Government of **Western Australia**
Mental Health Commission

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Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025

Supporting Paper

December 2020




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Acknowledgements

The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander[i] people as the Traditional Custodians of this country and its waters. The Mental Health Commission wishes to pay its respects to Elders past, present and emerging.

The Mental Health Commission also acknowledges young people with lived experience of mental health and alcohol and other drug-related issues, together with their families and carers, who contributed to this Supporting Paper and the Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025.

Accessibility

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Suggested citation

Mental Health Commission (2020). Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 - Supporting Paper November 2020. Mental Health Commission, Government of Western Australia.

[i] The reference to Aboriginal peoples within this document is inclusive of the Torres Strait Islander population. No disrespect is intended with the use of this terminology.

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Acronyms and abbreviations

Aboriginal	Aboriginal and Torres Strait Islander *The reference to Aboriginal peoples within this document is inclusive of the Torres Strait Islander population. No disrespect is intended with the use of this terminology.*
AOD	Alcohol and Other Drug
CADS	Community Alcohol and Drug Service
CaLD	Culturally and Linguistically Diverse Communities
CAMHS	Child and Adolescent Mental Health Service
Communities	Department of Communities
DoE	Department of Education
DoH	Department of Health
DoJ	Department of Justice
GPs	General Practitioners
IHPA	Independent Hospital Pricing Authority
HITH	Hospital in the home
HSP	Health Service Providers
LGBTQIA+	Lesbian, Gay Bisexual, Transgender, Queer, Intersex, Asexual or Questioning *The use of this acronym is not intended to be limiting or exclusive of certain groups and we recognise that not all people will identify with this acronym or use these specific terms.*
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHN	Mental Health Network
MHOA	Mental Health Observation Area
NGOs	Non-Government Organisations
OCP	Office of the Chief Psychiatrist
The Plan	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
WA	Western Australia
WA Police	Western Australia Police Force
WAAMH	Western Australian Association for Mental Health
WANADA	Western Australian Network of Alcohol and Other Drug Agencies
WAPHA	Western Australian Primary Health Alliance

1. Introduction

1.1 Purpose

1.1.1 Purpose of the Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025

The Western Australian Mental Health and Alcohol and Other Drug Services Plan 2015-2025 (**the Plan**) outlines the optimal level and mix of mental health, alcohol and other drug (**AOD**) services required to meet the needs of Western Australians until the end of 2025. In 2019, the Plan Update 2018 was released, providing revised modelling of service types, levels and locations required in Western Australia until the end of 2025. On 10 March 2020, the Minister for Mental Health released the WA State Priorities: Mental Health, Alcohol and Other Drugs 2020 – 2024 (**the WA State Priorities**), which outlines the Government's priorities to reform and improve the mental health and AOD sector over four years from 2020. In this Supporting Paper, these three documents are referred to as 'the three planning documents.'

The three planning documents were released prior to the declaration of a State of Emergency and Public Health Emergency in Western Australia in response to the COVID-19 pandemic. The COVID-19 pandemic, and the necessary government responses to it, have the potential to directly or indirectly impact on the mental health and AOD use of young people. Accordingly, the Mental Health Commission has developed the Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 (**the YPPA**) to identify whether the priorities for young people set out in the three planning documents remain relevant, or whether they need to be revised to better reflect the needs of young people throughout the COVID-19 pandemic and beyond.

To develop the YPPA, the Mental Health Commission sought the views of young people, their families and carers, clinicians, service providers, advocacy groups and peak bodies and other stakeholders. This occurred via a series of interviews, focus groups, workshops and other engagements during September and October 2020. Further details about these engagements, including the information and conclusions drawn from them, are set out in the Consultation Summary reports and papers, which are available at www.mhc.wa.gov.au/yppa.

In addition, on 8 August 2020, the Minister for Mental Health announced a targeted independent review (the Review) led by the Chief Psychiatrist, into how the public mental health system cared for a 13-year-old girl who died by suicide. The Review was focussed on her clinical care and commented on how to improve mental health services for young people across inpatient and community-based clinical services. The Review was completed in October 2020, and the findings have informed the YPPA.

The YPPA will guide the Mental Health Commission, and the broader mental health and AOD sector, in responding to the needs of young people aged 12 to 24 years over the next 5 years. The YPPA will also guide the work of any other organisations, including other Government agencies concerned about the mental health of, and AOD use by, young people aged 12 to 24 years.

1.1.2 Purpose of this Supporting Paper

This Supporting Paper was developed to inform and support the development of the YPPA, by setting out available evidence regarding young people in Western Australia, their mental health and

AOD-related issues, and current responses to these issues. This evidence includes recent reports about the impact of the COVID-19 pandemic on young people.

In addition, this Supporting Paper sets out data about young people's contact with mental health and AOD services, drawn from Mental Health Commission's own sources. This includes revised modelling of services required, updating the modelling which was set out in the Plan and Plan Update 2018.

The diagram below outlines the key documents and pieces of work which have fed into the development of the YPPA.

1.2 Scope

The YPPA and this Supporting Paper consider the mental health and AOD issues of children and young people aged from 12 to 24 years. To aid readability, this Supporting Paper refers to 'young people aged 12 to 24 years.' However, it is recognised that this age range covers several developmental stages in the life of a child and young person, and evidence about these developmental stages has informed the YPPA and Supporting Paper.

The needs of younger children and older adults are also important. The Mental Health Commission will be developing similar frameworks for these groups in future.

In developing the YPPA and Supporting Paper, the Mental Health Commission has considered issues and responses ranging from prevention and early intervention, to treatment and post-treatment support. These include responses that lie outside the mental health and AOD sector, such as education and training, housing and child protection, disability, sport and recreation and justice.

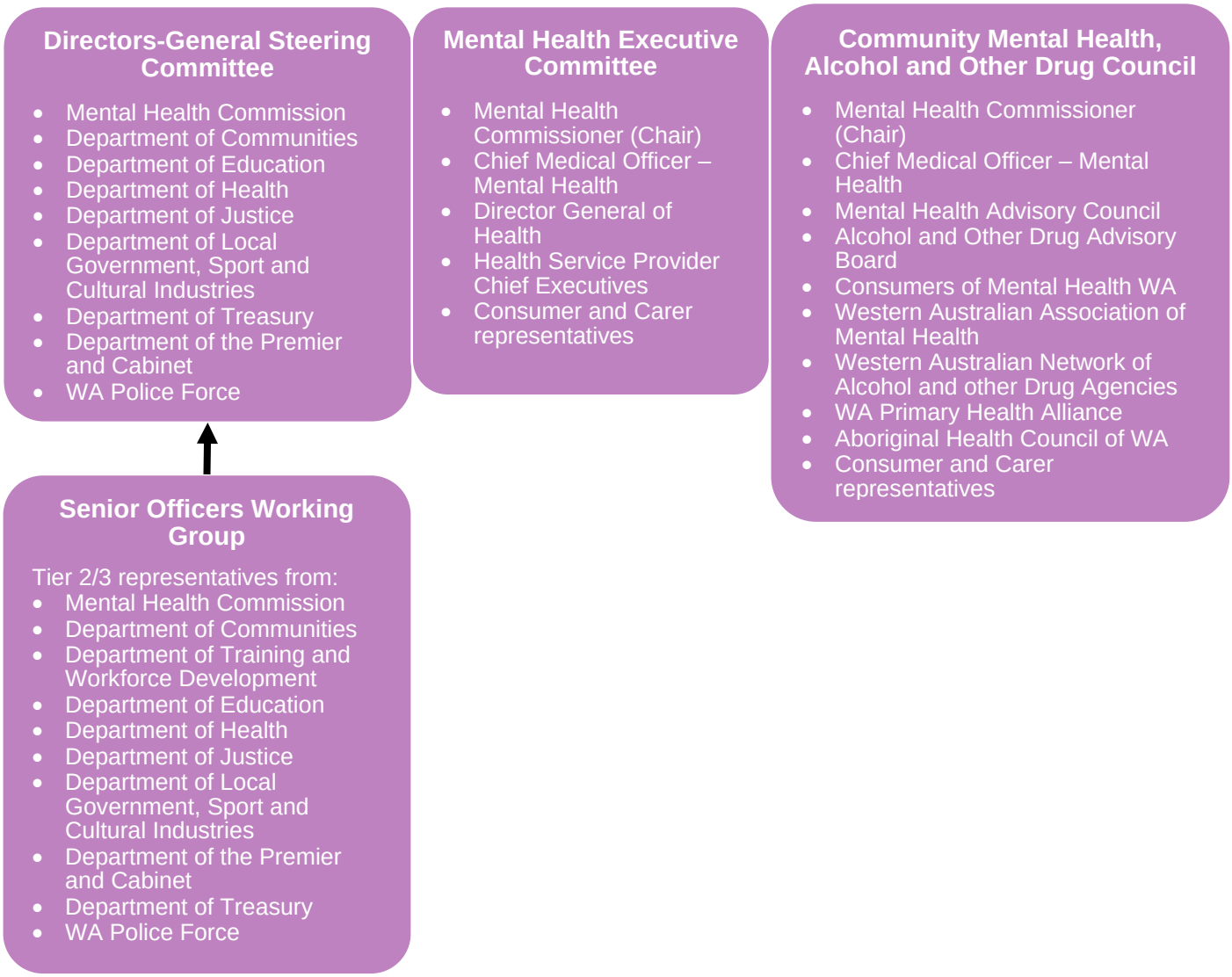
Future work will include designing and implementing specific initiatives to address the priorities identified in the YPPA. This work will be undertaken in partnership with the public health system, the community sector, other government agencies, local and Commonwealth governments and with young people with a lived experience of mental health and AOD use, their families, carers and communities.

1.3 Governance

Development of the YPPA and this Supporting Paper was overseen by a Directors General Steering Group, with advice from the Mental Health Executive Committee and Community Mental Health, Alcohol and other Drug Council, and informed by a Government Senior Officers Working Group. This Governance structure is detailed in Figure 1. In addition, regular updates were provided to the Public Sector Leadership Council, the Mental Health Cross-sector Working Group in the education sector,

and the Directors General Implementation Group (once it resumed), and members' feedback was incorporated into the YPPA and Supporting Paper.

Figure 1. Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 - Governance

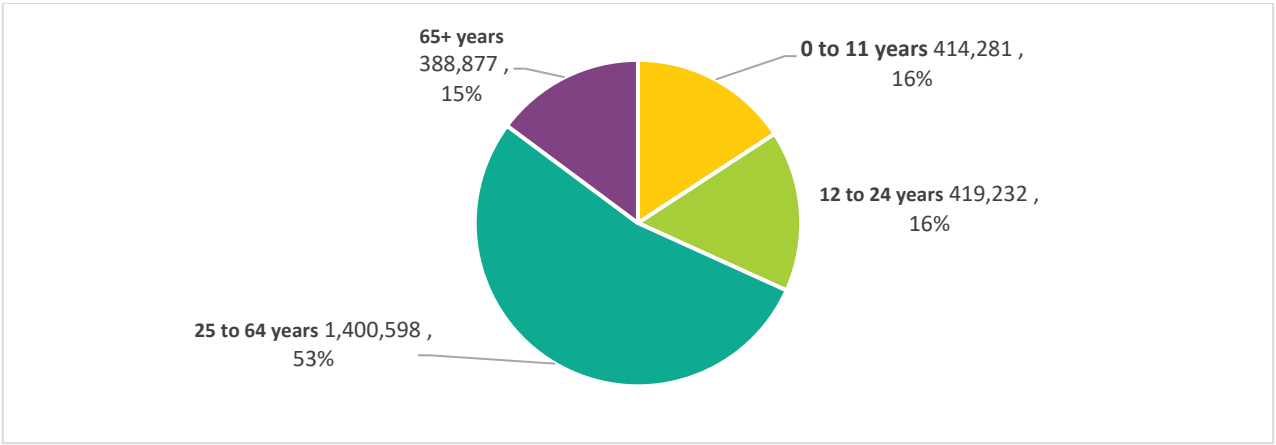


2. Western Australia's young people aged 12 to 24 years, and their mental health and alcohol and other drug use

2.1 At 30 June 2019, there were an estimated 419,232 young people aged 12 to 24 years in Western Australia

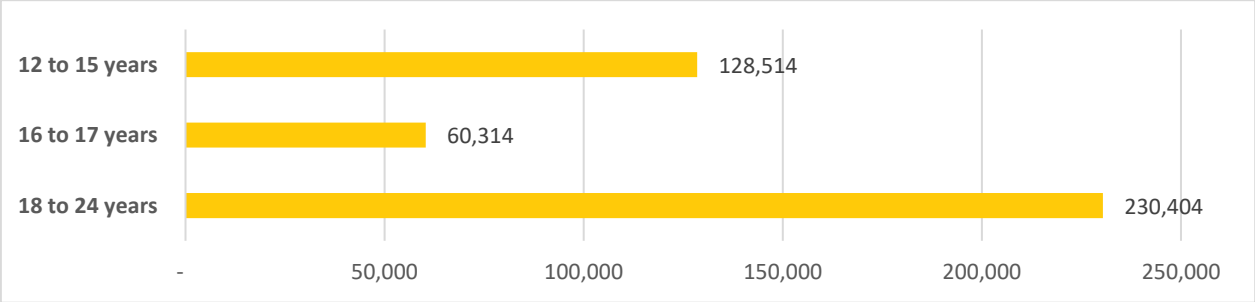
As at 30 June 2019, there were an estimated 419,232 young people aged 12 to 24 years in Western Australia, which was 16% of the Western Australian population (2,622,988 people)[1] (Figure 2). A breakdown of the age groups within the 12 to 24 age cohort can be seen in Figure 3.

Figure 2: Age group distribution of the Western Australia population, 30 June 2019, n = 419,232



Source: Australian Bureau of Statistics, 2020, National, state and territory population

Figure 3: Age group distribution of young people aged 12 to 24 years in Western Australia, 30 June 2019, n = 419,232



Source: Australian Bureau of Statistics, 2020, National, state and territory population

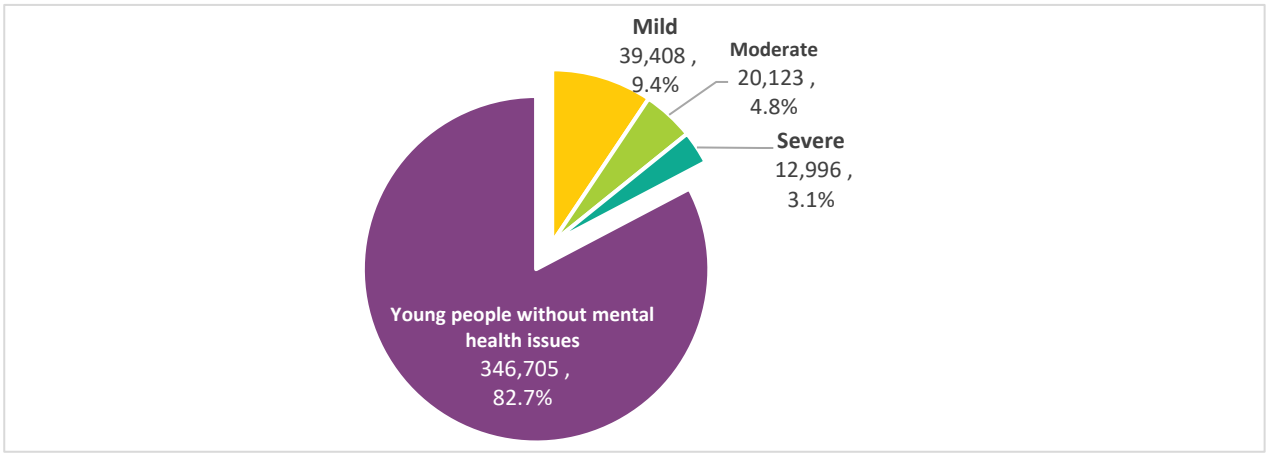
2.2 An estimated 17% of young people in Western Australia aged 12 to 24 years had mild, moderate or severe mental health issues in the past 12 months

There is no single, definitive source of information that identifies the total number of young people aged 12 to 24 years experiencing mental health and AOD issues. However, several sources discussed below provide some information about this question.

2.2.1 Population-wide prevalence

By applying population prevalence estimates used in the modelling for the Plan[2] to the 30 June 2019 Western Australia population estimates,[3] the Mental Health Commission estimates that a total of 72,527 (17.3%) young people aged 12 to 24 years in Western Australia had mild, moderate or severe[ii] mental health issues in the past 12 months (Figure 4).

Figure 4: Prevalence estimates of mental health issues – young people aged 12 to 24 years, 2019, n = 419,232



Source: Modelling from the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

[ii] The categories are based on the severity of the symptoms and its impact on day to day functioning. Definitions are as follows. Mild: Treated in primary care stream and do not need either specialised ambulatory support, specialised psychosocial support or inpatient care. Symptoms are usually resolved within a 12 month period and disruption to performing in normal roles is minimal (one to two days out of role). Moderate: Require 'enhanced primary care' services, but no inpatient services. Symptoms persist for longer than 12 months and days out of role is limited to several days only. Severe: May include the need for ambulatory only and/or inpatient care and many would benefit from community support services. Experience several negative symptoms that significantly impact on functioning.

Using a broader approach to understanding mental health issues, the Commissioner for Children and Young People (CCYP) found that 60% of Year 9 to Year 12 students in Western Australia surveyed as part of his 2019 'Speaking Out Survey' reported having felt 'sad, blue or depressed' for more than 2 weeks in a row in the previous 12 months[4].

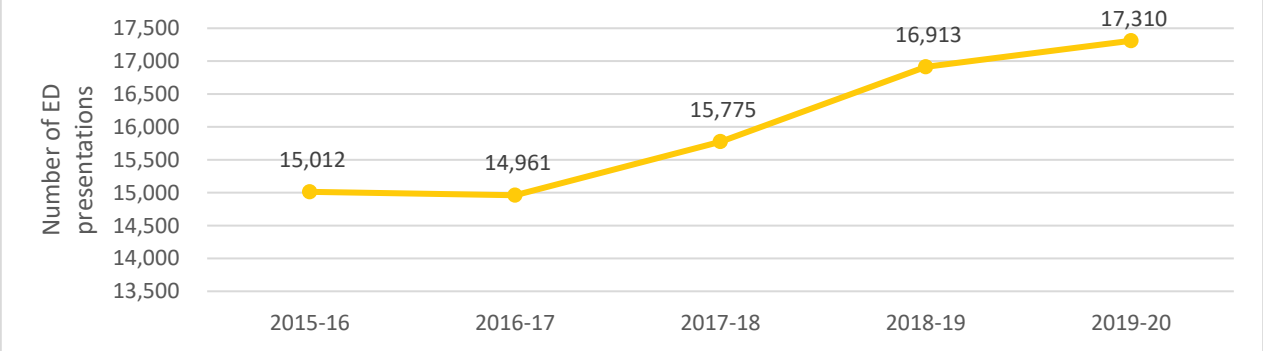
On an Australia-wide basis, the following information about the prevalence of mental health issues has been reported:

- The 2017-18 'National Health Survey' found that 18.5% (40,300) of young people in Western Australia aged 18 to 24 years had experienced high or very high psychological distress[5].
- The Australian Bureau of Statistics 'National Survey of Mental Health and Wellbeing' found that young people aged 16 to 24 years in Western Australia have the highest prevalence of mental health disorder of any population group, with approximately three in ten (30.7%) experiencing a mental health issue and/or mental illness each year[6].
- In 2018-19, young people aged 12 to 24 years accounted for 21% of all people receiving Medicare-subsidised mental health-specific services[7].
- The second 'Australian Child and Adolescent Survey of Mental Health and Wellbeing' (2015)[8], found that 14.4% of young people aged 12 to 17 years experienced a mental disorder in the 12 months prior to the survey. Of the mental health disorders examined in the survey, anxiety disorders were the most common (7.0% of respondents), followed by attention deficit/hyperactivity disorder (6.3%), major depressive disorder (5.0%) and conduct disorder (2.1%).

2.2.2 Emergency department presentations

Figure 5 shows that mental health-related emergency department presentations have been increasing over a five-year period. In Western Australia, there were 17,310 mental health-related emergency department presentations for the 12 to 24 age cohort across the State in 2019-20[9]. There has been an upward trend across the previous financial years, with 2019-20 seeing 15.3% more presentations than 2015-16 (Figure 5)[iii]. Within the 12 to 24 year-age group, the increase in mental health-related emergency department presentations was most pronounced for the 12 to 15 age group (37.8%; 2,609 to 3,595), followed by the 16 to 17 age group (14.5%; 2,635 to 3,018) and the 18 to 24 age group (9.5%; 9,768 to 10,697).

Figure 5: Number of mental health-related emergency department presentations in Western Australia, 12 to 24 years, 2015-16 to 2019-20.

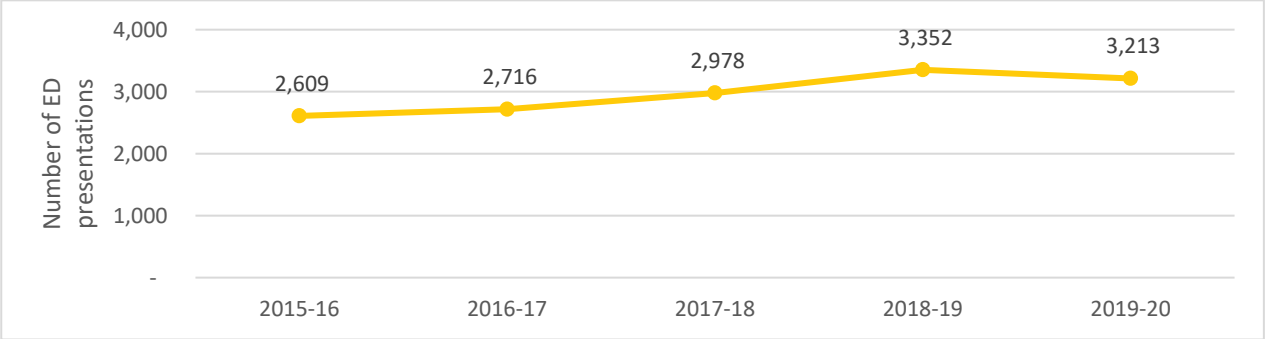


Source: Department of Health, 2020

[iii] Comparison should be interpreted with caution. From November 2012 until September 2017, rural sites began collecting Diagnosis codes and Symptom codes for emergency department presentations in a staggered approach. Numbers will increase due to these changes in reporting methodology.

Figure 6 shows that self-harm-related emergency department presentations have been on an overall upward trend over a five-year period[10]. In 2019-20, there were 3,213 mental health-related emergency department presentations for the 12 to 24 age cohort across the State, which is 23.2% more presentations than 2015-16[iv].

Figure 6: Number of self-harm-related emergency department presentations in Western Australia, 12 to 24 years, 2015-16 to 2019-20.

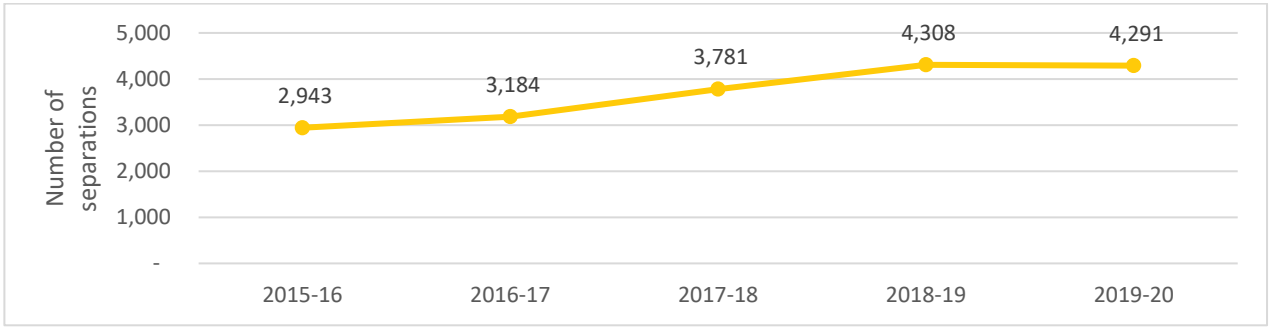


Source: Department of Health, 2020

2.2.3 Inpatient separations

There has been a similar increase in separations[v] from specialised mental health hospital wards for the 12 to 24-year age group in Western Australia over a five-year period[11] (Figure 7). In 2019-20, there were 4,291 separations, which is 45.8% higher than the number of separations in 2015-16 (2,943). Within the 12 to 24-year age group, the increase in separations was most pronounced for the 12 to 15 age group (108.7%; 335 to 699), followed by the 16 to 17 age group (69.5%; 478 to 810) and the 18 to 24 age group (30.6%; 2,130 to 2,782).

Figure 7: Number of separations from mental health hospital wards in Western Australia, 12 to 24 years, 2015-16 to 2019-20.



Source: Department of Health, 2020

[iv] Comparison should be interpreted with caution. From November 2012 until September 2017, rural sites began collecting Diagnosis codes and Symptom codes for emergency department presentations in a staggered approach. Numbers will increase due to these changes in reporting methodology.

[v] A mental health separation refers to an episode of care for an admitted patient in a designated psychiatric unit or ward where they separate from the ward after receiving specialised psychiatric care for their mental illness.

Whilst there are dedicated youth mental health hospital wards (catering to those aged 16 to 24 years), in 2019-20 it was observed that the majority of separations for the 18 to 24 age group were from adult mental health hospital wards (catering to people aged 18 to 64). In 2019-20, of the 2,782 separations for the 18 to 24 age group, 15.6% (433) were from dedicated youth mental health hospital wards and 84.4% (2,349) were from adult mental health wards.

Figure 8 below shows the five most frequent mental health diagnoses for young people aged 12-24 years in Western Australian specialised mental health hospital wards in 2019-20. The most common principal ICD-10[vi] mental health diagnosis for the 12 to 24 age group in specialised mental health hospital wards was 'disorders of adult personality and behaviour' (e.g. borderline personality disorder) accounting for 26.4% of total separations.

The figure also shows that young people with this diagnosis require, on average, 5.1 days in treatment. In comparison, less common mental health diagnoses such as 'schizophrenia, schizotypal and delusional disorders' (14.2% of total separations), require 22.9 days in treatment on average.

Figure 8: Five most frequent mental health diagnoses for specialised mental health hospital wards, 12 to 24 years, 2019-20.

Mental Disorder Diagnosis	Number of Separations	% of total Separations	Average Length of Stay (days)
Disorders of adult personality and behaviour	1,058	26.4	5.1
Neurotic, stress-related and somatoform disorders	965	24.1	6.5
Mood [affective] disorders	698	17.4	9.5
Schizophrenia, schizotypal and delusional disorders	568	14.2	22.9
Mental and behavioural disorders due to psychoactive substance use	411	10.3	9.3

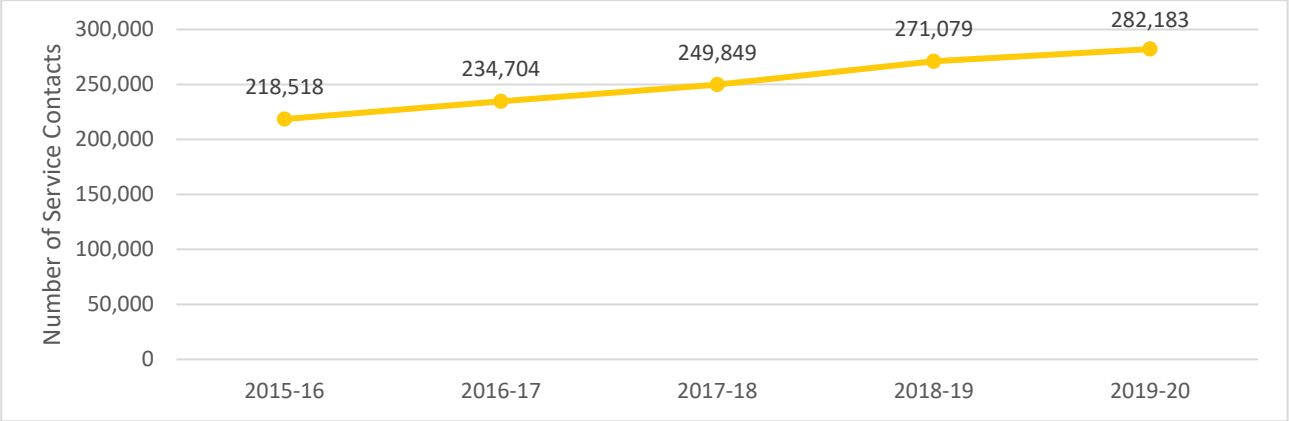
Source: Department of Health, 2020

2.2.4 Community mental health service contacts

A similar upward trend was observed for the number of community mental health service contacts[vii] provided to the 12 to 24 age group in Western Australia. 2019-20 saw 282,183 community service contacts, which is a 29.1% increase compared to 2015-16 (Figure 9). Within the 12 to 24-year age group, the increase in service contacts was most pronounced for the 18 to 24 age group (34.1%; 95,838 to 128,508), followed by the 12 to 15 age group (27.9%; 73,598 to 94,134) and the 16 to 17 age group (21.3%; 49,082 to 59,541).

[vi] ICD-10 refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision.
[vii] Community mental health service contacts in this section only include publicly funded community mental health services.

Figure 9: Number of community mental health service contacts in Western Australia, 12 to 24 years, 2015-16 to 2019-20.



Source: Department of Health, 2020

2.2.5 Suicide, suicidal ideation and self-harm

'An increased risk for suicide is seen for adolescents aged 12 and 17 years, with between 50 and 100 suicide attempts made for each suicide death; each year more and more young children are suiciding.' [12,13,14,15]

Informing Young Suicide Prevention for Western Australia[16]

Suicide is the leading cause of death for young people aged 15 to 24 years in Western Australia [17]. In 2019, 49 young people (15 to 24 years) died by suicide, making the State's age-specific rate of suicide 15.2 per 100,000[18]. This makes Western Australia the State with the fourth highest rate of suicide across the nation (Figure 10), with a rate above the national rate.

Figure 10: Age-specific suicide rates, 15 to 24 years, 2019-19

State/Territory	Age-specific suicide rate
Northern Territory	56.4
Queensland	17.1
Australian Capital Territory	16.9
Western Australia	15.2
South Australia	14.6
New South Wales	12.9
Tasmania	12.6
Victoria	11.3
Australia	14.1

Source: Australian Bureau of Statistics, 2020

The '2018 Health and Wellbeing Surveillance System'[20] found that, in Western Australia:

- during the past 12 months, approximately 1 in 10 (9.0%) respondents aged 16 to 24 years had ever thought seriously about ending their own life, compared to 1 in 20 (4.4%) individuals aged 25 years and over

- almost one quarter (24%) of respondents aged 16 to 24 years indicated that in the past 12 months any of their friends tried to end their own lives, which is significantly higher than the 5.9% of individuals aged 25 years and over.

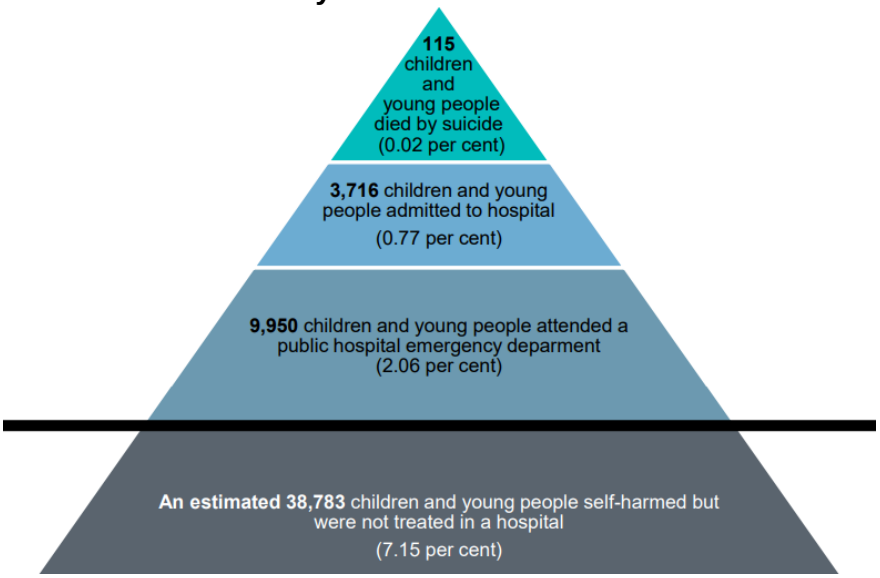
The Ombudsman Western Australia's 'Preventing suicide by children and young people 2020' report (the 2020 Ombudsman Western Australia Report),[21] found that between 1 July 2009 and 30 June 2018:

- 115 young people aged 10 to 17 died by suicide or were suspected to have died by suicide
- the number of deaths appeared to increase with age, with over half (60%) of young people who died by suicide aged 16 or 17 years at the time of their death
- however, 11 of those who died by suicide were 10 to 13 years of age.

As indicated in Figure 11, the 2020 Ombudsman Western Australia Report also estimated that, between 1 July 2009 and 30 June 2018:

- 13,666 children and young people (6 to 17 years) who attempted suicide or self-harmed either attended an emergency department or were admitted to hospital
- 38,783 children and young people (6 to 17 years) self-harmed but were not treated in a hospital.

Figure 11: Suicide and self-harm by children and young people in Western Australia, 1 July 2009 to 30 June 2018



Source: Ombudsman Western Australia

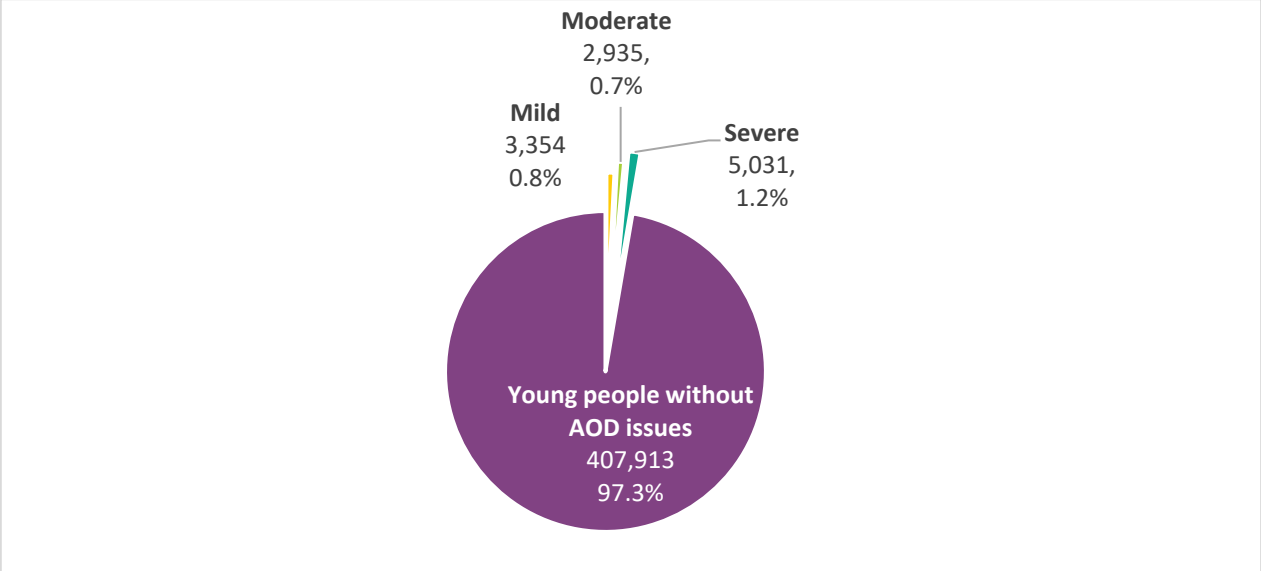
The second 'Australian Child and Adolescent Survey of Mental Health and Wellbeing' (2015)[22,23] found that, nationally in the previous 12 months:

- approximately 7.5% of respondents aged 12 to 17 years reported having suicidal ideation and 5.2% had made suicidal plans
- approximately one in ten young people aged 12 to 17 years (10.9%) reported having ever self-harmed, and of these, three-quarters harmed themselves in the previous 12 months
- the highest rate of self-harm was in young people with major depressive disorder - 32.5% of young people with major depressive disorder reported having self-harmed compared to 10.6% for those with other disorders and 4.2% for those with no disorder.

2.3 An estimated 3% of young people in Western Australia aged 12 to 24 years had mild, moderate or severe alcohol and other drug issues in the past 12 months

By applying population prevalence estimates used in the modelling for the Plan[24] to the latest 30 June 2019 population estimates,[25] the Mental Health Commission estimates that a total of 11,319 (2.7%) young people aged 12 to 24 years in Western Australia had mild, moderate or severe AOD issues in 2019 (Figure 12).

Figure 12: Prevalence estimates of alcohol and other drug issues – 12 to 24 years, 2019 n = 419,232



Source: Modelling from the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

2.3.1 Alcohol use

Alcohol is the most common drug used in Australia, and it's the drug most commonly used by young people[26, 27].

The 2017 national 'Australian School Students Alcohol and Drug Survey'[28] found that, in Western Australia, 41.8% of school students aged 12 to 17 years reported consuming alcohol in the past year, with the prevalence of drinking increasing with age (16.0% for 12-year olds compared to 77.4% for 17-year olds).

This survey also examined single occasion risky drinking[viii] for the students who had used alcohol in the last week and found that three in ten (30.0%) drank at levels associated with single occasion harm. This survey also found that 37.8% of young people aged 12 to 17 years chose not to drink[29].

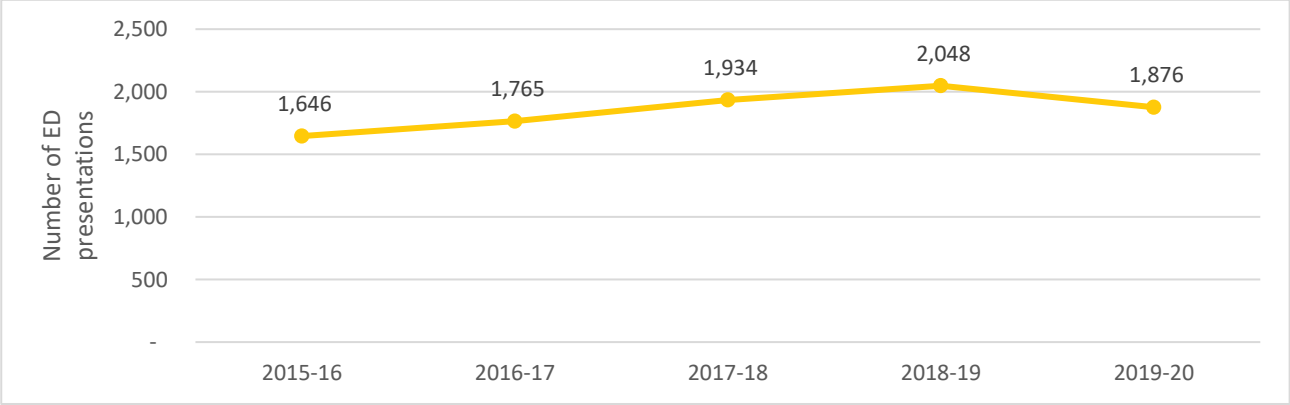
In Western Australia, the Australian Bureau of Statistics found that, for those young people aged 18 to 24 years, 16.2% reported drinking alcohol in the last week at levels that exceeded the recommended lifetime risk[30]. Australia-wide, alcohol contributes to all the leading causes of death for young people, namely suicide, land transport accidents, accidental poisoning, and assault[31, 32].

[viii] Single occasion risky drinking is defined as having more than four standard drinks on any one day.

On a national basis, the Australian Secondary Student Alcohol and Drug Survey 2017[33] found that, for young people aged 12 to 17 years, alcohol was the substance most commonly used on the same occasion as another substance (cannabis, 59%; ecstasy, 58%; amphetamines, 39%; hallucinogens, 37%; tranquilisers, 17%). For example, the survey found that 59% of young people who had used cannabis also consumed alcohol on the same occasion. These findings are consistent with the National Drug Strategy Household Survey 2019[34] which found that, nationally, at least 8 in 10 Australians aged 14 years and older who had used cannabis, cocaine, ecstasy or meth/amphetamines also used alcohol at the same time.

In Western Australia, there were 1,876 alcohol-related emergency department presentations for the 12 to 24-year age group cohort across the State in 2019-20[35]. There has been an overall upward trend across the previous financial years with 2019-20 seeing 14.0% more alcohol-related emergency department presentations than 2015-16 (Figure 13)[ix,x]. It is important to note that the alcohol-related emergency department presentations provided in Figure 13 are a significant underrepresentation of all alcohol-related presentations, due to the way in which such presentations are coded. Nonetheless, alcohol-attributable injury is a significant contributor to all alcohol related emergency department presentations for young people

Figure 13: Number of alcohol-related emergency department presentations in Western Australia, 12 to 24 years, 2015-16 to 2019-20.



Source: Department of Health, 2020

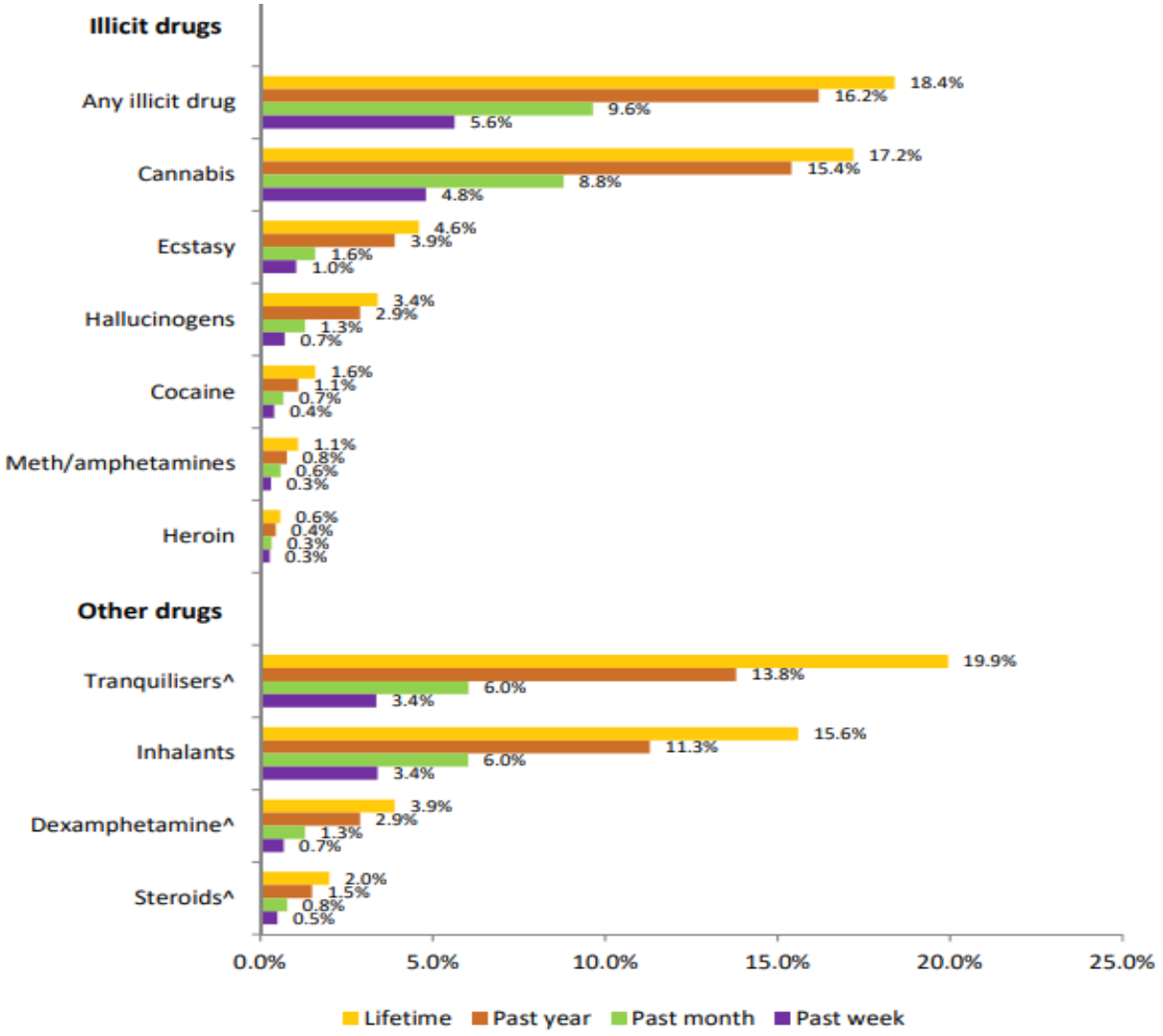
2.3.2 Illicit drug use

The 2017 Australian School Students Alcohol and Drug Survey[36] found that, in Western Australia, 16.2% of students aged 12 to 17 years reported using at least one illicit drug (including pharmaceuticals) in the past year, with cannabis being the most commonly used. Figure 14 provides a breakdown of specific illicit drugs used[37].

[ix] Comparison should be interpreted with caution. From November 2012 until September 2017, rural sites began collecting Diagnosis codes and Symptom codes for emergency department presentations in a staggered approach. Numbers will increase due to these changes in reporting methodology.

[x] These figures are an under-representation of the number of alcohol-related emergency department presentations as it does not capture all alcohol-related presentations due to existing coding frameworks.

Figure 14: Prevalence and recency of illicit drug use by students, 12 to 17 years – 2017 Australian School Students Alcohol and Drug Survey, Western Australia only



^Non-medical use

Any illicit drug use includes use of at least one of cannabis, ecstasy, hallucinogens, cocaine, meth/amphetamine or heroin.

Source: Mental Health Commission, 2020, Australian School Students Alcohol and Drug Survey 2017 Bulletin

The National Drug Strategy Household Survey 2019 found that, in Western Australia, the average age at which people first tried an illicit drug (including pharmaceuticals) was 20.0 years[38]. In addition, it found that 31.2% of young people aged 18 to 24 years had used illicit drugs in the last 12 months, an increase of 3% since the 2016[39] survey.

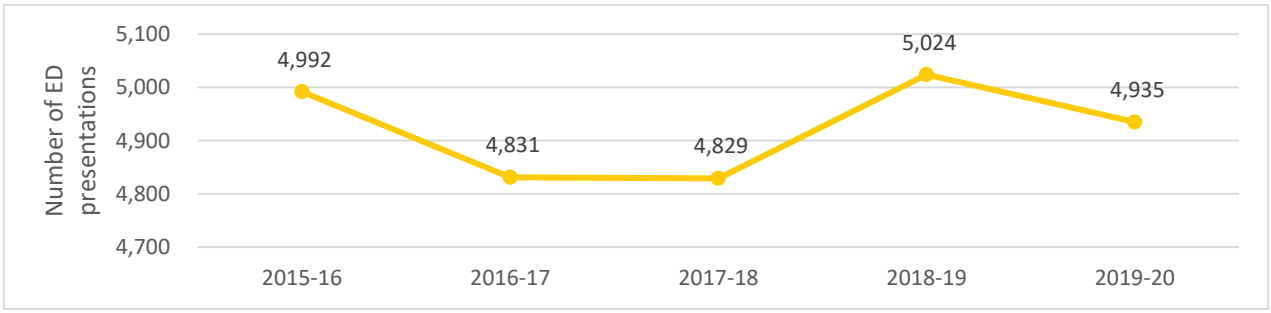
In 2019-20, there were 4,935 AOD-related emergency department presentations for the 12 to 24-year age group in Western Australia[40]. There has been a fluctuation across AOD-related emergency department presentations across the previous financial years, with 2019-20 seeing 1.1% less presentations than 2015-16 (Figure 15) [xixii]. However, within the 12 to 24 year-age group, the

[xi] Comparison should be interpreted with caution. From November 2012 until September 2017, rural sites began collecting Diagnosis codes and Symptom codes for emergency department presentations in a staggered approach. Numbers will increase due to these changes in reporting methodology.

[xii] These figures are an under-representation of the number of AOD-related emergency department presentations as it does not capture all AOD-related presentations due to existing coding frameworks.

16 to 17 age group showed an increase when comparing 2019-20 to 2015-16 (6.1%; 732 to 777), while decreases were found for the 18 to 24 age group (-2.6%; 3,755 to 3,657) and the 12 to 15 age group (-0.8%; 505 to 501).

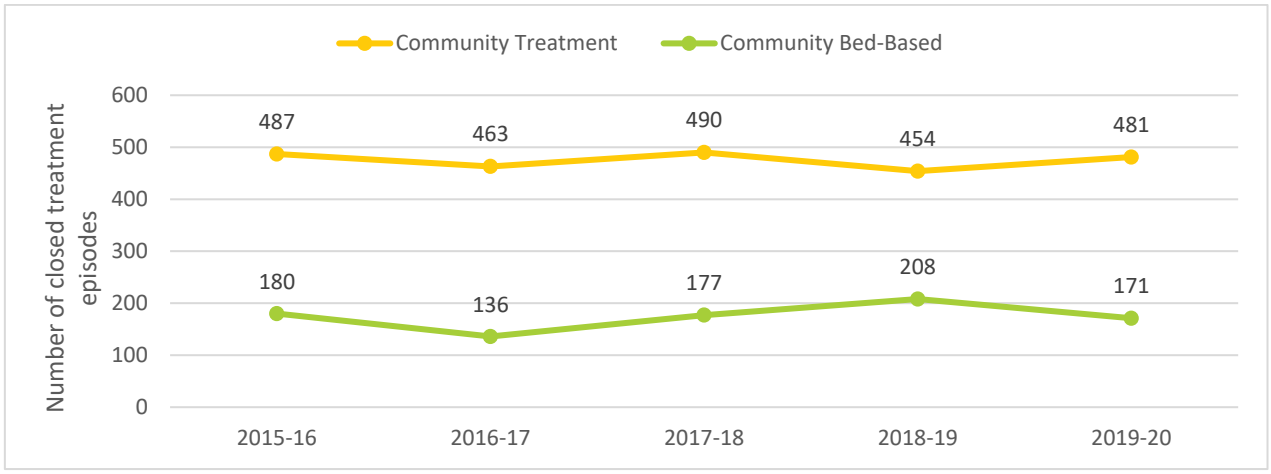
Figure 15: Number of AOD-related emergency department presentations in Western Australia, 12 to 24 years, 2015-16 to 2019-20.



Source: Department of Health, 2020

Like AOD-related emergency department presentations, the community treatment and community bed-based services provided by the Drug and Alcohol Youth Service reported fluctuations in the numbers of closed treatment episodes for the 12 to 24 age cohort in Western Australia across the previous financial years (Figure 16)[41].

Figure 16: Number of AOD-related closed treatment episodes in Western Australia, Drug and Alcohol Youth Service, 12 to 24 years, 2015-16 to 2019-20.



Source: Mental Health Commission, 2020

Volatile Substance Use[42]

Whilst there are small numbers of volatile substance use[xiii] incidents within Western Australia, volatile substance use has a significant impact on the community. For example, young people using volatile substances are often not engaged within the school system but are overrepresented in the justice and child protection systems. This eventually results in overrepresentation in the hospital and disability services system as volatile substance use can result in severe neurological deficits, cognitive impairment and subsequent complex needs which require considerable support.

As there is limited available Western Australian data and research, volatile substance use prevalence can be difficult to determine. However, it has been identified as an area of concern in some communities in the Goldfields, Kimberley, Mid-West, Metropolitan Perth, Ngaanyatjarra Lands and the Pilbara regions. Research indicates that volatile substance use is commonly short-term and experimental in nature and often occurs among young people aged 12 to 16 years, although there have been reports of volatile substance use occurring among younger children.

2.3.3 Co-occurring mental health and alcohol and other drug issues

'Mental health conditions are common among young people presenting for AOD treatment. These can include mood disorders, conduct disorder, anxiety disorders, attention deficit hyperactivity disorder (ADHD), psychotic symptoms and eating disorders. Late adolescence is the most common time for a psychotic disorder (e.g. schizophrenia, bipolar disorder) to emerge, and it can be difficult to distinguish between symptoms of a psychiatric disorder and symptoms of a drug-induced psychosis…Building effective working relationships with youth mental health services is key to providing an effective service to many young people with complex co-occurring AOD and mental health conditions.'

Counselling Guidelines: Alcohol and Other Drug Issues: Fourth Edition 2019[43]

Mental health and AOD issues often occur in conjunction with each other[44,45]. This is commonly referred to as 'co-occurring' and sometimes as 'co-morbidity'. Mental health issues may contribute to AOD issues, and likewise, AOD issues may contribute to the development of new, or increased severity of existing, mental health issues[46]. For example, acute intoxication can lead to alcohol-induced psychosis and this is prevalent among those who have become alcohol dependent at a younger age[47].

On the other hand, young people with existing, emotional, behavioural and mental health issues may use AOD to cope with and manage mental health issues[48]. Exposure to trauma during childhood may also lead to AOD use, dependence and other addictive behaviours[49].

Co-occurring and comorbid problems generally require long-term management approaches and an integrated approach with other services.

One in five Australians with a mental health disorder has a co-occurring AOD use disorder[50]. For young people this proportion is even higher. Research has identified that approximately 60% of young people with an AOD use disorder also have a co-occurring mental health diagnosis[51]. For example, the second Australian Child and Adolescent Survey of Mental Health and Wellbeing[52] found in 2015 that young people (aged 13 to 17 years) with major depressive disorder had higher rates of drinking alcohol (60.8%) compared to young people with other mental disorders (44.1%) and young people with no mental disorder (33.8%). Similar findings were made regarding the use of cannabis and other drugs (for example, ecstasy, amphetamines, cocaine).

[xiii] Volatile substance use, also known as inhalant use, sniffing or chroming, refers to the practice of deliberate inhalation of volatile substances (such as petrol, paint, glue and aerosols) for their intoxicating effects. Volatile substance use is a dangerous practice that can have a devastating effect on individuals, families and communities.

3. Determinants of mental health and alcohol and other drug use

3.1 Social determinants of health can impact on young people's health, mental health, and alcohol and other drug use

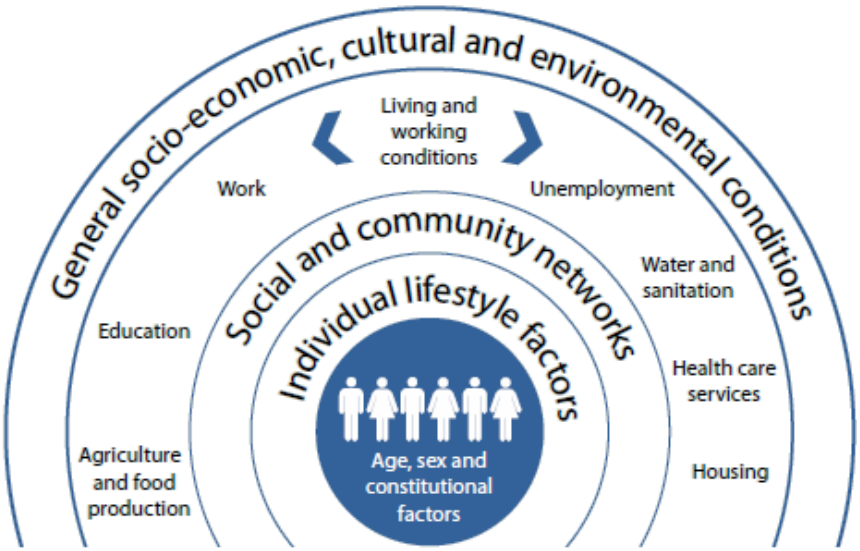
'The World Health Organization has described social determinants as: *…the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces[53]'.*

Research has identified a range of important factors that contribute to our health including: the choices we make; exposure to health and mental health promotion and prevention initiatives; access to timely and effective treatment and care; and social and environmental factors[54].

Evidence gathered from the ways in which social, economic, political and cultural conditions create health inequalities has led to the identification of 'social determinants of health'. These include socioeconomic position, early life circumstances, social exclusion, social capital, employment and work, housing and the residential environment[55].

The social determinants combine with other factors, including health behaviours and biomedical factors that are part of a person's individual lifestyle and genetic make-up, to influence ultimate health outcomes.

Figure 17. Social determinants of health



The social determinants of health are also important in determining our mental health and our AOD use[56,57]. Research has identified that adverse experiences in childhood, including poverty, child abuse and neglect, family violence, parental substance use, early mental health problems, poor

health and nutrition, and growing up in a family dependent on welfare, have a negative impact on the social and cognitive development of children, with lasting health and welfare impacts in adulthood[58,59,60]. Moreover, "developmental vulnerabilities are evident by the time a child starts school, and are associated with lower educational achievement, increased likelihood of teenage pregnancy, mental health problems, getting into trouble with the law, and poorer job outcomes" [61]. For example, students with mental disorders fall further behind such that by Year 9 they are, on average, 1.5 to 2.8 years behind their peers[62].

Such adverse experiences and vulnerabilities can also impact on the effectiveness of treatment and recovery for those with mental health and AOD issues.

Some of the social factors which are relevant for both mental health and AOD include: socioeconomic status; living conditions (for example, early childhood experiences, housing and homelessness, employment); and individual health-related factors[63].

In respect to AOD use, evidence suggests that there is a complex and multi-faceted relationship between alcohol use, inequities and social factors.

Research also finds that young people who have experienced abuse and neglect during childhood have an increased risk of[64]:

- behavioural problems including criminal behaviour
- depression
- post-traumatic stress disorder
- self-harm and attempted suicide
- health issues such as obesity
- AOD issues.

A report by the CCYP 'Improving the odds for WA's vulnerable children and young people'[65] highlighted that when children do not receive appropriate resources and opportunities as they are needed, they can become more disadvantaged. This can result in disengagement from learning, unemployment and mental health issues. More extreme outcomes can include multiple care arrangements, repeat contact with the youth justice system, homelessness, and suicide or permanent injury following risky behaviour.

3.1.1 Addressing the social determinants of health requires a whole-of-community and whole-of-government approach

As identified above, the social determinants of mental health and AOD issues include many that lie outside of the direct influence of the Mental Health Commission, and even the mental health and AOD system more broadly. Addressing the social determinants of health, mental health and AOD use requires action in areas such as early childhood development, education, child protection, housing and homelessness, employment and training, and justice. That is, improving the mental health of young people, and addressing AOD issues, requires combined action by many stakeholders on many fronts. This is a key reason why the Mental Health Commission is collaborating with agencies across government and the community sector on the YPPA.

3.2 The COVID-19 pandemic has affected a range of determinants of health and had a negative impact on the mental health and alcohol and other drug use of young people in Western Australia

In Western Australia, on 15 March 2020, the State Government declared a State of Emergency and Public Health Emergency in response to the COVID-19 pandemic. Some immediate measures which followed the declarations included physical distancing, restrictions to indoor and outdoor gatherings, hygiene measures, closure of State borders and restrictions on intra-state and interstate travel, and a requirement for businesses to prepare COVID-19 safety plans.

The COVID-19 pandemic has directly affected or is anticipated to affect a range of health, social, and economic factors which can impact the mental health and AOD issues experienced by young people. Of particular note:

Unemployment

- In September 2020, the youth unemployment rate was 14.5%, which was a 2.9% increase from March 2020 (prior to the declaration of the State of Emergency)[66].
- As of August 2020, 36.7% of young people (15 to 24 years) that are employed in Western Australia report being underemployed and wanting additional hours of work. This is significantly higher than the equivalent national rate of around 20.0% [xiv,67].
- According to Volunteering WA's recent survey, of those volunteering programs actively recruiting 51% have noticed an increase in younger people wanting to volunteer, and 43% have noticed more people wanting to volunteer as a pathway to employment[68].

Education

- In Western Australia, following the State of Emergency declaration on 15 March 2020, school education was disrupted with onsite attendance dropping to 10.6% attendance in week nine of term one[69]. On day two of term two, schools were open, and by week two of term two rates of attendance were at 90%. Throughout most of Western Australia, public school attendance has returned to pre-COVID-19 levels[70].
- Both Catholic and Independent schools largely followed the recommendations of the Department of Education and Department of Health, though some chose to close earlier. Students who were unable to learn at home were able to attend school and participate in remote learning, facilitated by school staff with some students continuing to attend school throughout the lockdown period.

Housing and homelessness

- Youth bed vacancies within homelessness services for those aged 15 to 25 years in the metropolitan area remain low but are similar to the same time last year. However, regional youth bed vacancies are now at much higher levels than for the same period in 2019[71].

Alcohol use

- Available national data indicates that many people, including young people, turned to alcohol as the supply of illicit drugs reduced, attributed to different reasons, including border controls associated with COVID-19 restrictions.
- A nationally representative online sample of 1,045 Australian respondents aged 18 years and over found that one in five (20%) of Australian households reported buying more alcohol than usual since the COVID-19 outbreak in Australia[72].
- Based on Commonwealth Bank data, a national study identified that there were increases in alcohol sales during the weeks following the initial declaration of the State of Emergency in March 2020 (week ending 27 March and 3 March). However, in the week ending 10 April 2020, there was a 13% decrease in spending compared to the previous year[73]. The same study also noted reports of increased online alcohol purchases during COVID-19 when compared to 2019 data[74].
- Increases of online shopping and home delivery, can also lead to alcohol purchases being left unattended without age verification[75].
- Negative impacts from harmful alcohol use can range from the modelling of poor drinking behaviours to young people, to child neglect, abuse and violence[76], leading to long-term harm to the mental health of children and young people.

[xiv] Smoothing of original data currently disabled due to break in series due to COVID. This is in line with the ABS disabling Trend series at this time.

- A recent study has found that approximately half (51%) of the surveyed frontline specialist domestic and family violence workers reported an increase in the involvement of alcohol as a stressor in family violence situations since the COVID-19 restrictions were introduced[77].

Given the impacts of the COVID-19 pandemic on the social determinants of health, it is anticipated that the COVID-19 pandemic will in turn increase mental health and AOD issues experienced by young people beyond the immediate response and recovery period. Some of these impacts have already begun to emerge, as discussed below.

3.2.1 What we've heard from young people on the impact of COVID-19

'Started off great, got a nice sleep in everyday but now it's just boring and tough. Hard to focus on any school work, lonely and the lack of face to face socialising is starting to impact my mental health.'

'For my family and I it hasn't affected us much as we live in a Western Australian rural town and have our business with the same demand. I do think there needs to be more action taken in regard to home-schooling and mental health awareness.'

'I have concerns about my future career, as the loss of jobs will mean people with more experience are more likely to get a job. Which means even starting to get my first job at 14 or 15, will be a struggle…'.

COVID-19: As told by WA children and young people, CCYP[78]

As highlighted from the above quotes, the Commissioner for Children and Young People's Report, entitled 'COVID-19: As told by WA children and young people'[79], identified that 'mental health, education and future impacts' were 'key themes of discussion and concerns for children and young people'.

A recent survey conducted by the Youth Affairs Council of Western Australia (YACWA) on the impact of COVID-19 on young people aged 12 to 25 years found that 91% of respondents had experienced significant or some impact on their mental health and stress levels, and 88% of respondents were concerned about their health and mental health[80].

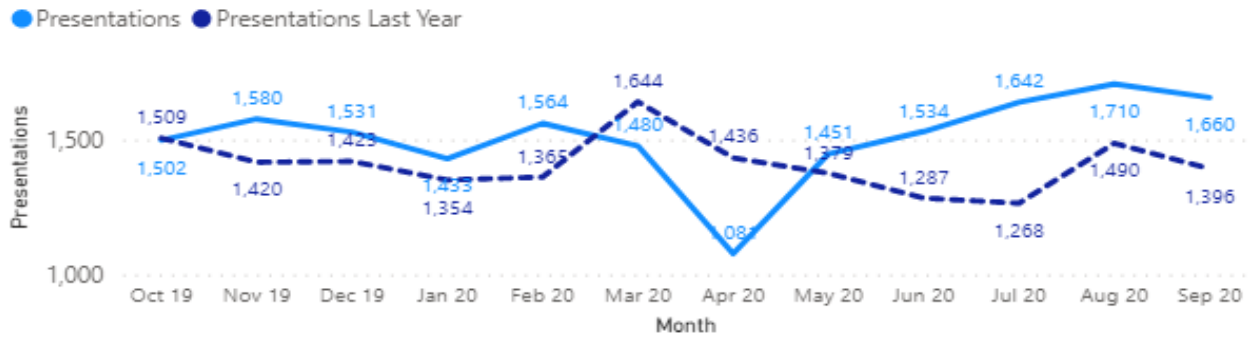
Nationally, young people aged 18 to 24 years have reportedly experienced the most significant increase in moderate and severe psychological distress of all age groups during the COVID-19 pandemic[81]. Kids Helpline and the Australian Human Rights Commission recently collaborated on a report on the impacts of the COVID-19 pandemic on children and young people aged 5 to 25 years who contacted Kids Helpline during January to April 2020. The report found that mental health concerns resulting from the COVID-19 pandemic was the top concern for these children and young people during this timeframe[82]. Social isolation (21%), education impacts (20%) (especially for high school students) and impacts on family life (19%) were also significant issues of concern[83].

3.2.2 Emergency department presentations

As identified above, in Western Australia, mental health-related emergency department presentations for the 12 to 24-year age group have been increasing for the previous five years. However, as shown in Figure 18, from late March 2020 to April 2020, these presentations declined. Anecdotal evidence suggested that the decrease was due to fear of contracting COVID-19 and public messaging to avoid hospitals.

Since April 2020, mental health-related emergency department presentations for the 12 to 24-year age group have been on an upward trend to levels above that of the same period in 2019, with August 2020 recording the highest number of presentations in a 24-month period (Figure 18). This finding suggests that COVID-19 has negatively impacted young people's mental health, increasing their likelihood of presenting to emergency departments.

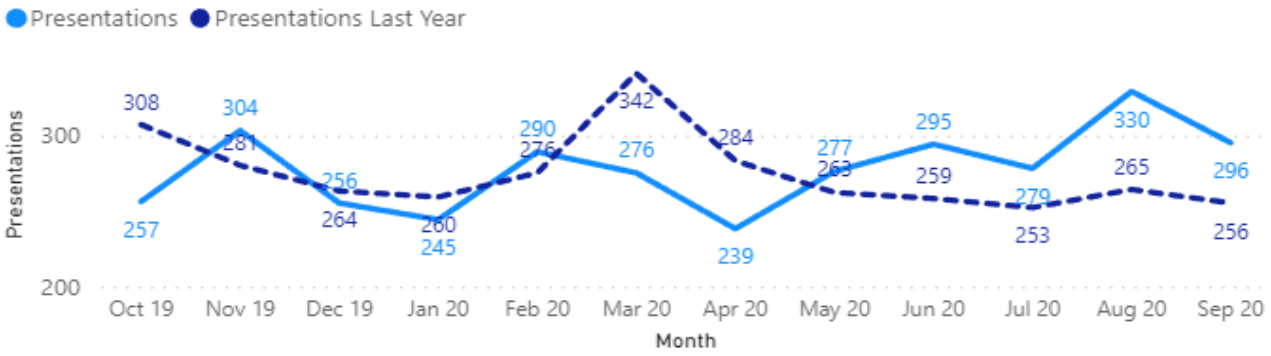
Figure 18. Mental health-related emergency department presentations in Western Australia, young people aged 12 to 24 years – October 2019 to September 2020



Source: Department of Health 2020

Similarly, emergency department presentations related to self-harm for the 12 to 24 age group decreased by approximately 10.9% from March 2020 to May 2020, compared to the same period in 2019. However, from 1 June 2020 onwards, the number of self-harm related emergency department presentations has rebounded to levels that are above the same period in 2019 (Figure 19).

Figure 19. Self-harm related emergency department presentations in Western Australia, young people aged 12 to 24 years – October 2019 to September 2020

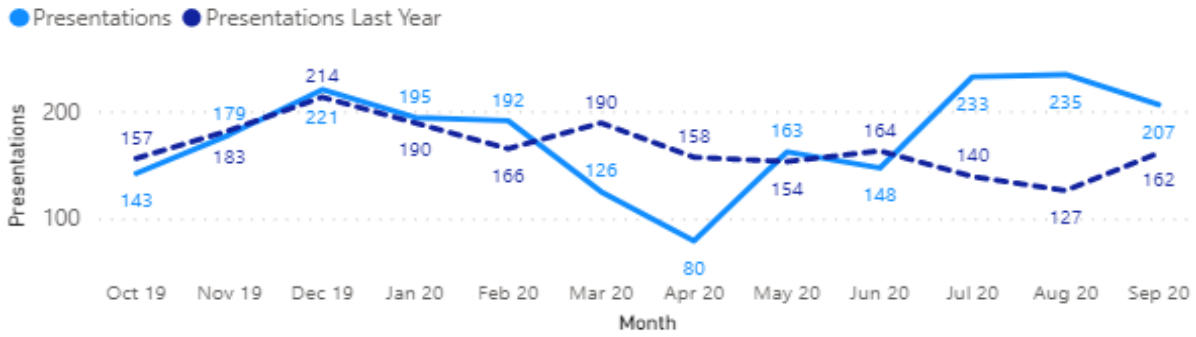


Source: Department of Health, 2020.

As illustrated in Figure 20 below[xv], alcohol-related emergency department presentations for the 12 to 24 year age cohort decreased by approximately 26.5% from March 2020 to May 2020 compared to the same period in 2019. However, from July 2020 onwards, the number of alcohol-related emergency department presentations has since rebounded to levels above the same period in 2019. For example, August 2020 recorded a 24-month high in the number of presentations. This is consistent with the above sources that have reported an increase in young people's consumption of alcohol.

[xv] These figures are an under-representation of the number of alcohol-related emergency department presentations as it does not capture all alcohol-related presentations due to existing coding frameworks.

Figure 20. Alcohol-related emergency department presentations in Western Australia, young people aged 12 to 24 years – October 2019 to September 2020



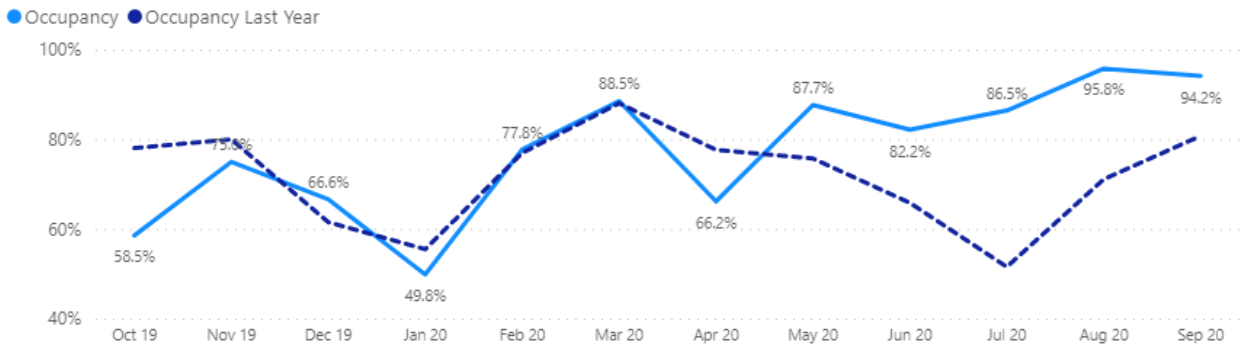
Source: Department of Health, 2020.

Similarly, the National Drug and Alcohol Research Centre [via the Ecstasy and Related Drugs Reporting System (EDRS)[84]] recently found that 34% of Western Australian participants aged 18 years and older reported that the main drug they used in the past month (April to June 2020) was different to February 2020, with the most common change being from ecstasy/MDMA use to cannabis and alcohol use.

3.2.3 Bed occupancy rates at the Perth Children's Hospital

Following an initial decrease in April 2020, monthly bed occupancy rates of the mental health ward at the Perth Children's Hospital have risen to levels above the same period last year since May 2020 (Figure 21)[85]. From August 2020, bed occupancy rates have remained particularly high around 95%. While these specialised mental health inpatient beds primarily cater for 0 to 15 year olds, the majority of the beds were used by young people aged 12 to 15. For example, in 2019-20, there were a total of 671 separations from Perth Children's Hospital across all ages. Of these, 95.5% (641) of separations were from young people aged 12 to 15. Consistently high bed occupancy leaves little capacity to admit young people with severe and persistent mental health problems.

Figure 21. Bed occupancy rates of the mental health ward in Perth Children Hospital - October 2019 to September 2020

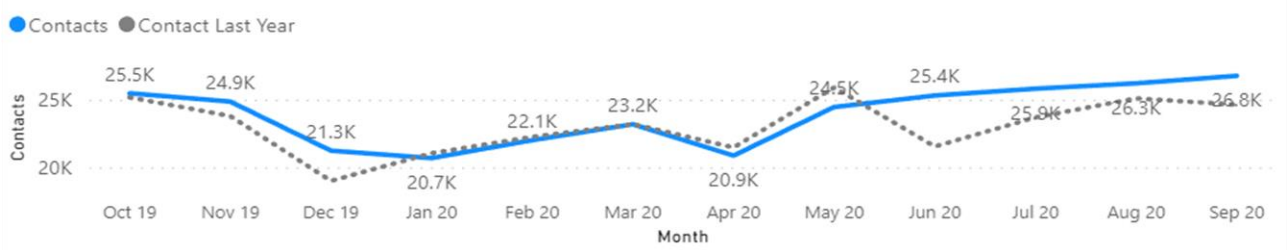


Source: Mental Health Commission, 2020.

3.2.4 Community mental health service contacts

Consistent with emergency department presentations, there was also a decrease in the number of community service contacts in April 2020. However, from June 2020, community service contacts for the 12 to 24-year age group in Western Australia have been on an upward trend to levels above that of the same period in 2019 (Figure 22). September 2020 had 26,821 service contacts which was a 24-month high.

Figure 22. Community mental health service contacts in Western Australia, young people aged 12 to 24 years – October 2019 to September 2020



Source: Department of Health, 2020.

3.3 Government response to the COVID-19 pandemic

3.3.1 Mental Health, Alcohol and Other Drug initiatives for children and young people

As part of the Government's immediate crisis response to COVID-19, the following mental health and AOD initiatives were developed for children and young people:

- Child and Adolescent Mental Health Service Emergency Telehealth Service to provide increased specialist emergency telehealth assessments (within the Perth metropolitan area) to young people as an alternative emergency service to Perth Children's Hospital, metropolitan emergency departments, general practitioners and psychologists.

- An additional 25 intensive psychosocial support packages to be provided for young people aged 15 to 18 years who have a severe and persistent mental illness and may also need support to maintain tenure in their living environments.
- Provision of additional funding to expand the Schools Response Program to the Midwest region. Services provided through this program include evidence-based counselling and psychological support; the 'Having a Conversation about Mental Health' program; and the 'Schools Response Program' collaborative postvention response across Western Australia.
- Enhancement of the long-term support for children and young people bereaved by suicide – 'Children and Young People Responsive Suicide Support' (CYPRESS) service. The CYPRESS service is a free, long-term support service for children and young people between the ages of 6 and 18 years who have been bereaved by suicide, and their caregivers, in the Perth Metropolitan area. The enhancement provides an additional bereavement counsellor to assist with the demand for the service and an intake officer role that will assess and triage referrals while providing brief intervention and psychological support for persons on the waitlist.

3.3.2 Government plan for recovery from the impacts of the COVID-19 pandemic: Services for young people aged 12 to 24 years

The WA Recovery Plan, released on 26 July 2020, provides an overview of key priorities and initiatives designed to build business and consumer confidence, while continuing to protect the health and wellbeing of the community now and in the future.

Targeted services for young people aged 12 to 24 years which contribute to the Government's plans for recovery from the COVID-19 pandemic are as follows:

- Youth Mental Health, Alcohol and Other Drug Homelessness Service: Establishment of an interim and long-term youth mental health and AOD homelessness service which will support up to 16 young people to transition from homelessness (or risk of homelessness) to more independent living, by working with them to improve functioning and reduce difficulties that limit their independence.
- Commitment to Aboriginal Youth Wellbeing: The Commitment to Aboriginal Youth Wellbeing is the Government's response to the State Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley, and Learnings from the Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas.
- Youth Digital Inclusion Project: This initiative provides young people with access to refurbished mobile phones, laptop and tablet computers and to connect with online support services during the COVID-19 recovery period.
- Western Australian Youth Services Directory Live Dashboard Update: Development of a live dashboard update of the WA Youth Services Directory.
- Aboriginal Community Connectors Program: The Aboriginal Community Connectors Program (ACCP) provides safe transport and personal support services to improve individual and community safety. The ACCP improves wellbeing for Aboriginal people and communities, specifically by supporting at-risk Aboriginal children and young people as one of its target cohorts.
- Kimberley Juvenile Justice Strategy: Initiatives funded under the Kimberley Juvenile Justice Strategy include safe place activities and night patrols where young people who are unsupervised or street present are engaged in constructive activities to reduce their risk of engaging in antisocial and offending behaviour. In addition, an educational industry skills program and Aboriginal Legal Service of Western Australia support for court and bail conditions for young people are part of the strategy.
- Children in Care package: This package includes the establishment of an Aboriginal Family-Led Decision-Making pilot to support improved collaboration with families at risk of child protection intervention, one-off COVID-19 support payments to foster carers, and additional therapeutic and consultation support for fosters and family carers.

4. Responding to mental health and alcohol and other drug issues for all young people

4.1 Responding to young people and their mental health and alcohol and other drug issues requires services and supports that range from prevention to primary care to specialist treatment

Figure 23 shows mental health and AOD services and supports provided across seven levels, ranging from prevention to primary care, to specialist community-based and hospital-based treatment services. These services and supports are provided by a mix of local government, State Government, Commonwealth Government, and privately funded sources.

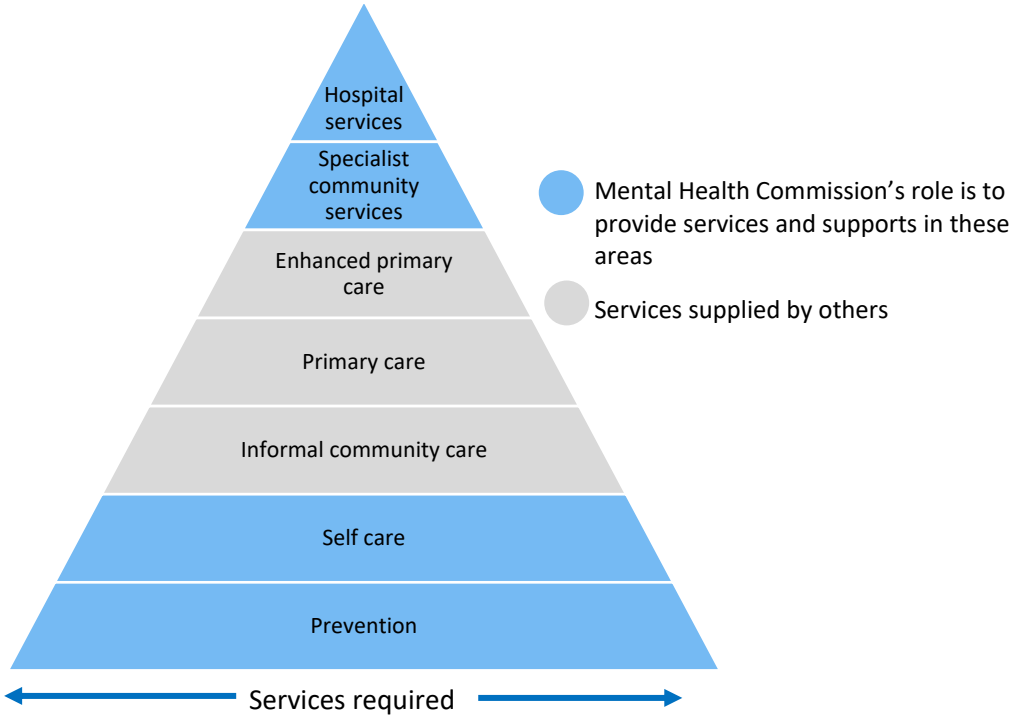
As identified in the previous chapter, these mental health and AOD-specific services and supports interact with a range of other activities, which also have important roles to play in addressing mental health and AOD needs for young people. These include education and training, housing, child protection, disability, sport and recreation, arts and culture, and those delivered by the justice sector.

However, through a review of literature, reports and engagement with key stakeholders, consumers families and carers, we've heard that the mental health and AOD services and the sector as a whole can often be fragmented, inconsistent, unbalanced and difficult to navigate. In addition, and as highlighted in the Western Australian Association for Mental Health (WAAMH) Youth Services Integration Report 2019, different funding arrangements, pathways and access points also contribute to issues across the sector[86].

These issues, along with accessibility and availability of appropriate services and supports can impact on the type and amount of support young people receive and their experiences in seeking help in the first place. This is particularly relevant for young people, who are at a stage in life where mental health and/or AOD issues may start to develop.

The remainder of this chapter discusses several levels of mental health and AOD services and supports in more detail. The discussion of each level includes current services and supports, the mental health and AOD issues they are seeking to address, and possible further services and supports for these issues.

Figure 23: Overview of services and supports for mental health and alcohol and other drug issues



Source: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Plan Update 2018

4.2 Prevention is particularly cost-effective for young people at risk of mental health and AOD issues

The economic case for prevention

Poor mental health in young people costs Australia at least $6.29 billion per annum, including $1.3 billion in direct health costs and $1.2 billion in unemployment and disability payments[87]. More broadly, it is estimated mental health conditions cost Australian workplaces approximately $11 billion per year through absenteeism, presenteeism (reduced productivity at work) and compensation claims[88].

It is estimated that AOD use costs the Australian community $55.2 billion per year, of which 27.3% is attributed to alcohol and 14.6% is attributed to illicit drug use[89]. In Western Australia, it is estimated that the health, social and economic harms associated with alcohol use cost $3.1 billion per year[90]. For example, in 2014, there were more than 19,400 hospitalisations in Western Australia attributable to alcohol, representing 113,549 bed days at a cost of over $155 million[91].

Similarly, significant police resources are directed towards responding to mental health and AOD-related issues, such as anti-social behaviour, violence, child abuse and neglect, driving under the influence of AOD and other drug-related crime. In 2006, it was established that 19.8% of the WA Police budget was spent responding to alcohol-related matters[92]. This equated to almost $280 million in the 2017 financial year.

Investment in prevention not only improves an individual's and the population's quality of life, it also makes financial sense. According to a 2017 systematic review[93], which assessed the return on investment across 52 public health interventions, for every $1 spent on prevention there is a $14 return on investment. In other words, for every $1 invested in effective prevention initiatives,

long term financial savings of up to $14 can be realised through reducing the need for treatment and other direct/indirect costs (for example, unemployment).

Excerpts from the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025

4.2.1 Protective factors and risk factors for mental health and AOD drug issues

Research has identified a range of protective factors and risk factors that can contribute to the prevention of, or development of, mental health and AOD issues. These factors are summarised in Figure 24 and Figure 25 below. It is important to acknowledge that if risk factors are present, it does not necessarily mean a person will experience mental health and AOD issues. Similarly, a person may experience mental health and AOD issues, even if there are multiple protective factors present.

Primary prevention focuses on strengthening protective factors and reducing risk factors. As mental health and AOD issues often co-occur and have a bi-directional relationship, where one issue can cause the other, prevention initiatives that seek to prevent mental health issues are likely to also prevent AOD issues, and vice versa[94]. Even in circumstances where a mental health issue is not preventable, secondary and tertiary prevention, as well as early intervention, are still likely to be effective.

Strategies and initiatives such as those that promote coping strategies, positive body image, effective problem solving, help-seeking behaviour, and increasing age-appropriate knowledge and skills in managing mental health and AOD issues are particularly relevant to young people in ensuring they stay well and to prevent mental health and AOD related issues.

These skills can act as strong protective factors for young people at a time when body image concerns, sexual orientation, relationship issues, bullying and social media use can have a significant impact on mental health and AOD use, including self-medication of mental health issues through the use of AOD[95].

Figure 24: Protective factors for mental health and AOD issues

Source: Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025

Figure 25: Risk factors for mental health and AOD issues

Source: Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025

4.2.2 Addressing the protective and risk factors calls for a whole-of-community and whole-of-government approach

The protective factors and risk factors set out above include many factors that fall beyond the responsibility or influence of the Mental Health Commission. Some factors lie within the responsibility or influence of other State Government agencies, and it is for this reason that the Mental Health Commission is collaborating with these other agencies in the development of the YPPA. Other factors fall within the responsibility or influence of other entities, such as local governments, Commonwealth Government, and non-government, community and voluntary organisations. The Mental Health Commission recognises that all these entities play a critical role in supporting young people, preventing mental health and AOD issues from arising and intervening early if they do.

Example - The role of schools in addressing risk and protective factors.

The school environment in particular, is an important setting where protective factors can be strengthened, and risk factors addressed. For example, personal skill-building programs and anti-bullying initiatives provided within the school-setting have the potential to increase protective factors and prevent mental health, and AOD issues[96]. Schools are often the place where young people may first experience mental health and/or AOD issues. This presents an opportunity for the provision of school-based prevention initiatives, and for school staff to respond to issues early, with appropriate support, resources and referral pathways where required.

Dedicated support people within schools are important in enabling schools to focus on understanding and responding to the needs of young people. This can include Student Services teams, school psychologists or counsellors, chaplains, school nurses, youth workers, social workers, as well as student peer support programs[97].

Schools also play an important role in promoting mental health and wellbeing through education and strengthening protective factors.

School engagement with other agencies and departments, and partnerships with community services are also valuable. Partnerships with family and community programs and initiatives are also important in enabling and supporting schools to respond to the needs of young people and could include the following relationships:[98]

- Department for Communities for referring child protection concerns and supporting and planning for students in care
- health providers such as general practitioners, Allied Health practitioners, onsite School Nurse, Royal Flying Doctor Service, Aboriginal health providers
- mental health service providers such as Child and Adolescent Mental Health Service, onsite school nurses, psychiatrists and psychologists, School of Special Educational Needs: Medical and Mental, Smiling Minds, headspace
- disability service providers such as School of Special Education Needs – Disability and Sensory, Senses and other disability support agencies
- sporting and recreation groups such as Clontarf Academy, local sporting organisations, Rotary Clubs, and Police and Community Youth Centres.

These relationships can also help with referrals to relevant services to provide students with support.

4.2.3 Current responses

In collaboration with other entities, the Mental Health Commission purchases and provides a range of prevention initiatives which seek to strengthen protective factors and reduce risk factors. Some of these initiatives include (but are not limited to):

- **School Drug Education and Road Aware Program** – a resilience-based program providing road safety and AOD education for children and young people aged 4 to 18 years. The Program also provides support for school staff, early childhood educators and community agencies through professional learning, resources and statewide consultancy.
- **Alcohol. Think Again, Parents, Young People and Alcohol campaign** - a statewide public education program that seeks to reduce alcohol-related harm among adolescents in Western Australia.
- **Mental Health Promotion, Mental Illness, Alcohol and other Drug Prevention Plan 2018-2015** – the Plan which guides the mental health, AOD and broader health and community sector in the prevention of mental health and AOD issues.
- **Creating environments and systems that support mental health and wellbeing and reduce and prevent AOD related harm in the community** - A 'settings' approach considers the contexts of everyday life, including homes, leisure, communities, schools and workplaces and how they influence health and wellbeing. These contexts are considered individually and as components of a larger interacting system so that interventions to minimise and prevent risk factors for harmful AOD use, and mental health issues can be implemented. Interventions include supporting evidence-based public health policy, separating child focused activity from alcohol, mentally healthy workplaces, and support resources for Local Government Public Health Planning.
- **Aboriginal Family Wellbeing project** – A project which acknowledges social and emotional wellbeing as a significant contributor to the prevention of suicide deaths in Aboriginal people, and aims to address the physical, mental, emotional, and spiritual issues that impact on an individual's wellbeing, family unity, and community harmony.
- **Changing Minds Program** - Delivered by Helping Minds, this school-based program provides population-wide strategies available to all school-aged children. Support and training is also provided to school staff to build their capacity to identify signs of mental illness to enable early intervention.
- **Fetal Alcohol Spectrum Disorder (FASD) project** – In July 2020, the Mental Health Commission commenced a comprehensive prevention strategy, including a mass-reach public education campaign, related resources, health worker training to address alcohol use in

pregnancy, and community action initiatives in Western Australia. The project has a role in leading, influencing and informing the knowledge and behaviours of the community to reduce the incidence rate of FASD.

4.3 Primary care plays a critical role in identifying mental health and AOD issues and intervening early

As shown in Figure 23, people who are well or experience mild or moderate mental illness and/or AOD issues may seek assistance from private and Commonwealth-funded primary care services. These include General Practitioners, services provided through the Western Australian Primary Health Alliance (WAPHA) and headspace.

4.3.1 General Practitioners

It is understood that approximately half of all lifetime mental health conditions in adulthood emerge before the age of 14, and three quarters emerge before the age of 25[99].

General Practitioners (GPs) are often the first point of contact for young people experiencing mental health difficulties and with emerging mental illness. 90% of Australians see a GP at least once a year[100]. GPs consistently report psychological issues to be the most common health presentations they manage[101]. GPs are the most frequently contacted health professional by those engaging in suicidal behaviour[102].

GPs may work with a young person to develop a Mental Health Care Plan, which identifies the type of health care the young person needs and sets out the agreed goals of the young person and their GP. The Mental Health Care Plan may also refer the young person to local mental health services.

If a young person has a Mental Health Care Plan, they will be entitled to Medicare rebates for up to ten individual and ten group psychological therapy sessions[xvi], plus some additional allied mental health services per calendar year. In response to the COVID-19 pandemic, an additional ten individual mental health sessions (20 in total) can be accessed, until 30 June 2022[103]. The Mental Health Care Plan is part of the 'Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule' initiative, which aims to improve outcomes for people with a clinically diagnosed mental disorder.

In respect to AOD issues, training is available to support primary care practitioners recognise and respond to AOD issues.

4.3.2 Western Australian Primary Health Alliance

Funded by the Australian Government, WAPHA commissions a range of mental health and AOD services for young people, including:

- national programs (e.g., headspace – refer to 4.3.3)
- programs targeted towards priority populations
- low intensity and brief intervention services
- psychological therapies for underserviced groups
- mental health and AOD treatment services
- a range of other services for young people, including community support services and early psychosis youth programs

[xvi] While MBS Better Access items may be provided by a clinical or registered psychologist, or by a social worker, occupational therapist or GP who has completed additional mental health training, the delivered item is referred to as psychological therapy.

- the HealthPathways WA program, which assists GPs and other clinicians to navigate their patients through the primary, community and acute healthcare system, with an aim to streamline management and referral processes.

4.3.3 headspace

Also funded by the Australian Government, the headspace network provides:

- a one-stop-shop for young people who need help with mental health, physical health (including sexual health), AOD issues and work and study support
- a National Telehealth Service
- eheadspace, a free online and telephone support and counselling for young people and their families and friends
- headspace Schools, which supports, engages and partners with education and health sectors across Australia, to build the mental health literacy and capacity of workforces, children, young people, their families and wider school communities
- an early psychosis program to support young people experiencing, or at risk of developing, psychosis
- free and confidential support for young people needing help with work and study, career mentoring and Individual Placement Support, which integrates employment and vocational services with clinical mental health.

headspace, and the broader primary care sector provide services for people with mild or moderate mental health issues. Those with more severe mental health issues will generally require access to specialised community-based services (e.g. community support, community treatment and community beds) and private and public inpatient services, some of which sit within the remit of the Mental Health Commission (see Figure 23).

4.4 Specialist community-based and hospital-based treatment services are needed for those with mental illness and AOD issues

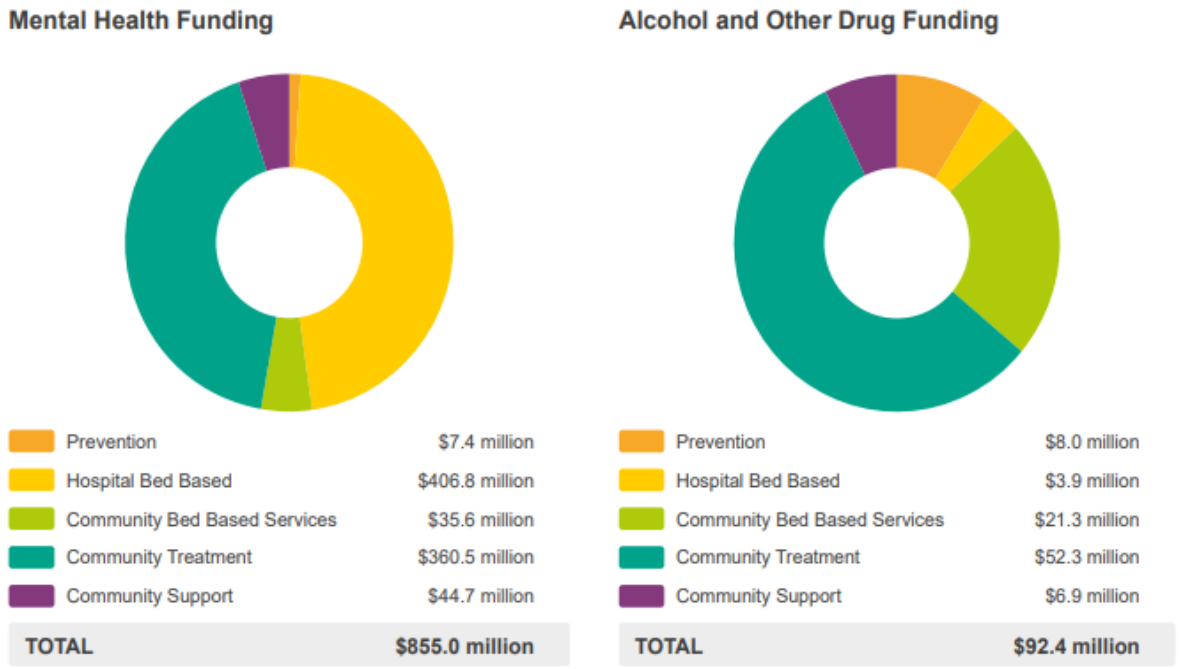
4.4.1 Overview of services purchased or provided by the Mental Health Commission

As depicted in Figure 23, the Mental Health Commission purchases and provides services and supports across several levels from prevention to specialist community-based and hospital-based treatment services.

In 2019-20[104], the Mental Health Commission invested a total of $947.4 million on mental health and AOD services and initiatives. This was an increase of 3.2% on the previous year. This funding is spread across five service streams: Prevention; Community Support Services; Community Treatment Services; Community Bed-Based Services; and Hospital Bed-Based Services. The breakdown of funding between these five service streams is shown in Figure 26 below.

Further explanation of these service streams, and the associated services and supports, are set out in Appendix 1, with full details provided in the Plan and subsequent Plan Update 2018.

Figure 26. Mental Health Commission 2019-20 investment in mental health and AOD services and supports, by service stream[105]



Source: Mental Health Commission 2019-20 Annual Report

The Mental Health Commission provides specialist community-based and hospital-based treatment services to the small proportion of the Western Australian population who experience severe mental illness and AOD issues by purchasing these services from a range of providers. These providers include public Health Service Providers, non-government organisations operating in the community sector and private service providers. The five public Health Service Providers in Western Australia are:

- Child and Adolescent Health Service
- East Metropolitan Health Service
- North Metropolitan Health Service
- South Metropolitan Health Service
- WA Country Health Service

These five public Health Service Providers, together with the Department of Health (which has the role of 'system manager') comprise the public health system, known as WA Health.

The Mental Health Commission is also responsible for the network of drug and alcohol treatment services formerly provided or purchased by the Drug and Alcohol Office. This includes:

- the Alcohol and Drug Support Service which provides 24/7 telephone counselling, information, referral and support lines
- the Next Step Drug and Alcohol Service which provides outpatient and medical support
- the integrated Drug and Alcohol Youth Service, which is a partnership between Mission Australia and Next Step for young people specifically.

The remainder of this Chapter discusses key issues in the provision of specialist community-based and hospital-based treatment for young people, current responses to these issues and possible further responses.

4.4.2 Volume of mental health, alcohol and other drug treatment services for young people

To underpin its purchasing of mental health and AOD services, the Mental Health Commission has undertaken modelling[xvii] to estimate the required number of services across all five service streams. To do this work, the Mental Health Commission used national modelling tools that are based on robust evidence including epidemiology, prevalence and an optimal service mix. Full details of the modelling are set out in the Plan and Plan Update 2018.

Figure 27 below sets out the 2017 estimated actual[xviii] and 2025 optimal levels[xix] of mental health and AOD services, which are commissioned or provided by the Mental Health Commission[106,107]. Figure 27 indicates that:

- whilst the estimated 2025 optimal mix outlines that there is more demand for community treatment services for adolescents (12-15 years) compared to youth (16-24 years), the Figure also demonstrates that in Western Australia, the 2017 estimated actuals are close to meeting the estimated 2025 optimal mix
- according to the 2017 estimated actuals and estimated 2025 optimal mix, the largest gaps in services for young people are in the four areas of prevention, community support, community bed-based services, and hospital-based services.

[xvii] Modelling tools included the National Mental Health Services Planning Framework (NMHSPF) and the Drug and Alcohol Service Planning Model (DASPM).

[xviii] *Estimated Actuals 2017* - Where possible, mental health beds for 2017 were based on actual counts as at 31 December 2017 extracted through BedState. For AOD, actuals were determined through a master bed list maintained by the Commission. Hours of service for both mental health and AOD services primarily relate to full time equivalent and estimated actuals were based on 16.39% actual service cost growth in the Commission budget from 2013-14 to 2016-17, attenuated by the sum of the Wage Price Index (8.30%) increase, from the Western Australia Budget Economic and Fiscal Outlook for the same period, to derive an estimated growth figure of 8.09%.

[xix] To determine this service activity estimation split in age ranges, we have used an age equalisation method, consistent with the modelling in the Plan and the Plan Update 2018. The 2017 estimated actual and the estimated 2025 optimal mix are shown for the State as a whole.

Figure 27: The Plan Update 2018 - Demand for Age Groups 12 to 15 years and 16 to 24 years

Service Type		State Totals	
		2017 Estimated Actual	2025 Estimate
Prevention and Promotion[xx]			
Mental Health[xxi] (all ages)	Percentage	1.4%	5.0%
Alcohol and other drug (all ages)	Hours ('000)	107	208
Community Support Services			
MH (all ages)	Hours ('000)	910	4,892
12-15 years			122
16-24 years			501
AOD (Harm reduction and personal support) (all ages)	Hours ('000)	6	232
12-15 years			3
16-24 years			34
AOD (Post Residential Rehabilitation) (all ages)	Beds	74	133
12-15 years			2
16-24 years			19
AOD (Safe places for intoxicated people) (all ages)	Beds	182	205
12-15 years			3
16-24 years			30
Community Treatment Services			
MH Infant, Child and Adolescent (0-15 years)	Hours ('000)	404	1,388
12-15 years			443
MH Youth (16-24 years)	Hours ('000)	366	408
AOD - All (non-residential treatment) (all ages)	Hours ('000)	611	1,700
12-15 years			24
16-24 years			247
Community Bed Based Services			
MH Community Based Beds (all ages)	Beds	328	873
12-15 years			1
16-24 years			76
AOD - Low Medical Withdrawal (all ages)	Beds	27	46
12-15 years			0
16-24 years			7
AOD - Residential Rehabilitation (all ages)	Beds	439	786
12-15 years			9
16-24 years			118
Hospital Based Services			
MH Infant, Child and Adolescent (0-15 years)	Beds	19	26
12-15 years			23
MH Youth Acute (16-24 years)	Beds	14	74
MH Youth Subacute/Non-acute (16-24 years)	Beds	0	13
MH Youth HITH (16-24 years)	Beds	8	21
AOD (High/Complex Medical Withdrawal) (all ages)	Beds	39	103
12-15 years			1
16-24 years			15
MH/AOD Consultation Liaison (all ages)	Hours ('000)	265	525
12-15 years			42
16-24 years			74

Source: Modelling underpinning the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) and Plan Update 2018

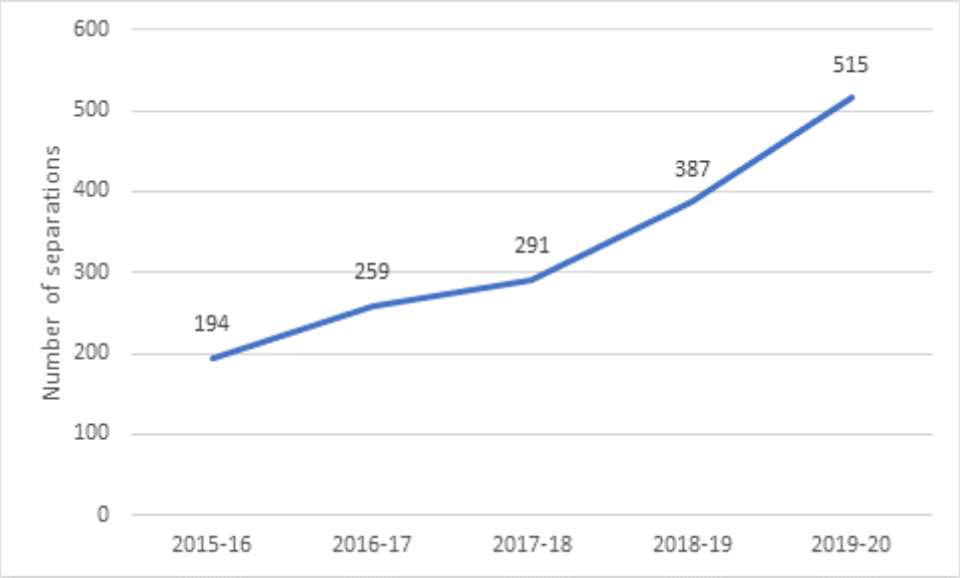
[xx] As the National Mental Health Services Planning Framework (NMHSPF) and the Drug and Alcohol Service Planning Model (DASPM) do not specifically address prevention service requirements for mental health and AOD. For mental health, a Promotion and Prevention Consultation Group (PPCG) was convened. The PPCG provided advice on the development of the Prevention section of the Plan, and undertook research upon which the mental health prevention resource requirement is based. Modelling for the AOD prevention components is based on existing programs, population projections and expert advice.

4.4.3 Eating disorder services for young people

There has been an increase in separations from specialised mental health hospital wards and general hospital wards for the 12 to 24-year age group diagnosed with eating disorders[xxii] in Western Australia over a five-year period (Figure 31). In 2019-20, there were 515 separations across all publicly funded hospital wards, which is 165.5% higher than the number of separations in 2015-16 (194). Within the 12 to 24-year age group, the increase in separations was most pronounced for the 16 to 17 age group (230%; 40 to 132), followed by the 18 to 24 age group (221.1%; 57 to 154) and the 12 to 15 age group (106.2%; 97 to 200).

Approximately three-quarters of separations for young people aged 12 to 24 diagnosed with eating disorders were from general hospital wards. For example, in 2019-20, of the 515 separations, 370 (71.8%) and 145 (28.2%) were from general hospital wards and mental health hospital wards respectively.

Figure 28: Number of separations from hospital wards in Western Australia diagnosed with Eating Disorders, 12 to 24 years, 2015-16 to 2019-20.



Source: Department of Health, 2020

The peak age of onset of eating disorders is between the ages of 12 and 25 years. Bulimia Nervosa and Anorexia Nervosa are the 8th and 10th leading causes (respectively) of burden of disease and injury in Australia in young women aged 15 to 24 years[108]. For this same cohort (15 to 24 years), the mortality rate as a result of Anorexia Nervosa is 12 times higher than the annual death rate from all causes[109].

Overall, approximately 55 per cent of individuals treated for eating disorders in Western Australian public hospitals are aged 16 to 25[110].

The Child and Adolescent Health Service provides a comprehensive eating disorder service for people 16 years and under including outpatient care, day treatment and in-reach support. However, there is currently no access to key components of a best practice eating disorders

[xxi] Percentage of the total Mental Health Commission budget.
[xxii] Separations include public patients treated in either public or private hospitals with a primary diagnosis of an Eating Disorder (ICD-10 code range F50.0 to F50.9).

continuum within the public mental health service for people aged 16 years and over in Western Australia (namely specialist inpatient beds, a day program and multidisciplinary outpatient care). Once young people with eating disorders turn 16 years of age, they continue to access some outpatient services through the Child and Adolescent Health Service while they transition to one of the three other metropolitan Health Service Providers or the WA Country Health Service. However, none of these Health Service Providers provide specialist eating disorder services. People with an eating disorder aged 16 and over requiring admission are admitted to adult general medical beds with care by consultation liaison psychiatrists. These settings are poorly resourced to deal with people with complex and specialist treatment needs.

The Western Australian Eating Disorders Outreach and Consultation Service is a multidisciplinary team that facilitates the provision of standardised, best-practice, compassionate care for youth and adults with eating disorders in Western Australia. This includes providing training and support to health professionals in all different settings, including Emergency Departments, medical wards, mental health units, Hospital in the Home teams, General Practitioners and community health and mental health care services from public, private and community managed organisations. This includes consultation liaison, mentoring and support to help clinicians manage their patients.

The Centre for Clinical Intervention provides treatment for people suffering from mood disorders, anxiety disorders and eating disorders. They provide evidence-based outpatient Urgent Stream Maudsley Family Based Therapy for children and adolescents on an outpatient basis. Their waiting list for 16 and 17 year olds is now reported to be around 4 to 5 months.

The Commonwealth funded extended MBS item numbers for people with eating disorder require assessment by a Consultant Psychiatrist or Paediatrician after 20 psychology sessions to enable treatment review and approval for access to the remaining 20 treatments. However, it is reported that few private psychiatrists are prepared to accept eating disorder patients in view of difficulties accessing acute care when needed.

As indicated in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan), there is a need to expand the availability of a range of high quality, effective and efficient specialised services to meet demand, including the development of a specialised statewide service for eating disorders. This includes the need to commission dedicated eating disorder inpatient beds and community treatment teams.

4.4.4 Services for people with emerging and ongoing Personality Disorders

Personality disorders captures a range of problems that start during adolescence and commonly co-occur with depression, AOD issues, eating disorders and anxiety. A person is said to have a personality disorder when their personality traits become pervasive, inflexible, deviate markedly from cultural norms and cause significant impairment and/or distress to the individual. Young people with emerging difficulties often resort to unhelpful behaviours to manage their emotions such as self-harm, drug and alcohol use, binge eating, social withdrawal, aggressive behaviour and risky sexual behaviour[111].

People most commonly present to mental health services with the features of borderline personality disorder. Whilst clinicians are reluctant to diagnose people with personality disorders before the age of 18, emerging personality difficulties are very common prior to the age of 18. Research suggests that approximately 22% of outpatients and 3% of young people in the community have a diagnosed personality disorder[112]. Borderline personality disorder is also seen in 78% of suicidal young people who present to emergency departments[113]. Borderline personality disorder is associated with substantial psychosocial impairment, distress and mental health symptoms, mortality and resource utilisation[114].

There are a number of risk factors associated with the development of a personality disorder including environmental and socio-economic risk factors, but also risk factors relating to

family/parental relationships and functioning, and experiences of bullying and rejection by peers as well as childhood sexual and physical abuse[115].

The difficulty in diagnosing personality disorders among young people is often due to being unable to distinguish between other mental health problems that also emerge during adolescence such as psychosis, anxiety and/or depression, normal development, and the features of a borderline personality disorder[116,117,118]. This may result in the rates of young people said to have a borderline personality disorder being underestimated.

There is good evidence that early intervention with young people at risk and with emerging disorders can be effective in reducing symptoms and improving life functioning. Barriers to diagnosis and access to services such as the stigmatising attitudes of health professionals and lack of public knowledge need to be addressed as well as access to appropriate services in schools, primary care, peer support and specialist care, including transdiagnostic assessments and evidence-based treatments such as Dialectical Behaviour Therapy (DBT) and Mentalisation Based Treatment (MBT).

Current Services

The Personality Disorders Model of Care Reference Group[xxiii], through the development of a Statewide Personality Disorder Model of Care has indicated that whilst GPs are a source of support and an entry point to seeking help, some may feel they lack knowledge and skills in responding to people living with personality disorders and to highly distressed clients. There is a lack of access to specialist evidence-based treatment and psychotherapy in the public system. Some clinicians in the public system in the Child and Adolescent Mental Health Service specialise in DBT and MBT but the availability of DBT in the public system can at times be limited. People living with personality disorders are often sent to emergency departments where their distress and symptoms can escalate, and they may be discharged with a high level of unmet need. For some services, borderline personality disorder may be used as an exclusion criteria, even if not explicitly, and there may be time limits placed on inpatients admissions which can lead to discharge without a comprehensive plan for support and care in the community.

4.4.5 Attention deficit hyperactivity disorder (ADHD)

ADHD is one of the most common developmental disorders in children. ADHD can negatively affect a young person's social, academic and/or occupational functioning[119]. The cost of ADHD to the community in both social and economic terms is high[120]. There are often long-term adverse effects on later academic, vocational, socio-emotional and mental health outcomes. Families who have children diagnosed with ADHD can experience increased levels of parental frustration, and marital discord. The direct cost of medical care can be substantial and represents a serious burden for the families. At a community level, children diagnosed with ADHD can require a disproportionate share of resources from school, health services, the criminal justice system and other social services agencies. Many students with ADHD are already below their peers in academic achievement in Year 3 and then fall further behind as they progress through school[121].

ADHD can have lifelong impacts, including on occupational attainment and the increased likelihood of crime and interaction with the criminal justice system. These impacts place significant pressure on Australian society and its institutions and imposes significant economic and wellbeing costs on the Australian population[122].

Conversely, children diagnosed with ADHD who are receiving effective treatment and support can live full and successful lives. There is good evidence that early intervention and specialist multidisciplinary, holistic treatment including psychological approaches, support for families,

[xxiii] The Personality Disorders Model of Care Project Reference Group includes the Co-Leads of the Mental Health Network, the Co-Chairs and members of the Personality Disorders Mental Health Sub Network, which includes people with lived experience, clinicians, service providers and other stakeholders. This group has overseen the development of a Statewide Personality Disorders Model of Care.

educational and vocational support and medication can greatly improve the outcomes and life trajectory of young people, including reducing suicide.

Young people with ADHD experience co-occurring other mental health issues at a much higher rate than those without ADHD. For example, compared to those without ADHD, adolescents and adults with ADHD are[123]:

- 1.5–3 times more likely to have a substance misuse disorder
- 8.4 times more likely to have a depressive disorder
- nearly 11 times more likely to have an anxiety disorder
- nearly 4 times more likely to attempt suicide
- 6.5 times more likely to make multiple suicide attempts.

An international study has also found that people 15 years and above with ADHD are also more likely than those without ADHD to partake in risky behaviours, including high rates of alcohol consumption, alcohol dependence, and illicit drug use[124].

In the public health system, assessment, early intervention and treatment for children up to 16 years with developmental disorders, including ADHD, is provided by community paediatricians in child development services. There is a large demand for these services and there can be long waits for assessment. The Western Australian Stimulant Regulatory Scheme 2017 Annual Report[125] reported that there were 9,587 children under 18 prescribed stimulants for ADHD in Western Australia. Of these, 2,011 were treated in public sector clinics. The rest were treated by private paediatricians and psychiatrists. The Child and Adolescent Mental Health Services do not prescribe for children with ADHD but provide treatment of co-occurring mental health problems. The Complex Attention and Hyperactivity Disorders Service (CAHDS) is a public specialist assessment and consultation statewide service for children, and their families, who have persistent complex attention difficulties and related conditions. It provides assessment and advice to treating clinicians but does not take on case management or prescribing.

Most services for adults (18+ years) with ADHD are delivered by privately practicing psychiatrists working with co-prescribing GPs which presents some challenges for young people transitioning from child and adolescent services. In the public health system, the youth and adult attentional disorder service (YACADS) provides specialist ADHD assessment and consultation liaison services to respond to the needs of those aged 18 years and above with ADHD and co-occurring conditions. People referred to YACADS must be case managed by Youth or Adult Public Mental Health Service providers. YACADS may establish a person on medication but then the medication has to be taken over by a private psychiatrist. The youth and adult mental health services will treat co-occurring disorders but not prescribe for ADHD.

4.4.6 Alcohol and other drug withdrawal and rehabilitation services for young people

The Drug and Alcohol Youth Service (which spans the community treatment and community bed-based service streams) is currently the only government-funded service that provides dedicated AOD withdrawal and rehabilitation services specifically for young people.

The Drug and Alcohol Youth Service, located in East Perth, has the capacity to assist young people ranging from 12 to 21 years (where deemed appropriate). AOD services at other Community Alcohol and Drug Services locations can also be accessed by young people from the age of 14 (where appropriate). However, this still means that many young people, particularly those living in regional, rural and remote areas may need to access typically adult-focussed services.

4.4.7 Responses to co-occurring mental health and alcohol and other drug issues for young people

'Service integration is the key to dealing with interconnected issues that affect mental health and which impact on young people's lives such as housing, employment, income, education, alcohol and drug use, physical health, sexuality and gender and violence and abuse'

Youth Services Integration Report, WAAMH[126]

Studies have identified that approximately 60% of children and young people with an AOD use disorder also have a co-occurring mental health diagnosis[127]. The National Mental Health Commission has recommended that people presenting with co-occurring mental health and AOD-related issues 'must be responded to in a comprehensive, integrated way wherever they present'[128]. It has been noted that the siloed nature of the Australian health system is a current barrier to the integration of treatment approaches[129].

The recently announced Youth Mental Health, Alcohol and Other Drug Homelessness Service is the only publicly funded, dedicated youth service that will be formally required to address co-occurring mental health and AOD issues in an integrated way.

Some existing services attempt to support young people with co-occurring issues, however this is often done informally and where there is the capacity to do so. For example, the Drug and Alcohol Youth Service seeks to accept young people into their service even when co-occurring issues are present (where appropriate) and seeks to engage, and work in an integrated and collaborative way with mental health services. However, such an informal approach does not provide any assurance that young people with co-occurring issues will be accepted and treated by the service that they approach.

Identified barriers to providing appropriate responses for young people with co-occurring mental health and AOD issues include:

- differing definitions of 'youth' across mental health and AOD services which results in young people only being able to access services if they are of a certain age aligning with the contact/service model for the service
- the limited availability/existence of services which are either co-located or funded to provide support for those with co-occurring mental health and AOD issues.

In addition to the above barriers, regional and remote areas may have difficulty being able to demonstrate enough demand to warrant a service being provided.

With respect to age ranges, youth community treatment mental health services typically provide services for young people aged 16 to 24 years. This age range is based on evidence and clinical advice regarding the efficiency and effectiveness of the clustering of services for young people at similar developmental stages.

Community services addressing AOD use, on the other hand, are typically split into adult services, which provide services for young people aged 18 years and over, and youth services, which provide services for young people aged 12 to 17 years. The application of these age boundaries is largely historical (this is with the notable exception of one youth AOD service, which provides services for young people aged 12 to 21 years).

In addition to this, some adult services provide support for those under 18 years. For example, Community Alcohol and Drug Services can be accessed by young people from the age of 14 (where appropriate). However, Community Alcohol and Drug Services are not funded to provide specialist youth workers and see very few young people under 18 years of age.

4.4.8 Finding help for young people where and when it is needed

'I called [mental health emergency service] because I was feeling unsafe and needed help and that was supposed to be what they were there for. They told me they couldn't help me and to call the police… so I did. The police came and put me in the back of a paddy wagon even though I had only called them because I was feeling unsafe. They took me to the hospital and handcuffed me to a rail. The nurses left me in a room for a few hours and told me I wasn't unwell enough to be admitted, so they sent me away.'

Youth Services Integration Report 2019 - WAAMH[130]

A young person's access to services may be restricted due to:

- services not being available in the postcode or region in which they live
- the young person not meeting the age range for the service, with these age ranges being inconsistent across services
- the young person not meeting other eligibility criteria for the service
- the service not being culturally appropriate or delivered in the young person's first language
- long waitlists
- the young person's perceptions that they are being stigmatised or discriminated against by the service
- the cost of the service
- the physical distance to the service, especially in more regional and remote parts of Western Australia
- complexity of issues and experiences

These obstacles make it difficult for young people and their families to navigate the system and receive the care they need, when they need it. In turn, this results in young people presenting to emergency departments when access to another service could have prevented this.

Many reports have identified that mental health and AOD services, as well as the sector as a whole, can be difficult to navigate. Different funding arrangements, pathways and access points contribute to these issues[131].

4.4.9 Young people presenting to emergency departments of hospitals

'Every time I went to the hospital, they would tell me I wasn't unwell enough… but they would ask me if I had taken anything. I saw that people who tried to kill themselves by taking pills got the nurses and doctors attention so that's what I started doing. I just wanted someone to help keep me safe, but I needed to be in that much danger to get the help… so I had to put myself in danger."

"My parents stopped taking me to the emergency department. There was no point in going, they're not very helpful, kind of just made me worse… my parents would lock me in their bedroom instead to keep me safe when I felt like hurting myself.'

Youth Services Integration Report 2019 - WAAMH[132]

Young people experiencing mental health and AOD issues frequently present to the emergency departments of hospitals. In 2019-20 there were:

- 17,310 mental health-related emergency department presentations for the 12 to 24 age group across Western Australia in 2019-20[133]. As shown in Figure 5, there has been an upward trend across the previous financial years with 2019-20 seeing 15.3% more presentations than 2015-16
- 1,876 alcohol-related emergency department presentations for the 12 to 24 age group across Western Australia in 2019-20[134]. As shown in Figure 13, there has been an upward trend across the previous financial years with 2019-20 seeing 14.0% more presentations than 2015-16.

Services and initiatives which aim to either support young people within emergency departments or divert them from emergency departments in the first place include:

- Stabilisation Assessment and Referral Areas - In line with the Government's commitment in the 2019 Full Government Response to the Western Australian Methamphetamine Taskforce Report (the Taskforce Report) and Strategy 2 of the Sustainable Health Review, the establishment of Stabilisation Assessment and Referral Areas were proposed to meet the needs of individuals with co-occurring mental health and AOD issues presenting to Emergency Departments. Consistent with this recommendation, Mental Health Observation Areas, Mental Health Emergency Centres, Urgent Care Clinics and Behavioural Assessment Units are being developed and implemented across Health Service Providers to meet the co-occurring needs of individuals in metropolitan emergency departments. However, these are generally only accessible to those 18 years and above.
- Safe places for people in crisis - Through the Taskforce Report, families identified a need for support and a safe place for individuals, other than emergency departments, in crisis situations where AOD was a contributing factor, particularly for those in psychosis. The Mental Health Commission is currently developing a service system model which aims to ensure that people in crisis due by problematic AOD use can access and seamlessly navigate an integrated suite of services that will keep them, their families and carers, and the community safe, as they are consistently supported to build a healthier and more stable future.
- Youth Community Assessment and Treatment Team – This is an intensive community-based youth service targeting acutely ill people at risk of developing serious mental health problems which can reach young people before presenting to emergency departments.
- After hours support options - Currently most after-hours support is delivered to young people via phone or online through national services such as headspace and Beyond Blue. The Emergency Telehealth Service (ETS) delivered by the Child and Adolescent Health Service (Perth) provides phone and online videocall support for children and young people who are experiencing a mental health crisis, as well as support and advice to families and carers between 8 am and 2:30am 7 days a week. If these services are not appropriate for the young person, most young people will present at an Emergency Department after hours.

Almost all current treatment for young people is available during office hours only, which means that if the crisis occurs outside of these hours then treatment and support options are limited. Additionally, treatment only provided during office hours means that the young person has to disrupt their schooling and other activities to attend appointments and receive services. There is a pressing need for after-hours services for young people.

In addition to the above, there have previously been teams which provide assertive outreach and responses for people with mental health problems. These types of teams are usually attached to community mental health teams and work with individuals who have a history of mental health problems and struggle to remain in contact with traditional mental health teams and therefore often receive limited or no service. However, these types of teams are currently not widely available, and are not dedicated youth teams.

Young people often disengage with traditional services and can struggle to receive ongoing treatment and support, therefore would benefit from a more assertive treatment approach. These teams can actively seek people in the community to provide treatment and support. An example is the adult Mobile Clinical Outreach Team who deal with those with a persistent mental illness who are homeless or at risk of being homeless.

4.4.10 Transition between services by young people

The Sustainable Health Review Final Report[135] highlights the need for increased focus on access to mental health services and integrated and connected services for young people, particularly to support their transition to and from community settings, hospitals, and forensic and correctional facilities. Further to this, the Mental Health Advocacy Service's report, *Forensic Youth Mental Health*

Mapping of Pathways: Access to Care, identified transition/handover process between services as one of the major system gaps to care for child and adolescent offenders, often resulting in loss to follow up or long waiting lists.

The Youth Services Integration Report 2019 also highlights issues with youth transitions between services noting that they are often poorly planned, explained, and executed which can result in negative outcomes[136].

The Mental Health Commission's accommodation and support strategy, A Safe Place: A Western Australian strategy to provide safe and stable accommodation, and support to people experiencing mental health and AOD issues 2020-2025 (A Safe Place), also recognises the importance of ensuring effective transitions, processes and pathways are established between specialist services and accommodation and support services for people with mental health and AOD issues[137]. This is especially important to ensure young people are not discharged into homelessness and are supported in seeking ongoing care.

4.4.11 Transition by young people from child to youth to adult services

'*Transitions from child to adult mental health and alcohol and other drug services can create a period of vulnerability for children and young people, as often transitions are based on a person's age and not their readiness for transition or their developmental needs.'*

Commissioner for Children and Young People[138]

'*The implications for children being placed on an adult ward or unit can be significant, from being in an unsuitable environment to the lack of access to a child and adolescent psychiatrist who specialises with this cohort.'*

Annual Report 2016-17, Mental Health Advocacy Service[139]

The transition between child and adolescent mental health services, youth services and adult mental health services is a key area of concern. The gap between child and adolescent, and adult mental health services can lead to a discontinuity of care and result in increased severity of mental health issues later in life[140].

The age at which young people are required to transition away from a child and adolescent service for treatment can vary from 16 to 18 years of age depending on the mental health service they are involved with (which in turn may be dependent on where the young person lives)[141]. This time of transition is a vulnerable time and may mean that young people aged 16 and 17 years do not receive appropriate care when they need it, with some falling through the gaps as they are too old for one service and too young for another. They may also end up moving to and from child and adolescent, youth and adult services if they require inpatient care.

For example, a 16 year old who is being treated for an eating disorder by the Child and Adolescent Health Service outpatient eating disorder service may be admitted to an adult general ward if acutely unwell, and from there, wait for a bed on a youth mental health unit before eventually returning to the Child and Adolescent Health Service outpatient service.

Currently, Child and Adolescent Mental Health Service community and outpatient services will see children and young people under 18 and their families. However, the Perth Children's Hospital mental health inpatient unit admits young people up to 16 years. Adult inpatient units and community mental health teams accept adult patients 18 and over. There are currently only two youth inpatient units, one at Fiona Stanley Hospital and the other at Bentley Hospital which admit young people between ages 16 and 24. There are some specialist community teams for young people between the ages of 16 and 24, including Youthlink, YouthReach South, Youth Axis, and Youth Hospital in the Home. However, youth community services are not available in all areas and are not able to provide a comprehensive program of mental health services to all young people with serious mental health disorders within the youth age cohort.

The establishment of dedicated youth mental health and AOD services for ages 16-24 in inpatient and community settings, which the Mental Health Commission has already commenced work on, will be important to addressing the vulnerability created by the transition from child to adult services and ensuring age appropriate services are available across the service spectrum.

4.4.12 Family and carer involvement in young people's care

Research confirms that involving a young person's family in the care and treatment of mental health and AOD-related issues is not only beneficial to the young person but also contributes to the success of the treatment[142]. This needs to be balanced with a young person's right to privacy and an acknowledgement that the involvement of families and/or carers should only be at the request of the young person (where appropriate).

'*I told [clinician] that I didn't want them to tell anyone that I was coming to [service] because it could make things worse for me at home, but they didn't get it. They told me I was just being dramatic, and it probably wasn't as bad as I thought. I had to move to Perth from the country because my mum found out I was going to [service]…*'

Youth Services Integration Project, WAAMH[143]

The involvement of families and carers is also important within the school setting, with research finding that parental engagement in learning supports the cognitive, emotional and social development of children and young people and can enhance their wellbeing and academic attainment[144].

Whilst family-focussed approaches are encouraged across the mental health and AOD sector and the broader sectors that young people engage with, there are inconsistencies in the approaches and practices being applied and ultimately the extent to which the concerns of families are heard and addressed.

In addition, while both public health and community sector services rely on families to support their young people, family units themselves may also be struggling, which may impact their ability to effectively meet the needs of their children, and need support in their caring role. Families and carers themselves also need support in attaining relevant knowledge to be able to confidently support their young people. One study has found that only 35% of Australian parents were confident that they could recognise signs of mental health issues in their child (0 to 17 years)[145]. This same study also found that less than half (44%) of parents were confident in knowing where to go for help if their child was experiencing mental health issues.

'*Most helpful is just being with other parents of kids suffering mental health issues*'

Carer Engagement Report, YACWA[146]

5. Responding to mental health and other drug issues for particularly vulnerable young people

5.1 Aboriginal young people

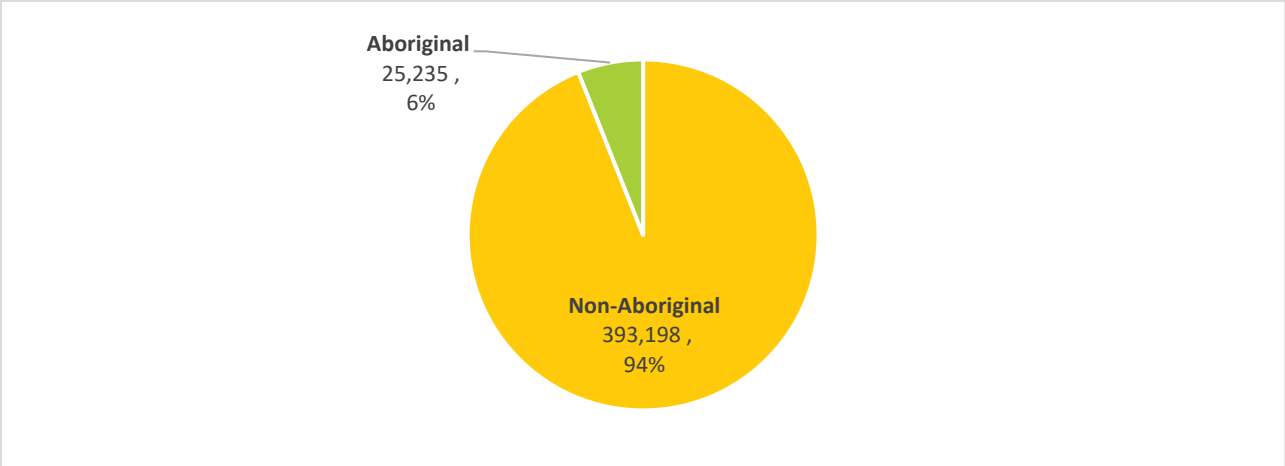
'Barriers are cultural in the main. If our health services were less officious and started employing Aboriginal ways of working, then young people might be more inclined to participate'.

Western Australia Aboriginal Youth Health Strategy 2018-2023, Aboriginal Health Council of Western Australia[147]

According to the most recent estimates (Figure 29),[148] in 2016 there were 25,235 Aboriginal young people aged 12 to 24 years in Western Australia.

These young people represented 6% of all young people in Western Australia aged 12 to 24 years (418,433), 25% of the total Western Australian Aboriginal population (100,512), and 1% of the entire Western Australian population (2,555,978).

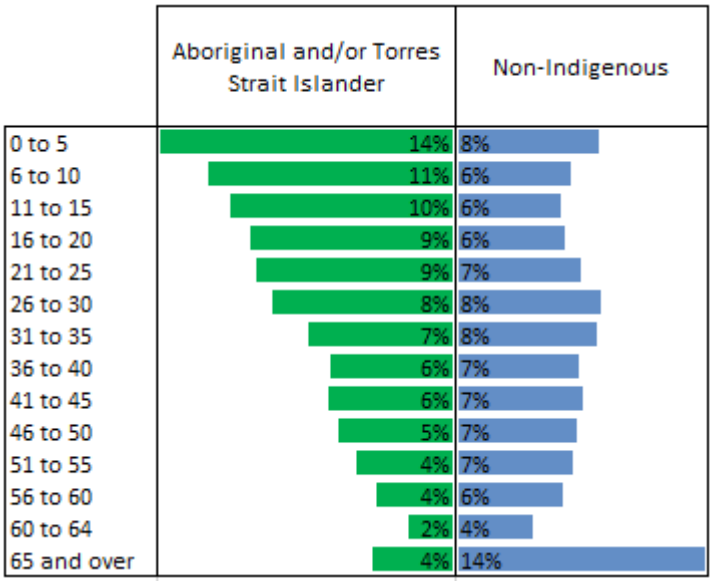
Figure 29: Aboriginal and non-Aboriginal young people in Western Australia – 12 to 24 years, 2016



Source: Australian Bureau of Statistics, 2016, Estimates of Aboriginal and Torres Strait Islander Australians

Figure 30 shows the age group distribution for Aboriginal young people and shows the relatively young age profile of Aboriginal people compared with non-Aboriginal people in Western Australia.

Figure 30: Age group distribution for Aboriginal and non-Aboriginal young people in Western Australia – 12 to 24 years, 2016[149].



Source: Australian Bureau of Statistics, 2016, Estimates of Aboriginal and Torres Strait Islander Australians

5.1.1 Overview of what the evidence tells us

- Aboriginal young people face multiple factors that increase the risk of mental health and AOD issues. These include intergenerational trauma, multiple and cumulative life stressors, stigma and marginalisation,[150] inadequate access to mental health and AOD services compared to the level of need, and exposure to suicide[151,152].
- As a result, Aboriginal young people are disproportionately impacted by mental health-related issues. A national Youth Survey 2018[153] found that nearly one third (31.9%) of Aboriginal respondents (aged 15 to 19 years) experienced psychological distress, compared to 23.9% of non-Aboriginal respondents.
- In 2014-15, across all states and territories, the proportion of Aboriginal young people (aged 15 to 24 years) reporting high to very high psychological distress was highest in Western Australia at 44%[154].
- In Western Australia, Aboriginal young people (aged 5 to 17 years) are eight and a half times more likely to die by suicide than non-Aboriginal young people[155]. This over-representation is consistent with findings published in the 2020 Ombudsman Western Australia Report,[156] which found that out of 115 suicide cases investigated (10 to 17 years), 37% were Aboriginal.
- In 2014-15, most Aboriginal young people (aged 15 to 24 years) in Australia had consumed alcohol, although not frequently[157].
- Older Aboriginal young people (aged 20 to 24 years) are more likely to consume alcohol than those aged 15 to 19 years[158].
- Approximately 67% of Aboriginal young people in Australia (aged 15 to 24 years) had not used illicit substances. However, for the young people who reported using illicit substances, cannabis was the common drug used[159].

5.1.2 Current responses

Mainstream mental health and AOD services from which the Mental Health Commission purchases services are required to provide culturally appropriate and secure services as part of their contracting arrangements.

The Mental Health Commission also funds and/or provides the specific initiatives set out below:

- **Strong Spirit Strong Mind Metro Project** (targets young people) - A culturally secure, AOD prevention project developed specifically for Aboriginal young people (aged 12 to 25 years) living in the Perth metropolitan area. The project includes delivery of a public education campaign which aims to prevent and delay the uptake of AOD amongst Aboriginal young people and increase their awareness of available support services. Project activities include an Aboriginal Youth Reference Group that provides culturally secure advice on campaigns, development of youth-specific promotional resources, and training and upskilling opportunities for services that work with Aboriginal youth.
- **Aboriginal Family Wellbeing project** - This project acknowledges social and emotional wellbeing as a significant contributor to the prevention of death by suicide by Aboriginal people (including but not limited to young people). The project aims to address the physical, mental, emotional, and spiritual issues that impact on an individual's wellbeing, family unity, and community harmony through building capacity within Aboriginal organisations and their surrounding communities, through the delivery of an adapted version of the Certificate II Family Wellbeing course.
- **Suicide Prevention frameworks** - Suicide Prevention 2020: Together we can save lives, and the Western Australian Suicide Prevention Framework 2021-2025 (Suicide Prevention Framework) acknowledge the increased risk of suicide for Aboriginal people and include a specific stream for Aboriginal people that empowers the Aboriginal community to develop regional Aboriginal suicide prevention plans that focus on support, aftercare and postvention, including activities for young Aboriginal people.
- **Specialist Aboriginal Mental Health Service Metropolitan (Wungen Kartup)** - An adult service with a whole-of-family approach that provides statewide consultation/liaison with service providers and the community, and advocacy for Aboriginal consumers. This service also operates as a peak body for Aboriginal mental health professionals.

There is also a network of **Aboriginal Community Controlled Health Organisations** across the State. These are federally funded organisations, initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate primary health care to the community (including but not limited to young people) which controls them (through a locally elected Board of Management). Aboriginal Community Controlled Health Organisations are supported by the Aboriginal Health Council of Western Australia.

Together with other government agencies, the Mental Health Commission has supported the **Commitment to Aboriginal Youth Wellbeing**,[160] (and its precursor Statement of Intent on Aboriginal Youth Suicide[161]), which seeks to address the social determinants of health and wellbeing including housing, employment, health and nutrition. For example, Commitment 9 focusses on better engagement with education, and Commitment 11 seeks to build youth capacity to develop the skills, knowledge and experience required to live healthy, confident and independent lives.

The Commitment to Aboriginal Youth Wellbeing was developed as part of the State Government's response to a range of reviews, reports and inquiries into deaths by suicide by young Aboriginal people, including:

- The State Coroner's Inquest into the Deaths of Thirteen Children and Young Persons in the Kimberley Region, Western Australia[162].
- Learnings from the message stick: the report of the Inquiry into Aboriginal youth suicide in remote areas[163].

In addition, the **National Agreement on Closing the Gap** (Agreement) aims to overcome the entrenched inequality faced by too many Aboriginal people so that their life outcomes are equal to all Australians. This Agreement addresses a range of key wellbeing factors for Aboriginal people through four priority reform areas and 16 socioeconomic outcomes. This includes the following outcome which relates to improving social and emotional wellbeing:

- *Outcome 14: Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing*, which seeks to achieve a significant and sustained reduction in suicide of Aboriginal people towards zero.

All Ministers have a role in implementing this Agreement. The Western Australian Government is committed to making progress against the targets of the Agreement and will co-design and develop WA's Implementation Plan in partnership with the Aboriginal Advisory Council of WA.

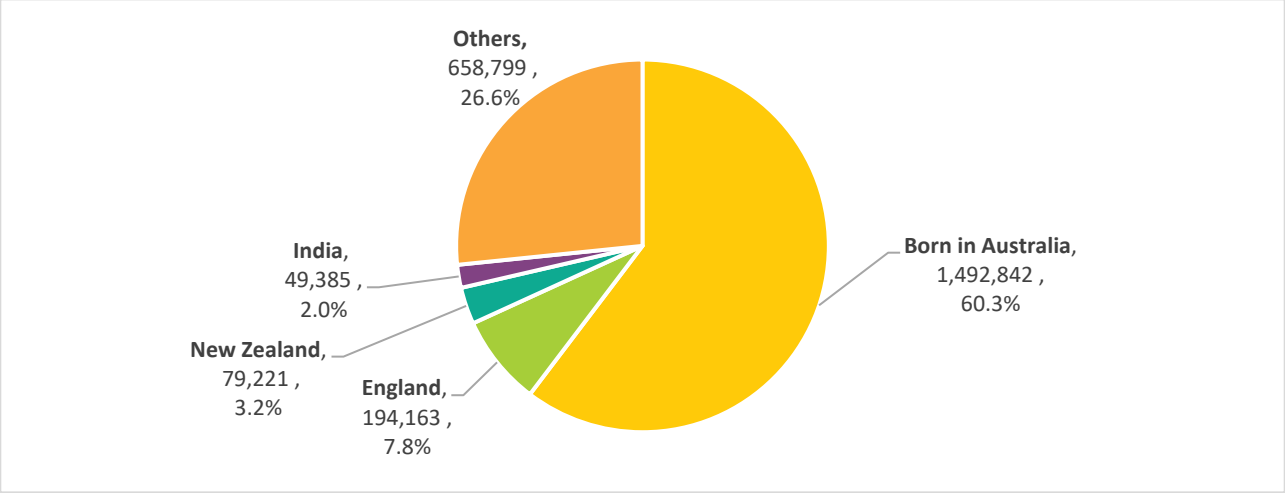
5.2 Young people from culturally and linguistically diverse (CaLD) backgrounds

For the purposes of this document, culturally and linguistically diverse (CaLD) is intended to be a broad, flexible and inclusive term. This term is generally applied to groups and individuals who differ according to religion, language and ethnicity and whose ancestry is other than Aboriginal or Torres Strait Islander, Anglo Saxon or Anglo Celtic.

Adapted from the Western Australian Multicultural Policy Framework[164]

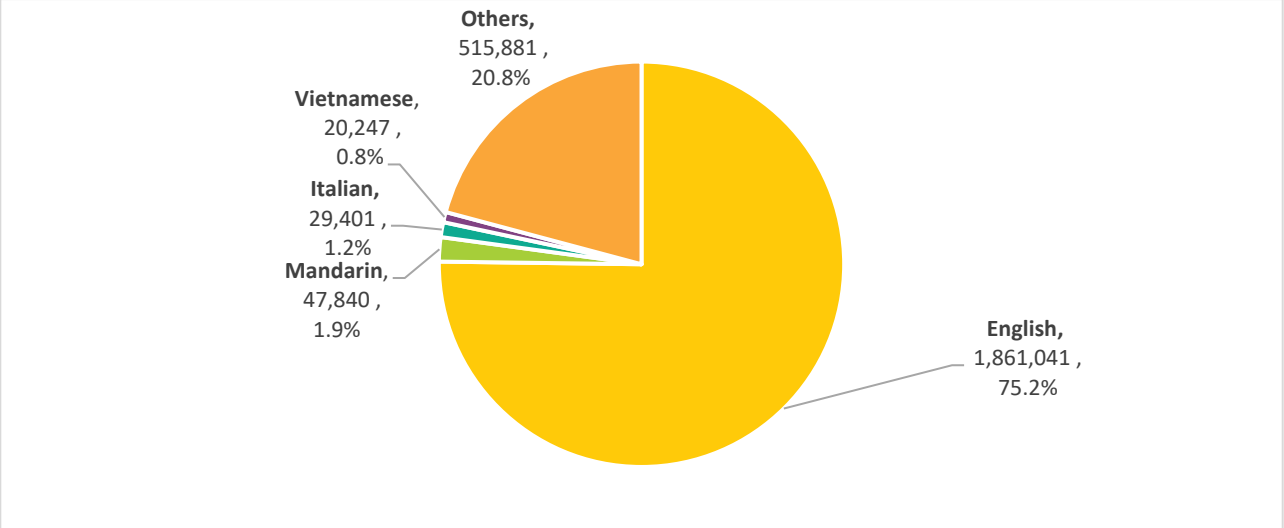
Results from the 2016 Australian Census[165] indicated that 39.7% of the Western Australian population were born outside of Australia (16% in non-main English-speaking countries; Figure 31), and 24.8% reported speaking languages other than English at home (Figure 32).

Figure 31: Proportion of young people in Western Australia who were born overseas – 12 to 24 years, 2016



Source: Australian Bureau of Statistics, 2016, Australian Census

Figure 32: Proportion of young people in Western Australia who spoke a language other than English at home – 12 to 24 years, 2016



Source: Australian Bureau of Statistics, 2016, Australian Census

5.2.1 Overview of what the evidence tells us

- Authoritative and comprehensive information about the mental health and AOD issues for young people from CaLD backgrounds, especially within Western Australia, is not available. Recent literature reviews commissioned by the Mental Health Commission found that there is no reliable research on the mental health of individuals from CaLD backgrounds in Western Australia[166], and there is limited prevalence data regarding AOD use[167].
- The lack of reliable data can be attributed to[168]:
  - use of English-language surveys creating a barrier for non-English speaking individuals
  - low survey participation rates
  - stigma associated with mental health and AOD issues amongst CaLD communities
  - lack of awareness as to how to appropriately collect CaLD data indicators.
- Young people from refugee and migrant backgrounds may experience a range of factors which negatively impact their mental health and wellbeing including separation from family, low socioeconomic status, insecure housing, lack of social networks, trauma, racism, discrimination and low levels of English proficiency[169].
- Stakeholder consultation has identified increases in racism during the COVID-19 pandemic as significantly impacting the mental health of young people from CaLD backgrounds.
- While young people from CaLD backgrounds are at greater risk of mental health issues due to the factors identified above, they often access mental health services at a lower rate compared with all young people,[170,171] which puts them at further risk of poorer life outcomes.
- Protective factors for mental health and suicide prevention among young people from CaLD backgrounds include family and community cohesiveness; sense of belonging; awareness of, and access to appropriate health services; and religious beliefs[172].
- The Australian Institute of Health and Welfare finds that people whose main language spoken at home is not English are more likely to abstain from AOD use compared to those whose primary language at home is English[173].
- Young CaLD people are also under represented at AOD treatment services, which could be due to barriers to access rather than a lower requirement for such services[174]. Some barriers include (but are not limited to):
  - limited access to appropriate cultural programs and services
  - language barriers
  - lack of awareness of support and services available
  - lack of trust in service providers
  - lack of mental health literacy

- stigma, shame and stereotypes associated with AOD use
- strong desire to be accepted by the welcoming country.

5.2.2 Current responses

Recommendation 43 of the Methamphetamine Action Plan Taskforce Report recommended that the Mental Health Commission, in consultation with the Office of Multicultural Interests and CaLD communities, should undertake and report on research and consultation to identify the use of illicit drugs, including methamphetamine, among CaLD communities in Western Australia. The scope of this research and consultation was later expanded to include mental health.

The mental health component of this research was guided and informed by the Multicultural Mental Health Sub-network, which is one of 10 advisory networks supported by the Mental Health Commission, to assist with implementing the Plan and identify emerging needs of the mental health sector in Western Australia.

The Mental Health Commission recently completed this research, and the findings and recommendations will be considered in the context of the Multicultural Policy Framework[175] and through the development of the Mental Health Commission's Multicultural Plan (both of which are currently in progress).

5.3 Young lesbian, gay, bisexual, transgender, queer, intersex, asexual or questioning (LGBTQIA+) people

'*Not having to educate my mental health services on LGBTI or culture or religion or occupation or recreational activities before receiving care. I should not be paying for me to provide them education instead of receiving care*'

LGBTI Health Strategy 2019-2024, Department of Health[176]

A 2016 population study estimated that 2.6% of the Western Australian population aged 18 and over identify as non-heterosexual[177]. This estimate is consistent with other studies that place the prevalence of LGBTQIA+ people in Australia at 3% (aged 16 to 69 years)[178] to 4.6% (14 to 19 years)[179].

5.3.1 Overview of what the evidence tells us

- Identification as LGBTQIA+ in and of itself is not a precursor to mental health and AOD issues. However, young LGBTQIA+ people are at heightened risk of mental health and AOD issues. This is due to their experiences of stigma, discrimination, exclusion[180], and a range of social, cultural and legal barriers they face because of their sexuality and gender[181].
- Many young LGBTQIA+ people also reported experiences of verbal (61%) and physical homophobic abuse (18%), 80% of which had been experienced in the school setting[182]. These types of experiences contribute to an increased risk of mental health and AOD issues[183].
- As a result, young LGBTQIA+ people (aged 16 to 24 years) have the highest rate of psychological distress of all age groups[184]. Compared to the general population, young LGBTQIA+ people aged 16 to 27 years are five times more likely to attempt suicide[185].
- With respect to young transgender people in particular: three quarters (74.6%) of young transgender people (aged 4 to 25 years) are diagnosed with depression at some time in their lives[186]; over three quarters (79.7%) of young transgender people (aged 14 to 25 years) have self-harmed; and almost half (48.1%) have attempted suicide at some point in their life[187].
- Young LGBTQIA+ people are more likely than the general population to smoke daily, misuse pharmaceuticals, consume alcohol in risky quantities, and use illicit drugs[188].
- Young LGBTQIA+ people experience a number of barriers to accessing health services[189,190] including: internalised homophobia; discrimination and/or exclusion; reduced awareness and

knowledge among healthcare professionals; and previous negative experiences with health services.

5.3.2 Current responses

The Mental Health Commission funds the initiatives set out below:

- **Gender Diversity Service** - this Service provides clinical multidisciplinary assessments and intervention for children and young people under 18 years of age who are experiencing gender diversity issues. The service also offers referral pathways, access to an expert assessment service, and provision of gender affirming information and treatment (if appropriate). The Service also offers treatment for identified severe psychological distress, psychological comorbidity, and advocacy to reduce social adversity experienced by children due to gender dysphoria.
- **WA AIDS Council Inc (the Freedom Centre)** - the Freedom Centre provides support to young people, families and whole communities to be healthy, happy and informed about diverse sexuality, gender and sex[191]. The Mental Health Commission provides funding to the Freedom Centre for the provision of prevention and support services for young people (aged under 26 years) who identify as LGBTQIA+. Programs supported by this funding include peer support, workshops, education, policy advice and information sessions for professionals.
- As part of the statewide suicide prevention strategy, **Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)**, a range of initiatives to support LGBTQIA+ young people have been funded, including peer support workshops and suicide prevention training for the LGBTQIA+ community (including but not limited to young people).

5.4 Young people living in regional, rural and remote areas

'*I think people don't really understand mental health as much ... I feel like people get very uncomfortable about it because … in the country there's a big emphasis on being rough and being tough ...*'— Male, 17, WA

ReachOut Australia and Mission Australia[192]

As at 30 June 2019, there are 56,463 young people (aged 15 to 24 years) living in rural, regional and remote areas of Western Australia, which is 17.5% of all young people aged 15 to 24 years in Western Australia[193].

5.4.1 Overview of what the evidence tells us

- Young people in regional, rural and remote areas often have higher levels of social connectedness, sense of belonging and general life satisfaction, and have a greater knowledge of where to go for help and support within their community than young people in the metropolitan region[194].
- However, a 2018 report by ReachOut Australia and Mission Australia[195] found that young people living in rural, regional and remote areas experienced feelings of loneliness and isolation, and that there were limited opportunities for employment, which impacted on their sense of purpose.
- Research has also estimated that one in four young people in regional and remote Australia had a probable serious mental illness[196].
- Compared on a national basis, remote Western Australia had the highest proportion of people (aged 14 years and older) who drank alcohol at levels that placed them at harm over a lifetime (36%)[197].
- Alcohol consumption among people living in Australian regional, rural and remote areas is significantly higher than those living in major cities[198]. In Western Australia, alcohol consumption for those aged 14 years and above living in outer regional and remote areas is significantly higher than their counterparts living in major cities[199].
- Remote Western Australia also had the highest proportion of people (14 years and older) reporting recent illicit drug use (36%)[200].

- Barriers to accessing services for young people in regional, rural and remote areas include:[201] perceived and self-stigma; services and gatekeepers not being seen as approachable and trustworthy; location of services requiring travelling long distances; current waitlists and limited opening hours; and concerns regarding privacy and confidentiality.

5.4.2 Current responses

The Mental Health Commission funds a range of initiatives which aim to address the mental health and AOD needs of people living in regional and remote areas across the State. While existing services cater to younger people where appropriate and possible, it is acknowledged that there are limited youth-specific services available across the regions.

- **Community Alcohol and Drug Services** – The Mental Health Commission provides funding to Community Alcohol and Drug Services which are delivered by non-government organisations located in metropolitan, regional and remote areas across the State. Whilst not a dedicated youth service, these services generally provide AOD support and treatment for those aged 14 years and older.
- **Suicide prevention coordinators** – As part of the current statewide suicide prevention strategy Suicide Prevention 2020: Together we can save lives, the Mental Health Commission has funded the placement of 10 Suicide Prevention Coordinators across the State, to build the capacity for community and relevant service providers to better identify and address local suicide-related issues and work in a collaborative manner.
- **WA Primary Health Alliance/Mental Health Commission Joint Regional Plans** - In line with the Fifth National Mental Health Plan, the Mental Health Commission and WAPHA, together with the five Health Service Providers, collaborate in the development of joint regional plans. WAPHA and the Mental Health Commission, work together to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.
- **Kimberley Youth AOD service** - As part of the 2019-20 Budget, the State Government allocated $9.2 million for the development of a comprehensive, specialist AOD service for young people with complex needs and their families. The model of service is being co-designed with a range of stakeholders across the Kimberley, including community Elders and young people. The co-design of the model will include consideration of residential rehabilitation, low medical withdrawal and stabilisation, day programs (including 'on-country' programs), family intervention, co-occurring mental health and AOD issues, and links with existing service providers in the Kimberley. Co-design of the model of service re-commenced in July 2020 after being delayed due to COVID-19 related travel bans across Western Australia. The model of service is now scheduled for delivery in December 2020, with operational service commencement planned for December 2021.
- **Kimberley Juvenile Justice Strategy:** As noted previously, initiatives funded under the Kimberley Juvenile Justice Strategy include safe place activities and night patrols where young people who are unsupervised, or street present are engaged in constructive activities to reduce their risk of engaging in antisocial and offending behaviour. The strategy also aims to expand access to alternative education and vocational programs, and the provision of targeted culture based intensive programs that address mental health, AOD and behavioural issues for young people in the Kimberley.

5.5 Young people with co-occurring intellectual, cognitive or developmental disability (including autism spectrum) and mental health, alcohol and other drug issues

"*For me personally I have a co-occurring mental illness diagnosis with a disability, being that I am also autistic. I have been passed from pillar to post trying to access a suitable community support that encompasses both of my disabilities. I would love there to be more accessible community mental*

health services for people that also live with a co-occurring disability… I am fed up of being siloed into boxes, with services saying we don't deal with autism or we don't deal with mental health issues"

Increasing and Improving Community Mental Health Supports in Western Australia[202]

- In Australia, it is estimated that 9% of young people aged 15 to 24 years are living with a physical, intellectual, psychological, or sensory/speech disability, or a disability related to a head injury, stroke or brain damage[203].
- In Australia, approximately 48% of people aged 15 to 64 years with a severe disability also experience mental health issues, compared with 6% of the general population[204].
- In respect to psychosocial disability[xxiv], some evidence suggests that approximately 4.5% of Australians reported having a psychosocial disability[205]. This rate has increased over time, with the largest increase being for people aged 15 to 24 years[206].
- At 30 September 2020, 12,087 National Disability Insurance Scheme (NDIS) participants with an approved plan in Western Australia had Autism as their primary disability. This accounts for 35% of all Western Australian NDIS participants[207].
- Evidence suggests that up to 70% of children with autism aged 10 to 14 experience at least one mental health issue[208].
- There are a number of mental health issues which commonly co-occur with Autism and include (but are not limited to) ADHD (28%), anxiety disorders (20%), sleep-wake disorders (13%), impulse control and conduct disorders (12%), and depressive disorders[209].

5.5.1 Overview of what the evidence tells us

- Young people with chronic illness, disability, or an intellectual disability are more likely to have mental health issues than the general population[210].
- Young people with an intellectual disability have also been identified as a group at risk of negative consequences of AOD use and increased likelihood of AOD-related issues[211].
- Research emphasises the complexity of providing appropriate care for people with co-existing disability, noting that services are often ill-equipped and need workforce planning, succession planning and more specialised training to respond to complex mental health needs[212,213].
- The presence of complex issues or co-occurring disability among school students in particular is a significant and common challenge in accessing specialised mental health care[214].

5.5.2 Current responses

The Chief Psychiatrist reported in his 2019-20 Annual Report[215] that there is currently no specialised coordinating structure or services for individuals with co-occurring intellectual or neurodevelopmental disabilities and mental illness, and that current mental health services often do not meet the needs of this group. He reported that to improve standards, Western Australia needed to work towards a coordinated process for this group.

One of the guiding principles of the Plan is that services are to meet the needs of people with co-occurring problems including co-occurring mental health and AOD issues, as well as physical health problems, disability and trauma. The Plan also recognises the need to enhance workforce capabilities to manage intellectual, cognitive or developmental disability (including Autism Spectrum Disorder), and Attention Deficient Hyperactivity Disorder. Establishment of a specialised service for people with co-occurring mental health issues and intellectual, cognitive or developmental disability (including Autism Spectrum Disorder) is also a key strategy of the Plan.

The Western Australian Council of Social Service has developed a core capability framework 'with an aim to achieving access to high quality mental health services and a seamless pathway for people with intellectual disability and a co-occurring mental health issue, their carer, family members or guardians'[216]. This framework has been developed with input from a broad range of stakeholders, including government agencies, service providers, consumers, families, and carers, and focusses

[xxiv] Psychosocial disability is a term used to describe a disability that may arise from a mental health issue.

on how best to provide services for, and respond to the needs of, those with intellectual disability and mental health issues.

5.6 Children in contact with the child protection system

'*I am still stuck in the system because there is nowhere for me to go. My Advocate has supported me at many big meetings with youth mental health services and Child Protection, who are trying to work out what to do. There have been so many meetings! I try and contribute but it's hard to focus and remember everything everyone is saying*.'

2018-19 Annual Report, Mental Health Advocacy Service[217]

As at 30 June 2020, there were 5,498 children in the care of the Chief Executive Officer of the Department of Communities (referred to in this Paper as 'children in care')[218].

5.6.1 Overview of what the evidence tells us

Children in care

- Aboriginal children are significantly over-represented among children in care; 3,082 (56.06%) of children in care at 30 June 2020 were Aboriginal, and 2,416 (43.94%) children were non-Aboriginal[219].
- Many children in care have experienced emotional, physical and/or sexual abuse, and neglect (including family and domestic violence). These experiences cause significant harm, which is cumulative over time, and the experience of being taken into care itself can also be traumatic.
- In turn, such experiences impact on a child's development. For example, in a Victorian study of children entering care for the first time, the study's authors found that '60% of participants met the criteria for a major psychiatric diagnosis, with post-traumatic stress and adjustment disorders being the most common diagnostic types.'[220]

Children leaving care

- Young people leave care when they turn 18 years of age and are then referred to as 'care leavers'. However, data suggests that young people often leave care between the ages of 10 to 14 years, with 78% of children leaving care under the age of 15 in Western Australia[221].
- Young people leaving care are at higher risk of unemployment, homelessness and problematic AOD use than young people who have not been in care[222]. For this reason, the Department of Communities, collaborating with community sector partners, provides support for care leavers up until the age of 25 years.

Children who are known to the Department of Communities

- In the 2019-20 year, the Department of Communities responded to 18,022 notifications relating to 18,328 children at risk of abuse and harm, and conducted 14,192 child safety investigations[223].
- The 2020 Ombudsman Western Australia Report[224] found that, of the 115 suicide cases aged 10 to 17 years investigated between 1 July 2009 to 30 June 2018, 69 (60%) were known to the Department of Communities; these 69 young people had been the subject of child protection reports raising concerns about their wellbeing.
- One third of the 1,000 young people that used the most state provided mental health services had either a period of care or had at least one child safety investigation by Child Protection and Family Support[225].

5.6.2 Current responses

It is a key role of the Department of Communities to support children and young people who are in out-of-home care, as follows:

- The Department of Communities assesses each child entering care, including to identify and address mental health and AOD concerns. The Department of Communities also undertakes tailored care planning for each child in care, including obtaining mental health and AOD treatment and support that the child needs.
- While the Department of Communities has a lead role in promoting the wellbeing of children in care, other State Government agencies have a shared responsibility to actively support these children and provide a priority service response, including to mental health and AOD services. Amendments to s.22 of the *Children and Community Services Act 2004* are proposed to help strengthen the responses by key State Government agencies to provide children in care with a priority service response.
- The Department of Communities also administers several programs to support young people leaving care, including **Home Stretch** (in conjunction with Anglicare WA), plus three **leaving care services** that provide information and support to young people aged 15 to 25 years who are or have been in care to move to independence.

5.7 Young people in contact with the justice system

'In comparison to young people in the community, young people in custody have poorer physical and mental health and are more likely to have a history of alcohol and illicit drug use and dependence. The custodial environment provides a unique opportunity to assess and manage the needs of young people who may not otherwise have access to services where these needs can be identified and met'.

Justice Health & Forensic Mental Health Network and Juvenile Justice NSW[226]

- In 2019-20 the average daily detention population (persons under 18 years of age) was 107[227].
- In 2019-20 the average daily prison population of persons 18 to 24 years inclusive was 907[228].
- In 2019-20 the average daily population of young people (persons under 18 years of age) supervised in the community was 1,305[229].

5.7.1 Overview of what the evidence tells us

- It is recognised that young people in contact with the justice system[230] are some of the most vulnerable and disadvantaged of all Australians[231].
- The prevalence of mental health issues among young people at every stage of the criminal justice process is higher than in the general community[232].
- Internal Mental Health Commission modelling estimates that approximately 65% of the juvenile detention population in Western Australia are known to have experienced mental health issues, approximately three times the prevalence of the general population[233].
- A 2017 study found that 36% of young people (13 to 17 years) within the only Western Australian juvenile justice centre fulfilled the criteria for FASD[234].
- Young people in the youth justice system have suicide prevalence rates four-times that of other young people, with high levels of suicidal ideation (29%) and a history of attempted suicide (21%), with 7% making a recent attempt[235].
- Research also suggests that those involved in youth justice systems (including but not limited to Western Australia) are a population at increased risk for developing serious and chronic mental illness[236].
- Aboriginal young people are even more over-represented in the juvenile justice system than they are in the adult criminal justice system with 74% of young people under 18 detained in custody[237] in WA and 54% of youth managed in the community[238] being Aboriginal in June 2020.
- Of the 7,850 young people under youth justice supervision in Australia (2012 to 2016), 1 in 3 (33%) received an AOD treatment service at some time during the study period, which is 30 times the rate of AOD treatment services for the Australian population of the same age (1%)[239].
- Research has identified that the mental health support received by young people in detention has the potential to prevent a lifetime of involvement in the criminal justice system[240].

5.7.2 Current responses

Whilst there are some mental health and AOD services available for young people in contact with the justice system (as listed below), there are currently no adolescent beds within Health Services specifically allocated for those in detention requiring admission. If a young person in custody requires inpatient treatment, there are three options, all of which are deeply unsatisfactory, and contrary to basic human rights and ethical standards of service provision.

- The first (and most common) is to remain unwell in custody, where there is no fit-for-purpose accommodation for their safe care and treatment.
- Secondly, admission can take place to the Perth Children's Hospital (if aged under 16) or to one of two Youth Mental Health Units for offenders aged 16 to 18 years in South Metropolitan Health Service and East Metropolitan Health Service. None of these units are designed for the safe and secure containment of those in Department of Justice custody.
- The third option, in exceptional circumstances, is admission to the Frankland Centre, where the adolescent will be accommodated on a forensic acute mental health ward with adult serious offenders who are also severely mentally unwell. It is difficult to meet their needs in such an environment, and difficult to maintain their safety, when they are potentially most vulnerable. It also violates their rights under the *Mental Health Act 2014* to be treated in an environment and with specific interventions appropriate to their developmental needs, sufficiently separated from where adults are being treated.

Excerpt from Forensic Youth Mental Health Mapping of Pathways: Access to Care[241]

Services/programs for young people under 18 years include[xxv]:

- **Children's Mental Health Court Diversion Program (Links):** Links provides a consultation and liaison model of support and linkage with appropriate service providers for young people who are appearing before the Perth Children's Court with suspected mental health issues. Links has a clinical team that is based within the Court, and a non-government community support team that provides assertive case coordination and support in the community.
- **Young Person's Opportunity Program (YPOP):** YPOP aims to divert young people (12 to 17 years-of-age inclusive) with low level offending who are in contact with a juvenile justice team (JJT) and who have emerging drug-related problems. In the Perth metropolitan area, referrals to YPOP are generally directed to the dedicated YPOP Diversion Officer at the Drug and Alcohol Youth Service. Outside the metropolitan area, Community Alcohol and Drug Services provide treatment for low level offending via JJT referrals; and for more serious offending via Court Conferencing referrals or community-based supervision orders.
- **Children's Court Drug Court:** The Children's Court Drug Court is based in Perth and operates a diversionary program for young people (aged 10 to 18 years) who have committed drug-related offences and want to receive treatment and support to make changes. The Children's Court Drug Court has two streams:
  - **Drug Court Regime:** For young people who have committed serious offences because of their substance use and who are facing immediate detention. This is a pre-sentence program that can run for up to 12 months.
  - **Youth Supervised Treatment Intervention Regime:** For young people with relatively less serious offences and drug-related problems than those who would otherwise be considered for inclusion in the Drug Court Regime.
- **Cannabis Intervention Requirement**: A statewide police diversion scheme for minor cannabis offences. Individuals aged 14 years and older are eligible.
- **Banksia Hill Detention Centre**: Currently, mental health service delivery at Banksia Hill Detention Centre includes the following:

[xxv] Please note, generally, matters related to offending that occur while the young person is under 18 are seen in the Children's Court and remain in that jurisdiction until sentencing. There are a few exceptions, particularly for more serious offences, where the Children's Court may transfer the matter to the Magistrates Court or a higher court.

- a three-tiered, trauma and culturally-informed age and developmentally based model that provides young people with services to address their assessed mental health needs
- allocation of one Full Time Equivalent (FTE) Mental Health Nurse, available Monday to Friday
- allocation of one Psychiatrist from the State Forensic Mental Health, who visits one day per week (two sessions)
- 6.4 FTE Clinical, Counselling/Forensic Psychologists based at Banksia Hill Detention Centre. The team works in collaboration with mental health staff in providing services to young people dealing with complex trauma histories and mental health issues, and who may be at risk of suicide.

Services/programs for young people over 18 years include:

- **Secure inpatient mental health services (The Frankland Centre)**: A high security forensic inpatient unit with 30 beds located on the Graylands Campus. Referrals are statewide, originating from the courts (Hospital Orders and Custody Orders) and prisons.
- **Forensic non-acute low secure inpatient service**: up to 6 beds are available for rehabilitation of patients who are transitioning out of high secure care.
- **Community Forensic Mental Health Service**: The Community Forensic Mental Health Service provides:
  - assertive case management for individuals living in the Perth metropolitan area who have severe and enduring mental illness and who present a high risk of serious reoffending in the community
  - a Court Liaison Service to all the Courts in Western Australia (in-person to metropolitan courts, and via videoconference to regional courts)
  - consultation and liaison service to local mental health services.
- **General mental health services:** Most mental health consumers coming into prison are known previously to general mental health services and most are referred to their local mental health service on release.
- **Mental Health Court (Start Court)**: A dedicated specialist mental health court located at Central Law Courts which provides assistance, support and specialist community treatment programs for individuals facing criminal charges with a mental illness.
- **General Court Intervention Program:** A Department of Justice three-year pilot program at the Perth Magistrates Court. This program provides a 12-week assessment and case management service for people on bail, which aims to address their identified needs, including mental health and AOD needs, through community programs and services.
- **Other Drug Intervention Requirement**: A statewide police diversion scheme for simple drug (other than cannabis) offences. Individuals aged 18 years and older are eligible.
- **Alcohol and Other Drug Diversion Program**: A statewide voluntary court diversion program available in Magistrates Courts suitable for adult early and low to moderate level offenders 18 years and over with AOD related problems.
- **Perth Drug Court**: A dedicated specialist drug court, operating in the Perth Magistrates Court. The court accepts referrals from the District and Supreme Courts, and other Magistrates Courts around the state. The Drug Court programs include:
  - **Drug Court Regime:** A pre-sentence program for participants with significant offending histories and significant drug related problems, who are facing current, serious charges.
  - **Pre-Sentence Order:** A pre-sentence program for participants who otherwise would be facing an immediate and substantial prison sentence.
- **Mental Health Co-Response (MHCR) team**: MHCR is a crisis intervention model that aims to provide the individual with a pathway to mental health treatment and support. In the metropolitan area mental health practitioners are co-located in the police operations centre, with mobile police teams attending mental health related police tasks and in the police watch-house. Whilst the MHCR mobile teams report very low numbers of engagements with children and adolescents, they do still respond to this cohort experiencing mental health crisis in the community. Referral to

a GP is a common practice by the MHCR clinician to enable the young person to receive a managed Mental Health Care Plan.

- **Prisons**: Mental Health and AOD nurses and counsellors employed by the Department of Justice work closely with psychiatrists, some employed by the Department of Justice and some by the Statewide Forensic Mental Health Service to provide mental health care to people in prison. The aim is to provide the equivalent care that a specialist community mental health team would provide. They refer acutely unwell prisoners to the Frankland Centre but often have to manage acutely unwell people in prison due to a shortage of forensic mental health beds. Services and programs within prisons include:
    - **Prison in-reach transition team** a team from the Statewide Forensic Mental Health Service assist the prison mental health teams to refer their patients for specialist follow up in the community by community mental health teams.
    - **A prison outreach program** in which psychiatric clinics are provided in the metropolitan prisons and three regional prisons to assist the Prison Medical Service in providing appropriate psychiatric follow-up for prisoners with significant but stable psychiatric conditions.
    - **A Parole in-reach Pilot Program (PiP)** involving the delivery of additional rehabilitation (including AOD) is operating at Acacia Prison and Wooroloo Prison Farm. Additionally, the PiP will also support paroled offenders in the community via the provision of 'through-care' treatment programs in the community.
    - **Female AOD treatment facility Wandoo Rehabilitation Prison** is an AOD treatment facility for up to 77 female prisoners. It commenced operation in August 2018.
    - **Male AOD treatment facility** Mallee Rehabilitation Centre is an AOD treatment facility for up to 128 male prisoners at Casuarina Prison. It commenced operation in October 2020.
    - **New Mental Health Prison Units**, in October 2020, a new 32-bed mental health facility was opened at Bandyup Women's Prison. Another 34-bed facility is to open at Casuarina Prison in the near future. Prisoners can receive appropriate MHAOD care, treatment and observation from appropriately skilled staff in these dedicated safe and therapeutic spaces.

Over the past decade, various reports and reviews have identified deficiencies in forensic mental health services for children and young people. The CCYP's *Our Children Can't Wait Report* recommended that the development of a dedicated youth forensic mental health service be undertaken as a high priority. The *Report of the Forensic Youth Mental Health Mapping of Pathways: Access to Care Working Group* recommended the development of a statewide forensic youth mental health stream within the health system; and the embedding of youth forensic beds within that stream.

In the 2019-20 Budget, through its Community Health and Hospitals Program, the Commonwealth Government committed to establishing a 10-bed youth forensic mental health inpatient service in Western Australia.

As identified in the Plan and reinforced in the Plan Update 2018, dedicated forensic services for young people are a high priority, in particular prevention and early intervention programs, specialised assessment, liaison with mainstream services, in-reach to police lock-ups, community forensic services, forensic inpatient services, in-reach to juvenile detention centres, community correction programs, and transition care (between the detention centre and community). Modelling also suggests a significant increase in hospital forensic services is urgently required.

5.8 Young people with complex needs

Complex needs[242,243] refers to the needs that a person may present with to mental health and/or AOD service in addition to other co-existing issues, such as cognitive impairment (including intellectual disability, acquired brain injury and FASD) and/or involvement with the criminal justice system.

These ‘needs’ are often severe and/or long standing, often proving difficult to ascertain, diagnose or treat. Individuals with complex needs are often at a crisis point and experience barriers to accessing services; usually requiring support from a range of services /agencies.

A person with complex needs may have a variety of the following:

- mental health and/or AOD issues, including when they co-occur
- a physical health condition
- a disability
- a history of offending behaviour
- employment problems
- homelessness or housing issues
- family and domestic violence
- social isolation
- poverty
- trauma.

For example, people with FASD often experience a range of health and psychosocial consequences including disrupted education, difficulties gaining employment, mental health and AOD use issues, and contact with the justice system[244,245].

5.8.1 Overview of what the evidence tells us

Many young people discussed above have multiple vulnerabilities, which places them at increased risk of mental health and AOD issues, including increased risk of suicide and self-harm[246,247,248].These multiple vulnerabilities also make providing appropriate and effective care and support more complex and difficult.

The Commissioner for Children and Young People’s Our Children Can’t Wait Report[249] and the 2020 Ombudsman Western Australia report[250] recognise the ongoing need to address the challenges faced by young people with complex needs in accessing appropriate specialised services.

Particular areas of concern are set out below.

<u>Family and Domestic Violence:</u>

A 2020 Report by the Domestic and Family Violence, Alcohol and other Drug and Mental Health Project Working Group[251] found that:

- Western Australia has the second highest rates of reported family and domestic violence of all jurisdictions in Australia
- experiencing family violence is a key social determinant of poor mental health for young people
- victims of family and domestic violence have higher rates of trauma-related mental health issues than those who have not experienced family and domestic violence
- children of mothers who have experienced family and domestic violence are more likely to access mental health services than those who have not.

Children and young people with sustained exposure to family and domestic violence may experience trauma symptoms that can have sustained effects on their development. These can include substance abuse, low self-esteem, anxiety, poor coping mechanisms, suicidal thoughts, eating disorders, and self-harm[252]. Furthermore, when a young person is also exposed to additional risk factors such as parental mental health and AOD issues; and socioeconomic disadvantage, more extreme negative outcomes can occur[253].

Exposure to family and domestic violence as a young person can also result in reduced social participation in early adulthood, physical and psychological disorders, suicidal ideation, behavioural difficulties, and homelessness[254]. The impact of family and domestic violence on homelessness

outcomes demonstrates the need for early intervention strategies that include mental health and AOD supports for women and children experiencing family and domestic violence[255].

Homelessness and housing:

Being homeless, or at risk of homelessness is key situational factor impacting young people. In Western Australia in 2017-18 young people were the fourth highest client group who were homeless or at risk of homelessness and accessing services[256]. Whilst Western Australia has the second lowest rate of homeless persons per 10,000 population for the 12 to 18 age group and the lowest rate of homeless persons per 10,000 population for the 19 to 24 age group compared to other jurisdictions (2016 Census), young people are still overrepresented compared to other age groups in Western Australia[257].

Research has found:

- Young people are one of the key population groups experiencing homelessness in Western Australia.
- Following a survey of 400 young people, 56% of homeless youth cases were found to have been linked to family and domestic violence; and 53% had been diagnosed with at least one mental health condition in their lifetime[258].
- homeless young people are more likely to have been exposed to AOD[259].
- following a survey of 298 young homeless people (13 to 25 years), approximately 90% had reported witnessing family and domestic violence; and 63% had been placed in some form of out-of-home care by the time they had turned 18[260].

5.8.2 Current responses

In addition to its five service streams, the Mental Health Commission provides specialised statewide services which offer an additional level of expertise or service response for people with particular clinical conditions or complex and high-level needs. However, it is also expected that general community treatment and inpatient services will have the capacity, capability and expertise to deliver effective, evidence-based care for a range of people with complex conditions such as personality disorder, conduct disorder, mood disorder, emotional dysregulation and those with a history of trauma[261].

Current initiatives which seek to respond to the needs of young people with complex needs include:

- **Young People with Exceptionally Complex Needs (YPECN) program** - an interagency initiative which aims to improve coordination across government agencies to reduce the barriers for young people with complex needs accessing services, and to improve their wellbeing and quality of life.
- **Target 120 project -** supports identified young people and families presenting with complex needs to reduce contact with the justice system and keep themselves and their community safe. This initiative aims to address the issues that increase a young person's likelihood of offending, including substance abuse, lack of housing, domestic violence, trauma, mental health issues, and poor attendance at school.

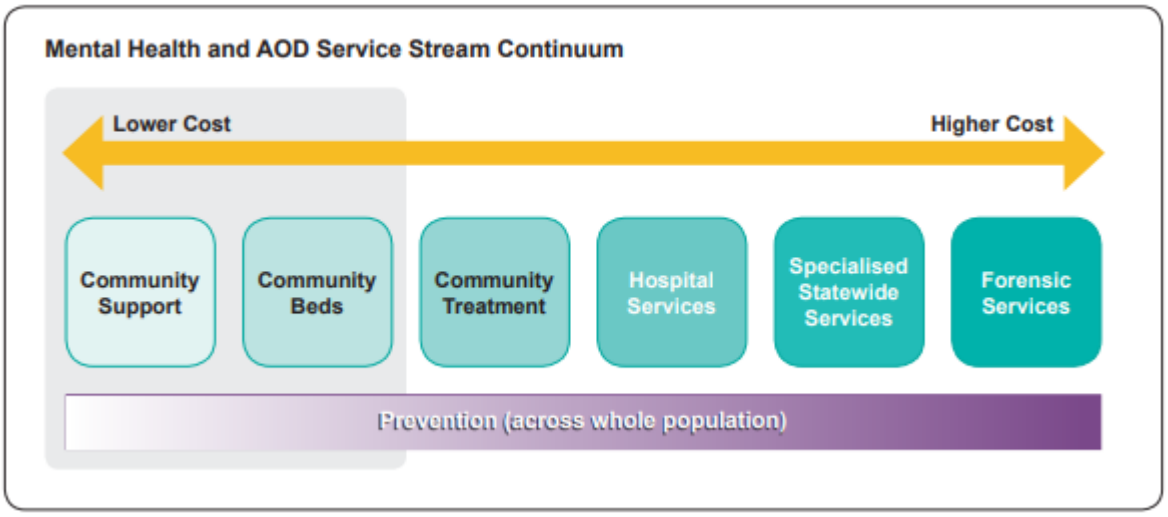
In addition, one of the recommendations from the 2020 Ombudsman Report includes a recommendation that Mental Health Commission, Department of Health, Department of Communities and Department of Education work collaboratively to develop and implement an evidence-based inter-agency model for responding to children and young people with complex needs, including those experiencing multiple risk factors associated with suicide. The YPPA and its implementation contribute to addressing this recommendation and strongly promotes the importance of cross-sector collaboration to respond to, and meet the often complex needs of young people with mental health, AOD and other related and impacting issues

Appendix 1 - The Current Mental Health and AOD Service System

There are seven service streams within the mental health and AOD system outlined in the Plan and as follows:

- Prevention
- Community Support Services
- Community Treatment Services
- Community Bed-based Services
- Hospital-based Services
- Specialised Statewide Services
- Forensic Services.

All of the streams across the continuum need to be engaged to ensure smooth transfers to and between services so that people do not fall through the gaps. Facilitation of access to the right services, and the ability to move between services when required, is essential.



Prevention

Mental health and AOD prevention refers to the initiatives and strategies implemented at national, statewide and local levels to reduce the incidence and prevalence of mental health issues, and delay the uptake and reduce the use of AOD and associated harms. Mental health promotion strategies aim to boost positive mental health and resilience. Effective strategies include raising community awareness, the creation of supportive environments and communities, enhancing healthy community attitudes/ skills, and building community capacity to address mental health and AOD issues.

Community Support Services

Community support services provide individuals with help and support to participate in their community. Community support services help people identify and achieve their goals and can include: personalised support programs (for example to assist in accessing and sustaining employment/education), peer support, initiatives to promote good health and wellbeing, home in-reach support to attain and sustain housing, family and carer support, flexible respite, individual advocacy services, and harm reduction programs. Community support services may be hosted in a number of environments such as school, community centre and may also include the provision of

accommodation and other support services. Accommodation under community support services are accessed by individuals who may not have an alternative place to live such as crisis and respite, and psychiatric hostels.

Community Bed-based Services

Community bed-based services provide 24 hours per day, seven days per week recovery-oriented services in a residential style setting. Community bed-based services aim to support individuals to enable them to move to more independent living. They assist people with mental health and AOD issues who may need additional support, but where admission to hospital is not required. They can also provide additional supports to assist people to successfully transition home from hospital, as well as work with an individual to prevent relapse and promote good general health and wellbeing. Some of these services require varying levels of clinical support often from community treatment services to address high support needs associated with more complex issues.

Community Treatment Services

Community treatment services provide clinical care in the community for individuals with mental health and AOD issues. Community treatment services generally operate with multidisciplinary teams who provide outreach, transition support, relapse prevention planning, physical health assessment and support for good general health and wellbeing. Services provided to individuals are non-residential, and can be intensive, acute or ongoing. AOD community treatment services include pharmacotherapy programs, screening and assessment programs, and specialist counselling.

Hospital-based Services

Hospital-based services include acute, subacute and non-acute inpatient units, emergency departments, consultation and liaison services, mental health observation areas, and AOD high/complex medical withdrawal services. Hospital-based services provide treatment and support in line with mental health recovery-oriented service provision, including promoting good general health and wellbeing.

Specialist Statewide

Services Specialised statewide services offer an additional level of expertise or service response for people with particular clinical conditions or complex and high-level needs. Services can include targeted interventions, shared care, comprehensive care for extended periods, and support to general services. Some services can be developed as centres of excellence that are located in the metropolitan area and provide expert advice and assistance across the State. Examples may include eating disorders, perinatal, and neurosciences and neuropsychiatry. Other services, where possible, can be delivered through a hub and spoke model.

Forensic Services

Forensic services provide treatment and support for people at all stages through the criminal justice system and aim at preventing people from re-entering the criminal justice system.

Services provided under each of the service streams

Prevention services: Programs/services which cover AOD prevention, mental health promotion, some elements of suicide prevention, and FASD prevention. These initiatives take the form of statewide campaigns, school-based programs, targeted programs for vulnerable groups, policy and legislative work and training. Some Mental Health Commission prevention initiatives which either directly or indirectly impact young people include (but are not limited to):

- Alcohol.Think Again Statewide public education program to reduce alcohol-related harm among adolescents.
- The Mental Health Commission in partnership with Sportwest and WAAMH to develop a guiding framework, based on best practice, to support sporting clubs, associations and leagues to implement prevention based mental health strategies.
- Funding for Community Alcohol and Drug Services to deliver AOD prevention activities
- Changing Minds program which teaches secondary school students (in either private or government schools) about mental health.
- Aboriginal Family Wellbeing project which acknowledges social and emotional wellbeing as a significant contributor to the prevention of suicide deaths in Aboriginal people, and aims to address the physical, mental, emotional, and spiritual issues that impact on an individual's wellbeing, family unity, and community harmony.

Community support services: Community support services are primarily delivered by community-based NGOs and seek to address a range of mental health and AOD related issues. They also provide targeted approaches to address the specific needs of particular cohorts (e.g. LGBTQIA+, severe and persistent mental health issues, early episodes of psychosis, accommodation and support needs).

Many of the community support services commissioned by the Mental Health Commission seek to involve the families, parents and carers of young people (where appropriate) and are provided in a variety of settings (including in the justice setting). The spread of these services are primarily metropolitan-based. Some Mental Health Commission funded services include (but are not limited to):

- Wanslea Family Services works with children and young people up to 18 years that are impacted by their parent's mental illness, aiming to improve their mental health outcomes.
- Perth Inner City Youth Service PILLAR program which provides intensive, individualised mental health services for young people aged 15 to 18 years who are experiencing severe and persistent mental illness.
- Youth Accommodation and Support Services are commissioned by the Mental Health Commission to employ a Drug Education Support Service (DESS) Worker to provide a range of services and support for young people.
- Children & Young People Responsive Suicide Support (CYPRESS) service which provides long term support for children and young people bereaved by suicide
- Schools Response Program which aims to ensure that school-aged youth experiencing mental health issues, demonstrating at-risk behaviour, or experiencing grief from suicide have access to required services and support.

The National Disability Insurance Scheme for People with Psychosocial Disability

Psychosocial disability is the term used to describe disabilities that arise from mental health issues. Psychosocial disability does not refer to a diagnosis but to the functional impact and barriers which may be faced by someone living with a mental health condition. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage including being prevented from engaging in opportunities such as education, training, cultural activities, and achieving their goals and aspirations. Additional challenges include community and social inclusion, access to finding and maintaining suitable housing and employment, and difficulties maintaining their physical health.

People with a psychosocial disability may qualify for the NDIS. Examples of NDIS-funded supports include:

- assisting with activities of daily living such as self-care tasks, grooming and hygiene
- assisting with meal planning/meal preparation, associated skills and independence
- development of a structured routine that integrates medication management
- assisting participants to obtain and/or maintain accommodation
- workplace help to allow a participant to successfully obtain or keep employment in the open or supported labour market
- mentoring, peer support or support with individual skill development.

In addition, from 1 July 2020, psychosocial recovery coaches will be available to support NDIS participants with a psychosocial disability. Recovery coaches will work collaboratively with participants, their families, carers and other services to design, plan and implement a recovery plan, and assist with the coordination of NDIS and other supports.

Community treatment services: The Community Treatment Services stream includes a number of dedicated youth services for young people ranging from 12 to 24 years and provide specialised mental health and AOD treatment and support for young people who are acutely unwell and at risk of developing serious mental health and/or AOD issues. These services are provided within the community and out of the hospital setting, and include services within regional areas of Western Australia. Mental Health Commission funded services include (but not limited to):

- Youth Community Assessment and Treatment Team, an intensive community-based youth service targeting acutely ill people at risk of developing serious mental health problems, currently only delivered within the Perth south metropolitan area.
- Child and Adolescent Health Services – There are 10 Child and Adolescent Health Services which provide support, advice and treatment to young people under 18 years of age and their families who are experiencing mental health issues.
- Provision of a specialist Child and Adolescent Mental Health Service Youth Psychiatrist in the Kimberley region from the WA Country Health Service to provide assessment and treatment to young people aged 0 to 24 years
- Youth Mental Health Program - a statewide youth mental health program, which aims to reduce the incidence, prevalence and impact of mental health and psychosocial problems for young people, in consultation and collaboration with other service providers and the broader communities in which young people reside and find themselves connected. This program includes the Youth Axis, Youth Hospital in the Home, YouthLink and YouthReach South services.
- Touchstone - a structured day service for young people aged 12 to 17 years and their families. The multi-disciplinary team comprises of a consultant child and adolescent psychiatrist, service manager, and an experienced therapy team of nurses, psychologists, social workers, occupational, art and creative therapists.
- Gender Diversity Service - Provides assessments and treatment of identified severe psychological distress, psychological comorbidity, and advocacy to reduce social adversity experienced by children and young people due to gender dysphoria.

Community bed-based services: These services provide 24-hour, seven days per week recovery-oriented services in a residential-style setting (in the case of mental health services) and structured, intensive residential rehabilitation for people with AOD issues (following withdrawal). Community bed-based services are designed to support a person to enable them to move to more independent living. Services are recovery-focussed, family-inclusive and are generally set up in home-like, cluster style facilities, staffed 24 hours a day, seven days per week. Mental Health Commission funded services include:

- Drug and Alcohol Youth Service (DAYS) provides comprehensive assessment; case management, individual counselling; medical assessment and review; clinical psychology services; group programs; mentoring and outreach; opiate and alcohol pharmacotherapy; parent

and family counselling; alternate therapies; and Aboriginal mentoring. This is the only specialist youth AOD community bed-based service in the State.

- Ngatti House – Provides transitional supported accommodation for young people between 17 and 22 years of age, who show signs and symptoms of mental illness while homeless or at risk of homelessness.
- Youth Residential Rehabilitation Treatment Service (YRRTS) - A 13 week residential AOD treatment program for young people aged 12 to 25 years provided 24 hours a day currently within a ten bed facility located at Carlisle. The YRRTS works with the Drug and Alcohol Youth Service to ensure that young people have a seamless transition between treatment modalities.

In addition, funding has been allocated for the development of Youth Mental Health, Alcohol and Other Drug Homelessness Service to be established in mid-2021.

Hospital bed-based services: These services provide 24-hour, seven days per week services in a hospital setting. Young people aged 16 to 24 years have access to dedicated youth inpatient facilities provided within the following health regions:

- East Metropolitan Health Service: East Metropolitan Youth Unit at Bentley Health Service – 12 beds (16 to 24 years).
- South Metropolitan Health Service: Fiona Stanley Hospital Youth Unit – 14 Beds (16 to 24 years).
- North Metropolitan Health Service: Hospital in The Home – 8 beds (16 to 24 years), which provides care in the home that would otherwise be delivered within a hospital as an inpatient.
- Child and Adolescent Health Service: Perth Children's Hospital – 20 dedicated child mental health beds (under 16 years).

A youth inpatient unit within the North Metropolitan Health Service area is also currently being established at the Joondalup Health Campus.

For young people outside of the metropolitan area, there are no dedicated youth inpatient beds. However, young people 18 years and above can access an adult mental health inpatient facility through the WA Country Health Service.

Specialist Statewide Services: Specialised statewide services offer an additional level of expertise or service response for people with particular clinical conditions or complex and high-level needs. Services can include targeted interventions, shared care, comprehensive care for extended periods, and support to general services. Some services can be developed as centres of excellence that are located in the metropolitan area and provide expert advice and assistance across the State. Examples may include eating disorders, perinatal, and neurosciences and neuropsychiatry. Other services, where possible, can be delivered through a hub and spoke model.

Forensic Services: Forensic services provide treatment and support for people at all stages through the criminal justice system, and aim at preventing people from re-entering the criminal justice system.

Within the criminal justice system young people are one of the groups that require special consideration in the development and the method of delivery of forensic services.

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[262] The below documents are examples of some of the key documents which the YPPA is aligned to and/or has been informed by. The Mental Health Commission have also drawn from a range of available data sources. The Mental Health

Commission acknowledge that the below list, and data used throughout the supporting paper and YPPA is not exhaustive and recognise that there may be other relevant polices, strategies, reports and data that align with and support the YPPA.

- Western Australia Mental Health, Alcohol and Other Drug Services Plan 2015-2025 and Plan Update 2018 - Mental Health Commission
- Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 – Mental Health Commission
- Western Australian Suicide Prevention Framework 2021 – 2025 – Mental Health Commission (DRAFT)
- WA Youth Health Policy 2018-2023 and Companion Document - Department of Health
- Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy 2019–2024 - Department of Health
- Preventing suicide by children and young people 2020 – Ombudsman Western Australia
- Our Children Can't Wait: Review of the implementation of recommendations of the 2011 Report of the Inquiry into the mental health and wellbeing of children and young people in WA - Commissioner for Children and Young People
- Speaking Out Survey 2019 – Summary Report - Commissioner for Children and Young People
- A Framework for Young People's Recovery from COVID-19 in Western Australia - Youth Affairs Council WA
- The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing - Young Minds Matter
- A Global Framework for Youth Mental Health: Investing in future mental capital for individuals, communities and economies - Orygen
- Prevent. Support. Heal. State Election Platform - Western Australian Association for Mental Health
- Youth Services Integration Report 2019 - Western Australia Association for Mental Health –
- Increasing & Improving Community Mental Health Supports in WA – Western Australian Association for Mental Health
- Western Australia Aboriginal Youth Health Strategy 2018-2023 - Aboriginal Health Council of Western Australia
- PICYS Most Significant Change, young people's stories - Perth Inner City Youth Service
- Informing Youth Suicide Prevention for Western Australia – Telethon Kids Institute
- National Action Plan for the Health of Children and Young People 2020-2030 – Australian Government, Department of Health
- Uti Kulintjaku Project: Summary Report - 2018 Evaluation - Samantha Togni on behalf of the Uti Kulintjaku Project Team