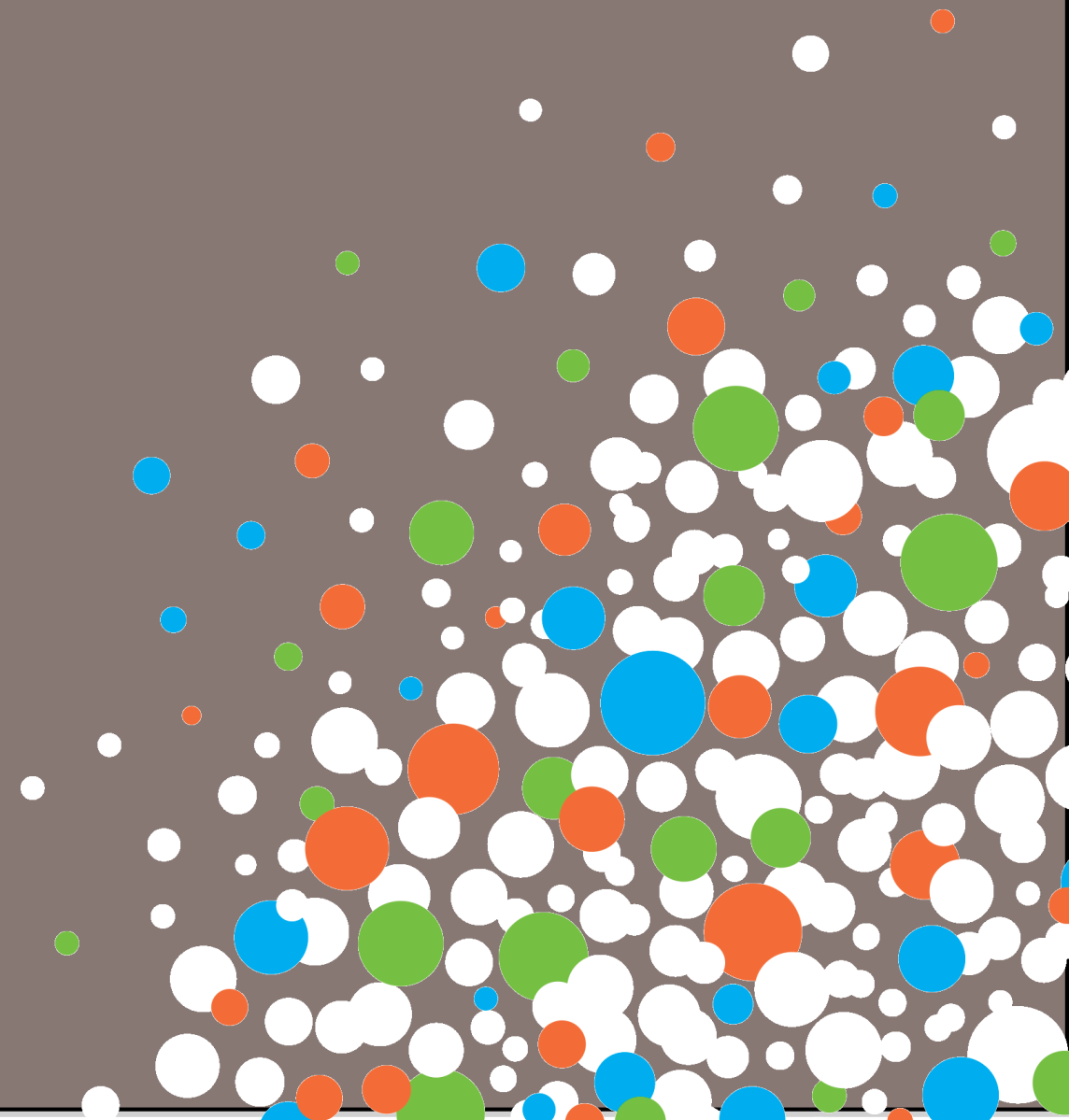
Orygen

The National Centre of Excellence in Youth Mental Health

International analysis of the transition in mental health services

Response from Australia



International analysis of the transition in mental healthcare services – Australia

Response from Orygen, The National Centre of Excellence in Youth Mental Health

Arbitrary transition points are a barrier to care

Transitioning young people at 18 years of age to an adult mental health system simply because they have had a birthday denies the varying rates and patterns of development in young people. The transition process can present barriers and diversions for young people with mental ill-health.

A study in the United Kingdom found that for most young people their transition was 'poorly' planned, executed and experienced. The transition process accentuated pre-existing barriers with continuity of care experienced by less than five percent of young people. Arbitrary transitions 'introduce discontinuities in care provision where the system should be most robust' (Singh et al., 2010).

A new service system with separate funding is required that specifically caters to the needs of young people aged 12-25 years of age. Youth mental health services provide a bridge over the gap between child and adult mental health services.

Two major reasons for a dedicated youth mental health service are (McGorry, Goldstone, Parker, Rickwood, & Hickie):

1. This population is heterogeneous with varying and clinically uncertain illness trajectories; young people in the early stages of a mental illness tend to present with comorbidities of variable intensity, particularly substance misuse and challenging personality traits, which necessitate an integrated model of care.
2. Developmentally and culturally appropriate approaches are essential for the management of emerging disorders; young people's individual and group identity and their help-seeking needs and behaviours need to be central to any service model.

A dedicated youth mental health system was introduced in Australia in 2006. An evaluation published in 2015 found that people using these services were approximately divided in half between people aged under 18 years and those aged 18 to 25 years. A small minority (<1%) fell outside of this age range (Hilferty et al., 2015). This finding demonstrates the appropriateness of a youth mental health service for 12 to 25 year olds as opposed to the historical divide into child and adult services.

This example is now being followed internationally, including two trial sites proposed in Amsterdam and Maastricht, in the Netherlands.

Prevalence of mental health among young people in Australia

Determining the prevalence on mental ill-health among young Australians aged 12-25 years is difficult due to differences in data collection. *The Mental Health of Children and Adolescents* report (2015) found the 12-month prevalence of any mental disorder was 14.4 percent of persons aged 12-17 years (Lawrence D et al., 2015). Older data (2007) found the 12-month prevalence of mental disorders was 26 percent for 16-24 year olds (Australian Bureau of Statistics, 2010). This increase reflects the increasing rate of onset of mental ill-health during this time of life.

How is the mental healthcare service for youth organised and financed?

In Australia, the funding of mental health services is divided between the Commonwealth (national government) and States and Territories (regional government). The Commonwealth predominantly funds primary or general mental health services and the States and Territories provide specialist care for people with severe mental illnesses. The Commonwealth also subsidises the cost of medications prescribed for a mental illness through the Pharmaceutical Benefits Schedule (PBS).

Primary mental health services

Primary mental health services are funded through Medicare, a national medical insurance scheme. The Medicare Benefits Schedule (MBS) sets out the rebate paid for a range of mental health services.

The majority of primary health services are provided by private practitioners. A practitioner is permitted to charge over the scheduled fee, with the gap paid by the person receiving the service. In some cases private health insurance may cover all or part of this extra fee. Alternatively some service providers accept the scheduled rebate resulting in no out-of-pocket expense for people receiving a service.

2013-14 data reported by the Australian Institute of Health and Welfare show that psychologists provided 3.9 million MBS subsidised mental health-related services; general practitioners (2.7 million); and psychiatrists (2.2 million).

The number of people aged 15-24 years accessing subsidised services and medications in 2011 (Australian Bureau of Statistics, 2016) was:

- 153,568 (5.4%) MBS subsidised services only.
- 72,440 (2.5%) PBS subsidised medications only.
- 82,780 (2.9%) both MBS and PBS subsidised services and medications.

Of this group 7.0 percent had seen a general practitioner, 1.4 percent a psychiatrist and 3.9 percent accessed psychology services (clinical; 1.5% and other; 2.4%).

Youth focused services

headspace, a youth health service was launched in 2006 to improve access to appropriate mental health services for young people aged 12-25 with mild-moderate mental ill-health. Utilising early interventions and integrated support across a range of domains: mental health care, physical and sexual health, alcohol and other drugs and education and employment. Services provided through headspace are charged at the scheduled rate, meaning young people do not incur any expense in accessing services.

In 2013-14 headspace provided 194,968 occasions of service to 45,195 young people (an average of 4.3 services per person) through 67 centres. Young women make up 62.8 percent of headspace clients. One-fifth of headspace clients (20.2 percent) were not studying or working. Data from *The Mental Health of Children and Adolescents* report show that between 13.0 percent (parent/carer reported mental disorder) and 20.2 percent (self-identified) of young people with a mental disorder had accessed headspace services (including telephone and online services).

Specialist mental health services

States and Territories provide specialist mental health services through different facilities. Most of these services are community based (number = 1,193); followed by a similar number of public hospitals (163) and residential services (166); and private psychiatric hospitals (56).

The most common principal diagnosis for people accessing these service are schizophrenia, a depressive episode and bipolar affective disorders. Service contacts by 15-24 year olds is estimated to be in the vicinity of 1.3 million (2013-14) (Australian Institute of Health and Welfare, 2015).

Youth focused service

In addition to the headspace initiative, the Commonwealth has begun investing in community based early intervention services for young people with more severe mental ill-health. The first step was the establishment of the Youth Early Psychosis Program in 2013. This specialist service is based on an early intervention program developed by Orygen. The next step identified by the Commonwealth is to extend the focus to other diagnostic areas.

Does a transition take place from child to adult mental healthcare services? And what does this transition look like?

The establishment of headspace means that a dedicated youth mental health service is available in Australia for young people experiencing mild to moderate mental ill-health. State and territory based community health services, however, are based on the provision of separate child and adolescent and adult mental health services. Child and adolescent mental health services provide specialist mental health treatment and care to children and adolescents up to 18 years of age.

There is recognition by State and Territory governments that an age based divide splits mental health services at a critical time for young people. At the same time health departments point out that a range of barriers exist in providing a youth orientated service. headspace has shown that youth mental health services remove barriers for young people and every effort should be made to remove systemic barriers to enable the delivery of youth focused mental health services beyond this model.

What are the outcomes of the systems? To answer this question, the following indicators will be used: the prevalence of early school-leavers, both the accessing and returning to the mental healthcare service after the age of 25, and unemployment rates due to mental ill-health.

headspace data show that many clients (67.7 percent) were engaged in education. A slightly higher proportion of young people aged 18-25 years (29.0 percent) accessing headspace services were not engaged in education, employment or training compared with 27.3 percent in the general age group population (Hickie, Scott, & Glozier, 2014).

Data (2011) shows that people (aged 15-64 years) who left school earlier were more likely to be accessing subsidised mental health medication or a combination of services and medication. Access to MBS services only is higher among people with higher levels of education attainment, however the in-group difference was smallest within this category.

The proportion of this age group who were not employed (excluding those people not in the labour force) at the 2011 census was 5.7 percent. This subgroup, however, was more likely to be accessing subsidised mental health services and/or medication:

- 6.6% MBS subsidised services only.
- 9.9% PBS subsidised medications only.
- 12.4% both MBS and PBS subsidised services and medications.

Selected findings from the second independent evaluation of the headspace program

Independent evaluation of the headspace program (Hilferty et al., 2015) found that young people, staff and parents 'generally identified headspace to be an accessible and engaging service'. Young people using headspace services 'showed greater improvement in mental health outcomes than young people receiving no treatment and alternative forms of treatment.'

The level of psychological distress (K10) experienced by young people fell for almost half (47 percent) of young people attending headspace services. The higher the distress recorded on first attendance the greater the likelihood that they experienced clinically or reliably significant improvements. A smaller group (29 percent) did not experience a change and one out ten young people experienced a decline. The number of young people who experienced a significant reduction in psychological distress was more than double those whose psychological distress increased. The greater the occasions of services the more likely a young people was to record a decreased level of distress.

Importantly, there was a decrease in suicide ideation and self-harm irrespective of any change in K10 scores, however, the greatest decrease was found for young people with a reduced level of psychological distress.

Interviews with young people found that an 'overwhelming majority felt that attending headspace had led to improvements in their mental health.' Similarly a majority of centre managers (24 out of 29) rated servicers 'as "very effective" in improving clients' mental health'.

A survey of young people using headspace services recorded high levels of satisfaction (88 percent), with a similar proportion indicating they would recommend headspace to a friend. Other findings included:

- 89.5 percent felt comfortable within headspace centres;
- 90 percent agreed their worries and views were taken seriously by staff; and
- around 85 percent felt that they were involved in decision making about their care.

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