CENTRE for SOCIAL IMPACT | UNSW SYDNEY | THE UNIVERSITY OF WESTERN AUSTRALIA | SWINBURNE UNIVERSITY OF TECHNOLOGY

MENTAL HEALTH DEEP DIVE

Community consultation & final report

September 2021

Report prepared by Lisette Kaleveld, Yasmine Hooper, Kelly Clark, Rachael Dufour, Aleksandra Olekalns and Aurora Elmes

Mental Health Deep Dive: Community consultation and final report

Suggested citation: Kaleveld, Lisette., Hooper, Yasmine., Clark, Kelly., Dufour, Rachael., Olekalns, Aleksandra. & Elmes, Aurora. (2021). ***Mental Health Deep Dive: Community consultation and final report***. Centre for Social Impact, University of Western Australia, University of New South Wales and Swinburne University of Technology.
DOI: 10.25916/3k4j-y790

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This report was produced collaboratively with Centre for Social Impact team members from The University of Western Australia (UWA), the University of New South Wales (UNSW), and Swinburne University of Technology (Swinburne).

Thanks to Professor Gemma Carey, Dr Liz Seabrook, Dr Meera Varadharajan, and Dr Ariella Meltzer for your contributions to this work.

This report forms part of the *Mental Health Deep Dive* research project, which is supported by Zurich Financial Services Australia and the Z Zurich Foundation as part of CSI's *Building Back Better* project.

Acknowledgement of Country

We collectively acknowledge and pay respects to the Traditional Owners, and Country on which we work – the Whadjuk Noongar people, who are the Traditional Custodians of the lands on which UWA is situated; the Bedegal and Gadigal People, both of the Eora Nation, and the Ngunnawal People, who are the Traditional Custodians of the lands on which UNSW is based; and the Wurundjeri People of the Kulin Nation, who are the Traditional Custodians of the lands on which Swinburne's Australian campuses are located in Melbourne's east and outer-east. We pay respects to the Country and Peoples, and to their Elders, past and present.

Acknowledgement of Lived Experience

We acknowledge the individual and collective expertise of those with a living or lived experience of mental health, alcohol, and other drug issues. We recognise their vital contribution and value the courage of those who have shared their perspectives and personal experiences for the purpose of learning and growing together to achieve better outcomes for all.

REPORT STRUCTURE

This report has been divided into nine main sections, as follows:

1. Executive summary
2. Introduction
3. Strategic context
4. Defining the current problems and needs
5. Promising and effective practice in mental health promotion and prevention with young people
6. Roundtables and discussions with mental health sector representatives
7. Conclusion and recommendations
8. References
9. Appendix

1. EXECUTIVE SUMMARY

1.1 Project overview

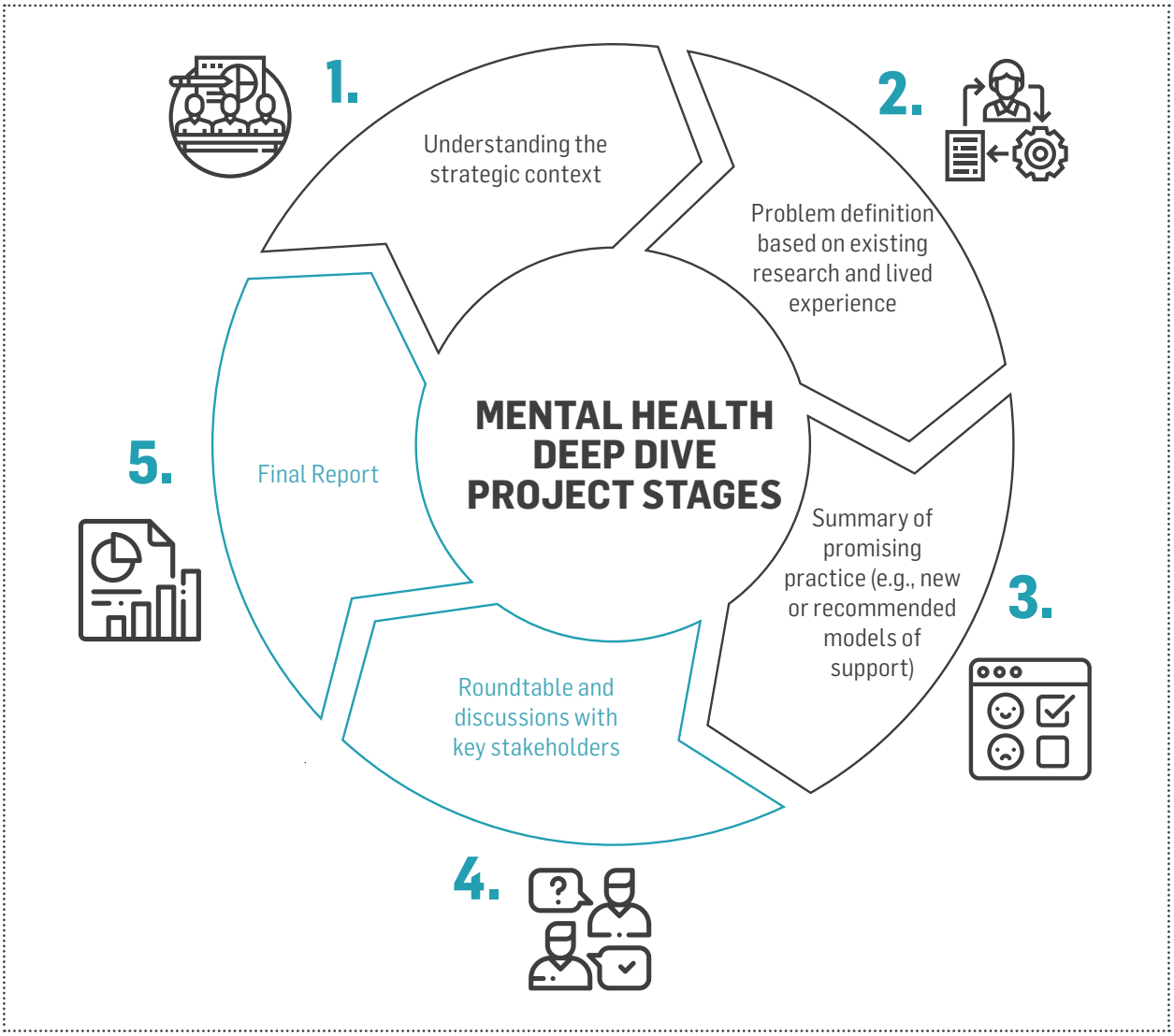
This report is the third in a series of three reports produced for the *Building Back Better – Mental Health Deep Dive* project. The *Mental Health Deep Dive* was a collaborative research project involving Centre for Social Impact team members from the University of Western Australia (UWA), University of New South Wales (UNSW), and Swinburne University of Technology (Swinburne).

The aims of this project were:

1. To understand how to better support mental health and wellbeing frameworks in Australia
2. To understand the complex policy/research and political landscape that surrounds the provision of mental health services

This final *Mental Health Deep Dive* report summarises the first two reports (project stages 1–3) and details the findings from the final stages of the project (stages 4–5) – roundtables and discussions with key stakeholders in mental health.

Figure 1– Mental Health Deep Dive project stages



1.2 Roundtables and discussions – Approach

Informed by the literature reviews, a high-level stakeholder engagement process was designed to understand the extent to which these findings resonated with practitioners currently working in youth mental health, sector advocates and policy makers. Workshops were conducted in a roundtable format and generative style, and focused largely on the prevention of, and early intervention in, poor social and emotional wellbeing.

Interactive and human centred design techniques were employed to capture the multijurisdictional and multisector perspectives provided by participants, and workshops were guided by the Lived Experience Lead at CSI UWA. Both metropolitan and regional perspectives were captured in the discussions. Key themes were identified and explored.

1.3 Roundtables and discussions – Findings

The findings are a summary of what stakeholders expressed in the roundtables and discussions, and are presented through two lenses that emerged from the analysis: what is needed to support the mental health of young people, and how do we get there? A summary of these findings is provided here under the main theme headings, with detailed findings presented in Section 6.

1.3.1 Improved ability to engage young people experiencing disadvantage

It is necessary to address barriers faced by high-need young people who are unwilling or unable to engage with mental health supports. To engage these populations, the following is required: proactive outreach that delivers services to where young people currently are, ease of access (i.e., low-threshold, low-barrier approaches), and the flexibility to permit change where required and meet local need.

1.3.2 Service delivery that makes a difference

There is significant scope to improve service delivery to facilitate better outcomes for young people who seek mental health supports. Improving services to enable significant and sustained outcomes for those who have sought mental health support comprises: building strong relationships and connections with young people (developing trust), listening to young people from a place of compassion and non-judgement to understand individual need, and the strengthening of the peer workforce and implementation of genuine co-design methods to support continuous service improvement.

1.3.3 Holistic approaches to address multiple needs

A holistic approach to mental health support – which is person-centred and strengths-focused, and also considers the social determinants of mental health – is needed to deliver effective mental health support to young people. Service hubs (co-location of services) and meaningful collaboration and communication between agencies and sectors to meet whole-of-life needs was a shared vision of the workshop participants.

1.3.4 Empowering young people

Young people should feel empowered and in control of their own care while accessing mental health support. To empower young people, there needs to be a provision of choice (i.e., options for when and how supports can be accessed or maintained), and spaces that are safe for young people to engage (i.e., culturally secure and responsive, respectful of LGBTQIA+ persons).

1.3.5 Funding structures and leadership that supports effective practice

Participants were also asked to consider what is currently required to create promising and effective practice in Australia. The sense is that the service delivery workforce is dedicated to doing their best for young people accessing mental health supports, however this needs to be adequately supported by secure and consistent funding structures. Additionally, organisational leadership and the support for promising practice is required. Leadership at organisational, state and federal levels needs to recognise and prioritise promising practices that support all young people.

1.4 Conclusion and recommendations

The findings of the stakeholder consultations were consistent with what was found in the literature review. The message for strategic thinkers working within the mental health sector to support young people is clear: no matter what type of support, or what the specific needs of the young person are, effective practice takes time because it requires meaningful and proactive engagement, collaboration, and genuine relationship building.

The findings about ***what works***, and ***how do we work*** to best support young people seeking mental health supports suggests that systems need stable, sustainable funding and a strong, well supported workforce of adequately trained staff who are able to provide warm, holistic and collaborative care. With this in mind, we need to turn our attention to how we now implement this into mental health practice – and how this may be sustained.

The roundtables highlighted that people working within the sector are likely to have a strong sense of what it is young people need, and they possess the skills to support these needs. However, for service providers to deliver these supports, supervision and funding structures need to enable fluid, person-centred care which supports meaningful collaboration between services and effective, structured pathways for young people to access care that meets their whole-of-life needs.

Our findings, from both the literature review and generative roundtable discussions, reiterated that removing system-level constraints to enable better engagement with young people, and adequately resourcing meaningful engagement, genuine relationships and trust building, was the priority. Creating more enabling funding models and commissioning practices has significant potential for enacting change and increasing the effectiveness of services for young people.

2. INTRODUCTION

This report is the third in a series of three reports produced for the *Building Back Better – Mental Health Deep Dive* project. This section begins by defining key terms used in this report, and then sets some context regarding mental health and wellbeing, and young people in Australia. We introduce the understandings of mental health promotion and prevention that have informed the findings presented in this report, and finally, we give an overview of the *Mental Health Deep Dive* project.

2.1 Terms used in this report

Barrier refers to the ease of access to a support based on environmental circumstances. Low barrier refers to ease in accessing support; there are no constraints that make it difficult to seek help. Alternatively, where there are many barriers, accessing help is more difficult. Barriers have the potential to reduce help seeking, and include but are not limited to: language, transport, or cost constraints.

Family members and carers refers to people with a lived experience as a carer, family member, friend or other supporter of a consumer. The term acknowledges that not all family members wish to identify as a 'carer', and there may be other important relationships in a young person's life or recovery process. These terms are used interchangeably in this report.

Indigenous Australians refers to the first inhabitants of the continent and surrounding islands of what is now called Australia. Broadly, this covers both Torres Strait Islander Peoples and Aboriginal Australian Peoples.

Lived experience refers to people with living or lived experience of a mental health condition, distress or challenges to social and emotional wellbeing. A definition of lived experience that was co-designed by Aboriginal and Torres Strait Islander people and the Indigenous Lived Experience Centre notes that: "*A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community. People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples ways of understanding social and emotional wellbeing.*" (Black Dog Institute, 2021).

Mental health The World Health Organization defines mental health as a state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life (World Health Organization and Calouste Gulbenkian Foundation, 2014). Understandings of mental health and social and emotional wellbeing vary among different cultures and communities, and some see distress or social and emotional wellbeing concerns as a response to adverse social conditions (Dudgeon et al., 2017).

Mental health promotion refers to approaches that aim to *promote mental health and wellbeing* (Everymind, 2017). For example, public policies that facilitate social inclusion; and community-based or school-based programs that create supportive environments and provide people with resources that enable relationships and individuals to flourish.

Peer workforce refers to the (usually) paid workforce engaged specifically for their lived or living experience of concerns relating to social and emotional wellbeing, or of mental health difficulties, or of using mental health services. Roles within this workforce include but are not limited to peer support workers, lived experience academics, peer advocates and advisors. This workforce complements and is distinct from other clinical and professional roles in the sectors relating to social and emotional wellbeing.

Prevention refers to approaches that aim to *prevent or reduce* the occurrence of mental health conditions (Everymind, 2017). Prevention programs include:

- ***Primary prevention,*** which aims to reduce risk factors and increase protective factors within the population, or groups at higher risk, in order to prevent mental health condition onset
- ***Secondary prevention,*** which aims to reduce the severity or length of mental health conditions through early intervention
- ***Tertiary prevention,*** which focuses on reducing the impact of a mental health condition on people's lives (Everymind, 2017)

Psychosocial refers to psychological and social factors that can impact or support a person's mental health and wellbeing. For example, access to meaningful activities, supportive relationships, belonging and safe housing can all be described as psychosocial factors affecting one's wellbeing and mental health.

Service-user refers to people with a lived experience of a mental health condition, distress or challenges who access mental health services.

Social and emotional wellbeing is a multifaceted concept that refers to an individual's wellbeing determined by interrelated domains: body, mind, family, community, culture, Country and spirituality. This is a preferred term among many Indigenous Australians and indicates a broad approach to wellness (Dudgeon et al., 2017).

Social determinants of mental health refers to the recognition that mental health is shaped significantly by the social, economic and physical environments in which people live.

Threshold refers to the ease of access to services due to service requirements or expectations – the 'hoops' people need to jump through to access help. Low-threshold services are easy to enter; the process of accessing support is simple, easy and open to a broad range of people regardless of where they currently sit on the wellness/illness spectrum. High-threshold services may require service-users to meet rigorous criteria or requirements, for example, related to severity or acuity of their mental health condition presentation.

Young people refers to people who are between 12 and 25 years of age, inclusive.

2.2 Mental health and wellbeing, and young people in Australia

In Australia, a mental health condition is commonly defined as a health problem that significantly affects how a person thinks, feels, or behaves (Manderscheid et al., 2009). Mental health conditions often emerge in early childhood and adolescence, and can have substantial and lasting impacts on life trajectory. In contrast, wellbeing in early life is associated with a range of positive outcomes, including improved social relationships, engagement, academic achievement and economic security (VicHealth, 2015). Prevention and early help for signs of psychological distress aim to prevent progression, duration and severity of mental health conditions.

Despite an estimated 4.8 million Australians who had a mental or behavioural condition in 2017–2018 (Australian Bureau of Statistics, 2018; Cook, 2019), and with almost half the population (45%) estimated to experience a mental health condition in their lifetime (Australian Bureau of Statistics, 2008; Cook, 2019), promoting and supporting mental health remains an issue in Australia. Young people's mental health and wellbeing significantly influences their life trajectory and long-term engagement within the community (The Centre for Adolescent Health, 2018; Productivity Commission, 2020). This highlights the need to promote and support young people's mental health early in life, and during the significant life transition from adolescence to adulthood.

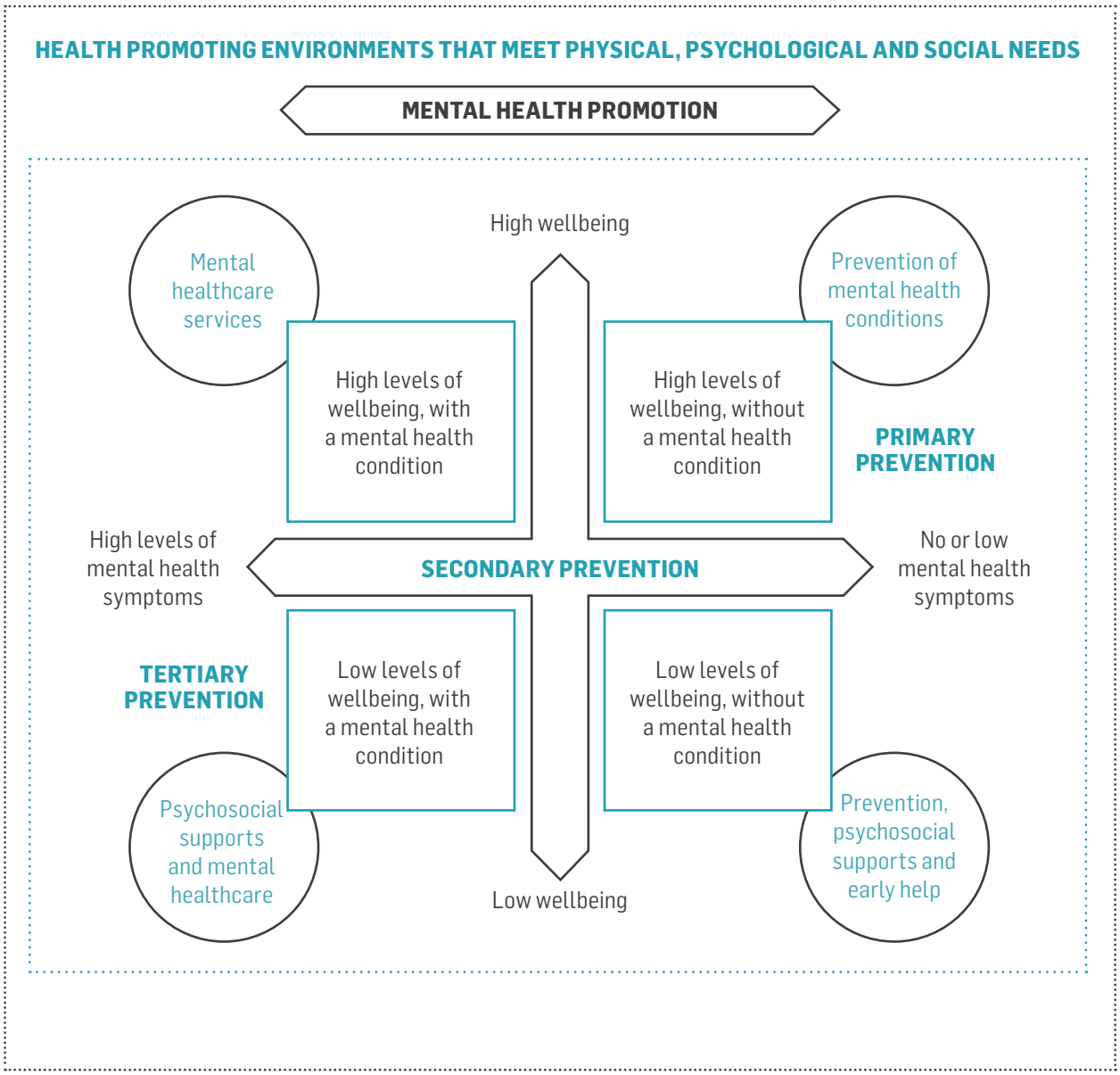
2.3 When health promotion and prevention approaches may be used

While everyone benefits from health promoting environments that meet their physical, psychological and social needs, a range of prevention efforts and supports may be applied as people experience lower wellbeing, or degrees of mental health distress or symptoms. Often, prevention interventions look to identify and modify factors associated with mental health conditions, including family and other interpersonal relationships,

and within education settings (Mrazek & Haggerty, 1994). Investing in the mental health and wellbeing of young people delivers significant returns, and impacts a broad range of outcomes, including engagement in education, and longer-term participation in a contributing and fulfilling life (The Centre for Adolescent Health, 2018; Productivity Commission, 2020).

Figure 2 illustrates some of the broad types of support that people can benefit from as they experience different levels of wellbeing and mental health, and shows the points at which different prevention approaches, and health promotion approaches are targeted. This illustration is a simplification of complex experiences and approaches, so some detail and nuance are necessarily omitted.

Figure 2 – Dual-continuum model of mental health and wellbeing
(adapted from Tudor, 1996 in Jay et al., 2017)



2.4 Prevention of mental health conditions

As shown in Figure 2, primary prevention efforts aim to prevent the onset of mental health conditions, so these approaches are often focused on reducing risk or increasing protective factors for the whole population before mental health conditions occur in individuals (Everymind, 2017; Fusar-Poli et al., 2021). Secondary prevention aims to reduce the severity, duration, or impacts of mental health conditions, so these approaches focus on supporting people with early symptoms of a mental health condition, often through identifying those at risk and facilitating access to treatment (Bridgman et al., 2019; Fusar-Poli et al., 2021; Platell et al., 2017). Secondary prevention efforts for young people are particularly important as young people are likely to not (yet) have sought a formal diagnosis of a mental health condition, and may also resist seeking a diagnosis (Kaleveld, Bock & Seivwright, 2020). Tertiary prevention aims to reduce the impacts on people with established mental health conditions, through efforts that support recovery and reduce relapse (Fusar-Poli et al., 2021). Young people are often targeted by primary and secondary prevention efforts, as youth (frequently defined in Australia as 12–25 years of age) is a common time for the onset of mental health conditions (Fusar-Poli et al., 2021; Sharma et al., 2021) – yet young people do not always seek, or receive early help (Boyle, 2020; Platell et al., 2017).

2.5 Promotion of good mental health

While primary mental health prevention shares some common approaches with mental health promotion in terms of increasing protective/health promoting factors within the population, these approaches differ in their aims – primary prevention aims to prevent mental health conditions from occurring, while mental health promotion aims to promote good mental health (Everymind, 2017). Prevention tends to approach mental health from a medical model, while mental health promotion is more aligned with a broader focus on supporting wellbeing and flourishing, in line with recovery/positive psychology models (Everymind, 2017). Mental health promotion can focus on the whole population, or particular groups of people, and health-promoting approaches can be utilised with people across the entire spectrum of health, health conditions, and wellbeing states (Everymind, 2017). There is evidence to suggest that effective health promotion can change the social determinants of health – the social, economic and physical environments in which people live and that influence health outcomes (Herrman, Saxena & Moodie 2005).

2.6 Project overview

Exploring the strategic context, systems and settings relevant to mental health in Australia is key to understanding the functioning of Australia's mental health system, the existing gaps and barriers in services, and how to best support promising and effective approaches to promote and support young people's mental health. The *Mental Health Deep Dive* project sought to do this through reviewing the existing evidence, and talking with key representatives from the mental health and youth sectors.

The first *Mental Health Deep Dive* report provided an overview of policy settings and the Australian mental health system, and drew on State, Territory and National policy frameworks, reports from current national consultations, academic literature and the mental health sector to identify key issues in:

- Prevention and early help
- Improving psychosocial and community-based supports
- Improving experiences of mental health services

Following the first report, the research team met with representatives of Zurich Financial Services Australia and the Z Zurich Foundation to discuss the core problem definitions and needs identified in relation to mental health in Australia. In co-developing the Needs Statements that guided our next stage of work, we considered:

- The significant evidence regarding the influence of social and economic inequities on both mental health risk, and access to support
- The clearly identified importance of early prevention, help and support for young people, and the potential to positively influence young people's life trajectories through effective practice
- The social impact goals held by Z Zurich Foundation, of improving mental wellbeing and enabling social equity

Drawing on these factors, a series of Needs Statements were generated (see Section 4) that informed the focus of the second report – mental health promotion, prevention and early help for young people experiencing socioeconomic disadvantage.

The second *Mental Health Deep Dive* report examined effective and promising practice in prevention and mental health promotion with young people, with a focus on young people experiencing socio-economic disadvantage. Our review of existing evidence and current programs found that both evidence and practice in prevention and mental health promotion with young people is still developing, and gaps in knowledge remain regarding the outcomes that interventions can achieve.

Many studies and practice examples focused on secondary prevention approaches, through improving young people's access to, and engagement with, mental healthcare at an early stage of distress or mental health challenges. There was less evidence about cohesive, community-integrated mental health promotion and primary prevention (such as strengths-based interventions and coping skills training with a wellbeing focus) *prior* to the emergence of clinically relevant distress. However, our review identified seven principles of effective and promising prevention and mental health promotion practice, and these are detailed in Section 5.

The third (current) *Mental Health Deep Dive* report details the findings from the final stage of this project – a series of roundtables and discussions with key stakeholders in mental health. The aim of these roundtables and discussions was to test the ideas that emerged from the literature, with current Australia-based understandings, and to see the extent to which the findings resonate with what practitioners and policymakers understand. High-level stakeholders within the broad youth mental health system were selected to participate in workshops.

2.7 Summarising the context, needs and findings so far

Before outlining findings from the roundtables and discussions, we briefly summarise the findings from the first two reports in this series to provide some background information on:

- The strategic context, systems and settings influencing mental health in Australia – particularly in relation to prevention and early help for young people (Section 3)
- The core problems and needs we identified (Section 4)
- The current state of evidence on effective and promising practice in mental health promotion, prevention and early help for young people – with a focus on young people experiencing socio-economic disadvantage (Section 5)

Following these sections, the findings from the roundtables and discussion with mental health sector representatives are presented in Section 6. Finally, Section 7 presents conclusions and next steps arising from the roundtable and discussion findings, and the project as a whole.

3. STRATEGIC CONTEXT

The first stage of the *Building Back Better – Mental Health Deep Dive* project was a strategic review of key mental health frameworks and evidence. The aims were: (1) to understand the strategic context, systems and settings influencing mental health in Australia, and (2) to identify the main issues and gaps within existing systems and settings in order to define a series of core Needs Statements for further exploration in the next stages of this project.

This review was informed by a design thinking approach that involved extracting and integrating various sources of evidence, including academic and grey literature, and State, Territory and National mental health policy frameworks. The findings were structured to reflect current understandings of mental health and the mental health system in Australia, including considerations of the social determinants of mental health.

A selection of key findings from our strategic review of mental health frameworks and evidence are summarised below (with the full findings available in the *Mental Health Deep Dive: Strategic context and problem definition report*). This summary highlights the findings that directly informed successive stages of this project – and specifically, our focus on mental health promotion and prevention of mental health conditions for young people facing socioeconomic disadvantage.

3.1 Exploring the strategic context, systems and settings influencing mental health in Australia

Exploring the strategic context, systems and settings relevant to mental health in Australia is key to understanding the functioning of Australia's mental health system, and the existing gaps and barriers in services.

Australia's mental health system is complex, with services provided through public healthcare funding and service responsibilities that are split across federal and state/territory systems, private health insurers, and non-government organisations. These systems provide a range of services across hospitals and in the community (Australian Institute of Health and Welfare, 2021; Cook, 2019).

Several recent reports into the mental health system in Australia suggest that increased funding and wide-scale reform is needed to remediate existing issues, such as:

- Under-investment compared with physical healthcare
- Complex regulation and governance arrangements
- Poor service planning and coordination
- Inadequate outcome measurement (Productivity Commission, 2020; Victorian Government, 2021)

Multiple recent inquiries into mental health in Australia acknowledge that risks to mental health are not equally distributed among the population (Productivity Commission, 2020). In addition to individual biological and psychological factors, a broad range of social, political, economic and environmental factors impact mental health for better or worse (Patel et al., 2018; World Health Organization and Calouste Gulbenkian Foundation, 2014), and risk factors for mental health conditions are strongly associated with social inequities (Allen, Balfour, Bell, & Marmot, 2014).

These same inequities in access to resources can make mental healthcare more inaccessible or unaffordable to those who most need it (Victorian Government, 2021). The additional challenges of COVID-19 intersect with existing social inequality and disadvantage, even more acutely impacting mental health (Kaleveld, Bock & Maycock-Sayce, 2020).

The recent Productivity Commission report into mental health suggests a series of priority reforms to improve the mental health system, to provide person-centred care and reduce preventable distress (Productivity Commission, 2020). Attention to people's social and economic circumstances, cultural understandings of mental health, and opportunities to prevent mental health conditions are also called-for by:

- Australian and international mental health researchers (Jorm, 2018; Patel et al., 2018)
- The recent public inquiry processes into mental health in Australia (Productivity Commission, 2020; Victorian Government, 2021)
- By organisations focused on increasing effective investment into mental health (Future Generation Investment and EY, 2021)

The Productivity Commission notes that adopting the recommended priority reforms could generate benefits to people's quality of life and economic participation, with an economic value in the order of $17 billion (Productivity Commission, 2020).

3.2 Identifying the main findings and gaps within existing systems

Overall, significant sections of our strategic context review spoke to the well-established evidence that young people's mental health and wellbeing significantly influences their life trajectory and long-term engagement within the community (The Centre for Adolescent Health, 2018; Productivity Commission, 2020). Our review findings also emphasised the need to support mental health in many settings and forms that reach people in the contexts of their everyday lives (for example, in school, university and community settings).

While prevention activities begin in infancy, our targeted focus on young people (approximately 12–25 years old) responds to the need to support mental health through significant developmental stages and life transitions (i.e., from adolescence to adulthood).

3.2.1 Key findings from the strategic context review

This strategic context review identified the critical need to design responses that are sophisticated enough to address the complexity of mental health, especially as mental health conditions strongly intersect with social disadvantage and the social determinants of mental health. These insights are important to integrate when defining effective prevention and early intervention responses for young people. Key findings include:

- Prevention and early intervention activities are instrumental throughout life, and play significant roles in long-term outcomes, including engagement and productivity within the community
- Early intervention and support services should provide responsive care for specific populations that experience higher risk of mental health conditions related to current social inequities
- Mental health and wellbeing care are not limited to activities within the mental health system, but intersect with other professions and sectors (i.e., education, employment) and with community life. This reveals the opportunity to better support people seeking to access services in a broad range of settings

In addition to these findings, there is evidence that investing in prevention and early intervention is critical for the effective prevention of severe illness. Thus, early intervention represents our best tool for reducing mental health impacts on individuals and costs and service delivery burdens on the mental health system. Given our current reliance on high-cost crisis care services, focusing greater resources towards prevention, early help, psychosocial and community-based supports, makes both economic and moral sense.

3.2.2 Key recommendations from the strategic context review

Our strategic context review presented several key recommendations regarding the nature and needs of prevention and early help activities for young people in Australia, including:

- The need to recognise and reduce current social inequities that affect mental health
- The need for an increased focus and resources directed towards the prevention of mental health conditions across the lifespan. This is particularly needed in under-funded and under-supported areas of mental healthcare, including mental health promotion, prevention and early intervention from infancy and childhood, through to education and workplace settings, and beyond
- The need to provide appropriate and sufficient training for professionals and community members across various social settings (e.g., where young people are experiencing major life transitions), to foster greater understanding of mental health and mental health conditions, and develop capacity to support people within the community

4. DEFINING THE CURRENT PROBLEMS AND NEEDS

Following the strategic context review (described in Section 3), design thinking methods were used to explore the key issues and gaps identified, and conceptualise several Needs Statements arising from these findings. The Needs Statements aimed to respond to the key problems identified within the current mental health system, including:

1. That, largely, mental health support is being received at crisis point, but not earlier
2. That social inequality prevents equitable access to services
3. That fragmented care prevents wrap-around support
4. That the current mental health crisis in Australia has not seen significant improvement despite ongoing investment

Beyond each of the above *key problems* (that manifested as a system failure or inadequacy as acknowledged by the literature), there is a *need* to address. Redefining a problem as a need better enables a response to be developed. In co-developing the Needs Statements to guide our next stage of work, we considered:

- The significant evidence regarding the influence of social and economic inequities on both mental health risk, and barriers to accessing support
- The clearly identified importance of early help and preventative support for young people (i.e., early in life and early in symptoms or episode), and the potential to positively influence young people's life trajectories through effective practice
- The social impact goals held by Z Zurich Foundation in relation to improving mental health and wellbeing and reducing social inequity

Drawing on these factors, a series of Needs Statements were generated that informed the focus of the second report – mental health promotion, prevention and early help for young people (approximately 12–25 years) experiencing socioeconomic disadvantage. The resulting Needs Statements are presented on the following page.

NEEDS STATEMENTS

1 ***Problem:*** Waiting for people to be in crisis and access acute care is not working.

Need: We need low-threshold, easy-to-access, consistent care which takes into account the complexity of people's lives and the stigma around accessing mental health support, that (both) feels and is available consistently.

2 ***Problem:*** Social inequalities are exacerbated by access barriers and system design.

Need: We need to reduce the barriers to accessing appropriate preventative and clinical care, particularly for young people experiencing high-risk mental health issues and social inequity

3 ***Problem:*** Care is fragmented/not coordinated well, it is difficult to support people where they are at, and to help them move through their experience to a holistic recovery.

Need: We need clear, holistic mental health care, available at the level and in the mode wanted by the person experiencing a mental health condition, with their care-needs coordinated, including access to emerging modalities, favoured practitioners and in the location each young person is in.

4 ***Problem:*** The mental health crisis in Australia is not improving despite investments.

Need: We need effective preventative and early-intervention (early in life, mental health condition, and episode) care, developed by collaboration between those with relevant lived experience and those with other expertise, that people actually use and with a focus on connection.

We need health and wellbeing policies – including, but not limited to funding decisions - to be designed, implemented, and overseen through collaboration between those with relevant lived experience & those with other expertise.

4.1 Summary

Our first review into the strategic context, systems and settings influencing mental health in Australia explored the main issues and gaps within current systems. This review led to the identification of a series of Needs Statements that were broadly unified in their focus on preventative and early-intervention mental healthcare. Given the significant evidence regarding the impacts of youth mental health on life trajectory and access to a meaningful, connected and contributing life (Productivity Commission 2020), and Zurich's identified interest in improving young people's mental health and increasing social equity, we adopted a particular focus on effective preventative and early mental healthcare for young people facing social inequity. This formed the focus for a second evidence review that was conducted in the next phase of this project (as described in Section 5).

5. PROMISING AND EFFECTIVE PRACTICE IN MENTAL HEALTH PROMOTION AND PREVENTION WITH YOUNG PEOPLE

Several of the Needs Statements identified an overarching need for effective prevention and early intervention, particularly for young people experiencing social inequities or risks to mental health. This need informed the next stage of the *Building Back Better – Mental Health Deep Dive* project: an evidence review exploring promising and effective practice in prevention and mental health promotion, with a focus on young people with experiences of socioeconomic disadvantage.

This second evidence review examined academic and grey literature (such as policy documents, government plans or reports), and included a targeted website review of a sample of mental health promotion and prevention programs and organisations. The key findings of this review are summarised below, with a focus on:

- The current evidence for the types of outcomes mental health promotion and prevention can achieve
- Some common principles of effective and promising practice
- Where the gaps in knowledge remain

5.1 Evidence for the outcomes promising and effective practice can achieve

Evidence from this review of effective and promising mental health promotion and prevention programs indicated some potential for universal (available to all) and selected (available to some) programs for young people that target:

- Reduction of mental health symptoms
- Promotion of good mental health
- Addressing the social determinants of health
- Improving services to support early help-seeking, access, and engagement in care

Findings related to each of these target outcomes are briefly summarised below.

5.1.1 Reduction of mental health symptoms

There is some evidence for reduction of symptoms and improved wellbeing through mental health education, physical activity and early access to help (Fusar-Poli et al., 2021; Joshua et al., 2015). A recent systematic review found that population health approaches targeting school environments or social determinants of health (including socioeconomic factors) have the most promise for reducing the risk of mental health conditions for the population as a whole (Fusar-Poli et al., 2021)

5.1.2 Promotion of good mental health

Mental health promotion programs can be effective in improving mental health, through improving mental health literacy, emotions, self-perceptions, quality of life, thinking skills and social skills (Salazar de Pablo et al., 2020). The reviewed organisations and programs provided some evidence for facilitating improved resilience, wellbeing, capability, help-seeking behaviours for students, and capacity of peers, educators, and parents to support young people's mental health.

Current evidence shows that psychoeducation (education about mental health and mental health conditions) is the most effective intervention for promoting mental health literacy and cognitive skills (Salazar de Pablo et al., 2020) and that well-designed and implemented school-based universal programs can be effective in promoting social and emotional wellbeing for students (Iizuka et al., 2015).

5.1.3 Addressing the social determinants of health

Recognising and reducing inequity is fundamental in planning, implementing and evaluating mental health interventions (Welsh et al. 2015). To ensure that social inequities are not perpetuated, and that programs do not stigmatise those who access them, universally available programs that provide support proportionate to need ('proportionate universalism') are recommended (Welsh et al., 2015). Promising examples of proportionate universalism include increased resourcing of universal supports in areas of low socioeconomic status (Currier et al., 2021); or universal parenting programs targeted to specific community needs but available to everyone (Habib et al., 2014).

5.1.4 Improving services to support early help-seeking, access and engagement in care

Many of the studies we reviewed focused on secondary prevention through improving young people's access to, and engagement with mental healthcare at an early stage of distress or symptoms (Welsh et al., 2015). Integrated, co-designed early intervention programs that work with schools to identify and address youth vulnerabilities are viewed as effective (Bradfield, 2018). There is some evidence that targeted creative/recreational programs in schools (Martin & Wood, 2017), and culturally responsive and local community-led organisations (Jones et al., 2021; Posselt et al., 2017) can support access to early help or reduce the impact of existing mental health conditions.

5.2 Identified gaps in evidence of promising and effective practice

Mental health promotion and prevention practice with young people in Australia (including those affected by socioeconomic disadvantage) is still developing – as is the evidence base for effective practice.

5.2.1 Effective mental health promotion

A large proportion of the reviewed research focused on early intervention and treatment for emerging mental health conditions rather than promotion of mental health and wellbeing. There were some inconsistencies between the findings of the literature review, and the review of current examples of mental health promotion. A recent systematic review of mental health promotion found no evidence of improved behaviours, relationships, or self-management strategies (Salazar de Pablo et al., 2020) – but several of the reviewed Australian programs reported improvements in participants' behaviour and relationships. These differences in reported outcomes might relate to variation in the effectiveness of specific programs, or to differences in how outcomes are measured. Regardless, these findings indicate that further evidence on mental health promotion and prevention outcomes is needed. There are calls for:

- More research into effective mental health promotion and prevention
- Greater involvement of young people in priority-setting, design and delivery of mental health promotion and prevention initiatives
- Increased focus on equity and addressing the social determinants of health

5.2.2 Effective mental health prevention

Evidence for programs being able to prevent the onset of mental health conditions entirely is still developing. Most reviewed prevention studies had limited or mixed results, largely contained to reduction of symptoms rather than prevention of mental health condition onset (Fusar-Poli et al., 2021). Further research with young people in Australia (including those who face socioeconomic disadvantage) is needed.

5.2.3 Evidence of mental health outcomes

Effective outcome measurement remains a challenge for the mental health sector (Productivity Commission, 2020). Many of the reviewed organisations and programs focused on measuring activities (such as the number of young people who participated in a program) and/or a cost–benefit analysis of intervention delivery – rather than focusing on what mental health outcomes changed through young people's participation in the program. While some programs did provide stronger evidence of mental health outcomes, it is evident that support for better outcome measurement and further research is required – particularly around co-designed mental health promotion and prevention models that better respond to the needs of young people, including those facing socioeconomic disadvantage.

5.3 Common principles of effective and promising youth mental health promotion or prevention practice

While some gaps in outcome measurement and knowledge remain, our second review enabled us to identify several common principles of effective and promising mental health promotion or prevention practice with young people. These principles for effective and promising practice suggest that programs, services and approaches should be:

- Co-designed or informed by young people, and peer-led
- Universally available (therefore less stigmatising) but adapted to the local and cultural context and with an equity lens to provide support in alignment with need
- Holistic, integrated and coordinated – engaging and addressing the whole person and their interests and needs, rather than focusing only on mental health
- Local, affordable, convenient and flexible in delivery
- Youth-friendly, culturally safe and responsive (e.g., welcoming, youth-friendly spaces, non-discriminatory, non-judgmental, non-stigmatising, culturally competent staff or facilitators)
- Able to facilitate positive connections with peers and trusted adults
- Longer-term – for example, ongoing for 12 months or more

The aim of this second review was to understand the current state of evidence and to present models of promising and effective practice in youth mental health promotion and prevention. The following section discusses the final stage of the *Mental Health Deep Dive* project, which involved engaging with representatives from the youth mental health sector in Australia. This final stage of the *Mental Health Deep Dive* was structured around key questions based on the Needs Statements co-developed by Zurich and CSI (Section 4) and informed by the literature review discussed here (Section 5). In this final stage of the project, high-level mental health stakeholders were engaged in two generative roundtables (alongside one individual interview), to test the findings of the promising practice review against current Australia-based understandings, and respond to some of the remaining knowledge gaps identified in the literature review. The method and findings of the roundtables and interview are discussed in Section 6.

6. ROUNDTABLES AND DISCUSSIONS WITH MENTAL HEALTH SECTOR REPRESENTATIVES

6.1 Approach and methodology

Following the literature review, a stakeholder engagement process was designed in order to test the ideas that emerged from the literature with current, Australia-based understandings; and to see the extent to which the findings resonate with what practitioners, sector advocates and policy-makers understand. High-level stakeholders from services, organisations and peak bodies within the youth and/or mental health sectors were selected to participate in workshops. These workshops were conducted in a roundtable format so that people with diverse experiences would meet as peers and equals, with all views to be considered, and were generative in style (i.e., participants' views would be actively sought and captured).

Data produced by these generative discussions focused largely on prevention of, and early intervention in, poor social and emotional wellbeing or poor mental health, rather than on the promotion of positive mental health (although this was not actively excluded).

6.1.1 Workshop design

The workshops were structured around key questions that were informed by the literature review and based on the Needs Statements co-developed by representatives of Zurich Financial Services Australia and the Z Zurich Foundation, with CSI.

The workshops used interactive techniques to determine how stakeholders define, conceptualise, and imagine promising practice that addresses youth mental health, grounded in professional and personal experience and in examples they have seen. Participants were presented with five categories of mental health care based on the literature review. They are broadly described here, but written in more detail in Section 9 (Appendix A):

- Low threshold, easy to access care
- Reduction of the barriers to accessing care
- Clear, holistic mental health care
- Effective preventative and early intervention (early in life, illness and episode)
- Health and wellbeing policies

Participants were asked to consider what they would see and hear, and how they would feel if these models of care were being delivered to young people seeking mental health care or support – these prompts were based on human-centred design techniques.

A choice of two roundtable dates were offered to participants and, as an alternative if these dates and times were not suitable, the opportunity to partake in an interview was offered and taken up by one participant. The workshop material used for both the roundtables and the interview can be found in Section 9 (Appendix A).

6.1.2 Participant recruitment

The CSI research team used their networks and experience in research about youth mental health to select stakeholders with extensive experience working in youth mental health. Care was taken to ensure that the invitees included participants from each of the states and territories.

Both multijurisdictional and multisector representation was considered to ensure that a breadth of knowledge was shared in the discussions. Invitees included staff from Offices of Chief Psychiatrists, from peak bodies for the mental health and youth sectors, and from commissioning bodies. The invitees also included senior teaching staff at schools, and doctors in general practice. Both metropolitan and regional perspectives were present.

The generative roundtables (plus a single one-on-one interview) comprised nine participants. In total, 19 were invited, however, 10 were unable to attend. Participants in attendance included one individual representing a national perspective, two from Queensland, and the remainder from Western Australia. Most attendees were staff from peak bodies and commissioning bodies from metropolitan locations. Two attendees represented a regional perspective: a senior educator and a doctor in general practice. Participants were not offered incentives for attending.

6.1.3 Data collection

The workshops and interview were guided by the Lived Experience Lead at CSI. The two group sessions were not recorded because two CSI Research Assistants attended to take notes during the sessions. However, the one-on-one interview was recorded with permission from the interviewee, so that the interviewer could be fully present to the conversation. Data were collected using the online platform, Menti, which allows participants to anonymously provide and view their feedback in real time. This platform allowed participants to respond to the prompt in their own words. Each workshop was held via Zoom for approximately 90 minutes on the 25th and 27th of August 2021.

6.1.4 Data analysis

The positive or promising examples that emerged from the discussions are non-exhaustive and cover a range of mental health promotion and preventative practices, based on the experiences and expertise of the participants. Written material collected via Menti and data collected via note taking were analysed. Key themes were identified for the five categories of mental health care that were presented to the participants (see Section 6.1.1, or Section 9 Appendix A for full details). Direct quotes are included to highlight or expand on perspectives presented.

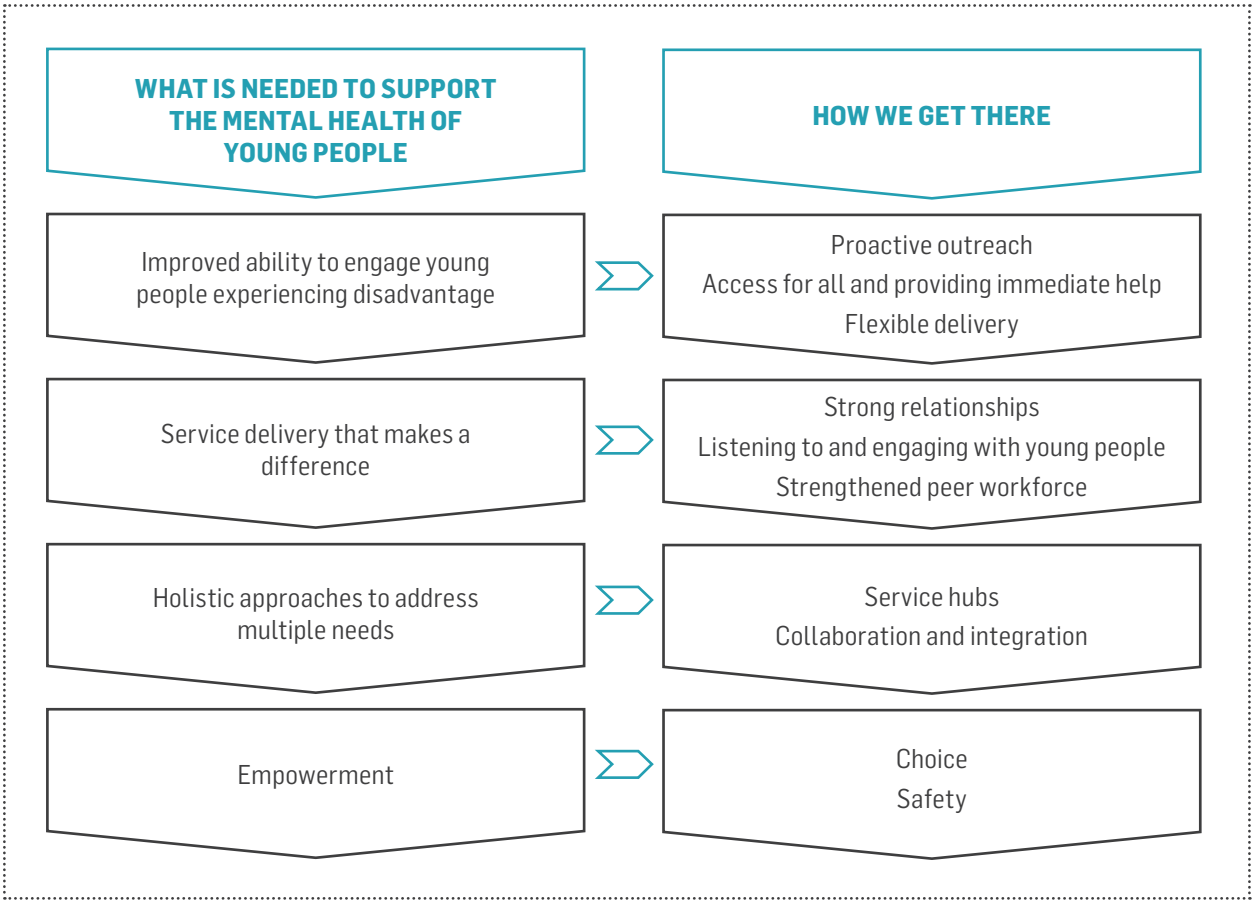
6.1.5 Limitations

Not all invitees were available to attend the roundtable workshop dates offered. Additionally, the second workshop comprised participants exclusively from Western Australia, so perspectives were not as diverse as they could have been with representation from other states or territories.

Attendees did not include any young people or service-users who had accessed a youth mental health service. Instead, the findings presented reflect only the perspectives of representatives who work closely with young people, and therefore have a systems understanding of current problems and gaps within the youth mental health system, rather than a direct experience of accessing a service.

6.2 Findings

The following findings are presented through two lenses that emerged from analysis:



Although most of the discussion covered the domains above, a third lens underpinned many of the stakeholder insights and applied to nearly all matters discussed: what happens 'upstream' to enable, or, more often, constrain the ability to implement what is needed. In our summary of findings, first, we discuss findings related to what is needed to support the mental health of young people. Then, we explore perspectives on how supports and services can meet these needs. Finally, we address the fundamental issue underpinning both of these lenses – the resources and leadership required to create and support promising and effective practice.

6.3 What is needed to support the mental health of young people?

Stakeholders described the most effective ways to support young people as being about taking the time to meet them where they are at. This section explores the implementation of this principle in various ways. For example, this could mean in a literal sense – for example going to settings where young people are, such as education settings – but also in terms of relational support. It means spending time to allow a young person to settle into a space, experience safety and engage on their own terms. Time for deep listening (rather than, for example, a run through of tick-box processes such as eligibility criteria), is essential to deeply and broadly understand the young person, where they are coming from, and what their needs are.

6.4 Improved ability to engage young people experiencing disadvantage

If we hope to connect with high-need young people who are currently unwilling or unable to engage with supports, it is necessary to proactively address barriers faced by these populations, groups or individuals. Services cannot assume that young people will always be able to understand that they need and can access mental health support, find the service, understand how to access it, and overcome the social or internalised stigma to reach out for help.

6.4.1 Proactive outreach

Looking at creative options for delivering services where young people are at is the key to breaking down barriers of inequality, and supporting the young people who are likely to need it most.

> *"We need more extensive networks of outreach services making regular visits to where young people need to be."*

Additional strategies to reach young people in need could be drop-in support, outreach, and in-reach (e.g., capacity building in sports clubs, or service provision within school settings), depending on the cohort. Services should meet young people where they currently are, such as in schools. This fits in well with early intervention approaches, such as embedding health promotion activities into early childhood education, which helps to normalise mental health and social and emotional wellbeing, and provide tools and strategies for managing mental health challenges in a peer environment.

> *"A wide range of diverse and specialised early intervention services complementing headspace and directly involving schools as part of this system – incorporating culturally appropriate and cohort specific services."*

6.4.2 Access for all and providing immediate help

Some of the common access barriers identified through the discussions with participants were age restrictions and service eligibility criteria that was too restrictive. Ideally, no young people should be required to wait more than one week for an initial appointment. When a young person initiates contact with a service, it may be the first time, and could be the last time, that they reach out for help. It is important for services to understand this and go out of their way to provide immediate help, relief, comfort, hope, or clinical assistance, if needed. Long waitlists suggest that current appointment-based models are not adequately meeting the needs of young people; considering alternative models, such as drop-in or digital services, may be one means of adapting to this demand.

> *"A service that has enough counsellors and support workers to meet demand, no waitlists beyond a week."*

Stakeholders agreed that young people should never be turned away from services. This can happen where young people are either considered as 'not sick enough' for a higher level of care but also may be 'too unwell' to access other available services or supports. Stakeholders insisted that "*support must be available for all young people, regardless of symptom severity.*" When turned away, young people feel rejected and helpless, and they are less likely in future to access subsequent supports.

> *"Nice for young people to know that whatever service they went to [they wouldn't be] turned around to go to another service. There is no wrong door and this is something we continue to strive for."*

The 'no-wrong-door' philosophy - *"...for young people to know that whatever service they go into, that the workers in that service will have the capacity to help them, and they won't be turned around to go elsewhere"*- is critical, especially if we are serious about supporting young people experiencing social inequality or disadvantage.

> *"Young people feeling like they can receive care when they truly need it – not just when they are in crisis."*

Participants acknowledged the complexities around offering a low-threshold, low-barrier approach, while also being able to address severity of mental health presentation. Rigidity, risk aversion and workforce skills were identified as current barriers to services working with all presenting young people, and services and staff would need to be well supported and equipped to accept a certain level of risk.

6.4.3 Flexible delivery

> *"When a program is expected to look the same, that's when issues arise..."*

The ability for mental health services to be flexible, and therefore permit a process of change when needed, is crucial for effective and promising practice. Participants suggested that applying a framework of service delivery is fine, but that staff must be willing, able, and enabled to adjust to address new or enduring problems

or needs. For example, situations such as extended lockdowns due to COVID-19, and/or job losses in regional areas, have impacted the mental health needs of young people in different ways, and require different responses, including capacity to respond to potential surges in demand.

> *"Things can change over time and if our programs are too rigid, we cannot allow flexibility."*

Services need a creative approach to problem solving; a careful consideration of what works, what does not, and ways to effectively cultivate solutions.

The need for local solutions was discussed in the context of rural and remote locations, and also resonated with metropolitan stakeholders. Both regional and metropolitan stakeholders reported that often services try and replicate what has been practiced in a completely different context, and therefore achieve poor outcomes rendering the service ineffective, with low levels of engagement and efficacy.

> *"...putting heads together to identify barriers in that location and find solutions that are localised to that area."*

Local problems require local solutions; *"local people, and a local response to a local area".*

6.5 Service delivery that makes a difference

Stakeholders felt there was room for improvement in service delivery, because staff were often too stretched to engage with young people in the most effective ways. When prompted, stakeholders described the heart of good service delivery to be based around the quality of relationships that staff or practitioners are able to establish with young people.

6.5.1 Strong relationships

Relationship building and connection with young people matters to service providers: *"People need longer for the engagement process – you can't do real listening and empathy and compassion in one session."*

Participants expressed a desire for service-users to have more time for an initial session, or to have an extended period of time during the initial stages of engagement, to allow trust to be built earlier in the process.

When asked how they would know this was happening, participants clearly said that, *"Genuine authenticity, which creates a compassionate service where everyone is listened to, would open up further conversation and trust."* The theme of trust was consistently raised as key to improving services, and as an indicator of improved service provision.

6.5.2 Listening and engaging with young people

Deep and empathetic listening so that young people seeking support truly feel heard, was considered an important contribution to improved mental health outcomes for young people. Feeling heard, listened to, and understood, from a place of compassion and non-judgement is a key component of establishing a successful support and underpins an effective therapeutic relationship. When practitioners, support workers and staff deeply understand the needs of young people, they can be responsive, and the probability of long-term transformational change and mental health recovery is increased.

> *"It takes courage to seek help and it's scary to hear when people say they haven't been listened to. If we don't listen, we might miss our opportunity to help that person."*
>
> *"People speaking in ways they feel comfortable with, and are able to be heard."*

It was also agreed that trust is developed through really getting to know young people and listening to their individual needs and desires. Keeping young people engaged in services so they can continue to get help as needed until they are ready to exit the service, was considered a key factor in promising practice. Feeling heard and listened to also means that even if a service or program did not achieve the intended outcomes in the first instance, young people can provide feedback and services can become more responsive to their needs.

> *"[young people saying] ...they didn't get it right at first, but they listened to me and made it fit what I needed better."*

Genuine partnership with young people is a key feature of promising practice. Stakeholders suggested that services regularly seek the advice of young people, including those with lived experience, service users and those not accessing services, to better understand their needs, and tailor offerings to meet those needs. An understanding of socio-demographic diversity and how this impacts young people's service use needs to be deeply understood by decision-makers.

> *"Young people at the table at all levels."*

6.5.3 Strong peer workforce

According to workshop participants, ongoing dialogue with people who have/had experience of living with a mental health condition or social and emotional wellbeing concern is vital to reducing barriers for young people – particularly young people with high-risk mental health issues and/or facing social inequity. This comprises lived experience representatives and advisors, service users, and peer support workers.

> *"Ongoing dialogue with lived experience advisors; not just strategy and consultation."*

Continuous feedback from the peer workforce, and bringing in their perspectives should be integral to how a service operates. Lived experience representatives/advisors, and service users, need to be consistently and meaningfully engaged throughout all levels of planning, implementation, review, and quality improvement. The insights offered by peer workers can uncover blind spots in practice that may be alienating young people, and point to small but powerful changes to increase meaningful engagement.

Genuine co-design with young people and service-users is critical for the development, implementation, and review of services: *"...**they** drive what is next."*

> *"Commission strategy that incorporates an understanding of co-design – to build a collaborative movement from design to implementation."*
>
> *"Continued co-design within the first 2-4 years of service (not just at the start)...involving lived experience, service users, families..."*

Co-design methods (including co-creation and co-production) need to be implemented and utilised more effectively in the youth mental health sector. There was consensus from participants that co-design needs to be better understood and embraced by decision makers, for its value to be realised.

> *"The consultation process is valued but it's 'we need to do this' and then after that there is no ongoing co-design efforts – a misunderstanding of co-design. There needs to be ongoing feedback and for [services to be overseen] by lived experience advisors and people who use the service."*

The limitations within the peer workforce were also acknowledged. There is a lack of diversity across many socio-demographic factors, and therefore often in a service, peer support workers will be drawing on similar experiences.

> *"There are assumptions that a peer worker represents diverse voices. But peer support work is different to ongoing conversations with many voices, and understanding of diverse lived experience."*

Limitations were likewise expressed about the adequacy and appropriateness of skills development training for peer support workers to ensure quality care and safety for peer workers as well as service users.

6.6 Holistic approaches to address multiple needs

The need for a holistic approach to mental health care for young people who are seeking support emerged as one of the strongest themes. A holistic approach is person-centred and strengths-focused, rather than illness-centred or deficit-focused, and it also considers the social determinants of mental health, which impact strongly on the experience of mental health conditions.

Ideally, this involves a practical, problem-solving approach, where young people can access wrap-around services that address their other, whole-of-life needs, along with their mental health.

> *"There needs to be a focus on the whole person. This needs to be personally significant, in a way that's not focused on 'what's wrong with me'."*

6.6.1 Service hubs

Co-located services – locations where young people can access more than one type of wrap-around support, with clear links and pathways between supports – were described by participants as a powerful model for making a difference to the lives of young people. However, this does not negate the need for other recommended service delivery approaches such as outreach, which may better suit some young people who are less likely to access a service hub. Having different service options is part of achieving flexible service delivery, as noted in Section 6.4.

It was important for a service hub to include services and programs that are not exclusively mental health related, but also address social, cultural, physical, and mental health and wellbeing needs. This may involve linking young people to gender services, housing and employment assistance, and legal support. Communication across these organisations allows young peoples' individual needs to be more efficiently addressed and allows different organisations to provide their expertise and resources, where required. Participants suggested that another effective co-location model was to have specialists in youth mental health embedded within other youth-focused services:

> *"Through co-location and integrated pathways – youth mental health specialist services are embedded into youth services, youth homelessness services, employment services, employment agencies, etc."*

Addressing the whole-of-life, whole-of-person needs is integral to supporting the mental health of young people. Strong collaboration between mental health and non-mental health professionals, within a community of practice is critical: *"Community approaches and working across the sectors to make creative solutions and take into account the strengths of each organisation"*. The interesting insight here is that stakeholders agreed that collaboration leads to creativity. Within the collaboration, people have an openness to change and from here potentially new ways of working can be explored.

6.6.2 Collaboration with other services and supports

The desire for meaningful collaboration between agencies and sectors was a shared vision of the workshop participants, and there was agreement that the current state of the service system falls short, with disparate and siloed organisations getting in the way of meeting individual needs. Emphasis was placed on the need for shared planning and communication between services, programs, and even sectors.

Increased communication and smoother transitions between mental health services are needed, so young people are not required to re-tell their story to different providers. Improved collaboration also allows for services to develop clear and correct referral pathways to address multifaceted needs. This increases the efficiency of mental health care.

Diverse skills and backgrounds within the workforce is critical to addressing the needs of young people, especially those experiencing social inequality - and collaboration enhances access to diverse supports and people. At different points, young people may need access to various types of expertise, including clinical and non-clinical mental health professionals, Indigenous workers, educators, and peer support workers or the expertise of people with lived experience. The mental health of young people may also benefit from links to other supports and perspectives such as the police, justice, housing, and employment which, together, provide wrap-around care, or the prevention of ongoing intergenerational disadvantage and/or social exclusion.

> *"It is difficult for one person to address all needs. We hope to hear about multiple supports coming from different perspectives – clinical, social, housing etc."*

This discussion extended to linking with the community, "*Engaging sporting groups and small businesses and local groups*" to increase social wellbeing and opportunities for ongoing connection.

Creating an ecosystem of support that spans across other services, both within the mental health system as well as outside of it, is important in addressing staff burnout. Participants spoke about this ecosystem of services as being strengthened by clear communication, collectively and creatively finding solutions to problems, and working in unified ways, rather than competitively against each other.

> *"...feeling like there is a less competitive mindset in service delivery – we are no longer jockeying for scraps of funding, and instead truly working together."*

6.7 Young people are empowered by the service, and given options

Participants emphasised that mental health supports should strive to empower the young people who are accessing them. Empowered young people are service-users who feel that they are in charge of their own care, and feel supported, safe, and less stressed about seeking mental health support. Practically, empowering service users comprises providing empathy, listening, and giving options and choice.

6.7.1 Provision of choice

To accommodate holistic, individualised, and empowering care, young people should be provided with options when first accessing a service (e.g., drop-in, referral, online – including apps and chats, and Telehealth). This includes accessing care at any point in time (or illness/wellness) and the choice regarding entry point. Young people should be provided with different options for care, a choice of services to access, and various modalities and treatment options should be available specific to their individual needs, preferences, desires, and self-perceived readiness to engage.

> *"Young people should decide how they access support, and that both digital and face-to-face channels are open."*
>
> *"Here are the choices, what do you want to engage in? We can offer you A, B, C, and D."*

Young people should also be deciding for how long they are engaged with a service, whether and how often they opt-in or opt-out.

Technology assisted service delivery has the potential to provide coordinated care, available wherever young people happen to be. Stakeholders acknowledged that there is significant opportunity for digital solutions, including client-apps and case management platforms to provide more responsive, timely and effective care across the continuum of young peoples' mental health journey. However, some stakeholders also pointed out that technology needed to be deliberatively designed for young people and that "*Good design work*" was essential in this space.

While technology can enhance mental health care, reduce barriers, and provide greater accessibility, the limitations of technological solutions were also noted. Technology alone, such as app-based services, cannot address the full range of needs young people may have; innovations require extensive research, development, and prototyping, aligned with human-centred design and user-centred design principles.

> *"Digital solutions can get young people where they live but can also lack design work and understanding."*

6.7.2 Spaces for young people to engage safely

A mental health service cannot be effective if it is not experienced as safe (psychologically, emotionally, culturally, and physically) by those who access it. Participants' definition of safety was that young people should feel accepted as they are, treated with respect, and provided with care, irrespective of their circumstances or differences. Young people need to feel welcomed, accepted and embraced. Some of the suggested ways of ensuring and signaling this safety were:

- being inclusive of Indigenous and other cultures, meaning culturally secure and responsive;
- being respectful of LGBTQIA+ persons, such as taking care with language and using correct pronouns;
- having staff with diverse backgrounds available
- non-stigmatising language and non-judgmental staff.

The physical space is a significant part of the experience of safety for a young person, and has a strong influence on their engagement. Spaces should not be clinical and, as much as possible, should be welcoming, friendly, comfortable, accommodating, and relaxed.

> *"Physical space…to see a space where young people feel safe to actually engage. Once that has already happened, we would see a level of engagement with young people – a relationship that is building over time in a place where the young people feel safe."*
>
> *"Young people walk into a place, it's beautiful, welcoming…someone gives them a cup of tea, chat on a couch, needs are identified, warm hand-over to someone else."*

6.8 What is required to create promising and effective practice?

Dedicated staff want to do their best for young people, but also work in restricted spaces where efforts such as relationship building and developing positive collaborations with other services is not adequately resourced or supported. Funding structures as well as organisational practices can create conditions where staff are encouraged to focus on rigid models of service provision, pressure to see many clients and where measures of performance or effectiveness are based on hours of contact or number of clients rendering some relationship-building work invisible.

The promising practice described above is not new, and is well supported throughout the mental health sector (including amongst all workshop participants, consensus tended to be strong). The reason our existing system falls short is not due to lack of vision or will from people who work in youth mental health, but rather structural issues that need to be addressed.

6.8.1 The need for well-funded and sustainable services

Participants of the generative discussion pointed out that the components identified as promising and effective practice could not be sustained without stable, consistent and properly allocated funding that allows for services to effectively deliver. This extends to the need for funding that is specifically allocated to early intervention of mental health concerns. This may look different to treatment models, as more time needs to be spent on engagement and building relationships. There also needs to be funding specifically allocated to collaboration with other supports (which can be resource-intensive). Service providers feel they are severely restricted by current funding models that tend to focus predominantly on hours of service, and this negatively impacts the other work that needs to happen to effectively meet the needs of young people.

> *"We need mental health system reform strategies that actually have funding attached to implementation."*

Providing dedicated, paid time for planning with other services would also help to address staff burnout. Participants reported that creating better collaboration between service providers would reduce fatigue and create feelings of relief for staff. Actions that relieve stress on staff are also critical for supporting authentic, timely and effective care to young people.

6.8.2 Organisational leadership support for promising practice

Organisational culture, staff wellbeing and safety policies, and human resources management, together with thoughtful operational practices, are all important ingredients for supporting and enabling individual employees to engage in promising practices, thereby increasing quality of care and improving mental health outcomes for young people.

Funding models and management practices tend to be tightly scoped and this can also act to discourage services from engaging young people with high needs or experiencing disadvantage. Therefore, leadership at organisational, state and federal levels needs to recognise and actively prioritise promising practices that support all young people, and provide adequate resources for supporting young people who are more likely to need help for their mental health.

7. CONCLUSION AND RECOMMENDATIONS

In this section, we integrate the key findings of the review of literature around promising and effective practice for supporting the mental health of young people, and the findings of the consultation with stakeholders working to support the mental health of young people. The roundtable discussions validate, to an extent, the published evidence – and the evidence supports the issues raised by stakeholders. This was not necessarily expected, because the literature review and stakeholder discussion processes ran in parallel, with the consultations based around open questioning and not necessarily designed to confirm specific findings. We also expected some debate and more diversity of views within the roundtable discussions, and yet generally all stakeholders were in strong agreement about what was expressed.

Despite the various limitations and constraints on this project (including that no young people were consulted), the congruence of the ideas across data sources and between the people we spoke to means we can speak with some confidence about what effective and promising practice might look like for supporting early intervention and promotion of mental health in young people.

7.1 Summary of effective and promising practice

Each stage of the Mental Health Deep Dive has highlighted similar themes about the ways in which the mental health system needs to improve how it addresses the needs of service users, and also how it engages with those less likely to access support.

Socially disadvantaged young people face greater risk factors for mental health conditions (Allen, Balfour, Bell, & Marmot, 2014) and also disproportionate barriers to accessing mental health supports, including social and internalised stigma. Creating interventions that reach young people where they are is important. For example, early intervention programs that work with schools to identify and address youth vulnerabilities are viewed as effective (Bradfield, 2018). There is some evidence that targeted creative/recreational programs in schools (Martin & Wood, 2017), and culturally responsive and local community-led organisations (Jones et al., 2021; Posselt et al., 2017) can support access to early help or reduce the impact of existing mental health conditions.

Implementing universally available supports with creative options for service delivery, or blended options, enables services to meet young people where they currently are – which was considered by stakeholders to be critical, and also an approach supported by published literature. Universally available supports minimise the risk of harm or stigmatisation and maximises potential for health promotion across the population (Fusar-Poli et al., 2021; Iizuka et al., 2015; Posselt et al., 2017; Salazar de Pablo et al., 2020) – though, specialised, targeted interventions are also necessary to reduce health disparities (Jones et al., 2021) and increase efficiency of service delivery.

What this means on the ground, according to stakeholders we spoke to, is to have low-threshold services readily available for all young people to access. For example, young people should not be required to fulfil criteria that are too narrow or restrictive, to endure long waitlists when they are experiencing distress, or to miss their opportunity to access support if they have a concern with their mental health – especially if this is in addition to any other dimensions of disadvantage. The "no wrong door" philosophy should allow young people to access help, support, or relief, whenever they need it.

Flexibility is required for services to adapt to local need, provide individualised delivery of supports, and develop innovative solutions to presenting problems. Flexible and convenient delivery of programs increase access and engagement from young people who may have different preferences regarding mental health supports, affirmed by the current literature (Hansen et al., 2019; McCann & Lubman, 2012; Platell et al., 2017; Robards et al., 2019).

This is further strengthened by use of co-design models and principles to continuously improve service delivery, a finding based in the literature, but further emphasised by stakeholders, who called on the sector to not just promote the idea of co-design and lived experience engagement, but to more deeply understand it and ensure decision makers commit to the co-design findings.

Meaningful and consistent lived experience engagement ensures that services, programs, or initiatives are informed by those who access them, which helps to create services that are relevant and valuable. Working in partnership with the peer workforce should be a continuous process, comprising design, implementation, and ongoing review. According to the literature, young people value peer-support and connection (Brown et al., 2016; Fusar-Poli et al., 2021; Sharma et al., 2021; Wearing, 2011), and services that are tailored to young people are more likely to be effective. Partnership with young people using genuine co-design and collaboration frameworks ensures that efforts to support mental health are optimised, and this ultimately improves the efficiency of service delivery (Brown et al., 2016; Fusar-Poli et al., 2021; Sharma et al., 2021; Wearing, 2011). Service providers need to properly understand the process of co-design to implement this process successfully and meaningfully.

The heart of good service delivery is relative to the quality of the relationship between the young person and the staff or practitioner (and in some cases, the service). Connection matters: stakeholders hope for more time for the engagement process to build trust, provide empathetic listening, and really understand the young person's concerns and presenting struggles. Building trust enables young people to safely communicate their needs and navigate their choices. Stakeholders consulted insisted that staff need additional time for relationship building, especially when a young person first seeks support.

Consistent with what was found in the literature, negative experiences deter engagement, while positive and supportive relationships with staff and peers encourage engagement, are valued by young people, and contribute to positive mental wellbeing (Boyle, 2020; Brooks et al., 2020; Brown et al., 2016; Posselt et al., 2017; Sofija et al., 2021). Stakeholders reported that trust is necessary, in order to make a difference in a young person's life. As young people navigate significant life transitions, they may not yet have established stable, reliable supports in their personal lives, they may have internalised stigma and be reluctant to seek formal treatment, therefore investing this time to build a genuine relationship with a young person is essential to service effectiveness, and to making a difference in their life.

Promising and effective practice is holistic. Holistic, person-centred practice considers people to be individuals with whole-of-life needs; not merely requiring mental health support in isolation. It considers the social, emotional, cultural, spiritual, and physical aspects of self. There is a need for strong wrap-around care and the co-location of services to best support young people. Consistent with the literature, young peoples' engagement with mental health programmes and services should be holistic, integrated and coordinated to increase access of services and deliver best practice (Boyle, 2020; Brooks et al., 2020; Brown et al., 2016; Jones et al., 2021; Oostermeijer et al., 2021).

Improved ability to support the mental health of young people experiencing disadvantage will require letting go of some service-centric processes such as rigid eligibility criteria, or offering only limited treatment options. Holistic approaches to address multiple needs is in line with everything we know about the social determinants of mental health, and this cannot happen without consideration and planning (for example, collaboration to develop referral pathways, co-located service hubs).

Meaningful collaboration between agencies and sectors is key to effective practice, and currently, where the youth mental health landscape falls short. It allows free-flowing communication, the sharing of expertise, and a reduced risk of burn-out. Increasing the prominence and visibility of the relationship-building work in any service or support is in line with evidence presented in the literature (Bradfield, 2018; Tracey, 2019). This is also consistent with contemporary models for system change, such as Theory U. Developed by the Presencing Institute at MIT, Theory U describes a model consistent with what our stakeholders shared: the need to attend, connect, co-initiate, and work as a team (Scharmer, 2009).

Young people should be active participants in their own treatment and feel empowered by the service that they are accessing. Effective mental health supports recognise that young people possess individual needs, preferences, and desires, and ensure that these aspects of self are respected by providing service-users with choice and options. Giving young people choice and responsibility to manage their lives is a core aspect of person-centred approaches, and considers the coordination of care and whole-of-life needs (Boyle, 2020; Productivity Commission, 2020). Stakeholders felt that empowering young people comprised provision of choice (e.g., service delivery mode or for how long they access a service) and creating safe spaces for support where young people feel accepted, respected, and cared for. If young people do not feel welcomed or safe, they will not actively engage in mental health treatment (Boyle, 2020; Brooks et al., 2020; Brown et al., 2016; Jones et al., 2021; Posselt et al., 2017).

Diversity of treatment options allows services to adapt to the individual need of young people, and therefore, meet young people where they are currently at. Adaptable services that are resourced to provide support in alignment with need are ultimately a best practice approach (Welsh et al., 2015). Stakeholders know how to effectively help young people. Unfortunately, there are often constraints impacting the ability of staff to provide effective practice. Sustainable funding structures and supportive organisational structures are needed to deliver the best outcomes.

7.2 Concluding thoughts

The findings of the generative discussions may seem unsurprising to those working in mental health. They are what the mental health sector, and especially lived experience voices within the sector, have been calling for over many years. In this sense, the roundtables conducted with stakeholders matches the broader evidence base covered in both the strategic context report and the second report about evidence for effective and promising practice for supporting youth mental health.

Although similar discussions on improving collaboration and creating person-centred services have been happening for a few decades, what is not often obvious is the felt urgency of the need for change – as reflected in the voices of sector representatives. Researchers from CSI noted strong emotive words used by participants who were reflecting on what it would be like to see promising and effective practice for young people; words such as 'relief', 'joy', and 'hope'. Participants also openly described their 'apprehension' and even 'sadness' that where effective practice does exist, it may just as easily disappear due to a lack of sustained funding, or that these ways of working are outliers and not consistently valued (or even recognised) by decision-makers.

In the final stage of the *Mental Health Deep Dive*, discussions allowed for more of a focus on why these well-established effectiveness principles have not yet been operationalised into practice throughout the sector. Participants put a strong emphasis on the need for time to be deliberately scoped for this work. For example, allocated time to collaborate: within services, within geographic locations, across service-types, with colleagues, and with young people and their families. Likewise, a generous allocation of time is needed to build trusting relationships, which was deemed essential to effective practice. Those instances where this time was enabled were pointed to as exceptionally promising and effective, although their funding going forward not always necessarily secure (see Section 9 – Appendix B for lists of promising examples that were identified by stakeholders consulted in the roundtables).

In weighing up the findings of all evidence gathered in this *Mental Health Deep Dive*, we feel that operationalising the principles of promising practice (such as additional allocation of time to develop relationships) ought not to rely solely on the good will of practitioners – of which there is naturally plenty – because, as researchers were told, this leads to staff burnout. Instead, the funding model itself was key to supporting promising practice in sustainable ways.

Although our stakeholder consultations were limited and not extensive, the feedback received was consistent. The overarching message from strategic thinkers working in various parts of the mental health sector confirmed that no matter what type of support, which state or territory, or what the specific mental health needs of the young person might be, effective practice takes time because it requires:

- Proactive engagement
- Flexibility over standardised approaches
- Relationship-building
- Meaningful engagement with young people
- Effective collaboration with other services and supports, and
- Continual improvement in response to co-design and creativity and innovation

When reviewing how treatment models or service contracts are written, some of this work that is essential to promising and effective practice is not nearly as visible, explicit or adequately resourced as is warranted. These may seem to be less tangible elements of practice, but according to most of the stakeholders consulted, if these elements exist, the 'magic' of the service or support, and its ability to make a lasting difference to the lives of young people, is palpable.

Prioritising relationships and individual needs over more standardised processes and interventions may be more resource intensive, and it also may challenge the usual ways of doing things. For example, currently many services operate within the bounds of strict eligibility criteria, or provide only specific types of support, but cannot address other needs (including, sometimes, even basic needs).

We heard from people with experience working with the sector that practitioners working with young people are likely to have a strong sense of what young people need and have the skills to support them. However, importantly, practitioners also need the support of supervision and funding structures which enable more fluid, person-centred care. They need adequate time to develop meaningful collaborations between services and create supported pathways for young people, and time for relationship-building with young people which can uncover whole-of-person needs.

While our literature review and consultation processes sought to find examples of promising activities, programs or ways of supporting young people, our findings reiterated that rather than trying to replicate existing models, the critical work to do could be around removing system-level constraints to enable better engagement with young people, and adequately resourcing relationships. These findings suggest that creating more enabling funding and commissioning practices could hold the greatest potential for creating change and increasing the effectiveness of services for young people.

The Productivity Commission (2020) also highlights the need to look at funding issues in mental health including the complex governance structures, under-investment in mental health compared to physical health, and poor service planning and coordination. In relation to funding distribution, Welsh et al. 2015 argues for "proportionate universalism" – making programs universally available, but with funding in proportion to specific community needs.

Experiences in the service sector of strain on resources, as expressed during consultations, could also reflect the general under-investment in promotion, prevention and early intervention activities in the mental health sector. As our first Mental Health Deep Dive report notes, a greater spend is focused on high-cost acute and crisis care, with prevention, early help, psychosocial and community-based supports being given less. It is our hope that the findings of this final Mental Health Deep Dive report help make the case for effective and promising practice, as it is described here, and in particular for intervening and supporting young people as soon as possible in the context of their struggles, and as early as possible in their lives and transitions to adulthood.

8. REFERENCES

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, 26(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Australian Bureau of Statistics. (2008, October). *National Survey of Mental Health and Wellbeing: Summary of Results*. https://www.abs.gov.au/statistics/health/mental-health/national-surveymental-health-and-wellbeing-summary-results/latest-release

Australian Bureau of Statistics. (2018, December). *National Health Survey: First Results*, 2017–18. Canberra, Australia. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

Australian Institute of Health and Welfare. (2021). *Mental Health Services in Australia*. Retrieved April 22, 2021 from https://www.aihw.gov.au/reports/mental-health-services/mental-healthservices-in-australia/report-contents/summary-of-mental-health-services-inaustralia/australias-mental-health-system

Black Dog Institute. (2021). *Aboriginal and Torres Strait Islander Lived Experience Centre*. https://www.blackdoginstitute.org.au/education-services/aboriginal-and-torres-strait-islander-network

Boyle, C. (2020). A welcome home: Youth homelessness and mental health. Orygen.

Bradfield, S. (2018). Can social and educational markers predict risk for future health vulnerabilities? A population health approach for vulnerable young people on the Central Coast of NSW Australia. *International Journal of Integrated Care (IJIC)*, 18, 1–2. https://doi.org/10.5334/ijic.s1078

Bridgman, H., Ashby, M., Sargent, C., Marsh, P., & Barnett, T. (2019). Implementing an outreach headspace mental health service to increase access for disadvantaged and rural youth in Southern Tasmania. *Journal of Rural Health*. https://doi.org/10.1111/ajr.12550

Brooks, M., Hooker, C., & Barclay, L. (2020). Artspace: Enabling young women's recovery through visual arts: A qualitative study. *Health Promotion Journal of Australia*, 31(3), 391–401. https://doi.org/10.1002/hpja.328

Brown, A., Rice, S. M., Rickwood, D. J., & Parker, A. G. (2016). Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people: Barriers and facilitators to youth mental health care. *Asia-Pacific Psychiatry*, 8(1), 3–22. https://doi.org/10.1111/appy.12199

Cook, L. (2019). *Mental health in Australia: a quick guide*. Parliament of Australia. Retrieved April 22, 2021 from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Librar y/pubs/rp/rp1819/Quick_Guides/MentalHealth

Currier, D., Patton, G., Sanci, L., Sahabandu, S., Spittal, M., English, D., Milner, A., & Pirkis, J. (2021). Socioeconomic disadvantage, mental health and substance use in young men in emerging adulthood. *Behavioral Medicine*, 47(1), 31–39. http://doi.org /10.1080/08964289.2019.1622504

Dudgeon, P., Bray, A., D'Costa, B., & Walker, R. (2020). Decolonising Psychology: Validating Social and Emotional Wellbeing. *Australian Psychologist*, 52(4), 316–325. https://doi-org /10.1111/ap.12294

Everymind. (2017). Prevention First: A Prevention and Promotion Framework for Mental Health, Version 2. Newcastle. Australia.

Fusar-Poli, P., Correll, C. U., Arango, C., Berk, M., Patel, V., & Ioannidis, J. P. (2021). Preventive psychiatry: A blueprint for improving the mental health of young people. *World Psychiatry*, 20(2), 200–221. http://doi.org/10.1002/wps.20869

Future Generation Investment and EY. (2021). *Australia's mental health crisis: why private funders are not answering the call*. https://futuregeninvest.com.au/wpcontent/uploads/2019/10/Australias_Mental_Health_Crisis.pdf

Habib, C., Toumbourou, J. W., McRitchie, M., Williams, J., Kremer, P., McKenzie, D., & Catalano, R. F. (2014). Prevalence and community variation in harmful levels of family conflict witnessed by children: Implications for prevention. *Prevention Science*, 15(5), 757–766. http://doi.org /10.1007/s11121-013-0416-4

Hansen, A., Broomfield, G., & Yap, M. B. H. (2019). A systematic review of technology-assisted parenting programs for mental health problems in youth aged 0–18 years: Applicability to underserved Australian communities. *Australian Journal of Psychology*, 71(4), 433–462. https://doi.org/10.1111/ajpy.12250

Herrman, H., Saxena, S., & Moodie, R. (2005). Promoting mental health: concepts, emerging evidence, practice: report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. https://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf

Iizuka, C. A., Barrett, P., Gillies, R., Cook, C., & Marinovic, W. (2015). Preliminary Evaluation of the FRIENDS for Life Program on Students' and Teachers' Emotional States for a School in a Low Socio-Economic Status Area. *Australian Journal of Teacher Education, 40*(40). https://doi.org/10.14221/ajte.2014v40n3.1

Jay, L., Macadam, B., Gardner, P., Mahboub, L. (2017). Hope headquarters: recovery college. *Health Promotion Journal of Australia* 28(2): 170–173. https://doi.org/10.1071/HE17034

Jones, N., Kamens, S., Oluwoye, O., Mascayano, F., Perry, C., Manseau, M., & Compton, M. T. (2021). Structural Disadvantage and Culture, Race, and Ethnicity in Early Psychosis Services: International Provider Survey. *Psychiatric Services*, 72(3), 254. http://doi.org /10.1176/appi.ps.202000211

Jorm, A. F. (2018). Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian & New Zealand Journal of Psychiatry*, 52(11), 1057–1062. https://doi.org/10.1177/0004867418804066

Joshua, P., Zwi, K., Moran, P., & White, L. (2015). Prioritizing vulnerable children: Why should we address inequity? *Child: Care, Health and Development*, 41(6), 818–826. http:// doi.org/10.1111/cch.12264

Kaleveld, L., Bock, C., & Seivwright, A. (2020). *Increasing and improving community mental health supports in Western Australia*. Centre for Social Impact. https://doi.org/10.26182/5f5719f478a17

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2009). Evolving definitions of mental illness and wellness. *Preventing Chronic Disease*, 7(1), 1–6. https://www.ncbi.nlm.nih.gov/pmc/PMC2811514

Martin, K. E., & Wood, L. J. (2017). Drumming to a New Beat: A Group Therapeutic Drumming and Talking Intervention to Improve Mental Health and Behaviour of Disadvantaged Adolescent Boys. In *Children Australia* (Vol. 42, Issue 4, pp. 268–276). Cambridge University Press. https://doi.org/10.1017/cha.2017.40

McCann, T. V., & Lubman, D. I. (2012). Young people with depression and their experience accessing an enhanced primary care service for youth with emerging mental health problems: A qualitative study. *BMC Psychiatry*, 12, 96. https://doi.org/10.1186/1471-244X-12-96

Mrazek, P.J. & Haggerty, R.J. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. National Academy Press.

Oostermeijer, S., Bassilios, B., Nicholas, A., Williamson, M., Machlin, A., Pirkis, J., Harris, M., & Burgess, P. (2021). Implementing child and youth mental health services: Early lessons from the Australian Primary Health Network Lead Site Project. *International Journal of Mental Health Systems*, 15(1), 16. https://doi.org/10.1186/s13033-021-00440-8

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., Prince, M., Rahman, A., Saraceno, B., Sarkar, B.K., De Silva, M., Singh,

I., Stein, D.J., Sunkel, C., Unützer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Platell, M., Cook, A., & Martin, K. (2017). Barriers to mental health care for disadvantaged adolescents: Perspectives of service providers. In *Advances in Mental Health* (Vol. 15, Issue 2, pp. 198–210). Routledge Journals, Taylor & Francis Ltd. https://doi.org/10.1080/18387357.2017.1317216

Posselt, M., McDonald, K., Procter, N., de Crespigny, C., & Galletly, C. (2017). Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers. *BMC Public Health*, 17, 1–17. Academic Search Complete.

Productivity Commission. (2020). *Mental health: Productivity Commission inquiry report*. Australian Government. https://www.pc.gov.au/inquiries/completed/mental-health/report

Robards, F., Kang, M., Steinbeck, K., Hawke, C., Jan, S., Sanci, L., Liew, Y. Y., Kong, M., & Usherwood, T. (2019). Health care equity and access for marginalised young people: A longitudinal qualitative study exploring health system navigation in Australia. *International Journal for Equity in Health, 18*. http://doi.org/10.1186/s12939-019-0941-2

Salazar de Pablo, G., De Micheli, A., Nieman, D. H., Correll, C. U., Kessing, L. V., Pfennig, A., Bechdolf, A., Borgwardt, S., Arango, C., van Amelsvoort, T., Vieta, E., Solmi, M., Oliver, D., Catalan, A., Verdino, V., Di Maggio, L., Bonoldi, I., Vaquerizo-Serrano, J., Baccaredda Boy, O., … Fusar-Poli, P. (2020). Universal and selective interventions to promote good mental health in young people: Systematic review and meta-analysis. *European Neuropsychopharmacology*, 41, 28–39. https://doi.org/10.1016/j.euroneuro.2020.10.007

Scharmer, O. (2009). Theory U: leading from the future as it emerges; the social technology of presencing. San Francisco: Berrett-Koehler Publishers.

Sharma, V., Hendon, J., Churchill, R., Fortune, S., Simmons, M., Bowden, L., & Hetrick, S. (2021). Improving child and youth mental health: Stakeholder perspectives from a cross-sectional survey to inform research priorities. *Mental Health & Prevention, 22*, 200201. https://doi.org/10.1016/j.mhp.2021.200201

Sofija, E., Harris, N., Sebar, B., & Phung, D. (2021). Who Are the Flourishing Emerging Adults on the Urban East Coast of Australia? In *International Journal of Environmental Research and Public Health* (Vol. 18, Issue 3). MDPI. https://doi.org/10.3390/ijerph18031125

The Centre for Adolescent Health, Murdoch Children's Research Institute (2018). *Student Wellbeing, Engagement and Learning across the Middle Years*, Canberra: Australian Government Department of Education and Training.

Tracey, F. (2019). A question of equity; Partnering across Government agencies to improve health outcomes for vulnerable children and young people—Navigate your Health. *International Journal of Integrated Care (IJIC), 19*(S1), 1–2. https://doi.org/10.5334/ijic.s3443

Tudor, K. (1996). Mental Health Promotion: Paradigms and Practice. Routledge: London.

VicHealth. (2015). *Epidemiological evidence relating to resilience and young people: a literature review*. Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/Mental%20health/Epidemiological%20evidence%20relating%20to%20resilience%20and%20young%20people.pdf?la=en

VicHealth. (2021). *VicHealth Local Government Partnership: Young People Leading Healthier Communities*. Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/-/media/ResourceCentre/Local_Government_Partnerships-26042021_V2-(1).pdf?la=en&hash=172C523CB6153D38F5A6FEA3F320BA3DB3B563BC

Victorian Government. (2021). Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations. https://finalreport.rcvmhs.vic.gov.au/downloadreport

Wearing, M. (2011). Strengthening youth citizenship and social inclusion practice—The Australian case: Towards rights based and inclusive practice in services for marginalized young people. *Children and Youth Services Review, 33*(4), 534–540. http://doi.org/10.1016/j.childyouth.2010.05.012

Welsh, J., Strazdins, L., Ford, L., Friel, S., O'Rourke, K., Carbone, S., & Carlon, L. (2015). Promoting equity in the mental wellbeing of children and young people: A scoping review. *Health Promotion International, 30*(Supplement 2). https://doi.org/10.1093/heapro/dav053

World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en

9. APPENDIX

9.1 Appendix A

Promising Practice in Youth Mental Health: A Mental Health Deep Dive

> ***Effective Preventative & Early-Intervention***
>
> - Developed in collaboration between young people with lived experience & folk with other expertise
> - That people actually (want to) use
> - Which focuses on connection

1. We heard the need for 'low threshold' and 'low barrier' services, what do you see as the practical difference and similarities of these needs?
2. We're now going to do a series of look-listen-feel questions. We need your responses to be based on what you would see, hear, and feel in the following five scenarios:

- Low threshold, easy to access, consistent care which takes into account the complexity of young people's lives and the stigma around accessing mental health support (and which feels and is available consistently). What would you be seeing? What would you be hearing? What would you be feeling? Please share any examples where this exists or is beginning to exist.
- Reduction of the barriers created by lack of listening and empathy allowing access to appropriate preventative and clinical care; especially for young people experiencing high-risk mental health issues and social inequity. What would you be seeing? What would you be hearing? What would you be feeling? Please share any examples where this exists or is beginning to exist.
- Clear, holistic mental health care available at the level and in the mode wanted by the young people experiencing mental ill-health with their care-needs coordinated including access to emerging modalities, favoured practitioners, and the location each young person is. What would you be seeing? What would you be hearing? What would you be feeling? Please share any examples where this exists or is beginning to exist.
- Effective preventative and early intervention (early in life, illness and episode) - developed by collaboration between those with relevant lived experience and those with other expertise – which people actually use and which focus on connection. What would you be seeing? What would you be hearing? What would you be feeling? Please share any examples where this exists or is beginning to exist.
- Health and wellbeing policies – including but not limited to funding decisions – designed, implemented and overseen through collaboration between those with relevant lived experience and those with other expertise. What would you be seeing? What would you be hearing? What would you be feeling? Please share any examples where this exists or is beginning to exist.

9.2 Appendix B

1. *Low-threshold, low barrier, consistent care which takes into account the complexity of young peoples' lives and the stigma around accessing mental health support, and which (both) feels and is available consistently*

Examples of it happening:

- YouthLink (Western Australia): Young people with complex mental health problems and/or risk of homelessness – good record with solid work with young people; works collaboratively with services and strong clinical perspective
- Logan Together (Queensland): Childcare providers, community service providers, different disciplines providing different services for families with vulnerabilities (play-based activities)
- Headspace (National): Young people involved using a reference group; do well with integration, however, still very Westernised and clinical
- Alive and Kicking Goals (Kimberly region): strong youth-led initiatives
- Kimberly Aboriginal Medical Service: Youth leadership forums and the follow on from the forums
- Chaired Community to mental health (WA): Engagement with Mental Health Commission, local shire, South West Alcohol and Other Drug Mental health, Education, Health, Police, sporting groups, small businesses, etc
- Individual Placement and Support (WA): Employment service, co-located mental health service
- Anglicare (WA): Efforts into building programs around the needs of young people
- Pilbara headspace: Imbedding headspace programs into existing services where young people go

2. *Reduction of the barriers created by lack of listening and empathy allowing access to appropriate preventative and clinical care, especially for young people experiencing high-risk mental health issues and social inequity*

Examples of it happening:

- Brisbane South, MetroSouth, Primary Health Network and youth services (Queensland): co-located and have created a network
- Smaller communities (i.e., informal collaboration and communication)
- The Mental Health Network
- Child and Adolescent Mental Health Service Gender Diversity Services (when clients get through the extensive waitlist)
- Yiriman Project Fitzroy Crossing & Olabud Doogethu in Halls Hill: Aboriginal-led and culturally-based initiative
- Australian Health Practitioner Regulation Agency: Undertook co-design with mob to define what cultural safety is based around mental health/early intervention programs
- No service is a plethora of services for a multitude of needs

3. *Clear, holistic mental health care available at the level (and in the mode) wanted by the young person experiencing mental ill health with their care-needs coordinated including access to emerging modalities, favoured practitioners, and in the location each young person is*

Examples of it happening:

- Moderated online therapy (Orygen, VIC)
- Integrating digital activities and support into the youth sector
- Hybrid services (applications are not enough)
- Flexible learning in schools (social and emotional wellbeing, holistic wellbeing)
- When services work together, holistic (e.g., social, cultural, suicide prevention)

4. *Effective preventative and early intervention (early life, illness and episode) developed by collaboration between those with relevant lived experience and those with other expertise – which people use and which focus on connection*

Examples of it happening:

- First 1000 days
- Accoras Psychology Services: Coordination; specific program on early intervention
- Nagaala Wesley mission & Gift of Gallang: local primary schools, suicide prevention (social and emotional wellbeing focused)
- Community Mental Health Action Team (Boyup Brook, Western Australia)
- Foyer Oxford (Western Australia)
- Brain and Mind Centre (New South Wales): Highly personalised
- My Local Mind Inc
- Tomorrow Man and Tomorrow Woman

5. *Health and wellbeing policies, designed, implemented, and overseen through collaboration between those with relevant lived experience and those with other expertise*

Examples of it happening:

- Aboriginal and Torres Strait Islander Lived Experience Centre at the Black Dog Institute
- Youth Advisory Council of Western Australia (Western Australia): The development of high skilled and capable policy officers. Young people who are passionate and interested in this space who can bring their perspective to interpret and action things through consultation
- Mental health in schools project (Western Australia): Gatekeeper suicide prevention training, Mental Health First Aid, social and emotional program
- Homestretch: Youth-led pilot that is developing a holistic care model for a critical cohort of those who are leaving care
- Youth Disability Advocacy Network
- Mental Health Commission Working Together Framework and toolkit
- Community Wellbeing Plans