people in the justice system. Disadvantaged access to mental health services for young people continues to be 'particularly evident in forensic contexts' (67).

For young people serving detention orders there are gaps in primary and specialist mental health services. Minimal primary mental health services and generic programs often fail to provide the breadth of mental health treatment young people require. For example, the Victorian Ombudsman has previously found that the Melbourne Youth Justice Precinct was 'struggling to meet adequately the needs of children who are seriously mentally ill' (68).

There is an opportunity to increase investment in early intervention in mental health services for young people in contact with the justice system and better incorporate mental health in diversion programs. There is evidence for both diversion programs and interventions for young people serving detention orders. In the United States, analysis of established diversion programs (not all with mental health components) has identified positive reductions in recidivism and cost-benefit ratios. The early identification of suitable participants is a factor in the success of diversion programs (69).

Young people in out of home care

Young people in out of home care are those aged 0-17 years who have been removed from their families by the state because of significant risk of harm from abuse, neglect or other adversities. The three main types of care are kinship, foster and residential care. The number of young people in out of home care in Australia is rising and the rate is 10 times higher for young people who are Aboriginal and Torres Strait Islander (70). At 30 June 2017, there were 47,915 young people in out of home care in Australia.

The prevalence of mental health problems for young people in out of home care is much higher than for the general population. These young people often have multiple and complex needs, particularly poor mental health and social functioning, both during and after care. They are also less likely to have timely access to mental health care.

It is now understood that the out of home care system needs to be based on therapeutic principles. Cross-service practice models that offer integrated and trauma-informed mental health support are required, but these are rarely available. A program being trialled in Victoria, the Ripple project, shows that strengthening the therapeutic capacity of carers and implementing complex mental health intervention across sectors is potentially feasible and cost-effective, and likely to be essential to improving the mental health and wellbeing of young people in out of home care (71).

Young people transitioning from out of home care, at age 18, are particularly at risk (72). They encounter limited opportunities for work and further education and are at high risk of homelessness. Alarming statistics reveal that nearly half had attempted suicide within four years, one third of young women had become pregnant or given birth within 12 months of leaving care, and over one third had become homeless within 12 months of leaving care (71). After transition, these young people are no longer supported by the out of home care system and are left extremely vulnerable, thus, extending support post care to age 21-25 year is advocated (73). A socioeconomic cost benefit analysis of supporting young people through to age 21 reported the overall cost/benefit ratio to be $1.84 (2015 Australian dollars) (74).

Young men

Young men have been found to be slipping through the gaps in care (75). While young men account for 43.1% of all 12-25 year olds with a diagnosable mental health disorder, they comprise 37.9% of clients presenting to headspace centres, 17.9% of clients accessing eheadspace, 36% receiving mental health treatment plans (76), and 31% of those who receive access to allied psychological services (ATAPS) (77).

Young men do, however, present at a higher rate to specialist and tertiary services, accounting for 57.7% of clients in hYEPP services (reflecting the higher prevalence of early psychosis among young men) and 46.1% of contacts per capita with specialist state and territory services (49).

Case study: Reaching young men

Between July-September 2018, headspace ran a young men's campaign with the aim to help young people understand that actively maintaining their mental health is as important as maintaining their physical health, and to share advice from high-profile athletes to support these messages. The campaign reached just over one quarter of young men in Australia aged 18-25 years. Of those, 64% then either visited the headspace website, spoke to a friend or family member about their mental health, or shared the campaign with others on social media.

Rural and remote young people

As highlighted in a report by ReachOut and Mission Australia, young people living in regional and remote areas may be exposed to a unique set of structural, economic and social factors that result in poorer mental health outcomes (78). They also experience an increased risk of suicide. The Young Minds Matter report shows that 12-17 year olds outside greater capital cities who had experienced a major depressive disorder showed percentages 6.5% higher for suicide ideation, 13.6% higher for suicide planning, and 9.6% higher for attempting suicide than those living in greater capital cities (42).

Yet young people outside major metropolitan areas struggle to access the same level of support services as young people in urban areas. We know rates of access of Medicare-subsidised mental health services per population decrease significantly with rurality (79). In rural and remote areas, the distance to any kind of service, particularly one that caters for youth mental health, can be prohibitive (80). A review of headspace centres found most young people attended a headspace within 10kms of where they live. As few as 1% of young people in remote Australia live within 30km of a centre (38).

5.5 Structural and funding changes needed to address demand, severity and complexity.

Continued growth in funding to meet demand and provide all the pillars of care in headspace

With the growth in access to headspace centres and eheadpsace nationally there is an urgent need to review the funding models for both services so as to provide levels and security of funding that can deliver:

- a workforce to meet the increasing demand and level of need in young people presenting for services (discussed more in Section 8), including an increase in core funding allocations to employ a larger number of base salary staff which can enable the services to 'flex up' or 'flex down' dependent on the number and nature of service presentations.
- infrastructure that is commensurate to the service need. Centre size and space exacerbate wait times – limited space renders centres unable to accommodate the workforce required to increase services. This will require relocation in some instance or new lay-outs or expansions within current locations.

- Supported and evidence-based AOD treatment and centres. In FY17/18, headspace centres were able to provide only 1.8% (n=6,474) of services by AOD workers. Of these, 55.3% were funded by in-kind support from partner organisations, 19.7% funded by headspace grant, 17.4% (1,126) funded by 'other government funding', 6.7% funded by MBS, and 0.8% funded by ATAPS.

The key issue here is we need a much greater investment of funds into the youth mental health service. We know what to do. We know how to look after early onset, we know how to look after a whole range of complex mental health issues. We have great people right here in Victoria. The problem is, the government is just not giving us the injection of funds that we need.
Parent

Trial a model to build on the headspace platform to optimise care for the 'missing middle'

There is an opportunity to gradually build and leverage the capacity of the headspace national youth mental health platform to provide timely and expert mental health care for young people with early symptoms of moderate to more severe experiences of mental ill-health. Developing and trialling a model of enhanced headspace services (delivered through a cluster of 3-4 headspace centres, similar to the hYEPP model) would focus on providing young people with support and care beyond what is currently available through headspace centres. This enhanced model would provide:

- extended clinical psychological and allied care beyond the entry level 10 Better Access sessions provided through the MBS -- it would provide additional sessions of such psychological care for the full 12 month period each year as required (in the range of an additional 10-20 sessions)
- additional medical time with access to GPs, mental health nurses, psychiatrists, addiction specialists and specialised allied health staff to provide clinically appropriate use of medication and coordination of other clinical care and case management
- assertive community outreach over extended hours and weekends for young people who struggle to engage with clinic-based services.

Better integration of services with technology

In this current situation where there are not enough practitioners to meet service demand, young people who need services immediately are put on waiting lists. In the national survey of headspace centres, 63% of centres agree that support from a dedicated phone or online service could help to manage wait times and ongoing demand. It is imperative that young people have access to support while waiting for a service; phone and online services not only help to improve the level of engagement with young people, but also complement existing services and offset potential risk. Additionally, although more economic research is needed, there is promising evidence that online mental health interventions are cost-effective (81).

Digital technologies can certainly assist, however, at present they are generally used as a stand-alone tool, separate from the face-to-face service provided. Stand-alone online tools may not be suitable for most young people, who show a preference for face-to-face services, followed by not seeking help at all (82). For many digital services, there is limited quality control, safety measures and evidence being utilised to inform their development, making them unsuitable as stand-alone supports for vulnerable young people (eheadspace and Orygen's Moderated Online Social Therapy (MOST) program are notable exceptions).

Orygen's ehealth program is developing a number of innovative online platforms for young people with severe and complex mental ill-health or those who are hard to reach, ensuring that they can

access online support as an adjunct to face-to-face care. It is a mental health support that uses technology to assist in service delivery and to create a way for the client to remain engaged with support between sessions. This is particularly important in rural and remote settings and working with Aboriginal and Torres Strait Islander populations, as they often go longer between sessions, experience the most barriers to access and acceptability, and rely on eHealth approaches to access services. The development of comprehensive and evidence-based online platforms is essential for the 16% of young people who have a preference for online supports (82).

The efficacy of face-to-face and online care could also be increased by investing in hybrid models that augment the treatments and include other elements, such as peer support and family engagement, to enhance the experience for young people. We can leverage the existing national infrastructure (headspace) to enhance services in this way.

Review the MBS for youth mental health care

MBS mental health items are currently being reviewed by the Medicare Benefits Schedule Review Taskforce: Mental Health Reference Group which has recently published a discussion paper describing a number of key recommendations, including expanding access to Better Access for at-risk patients (without the need for a Mental Health Care Plan) and a three-tiered system for access to an increased number of sessions available dependent on diagnosis, complexity and severity (83). Orygen has recommended in a number of previous policy reports that there is a need to increase the number of MBS sessions available to those young people experiencing severe and complex mental illness, including eating disorders (59), complex trauma (58), and comorbid alcohol and other drug conditions (10) in order to access better long-term treatment options and achieve improved treatment outcomes.

At present, anecdotally, we know there are many young people with moderate to severe mental health issues who are 'rationing' their ten MBS sessions for psychological treatment over the course of a year (see case study below). This includes spacing out visits evenly and/or going for long periods of the year without any care after exhausting their allocation in the first 3-6 months. In these situations, any potential outcomes or benefits from the care provided are squandered as the provision of the dose, duration and frequency of treatment, in accordance with the evidence base is not possible in 10 sessions.

Case study – MBS inadequacies

When I turned 12, I become very withdrawn. Things kept building up emotionally and in year 11 I realised maybe this wasn't normal. My mum booked me an appointment at headspace and I saw a psychologist every two weeks. Under Medicare you get 10 sessions. The implication being that after 10 sessions you should be better. On my eighth session nothing was improving and then I realised; there's nothing to help me. I felt almost abandoned. I was thinking: "I'm just going to be stuck feeling this awful way".

I only had two sessions left and I started to freak out. On [date] I had a suicide attempt. I had come home from school and just had had enough. I ended up calling the ambulance myself because I looked out the back door and my dog was sitting there looking at me. I thought: "I can't leave you". I was in an emergency room overnight. The next morning when I saw a mental health worker he wouldn't give me a referral to a psychiatric ward, even after what had happened the night before. Apparently it still wasn't severe enough. It took another three days before I was admitted to a psychiatric ward.

At the moment I'm seeing a counsellor through uni. It's helping and I really like the counsellor. The thing is, you only get six sessions. I've only used two of my sessions because I've been rationing them. I'm not feeling great at the moment, but I need to save the sessions for when exams come

around because I know I'm going to be even worse then. I should be able to maintain good mental health, not just treat it when it's bad.
Young person

There is an opportunity to further modify MBS items relating to provision of GP and allied health services in youth mental health service platforms, such as headspace, to encourage increased GP participation in multidisciplinary, holistic early intervention care settings. Specialised MBS items relating to psychological services for young people (which allow for greater consultation time and compensation for 'do not attends') could help to address this gap and encourage more GPs, psychologists and other allied health staff to operate in multidisciplinary youth mental health focused environments or provide quality care within their own clinics. In addition, there is an opportunity to consider expanding MBS treatment items based on available evidence to include:

- neuropsychologists, dieticians, exercise physiologists, and sexual health nurses (particularly those providing physical and sexual health monitoring and treatment in youth mental health service platforms) who would improve provision of holistic support for young people
- case coordination within and between services
- an MBS item for a Single Session Family Consultation (SSFC) to address a gap in funding support for family inclusive practice. This is a brief process for engaging and meeting with families that aims to clarify how the family will be involved and to help family members identify and address their own needs, particularly as they relate to their own supportive role for a young person. The support of families is critical in young people's treatment, yet there is no funding stream to support their involvement in treatment.

National partnerships for funding of services

Coordination of care across the various components of the health and mental health system/s has been highlighted as a key priority area that requires addressing within most state and federal mental health policy and planning documents for decades. Despite being identified as a priority in the Fifth National Mental Health Plan, implementing this has proven difficult within the health system, let alone coordination across other services and systems such as justice services.

This is in part due to limited funding and guidance on implementing service coordination and integration, lack of evaluation and promotion of good practice, and competing agendas between stakeholders at a local level. There is an opportunity for the Commonwealth and state and territory governments to co-invest in regional commissioning of mental health services that ensures a continuum of care is provided for young people across all stages of ill-health.

PHNs provide an established mechanism through which to facilitate this process (led by a clear policy direction and the development of National Partnership Agreements for youth mental health). However, there is also a need to ensure commissioning bodies such as the PHNs are provided with clear national guidance and specifications, and are directed to engage our organisations in their commissioning process to ensure implementation of evidence-based models of care for any youth mental health funding including:

- existing funding such as headspace centres, hYEPP, youth severe and any other proportion of mental health funding that is to be targeted at young people
- any future funding to expand on the headspace platform or regional youth mental health service models drawing on Commonwealth or state/territory funding allocations (in health or in other portfolios).

Greater integration and/or coordination between mental health and other services

Despite the headspace model being based on early intervention, it is increasingly common for young people to present with more complex needs which are beyond the scope of a primary care service.

This can lead to headspace needing to invest resources into linking a young person with tertiary or other services (including homelessness, AOD and vocational services).

Transition between services is a key time for young people to disengage from care, and so supporting the young person safely into other services is crucial to promote the best outcomes. Opportunities to support improved care coordination between services for young people with more complex needs include:

- increasing the proportion of salaried funding to facilitate case coordination within and between services (including out of home care, housing services, AOD services, family mediation)
- integrated mental health services. These are particularly important for young people in the justice system who need= early intervention to effectively treat mental disorders, reduce rates of illness-driven offending and recidivism, and build more functional pathways to schooling or employment. Supported integration with a community-based specialist mental health service is needed to ensure a continuity of care approach is available to young people transitioning from the justice system. Post-release support services need to be provided for up to two years to be effective (84).
- increased/integrated coordination with Aboriginal community controlled health services. There is also need to ensure safe and culturally appropriate assessment, treatment and service approaches in all services (including headspace), drawing on trauma-informed models of care (that are holistic and person-centered, and incorporate cultural, spiritual and community wellbeing as well as physical and emotional considerations).

Continue to increase awareness particularly among hard to reach population groups

headspace campaign evaluations show that current funding enables reach to approximately 20% of the target audience, which means that a large proportion of young people (and their parents) are not made aware of headspace or the services available to them. In particular, headspace research has identified a need for targeted community awareness campaigns for high-priority population groups with significant unmet mental health needs including young men, the homeless, Aboriginal and Torres Strait Islander young people, LGBTIQA+ and those who are culturally and linguistically diverse. These population groups require targeted campaigns and tailored engagement techniques to ensure campaign relevance and suitable calls to action.

KEY RECOMMENDATIONS

Recommendation One

Future youth mental health investment should be directed to strengthen and extend access to headspace, the Australian Government's national platform for youth mental health care, so as to:

- build on and leverage its capacity
- optimise integration
- reduce service and administrative duplication.

Specifically, any national investment (including from outside of the health portfolio) related to the following core areas of headspace delivery should be prioritised through this platform:

- services related to the core pillars of the headspace model – mental health, alcohol and other drugs, physical and sexual health, and vocational services
- mental health services for key priority population groups, particularly Aboriginal and Torres Strait Islander young people
- youth suicide prevention and postvention services in schools.

In addition, it is recommended that state and territory governments consider co-investing in headspace centres where there is a specific policy and program focus on mental health prevention and early intervention for young people.

Recommendation Two

Australian governments should provide greater sustainability and security of funding for youth mental health services, like headspace. This would require:

- the Australian Government's Department of Health to contract PHNs on five (5) year cycles.
- that PHNs then contract headspace centres/commission other youth mental health services on a five (5) year cycle with recontracting/recommissioning to commence at three (3) years.
- that there is a clearly articulated approach on the process and timeframe for decommissioning and recommissioning of services.
- that CPI is applied for all youth mental health funding (operational, services provision, infrastructure).

Recommendation Three

Develop and implement a **comprehensive and enhanced model of youth mental health care** that augments the existing headspace platform to provide: a) better care for young people with more severe and complex conditions (the 'missing middle') and b) better responds to local service demand and priority populations such as Aboriginal and Torres Strait Islander young people. This would require:

- a comprehensive assessment for each centre regarding the level of service demand, type of presentations and severity/complexity of presentations among service users, and the type of services required to meet these needs
- the development of a mixture of blended funding approaches that could then be tested across centres based on level of need. These could include funding packages of care for young people with more severe and complex conditions, and increasing the number of salaried staff within these services.

Recommendation Four

Future commissioning of youth mental health services and programs by PHNs should be informed by the evidence base and protect the integrity of the headspace platform. To achieve this it is recommended that the Australian Government:

- ensure national oversight of the commissioning, implementation and evaluation of headspace services by headspace National and Orygen
- ensure national oversight of the commissioning, implementation and evaluation of headspace early psychosis services and services for more severe and complex mental health conditions by headspace National and Orygen
- ensure that extensions and enhancements to the headspace model are planned through headspace National and Orygen, and subject to robust implementation and outcome evaluation.

Recommendation Five

There is an urgent need to update the MBS to provide items that support essential service provision and evidence-based treatment dose and duration for young people aged 12-25 years. Our organisations are aware that the Mental Health Reference Group has released a paper for consultation on proposed amendments to the MBS to better meet the needs of people with mental health conditions. We believe there is good evidence to support:

- an increased number of available sessions (over the current cap of 10) for young people with more moderate to severe/complex mental health issues (including but not limited to complex trauma, personality disorders, severe anxiety or depressive disorders and those compounded by comorbidities). There would need to be a mechanism developed through which additional sessions would then be activated.
- the wider provision of telepsychiatry and telepsychology where there is demonstrated need through a review of the moratoriums on telehealth services and restrictions on MBS benefits
- new items for single session family consultation
- new items for case coordination between health professionals (where they currently do not exist e.g. allied health)
- new items for early intervention in risky alcohol and other drug use
- exploration of the evidence and demonstrated need for other allied health service provision such as neuropsychological services.

Recommendation Six

Consolidate and further develop the evidence base for the multitude of digital mental health services, so that those with demonstrable impact can be scaled up and appropriately integrated with face-to-face service provision. This could then involve:

- scaling up platforms such as eheadspace alongside other integrated mental health interventions (such as the eHealth platforms developed by Orygen) so as to provide interventions across the entire spectrum of interventions – from self-help to adjunctive support for treatment and continuing care – enabling young people to choose interventions that suits where, how and when they need to engage with services and interventions
- test and trial new ways to use technology to engage those young people who face greater barriers to access and engagement, such as young men, and young people in rural and remote areas.

Recommendation Seven

Governments to bolster mental health services and awareness programs targeting key priority populations of young people with an increased risk of mental ill-health and low service engagement. Specifically there is a need::

- to provide greater investment to enable mainstream services to engage with Aboriginal and Torres Strait Islander young people and their communities to make it safe and more secure for them to seek help
- to develop and trial new or adapted models of care and assessment approaches, which should be widely implemented when effective, and suitable for Aboriginal and Torres Strait Islander young people and CALD populations, especially refugees and new migrants.
- for governments to review and evaluate the broad range of existing mental health literacy and awareness campaigns to ascertain appropriateness and efficacy at improving self-help for particularly at risk youth populations.

Section 6: Improve education and workforce participation for young people with mental illness

KEY ISSUES

- Young people with mental health conditions are more likely to be not participating in employment education and training (NEET) compared to the general youth population.
- Many find themselves disadvantaged in attaining educational outcomes and meeting job seeking activity requirements due to experiences of stigma, difficulties navigating a fragmented system between mental health and vocational supports, and a lack of understanding regarding their particular barriers to study and employment.
- The lack of integration between educational, vocational and mental health services will continue to result in large numbers of young people falling through the gaps between these systems, increasing their risk of long term unemployment and exacerbated mental ill-health.
- There is increasingly strong evidence that supported employment and education programs, embedded within mental health services (including those delivered online), improve employment outcomes, improve mental health outcomes and mitigate against future reliance on social welfare supports among young people with mental illness.

6.1 Rates of educational attainment and workforce participation

37.6% of all people with a mental illness (or 67.3% with severe mental illness) are unemployed or not in the labour force, compared to 22.3% of people without mental health conditions (85).

Evidence also shows that the unemployment rates for young people experiencing mental illness can be up to three times that of the standard youth unemployment rate (86). During 2017-2018, more than one-quarter (25.8%) of young people presenting to headspace centres were not participating in employment, education, or training (NEET), increasing to more than 30% in regional and rural areas, and above 40% for some centres in regional Queensland, Victoria and Tasmania. At Orygen Youth Health, a tertiary youth mental health service in Melbourne, the rates of young people who were NEET were 26.5% of young people with severe and complex depression, 24.4% of young people with borderline personality disorder and 46.9% of young people with psychosis (87). Importantly, this does not depict the quality of vocational engagement for those engaged in education or employment, with many other young people under-employed or employed in casual or unstable jobs. These results are well above the 2016 national rates, with 8.8% of people aged 15-24 reported as being NEET: 5.1% of adolescents (aged 15-19 years) and 12.0% of young adults (aged 20-24) (88).

Compared to the general population's high school completion rate of 78%, the completion rate among young people with mental ill-health varies between 32% and 62%, depending on the type and severity of illness (89). Students with an identified mental illness have low subject completion rates in vocational education and training (VET) (67%) and the lowest award rate of all the major disability groups, considerably lower than the total VET population (90, 91).

Australian research has also found that 86% of university students severely affected by mental illness withdraw from courses (92). Additionally, there have been year-on-year increases in the numbers of undergraduate university students considering an early course exit for health and stress-related reasons, which are the most cited reasons for considering an early departure (45% in 2017) (93).

Sub-populations may be particularly vulnerable, or experience compounding barriers. A study of NEET headspace clients found characteristics most strongly associated with non-participation included

being Aboriginal or Torres Strait Islander, male, homeless, diagnosed with a substance use disorder, or having a neurodevelopmental disorder in young adulthood (94).

Similarly, an analysis of the 2013 Student Experience Survey found that university students from low socio-economic backgrounds, rural and regional areas, and Aboriginal and Torres Strait Islander students were more likely to consider exiting university early due to health and stress reasons (95).

6.2 Key barriers to participation in education and work for young people with mental ill-health

There are a number of barriers to completion of studies/school retention for students experiencing mental ill-health, including:

- cognitive or attention difficulties associated with illness symptoms and/or effects of medication
- stigma, discrimination, fear of failure and lowered perception of academic aptitude (particularly when past educational experiences have been negative)
- disruptions to participation due to periods of exacerbations in the illness
- other life issues such as financial pressures, housing and relationships which may also be related to experiences of mental ill-health (96).

Should mental ill-health impact on school completion, the resultant low educational attainment, training or skills are then perceived as barriers to finding work. Other barriers include:

- concern from those close to the person, including family members or carers and clinicians, that there will be a negative impact from engagement in work (increased pressure, stress and potential for discrimination), potentially exacerbating illness
- perceived or actual stigma and discrimination in workplaces deterring individuals from disclosing their mental health condition and negotiating appropriate arrangements with their employer to accommodate their needs
- difficulties in self-managing the coordination of fragmented services including employment supports, education, mental health care and government payments
- fear of losing other government benefits
- being channelled towards employment services targeted at the general community (such as jobactive) which do not offer low enough caseloads and lack the subject matter expertise to support young people with mental ill-health (97).

Evidence from across the headspace platform indicates that existing and traditional employment and study support mechanisms are not working for young people with mental health problems. With ongoing stigma and low mental health literacy among service providers across the vocational support system, young people report that they do not feel comfortable to engage with the traditional vocational supports available to them. In addition, issues of high staff turnover, poor skill sets and a tendency towards a punitive approach to employment support within these systems has had a detrimental impact on satisfaction, with 73% of respondents dissatisfied with mainstream employment service (98). Indeed, the providers' role in the benefit compliance system (and risk of loss of payment) was a major source of anxiety (98).

Many university students still believe that the disclosure of mental ill-health might jeopardise their future academic and career outcomes, fearing they will be perceived as less capable than other students. These students go to considerable lengths to conceal their mental ill-health, regardless of the impact that it has on their ability to meet academic requirements (99). This perceived stigma

appears to be higher among males, international students, students with lower socio-economic status backgrounds, and students with current mental health problems (100).

I didn't want my HECS debt to increase and I was highly distressed at the time so I had to talk to the counselling service and explain to them why I wasn't submitting my assignments. I had to go through all this red-tape of the 'Withdrawal without Financial Penalty' forms and then wait a couple of weeks to see if it's approved, and get all of this paperwork from GPs or psychologists which was also really stressful.

Young person

6.3 Economic impact and case for investment

As described in the Issues Paper, one of the greatest contributors to the burden of disease of mental illness is lost productivity, and the onset of mental ill-health is usually during the prime years – years when the foundations of employment are laid down through education and early employment experiences.

Disengagement from study and work at this time of life has major, ongoing, negative consequences for economic and social participation throughout adult life. The Australian government's own projections illustrate the impact of this need, with a 2017 Priority Investment Approach estimation indicating that young people (aged 16-21) receiving Youth Allowance or a Disability Support Pension (DSP) (with mental health as their primary barrier) hold a $306,000 future lifetime cost per person, with the total future lifetime cost for the group estimated at $33.4 billion (101). If nothing changes, it is estimated that 42% of these young people will be receiving income support payments in 10 years (101). While these are transfer payments, and therefore only a cost to society through the cost of collecting taxes, these figures can be seen as indicative of the avoidable productivity loss associated with mental ill-health. The Parliamentary Budget Office found that these young people were likely to be the major contributor to growing DSP expenditure over the long term (102).

Australian research supports the importance of early intervention, including findings that a person unemployed for one year has more than a 50% chance of becoming long term unemployed (two years or greater) and, after a second year of unemployment, there is a six out of 10 chance of remaining unemployed for an additional year (103).

6.4 Effective current programs and interventions

Australian governments have recognised the impact of mental ill-health on education and workforce participation, and have implemented a number of measures across education, employment services, mental health service delivery and social services. Notably, given the social and economic benefits of employment and education for young people with mental ill-health, some youth mental health platforms (like headspace and hYEPP) have been specifically developed to create integrated pathways, a holistic focus, and include vocational supports within their services.

I talked to a University counsellor who was pretty helpful, she said she couldn't really do much for me but referred me on to a headspace centre. After seeing my local headspace I slowly started getting better. And as a result of accessing support graduating with distinction and then making it into a Masters course.

Young person

Access to effective psychological care

A 2009 evaluation found that approximately 50% of young people believed that headspace had improved their ability to go to school, work, TAFE or university, or find work. However, this 'improved

willingness to engage with work or education was largely attributed to psychological support received through headspace, rather than support from the vocational service providers' (104).

A subsequent evaluation in 2015 also found that among young people attending headspace with significant psychological distress, the improvements in their mental health had positive benefits on their social and economic participation, with days out of role (in study or work) decreasing from 7.6 to 3.1 days per month (38). Again, with only 1% of headspace clients accessing the service for vocational support, these results are indicative of good quality clinical care, supports, and decreasing psychological distress, therefore improving the likelihood of engagement in education and employment.

Vocational support

One of the four core streams of the headspace model is vocational support (105). This is a unique feature of this youth mental health platform, which responds to an indisputable need for tailored, youth-specific alternatives with soft entry points to clinical and vocational assistance for young Australians living with mental health challenges who are at very high risk for ongoing welfare dependency and social isolation.

Despite the clearly evident need, the vocational stream of headspace has been one of the greatest challenges to the initiative. While headspace centres are expected to provide vocational services, there is no funding stream that supports such services, with centres expected to draw upon 'in-kind' support from consortium partners. Traditional vocational and educational funding streams are not suitable because they are limited in their reach or not suited to the unique needs of this cohort (e.g. by having a disability focus).

To attempt to fill this large service gap, headspace has been progressive in developing innovative programs. These include the IPS trial, the DWSS, and the Digital Industry Mentoring Service.

1) Individual Placement and Support (IPS)

A 2014 report by Orygen presented strong evidence for the IPS employment services model which was shown to be an effective and cost-effective way to increase workforce participation among young people experiencing mental ill-health, and divert them from the DSP (97).

In 2016, the Australian Government announced more than $13.6 million for a three-year national trial of the IPS model of vocational assistance for young people aged 25 years and under with mental ill-health. An initial 14 IPS trial sites were rolled out in headspace centres, along with a separately funded evaluation and fidelity review process. In January 2019, it was announced that funding for the 14 trial sites would be extended for a further two years and an additional 10 IPS sites would be established.

While the 2018 evaluation of the IPS is not publicly available, nine IPS sites have separately provided Orygen with outcome data. Combined, these data demonstrate: placements of 419 young people into employment, 185 young people into education, and a placement rate into either work or education of 72.2%. In the announcement of the additional sites, the Minister for Social Services said that the unpublished evaluation had shown that of the 879 participants in the IPS trials, 50% had achieved an education or employment placement.

A recent international meta-analysis of randomised controlled trials provides strong evidence for the competitive employment outcomes provided through the IPS. The analysis found that participants in IPS, compared to usual treatment conditions, had better vocational outcomes (106). Another systematic review and meta-analysis in 2016 found that IPS was more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation (107).

The cost-benefits of IPS against treatment as usual remain somewhat contested in the international literature (particularly when all ages are considered). owever, it would be fair to say that when IPS delivers education and employment outcomes for young people the future cost savings would be much more substantial. For instance, given that the DPS costs the government approximately $471,940 per recipient over 20 years (=at current costs), Orygen and headspace estimate that the cost of the IPS trials would have been offset through diverting only 29 young people from a path that would otherwise have led to the DSP. Additionally, these estimates do not include the tax paid by those now in work, or the additional gains associated with minimising productivity loss.

Finally, adapting the IPS model to include support into education has also been shown to have positive effects, particularly when supported education and employment were provided together through an IPS model. A recent study by the Orygen research team evaluating the feasibility and effectiveness of adapting the IPS model to focus on education found that 95% of participants who completed the intervention achieved positive education results (108).

2) Digital Work and Study Service (DWSS)

The Digital Work and Study Service greatly improved my work situation by providing me with effective strategies and skills relating to resume writing and interviews that have allowed me to remain consistently employed at various workplaces over the past year.

Young person

The DWSS is delivered via phone, webchat or web conferencing and has provided an option for young people who don't have access to the IPS centre trial, are in regional areas or unable to access face-to-face support. With clinical collaboration, the service combines mental health and employment support.

Evaluation of DWSS identified that the majority of young people (55%) achieved a work or study outcome while still in the program, increasing to 72% for those who completed at least 10 sessions of support (109). In addition, 90% of young people surveyed felt the service supported them to achieve their work and study goals, 77% believed that they gained skills that would help them to achieve their work and study goals, and 93% thought that the service was appropriate for the age group. Additional but important psychosocial outcomes from the DWSS included 82% of young people surveyed had improvements in optimism about the future and 82% felt that the service helped them to understand how mental health and wellbeing issues were impacting on their work and study situation.

These results appear to be a significant improvement when compared to the outcomes reported for young people accessing Disability Employment Services (DES). Caution should be taken in making comparisons with the headspace services because of the varied nature of the programs, clients and outcomes; nevertheless, for FY 17/18, the DES program achieved positive outcomes, comprising engagement in study or paid work three months after completing the program, for 59% of those aged 15-20 years and 54.6% of those aged 21-25 years (110). Additionally, the jobactive program for the most disadvantaged job seekers assisted through stream C (which includes those with mental health issues), showed only 26.4% were employed three months after participating in the program.

Case Study: Digital Work and Study Service
Stacey is a 21 year old Aboriginal young person who was referred to the Digital Work and Study Service from a regional headspace centre. Stacey presented with long term mental health issues which included having depression, anxiety and is in recovery from an eating disorder.

At the time of accessing the service, Stacey was unemployed and had limited work history, with short 5-6 month stints of working in hospitality, which was negatively impacting her mental health. Stacey was involved with a job service provider. As a carer for a family member who is unwell, Stacey's goal was to find part time work and more educational experience to enable her to find work outside of the hospitality industry. Her priority was finding both work and study opportunities.

Stacey did not have access to the internet at her home so she worked with her Digital Work and Study Specialist over the phone, including seven phone sessions over eight weeks. These sessions involved discussing opportunities for training courses, volunteer opportunities and jobs. When Stacey had a job interview, a mock interview was organised. As Stacey mentioned during her session that she did not have appropriate clothing to wear for her interview, she was given a $100 Big W clothes voucher for her to buy work clothes.

Outcome:
Stacey gained work in sales for 10 hours a week. Stacey studied a short-term book keeping course, and is now enrolled in a Certificate 3 Business Administration course.

"It has been a great opportunity to be involved in this work and study service. For me a big highlight was being able to get a gift voucher to buy clothes for job interviews. Being able to buy professional clothing gave me the confidence I needed to apply for jobs and be confident in interviews. Also getting a gift voucher made me feel like people believed in me and it made me feel good. In a short time I went from not doing anything to studying and working" **Stacey**

3) Digital Industry Mentoring Service (DIMS)

The DIMS is an Australian first program where headspace has initiated industry partnerships to provide an online career mentoring service for young people living with mild to moderate mental health challenges. The service links headspace young people with industry volunteers, who act as mentors to support the young people's work-related confidence and capacity to find and maintain work. Young people and mentors are matched online for a period of six months, meeting online on a fortnightly basis to work on identified work goals. Mentors receive training in mental health literacy and mentoring skills, and provide young people with a champion who isn't a clinician, employment service provider or family member.

The service commenced active mentoring in 2018 and to date over 170 young people have been engaged with over 100 mentors, representing a wide range of industries. An evaluation is underway and will be completed by mid-2019, but current data show that of those participants who have completed a mentoring relationship, over 50% of young people recorded a job outcome during their time in the service. For those young people who have completed a relationship and provided satisfaction data: 100% reported they found the service useful and would recommend the program and over 96% were more optimistic about their work future.

Furthermore, feedback from mentors shows that the program also has significant benefits to the mentors and their workplaces as the mentors become more mental health literate, potentially helping to make the participating workplaces more mentally healthy.

Education settings

Programs focused on increasing the capacity of schools to promote mental wellbeing, build resilience, identify signs of risk, and make appropriate supports available or refer to external information and services, have been adopted both at a national and state/territory level.

One particular example is the Be You initiative (Beyond Blue), which was only recently rolled out across all Australian educational providers, from early childhood through to secondary school. While the program focuses primarily on building the mental health literacy of school staff (including school leadership) through online and face-to-face training, suicide postvention support (previously known as headspace school support) has also been integrated into the initiative.

Be You was a policy response by the Australian Government to gain efficiencies by packaging up a suite of existing school-based programs (including KidsMatter, Mind Matters and headspace School Support), delivered by separate organisations. It will be several years before the outcomes delivered by this initiative can begin to be evaluated. There is evidence that participation in mental health literacy programs does result in attitudinal changes and preparedness to respond in educational settings. What is not known is the impact on student help-seeking or mental health outcomes (111).

The rollout of this national program may also present challenges for state and territory governments which have developed their own initiatives that aim to build the capacity of schools to respond to mental health issues. There needs to be careful consideration from this point forward to understand how jurisdictional governments can leverage from the Be You infrastructure, rather than compete or duplicate.

Be You is also another example of government mental health investment in educational settings being targeted to primary and secondary education systems, while tertiary education systems appear to have been largely neglected. However, Orygen received funding in 2018 to develop a National University Student Mental Health Framework, which will be delivered in 2020 and aims to articulate a whole-of-university approach to support university students' mental health and wellbeing and provide evidence-informed strategies to assist universities in meeting student needs.

Workplace settings

Unhealthy workplaces are estimated to cost $11 billion per year through absenteeism, presenteeism and compensation claims (112).

A key challenge is increasing the mental health literacy of workplaces, in particular those that employ young people. We could drive a significant uplift in mental health literacy if we funded, coordinated and scaled approaches within industries that traditionally employ young people, such as retail, hospitality, construction and entertainment. This approach enables young people to learn self-help strategies to help them stay mentally healthy and engaged in the workforce, and simultaneously helps managers learn the skills to identify and support an employee experiencing mental health issues.

Through the [mentoring] program I've also become accredited in Mental Health First Aid (Youth) and that's enabled me to be more aware in my job to look for signs in colleagues and know what to do when someone is experiencing a mental health issue or episode.
Viva Energy employee

There is strong evidence that when mental health is valued by leaders, and appropriate resources are available in the workplace, there are significant benefits to business, which can be measured as a return on investment of $2.30 in terms of improvements related to mental health (113).

Both Orygen and headspace have delivered a number of employer/company focused programs to employers, such as Viva energy and Wesfarmers (Coles), to build the youth mental health awareness

and literacy of these organisations so as to better provide a supportive workplace for young people who may have experiences of mental ill-health.

6.5 Opportunities to strengthen economic and social outcomes of existing programs

Continued expansion of IPS and DWSS

Given the IPS has been shown to deliver employment and education outcomes for young people in the Australian headspace trials, it is timely to consider the scalability of the program nationally so that it is eventually delivered in all 110 (existing) headspace centres (as a consistently delivered evidence-based component of the vocational core service stream of the headspace model).

While the IPS programs in headspace centres are funded by the Australian government to achieve both education and employment outcomes, other government-funded IPS programs are required to report only on employment outcomes. Given the importance of education in providing the basis for a long-term career-focused outcome it is important that all government-funded IPS programs targeting young people support both education and work outcomes.

There are also opportunities to address long wait lists for IPS services by integrating peer and online supports (such as DWSS and YOTES, detailed below). This could be further explored as a cost-effective way to boost the program's capacity to respond to client demand in between consultations with IPS workers.

Build the workforce

To support the further expansion of the IPS and other employment support models for young people experiencing mental ill-health, there is a need to upskill career counsellors and vocational service practitioners across Australia to work effectively with young people experiencing mental ill-health and re-engage them in vocational pathways. The inclusion of mental health modules within career practitioner training could be one strategy to build a skilled and sustainable vocational support workforce to deliver a number of programs with a focus on supporting young people with mental ill-health.

The inclusion of youth vocational peer workers has been trialled in Orygen's IPS program funded through the Victorian state government. These positions work collaboratively with IPS workers and clinicians to provide emotional and social support to others with whom they share a common experience. In the employment and education context, this can include supports such as talking to participants about disclosing their mental health with employers or developing strategies with young people to manage their mental health when balancing life and work or study. Peer workers can also provide ongoing post-placement support, supplementing the role of the IPS worker.

Benefits of peer work programs include the creation of entry level career opportunities for people experiencing long-term unemployment or for people with limited work experience, and increased uptake and program participation as peer workers can improve engagement with support services.

Integrate face-to-face supports with technology

Young people have differing preferences for how and when they receive support, with online channels becoming an increasingly important resource. There is emerging evidence available for the efficacy of providing online vocational education assistance for young people with mental ill-health, with some research conducted on the inclusion of online, peer support networks in an enhanced IPS model (114).

Along with the headspace DWSS program, Orygen has also commenced development and trials of the Youth Online Training and Employment System (YOTES). This is a comprehensive web-based employment support package for Victorian young people aged 15-24 who are experiencing barriers to obtaining and remaining in work due to mental ill-health. It features moderated social interaction

with other young people and targeted career support provided by online vocational specialists and peer motivators in real-time.

Data and evaluation

Many outcome measures being utilised in IPS services for young people with mental illness are narrow and do not assess the true impact of the program. For example, measuring benefits such as studying, volunteering, or participating in internships is not a reporting requirement for many funders, yet these are important vocational steps for young people.

There may be opportunities to incorporate measures of self-reporting and satisfaction with the service along with the outcomes these produce, such as greater sense of autonomy, community engagement, and reduced feelings of isolation. The evaluation of DWSS conducted by headspace makes an important contribution to not only the self-reported employment outcomes, but also the satisfaction with the service and its contribution to other aspects of the participants' mental health and wellbeing.

In additional, many IPS or other employment support providers find the administrative load of following up with clients on a regular basis to obtain evidence of work (e.g. payslips) reduces their ability to meet their potential client capacity. Given this same information could be accessed through the Australian Tax Office (ATO), via a client's Tax File Number (TFN), there is some opportunity that administrative efficiencies could be found in data linkage and integration with employment services and Centrelink.

Increasing a focus on mental health in tertiary education settings

There is a major opportunity for a more concerted focus and investment to deliver the components of the National University Mental Health Framework once it is delivered in 2020. There is also a need to develop tailored approaches to respond to the diverse range of private higher education providers and VET providers, including TAFEs.

In Australia, there has not been an economic cost-benefit study of investing in tertiary student mental health. However, a study in the United States found a social return of $6.49 on every $1 spent by the government on prevention and early intervention in college student mental health (115). This was based on mitigating against course incompletion, loss of future workforce potential and downstream mental health system costs. The report highlighted that for the community college students (where we can draw the closest parallels with Australian TAFEs), the net benefits were estimated to increase to $11.39 for each dollar invested.

RECOMMENDATIONS

Recommendation Eight

Increase investment in vocational support programs within all youth mental health services (including headspace services). This would include:

- recognition of the evidence for the outcomes and potential economic return on investment from the Individual Placement and Support (IPS) program and investment in this program through all appropriate government policy portfolios focused on youth employment programs. For the Australian Government, through the Department of Social Services, this would mean continuing to stage a stepwise rollout of the IPS program so that it is delivered in all headspace centres by 2023-24
- prioritising trial and testing of opportunities to augment the IPS program to enhance capacity and meet need through integration of online supports and the peer workforce
- the Department of Social Services to continue to fund the Digital Work and Study Service (DWSS) to complement the IPS program (and provide a service for young people in all

headspace centres while the program is scaled up). The department should increase investments in this online program as evidence of demand and effectiveness is provided

- development and implementation of professional development activities across the Australian vocational workforce to build mental health literacy and capacity to provide effective vocational support to young people experiencing additional barriers to vocational engagement due to mental ill-health.

Recommendation Nine

Develop and fund workplace mental health approaches to increase mental health literacy and promote workplace approaches to responses that support ongoing engagement in employment for young people experiencing mental ill-health by:

- focusing on industries where young people are highly concentrated, including but not limited to, hospitality, retail, construction and entertainment industries
- providing managers and supervisors in these settings with mental health literacy programs.

Recommendation Ten

Develop and implement education settings-based approaches (across secondary schools but also with a focus on vocational education and training providers, and universities) for young people experiencing mental ill-health to prevent early exit or enable re-engagement with education. It is important that these programs are:

- focused on building capacity for enhanced case detection and supporting help-seeking and early access to treatment
- evaluated against outcome measures reflecting their impact in educational settings, including on retention and educational attainment for young people with identified mental health issues.

Section 7: Reduce self-harm and suicide-related behaviours in young people

KEY ISSUES

- Suicide and self-inflicted injuries **are the leading burden of disease** for young males in Australia aged 15-24 years.
- The most recent ABS release of suicide data showed that suicide remains the leading cause of death among young people aged 15-24 years. The largest increases in suicide rates across all ages were among young people, particularly the number of suicides of women aged under 25.
- There remain critical gaps in care provision in health systems (including at points of entry and discharge from mental health services and hospitals). There are also missed opportunities for coordination of supports between health and education providers and strengthening of postvention responses for young people.

Suicide and self-harm, particularly among young people, are among the greatest contributors to economic and productivity losses in Australia. The recent report, *Australian Burden of Disease Study: Impact and causes of illness and deaths in Australia,* found suicide and self-inflicted injuries accounted for the leading burden of disease for young males in Australia aged 15-24 years (116).

A cost of illness study estimated that the 2014 economic loss of youth suicide in Australia was $511 million, with the average cost per youth suicide being $2,884,426 (117). The direct costs, such as ambulance costs, coronial inquiry, policing costs and funeral expenses, only account for 0.01% of the total cost, which largely consists of indirect costs, such as lost economic productivity (117). Self-harm in young people is also associated with high costs, with hospital-related costs representing a small portion of total costs (118).

In both general suicide education and peer work programs, a conservative analysis found that these programs would provide at least a cost-benefit of a $22 million (US dollars) a year, with the peer support program providing $3.71 benefit to society for every dollar invested and the general education program providing $2.03 of benefit (119).

7.1 Rates of suicide, suicide-related behaviours and self-harm among young Australians

Suicide prevention policy and programs have been delivered nationally (and through state and territory governments) for almost two decades in Australia, starting with the world leading Youth Suicide Prevention Policy in 1995. While much has been delivered and achieved through these efforts, the most recent ABS release of suicide data showed that suicide remains the leading cause of death among young people aged 15-24 years and the largest increases in suicide rates across all ages were among young people. In particular, the number of suicides of women of aged under 25 has increased by 76% over the past 10 years (4).

Australia has been shown to have a crude rate of youth suicide of 11.6 per 100,000, which is higher compared to other countries with similar economic prosperity (as measured by gross domestic product per capita), including Canada (11.2 per 100,000), Sweden (8.9 per 100,000) and the Netherlands, (5.9 per 100,000) (120).

In addition, suicide attempts and self-harm are up to 20 times more common than suicide and are the primary risk factor for future suicide. Many more young people think about or attempt suicide. The most recent Australian Child and Adolescent Health and Wellbeing Survey found that in the past 12

months 7.5% of young people aged 12-17 years reported having considered suicide and 2.4% (or approximately 41,000 Australian adolescents) had made an attempt. A further 10% reported having self-harmed in their lifetime (42) and recently there has been a significant spike in hospital admissions for self-harm among young women aged 15-19 years (121).

Data captured through the headspace School Support show that:

- The headspace school support service responds to 4-5 deaths a week (across Australia), with a notable increase in requests for support from primary schools.
- From 2012-2018, the headspace school support service were notified of 1,194 suicides and 714 suicide attempts.
- The majority of suicide deaths responded to by headspace School Support were for students in year 10 (27%) and year 11 (28%) and incidents peaked in mid-late October each year. There were 2% of suicide deaths among primary school aged children.

7.2 Opportunities to respond to youth suicide, suicide-related behaviours and self-harm

Health systems

One of the most significant risk factors for suicide and suicide-related behaviour is an experience of mental ill-health yet, as identified earlier in this submission, young people with complex and severe mental health conditions are often unable to access the expert and specialist mental health care they need. There also needs to be a 'no risk is too little' approach, just like the 'no wrong door' approach for those with more complex needs, who need help now.

It is particularly alarming that the rates of suicide have increased so dramatically in young women, a group who are known to present to mental health services in greater proportions than young men, as well as, present in much greater numbers to hospitals after an episode of self-harm. Given this, there are some emerging questions about their experience of help-seeking and how successful they have been at getting the help that they need.

The headspace platform should be positioned to ensure this early and immediate access to mental health care for young people who are at risk or engaging in self-harming behaviours. However, as demonstrated through the data on waitlists at headspace and wait times for eheadspace, a significant boost in funding and workforce capacity is needed within headspace centres and services to ensure no young people who could potentially be at risk fall through the cracks. The evidence shows that even a small amount of investment during this 'waiting period' can be hugely beneficial to reducing suicide attempts (123), as the individual still receives care in the form of support and monitoring, while waiting for ongoing clinical support.

Points of presentation and discharge at hospitals and emergency departments are also critical and it is now widely acknowledged that the period following discharge from psychiatric inpatient care or admission for a previous suicide attempt carries a very high risk for suicide or further attempts (124).

In addition, we believe the standards of care for young people who present to hospital after self-harm or a suicide attempt urgently need to be improved. Orygen's *Looking the other way: Young people and self-harm* report found some instances of alarmingly poor responses to young people presenting with self-harm in emergency departments and hospitals (122). These responses often lacked compassion and were sometimes antagonistic and harmful.

A doctor asked me if I was doing it for sympathy. A doctor! You'd think he would be someone who would know better.
Young person (122)

Emphasis needs to be placed on investing in programs and initiatives that assist people at these points. There has been modelling done about investment in suicide responses and initiatives, and evidence supports that the best return on investment occurs in the most high risk areas (for example emergency departments and post-treatment) (125).

Education settings

Due to the unpredictable and irregular occurrence of suicide events, the challenge still remains of how to provide flexible and responsive support to school communities to prepare, respond to and recover from a death by suicide of young people. Of particular concern is the increasing number of suicides and suicide attempts among primary school students. While there is a scarcity of evidence around the causes and appropriate responses to self-harm and suicide, there is growing evidence of a strong correlation between exposure to suicide/suicide attempts in young people and their own suicidal ideation and behaviour in subsequent years.

Evidence is now emerging to suggest that suicide prevention programs can be delivered safely in schools if done so carefully (126). Orygen's report Raising the Bar for Youth Suicide Prevention (127) highlighted a number of studies that show training students how to identify and respond to suicide risk in oneself and others has the potential to improve knowledge, confidence, attitudes, and help-seeking intentions. There also appears to be emerging evidence for the cost-benefits of these educational and training-based programs (128) and school-based suicide prevention programs when calculated against a willingness to pay (129).

The headspace School Support service developed a national postvention service model in response to the growing evidence of suicide attempts and deaths by suicide among young people. The service model provides a comprehensive range of tools and services throughout the stages of response and recovery, delivered to schools at the front-line. By 2017, headspace school support had assisted over 250 schools and 2000 school professionals. A survey of the need for and acceptance of this program in Australian secondary schools found respondents reported that the service increased their perceived knowledge, skills and capacity to manage suicide issues, and satisfaction with the service was high (130). headspace School Support is now integrated into the Be You education initiative.

We feel better equipped to respond if this occurs as we have an increasing number of students engaging in self-harm and with suicidal ideation and attempts. There has been an increase in staff reporting warning signs and referrals to other agencies as a result of the increased awareness raised.

From the headspace school support evaluation report

While there is some evidence for the cost-effectiveness of postvention programs in the general community (131) there is a need to develop more evidence on the cost-effectiveness of school-focused postvention programs among young people. There is also a need to continue to develop the postvention service design by incorporating the perspectives of young people and their family/carers – particularly members of populations that are over-represented in self-harm and suicide statistics in order to create a responsive service.

Technology

Online services are increasingly being used by young people including those at risk of, or considering, suicide. As such, many mental health and suicide prevention services are now reaching more young people through: TeleWeb services (including crisis support such as Kids Helpline and Beyond Blue); web-based information; directed self-help through web programs or apps; online counselling; and through social media platforms, which are particularly relevant for young people (132).

Young people are already engaging so much with Instagram, Facebook, Snapchat, What's app etc and so I think the solution lies within the current platforms as opposed to creating something completely new.
Young person (127)

To date, limited evidence has been published on youth-specific technology-based suicide prevention interventions or the cost-effectiveness of online suicide prevention interventions. Some studies have shown effects on a range of outcome measures including: increase in help-seeking attitudes and intentions, decrease in suicidal ideation and a decrease in stigma (133, 134). Social media presents particular opportunities and challenges/risks when delivering suicide prevention interventions (135), yet young people regularly use these platforms. As such, there is an urgent need for more research on how social media can be safely utilised in suicide prevention interventions.

Coordination of responses within communities

Where services and referral pathways exist, there is often fragmented communication between schools, health services and the community, as well as among health services themselves. Notably, Commonwealth, state and local boundaries frequently confound coordination efforts. For young people, there is an opportunity to establish a coordinating function that helps bring together the emergency departments, headspace centres, first-responders, schools, and other state-funded clinical care providers in a community to support young people overcome suicide. Prioritising the enhancement of communication channels between key stakeholders is required in responding to serious mental health concerns to ensure an integrated care coordination approach occurs across education and health settings.

Technology shouldn't only be viewed in terms of how it can assist help-seekers, it should also be investigated as a tool to assist those helping young people, including to help them share information and referrals and manage young people's needs in a more coordinated and effective way. Where possible, access to services such as telehealth and face-to-face support should be provided conjunctly, particularly in rural, remote and high risk settings.

For Aboriginal and Torres Strait Islander young people, the Central Australian Aboriginal Congress provided headspace with this recommendation:

"Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services, healing programs, culturally secure SEWB programs and, where appropriate, Aboriginal families living on country."

Data and surveillance

While national data on hospital admissions for self-harm are available from the Australian Institute of Health and Welfare via the National Hospital Morbidity Database, no standardised (nationally

coordinated) systems are in place to collect robust data on the number of self-harm presentations to the emergency department or other emergency services. The only system in place to assess the community prevalence of self-harm (including among those who do not present to the public health system) is via the National Survey of Mental Health and Wellbeing, last conducted in 2007.

Of the data that is collected, significant gaps and inconsistencies exist. In particular, the various classifications of suicidal behaviour (e.g. deliberate self-harm, self-injurious behaviour, non-fatal self-harm) have resulted in fragmented data collection. Moreover, information on vulnerable demographic groups in Australia, such as LGBTQI+ status, and mental health history is not routinely available. This information is necessary to develop and deliver suicide prevention services tailored to the specific needs of local communities and is relevant also to real-time surveillance.

It is crucial that both monitoring and surveillance systems for the collection and provision of data on suicide and self-harm are developed. This will increase our capacity to intervene to prevent further deaths, and will provide a lead indicator allowing us to track our progress (and therefore the social and economic efficacy of suicide prevention strategies) towards reducing suicide rates.

DEFINITIONS: Monitoring and surveillance systems

An important distinction exists between a) real-time surveillance and b) monitoring of suicide and self-harm.

Monitoring typically involves periodically collected data that enables long-term comparisons of self-harm and suicide over time. While accurate, monitoring systems are retrospective, and often do not necessarily reflect the current burden of self-harm and suicide in the community or inform a timely response.

A surveillance system involves the identification of self-harm and suicide, as they occur in real-time. As such these systems provide an opportunity to identify potentially emerging clusters of suicide and self-harm and, if established correctly, can trigger an immediate community response, thereby reducing the risk of further suicides or suicide attempts as well as related morbidity among those bereaved.

RECOMMENDATIONS

Recommendation Eleven

Make youth suicide prevention a key focus in schools, primary care services, mental health services and hospital/emergency departments. Specifically there is a need to ensure:

- all schools have access to suicide postvention support to prevent the risk of further suicides
- all service providers in primary care settings are trained in suicide risk assessment
- assertive follow-up care is provided to young people following discharge from inpatient care, or emergency department presentations relating to mental health conditions, self-harm or suicide-related behaviours.

Recommendation Twelve

Develop a real-time surveillance system for suicide and suicide-related behaviour. This would involve:

- collating data from multiple agencies including state coroners, police, ambulance and hospital emergency departments. This system should be linked to an evidence-based and strategically coordinated immediate response delivered at community level.
- standardising data collection among existing monitoring systems, including:
  - a standardised definition of suicide and self-harm behaviour
  - development of a core demographic dataset implemented in each state/territory

    - improvement in the collection of significant suicide indicators such as engagement with mental health services, Aboriginal and Torres Strait Islander background and LGBTQI+ status
- standardised reporting across agencies to minimise duplication of reporting among sector partners.

Section 8: Build a youth mental health workforce to meet the current and future needs

KEY ISSUES

- Attracting people to new youth mental health services in Australia has had mixed success, with recruitment of youth workers and allied health staff, especially psychologists, being relatively more successful than recruitment of GPs and psychiatrists.
- There remain significant gaps in the youth mental health workforce availability, as well as issues attracting and retaining staff, particularly in community-based youth mental health services.
- There is a need to look for more opportunities to incentivise and promote careers and job pathways in youth mental health and extend the scope of the workforce to a much broader field of professionals, including building a peer and family workforce.

8.1 The youth mental health workforce

The mental health workforce is broadening. As described in Orygen's National Youth Mental Health Workforce Strategy (136), the youth mental health workforce spans a diverse range of professionals – in a variety of contexts – seeking to provide effective assistance to young people (aged 12-25) who are at risk of, or already experiencing, mental health problems. This workforce includes (but is not limited to):

- health and mental health professionals in a wide range of primary care and specialist mental health settings (including alcohol and other drug services). They include occupational therapists, social workers, mental health nurses, psychologists, GPs and psychiatrists
- teachers and other educational providers in TAFEs or universities (often providing early recognition and support for students struggling with mental health issues)
- police, juvenile justice/correctional staff
- welfare staff and youth workers (e.g. out of home care, homelessness services)
- youth and family peer workforces.

What are the attributes of the youth mental health workforce that we need?

The National Youth Mental Health Workforce Strategy outlines four key domains for an effective youth mental health workforce. These are:

1. A capable and skilled clinical and non-clinical youth mental health workforce which can provide young people with emerging mental health problems with early detection, and evidence-based responses that are appropriate to their needs, circumstances and age group.
2. A sustainable, secure and ongoing supply of appropriately qualified youth mental health professionals and specialists to address the current and continuing shortage of specialist workers within the youth mental health workforce.
3. A culture of innovation and continuous improvement which is embedded across the youth mental health workforce. This includes building collaborative partnerships between researchers, evaluators and service deliverers to ensure effective and rapid knowledge transfer and translation.
4. A responsive, collaborative and flexible youth mental health workforce that is enabled to provide shared and integrated care for young people.

8.2 Current workforce issues in youth mental health

There is significant variability in terms of who the workforce is, which differs depending on state/territory, PHN, or federal) level. How a service is commissioned will affect how they prioritise their service delivery and what kind of workforce they will need to deliver those services. This means that the focus remains on fitting help-seekers into the existing framework of services, and there is not enough emphasis on providing the evidence-based care that they need.

While Orygen has developed a National Youth Mental Health Workforce Strategy (2016-2020), there is currently no Australian government national mental health workforce strategy or framework to support the development of a mental health workforce that can meet the needs of the Australian community now and into the future. A national focus and approach to: a) addressing workforce shortages and b) describing the configuration and capabilities required for an effective and efficient mental health workforce is urgently needed.

Poor workforce attraction and retention

Attracting people to new youth mental health services in Australia has had mixed success, with recruitment of youth workers and allied health staff, especially psychologists, being relatively more successful than recruitment of GPs and psychiatrists (137).

At present the headspace centre network is hamstrung by limited access to a workforce capable of delivering the evidence-based care that is required to ensure that young people are mentally healthy and able to participate both socially and economically. The 2018 national survey of headspace centres showed that 87% of centres have difficulty attracting and retaining staff. Even in regions where a sufficient private practitioner workforce exists, the ability to increase the workforce to meet demand is often hampered by the physical size of the centre, which is unable to accommodate additional workers.

In particular the headspace network has had difficulty with:

- attracting GPs: 27% of centres reported that they didn't have access to a GP, and for those centres that did, most had a GP presence for fewer than 15 hours per week
- attracting GP registrars – only a handful of GP registrars are currently placed in centres
- limited access to telepsychiatry outside of rural and remote locations
- the significant national dearth of appropriate workforce in healthcare roles from Aboriginal and/or Torres Strait Islander and CALD backgrounds to deliver culturally appropriate services for these population groups.
- accessing private practitioners in outer regional, rural and remote areas.

Youth Mental Health Practitioner roles are very difficult to recruit appropriately experienced staff with the right attitude/right fit for the service in regional remote area. Funding provided currently does not cater to the salary levels with additional benefits needed in our region. Increased resourcing to address need for more Aboriginal staff and build the capability of the Aboriginal workforce (through generous PD/training benefits) - including MH [mental health] trainees would be of high benefit.
Service provider

In addition, there is a large body of literature about why people leave the mental health workforce. Commonly cited reasons for high staff turnover in the mental health sector include:

- remuneration issues in the sector and job insecurity resulting from short term contracts
- limited access to professional development, lack of career paths and professional recognition (138)

- excessive workload (139), burnout and high rates of absenteeism due to perceptions of system failure (140).

8.3 Opportunities to build and support a national youth mental health workforce

Address funding inadequacies

One reason that the community youth mental health sector struggles to attract and retain staff concerns the inadequacies in the funding models. In particular, the limited amount of core operational and infrastructure funding, and a need to operate from a 'no gap' or low cost offering for young people to address any financial barriers to accessing care, make it difficult for youth mental health services such as headspace to:

- compete with private provider organisations (who charge private fees, deliver shorter consultations and, due to the more significant financial investment on behalf of the person accessing treatment, have fewer 'do not attends' impacting on MBS claims)
- provide long term job security (due to short term funding contracts).

The funding model […] directly impacts on the outcomes of the centre: a) we cannot compete with wages/salaries of other mental health services, b) we cannot offer an incentive that wage/salary will increase after 12 months – because funding is unknown, c) employee numbers are not high enough for this location and for the number of occasions of service that continue to increase, d) current funding (which has remained the same for a number of years) means we have to cap the staff numbers.
headspace centre

Section 5 of this submission provided some detail on the need to develop new funding models to better support the workforce to meet demand. This would also reduce burnout, stress and the general feeling of failure which results in high turnover of staff. In particular, there is a need for:

- longer funding cycles for community government funded youth mental health services from both Commonwealth and state and territory governments
- annual CPI increases built into funding
- increased operational funding to build the required 'wrap around' supports and integrated models of care that include AOD and vocational and provide more opportunities for professional development
- greater funding provision through the MBS to deliver family engagement sessions, secondary consults to support professional development, and telepsychiatry outside of remote and rural areas where difficulties accessing psychiatrists are evident.

Provide greater incentives

Funding shortfalls in mental health have also made it difficult for youth mental health services to provide other incentives for employment, such as paid professional development. In the GP context, only a handful of centres have senior GP roles that support workforce development – including GP recruitment, induction, support and retention. This problem is compounded by limited capacity for centres to capitalise on existing GP skills, for example, in training GP registrars and participating in service delivery planning and clinical governance.

There is a need to trial various financial and other incentive approaches, such as gap payments, to supplement the private practitioner model in headspace centres. This will:

- allow headspace centres to top-up fees for bulk-billed sessions – to be a more viable and competitive employer
- support the integration of private practitioners in team meetings/case reviews and care coordination – to provide more comprehensive care to young people with complex needs, to

support those in between intake and other sessions, and provide better coordination for young people
- provide access to supervision and secondary consultation support mechanisms out of clinical sessions – to foster greater support and team integration
- support private practitioners to better integrate into the headspace centre workforce (e.g. by providing funding for their time to contribute service planning and clinical governance) in order to enhance primary care delivery
- encourage GP/psychiatrists/psychiatry registrars to work in areas and locations of workforce shortage, in particular rural and remote areas and in headspace centres. A national program is required which could include:
    - establishing more regional training hubs to better coordinate training opportunities and build local training capacity
    - funding to support additional places and training, research or study bursaries for medical registrars and early career psychologists targeted specifically to rural areas and/or headspace centres.

Obtaining practitioners is the most difficult aspect of the recruiting in this centre. This can be attributed partly to location but also to the structure of session payments and arrangements. If there was more stable permanent payment type structure this would be a big help to solving the demand issues.
headspace centre manager

Training and professional development

The youth mental health workforce has variable skills and competencies and these strongly depend on what settings they work in and what professional and clinical accreditations they have. In addition, we believe that it is not necessary for highly qualified clinicians to deliver low intensity support services, and that these could be delivered by a trained community workforce, especially in services that could provide supportive coaching by those with lived experience, including the use of digital platforms.

There is currently a limited view on what constitutes 'workforce development' and it is often considered to be achieved through participation in a one to two-day training workshop that is really restricted within that time period to providing a broad theoretical overview and some key tools useful to providing support to this area. Often there is little follow-up training or the ability to provide a mentoring or supervisor service to those individuals who are the only person providing that service in their setting or who don't have additional support to implement their knowledge successfully.

There is also a tension between pre-service training and on-the-job training, where some providers expect a minimum amount of knowledge and experience, but don't provide support to continue to develop these skillsets.

There have been instances where training is funded and provided to the workforce in order to specialise in an area of service delivery. If this is coordinated and delivered alongside regular duties, this can have a beneficial effect of providing the ongoing support and mentoring necessary to embed the skills and competencies developed from training. This supports a more incentivised approach to training that creates a workforce with standardised knowledge and practices. This on-the-job training must be specific to the setting and provide an overview of the system in which the employees operate in.

Supporting an Aboriginal and Torres Strait Islander and CALD workforce

There is an opportunity to build the capacity and capabilities of the youth mental health workforce to respond to the preferences, needs and unique circumstances of Aboriginal and Torres Strait Islander young people and young people from CALD communities, particularly newly arrived young people or young people from a refugee background. These include:

- including cultural training requirements into contractual agreements for all youth mental health and wellbeing funded programs and services
- including cultural security training, social and emotional wellbeing perspective and trauma-informed training
- additional and long term funding targeted at building the Aboriginal and Torres Strait Islander and CALD youth mental health and wellbeing workforce, such as traineeship opportunities for young people. For example, the headspace Aboriginal and Torres Strait Islander Youth Mental Health Traineeship Program has built the Aboriginal and Torres Strait Islander youth mental health workforce, reached Aboriginal and Torres Strait Islander young people in rural and remote areas, and increased the involvement of Aboriginal and Torres Strait Islander young people in the design and delivery of mental health services
- establishing and formalising mechanisms for youth mental health services to work with Aboriginal Health Services – providing young people with an entry point through these services if that is their preference.

Supporting a peer workforce

The peer workforce has become integral to an effective youth mental health system, with the National Mental Health Commission identifying that an increase to the number of mental health peer workers is an immediate priority (85). In addition to improving empowerment, social functioning, empathy, hope and reducing stigma, a review of mental health peer support found reduced admission rates and longer community tenure, with one peer outpatient program resulting in a 50% reduction in rehospitalisation (141). In the first three months of an Australian mental health peer support service, one study found that 300 bed days were saved, equating to $93,150 saved after project costs of approximately $19,850 (142). The social benefits and the costs averted from hospitalisation and acute care solidify the role of the peer workforce in a cost-effective mental health care.

Given the identified need and growth of the workforce, there is a strong need to support and retain youth and family peer workers. Consultations with youth peer workers identified the need for clearer role definition, professional development through peer-led training and supervision, and enhanced job security for the workforce (143).

RECOMMENDATIONS

Recommendation Thirteen

Urgently develop a plan to implement the Youth Mental Health Workforce Strategy to address the training, recruitment and retention of an appropriate workforce, with a specific focus on:

- developing and embedding training in youth mental health into the education pathways of all the main professions for mental health – psychiatry, psychology, general practice, social work, occupational therapy, mental health nursing
- developing and embedding training in holistic multidisciplinary care (including mental health, vocational, and psychosocial needs) into the education pathways of all the main professions for mental health – psychiatry, psychology, general practice, social work, occupational therapy, mental health nursing

- supporting clinical placements in youth mental health through funding and resource incentives for general practice, psychiatry, psychology, social work, mental health nursing, occupational therapy
- designing roles and developing training for a workforce that provide low intensity interventions delivered by workers without clinical specialisation (such as the peer workforce), and ensure adequate clinical backup and supervision.

Recommendation Fourteen

Address barriers for the recruitment and retention to the youth mental health workforce including:

- enabling headspace services to 'top-up' private practitioners' funding (GPs, allied health professionals) who are funded through MBS items (while this funding approach is still in place) to take into account the particular considerations for providing services to this age group including:
  - a greater period of time needed to support disclosure and communication
  - an increased proportion of clients that do not attend
  - ways to enable opportunities for collaborative care (consultation and review) that is possible through the provision of the holistic four pillars of care through the headspace platform.
- providing funding for supervision and secondary consultation to support the provision of high quality clinical services
- providing incentives for psychiatrists and other specialists to work in areas of workforce shortage (particularly regional, rural and remote areas).

Section 9: Drive improvements through research, data and outcome monitoring

KEY ISSUES

- Mental health remains proportionately underfunded compared to a) the contribution of mental illness to the burden of diseases and b) research funding allocated to other non-communicable diseases.
- The current national data surveys on mental health are out-of-date and do not provide data sets that can be easily accessed and interrogated for the 12-25 year old age group (even though providing service and program responses specifically for this age group has been a focus for governments over the past 10 years).
- There are also no standard outcome measure tools available that are specifically designed for young people aged 12-25 years that can inform governments, other funders, service planners and providers on the efficacy and impact of the services and care being provided.

In Australia, a much stronger focus and commitment to research, data and outcome measurement is needed in order to drive continuous improvements in prevention and early intervention, treatments, coordinated and integrated care and broader system design.

These improvements would be anticipated to have: a) a significant impact on the social and economic outcomes of young people experiencing mental ill-health, and b) implications for future expenditure and sustainability of mental health service delivery through the development of strong evidence relating to cost-benefits and cost-effectiveness of various service models, configurations and treatments.

There is also a need to find ways to more rapidly translate evidence emerging from a) national data, b) research and c) monitoring of outcomes into policy and practice.

9.1 Research to inform effective interventions and models of care

The greatest opportunity for mental health research to have a sizable economic and social impact is through building the evidence for early interventions in young people which can reduce the risk of lifelong illness. Appropriately funded mental health research will not only translate into local service improvements but also play a key role in informing national and international service and policy reforms to enhance the mental health of young people.

Mental health continues to be proportionately underfunded in medical research grants and investment globally. Despite these conditions posing the greatest threat to worldwide economic growth of all non-communicable diseases, including cancer and cardiovascular disease, in 2015 only 8.6% of National Health and Medical Research Council (NHMRC) funding across all health categories went to mental health research, a reduction on 9.5% of total health research funding from the NHMRC in 2009. This is a significant shortfall (41%) on the 14.6% contribution of mental illness to the burden of disease nationally, compared to the shortfall in cancer (29%) and the gains in cardiovascular research (6%) and diabetes research (41%) (144).

There have been efforts to increase funding for mental health research, most recently through the government's Million Minds Mental Health Research Mission which aims to develop new approaches to prevent, detect, diagnose and treat mental illness. The first round of funding will target child and youth mental health, Aboriginal and Torres Strait Islander mental health, and eating disorders.

Our organisations believe there is a strong economic argument for governments (Australian and jurisdictional) as well as the private mental health sector to continue to prioritise and fund Australian youth mental health research focused on:

- contributing to a better understanding of the causes and impacts of mental ill-health in young people and the further development of a holistic, staged and pre-emptive paradigm for prevention, diagnosis and treatment
- discovering novel treatments and supports to appropriately respond to emerging mental illnesses in young people at different stages of illness and with varied personal attributes. This includes biological and psychosocial interventions such as Cannabidiol, N-Acetyl Cysteine, technology assisted recovery-oriented therapies and staged interventions from early in the illness course
- research into new service models which integrate face-to-face, mobile and online services
- supporting the development of accessible, effective, equitable and sustainable service responses to improve the mental health of young people
- providing supporting infrastructure and a workforce strategy to allow the development of a youth mental health research program that continues to provide leadership within Victoria which can inform an Australian and International youth mental health research agenda
- designing research projects so that they fit into clinical settings and complement their activities without causing disruption or placing unduly onerous requirements on clinical staff or young people
- leveraging the asset of headspace – Australia's world leading youth mental health service system infrastructure – through undertaking the types of large scale studies that are now possible for the first time ever in the youth mental health field.

9.2 Improving national data collection on young people's mental health

National mental health survey data (including prevalence, help-seeking and treatment engagement) for the general population is out-of-date and inconsistent. This is evident in that the Productivity Commission has had to rely on 2007 National Mental Health and Wellbeing Survey (NMHWS) data for indicators of prevalence – data that is now 12 years old.

Orygen and headspace are aware of a number of mental health organisations that have called for the Commonwealth Government's Department of Health to update and expand a national mental health survey urgently, and we strongly support this call for action. We also recommend that this survey is undertaken every five years into the future.

The Child and Adolescent Mental Health and Wellbeing Survey (Young Minds Matter) was conducted more recently in 2015, however there are limitations to the value and use of this data in informing the development of policy, systems, services and interventions for youth mental health. The most significant being the limitation of this survey to young people under the age of 18 years.

Mission Australia and Black Dog also produce a Youth Mental Health Report, providing an analysis of data collected in an annual survey of young Australians aged 15-19 years. The survey, which had a sample size of 21,172 young people in 2016 (the most recent year for which data is available), uses the Kessler 6 (K6) to measure non-specific psychological distress.

Orygen has prepared a number of policy reports that have consistently recommended the need for improvements in collection and access to national data sets on the mental health and wellbeing of 12-25 year olds. This could include:

- a dedicated survey of this target age group, with particular consideration to understanding prevalence, help-seeking, service use and experiences for different priority sub-groups
- extending the Child and Adolescent Mental Health and Wellbeing Survey to a 0-25 year old age cohort and conduct every five years
- over-sample young adults (18 to 25 years) in the next NMHWS and provide easy access to compiled data for the 12-25 year age group (bringing together the NMHWS and the Child and Adolescent Mental Health and Wellbeing Survey data).

In addition we would be seeking to expand on the detail collected through these survey instruments to ensure existing gaps in data could be addressed across a range of areas in youth mental health and in particular, priority population groups who are at increased risk. These include but are not limited to:

- questions relating to self-harming and risk-taking behaviours. This should include targeted data collection strategies to increase the sample of young people and high risk groups of young people
- the incidence of comorbidity in young people, including the age of onset, duration of illnesses and relationship between mental ill-health and incidence of AOD use
- questions relating to educational status that allow breakdown by primary, secondary, VET and university level study
- oversampling of groups of Aboriginal and Torres Strait Islander young people and CALD young people.

There are additional issues with the current national data collection mechanisms also not providing utility for longitudinal comparison or more localised/regional/population sub-group data which is needed for planning for services and programs at a PNH or Local Health Network (LHN) level.

9.3 Improving outcome measurement

With the emerging focus on developing and delivering specific mental health service and program responses for young people aged 12-25 years there is also a need to design outcome measures that can provide meaningful information across a range of domains, can provide meaningful and useful information back to governments, service planners, service providers, clinicians, researchers, as well as, young people and their families. A review of outcome measure tools found no measures specifically designed for young people aged 12-25 years. The authors recommended that there was a need for future research to develop age-appropriate mental health outcome measures for this age group (145).

headspace and Orygen have identified the need to develop a single National Youth Mental Health Report Card with enough scope and depth to get an indication of the level of impact of broader youth mental health activities and services to help inform future planning by governments, PHNs, LHNs (Local Health Districts (LHDs) or their equivalent), school systems/sectors, service providers and organisations invested in child and youth mental health and wellbeing.

headspace already has a strong focus on continual quality improvement and providing evidence-based and best practice services. To enable this, all the main headspace services have (1) a minimum data set (MDS) routinely collected that is used to monitor and report on the service, and (2) an evaluation framework, based on a program logic, which is used to provide each service with regular feedback on outcomes being achieved and areas of need. headspace is committed to:

- understanding what works, what doesn't and why
- determining the effectiveness of headspace services in achieving outcomes for young people, their families and communities

- continuous improvement of headspace services to provide the best service to young people, their families and communities
- transparency, including reporting on service delivery and effectiveness to funders and other stakeholders, and
- contributing to building the evidence base about early intervention in the youth mental health field.

The headspace MDS are developed through major consultation with all relevant stakeholders, including young people, their families, service providers, program content experts, headspace National, and the headspace network (centres, lead agencies, PHNs). headspace was required to invest to build a data collection information technology infrastructure (hAPI) to collect, store and report data, because nothing suitable was available. For most services, data are collected from young people (including patient reported outcome measures) as well as service providers (clinician reported outcome measures). The data have multiple uses, they are available: to clinicians to inform clinical practice, to centre managers and Lead Agencies to guide service improvement, to PHNs to monitor local area implementation and progress, to headspace National to inform continuous quality improvement and model fidelity, and to the Department of Health to monitor progress.

The MDS for the headspace centre network is the most developed. A very preliminary MDS was in place in 2009. A major review in 2012 led to the development of the hAPI system, and a new comprehensive MDS, which was implemented early in 2013. Another major review was recently undertaken and a revised MDS and hAPI 2.0 system will be implemented in mid-2019. Importantly, this system will have the capacity for data to be provided to Department of Health PMHC-MDS. An MDS for eheadspace, hYEPP, as well as the DWSS and DIMS programs, were put in place at the inception of these programs.

9.4 Improving the economic evidence base in mental health

The mental health prevention, early intervention and treatment service system is highly complex. Some of the issues that contribute to sub-optimal financing and organisation of this system are well documented and have immediately available remedies (e.g. increasing investment in cost-effective treatments and service models). However, there is also a need to sustain reform efforts over the longer-term and to invest in a supportive program of research to address knowledge gaps. Much of this research need will be economic research that is closely aligned to the four goals of:

1. Improving priority setting in health by addressing the underfunding of youth mental health services.
Economic research to advance this goal include more and better economic evaluations, research/tools to allow economic evaluation evidence to be generalised to regional commissioning contexts, and the elicitation and valuation of the preferences of young people and their families for mental health supports.

2. Improving the technical efficiency of youth mental health services.
Optimisation/operations type economic research, research into provider incentive design and nudges and the pricing of implementation risk/development of novel financing instruments to mitigate that risk are all potential research topics to help achieve this goal.

3. Co-financing of youth mental health services from non-health sectors.
Better understanding of the externalities of youth mental health prevention and treatment through high-quality cost of illness studies using incidence based approaches and economic evaluations with long time horizons that include a societal perspective on costs.

4. Fiscal policy that supports the mental wellbeing of young people.

Social determinants/production of health research combined with understanding mental health related externalities arising in non-health transactions (e.g. social media, advertising) and the design of ex-ante analysis of proposed regulatory, taxation and subsidy responses to those externalities.

RECOMMENDATIONS

Recommendation Fifteen

A clear expectation and funding support for major youth mental health service platforms, like headspace, to be harnessed as clinical research platforms to develop and test new treatment modalities and interventions (including digital/online) and translate this evidence into practice through timely and large scale adoption and implementation of effective approaches.

Recommendation Sixteen

Regularly collect and report national data including epidemiological and health service data on the mental health and wellbeing of young people in Australia. Specifically:

- undertake national population prevalence studies of mental health issues every five years, including a specific focus on the 12-25 year age range when most mental disorders first emerge
- support further development of a National Report Card for youth mental health (currently being developed by headspace and Orygen), to track change in key measures relevant to youth mental health
- ensure adequate support for service-related data collections in youth mental health, such as the headspace MDS
- facilitate the AIHW to collate and national data collections relevant to youth mental health.

Recommendation Seventeen

There should be increased investment in economic research in mental health, with a particular focus on addressing the following knowledge gaps:

- externalities associated with mental health prevention and treatment in young people (e.g. through incidence based cost-of illness studies and economic evaluations with long time horizons that incorporate societal perspectives on costs)
- youth mental health related externalities of private transactions in the wider economy and innovative regulatory, tax or subsidy responses to those externalities, with an initial focus on media/social media transactions
- the generalisability of economic evaluation evidence to regional commissioning contexts
- the elicitation and valuation of youth mental health service preferences of young people and families
- process optimisation and service re-configuration
- the pricing and financing of implementation risk
- provider incentives and behaviours
- the role of insurance markets in youth mental health.

References

1. Bloom DE, Cafi ero ET, Jane-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The global economic burden of non-communicable disease. . Geneva: World Economic Forum; 2011.
2. Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet (London, England). 2011;377(9783):2093-102.
3. ABS. National Survey of Mental Health and Wellbeing: Summary of Results, 4326.0, 2007. Canberra: Australian Bureau of Statistics; 2009.
4. ABS. 3303.0 Causes of Death, Australia, 2017: Table 11.1 Intentional self-harm, Number of deaths, 5 year age groups by sex 2008-2017. In: ABS, editor. 2018.
5. headspace National Youth Mental Health Foundation. headspace brand health survey. 2018.
6. Colmar Brunton & headspace National. headspace National Youth Mental Health and Wellbeing Survey, 2018. 2019.
7. Ciobanu LG, Ferrari AJ, Erskine HE, Santomauro DF, Charlson FJ, Leung J, et al. The prevalence and burden of mental and substance use disorders in Australia: Findings from the Global Burden of Disease Study 2015. Australian & New Zealand Journal of Psychiatry. 2018;52(5):483-90.
8. AIHW. Expenditure on mental health services. Canberra: AIHW; 2019.
9. ABS. National Survey of Mental Health and Wellbeing: Summary of Results 2007. Canberra: Australian Bureau of Statistics; 2008.
10. Baker D, F. K-L. Two at a time: alcohol and other drug use by young people with a mental illness. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.
11. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jonsson B, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol. 2011;21(9):655-79.
12. Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. Lancet. 2007;369(9569):1302-13.
13. Whiteford H, Ferrari A, Degenhardt L. Global Burden Of Disease Studies: Implications For Mental And Substance Use Disorders. Health Affairs. 2016;35(6):1114-20.
14. Organization WH. Investing in mental health: Evidence for action: World Health Organization; 2013.
15. Canada MHCo. Making the case for investment in mental health. 2013.
16. Sanderson K, Andrews G, Corry J, Lapsley H. Reducing the burden of affective disorders: is evidence-based health care affordable? J Affect Disord. 2003;77(2):109-25.
17. Commission NMH. Report of the National Review of Mental Health Programs and Services. Sydney; 2015.
18. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. The Lancet.370(9590):878-89.
19. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. The Lancet Psychiatry. 2016.
20. Andrews G. Tolkien II : a needs-based, costed, stepped-care model for Mental Health Services : recommendations, executive summaries, clinical pathways, treatment flowcharts, costing structures. Sydney, N.S.W.: World Health Organization, Collaborating Centre for Classification in Mental Health; 2007.
21. Andrews G, Issakidis C, Sanderson K, Corry J, Lapsley H. Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. Br J Psychiatry. 2004;184:526-33.
22. Wagstaff A, Culyer AJ. Four decades of health economics through a bibliometric lens. Journal of Health Economics. 2012;31(2):406-39.
23. Frank RG, McGuire TG. Economics and mental health. Cambridge, MA; 1999. Contract No.: 7052.

24. Walker ER, McGee RE, Druss BG. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry. 2015;72(4):334-41.
25. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):593-602.
26. Knapp M, Snell T, Healey A, Guglani S, Evans-Lacko S, Fernandez JL, et al. How do child and adolescent mental health problems influence public sector costs? Interindividual variations in a nationally representative British sample. J Child Psychol Psychiatry. 2015;56(6):667-76.
27. Access Economics. The economic impact of youth mental illness and the cost effectiveness of early intervention. Canberra; 2009.
28. Degney J, Hopkins B, Hosie A, Lim S, Rajendren AV, Vogl G. Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy. Inspire Foundation; 2012.
29. Hamilton MP, Hetrick SE, Mihalopoulos C, Baker D, Browne V, Chanen AM, et al. Identifying attributes of care that may improve cost-effectiveness in the youth mental health service system. Med J Aust. 2017;207(10):S27-S37.
30. Aceituno D, Vera N, Prina AM, McCrone P. Cost-effectiveness of early intervention in psychosis: systematic review. Br J Psychiatry. 2019:1-7.
31. Welfare AIoHa. Young Australians: their health and wellbeing 2011. Canberra; 2011.
32. KPMG. The economic cost of suicide in Australia. 2013.
33. Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P. Is early intervention in psychosis cost-effective over the long term? Schizophr Bull. 2009;35(5):909-18.
34. Neil AL, Carr VJ, Mihalopoulos C, Mackinnon A, Morgan VA. Costs of psychosis in 2010: findings from the second Australian National Survey of Psychosis. Aust N Z J Psychiatry. 2014;48(2):169-82.
35. Hilferty F, Cassells R, Muir K, Duncan A, Christensen D, Mitrou F, et al. Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program. Sydney: Social Policy Research Centre, University of New South Wales.; 2015.
36. SCRGSP (Steering Committee for the Review of Government Service Provision). Report on Government Services 2015. Canberra: Productivity Commission; 2015.
37. SCRGSP (Steering Committee for the Review of Government Service Provision). Report on Government Services 2017. Canberra: Productivity Commission; 2017.
38. Hilferty F, Cassells R, Muir K, Duncan A, Christensen D, Mitrou F, et al. Is headspace making a difference to young people's lives? Final Report of the independent evaluation of the headspace program. Sydney: Social Policy Research Centre, UNSW; 2015.
39. Chisholm D, van Ommeren M, Ayuso-Mateos JL, Saxena S. Cost-effectiveness of clinical interventions for reducing the global burden of bipolar disorder. Br J Psychiatry. 2005;187:559-67.
40. Brimblecombe N, Knapp M, Murguia S, Mbeah-Bankas H, Crane S, Harris A, et al. The role of youth mental health services in the treatment of young people with serious mental illness: 2-year outcomes and economic implications. Early Intervention in Psychiatry. 2015:n/a-n/a.
41. McCrone P, Singh SP, Knapp M, Smith J, Clark M, Shiers D, et al. The economic impact of early intervention in psychosis services for children and adolescents. Early Interv Psychiatry. 2013;7(4):368-73.
42. Lawrence D, Johnson S, Hafekost J. The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health; 2015.
43. Corrigan P. How stigma interferes with mental health care. Am Psychol. 2004;59(7):614-25.
44. Wright A, McGorry PD, Harris MG, Jorm AF, Pennell K. Development and evaluation of a youth mental health community awareness campaign – The Compass Strategy. BMC Public Health. 2006;6(1):215.
45. Mission Australia and Black Dog Institute. Youth mental health report: Youth Survey 2012-16. Mission Australia and Black Dog Institute; 2017.

46. AIHW. Medicare-subsidised mental health-specific services: Table MBS.2: People receiving Medicare-subsidised mental health-specific services, by provider type(a), patient demographic characteristics, 2016–17. In: Welfare. AIoHa, editor. 2018.
47. Royal Australian College of General Practitioners. General Practice: Health of the Nation. East Melbourne: RACGP; 2018.
48. AIHW. Mental health services in Australia - Mental health-related care in general practice: Table GP.2. In: AIHW, editor. 2017.
49. AIHW. Mental health services in Australia: State and territory community mental health services: Table CMHC.3: Community mental health care service contacts, by sex and age group, states and territories, 2016–17. In: Welfare. AIoHa, editor. 2018.
50. AIHW. Mental health services in Australia: Services provided in public hospital emergency departments. Table ED.3: Mental health-related emergency department presentations in public hospitals, by triage category, 2004–05 to 2016–17. Canberra: Australian Institute of Health and Welfare; 2018.
51. AIHW. Mental health services in Australia: Services provided in public hospital emergency departments. Table ED.6: Mental health-related emergency department presentations in public hospitals, by patient demographic characteristics, 2016–17. Canberra: Australian Institute of Health and Welfare; 2018.
52. Rickwood D, Anile G, Telford N, Thomas K, Brown A, Parker A. Service Innovation Project Component 1: Best Practice Framework. Melbourne: headspace National Youth Mental Health Foundation; 2014. Report No.: 0646920618.
53. Rickwood D, Wallace, A., Kennedy, V., O'Sullivan, S., Telford, N., & Leicester, S. (in press). Young people's satisfaction with an online mental health service – development of a service satisfaction measure and implementation in eheadspace. JMIR Mental Health. Accepted 20/12/2018.
54. Rickwood DJ, Telford, N., Mazzer, K., Parker, A., Tanti, C.P., & McGorry, P.D. Changes in psychological distress and psychosocial functioning for young people accessing headspace centres for mental health problems. Med J Australia. 2015;202(10):537-42.
55. Peiper N, Illback RJ, O'Reilly A, Clayton R. Latent class analysis of need descriptors within an Irish youth mental health early intervention program toward a typology of need. Early Intervention in Psychiatry. 2017;11(1):37-46.
56. O'Reilly A, Illback R, Peiper N, O'Keeffe L, Clayton R. Youth engagement with an emerging Irish mental health early intervention programme (Jigsaw): participant characteristics and implications for service delivery. Journal of Mental Health. 2015;24(5):283-8.
57. WentWest, the Western Sydney Primary Health Network. Mental Health and Suicide Prevention Initial Commissioning Activities: 2016-2018. 2016.
58. Bendall S, Phelps A, Browne V, Metcalf O, Cooper J, Rose B, et al. Trauma and young people. Moving toward trauma-informed services and systems. . Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2018.
59. Orygen and Butterfly Foundation. Nip it in the bud: Young people and eating disorders. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.
60. NDIS. National dashboard as at 31 December 2018. NDIS; 2018.
61. AIHW. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: Australian Institute of Health and Welfare; 2011.
62. Knudsen HK. Adolescent-only substance abuse treatment: availability and adoption of components of quality. Journal of substance abuse treatment. 2009;36(2):195-204.
63. Centre for Multicultural Youth. Mind Matters: The mental health and wellbeing of young people from diverse cultural backgrounds. Melbourne, Victoria: CMY; 2014.
64. de Anstiss H, Ziaian T, Procter N, Warland J, Baghurst P. Help-seeking for mental health problems in young refugees: a review of the literature with implications for policy, practice, and research. Transcult Psychiatry. 2009;46(4):584-607.

65. Rickwood D, Telford N, Mazzer K, Anile G, Thomas K, Parker A, et al. Service Innovation Project Component 2: Social Inclusion Model Project. Melbourne: headspace National Youth Mental Health Foundation; 2015. Report No.: 0646920618.
66. Liebenberg L, A. UM. A comparison of service use among youth involved with juvenile justice and mental health. Children and Youth Services Review. 2014(39):117-22.
67. Griffiths KM, Mendoza J, Carron-Arthur B. Where to mental health reform in Australia: is anyone listening to our independent auditors? Med J Australia. 2015;202(4):172-4.
68. Victorian Ombudsman. Investigation into conditions at the Melbourne Youth Justice Precinct. Melbourne: Ombudsman Victoria; 2010.
69. Australian Institute of Criminology. Court-based mental health diversion programs. Canberra: Australian Government; 2011.
70. AIHW. Child protection Australia 2016–17. Canberra: Australian Institute of Health and Welfare.; 2018.
71. Herrman H, Humphreys C, Halperin S, Monson K, Harvey C, Mihalopoulos C, et al. A controlled trial of implementing a complex mental health intervention for carers of vulnerable young people living in out-of-home care: the ripple project. BMC psychiatry. 2016;16(1):436.
72. Rahamim A, Mendes P. Mental health supports and young people transitioning from out-of-home care in Victoria. Children Australia. 2016;41(1):59-68.
73. Campo M, Commerford J. Supporting young people leaving out-of-home care: Australian Institute of Family Studies; 2016.
74. Deloitte Access Economics. Raising our children: guiding young Victorians in care into adulthood. Socioeconomic cost benefit analysis. Report commissioned by Anglicare Victoria. 2016.
75. Baker D, Rice S. Keeping it real: Reimagining mental health care for all young men. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2017.
76. Department of Human Services. Medicare Item Reports. 2016.
77. AIHW. Access to Allied Psychological Services. Canberra: Australian Institute of Health and Welfare; 2015.
78. Ivancic L, Cairns K, Shuttleworth L, Welland L, Fildes J, Nicholas M. Lifting the weight: Understanding young people's mental health and service needs in regional and remote Australia. Sydney: ReachOut Australia and Mission Australia; 2018.
79. National Rural Health Alliance Ltd. The little book of rural health numbers. November 2015 Edition.: National Rural Health Alliance Lt; 2017.
80. Brown A, Rice SM, Rickwood DJ, Parker AG. Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. Asia Pac Psychiatry. 2016;8(1):3-22.
81. Donker T, Blankers M, Hedman E, Ljótsson B, Petrie K, Christensen H. Economic evaluations of Internet interventions for mental health: a systematic review. Psychological Medicine. 2015;45(16):3357-76.
82. Bradford S, Rickwood D. Adolescent's preferred modes of delivery for mental health services. Child and Adolescent Mental Health. 2014;19(1):39-45.
83. Mental Health Reference Group. MBS Taskforce Report from the Mental Health Reference Group. 2018.
84. Legal and Social Issues Committee. Inquiry into youth justice in Victoria. Victoria; 2018.
85. National Mental Health Commission. The National Review of Mental Health Programmes and Services. Sydney: NMHC; 2014.
86. headspace. [Available from: https://headspace.org.au/news/deep-dive-reveals-higher-numbers-of-young-people-struggling-with-unemployment-and-mental-health-difficulties/.
87. Caruana E, Cotton S, Farhall J, Parrish E, Chanen A, Davey C, et al. A comparison of vocational engagement among young people with psychosis, depression and borderline personality pathology. Community mental health journal. 2018;54(6):831-41.
88. AIHW. Australia's welfare 2017: Australia's welfare series no. 13. AUS 214. In: AIHW, editor. Canberra2017

89. ABS. Australian Social Trends. Year 12 Attainment. 2011.
90. Cavallaro T, Foley P, Saunders J, Bowman K. People with a disability in vocational education and training: A statistical compendium. Adelaide: National Centre for Vocational Education Research; 2005.
91. Karmel T, Nguyen N. Disability and learning: How much does the disability really matter? Adelaide: NCVER; 2008.
92. Stallman HM. Prevalence of psychological distress in university students--implications for service delivery. Aust Fam Physician. 2008;37(8):673-7.
93. QILT Social Research Centre. 2017 Student Experience Survey National Report. Australian Government; 2018.
94. Holloway EM, Rickwood D, Rehm IC, Meyer D, Griffiths S, Telford N. Non-participation in education, employment, and training among young people accessing youth mental health services: demographic and clinical correlates. Advances in Mental Health. 2018;16(1):19-32.
95. Edwards DM, J. Completing university in a growing sector: Is equity an issue? : Australian Council for Educational Research; 2015.
96. Hartley M. 'Increasing resilience: strategies for reducing dropout rate for college students with psychiatric disabilities'. American Journal of Psychiatric Rehabilitation. 2010;13(4):295-315.
97. Orygen Youth Health Research Centre. Tell them they're dreaming: work, education and young people with mental illness in Australia. 2014.
98. ACOSS. Voices of Unemployment: Result of an ACOSS survey of jobactive service users. 2018.
99. Martin JM. Stigma and student mental health in higher education. Higher Education Research & Development. 2010;29(3):259-74.
100. Golberstein E, Eisenberg D, Gollust SE. Perceived stigma and mental health care seeking. Psychiatr Serv. 2008;59(4):392-9.
101. Department of Social Services. Try, Test and Learn Fund – At-risk young people on income support. Australian Government; 2017.
102. Parliamentary Budget Office. Disability Support Pension: Historical and projected trends. Report no. 01/2018.: Commonwealth of Australia; 2018.
103. Davidson P. Did 'Work First' Work?: The Role of Employment Assistance Programs in Reducing Long-term Unemployment in Australia (1990-2008). Australian Bulletin of Labour. 2011;37(1):51.
104. Muir K, McDermott S, Gendera S, Flaxman S, Patulny R, Sitek T, et al. Headspace Evaluation Report Sydney, NSW: Social Policy Research Centre: University of NSW; 2009.
105. Rickwood D, Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., & McGorry, P. Australia's innovation in youth mental health care – the headspace centre model. Early Intervention in Psychiatry. 2018(doi:10.1111/eip.12740):1-8.
106. Frederick DE, VanderWeele TJ. Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. PLoS One. 2019;14(2):e0212208.
107. Modini M, Tan L, Brinchmann B, Wang MJ, Killackey E, Glozier N, et al. Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. Br J Psychiatry. 2016;209(1):14-22.
108. Killackey E, Allott K, Woodhead G, Connor S, Dragon S, Ring J. Individual placement and support, supported education in young people with mental illness: an exploratory feasibility study. Early Intervention in Psychiatry. 2016;DOI: 10.1111/eip.12344.
109. Kennedy V, Miyazaki K, Carbone S, Telford N, Rickwood D. The Digital Work and Study Service: Final Evaluation Report. Melbourne: headspace National Youth Mental Health Foundation; 2018.
110. Australian Government. Employment Services Outcomes Report: Disability Employment Services. April 2017 – March 2018. 2018.
111. Orygen, The National Centre of Excellence in Youth Mental Health. Under the radar: The mental health of Australian university students. Parkville, Victoria: Orygen; 2017.

112. Price Waterhouse Coopers. Creating a mentally healthy workplace. Return on investment analysis. PwC; 2014.
113. beyondblue and Price Waterhouse Coopers. Creating a mentally healthy workplace: Return on investment analysis. Price Waterhouse Coopers; 2014.
114. Luciano A, Drake RE, Bond GR, Becker DR, Carpenter-Song E, Lord S, et al. Evidence-based supported employment for people with severe mental illness: Past, current, and future research. Journal of Vocational Rehabilitation. 2014;40(1):1-13.
115. Ashwood J, Stein B, Briscombe B, Sontag-Padilla L, Woodbridge M, May E, et al. Payoffs for California College Students and Taxpayers from Investing in Student Mental Health. California: RAND Corporation; 2015.
116. AIHW. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Canberra: Australian Institute of Health and Welfare; 2016.
117. Kinchin I, Doran C. The cost of youth suicide in Australia. International journal of environmental research and public health. 2018;15(4):672.
118. Kinchin I, Doran CM, Hall WD, Meurk C. Understanding the true economic impact of self-harming behaviour. The Lancet Psychiatry. 2017;4(12):900-1.
119. Sari N, de Castro S, Newman FL, Mills G. Should we invest in suicide prevention programs? The Journal of Socio-Economics. 2008;37(1):262-75.
120. World Health Organisation. WHO Mortality Database. Geneva, Switzerland: WHO; 2016.
121. AIHW. Suicide and hospitalised self-harm in Australia: trends and analysis. Canberra: Australian Institute of Health and Welfare.; 2014.
122. Robinson J, McCutcheon L, Browne V, Witt K. Looking the other way: Young people and Self-harm. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.
123. Page A, Taylor R, Gunnell D, Carter G, Morrell S, Martin G. Effectiveness of Australian youth suicide prevention initiatives. Br J Psychiatry. 2011;199(5):423-9.
124. Suicide Prevention Australia. Position Statement: Mental Illness and Suicide. 2009.
125. Cosgrave EM, Robinson J, Godfrey KA, Yuen HP, Killackey EJ, Baker KD, et al. Outcome of suicidal ideation and behavior in a young, help-seeking population over a 2-year period. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2007;28(1):4-10.
126. Robinson J, Bailey E, Spittal M, Pirkis J, Gould M. Universal Suicide Prevention in Young People: An Evaluation of the safeTALK Program in Alice Springs High Schools. Final Report to the Lifeline Research Foundation. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health.; 2016.
127. Robinson J, Bailey E, Browne V, Cox G, Hooper C. Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2017.
128. Ashwood J, Briscombe B, Ramchand R, May E, Burnam M. Analysis of the Benefits and Costs of CalMHSA's Investment in Applied Suicide Intervention Skills Training (ASIST). RAND Health Quarterly. 2015;5(2).
129. Ahern S, Burke LA, McElroy B, Corcoran P, McMahon EM, Keeley H, et al. A cost-effectiveness analysis of school-based suicide prevention programmes. Eur Child Adolesc Psychiatry. 2018;27(10):1295-304.
130. Rickwood D, Telford N, Kennedy V, Bailey E, Robinson J. The Need For and Acceptance of a Suicide Postvention Support Service for Australian Secondary Schools2017. 1-11 p.
131. Comans T, Visser V, Scuffham P. Cost effectiveness of a community-based crisis intervention program for people bereaved by suicide. Crisis. 2013;34(6):390-7.
132. yourtown. Preventing Suicide by Young People: Discussion Paper. Boystown; 2015.
133. King CA, Eisenberg D, Zheng K, Czyz E, Kramer A, Horwitz A, et al. Online suicide risk screening and intervention with college students: A pilot randomized controlled trial. Journal of Consulting and Clinical Psychology. 2015;83(3):630-6.
134. Robinson J, Hetrick S, Cox G, Bendall S, Yuen HP, Yung A, et al. Can an internet-based intervention reduce suicidal ideation, depression and hopelessness among secondary school students: Results from a pilot study. Early Intervention in Psychiatry. 2014:No Pagination Specified.

135. Robinson J, Cox G, Bailey E, Hetrick S, Rodrigues M, Fisher S, et al. Social media and suicide prevention: a systematic review. Early Interv Psychiatry. 2016;10(2):103-21.
136. Orygen, The National Centre of Excellence in Youth Mental Health. National Youth Mental Health Workforce Strategy: 2016-20. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.
137. Carbone S, Rickwood D, Tanti C. Workforce shortages and their impact on Australian youth mental health service reform. Advances in Mental Health. 2011;10(1):92-7.
138. ConNetica. Queensland NGO Mental Health Sector Workforce Profile & Analysis Report 2009. 2009.
139. Workplace Research Centre. Identifying patterns to skills growth or skills recession: Decisions for workforce development in the community services and health industries. Surry Hills NSW: Community Services and Health Industry Skills Council; 2008.
140. Andrews G, Titov N. Changing the face of mental health care through needs-based planning. Australian Health Review. 2007;31:S122-S8.
141. Repper J, Carter T. A review of the literature on peer support in mental health services. Journal of Mental Health. 2011;20(4):392-411.
142. Lawn S, Smith A, Hunter K. Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. Journal of Mental Health. 2008;17(5):498-508.
143. Fava N, O'Bree B, Randall R, Kennedy H, Olsen J, Matenson E, et al. Building a strong and supported youth peer workforce. In: Fong T, Stratford A, Meagher J, Jackson F, Jayakody E, editors. Peer Work in Australia: A New Future for Mental Health: Flourish Australia; 2018.
144. Batterham PJ, McGrath J, McGorry PD, Kay-Lambkin FJ, Hickie IB, Christensen H. NHMRC funding of mental health research. Medical Journal of Australia. 2016;205(8):350-1.
145. Kwan B, Rickwood DJ. A systematic review of mental health outcome measures for young people aged 12 to 25 years. BMC Psychiatry. 2015;15:279.

Attachment 1: How the recommendations can contribute to four key goals.

Recommendation	Goal 1: Better priority setting in health	Goal 2: Technical efficiency in mental health programs	Goal 3: Co-financing of youth mental health services from non-health sectors	Goal 4: Supportive fiscal policy
Recommendation One Future youth mental health investment should be directed to strengthen and extend access to headspace, the Australian Government's national platform for youth mental health care.	√		√	
Recommendation Two Governments provide greater sustainability and security of funding for youth mental health services, such as the headspace platform, including longer funding cycles and consumer price indexation.	√	√	√	
Recommendation Three Develop and implement a comprehensive and enhanced model of youth mental health care, augmenting the existing headspace platform to provide: a) better care for young people with more severe and complex conditions (the 'missing middle') and b) better respond to local service demand and priority populations such as Aboriginal and Torres Strait Islander young people.	√		√	
Recommendation Four Future commissioning of youth mental health services and programs by Primary Health Networks (PHNs) to include oversight by headspace National and Orygen to ensure evidence-based commissioning and to protect the integrity of the headspace platform.	√	√		

Recommendation Five Urgently update the Medicare Benefits Schedule (MBS) to provide items that support evidence-based treatment dose and duration for young people aged 12-25 years.	√			
Recommendation Six Consolidate and further develop the evidence base for the multitude of digital mental health services so that they can be scaled-up and appropriately integrated with face-to-face service provision.	√	√		
Recommendation Seven Governments to bolster mental health services and awareness programs targeting key priority populations of young people with an increased risk of mental ill-health and low service engagement. In particular, there should be greater investment to enable mainstream services to engage with Aboriginal and Torres Strait Islander young people and their communities to make it safe and more secure for them to seek help.	√		√	
Recommendation Eight Increase access to vocational support programs such as Individual Placement and Support (IPS) and Digital Work and Study Service (DWSS) within youth mental health services including in all headspace services.	√		√	
Recommendation Nine Develop and fund workplace mental health approaches to increase mental health literacy and promote workplace approaches to supporting ongoing engagement in employment for young people.	√		√	

Recommendation Ten Develop and implement education and training settings-based approaches across schools, vocational and tertiary institutions to prevent early exit from education and to enable re-engagement with education for young people experiencing mental ill-health.	√		√	
Recommendation Eleven Make suicide prevention a focus for all settings and services engaged with young people, including schools, primary care services, mental health services and hospital emergency departments.	√		√	
Recommendation Twelve Develop a real-time surveillance system with standardised data collection and reporting for suicide and suicide-related behaviour.	√		√	
Recommendation Thirteen Build the capacity and supply of a youth mental health workforce with the skills and motivation to provide engaging, high quality and evidence-based care to young people.	√	√	√	
Recommendation Fourteen Address barriers, including job insecurity and poor incentive design, for the recruitment and retention of the youth mental health workforce.	√	√		
Recommendation Fifteen Ensure major youth mental health service platforms, like headspace, are harnessed as clinical research platforms to develop and test new prevention, early intervention and treatment modalities and interventions.		√		

Recommendation Sixteen Regularly collect and report national data, including epidemiological and health service data on the mental health and wellbeing of young people aged 12-25 years in Australia.		√		√
Recommendation Seventeen Invest in economic research in youth mental health to help achieve fairer allocation of the health budget for young people's mental health needs, do more with the allocated budget, co-finance youth mental health supports from sectors beyond health, and inform fiscal policy responses that underpin the mental wellbeing of young people.	√	√	√	√