Australia case study:

Building policy attention and support for a new model for youth mental health

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1. Introduction

This case study is implemented within the project 'Fostering policy support for child and family wellbeing - Learning from international experience' Using a thematic and analytic framework for the project that draws on Kingdon's multi-streams theory,[2] we are gathering and sharing evidence and learning on what has led to increased policy recognition of and policy change in family and child health and wellbeing (FCHW). In specific countries that have demonstrated policy recognition and change in FCHW post 2000, we are exploring within their context how different policy actors have come together to raise policy attention, develop policy options and promote their political adoption as processes for policy change, taking advantage of windows of opportunity for that change. The case studies were implemented with key informant input from people with direct knowledge or experience of the policy process and evidence from published and grey literature.

This case study explores the change post 2000 in policy and practice on youth mental health, towards the adoption of *headspace* as an early intervention model.

By 2000, growing evidence of the prevalence and burden of mental illness in youth and the inadequacy of resources and services to address it led to public and professional dissatisfaction with youth mental health care.

Colonial Foundation and federal funding provided resources for a consortium of researchers and a tenacious and energetic advocacy capacity and expertise at Orygen, led by Professor Pat McGorry. This team brought evidence and public testimony into multiple platforms, using simple messages to critique the system in a manner that drew policy attention and demanded action.

They developed a policy model, *headspace*, drawing on international experience, and proposed it as an affirmative, common sense response to a demand for early intervention, ready to take to scale. Their accessible communication attracted support more effectively than technical actors raising wider system approaches. Connections with political actors in the states levered funding and support to pilot and expand *headspace*. Visible 'bricks and mortar' implementation generated community support, while showing feasibility and a visible brand that politicians wanted to be associated with.

Public pressure and expectation, a concern for youth, a strong media profile and the visibility of community support elevated youth mental health as an electoral issue in 2010. A highly visible public advocacy campaign and work with the opposition party when government support was slow generated further pressure for the political response. The government provided a new federal minister for mental health and significant investment in mental health, including for *headspace*.

As effective policy entrepreneurs, the Orygen team bridged social, political and technical actors to build support in different constituencies over time, aligning them to a common cause, understanding and responding to public and political views and negating opposing arguments. While the focus was highly effective for introducing *headspace*, it left wider deficits in the health system for more complex conditions and longer term outcomes. Concerns, debates and advocacy thus continue on these unaddressed issues of fragmentation and poor co-ordination in youth mental health services.

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2. The context

Australia is a high-income country in the Pacific region. Its population of 25.1 million in 2019 mainly live in coastal areas, with an indigenous Aboriginal and Torres Strait Islander population of over 548 000. The population is ageing, but with almost a fifth of people under 15 years. In the 2016 Census, 18.7% of the population was below the age of 14 years and a further 6.1% 15-19 years of age (World Population Review, 2019). While the country has a strong economy and a high per capita income, the poverty rate increased from 10.2% to 11.8% between 2000 and 2013.

Australia map, Source: [Lasunncty 2016,](#) creative commons

The country has a federal system with 6 states, shown in the map adjacent and two mainland territories, the Australian Capital Territory and the Northern Territory. Each state has its own parliament with legislative power, including in areas of health, education and other social policy, although federal laws prevail where there are inconsistencies across states. The federal level has powers to levy income taxes and to make grants to states to incentivise policy areas over which it has no legislative powers.

The first survey on mental health in Australia in 1997 by the Australian Bureau of Statistics (ABS) excluded people under 18 years (AIHW, 1998). In 2015, 14% of children 4–17 years met diagnostic criteria for at least one mental health disorder, which if unmanaged would affect their development, education and future opportunities, with significant costs to the community (Paton and Hiscock, 2019). Late adolescence and early adulthood are reported to be peak periods for onset of mental illness in Australia, with higher risks for some groups: *Aboriginal people experience higher levels of mortality and morbidity from mental illness and from related injury and suicide than the non-Aboriginal population* (Simpson and Howe, 2017:2; Hickie et al., 2005). Suicide was the leading cause of death for Australians between 15-34 years of age (ABS 2012; 2013). Despite this profile of mental illness, around half of all Australian children and adolescents who met the criteria for mental illness were reported to receive sub-optimal management or to not access treatment at all, due in part to parental and community perceptions and attitudes, cost, transport, not knowing where to go and stigma (Paton and Hiscock, 2019).

Concern grew in the 1990s on weaknesses in mental health services. Primary care (GP) and hospital services are funded by Federal government and community services by the state. States raised concerns on mental health services within Ministerial councils, but without adequate response and studies presented, and without a strong lobby on the evidence. A 1993 national inquiry into the rights of people with mental illness, the '[Human Rights and Mental Illness Report](#)' acknowledged the lack of attention to mental illness, especially for adolescents. Young people received services in adult mental health settings that poorly addressed their specific needs. They faced service gaps, poor experiences and limited early intervention. The 1993 report called for appropriate programs and facilities for young people (Hickie et al., 2005; HREOC, 1993). National Mental Health Plans in the 1990s advocated for a change in the balance of services, to overhaul prevailing institution-centred systems of care, to provide improved information systems and to strengthen involvement of clients and carers in care decisions (Dept. of Health, 2013; ADHA, 2005; Goodwin and Happell, 2006).

These identified deficiencies were particularly profound for young people. Poor and late uptake of care, low investment in their services that were poorly organized to overcome the barriers young people faced meant that many youth slipped through the gaps (Whiteford et al., 2016).

3. The policy change

Over the 2000s there was a shift towards policy adoption of and investment in one-stop early treatment for young people with mild to moderate mental health disorders. This section describes the content of this policy reform post 2000. Given the focus of this case study on the drivers of the policy change, rather than an evaluation of the model, the advocacy, technical and political processes that contributed to this change are described in the next sections.

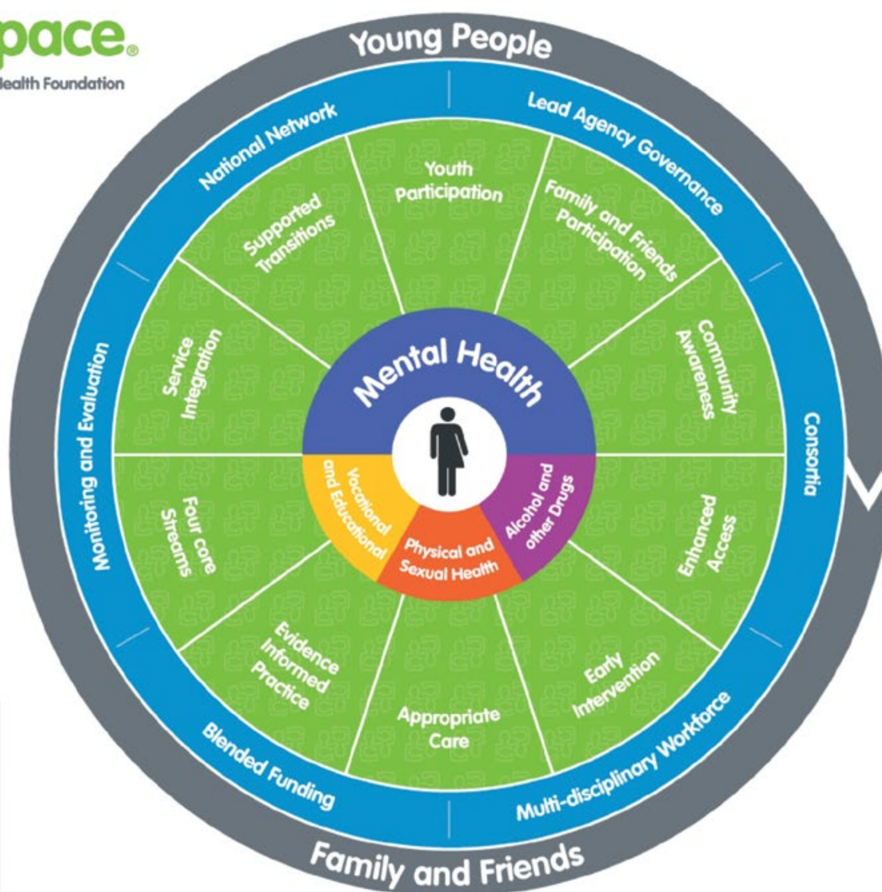
In the 1990s and early 2000s, various processes in the professional community in dialogue with international actors, in the Mental Health Council, in the Brain and Mind Research Institute explored the weaknesses in mental health care, generally, for youth and at primary care level. The Third National Mental Health Plan 2003-2008 promoted the role of primary health care in the promotion and prevention of mental health and called for strategies to implement this. Various processes described in later sections contributed to shaping the potential reforms. In 2006, Prime Minister John Howard initiated a new 5-year national reform plan including a commitment to youth mental health and psychological services, to be led by the Council of Australian Governments and with a five year $1.9 billion investment (Hickie et al., 2014). Included in this was the creation of *headspace*, a policy that aimed to improve access, service cohesion and quality and health and social outcomes for young people aged 12–25 years experiencing mental illness and related substance use problems.

With a high unmet burden of youth mental health problems and federal level funding allocated to non-state actor interventions, two policy approaches were proposed, Early Psychosis Prevention and Intervention Centres (EPPIC) and *headspace*. EPPIC is an integrated mental health service aimed at youth aged 15 to 24 years with a first episode of psychosis based in Victoria. *Headspace* comprises one-stop early treatment centers aimed at improving youth mental health and providing drug and alcohol, employment and other integrated social services (Whitford et al., 2016). This case study focuses on *headspace*, providing early care for young people with mild to moderate mental health disorders, while the state government provides services for moderate to severe disorders. The focus on *headspace* does not negate recognition that a gap remains in relation to moderate, longer term disorders, described as the 'missing middle', and that fragmentation in and duplication of services continues. The final sections raise this ongoing demand for policy debate on attention to be given to these issues, to alternative services and to more systematic evaluation of all services.

At the heart of the *headspace* initiative is the *headspace* centre, an easy-access, youth-friendly, primary care service that builds on service capacities in the local community to provide early interventions for youth mental health problems. Youth participation is core to the model, albeit with variable application, to respond to young people's needs and preferences. This occurs at three levels, firstly to support their participation in care decisions at all points in their care pathway. Secondly, through centre-specific Youth Reference Groups providing input into service design, delivery and evaluation. Thirdly, through including youth in the governance and strategic planning of centres (Rickwood et al., 2018).

Each *headspace* centre is managed by a lead agency, an independent organization commissioned to operate one or more *headspace* centres, capable of delivering the apoproach in safe high quality services and to provide the infrastructure and governance for this (Rickwood et al., 2018). A consortium of local service providers collaborate with the lead agency to give strategic direction, additional capacity and local oversight. The consortia include a range of services, including those related to mental and physical health, alcohol and drug use programs and vocational services, and are led by an independent chair. They connect the centre with local community support, collaboration and partnerships to increase the reach and continuity of care of *headspace* services. At national level, multiple channels were set up for personnel to share learning and innovations from evidence-based practice and practice-based evidence and to provide materials and online education (Rickwood et al., 2018). The model is described graphically overleaf.

In terms of the policy adoption, in 2007, the federal government established the National Youth Mental Health Foundation to ensure delivery of the approach and *headspace* sites were established in each state and territory across Australia (Howe et al. 2013).



Source: Rickwood et al., 2018:161, with permission from the author

Headspace centres were set up across the country, from an initial 10 centres in 2007 scaling up to 110 in 2018. In 2014-15, *headspace* at national level funded innovation projects across Australia. In six regions, centres were vertically integrated with specialized services for more complex, low prevalence disorders. A range of other innovations were introduced, including an online youth mental health service "eheadspace", *headspace* mental health in schools, an interactive website and a digital work and study service (Rickwood et al., 2018). An Orygen video at the 2019 American Psychiatric Association meeting captures some of these key features.

As a sign of policy recognition, there was a growth in investment in mental health services, particularly those for young people, at both state and federal level. Between 1992-93 and 2010-11, annual state and territory government spending on all mental health services grew by $2.6 billion, or 283%, about two thirds of which was invested in community-based services. A significant part of this increase in support was to services provided by non-government organisations (NGOs), such as *headspace*. This improvement in investment was not system wide, and there was some corresponding loss of attention to other parts of the system. For example, in the same period, spending on stand-alone psychiatric hospitals fell by $289 million (by 35%) (Dept of Health, 2013). In the 2010 federal election, Prime Minister Gillard committed $2.2 billion over 5 years to mental health care reform, including $492 million to expand youth services (Hickie et al., 2014). In 2011, the government announced a commitment of $419.7 million to EPPIC and *headspace*.

Notwithstanding these signs of policy recognition and change, debates continue on what constitutes an optimal system, discussed later. A National Mental Health Commission (NMHC) was established in 2012 to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change to achieve and be accountable for improvements, including through engaging independent reports and ongoing monitoring and reporting to assess the impacts of reforms (NMHC, 2019).

In 2019, a Royal Commission into mental health services in Victoria is exploring options for improving Victoria's mental health system and a Productivity Commission is also examining the impact of mental health disorders on participation in the labour market.

The key reforms related to this case study are outlined in the timeline below. The next section discusses the actors, actions, processes and relationships that contributed to these outcomes.

Timeline of policy and legal reforms on youth mental health

Year	Policy/ law/ program/institution
1990s	1992: National Mental Health Policy and a national Mental Health Strategy adopted with an intention to promote more community based approaches 1993: National inquiry into the rights of people with mental illness report published. 1998: Second National Mental Health Plan 1998-2003 sets priorities for service responsiveness, mental health promotion and prevention and partnerships 1999: Mental Health Consumer Outcomes Task Force statement on the rights of people with mental illness.
2003	Third National Mental Health Plan 2003-2008 promotes the role of primary health care in promotion and prevention of mental health. Mental Health Council in collaboration with the Brain and Mind Research Institute publishes community priorities for mental health policy
2004	'Investing in Australia's future" is published making a case for the economic benefit of investing in mental health and calls on political leaders to play their part.
2005	Senate Select Committee on Mental Health created to conduct a wide-ranging inquiry into the national mental health policy and strategy
2006	Prime Minister John Howard initiated a new 5-year national reform plan to be led by the Council of Australian Governments including *headspace* and EPICC
2008	Senate inquiry on mental health services recommends a greater focus on meeting the mental health care needs of specific groups, especially youth
2010	Over 60 mental health organizations demand attention to mental health in wider health care reforms. GetUp! highlights youth mental health before the August 2010 election. Prime Minister electoral campaign commits $2.2 billion to mental health care reform
2011	The Independent Mental Health Reform Group publish "Including, Connecting, Contributing: A Blueprint to Transform Mental Health and Social Participation in Australia." Parliamentarians identify barriers to adequate services for youth. Australian government announces $419.7 million for EPPIC and *headspace*.
2012	The National Mental Health Commission (NMHC) is established, complementing state-based commissions in Western Australia, NSW and Queensland.
2014	2014 - A cross-parliamentary group to raise awareness for youth mental health
2018	Government provides $125 million in the 2018/19 budget for mental health research
2019	Establishment of a Royal Commission into mental health services in Victoria and Productivity Commission on the employment impact of mental health disorders

Sources: Groom, 2003; Hickie et al., 2004; ADHA, 2005; MHCA and BMRI, 2005; Hickie et al., 2005; Rosen, 2006; Rosenberg et al., 2009; Hagan, 2010; Comm Australia: House of Representatives, 2011; Hickie et al., 2014; Wright, 2014; Whiteford et al, 2016; Australia Dept of Health, 2018

There is some evidence of the impact of these reforms. Process and milestone evaluations were implemented of the *headspace* model within the funder contract. In relation to *headspace*, an independent review found the program to be accessible for a diverse group of young people, including from marginalised and disadvantaged groups and indigenous young people. Homeless young people or those living in insecure housing (7-16% of clients) were less likely to return to headspace after their first visit than all other clients, *indicating that sustained engagement with mobile young people is challenging* (Hilferty et al., 2015:3).

Stakeholders (clients, staff and parents) generally identified *headspace* to be accessible and engaging, albeit with some remaining practical and socio-cultural barriers. In terms of mental health outcomes, the evaluation found a small program effect in levels of psychological distress, albeit with wide variations across different groups and some groups showing increased distress. Suicidal ideation and self-harm decreased for all groups.

Young people treated by *headspace* and whose mental health improved also benefited from a range of positive economic and social outcomes, in terms of ability to work or study and the review noted a wider community impact on terms of a change in community awareness and reduction of stigma (Hilferty et al., 2015).

A further 2015 evaluation, albeit without a control group, found that the centres primary serviced clients seeking help for 'mental health and behaviour' problems, primarily anxiety and depressive symptoms, and provided mainly cognitive-behaviour therapy in 1-2 sessions and less other forms of psychological therapy (Jorm, 2015).

At the same time, there is still need to identify rigorous measures of longer term impacts and the cost effectiveness of the services is still to be tested. A number of barriers to optimal care exist for children with complex mental health conditions at a systemic, clinician and family level, including in transitioning to adult services. This is reported to call for longer term efforts to strengthen multi-disciplinary, co-located and integrated care services (Paton and Hiscock 2019).

Graphic at a light control box Brisbane, L Matthews, 2015

4. The story of the change

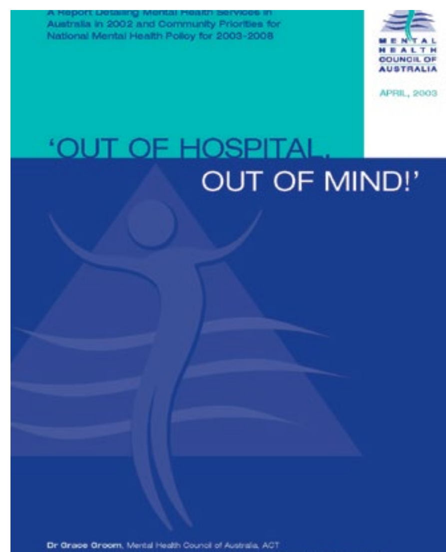
4.1 Raising youth mental health as an issue demanding action

Concern was expressed in the 1990s about the effectiveness and nature of mental health services, as noted earlier. Discussions were taking place between like-minded professionals in Australia and across countries with those in countries such as UK, Canada and Denmark on how to respond early to youth mental health and early psychosis and to address the deficits in primary care services for mental health. The debate and advocacy on youth mental health services escalated, however, in the early 2000s. **This section outlines how the issue was raised on the policy agenda.**

As stated on the Colonial Fund website, in 2001, the Colonial Foundation provided funding to catalyse Professor Patrick McGorry's team's initial work on early interventions for young people with mental ill-health. This led to the establishment of Orygen in 2001-02 as a collaborative partnership of the Colonial Foundation, University of Melbourne and Melbourne Health (Colonial Foundation, 2018). Significant resources were invested in advancing the approach. Contributions over 17 years by the Colonial Foundation of AUS$46.2million supported Orygen's development of a comprehensive research base and service platform for youth mental health and supported employment of advocacy capacities in Orygen.

The core funding was used to lever 'nearly a billion dollars (AUS$) of Australian Government support' (Colonial Foundation, 2019:online). The foundation provided a five year grant to Orygen, with AUSD2.6mn in 2018 as an indication of the annual funding, and a further AUSd2.5 mn for development of Orygen's campus (Colonial Foundation, 2018). While the use of such resources to develop the *headspace* centres and early psychosis centres are discussed in the next section, the philanthropic and government funding enabled the development of a tenacious and energetic advocacy capacity and expertise, coalitions with community groups and an organisational capacity to mobilise and direct funding to the new approaches being proposed (Colonial Foundation, 2019).

In 2003, the Mental Health Council of Australia (MHCA) in collaboration with the Brain and Mind Research Institute (BMRI) published a report, 'Out of hospitals, out of mind!' that detailed the challenges facing young people with mental health issues and the priorities to address this as advocacy input for the National Mental Health Policy 2003-2008 (Groom, 2003). Grace Groom, as chief executive of the MHCA in 2003-2005 and Professor Ian Hickie, co-director of Health and Policy at the University of Sydney's BMRI were key advocates in getting mental health and particularly the deficits in community mental health onto the political agenda.



Cover page of 'Out of hospital, out of mind!'

They published and promoted evidence, including from community consultations, critiquing the current system. They brought testimonies of people's experiences of the mental health care system into public and policy domains. 'Out of hospitals, out of mind!' pointed to the fact that a chronically disadvantaged group in Australia, youth, was being ignored. It argued that while the broad commitment was there to do things differently, but it had not been translated to practice (Groom, 2003).

Numerous reports from these research centres and researchers in other institutions presented further evidence on the deficits in the current situation. The leads (McGorry, Hickie, Groom and others) provided strong messages in accessible reports on the gap to be addressed, sometimes contesting official reports. A professional 'movement' grew that gathered and engaged with evidence on both the problem and options for how to address it, including in person to person dialogues with political actors in both major parties and with media.

When the 2004 National Mental Health Report indicated progress in mental health services, a survey in the same year by the MCHA and the BMRI, in association with the Human Rights and Equal Opportunities Commission (HREOC) provided contrary evidence from services and practitioners that little had changed and that community priorities were not being achieved (MHCA and BMRI, 2005). In 2005, the same organisations published "Not for Service: Experiences of injustice and Despair in Mental Health Care in Australia', presenting further personal stories of practitioners and users of mental health services with the view that "governments needed to hear how Australia's mental health consumers and professionals felt about the system that they were dealing with" (MHCA and BMRI, 2005:iii). The negative picture was reinforced by evidence of low levels of mental health service uptake in youth reported in the 2007 National Mental Health and Wellbeing Survey and in 2008 Senate enquiries (Whiteford et al., 2016).

The researchers producing such reports, including David Cappo, Patrick McGorry, Ian Hickie, Sebastian Rosenberg, John Moran, and Matthew Hamilton, formed a strengthening and mutually reinforcing advocacy group and network, discussed further in the next section. They played a key role in raising problems with mental health services and the need for reform the on the policy agenda. Professor Ian Hickie, and Professor McGorry, executive director of Orygen, went further to lead development and advocacy on alternative approaches for young people, discussed later. They were able to turn the science into a simple and positive message on a response to challenges in youth mental health services. While there was professional debate around the approach, discussed later, the Orygen team were more effective than those arguing competing approaches in framing the problem and an affirmative approach to dealing with it in a way that attracted attention and support.

From 2004, assuming it would be persuasive, the evidence and key messages also turned to the benefits of investing in mental health, the costs of not doing so and the urgency to respond. 'Investing in Australia's future: the personal, social and economic benefits of good mental health' raised community perceptions of mental health as a priority and their frustration that their views are not reflected in public spending. The report pointed to four themes for alternative responses, including: promoting early intervention for all severe disorders among young people; providing effective pharmacological and psychological treatment in psychiatric primary care; maximizing returns to full social and economic participation; and investing in innovation, research and sustainability (Hickie et al., 2004). Concern about young people, public concern over the deficits in the system and the possibility and visibility of the feasible, community-supported approaches for addressing the deficits discussed in the next section were seen to have been key drivers at that stage if public pressure on political decision-makers.

In 2005, a Senate Select Committee on Mental Health was set up to conduct a wide-ranging inquiry, including on the extent to which the National Mental Health Strategy was being implemented for young people and disadvantaged groups and the opportunities to improve service delivery (Senate Select Committee on Mental Health, 2006). While not engaged with by the wider network of psychiatry professionals and while its 10 recommendations did not directly relate to *headspace* work, the Senate Committee inquiry provided an opportunity to raise public debate and for more direct voice from young people, with members of Orygen's youth participation group sharing their experience of early intervention services (Orygen, 2019).

This opportunity of a platform for public input was repeated in the 2009 National Health and Hospital Reform Commission set up by the Rudd government to make proposals for improved equity and access in the health system. It called for a strengthened consumer voice and empowerment in health care, including in the development of health policy on chronic illnesses. While its focus went beyond mental health, it gave additional momentum to public views on mental health and particularly youth mental health and on measures for improving access to mental health services (Jowsey et al., 2011).

As the harms of ignoring youth mental health gained profile, reports and advocacy turned to the economic and employment cost of disability from mental illness and the cost benefit of the proposed treatment options, particularly as investments in this area still faced competition from other priorities, and because of the time lag between spending and benefit in this area (Whiteford et al., 2016).

In 2010, the cost to the economy of untreated mental illness from lost productivity and lost lives for the economy and the family was estimated at A$30 billion (US $25 billion). Mental illness was identified as a major contributor to unemployment and to long-term receipt of welfare (Whiteford et al., 2016). Reports raised the inequity of a lack of effective responses to a rising level of youth mental illness and demand for services in more disadvantaged youth, in female youth and in Aboriginal and Torres Strait Islander young people, affecting their school achievement and leaving them more likely to find help from friends, parents and the internet than from services (Mission Australia, 2017).

The advocacy came primarily from the lead academics and community advocacy groups, such as the Schizophrenia Advocacy Foundation. The researcher advocacy was amplified by the media, with stories about the burden of youth mental illness and the risk of mental health problems appearing before the age of 25 years in one in three young Australians (Australian Associated Press, 2008). Media stories put a human face on the high level of youth need for mental health services (Jones, 2010; Marcus, 2008; Whiteford et al, 2016). The media was important for raising awareness of both the problem and the solution. Its influence was recognized also by the Australian Government's Department of Health, with a national program, Mindframe aimed at supporting safe media reporting, portrayal and communication about suicide, mental ill-health and alcohol and other drugs. The program was managed by Everymind, a leading national Institute dedicated to reducing mental ill-health.

Quantitative evidence, used to create a publicly visible problem, together with public testimony by clients, carers, and professionals was used to create pressure on government (Whiteford et al., 2016). The intensity and volume of evidence generated in the public domain raised the public and policy profile of the issue. It was framed as demanding action, *using data from suicide rates, burden of illness, inequity in access to services, economic costs of not treating mental illness, with the argument that existing programs were not fit for purpose in dealing with the problem* (Whiteford et al., 2016:7). The research advocates in Orygen learned to present their evidence in ways that were accessible for media and for different audiences. The *headspace* propositions were framed in clear simple messages that appealed to common sense. Working as a consortium of professionals committed to change and having a team of people involved enabled the blending of different skills and functioning of the team as both a technical group and a campaign team. It brought different skills to the process, enabling communication with and credible messengers for different audiences. The media profile and access was significantly enhanced by Patrick McGorry being identified by the Australia Day Council as 'Australian of the year' in 2010 for his services to youth mental health. This profile and the budget resources it brought helped to raise and keep public attention and pressure on youth mental health at a time of electoral and governmental change, discussed later.

An accessible message on how to respond to the issue, building on the practical interventions discussed in the next section, and person to person, public and media engagement engaged the political and public concern over youth mental health and raised pressure to respond to it. The next section explores how the policy options were generated in response to and alongside that demand.

4.2 Developing and demonstrating implementable policy options

Alongside the work noted in the previous section to profile the issues, a consortium led by the Orygen Research Centre at the University of Melbourne, the Australian General Practice Network, the Australian Psychological Society, and the BMRI at the University of Sydney worked on and advocated the possible responses. Amongst them, Orygen, as a blend of a youth mental health service and a research centre, had developed over a decade of experience in treatment and research and early intervention models for mental disorders in young people from the early teens to the mid-20s (Orygen, 2019).

They proposed *headspace* and EPPIC as the primary policy solutions, arguing that them to be effective and ready to take to scale. Other options such as traditional mental health services, primary care or no action were not encouraged (Whiteford et al, 2016).

EPPIC and *headspace* had been pretested on small scale in Australia and on a larger scale internationally, EPPIC since 1992 and *headspace* since 2006. They were based on a proposition that crucial to solving the problem of young people with mental health problems not entering the services was developing a strong and youth-friendly primary care system run by mental health professionals rather than primary care professionals.

Youth dialogue © Orygen. Reproduced with permission http://orygen.org.au/

The consortium drew on experiences in Canada, and Denmark with *headspace* and exchanged on later experiences in Ireland with Jigsaw and Headstrong. As outlined by McGorry (2017), they proposed an Australian *headspace* concept of accessible, local facilities with an easy entry, where young people can talk to someone about any problem they have, "or only to drink a cup of coffee" but with multi-disciplinary expertise from health, social care and other disciplines available on site and also collaborating with schools, labour market agencies, social work and youth work organizations.

In subsequent years efforts were made to secure formal support for the approach. Following the 2005 Senate Committee noted earlier, Sebastian Rosenberg, a public servant working in health in both state and federal level and at the Mental Health Council of Australia, proposed with colleagues six priority areas for national action on mental health, including youth mental health, linked to key measures for improving health system performance. Endorsing the *headspace* model, the proposal called for urgent reforms and preferential national funding for new models of collaborative practice and early intervention services, especially youth services, for stimulating employment of people with mental disorders and to link accommodation support with clinical services (Rosenberg et al., 2009). Building on this and before receiving formal budget support in 2011, the group of advocates noted earlier acting as 'the Independent Mental Health Reform Group', prepared a formal proposal: 'Including, Connecting, Contributing: A Blueprint to Transform Mental Health and Social Participation in Australia'. The proposal defined the services that government should invest in as ready for immediate implementation, showing the consistency with the Senate inquiry recommendations (Independent Mental Health Reform Group, 2011; Whiteford et al., 2016).

As noted by one analyst, *the way the problem was framed, in terms of the high prevalence and low treatment rates of mental illness, was not new; the data had been available for many years. However, this research evidence was marshaled to construct the problem, and references to the effectiveness of the proposed programs were used to justify their adoption. Evidence was presented in the media by highly effective advocates and supported by media advocacy campaigns by GetUp! These effectively generated a perceived change in national mood that convinced politicians that something should be done. Widespread dissemination of early intervention as a policy persuaded them that something could be done* (Whiteford et al., 2016:8).

Connections with political actors in the states opened the door to federal funding of over AUS$54 million and to state level processes (McGorry et al., 2007b). Proponents of the new approaches thus undertook efforts to support their expansion to demonstrate the practice and to report youth and carer experiences and community assessments of the implementation of the service reforms, comparing the experiences with those from 2004 (Mendoza et al, 2013).

In 2008, the new approaches were rolled out in ten pilot sites that all contributed to applying and inputting to the model, expanding thereafter nationally to over 80 centres by 2016. With funding primarily from the Australian Government, some co-investment by state and territory governments and support of local communities, a system of *headspace* youth services were organized in a national network, supported by community awareness, workforce training and evidence-based resource materials (McGorry et al., 2007b). New sites were profiled in public meetings and media stories. Their visible 'bricks and mortar' and their involvement of and support from local communities generated consumer pressure for their spread, as a model that politicians wanted to be associated with. A collaborative learning network shared learning from implementation across sites, raising also challenges, such as how to secure young people's employment in jobs outside *headspace* centres.

The expansion of the *headspace* model took place within a system where the health care networks providing mental health and other services above the level of general practitioners were state funded. The federal funding obtained by *headspace* was limited to complementary non-state activities and services. The initiative was thus resourced through non-state actors, partly due to this constraint, partly to control the consistency of its application and branding and in part because states were not authorized to lobby political actors on resources and did not negotiate ways of integrating these resources into state services. Only in later years was it made possible for state services to access the resources more directly.

The spread of the *headspace* thus depended in part on states investing and applying their own innovations, to complement the early intervention services and to generate evidence of their feasibility and value. However, the resources that the *headspace* initiative brought from federal level funding often overshadowed less well-resourced state-funded primary care services. Many state officials took on the changes without planning for or accessing resources to integrate the initiative with wider services, or to evaluate the performance of the whole system.

While political support enabled the rapid spread of *headspace*, there was thus some professional caution on the continuing fragmentation between services, and for *headspace*, that *it is not inevitable that they will lead to improved economic, social or health outcomes. To achieve these goals, the headspace network needs to be enhanced by skilled service development, regular reporting of outcomes and clear linkage to new specialist health, employment and education services* (Hickie et al., 2014: 445). Competitive tendering and fragmented funding of the mental health system themselves led to fragmentation and duplication, exacerbated by multiple non-state actors organized around specific approaches. This fragmentation of services was generally recognized, but debates on how to address it attracted strong, divergent and sometimes confrontational positions, including on the relative balance between medical, psychosocial and social determinants approaches.

In one example, there were early efforts to achieve that integration between *headspace* services for less severe mental health care and services for more severe disorders, reflecting awareness of the evidence on service issues and need for early intervention that the *headspace* and EPICC models also responded to. In 2006, the NSW State Government committed AUD$18.6 million to a reform agenda to reconfigure and integrate mental health care for young people, as co-located 'one stop shops. Funds were allocated across NSW to support the reorientation of mental health services and enhance their capacity to work with young people. A consortium set up the Gosford y-central youth mental health (YMH) program provided services locally across the spectrum of severity. This was a pilot project for NSW State YMH, with a component to develop with input from young people, nine key principles for youth mental health services, shown in the adjacent box.

Principles for YMH services

1. Commitment to a promotion and prevention framework for mental health
2. Improving early access
3. Sustainable clinical governance of youth mental health and quality control
4. Promoting 'best practice' youth mental health clinical services
5. Developing effective strategic partnerships
6. Focusing on recovery and hope
7. Establishing youth participation in governance, planning and implementation
8. Improving participation of families and carers in mental health services
9. Developing a youth mental health workforce

Principles for youth mental health services, Gosford Australia, Simpson and Howe, 2017

These principles were intended to be applied for youth mental health services across the state. This bottom-up reform took place before the introduction of *headspace*. When the *headspace* funding and model arrived a year later, in 2008, the local Central Coast Consortium led by the Central Coast Division of General Practice in NSW was thus able to negotiate to be one of the first 10 federal (national) grants to establish *headspace* Central Coast, called *headspace* Gosford (Simpson and Howe, 2017). It was an unusual case of a state primary care service receiving resources for the program and offered opportunities for integration with primary care. In partnership with *headspace* Gosford, from 2007-2009, Children and Young Peoples Mental Health (CYPMH) established the Youth Alliance (YA) model, employing 16 young people aged 15–24 years on a casual basis to help engage and support other young people, supported by a full-time paid coordinator, while contributing to the ongoing development of the NSW YMH Service Model (Simpson and Howe, 2017).

The *headspace* approach has itself integrated young people in decisions in various ways. Each headspace centre had a youth advisory group as did the national secretariat. More recently, young people have been included on the Board of the program. Young people have contributed to the design of the centres and their internal space to make them youth friendly, including for the national Orygen building and have initiated youth peer workers and youth groups to provide peer support.

Local applications of the *headspace* approach gave confidence for their wider application. The sites generated engagement and commitment from the communities they were located in. At the same time, they pointed to the need to address continuing policy debates, including on how early intervention approaches link to a system for dealing with complex conditions and longer term outcomes and how to ensure their integration within adequately resourced services that address the full spectrum of mental health disorders (Jorm, 2015; Donovan, 2016; Sawyer and Patton, 2018). Hiscock et al., (2018) found, for example, that the number of children who presented to Victorian public hospital emergency departments for mental health problems increased during 2008–2015, particularly for self-harm, depression, and behavioural disorders. General practitioners, found in the study to be the most common source of professional help, typically referred children to specialist services that often involved out-of-pocket costs that caregivers could not afford, delaying treatment, and resulting in crisis presentations to emergency care (Hiscock et al., 2018). These findings reflect in part the under-resourcing of state mental health services to ensure such integration. Hence for example, while the integration across the spectrum of services in the Gosford ycentral YMH example above was viewed by the local providers and by the *headspace* team as a useful approach, in 2017/8 the ycentral YMH site was decommissioned and only the *headspace* element continued, while the clinical youth mental health service was continued by the state (Coates et al., 2016; Simpson and Howe, 2017).

The simple messages and accessible approach that were highly effective in spreading the ideas in *headspace* and addressing one aspect of service delivery still leave unresolved the wider system demands to deal with more complex presentations in youth mental health. The evidence suggested a fragmentation in the system with poor co-ordination between *headspace* centres and the primary care and specialist services that is still to be addressed. Some of those involved with *headspace* called it the 'missing middle', services for people who are too ill for *headspace* but not ill enough for the very limited provision of care through state government services (Donovan, 2016; Higgins and Collard, 2019).

There are some initiatives underway on this, although this is still a work in progress with unclear policy impact in the complexity of Australia's mental health system: In 2012, a National Mental Health Commission was set up to provide independent reports and advice to the community and government on what is working and what is not. This Commission recommended in 2015 major reforms of the sector. There is a call for such reforms to be tested and their quality and impact assessed before any national roll-out (Jorm, 2015). In 2018/19, government announced a distribution of $125 million from its Medical Research Future Fund over 10 years for research on prevention, diagnoses and treatment approaches for mental health, with a particular focus on the causes of mental illness and equity in the responses, with a stated aim to widen the pool of researchers contributing to evidence (Australia Department of Health, 2018).

A subsequent Royal Commission on mental health in Victoria is also exploring ways of overcoming the fragmentation. While service models have been suggested, such as mental health hubs for GP referrals and provision of outreach teams, there are still debates on how to address the underlying gaps in the federal and state funding approaches to the different elements of the mental health system.

This section indicates how a consortium of researchers raised the demand and options for new approaches for youth mental health services, with clear, accessible messages on these options as a response to a publicly raised need to persuade state and federal actors and funders of their feasibility. The significant roll out of the approach points to the success of this engagement, albeit with ongoing debate on the wider system for the spectrum of youth mental health service needs.

4.3 Engaging political decision-making to support reforms

The earlier sections outline how a technical consortium used initial resources to gather evidence and to link this to effective advocacy on accessible, engaging messages for new models for youth mental health, particularly with political actors from both major parties at federal level, and at state level to support the introduction and later expansion of the model.

This section describes further how this political engagement and the demonstration of the model described earlier levered formal support for the model and the federal resources to expand the initiatives across states.

There was growing political concern, noted earlier, about adolescent mental health, suicide and the problems in youth mental health services. As a formal response, the 2008 Senate inquiry noted earlier engaged politicians and parliamentarians on evidence and testimonies on the barriers to adequate mental health services for young people, the fragmentation of the mental health sector, the lack of collaboration, co-ordination and of intersectoral linkages (The Senate Standing Committee on Community Affairs, 2008; Whiteford et al., 2016; Commonwealth of Australia HOR, 2011).

Parliamentarians identified the barriers youth faced as geographical, such as lack of access in rural and regional areas, financial, in their ability to pay for services and social, such as the stigma of being labeled mentally ill (Commonwealth of Australia HOR, 2011). They agreed that these barriers could not be overcome using existing health services (Commonwealth of Australia: Senate, 2011).

As noted above, while economic arguments were presented of the cost benefit of early intervention, it was the public pressure and expectation, the concern for youth and the visibility of community supported options that had impact on political actors. A media profile and public pressure made youth mental health an electoral issue, with many letters on this written to politicians. Equally, the promotion and demonstration of a model was appealing to political actors looking for solutions.

The 2010 elections provided a critical moment for translating the growing political attention into firmer support for formal policy change. As 'policy entrepreneurs', the consortium of researchers identified earlier had already individually and collectively developed links with politicians. *Hansard analysis reveals that politicians on both sides of the house responded to media appearances and comments by this core group of policy entrepreneurs and also attempted to obtain experts' approval for their policies* (Whiteford et al, 2016:7). The Orygen team and evidence of local community demand for *headspace* centres had generated political enthusiasm for the approach. With other professionals having limited engagement in political forums and a legal constraint on state officials engaging in policy advocacy, the consortium filled a gap in political platforms with a clear and appealing message for a recognized problem.

The pressure on politicians was reinforced by the promotion of mental health in electoral processes through a highly visible public advocacy organization *GetUp!*, that highlighted mental health issues generally and youth mental health in particular. In the months before the August 2010 election, *GetUp!* ran a campaign that included candlelight vigils across the country, national TV and newspaper adverts.

The campaign also included a mass emailing campaign to politicians and organization and delivery to government of a petition signed by 103 000 Australians (Hagan, 2010; Whiteford et al, 2016). In June 2010, a letter signed by over 60 of the nation's peak mental health organizations demanded that greater attention be paid to mental health in the wider health care reforms. While this public pressure did not necessarily reflect the views of a representative section of the voting public, it was a group of the public that effectively utilized social media to make their views known (Whiteford et al., 2016).

The 2010 election was heavily contested and produced a minority Labor government in August 2010 that wanted to move away from commitments on mental health and that provided little new funding for it. This was heavily criticized in the House of Representatives, with mental health labeled a "poor relation" , and the CEO of the National Advisory Commission on Mental Health resigning in protest (Commonwealth of Australia: House of Representatives, 2010:1495; Whiteford et al, 2016). The resignation of Prime minister Kevin Rudd and succession of Deputy Prime Minister Julia Gillard and strong bipartisan support for mental health shifted the political mood, and provided an opportunity for a new leader to move away from the previous leader's non-committal stance on investing in mental health (Whiteford et al., 2016; Hickie et al, 2014).

When Prime Minister Gillard moved slowly on the issue, the consortium of researchers worked with the political opposition to develop an alternative mental health 'Action Plan' that committed higher budget support and emphasized early intervention. This put pressure on Labor politicians in government to rethink their approach. The fact that Pat McGorry was 'Australian of the year' at the time further facilitated the high profile given to this issue.

In response, Prime Minister Gillard appointed an inaugural federal minister for mental health to demonstrate and give greater policy attention to the issue and committed $2.2 billion over 5 years to mental health care reform, including $571 million to enhance care for 24 000 Australians with severe and debilitating mental illness, and $492 million to expand youth services, designed to eventually reach 72 000 young people annually (Hickie et al, 2014). In 2011, the government announced a further $419.7 million for EPPIC and *headspace*, and in 2012 Gillard established the National Mental Health Commission (NMHC) for accountability and reporting of the outcomes from these investments (Hickie et al., 2014). A further investment of AUD$110 million in 2018 supported child and youth mental health. This included support for the *headspace* National Youth Mental Health Foundation and its support to Primary Health Networks to commission *headspace* services and for other school-based initiatives (Cook, 2018).

With the interventions rolling out over time, the political support needed to be sustained, while debates on the wider system also called for political scrutiny. In 2014, a cross-parliamentary group was launched to raise awareness for youth mental health, supported by almost 40 parliamentarians. Established by Australian Greens, the group, termed the 'Parliamentary Friends of Youth Mental Health' aimed to work with mental health bodies to develop a multi-partisan understanding of the specific mental health needs of young people. Over 20 mental health NGOs affiliated with the Parliamentary Friends group including Young and Well CRC, *headspace*, Orygen Youth Health, Rogue and Rouge, Beyond Blue, SANE Australia and the Mental Health Council of Australia (Wright, 2014). These parliamentary groups are not sustained. They change as new members are elected.

The fragmentation of the system thus remains a widely shared concern that is yet to be addressed by government. On 24 February 2019, Premier Daniel Andrews and Minister for Mental Health Martin Foley released the terms of reference of a Royal Commission into mental health services in one of the states, Victoria, taking submissions in July from across the spectrum of institutions and stakeholders in the sector. The Commission aims to provide a clear and ambitious set of actions that will change and improve Victoria's mental health system; to reduce the stigma and discrimination associated with mental illness and to solve system-wide issues. The Productivity Commission is also in 2019 examining the effect of mental health on people's ability to participate in and prosper in the community and workplace, and the effects it has more generally on the economy and productivity, taking input from a range of stakeholders, including communities and carers.

5. Summary of and learning on key drivers of the policy change

5.1 Summary of drivers and processes fostering policy change

By the 2000s there was growing evidence of the prevalence and burden of mental illness in youth and the inadequacy of resources and services to address. There was evidence and a social perception that fragmented mainstream services poorly addressed the range of social barriers young people faced and led many to 'slip through the gaps'. This case study shows how *headspace* as a one-stop early treatment centers providing early care for young people with mild mental health disorders was argued for, proposed, introduced and spread as an option to address this situation.

Funding from the Colonial Foundation was used to lever wider federal funding generating significant levels of resources to build a tenacious and energetic advocacy capacity and expertise in a team at Orygen led by Professor McGorry. Their research, coalitions with community groups and capacity to mobilise funding facilitated their development of comprehensive evidence from research and community consultations, critiquing the current system in a manner that demanded action.

They brought this evidence and people's experiences of the system into public and policy domains, including through platforms such as Senate inquiries. As a consortium of change-driven and committed professionals they were able to blend different skills to function as a technical group and a campaign team, enabling communication with and credible messengers for different audiences.

They developed a policy model, drawing on international experience, and proposed it as effective and ready to take to scale. They turned the science into a simple and positive message on a response to challenges in youth mental health services, with their model proposed as an affirmative, common sense approach to dealing with the problem in a manner that attracted attention and support more effectively than technical actors raising competing system approaches.

Connections with political actors in the states opened the door to federal funding and to state level processes to support expansion of *headspace*. This enabled demonstration of the policy model and report on its implementation, including through a collaborative learning network. *Headspace* expanded from ten pilot sites in 2008 to over 80 centres by 2016, with public meetings and media stories on the centres. These local applications gave confidence for their wider application. Their federal funding being limited to non-state actors outside the state primary care system coincided with a desire to control the approach and ensure branding in this scale up. The visible 'bricks and mortar' of the centres and their support from local communities generated consumer pressure for their spread and a perception of the model as one that politicians wanted to be associated with.

While arguments on the cost benefit of early intervention were presented, it was the public pressure and expectation, the concern for youth, the media profile and the visibility of community support that impacted on political actors and made youth mental health an electoral issue. The 2010 elections provided a critical moment for translating the political links and attention into formal policy change. A highly visible public advocacy campaign highlighted mental health, using candlelight vigils, adverts, mass emailing to politicians, a public petition and a letter signed by mental health organizations. Pat McGorry being 'Australian of the Year' at the time further facilitated the profile of youth mental health. When Prime Minister Gillard moved too slowly on the issue, the research consortium worked with the political opposition to develop an alternative mental health plan and budget support that also emphasized early intervention. This put pressure on government, provoking measures to demonstrate policy support, including an inaugural federal minister for mental health and a significant financial commitment to mental health, including for *headspace*.

Pat McGorry, Ian Hickie, and others were highly effective policy entrepreneurs and advocates for the *headspace* model, overshadowing other, less politically engaged or connected professionals. The *headspace* experience has raised wider deficits in the mental health system, including how early intervention approaches link to methods for more complex conditions and longer term outcomes. The fragmentation in the system, poor co-ordination between *headspace* centres and the primary care and specialist services is still to be addressed, as is the lack of a unified conceptual understanding of the mental health system across the various actors involved in it. Competitive tendering and fragmented funding of the mental health system has led to fragmentation and duplication, including with core non-mental health disciplines, exacerbated by multiple non-state actors organized around specific approaches.

While these issues are widely recognised, debates on how to address them are ongoing. While this case study does not intend to critique any particular model, there is evidence of strong, divergent and sometimes confrontational positions on the mental health system, and a sense that a singular focus of attention and resources on one aspect, such as *headspace*, can leave other aspects unaddressed in a system that is more widely problematic.

5.2 Learning and insights on the facilitators of policy change

The reflections of those involved in these policy changes raise further insights from the experience:

In raising and keeping the issue on the policy and political agenda, find your 'tribe', organise and support those aligned to your thinking and activate all parts of the system to a common cause. This means being clear about the issue and using best evidence available; on it, tailored to context and audience. Dealing only with the technical evidence is necessary but insufficient to raise policy attention: it needs media capacities that can give 'oxygen' to public awareness.

It needs an understanding of the different approaches to differently engage innovators, early adopters and late adopters of ideas, to get the latter on board, while also needing to tackle arguments of those who oppose or detract. It also needs an understanding of public views and analysis and an ability to move with it, when this changes. This demanded different capacities and messengers in a stable team or consortium of people with shared goals, including to provide moral support. This was also supported by having a charismatic leader and significant resources to invest in political advocacy and to operationalize and demonstrate the policy idea in practice.

For the development and adoption of policy options, research needs to be motivated by a desire for practical change in a strong, values-driven team with diverse capacities. The process needs to be planned for and demands many forms of evidence and understanding. Having credibility as clinicians and using evidence from international level research helps, but so too does the advocacy by local actors, communities and states. The health system is complex and influenced by funding flows and by the way political and policy actors chose policy approaches. It is important therefore to understand the motivations and to have a persuasive local model that can build support. While practices from elsewhere may be shared, securing the seed and wider funding to demonstrate practice and show how it works under local conditions is important. It also calls for a capacity to respond to and engage in bureaucratic and formal policy development processes.

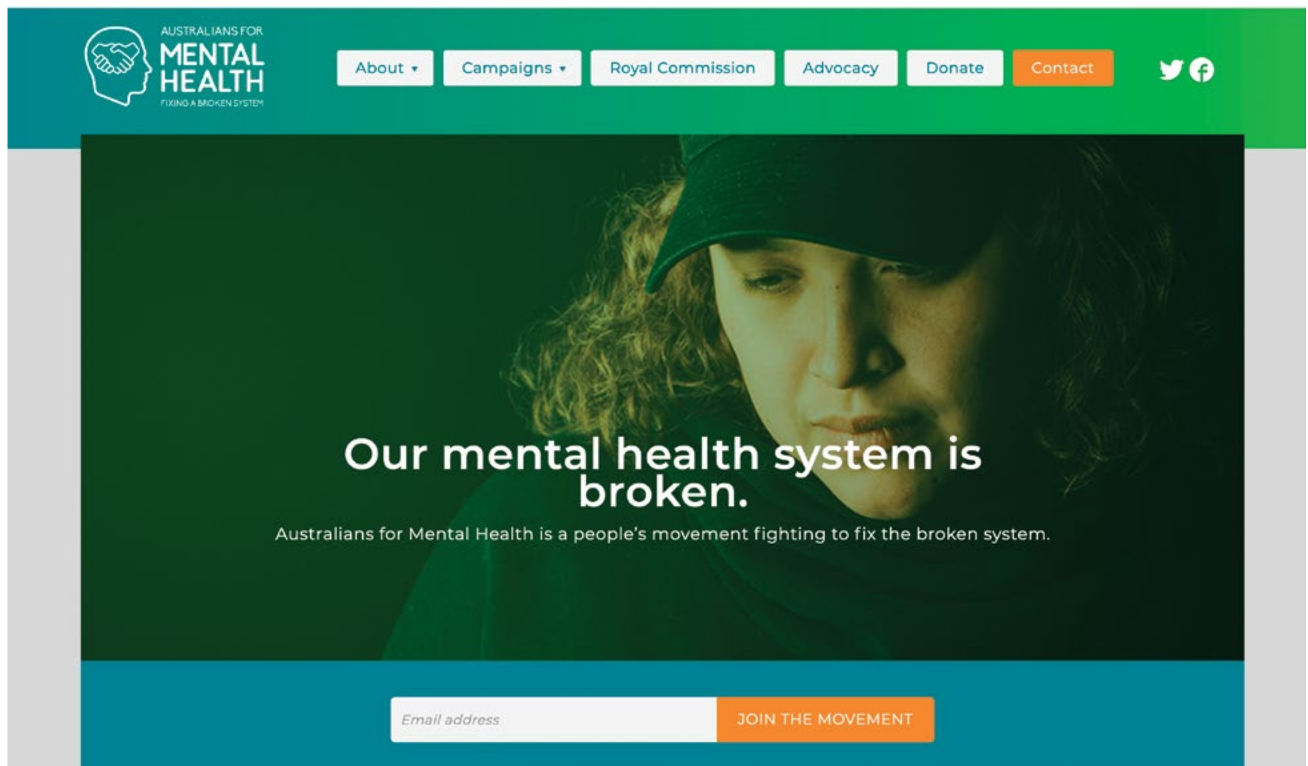
In building political and public support and sustaining policy implementation, it is important to create a groundswell with influential people, to get political buy in, through an accessible message, a visible model, or backing from strong advocates and champions. Key influential people were thus identified and brought on board in the legislature, in states and political parties, with positive messages, but also negation of opposing voices and ideas. This meant speaking truth to policy, but also managing the diplomacy of working with multiple actors. It also meant building the strategic review, internal think tank, short and long term planning and resources for political engagement. Oversight, monitoring and evaluation is important to sustain political support, done in a way that captures short and longer term changes and specific and system impacts.

There has been limited formal evaluation of *headspace*, but one independent review found it to be accessible for diverse young people, to have led to improved mental health, economic and social outcomes and to have community support. There was also variation in the youth mental health outcomes, and continued barriers for youth with complex mental health conditions in accessing care.

The successful adoption and implementation of *headspace* is one that has been driven by a well-organized, sustained strategy covering social, technical and political drivers led by a tenacious and creative consortium, with a well-resourced and capable team and strong leadership. The process of policy engagement and change has been highly successful in raising attention and producing change in early intervention for youth mental health. At the same time fragmentation and polarised positions can result from the intensity of processes, leaving wider system issues remain unresolved.

A mix of actors now see a need for a more balanced investment in a 'joined-up system'. A 2009/10 Mental Health Plan set a commitment across states to strengthen co-ordination across services, albeit with still limited investment in the processes for this. Organisations such as Beyond Blue, SANE Australia, Blackdog Institute and others have strengthened co-ordination to collectively raise and sustain advocacy on responses to the fragmentation in the system and splintering of actors.

A new 'people's movement' on mental health, the 'Australians for Mental Health' involving people suffering mental ill-health, their families and friends aims to achieve fundamental, systemic reform of the mental health system. While debate continues with a diversity of voice on how to make the improvements, there is consensus that policy change on the youth mental health system is still far from complete.



Australians for Mental Health Website

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Endnotes

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2 See Loewenson and Masotya (2018) for information on the conceptual and analytic framework used.