The specialist youth mental health model: strengthening the weakest link in the public mental health system

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> Our health system needs to take the next step forward in removing the barriers between health professionals and young people. It needs to start listening to what we are saying and what we are asking for. To know what works best for us, the system has to become youth-friendly and youth-oriented. *(Vittoria Tonin, Platform youth participation program, ORYGEN Youth Health, 2007)*

ABSTRACT

- Despite mental disorders being the dominant health issue confronting young people, youth mental health is yet to be recognised as a discrete, unified program area; responsibility for young people's mental health is currently split across multiple levels of government.
- Public specialist mental health services have followed a paediatric–adult split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest.
- Young people need youth-friendly services that recognise and respond to their special cultural and developmental needs. At the primary and community level, *headspace*: the National Youth Mental Health Foundation, is a national response to this and aims to provide better access, engagement and enhanced multidisciplinary care for young people across Australia.
- The specialist mental health service level should be complemented by youth-specific specialist mental health services for young people, aged 12–25 years, which would strengthen the existing system with a better targeted stream of care, providing access to integrated mental health, substance use, and vocational-recovery services. Alternative approaches to creating this capacity should be urgently developed and evaluated, and sustained reform informed by evidence as well as values.

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Mental disorders account for around 50% of the total disease burden among young people aged 12–25 years in Australia.[1] It is generally agreed that there are high levels of unmet need, poor access to and fragmentation of services, and a lack of quality care for adolescents and young adults with emerging mental disorders, and that this requires serious policy attention, and additional investment and reform. However, the best way to address this within specialist mental health systems remains an area of debate.[2-6] Some have maintained that retaining and investing within the traditional structure of specialist services, namely the Child and Adolescent Mental Health Services (CAMHSs)/Adult Mental Health Services (AMHSs) model, will be sufficient, and that to consider more ambitious reforms could be harmful.[7] Nonetheless, most international definitions of "young people", national youth forums, national health data collections processed, and local government services focus on the age group 12–24 years, which spans these two services.[1]

Whatever the structural model selected, it is not contentious that we need effective health care service systems that can rapidly engage young people and provide the comprehensive, integrated treatment and support services they need to achieve clinical remission and full functional recovery. Many young people can be successfully managed through primary care and enhanced youth-oriented primary care service models (eg, *headspace*, McGorry et al, *page S68*). However, a subgroup of young people with a range of diagnoses requires timely access to more comprehensive, multidisciplinary, youth-specific specialist mental health services. This has been clearly identified in a recent landmark report as a serious gap in services.[8]

There may be more than one way to achieve these goals, but substantial investment and some degree of restructuring of the existing system is inevitable. Alternative approaches should be actively explored and evaluated; however, critics will find it increasingly difficult to argue in support of the status quo. On the other hand, serious reform in this area represents a long-term challenge that will stimulate resistance from interest groups, but will also attract widespread support from the public and other key community sectors.

The status quo: CAMHSs and AMHSs

The development of the subspecialty of child psychiatry is a relatively recent feature of service provision in mental health, and it remains under-resourced and poorly distributed across communities.[9] Even more recent is the attempt to create an adolescent focus within child psychiatry, which has led to the broader labels of "child and adolescent psychiatry" and CAMHSs. CAMHSs have certainly tried to evolve a somewhat distinct adolescent focus; however, this has achieved only limited success for reasons outlined some years ago,[2] and in many countries has not even reached first base. A key obstacle is the premature truncation, on educational and legal grounds, of the upper age limit at 18 years (or even earlier if the young person has completed secondary education). A qualitatively different clinical approach is required for adolescents and young people, one which tends to look forward into their future life rather than backward into childhood. This notion of responding to young people after puberty more as young and emerging adults, rather than as children or adolescents, has recently been characterised in detail by the British child and adolescent psychiatrist, Phillip Graham, who argues that the age of 14 years is the best demarcation zone.[10] At best, we can say that adolescent or youth psychiatry is an embryonic subspecialty, which reached an impasse some time ago.[2] The strengths of child and adolescent psychiatry include a focus on developmental and family issues, and an ability to work flexibly with a range of other service providers, including the education sector. However, spe-

Streamed youth-friendly mental health services

Streamed youth-friendly mental health services are more appropriate for young people, who are more likely to:

- be using the mental health (or health) system for the first time
- have families and friends who are being exposed to the mental health system for the first time
- be treatment-naïve and more sensitive to iatrogenic effects (medical or environmental)
- experience multiple comorbidities, especially substance use, that require an integrated model of care
- be a heterogeneous group, with varying, and clinically uncertain illness trajectories
- be prone to relapses, as they have not had the time to learn about their illness and how to manage it successfully
- be prone to exhibit more disruptive behaviour and deliberate self-harm when acutely unwell, because they are cognitively and emotionally less mature, are younger and fitter, and more likely to have comorbid substance use disorders. ◆

cialist child and adolescent services are even more poorly resourced than adult mental health services, private child psychiatrists and psychologists are relatively few and poorly distributed, and consequently the bulk of mental health care for children is provided in primary care and by paediatricians. CAMHSs are currently better equipped to respond to disorders with an onset in the prepubertal period, such as attention deficit hyperactivity disorder (ADHD), conduct disorder, and developmental disorders. They tend to struggle operationally and clinically with adult-type disorders, such as mood, psychotic, substance use, and borderline personality disorders, which begin to emerge during adolescence, manifesting fully in early adulthood.

Despite deinstitutionalisation and, supposedly, better community integration, AMHSs have retreated in recent years to cover acute management of risk and disturbed behaviour and, specifically, the care of people with chronic mental illness, mainly those with severe, relapsing and disabling disorders and, typically, schizophrenia. The patients are middle-aged on average, and are inevitably the marginalised subset of people who experience severe mental disorders with poor prognoses. The environments and cultures of these services are insensitive to phase of illness, to developmental stage, and to the needs of families and friends.[7] Despite the best efforts of clinical staff, morale and optimism are at a low ebb, and young people entering these services are therefore at great risk of iatrogenic harm in a number of ways. However, the positive features of the best adult psychiatry services, namely the capacity to skilfully and safely manage highly disturbed behaviour, and the more sophisticated psychopharmacological skills, are often lacking in the services provided by CAMHSs.

Creating specialist youth mental health services

A new "youth mental health" approach is required that builds on, but is qualitatively different from, existing child and adolescent and adult approaches, which have both struggled to address the mental health needs of teenagers and young adults[3,4,10-12] (Box). Youth-specific approaches are defined by their developmentally oriented and culturally attuned approach to the management of mental and substance use disorders, which acknowledges the evolving nature and complex pattern of morbidity in this age group, young peoples' individual and group identity and unique life-stage issues, and their help-seeking needs and behaviours.[2,3,10,13,14] Similar arguments were made some years ago and underpinned the establishment of streamed services for older people with mental disorders and the now secure subspecialty of geriatric psychiatry.

Youth mental health service provision is a new and rapidly evolving field of practice. The ORYGEN Youth Health program in Melbourne has been established and has evolved, with the support of the Victorian Government, with the aim of creating a real-world model for reform in early intervention and youth mental health. ORYGEN has successfully adjusted its target age range to coincide with the peak period of onset of mental health and related substance use disorders, and provides access to young people with the full range of mental health problems in this age group, including mental health and substance use comorbidity. While it has been unable to cover the ideal age range of 12–25 years, the focus on the 15–25-years age group achieves most of the clinical objectives targeted. However, the model remains significantly underfunded in relation to demonstrable local unmet need for specialist mental health care for young people and in comparison with the surrounding AMHS system.

The experience and scientific data flowing from the ORYGEN model have already influenced clinical service provision in Victoria, across Australia, and internationally, particularly in the area of early psychosis, through the Early Psychosis Prevention and Intervention Centre (EPPIC) program.[15,16] This model provides value for money,[17,18] as it focuses on early intervention with the population cohort most at risk of developing potentially disabling mental health and related substance use disorders, and provides comprehensive services that successfully address health as well as social outcomes.

The advent of *headspace*: the National Youth Mental Health Foundation (McGorry et al, *page S68*) now means that a unique opportunity exists for public youth-specific specialist mental health services to be developed within each state and territory. Such reform and investment would complement the *headspace* model, as well as fill a large gap in the existing specialist mental health service system, and allow a more targeted response to the mental health needs of young people.

In this model, youth-specific specialist mental health services would be available to young people, aged 12–25 years, with emerging, potentially severe or complex mental disorders, especially psychoses, mood, personality and substance use disorders. Youth-specific specialist services would provide a range of community-based services for consumers living within their catchment zone, including:

- triage and assessment services;
- extended hours, mobile multidisciplinary teams providing intensive community-based crisis response and home treatment;
- mobile youth-intensive case management services for young people with complex needs who are difficult to engage in office-based care;
- psychosocial case management and therapeutic individual and family services;
- specialist disorder-specific services for young people with severe personality disorders, mood disorders and psychoses;
- comorbidity clinics;
- consumer and carer peer-support programs; and

- comprehensive group-based personal, social, and vocational recovery programs.

Specialised youth inpatient units would form an essential central element of a new youth mental health model. These would need to be purpose-built with special design and clinical service features to optimally meet the needs of young people and their families. While a detailed description of these issues is beyond the scope of this article, the key features, based on the ORYGEN experience, as well as a series of international visits and consultations, include:

- substreamed mini-units with a home-style atmosphere and active involvement of families and friends;
- increased staff–patient ratios, in contrast to older adult or child units;
- integrated mental health and drug and alcohol service provision; and
- peer-support workers.

The move from institutional to mainstream hospital and community care is now acknowledged to have resulted in an excessive loss of beds, which is now manifesting as critical bed shortages across all levels of inpatient care. The quality of care in inpatient units has also been eroded by much higher levels of acuity in the face of poor design, weakened leadership, and inadequate staffing levels and experience.[6,19] The strategic development of specialised inpatient units for young people would go a long way towards solving many of these "downstream" problems.

In summary, youth mental health services would aim to provide an intensive, comprehensive and integrated service response to young people and their families, focused on symptom remission, social and vocational recovery, and relapse prevention.

Options for reform

The development of youth-specific services could be achieved in one of two ways. Firstly, the current system could be restructured and enhanced through a strengthening and extension of the adolescent component of the current CAMHS model. The upper age limit could be extended to 25 years, and the currently fragile adolescent focus could be more strongly differentiated from the child focus by the creation of more youth-friendly service settings and systems, as described above. The developmental and family perspectives which characterise existing CAMHSs could be safeguarded and further specialised, while the influx of new resources would strengthen the capacity of the system. The existing three-stream structure of mental health services and professional practice could be retained, and a stronger subspecialty of child and youth psychiatry could emerge.

Alternatively, a new stream of care originating at the lower age range of adult psychiatry could be created, as has been established with the early psychosis services developed all over the world in recent years. The endpoint of this latter approach would be four substreams of care (child, youth, adult, and older people) with different service models and environments for each stream. In essence, there is little difference, from a consumer and societal perspective, between these two approaches, although the politics of reform could be quite different.

Children (under 12 years) would be treated within one stream, predominantly in community settings, including specialised clinics and teams for specific disorders such as ADHD, conduct disorder and autism. The need for mobile teams and inpatient beds would be relatively less. This system could retain its links with the youth system described, and it could usefully integrate more strongly with mainstream paediatric services. Adolescents in secondary school and young adults up to 25 years of age would be treated in comprehensive, multicomponent service centres similar to, but larger, in scale, scope and tenure, than the current ORYGEN model. These services would be qualitatively and structural different from both adult and child-oriented services. Early intervention for emerging, potentially serious, mental disorders would be a key objective (in addition to the transitional care of existing childhood-onset cases), and could be ensured through close cooperation with the primary care workforce and linkages with the enhanced primary care structures that will be progressively developed through *headspace*. Specialised substance use services for young people should also be expanded and integrated within this youth health model under a single service system, thus avoiding many of the chronic fracturing and staff-centred tensions of the current system. This integration could prove a prototype for the widely sought, but elusive, full reintegration of mental health and drug and alcohol services.[20]

Some critics have claimed that such a system would increase fragmentation of services by the creation of an additional tier of services. This could particularly affect those patients whose illnesses emerge before puberty (eg, ADHD and developmental disorders) and who need ongoing care into the adolescent period. This should be addressed by a flexible interface at the border between child and youth streams of care, which would be desirable from a number of standpoints. There is legitimate debate about the lower boundary, and whether it should be around 12 (or perhaps 14) years of age.[10] The fundamental change of shifting the upper transition point from 16 or 18 years to 25 years does not add to the complexity, and in fact overcomes a much more serious break in continuity and culture of care at a younger age. Again, strong linkages between youth and older adult services are the antidote to potential problems.

The proposals we have outlined for reform and investment in the public state-funded mental health system in Australia would strengthen the system at the acute and complex end to complement both the existing public mental health structures, and the emerging multidisciplinary communities of youth services funded through *headspace* (also focused on 12–25 year olds). The proposals are based on many years of clinical experience, backed up by accumulating data. Further data will follow stepwise reform, which can remain "evidence-informed". Critics and those opposed to reform typically argue that conclusive evidence is required to justify major reforms in health care. Such a perspective is unrealistic, as very few reforms of lasting value have followed this pattern. Typically, governance, strategic and service delivery policies have their roots in values, with evidence providing insurance and guidance.[21-23] Evidence is not the only legitimate influence on the direction and pace of reform.[22,23]

Indeed, evidence of the required type can only be assembled in the wake of, rather than in advance of, system reform, which optimally is a sequential process. When serious problems with the status quo have been identified, as they have in mental health and specifically youth mental health, the onus is on governments and health departments to respond with better models, while safeguarding the positive aspects of the original system. It is worth noting that the current system has evolved in an ad-hoc manner, with very little evidence to support its key features, notably here the CAMHS/AMHS structure. This former and optimal approach was not followed in earlier waves of mental health reform, which

saw the welcome construction of community-based mental health care for the first time, yet witnessed a decline in quality of inpatient care. The conclusive evidence demanded by critics is the horizon we strive to reach, rather than a prerequisite. All too often, this demand can be revealed as a tactic that seeks to oppose any change. Evidence is more appropriately a guide for change rather than a driver, and we should accept that evidence-informed and values-based models of care should be combined in policy making, service design, commissioning, and clinical practice.[20] Funding is already committed in several regions of Australia to pursue this reform agenda, and provided these early-adopter programs are carefully examined and evaluated as they evolve, they can provide a vital learning space for the rest of Australia, as it creates its 21st century mental health care systems.

Competing interests

None identified.

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