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PRODUCTIVITY COMMISSION
DRAFT REPORT INTO THE
SOCIAL AND ECONOMIC
BENEFITS OF MENTAL HEALTH

ORYGEN FEEDBACK

CONTENTS

ORYGEN FEEDBACK AND RESPONSE TO INFORMATION REQUESTS

- ABOUT ORYGEN..... 3
- INTRODUCTION..... 3
- SECTION 1: OVERALL RESPONSE 5
- SECTION 2: CONTESTED RECOMMENDATIONS..... 10
- 24.2 REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING 10
- 5.3 ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE 14
- SECTION 3: SUPPORTED RECOMMENDATIONS 18
- SECTION 4: INFORMATION REQUESTS 22
- 5.2: MENTAL HEALTH TREATMENT PLANS..... 22
- 14.1: INDIVIDUAL PLACEMENT AND SUPPORT EXPANSIONS OPTIONS 22
- 18.1: GREATER USE OF ONLINE SERVICES IN TERTIARY EDUCATION SETTINGS..... 24
- 18.2: WHAT TYPE AND LEVEL OF TRAINING SHOULD BE PROVIDED TO EDUCATORS?..... 25
- 18.3: INTERNATIONAL STUDENTS ACCESS TO MENTAL HEALTH SERVICES..... 26
- 23.1 ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM..... 28
- APPENDIX 1 30
- APPENDIX 2 – EVIDENCE IN EARLY PSYCHOSIS 31
- REFERENCES 37

ORYGEN FEEDBACK AND RESPONSE TO INFORMATION REQUESTS

PRODUCTIVITY COMMISSION DRAFT REPORT INTO THE SOCIAL AND ECONOMIC BENEFITS OF MENTAL HEALTH

ABOUT ORYGEN

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Orygen conducts clinical research, runs clinical services (four headspace centres), supports the professional development of the youth mental health workforce and provides policy advice relating to young people's mental health. Our current research strengths include: early psychosis, mood disorders, personality disorders, functional recovery, suicide prevention, online interventions, neurobiology, and health economics.

INTRODUCTION

Greater investment in prevention and early intervention is critical in terms of making inroads into the incidence of mental ill-health in young people. This can help to address young people's mental health issues before they progress to more serious and longer-lasting conditions.(1) Prevention and early intervention is a high priority in mental health given that:

- 75 per cent of mental health issues are established before the age of 25.(2)
- The incidence of mental ill-health in Australia is highest among young people aged 16–24, with one in four young people experiencing symptoms.(3)
- Many young people do not seek help. Young people aged 15-24 **with a mental health condition** were almost twice as likely to not see a GP because of cost barriers compared with those without a mental health condition and two and a half times more likely to delay or not get prescribed medication due to cost compared with those without a mental health condition.
- There has been a large spike in the number of mental health-related emergency department presentations in the age ranges of 12-17 and 18-24 years.
- Children and young people aged less than 17 years were twice as likely to experience significant deterioration in their mental health due to hospital inpatient treatment compared to those aged 18-64 at 8.9 per cent compared with 4.2 per cent according to latest available data.
- Readmissions for separations associated with both persons under 15 years and those aged 15-24 years have remained higher than readmissions for all ages since 2013-14.
- This age group has an increased risk of comorbidities, including drug and alcohol issues, lifelong social exclusion, and economic marginalisation if mental health issues are not addressed.(4) For all mental disorders, persons aged 12-17 years had consistently higher average numbers of days missed from school compared with person's ages 4-17 years.
- The leading cause of mortality in Australian young people aged 15–24 is suicide.(5) Indeed, new data shows there is a significant leap in rates of suicide between males aged 12-17 and

those aged 18-24 – from 6.9 per 100,000 to 21.3 per 100,000 or more than 300 percent. For females in those age ranges, the rates of suicide increase from 4.2 per 100,000 to 6.7 per 100,000 or 60 percent.

In April 2019, Orygen provided a joint submission with headspace National Office as part of the first call for submissions to the Productivity Commission's inquiry into the social and economic benefits of mental health in Australia.

This submission outlined five key priorities areas and 17 recommendations for the Commission to consider as part of its initial assessment, including:

1. Increase access to effective mental health services and supports for young people across all stages of mental ill-health. Recommendations included:
 - Future youth mental health funding should be directed to strengthen and extend access to headspace, the Australian Government's national platform for youth mental health care.
 - Future commissioning of youth mental health services and programs by Primary Health Networks (PHNs) to include oversight by headspace National and Orygen to ensure evidence-based commissioning and to protect the integrity of the headspace platform.
2. Improve education and workforce participation for young people with mental illness. Recommendations included:
 - Increase access to vocational support programs such as Individual Placement and Support (IPS) and Digital Work and Study Service within youth mental health services including in all headspace services.
 - Develop and implement education and training settings-based approaches across schools, vocational, and tertiary institutions to prevent early exit from education and to enable re-engagement with education for young people experiencing mental ill-health.
3. Reduce self-harm and suicide-related behaviours in young people. Recommendations included:
 - Make suicide prevention a focus for all settings and services engaged with young people, including schools, primary care services, mental health services and hospital emergency departments.
 - Develop a real-time surveillance system with standardised data collection and reporting for suicide and suicide-related behaviour.
4. Build a youth mental health workforce to meet current and future needs. Recommendations included:
 - Build the capacity and supply of a youth mental health workforce with the skills and motivation to provide engaging, high quality and evidence-based care to young people.
 - Address barriers, including job insecurity and poor incentive design, for the recruitment and retention to the youth mental health workforce.
5. Drive improvements through research, data, and outcome monitoring. Recommendations included:
 - A clear expectation and funding support for major youth mental health service platforms, like headspace, to be harnessed as clinical research platforms to develop and test new prevention, early intervention and treatment modalities and interventions.
 - Regularly collect and report national data, including epidemiological and health service data on the mental health and wellbeing of young people aged 12-25 years in Australia.

These priority areas were developed following significant consultation with a variety of key stakeholders, including young people and their families, service managers, clinical advisers and researchers. Orygen maintains the stated position, priorities and recommendations contained in the original submission, which can be accessed [here](#).

SECTION 1: OVERALL RESPONSE

Orygen welcomes the Commission's analysis and commentary on the prevalence of mental ill-health in Australia and its recognition of the significant personal, social and economic impact resulting from experiences of mental illness. We would like to acknowledge the Commission for the breadth and depth of the analysis contained in the draft report and the considerable effort required to deliver such an undertaking.

Orygen will not respond to all 87 draft recommendations in the report. Instead we note and/or provide comment specifically where we strongly support a recommendation and/or where we strongly contest a recommendation. Table 1 also provides a high level summary. Where we do not provide a specific response, it is either because:

- Orygen provisionally supports the recommendation;
- The recommendation does not directly relate to our target population (12-25 year olds); or
- We are not in a position to assess the merits or flaws of the recommendation.

Section 4 of this document provides a response to a number of the information requests contained in the draft report.

Orygen believes that the Productivity Commission's inquiry has the potential to historically alter the future of Australia's mental health system and is hopeful that this can be a positive, sustainable and equitable process

Globally, Australia is at the forefront of youth mental health service research, design, development and delivery. A number of nations around the world have leveraged Australian expertise to develop and deliver their own youth-specific support services to support this highly vulnerable age group(6).

Orygen strongly believes that scaled-up investment in youth-specific, holistic, and evidence-based early intervention will transform the lives of young people and their families, and deliver significant social and economic benefits, not only to the Australian community, but in communities around the world.

While Orygen is supportive of the Commission's 'diagnosis' of the problem, including the scale and economic cost of mental illness in Australia, there are a number of areas of concern relating to the proposed solutions/recommendations and their limitations in addressing the most significant challenges that are currently faced in efforts to improve the mental health and wellbeing outcomes of young Australians. These include:

- The continued contextualisation of a system for 'child and adolescent' and 'adult' service provision. This outdated paradigm ignores the research and data concerning prevalence across age groups, age of onset, burden of disease and the youth mental health models of care and services developed in Australia that have informed worldwide system reforms.
- The over emphasis on stepped-care as the preferred model for mental health service delivery which appears to be motivated by an intent to shift care down a step into lower-intensity interventions and online/digital substitutions for face-to-face care (many of which have limited available evidence to support efficacy), as an effort to reduce demand and be less costly. Orygen believes a 'staging model' (7, 8) rather than stepped-care is a more transformative and effective approach. The staging model is presented at Appendix 1.
- The lack of clear response to how services will be funded and positioned to provide the appropriate dose and duration of treatment in community-based settings for those young people with more moderate to serious mental health issues who are currently missing out on effective and expert care.
- The removal of protection of funding for evidence-based programs which specifically support young people with mental ill-health. Orygen believes there is a need for a clear national template and specifications for commissioning mental health services across all age groups

(informed by area experts, e.g. in youth mental health, trauma, Aboriginal and Torres Strait Islander populations). This would direct commissioners to fund evidenced-based care that adheres to fidelity measures and limit discretion in funding decisions where strong evidence for models/services already exist.

Orygen contests two key recommendations in the draft report (discussed in detail in Section 2). They are:

Draft Recommendation 24.2 Regional autonomy over service provider funding will increase the likelihood that crucial early intervention services, which have been carefully researched, adapted and delivered specifically for young people, will be placed at risk, reducing young people’s access to these recognised, appropriate and acceptable services and result in a fragmented and difficult-to-navigate system for this age group.

Draft Recommendation 5.3 Ensuring headspace centres are matching consumers with the right level of care is ill-considered, primarily as there is currently mixed evidence and uncertainty around the effectiveness of low-intensity treatments for young people. In addition, this recommendation does not recognise that a significant challenge for headspace centres at present is the increase in the number of young people with more complex and severe mental health issues presenting to these services as they have no other care option available to them. Placing targets on centres for low-intensity services could result in these young people falling through the service gaps completely.

Orygen strongly recommends that the Commission consult specifically with young people on the recommendations related to headspace centres to ensure their voices are included in the development of the final report and recommendations

TABLE 1. Overall response to the Productivity Commission draft recommendations

STRONGLY SUPPORTED

Recommendation	Additional comments
5.4 MBS Rebated Psychological Therapy	<p>Orygen supports increasing the number of MBS Better Access Sessions for individuals whose mental ill-health requires more than 10 psychological therapy sessions in 12 months.</p> <p>Additional specific funding is required for case and care coordination for young people with more complex and serious mental health issues within the primary care system.</p>
5.5 Encourage more group psychological therapy	<p>Group therapy and group/social programs are highly acceptable to some young people.</p> <p>Medicare Benefits Schedule (MBS) items are needed to appropriately reflect the duration and size of group therapy.</p> <p>State and territory mental health funding for mental health should also be allocated to the provision of group programs.</p>
5.9 Ensure access to the right level of care	<p>Orygen supports service and system reforms that ensure individuals have access to the appropriate dose, duration and intensity of care they need. This focus needs to be matched with significant investment in research to develop the evidence needed to inform service and treatment approaches.</p>
6.1 Supported online treatment options should be integrated and expanded	<p>Orygen supports integrating online treatment with face-to-face care. However, there is a need to move beyond a focus on mild-moderate mental health issues and recognise the benefits of integrating online clinician assisted therapies into face-to-face care for individuals with moderate-severe and complex mental health issues and into recovery.</p>

8.1 Improve emergency mental health service experiences	<p>Orygen is undertaking work to improve the responses to presentations of self-harm or suicide-related behaviours to emergency departments. A study is currently underway to:</p> <ul style="list-style-type: none"> • examine hospital staff perceptions of the current barriers to delivering optimal care for young people who self-harm and present to emergency departments; and • examine young people’s perspectives of the treatment they received.
8.2 Provide child and adolescent mental health beds that are separate from adult mental health wards	<p>Orygen supports the need for dedicated and separated beds for specific age groups, However, we would like to see the Productivity Commission contextualise the future system as a ‘child’ ‘youth’ ‘adult’ and ‘aged’ system and therefore include in this recommendation the need for youth beds (for 12-25 year olds).</p>
10.4 Care coordination services	<p>Supported with dedicated funding and incentives for providing care coordination including dedicated staff in services, training for allied health practitioners and greater support for mental health nurses.</p>
11.1 The National Mental Health Workforce Strategy	<p>Orygen supports the sub recommendations contained in 11.1 and specifically recommends, where possible, funding, systems and infrastructure that can support the colocation of mental health-related practitioners e.g. mental health nurses, GPs, social workers, occupational therapists in mental health services.</p>
11.3 More specialist mental health nurses	<p>Mental health nurses are a critical part of the mental health workforce. There is a need to increase and protect funding for mental health nursing and incentivise the field for those studying nursing including:</p> <ul style="list-style-type: none"> • Undergraduate units on emerging evidence for mental health interventions • Funded places (scholarships) • Flexible entry pathways that allow current nurses to upskill into the profession via certificates or diplomas. <p>Leadership in the nursing field to promote the area and reduce stigma/misconceptions regarding working in the field.</p>
11.4 Strengthen the peer workforce	<p>Strongly supported.</p>
13.3 Family Focused and carer inclusive practice	<p>Family support is a positive determinant of young people accessing mental health services and benefits.</p> <p>Family sessions and family inclusive practice requires dedicated funding.</p>
14.3 Staged Rollout of Individual Placement and Support model	<p>Strongly supported and needs to include every headspace centre nationally, the new adult mental health hubs, as well as, state and territory mental health services.</p>
18.1 Training for educators in tertiary education services	<p>There is a significant gap in the continuity of care for young people post-school. However there needs to be systematic and evidence-based approach to training educators in tertiary settings. The National University Student Mental Health Framework is anticipated to provide guidance and direction specifically to universities on mental health training in university environments.</p>
18.2 Student mental health and wellbeing strategy in Tertiary education institutions	<p>Orygen supports this recommendation and notes that we are currently developing a National University Student Mental Health Framework with partners across the university and mental health sectors. This will be finalised in late June 2020. Orygen acknowledges that: 1) uptake of the framework by universities will require a good understanding of the most effective levers for</p>

	universities and 2) that this framework is currently limited in scope to only Australian public universities.
21.2 Empower indigenous communities to prevent suicide	Place-based suicide prevention strategies designed and implemented by Aboriginal and Torres Strait Islander communities and organisations have the potential to respond to, and anticipate, community needs. Organisations should demonstrate: <ul style="list-style-type: none"> • cultural competence • a clear understanding of community needs • processes to co-design strategies with communities • ability to leverage evidence to design culturally appropriate suicide containment strategies.
21.3 Approach to suicide prevention	Young people with a lived experience of mental ill-health should be engaged in developing the National Suicide Prevention Implementation Strategy. Orygen has undertaken considerable research and policy work in youth suicide prevention and has recommended the need for a youth-specific strategy or at the least a youth specific suicide prevention implementation plan.
22.3 Enhancing Consumer and Carer Participation	Consumers, carers and families provide valuable insight on the quality, effectiveness, accessibility and appropriateness of mental health services. Non-tokenistic, meaningful engagement with young people and their families and friends is being demanded and reflected in the mental healthcare system and should be considered the gold standard in participation in the mental health system. Young people require specialised support to amplify their voice. Targeted support should be provided to ensure the perspective of a diverse range of populations is captured. Capacity will need to be built within the existing workforce to listen to, and engage with, young people and their perspective.
25.2 Routine national surveys of mental health	Strongly supported.
25.9 A Clinical Trials Network should be established.	Strongly supported.

STRONGLY CONTESTED

Recommendation	Additional comments
5.3 Ensuring headspace centres are matching consumers with the right level of care	Detailed response commencing at page 10.
24.2 Regional autonomy over service provider funding	Detailed response commencing at page 14.

REQUIRES FURTHER CONSIDERATION

Recommendation	Additional comments
5.1 Low-intensity therapy coaches as an alternative to psychological therapists	Limited evidence.

17.2 Social and Emotional Development in Preschool Children Very limited evidence.

17.6 Data and child social and emotional wellbeing Should be a specific data set on youth mental health.

23.3 Structural Reform is Necessary Orygen believes that any change to State and Federal commissioning arrangements still requires the establishment of an overarching national commissioning body which can oversee and direct approaches to regional commissioning to align with the evidence base as it exists and emerges. We would also emphasise the need for any structural reform to address the 'missing middle' as a core responsibility of both primary and tertiary level services.

SECTION 2: CONTESTED RECOMMENDATIONS

While the Productivity Commission recognised that in 75 per cent of circumstances the age of onset of mental ill-health is under 25 years, much of the analysis and discussion contained in the draft report continues to contextualise a system framed around child/adolescent and adult age ranges; not ‘youth’ mental health.

In addition, outside of school-based interventions and programs there are only a handful of findings and recommendations that directly relate to young people (aged 12-25 years). Despite acknowledging that young people are more likely to experience mental ill-health in any given year compared to other age groups, the draft report does not sufficiently outline how those working within the health sector can better assist the unique challenges faced by Australian young people and provide effective early intervention.

In fact, the recommendations relating directly to the current national youth mental health services in Australia (Draft Recommendation 24.2 and Draft Recommendation 5.3) place this critical infrastructure and evidence-based programs that are delivered through this platform, such as the Early Psychosis and IPS programs, at a high level of risk.

This could dismantle 15 years of progress in youth mental health in Australia, be counter to the global reforms that have developed in this area (drawing into question Australia’s position as world leaders in this space) and most importantly, have long-term ramifications for Australian young people and their access to quality, evidence-based care.

24.2 REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING

The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit.

Young people report that they need affordable, approachable, easy-to-reach mental health services that provide support tailored to their individual needs(9). They desire a ‘soft entry point’ to the mental health system, one that is non-stigmatising, is welcoming and recognises the complexity of mental health, including both social and medical factors and treatment responses(9).

Often, young people do not find it easy or approachable to access those non-specialised community mental health services currently available in the broader system(9). For many years now, the only local, youth-specific mental health service available to young people, with a ‘no wrong door’ approach to getting help, has been the headspace centre network.

The influence of the evidence for models of care and outcomes developed and evaluated through Orygen’s research in Parkville and headspace has led to significant growth in youth mental health overseas. These locally developed clinical service innovations have been directly adopted or adapted in more than 15 countries, including early psychosis programs and the headspace, multidisciplinary primary care model.

headspace

Since 2006, over 520,000 young people have accessed almost 3 million face-to-face and online services provided by headspace (10). Young people report high levels of satisfaction ranging from 85 per cent for eheadspace, to 87 per cent for headspace centres, and 94 per cent for headspace Early Psychosis(10).

Over the last two decades, headspace services have been purposefully designed to meet the needs of Australian young people and it is now a nationally trusted brand, with 77 per cent of young Australians recognising headspace as a youth-specific mental health organisation(11).

Improved mental health outcomes translates into significant wellbeing, employment and productivity benefits. Evidence suggests headspace clients have improved mental health outcomes as listed below.

headspace clients report:

- reduced psychological distress and increased functioning – 60.4 per cent of young people accessing headspace services between 2015 and 2019 reported improvement in their psychological distress and/levels or in their social and occupational functioning, as measured by K-10 and/or Social and Occupational Functioning Assessment Scale (SOFAS). This increases to 68 per cent for those who attended five or six sessions at headspace;
- greater engagement with school and work even after two years from exiting headspace services; and
- improved mental health literacy, wellbeing and daily functioning which were also sustained up to two years later.

Deloitte Access Economics estimates that activities through headspace contributed around \$230 million to Australia's gross domestic product (GDP) in 2018–19. headspace's role in improving outcomes for young people resulted in a GDP increase of \$18 million in 2019 due to improved employment outcomes, and an average \$450 million worth of benefits from net gains in wellbeing annually. In addition, the value of young lives saved through headspace is between \$31.2 million and \$49.4 million on average annually. Fewer individuals also require informal care, saving between \$122.1 million and \$193.5 million on average per year based on the value of carer time¹.

Furthermore, these positive outcomes can also result in a range of broader economic benefits, for example:

- decreased psychological distress when mapped to disability weights result in a net benefit worth around \$2.2 billion between 2015 and 2019. Extrapolating this figure to the average life expectancy of a young person, this equates to a lifetime net present value of \$9.4 billion.
- reduction in the number of young lives lost to suicide is estimated to be worth \$247.1 million over five years.
- increased productivity – headspace clients who are employed reported being able to work for an average additional 8.2 days annually at the end of their treatment compared to the start due to reduced absenteeism (translating to an additional 39,713 days worked per annum). Clients are also estimated to be between 0.6 per cent and 1.2 per cent more productive over a given year due to reduced presenteeism (translating to between 6,873 and 11,056 additional days worked per annum) between 2015 and 2019
- headspace clients being more fully engaging in the workforce through increased productivity and participation increased GDP by between \$74 million and \$100 million in net present value (NPV) terms (in 2018–19 dollars) than what would have otherwise occurred over the last five years
- an estimated reduction in young people accessing more acute and more expensive health services, is projected to be saving between \$7.5 million and \$11.9 million over five years an estimated reduction in annual informal carer costs of between \$122.1 million and \$193.5 million in 2019

In addition, headspace has been assessed as providing a direct economic contribution worth \$173.3 million in GDP in 2018–19, and an indirect contribution worth \$57.1 million in GDP in 2018–19.

¹ Deloitte Access Economics (2020). The Economic and Social Value of headspace. Unpublished.

headspace and Orygen also play a pivotal role in supporting stakeholders across the health system, including PHNs, lead agencies, education providers, and contributes to much needed research and development on evidence-based youth mental health practices.

In our joint submission, Orygen and headspace outlined the need to develop and implement a comprehensive and enhanced model of youth mental health care that augments the existing headspace platform. Both organisations have historically advocated for increased research, service, and evaluation funding to achieve a fully comprehensive, seamless system of care for all young people in Australia, across all stages of mental ill-health. Orygen believes that the headspace infrastructure provides the best opportunity to build this model of care.

Early Psychosis Youth Service

The highest possible grade of evidence (Cochrane level 1) exists for the positive clinical and functional outcomes and cost-effectiveness of these early psychosis interventions (12). Based on the strength of this evidence, early psychosis models that were pioneered in Australia have been adopted in over 50 countries around the world.

Orygen is not aware of any other service model/intervention in mental health with the same level of evidence. This observation is based on the original studies of the Early Psychosis Prevention and Intervention Centre (EPPIC) run by Orygen Youth Health in Melbourne(12) and the now extensive body of research relating to international implementation of early psychosis programs (included at Appendix 2). Recent correspondence from Robert K. Heinssen, Director, Division of Services and Intervention Research at the National Institute of Mental Health America further highlights the significant expansion of services and treatment for early psychosis in the United States. This letter is provided as Attachment 1 to this submission.

When converting the results from all economic evaluations of early psychosis services, the annual per-patient healthcare cost was \$19,910 for early psychosis services compared to \$26,303 for routine care (figures in 2014 Australian dollars)(13). Cost savings to the wider economy could be greater, but as the available evidence base largely adopts a healthcare perspective on costs, such impacts are largely unquantified. However, it has been estimated that 72 per cent of the economic costs of psychosis in Australia are imposed outside of the healthcare sector(13).

During 2018–19, headspace Early Psychosis provided 296,539 services (direct and indirect) to 3,077 young people across the 14 headspace centres delivering the program.

Early analysis the headspace program data shows improved outcomes for young people accessing support from headspace Early Psychosis. The following demonstrates significant improvements during treatment for young people in the First Episode Psychosis stream at the twelve month review:

- 48.9 per cent showed significant improvement in levels of psychological distress (measured by the K10)
- 53.6 per cent showed significant improvement in experience of psychosis symptoms (measured by the Brief Psychiatric Rating Scale)
- 60.0 per cent showed significant improvement in their social and occupational functioning (as measured by the SOFAS).

For young people at risk of experiencing psychosis and accepted into the Early Psychosis Program under the Ultra High Risk stream, outcome results at the six month review are as follows:

- 61.3 per cent showed significant improvement in levels of psychological distress (measured by the K10)
- 47.0 per cent showed significant improvement in their social and occupational functioning (as measured by the SOFAS)
- 51.5 per cent showed significant improvement in their quality of life (as measured by the MyLifeTracker).

Orygen is concerned that Recommendation 24.2 'Regional Autonomy over Service Provider Funding' ignores and contradicts the evidence base and global scale-up of youth early psychosis programs and instead, emphasises non-evidence-based initiatives in early childhood and school settings. Separate submissions, both written (Appendix 2) and through presentations to the public community hearings, have been made to the Commission post the draft report's release relating specifically to the evidence base for Early Psychosis Program and the impact of this recommendation on the security of this program into the future.

Access to early psychosis intervention services in Australia are already limited when compared to other nations; the Commission's proposed changes would see these further undermined and in some cases, ceased completely.

The Youth Early Psychosis program is one of only a handful of mental health programs in Australia accountable via rigorous specifications and a fidelity model, yet the Commission fails to recognise its long-term social and economic potential, particularly when scaled-up to benefit young people across Australia.

Impact of Recommendation 24.2

Should Recommendation 24.2 be accepted and the Government cease directing PHNs (or RCAs) to protect the headspace and headspace Youth Early Psychosis program, the future of these evidence-based programs would be placed in considerable risk.

In 2016, when the PHNs were established, funding for headspace centres and the headspace Youth Early Psychosis program, were hypothecated (or protected) within the PHNs flexible funding pool, preventing the use of these funds for other purposes. This arrangement was signed-off by the Prime Minister and the Health Minister after the risks to the integrity of these programs posed by a fully devolved commissioning model became evident.

This risk has been further reduced in 2019 with the Minister's decision to formally embed headspace National Office in all stages of the commissioning process of new centres and the recommissioning of existing programs by PHNs. Orygen views this as a positive step to ensuring young people get the best quality care provided through the most skilled and capable providers.

Orygen believes that if the hypothecated investment was to cease there is a significant risk that the funding for headspace and the Youth Early Psychosis program could be:

- reallocated by commissioning agencies in its entirety to a range of other programs with significantly less evidence behind them;
- continued but potentially at a reduced cost, and therefore, not to fidelity; or
- diluted in efforts to make (what is in reality) a limited pool of funding provide coverage for a greater number of geographic areas and diagnostic categories.

As a result, there is a high likelihood that the following would occur:

- There would be a gradual erosion and fragmentation of the model. This would be replaced with disparate elements of service provision and components of care being delivered by different providers. This would leave young people and their families with the impossible task of negotiating services, exacerbation of service and geographic gaps and a lack of consistent and holistic approaches.
- A culture of 'good enough' rather than excellence and evidence-based care would creep into the development and delivery of services for this vulnerable group. When Orygen began implementing fidelity reviews across the headspace Youth Early Psychosis programs, many of the services were not attending to the parts of the model that were seen as not 'core-clinical' (e.g. functional recovery and youth partnerships). The clear specifications of the model, the measurement of performance against these, the provision of technical guidance and support

by Orygen, as well as the protection of funding, led services to put effort into improving the quality of care they provided.

In areas of the world where investment has not been protected for the appropriate delivery of these services, the funding and the quality of care has suffered significantly due to cost-saving measures and a lack of understanding of the necessity that the essential elements of the care provided in early intervention in psychosis services contribute to the good clinical and economic outcomes. Even in other government jurisdictions in Australia, where state/territory community mental health funding has not been ring-fenced, it has become vulnerable to being redirected by the Local Health Networks/Local Health Districts into other areas of the acute health system and away from mental health care. The Victorian Auditor General Report's into both [Child and Youth Mental Health Services](#) and [Access to Mental Health Services](#) provide evidence for this occurring.

As such, Orygen strongly contests the inclusion of Recommendations 24.2.

ORYGEN RECOMMENDS THAT THE COMMISSION:

- **Remove Draft Recommendation 24.2 from its Final Report** as it will create long-term negative impacts on young people's ability to access crucial early intervention services that have been carefully researched, adapted and delivered specifically for them. In addition, it will decrease the numbers of young people seeking help, place the national headspace infrastructure in jeopardy and result in a fragmented and difficult-to-navigate system for young people.
- Consult specifically with young people on the recommendations related to headspace centres to ensure their voices are included in the development of the final report and recommendations.
- Recommend the expansion of the Early Psychosis program into at least every state and territory in Australia within the next 2 years with a view for further expansion nationally so that all young people experiencing early psychosis will have access to this evidence-based model of care.
- Recommend that the Australian Government and the commissioners of primary mental health service utilise future youth mental health funding to augment and expand the service offering of the headspace centre network, particularly to address the emerging issue of the 'missing middle' (described further on page 15).

5.3 ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE

headspace centre funding should be conditional on centres following the stepped-care model. In the medium term (over 2-5 years) headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to low-intensity services. The targets set by commissioning agencies for each centre should depend on the full range of relevant characteristics of the young people they see. The targets should start low and increase of time.

Orygen agrees that young people should be able to access the services that best align with their needs, although we would like to see this framed within a 'staged care model', rather than stepped-care. As noted by the Productivity Commission, low-intensity services:

- Enable access, and quicker access, to treatment; and
- Increase the total number of people who can access treatment;
- Increase service flexibility, responsiveness and capacity;
- Provide greater client choice; and,
- Are typically more cost-effective(14).

- An evaluation of the headspace low-intensity service model showed improved clinical outcomes in young people with low-intensity needs, and improvements in ability to manage challenges in their lives(14).

However, at this point in the development of evidence for low-intensity interventions and the early development of commissioning approaches in Australia, Orygen contests Draft Recommendation 5.3 on the following basis:

- The requirement for headspace services to be driven by arbitrary, premature targets where there is currently limited evidence as to where the target should be set, along with, the lack of such stipulations and targets required of other youth mental health services.
- The lack of acknowledgement of the pressure on the headspace centre network as it responds to increasing demand from young people with more complex and serious mental health issues who are unable to access care anywhere else in the system (the 'missing middle').
- That this disregards the needs of young people presenting to headspace centres for support.

Insufficient evidence to set targets

We know that low-intensity services are important but they are not the only appropriate treatment pathway for young people. Appropriate care is about matching the right type and degree of care or intervention to a young person's changing needs and unique preferences.

However, Orygen has found that there is currently mixed evidence and uncertainty around the effectiveness of low-intensity treatments for young people. With respect to mental health outcomes, it is unclear whether low-intensity treatments are a significant improvement over treatment as usual alternatives. Studies in this field have expressed the need for further research on these approaches. Additional research is needed in order to establish whether any formal policy changes to low-intensity supports would be supported by the evidence and the preferences of young people.

Further, the introduction of referral targets places additional pressure on already stretched headspace centres. It does not consider a number of factors, specifically that some regional areas have limited appropriate youth mental health services. Constraining services to either low or high intensity services may exclude young people from accessible healthcare.

Orygen believes setting quota targets for low-intensity treatment referrals as described in Draft Recommendation 5.3 is:

- ill-considered as youth mental health services should align with individual needs and not be driven by arbitrary targets
- premature without an evidence base for where the target should be set
- not appropriate care for the myriad of young people who seek services at headspace especially those who fall into the 'missing middle' category (see below)
- going to increase pressure on already stretched headspace centres especially those in rural and regional areas
- inconsistent with requirements placed on other providers of youth mental health care across the system.

The 'missing middle'

While low-intensity services are an important treatment pathway for young people, many need greater higher intensity support than is currently funded. The 'missing middle' is now frequently utilised as a term used to describe people whose needs are not met by current mental health services. They are often too unwell for primary care, but not unwell enough for state-based services. Orygen goes further to include in the missing middle those individuals who may have accessed services in the past year, however, these services were not able to deliver either the duration of care, or level of specialist care, appropriate for more complex and serious mental health issues.

Therefore Orygen defines the 'missing middle' as people who:

- are not receiving any services for their mental health needs

- are currently accessing primary care services, but are underserved as they require more specialist care and expertise, particularly for specific diagnoses
- are on long waiting lists for services
- have exhausted the ten sessions of their Mental Health Treatment Plan and still require support which is unavailable in the community
- have seen a GP but do not or cannot follow through with a Mental Health Treatment Plan to see allied health (often because they cannot leave the home or get to the appointment, or they are unable to engage with a private psychologist due to a range of reasons including unaffordable gap payments)
- have accessed inpatient/community-based state funded care but are discharged too early, with these services not able to deliver the duration of care needed due to demand pressures
- have presented to emergency departments due to mental health issues. Presentations which:
 - a) could have been avoided with adequate care in the community and
 - b) often leave the emergency department without adequate and assertive follow-up.

Examples of the impact of the ‘missing middle’ on headspace centres includes:

Increase in presentations of moderate-severe mental health issues: headspace was designed to provide services to young people with experiences of mild-to-moderate mental ill-health, yet centres across the country are reporting an increasing proportion of high risk and complex presentations.(15) In 2017-18, among first presentations to headspace centres 47.2 per cent (n=45,744) had high or very high psychological distress on the Kessler 10, indicating they were likely to have a severe mental disorder.(15) 40 per cent of existing headspace clients do not improve in clinical symptoms with this rationed primary care offering and as such should also be considered a group in the ‘missing middle’.

Turned away after rationed care: A recent survey from headspace found that 14 per cent of young people stopped attending headspace because they had used their rationed Mental Health Treatment Plan services and weren’t able to return.(16)

Waiting lists: In late 2018, a survey of headspace centres found that 90 per cent of centres listed wait times as a significant concern, with average wait times of 10.5 days for an intake session, 25.5 days for a first therapy session and 12.2 days for a second therapy session.(15) In part, the increased wait times are a result of service capacity being consumed with more complex presentations which require a longer duration of care and case coordination.

For young people there already exists a national platform of primary mental health care through headspace that can be:

- built on to connect young people to more specialised and intensive services should they require this, and
- better integrated with state funded services to provide more seamless pathways of care.

This will require detailed planning and system design on how to meet the needs of the ‘missing middle’ both within the existing infrastructure and through additional service enhancements and new funding models. The Youth Enhance Service (YES) funding goes a small way to providing additional funding for this group, however the funding based would need to be expanded significantly and a requirement on the commissioning bodies to direct this investment toward building on the headspace infrastructure.

The end goal should be ensuring the national headspace centre network are resourced to provide the right level of care at the right time for young people (including those requiring low-intensity interventions).

ORYGEN RECOMMENDS THAT THE COMMISSION:

- **Remove Draft Recommendation 5.3 from its Final Report.**
- Recommend that additional funding (including through the YES funding stream) is provided to build the capacity of the headspace centre network to enable care coordination and increase

primary care service provider capacity to better support and connect young people with complex needs to appropriate higher intensity services (the 'missing middle').

- Recommend the Government commit funding to additional research into the efficacy, appropriateness and acceptability of low-intensity interventions for young people and that any potential policy development in this area should be strongly linked to that research agenda.
- Consult specifically with young people on the recommendations related to headspace centres to ensure their voices are included in the development of the final report and recommendations.

SECTION 3: SUPPORTED RECOMMENDATIONS

Recommendations in the draft report which Orygen strongly supports include (but not limited to):

Draft Recommendation 5.4 MBS Related Psychological Therapy. Orygen strongly supports the undertaking of trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. This would increase the capacity of the primary mental health care system to better respond to the needs of individuals with more complex and serious mental health issues in the community and go some way toward addressing the 'missing middle'.

Draft Recommendation 14.3 Staged rollout of the Individual Placement and Support (IPS) model. This recommendation recognises the strong evidence for the IPS model and the need to expand its currently limited application in Australia (including in only a handful of headspace centres trial sites) to all community mental health services.

The independent evaluation of the Department of Social Services (DSS) headspace trial sites released in November 2019 has made a further contribution to the strong evidence base for IPS in youth mental health settings. It found:

- 43 per cent of participants achieved an employment or education outcome (this compares to employment outcome rate after three months of Disability Employment Services (DES) during 2018 at 29.5 per cent².)
- the integration of clinical mental health services and vocational services was considered to improve young people's wellbeing as well as vocational outcomes.
- headspace was a highly appropriate setting for IPS, facilitating engagement with young people and providing a supportive setting to co-locate vocational specialists with clinical teams.

Orygen supports the Commission's recommendations relating to extending IPS and emphasises its desire to see greater expansion of this model carefully monitored and effectively delivered, preferably with Orygen and headspace playing a key role in this process. Orygen acknowledges that the report's proposed expansion requires additional clarification and detail, should this occur across the headspace centre network as well as in State and Territory-funded community mental health care settings.

Orygen recommends the Commission to specifically include in its final recommendations that IPS should be rolled out to every headspace centre in Australia (based on the evidence of its successful implementation in the trial sites). Further detail is provided in the information request response at page 22.

Draft Recommendation 13.3 Family focused and carer inclusive practice is particularly important for many young people and there is a clear need to provide dedicated funding for mental health services to embed family inclusive practice. This should include (but not be limited to) a dedicated MBS item for single-session family consultations.

Draft Recommendation 11.4 Strengthen the peer workforce. The peer workforce is highly acceptable for many young people and can increase the likelihood of service uptake and retention in care. Orygen agrees there is a need for national peer workforce representation, guidelines and work standards, along with general education across the sector to understand the specific role and value of the peer workforce.

Draft Recommendation 6.1 Supported online treatment options should be integrated and expanded. It is crucial that we move towards integrating evidence-based digital technologies with other modes of clinical care as a way to provide people with access to clinical support as soon as they

² [Disability Employment Services, Employment Services Outcomes Report, January 2018 – December 2018.](#)

need it, and augment care between appointments. However, current online treatment offerings are generally not resourced or designed to integrate with face-to-face support and this recommendation will require careful implementation to ensure that it does not result in online offerings replacing face-to-face care.

Orygen recommends this recommendation be strengthened by expanding the scope to beyond mild-moderate presentations and recognise the value of supported and integrated online care in the treatment of more complex and severe mental health issues and in supported recovery. However, we suggest that this recommendation will require further examination of the evidence regarding successful implementation of integrated online treatment with primary care.

Orygen believes that established mental health service settings with significant infrastructure in place (such as headspace centres) provide a good opportunity for further trialling and evaluating this approach.

One option that could be considered for further testing within the headspace centre network is the Moderated Online Social Therapy (MOST) platform, an advanced digital solution developed by eOrygen that:

- provides instant access to low-intensity clinician-supported online support, including self-help resources and networks of peers and clinicians;
- integrates digital care with face-to-face clinical services for young people with more moderate to complex mental health needs; and
- ongoing access to support once face-to-face care has ceased, to avoid relapse or increase the duration of time between relapses.

Draft Recommendation 18.2 Student mental health and wellbeing strategy in tertiary education institutions and Draft Recommendation 18.3 Guidance for tertiary education providers. The Commission's inclusion of recommendations relating to strengthening whole-of-institution mental health and wellbeing responses in tertiary education settings is strongly supported by Orygen. In particular, the focus on extending the development of guidance beyond university settings and into other higher education and vocational education and training settings is welcomed. There is currently a lack of evidence-informed advice for VET/TAFE sectors. Although Orygen is currently developing a National University Student Mental Health Framework – to be finalised in June 2020 - which could assist with the implementation of 18.2 and 18.3.

One of the key challenges for developing mental health responses for tertiary settings is the difficulty in accessing national and regional level data relating to experiences of psychological distress and mental ill-health in student populations. Many tertiary institutions collect health and wellbeing data about their students, but can still experience significant difficulties exporting this information to use in effective and meaningful ways. While the application of data collection and 'big data' sets is a challenge faced by institutions around the world, Australian universities own a significant amount of information about the mental health and wellbeing of young Australians and international students. This information could be better used to improve our understanding of prevalence rates, help-seeking behaviours, demographical differences between various youth populations, and the accessibility and efficacy of student support services. Many universities operate on independent systems and use data formats that do not integrate easily with other datasets. As such, most will require support to export and mine this data for insights, and to combine these with other de-identified sources to create larger datasets. The Government is well-placed to support this process, as digital transformation becomes a part of day-to-day operations.

Orygen believes a centralised Tertiary Student Wellbeing Office could be established within the Australian Government Department of Education and Training to lead the development of policy, programs and delivery of evidence-based best-practice resources and references for the tertiary sector. This Office could then support universities and other higher education/VET providers to use

these to inform and adapt their services to ensure that they are most relevant to their student cohort, based on location, demographics, and need.

Orygen recommends the development and implementation of education settings-based approaches specifically focused on vocational education and training providers and universities to students in these settings who are experiencing mental ill-health to prevent early exit and/or enable re-engagement with education. It is important that these programs are:

- Led through a centralised and dedicated student wellbeing office within the Australian Government's Department of Education and Training.
- Informed through the development of, and access to, national datasets of de-identified information relating to student mental health and wellbeing collected by institutions.
- Focused on building capacity for enhanced case detection and supporting help-seeking and early access to treatment.
- Evaluated against outcome measures regarding their impact in educational settings regarding their impact on retention and educational attainment for young people with identified mental health issues.

Draft Recommendations 21.1, 21.2 and 21.3 (contained in Reform Objective: Reduce suicide deaths and intentional self-harm). Orygen commends the Commission's focus on suicide prevention activities, aftercare with assertive follow-up, clear governance structures for suicide prevention activities across governments, and stronger outcome measurements for programs. Given the recognised prevalence and devastating social and economic impacts of youth suicide and suicide-related behaviour, Orygen emphasises the need for national commitment and investment in youth-specific strategies, systems and interventions designed in partnership with young people.

Draft Recommendation 25.2 Routine national surveys of mental health are critical to informing service need, nationally, regionally and locally and provide valuable information on the impact and outcomes being delivered through our mental health system. Orygen is strongly supportive of the Commission's emphasis on the need for regular, large scale, robust research and data collection activities, particularly regarding young people's mental health and wellbeing, to ensure that these results can be used to effectively inform program development and deliver. Orygen is open to shaping this process and working alongside Government to create large scale, meaningful data sets. We also encourage the Commission to note that existing data collection methods measuring 'youth' currently use conflicting age ranges, making it difficult to meaningfully compare results. The Commission should address this issue by using the 12-25 years age range proposed in our joint submission in its final report.

Orygen recommends that the Commission strengthen this recommendation by including the commitment to an annual publication of a specific National Report Card on the Mental Health and Wellbeing of Children and Young People:

- This recognises these are the most vulnerable and important developmental periods in life
- The performance indicators should be determined by a consultation process which involves children and young people, their families and other support people
- Recognising that not everything that needs to be measured, can be measured at this stage. Accordingly, development of the National Report Card should be iterative and be enhanced and embellished over time – it should work with what is possible but always aspire to what is needed (as this Report has aimed to do)
- The Report Card should be available online so as to be easily accessible, interactive so as to invite and encourage analysis and feedback, link to new research and other data

sources, and updated automatically as new data, surveys, scientific papers and research becomes available.

Draft Recommendation 25.9 A Clinical Trials Network (CTN) should be established. A much needed mental health CTN would provide critical national scaffolding and support for research funded through Million Minds over the next decade. Scope for increased care to Australians through a mental health CTN would include at risk, early stage illness, prevention, treatment, recovery, remission, and patient-centre care. Orygen believes that the CTN should commence with a focus on youth where most of the clinical trial capacity and collaborations exist but evolve over time to cover the lifespan.

Overall, the Commission's proposed monitoring, evaluation and research framework is a positive inclusion, but Orygen would like to see additional emphasis on the importance of clinical research in developing ground-breaking improvements in treatment and service delivery. Strong integration of clinical research and service delivery ensures research is relevant and can be translated into best-practice treatment and service design. Orygen is leading the way in clinical research in youth mental health – increasingly at the international-level – and is hopeful that an increased emphasis will result in greater investment and resourcing of this critical element of effective service design and delivery, to ensure that current underspends are effectively addressed.

SECTION 4: INFORMATION REQUESTS

Orygen is responding to a number of the information requests outlined in the draft report, as a means to assist the Commission in their final drafting process. These are outlined below:

5.2: MENTAL HEALTH TREATMENT PLANS

What should be added to the MHTP or MHTP Review to encourage best-practice care?

Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?

Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?

A Mental Health Treatment Plan (MHTP) is required for any young person to access Medicare subsidised specialist mental health services through the Better Access program. Currently, the MHTP requires diagnosis of a mental illness by the referring GP. The intention of this requirement is to ensure that services (and public health funding) are provided to young people who need them.

Young people aged 15-24 have the highest rates of service contacts for MHTPs at 2,173 per 100,000 population followed by those aged 25-34 at 1,996 per 100,000 population.

While intended as an accountability measure, in practical terms, a mental health professional will undertake their own assessment of a young person following a referral. Rather than requiring a GP to make a diagnosis, there is greater benefit in collecting information relevant to a young person's circumstances and potential impact on their mental health, to inform the referral process. Such an approach would fit with what GPs are already confident in applying and those used in other health domains (e.g. GPs are not required to make a diagnosis to refer people to a physical health specialist).

An alternative assessment that is currently available, and could be used to support a young person's referral to the Better Access program, is the simplified HEADSS assessment. The HEADSS assessment collects the following information about a young person: Home, Education and employment, Activities, Drug and alcohol use, and Sexuality and Suicide risk/depression. Existing versions of the HEADSS assessment have been adapted for young people (i.e. those used by headspace) and could be readily implemented by GPs, with support from the Royal Australian College of General Practitioners.

Orygen recommends that a GP assessment and referral should be a gateway - not a hurdle - to appropriate care. Rather than increasing the time and financial burden on GPs to make a mental health diagnosis, MHTP assessment requirements should enable them to provide valuable input of a young person's circumstances which are impacting negatively on their mental health and/or sign posts that their mental health requires further inquiry and support.

14.1: INDIVIDUAL PLACEMENT AND SUPPORT EXPANSIONS OPTIONS

The options are:

- ***direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding***
- ***a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).***

What are the pros and cons of each option? Which is your preferred option and why?

Direct employment

Direct employment of IPS specialists will allow IPS to be fully integrated within the clinical work environment; an essential component of successful IPS programs. This would enable community mental health services to have full oversight and management responsibility for their IPS workforce, including the responsibility for hiring IPS workers, enabling:

- more accurate assessment and acquisition of the skills and characteristics necessary for specific roles,
- better cultural alignment between IPS workers and the community mental health service team, and
- reduced costs associated with mismatched recruitment.

In this option, IPS workers will be fully employed by community mental health services and spend all of their time in those services, allowing integration with their clinical colleagues, which is a key challenge that has been well-documented in IPS literature.

While the direct employment option would require community mental health services to invest additional resources to oversee IPS workers, this would still be more cost-effective than the partnership option. Direct employment would significantly reduce the time and money spent on administrative duplication that would be required under a partnership model, eliminating the inefficiencies that come with complex governance and management arrangements between organisations.

The single governance structure enabled under the direct employment option would also provide IPS workers with unfettered access to data, client records and information held by the community mental health service. This would enable IPS workers to gain a greater understanding of the clients they are working with and create stronger integration between IPS workers and clinical staff. Data collection would also be streamlined, reducing time and costs in the fidelity review process.

Partnership option

The partnership option creates significant challenges to the implementation of IPS in community mental health services, particularly regarding cost, management and integration of IPS workers, as well as the ongoing integrity of the IPS model.

The partnership option would require IPS workers to be employed by an IPS provider, but operate in a community mental health service. This would require duplication of many administrative elements, such as inductions, reporting and management, which would significantly increase the cost of implementation. Such an employment arrangement would also limit the ability of community mental health services to effectively manage IPS workers. Services would have reduced authority to manage worker performance, address training issues, and be heavily reliant on an external agency to provide the majority of support.

The employment arrangement under the partnership option would further reduce the integration of clinical and IPS workers. Community mental health services would have reduced input into the hiring of IPS workers, decreasing the likelihood of selecting effective IPS workers with the skills, capabilities and cultural fit required in that particular service setting. The need to report to two workplaces may result in less time spent in the team environment and potentially undermine the relationships critical to the success of a multidisciplinary team.

Combined with the administrative challenges of the employment arrangement, this may result in reduced data- and information-sharing that would limit the effectiveness of IPS workers and exacerbate the problem of isolation that many IPS workers report. The provision of IPS workers by an external organisation would also pose the risk that, in the event that a provider ceases provision of IPS workers, their partnered community mental health services would be left without access to IPS workers.

The payment structure employed in the partnership option could be effective in creating strong incentives for community mental health services and providers to excel. However, it is critical that such a structure is designed and implemented with precision to maintain the integrity of the IPS model. For example, if the payment structure was focused on the amount of clients seen or exited from the service (as is the case with JobActive), services and providers may be incentivised to quickly shift people off their caseload, cherry-pick the more 'job ready' clients, and take on higher numbers of cases, both of which are in direct contradiction of IPS principles of individualised support and maintaining fixed low caseloads. As such, the proposed partnership option poses great risk to the integrity of the IPS model, unless managed with significant planning and oversight.

Orygen strongly recommends direct employment of IPS workers in mental health services, as it is significantly more efficient and cost-effective than the proposed partnership option.

If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service?

Currently, State funded community mental health services divert funds intended for clinical positions to employ IPS workers, reducing overall clinical capacity in order to support vocational outcomes for clients. There are some examples of direct funding being provided specifically for IPS workers, however this is generally a part of efficacy trials, as is the case for the DSS funding for headspace centres currently trialling the IPS model.

If the direct employment option is pursued, additional funding should be allocated to community mental health services to employ IPS workers, to avoid the need to make difficult resourcing decisions in areas of need. As stated in the recent DSS evaluation of IPS, successful placements cost around \$4,000 - \$5,000 per outcome(17). This is compared with potential costs of between \$5,500 and \$21,500 under Disability Employment Services (DES)(18), meaning significant cost savings can be derived by diverting clients away from DES and into IPS. As such, it is suggested that funding for further IPS services could be sourced from repurposed DES funds.

If an incentive-based payment structure is employed, it is critical that it be designed in accordance with IPS principles to ensure that appropriate incentives are created. Such a structure should focus on a combination of:

- Fidelity scores of the community mental health service in delivering IPS, which are often a strong predictor of education and employment outcomes;
- Extent to which clients undertake work-like activities that are directly linked to their careers goals;
- Client satisfaction ratings regarding their experience of the IPS service;
- Education and employment placement rates of clients, and;
- Duration of clients' placements.

18.1: GREATER USE OF ONLINE SERVICES IN TERTIARY EDUCATION SETTINGS

Should tertiary institutions play a more active role in promoting the use of online services for student mental health? To what extent could (and should) an increase in the use of online services in tertiary institutions be used to improve information on, and practical support for, the mental health of student populations?

Orygen supports the Commission's focus on opportunities to reduce the prevalence and impact of mental health issues in tertiary student populations.

The provision and use of online mental health support services plays an important role in these processes and can be of particular interest to students who do not typically seek help from mental health services or a GP.

Orygen has conducted research and consultations with a range of tertiary institutions and students in the development of the National University Mental Health Framework and in separate work undertaken regarding international students. We have found that online services are increasingly being used by tertiary institutions as a method of triaging students or providing options for low-intensity, self-directed mental health care. This can help when waiting times to access face-to-face support services are significant and as a stepped-care approach to ensuring students still receive some kind of evidence-based support in the meantime.

However, there are a few challenges including:

- The vast number of online interventions, tools and apps available with varying evidence to support their efficacy. Some universities do recommend existing tools to students, such as Mood Gym and My Compass, but there is no consolidated, evidence-based tool available to guide university services in regards to the level of quality and efficacy of other online interventions for this group.
- Many students still prefer face-to-face support services when they need them. As such online services should not be seen as a replacement for treatment or support, and should always be used to integrate with and augment, rather than diminish, existing services.
- Many students spoke about confidentiality as being a primary factor in how they access supports, as many feared that they would be academically penalised for accessing university services and that this could put their future employability at risk, particularly for those studying courses leading to professional accreditation (such as medicine, dentistry, etc.) Any online support services embedded within academic systems should be carefully managed to ensure that these allow students to opt-out of data monitoring or collection, as a means to allay their confidentiality and privacy concerns.

Orygen has also found that wellbeing information is often offered to students during their initial orientation, as part of formal inductions onto online systems, and during exam periods, but is not often delivered outside of these periods. This can create a divide in how students understand mental health and wellbeing within the university context, and impact how and when they access services. The Australian tertiary sector has the opportunity to increase awareness and promote greater discussion of mental health and wellbeing throughout the duration of student engagement in these settings by

- Providing students with support information and links when they log into the various online systems they are required to use (such as their formal evaluation at the conclusion of each study period) and when they request other academic supports (such as ordering transcripts or applying for scholarships).
- Incorporating key messages into their ongoing e-communication activities with students.

Orygen recommends that online service offerings in tertiary education settings be integrated with face-to-face supports (either on or off campus) and not utilised as a low-intensity support replacement unless there is good available evidence for the efficacy of the online intervention and the students indicate a preference for online support only.

18.2: WHAT TYPE AND LEVEL OF TRAINING SHOULD BE PROVIDED TO EDUCATORS?

What type and level of training should be provided to teaching staff to better support students' mental health and wellbeing?

Orygen provides professional development resources and delivery programs aimed at upskilling secondary school staff. It also produces a number of resources aimed at the education sector more broadly, including guidelines, toolkits, training modules, and factsheets. These are available on the Orygen [website](#) and can be accessed by the public free of charge and provide the option to conduct self-directed learning, at their own pace and in their own direction, in order to develop a better

understanding of the factors that impact youth mental health and how to best support young people experiencing challenges.

Orygen currently supports a number of State and Territory education departments, by providing expertise and assistance to various student mental health initiatives. For example, Orygen is involved in the Victorian Government's Mental Health Practitioners (MHP) initiative, supporting the establishment of a new mental health and wellbeing workforce in schools and enhancing their youth mental health expertise. The Orygen project team are currently designing a comprehensive toolkit using evidence-based youth mental health content adapted to fit the school context. A secondary consultation service for practitioners – a telephone advice line serviced by senior clinicians at Orygen – is also a key component of the implementation of the MHP initiative, empowering practitioners with advice and specific or additional information as they need it. Further, Orygen is currently producing an evidence summary analysing all available evidence for school-based interventions, for completion mid-2020.

Be-you delivers a comprehensive suite of training and information for educators across the early childhood, primary and secondary school sectors, Orygen believes a distinct opportunity to provide a standardised, evidence-based mental health literacy training course to tertiary teaching staff was missed in the scope of this Australian Government mental health education initiative.

Many university and TAFE student support services already provide mental health training to other staff within their institution. As such, there is a breadth of good practice and information which could be drawn from these examples to inform a national training resource which would:

- Provide an overview of different factors that contribute to mental health and ill-health, warning signs, ways to check-in with students, and appropriate referral pathways
- Be adaptable to include university-specific information and localised support options, taking into consideration specific demographic and geographic factors when developing options that suit the needs of students
- Co-designed, implemented, and evaluated in partnership with young people.

Orygen strongly supports the Commission's recommendation that future work on training and supporting education staff should now focus on tertiary education settings. The level and type of training should be informed by initiatives implemented in other education levels (including secondary schools) in particular, the be-you initiative and the work being undertaken internally by university and TAFE student support services

18.3: INTERNATIONAL STUDENTS ACCESS TO MENTAL HEALTH SERVICES

The Productivity Commission is seeking more information on:

- ***the difficulties international students face accessing mental health services, including any problems with the Overseas Student Health Cover and the merits of requiring tertiary institutions to take responsibility for ensuring their international students have sufficient healthcare cover***
- ***what reforms are required to improve the treatment of and support provided to international students.***

In the last two years, Orygen has conducted research, including facilitating focus groups with international students in Victoria, into what university support services are available to international students and how they access these services.

For many international students, there are significant barriers to accessing appropriate and affordable support when studying in Australia. Most international students rely heavily on their tertiary institutions to support a variety of their needs, from housing and visa services, to social activities and academic guidance.

Key issues for international students include:

Health cover arrangements. Though international students are required to obtain Overseas Student Health Cover (OSHC) prior to applying for a student visa to study in Australia, many are unsure as to the extent of their coverage or how to use the OSHC when accessing services. International students can experience significant confusion and anxiety over which external clinical services will accept their private insurance coverage, which will charge a gap fee, and which will provide the services they need during times and in locations that are accessible. Despite being specially designed with young people in mind, some international students report that they are unable to access headspace services, as they do not have Medicare coverage and some centres do not allow private, fee paying youth to access their services. In some instances, students report that this is simply because they lack the necessary EFTPOS and/or HICAPS processing tools.

Delay in help-seeking. Some international students do not access support services until they are very unwell, which can be particularly detrimental to both their long-term physical and mental health. This is reportedly due to a number of factors: not wanting to pay to access services; holding off from accessing support until they return home; and being uncomfortable accessing Australian services. This discomfort can be due to the fact that they do not know what to expect during consultations, they fear stigma and shame for accessing mental health supports, and these services are often different to what they are used to. As part of Orygen's research, a number of international students outlined that they had waited until they were so sick that they were obliged to access emergency services at their nearest hospitals. Alarmingly, there were examples of students being asked to first fill out paperwork and pay in advance of receiving life-saving services. They found this treatment particularly distressing and confronting, considering their urgent level of need.

Orygen recommends a focus on early identification of mental ill-health in international students through links between student and international student services and teaching staff, red flag systems which can identify students whose academic progress has dropped early, rather than at the point of failing, and seeking special consideration. International students should be provided with information at time of departure from their home country, arrival in Australia and at regular intervals during their study here on mental health services and resources and how to access them.

Economic pressures and financial stress can negatively impact international students' mental health and wellbeing. During Orygen's consultations with international students, many outlined the challenges involved in finding suitable employment to help ease the financial pressure of studying overseas and paying higher prices for goods and services when compared with their home country. Some highlighted that even when they did find employment, they were at a significantly higher risk of being exploited or underpaid, as their knowledge of Australian labour regulations was minimal and they had a limited network with whom to consult about the lawfulness of their employment obligations.

Orygen recommends a more holistic response to providing mental health support to international students, including entry points which address less stigmatised (and in some cases higher priority) issues such as housing, employment, responding to financial stress but which can then link students into mental health-related information.

Difficulties accessing external support services. International students also outlined the difficulties that they had accessing support services externally, in part due to financial and geographical limitations, particularly from public transport. Despite their full-time student status, in some States/Territories international students are required to pay a full fare on public transport systems, which can place significant pressure on already limited budgets.

Orygen recommends extending student concessions to this cohort (where they are not currently available) would assist in ensuring that they are able to use public transport to access various services, including mental health supports, outside of their university campus and actively participate in their communities.

23.1 ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commission, alcohol and other drug services?

If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.

Orygen does not have a position on whether the RCA (rebuild) or enhanced PHN (renovate) option is preferable. What we would like noted is that whatever funding/mental health commissioning and funding model is put in place, that there needs to be significant improvements to the oversight, transparency and accountability of commissioning practices to ensure the appropriate, effective and efficient use of mental health funding into the future.

Mental health service commissioning is still in its early stages of implementation in Australia. As such, the experience over the past four years has included, at times, an ad-hoc and inconsistent approach to commissioning informed by a diverse range of commissioning 'rationales', some of which are ill-considered or counter-productive. Examples of this include:

- Disruptive innovation (where stability is required).
- Attempts to deliver equitable funding distribution across:
 - providers (where economies of scale and continuity of quality care would be better achieved through a smaller number of providers); and/or
 - geographic areas (dispersing resources so thinly, particularly in rural and remote areas, which compromises the ability to provide quality and evidence-based care).
- Reshaping the market (where the market readiness has not been proven).

Currently national mental health commissioning processes are not easily subject to review when a decision is made which stakeholders believe may not be in the best interests of high quality health care. This does not align with contemporary practices in almost all industries and particularly in health and human services.

As such, Orygen believes there needs to be greater accountability and transparency required of commissioning activities to:

- justify that the right decisions are being made in regards to funding primary mental health services;
- adhere to the evidence base where it exists and only commission for innovation and service disruption where there is no clear evidence base available to inform decisions;
- provide information to the community on the services it has commissioned and the outcomes being delivered by these services; and
- ensure that there is full transparency and consistency with regard to how these processes are managed and decisions are made.

Orygen recommends regardless of the commissioning structure (RCA or PHNs):

- *The establishment of a central commissioning support agency.*
- *The development of a clearly articulated national commissioning process and framework, underpinned by a government policy position on the purpose and objective of mental health commissioning.*

- *The development of national standards and clinical service specification documents informed by content experts in regards to particular populations (e.g. youth mental health, suicide prevention and trauma).*

APPENDIX 1

STAGING MODEL FOR PSYCHIATRIC DISORDERS

Stage	
0	Increased risk of psychotic or severe mood disorder (No symptoms currently).
1a	Mild or non-specific symptoms (including subtle neurocognitive deficits) or psychosis or severe mood disorder. Mild functional change or decline.
1b	Ultra high risk: moderate but subthreshold symptoms, with neurocognitive changes and functional decline to caseness (GAF<70).
2	First episode of psychotic or severe mood disorder. Full threshold disorder with moderate to severe symptoms, neurocognitive deficits and functional decline (GAF 30-50).
3a	Incomplete remission from first episode of care. (Patient's Management could be linked or fast tracked to Stage 4).
3b	Recurrence or relapse of psychotic or mood disorder which stabilised with treatment or with residual symptoms or neurocognition below the best level achieved after remission from the first episode.
3c	Multiple relapses with worsening in clinical extent and impact of illness objectively present.
4	Severe, persistent or unremitting illness as judged by symptoms, neurocognition and disability criteria.

Adapted from McGorry et al 2007 Service Models for the Future, Medical Journal of Australia supplement.

APPENDIX 2 – EVIDENCE IN EARLY PSYCHOSIS

Orygen wishes to emphasise that solutions (many pioneered in Australia and shared with other countries) to this national and global crisis already exist, or can be designed and scaled. It is crucial that all recommendations from the Productivity Commission regarding reform and investment are based firmly on the best available evidence. While some of the Commission's interim suggestions met this standard, Orygen are concerned that a number did not, and some highly evidence-based programs were either omitted or not appropriately endorsed for growth and national coverage. In this initial response, we focus on early intervention for psychosis.

WORLDWIDE ADOPTION

Early psychosis programs were first developed in Melbourne at EPPIC in 1992. This model, which blended early detection with intensive multimodal treatment during the critical period of the first 2-5 years post-diagnosis, has now been extensively researched, trialled and established worldwide in over 50 countries, including the US, Canada, Denmark, the UK, Hong Kong, Singapore, India, Brazil and South Africa. A number of these countries, such as the UK, Denmark, Canada, Hong Kong and the US have embarked on major country-wide scale-up of services based on the Australian EPPIC model which is implemented in the headspace Youth Early Psychosis program (Box 1).

England now has over 150 services for early psychosis patients and these services have been recognised as the first mental health priority area to receive a waiting time target, similar to those championed for cancer (19). As in Australia, these services are measured against a national fidelity scale which has been a major part of driving excellence. Denmark also has full national coverage of early psychosis programs, as have many provinces of Canada. Early psychosis programs have been established based on clear evidence of improved outcomes for patients as well as a compelling economic argument. In the US, the recent government-funded Research After an Initial Schizophrenia Episode (RAISE) study demonstrated excellent outcomes at 2 and 5 years (20). On the basis of this evidence, there are now over 300 services and growing in the US (21), a major service reform (22). The State of New York alone has 15 early psychosis programs under the brand name "On Track New York".

Box 1: THE headspace youth early psychosis MODEL

This model now has 14 sites working across Australia in six states/territories. The model, including the essential evidence-based elements, has been fully described.

The implementation has been significantly hampered by funding uncertainty and not expanded in the way that was initially intended. These implementation challenges, particularly uncertainty around the future of the program, made attracting and retaining staff difficult and hampered efforts to create relationships with other local providers, such as state funded inpatient units.

Despite these barriers, the sites are delivering very high-quality care to young people with emerging psychotic disorders. The implementation of these sites has been underpinned by a clear evidence-based model and the fidelity to this model has been assured throughout the process via measurement with a comprehensive fidelity scale, an approach championed by these services.

In healthcare, as in other areas of practice, we know that fidelity to well-researched models provides much better outcomes to patients. Therefore, we can be sure these services are delivering the key elements of this high-quality specialised health care, a situation that is lacking in many other areas of mental health care where evidence-based practice and associated good outcomes cannot be assured. In fact, to the best of our knowledge, there is no other program of this scale in Australia that is as rigorous in ensuring fidelity, nor based on such a defined and evidence-based model.

CLINICAL OUTCOMES

A subset of the available research nationally and internationally for clinical improvements and recovery rates for early intervention in psychosis is included in Table 1 below.

Table 1: Clinical outcomes from early intervention in psychosis (subset of evidence)

Research finding	Study
In early-phase psychosis, Early Intervention Services (EIS) are superior to Treatment as Usual (TAU) across all meta-analysable outcomes. These results support the need for funding and use of EIS in patients with early-phase psychosis. This meta-analysis represents Cochrane level 1 evidence for this reform as a highly evidence-based program.	(23)
Meta-analysis also shows that intervening early can delay the onset of first episode psychosis by one to up to four years (proven in 15 RCTs) using CBT-based approaches with a Number Needed to Treat (NNT) of 8-13. This represents Cochrane level 1 evidence for this complimentary strategy to EIS.	(24)
The Norwegian Treatment and Intervention in Psychosis Study (TIPS) demonstrated that reducing treatment delay prior to the first treated episode of psychosis has a beneficial effect by doubling recovery rates at ten year follow-up.	(25)
Rate of relapse at 24 months after specialised early intervention for psychosis was 38 per cent compared to 49 per cent TAU; at 10 years it was 54 per cent for the early intervention group compared to 76 per cent TAU.	(26)
People with first episode psychosis who used EPI services had mortality rates that were four times lower than those with first episode psychosis who did not use these services, as well as better outcomes across several health care system indicators.	(27)

FUNCTIONAL OUTCOMES

Early psychosis services were developed not only to address the symptoms of psychosis, but to intervene to prevent the disability associated with psychotic illness. The integration of functional recovery approaches has been central to early intervention in psychosis.

In fact, the one part of the Australian mental health system that is already integrating an evidenced-based model of vocational support for individuals with mental illness, recognised in the Commissions draft report, is the Individual Placement and Support model (IPS) through the headspace centre network and headspace early psychosis program. The following papers in Table 2 address educational and employment outcomes.

Table 2: Functional outcomes from early intervention in psychosis (subset of evidence)

Research finding	Study
Demonstrated that IPS could effectively be implemented in an early psychosis service in South London, UK.	(28)
Showed that 85 per cent of young people with psychosis could be helped back to school and work with IPS, compared with 29 per cent in the control condition.	(29)
Showed that 83 per cent of people with recent-onset schizophrenia (the US term at the time for what we would call early psychosis) were assisted by IPS to return to school or work compared to 41 per cent in control condition	(30)
IPS adapted to focus on education was associated with 18 of 19 participants making a successful return to education.	(31)
Supported employment and education was associated with an increase in school and workforce participation in the US RAISE study of people with first episode psychosis.	(32)

A second RCT from Orygen on IPS showed that 89 per cent of young people with first episode psychosis could be assisted back to school or work compared to 70 per cent in the control group. Eighty per cent of the IPS group with good vocational outcome at end of study were still vocationally engaged 12 months later. (33)

ECONOMIC EVIDENCE

The economic evidence relating to the cost-effectiveness of prevention treatment is very well characterised in psychotic disorders. In this section, we summarise this evidence with all costs converted to a common price year (2014 A\$).

Cost of psychotic disorders

The cost of psychotic disorders in Australia has been described by a number of **high quality studies** over the last two decades (13, 34-36). The total annual healthcare costs associated with psychosis in Australia are substantial at about \$26,000 per person (13).

Although substantial, healthcare costs may account for less than a third of the societal costs relating to psychosis (13). Productivity and justice costs (13) and supported accommodation costs (13, 37) can be high for this population. Young people with psychosis are among the most economically disadvantaged in society as the disorder often starts in late adolescence/early adulthood; a time of maximum involvement in education and transition to the workplace. **The overall societal costs of psychosis in Australia is over \$5.5bn (13), with more than two-thirds of this figure accruing to Australian Governments.**

Cost-effectiveness of prevention and treatment for early psychosis

Economic evaluations and international expert consensus position early intervention in psychosis as an unequalled care model to reduce distress and economic burden (38). In a recent review on the economic case for improved coverage of public mental health interventions, published in the *Lancet Psychiatry*, early intervention in psychosis was reported as delivering a 17:1 saving (39). Based on the consistent direction across 16 economic studies, a recent systematic review also concluded that early intervention in psychosis is at least cost-effective and may also be cost-saving (40).

Most of the current economic evaluation evidence considers only the impact on healthcare costs. Given the substantial costs imposed by mental disorders beyond the healthcare sector, the current evidence base is likely to under-represent the benefits of effective early intervention. Better employment outcomes may be expected in early intervention services (41), particularly those that implement programs to improve rates of vocational recovery.

Early psychosis services may be associated with lower costs relating to accommodation (42), education and employment (43) and violent death (43). Governments may also be interested in analysis of the large welfare transfers associated with psychotic disorders (13).

We are aware of at least 23 peer-reviewed studies that are either directly or indirectly relevant to assessing the cost-effectiveness of early intervention in psychosis services. Sixteen of these were included in the systematic review, while seven others did not meet the inclusion criteria for that review (typically because they explored only costs), but provide relevant economic data. These studies have been summarised in Tables 3-8 below.

Table 3: Economic evaluations of EIP services (First Episode Psychosis (FEP) or FEP + At Risk Mental State (ARMS)) compared to routine care that assess both costs and benefits

Study	Country	Outcomes	Costs	Authors conclusions about EIP services
(41)	UK	Better accommodation, employment, HONOS emotional wellbeing.	Lower healthcare and societal costs.	Better outcomes at lower costs

(44)	USA	Better quality of life and PANSS. These results were mapped to QALYs using algorithm.	Trend to higher healthcare costs.	Benefits exceed additional costs.
(45)	Ireland	Better DUP.	Lower hospital costs.	Further research required to determine if reduced hospital costs are negated by increased community costs.
(37)	Denmark	Better GAF at 2 years, no significant difference at 5 years.	No significant differences in public sector costs.	High probability of being cost-effective
(46)	China	Better PANSS Negative.	No significant difference in public mental healthcare costs.	Likely to be cost-effective
(47)	Italy	No significant difference in HONOS (trend towards better scores).	No significant difference in public healthcare costs.	Better outcomes, potentially lower costs
(48)	UK	No significant difference in vocational recovery. Better MANSA.	No significant difference in public healthcare, social care and justice costs.	High probability of being cost-effective.
(12)	Australia	Better BPRS positive psychosis symptoms, GAF, remission and course of illness. Trend to better vocational outcomes.	Lower public mental health care costs.	Better outcomes at lower costs.
(42)	Canada	Better rates of violent behaviours and injuries prior to hospital admission (post-index admission). No significant differences in suicide attempts and aggressive behaviours during admission and legal involvement. Trend to better aggressive behaviours during admission.	Lower hospital costs [but time series analysis of days spent in hospital showed no evidence of structural change in resource use].	Better outcomes, unclear impact on resource use. May be beneficial to patients and health system.
(49)	Sweden	Better functioning compared to HC and equivalent to PC.	Lower healthcare costs (v PC) in year one, no significant differences in years 2 and 3. Lower rates of disability allowance and sick leave compared to both comparators.	Large scale implementation is clinically and economically feasible.

(50)	Australia	Better SANS negative symptoms and QLS functioning.	Lower public healthcare costs.	Cost-effective (not conclusive)
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Table 4: Economic evaluations of EIP services (FEP or FEP + ARMS) compared to routine care that assess only costs

Study	Country	Costs	Authors conclusions about EIP services
(43)	UK	Lower healthcare and societal costs.	Can reduce healthcare costs and deliver broader economic benefits.
(51)	Italy	75% probability of being cost-saving.	Use is supported and may improve outcomes and lower costs.

Table 5: Economic evaluations of the CBT for ARMS component of EIP services compared to routine care that assess both costs and outcomes.

Study	Country	Outcomes	Costs	Authors conclusions on CBT for ARMS
(52)	Netherlands	Better rates of transition to psychosis. Trend for better EQ-5D QALYs.	Lower mental healthcare costs.	High likelihood of being cost-effective.
(53)	Netherlands	Better rates of transition to psychosis. Trend for better EQ-5D QALYs.	Lower societal costs.	Cost-saving.
(54)	Australia	Better rates of transition to psychosis. [Significance not reported]	Lower healthcare costs. [Significance not reported]	Recommended for adoption, subject to further evaluation.

Table 6: Economic evaluations of the ARMS component of EIP services compared to routine care that assess only costs

Study	Country	Costs	Authors conclusions about ARMS services.
(55)	UK	Higher societal costs at one year, lower societal costs at two years. [Significance not reported]	May be cost-saving.
(56)	Australia	No significant differences in healthcare costs over 3 years. Higher healthcare costs in first six months.	May be associated with cost savings.

Table 7: Other economic (or economic related) studies related to EIP services (FEP or FEP + ARMS)

Study	Country	Focus	Outcomes	Costs / Resource use	Authors conclusions
(57)	UK	Fidelity to EIP service model.	Tiny gain in EQ-5D QALYs for high fidelity EIP service compared to medium fidelity service. Tiny gain	High fidelity EIP service had higher costs (healthcare, social care, carer and justice) than medium fidelity EIP services	A minimum level of fidelity may be required for efficient resource use, but

			in EQ-5D QALYs for low fidelity service compared to both medium and high fidelity services.	and lower costs than low fidelity EIP services. Medium fidelity EIP services had lower total costs than low fidelity EIP services.	maximising fidelity may be unwarranted.
(58)	Canada	Impact of perspective on costs.	N/A	Government and non-Government Healthcare, Social Services and Justice.	Sectors other than health (both Government and private) can incur a sizeable share of the costs associated with EIP clients.
(59)	Norway and Denmark	Outcomes and un-costed resource use for EIP v RC.	Better (DUP, PANSS, GAFF +)	Lower rates of hospitalisation (un-costed)	Positive impact on clinical and functional status.
(60)	UK	Social recovery adjunct to EIP service v EIP service alone.	Better EQ-5D QALYs for social recovery adjunct. [Significance not reported]	Higher healthcare and social care costs for social recovery adjunct. [Significance not reported]	Social recovery adjunct may be more cost-effective than routine care, but more research is needed.

Table 8: Other economic (or economic related) studies relating to the ARMS component of EIP services

Study	Country	Focus	Outcomes	Costs	Authors conclusions
(61)	UK	Liaison plus information to primary care physicians for ARMS service referrals compared to both information only and RC.	Better referral rates for liaison plus information compared to information only (both higher appropriate and inappropriate ARMS & FEP combined referrals but no significant difference in appropriate ARMS only referrals).	Lower public health and social care costs for information plus liaison compared to both comparators.	Clinically- and cost-effective to improve liaison between primary and secondary care clinicians.

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