YACVic's response to the Senate Select Committee on Mental Health

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THE YOUTH AFFAIRS COUNCIL OF VICTORIA

The Youth Affairs Council of Victoria (YACVic) is the peak body representing the youth sector. YACVic provides a means through which the youth sector and young people voice their opinions and concerns in regards to policy issues affecting them. YACVic works with and makes representations to government and serves as an advocate for the interests of young people, workers with young people and organisations that provide direct services to young people. YACVic also promotes and supports the participation of young people in debate and policy development areas that most affect them. YACVic's resources are primarily directed towards policy analysis and development, research and consultation and to meeting the information, networking, education and training needs of our constituency.

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INTRODUCTION

Mental health issues represent the majority of young people's health burden and mental illness is more common in young people than any other age group. Therefore, young people suffer disproportionately from the under-funding and under-performance of the mental health system. For these reasons the Youth Affairs Council of Victoria welcomes the opportunity to make a submission to the Senate Select Committee on Mental Health.

This submission will focus on the need for youth appropriate mental health services to be developed and made available to all young people in Australia. This is our focus because young people with mental illness do better in mental health services tailored to the needs of young people. Unfortunately, in Australia mental health services for young people are rare and difficult to access.

Mental illnesses generally first emerge in young people and youth is the best time to treat mental illness. To reduce the incidence of mental ill health in Australia a focus on the nature of mental illness in the youth population and on young people's specific needs in accessing effective treatment is imperative.

This submission addresses some of the terms of reference set by the committee though a discussion of some key broad issues which are of most relevance to terms b, c, e, f, h and l.

YOUNG PEOPLE AND MENTAL HEALTH

Impact of mental disorders on young people

The incidence of mental illness in young people is well documented and the highest of any age group. Recent landmark surveys have revealed that the onset of major mental disorders, such as schizophrenia, bipolar disorder, depression and anxiety, substance use disorders, eating disorders and personality disorders is most common in adolescence or young adult life, between the ages of 12 and 26[1].

Recent Australian surveys confirmed this, finding that the peak period for mental disorder is the young adult period of 18 – 24 years[2]. The rate among young adults (27%) is nearly double that seen in children and younger adolescents (14%)[2,3] Youth is not only the peak period for the onset of psychiatric illness; it is also a complex and often precarious phase in the life cycle for psychosocial development.

The evaluation of the National Youth Suicide Prevention Strategy reported "young people suffer serious disadvantages in their access to health and social resources compared to other populations, particularly in the area of mental health"[4]. This is especially true of young men, in whom the peak suicide rates seem to be between 20 and 30 years. Only one in four young people aged 4-17 years with a mental disorder, and only half of those with the most severe problems, received professional help[3]. The situation is even more serious in those aged between 18 and 25, where the prevalence rates are nearly twice as high.

There is a high prevalence of depression amongst young people, where 50% or more of those who develop depression have their first episode before age 25. Epidemiological studies suggest that up to 24% of young people have suffered at least one period of major depression by the time they are 18 years old[5] and between 15 and 40% of young people report symptoms of depressed mood and depressive symptomatology[6].

Depression is often associated with high rates of associated health problems including substance use and dependence, anxiety disorders, non-fatal deliberate self-harm, eating disorders and a range of other health risk behaviours. Depression is also the most common factor associated with suicide in all age groups. The majority of suicide victims meet criteria for depressive disorder in the weeks before death[6].

Young people who suffer from mental health disorders are commonly stigmatised and face discrimination and anxiety as a result of this. Anecdotal evidence collected by YACVic

suggests that stigma around mental health impacts on young people's willingness to seek help and to disclose information about their condition to others, at times meaning that disabilities they may be facing as a result of the illness are not understood.

The 1997 survey of Mental Health and Well-Being confirmed high rates of disability associated with depression and other common mental disorders[7]. This high level of disability is associated with impairment in work productivity, absenteeism, educational failure and poor family functioning.

It is likely that many young Australians who have a mental illness may go for some time before the illness is detected, if it is detected at all. It is often not until early adulthood, when the illness becomes more serious and associated with a crisis or prolonged disorder, that the problem is detected. This group make up a large proportion of young people who complete suicide[8].

Services for young people with mental disorders

A range of services are currently available to meet the mental health care needs of young people. At present, the majority of mental health care is provided by general practitioners (GPs) operating at the primary care level[9,10]. While many GPs have recognised the importance of adopting a specific approach to young people and several have established 'youth friendly' service settings[11], an explicit focus on early intervention is far from universal.

Over recent years, considerable emphasis has been placed on further strengthening the role of GPs through various initiatives which provide GPs with better access to education, training, consultation support and financial incentives to provide quality mental health care[12]. These initiatives include the Commonwealth government's Enhanced Primary Care (EPC) and Better Outcomes in Mental Health Care (BOiMC) initiatives, as well as the Victorian government's Primary Mental Health and Early Intervention (PMHEI) Services.

However, while it is accepted that GPs are well placed to provide the majority of mental health care, it is also agreed that there is a 'ceiling' to the number of people and the level of complexity and severity of problems that can be managed within the structure of general practice[13]. This fact is acknowledged within the recent Commonwealth and State GP mental health policy initiatives which all include strategies to enhance GPs' access to specialist support in addition to their focus on GP skill enhancement.

The secondary service level is more complex and harder to define. It consists of a range of quite diverse service providers including psychiatrists and allied health workers in private practice, counsellors in community health services (who are sometimes considered to be primary care providers), as well as providers in educational, employment, drug and alcohol, child protection, youth and family services, juvenile justice, and other settings, each of which offer some type of specialist service. Ideally the secondary level should have two broad roles — to provide consultation support to primary care providers to enable them to continue to manage their patients' needs, and to provide direct assistance to people who require this level of support. In theory therefore, access to this specialist level is best managed through providers such as GPs, in order to maintain their important coordinating and continuing care role.

The providers at the secondary level are largely independent of one another, or only loosely organised together through local information sharing networks. In addition, while some providers at this level have a broad focus (eg community health counsellors) many provide services to very specific population subgroups. This has led to the development of a fragmented system of multiple services each with their own, non-overlapping eligibility criteria. Other problems evident at the secondary level include the uneven or poor availability of certain providers in certain areas, long waiting lists for services, and cost barriers (eg private allied health workers).

Although recent Commonwealth and state initiatives have increased access to specialist services, this contact is usually very time limited, is dependent on the person's ability to find a GP participating in one of the initiatives, and the GP's willingness to utilise this option. For example, the uptake of the EPC and BoiMC initiatives among GPs while impressive is far from universal[14,12]. In addition, referral to allied health workers within the BoiMC initiative has been under-utilised by some GPs who find referral arrangements too time consuming and administratively complex to use.

The potential of the secondary service level therefore remains under-developed. While progress is being made, it remains a poorly coordinated system of services, inadequately integrated with each other and with primary care, in part due to the complex split between Commonwealth and state areas of responsibility. Furthermore, as with the primary care sector, an early intervention focus has yet to be operationalised in a systematic fashion within the secondary level.

The tertiary level is comprised of state-funded specialist clinical mental health services and psychosocial disability rehabilitation and support services (PDRSS) along with a number of private, mostly bed-based, services. In contrast to the secondary service level, the tertiary level is much more consistently organised and geographically available and a clear focus on early intervention is emerging, albeit restricted to psychotic disorders. The greatest limitation of publicly funded specialist mental health services is that they are targeted to the most seriously ill 3-5% of the population yet the need for these services is considerably higher, particularly in areas where primary and secondary mental health services are underdeveloped, or absent.

Regrettably then, while a range of providers are theoretically available to meet the mental health treatment needs of young people, gaps exist in the continuum of care as a result of under-resourcing and/or poor coordination. Young people with clinical disorders of moderate severity, especially those with complex co-morbidity such as problematic

substance use or forensic issues, are a group whose treatment needs are particularly poorly met by the existing system.

The need for youth appropriate services.

Youth is not only the peak period for the onset of psychiatric illness; it is also a complex and often precarious phase in the life cycle for psychosocial development. Evidence[15, 16, 17] demonstrates significant benefits from a separate system of youth psychiatry. Most young people within the public mental health system in Australia are either treated by child services (often more focused on the needs of younger children) or by overstretched adult services predominantly focussed on the chronically unwell with entrenched disability. These existing child (CAMHS) and adult (AMHS) services face their own particular challenges that mean they are often inappropriate environments for older adolescents and young adults with emerging (and treatable) mental illnesses.

Despite this need for youth appropriate services, clinical and public health responses have been few, piecemeal and relatively ineffective to date[16]. In Victoria the Public Mental Health service structure dictates that a person turning 18, can utilise the services of an adult service only if they have a defined 'serious mental illness' (meaning in most cases 'psychosis', especially schizophrenia). Therefore a myriad of other mental health problems of young people in the 18-25 age group largely go either undetected or receive no intervention whatsoever. This poses a serious challenge to health services especially in countries like Australia undergoing rapid industrialisation, urbanisation and socio-cultural change, where disturbance rates are highest[15].

Young people are often reluctant to seek help and are very discerning about when, where and from whom they seek assistance[21]. There is a critical need for youth oriented services. Young people who don't necessarily have a 'serious mental illness', and even those who do, must also deal with the stigma associated with attending a mental health clinic. The need is twofold; to provide mental health services with a 'youth' focus, and

resource the primary care sector to better detect and manage the more high prevalence mental health problems.

Early intervention and prevention

Existing Commonwealth Government policy articulates the need to address youth mental health issues early: “Three quarters of mental health problems begin before the age of 25 years of age. Early intervention to address mental health problems in young people is vital.” *Prime Minister John Howard 29/09/04.*

Early case identification and intensive treatment of the first episode of mental illness constitutes a preventively oriented strategy, which should reduce prevalence, cost and morbidity[1]. Research demonstrates that early intervention and prevention in psychosis is a crucial determinant in minimising the potential impact of such illnesses[18]. Research has also pointed to both the short and long-term benefits of early intervention for clinical and personal outcomes. Early intervention has also been shown to reduce the need for inpatient treatment and is associated with better outcomes and subsequent cost reductions for the health care system[19].

This has led to a shift in focus to the important role which early detection and intervention can play in reducing the impact of mental health problems. Reducing the delays into treatment is pivotal to achieving the benefits associated with early intervention in psychosis. The development and implementation of a preventative model for psychiatric disorders can have a number of potential benefits, such as reducing the suffering and psychosocial damage for young people, as well as reducing the subsequent economic costs[19].

Young People Accessing Health Services

A 2002 New South Wales Department of Health study into young people's access to health services found that the most significant barriers to seeking help described by young people were concerns about confidentiality and trust in terms of the patient/provider relationship and having to deal with embarrassment and shame in disclosing concerns. Also noted was young people's lack of knowledge of what services were available, what they provided, the competencies/skills of the providers and how to access them.[20]

The key is trust. Given an opportunity to become familiar with or to develop a trusting relationship with a service provider, young people are far more willing to make use of their services.

When the study explored young people's preferred sources of help they found that:

- Only a small number of young people considered seeking help from a service provider and even then, had usually come to know a particular service provider by coincidence and had subsequently formed a positive relationship with them.
- Approximately half of all young people did not seek help from anyone at all, particularly males.

Similar themes emerged from a study undertaken by the Illawarra Division of General Practice in New South Wales, investigating the barriers to young people seeking help from General Practitioners. They found young people:

- Wanted health care to be independent of family.
- Experience aversive emotions, particularly fear, anxiety, and shame in relation to getting help.

- Have limited knowledge about how to go about seeking appropriate help, including that of a GP.
- Have generally low intentions to consult a GP for problems of ill-mental health.
- Have similar levels of intentions to consult a GP for personal-emotional and suicidal problems than other groups.[21]

Accessing mental health services can be made more difficult for geographically isolated young people. Not only do young people living in a rural settings face particular difficulties accessing services, but young people living on the urban fringes of city centres can face similar problems. Youth service providers on the urban fringe of Melbourne have reported to YACVic that barriers to access to mental health services for young people are a key concern for them.

Unmet need

The extent of unmet need is even more clearly highlighted by the Grey Zone research study (Cosgrave et al., 2004) undertaken by the ORYGEN Youth Health Service in Melbourne, the only publicly funded mental health service of its type for young people in Australia. The Grey Zone study followed 150 young people over a 6 month period in order to examine and compare the mental health difficulties of young people accepted into the service, with those who were not accepted into the service based on existing access criteria for state funded specialist mental health services. The study found that:

- Young people in both the accepted and not accepted groups displayed considerable levels of mental ill health.

- While members of the accepted group were more likely to have a current mental illness and to exhibit higher levels of functional impairment compared with those who were not accepted, almost two thirds of the not accepted group had at least one mental illness and nearly one third had two or more current diagnoses.

- 24% of young people in the not accepted group had made at least one suicide attempt in the previous 12 months.

- Problematic substance use was high and equally prevalent in both groups of participants.

- While both groups showed a reduction in symptomatology and an improvement in functioning over the 6 month follow-up period, the improvement in the accepted group was much faster than the improvement in the not accepted group, many of whom still had continuing mental health difficulties 6 months later.

The study concluded that while ORYGEN Youth Health was correctly targeting those 'most in need', a substantial number of very unwell young people had to be turned away because of resource limitations (Cosgrave et al., 2004).

YACVic is aware that unmet need in homelessness assistance and accommodation, employment, family and social support services also can impact on young people's mental health and present a barrier to better mental health outcomes. For example, the Council to Homeless Persons and Orygen Youth Health report that 'homeless young people in Australia have much higher rates of psychological distress and psychiatric disorders than young people in more stable living situation.'[22] Their access to accommodation is impacted upon by a lack of specialist mental health accommodation.[23]

Recommendations

Key Recommendation - Youth appropriate mental health services should be developed and made available to all young people in Australia.

This submission makes three recommendations that will advance achieving this goal.

Recommendation 1

Young people with emerging mental illnesses of moderate severity should be provided with timely help through enhancing "secondary level" services. The Commonwealth Government's $50 youth mental health has the potential to be a first step towards achieving recommendation. To do so:

- It should provide meaningful youth friendly services –quality service centres should be established where GPs are supported by multi-disciplinary teams of psychologists, occupational therapists, social workers, etc.
- It should promote new services widely, so young people are encouraged and supported to access them.
- It should provide quality services in both rural and urban areas, and take into consideration the needs of young people on the urban fringe of major cities. Once proved effective, the initiative should be swiftly expanded to provide nationwide coverage

Recommendation 2

Young people with emerging severe mental illnesses should have access to specialist youth mental health services. Young people aged 12-25 should be treated alongside their peers where the therapies, physical environments, group activities, vocational support, staff and work-practices are appropriate to the needs of young people.

Recommendation 3

Young people with both mental illness and substance abuse problems should receive integrated treatments. Treatment of both the mental illness and the substance use disorder by the same treating team at the same time is more effective than non-integrated treatments for people with both mental health and drug and alcohol problems[24,25,26,27] The

lack of integration between drug and alcohol and mental health services in Australia has significantly contributed to the poor detection and treatment of mental illness amongst young people with substance abuse. This results in waste of resources and long-term psychiatric and substance use problems for individuals who could otherwise be helped. The National Drug Strategy 2004-2009 committed to “build strong partnerships between drug treatment services and mental health services to enhance responses to co-existing drug and mental health problems.” It is important that these services are supported to meet this goal.

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