Eóin Killackey

Orygen, The National Centre of Excellence in Youth Mental Health

Working things out: Models of youth mental health care and vocational recovery

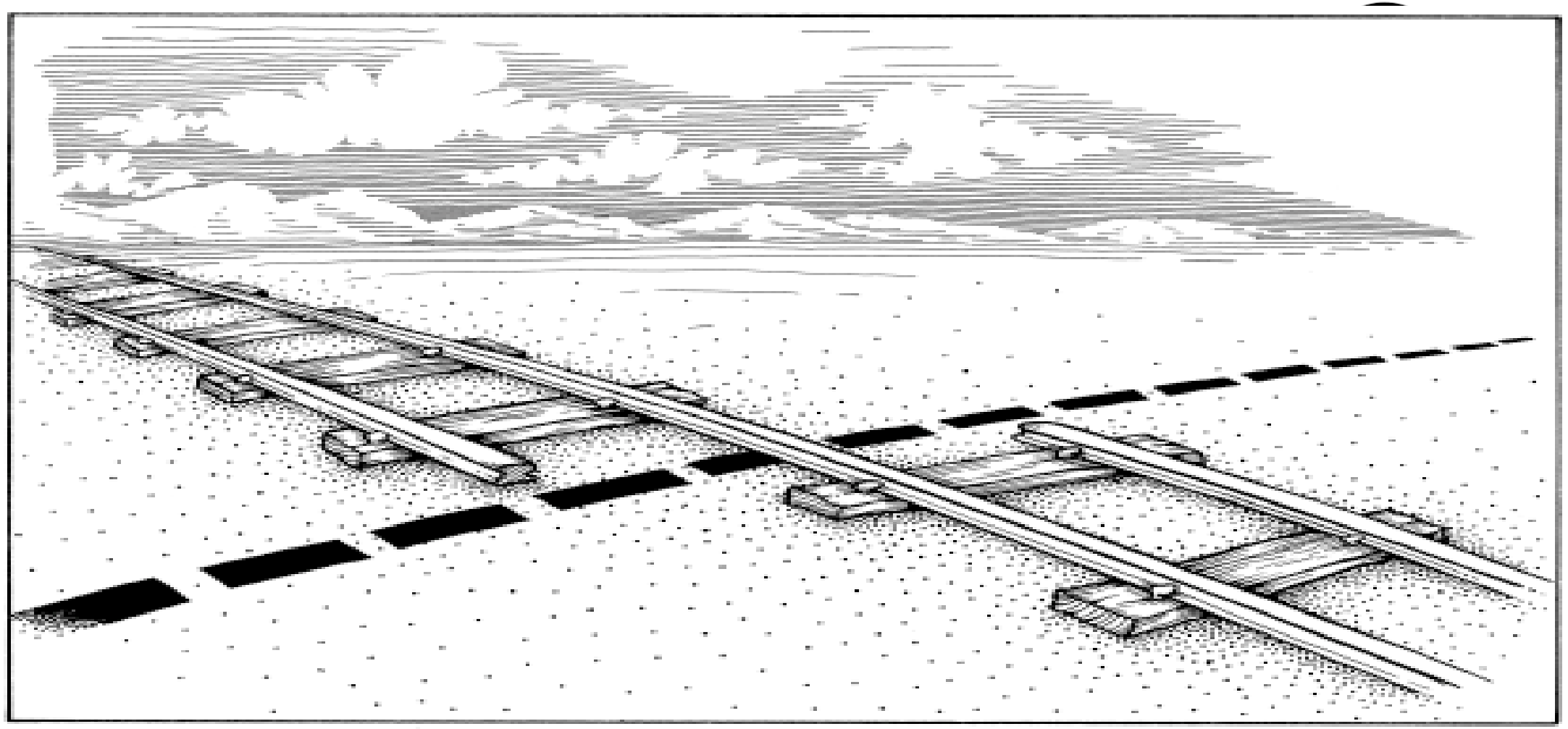
Outline

Why we need a youth mental health system

Functional recovery within a youth mental health system

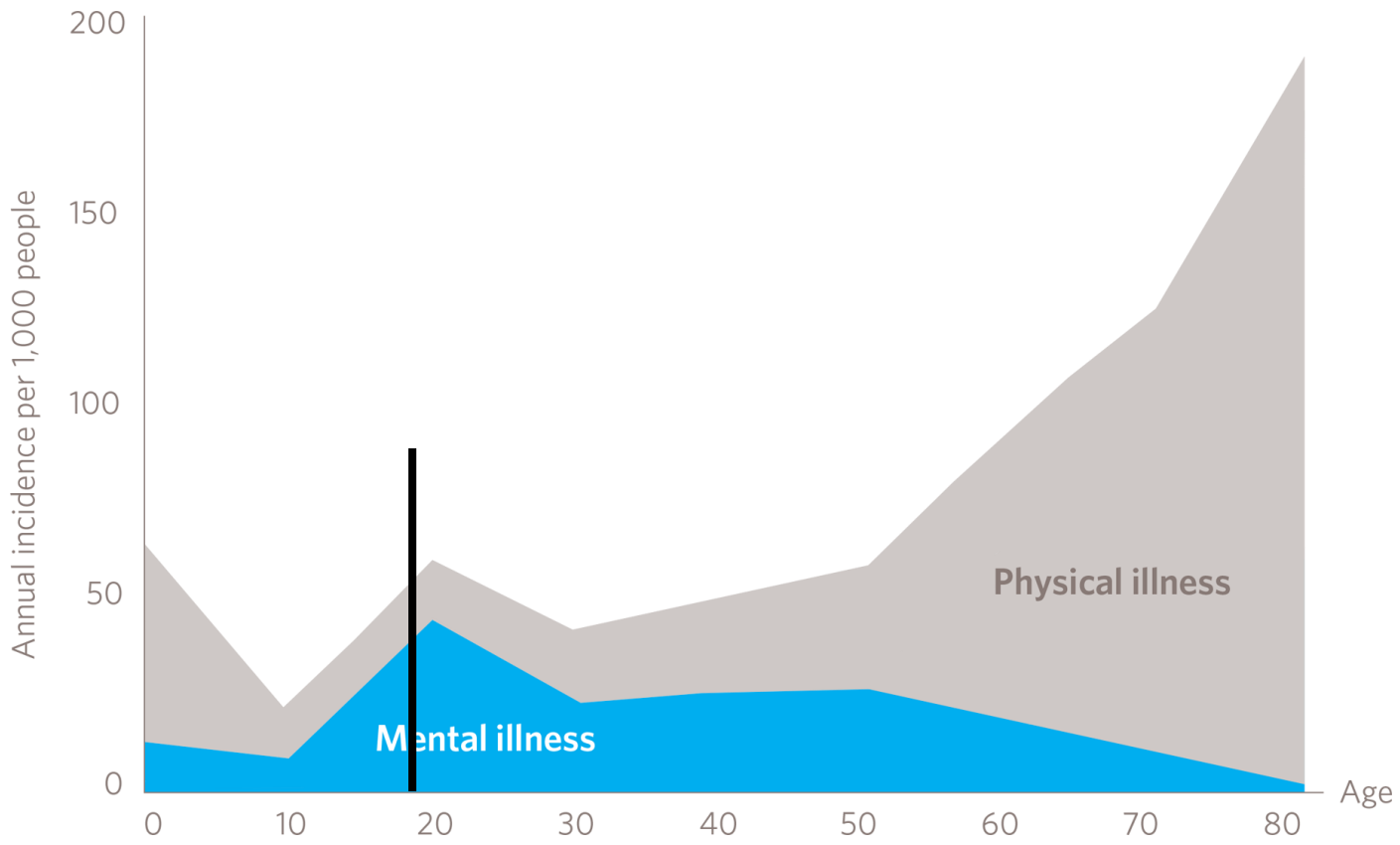
Global framework for youth mental health care

The mental health system



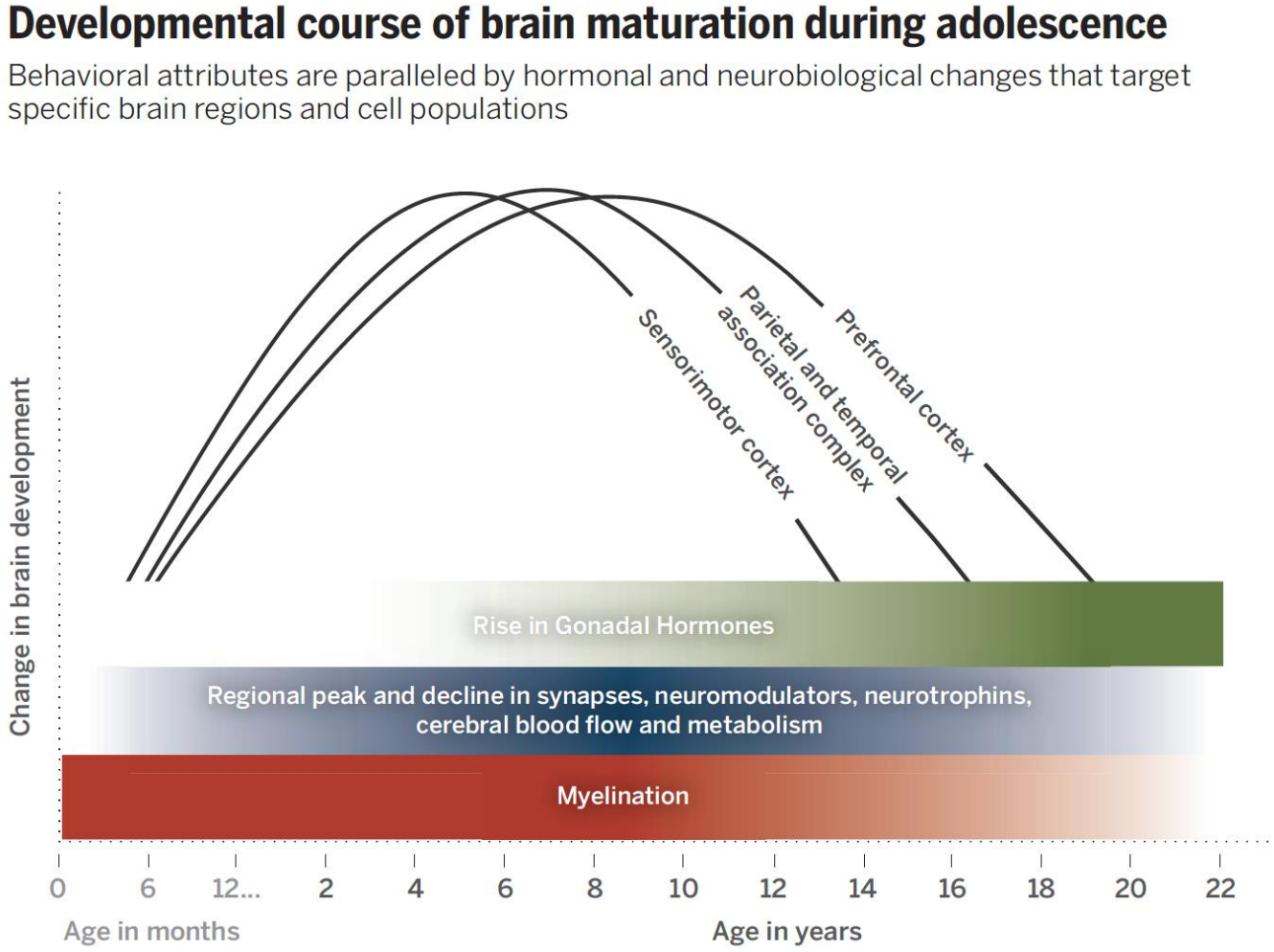
The mental health system does not match the epidemiology

Burden of disease by age

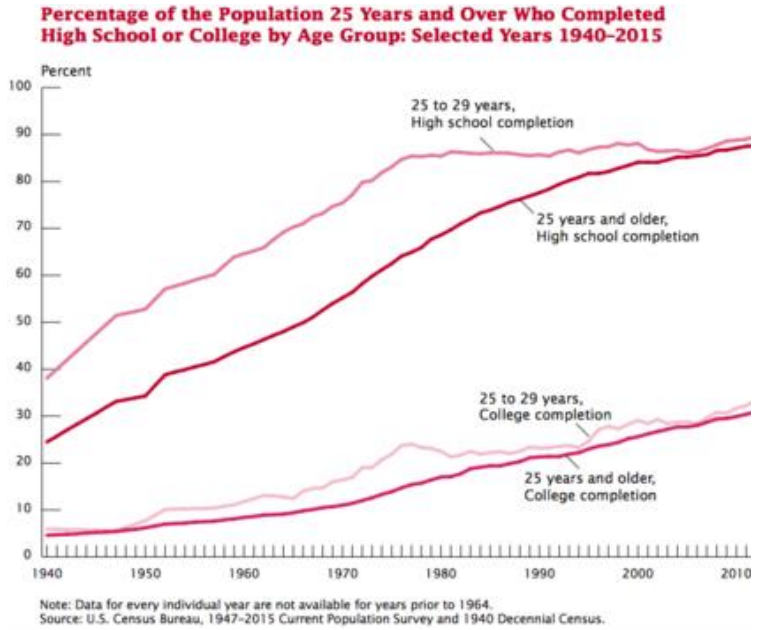


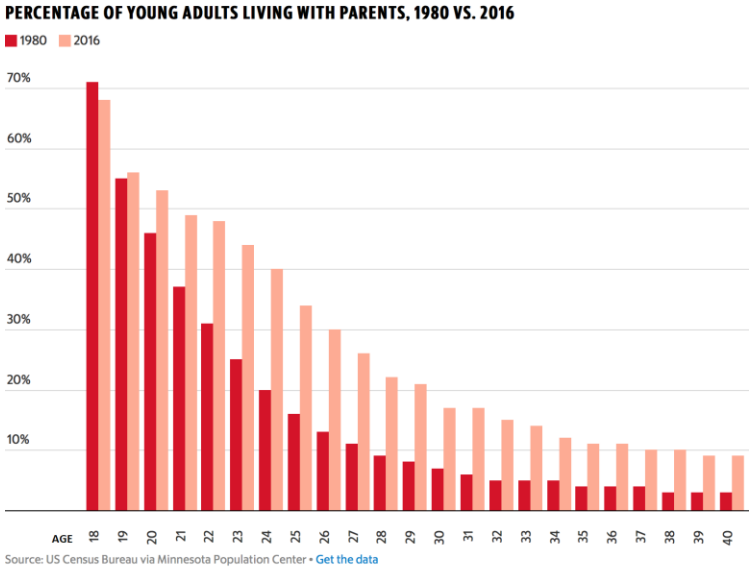
The mental health system does not correspond with brain development

Lee et al., (2014) Science



The mental health system does not align with social development





With increased societal development comes a longer transition to independence

The current system will not address the economic challenge of mental ill health

Economics

Table 13: Mental illness costs expected to more than double by 2030
Global cost of mental health conditions in 2010 and 2030. Costs shown in billions of 2010 US$

	Low- and Middle-Income Countries			High-Income Countries			World		
	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness
2010	287	583	870	536	1,088	1,624	823	1,671	2,493
2030	697	1,416	2,113	1,298	2,635	3,933	1,995	4,051	6,046

Figure 3a: Mental health and cardiovascular diseases are top drivers of lost output
Breakdown of NCD cost by disease type, based on EPIC model

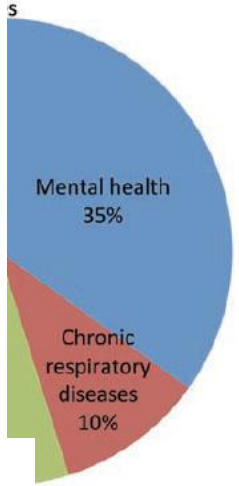
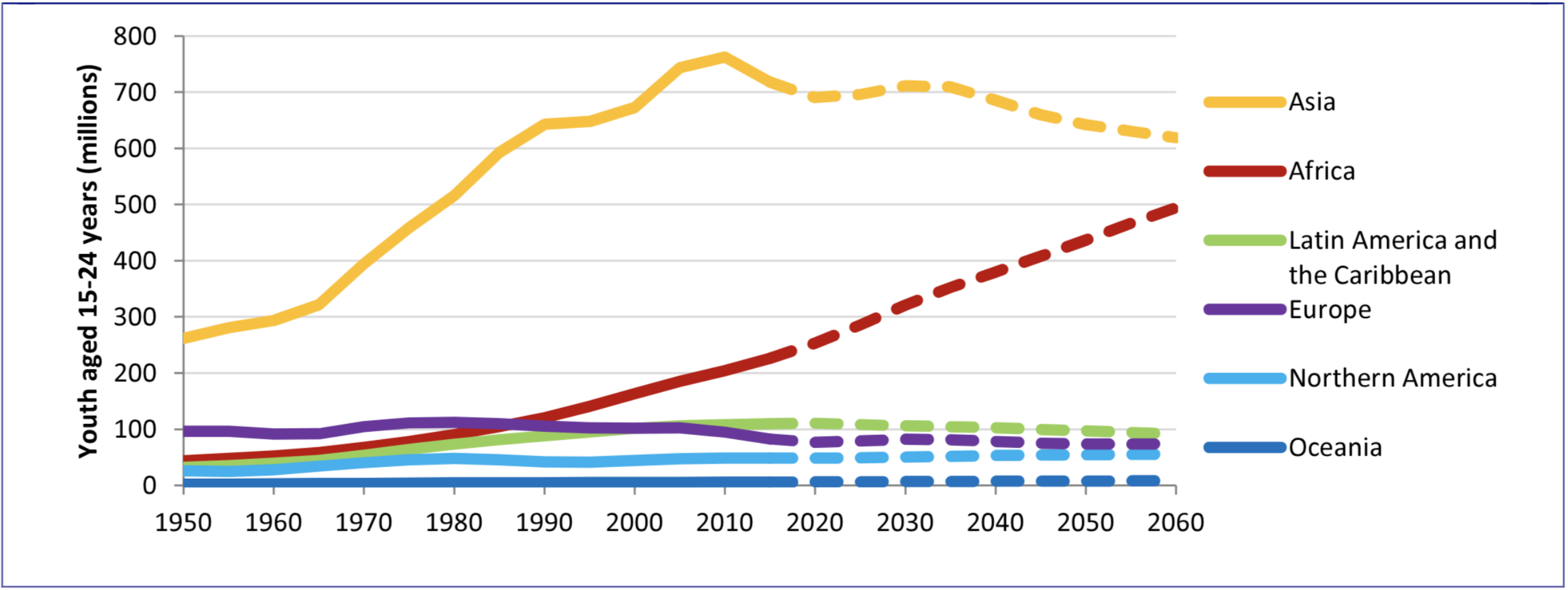


Table 16: Mental illness hits output hard
Breakdown of output losses by disease type and income category, 2010 and 2030, trillions (2010 US$), using the VSL approach

	2010						2030					
	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental Illness	Total	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental Illness	Total
High Income	1.7	1.5	5.4	0.7	5.5	14.8	2.2	2.0	7.2	1.0	7.3	19.7
Upper Middle Income	0.6	0.5	1.9	0.3	1.9	5.1	1.9	1.8	6.3	0.9	6.5	17.4
Lower Middle Income	0.3	0.2	0.9	0.1	0.9	2.4	0.6	0.5	1.9	0.3	2.0	5.3
Low Income	0.1	0.1	0.2	0.0	0.2	0.5	0.1	0.1	0.4	0.0	0.4	1.0
World	**2.5**	**2.4**	**8.3**	**1.2**	**8.5**	**22.8**	**4.9**	**4.5**	**15.8**	**2.2**	**16.1**	**43.4**

oom et al., 2011

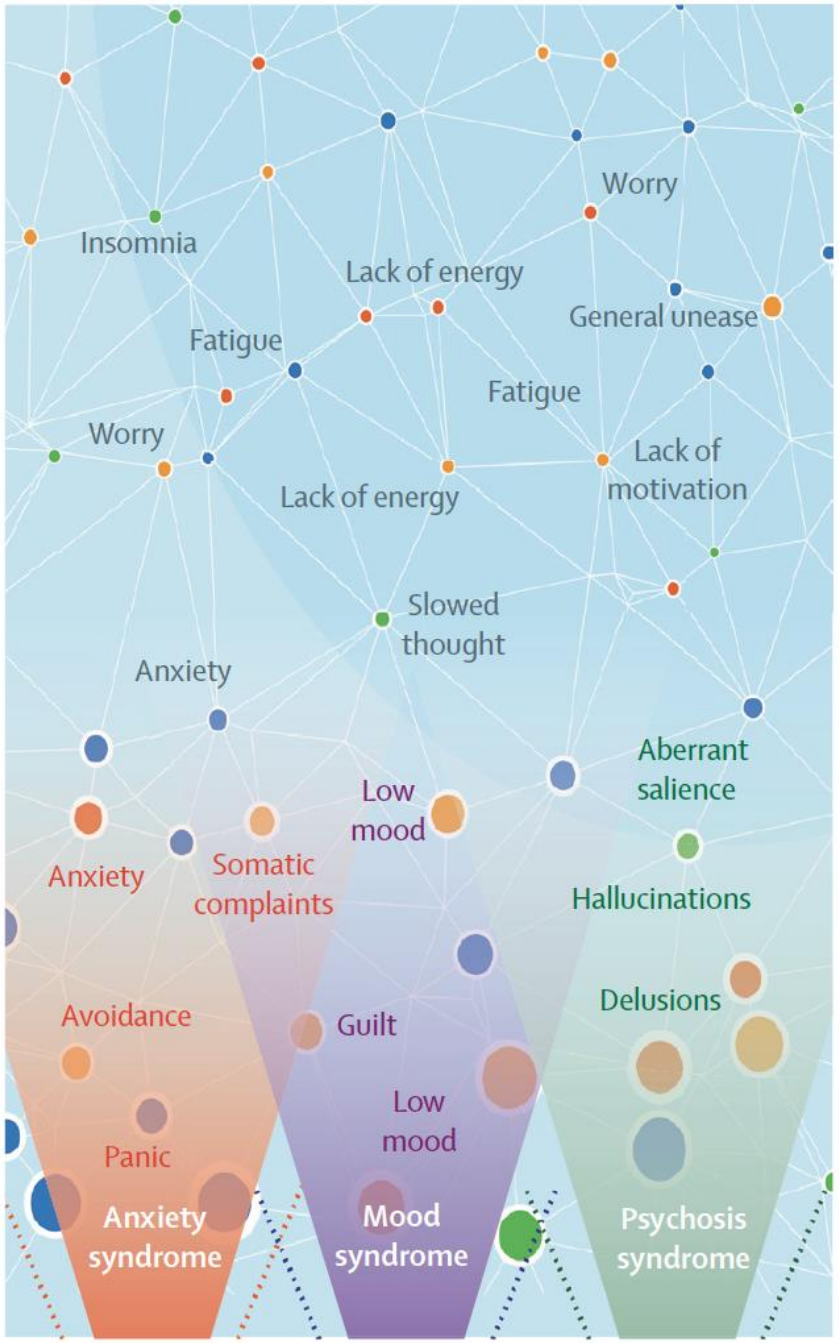


Data source: United Nations (2013) *World Population Prospects: The 2012 Revision.*

So we need a new youth mental health system

Increasing symptom specificity and severity

From diffuse, non-specific symptoms causing intermittent mental distress to clear syndromes causing increasingly severe functional impairment



Mental wellbeing
No distress

Stage of non-specific mental distress
Need more awareness and understanding to promote self-help

Early treatment
Better management and prevention for improvement of overall mental health and reduction of symptoms

State of specific mental syndrome
Progressive treatment aligned to evidence related to specific disorders

Stage 0 **Asymptomatic**
- Public mental health promotion and illness prevention
- No individual treatment or intervention

Stage 1a **Non-specific mental distress**
- Self-help and support from informal networks
- Interventions raising population mental health literacy
- Identification of stressful or noxious environmental exposures
- Exploration of environmental modification or development of coping strategies

Stage 1b **Subsyndromal or subthreshold symptom profile**
- Advice and transdiagnostic psychosocial support from PHC
- Identification of high-risk individuals and monitoring

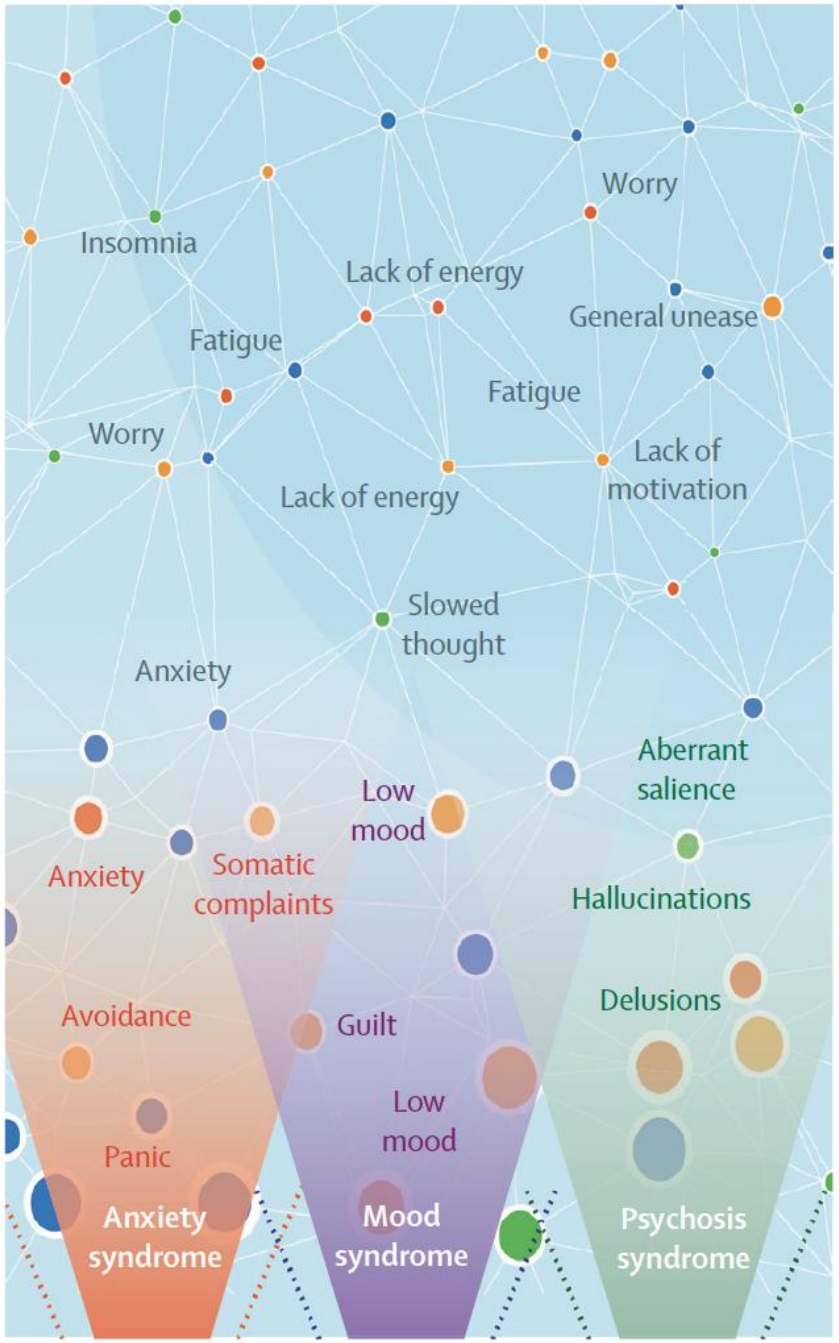
Stage 2 **Full defined syndrome**
- First episode treatment in primary care
- Specialist care available for primary health services through properly resourced collaborative models
- Effective referral through stepped care for complex

Stage 3 **Recurrence, persistence**
- Specialist mental health service in collaboration with PHC
- Ongoing community and multisectoral support

Stage 4 **Treatment resistance**
- Specialist mental health service in collaboration with PHC
- Rehabilitation and ongoing community support

Increasing symptom specificity and severity

From diffuse, non-specific symptoms causing intermittent mental distress to clear syndromes causing increasingly severe functional impairment



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Stage 2 **Full defined syndrome**
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- Effective referral through stepped care for complex or unresponsive cases

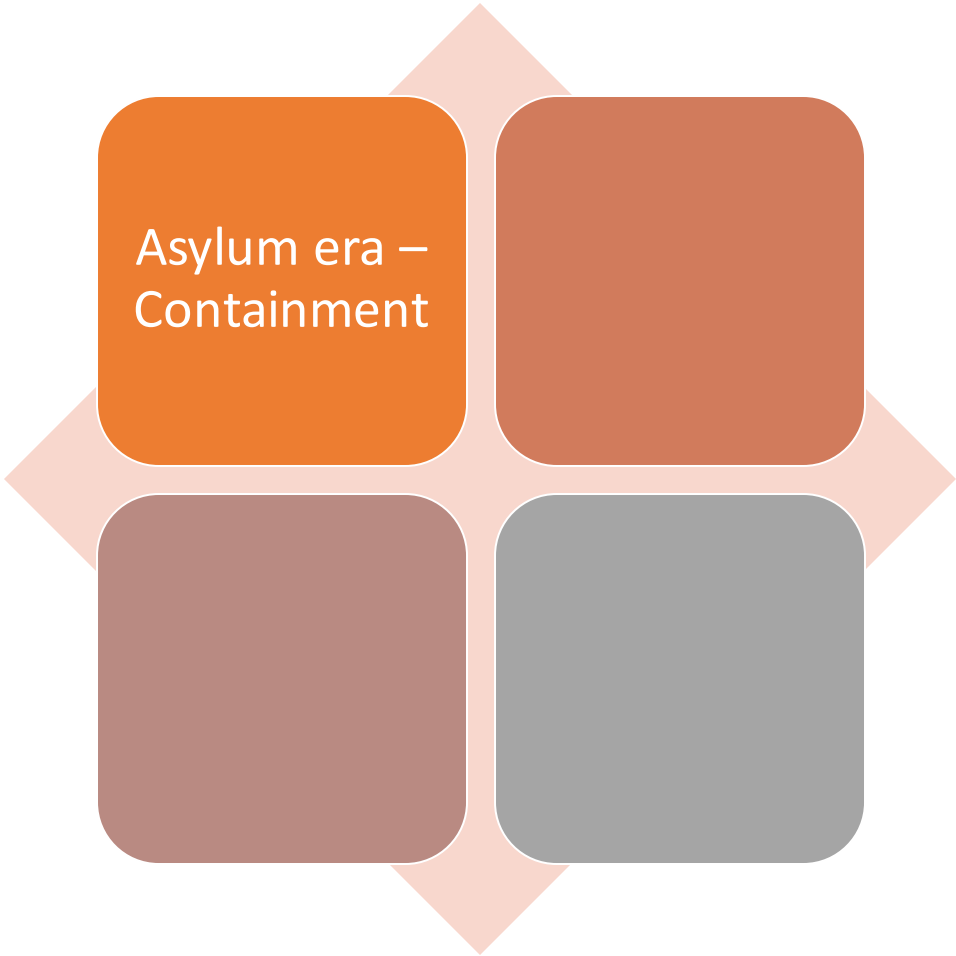
- Specialist mental health service in collaboration with PHC
- Ongoing community and multisectoral support

Stage 4 **Treatment resistance**
- Specialist mental health service in collaboration with PHC
- Rehabilitation and ongoing community support

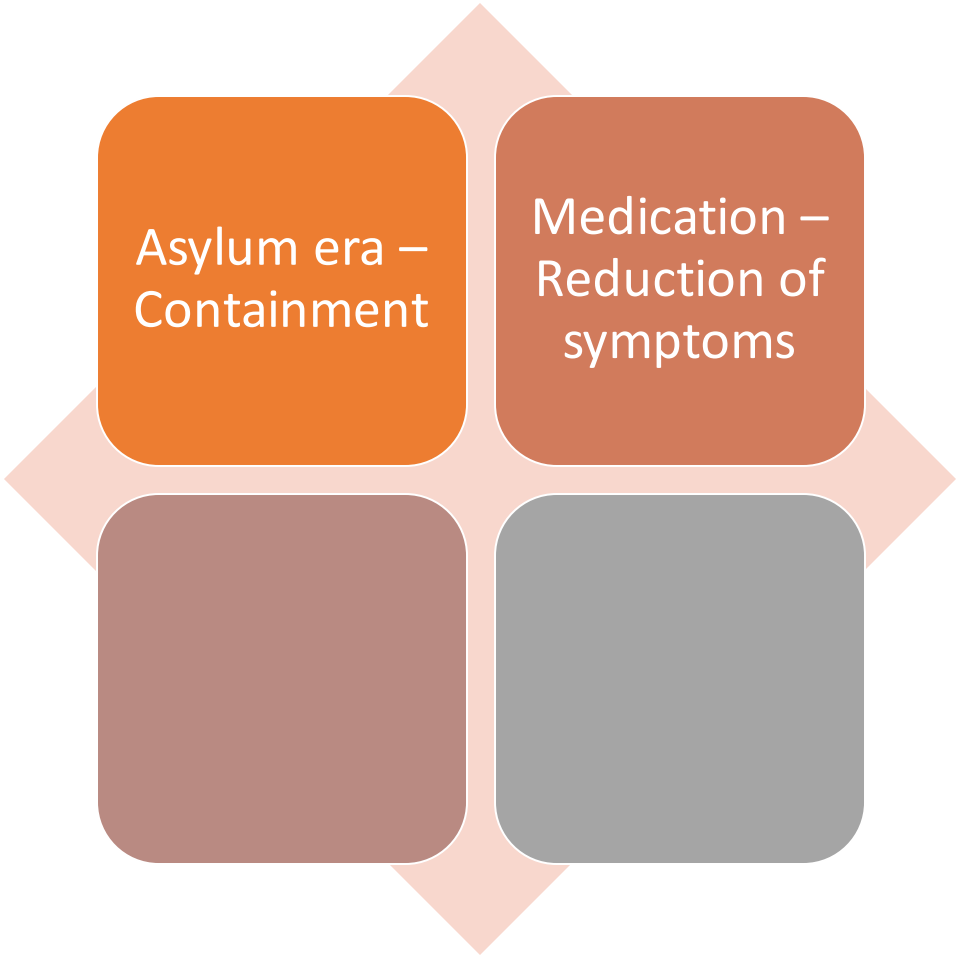
Where is the place of recovery in the system?

History

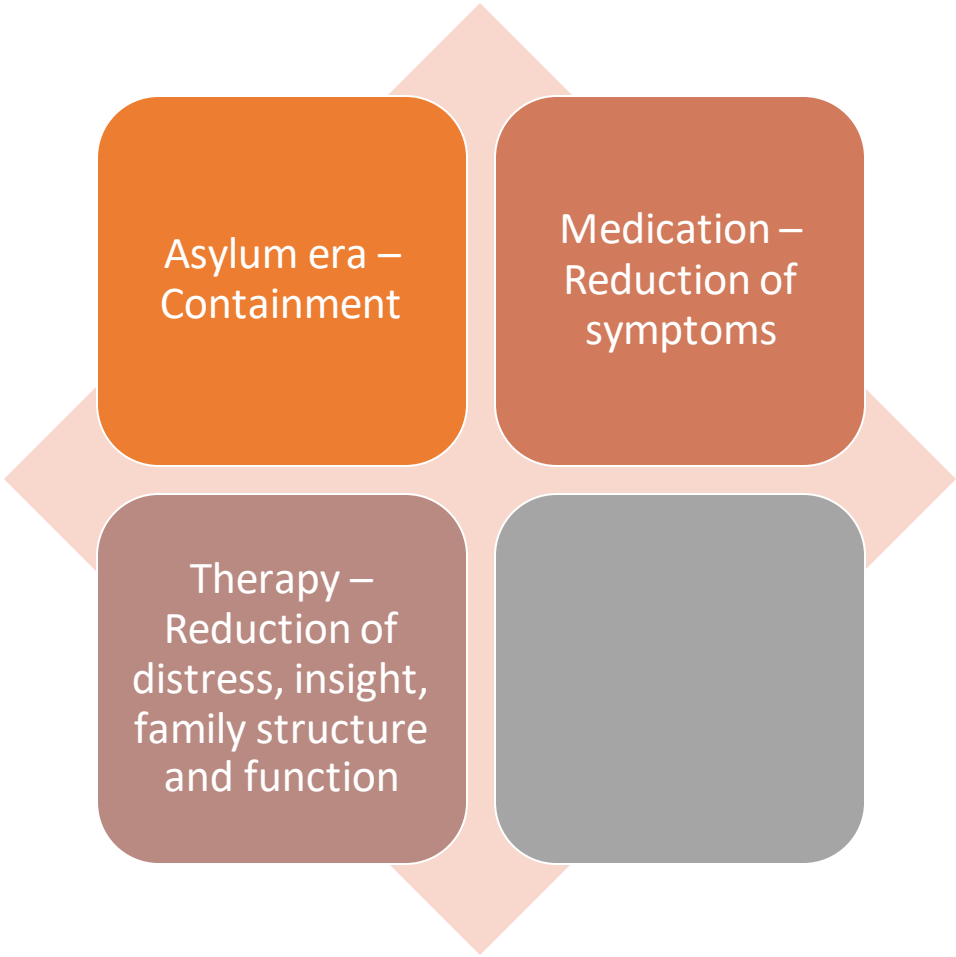
Purposes of treatment



Purposes of treatment



Purposes of treatment



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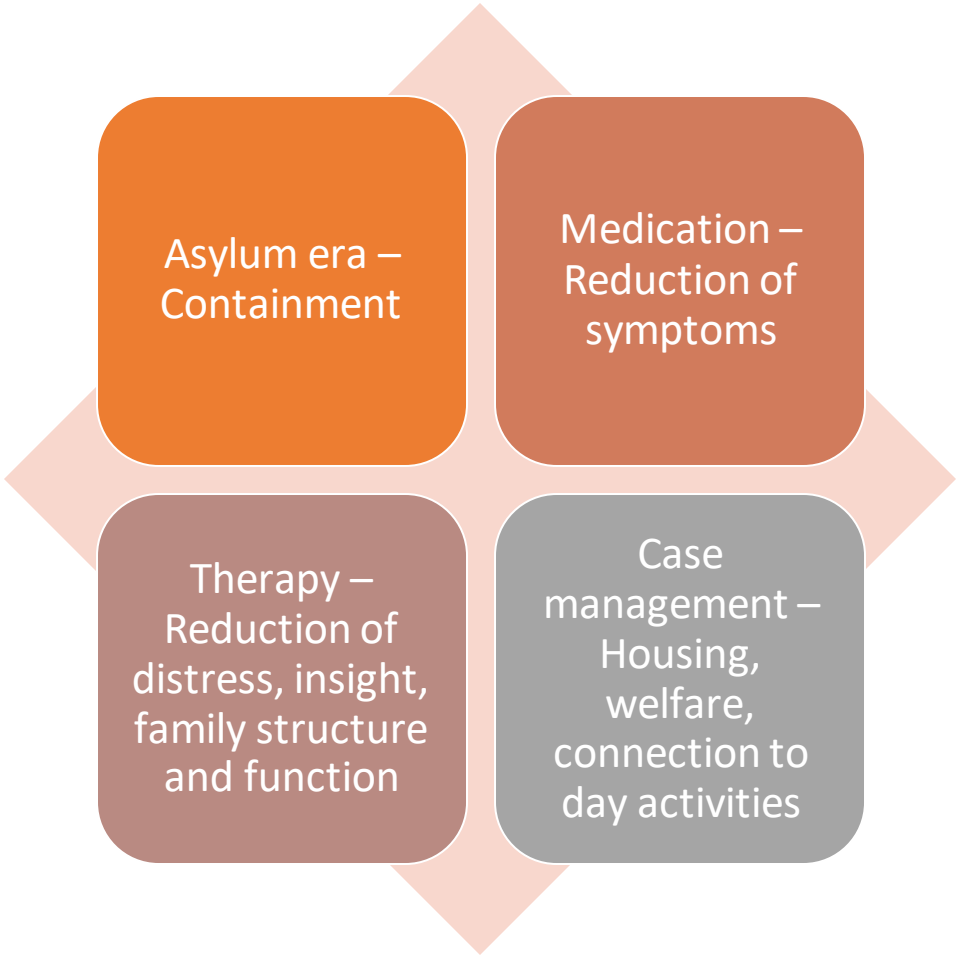
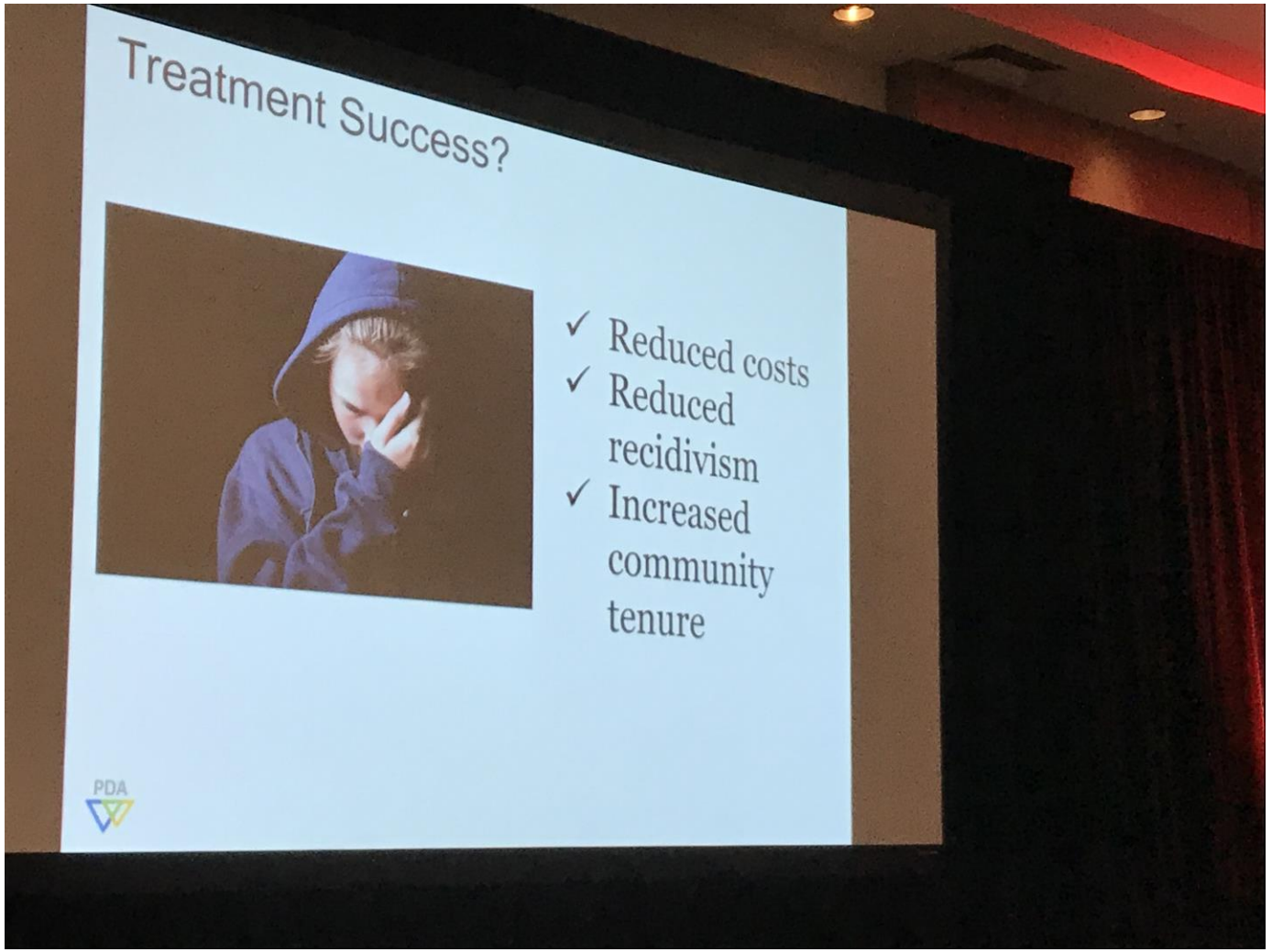


Slide from Patricia Deegan's Presentation at IPSWorks 2019




Recovery

No assumption of recovery

“The concept of recovery…would have been considered something of an oxymoron in the literature a generation ago”
- Allan Bellack, 2006

Some definitions

"Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process."

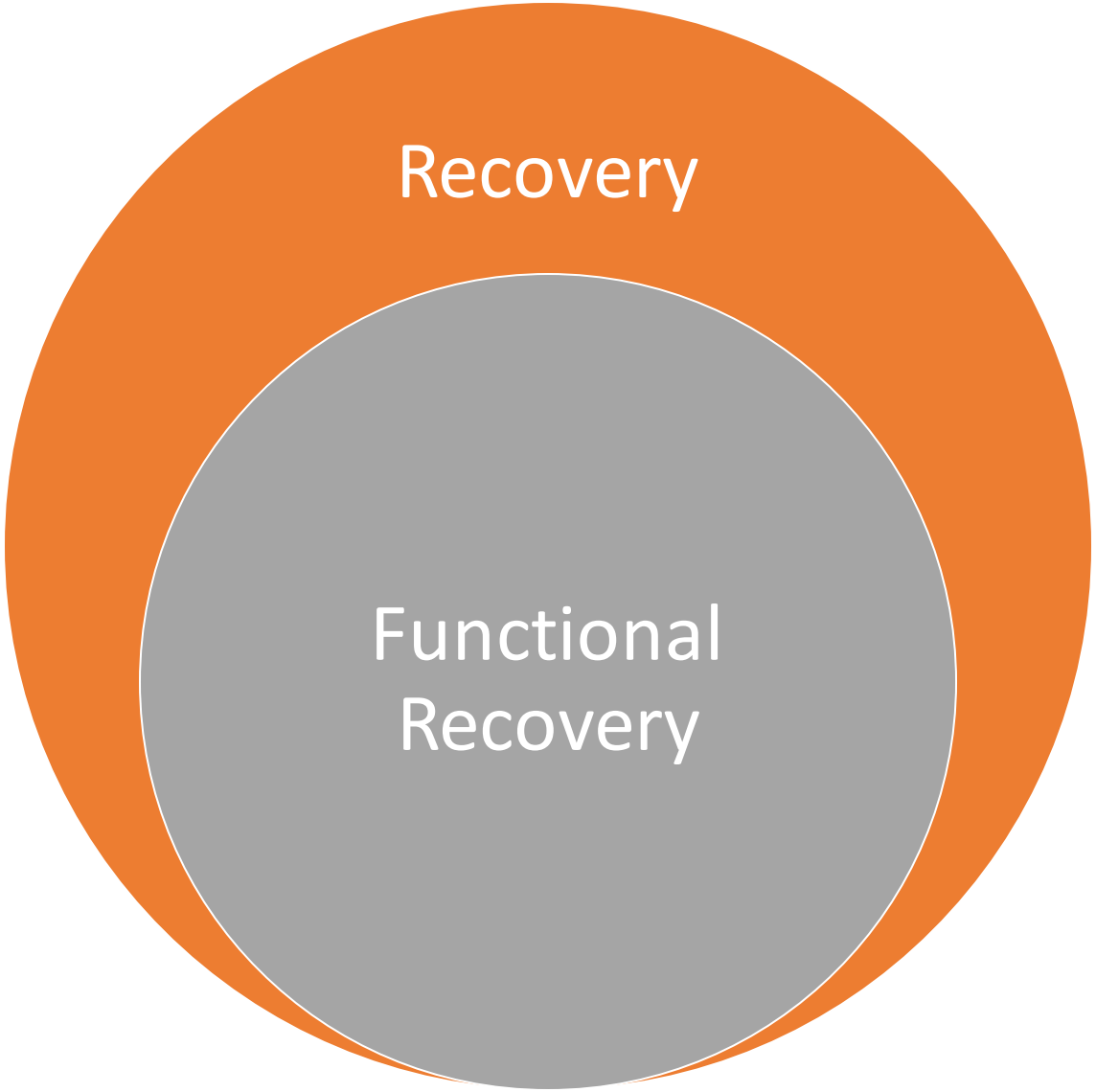
"Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover

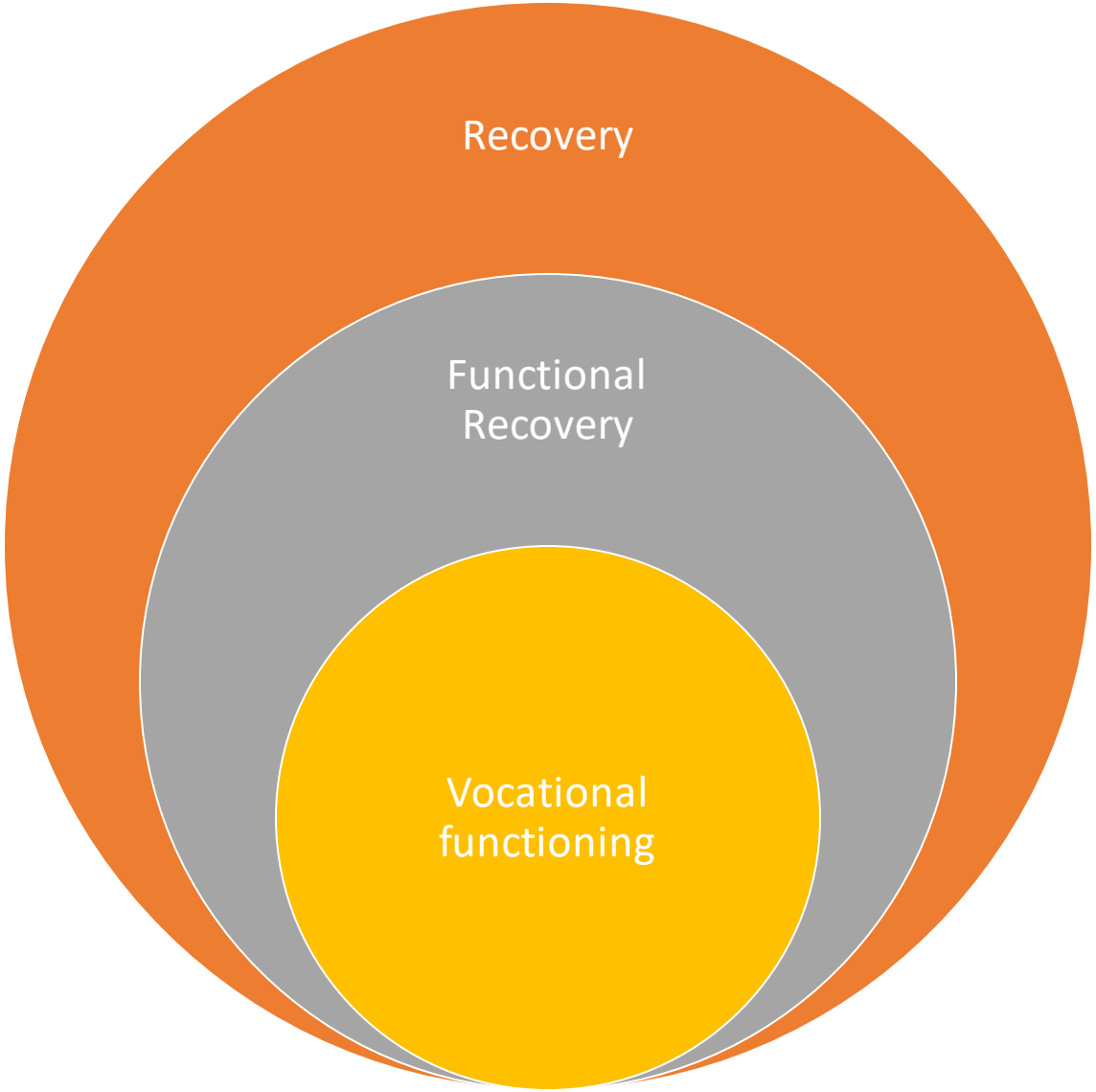
- Anthony, 1993 (Psychosocial Rehabilitation Journal)

"The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes"

- Deegan, 1996 (Psychiatric Rehabilitation Journal)


Recovery


Recovery
Functional Recovery


Recovery
Functional Recovery
Vocational functioning

What is functional recovery and why do we need it?

What is Functional Recovery

Fulfillment of age appropriate role expectations,

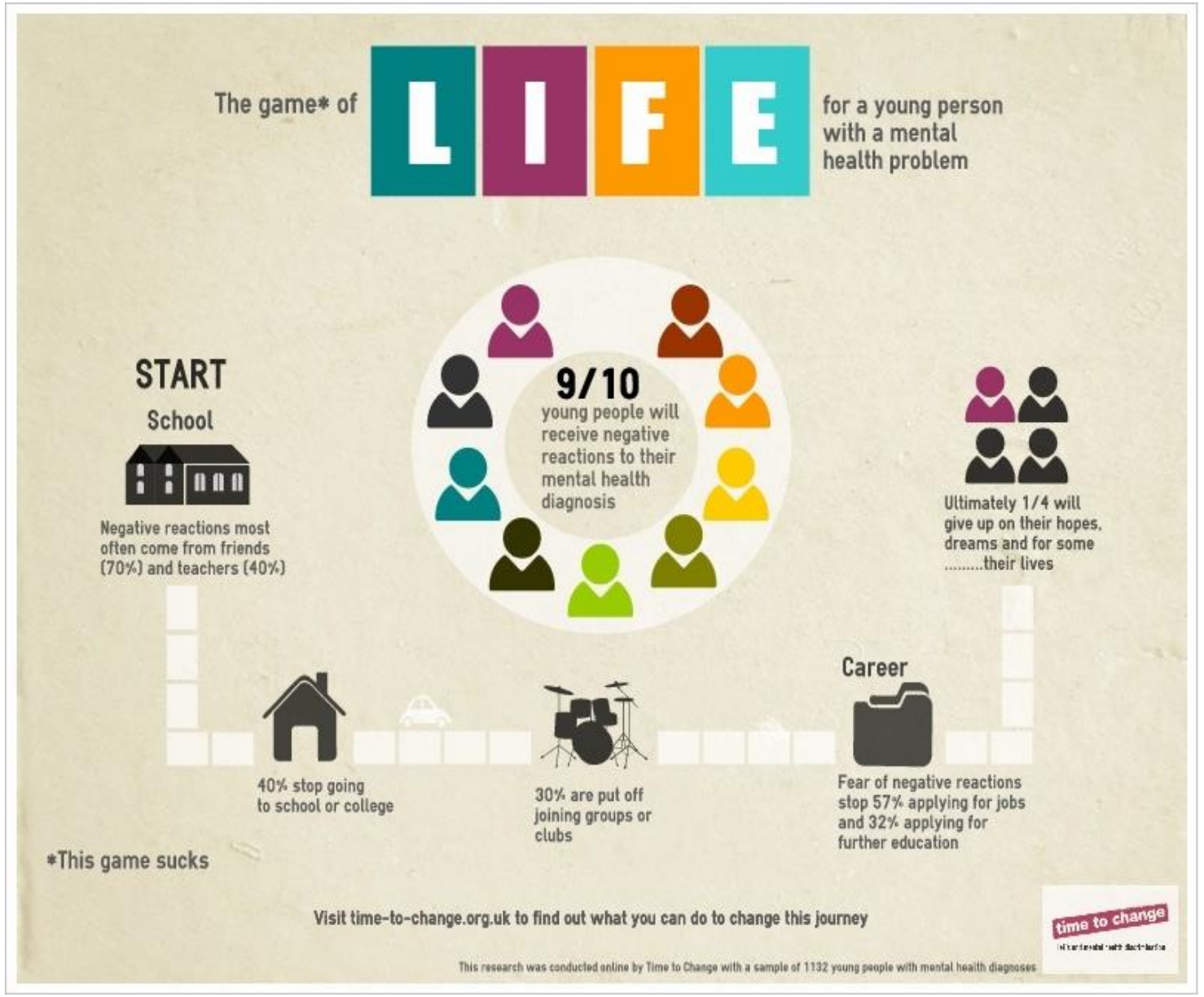
Education

Employment

Engagement in social interactions

Performance of daily living tasks without supervision

And why do we need it?



What is Functional Recovery

Fulfillment of age appropriate role expectations,

- Education
- Employment

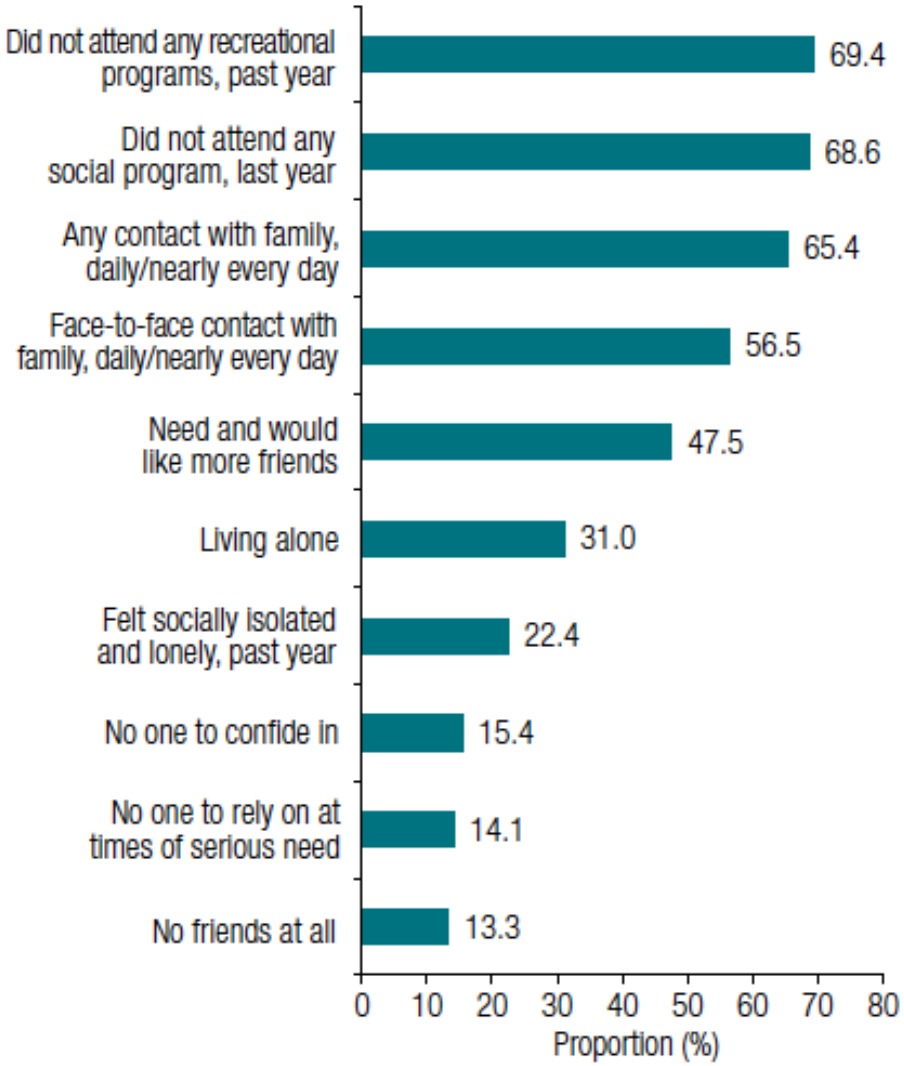
Engagement in social interactions

- Friends
- Intimate relationships
- Community participation

Performance of daily living tasks without supervision

And why do we need it? - Social contact

Figure 23: Contact with others and formal social events



What is Functional Recovery

Fulfillment of age appropriate role expectations,

- Education
- Employment

Engagement in social interactions

- Friends
- Intimate relationships
- Community participation

Performance of daily living tasks without supervision

- Care of self
- Accommodation
- Physical health

Housing types	Current housing *n* (%)	Preferred housing (irrespective of current housing) *n* (%)	Proportion not living in preferred housing *n* (%)
Public rented house/unit	490 (26.8)	472 (25.9)	187 (39.6)
Private rented house/unit	397 (21.8)	313 (17.2)	174 (55.6)
Family home	349 (19.1)	190 (10.4)	56 (29.5)
Own house/unit	239 (13.1)	726 (39.8)	506 (69.7)
Supported group accommodation	200 (11.0)	51 (2.8)	8 (15.7)
Homeless: primary, secondary or tertiary	94 (5.2)	44 (2.4)	33 (75.0)
Institution/hospital	36 (2.0)	2 (0.1)	0 (0.0)
Other, including caravan, prison	20 (1.1)	24 (1.3)	19 (79.2)
Total[a]	1825 (100)	1822 (100)	

Figure 9: Overweight and obesity

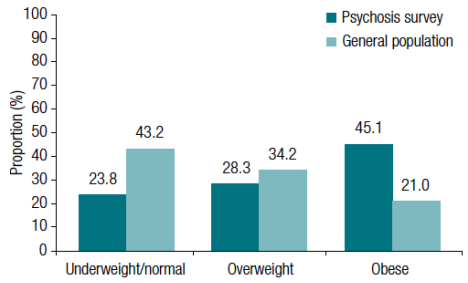
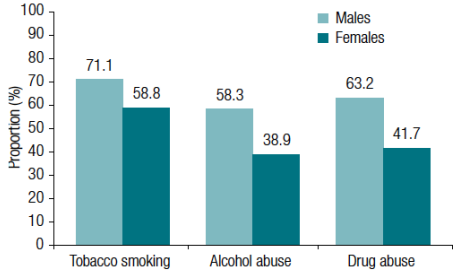
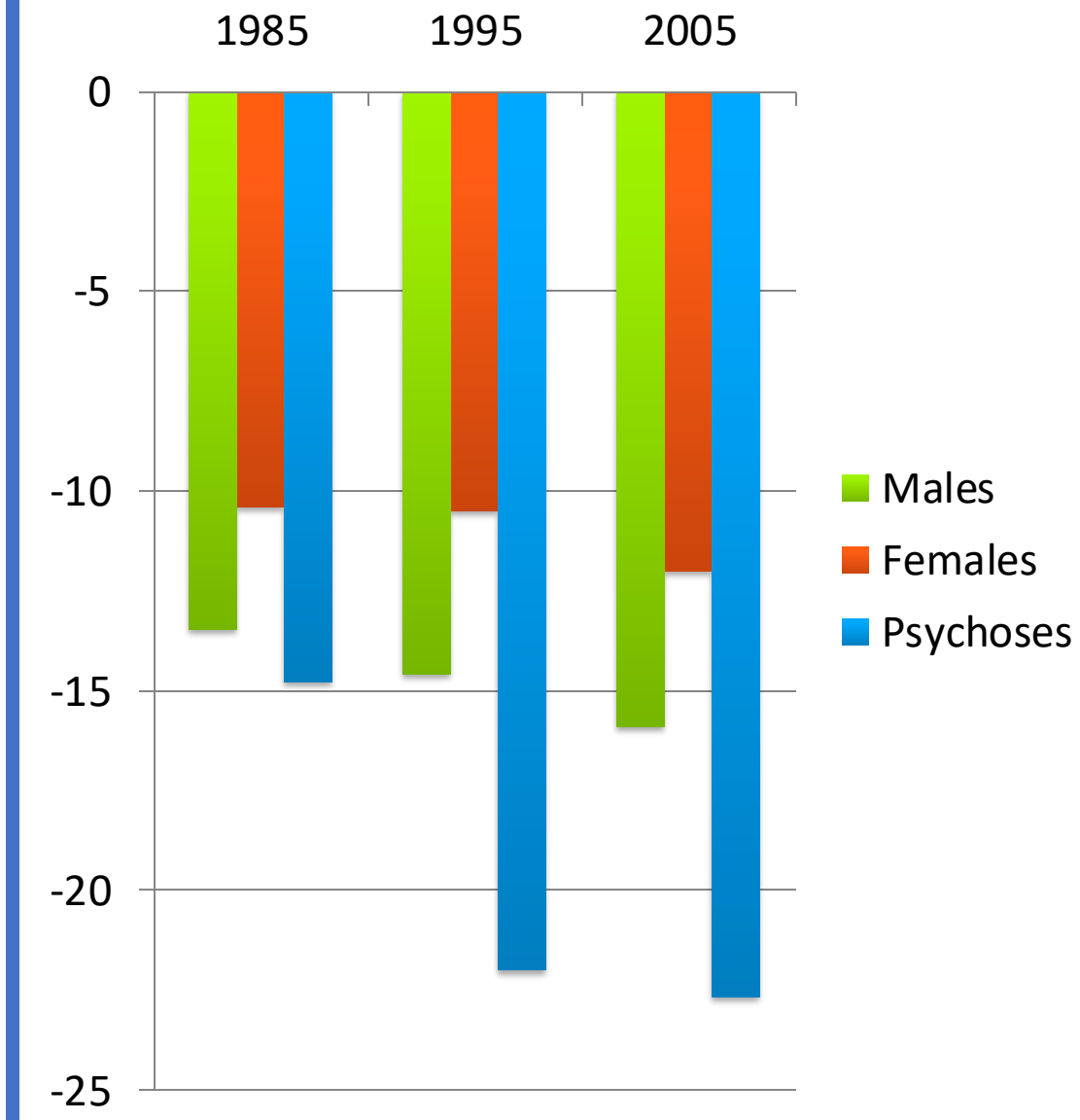


Figure 10: Smoking, and alcohol and drug abuse

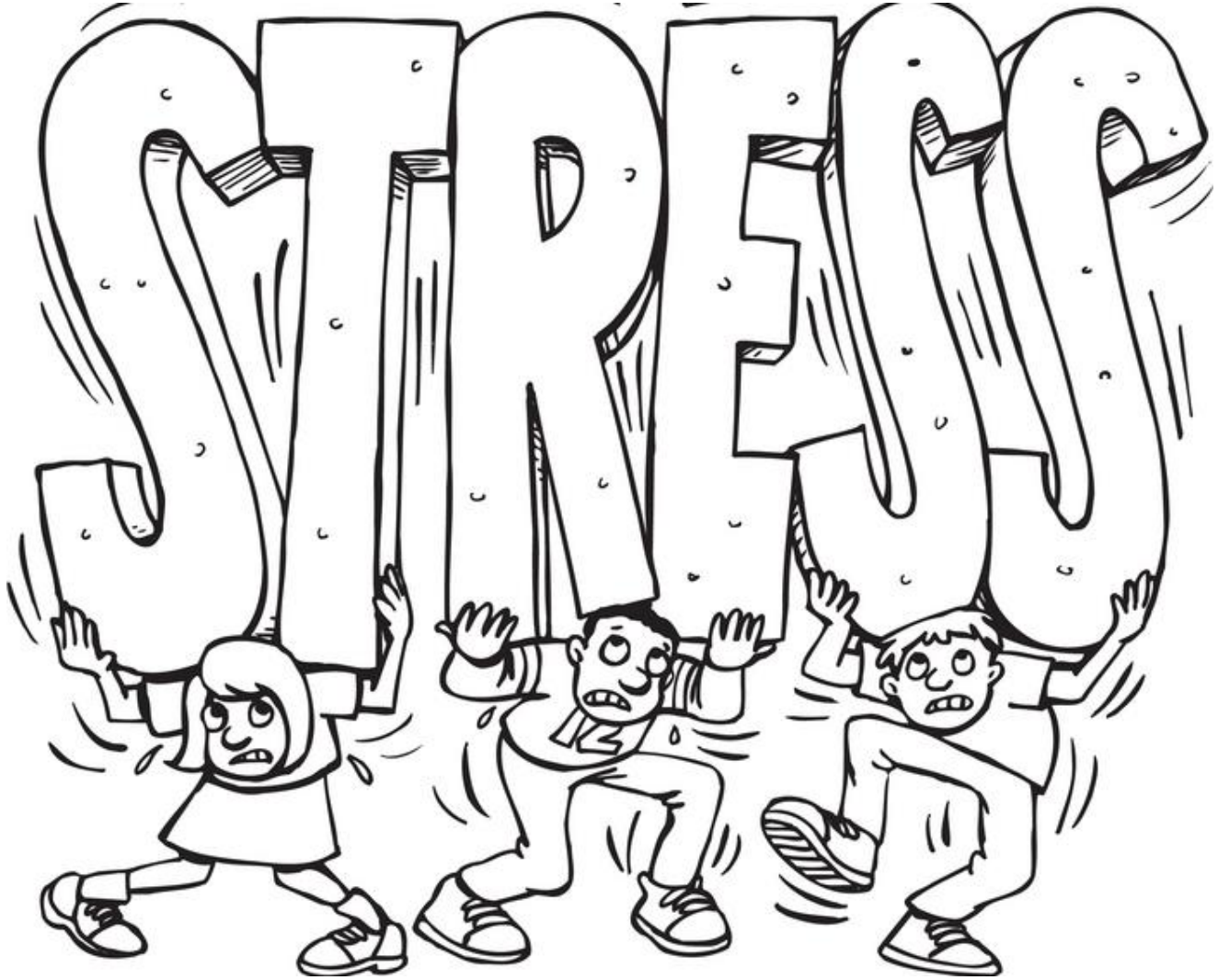




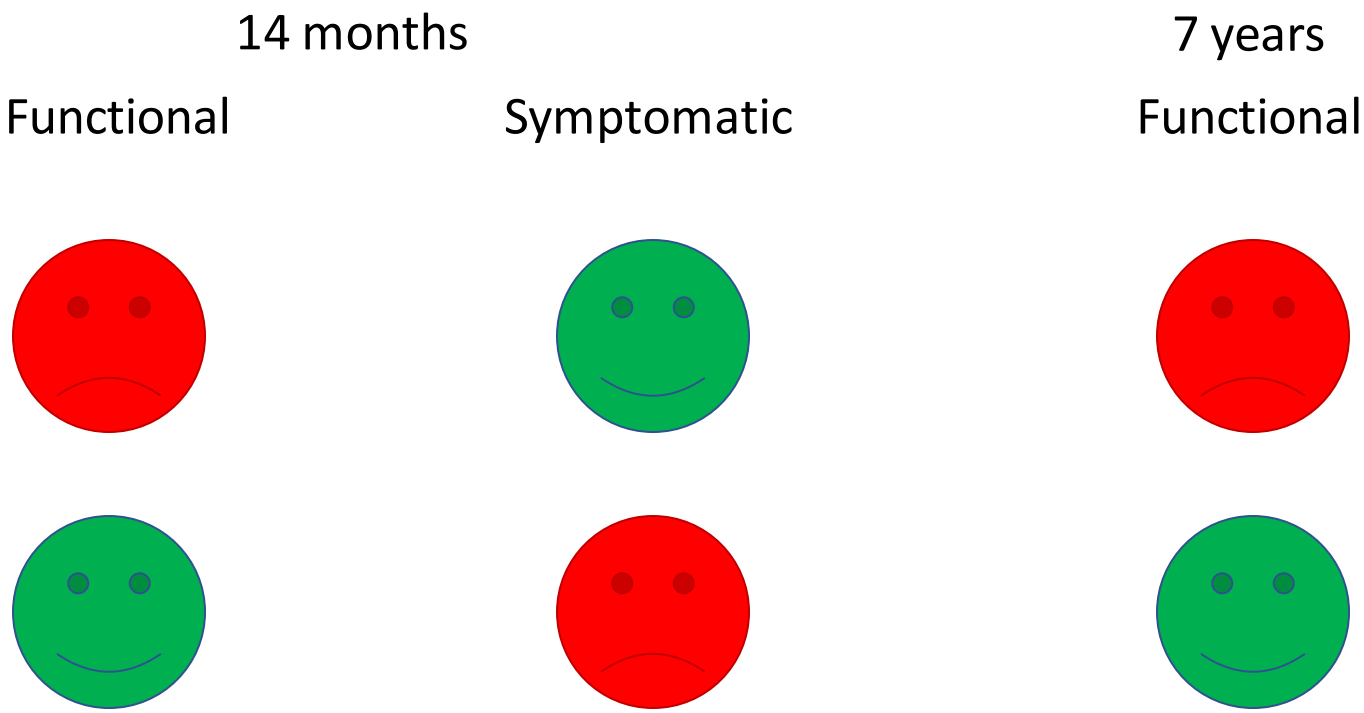
And when should we address functional recovery?

What I was taught

- Work would be too stressful
- Would exacerbate illness
- Would be failed
- Would entrench hopelessness
- Best avoided until well
- Help people access disabiity benefits

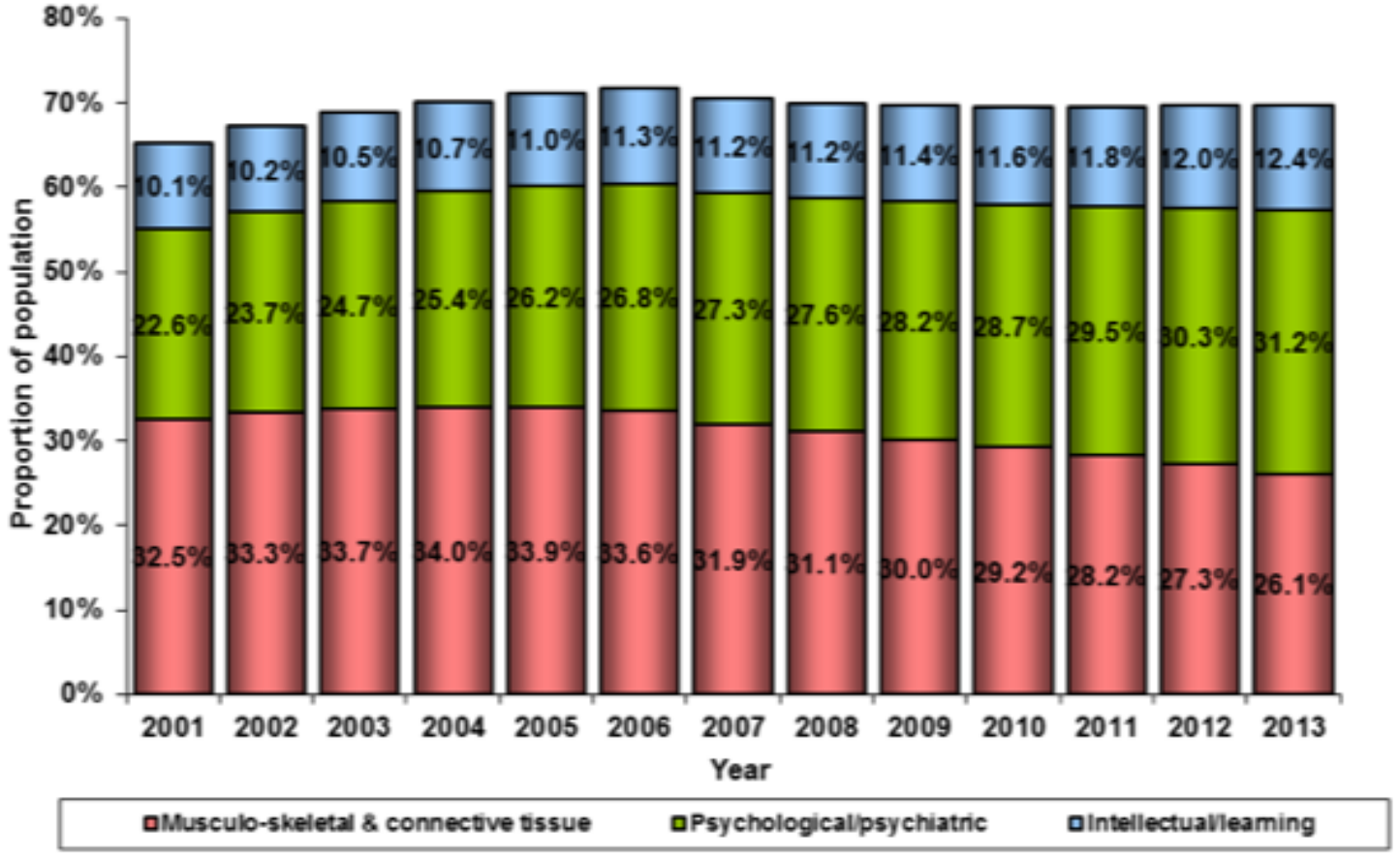


Importance of Early Focus on Functioning



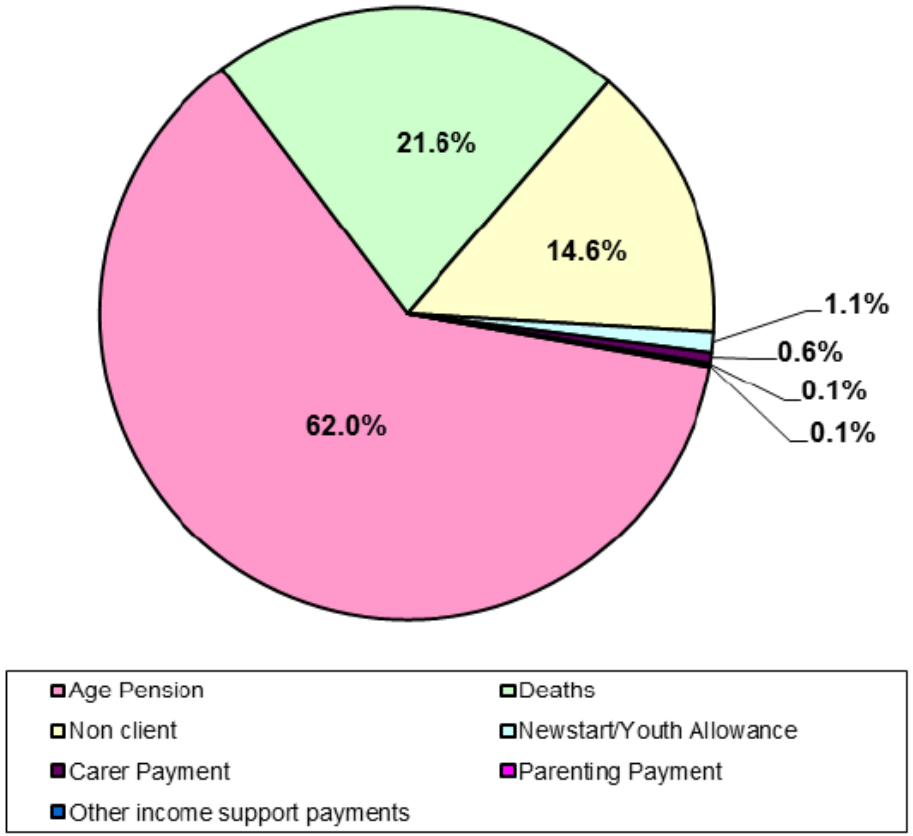
Alvarez-Jimenez et al. (2012). Psychological Medicine 42(3), 595-606

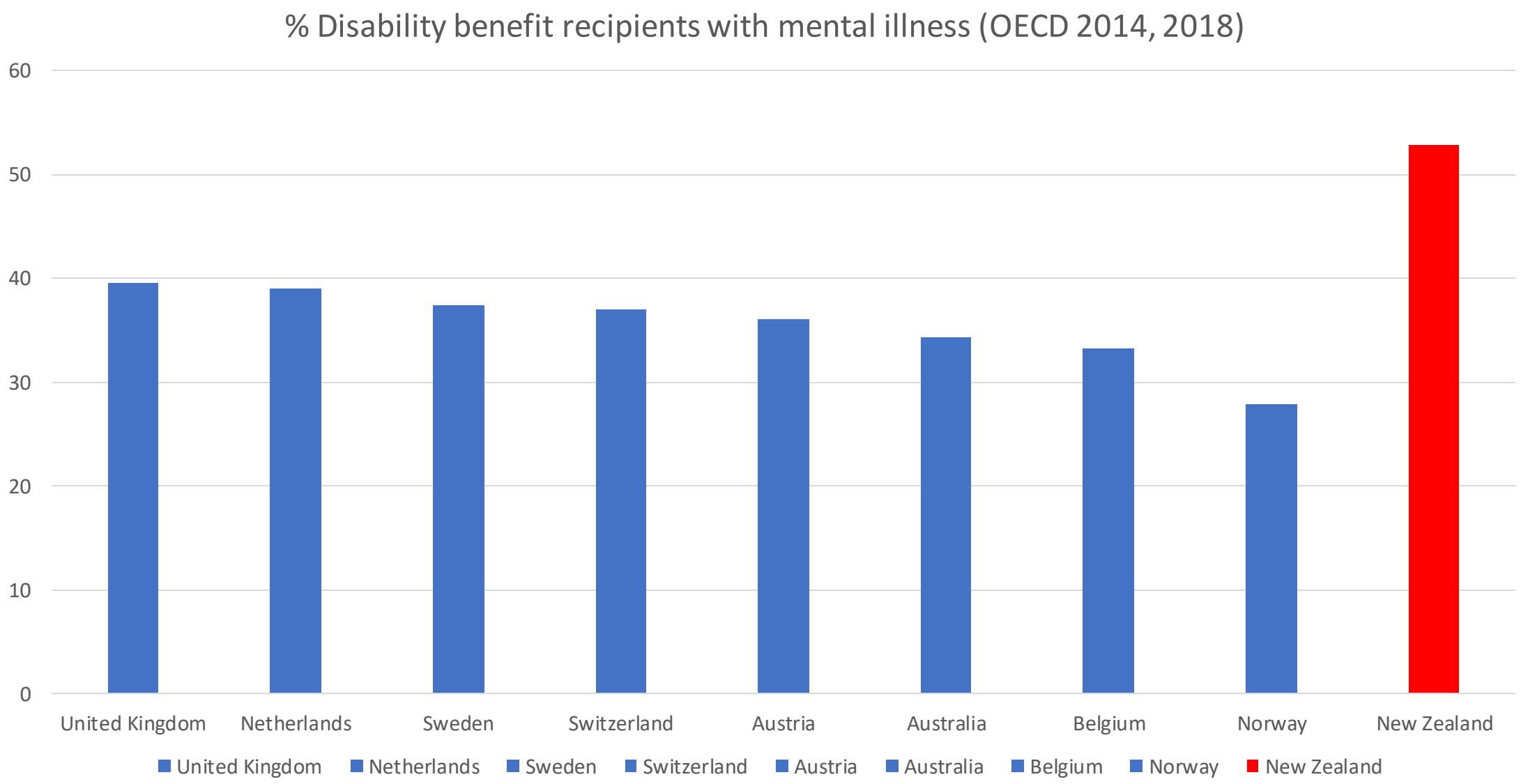
Disability Support Pension



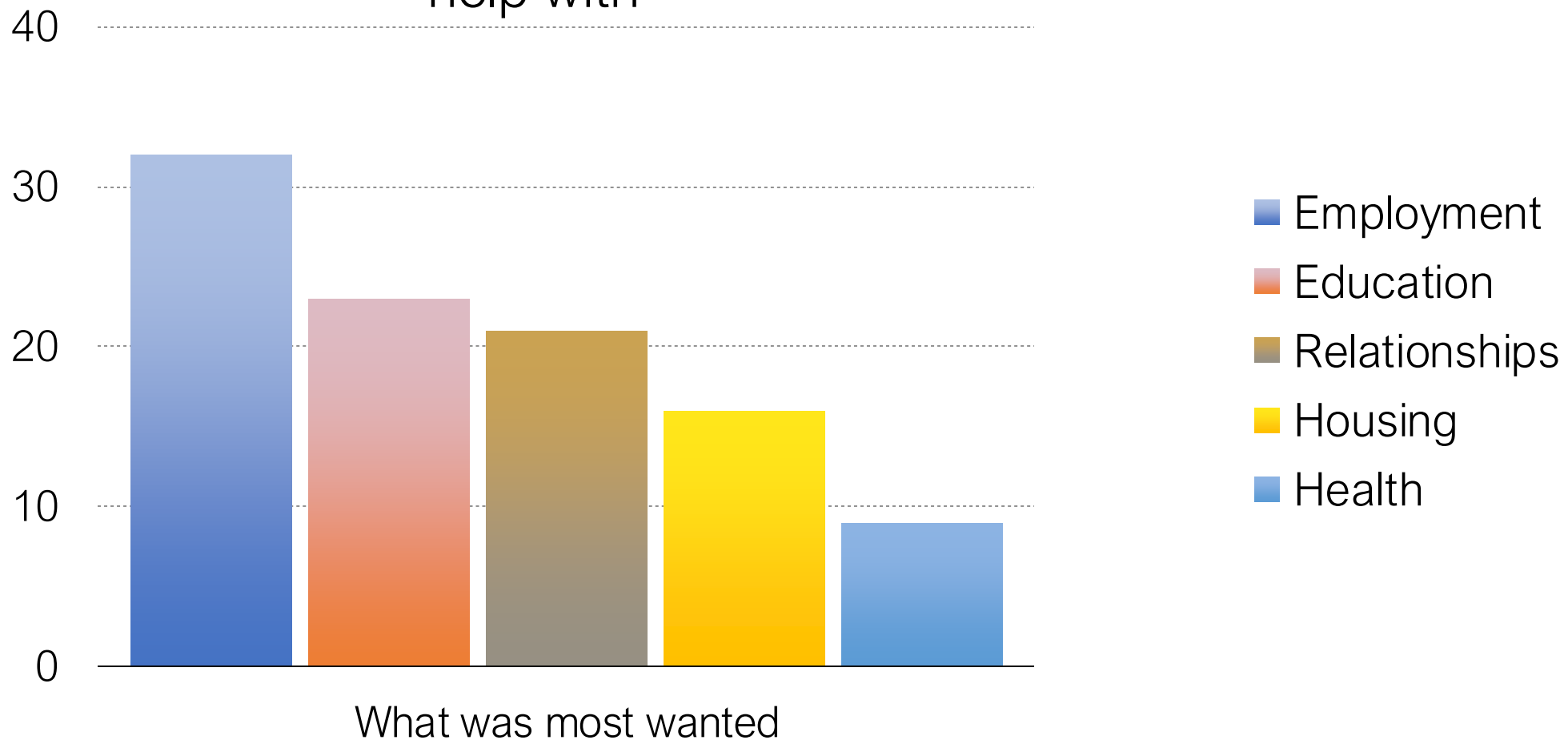
DSP

Exits by subsequent status/income support payment type – 2013




% Disability benefit recipients with mental illness (OECD 2014, 2018)
60
50
40
30
20
10
0
United Kingdom
Netherlands
Sweden
Switzerland
Austria
Australia
Belgium
Norway
New Zealand
United Kingdom
Netherlands
Sweden
Switzerland
Austria
Australia
Belgium
Norway
New Zealand

What do young people with mental ill health most want help with

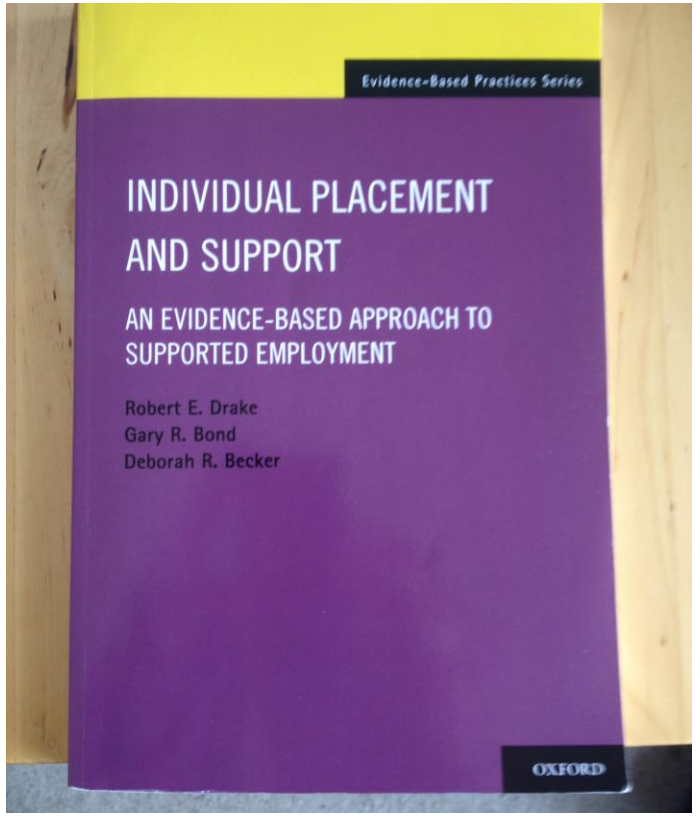


Ramsay, 2011; Iyer, 2011

Development of employment interventions

Employment interventions were developed

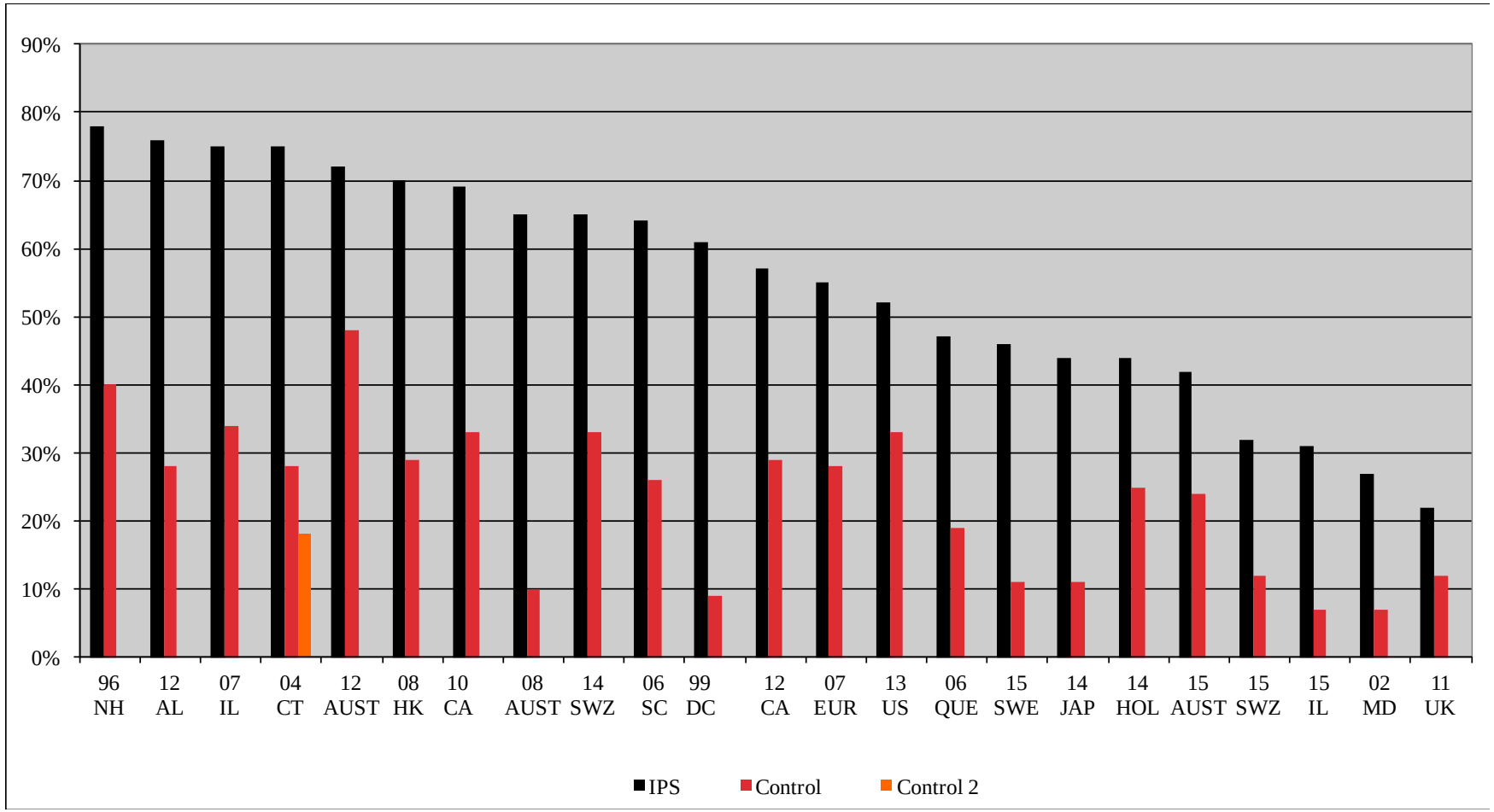
- Social firms
- Transitional employment
- Supported employment



Individual Placement and Support

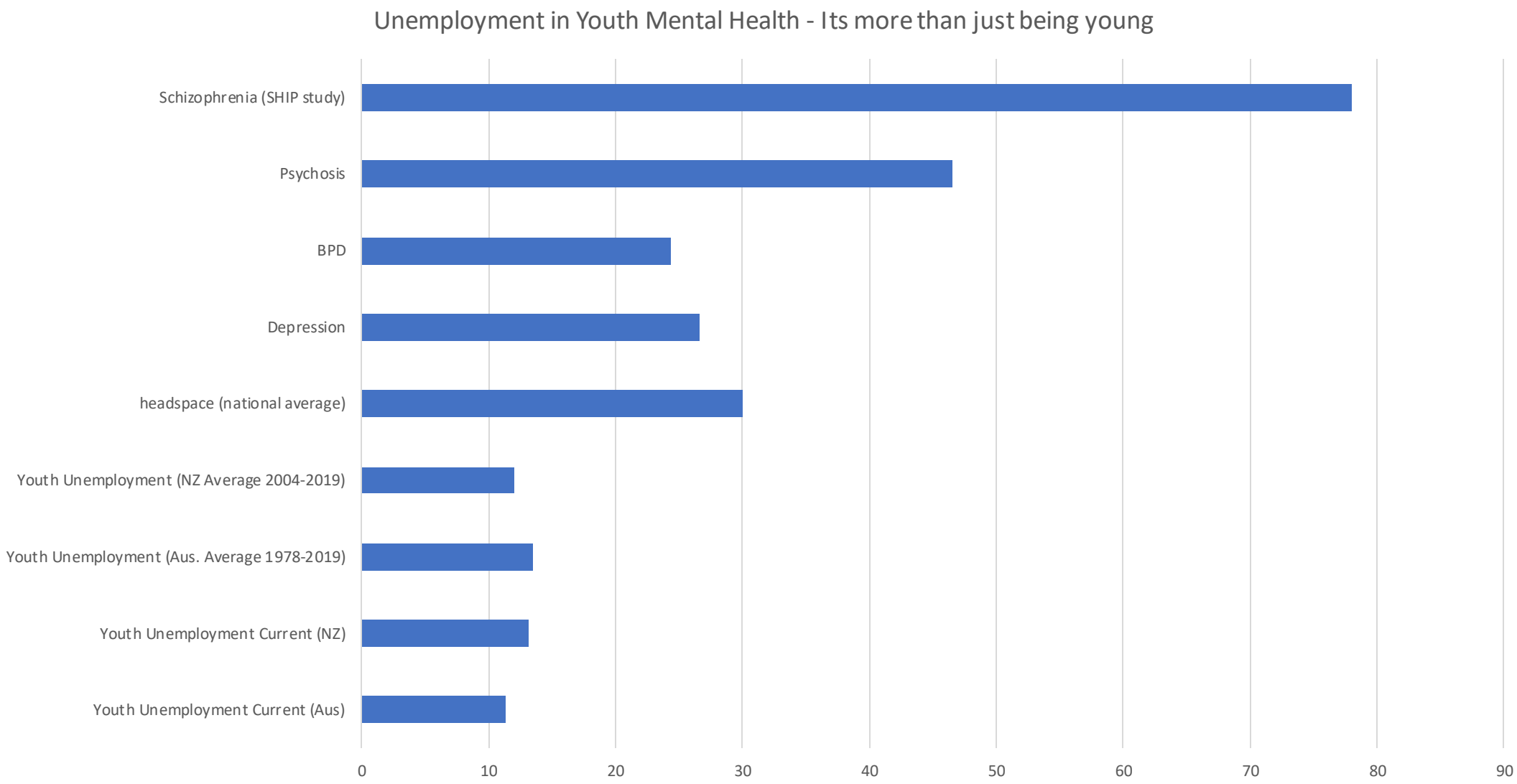
- Open to any person with mental illness who wants to work
- Integrated with MH treatment team
- Focus on competitive employment
- Benefits planning
- Rapid job search without concept of job readiness
- Development of employer networks
- Jobs based on consumer preference
- Time-unlimited support

Competitive Employment Rates in 23 Randomized Controlled Trials of IPS



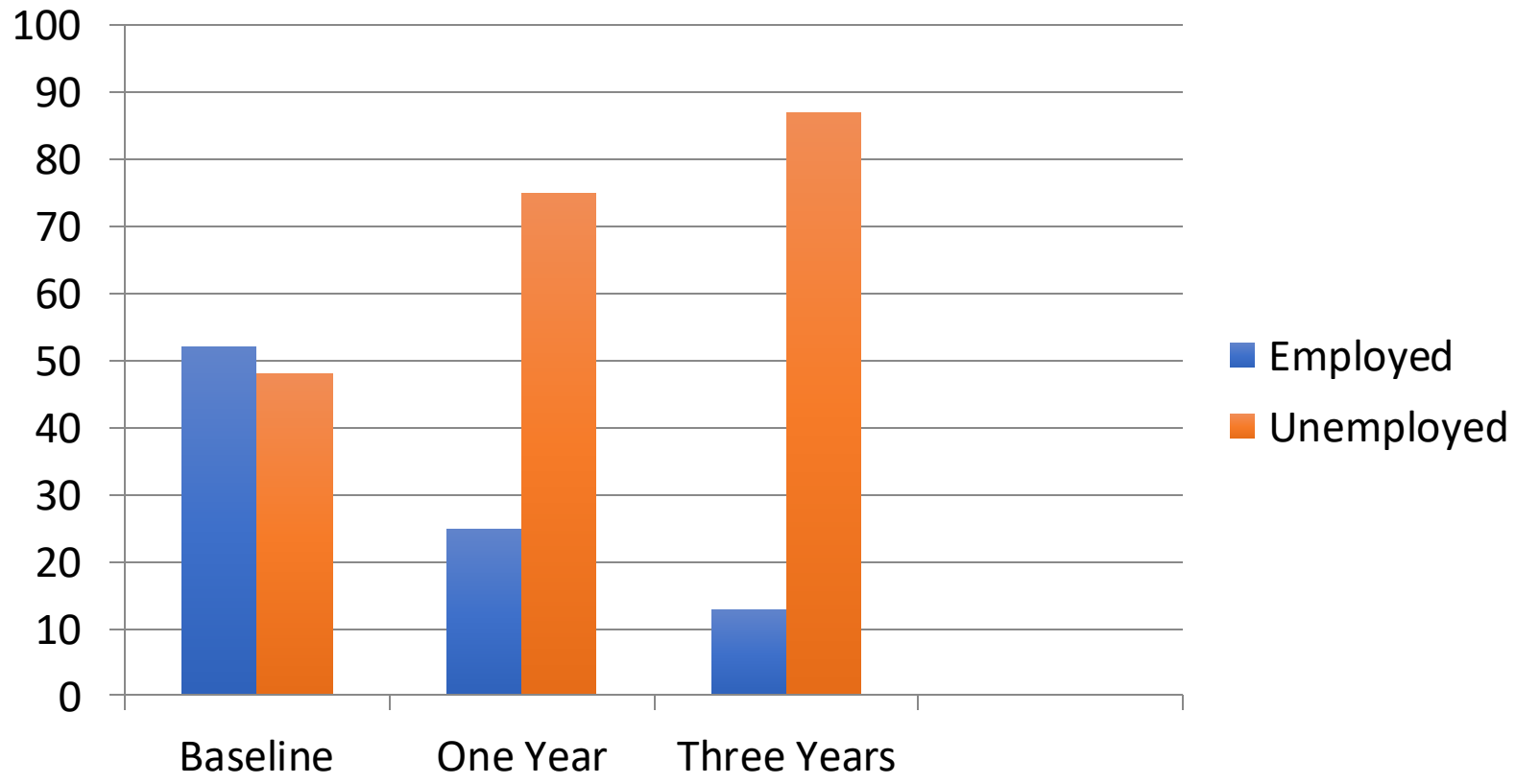
Bond, From https://www.ipsworks.org

Does IPS work in youth mental illness?



Sources: ABS; Stats NZ; headspace; Caruana et al., 2018, Community Mental Health Journal; Waghorn et al., 2012, ANZJP

Unemployment in early psychosis



Rinaldi et al, 2010

2004 – 2019
15 years of IPS in FEP research

original papers

Psychiatric Bulletin (2004), **28**, 281–284

MILES RINALDI, KAREN McNEIL, MIKE FIRN, MARSHA KOLETSI, RACHEL PERKINS AND SWARAN P. SINGH

What are the benefits of evidence-based supported employment for patients with first-episode psychosis?

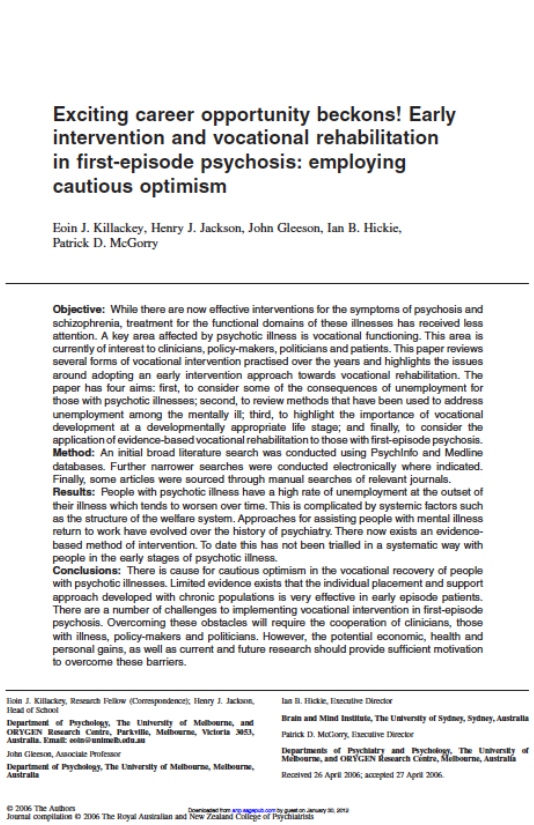
AIMS AND METHOD
To examine the effectiveness of integrating evidence-based supported employment into an early intervention service for young people with first-episode psychosis. Demographic, clinical and vocational data were collected over a 12-month period to evaluate the effect on vocational outcomes at 6 months and 12 months of the employment of a vocational specialist, and to assess model fidelity.

RESULTS
Following vocational profiling and input from the vocational specialist and the team, there were significant increases in the proportion of clients engaged in work or educational activity over the first 6 months of the intervention, and in a subsample over a second 6-month period. The evidence-based Supported Employment Fidelity Scale was used to measure the degree of implementation, which scored 71, signifying 'good implementation'.

CLINICAL IMPLICATIONS
The results suggest that implementing evidence-based supported employment within an early intervention service increases employment and education opportunities for patients within the service.

Table 2. Vocational status of clients at baseline, 6 months and 12 months

Vocational status	Baseline (*n*=40) *n* (%)	6 months (*n*=40) *n* (%)	12 months (*n*=22) *n* (%)
Open employment	4 (10)	11 (28)	9 (41)
Voluntary work/ work experience	0 (0)	2 (4)	0 (0)
Education/training	13 (33)	13 (33)	6 (27)
Job search agency	1 (2)	11 (28)	6 (27)
Unemployed/unoccupied	22 (55)	3 (7)	1 (5)



Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first-episode psychosis: employing cautious optimism

Eoin J. Killackey, Henry J. Jackson, John Gleeson, Ian B. Hickie, Patrick D. McGorry

Objective: While there are now effective interventions for the symptoms of psychosis and schizophrenia, treatment for the functional domains of these illnesses has received less attention. A key area affected by psychotic illness is vocational functioning. This area is currently of interest to clinicians, policy-makers, politicians and patients. This paper reviews several forms of vocational intervention practised over the years and highlights the issues around adopting an early intervention approach towards vocational rehabilitation. The paper has four aims: first, to consider some of the consequences of unemployment for those with psychotic illnesses; second, to review methods that have been used to address unemployment among the mentally ill; third, to highlight the importance of vocational development at a developmentally appropriate life stage; and finally, to consider the application of evidence-based vocational rehabilitation to those with first-episode psychosis.
Method: An initial broad literature search was conducted using PsychInfo and Medline databases. Further narrower searches were conducted electronically where indicated. Finally, some articles were sourced through manual searches of relevant journals.
Results: People with psychotic illness have a high rate of unemployment at the outset of their illness which tends to worsen over time. This is complicated by systemic factors such as the structure of the welfare system. Approaches for assisting people with mental illness return to work have evolved over the history of psychiatry. There now exists an evidence-based method of intervention. To date this has not been trialled in a systematic way with people in the early stages of psychotic illness.
Conclusions: There is cause for cautious optimism in the vocational recovery of people with psychotic illnesses. Limited evidence exists that the individual placement and support approach developed with chronic populations is very effective in early episode patients. There are a number of challenges to implementing vocational intervention in first-episode psychosis. Overcoming these obstacles will require the cooperation of clinicians, those with illness, policy-makers and politicians. However, the potential economic, health and personal gains, as well as current and future research should provide sufficient motivation to overcome these barriers.

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BJPsych The British Journal of Psychiatry (2008) 193, 114–120. doi: 10.1192/bjp.bp.107.043109

Vocational intervention in first-episode psychosis: individual placement and support *v.* treatment as usual

Eóin Killackey, Henry J. Jackson and Patrick D. McGorry

Background
Unemployment is a major problem for people with first-episode psychosis and schizophrenia. This has repercussions for the economy, social functioning and illness prognosis.

Aims
To examine whether a vocational intervention – individual placement and support (IPS) – which has been found to be beneficial in populations with chronic schizophrenia, was a useful intervention for those with first-episode psychosis.

Method
A total of 41 people with first-episode psychosis were randomised to receive either 6 months of IPS + treatment as usual (TAU) (*n*=20) or TAU alone (*n*=21).

Results
The IPS group had significantly better outcomes on level of employment (13 *v.* 2, *P*<0.001), hours worked per week (median 38 *v.* 22.5, *P*=0.006), jobs acquired (23 *v.* 3) and longevity of employment (median 5 weeks *v.* 0, *P*=0.021). The IPS group also significantly reduced their reliance on welfare benefits.

Conclusions
Individual placement and support has good potential to address the problem of vocational outcome in people with first-episode psychosis. This has economic, social and health implications.

Declaration of interest
This research was supported by a National Health and Medical Research Council Program Grant (ID: 350241) and an unrestricted study grant from Bristol Myers Squibb. ORYGEN Research Centre is supported by the Colonial Foundation.

A key problem facing people with psychotic illnesses is unemployment.[1] This is despite surveys consistently showing that gaining a job in open employment is a primary goal of most people with mental illnesses.[2] Unemployment is the largest contributor to indirect costs of psychotic illnesses.[3,4] In response to this problem, a method of vocational intervention called 'individual placement and support' (IPS) has been developed. This highly defined form of supported employment has proven, through a number of randomised controlled trials, to be an effective intervention for people with chronic mental illness.[5] However, there have been no published randomised controlled trials of this approach in those with first-episode psychosis, a group who also have high levels of unemployment and who are normally in a phase of life where vocational development typically occurs. This study aimed to examine the effectiveness of IPS in a group of young people with first-episode psychosis who wanted to find work.

Method

Participants

Between October 2005 and April 2006, 41 people who were attending a specialist public mental health service and who wanted help in finding work were recruited to the study. All were patients of the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia. This service treats all cases of a first-episode of psychosis in people aged between 15 and 25 years living in a defined catchment area of about 1 million people. Within this catchment area, the number of people aged 15–25 years is estimated to be 250 000.

Individuals were eligible for the study if they wanted to find work (including a different job if they currently held one) and had at least 6 months of care left at EPPIC (EPPIC is limited to providing 18 months of care). The only exclusion criterion was lack of fluency in English. Nobody needed to be excluded on this basis.

Informed consent was required to participate in the study, and decisions regarding participation did not influence clinical care in any way. Participants were recruited via EPPIC case managers identifying people from their case-load who were interested in seeking work. There were no refusers. Assessments were conducted by an experienced, trained research assistant who was also an advanced psychology doctoral student. Assessments were generally conducted at EPPIC but some were also completed in participants' homes.

Interventions

In this study, IPS + treatment as usual (TAU) (the vocational-intervention group) was compared with TAU alone as there is no established evidence-based vocational intervention for those with first-episode psychosis. Treatment as usual consisted of participants continuing to receive EPPIC care. This involves individual case management and medical review, referral to external vocational agencies, as well as involvement with the group programme at EPPIC, which may involve participation in the vocationally oriented groups within the group programme. Treatment as usual was delivered primarily by EPPIC case managers.

Individual placement and support is a highly defined form of supported employment and has six key principles:

(a) it is focused on competitive employment (i.e. jobs which are not set aside but open to applications from anyone with the appropriate skills or qualifications) as an outcome;

(b) it is open to any person with mental illness who chooses to look for work and acceptance into the programme is not determined by measures of work-readiness or illness variables;

BJPsych The British Journal of Psychiatry (2018) Page 1 of 7. doi: 10.1192/bjp.2018.191

Individual placement and support for vocational recovery in first-episode psychosis: randomised controlled trial

Eóin Killackey, Kelly Allott, Henry J. Jackson, Rosanna Scutella, Yi-Ping Tseng, Jeff Borland, Tina-Marie Proffitt, Sally Hunt, Frances Kay-Lambkin, Gina Chinnery, Gennady Bakshelev, Mario Alvarez-Jimenez, Patrick D. McGorry and Susan M. Cotton

Background
High unemployment is a hallmark of psychotic illness. Individual placement and support (IPS) may be effective at assisting the vocational recoveries of young people with first-episode psychosis (FEP).

Aims
To examine the effectiveness of IPS at assisting young people with FEP to gain employment (Australian and Clinical Trials Registry ACTRN12608000094370).

Method
Young people with FEP (*n* = 146) who were interested in vocational recovery were randomised using computer-generated random permuted blocks on a 1:1 ratio to: (a) 6 months of IPS in addition to treatment as usual (TAU) or (b) TAU alone. Assessments were conducted at baseline, 6 months (end of intervention), 12 months and 18 months post-baseline by research assistants who were masked to the treatment allocations.

Results
At the end of the intervention the IPS group had a significantly higher rate of having been employed (71.2%) than the TAU group (48.0%), odds ratio 3.40 (95% CI 1.17–9.91, *z* = 2.25, *P* = 0.025). However, this difference was not seen at 12- and 18-month follow-up points. There was no difference at any time point on educational outcomes.

Conclusions
This is the largest trial to our knowledge on the effectiveness of IPS in FEP. The IPS group achieved a very high employment rate during the 6 months of the intervention. However, the advantage of IPS was not maintained in the long term. This seems to be related more to an unusually high rate of employment being achieved in the control group rather than a gross reduction in employment among the IPS group.

Declaration of interest
None.

Keywords
First episode psychosis; vocational recovery; randomized controlled trial; psychosocial interventions.

Young people with psychotic illness, as part of their recovery, want to complete their education and gain employment more than they want to address their mental health symptoms.[1] Despite this, the vocational trajectory of young people with psychosis is marked by low educational completion rates[2] and rapid transition into unemployment.[3] Typically, the employment needs of young people with mental illnesses are referred out from mental health services to private- or government-contracted employment providers. Young people with mental ill health often have difficulty accessing these services,[4] and even where they do, employment outcomes are scandalously low.[5] The individual placement and support (IPS) model was designed to assist people with chronic severe mental illness to return to mainstream employment. IPS has been very successful,[6] even showing resilience to external economic downturns.[7] Most of the previous studies of IPS have been in populations of people with chronic illness. Two small trials[8,9] in young people with first-episode psychosis (FEP) have shown very promising results. In this paper we report on a large randomised controlled trial (RCT) of IPS in a FEP population over an 18-month follow-up period (Australian and Clinical Trials Registry ACTRN12608000094370). This allows for an examination of employment outcomes at the end of the intervention as well as the duration of effects of IPS.

Method

The background and methodology of the study has been described in detail elsewhere.[10] Key aspects of the study methodology as well as specific details concerning the participants, interventions and analyses are briefly described here. The study received ethical approval from the Melbourne Health Mental Health Research and Ethics Committee.

Trial design

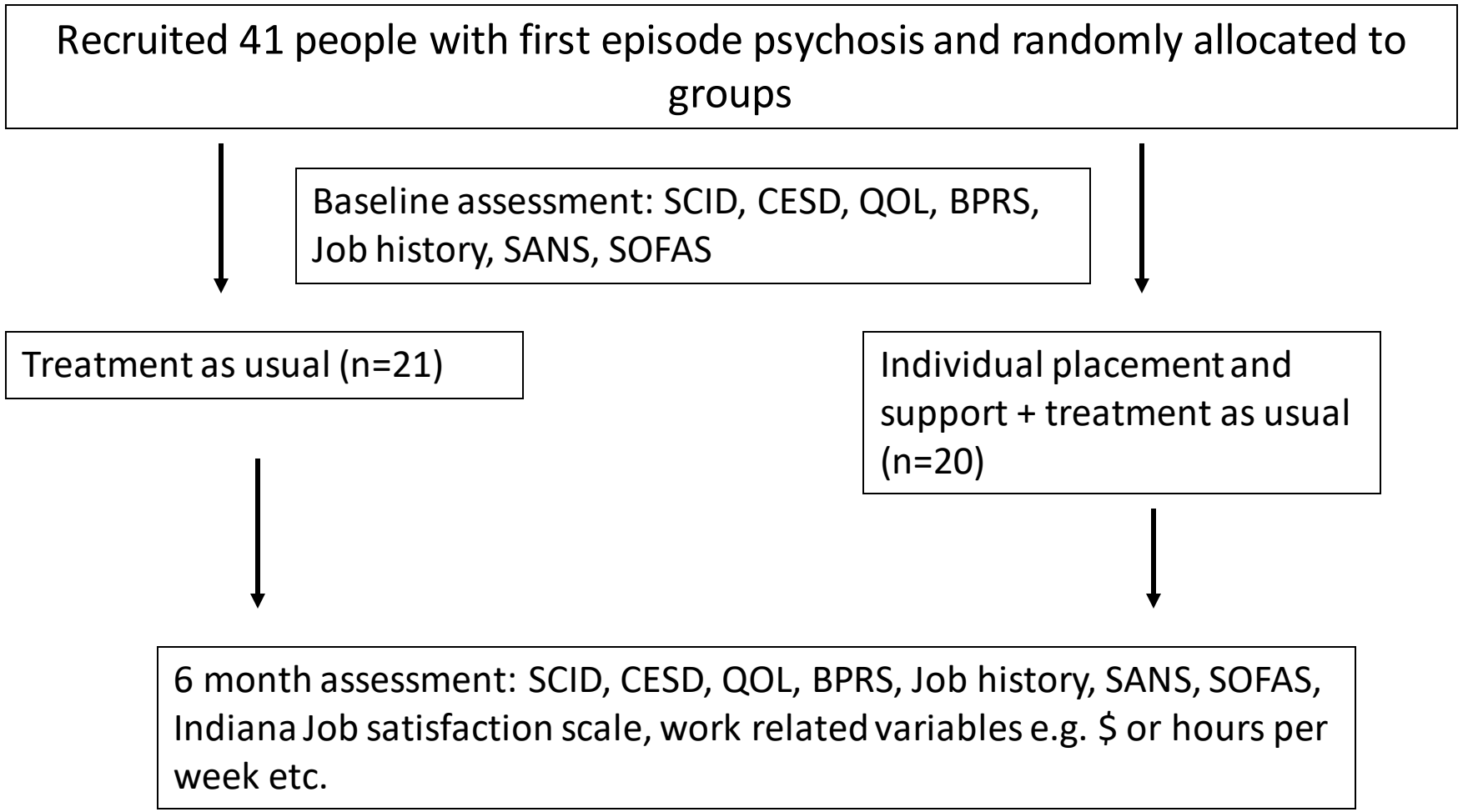
This study was a parallel single-blinded RCT comparing IPS with treatment as usual (TAU) on employment and education outcomes in young people with FEP. Sample size was determined based on the results of our pilot study[9] and calculated using SamplePower 2.0. Randomisation was undertaken by the study statistician (S.M.C.) using a computer program for blocked randomisation in random permuted blocks of four and eight with an allocation ratio of 1:1. Use of permuted blocks was in order to prevent prediction of group membership before it was assigned. The statistician was not associated with assessments and treatments and was the only person aware of the allocation sequence. Group allocation was provided to the study lead who informed the employment consultant and the participant's case manager of the participant's group allocation. All effort was taken to keep research assistants masked to study condition. Research assistants had no contact with the employment consultant, and participants were reminded at the start of each assessment that they were not to let the research assistant know whether they had been working with the employment consultant or not. Recruitment occurred over a 3-year period.

Participants

Young people with FEP who had expressed an interest in vocational recovery were approached to participate. Those who agreed to

IPS in FEP in Australia – a 13 year journey

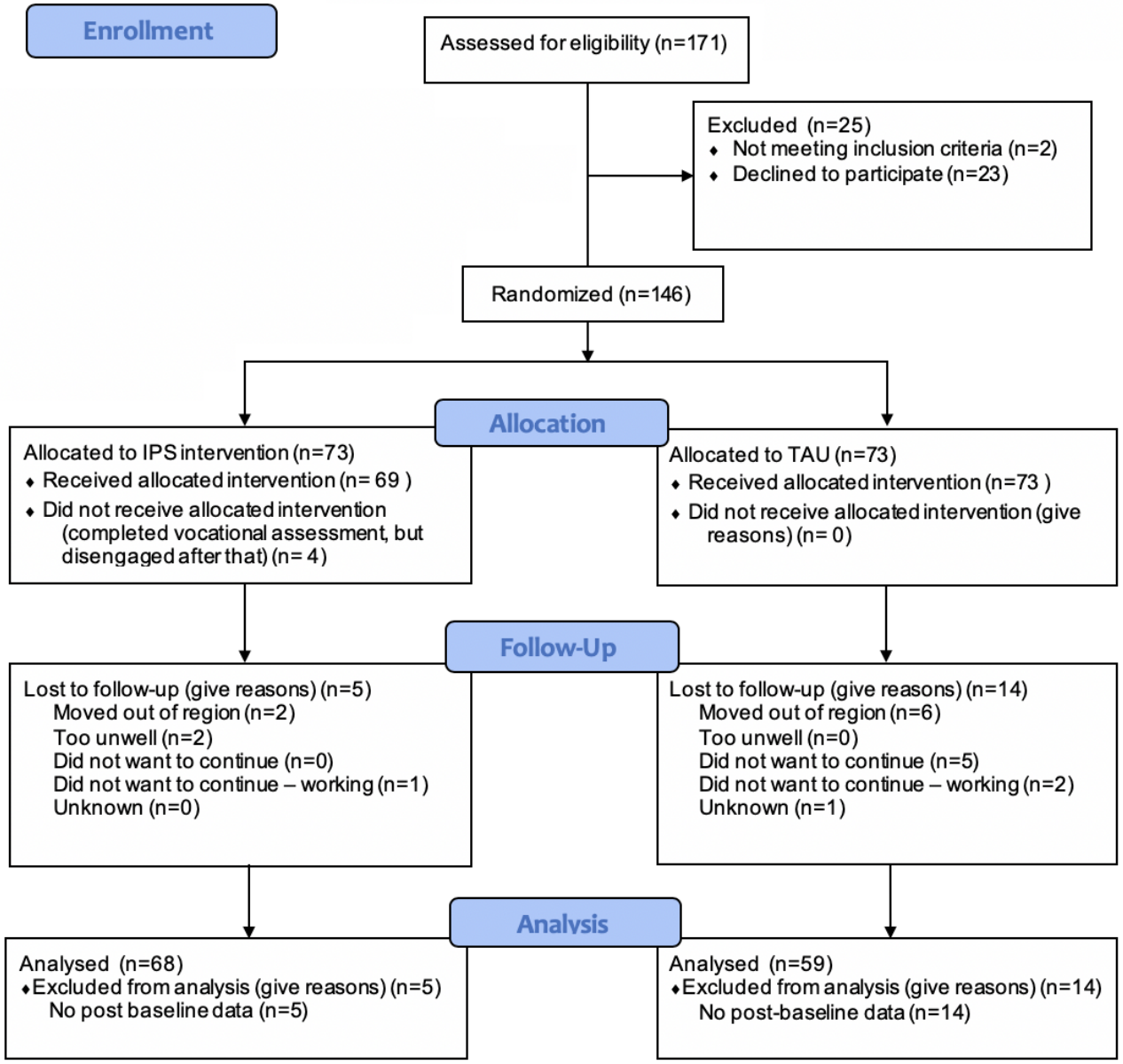
Study 1


Recruited 41 people with first episode psychosis and randomly allocated to groups
Baseline assessment: SCID, CESD, QOL, BPRS, Job history, SANS, SOFAS
Treatment as usual (n=21)
Individual placement and support + treatment as usual (n=20)
6 month assessment: SCID, CESD, QOL, BPRS, Job history, SANS, SOFAS, Indiana Job satisfaction scale, work related variables e.g. $ or hours per week etc.

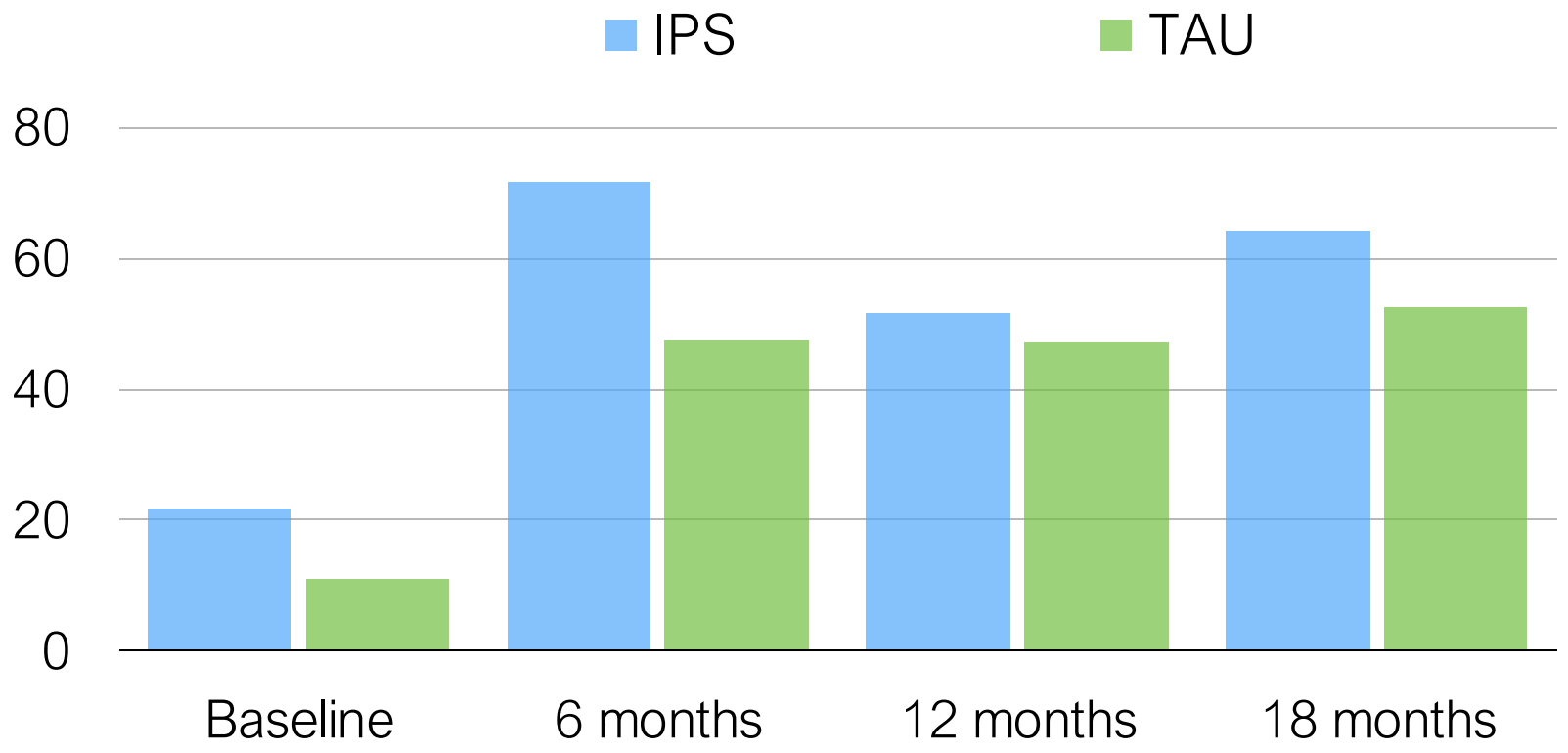
Results Study 1

	IPS (n=20)	TAU (n=21)	Sig.	
Jobs	13	2	P<0.000	
Courses	4	4	ns	
Weeks worked	5	0	P=0.021	
Pay	2432	0	P=0.012	
Benefits (change)	-30%	0%	P=0.025	P=0.317

Study 2


Enrollment
Assessed for eligibility (n=171)
Excluded (n=25)
Not meeting inclusion criteria (n=2)
Declined to participate (n=23)
Randomized (n=146)
Allocation
Allocated to IPS intervention (n=73)
Received allocated intervention (n= 69)
Did not receive allocated intervention (completed vocational assessment, but disengaged after that) (n= 4)
Allocated to TAU (n=73)
Received allocated intervention (n=73)
Did not receive allocated intervention (give reasons) (n= 0)
Follow-Up
Lost to follow-up (give reasons) (n=5)
Moved out of region (n=2)
Too unwell (n=2)
Did not want to continue (n=0)
Did not want to continue – working (n=1)
Unknown (n=0)
Lost to follow-up (give reasons) (n=14)
Moved out of region (n=6)
Too unwell (n=0)
Did not want to continue (n=5)
Did not want to continue – working (n=2)
Unknown (n=1)
Analysis
Analysed (n=68)
Excluded from analysis (give reasons) (n=5)
No post baseline data (n=5)
Analysed (n=59)
Excluded from analysis (give reasons) (n=14)
No post-baseline data (n=14)

Employment in study 2



RAISE CP (Humensky, 2017)

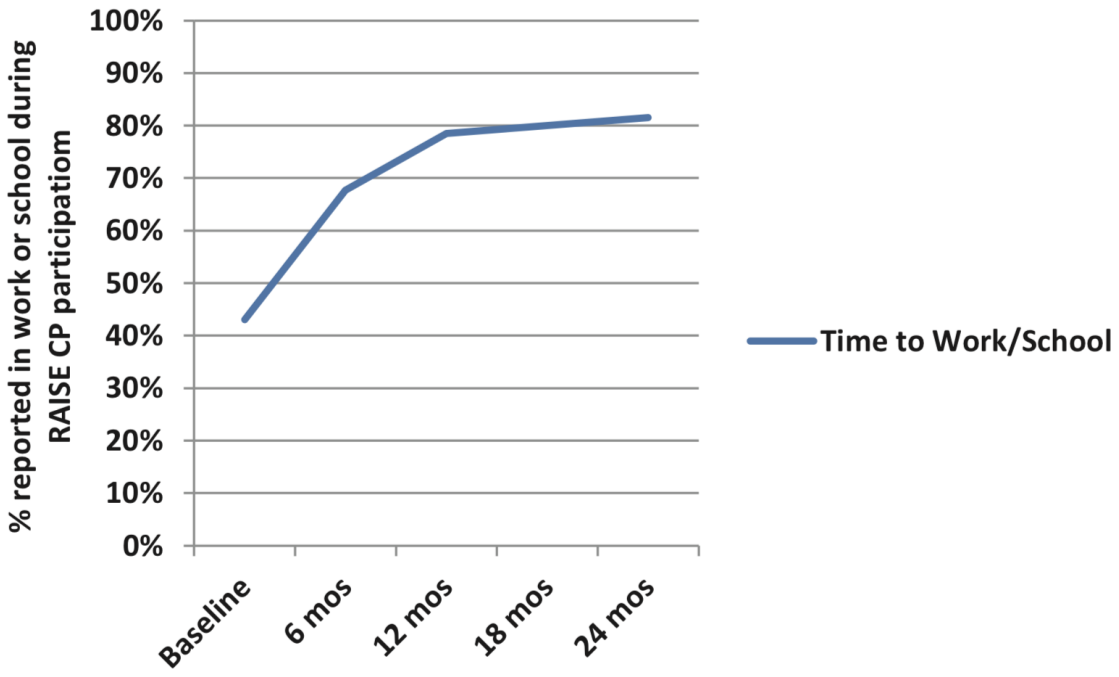


Figure 1. Time to engagement in work and/or school.

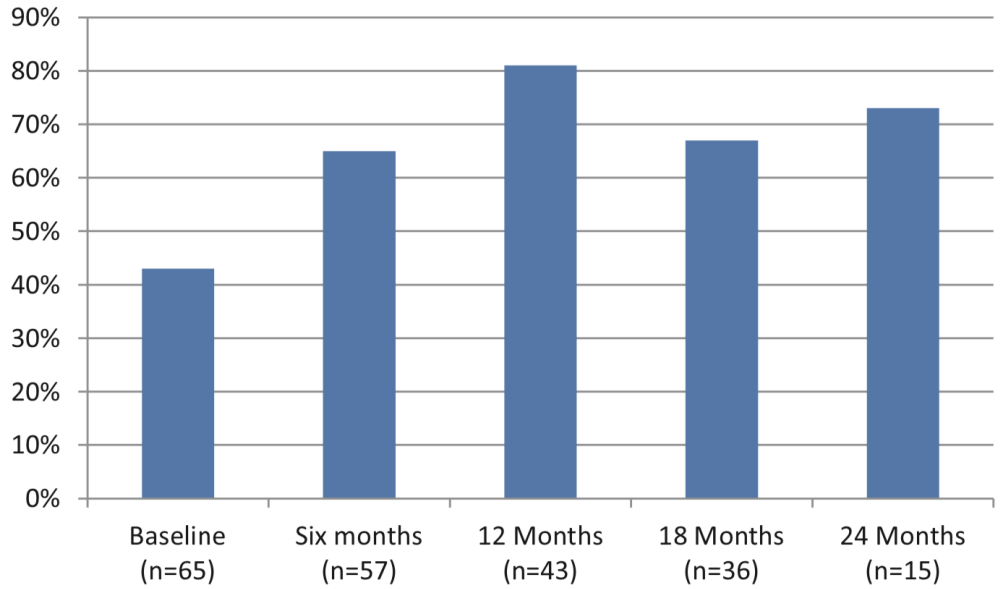
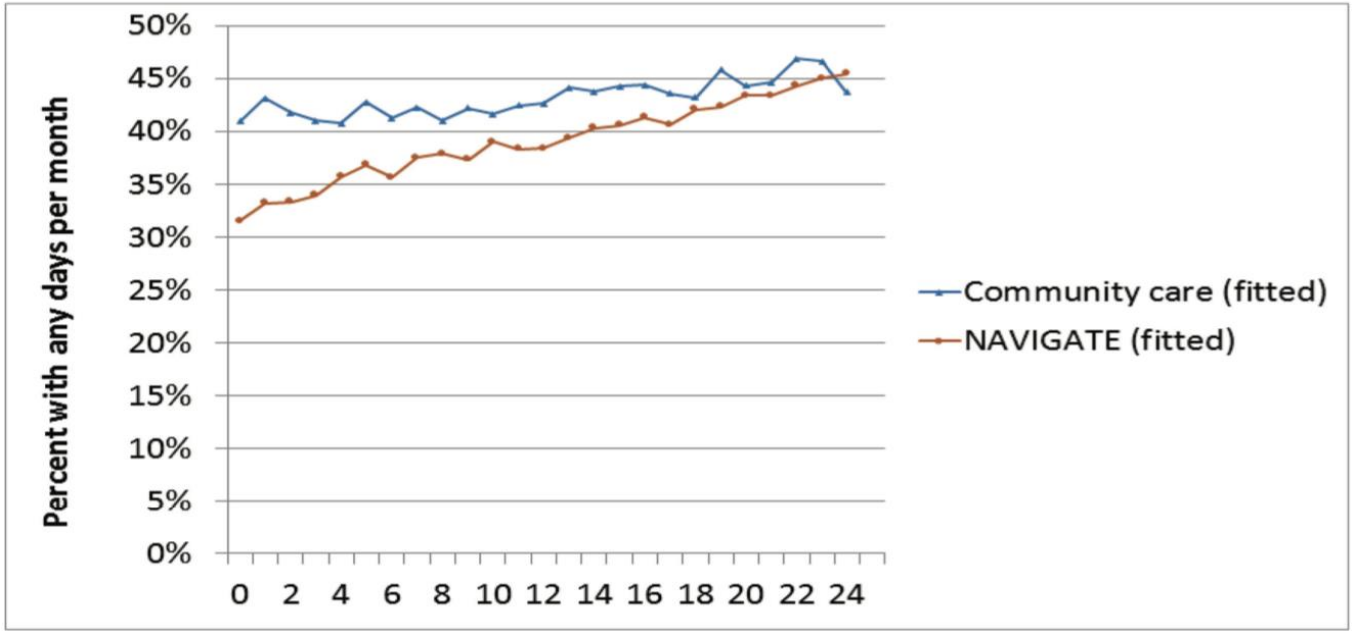


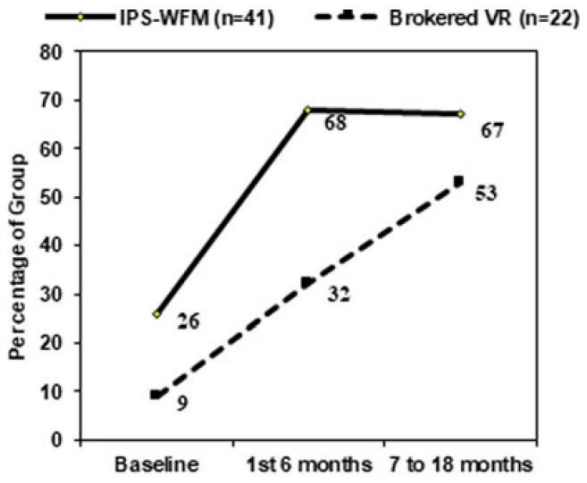
Figure 2. Percent of participants working or in school at each interview.

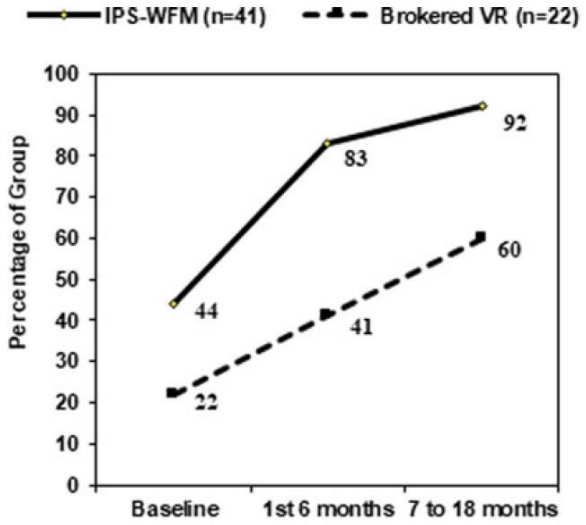
RAISE Navigate (Kane et al., 2016)

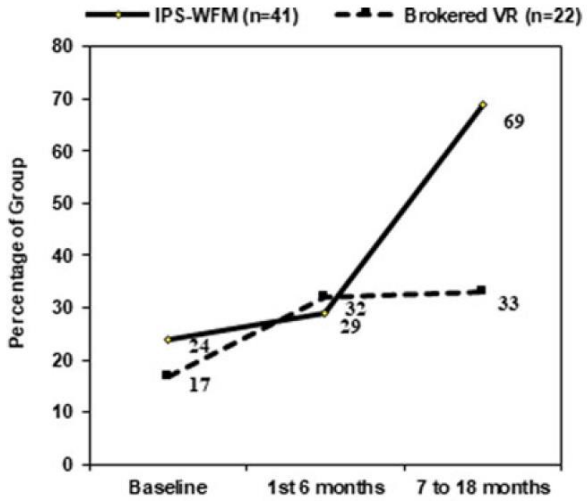
Figure S3. Percent with any work or school days per month



Group by time interaction: p=.044







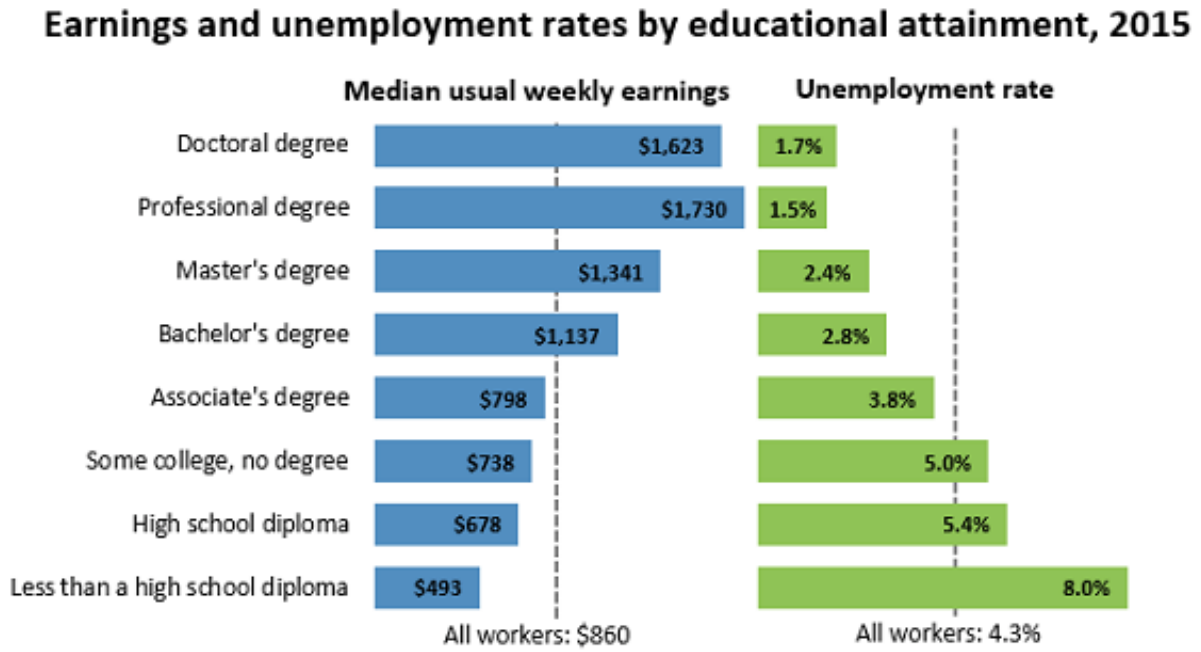
UCLA Study (Neuchterlein et al., 2019)

Andrew Chanen et al.

The INVEST Study Individual Placement and Support for Young People with BPD

What about education?

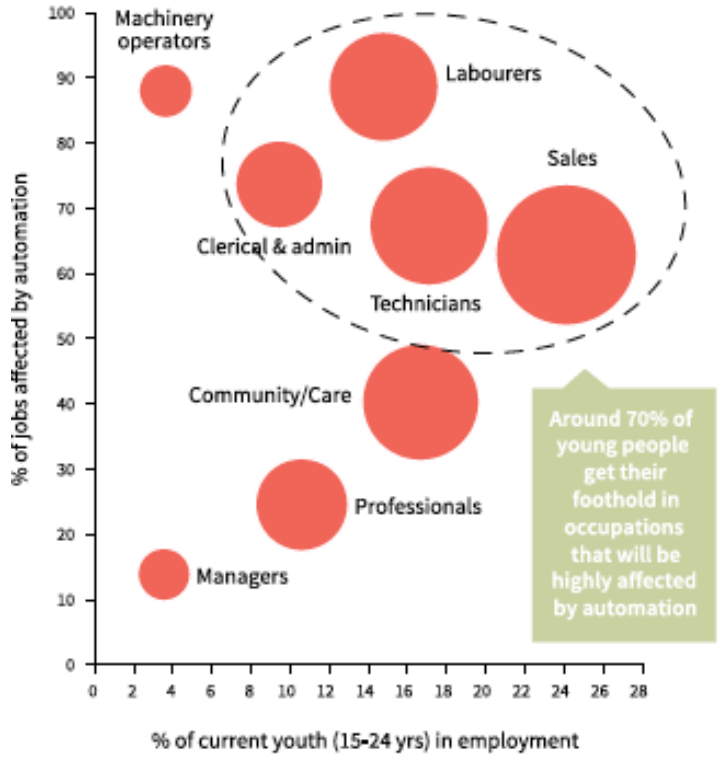
Education protects



Note: Data are for persons age 25 and over. Earnings are for full-time wage and salary workers.
Source: U.S. Bureau of Labor Statistics, Current Population Survey

Fig 13. Most young people in Australia enter the labour market in jobs that will be radically affected by automation

Bubble size = % of employed youth (15-24 yrs) in that occupation



Foundation for Young Australians, 2015 (www.fya.org.au)

IPS Principles adapted to education

- Focused on enrolment in a **community education or training course**
- IPSed is open to any person with mental illness who would like to return to **school/training, or who feels that they would like extra support to remain in their current educational environment.**
- Identifying appropriate **courses and where possible enrolment into them**, commences rapidly on entry into the program;
- IPSed is integrated with the mental health treatment team;
- Potential courses are chosen based on consumer preference **with reference to their educational and career goals;**
- The support provided in IPSed is time-unlimited;
- The education consultant **makes relationships with local education providers**.

Education Intervention Study

- 19 participants 15-20 years of age
- 6 month intervention
- At baseline 11 enrolled and not attending
- 8 not enrolled neither “earning or learning”
- Outcome: 18 enrolled and either attending or completed
- 1 neither earning or learning

Early Intervention IN PSYCHIATRY
First Impact Factor released in June 2010 and now listed in MEDLINE!
Early Intervention in Psychiatry 2016; ••: ••–••
doi: 10.1111/eip.12344

Early Intervention in the Real World

Individual placement and support, supported education in young people with mental illness: an exploratory feasibility study

Eóin Killackey,[1,2] Kelly Allott,[1,2] Gina Woodhead,[3] Sue Connor,[3,4] Susan Dragon[1] and Judy Ring[3,4]

Preliminary outcomes from an individualised supported education programme delivered by a community mental health service

Emma Robson,[1] Geoff Waghorn,[2] Joanne Sherring[3] and Adrienne Morris[4]

British J of OT, 2010

20 participants
70% positive outcomes
(finishing or continuing)

Translation and Implementation

Social-Service.—Some patients are referred for more investigation to aid diagnosis, others for employment, a special worker being maintained who has charge of the latter. Many are referred for supervision, it being found that certain tractable insane persons, or those with abnormal personalities, can get along satisfactorily in the community with a varying degree of social-service supervision.

Importance of translation & implementation

How do we create systems of care that have recovery at their heart?

A globally adaptable framework for youth mental health services

A collaboration between Orygen, The National Centre of Excellence in Youth Mental Health and

The World Economic Forum

Background to the Orygen-WEF Project

Date	
October 2017	Introduction by Carlo Guerra to World Economic Forum through his role as both Youth Research Council member at Orygen and Global Shaper for the WEF
November 2017	2 page briefing for the WEF on the economic imperative for youth mental health
July 2018	Invited to complete a project design submission for joint venture initiatives
September 2018	Interviewed by the WEF on the project design and partnership proposal
October 2018	Approved as a Tier 2 Project for the Forum's system focusing on health care and mental health
December 2018	Team engaged and project commenced

Background to the WEF Project

Partnership between Orygen and the World Economic Forum is part of the Forum's system initiative *in shaping the future of health and healthcare*

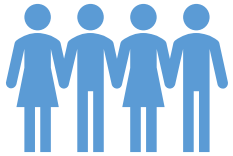
Four key deliverables:

A global model of youth mental health care with flexibility that can be adapted across a range of countries with variable resourcing capacities.	An investment framework indicating the level of public and private investment required across different countries.	An economic briefing for governments supporting investment in this field of work.	A toolkit to support local advocates of youth mental health in their efforts to engage public and private sectors to invest.

The team

- Craig Hodges – Project Lead
- Eóin Killackey – Research Lead
- Viv Browne – Government and Advocacy Lead
- Ella Gow – Youth Partnerships Facilitator
- Corinne Rugulo - Administration

Youth engagement



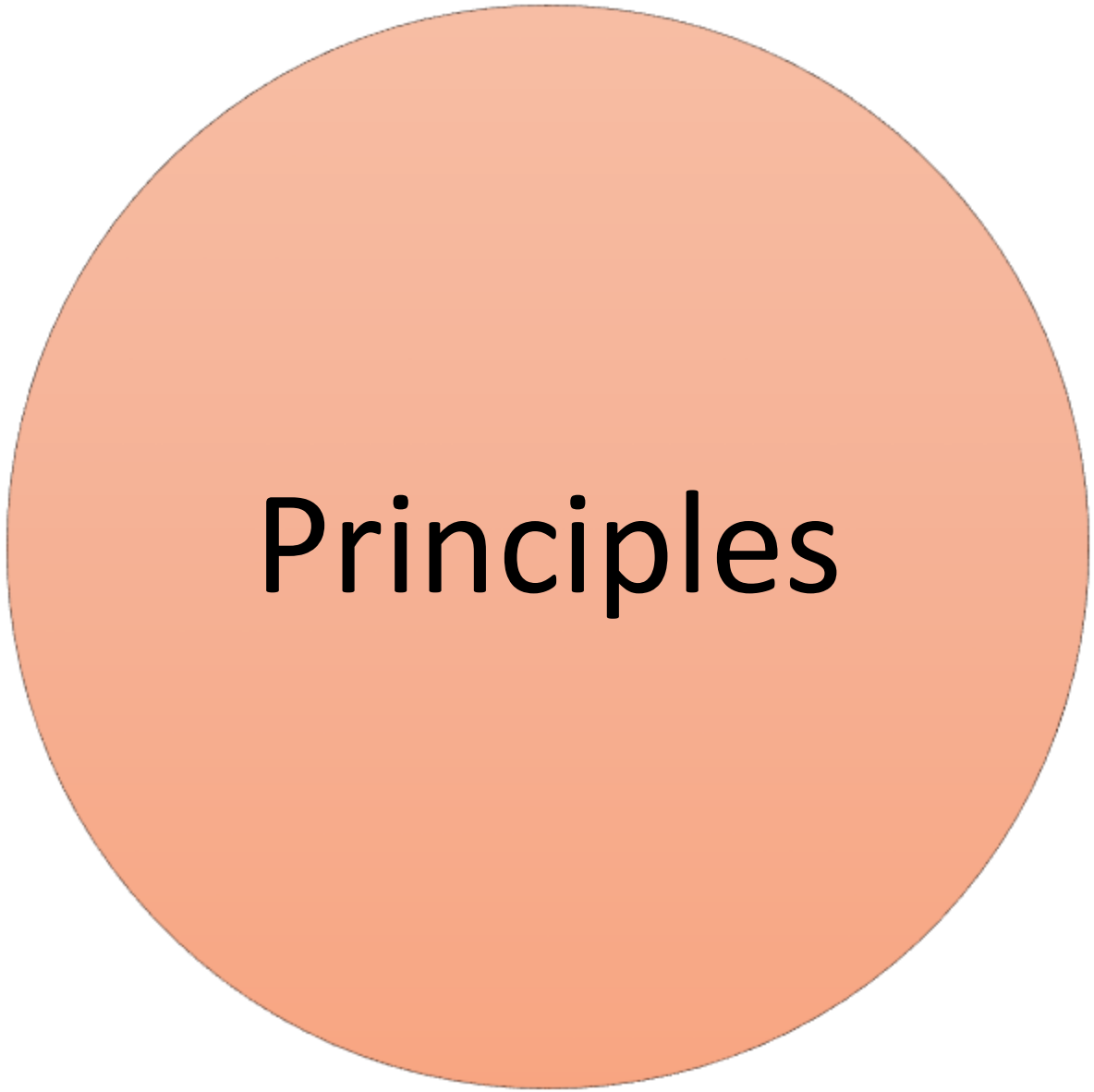
Two young people appointed to Project Steering Group

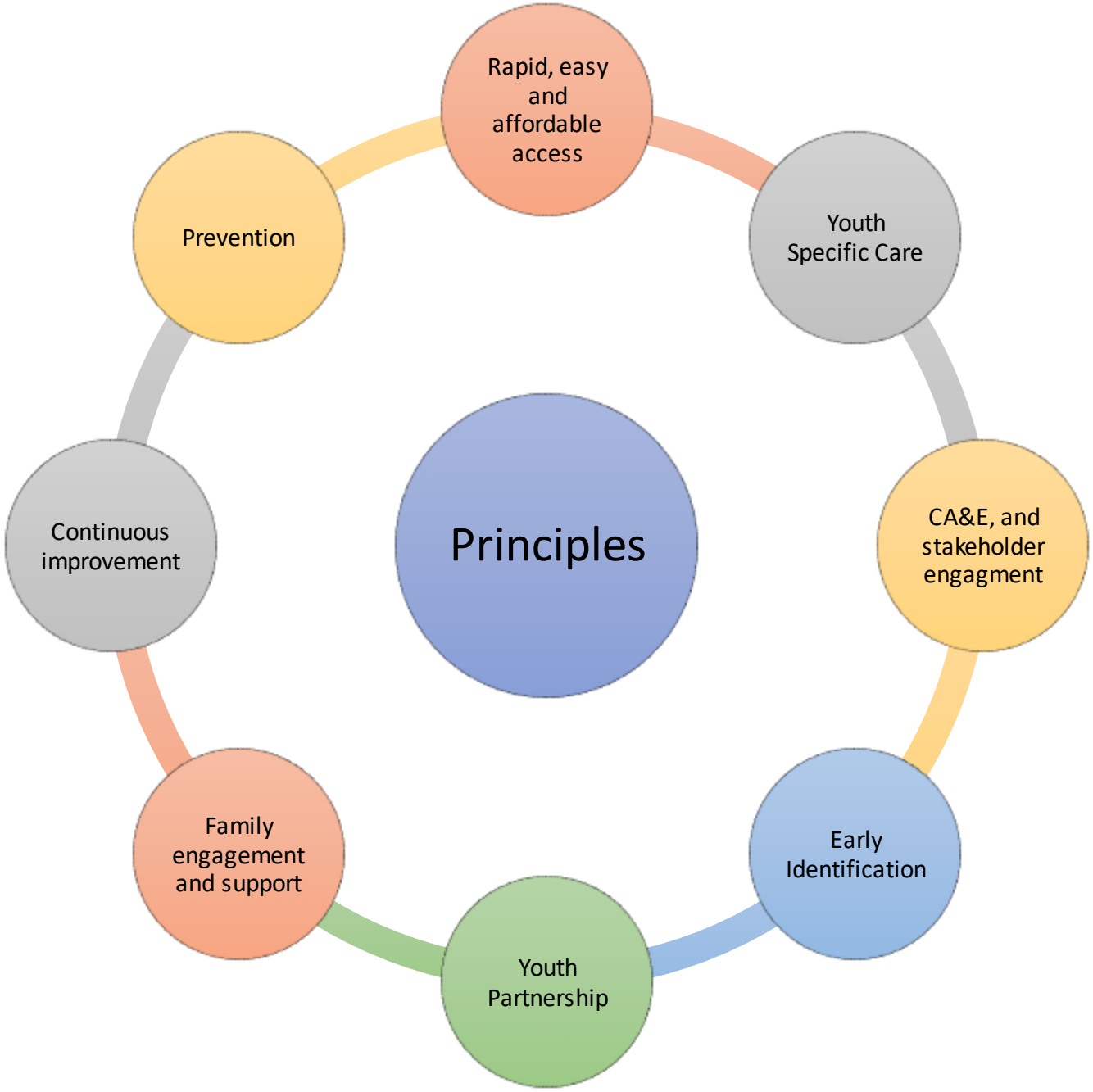
Youth Partnerships Facilitator – Ella Gow

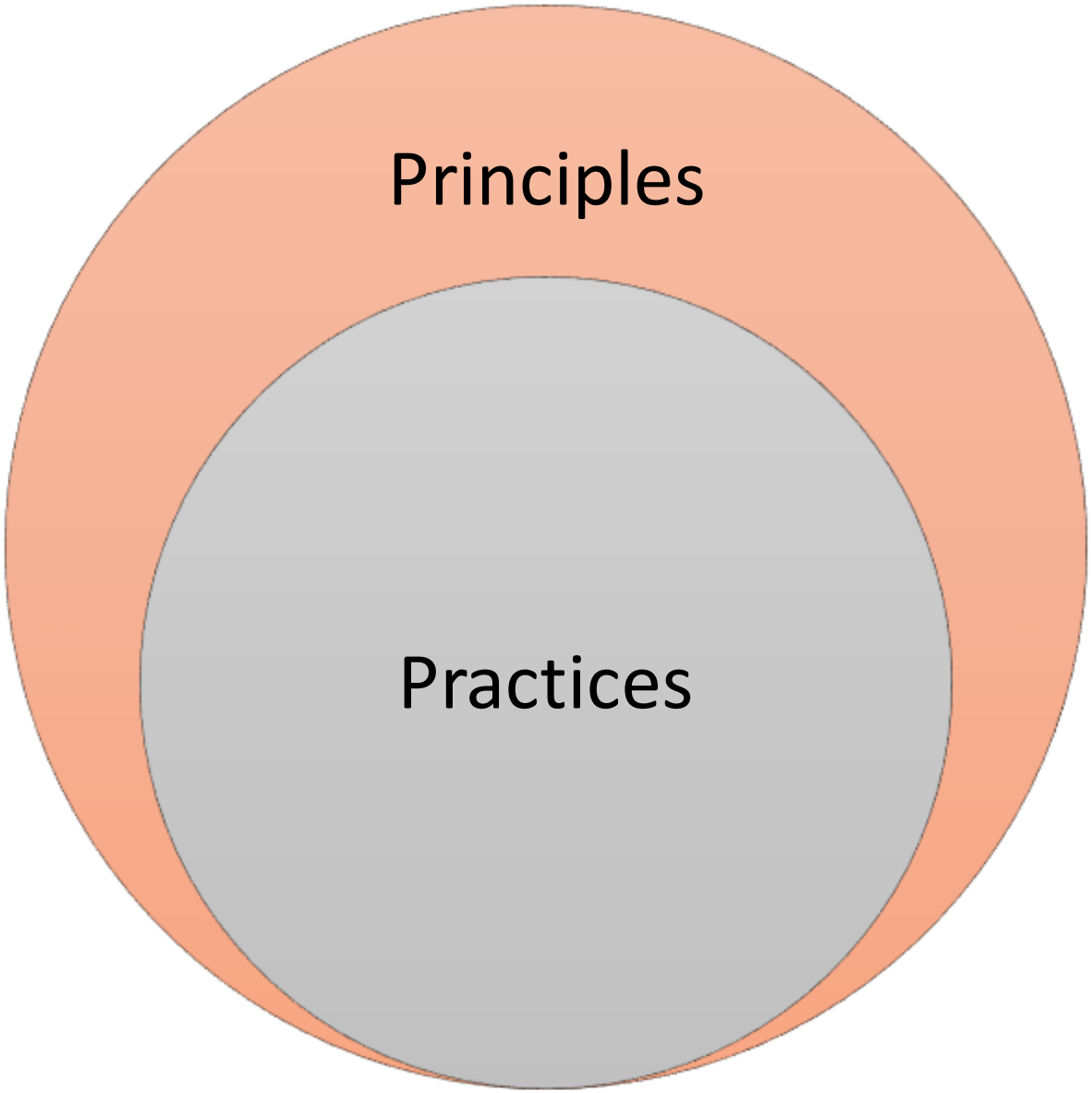
Working with the Forums Global Shapers Network to engage young people from a range of different counties and contexts.

Will work to engage young people in focus groups in their community and online, to provide input into the model and advocacy toolkit being developed.

Proposed framework for youth mental health services

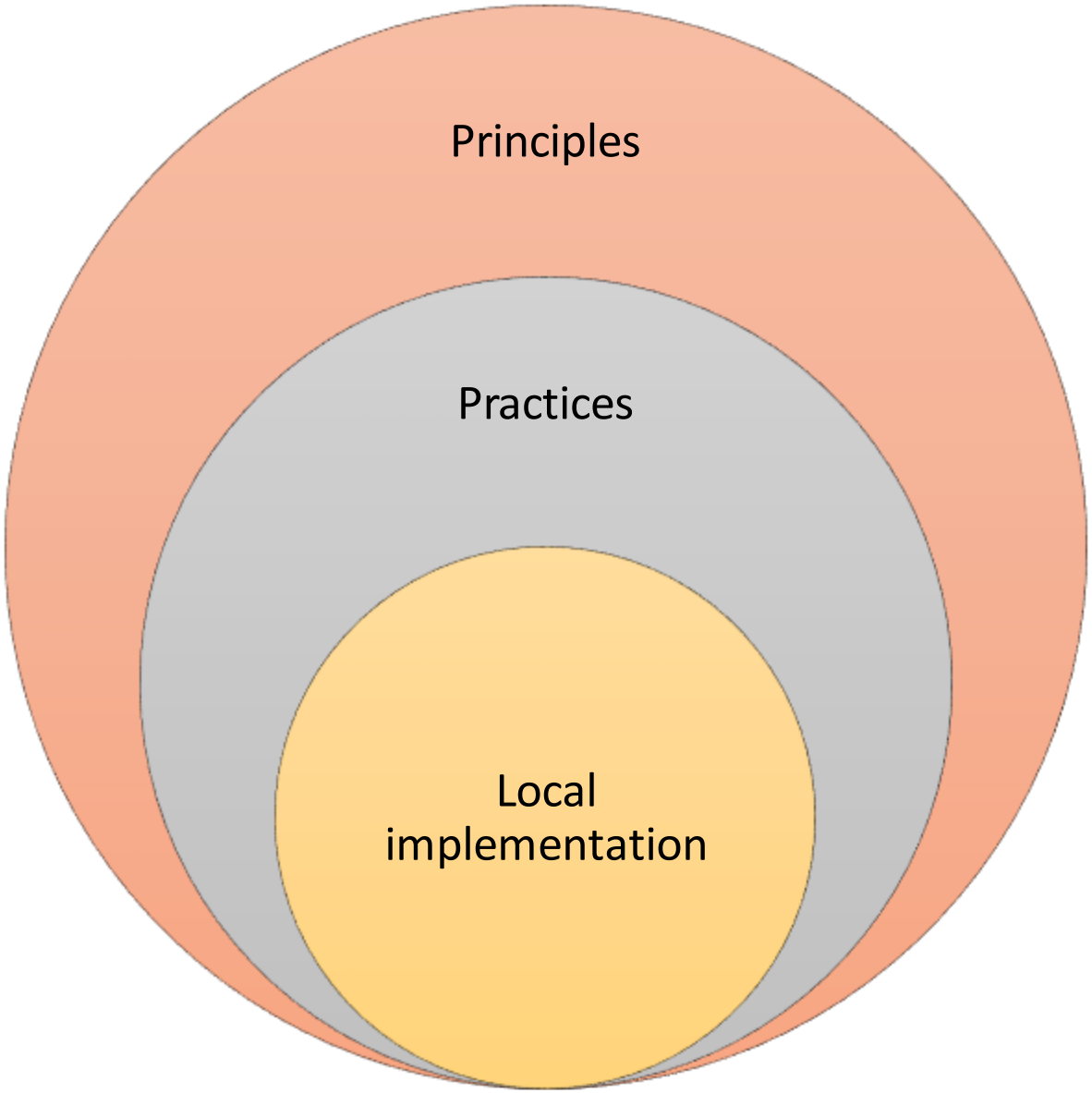

Principles

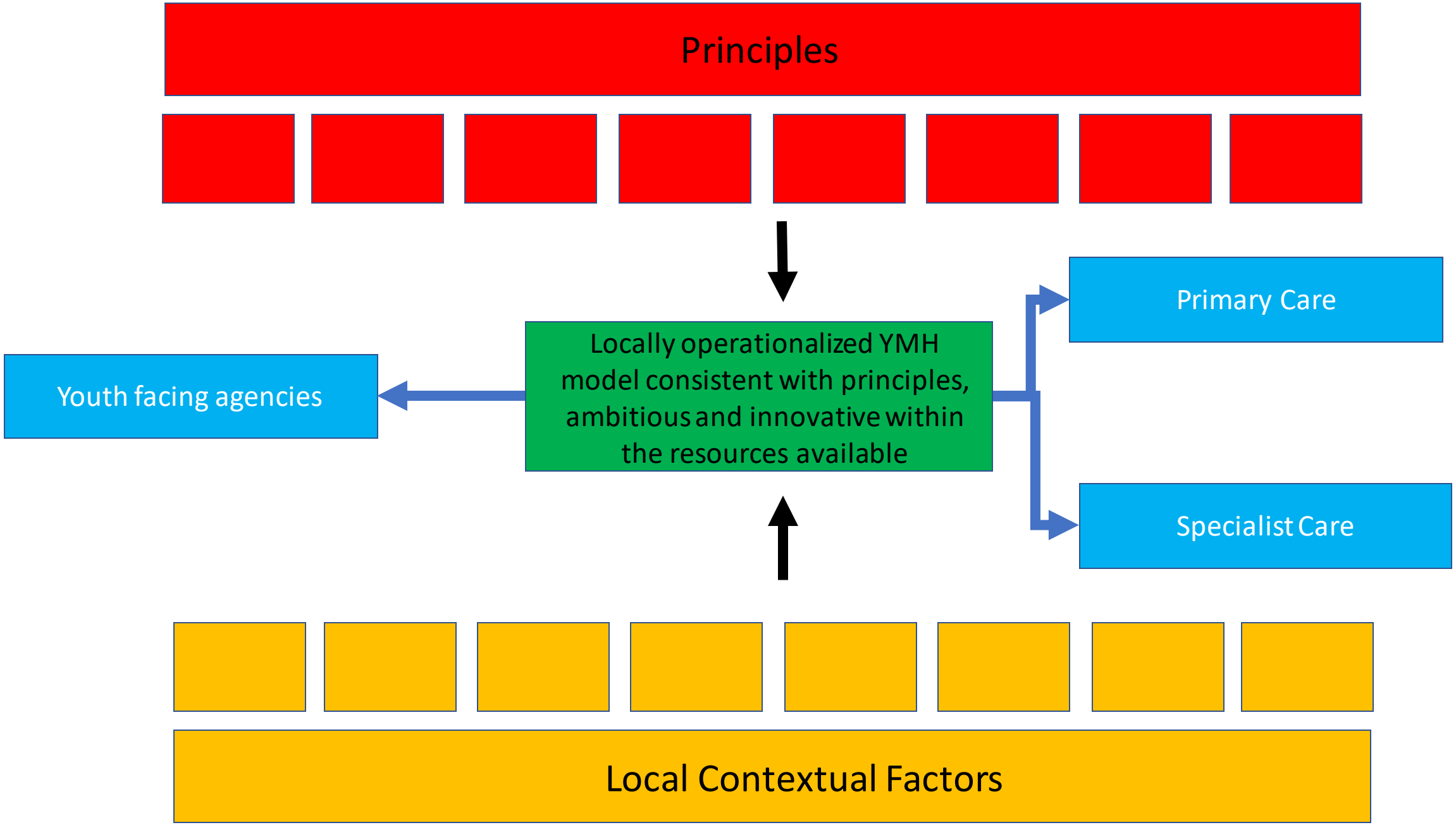

Principles
Rapid, easy and affordable access
Youth Specific Care
CA&E, and stakeholder engagment
Early Identification
Youth Partnership
Family engagement and support
Continuous improvement
Prevention


Principles
Practices

Several practices facilitate rapid and easy access for young people and families. The underlying driver is to identify and remove barriers. For example:

- no requirement for a referral to the service removes the need to visit, convince and possibly pay a gatekeeper such as a GP to allow access.
- developing good relationships with child mental health services allows for there to be little lag time if a young person is transitioning from one service to the other.
- Ease of access is facilitated through considerations such as locating the service close to public transport hubs, or in an area which can be easily accessed should transport be limited or non-existent.
- ensuring that the service is open when young people can access it (not necessarily traditional 9 to 5 working hours). This may include offering services over an evening or a weekend.
- Ensuring that, where possible, there is no direct cost to the young person, and where this is not possible, minimising this cost so as to ensure that finance is not a barrier to seeking access.
- Providing simple, free and a direct means of contact. This may be via toll free telephone numbers, internet or walking in.


Principles
Practices
Local implementation


Principles
Primary Care
Youth facing agencies
Locally operationalized YMH model consistent with principles, ambitious and innovative within the resources available
Specialist Care
Local Contextual Factors

Conclusions

- Youth is a biologically, developmentally and epidemiologically distinct period
- Mental health system design should reflect this
- A key developmental task in this stage relates to vocational functioning
- People with mental illness are disproportionately vocationally disadvantaged
- Evidence exists of interventions that make a significant difference for young people with mental illness in relation to their vocational functioning
- New models of care, with functional recovery as a key part of service are needed
- These need to have no access barriers and serve the entire spectrum of young people with mental health needs
- Young person centered, culturally appropriate, co-designed and optimistic about the future for young people

Thanks!

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