

Consensus Conference on the Mental Health of Emerging Adults

Making Transitions a Priority in Canada

**Lasting Solutions for Emerging
Adults with Mental**

Ill-health : Genuine Reform not Transitional Band aids

Professor Patrick McGorry

Executive Director

Oxygen – The National Centre of Excellence
in Youth Mental Health

November 2, 2015

Which Transition?

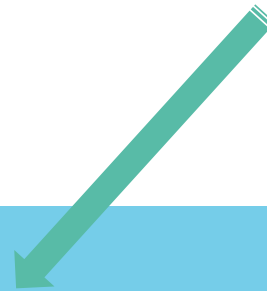




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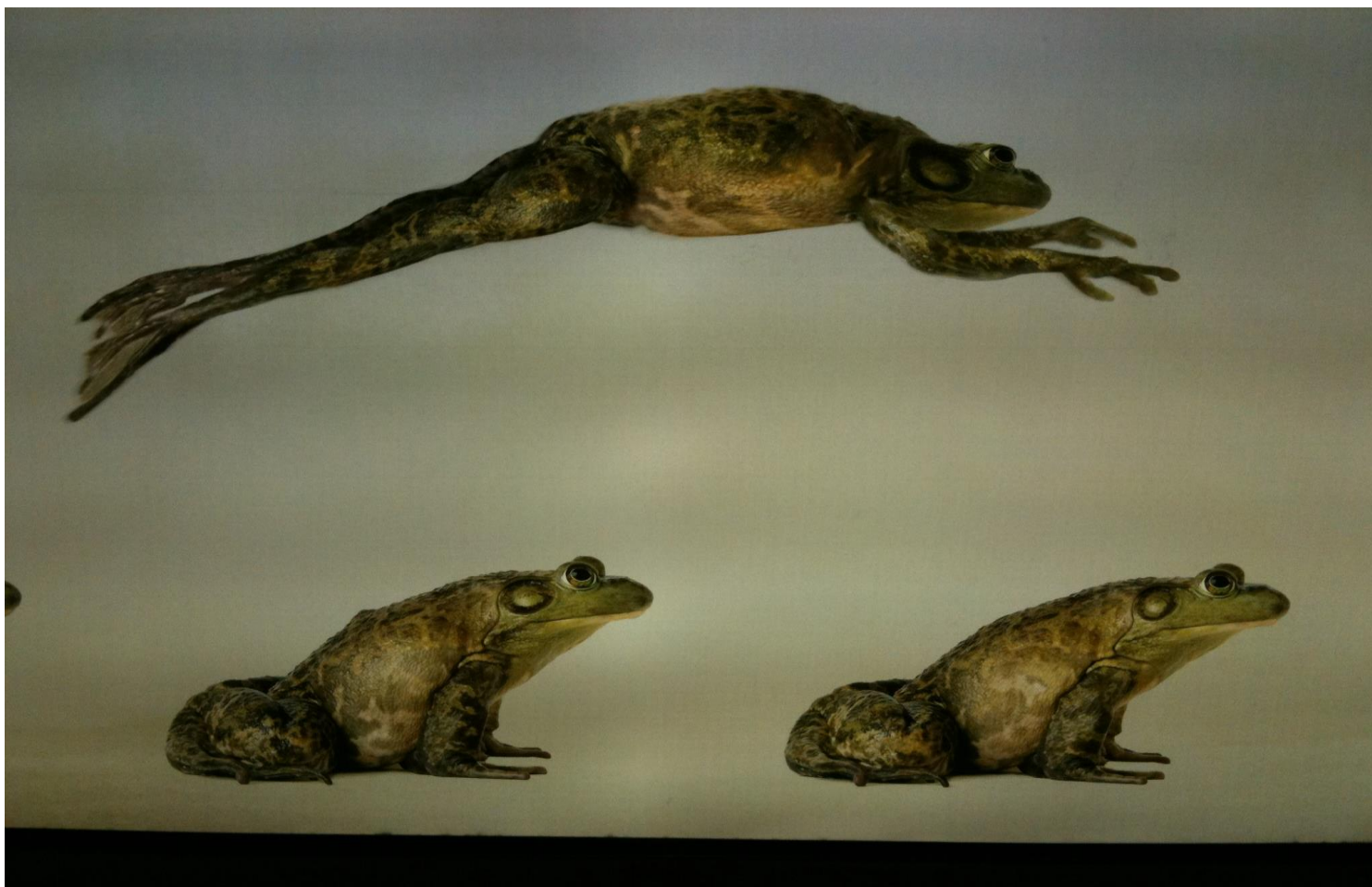
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IS THIS THE RIGHT QUESTION?



BRIDGING THE GAP BETWEEN CHILD AND YOUTH MENTAL HEALTH SERVICES AND ADULT MENTAL HEALTH SERVICES





Gaps to Junctions



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INITIAL QUESTIONS

- 1) Transition for people from childhood to adulthood? OR
- 2) Transition from one service silo to the next?
- 3) Where should the shifts in service culture and expertise be?

Gaps vs junctions/transitions

- 4) Where are the optimal points for these?
- 5) What should guide these design decisions?

Tradition? Status Quo?

Developmental and cultural considerations?

Epidemiology?

Young people?

Families

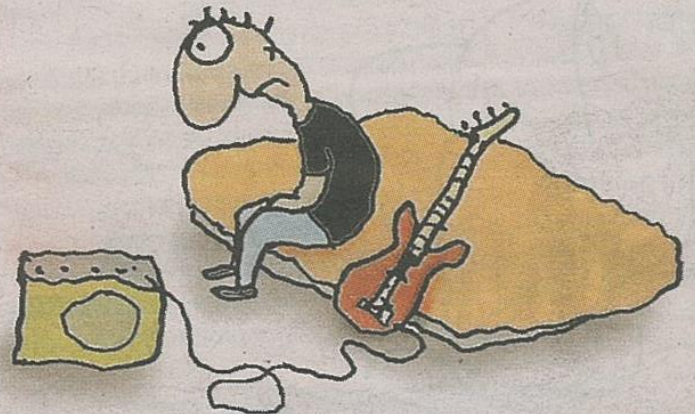
THE NEGLECT OF ADOLESCENT PSYCHIATRY



“It has always been a puzzle to me that the period of life of maximum disturbance, adolescence, is the one of least interest to both psychiatrists and governments....
.....the neglect of adolescent psychiatry is a special form of self-harm undertaken by adult society.”

John Gunn 2004

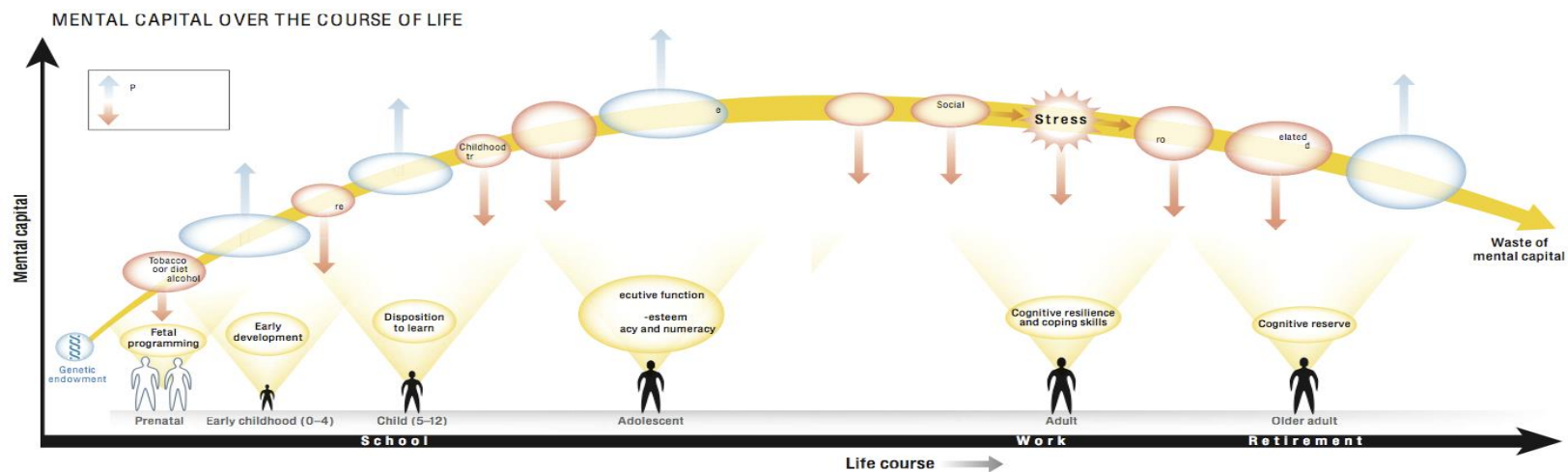
Son, I'm worried about your mental health...
sitting in your bedroom doing this self-harm
nonsense. Get out and do some harm in the
world like normal successful people do.





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Worth More in Young Adulthood than in Early or

“If individuals are forced to choose between saving the life of a 2 year old and saving it for a 22 year old, most prefer to save the 22 year old. A range of studies confirms this broad social preference to “weight” the value of a year lived by a young adult more heavily than one lived by a very young child or an older adult.”

Murray and Lopez 1996 (GBD)

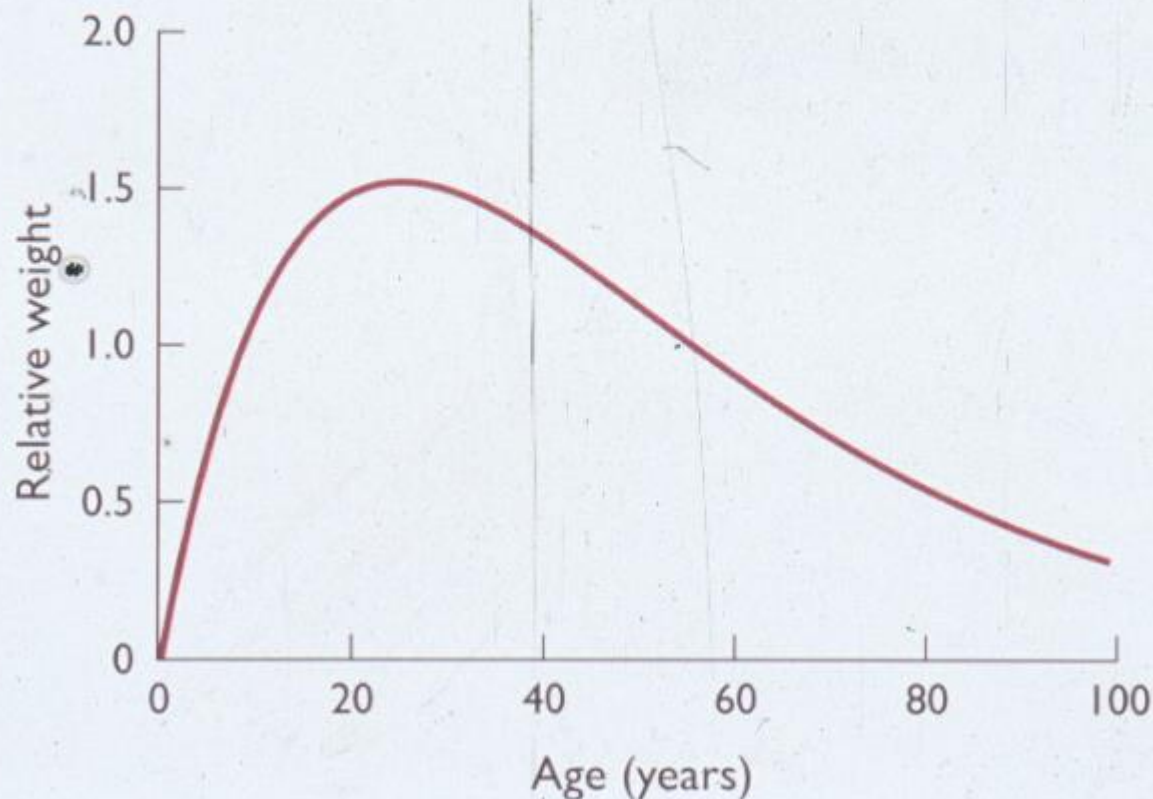


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Figure 5 The relative value of a year of life lived at different ages, as incorporated into DALYs

Vol I p 60



Adolescent mental health 3



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The new life stage of emerging adulthood at ages 18–29 years: implications for mental health

Jeffrey J Arnett, Rita Žukauskienė, Kazumi Sugimura

Since 1960 demographic trends towards longer time in education and late age to enter into marriage and of parenthood have led to the rise of a new life stage at ages 18–29 years, now widely known as emerging adulthood in developmental psychology. In this review we present some of the demographics of emerging adulthood in high-income countries with respect to the prevalence of tertiary education and the timing of parenthood. We examine the characteristics of emerging adulthood in several regions (with a focus on mental health implications) including distinctive features of emerging adulthood in the USA, unemployment in Europe, and a shift towards greater individualism in Japan.

Lancet Psychiatry 2014;
1: 569–76

This is the third in a *Series* of
three papers about adolescent
mental health

Clark University, Worcester,
MA, USA (JA mett PhD);



Joseph Campbell and the "Hero's Journey"



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ada

The Royal Society of Account Planning

www.royalsocietyofaccountplanning.blogspot.com

(Quoted from: <http://en.wikipedia.org/wiki/Monomyth>)

Call to Adventure

The hero starts off in a mundane situation of normality from which some information is received that acts as a call to head off into the unknown.

Refusal of Call

Often when the call is given, the future hero refuses to heed it. This may be from a sense of duty or obligation, fear, insecurity, a sense of inadequacy, etc.

Supernatural Aid

Once the hero has committed to the quest, consciously or unconsciously, his or her guide and magical helper appears, or becomes known.

Crossing First Threshold

This is the point where the person actually crosses into the field of adventure, leaving the known limits of his or her world and venturing into an unknown and dangerous realm where the rules and limits are not known.

Belly of the Whale

The belly of the whale represents the final separation from the hero's known world and self. By entering this stage, the person shows their willingness to undergo a metamorphosis.

Road of Trials

The road of trials is a series of tests, tasks, or ordeals that the person must undergo to begin the transformation. Often the person fails one or more of these tests, which often occur in threes.

Meeting with the Goddess

This is the point when the person experiences a love that has the power and significance of the all-powerful, all encompassing, unconditional love that a fortunate infant may experience with his or her mother.

Temptation

This step is about those material temptations that may lead the hero to abandon or stray from his or her quest.

THE 17 STAGES OF JOSEPH CAMPBELL'S MONOMYTH

SEPARATION

RETURN

INITIATION

Freedom to Live

Mastery leads to freedom from the fear of death, which in turn is the freedom to live. This is sometimes referred to as living in the moment, neither anticipating the future nor regretting the past.

Master of Two Worlds

Achieving a balance between the material and spiritual (the inner and outer world).

Crossing the Return Threshold

Retaining the quest, integrity, human life, and wisdom with...

Rescue

Often times powerful gods back to even the person weakened...

Magic

Sometimes escape be just a dangerous journey...

Refuge

Having enlightened the hero to the end of the book...

The Ultimate

The ultimate achievement of the quest. It is what the person went on the journey to get. All the previous steps serve to prepare and purify the person for this step.

Apostasis

When someone dies a physical death, or dies to the self to live in spirit, he or she moves beyond the pairs of opposites to a state of divine knowledge, love, compassion and bliss.

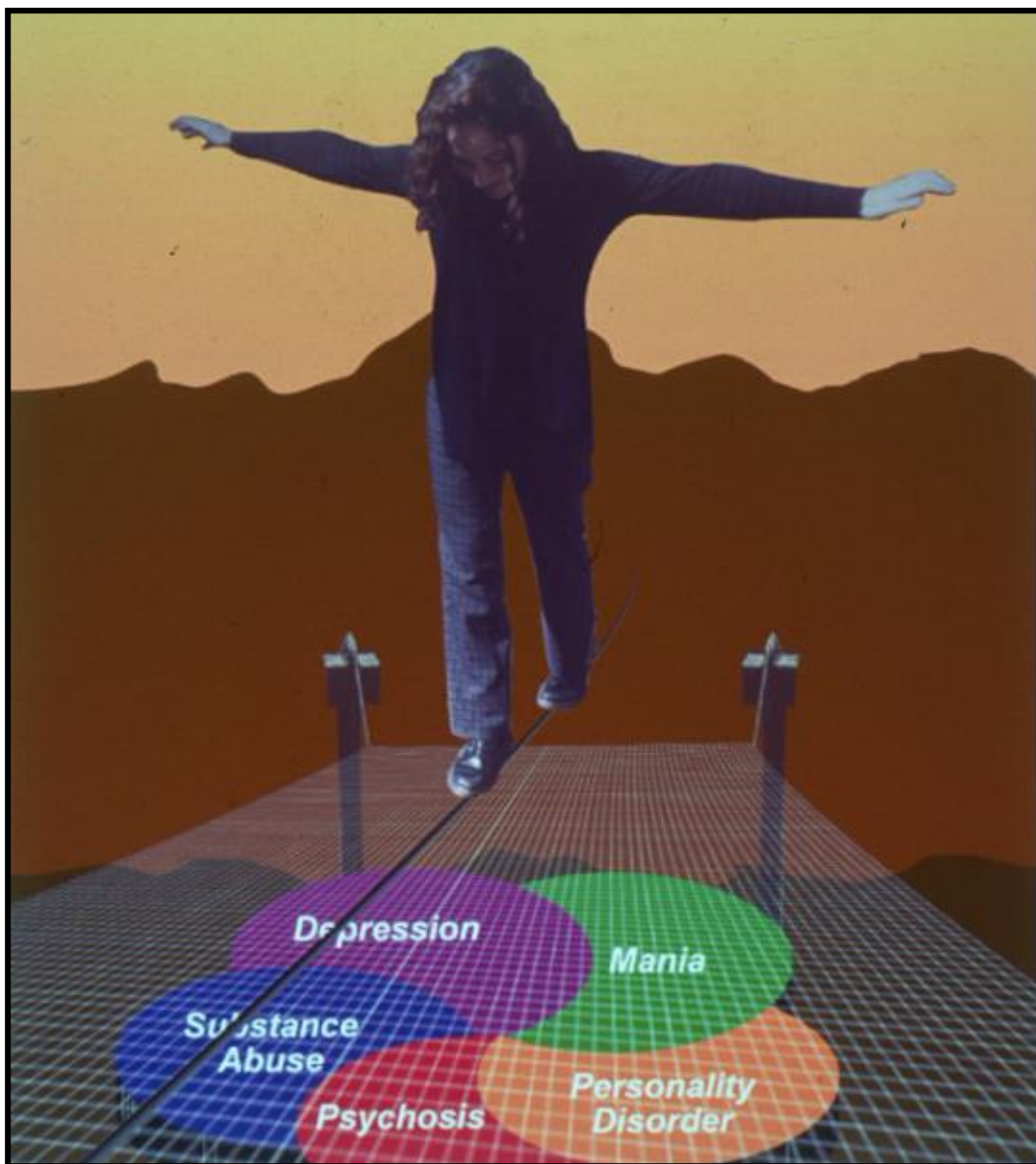
Atonement with the Father

In this step the person must confront and be initiated by whatever holds the ultimate power in his or her life. In many myths and stories this is the father, or a father figure who has life and death power. This is the center point of the journey.



“The transition to adulthood is poorly understood in spite of the fact that it is probably the age period when most adult disorders have their peak rates of incidence”

- Mrazek & Haggerty, 1994



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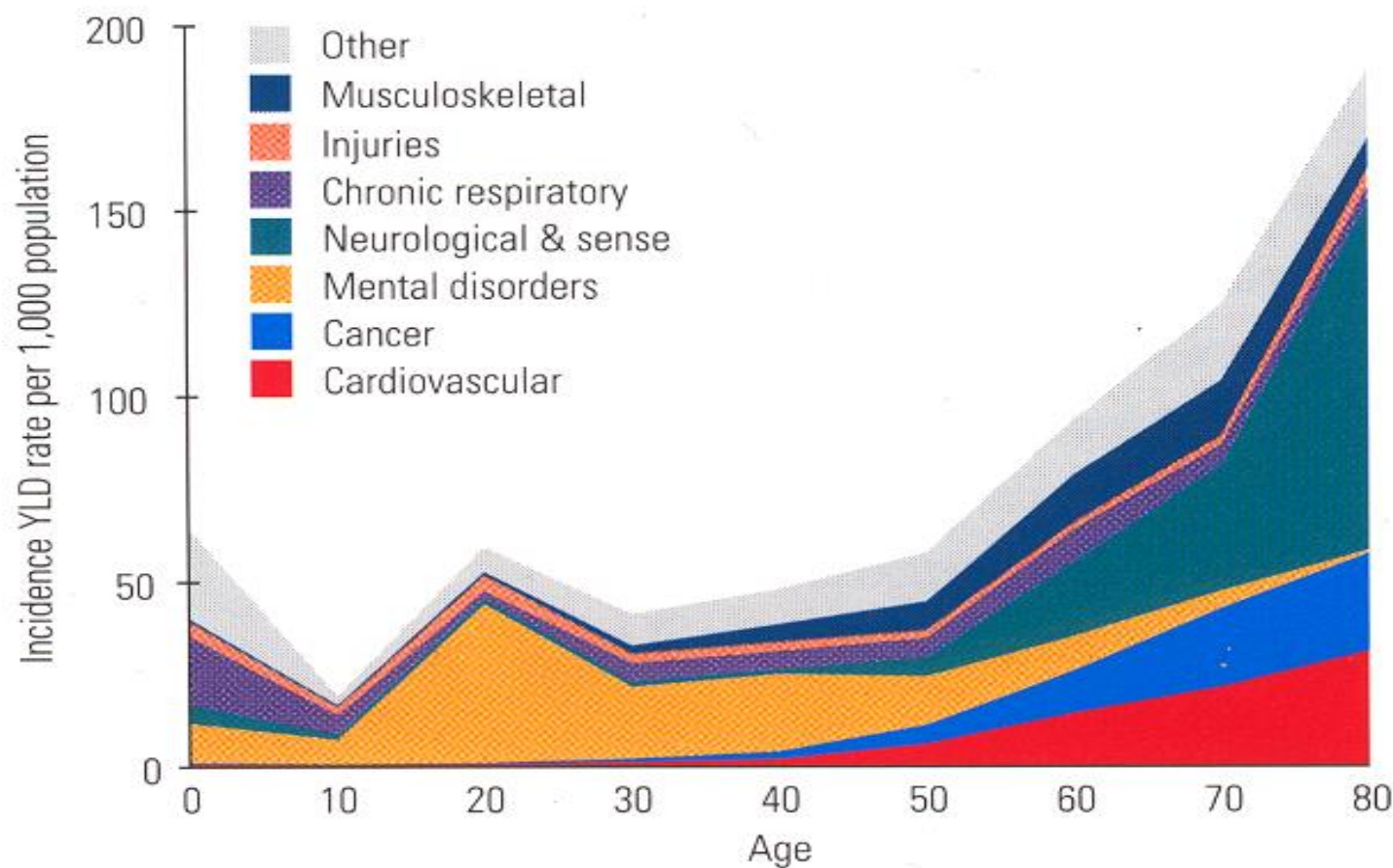
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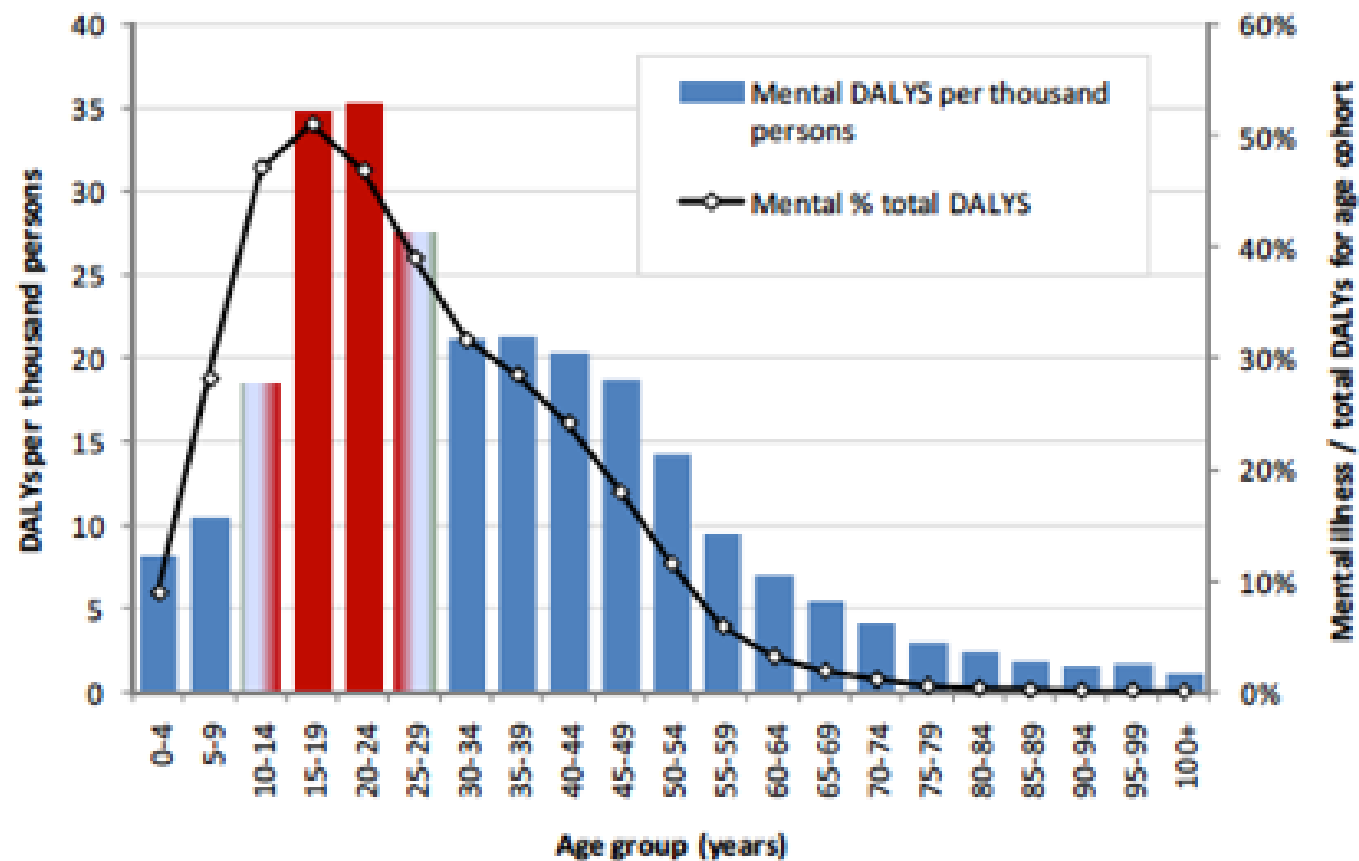
Figure 6 Incident YLD Rates per 1,000 Population by Age and Broad Disease Grouping, Victoria 1996





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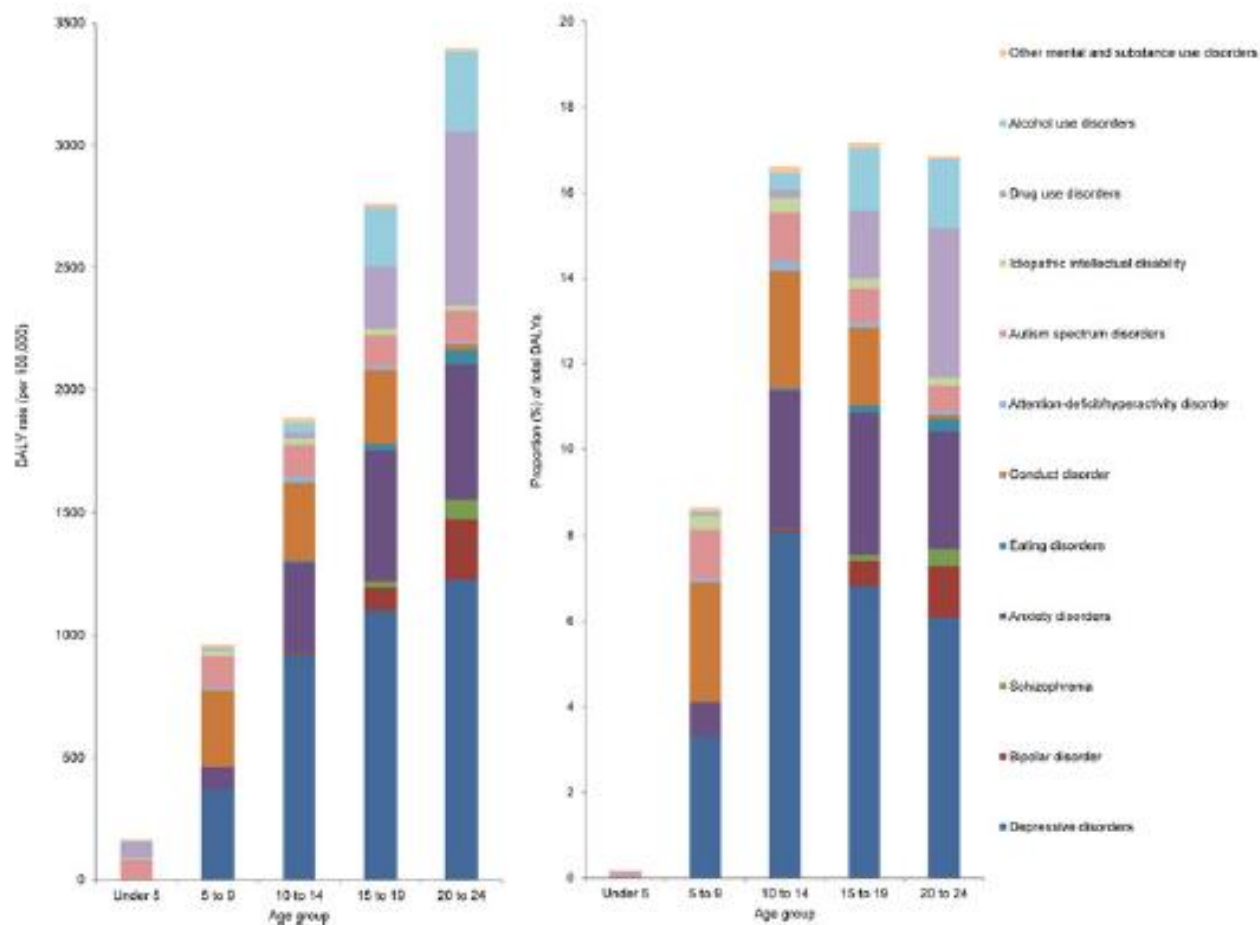


Fig. 1. Disability-adjusted life year (DALY) rates (per 100 000) and proportions (%) for mental and substance use disorders for persons in each age group across childhood and youth in 2010.

2015



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The Mental Health of Children and Adolescents

REPORT ON THE SECOND AUSTRALIAN
CHILD AND ADOLESCENT SURVEY
OF MENTAL HEALTH AND WELLBEING

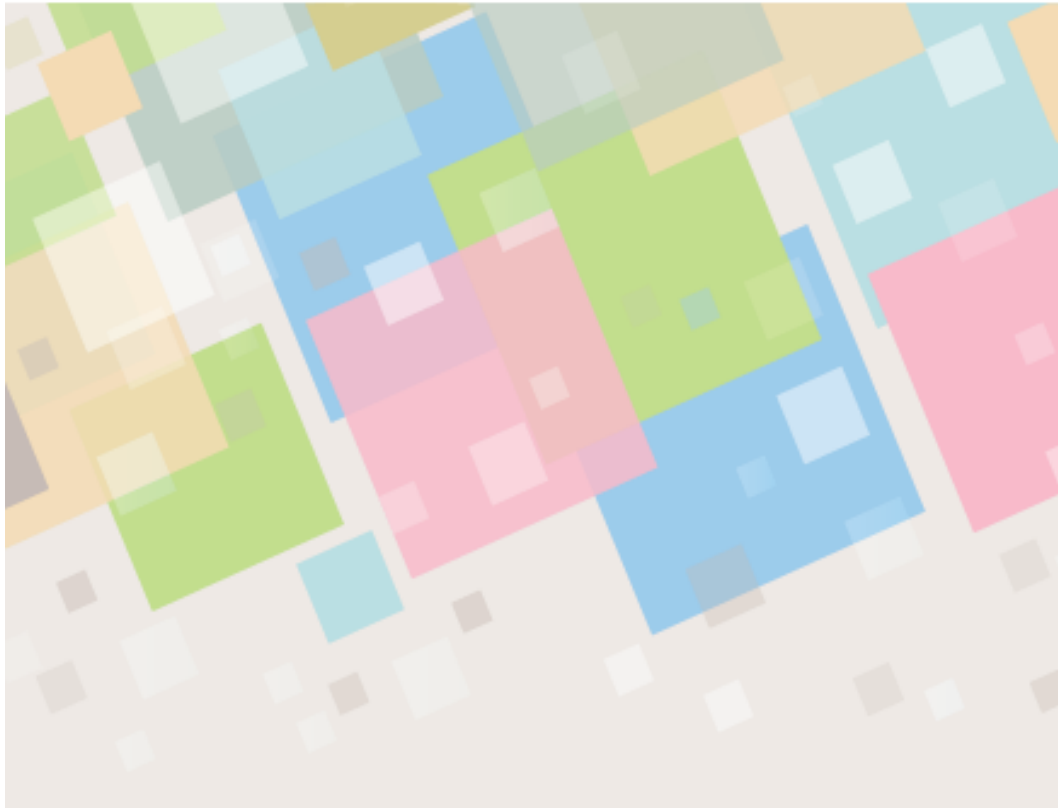


Figure 1: Prevalence of mental disorders in 4-17 year-olds in the past 12 months

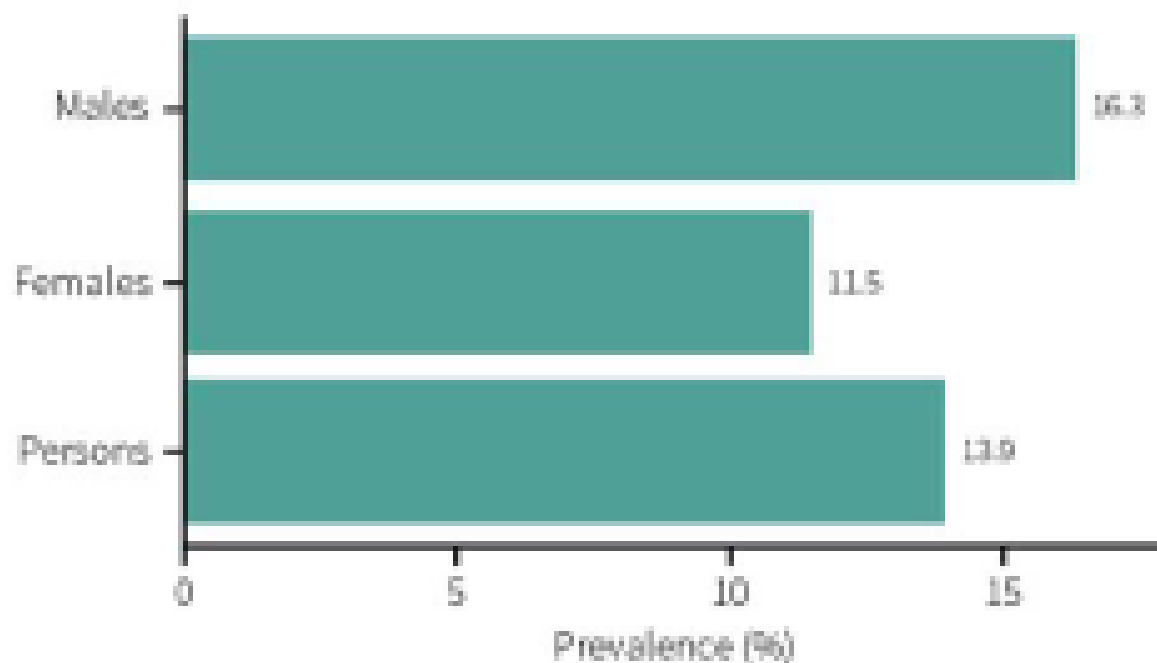
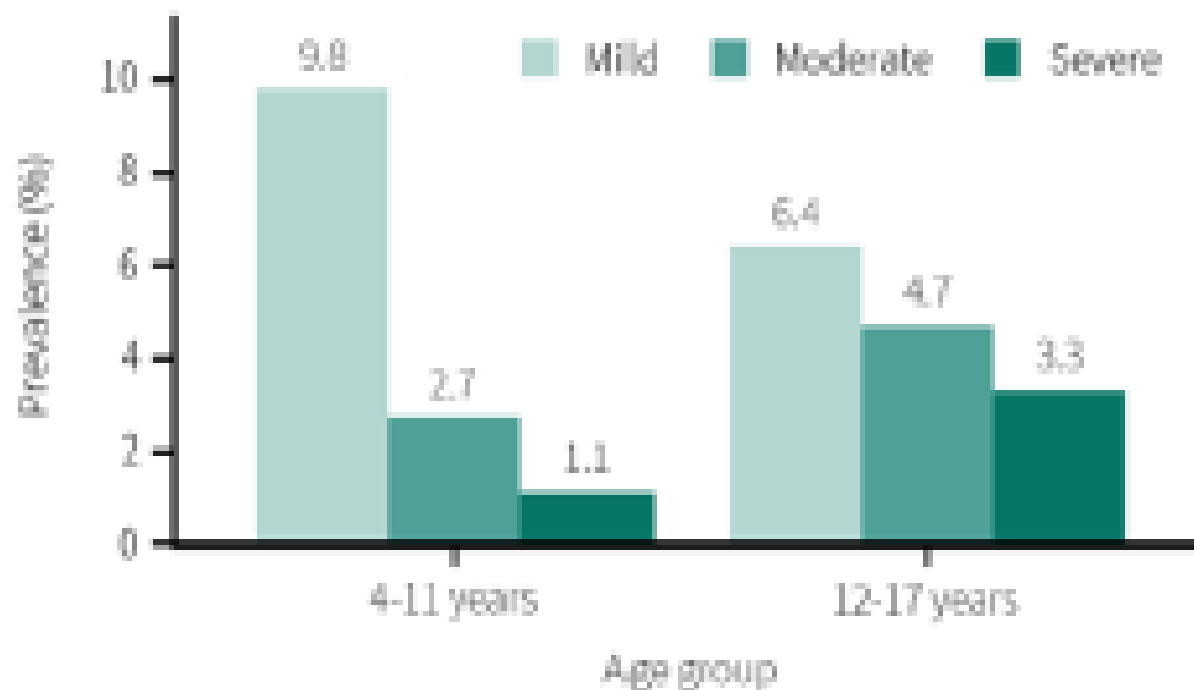
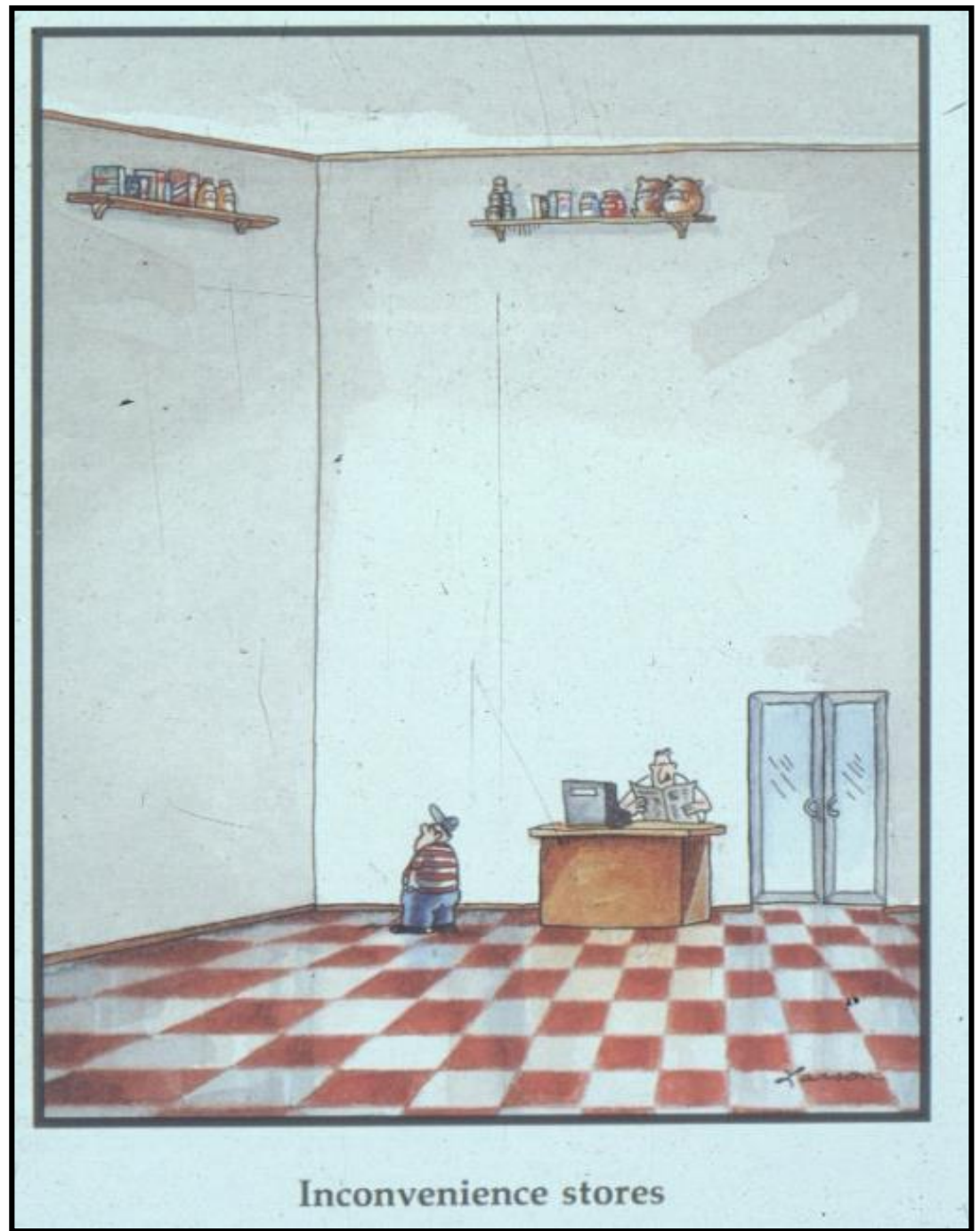


Figure 6: Severity of mental disorders experienced by 4-17 year-olds in the past 12 months by age group



EARLY
INTERVENTION:
Models of Intervention



Inconvenience stores



Cumulative Prevalence of Psychiatric Disorders by Young Adulthood: A Prospective Cohort Analysis From the Great Smoky Mountains Study

William Copeland, Ph.D., Lily Shanahan, Ph.D., E. Jane Costello, Ph.D.,
Adrian Angold, M.R.C.Psych.

Objective: No longitudinal studies beginning in childhood have estimated the cumulative prevalence of psychiatric illness from childhood into young adulthood. The objective of this study was to estimate the cumulative prevalence of psychiatric disorders by young adulthood and to assess how inclusion of not otherwise specified diagnoses affects cumulative prevalence estimates. **Method:** The prospective, population-based Great Smoky Mountains Study assessed 1,420 participants up to nine times from 9 through 21 years of age from 11 counties in the southeastern United States. Common psychiatric disorders were assessed in childhood and adolescence (ages 9 to 16 years) with the Child and Adolescent Psychiatric Assessment and in young adulthood (ages 19 and 21 years) with the Young Adult Psychiatric Assessment. Cumulative prevalence estimates were derived from multiple imputed datasets. **Results:** By 21 years of age, 61.1% of participants had met criteria for a well-specified psychiatric disorder. An additional 21.4% had met criteria for a not otherwise specified disorder only, increasing the total cumulative prevalence for any disorder to 82.5%. Male subjects had higher rates of substance and disruptive behavior disorders compared with female subjects; therefore, they were more likely to meet criteria for a well-specified disorder (67.8% vs 56.7%) or any disorder (89.1% vs 77.8%). Children with a not otherwise specified disorder only were at increased risk for a well-specified young adult disorder compared with children with no disorder in childhood. **Conclusions:** Only a small percentage of young people meet criteria for a DSM disorder at any given time, but most do by young adulthood. As with other medical illness, psychiatric illness is a nearly universal experience. *J. Am. Acad. Child Adolesc. Psychiatry*, 2011;50(3):252–261. **Key Words:** epidemiology, prevalence, not otherwise specified disorders, psychiatric disorders



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Burden of psychiatric disorder in young adulthood and life outcomes at age 30

Sheree J. Gibb, David M. Fergusson and L. John Horwood

Background

Psychiatric disorders are common during young adulthood and comorbidity is frequent. Individual psychiatric disorders have been shown to be associated with negative economic and educational outcomes, but few studies have addressed the relationship between the total extent of psychiatric disorder and life outcomes.

Aims

To examine whether the extent of common psychiatric disorder between ages 18 and 25 is associated with negative economic and educational outcomes at age 30, before and after controlling for confounding factors.

Method

Participants were 987 individuals from the Christchurch Health and Development Study, a longitudinal study of a birth cohort of individuals born in Christchurch, New Zealand, in 1977 and followed to age 30. Linear and logistic regression models were used to examine the associations between psychiatric disorder from age 18 to 25 and workforce participation, income and living standards, and educational

achievement at age 30, before and after adjustment for confounding factors.

Results

There were significant associations between the extent of psychiatric disorder reported between ages 18 and 25 and all of the outcome measures (all $P < 0.05$). After adjustment for confounding factors, the associations between psychiatric disorder and workforce participation, income and living standards remained significant (all $P < 0.05$), but the associations between psychiatric disorder and educational achievement were not significant (all $P > 0.10$).

Conclusions

After due allowance had been made for a range of confounding factors, psychiatric disorder between ages 18 and 25 was associated with reduced workforce participation, lower income and lower economic living standards at age 30.

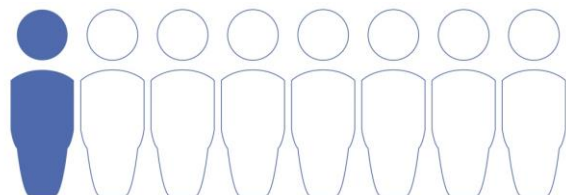
Declaration of interest

None.

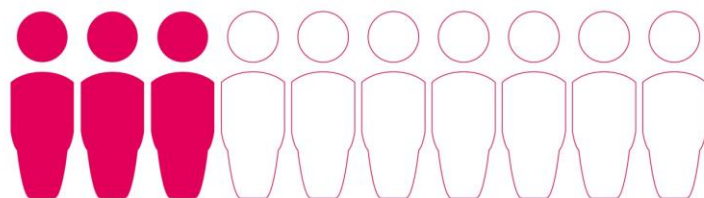
UNMET NEED IN NW Melbourne ca. 2002

- 880,000 in catchment area
- 50,000 cases (15 -24 years) in any one year
- 2,000 referrals to intake per annum now stable - only 800 can be accepted
- 2/3 of those NOT accepted have significant mental disorders, with poor functioning, and 22% have a recent history of suicide attempt
- Those not accepted do very poorly at 2 year follow up (Cosgrave et al 2007)

Young people don't seek or get professional help!!



Only 13% of young men and 31% of young women access professional mental health care



Young men aged 16-24 have the lowest professional help-seeking of any age group

Tiered/Nested Approach Vital



- Primary Care – not functioning at all for EA's
- Need to build a stigma free highly engaging and accessible portal with capacity for high volume and positive experiences and outcomes, and
- And expanded specialist YMH system with capacity for more expert, mobile, intensive and longer tenure as required

OPTION 1

STATUS QUO



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CAMHS



- Caring culture, but child culture vs youth culture?
- Playdough vs hipsters
- Under-resourced and under-researched
- Already splits prepubertal and kids and postpubertal adolescents
- Developmental focus but only some staff specifically trained in this
- Problems with older clients 15 plus?
- Selective and weak grip on 15 -18 year olds?
- Need to expand developmental and family perspective especially to older adolescent -young adult phase

Adult/AMHS

- Massive bottleneck for transition
- Under-resourced even for “SMI”/Schizophrenia focus
- Diagnostic censor/triage
- Targeting of SMI a serious problem for EI and full coverage
- Minimal developmental or family expertise or commitment
- Evidence base better but poor translation
- Soft bigotry of low expectations
- Stigmatised, often crude and still traumatic

OPTION 3



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“New Band of Care for Young People/Emerging Adults”





Youth Model

- Makes sense to young people as a subcultural entity with soft transitions and shifts
- Developmental, family and community cohesion principles can be implemented
- Needs to be fluid diagnostic framework
- New structures required
- Capacity to handle stigma, engagement, and uncertainty
- Youth precincts
- EI paradigm central
- Not possible in current service systems CAMHS or Adult as currently developed
- Analogy with Old Age Psychiatry

OPTIONS FOR REFORM



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Ca---AD---O 0-18, 16-64, 65-

C=Y-AD-O 0-25, 26-64, 65-

C-EA-AD-O 0-12/14, 15-30, 31-64, 65-

DEFINITIONS: YOUNG PEOPLE

- WHO 10-24 yrs
- United Nations 15-24 yrs
- Australian Institute for Health and Welfare 12-24 yrs
- Children 0-14 yrs
- ABS 12-25 yrs

- Local Government 12-25 yrs
- Headspace (Australia) 12-25 yrs
- Headstrong (Ireland) 12-25 yrs

- 20% of population in Australia

14TLP0224

Series

FT

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S2215-0366(14)70396-7

Embargo: [add date when known]

Adolescent mental health



Cultures for mental health care of young people: an Australian blueprint for reform

Patrick D McGorry, Sherilyn D Goldstone, Alexandra G Parker, Debra J Rickwood, Ian B Hickie

Mental ill-health is now the most important health issue facing young people worldwide. It is the leading cause of disability in people aged between 10 and 24 years, contributing 45% of the overall burden of disease in this age-group. Despite their manifest need, young people have the lowest rates of access to mental health care, largely as a result of poor awareness and help-seeking, structural and cultural flaws within the existing care systems, and the failure of

Lancet Psychiatry 2014;XX:xx-xx

This is the X in a Series of X papers about adolescent mental health.

One stop service for mental health,
AOD, physical health, vocational
assistance that is youth friendly and
free or low cost



Headspace Film



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Headspace Annual Report



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headspace centres 2014

Northern Territory

Alice Springs
Darwin

Western Australia

Albany
Broome
Bunbury
Rockingham
Armadale*
Kalgoorlie*

Perth

Fremantle
Joondalup
Midland
Osborne Park

South Australia

Berri
Murray Bridge
Port Augusta

Adelaide

Edinburgh North
Noarlunga
Woodville
Norwood*

Queensland

Cairns
Hervey Bay
Ipswich
Mackay
Maroochydore
Mt Isa
Redcliffe

Rockhampton
Southport
Townsville
Warwick
Logan*
Toowoomba*

Brisbane

Inala
Nundah
Woolloongabba
Indooroopilly*

New South Wales

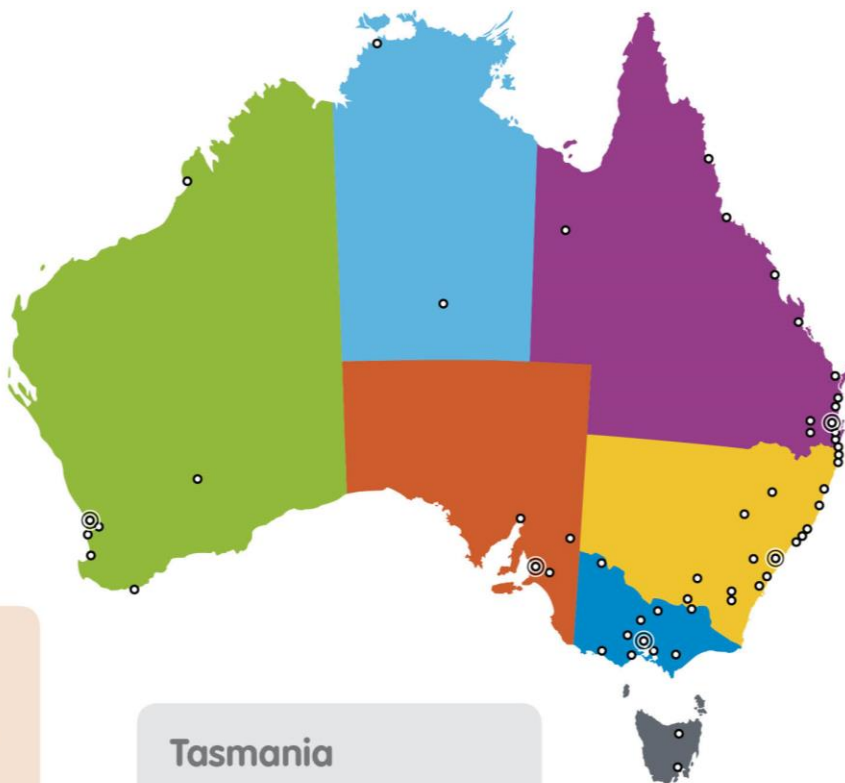
Bathurst
Coffs Harbour
Gosford
Lismore
Maitland
Newcastle
Nowra
Port Macquarie
Tamworth
Wagga Wagga
Wollongong
Dubbo*
Queanbeyan*
Tweed Heads*

Sydney

Brookvale
Campbelltown
Camperdown
Chatswood
Hurstville
Liverpool
Miranda
Mt Druitt
Parramatta
Penrith
Bankstown*
Bondi Junction*
Strathfield/Burwood*

ACT

Canberra



Tasmania

Hobart
Launceston

Victoria

Ballarat
Bendigo
Frankston
Geelong
Morwell
Shepparton
Warrnambool
Mildura*
Wodonga/Albury*

Melbourne

Collingwood
Craigieburn
Dandenong
Elsternwick
Glenroy
Hawthorn
Knox
Sunshine
Werribee
Narre Warren*

headspace — Australia's innovation in youth mental health: who are the clients and why are they presenting?

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headspace National Youth Mental Health Foundation is the Australian Government's major investment in the area of youth mental health.¹ The National Survey of Mental Health and Wellbeing (NSMHW) revealed that one in four young people experience a clinically relevant mental health problem within any 12-month period, compared with one in five in the general population.² Half of a cohort of young people were shown to suffer diagnosable mental ill health at some point during the transition from childhood to adulthood, which reduces fulfilment of their potential and increases likelihood of disability and premature death.³ Australian data are consistent with international trends and the adolescent and early adult years are periods of peak prevalence and incidence for most mental disorders.^{4,5} Yet, despite having the highest prevalence, young people have the lowest level of professional help seeking for

Abstract

Objectives: To provide the first national profile of the characteristics of young people (aged 12–25 years) accessing headspace centre services — the Australian Government's innovation in youth mental health service delivery — and investigate whether headspace is providing early service access for adolescents and young adults with emerging mental health problems.

Design and participants: Census of all young people accessing a headspace centre across the national network of 55 centres comprising a total of 21 274 headspace clients between 1 January and 30 June 2013.

Main outcome measures: Reason for presentation, Kessler Psychological Distress Scale, stage of illness, diagnosis, functioning.

Results: Young people were most likely to present with mood and anxiety symptoms and disorders, self-reporting their reason for attendance as problems with how they felt. Client demographic characteristics tended to reflect population-level distributions, although clients from regional areas and of Aboriginal and Torres Strait Islander background were particularly well represented, whereas those who were born outside Australia were underrepresented.

Conclusion: headspace centres are providing a point of service access for young Australians with high levels of psychological distress and need for care in the early stages of the development of mental disorder.

behalf of a local partnership of organisations responsible for the delivery of services, comprising mental health, alcohol and other drug, primary care,

between 1 January and 30 June 2013. This comprised data from 21 274 clients across the 55 current headspace centres. The centres have been open

The services provided to young people by *headspace* centres in Australia

The headspace initiative engages young people with a range of health and wellbeing concerns, not just ... mental health problems

headspace, the National Youth Mental Health Foundation, was initiated by the Australian Government in 2006 because it was recognised that the prevalence of mental disorders and the burden of disease associated with mental health problems was greater for those in their adolescent and early adult years than in older adults, but that young people were less likely to access professional help.¹ *headspace* centres aim to be highly accessible, youth-friendly integrated service hubs that respond to the mental health, general health, alcohol and other drug, and vocational concerns of young people aged 12 to 25 years.² The main goal is to improve mental health outcomes by reducing help-seeking barriers and facilitating early access to services that meet the holistic

Abstract

Objectives: To describe the services provided to young people aged 12–25 years who attend *headspace* centres across Australia, and how these services are being delivered.

Design: A census of *headspace* clients commencing an episode of care between 1 April 2013 and 31 March 2014.

Participants: All young people first attending one of the 55 fully established *headspace* centres during the data collection period (33 038 young people).

Main outcome measures: Main reason for presentation, wait time, service type, service provider type, funding stream.

Results: Most young people presented for mental health problems and situational problems (such as bullying or relationship problems); most of those who presented for other problems also received mental health care services as needed. Wait time for the first appointment was 2 weeks or less for 80.1% of clients; only 5.3% waited for more than 4 weeks. The main services provided were a mixture of intake and assessment and mental health care, provided mainly by psychologists, intake workers and allied mental health workers. These were generally funded by the *headspace* grant and the Medicare Benefits Schedule.

Conclusions: *headspace* centres are providing direct and indirect access to mental health care for young people.

Changes in psychological distress and psychosocial functioning in young people accessing *headspace* centres for mental health problems

all centres pursue a common vision of youth-focused, evidence-based, early intervention

Improving the mental health and wellbeing of adolescents and young adults is receiving increasing attention throughout the world.¹ The Australian Government was the first to invest significant funds in a practical and systematic response to this challenge, initiating a national reform process that created new service platforms for young people through its founding of *headspace*, the National Youth Mental Health Foundation.²

The initiative commenced in 2006, establishing an initial 10 centres and is set to increase to a network of 100 centres across Australia by 2016. *headspace* centres are one-stop entry points offering a mix of the services that young people need most. Centres provide early intervention by responding to early presentations of mental health problems and by assisting young people at greater risk of developing mental disorders. Being youth-friendly

Abstract

Objectives: To examine changes in psychological distress and psychosocial functioning in young people presenting to *headspace* centres across Australia for mental health problems.

Design: Analysis of routine data collected from *headspace* clients who had commenced an episode of care between 1 April 2013 and 31 March 2014, and at 90-day follow-up.

Participants: A total of 24 034 people aged 12–25 years who had first presented to one of the 55 fully established *headspace* centres for mental health problems during the data collection period.

Main outcome measures: Main reason for presentation, types of therapeutic services provided, Kessler Psychological Distress Scale (K10) scores, and Social and Occupational Functioning Assessment Scale (SOFAS) scores.

Results: Most *headspace* mental health clients presented with symptoms of depression and anxiety and were likely to receive cognitive behaviour therapy (CBT). Younger males were more likely than other age- and sex-defined groups to present for anger and behavioural problems, while younger females were more likely to present for deliberate self-harm. From presentation to last assessment, over one-third of clients had significant improvements in psychological distress (K10) and a similar proportion in psychosocial functioning (SOFAS). Sixty per cent of clients showed significant improvement on one or both measures.

Conclusions: Data regarding outcomes for young people using mental health care services similar to *headspace* centres are scarce, but the current results compare favourably with those reported overseas, and show positive outcomes for young people using *headspace* centres.

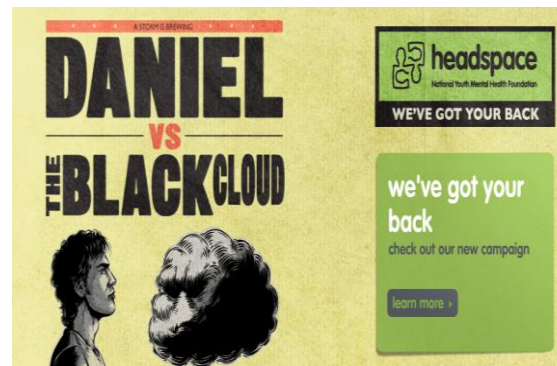
Accessible - awareness

Australian National Survey of Adolescents – 2014 (Young Minds)



Heard about headspace:

- 50.7% all parents
- 64.6% of parents of adolescent with a mental disorder
- 37.2% all 13-17 year olds
- 54.4% of adolescents with major depressive disorder



Accessible - awareness



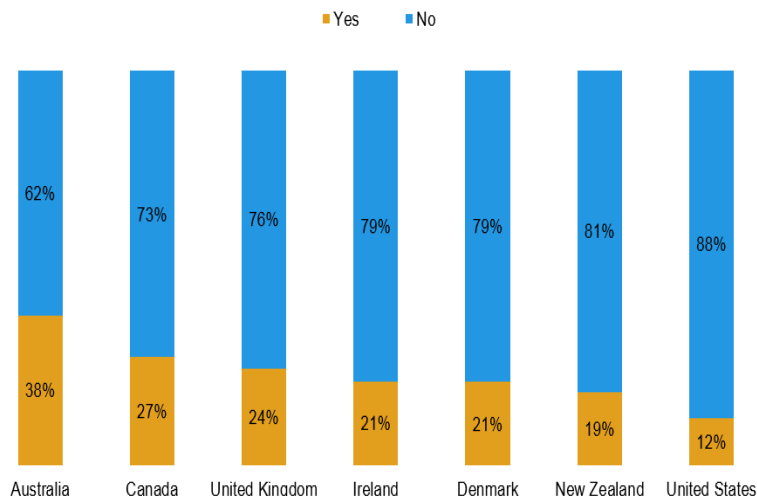
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International awareness study conducted by RIWI - 2015

Have you heard of headspace (the National Youth Mental Health Foundation)?

Respondents 12-25 only

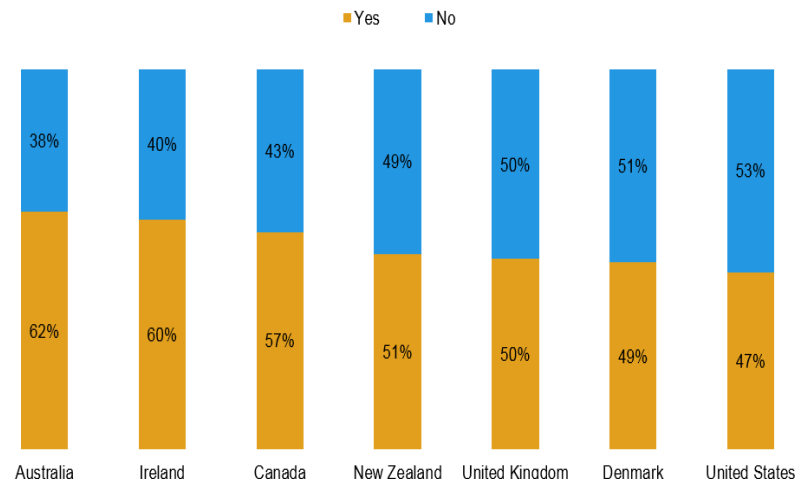


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3

Do you consider mental health to be the main health problem for young people aged 12-25?

Respondents 12-25 only



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5

For a review of RIWI's peer-reviewed, patented, and award-winning methodology, see:
<https://riwi.com/how-rdit-works/>

Accessible



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du Canada

Centres:

- N=74,804 (2013-2015) - 60% female
- 23% aged 12-14; 34% aged 15-17; 14% LGBTIQ (vs. 1-3% population)
- 9% Aboriginal or Torres Strait Islander (vs. 4% population)
- 7% CALD (vs. 25% population)

eheadspace:

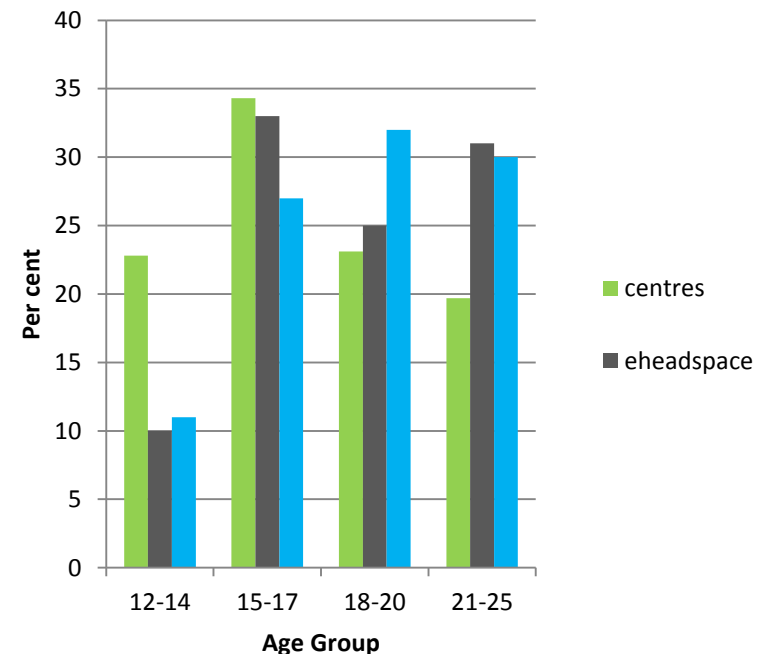
- over 60,000 registrations, 150 yp each day
- 79% female
- 10% aged 12-14, 33% aged 15-17

School support

- One third of all secondary schools in Australia

Early psychosis program

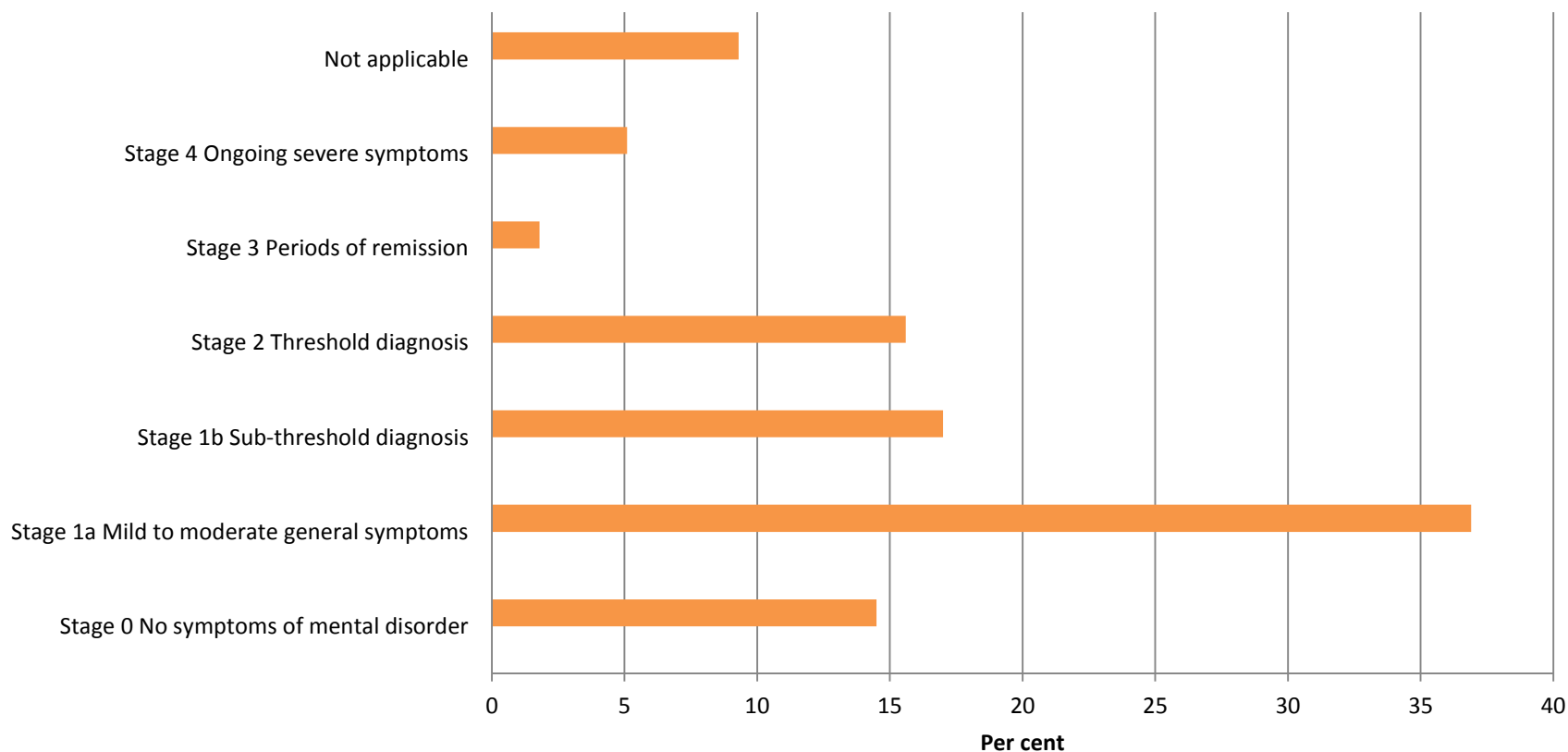
- 55% male (preliminary data)



Appropriate

April 2013 – March 2015

Stage of illness



Appropriate



PRESENTING TO THE CENTRE

Young people presented to the centre with these issues ...

DEPRESSION
28%



**PHYSICAL/
SEXUAL HEALTH**



7%

SITUATIONAL
home conflict –
relationships –
bullying –
homelessness –



13%

**OTHER MENTAL
ISSUES**



23%

ANXIETY
22%



**ALCOHOL &
OTHER
DRUGS**



3%

**WORK &
STUDY**
2%



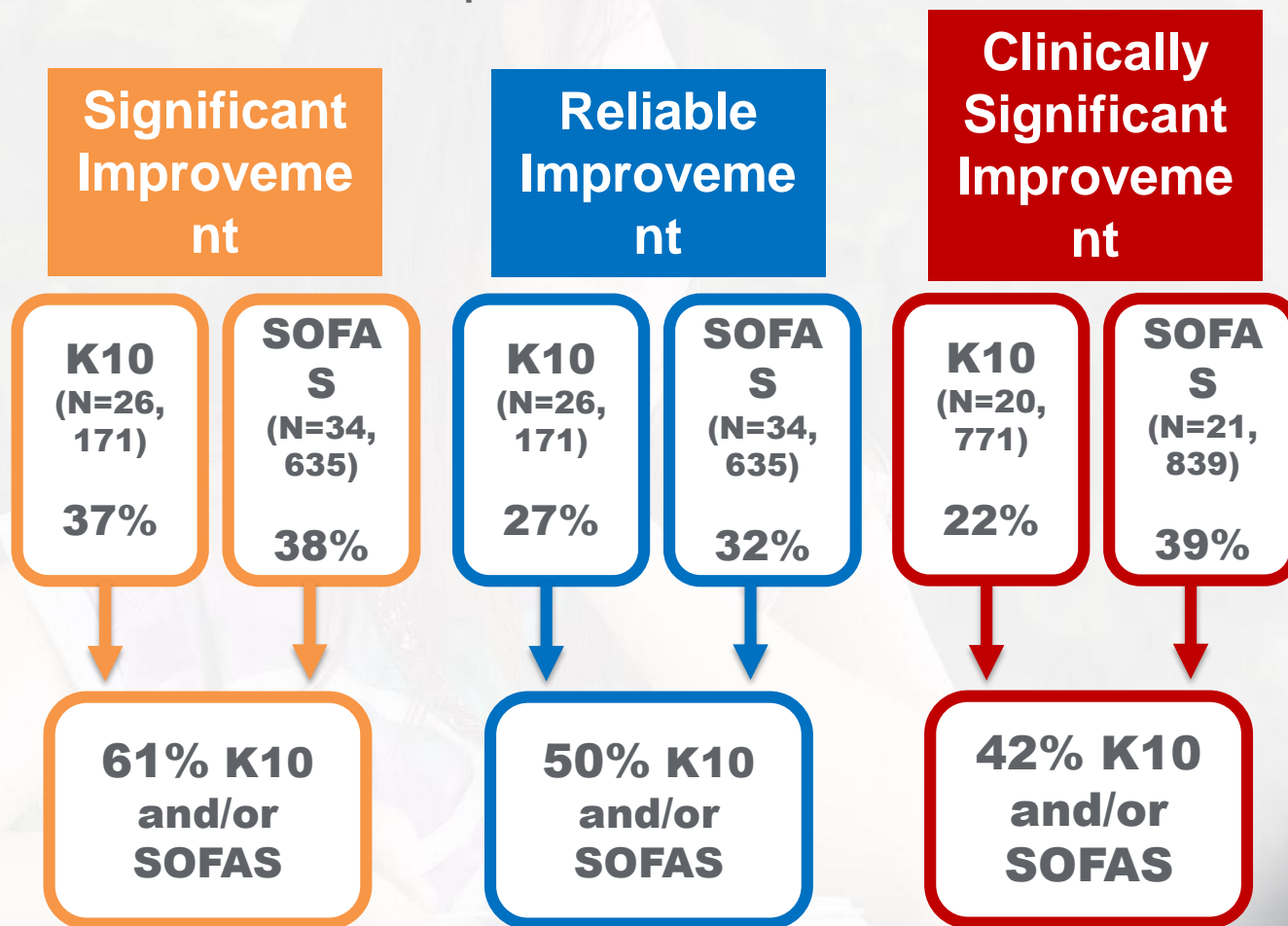
OTHER
2%



Effective

April 2013 – March 2015

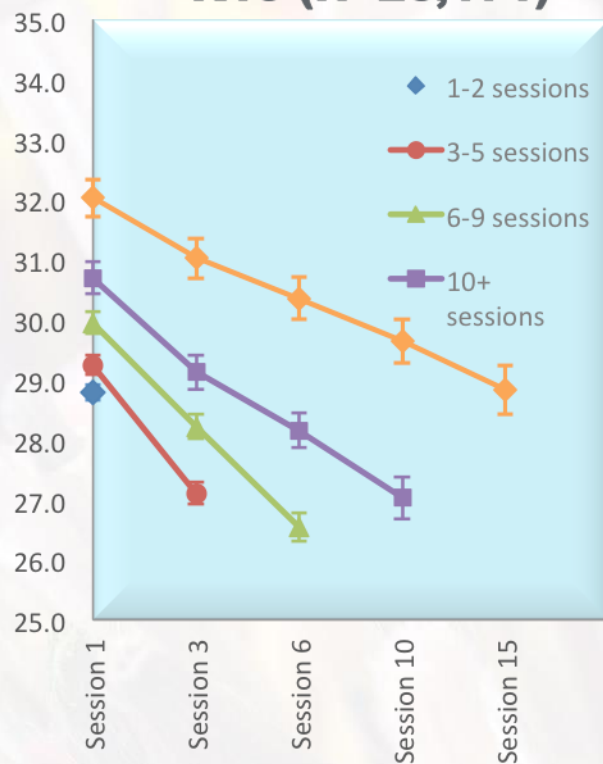
headscape centres



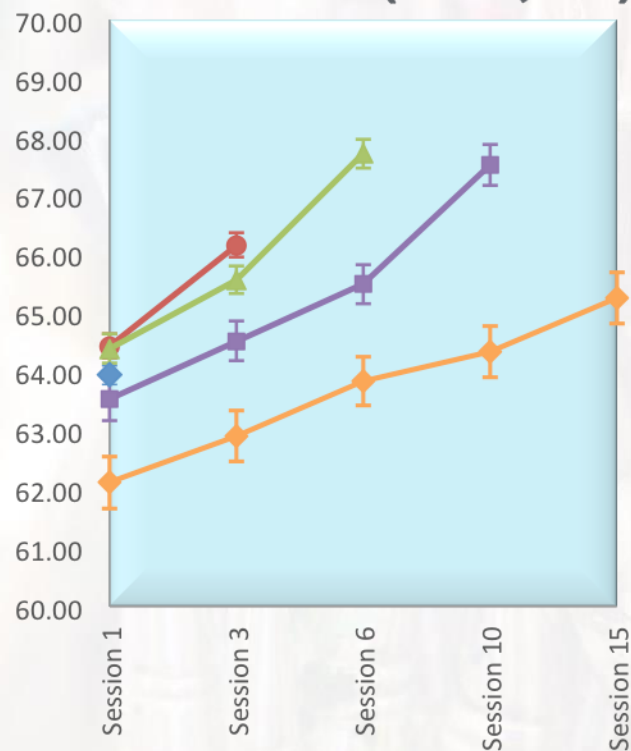
Effective

April 2013 – March 2015

K10 (N=26,171)



SOFAS (N=34,635)



Accessible

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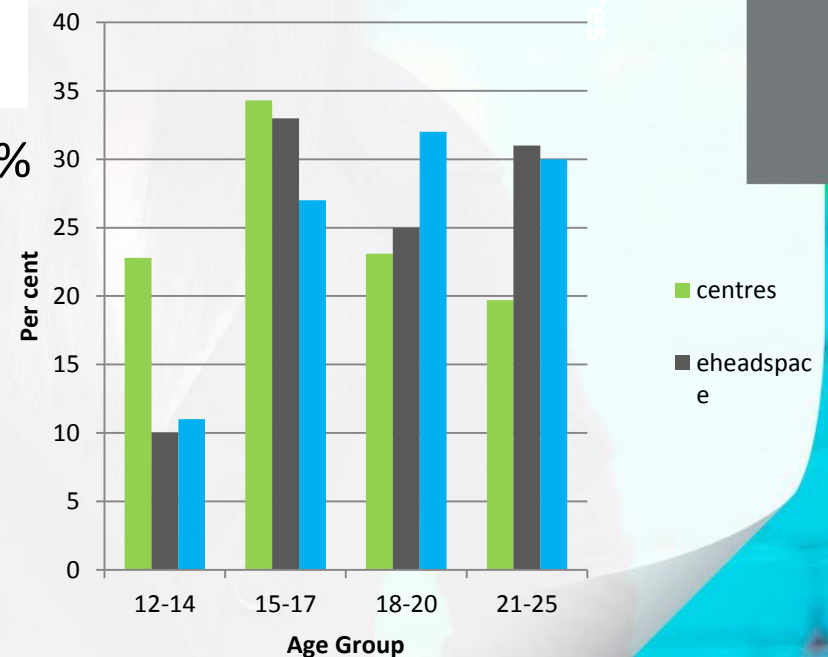
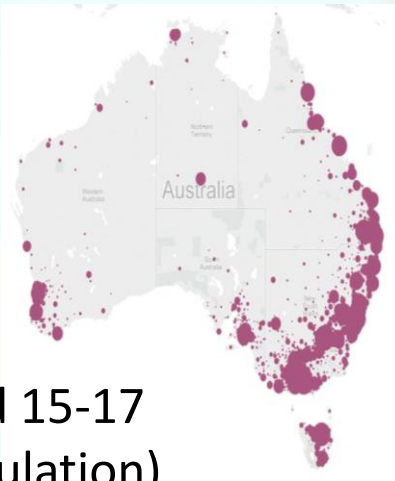
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Early Intervention in the Real World

Treatment patterns and short-term outcomes in an early intervention youth mental health service

Shane P.M. Cross, Daniel F. Hermens and Ian B. Hickie

Abstract

Aim: Early intervention mental health services tailored for young people are being developed across the world, yet reports on service use patterns and short-term clinical outcomes for the clinically diverse group accessing these services are very limited. The current study employed the clinical staging model to examine whether young people within the two clinical stages that precede full-threshold disorder (stage 1a and stage 1b) differed in terms of treatments received and short-term symptomatic and functional outcomes.

Methods: Eight hundred ninety young people aged 12–25 years seeking mental healthcare within a 12-month period were analysed in this study.

Results: Attenuated syndrome (stage 1b) patients used significantly more services than help-seeking (stage 1a) patients, including significantly higher rates of psychotropic medication prescription (9.3% vs. 43.6%). Stage 1a patients started with significantly lower levels of psychological distress and significantly higher levels of functioning at service entry and showed improvement only in psychological distress over 10 sessions. Despite using significantly more services, stage 1b patients remained impaired on both measures after 10 sessions; however, they showed some modest improvements in their levels of psychological distress and functioning over this time.

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Specialist Expertise



Mental Health
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du Canada



PSYCHOSIS



MOOD



PERSONALITY
DISORDERS



EATING DISORDERS



SUBSTANCE USE
DISORDERS

Vision for Youth Mental Health

“In 2020 young people in all communities will have access to the knowledge, skills and services necessary to respond to, and support them in periods of mental ill-health”



The International Declaration on Youth Mental Health

A shared vision, principles and action plan for mental health service provision for young people aged 12–25 years



Imagine a world where...

- ➡ Every young person has a meaningful life and can fulfil their hopes and dreams
- ➡ All young people are respected, valued and supported by their families, friends and communities
- ➡ Young people feel empowered to exercise their right to participate in decisions that affect them
- ➡ Young people with mental ill-health get the support and care they need when and where they need it
- ➡ No young person with mental ill-health has to endure stigma, prejudice and discrimination
- ➡ The role of family and friends in supporting young people is valued and encouraged

10-year targets

1. Suicide rates for young people aged 12–25 years will have reduced by a minimum of 50% over the next ten years. This minimum target means that we do not accept that the death of any young person by suicide is inevitable.
2. Every young person will be educated in ways to stay mentally healthy, will be able to recognise signs of mental health difficulties and will know how to access mental health support if they need it
3. Youth mental health training will be a standard curriculum component of all health, youth and social care training programmes
4. All primary care services will use youth mental health assessment and intervention protocols
5. All young people and their families or carers will be able to

Why an International Declaration on Youth Mental Health?

“International declarations that articulate core values, goals and standards have played an important role in enhancing the quality of care in a number of areas of medicine”

(Bertolote & McGorry 2005)

The World Health Organization



Announcing the Third International Youth Mental Health Conference

Transformations: Next Generation Youth Mental Health

**Hosted by the International Association of Youth Mental Health in
partnership with The Graham Boeckh Foundation and McGill
University**

8th – 10th October 2015, Place des Arts, Montreal, Quebec, Canada





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BRIDGING THE GAP BETWEEN CHILD
AND YOUTH MENTAL HEALTH
SERVICES AND PHYSICAL
HEALTH SERVICES

Recommendations

1. Restrict “TRANSITION” to the developmental task not to service transitions
2. Service transitions must be soft ones and flexible
3. The public health issue is huge and society should not be sold short through band-aid changes
4. Fundamental reform is essential, overdue and possible
5. MVP products already exist and can be built in Canada
6. Unlike any other area of health reform this one is an investment not a cost
7. Young people and families must be centrally involved

Recommendations

8. Philanthropy decisive as a catalyst – government to embrace
9. Full consensus not always possible and seeking it at all costs will slow reform
10. International synergy and cooperation an asset