The reality of mental health care for young people, and the urgent need for solutions

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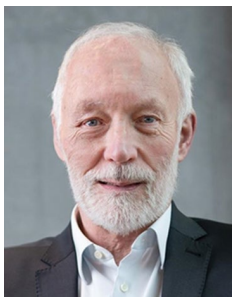
We must acknowledge the magnitude of the problem and show some urgency in implementing reform



The transition to adulthood is the peak period for the onset of the mental and substance use disorders[1] that have such serious impacts on the productive years of adult life. Mental ill health is by far the principal source of burden of disease for people aged 12–25 years,[2] and at least 50% of young people will experience mental health problems.[3] Further, the mental health of young people has been steadily undermined in recent decades by a cluster of socio-economic forces.[4] This syndemic trend has accelerated during the COVID-19 pandemic, with surveys[5] and health department data[6] documenting the wave of distress, mental ill health, and suicidal behaviour flowing into emergency departments and bloating waiting lists. We saw a 25% global increase in anxiety and depression during 2020.[7] This surge or "shadow pandemic"[8] was predicted by Orygen modelling in May 2020.[9] The under-resourced mental health system has been overwhelmed in Australia, with general practices and *headspaces* inundated, emergency departments flooded with demand, and the mental health workforce dwindling and exhausted. While telehealth keeps the channel partially open, care has become detached, dispersed, and diluted. Despite welcome policy and funding announcements, timely access to quality care for young people with mental ill health is more difficult than ever.

Australia recognised the need to develop a bespoke youth mental health system well ahead of other nations, and has built a national platform of enhanced primary care in response. *headspace* was initiated in 2006, and by the end of 2023 will be available in 164 communities across Australia.[10] *headspace* offers stigma-free access to a one-stop shop of primary care, with the capacity to respond to early stage and less complex mental health disorders, physical health concerns, interpersonal crises, substance misuse, and vocational disruption.[10] It has provided a trusted first port of call for young people and their families, and has inspired similar models of care in other countries.[11] It is, however, a thin green line, and only the initial stage of a comprehensive response to mental ill health in young people. Flooded with demand, *headspace* urgently needs a much more robust financial model and linked workforce strategy.

The findings reported by Iorfino and colleagues in this issue of the *MJA* are sobering, and clearly illustrate what else is needed. Over a two-year period, only 35% of a large sample of 1510 young people aged 12–25 years who visited *headspace* and linked services at the Brain and Mind Centre in Sydney had good functional outcomes, while nearly two-thirds experienced either persistent functional impairment or deteriorating

and volatile functional trajectories.[12] While primary care-based models offering soft entry to care for all young people is effective for some, it is clearly insufficient for most young people with more substantial needs, well characterised as the "missing middle".[13,14] They require more sustained, expert, and multidisciplinary care to deal with evolving and ambiguous symptomatology, substantial comorbidity, and social and vocational impairment.

The valuable research by Iorfino and his colleagues[12] paves the way for services to stream, fast-track, and augment the clinical care of more complex cases from the outset, but only if the required resources and tiers of care have been assembled and are accessible. The profile of such patients is clear, with both clinical stage and complexity of illness essential guides.[15] Young people who are already beyond the initial stage of mental ill health (characterised by anxiety and depression alone), in whom more specific, sustained, and disabling clinical features and comorbid conditions are emerging, fit this profile. Other elements include substance use, physical health problems, and not being engaged in education, employment or training.

Evidence-based templates for delivering community-based care for this missing middle have been carefully designed and can be rapidly deployed. Ten years ago, the Australian government funded an evidence-based platform of care for young people with early psychosis, linked with *headspace* centres and other primary care, initially in six regions of Australia. Key elements of this model include early detection, acute phase care, and recovery-focused continuing care. It has been highly effective,[16] but its extension to the rest of Australia has stalled. At Orygen,[17] we have shown that this model, which has been scaled up in hundreds of locations around the world, is capable of trans-diagnostic expansion to accommodate the full range of more complex cases of mental dysfunction identified by Iorfino and colleagues.[12] In addition to those with emerging psychosis, young people with mood, personality, eating, and substance use disorders or

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comorbid blends can be offered more sustained evidence-based care in a timely fashion.

This early intervention platform should now be rapidly installed across the nation as an overdue back-up system for assisting the hundreds of thousands of "missing middle" young people, currently locked out of state government services, yet manifestly unable to benefit from primary care alone. Similar hub-based models have been funded for adults of the "missing middle", but not yet for young people. The solution to the shadow pandemic is to rapidly scale up these platforms of care and to mobilise and expand the skilled workforces to operate them. With the additional mental health burden caused by the COVID-19 pandemic, it should arguably be our top health priority. Countless lives and futures will be saved. The missing ingredients are acknowledgement of the magnitude of this public health problem and of the shadow pandemic, a sense of urgency, and the capacity to implement reform.

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