DEFINING THE MISSING MIDDLE

"We hear that a lot, like, "just ask for help". When people do ask for help, a lot of the time the help isn't available. I think that's sometimes where the issue is in Victoria and Australia. I think we're working really hard on the stigma and telling people to reach out, but if the services aren't there and they're not accessible, I don't know how helpful telling people to ask for help is." [1]

The 'missing middle' is a term used to describe people whose needs are not met by current mental health services. They are often too unwell for primary care, but not unwell enough for state-based services. They may have accessed services in the past year, however, these services were not able to deliver either the duration of care, or level of specialist care appropriate for more complex and serious mental ill-health.

The 'missing middle' describes people who:

- are not receiving any services for their mental health needs;
- are currently accessing primary care services, but are underserved as they require more specialist care and expertise, particularly for specific diagnoses;
- are on long waiting lists for services;
- have exhausted the ten sessions of their Mental Health Treatment Plan and still require support, which is unavailable in the community;
- have seen a GP but do not or cannot follow through with a Mental Health Treatment Plan to see allied health professionals (often because they cannot leave the home or get to the appointment, or they are unable to engage with a private psychologist due to a range of reasons including unaffordable gap payments);
- have accessed inpatient/community-based state-funded care but are discharged too early, with these services not able to deliver the duration of care needed due to demand pressures; or
- have presented to emergency departments due to mental ill-health. Presentations which could have been avoided with adequate care in the community and often leave the emergency department without adequate and assertive follow up.

Across the Australian population:

- Nine per cent are experiencing mild mental ill-health (2.3 million Australians);
- 4.6 per cent are experiencing moderate mental ill-health (1.2 million Australians); and
- 3.1 per cent are experiencing severe mental ill-health (0.8 million Australians).[2]

Despite 3.1 per cent of Australians experiencing severe mental ill-health, only 1.8 per cent of the population received state or territory funded community mental health care in 2017-18, resulting in a gap in community specialist public mental health care provision for approximately 328,7000 Australians.[4]

In addition, a further 1.2 million Australians with moderate mental ill-health are largely underserved by both Medicare-subsidised mental health supports and may require secondary or tertiary care.

While 10.2 per cent of Australians access Medicare-subsidised mental health services, inclusive of many of the 2.3 million Australians experiencing mild mental ill-health, the majority of these services are delivered by GPs and include the creation of a Mental Health Treatment Plan, inaccurately reflecting access and the provision of the necessary level of psychological care and treatment within the mental health system.[3]

YOUNG PEOPLE (12-25 YEAR OLDS) IN THE MISSING MIDDLE

Further illustrations of the missing middle specifically in the population of Australian young people are described below.

TURNED AWAY AFTER RATIONED CARE

There are significant numbers of young people who are still experiencing mental ill-health after all their subsidised care sessions through *Better Access* have been utilised, highlighting long-standing discrimination and discrepancies in supporting young people with mental ill-health versus young people requiring other forms of treatment, such as treatment for cancer. A recent survey from headspace found that 14 per cent of young people stopped attending headspace because they had used their rationed Mental Health Treatment Plan services and weren't able to return.[8]

WAITING LISTS

In late 2018, a survey of headspace centres found that 90 per cent of centres listed wait times as a significant concern, with average wait times of 10.5 days for an intake session, 25.5 days for a first therapy session and 12.2 days for a second therapy session.[1]

SERVICES NOT DESIGNED TO MEET COMPLEXITY AND SEVERITY

headspace was designed to provide services to young people with experiences of mild-to-moderate mental ill-health, yet centres across the country are reporting an increasing proportion of high-risk and complex presentations.[1] In 2017-18, among first presentations to headspace centres, 47.2% (n=45,744) had high or very high psychological distress on the Kessler 10, indicating they were likely to have a severe mental disorder.[1] Forty per cent of existing headspace clients do not improve in clinical symptoms with this rationed primary care offering and as such should also be considered a group in the missing middle.

TERTIARY SERVICES

For young people with severe and complex experiences of mental ill-health, access to the mental health system is through the emergency department and tertiary mental health services, where they may still struggle to meet eligibility thresholds for ongoing care or be supported for a suitable length of time. In north-west Melbourne, Orygen can only provide support for 1,000 young people with the most acute needs, while not being able to accept 3,000 others who present to the services' triage.[10]

ADDRESSING THE MISSING MIDDLE ACROSS THE AGE SPAN

Economic evidence and international consensus positions early intervention and community mental health care as the greatest model of care to reduce distress and economic burden in mental health, largely due to a reduction in hospital service use.[11, 12]

However, there is a serious question as to whether the mental health system perversely increases the severity of mental ill-health, or whether the mental health system requires people to experience much more severe symptoms of mental ill-health before they can gain access to the next level of care after primary mental health – which, in the absence of a secondary mental health service offering, remains state/territory acute services and the hospital system.

New vertically and horizontally integrated services are needed to work in the divide between primary and tertiary services. Teams of clinicians must be trained to support people with complex and severe mental ill-health upstream in the community, ensuring that current mental health services in the community can provide high quality effective care to not those experiencing mild mental ill-health, but also those with more moderate-to-severe/complex presentations, reducing demand and wait lists/times across primary and tertiary mental health services and emergency departments.

For young people, there already exists a national platform of primary mental health care through headspace that can be: a) built on to connect young people to more specialised and intensive services should they require this; and b) better integrated with state funded services to provide more seamless pathways of care. This requires detailed planning and system design on how to meet the needs of the missing middle both within the existing infrastructure and through additional service enhancements and new funding models.

In the adult population, where this national infrastructure does not currently exist, the newly announced adult community mental health hubs are an opportunity to design a system that addresses the unmet needs of adults with moderate and severe mental ill-health, building on the primary mental health services currently provided through GPs and services for those experiencing mild mental ill-health.

To address the missing middle, these hubs will need to provide a central source of community-based mental health services augmented through formalised partnerships with other key health, community and social services and local/regional service agreements to reduce gaps and avoid duplication with state-based services. Service delivery must comprise a suite of interventions, including but not limited to: care coordination, case management, medical and psychiatric treatments, drug and alcohol treatment, psychosocial interventions, assertive outreach and peer and family supports.

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