Youth Mental Health submission to the Productivity Commission inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

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1.0 Introduction

Youth Mental Health, North Metropolitan Health Service (NMHS), Department of Health, Western Australia involved carers, young people and staff in the review of the Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health.

The response focused on key areas that are important for young people and their families. A number of personal stories are provided within this response.

2.0 Inquiry scope and relationship to other reviews

2.1 Young people

It is noted that the inquiry scope intends to include young people (see page 5 of the *Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health (January 2019)* as one of the focus areas where there are the largest potential improvements.

Mental health, alcohol and other drug disorders account for over 50% of the burden of disease in young people aged 15 to 25[1], and 75% of mental health problems that affect people across the lifespan emerge for the first time by age 25[2]. Young people with significant functional impairment and distress often present seeking care with evolving, unclear, or mixed mental health symptoms[3]. Psychiatric diagnostic systems commonly used in Adult mental health services are limited in their application to these young people, which results in many receiving no care or suboptimal care.

Arising from these issues, there needs to be a dedicated youth mental health stream across Australia to reduce structural and systemic barriers to effective service delivery for this age range. Supporting continuity of care by providing accessible and developmentally appropriate mental health services through this critical age range can dramatically improve outcomes across the life span[4,5] and reduce the adverse economic impact of mental health problems[6]. Maintaining people in their roles for work/study is a critical success factor. Dedicated youth mental health services diminish stigma, are inclusive of diversity, aid diagnostic clarity and support integration with other services and sectors[7,8].

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[1] Australian Institute of Health and Welfare. Young Australians: their health and well-being 2007. Canberra: AIHW, 2007.

[2] 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;62:593–602.

[3] Cross SPM, Hermens DF, Scott EM, Ottavio A McGorry PD & Hickie IB (2014) A Clinical Staging Model for Early Intervention Youth Mental Health Services. Psychiatric Services July 2014 Vol. 65 No. 7, 939-943.

[4] McGorry P and Goldstone S (2011) Is this normal?: Assessing mental health in young people. Australian Family Physician, 40(3), 94-97.

[5] Abidi S (2017) Paving the Way to Change for Youth at the Gap between Child and Adolescent and Adult Mental Health Services. The Canadian Journal of Psychiatry, 62(6) 388-392.

[6] Boston Consulting Group (2006). Improving Mental Health Outcomes in Victoria - The Next Wave of Reform. July 2006.

[7] WA Health (2011) A Better Deal for Youth Mental Health: Prevention Meets Recovery. A collaborative approach to development of youth mental health services in WA.

[8] Western Australian Association for Mental Health (WAAMH), Report on the Youth Mental Health Services Integration Project, WAAMH, Perth October 2018.

Youth Mental Health (NMHS) Department of Health, Western Australia supports the focus on young people as there is significant potential to improve economic outcomes across the lifespan if young people receive appropriate care

 "*For years I have grieved for the things I lost due to mental illness – friends, family, experiences, happiness and hope. At 16 I gave up, I was certain that my life had come to its end that I had nothing to live for and no reason to fight… something changed when I moved into Ngatti House. Ngatti House did not save my life, instead it helped me save myself, for this I am forever grateful. I have hope now, I have dreams back… I'm not afraid anymore. (Mental Health Advisory Council – Youth Mental Health Report 2017)*
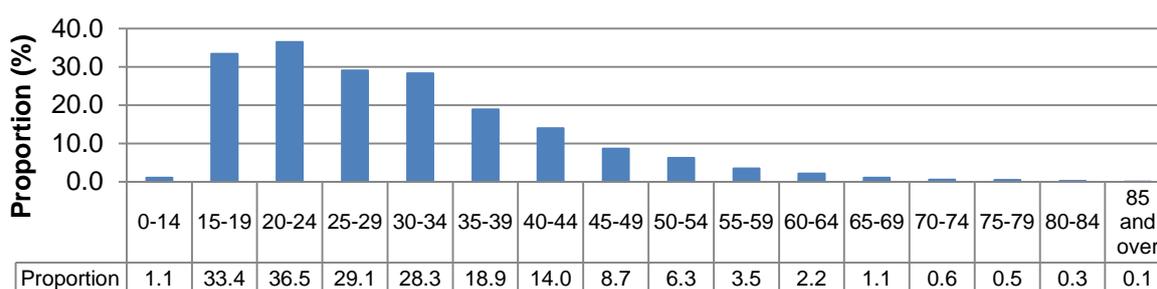
2.2 The economic cost of suicide

Youth Mental Health notes that suicide results in a profound direct and indirect economic cost. In 2017, in Australia:

- Deaths from suicide increased 9.1% from 2016.
- The 2017 preliminary standardised death rate was 12.6 deaths per 100,000 people and was equal with 2015 as the highest rate in the past 10 years.
- Suicide was the leading cause of years of potential life lost (YPLL) in 2017, contributing 11.4% of total YPLLs.
- Suicide was the most likely cause of death for males, with 301 male deaths for every 100 female deaths.
- The suicide death rate was 2.0 times higher in Aboriginal people (25.5 per 100,000 people for Aboriginal people compared to 12.7 per 100,000 for non-Aboriginal people)[9].

Suicide consistently accounts for a higher proportion of total deaths for 15-19 and 20-24 year olds than for other age groups (see Figure 1) and for a higher proportion of total deaths for males than for females aged 15-24 years (see Figure 2)[10].
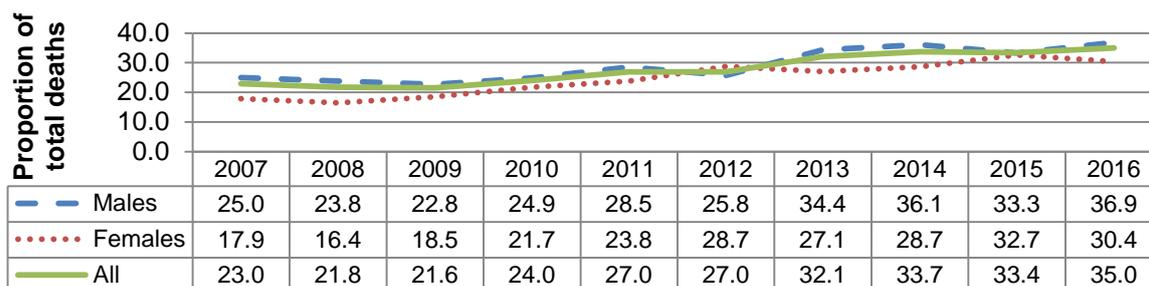
Figure 1: Proportion of total deaths due to suicide in Australia, 5 year age groups, 2016.

	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over
Proportion	1.1	33.4	36.5	29.1	28.3	18.9	14.0	8.7	6.3	3.5	2.2	1.1	0.6	0.5	0.3	0.1

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[9] Australian Bureau of Statistics (2018) 3303.0 Causes of Death, Australia, 2017. LATEST ISSUE Released at 11:30 AM (CANBERRA TIME) 26/09/2018. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/0/47E19CA15036B04BCA2577570014668B?Opendocument.
[10] AIHW Deaths Web report. Last updated: 07 Feb 2017. Available from: https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death
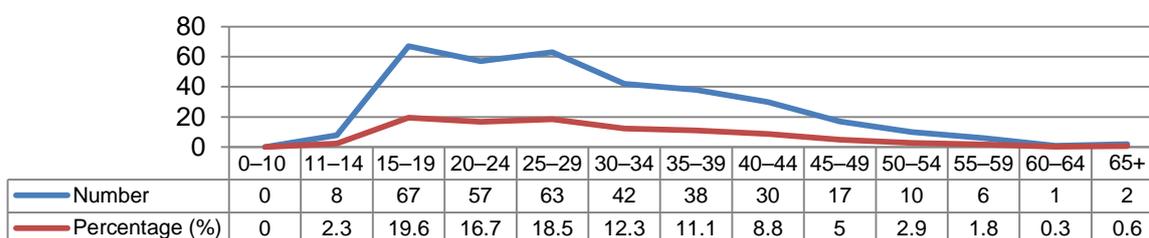
Figure 2: Proportion of total deaths due to suicide in Australia for 15-24 year olds by sex, 2007-2016.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Males	25.0	23.8	22.8	24.9	28.5	25.8	34.4	36.1	33.3	36.9
Females	17.9	16.4	18.5	21.7	23.8	28.7	27.1	28.7	32.7	30.4
All	23.0	21.8	21.6	24.0	27.0	27.0	32.1	33.7	33.4	35.0

In 2017, Western Australia had the third highest overall death rate (15.8 per 100,000 people) due to suicide compared to other states and territories in Australia and the highest age-standardised death rate (38.5 per 100,000 people) due to suicide for Aboriginal people.

Consistent with these figures, the Western Australian suicide prevention strategy, *Suicide Prevention 2020: Together we can save lives*, identifies suicide as the main cause of preventable death for adolescents[11] and notes that the 2014 State Ombudsman's investigation into suicide deaths of 36 young people aged 13-17 years found that Aboriginal young people made up 36% of suicide deaths, yet constitute only 6% of the youth population in Western Australia[12]. Further to this, a closed submission to the parliamentary inquiry into Aboriginal youth suicide in remote areas shows that between 2006 and 2016 inclusive, 36.3% of suicide deaths in Aboriginal people were in young people aged 15 to 24 years[13] (see Figure 3).

Figure 3 Deaths due to suicide for Aboriginal people by age range in WA, 2006-2016.

	0–10	11–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
Number	0	8	67	57	63	42	38	30	17	10	6	1	2
Percentage (%)	0	2.3	19.6	16.7	18.5	12.3	11.1	8.8	5	2.9	1.8	0.3	0.6

The increasing trend in suicide for youth is matched by exposure to suicide attempts by those they know (see Figure 4)[14]. A review of emergency department mental health attendances for youth (16 to 24 years) in 2013-2014 and 2014-15 found that the top presenting symptom was suicidality (see Figure 5)[15]. Providing young people with accessible and developmentally appropriate acute community treatment services has the potential to save lives.

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[11] Suicide Prevention 2020: Together we can save lives.

[12] Ombudsman Western Australia. Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people. In: Investigations TPCfA, editor. 2014.

[13] Western Australian Education and Health Standing Committee (2016) Learnings from the message stick: the report of the Inquiry into Aboriginal youth suicide in remote areas Perth, WA: Parliament of Western Australia.

[14] Health and Wellbeing Surveillance System, Mental Health of Young Adults 2006-07 and 2014-15 Department of Health (2016).

[15] Dragovic M, Piscitelli A, and Donnellan A. (2017) Planning for Youth Mental Health Services Mental Health Attendances at Hospital Emergency Departments 2013/2014 and 2014/2015. North Metropolitan Health Service, Mental Health Public Health and Ambulatory Care.

Figure 4: Exposure to suicide attempts 2014-2015.

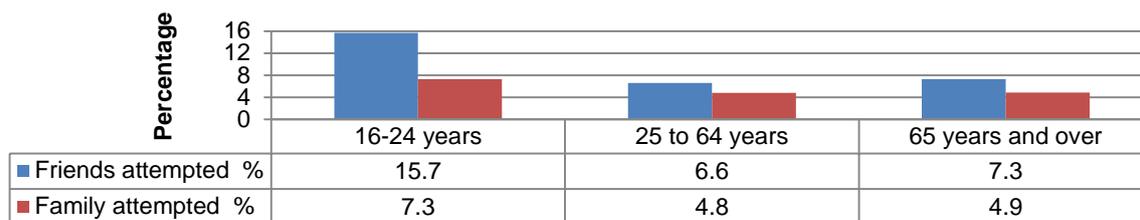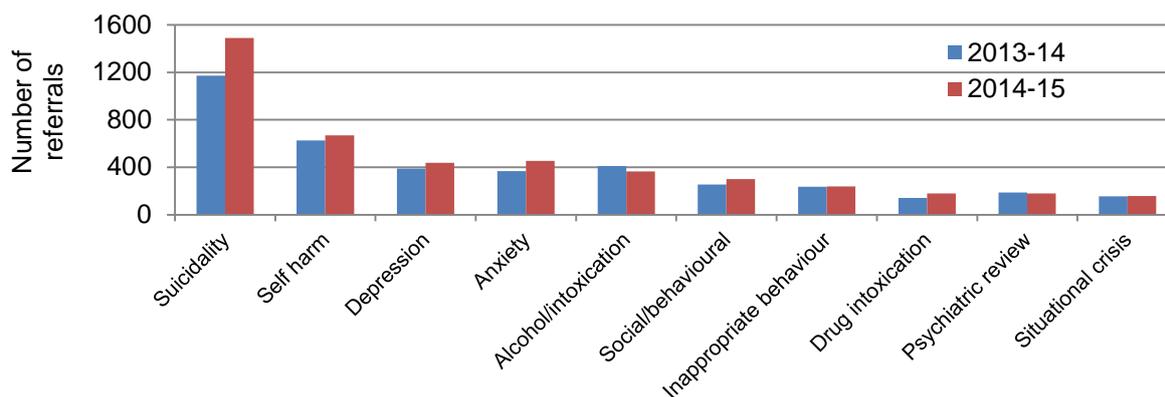| Percentage	16-24 years	25 to 64 years	65 years and over
Friends attempted %	15.7	6.6	7.3
Family attempted %	7.3	4.8	4.9

Figure 5: Top ten presenting symptoms for youth (16 to 24 years) mental health attendances to emergency departments in metropolitan Perth, 2013-14 and 2014-15.

Mood disorders, including depression, were the most common (present in 43.0% of suicide deaths). Five of the top seven co-occurring conditions across all ages were related to mood and mental health.

In Western Australia:

- In 2017, deaths from suicide increased 10.2% from 2016[16].
- Western Australia has the highest rate of suicide deaths for Aboriginal[17] people of any Australian state or territory. Young people aged 15 to 24 years account for the highest proportion (36.3%) of these deaths[18].

2.3 Co-occurring conditions

Youth Mental Health also supports the inclusion of co-occurring conditions (such as substance use disorders and Autism Spectrum Disorders/neurodevelopmental disorders) in the scope of this review.

Neurodevelopmental disorders are often not recognised or are misdiagnosed and can complicate mental health intervention. The cost of accessing specialist assessment neuropsychological testing through the private sector is prohibitive. A frustration for many consumers and their families and carers is that they cannot even get on the waiting list for public specialist assessment services without a recognised

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[16] Australian Bureau of Statistics (2018) 3303.0 Causes of Death, Australia, 2017. LATEST ISSUE Released at 11:30 AM (CANBERRA TIME) 26/09/2018. Available from:
http://www.abs.gov.au/ausstats/abs@.nsf/0/47E19CA15036B04BCA2577570014668B?Opendocument.
[17] Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community (OD0435/13).
[18] Western Australian Education and Health Standing Committee (2016) Learnings from the message stick: the report of the Inquiry into Aboriginal youth suicide in remote areas Perth, WA: Parliament of Western Australia.

pre-existing condition. Lack of effective access to specialist assessment can hamper access to financial benefits for treatment and support (e.g. National Disability Insurance Scheme).

Intellectual disability and other neurodevelopmental disorders such as Foetal Alcohol Spectrum Disorder (FASD) and Attention Deficit and Hyperactivity Disorder (ADHD) and processing disorders need to be included as co-occurring conditions. The findings of a recent study highlight the adverse economic impact of inadequate access to assessment.

The study of young people in detention in Western Australia's justice system found that 89% had at least one domain of severe neurodevelopmental impairment, and 36% were diagnosed with Foetal Alcohol Spectrum Disorder (FASD). Only two young people had been diagnosed with FASD prior to participation in this study. For many of the young people, participation in the study was the first time they had received a comprehensive assessment to examine their strengths and difficulties despite attending school and, in many cases, prior engagement with child protection services and the justice system. This reflects missed opportunities for earlier diagnosis and intervention which may have prevented or mitigated their involvement with resource-intensive justice services.

Carer's Story:

My son developed anxiety/depression/PTSD when he was bullied in primary school because of a medical condition. At that age and stage, I was able to pick him up when he was experiencing anxiety and carry him into the school, where he would sit in the Principal's office for up to an hour calming himself before he could face the day. In high school, I could no longer carry him into school as that would shame him and there was a lack of a supportive someone to help him start his day.

Over a period of two years his attendance dropped to 60% and eventually it just became too hard to continue with 'normal' school because he simply did not want to be there. He cited his reasons as being, *"No-one understands"; "Teacher's shame me"; "I can't concentrate in class"; "I get in trouble if I fidget"; "Other kids don't like me"*; and *"They call me names."*

I then tried home school but he struggled to engage with online learning resources. We tried re-engaging with mainstream school with the support of Child and Adolescent Mental Health Services (CAMHS), but initially they sent him to distance education because it was too late in the year to join a class group. Once again, this didn't work because of he couldn't engage with online resources.

He then tried participating in that school the following year, but to quote the CAMHS School Liaison Officer, *"This is excruciating"* relating to the depth of despair he was feeling. Surrounded by six adults all trying to work out how to help him, through his tears he reported feeling like a 'ghost' as people looked straight through him and didn't connect with him.

We then tried two different alternative education (private) but we had no success because the first program they thought he was too difficult to manage in a small group setting because his needs were too high, so they transferred him to their distance education program and once again he struggled to engage online. The truth is the schools were ill equipped to deal with a child who is well behaved, intelligent,

but has mental and physical health needs that require individual support.

It was then that CAMHS ran some neuroscience testing – WISC and CONNORS. Through these we discovered a significant deficit in processing speed and potentially ADHD (currently being assessed), which explained his inability to participate in classroom and online activities without significant support and understanding.

Finally, we tried a mainstream high school with an alternative education program, catering for 16 plus age group. His older sister, who also has a diagnosis of anxiety/depression due to complex trauma, had achieved success at that school after an interrupted high school experience and trying a range of different educational options. As my son was now old enough to enrol at the school, we tried it.

He entered the Year 11 bridging program, which is specifically designed to support students who slip through the gaps of normal schools for whatever reason. The school has a very strong student support service, with psychology and nursing staff, as well as, social support services. His class has a teacher, an education support worker and a teacher's assistant. It has a program that integrates a Cert II in Volunteering qualification into the program, life skills development (cooking etc) and the basic essentials of maths and english, plus technology skills and a few others. The room has a time out zone for anyone who is not coping and students are encouraged to make use of the zone. The school is also more relaxed in relation to non-attendance, as it focuses its attention on celebrating the small recovery wins of students, which is a major relief as a parent and student. We finally feel like we can breathe because the school gets it!

On reflection, there were several failures in my son's case:

- The lack of support for the transition to high school was a crucial failure in ensuring my son's success in education.
- The lack of clear diagnosis of his medical condition and learning disability, which were initially treated as behavioural issues, greatly impaired his life. He didn't receive a diagnosis of 'slow transit' causing chronic constipation until 10 years of age. This meant her enduring 10 years of constipation and being treated like he was a naughty child. He also didn't receive a diagnosis of his learning disability until Year 10, despite my telling his GP, his Paediatrician, his teachers etc that something was not right from the time he was a toddler.
- The lack of flexibility in the education system. The lack of flexibility on curriculum results in students like my son, not being able to participate in accordance with their capacity to learn. Ie. lack of part-time study options means that if a student is unable to cope with a full-time load due to mental or physical illness there is this continual sense of failing plus additional stress on the family, which embeds a lack of hope, causes tension and stress in the family dynamics and damages the self-worth of the young person.

The changes that would make a difference for young people like my son are:

- School programs like this being more readily available and well-advertised. This school has no geographical boundaries, allowing access to all potential students.

- Screening to ensure earlier diagnosis of learning disabilities. An earlier diagnosis of his learning disability would have made a significant difference to his educational outcomes.
- Removing the barriers to access to neurological testing for low income earners. Currently you must have co-occurring significant diagnosis (ie. epilepsy, etc). My son was referred by his GP for this investigation when he was 10, however was knocked back by public services (Neurosciences). (Hayley, Carer).

2.4 Trauma-informed treatment and support

The economic impact of trauma needs to be included in the scope of this inquiry. Trauma-informed and trauma-based competencies are needed in mental health and alcohol and other drug services.

Child Protection and Family Services (CPFS) in Western Australia cut off at 18 years of age. Transitional leaving care support services (pp. 23 and 25) are needed up to age 25.

"Children leaving the care of CPFS have significant needs including mental health. They are a vulnerable population in which there is not adequate care provision presently. As a result they have an increased risk of homelessness, higher mental health needs, lower employment rates and are a high proportion of the adult justice system. The transition from Child and Adolescent Mental Health Service to the Adult Mental Health Service could be improved" (Youth Mental Health Snapshot Survey; Youth Mental Health Sector, 2017)

Public mental health services across Australia use the National Outcomes and Casemix Collection (NOCC). NOCC measures are limited in their measures of social determinants of mental health/well-being. Greater evaluation of social connection/participation, housing, employment and education is required. These need to be strengthened in the outcome measures used by mental health services.

3.0 Specific health concerns

Accessibility and affordability of GP appointments for young people.

Acute mental health assessments are a gap. A service response is required that enables GP's to refer young people for an acute assessment within 24 hours. Alternative referral pathways to Emergency Departments (ED) are required to facilitate early case identification.

There is a gap in communication to consumers and carers and family members about how to navigate care pathways. Mental health literacy is also required for consumers and carers.

In the United Kingdom (UK) some areas have implemented a crisis concordat that provides an agreement that all services in an area will provide a response. The UK has also implemented crisis cafes, improving accessibility to crisis support and diversion from ED. Some of this is peer led.

Separate triage system at hospital ED's to enable mental health presentations to be assessed and managed separately from the general health sector would also be beneficial to consumers and carers.

Youth Mental Health also recognise the impact of metabolic syndrome arising from medication use, and increase in self-poisoning rates using psychotropic medications in children/youth[19].

Indigenous mental health service responses need to be enhanced. An Aboriginal workforce needs to be integrated as a core component of the multidisciplinary team. Mental health services need to prioritise the service needs of Aboriginal people as a priority in service design. Although they are a small percentage of the overall population, they are a greater percentage of the mental health consumers.

4.0   Housing and homelessness

Housing is an important focus area. The WA Independent Living Program and Foyer Oxford models are exemplars of effective housing models for young people and people with a mental illness. The provision of psychosocial support integrated with stable accommodation has been demonstrated to have efficacy.

Co-occurring Alcohol and Other Drug (AOD) and mental health problems are a barrier to accessing stable accommodation and community sub-acute services where alcohol and other drug use is prohibited. There is a need for services that can address both AOD and mental health problems simultaneously.

Permanent housing is also needed for homeless people with mental health problems.

Continuity of care for transient consumers with mental health problems across catchment areas is required. Integrated health records could improve health service delivery to transient consumers.

The Housing first model is effective in maintaining housing for 15-24 year olds.

 "B*eing homeless made me feel pathetic and worthless to the point of 17 suicide attempts…I'm no longer homeless, and my sense of wellbeing has improved greatly. Not being homeless has made me feel secure and safe." (Mental Health Advisory Council – Youth Mental Health Report 2017)*

5.0   Social services

There are no alternative human services income support streams. You are either on a pension or on a job seeker allowance. Young people with mental health problems or disorders need to have access to social supports that enable them to engage in treatment and support. The current welfare system doesn't cater well for episodic illnesses, and doesn't cater well for carer needs.

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[19] Cairns R, Karanges EA, Wong A, *et al.* Trends in self-poisoning and psychotropic drug use in people aged 5–19 years: a population-based retrospective cohort study in Australia. *BMJ Open* 2019; 9:e026001. doi:10.1136/ bmjopen-2018-026001

This system is insensitive to holistic needs of family systems, is inflexible and is oriented to physical conditions not mental health conditions. A job seeker service who is paid for outcomes may not deliver client-centred services and may not lead to positive and enduring outcomes in terms of job placement.

Accessing Centrelink under the age of 24 is very difficult. Leaving a traumatic/problematic family home environment is difficult if parents won't complete the form to endorse 'unreasonable to live at home' allowance or they don't meet the criteria.

Carers Story:

Our family has experienced an enormous amount of stress due to the current inflexibility in the Human Services system in catering to the holistic needs of families experiencing episodic mental illness. As a parent with five family members (partner and 4 young adults/teenagers) who are periodically unwell, my mutual obligations to work are often hindered by call outs to transport to appointments, respond to emergencies or provide support by staying with the individual.   This has significantly impacted on our quality of life and economic opportunities. It has also meant that I am reliant on being in the social welfare system, as I occasionally require support to top up work payments.

At times I have had to ask my doctor for a medical certificate to get some time out from the system as it becomes overwhelming. The demands of job networks to sign contracts agreeing to do 20 job searches a month, when you are already working to capacity and caring on top of that, as well as, volunteering in the community has almost tipped the bucket for me.

I have also observed my young people and at times they have been really distressed by their interactions with job networks. What should be a 50:50 relationship often ends up being more like an 80:20, with the young person doing all the leg work and being let down when the job network fails to record information accurately, resulting in suspension of payments or having to resubmit information. It gives the appearance of being all about the job network making money off the young person without really caring for them holistically.

From our perspective, there needs to be a more responsive system, with alternative income support payments for psycho-social disability and the stigma of 'dole bludgers' removed from people who are genuinely making an effort to contribute but are at capacity due to caring responsibilities or their mental health illness. Barriers need to be identified and a person-centred approach to planning how to address those barriers negotiated with the person having their voice heard. (Hayley, Carer)

6.0 Justice

Start Court is an example of a court diversion service aimed at breaking the cycle of offending and mental health.

There are gaps in the mental health consultation liaison services to prisons. There are no forensic youth beds in WA and a paucity of specialist community clinical follow-up services for people exiting prison.

Multi Systemic Therapy is effective in intervening with young people who are demonstrating behaviours leaving them at risk of offending. Young people in the justice system are not well connected to valued roles. The social determinants of mental well-being need to be addressed. Effective alternatives to incarceration are needed.

Cyril Jackson Senior Campus has an effective model for intervening with young people with externalising behaviours and has site-based services on campus. It partners closely with other services such as Child and Adolescent Mental Health Services (CAMHS) and Juvenile Justice. In Year 11, there is a bridging program for young people who do not benefit from mainstream education models.

Primary health/GPs have a lack of understanding of externalising behaviours in children and adolescents. System navigation support is needed.

Young Persons Story:

My life was out of control. I was cutting myself, stealing, running away from home, threatening to kill myself, vandalising property, doing drugs. My mum kept trying to get me help. Private rehabs, alternative school programs, counselling, etc but nothing really worked for me. She sent me to Esperance to Teen Challenge, which lasted 5 days before I ran away.

Eventually I moved out to live with my boyfriend at 16. It was around this time that she talked to me about Cyril Jackson SHS. It sounded alright so I gave it a go. At Cyril Jackson I found myself. I had the best teacher ever, who was like my second mother. The arts community embraced me. Even though I was struggling and didn't attend all the time because of what was going on in my home life with my partner. My teacher just believed in me and told me to keep trying.

I still have a long way to go to address my complex trauma, as I was a victim of domestic violence with my boyfriend. I now have a job, my Cert III in Visual Arts and Cert II in Hospitality and I have found a good Clinical Psychologist who is helping me to rebuild my life after I left that relationship. (Anon, 20)

7.0   Coordination and integration

Consistent with the stated scope of the inquiry, Youth Mental Health supports the need for services to work together to provide a coordinated service response to adequately meet the needs of people presenting with these conditions. Whole-of-government responses that reduce barriers for integrated service delivery to meet the social determinants of mental health are critical to realising economic benefit and minimising the potential human cost.

The current service system is fragmented and confusing with no single entry point. Mental health services need to support people to access appropriate support services. Mental health services need a 'no wrong door' approach and 'one stop shop' approach.

Effective service integration facilitates a seamless pathway for the patient through the different parts of the mental health system. It depends on good communication at

the interface between services, particularly around referral, admission, transfer and discharge. To be sustainable, an integrated approach to service delivery needs to be underpinned by opportunities for professionals from different backgrounds to train and learn together[20].

Effective service integration can also facilitate patient flow and help minimise the 'access block' that can be so problematic in facilitating timely access to treatment and support. 'Patient flow' refers to the ability of healthcare systems to manage patients effectively in an appropriate treatment environment and with minimal delays as they move through stages of care. One of the consequences of poor flow is that patients are admitted to services that are not best suited to manage their care, which may mean they have worse clinical outcomes and correspondingly worse economic outcomes. [21]

"…more comprehensive youth services across the continuum of care (rather than child and adolescent and adult services), and better transition between services so people don't fall through the gaps". (Youth Mental Health Snapshot Survey; Youth Mental Health Sector 2017)

7.1 Least restrictive mental health care

Finally, good information flow between services can increase the likelihood of patients receiving appropriate treatment and support, aiding least restrictive mental health care. This is critically important as restrictive practices have long been recognised to have the potential to result in significant adverse and traumatic consequences for patients and staff[22][23], and raise concerns regarding human rights breaches[24]. These adverse effects include physical and psychological harm to both patients and staff and instances of sudden death in both Australia and internationally[25][26][27][28][29]. For example, the Victorian Department of Health's framework for reducing restrictive interventions provides a case study that illustrates the effectiveness of establishing linkages and protocols for information sharing and

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[20] International Journal of Integrated Care – Vol. 5, 3 October 2005 – ISSN 1568-4156 – http://www.ijic.org/ Integrated mental health services in England: a policy paradox?

[21] NHS Good practice guide: Focus on improving patient flow July 2017 Beckett D (2014) Boarding: Impact on patients, hospitals and healthcare system. Available from: www.acutemedicine.org.uk/wp-content/uploads/2014/11/Plenary-5-1030-Wrong-Place-Anytime-Why-Boarding-is-Bad-for-Patients-Hospitals-and-Healthcare-Systems.pdf

[22] Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvegeot JA, and Cousins VC. (2005) Patients' reports of traumatic or harmful experiences within a psychiatric setting. Psychiatric Services, 56, pp.1123-1133.

[23] Gerace A, Pamungkas DR, Oster C, Thomson D. and Muir-Cochrane E. (2014) 'The Use of Restraint in Four General Hospital Emergency Departments' Australasian Psychiatry', Australasian Psychiatry, 22(4), pp. 366-369.

[24] Kumble S and McSherry B. (2010) 'Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective', Psychiatry, Psychology and Law, 17(4), pp. 551-561.

[25] Coroner's Court of WA (2011) Record of Investigation into Death: Warwick Andrew Ashdown. Ref No: 25/11.

[26] Coroner's Court of NSW (2011) Coronial Inquest into the Death of X.

[27] Substance Abuse and Mental Health Services Administration (2010) Promoting Alternatives to the Use of Seclusion and Restraint: making the business case. Issue brief #4. Rockville: US Department of Health and Human Services.

[28] Substance Abuse and Mental Health Services Administration (2011) The Business Case for Preventing and Reducing Restraint and Seclusion Use. Rockville: US Department of Health and Human Services.

[29] Duxbury J (2015) Minimising the use of coercive practices in mental health: the perfect storm. Journal of Psychiatric and Mental Health Nursing 22, pp. 89-91.

working with multiagency input to support minimally restrictive care for patients with autism spectrum disorders and intellectual disability[30].

7.2 Policy and governance

Government needs to take a leadership role to support integrated, whole-of-government approaches to meeting the needs of people with mental health conditions. This can be achieved through creating policy and governance structures in government services that support coordination and integration[31]. Engagement across consumers, carers, clinicians, communities and organisational management is required to deliver sustainable and effective services.

Intergovernmental relationships need to be strengthened to ensure effective service response in transitions between services for people presenting with mild to moderate mental health problems (typically funded by the Commonwealth government) and those presenting with severe mental health problems (typically funded by the State government).

Within public mental health services, consistent criteria and service levels are needed across all jurisdictions to reduce duplication and improve consistency and continuity of response.

Simplifying governance can also help in coordinating service delivery in a client-centred way. For example, there is recognition that a dedicated youth mental health service stream can facilitate coordination and integration of services for this target age group[32] [33]. A dedicated mental health program for youth with a jurisdiction across the whole of metropolitan Perth working in partnership with community agencies would improve coordination and integration within health and across sectors. In Western Australia, the Alcohol and Other Drug and Mental Health sectors are governed and funded separately. They need to be integrated (for example, New South Wales has integrated these sectors).

Currently, Youth Mental Health fosters coordination and integration by undertaking youth sector capacity building. It provides training to enhance the knowledge and skills of those in the community sector working with young people.

In 2017, Youth Mental Health undertook a major sector-wide survey to determine and prioritise the training activities it delivers to workforce in the youth, accommodation, education and mental health sectors (both government and non-government). Based on its findings, future training will be delivered at Introductory and Advanced skill levels. Youth Mental Health provides an annual calendar of training to the community sector including: Working with People with Complex Trauma; Personality Disorders; Diverse Sexuality and Gender; Risk Assessment and Management of Suicide and Self-harm; Managing Aggression and Difficult Behaviours; and Working with ATSI Young People.

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30 Victorian Department of Health (2013) Providing a safe environment for all: Framework for reducing restrictive interventions. Mental Health, Drugs and Regions Division; Melbourne; Victoria.
[31] Working Together: One Public Sector Delivering For WA. October 2017. Final Report To The Western Australian Government Service Priority Review.
[32] Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health by Professor Bryant Stokes (2012)
[33] Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission.

8.0 Funding arrangements

8.1 Activity based funding

The activity-based funding model for health services is not well suited to the characteristics of mental health service delivery. A funding structure that addresses the social determinants of mental health and well-being is needed. This needs to be sensitive to and support integration with support services that can respond to the impact of mental health on education/social support needs. As noted in section 10.0, *Coordination and integration*, this would support a more whole-of-government and whole-of-person approach.

Supported education and employment are needed in addition to income support payments. This would reduce income support payments in the longer term.

Inadequate Medicare benefits for mental health services. Medicare benefits need to be predicated on evidence base treatment. The short-term nature of funding to many community organisations has adversely impacted service continuity and development, depth of expertise and experience in specific focus areas.

The introduction of the NDIS has adversely impacted continuity of funding and service delivery for people with severe and enduring mental illness. Its funding model has not supported a well-organised system across the longer term.

8.2 Procurement, contracting and recruitment

Procurement and contracting processes can also foster greater coordination and integration. For example, competitive tendering processes can be managed sensitively to foster consortiums and cooperation rather than competition.

Consumers and carers need to be more proactively involved in decision-making about commissioning and procurement of services; and consumer and carer satisfaction needs to inform future funding decisions. Independent mechanisms for commissioning bodies to evaluate consumer and carer satisfaction are needed.

Short term contracts for community organisations have prevented their continuity of service delivery. Improved support to community services to help them build robust services and governance systems and ensure they meet key performance indicators is needed.

Temporary employment and fixed term contracts throughout the public sector erode continuity of service delivery and consistent implementation of service models. Further, the constancy of change through re-alignments of departments and changes of government is causing change fatigue in workers and we are losing highly skilled workers due to a lack of security of tenure. This in turn hampers efforts at system reform.

9.0 Monitoring and reporting outcomes

More accessible feedback mechanisms are needed that facilitate immediate feedback from consumers and carers. As noted in section 11.2, *Procurement,*

contracting and recruitment, consumer and carer satisfaction measures need to inform future funding decisions.

Key Performance Indicators that show good care coordination and integrated service strategies are needed.

10.0 Education and training

Currently, there is inadequate integration of mental health and education services.

There is a need for better resourcing of health and mental health supports in schools. School nurses, psychologists and participation officers are critical elements but are overstretched.

Middle school and early high school is a critical period where mental health problems may emerge. There is a need to enhance teacher education in mental health literacy and responding supportively to the needs of young people with mental health problems. The headspace 'Be You' support services are new and a positive initiative in this context.

Capacity to screen and respond effectively to neurodevelopmental conditions and specific learning disorders is required. It is particularly problematic to identify these and then fail to provide resources to support learning. Long delays in accessing specialised assessment and cost-prohibitive assessment pathways do not service young people or their families well and can have a lifelong adverse impact on engagement in education and training.

More responsive educational pathways are needed to accommodate the learning needs of children who do not fit the prescribed curriculum. This includes vocational pathways instead of academic pathways.

Young Person's Story:

The teachers' lack of understanding of mental health and their inability to recognise that something was wrong significantly set me back educationally.   The scarcity of people that I could talk to about this issue, especially when I was transitioning to high school, made me feel like nobody cared. Essentially, I felt like nobody gave a sh#*.

I believe it is important that teachers are trained to recognise kids with mental health and also to actually be able to talk to them and be helpful. To give kids a platform where they can communicate is important because they feel like nobody cares about their issues. When teachers shame you, whether intentionally or unintentionally, by picking you out of the crowd, it makes you feel worthless. – Anon, 16 years

11.0 Government-funded employment support

The evidence shows that subsidised employment placements are more effective than temporary work experience placements and voluntary internships. Traineeships are extremely valuable. People who have access to a supportive employment environment benefit from the experience. For example, in the intake for the WA Public Service Traineeships only 6 out of 200 applicants were offered a traineeship, indicating there is a need to expand this program.

Integrated Placement and Support (IPS) is a model that has demonstrated efficacy in assisting people with mental illness to obtain employment. IPS should be available for all people with mental health conditions (NDIS and also for people who do not come under the NDIS system). Research by Rinaldi demonstrated that high fidelity IPS was significantly more effective in enabling people with severe mental illness and 6-7 times more efficient in terms of delivering open employment than the non-integrated vocational services.[34]

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[34] Rinaldi M and Perkins R. (2007). Comparing employment outcomes for two vocational services: Individual Placement and Support and non–integrated pre-vocational services in the UK. Journal of Vocational Rehabilitation, 27, pp. 21-27.