2022

Comparing the Mental Health Care Policies and Economic Effects in Australia and the United States: Implementing the “headspace” Centre Model

Catherine J. Michelutti
Univeristy of Pennsylvania

Comparing the Mental Health Care Policies and Economic Effects in Australia and the United States: Implementing the “headspace” Centre Model

Abstract

The prevalence of mental and behavioral health problems is currently high in most, if not all, countries. In the U.S. and elsewhere we have seen the impact of an increasingly stressful time, as we live through the pandemic, social unrest, war, and divisive politics. Costs of mental health problems include not only the direct expense of treatment but also indirect costs of loss of productivity and the impacts on society, including substance abuse, family dysfunction, homelessness, crime, etc. The *headspace* model, which originated in Australia, is a new approach for addressing mental health issues for adolescents and young adults. After almost two decades in operation, this model has demonstrated an encouraging degree of success. Because of the positive results from Australia, several other countries have tried (or are trying) to adopt the same model, typically focused on the youth. This paper aims at exploring how the new Australian approach to mental health care might be applied more broadly across the population, and specifically, how the *headspace* model might be an example for designing services for adults in the U.S. Why focus on adults? Because their disorders are more likely to be more deeply embedded, they have more direct impacts on the economy and the community, and they do *not* have a safety net of a school system or parental influence.

Keywords

Mental Health, Healthcare Equity, Early Intervention, Wellness Affordability, Integrated Health Services, Underserved Populations, Hesitancy, Stigma

Disciplines

Business | Mental and Social Health | Public Health

Comparing the Mental Health Care Policies and Economic Effects in Australia and the United States: Implementing the "*headspace*" Centre Model

Student Researcher & Author: Catherine Michelutti

The Wharton School

Faculty Mentor: Prof. Molly Candon

ABSTRACT

What's the big deal? Depression, anxiety, bipolar personality, post-traumatic stress, etc. Are these really so important? Sure, they're uncomfortable and inconvenient, but how urgent are they compared to *real* problems like a pandemic or global warming? Surely, we are over-blowing the importance of mental health, right?

Wrong! Actually, we're ***not*** exaggerating the importance of mental health. The personal, local, and global impacts of mental disorders are a huge burden and cost to society. They say that to solve a problem, first, we must agree that there *is* a problem. Also, finding the solution sometimes requires a different approach. At this time, it seems most would agree that there is a problem with mental health in this country and worldwide, but is there a better approach, and if so, what is it? This is the story presented here.

The prevalence of mental and behavioral health problems is currently high in most, if not all, countries. In the U.S. and elsewhere we have seen the impact of an increasingly stressful time, as we live through the pandemic, social unrest, war, and divisive politics. Costs of mental health problems include not only the direct expense of treatment but also indirect costs of loss of productivity and the impacts on society, including substance abuse, family dysfunction, homelessness, crime, etc. The *headspace* model, which originated in Australia, is a new approach for addressing mental health issues for adolescents and young adults. After almost two decades in operation, this model has demonstrated an encouraging degree of success. Because of the positive results from Australia, several other countries have tried (or are trying) to adopt the same model, typically focused on the youth. This paper aims at exploring how the new Australian approach to mental health care might be applied more broadly across the population, and specifically, how the *headspace* model might be an example for designing services for adults in the U.S. Why focus on adults? Because their disorders are more likely to be more deeply embedded, they have more direct impacts on the economy and the community, and they do *not* have a safety net of a school system or parental influence.

Keywords
Mental Health, Healthcare Equity, Early Intervention, Wellness Affordability, Integrated Health Services, Underserved Populations, Hesitancy, and Stigma

Disciplines
Public Health | Social Impact |Healthcare Accessibility| Healthcare Management |Healthcare Policy | Mental Health Policy | Nonprofit Management

ACKNOWLEDGMENT

I would like to thank The Wharton School for funding this project and particularly Dr. Molly Candon for her advice and guidance. Also, I owe a special thanks to the representatives of the Australian organizations of Orygen and *headspace* for giving me their valuable time. Meeting them and their teams in person, and hearing about their work in youth mental health was critical in my understanding of the benefit of a new approach.

TABLE OF CONTENTS

INTRODUCTION

Did you catch these news headlines?

- *Innocent lives were lost yesterday at the hand of a young man who started shooting randomly with an automatic weapon in a local high school. Some friends state that he had shown troubling signs of behavior, but no one believed that intervention was necessary. "We didn't see this coming at all. No Way!" said the suspect's mother.*
- *A successful TikTok model, influencer, and former pageant winner commits suicide. Friends and family are puzzled by the tragic loss of a beautiful and successful woman but can't determine what drove her to this end. Although, some remember that she had seemed depressed and had planned on seeing a counselor but never got to it*
- *The local school district asked authorities to clear a homeless encampment near a middle school because they are concerned that drug use and other antisocial behavior at the camp could put students at risk. The city has worked with local non-profit organizations to set up shelters to house the homeless. However, many of the unhoused people simply don't want assistance and prefer to live on the street, even with all of the problems and risks it involves.*

The above headlines are fictitious in terms of not being about specific incidents, but each is representative of something we see very frequently in the news. Each of the headlines is not only believable but familiar. We've seen them all before, in one form or another. The reason for using generic examples is because these incidences don't just happen in "some other place", they can and *do* occur where each of us live. And, in each story, there is a trail to some form of mental distress or disorder. So, we have to ask if some of these incidents might have been avoided if help had been given to the individual before the situation becoming a crisis.

Mental Health America's 2022 report says that over half of adults with a mental illness do not receive treatment, totaling over 27 million adults in the U.S. who are going untreated[1]. A contributing factor could be that both adults and youth in the U.S. continue to lack adequate insurance coverage. 11.1% of Americans with a mental illness are uninsured[1].

The issues of mental health are widely studied in the U.S. and internationally. It is broadly recognized that the problem is acute and warranting not just more of the same strategies, but perhaps a new approach. We can ask what has changed in the past twenty years to put mental health under such urgent attention of researchers and practitioners. Contributing factors to the worsening problem could be increased anxiety due to social threats such as the pandemic, climate change, the economy, crime, international relations, and a host of other general stressors.

This paper will look at the current state of mental health and look at the possible benefits of adopting a new service delivery model, such as the one developed in Australia (*headspace*) and

being adopted by some other developed countries. The new model for mental health care focuses on prevention and early detection in a field that has traditionally been the 'poor cousin' of the medical industry.

When a 'new model' is shown to add value to a nation that already has a national health system (Australia), we have to ask, what new elements have made the difference. Do these new elements give a clue as to how the methods of treatment should evolve?

QUESTION AND HYPOTHESIS

There is an urgent need to assist the many suffering from mental health challenges to lead a more positive life and to reduce the impact these problems can have on the community and society at large.

Is there enough being done to alleviate mental health problems in our population? Are we not doing enough, or are we just not doing it in the right way, or both?

Australia initiated a new program for tackling mental health in youth almost two decades ago, with good signs of success. Adopting some of the standards and practices used in the Australian *headspace* model for early intervention for youth could lead to significant improvement of mental health services for adults as well.

METHOD

The following approach was taken to assess the suitability of the *headspace* model in framing a better approach to mental health care.

I will summarize the state of mental health in the U.S. to represent the baseline or current state of the issue. This will be in the form of a background survey using information in the public sphere.

I will develop a schematic diagram to represent a theoretical model for mental health services and identify the 'essential elements of a functional system. This model will be used as a basis to study the current U.S. services in mental health at the local and national levels. In this context, local refers to my residential area, Whatcom County in Washington State. It is assumed that my local area is representative of other regions in the U.S. It is noted that information regarding the service providers comes from publicly accessible sources such as their corresponding web pages.

From the information collected above, I will try to identify the methods and processes that represent success in their operations, or which might be gaps or weaknesses.

I will review the basic premise of *headspace* in Australia and select other countries where the model is being replicated. Sources of information will be publicly reported information.

It is only in the case of headspace Australia that interviews were conducted, and specific, pre-approved questions were asked. Information learned in the interviews augments what is publicly available.

In addition to Australia, variations of the Australian model have been implemented in other countries as shown below.

Examples in the use of the **'new' model** include the following (Country – Name of Program)

- Australia – *headspace* headspace National Youth Mental Health Foundation
- Canada – Foundry Foundry - Where Wellness Takes Shape - (foundrybc.ca)
- Ireland – Jigsaw Visit Jigsaw.ie | The National Centre for Youth Mental Health
- Denmark – *headspace* Home - headspace
- Israel – *headspace* En - HeadSpace
- California – alcove Contact - allcove

All the above organizations have published a lot of information about themselves. This public information makes it possible to develop an understanding of how they work.

A fundamental question to explore is: What special features of the new model were game changes for youth mental health? Could the new model close some of the gaps found in the current system of mental health care, and could this apply to the general population, not just the youth? What would have to change at the operational and policy level in the U.S. to facilitate a redesign of our mental health services?

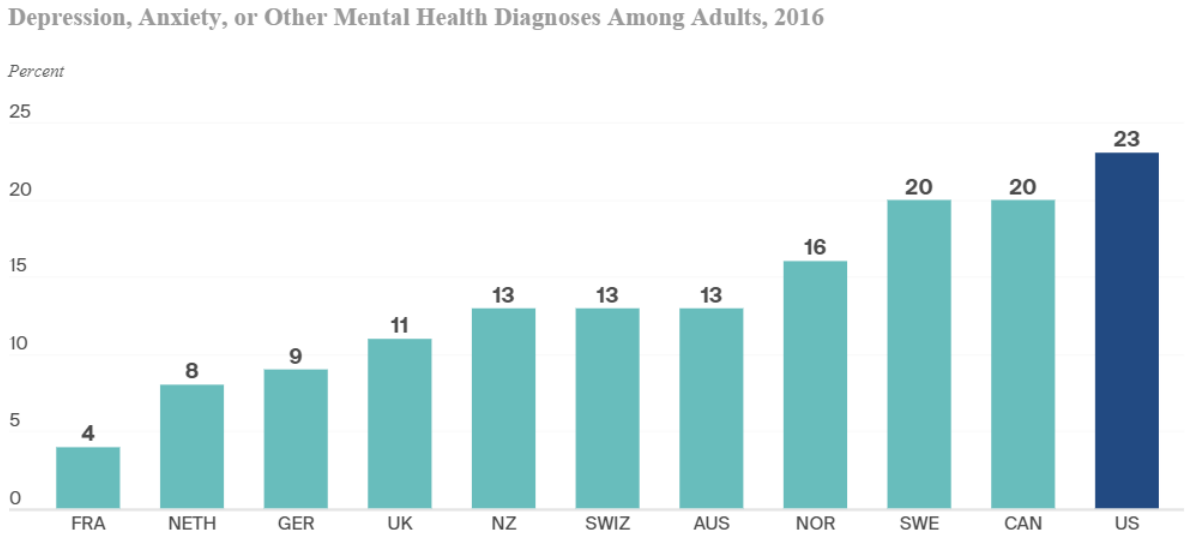
In comparing our current situation on mental health services with those of the new model, I will try to determine what changes might result in improvements.

CURRENT STATE OF MENTAL HEALTH IN THE U.S.

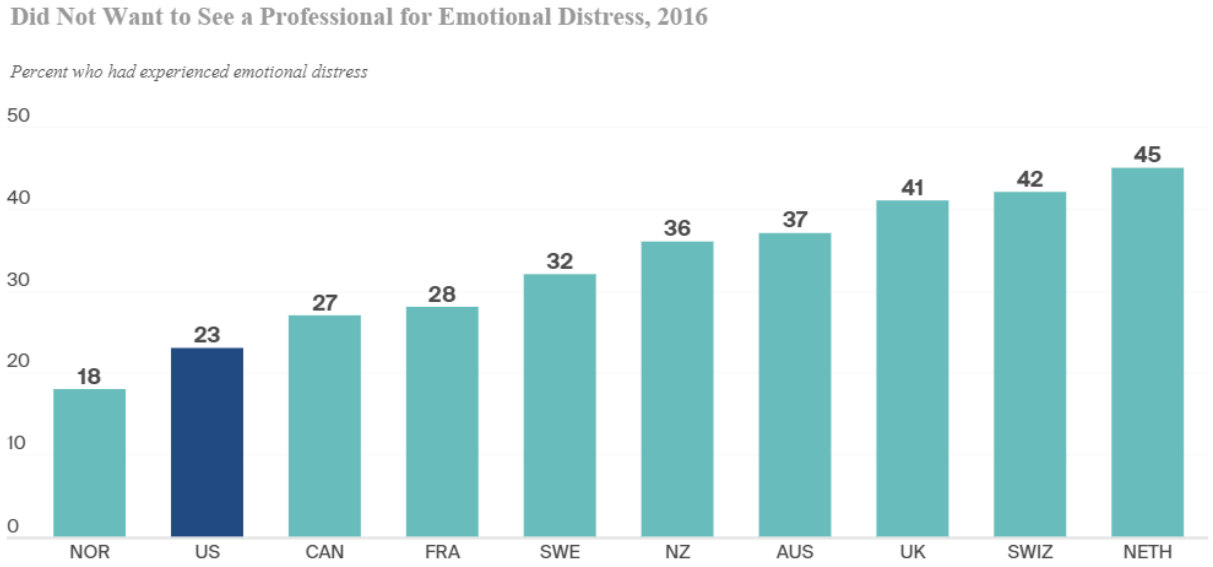
Overall State of Mental Health in the U.S.

The United States has one of the highest incidences of mental health diagnoses among high-income countries, and one of the worst records of related outcomes, including suicide and drug-related deaths. While the U.S. population is more likely to seek professional help for mental disorders, it has a relatively high barrier to access related to affordability and availability of qualified professionals. In summary, U.S. adults, compared to those of other high-income countries, are more likely to experience mental health issues, more likely to seek help, but less likely to be able to afford the appropriate treatment[2].

More U.S. adults have received mental health diagnoses than adults in other high-income countries.



U.S. adults are among the most likely to want to see a professional when experiencing emotional distress.



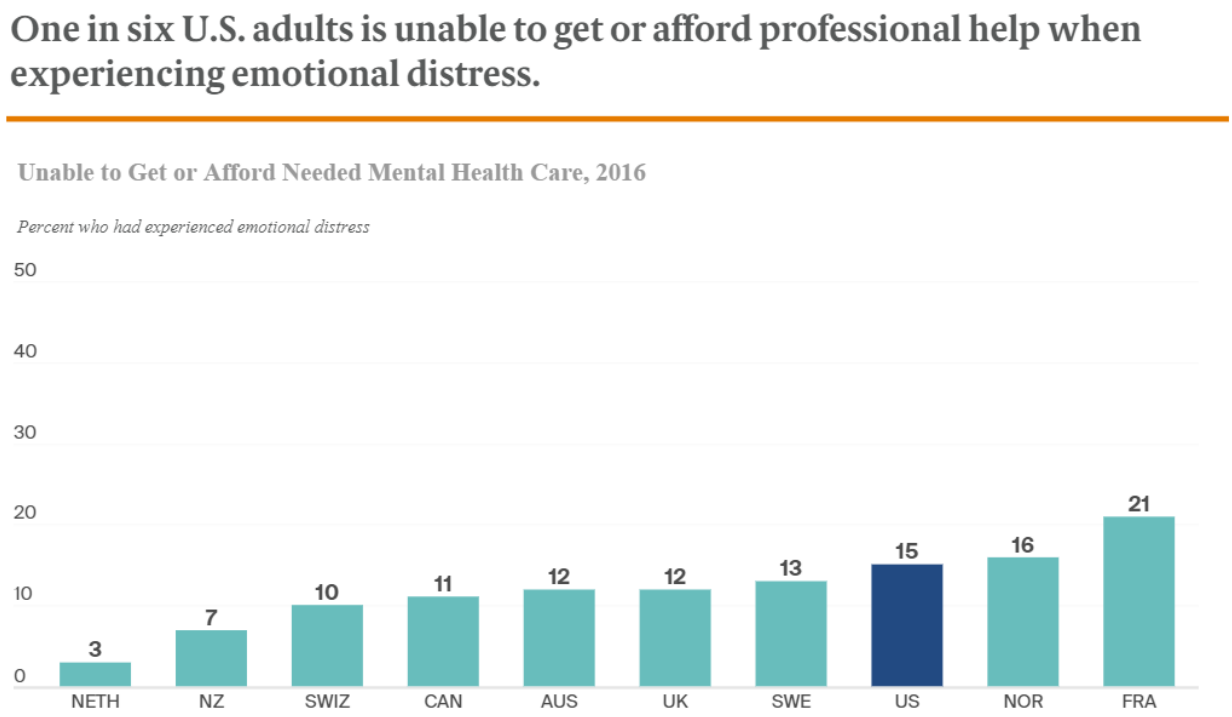


Figure 1: Comparing mental health burden, will get treatment, and accessibility and affordability of treatment across countries. Source: Roosa Tikkanen et al., Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries (Commonwealth Fund, May 2020). https://doi.org/10.26099/09ht-rj07

Costs of Mental Health Conditions in the U.S.

As the prevalence of mental health issues increases, so do the costs, both to the individual and to the host society. A recent report by the Open Minds group states that spending on mental health over the past 10 years has increased by over 50%. In 2019 it is estimated that spending on therapy, medication, and rehabilitation was about $225 billion, and this does not include indirect costs of lost productivity[3].

The cost of help to the individual is high, and while the 2008 Mental Health Parity and Addiction Equity Act has helped reduce disproportional restrictions on mental health coverage, there are still insurance loopholes and a general shortage of qualified professionals[3]. Therefore, there are still significant barriers to accessing treatment. The Nation Institution on Minority Health and Health Disparities has estimated that only about half of patients with mental health disorders receive proper treatment, and for even far fewer is the treatment completely effective.[3]

The United States is somewhat unique among the richer developed countries in that it doesn't have a national health system. We typically rely on a combination of private insurance, Medicare

(typically for those over 65 years of age), Medicaid (for those with limited income), the Veterans Health Administration, and the Children's Health Insurance Program. It is noted that the cost of private insurance is high and for many, this insurance is provided as a benefit from their employer. A common personal criterion for retirement is reaching the age of eligibility for Medicare.

The United States is not alone in facing the growing challenges of mental health. Many countries, including the wealthier economies, experience high rates of prevalence and related costs directly associated with mental disorders[4].

After reviewing the Australian model and speaking with *headspace* representatives, which will be discussed in depth later in the paper, it is clear that one of the reasons for *headspace's* accessibility is Australia's Medicare. This national health insurance covers all people over fifteen years of age. (Children below that age are under parents' coverage). In the U.S., the high cost of private health insurance, which may not cover mental health services, could be one of the contributing factors to the statistic in Figure 1, showing that one in six adults is unable to get professional help when facing emotional distress.

Mental Health and Homelessness in the U.S.

General

In the above, I have already noted the high incidence of mental health problems in the U.S. Another regrettable statistic in this country is the high level of homelessness, especially in a wealthy developed country. How are mental health and homelessness related since one is a behavioral issue and one is an economic issue? Through numerous studies and common direct observations, we see that many of the chronically homeless seem to have problematic behavioral conditions. It's a two-way street. The experience of being homeless can cause or hasten the onset of mental challenges. Similarly, certain mental disorders can directly or indirectly lead to homelessness. The two conditions often coexist, and they can also be accompanied by alcoholism, substance abuse, and a host of other legal and social problems. The compounding of these behavioral issues tends to ramp up the overall state of personal dysfunction.

In the interest of understanding the challenges of disadvantaged and underrepresented groups, I have included a review of the homeless population, who need mental health care but face barriers to access due to poverty, addiction, or stigma. Not only are the homeless more likely to suffer from mental problems, but they are also less capable of getting help.

Over the past few years, the U.S. has seen homelessness increase, particularly in some of the large urban areas and on the west coast. This concern has gained the attention of many private and public organizations, and many causes and remedies have been studied. Among the factors

related to homelessness are poverty, mental health, crime, and drug addiction. In many cases, these factors are cross-linked and tend to worsen the effect of individual problems.

In 2022 there is an estimated total of about half a million people experiencing homelessness in this country[5]. About 2/3 of these are single individuals and 1/3 are in family groups[5]. The causes of homelessness are complex but include a combination of possibly related factors including economic, social, and mental health. The number of homeless persons varies by state, with the highest numbers in descending order are[5]:

- California 162k
- New York 91k
- Florida 27k
- Texas 27k
- **Washington 23k**
- Massachusetts 18k
- Oregon 14k
- Pennsylvania 13k
- Arizona 11k
- Ohio 11k

It is noted that Washington State, which is 13th in the overall population is 5th in terms of the homeless population.

According to a 2015 assessment by the U.S. Department of Housing and Urban Development, about 25% of homeless people have a *serious* mental illness. This compares with a prevalence rate of about 4.2% for all U.S. adults[6].

Homelessness can exacerbate an existing mental illness, and further if combined with alcohol or substance abuse can cause additional incidents involving crime, victimization, and encounters with the police.

It can be inferred that the problems associated with mental health among the homeless are disproportionately greater than for the overall population.

<u>The Homeless as an Underserved Population</u>

Whatever the challenges to mental health care by the general population, whether they are related to hesitancy or other factors, it is likely that for homeless people the challenges will be even greater. The homeless populations lack the financial and logistical capability, as well as possibly lacking a family or friend support network. Therefore, they are likely to face greater

challenges accessing mental help, especially as they have to be concerned about food, water, shelter, safety, and other survival factors.

Per the anecdotal experience of outreach organizations that try to bring help to the homeless, many homeless individuals actively resist identification and the assistance that is offered. In many cases, it takes weeks or months for outreach workers to gain the trust of a homeless person, and to gain the ability to help that person beyond the basic survival needs. It seems that while the homeless population, has a greater prevalence of mental disorders, and fewer resources, at least there are proactive efforts made to assist them through outreach.

One of the underlying facts of mental illness is that most treatments require long-term effort. This effort can be labor intensive on the part of the provider and requires 'stick-to-it' on the part of the recipient. It is more difficult to maintain people's engagement when they don't have housing stability. In the case of Whatcom County, WA (my local community), a **'housing first'** approach has been adopted. This means that getting into a stable home makes it easier to solve many other problems the individual might have, such as drug use or mental disorder. Get a house first, and other things will be easier to deal with. However, there is within this county and many others, a severe shortage of affordable housing. Additionally, for those individuals requiring more intensive services, there is a serious shortage of qualified clinicians.

To learn about what mental health resources exist for the homeless population, I did some background research on the prevalence of homelessness and available resources in Whatcom County, WA.

<u>Prevalence of Homelessness in Whatcom County</u>

Lack of affordable housing is the main factor leading to homelessness and this is compounded by the difficulty in accessing treatment for medical or behavioral problems. The county and several partner organizations endeavor to provide housing and general assistance, with priority given to those more at risk of other harm. While efforts are made and progress is gained, there are limitations of housing units and professional workers, making it difficult to keep up with the demand. The reference cited here is a strategic plan to end homelessness in the county, called "A Home for Everyone" by the Whatcom County Health Department[7].

Some of the information included in the reference[7] includes the following:

We need better coordination between different agencies working on the homeless effort and if possible, we should create a single point of entry for those seeking help.

The participants providing service to the homeless should include those who themselves have had homeless experiences. People with prior homeless experience will have a better perspective and possibly better credibility.

Although there may be many coexisting problems, the priority should be to provide housing first and then deal with the other issues. Also, higher priority should be given to the medically fragile.

The host community should be informed of homeless issues and be a source of input for ideas and solutions.

The most common element leading to homelessness is financial stress. Many families are within one unexpected expense (say $400) of being financially desperate. About 65% of Whatcom renters pay more than 30% of their income in rent, which is an accepted definition of 'cost-burdened'. A 2019 study by Western Washington University found that homelessness and housing affordability were the first and second major challenges facing the City of Bellingham.

Behavioral health and substance abuse are contributing factors to becoming homeless, and the shortage of medical and other professional help to treat these disorders is an enormous challenge

Assistance services must rely on 'outreach' tactics to reach the unsheltered population (those not housed in organized shelters, but out on the street, in encampments, or vehicles). Among the homeless, particularly those unsheltered, are people that do not wish to be identified or officially helped. These folks are hard to engage in the long term and therefore difficult to assist. Many of these are 'deliberately' homeless, angry, defiant, and generally not cooperative

In 2019 there were about 700 homeless in the county with about 40% unsheltered. The unsheltered were mostly in the 18 to 54-year age group and mostly lived as unaccompanied individuals with about one-half female. There are also households with minor children.

Community health centers are available to serve the homeless in Whatcom County. Including a range of services from behavioral health to medical, dental, and pharmaceutical services. The main hurdle is the capacity constraint on the part of the provider leading to long wait lists and missed opportunities. Again, one major issue is the shortage of professionally qualified staff.

Another issue for some homeless people is a reluctance to accept the service or the unwillingness to conform to the rules of an official shelter. Some people who might benefit from mental health services refuse to engage in such services. This reluctance to receive assistance reflects attitudes and fears that might apply to many in the general population, thereby representing strong barriers to seeking help.

Services Available for the Homeless in Whatcom Co.

Community health centers are available to serve the homeless in Whatcom County. These include the following, offering a range of services from behavioral health to medical, dental, and pharmaceutical services. The main hurdle is the capacity constraint on the part of the provider leading to long waitlists and of course, missed opportunities

The Opportunity Council in Bellingham includes a Homeless Service Center, which acts as a point of first call for the homeless, who might then be referred to more specialized assistance[8].

As part of the service of this group is an outreach team that works in the field daily to connect with the unsheltered homeless, in camps/tents, doorways, vehicles, and generally in places not intended to house humans. The outreach team often invests weeks and months to establish a degree of trust with homeless individuals, many of whom make an effort not to cooperate with any form of official help other than for basic survival needs. Service organizations include the following.

- Unity Health Care Northwest Unity Care NW
- Sea Mar Community Health Center Sea Mar - Community Health Centers
- Compass Health Compass Health | NW Washington's Behavioral Healthcare Leader
- Lake Whatcom Center Home - Lake Whatcom Center (lwrtc.org)

While the prevalence of mental illness is high among the homeless it is often difficult to identify cases where there is a high risk of violence or other anti-social acts, and therefore difficult to intervene. Therefore, we continue to see examples of behavior which include serious crimes.

Mental Health Hesitancy

There has always been a hesitancy to admit to any form of mental stress. This hesitancy, often due to fear of stigma must be increasingly addressed so as not to impede offering assistance to those in need. To combat the stigma, mental health should be increasingly a part of the private and public conversation. We have recently seen more examples of this conversation with younger people and public figures, for example in the case of well-known gymnasts, tennis players, and members of the British royal family. Some techniques can be applied to assist in convincing people that non-judgmental help is available.

Mental health stigma varies across age groups and cultural backgrounds. A study from San Diego State University found that non-Hispanic White and Hispanic adults tended to hold the highest level of perceived public stigma on mental health. Middle-aged non-Hispanic Whites were more likely to be concerned about stigma than their older counterparts, and black adults showed the lowest level of concern.

Additionally, the National Latino and Asian American Study found that Asian Americans are less likely to seek mental health services compared to the general population[9]. Another study found that white U.S. citizens are more likely to use mental health services at a rate of three times that of Asian Americans[10]. There are stronger cultural stigmas in Asian communities. However, these populations are also more likely to rely on their own social networks for help, including family, friends, and religious organizations.

Personal and perceived stigma affect a person's appraisal of their own mental illness and their tendency to seek help.

Barriers to Accessing Mental Health Services

There appears to be a variety of barriers to accessing mental health services that affect the greater U.S. population. In a recent review of mental care access, the Social Solutions group listed the five main barriers facing patients in the U.S.[9]:

1. Financial Barriers
2. Shortage of Qualified Providers & Mental Health Professionals
3. Mental Health Education and Awareness
4. Social Stigma
5. Racial Barriers

Even with the effort of many good groups, organizations, and private and public institutions, there is still work to be done to reduce the barriers preventing about half of those with mental disorders from accessing the help they need.

Based on these barriers, I will review selected local services and elaborate on possible gaps and opportunities for improvement in mental health services that I have deduced from my background research.

Review of Selected Local Services

A quick search of publicly available information indicates that within Whatcom County and the immediately surrounding areas there are several organizations available to help the public with mental health and several related problems. Typically, these 'help' organizations are either government funded or operated by nonprofit groups. These groups are all different and between them cover a wide range of services.

Although the following organizations apply to this region (Whatcom Co. WA), it is assumed, but not verified, that this county is representative of other regions of the country. One factor that seems common to all regions is a large unserved need for mental health services and a shortage of qualified professional providers.

A search at a local level shows the existence of several agencies providing care and assistance in one form or another. These are summarized below.

SAMHSA: The Substance Abuse and Mental Health Services Administration, a part of the U.S. Department of Health and Human Services provides comprehensive information and statistical data, as well as tools for seeking organizations to provide support services.

A search on the SAMHSA data map, around the City of Bellingham WA, identified about 100 sources of service assistance within 82 miles.

Typically, the websites of these organizations are rich with information and demonstrate a commitment to providing the best help possible. In many cases, however, their ability to provide service is limited by their resource capacity, both staffing and infrastructure. Capacity constraints unfortunately lead to a bottleneck in service and long wait times.

The following organizations provide support in several areas, not just mental health, but areas including housing, jobs, substance abuse, sexual health counseling, and a variety of issues relating to the individual and how they interact in the community. Some organizations even provide a service to go out on calls in the case of an urgent need.

The dissimilarity of the selected organizations makes it difficult to assess them with a common yardstick. They each provide a good service in their own way, with a few areas of overlap and possibly a few gaps.

Many other organizations are providing some degree of service, but for practical reasons, the following were chosen as representatives for closer review.

- Catholic Community Services:

Whatcom County - Catholic Community Services and Catholic Housing Services of Western Washington (ccsww.org)

Provides mental health services to Medicaid-eligible children and their families in Whatcom, Skagit & Snohomish Counties. After an initial assessment, core mental health services available include individual and family counseling and therapy, coordination with primary health physicians, and case management.

- Compass Health:

Compass Health | NW Washington’s Behavioral Healthcare Leader

Claims to be northwest Washington's behavioral healthcare leader. Provides a range of services from counseling to outpatient treatment to residential treatment. Assistance is for behavioral and other community-based issues.

- Lake Whatcom Center:

Home - Lake Whatcom Center (lwrtc.org)

Provides residential (voluntary) and outpatient programs and treatment for chronically mentally ill adults, and for those who wish to transition back to the community. Service is for those who have been diagnosed with more serious disorders. The treatment intensity level and/or frequency of meeting with the clinician depends on the severity of the client's condition.

- Resource Round Table – Whatcom Family and Community Network:

Whatcom Family Community Network - Whatcom Family Community Network (wfcn.org)

"*Promotes the well-being of children, youth and families by convening and supporting communities to build their capacities*". One of the missions of this organization is to establish a data center for all community resources with a friendly user interface where a person can begin to resolve their particular needs. Perhaps this will end up being the community's common door to assistance.

- Mount Baker Foundation:

Welcome | Mount Baker Foundation (mtbakerfoundation.org)

"*Catalyst for community & generational transformation …Supporting individuals, families & neighborhoods & communities become stronger & healthier…."*

- Whatcom County Health Department's Human Services Programs:

https://www.whatcomcounty.us/783/Programs

County-level projects sponsored or supported by local government.

- National Alliance on Mental Illness – Whatcom County Chapter:

https://www.namiwhatcom.org/
Non-profit agency providing services for the community. This organization does not provide treatment beyond counseling, peer and family therapy sessions, and advocacy.

- North Sound Behavioral Health Administrative Services Organization:

https://nsbhaso.org/

The quasi-governmental regional entity that funds services in Whatcom, Skagit, Island, San Juan, and Snohomish Counties.

- Northwest Youth Services:

https://www.nwys.org/

Local non-profit provider of housing and support services for youth aged 13-24.

- Behavioral Health Advisory Committee:

https://www.whatcomcounty.us/262/Behavioral-Health-Advisory-Committee

Elected officials, county staff, and appointed community members' forum for input on behavioral health funding and programs; quarterly meetings are open to the public.

- GRACE & LEAD Programs:

GRACE and LEAD Programs | Whatcom County, WA - Official Website

Whatcom County has also recently set up two new organizations which aim at redirecting the burden from emergency and police services to more suitable forms of attention, thereby allowing the emergency services to concentrate on the true emergencies.

As seen in the above sample of local organizations, there are many forms of public services available to assist with behavioral issues in the community.

In reviewing the public information about the above list of organizations, I tried to find answers to the following questions. General answers are noted based on what was stated or implied by their published information.

What is the main area or specialty of the service?

A wide range of services is covered from homelessness and drug use to more psychologically based problems. Service varies from counseling to in-patient residential care. What appears to be missing is a one-stop-shop or at least a single-entry point that will either offer comprehensive services or undertake the coordination of a case in the long term after a referral is made. What is needed is a 'front door' for all services. Ideally, there would be 'no wrong door'. It would be

very discouraging to seek help from a resource only to be told that the applicant needs to go elsewhere.

Who are the typical clients and how do they come for help?

Most clients are initially walk-ins when services sought are community-related, such as home or food security or family dysfunction. For issues related to mental health, including depression, anxiety, and more serious disorders, it is a combination of walk-in self-report, family recommendation, or more formal referrals from primary care providers or the justice system.

Is there a fee for services?

Typically, there is no fee for initial support, although if subsequent treatment is necessary, at some point reimbursement will have to be addressed. In most cases, the organization tries to avoid having an out-of-pocket cost for the client and tries to use private or public insurance, like Medicaid.

Does the organization interface, collaborate or compete with other organizations that assist?

There is some collaboration but in general, the organizations seem to work independently, other than perhaps referring to one another. Most organizations are fully occupied and even overwhelmed in just dealing with their particular mandate, leaving little time to step back and appreciate the broader multi-agency perspective. Limited time and staffing are factors restraining collaboration and sharing of ideas and practices. Exchanging ideas is very important, as is being able to assess performance and make improvements where necessary.

What are the main barriers preventing more people from seeking assistance?

There is often a reluctance to seek help until the situation becomes serious. Many clients express reservations due to embarrassment or stigma. Affordability is another barrier. This is often a concern to the potential client. For the service organization, reimbursement is often a problem. Even when insured, a client's insurer might not consider a treatment to be qualified or might only qualify the treatment if it is with the insurer's preferred provider.

Service eligibility is another important issue. If a potential client has to jump through hoops before being accepted into a treatment program, that person might just give up. There have been cases where an applicant seeking help is overwhelmed with paperwork and questions. In some cases, applicants have expressed frustration with the form: "I've already told my story many times, and now I've had enough, so forget it".

How is the organization promoted to the community to provide education and awareness?

Most of the organizations maintain a quality webpage. Some are more active than others in community outreach and education. Contact with the community through schools and other organizations is often made ad-hoc by board members or staffers. There are instances of community events and informational talks, but generally, the method of promotion or advertising is not systematic or particularly aggressive. Sometimes the best advertising is by word of mouth by clients themselves and their families.

Does the organization have a recognizable brand name?

In general, the answer is no. While the organizations can be found by searching, it requires some research to understand what they do and how they do it. None of the agencies reviewed seems to have a pre-made image that represents who they are and what they do.

How is the organization funded?

Funding is typically a combination of government money from federal or state departments of health and human services, donations from individuals and corporations, and reimbursement from clients' insurance plans. Often the reimbursement comes from Medicaid. It is noted that assuring reimbursement is often difficult. This can be a deterrent for the client, and a cause of effort by the provider. This can and does limit the amount of service that can be given.

Do financial limitations restrict the number of services the organization can provide?

Definitely. Covering the operating costs is a major limitation in providing the service. In some cases, this means a shortage of staff or limits in hours of operation. One of the major expenses is for higher-end clinical staff such as psychologists and psychiatrists. Often, these might only be available to organizations for limited hours per week.

Is the organization able to find qualified staff to meet the needs of your clients & potential clients?

This is a big problem throughout the country, and most other countries as well. There is an acute shortage of qualified therapists, psychologists, social workers, and psychiatrists. Even when qualified personnel is available, they might not be within the region. Some professionals work exclusively in the private-patient sector, and/or work only for cash.

In general, availability of and access to qualified clinicians is a critical problem in delivering mental health care. Washington State is classified as an underserved region with regard to mental health services.

Is the organization generally accessible in terms of location, available transportation, and convenience?

General accessibility is OK for people that live in town, but this county is mostly rural. For many folks transportation might be an issue. It is noted that mental health care is typically long-term and so might require periodic visits or meeting with a provider, so the convenience of frequent access is important in maintaining treatment in the long term.

Is the organization able to respond quickly in serving a client, or are there significant waiting periods?

The waiting period is an issue. If a problem is not at the urgent or a critical stage, there might be a wait time before getting an appointment. This is very similar to making an appointment with a regular primary health provider. Even if it is possible to get an initial consultancy with a general practitioner in short order, it might take a long time to book a specialist.

Is the organization under governance and subject to periodic performance and quality reviews?

Most organizations operate under a board of directors who provide governance and direction. There is no common body for oversight or governance. Most organizations adhere to evidence-based best practices. And while there is typically some form of self-assessment, not all is rigorous and regularly scheduled.

Is the organization able to maintain sufficient clinical staff, and if not, how does it compensate?

Staff turnaround is a problem, and this causes some issues for logistics and continuity. Contributing factors to people leaving, particularly the clinical staff include burnout, and lower pay than in private practice. It is noted that working with a mental disorder is time-consuming, exhausting, and often thankless.

Other points of relevance

There is a need to be responsive to requests for assistance. Any delay might be an opportunity lost. No one should be left behind.

It also appears that any new approach to mental health might need to be transformative, that is, shift the approach from ‘fixing the problem’ to ‘avoiding the problem by promoting wellness. This approach would certainly help in the case of mental health, as it does in the field of regular medicine, but there will always be a need to treat existing conditions that have not been avoided in advance.

Based on the review of the service providers listed above, and in the context of the questions considered, the following is my summary of attributes.

- Services include behavioral disorders, addiction, homelessness, and victimization
- Clients are either ‘drop-in’, referred by a professional, or brought in by a family member or friend
- Different organizations might make referrals to each other.
- Collaboration between the organizations is largely through giving links and contact information to clients. There does not seem to be a lot of evidence of joint work
- There are some eligibility requirements for particular services in some cases
- Information to the public is mainly through web pages, although, there are some examples of proactive outreach, such as holding events, public speaking, or visiting schools or community groups
- Apart from information on web pages and brochures, most organizations do not have a widely recognizable name or ‘brand’
- Services, in many cases, seem to be constrained by financial limitations
- Services, in many cases, seem to be constrained by the availability of staff, especially clinicians, leading to longer wait times for service

Gaps and Opportunities for Improvement

A review of existing organizations shows us how much good work is being done in serving the public and specifically those in need of mental and other assistance. Nevertheless, we can see several areas for possible improvements. Some ideas follow.

Are there too many (presumed) options? Should mental health services be consolidated into a “one-stop shop”? Too many options can create a paradox of choice. It might be helpful to have a common entry point for those seeking help; a one-stop-shop with a national brand. Such as in the case of *headspace* in Australia.

It is highly desirable for a client to feel that the provider will be able to deal with all their issues without having to be shunted between different organizations. This is not always possible. It is common for a potential client to have a diversity of concerns, as the problems tend to mingle, for example in the case of coexisting depression and alcohol abuse. Unless a caregiver can see the full context of a client’s problems the treatment might be less effective.

It’s a disincentive for a potential client to be told that they have entered the ‘wrong door’. There should be no wrong door. If a client needs help beyond what is available at a particular provider, they should at least be assessed and appropriately referred. And, with the referral, there should be some form of follow-up to help the client navigate any subsequent steps taken.

The current systems lack a systematic early intervention approach, and it’s difficult to see an overarching organization providing oversight and governance to the individual organizations or providing coordination between them.

Access to Professional Care Providers is definitely a problem. Across the country, more than 60% of rural Americans live in mental health professional shortage areas, and less than 10% of psychologists and psychiatrists work in non-metropolitan areas[11]. To make the shortage of clinicians even worse, many professionals don't accept Medicaid, making them less accessible for public service. Perhaps more needs to be done to incentivize the training and initial assignment of such professionals.[15,16]

There is a lack of general 'brand' name recognition. The organizations and their works are not widely known. Greater familiarity would result in greater trust, confidence, and a greater tendency to approach them for help.

Cultural inclusivity is an important factor in any public or private service. This is clearly recognized and practiced by the organizations. However, it is limited by the availability of employees reflecting the cultural nature of the community.

Regarding the issue of affordability, organizations generally provide no-cost services wherever possible. This is very important, especially for the first contact. However, if the cost of service is not reimbursed to the organization it puts additional strain on its operation and sustainability.

MODEL OF BASIC ELEMENTS OF MENTAL HEALTH CARE

I developed a model of the basic elements of mental health care, as shown in the figure below. The process of health care service can be thought of as being made up of the following components, or elements representing the relevant factors for the client and the service provider.

Client factors include their awareness, acknowledgment of a problem, and the possible hesitancy against seeking help. Hesitancy might include stigma, affordability, lack of knowledge about service availability, low convenience, and skepticism of mental treatment methods. Another factor could be the clients' family, friends, and social networks, and their support for pursuing professional help.

The service provider organization is represented in three components. The 'face' is the part of the organization visible to the public and prospective clients. It is responsible for promotion, brand name, public education, and outreach. It is also the key element in creating a positive first contact with a client.

The 'administration' is the component responsible for funding, management, infrastructure, legal issues, staffing, data management, and collaboration with sister organizations.

The 'treatment' component is responsible for the initial assessment and treatment of the client, involving professional clinicians to the extent necessary, and making any referrals, if necessary, to more specialized treatment.

This simplistic breakdown is a way to facilitate a clear discussion of the components, their expectations, limitations, and performance. We want to understand the dynamic efficiency of the system and the barriers preventing efficient flow.

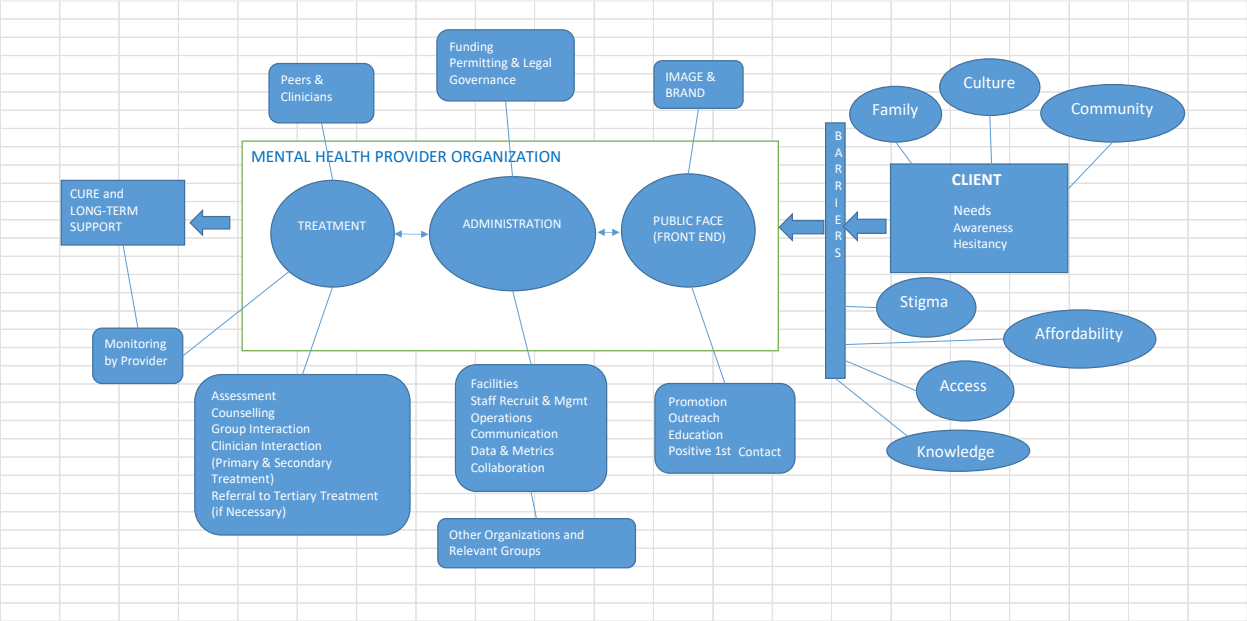


Figure 2: Model of the Basic Elements of Mental Health Care. Illustration: Catherine Michelutti

The following is a summary of the basic elements.

The Client in Mental Health

"Client" refers to potential recipients of mental health services. Below, I list some of the challenges a client might face that prevent them from accessing mental health resources.

<u>Client Challenges</u>

Awareness: A client might be unaware of an existing or potential problem. Some disorders would tend to prevent self-awareness.

Denial: This is the easy way to avoid facing the facts. Someone might say "I'm OK, this isn't really a problem, so I'll ignore these symptoms."

Hesitancy: A client might also be unwilling to seek help for fear of stigma. A person might think "Will this prevent me from getting a job and what will my friends think?" This fear might be even greater in some cultures in which any mental problem is looked upon as a major failing, if not a family disgrace.

Accessibility and Affordability: Lack of convenience or financial challenges can be huge hurdles to overcome, and these are easy excuse to avoid seeking help.

Confidentiality: Understandably, in the age where mega data is collected and transferred without the knowledge of the individual, confidentiality is a major concern. Most organizations make a point to emphasize their commitment to confidentiality and data protection, but very regularly we hear news of data thefts by hackers. Even if a data breach is not based on a nefarious purpose, it still poses a threat of exposure to stigma.

Skepticism: Many people likely think that any mental therapy is just 'mumbo jumbo' and therefore not appropriate for them.

Confusion: It's easy to become overwhelmed with information on available help. This can a disincentive if it leads to confusion about where to go, or if it leads to someone being told they are in the wrong place and should try somewhere else.

To offset the many disincentives to seeking mental health help, a client may be motivated by family or friends, or by the recommendation of their doctor or social worker. The support of the client's personal network can be a large factor in launching someone on a path of treatment and cure.

Client Expectations

We have stated many causes of barriers between the client and a service organization. Having crossed the barriers, a client will likely have several expectations. The client must have trust in the provider and confidence that they are interested in improving their mental health. The first contact is very important. A person who is anxiously seeking help needs to find a 'friend' and ally who is willing to be his advocate over the long term. A client also would like to feel that the service is comprehensive enough so that it's not necessary to hop around to multiple agencies, repeating his 'story' each time.

The Service Providers in Mental Health

Service Provider Challenges

For the sake of clarity, the overall service organization is 'separated' into three functional components. These comprise the Face (how the provider is seen from the outside, e.g., by potential clients and on first contact), the Administration, and the Treatment. Each component has its opportunities and challenges. The challenges become even more daunting when the organization is operated on a shoestring budget.

The '**Face'** of the organization is what is visible to the public. It deals with public relations, community education and outreach, promotion, advertising, and building a 'brand'. Related to this is offering a comfortable first contact with a potential client, hopefully without needing a long waiting period. The expectations are not easily accomplished but are key in lowering the barriers facing potential clients.

The '**Administration'** deals with general operations and includes funding, financial management, staff management and recruiting, infrastructure, logistics, and maintenance of facilities. Other roles include interfacing with other public, private, and governing agencies, management of data, and ensuring quality. Many of these challenges are common to most small businesses, and cannot be minimalized, however, for a nonprofit organization without a conventional revenue stream, the need to secure long-term financial support is a huge part of the effort.

The '**Treatment**' component of the organization deals with the clinical handling of the client's concerns. Related responsibilities might include screening assessment, diagnosis, counseling, therapy with a peer group or one-on-one session with a clinician, a consultancy with a psychologist or psychiatrist, and referral to a specialist if necessary. It is in this function that the shortage of qualified professionals is most deeply felt.

Typical discussion and documentation of mental health issues refer to the different stages of treatment. Some Relevant Definitions of the Stages of Treatment are as follows.

Primary treatment focuses on prevention including education, youth, and community groups. Secondary care deals with early detection, intervention, and screening for more serious conditions. Examples of this might include social worker support or telephone hotlines. Tertiary care involves helping a patient recover and might include hospitalization or outpatient treatment and medication therapy[11].

There are obviously many components involved in delivering mental health support, and weakness or failure in any one of these can jeopardize a successful outcome. Some of these components relate to operational factors, others to financial factors, and some are influenced by the overall economic and policy environment. In reviewing information about various organizations providing mental health support, their positions regarding the essential elements were considered.

THE HEADSPACE MODEL IN AUSTRALIA

The origin was "Orygen"

Patrick McGorry is a psychiatrist and professor of youth mental health at the University of Melbourne in Australia. He is the executive director of an organization called Orygen promoting

mental health and early intervention for youth. His advocacy for reform in this area led to the implementation of *headspace* in 2006.

headspace **Australia – Overview**

headspace is a nationwide program for the promotion of youth mental health in Australia. It can be thought of as a template of ideas and methods which can be adopted and operated by 'leading agencies' at different locations and for different populations. This makes it suitable for 'export'. The replication of the fundamental concepts of the model is guided by a central office that plays a role in model integrity, oversight, and information sharing. The central office also supports the establishment of new service centers, and each service center/leading agency works with its own network of local partners to support its work in the community.

Why has *headspace* made a successful impact in a country where national health is already one of the most comprehensive in the world? This question is partially answered by considering the following attributes[14]:

The new program was initially well funded with bilateral political support, and it has a long-term blended funding scheme. There is a national central group to provide governance, quality control, continuity, and guidance in expansion to new centers. The national center also provides training, compiles data, and maintains performance metrics. It holds a consistent set of standards and practices which are replicated at each new center, thereby making it easier to expand to new centers.

The organization focus on adolescents and young adults, the ages at which most mental health issues appear. Its facilities, staff, and methods reflect the youth-centric identity. In fact, many of the features of the organization were co-designed by young people. Also, *headspace* centers try to be representative of the population in the area they serve. This might relate to staffing, language, and in decoration style.

headspace has sought to tackle early intervention, thereby helping avoid later problems that might lead to a crisis mode of action. Very importantly *headspace* has made special efforts to reduce stigma, a major barrier for those needing help. It offers a broad range of support including counseling, career advice, dietary advice, sexual health, and drug and alcohol-related counseling. The program integrates mental health with general medical health and well-being. Focusing on general well-being could avoid later problems with either mental or physical health. Because of this diversity of service, it gets closer to being a 'one-stop-shop', an attractive feature for prospective clients.

Different centers are hosted and managed by different public or private agencies, while still preserving the basic characteristics of the model. The brand name itself has become well

recognized and trusted throughout Australia through a deliberate plan of promotion, public relations, and community outreach.

It aims to offer 'appropriate' care using a stepped approach. Consultation might start with peers rather than clinicians, and the treatment might not escalate beyond that if it is not necessary. This helps control the costs of services. Interaction with psychologists and/or psychiatrists might be necessary where the mental health concerns are greater, but even this is carefully measured to use the professional intervention most cost-effectively. Typically, a referral process is used if a condition requires more intensive treatment. *headspace* focuses mostly on primary and secondary intervention and refers to specialists for tertiary care. It attempts to maintain contact with the client even after they have been referred to higher-level treatment. It, therefore, provides a long-term 'buddy' support.

headspace **– Main Principles**

The main principles of the organization, as stated in the reference paper[14] and the following graphic are as follow:

1. Youth Participation
2. Family & Friend Participation
3. Community Awareness
4. Enhanced Access
5. Early Intervention
6. Appropriate Care
7. Evidence-Informed Practice
8. Four Core Streams
    - Mental Health
    - Vocational and Educational
    - Physical and Sexual Health
    - Alcohol and other Drugs
9. Service Integration (on-site, off-site)
10. Supported Transitioning

The main principles are illustrated in the graphic:

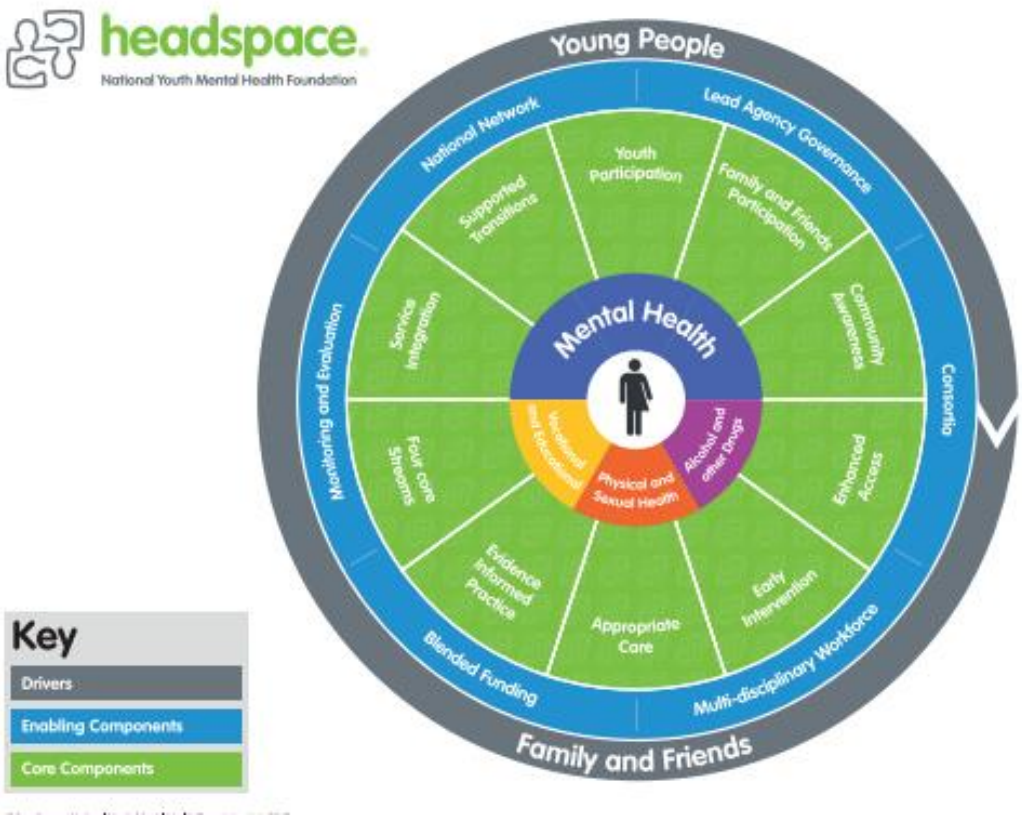


Figure 3: The headspace Centre Model. Source: Early Interv Psychiatry. 2019 Feb; 13(1): 159–166. Published online 2018 Oct 12. doi: [10.1111/eip.12740](10.1111/eip.12740)

headspace Additional Background Information

headspace is heavily involved in international collaboration on the subject of youth mental health and participates in related conferences. In 2022 the youth mental health conference is being held in Copenhagen

As *headspace* centers are set up in different parts of Australia, typically to be operated by different ‘lead agencies’, the central organization provides ‘model integrity’ influence to assure common practices, with tailoring for the needs of specific locations. What started with one or two centers in the state of Victoria, has expanded to about two hundred centers across all states and provinces.

The use of a standard model of operation facilitates the replication of centers to new locations. In Australia, once the ‘brand’ of headspace was established, many different locations were motivated to set up their own centers.

headspace took the new approach to focus on early intervention, addressing issues before they become a crisis. It places great importance on making the 'first contact' as safe and comfortable as possible by using peers and people of similar demographics assigned to the front end of the center.

VISIT ORYGEN AND HEADSPACE – MELBOURNE AUSTRALIA

As part of my project, I traveled to Melbourne Australia to visit an Orygen Center and the *headspace* National Center. I spoke with Orygen and *headspace* representatives who worked in administration and outreach. I used a questionnaire that was pre-approved by the University of Pennsylvania Institutional Review Board. No patients or vulnerable populations were interviewed.

Visit Orygen Organization in Parkville, Victoria, Australia

I visited the headquarters of Orygen in Parkville, an inner suburb of Melbourne Australia.

My first impressions of the facility were very positive. The headquarters building is large, and new, with open architecture and open views of the exterior's extensive landscaping. The general feeling was one of making any visitor, or staff member feel comfortable, welcome, and relaxed. Many of the decorations are related to First Nations (Aboriginal) artwork. It should be noted that with the newly elected Prime Minister, Anthony Albanese of the Labor Party, there has been a lot more emphasis on honoring the indigenous population of Australia.

While this building is essentially the administration and research center, not directly dealing with clients or the general public, the waiting area provided a lot of opportunities to gain information from brochures, signs, slogans, and general messaging of the selected decoration.

I waited for my appointment in the morning at about the time work was starting and the staff was arriving. Per my observations, the staff appeared to be young, smartly dressed, motivated, professional-looking, and seemed to be happy to be there.

Overall, the Orygen headquarters office made a very positive impression. While not opulent, the facility looked like it was well funded, not operating on a shoestring or just relying only on overworked volunteers. Clearly, Orygen is a well-supported and valued organization.

The Orygen manager I spoke to was formerly a manager of a *headspace* center and mentioned a few things about the organization and how it operates. For example:

headspace rigorously guards its public image, and so carefully monitors the individual centers to be sure that the high standards are maintained and there are no negative episodes that would detract from its reputation. The *headspace* model has been so successful in attracting clients for

its services, that it is currently pushed to the limit to keep up with demand. Also, the organization makes a great effort to document its experience with clients and collect data that can be used to continuously monitor and improve performance. General data is made available to individual centers to assist their performance and levels of care for clients. It was also pointed out that the organization deliberately writes its name in lowercase letters only.

Visit *headspace* Center in Sunshine, Victoria, Australia

After giving me a tour of Orygen, the Orygen manager drove me to a *headspace* center in a Melbourne suburb. As mentioned earlier, *headspace* centers are operated by different leading agencies. In the case of the Sunshine center, this is operated by the Orygen organization. Sunshine is a working-class suburb of Melbourne located about ten miles west of the city center.

The Sunshine center is located in a commercial area of Sunshine. The host building is a part of the surrounding landscape with no particular distinguishing features other than an external sign. It is noted that this facility because it is operated directly by Orygen, is also jointly used for other purposes of the Orygen organization.

The internal appearance of the center was bright and cheery, with young and upbeat staff. The decoration was colorful with many instances of appropriate messaging for visitors and patients. There was an abundance of posters, brochures, and booklets providing information on all of the available services and also giving general advice on everything from anxiety/depression to coping with stress to a healthy diet to substance abuse and sexual health. All messages had a common theme of optimism and inclusion.

I met jointly with the Orygen manager from the headquarters facility in Parkville and a person working in community outreach at the *headspace* Sunshine center. The questions listed below were in my pre-approved questionnaire. They were asked as the basis for conversation. I have paraphrased and captured the gist of the representatives' responses.

Questionnaire – Paraphrased Responses from Orygen and *headspace* Sunshine representatives

1. What types of services does your organization provide and who is the target population?

headspace services are for 12-25-year-olds. It's a range of services geared towards awareness/engagement and assessments/interventions. There are group programs for young people and their families as well as 1-on-1 support. It's a one-stop shop for all services. There is work and study support, and sexual health/drug/alcohol support. We partner with other agencies to bring in practitioners in these other fields.

2. What has your organization added to mental health services in your country that was not previously present?

It transformed everything. There was nothing like it before. It has become so large and well known, that it's almost unmanageable. We made mental health services more accessible. Our services are at no cost or low cost. It's the only free mental health service available.

3. How does the target population access your services? (e.g., referrals or advertisements)

Social media outreach, our website, and connections with schools. It's now easy to recognize the brand. Branding is consistent across 200 centers. headspace forms relationships with general practitioners who can refer young people to headspace.

4. How does your organization collaborate with other organizations treating this target population?

headspace is a platform of services. We form partnerships with other organizations to provide services to young people. For example, sexual health nurses who work for other organization comes here to deliver services. People are already working for other organizations but form a collaboration with us.

5. What do you think are the main barriers preventing more people from seeking your services? What is being done to overcome these barriers?

Barriers are demand and wait time. To solve this, we are trying to refocus more access to peer workers and provide more low-intensity interventions. Earlier interventions will make more of a difference than waiting to see a psychologist. By waiting, problems get worse. At the end of the day, young people want to connect with other young people. Having more options than just seeing a therapist is important. Other barriers are language interpreting sources and helping families come together. We currently cater more to people from Western/European cultures. We need more translators and interpreting services for more culturally diverse clients. Language is a big barrier.

6. How do you promote your organization to the community or educate the community about your services? Do you believe your organization has a recognizable brand name?

We have fantastic brand recognition. We're very strict about the brand to stay recognizable. We speak to schools, host events for mental health month, and "Are You Okay?" Day. People can come to visit in stores or at tables. headspace national has a big marketing and communications team.

7. Are you able to find and retain qualified staff to meet the needs of your target population?

It's hard. Often headspace is people's first job. They may work here for a few years and then think about going private. It's our job to build the workforce whether they stay here or go somewhere else. The retention rate isn't terrible, but it fluctuates. Psychologists are contracted. It's hard to keep them on board because you earn more going private. People who stay are genuinely good people.

8. Are you generally accessible in terms of location, available transportation, and convenience?

It's our trademark to be right next to a train or bus station. Our centers also are required to have disability access.

9. What are your short-term and long-term funding sources? (e.g., government grants, private donations, etc.)

Federal funding. It doesn't quite cover all costs, so we also get some grants and state-funded programs. There are some private donations (pretty small), but we don't have the resources to go after that. That would be on Orygen's end. For community awareness, people do go apply for grants.

10. What are the main methods of reimbursement for services? (e.g., national health, private insurance, out-of-pocket)

Medicare makes it free for everyone or at a very low cost.

11. If you could change public policy to be more favorable to your organization's success, what would you change?

When the model was set up, it was based on a private model. Now it needs to be a fully funded model because it's really grown. We also need to think about digital and other ways to connect with young people. The way it's set up doesn't quite meet the needs of young people now. headspace has expanded at a faster rate than can be supported by the workforce. We need to find ways to retain and look after staff. How do we provide services for more marginalized people? It's currently a very white, middle-class model.

12. Your organization focuses on adolescents and young adults. What would you have to change to expand services to include adults and elderly people?

They currently are trying to expand to children and older adults. It comes down to the funding is missing. We would have to change branding and set up separate centers for adults. There's something very unique about the experience of young people. We don't want to disrupt that by adding other age groups. A parallel organization would be developed for older adults.

Visit *headspace* National Organization in Melbourne, Victoria, Australia

I met with a representative of *headspace* National which is the central organization overseeing each service center, performing central functions for all of the *headspace* in Australia, and advising the new derivative organizations in other countries.

Again, the questions below were asked and used as a basis for conversation.

Questionnaire – Paraphrased Responses from *headspace* National representative

1. What types of services does your organization provide and who is the target population?

headspace services are for 12-25-year-olds. It's a range of services geared towards awareness/engagement and assessments/interventions. There are group programs for young people and their families as well as 1-on-1 support. It's a one-stop shop for all services. There is

work and study support, and sexual health/drug/alcohol support. We partner with other agencies to bring in practitioners in these other fields.

2. What has your organization added to mental health services in your country that was not previously present?

Pretty much everything. headspace was the first to provide access to youth-orientated youth mental health services in communities. Before, a young person went to their general practitioner. There was nowhere for mild to moderate cases to go. Now there are better ways to engage in person and online. A client has access to choice. headspace has also done a lot to break down stigma.

3. How does the target population access your services? (e.g., referrals or advertisements)

Young people may be referred by GPs, school well-being coordinators, or their parents.

4. How does your organization collaborate with other organizations treating this target population?

At the center level, we get other service providers involved and build relationships and referral pathways. At the higher level, we work with other mental health organizations. A board of people from different mental health organizations collaborates with campaigns. Through corporate partnerships too. We look for partners that align with their values and at organizations that employ a lot of young people or employ families and friends.

5. What do you think are the main barriers preventing more people from seeking your services? What is being done to overcome these barriers?

Waitlists and demand are barriers. Some might think "What's the point, I have to wait." A lot of work is being done around demand management such as bringing in single-session therapies and improving the intake and assessment process.

6. How do you promote your organization to the community or educate the community about your services? Do you believe your organization has a recognizable brand name?

We have fantastic brand recognition. We're very strict about the brand to stay recognizable. We speak to schools, host events for mental health month, and "Are You Okay?" Day. People can come to visit in stores or at tables. headspace national has a big marketing and communications team.

7. Are you able to find and retain qualified staff to meet the needs of your target population?

We have a pretty high turnover. We may not have the physical space to add more staff. One-off additional funds are needed to renovate or move to a bigger center.

8. Are you generally accessible in terms of location, available transportation, and convenience?

Part of the establishment process is finding a location that is accessible. Often in commercial hubs and close to public transport is a must. Some centers are slow to start up because they're trying to find locations that fit those needs.

9. What are your short-term and long-term funding sources? (e.g., government grants, private donations, etc.)

First and foremost: government funding and strong commitment from the government. Both parties are committed to investing in youth mental health. We're starting to see the emersion of state funding to bridge the gap between primary and tertiary health. As an organization, we are diversifying funding and looking more to corporate investment. Need to keep changing, especially in technology.

10. What are the main methods of reimbursement for services? (e.g., national health, private insurance, out-of-pocket)

Medicare makes it free for everyone or very low cost.

11. If you could change public policy to be more favorable to your organization's success, what would you change?

There needs to be a review of the funding models to account for inflation, cost of rent, salaries in today's world. We also need to improve the workforce pipeline by creating a vocation in mental health to get more investment in universities. Establish vocational programs in social work, psychology, nursing, etc. Getting student placements and graduate opportunities.

12. Your organization focuses on adolescents and young adults. What would you have to change to expand services to include adults and elderly people?

I wouldn't expand headspace. Recognize that our skillset is in the 12-25 range. Within the 12-25 range are key transition points. Expansion 100% can be done with research and evidence. Our approach to participation and voice would need to change. Clients would need to be more engaged. We would need to continue breaking down the stigma. Many elements of what we do could be tailored to the adult space.

MOVING FORWARD

Summary of What Has Worked in Australia

So, what is it, in Australia and the other countries trying to replicate this new model of mental health service that is leading to success? The common factors appear to be the following.

Funding is mostly through governmental support across all political parties. The focus is on proactive early intervention and wellbeing, not just solving a problem after it becomes critical. Services provided cover a range of factors spanning beyond mental health, making the organization operate as a one-stop-shop.

The organization has built up a strong public image and a trusted and respected brand. It has been disciplined in maintaining a uniform set of standards and practices while allowing for

continuous improvement and adaptation to different regional and cultural circumstances. It has taken steps to include marginalized communities, such as the indigenous population, and has worked to reduce stigma. The individual centers try to reflect the culture and language of their host community. The centers themselves are co-designed and co-staffed by people similar to the intended clientele. The centers use a cheery welcoming style of décor with upbeat informational brochures, posters, art, and graphics. Friends and family of clients are encouraged to become involved, which can help the client and also broaden community support.

Special effort is made to ensure the first contact with a client is positive, beginning with the reception. A stepped approach to the level of treatment makes the process more comfortable and less costly. Clinicians are used only where necessary, after starting with peers or counselors. This tends to make younger clients more comfortable and encourages sticking to it over the long term if necessary.

By having different centers operated by different leading agencies it is possible to leverage the support of more civic and private organizations and resources, while still preserving the core principles under the governance of a central body.

The factors cited above have all contributed to the success of the *headspace* model for youth in Australia. The initial setup would not have been possible without Orygen, the work of Professor Patrick McGorry, government support and funding, and a well-designed operational structure.

With *headspace*, there is a good balance between the national body providing oversight, and the individual service centers. This type of organizational structure is similar to a franchise arrangement, where separate and otherwise independent entities operate their own facilities based on the model ‘template’ of the national body. Because of this structure, growth and expansion can occur with maximum efficiency and minimum risk of losing sight of the original mission.

The ability to reach many youths in need of help has been enabled by the easy access, affordability of the service, reduction of stigma, and the inclusive nature of the centers/staff themselves providing a good interface with the client and the community.

The *headspace* model, through a combination of its attributes and methods, has made progress in the area of youth mental health, even with Australia having a comprehensive national health system. The program was a new approach, and its success demonstrates that it satisfied a need and filled a gap in the system.

What More Could Be Done?

The main areas for improvement that I recognized from my interviews were: increasing employee retention and making *headspace* practices more inclusive for diverse patients.

After starting at *headspace* or another public clinic, a lot of clinicians are attracted to private practice where they can earn more money by providing services that can charge more than the baseline Medicare coverage. One of the interviewees suggested a solution to this could be starting vocational programs in high school and college to get people interested in working in the public sector of mental health care.

Some interviewees had concerns that the current *headspace* model is mostly geared towards white, middle-class clients. *headspace* is already attempting to reach a more diverse clientele by setting up clinics in diverse suburbs, and rural areas, and by expanding the telehealth option. Improvement could be made by hiring practitioners from diverse backgrounds who can speak other languages and tailor care to the unique needs of different underrepresented groups.

WHAT WOULD HAVE TO CHANGE IN THE U.S. FOR YOUTH/ADULT CARE

A replication of the *headspace* model has been piloted in California under the name of “allcove”. Like the Australian organization, the target clients for “allcove” are the younger groups from adolescents to young adults. This program is currently in its infancy with a time limit on government funding. It is attempting to grow and stabilize funding sources as it experiences its first year or two of operation. Time will tell if the Australian success with youth can be

duplicated in California and beyond. So where do we go from here to expand the program, and basic model, into other areas and serve a broader client base?

The allcove program was preceded by the appropriate feasibility studies, funded by a foundation, and its development has been led by Stanford University. If we expand beyond 'youth', should it be by modifying the mission of allcove, or should the basic model be applied to a *new* organization of a different name, say "mind peace" or some other catchy title? Who would lead the study and development? And who would sell the idea to influential public and private figures? Obviously, we could learn a lot from the allcove experience, but it may be still too early to draw clear conclusions, and at this stage, we might not even know all the questions to ask. However, the time is already late in terms of looking to find a broader solution to the growing prevalence of mental disorders and the accompanying costs. As in the case of Australia, what is needed is not just a re-tuning of the system but establishing a new approach to promoting mental well-being.

Here are a few preliminary thoughts on what critical factors could be.

We need to identify an organization such as a university or well-connected nonprofit that could lead a comprehensive feasibility study. We also need a leader of nationally recognized stature to act as spokesman, lobbyist, and overall 'booster' to promote the new ideas to those in power. This person would serve as a U.S. 'CZAR', equivalent to Patrick McGorry in Australia.

Of primary importance is a source of funding. Just making an estimate of projected costs will be a significant investment. Financial support will be necessary for the study organization, for the initial setup of a pilot program, and the ongoing costs of operation and expansion. Some of this funding could come from the diversion of current investment to existing organizations. Some of the long-term revenue should be through reimbursement for client services which means that insurance organizations and Medicaid, in particular, might have to expand their eligibility policies. Because the U.S. does not have a national health insurance plan, like Australia and other wealthy nations, the reimbursement strategy will be a large factor in establishing

feasibility. Special grants, endowments, and donations might also be important elements in long-term funding. This has to be studied carefully.

The new organization should adopt the basic attributes of the *headspace* model as described above, and these should be a common core across the whole country

The organization should have a nationally recognized brand and consistent image across the whole country. This will require a strategic communication and marketing plan. It is noted that in Australia, *headspace* is almost a household name, known even to people who have never, nor will ever need its services. Can we create a brand name that is commonly recognized and trusted?

headspace Australia and allcove in California have adopted a growth model that begins with a single or pair of centers achieving success, and then using these to inspire and motivate the opening of the next new center. The common core features of the model make it easier to replicate in other regions.

As mentioned in this report, there are already numerous organizations providing a range of services related to mental health and general support at the national, state, and local level. Can we create a parallel organization that leverages the strengths of the existing groups, but provides a single point of entry for those seeking help?

Related to the point above, can some of the funding to the existing organizations be used to support the new entity? And, beyond that, it might be possible for some of the existing agencies to consolidate or morph into the new program, providing some of the staffing and infrastructure.

An organization providing services for adults in this country would have to be a separate or parallel organization to allcove. As I learned from one of the interviewees, there is something special and unique about the experiences of a young person. We shouldn't assume that adults would generally respond to the same encouragement and treatments as the youth. For adults, there is probably a different approach that works best. Also, we don't want adults to encroach on a space created for young people, such as allcove. Additionally, the training and practices needed

to provide support for older adults vary greatly from that to support young people. However, it seems clear that many of the positive attributes of the headspace or allcove model would be of benefit for the service of people of all ages.

Perhaps the fundamental need for the success of a new national program is to have broad support across cultural and political lines. This is no easy task as witnessed by our country's divided response to Covid vaccinations and a host of other social and political matters in the past few years. Part of the success of the Australian model is that it is broadly supported across the overall society and political spectrum.

We can learn from the twenty-year history of *headspace* Australia, the two-year history of allcove, and the recent experience in other countries that have replicated the basic model in their own national program. So, to develop a new program here doesn't mean we begin from scratch.

CONCLUSION

There is a huge unserved need in this country for the treatment of mental disorders. Prevalence appears to be rising in current times, as we see more incidence of crime, homelessness, economic distress, and general societal and political division. Fortunately, there is general recognition that mental health is a growing concern, and many governmental, public, and private organizations strive to assist. There is in fact a very large effort and investment to address mental health. However, it is generally recognized that we are not making gains in solving the problem.

As described in this paper, the Orygen and *headspace* organizations in Australia recognized that what was needed was not just a tuning up of existing service institutions, but a whole new approach. Their focus was on the youth element of the population. Their approach included early intervention/prevention and emphasis on maintaining overall wellness, not just fixing 'the problem' when it has already developed. Through the support of government funding, creative planning, effective promotion, innovative ideas, and the efforts of many people, Australia has established a well-recognized and trusted program that over the past two decades has made significant advances in youth mental health.

Here in the U.S., we have numerous public and private organizations working to improve the mental health of our society, and yet we seem to be unable to reverse the trend of a worsening prevalence of mental disorders. While California is starting up the allcove organization for youth mental health. The time seems right for the United States to also consider a new approach to the problem of the overall population. We have some excellent examples to consider. What we need now is to unite all of our efforts into a single nationally recognized program that can offer an accessible entry point to the road to mental health.

REFERENCES

[1] "The State of Mental Health in America." *The State of Mental Health in America*, Mental Health America, 2022, https://mhanational.org/issues/state-mental-health-america.

[2] "Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries." *Mental Health and Substance Use in the U.S. and 10 Other Countries | Commonwealth Fund*, The Commonwealth Fund, 21 May 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries#:~:text=The%20United%20States%20has%20some%20of%20the%20worst,of%20mental%20health%20workers%2C%20particularly%20psychologists%20and%20psychiatrists.

[3] Leonhardt, Megan. "What You Need to Know about the Cost and Accessibility of Mental Health Care in America." *What You Need to Know about the Cost and Accessibility of Mental Health Care in America*, CNBC, 10 May 2021, https://www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html.

[4] Center, The Carter. "Mental Illness Will Cost the World $16 USD Trillion by 2030." *Psychiatric Times*, Psychiatric Times, 16 Nov. 2018, https://www.psychiatrictimes.com/view/mental-illness-will-cost-world-16-usd-trillion-2030.

[5]*Homeless Population by State 2022*, 2022, https://worldpopulationreview.com/state-rankings/homeless-population-by-state.

[6] "Homelessness and Mental Illness: A Challenge to Our Society." *Brain & Behavior Research Foundation*, Brain & Behavior Research Foundation, 3 Feb. 2020, https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society.

[7]*Strategic Plan to End Homelessness - Whatcom County*. Whatcom County Health Department, https://www.whatcomcounty.us/DocumentCenter/View/44575/Strategic-Plan-to-End-Homelessness-in-Whatcom-County-2019.

[8]"Whatcom Homeless Service Center." *Opportunity Council*, Whatcom Homeless Service Center, 6 July 2022, https://www.oppco.org/whsc/.

[9]Min, Jong Won. "The Influence of Stigma and Views on Mental Health Treatment Effectiveness on Service Use by Age and Ethnicity: Evidence from the CDC BRFSS 2007, 2009, and 2012." *SAGE Open*, vol. 9, no. 3, Sept. 2019, pp. 1–12., https://doi.org/10.1177/2158244019876277.

[10]"Why Asian Americans Don't Seek Help for Mental Illness." *Why Asian Americans Don't Seek Help for Mental Illness | McLean Hospital*, McLean, 1 May 2022, https://www.mcleanhospital.org/essential/why-asian-americans-dont-seek-help-mental-illness.

[11]"Top 5 Barriers to Mental Healthcare Access." *Social Solutions*, https://www.socialsolutions.com/blog/barriers-to-mental-healthcare-access/.

[12]Parkes, Cathy. "Psychiatric Mental Health, Part 12: Primary, Secondary, Tertiary Prevention of Mental Health Disorders." *LevelUpRN*, 30 July 2021, https://www.leveluprn.com/blogs/psychiatric-mental-health/principles-12-primary-secondary-tertiary-prevention.

[13]Price, Johneth. "Mental Health: Will It Finally Be an American Legislative Priority?" *Harvard Political Review*, 23 Feb. 2021, https://harvardpolitics.com/mental-health-legislation/.

[14]Rickwood, Debra, et al. "Australia's Innovation in Youth Mental Health Care: The Headspace Centre Model." *Early Intervention in Psychiatry*, vol. 13, no. 1, 2018, pp. 159–166., https://doi.org/10.1111/eip.12740.

[15]Bishop, Tara F., et al. "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care." *JAMA Psychiatry*, vol. 71, no. 2, 2014, p. 176., https://doi.org/10.1001/jamapsychiatry.2013.2862.

[16]Andrilla, C. Holly, et al. "Geographic Variation in the Supply of Selected Behavioral Health Providers." *American Journal of Preventive Medicine*, vol. 54, no. 6, 2018, https://doi.org/10.1016/j.amepre.2018.01.004.