INTERVENTION INSIGHTS

Mental health services for young people – the challenge of integrating services

The argument for increased attention to and resourcing of mental health prevention and early intervention strategies for children and young people is overwhelming. In a recent Access Economics report, it is estimated, that 24.3% of all Australians aged between 12 and 25 years of age suffered from a mental disorder in 2009. The financial cost for each affected individual equates to $10 544 (Aus) per annum, with the majority due to lost productivity, because of lower employment, absenteeism and premature death (1). Furthermore, Australian Bureau of Statistics data in 2007 shows that only 25% of young people aged 16–24 years who have a mental illness receive any treatment (and only 15% of males) compared with 35% of the total population with mental illness (2).

Opinions differ as to where along the childhood-early adulthood spectrum increased investment will produce the best overall outcomes. However, governments, clinicians and academics all agree increased investment is needed. The more difficult decision for those who are responsible for service delivery, and the subject which has generated most controversy in the literature, is how services to older adolescents and young adults should be organized and delivered. Birleson argues that it makes more sense developmentally, legally and socially to group adolescents with children than to link them with young adults (3). He additionally suggests that the creation of a youth model will create two transition points (child to youth service and youth service to adult service) instead of the traditional one (from child and adolescent services to adult services). This, Birleson states, will further increase difficulties with continuity of care and he argues that what is required is additional support and funding along the whole spectrum (3).

McGorry argues for the development of a youth model, which integrates mental health, drug and alcohol and physical care. This model should be youth friendly, incorporate specialist expertise in relation to a working with young people and their individual culture and give the young person more choice about their care including involvement of family (4). Currently youth mental health services are being established, or being considered, in many countries including Britain, Ireland, Canada and Australia. In Australia, the Federal Government supported the establishment of *headspace*, the National Youth Mental Health Foundation launched in 2006, and funded the establishment of 30 Communities of Youth Services across the country (5). A recent review of *headspace* concluded that while there are some ongoing challenges, the *headspace* initiative has promoted and facilitated improvements in young people's mental health, social well-being and participation in education, training and employment (6).

If the establishment of youth mental health services is to address the many criticisms of them, they must be designed so as to achieve certain outcomes (3,4). Firstly, they must be accessible and acceptable. It is believed that stigma associated with mental illness is even greater for young people than for the adult population (7). Services must be youth friendly, respectful and flexible given that many young people do not fit neatly into the more traditional office-based practice system often associated with traditional child and adolescent services. Sometimes the young person will only be agreeable to speak with a clinician on the first assessment for a few minutes. A rigid assessment process which demands full assessment is unrealistic and risks alienating many young people. Services must, in addition, have the capacity to engage with and support the young person's family or carer, if that is his or her wish, or to see the young person on their own. The service should not rely on the young person's family or carer to keep them engaged with the service, as is the case with many existing child and adolescent services. A capacity for outreach is essential in order to engage some clients – something that many child and adolescent services are unable to provide. The inclusion of young people and families in the design and ongoing operation of these services will also support making them accessible and acceptable.

Secondly youth mental health services must be integrated with other health services for young people. This is essential for numerable reasons and, in our experience, presents the biggest challenge to their establishment. These services must include primary care services including General Practitioners (GPs) who can provide general health and sexual health services, alcohol and other drug services, rehabilitation services including vocational and educational support, psychological services, occupational and social worker services as well as specialist mental health services. By their very nature young people require a 'one-stop shop' for their health needs. Many of the difficulties in relation to access, flexibility and acceptance concerns which we have about young people accessing mental health services also apply to drug and alcohol services and general practice. From the young person's

https://doi.org/10.1111/j.1601-5215.2010.00465.x Published online by Cambridge University Press

point of view, being referred from one service to another discourages access and many are not only unwilling but simply unable to navigate services. Young people find it difficult and unacceptable to have to repeat their history to different service providers. Integrated services do not mean simply formal arrangements with external providers, referral agreements or shared case management alone. In addition, services being delivered from the same site allow for opportunities for face-to-face communication and discussion by all parties, which improves collaboration (8). It is desirable that processes such as intake, case conferencing and patient records be integrated. Thus, an electronic health file with appropriate sharing of information between programs can be an important element of an integrated youth health service.

From a specialist mental health service perspective, an important aim of establishing a youth mental health service is to be able to identify serious illness as early as possible. This can only be achieved if adequate collaboration and continuity is established with those services more likely to have first contact with those who manifest early symptomatology of severe illness. A weakness of traditional adult services is they often only accept referrals of those with psychotic illnesses and that they do not have a tradition of continuity with primary care. This greatly reduces their capacity to intervene at the symptomatic ultra-high risk stage, prior to the emergence of threshold symptoms. Specialist mental health services often have a perception that GPs are unable to recognize early psychotic features or that they do not wish to be involved in managing mental health. But this perception may be the indirect consequence of adult mental health services discontinuity with primary care or reluctance to accept referrals until the patient is very ill which is, a consequence of their necessarily high threshold for acceptance of referrals. In contrast, services for young people need to have a very different approach to triage.

While the benefits of health service integration are recognized by many health professionals, governments and funding bodies, research would indicate that failure to either implement or sustain service integration is common. This failure in service integration usually centres upon the varying effectiveness of the change management strategies and people engagement processes used by organizations on their journey towards service integration. Professionals and employees working within the services which are attempting integration find the experience of change highly stressful. There are two elements to the change: structural and cultural. Structural elements to the change towards integration include procedural and administrative reorganization. It is, of course, the cultural change which is of the most difficult to achieve, and is, paradoxically, afforded the least attention. Cultural change refers to the establishment of norms, attitudes and interpersonal relationships that will foster working together and working towards a shared vision of improved services for young people.

Those establishing an effective youth health service will additionally need to consider promotion, community engagement and community literacy in relation to illness. The establishment of a consumer advisory or support group for the youth health service is an important element of this undertaking. Public mental health services usually have limited experience of these dimensions and have tended to avoid them, in part at least, because increasing access to their services has often not been their focus.

In Geelong, Australia, we opted for an integrated youth mental health model. A consortium was formed including specialist mental health services, psychiatric rehabilitation services, drug treatment services and a young persons GP health service, and was successful in seeking *headspace* funding with the Geelong GP Association being the lead agency. Significant funding to establish infrastructure including the employment of a manager and some community development workers was received, and two multi-agency *headspace* hubs have been established for the region serving 270 000 people.

Several evaluations conducted over the past 3 years taught us lessons which may be of value to others considering establishing such a service. The first evaluation concluded that we had initially underestimated the significant cultural differences between each of the collaborating services (9). These differences translated into differences in attitudes towards inclusion of carers, willingness to be assertive in offering care, priorities in relation to biological, psychological and social issues and attitudes towards management, records keeping, systematization of workflow and monitoring of performance and outcomes.

Recruiting GPs to work within the service was much more difficult than originally anticipated. Although some GPs were attracted to work with the service, our initial design which had mental health services running the practice was unattractive to GPs because they perceived the service to have a public mental health culture and because of characteristics of the clientele including a high 'failure to attend' rate. A more recent evaluation focused on the effectiveness of the integration of the existing services which came together (10). It concluded that pivotal to *headspace* Barwon's success in establishing itself within the region was its ability to mould itself to the unique characteristics of the local health sector environment, particularly at the strategic and higher levels. It was contended by those who contributed to the evaluation that this has been possible because *headspace* Barwon did not seek to create something new, but has instead built on what already existed and worked well within the region. The objective was not to envelop any other consortium members, but instead to establish an umbrella system which facilitates service integration across agencies. This highlights an important risk. It may seem easier to establish a youth service from scratch, if resources are available, rather than face the challenges associated with integrating existing services. But this may simply lead to the creation of another service isolated from existing services for young people. In particular, we would contend that the engagement of public mental health services is difficult but critical. However, the recent review of our service found that the sense of integration success of *headspace* Barwon was not shared by all levels of staff and that there are varying degrees of identification with it amongst staff, perhaps because many are still strongly attached to their previous agency identity and may perceive the headspace identity as devaluing their original identity. Thus there is considerably more work to be done in the development and implementation of strategies surrounding staff engagement.

We believe that the ideal vehicle for the provision of mental health and drug and alcohol services is an integrated health service geared toward young people from early teens to mid-1920s. We reorganized our mental health services towards a youth

https://doi.org/10.1111/j.1601-5215.2010.00465.x Published online by Cambridge University Press

model because we did not believe our child and adolescent services could easily attend to the specialist needs of children including forming linkages with schools and paediatricians and simultaneously collaborating intensively with young peoples' health services. Nor did we believe that our adult services, which were once focused on 18 to 65-year olds, could attend to their older clientele and focus on the needs of their younger adults. The challenges associated with integrating services should not be underestimated – it requires leadership, local commitment and support from government. This is needed if we are to redress the situation whereby our young people receive a disproportionately lower level of service than their older counterparts when what they need, if we are to be serious about early intervention, is the opposite.

Thomas Callaly[1,2], Kathryn von Treuer[1], Seetal Dodd[2,3], Michael Berk[2,3,4,5]

[1]School of Psychology, Deakin University, Geelong, VIC, Australia;
[2]Mental Health, Drugs and Alcohol Services, Barwon Health, Swanston Centre, Geelong, VIC, Australia;
[3]Department of Clinical and Biomedical Sciences, The University of Melbourne, Barwon Health, Melbourne, VIC, Australia;
[4]Orygen Research Centre, The University of Melbourne, Melbourne, VIC, Australia; and
[5]Mental Health Research Institute, Melbourne, VIC, Australia

Professor Thomas Callaly,
Mental Health, Drugs and Alcohol Services,
Barwon Health, Swanston Centre,
PO Box 281, Geelong 3220, Australia.
Tel: +61 3 5226 7573;
Fax: +61 3 5226 7454;
Email: thomas@barwonhealth.org.au

Acta Neuropsychiatrica 2010: 22: 158–160
© 2010 John Wiley & Sons A/S
DOI: 10.1111/j.1601-5215.2010.00465.x

References

1. Access Economics. The Economic Impact of Youth Mental Illness and the Cost-Effectiveness of Early Intervention. 2009. http://www.headspace.org.au/_uploads/documents/2009%20media%20releases/CostYMH_Dec2009FINAL.pdf [accessed on 12 December 2009].
2. Australian Bureau of Statistics. National survey of mental health and well-being. Summary of results. Canberra: Australian Bureau of Statistics, 2008.
3. Birleson P. Should youth mental health become a specialty in its own right? No. BMJ 2009;**339**:834–835.
4. McGorry P. Should youth mental health become a specialty in its own right? Yes. BMJ 2009;**339**:834–835.
5. www.headspace.org.au [accessed 12 December 2009].
6. Social Policy Research Centre University of New South Wales. Headspace Evaluation Report. Independent evaluation of headspace: the National Youth Mental Health Foundation, 2009. http://www.sprc.unsw.edu.au/media/File/Headspace_evaluation_plan.pdf [accessed 12 December 2009].
7. BMA Board of Science. Child and Adolescent Mental Health: A Guide for Health Care Professionals, 2006. http://www.bma.org.uk/images/ChildAdolescentMentalHealth_tcm41-20748.pdf [accessed 12 December 2009].
8. Institute of Medicine. Improving the quality of health care for mental health and substance-use conditions. Washington: Institute of Medicine, 2005: 238.
9. Callaly T, Dodd S, Ackerly C, Hantz P, O'Shea M, Berk M, Description and qualitative evaluation of Jigsaw, an integrated young persons mental health program. Australas Psychiatry, 2009;**17**: 480–483.
10. von Treuer K, McGillvray J, Windle K. Headspace Barwon: the story so far. Geelong: Deakin University, 2009.

https://doi.org/10.1111/j.1601-5215.2010.00465.x Published online by Cambridge University Press