Needs Analysis

And

Programme Description

Contributing Authors:

Professor Richard R. Clayton, PhD
Director, Center for Prevention Research
and, Visiting Research Scientist
Headstrong - The National Centre for Youth Mental Health

Professor Robert J. Illback, PsyD
Senior Evaluation Researcher & Chief Executive Officer
REACH of Louisville, Inc.
and, Deputy CEO
Headstrong - The National Centre for Youth Mental Health
Copyright © 2013 The National Centre for Youth Mental Health

All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher, except in the case of brief quotations embodied in critical reviews and certain other noncommercial uses permitted by copyright law. For permission requests, write to the publisher, addressed “Attention: Permissions Coordinator,” at the address below.

Headstrong – The National Centre for Youth Mental Health
16 Westland Square, Pearse Street, Dublin 2, Ireland
+353 1 472 010

This publication is supplied with the understanding that the authors, designers, and editors are not responsible for the results of any actions taken on the basis of information in this work, nor for any errors or omissions, and the publisher is not engaged in rendering legal, mental health, or other professional advice or services.

This document should be cited as follows:

## Contents

**Executive Summary**  
1

Introduction to the Economic Justification  
3

How are the Four Papers Organised?  
3

Why Focus on the Mental Health of Young People?  
4

Why Is This Generation’s Mental Health So Important to Ireland’s Economic Future?  
6
    - Increasing Dependency Ratio  
    - Today’s Young People are Vital to Ireland’s Economic Future  
6

What is it Like to Come of Age in 21st Century Ireland?  
8
    - Societal Changes  
    - Assessing the Need  
    - Emergent Themes and Conclusions  
9

How Prevalent is Mental Ill-Health among Young People?  
11
    - An International View  
    - An Irish View  
12

How Responsive is the Irish Mental Health System to the Need?  
16

What is Being Done about Youth Mental Health in Other Countries?  
18
    - Australian System Development  
    - Other Youth Mental Health Systems of Care Initiatives  
19

What Does a Typical Jigsaw Site Look Like?  
21
    - Core Elements of a Jigsaw Programme Site  
    - Core Concepts Underlying the Jigsaw Model  
    - The “Hub” and the Youth Centred Practice (YCP) Network  
    - Capacity Strengthening & Community-Level Activities  
    - Governance, Linkages with Statutory and Voluntary Services  
    - Role of Community Partners  
    - From Installation to Full Implementation  
    - Evidence Base for Programme Components  
26

What Impact Will the Jigsaw Programme Have in a Typical Community?  
27

How Does Jigsaw Fit into the Broader “Landscape” of Youth Mental Health?  
28

What Has Been Accomplished to Date?  
29

References  
30
Executive Summary

Youth is widely defined as the time in life when the developing individual attains the skills and attributes necessary to become a productive adult. While most young people navigate through the period with no (or few) major disruptions, even those who are not in deep distress have normal stresses that require support and direction. Youth is more than just an age-defined timeframe; it represents a period of profound change. Youth is the space between a world that is disappearing and another world that has yet to appear.

Young people, defined as adolescents (12-17) and young adults (18-25), represent 16.7% of Ireland’s citizenry, or about 760,280 people. These individuals represent Ireland’s future, not least because the economic future of the country depends on their health, productivity, and vitality. In the words of Robert Kennedy, “This world demands the qualities of youth: not a time of life but a state of mind, a temper of the will, a quality of imagination, a predominance of courage over timidity, of the appetite for adventure over the life of ease…”.

Following a comprehensive needs assessment of the mental health needs of young people, Headstrong concluded that they often seemed lost in their attempts to negotiate all of the challenges growing up in Ireland entailed. Support systems that previous generations took for granted were less available, and while Ireland had grown dramatically in terms of wealth, it had lost much of its social capital, the sense of connectedness and belonging within communities. The strong influence of religious institutions had weakened, family structures and supports had eroded, and quality family time was less available. In an increasingly disconnected society, many young people felt isolated as they sought to cope with emotional turmoil and the mounting pressures they faced. And all of this was occurring at a time when community-based systems of mental health support were severely under-developed or non-existent.

There is ample evidence that mental ill-health is a problem for Irish young people. Ireland has one of the highest youth suicide rates in Europe, self-harming behaviour is seen in emergency rooms at epidemic levels, and there is ample evidence that a variety of other risk-taking and anti-social behaviours are of concern. Recent epidemiological studies have found that about a fifth of adolescents are experiencing symptoms of psychological disorder. And Headstrong’s My World Survey, administered to almost 14,500 young people across Ireland in 2011, found that:

- About 8% of adolescents and 14% of young adults experience depressive symptoms classifiable as severe or very severe. An additional 22% of adolescents and 26% of young adults experience mild to moderate depression.
- 6% of adolescents and 20% of young adults are classifiable as hazardous or dependent drinkers, and an additional 15% of adolescents and a stunning 41% of young adults engage in occasional problem drinking.
- About 21% of young adults report that at some point in the last year they have deliberately hurt themselves without wanting to take their life (deliberate self-harm).
Executive Summary (continued)

- Nearly 42% of adolescents reported that they had been bullied at some point.

- An astounding 7% of the young adult sample (predominantly 3rd level students) indicated that they had made an attempt to take their own life, 24% of which had been in the last year. For this age range alone, this equates to around 18,000. Even more sobering, 51% said that they had at some point thought about taking their life.

The Jigsaw model of service delivery is Headstrong’s response to the challenge of transforming how young people in Ireland access mental health support and attain positive developmental outcomes. Jigsaw brings services and supports together to insure that every young person has one good adult in their life to support them, whatever their level of need. Thus, Jigsaw seeks to: (1) ensure access to youth friendly integrated mental health supports when and where young people need them, (2) build the confidence and capacity of front line workers to directly support young people and to connect them to Jigsaw, and, (3) promote community awareness around youth mental health to enhance understanding of young people and the risk and protective factors that contribute to their mental health and well-being.

The Jigsaw model offers a service to young people that complements, strengthens, and integrates mental health services and supports currently available within the primary care system. When fully operational, Jigsaw sites can occupy an important space in the community mental health services “landscape”. The programme is not intended to supplant other forms of mental health care and support, but rather to complement and help integrate them. A typical Jigsaw project is designed to have capacity to provide direct support for about 6% of a community’s youth population aged 12-25 years, but reaches a far greater number indirectly through capacity-building and outreach.

Core elements of Jigsaw programmes include a comprehensive needs and resource assessment, the availability of a premises (Hub) and staffing to provide person-centred and accessible support to young people, outreach into the community and capacity building in partner organisations, comprehensive training for front-line providers, interagency management, clinical governance and accountability processes, deployment of evidence-based approaches to practice, meaningful youth engagement and participation, integration with the primary and specialty mental health system, and use of an online information management system for tracking and programme evaluation.

As of May-2013, nine communities/counties have opened Hubs and are providing direct support to young people (Donegal, Galway, Kerry, Meath, Offaly, Roscommon, Clondalkin, Tallaght, Dublin 15), and several others are due to open shortly (Limerick, North Fingal). Counties Mayo and Limerick have also completed planning and programme development processes and expect to open in the near term, pending resourcing. A number of other communities are engaged in training through the Headstrong Learning Network to become more ready for implementation when funds are available.
**Introduction to the Economic Justification**

Headstrong’s overall mission is to change how Ireland thinks about young people’s mental health through research, advocacy and service development. The Jigsaw model of service delivery is Headstrong’s response to the challenge of transforming how young people in Ireland access mental health support and attain positive developmental outcomes. Jigsaw brings services and supports together to insure that every young person has one good adult in their life to support them, whatever their level of need. Thus, Jigsaw seeks to: (1) ensure access to youth friendly integrated mental health supports when and where young people need them, (2) build the confidence and capacity of front line workers to directly support young people and to connect them to Jigsaw, and, (3) promote community awareness around youth mental health to enhance understanding of young people and the risk and protective factors that contribute to their mental health and well-being.

The Jigsaw model is aligned with the philosophy underlying the Health Service Executive’s (HSE) Primary Care Strategy, which is defined as “…an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing.” The Primary Care Strategy highlights many of the defining features of the Jigsaw model, including easy access, the need to span a spectrum of activities from mental health promotion to intervention, and the importance of being embedded within communities.

The Jigsaw model offers a service to young people that complements, strengthens, and integrates mental health services and supports currently available within the primary care system. Given that mental health problems are implicated in a great number of primary care consultations (depression is the third most common reason for GP consultation), and that 75% of mental health problems occur prior to age 25 (most emerging during adolescence and young adulthood), investment in youth mental health through a primary care approach makes considerable sense.
Moreover, Jigsaw is a multi-systemic early intervention and prevention model. In this context, it:

- Promotes positive mental health for young people by deploying strategies that target the whole population to enhance strengths, thereby reducing the risk of subsequent negative outcomes (e.g., community-level mental health awareness training);

- Utilizes universal prevention strategies designed to address risk factors in the whole population without attempting to discern which young people are at elevated risk (e.g., anti-stigma media campaigns and youth advocacy);

- Targets groups of young people at risk for developing mental health difficulties through selective prevention strategies (e.g., Youth Centred Practice training for front-line providers);

- Provides indicated early intervention/prevention supports and services for young people with mild / emerging mental health difficulties (e.g., brief interventions delivered through the Jigsaw Hub).

When fully operational, Jigsaw sites can occupy an important space in the community mental health services “landscape”. The programme is not intended to supplant other forms of mental health care and support, but rather to complement and help integrate them. A typical Jigsaw project is designed to have capacity to provide direct support for about 6% of a community’s youth population aged 12-25 years, but reaches a far greater number indirectly through capacity-building and outreach.
How are the Four Papers Organised?

This series of papers synthesises a wealth of available information about the mental health of young people in Ireland in order to: (1) describe the prevalence and complexity of mental ill-health among young people in the context of the present system of mental health services and supports, (2) establish some parameters for the direct and indirect economic cost of youth mental ill-health to Irish society, and in particular, to government, (3) specify the costs and presumed benefits of adopting Jigsaw as a key component of the youth mental health “landscape”, and, (4) summarise the core economic justification for the model.

Paper 1 (Need Analysis and Programme Description) provides context for the economic evaluation of Jigsaw by discussing issues such as: Why focus on the mental health of young people? What is it like to come of age in 21st century Ireland? What are the mental health needs of young people in Ireland? What is the magnitude of problems experienced by young people? What international evidence exists regarding youth mental health and systems design? What is the Jigsaw model and how does it address these needs? Where does Jigsaw fit in the “landscape” of youth mental health services and supports? What potential impact will it have? What has been accomplished to date?

Paper 2 (Economic Burden and Cost to Government Analysis) reviews the literature on estimation of the global burden of ill-health across the world, with specific focus on mental health. Then, extrapolating from Headstrong’s My World Survey and other population surveillance data sources, an estimate of the global burden of youth mental ill-health in Ireland is calculated. The paper goes on to describes, in considerable detail, the specific cost to government of youth mental health programmes, services and supports across various expenditure “streams and tributaries” in health, mental health, education, justice, youth services, and related sectors.

Paper 3 (Jigsaw Cost Analysis) provides detailed description of the cost of selecting, installing, operating, and supporting a Jigsaw site based on data gleaned from demonstration sites, and establishes cost projections associated with scale-up activities.

Paper 4 (Cost Benefit Analysis) discusses how adoption of the Jigsaw programme, as an integrating element of the system of care and support for young people, can avert costs and improve mental health outcomes for young people. It then examines the benefits of a transformed system of services and supports that includes Jigsaw as a core early intervention and prevention element. The paper concludes with specific (and verifiable) hypotheses about how Jigsaw is likely to yield cost offsets that justify its incorporation by government into the system of services and supports.
Why Focus on the Mental Health of Young People?

Young people in Ireland are comprised of two distinct demographic subgroups, adolescents (12-17 years old) and young adults (18-25 years old). The population of the Republic of Ireland is approximately 4.6 million (CSO, 2011). Adolescents constitute 7.6% of this total population and young adults constitute an additional 9.0%. Combined, they represent 16.7% of Ireland’s citizenry, or about 760,280 people.

This large and complex cohort represents Ireland’s future. As they emerge from childhood into the adult world, they can bring to it a freshness and creativity that allows society to flourish and continuously redefine itself. Their contributions can reflect what is nurturing and inspiring in Irish culture. But their experience can also reflect aspects of growing up in modern Ireland that are confusing, hurtful and unjust.

Youth is widely defined as the time in life when the developing individual attains the skills and attributes necessary to become a productive adult. While most young people navigate through the period with no (or few) major disruptions, even those who are not in deep distress have normal stresses that require support and direction. Youth is more than just an age-defined timeframe; it represents a period of profound change. Youth is the space between a world that is disappearing and another world that has yet to appear.

Headstrong chose to focus on the mental health needs of young people because:

---

**Neurobiological changes**

In addition to the well-known hormonal influences associated with rapid physical development, there is new and compelling evidence from neuroscience that their developing brains are changing more dramatically than was once known. It is now clear that the prefrontal cortex, the site of executive decision-making in the brain, is also emerging and evolving. During the teen years, the grey matter of the brain can double in one year due to neuronal growth, but what is also occurring is a synaptic pruning process in which the brain is sculpting away excess material and connections in order to make a more refined, more efficient, and more adult brain. Brain development during this period follows the principle of “use-it-or-lose-it”. New neural connections that get exercised are retained, while those that do not are lost. This has significant implications for how young people think, feel, and behave, because the prefrontal lobes are responsible for reasoning ability, goal and priority setting, planning and organisation, making sound judgements and emotional control. This explains why young people often struggle to set priorities, multi-task, read emotions, and reflect on experience. It also provides a neurobiological understanding for risk-taking, thrill-seeking, and behaviours that can bring them into conflict with society’s norms. Thus, similar to early childhood, this stage of life is a second window of opportunity, a second chance to shape life-long developmental processes and functioning.
Unique developmental challenges
Adolescence and young adulthood is a time of rapid growth that impacts on every young person and demands adaptation to physical, psychological, and social factors. Dramatic changes are occurring in body proportions, size, weight, sexuality and reproductive functions. There is an emerging capacity to be acutely self-aware and the related need to define for oneself a sense of identity. Pressure from peers to conform in specific ways that confer a sense of belonging is omnipresent. Young people also feel pressure to succeed academically and make critical decisions regarding the future. And there is the core developmental “push” to establish oneself as increasingly autonomous and independent of one’s family. All of these issues contribute to making this period of the lifespan uniquely challenging.

Critical stage for adult development
This stage of development is a time where many life-long patterns of behaviour are established, including behaviours that can be health promoting and maladaptive behaviours that can jeopardise one’s health and well-being. An example of maladaptive behaviour would be where a young person does not seek or receive appropriate help or support, and this increases their risk of emotional isolation and feeling stuck.

The search for meaning and connectedness
For young people, a sense of idealism and altruism are either fostered such that the person feels they are part of a larger story to which they have something unique to contribute, or their idealism is discouraged as they retreat into a self-protective shell and become increasingly disconnected from any sense of vital participation in their communities.

Vulnerabilities
Youth is a time of unique vulnerability for those individuals whose early childhood was marred by abuse or rejection, and for those with disabilities or special needs. These young people may find it hard to “fit in” and experience painful social exclusion, which in turn can lower their self-esteem and reduce their capacity to develop meaningful relationships with others. Sensitivity to the needs of vulnerable populations is critical at this stage of life if they are to achieve a belief in their ability to thrive.

Relationship to adult well-being
Adolescence is the time when the vast majority of chronic mental disorders and difficulties develop. Many of these conditions arise from crises in the young person’s life that required intervention and support, but needed expertise was either unavailable or inaccessible. Problems that can be resolved and become opportunities for development of resilience can all too easily become chronic conditions in adulthood that disable an individual for much of their life. The evidence in support of early intervention is considerable, and from a public health perspective argues for making youth mental health a central and critical strategy for improving the well-being and productivity of the Irish population.

In sum, youth is the developmental stage when investment of time, energy, and resources is likely to pay dividends throughout the lifespan, both for the individual and for Irish society. Even troubled young people, with proper support, can learn restraint, good judgment, and empathy. Teachers, coaches, youth leaders, parents, friends can all play a major role in the young person’s development and subsequent capacity to become a fully functioning and contributing adult.
Why Is This Generation’s Mental Health So Important to Ireland’s Economic Future?

Increasing Dependency Ratio

Government reports about demographics often cite the dependency ratio as an important economic measure. Essentially, this number represents the proportion of the population that is not in the labour force (the dependent group) in relation to those that are (the productive group). A nation that has a high dependency ratio will have economic difficulties because the largest portion of a nation’s typical expenditure is on health, social protection, pensions, and education (services provided predominantly to the young and the old).

The dependency ratio in Ireland based on data from the 2011 census is 49.3%, up from 45.8% in 2006 (CSO, 2011). This is a 3.5 percentage point increase, an increase of 7.6%. This increase in the dependency ratio imposes enormous challenges for Ireland in the next several decades.

Today’s Young People are Vital to Ireland’s Economic Future

Ireland in the 2nd decade of the 21st century is in an interesting and challenging position from a demographic perspective. Very high birth rates in the late 1970s and early 1980s reached a peak in 1980, but the birth rate fell over the next 15 years, reaching a low point in 1994, the year in which today’s 17 and 18 year olds were born.

This demographic fact is critical for understanding why youth mental health is so important for the future of Irish society.

- A physically, mentally and emotionally healthy work force is essential at any time.
- Young people 12-25 years old in 2011 are one of the smallest birth cohorts in recent history.
- The young people in these particular birth cohorts, and their successor cohorts, will be responsible for economically supporting large numbers of their younger and older fellow citizens.
- Yet, those on whose work and productivity the youngest and oldest members of Irish society must rely in the next several decades are almost invisible from a public policy viewpoint.

Insuring the positive mental health of 12-25 year olds in 2012 is an important priority in Ireland from an economic development and vitality standpoint. To some extent, today’s young people are “hidden in plain sight” when it comes to public economic policy development.
“Our answer is the world’s hope; it is to rely on youth. The cruelties and the obstacles of this swiftly changing planet will not yield to obsolete dogmas and outworn slogans. It cannot be moved by those who cling to a present which is already dying, who prefer the illusion of security to the excitement and danger which comes with even the most peaceful progress. This world demands the qualities of youth: not a time of life but a state of mind, a temper of the will, a quality of imagination, a predominance of courage over timidity, of the appetite for adventure over the life of ease…”

Robert F. Kennedy (1966)
What is it Like to Come of Age in 21st Century Ireland?

Societal Changes

In the past one hundred years, Ireland has undergone unprecedented demographic, social and economic changes that have fundamentally transformed the pace of life, the places where people live, how communities function, and the lifestyles of its inhabitants. For example, life expectancy has increased from 45 and 49 for males and females in 1900 to 76.8 and 81.6 respectively in 2010. This represents over a thirty-year increase in life expectancy. Relative to other nations, Ireland’s birth rate has remained high, but this has been accompanied by dramatic reductions in maternal and infant mortality. Similar to other Western countries, there has been a dramatic shift in the “leading” and “actual” causes of death in Ireland, from diseases resulting from public health deficits (e.g., contaminated water and air, communicable diseases) to a preponderance of deaths caused by chronic diseases that are to some degree preventable (e.g., cardiovascular diseases, diabetes, lung cancer).

While the “traditional” nuclear family in Ireland is alive and well in the second decade of the 21st century, marriage patterns have changed and there is a dramatic increase in single parents. In addition to large changes in the agricultural and manufacturing sectors of society, the population in Ireland has become more urban than rural, and more mobile due to a dramatic rise in families with cars. Innovations in communications (radio, television, cinema, personal computers, GPS devices, the internet, search engines, mobile phones, social media) have transformed the lives of everyone in Ireland, especially young people.

From the early 1990s through 2007, Ireland experienced a period of unprecedented economic growth with the “good times” creating a pervasive sense of optimism for the future. The boom became bust in 2008 and the economic crisis continues to create turmoil in Ireland in 2012. The recession has had significant and far-reaching consequences for individuals, families, communities and the entire society, contrasting unemployment levels of less than 5% at the peak of the Celtic Tiger to current levels that hover around 15%. In certain ways, no population subgroup in Irish society has been affected to a greater extent by the economic downturn than young people.
Assessing the Need

To understand the impact of all of these changes on young people, Headstrong undertook (in 2007) a learning process with hundreds of young people, service providers in both statutory and voluntary service sectors, parents, community members, and government officials. Needs data were gathered through focus groups, key informant interviews, community meetings, and informal interviews. In 2008, Headstrong also conducted a survey (called My World) with a representative sample of about 1,000 adolescents (12-18) across the country. All of these data yielded an extensive empirical base for understanding what was happening with young people.

This work was occurring at a time when high rates of suicide and self-harm were driving Irish society’s sense of alarm about youth mental health. The national rate of suicide for young people had increased relentlessly, despite the economic boom unprecedented in Irish history. By 2008, Ireland’s National Office of Suicide Prevention reported that the rate of youth suicide was the 4th highest in Europe and by far the highest in Western Europe. Whilst for many countries the rate of youth suicide had stabilised and begun to decline, in Ireland the rate seemed only to level off. Suicide remained the leading cause of death among young people age 15-24 in Ireland. As study after study confirmed high rates of youth mental health problems among youth, an escalating drumbeat of media stories about suicide, anti-social behaviour, school failure, and substance abuse reinforced the perception of crisis.

Emergent Themes and Conclusions

The data gathered from all of these sources validated the overwhelming consensus across Irish society about the need for change. While several pockets of remarkable creativity and innovation were discovered (e.g., youth cafes, suicide prevention and mentoring programmes), the depth and complexity of the challenges for systems change were readily apparent. They included that: (1) pathways to care for young people were dysfunctional, (2) there was not a coherent continuum of services and supports, (3) providers tended to operate within silos and did not communicate or collaborate, (4) narrow funding streams and territoriality resulted in rigidity in the way people thought about young people, and (5) young people felt they had no voice.

Several cross-cutting themes emerged from the initial analysis. Perhaps strongest of these was the sense that young people were not connected to their communities. They frequently expressed frustration about being misjudged or mistrusted. One said, “Whenever people talk about youth, they talk about them as having problems or causing problems.” The high level of stress related to school performance was also striking. Young people were frank about the extent to which they experienced frustration, anxiety, and depression. At the same
time, it was clear than many did not have a language to talk about their inner lives, and many cited the stigma attached to discussing mental health issues in Ireland. Help-seeking was seen as an expression of weakness, especially among young males. Young people’s lack of information about how and where to access mental health services and supports was also notable. Many said they were not comfortable accessing statutory services because they were not youth-friendly.

Headstrong concluded that the Ireland that young people were growing up in bore little resemblance to that of their parents’ generation. There is little doubt that young people in Ireland benefitted enormously from the prosperity brought by the Celtic Tiger, but young people have also been vulnerable to many effects of the severe economic downturn. They often seemed lost in their attempts to negotiate all of the challenges that growing up in Ireland entailed. Support systems that previous generations took for granted were less available, and while Ireland had grown dramatically in terms of wealth, it had lost much of its social capital, the sense of connectedness and belonging within communities. The strong influence of religious institutions had weakened, family structures and supports had eroded, and quality family time was less available. In an increasingly disconnected society, many young people felt isolated as they sought to cope with emotional turmoil and the mounting pressures they faced. And all of this was occurring at a time when community-based systems of mental health support were severely under-developed or non-existent.
How Prevalent is Mental Ill-Health among Young People?

It is not within the scope of this document to provide a comprehensive literature review regarding young people and mental ill-health, but what is known is summarised to provide a context and, in particular, to provide a sense of the alarming extent to which Irish young people are in distress.

An International View

The field of psychiatric epidemiology has made enormous contributions to our understanding of the emergence, prevalence, risk, and lifetime course of a variety of mental disorders. Several landmark studies in the United States, Europe, and Australia provide a useful backdrop within which to understand youth mental health (and mental ill-health) in Ireland. Most of what is known about the parameters of mental ill-health in young people comes from studies within the “general” population (Merikangas et al. 2010, 2011). These studies utilize surveys of young people and ask them to report symptoms of mental, emotional and behavioural disorders. Some are conducted via diagnostic interviews in which it is possible to classify mental disorders according to DSM-IV and/or ICD-10.

Anxiety disorders are the most common disorders in general population surveys (31.9%) followed by behavioural disorders (19.1%) and mood disorders (14.3%) and substance use disorders (11.4%). The prevalence of disorders classified as “severe impairment” and/or distress is 22.2%, consisting of mood disorders (11.2%), 8.3% with anxiety disorders and 9.6% for behavioral disorders. The median age at onset of anxiety is 6, age 11 for behavioural disorders, age 13 for mood disorders and age 15 for substance use disorders (see Merikangas et al. 2010). About one in five young people in the United States meet criteria for a mental disorder with severe impairment across their life. Approximately one-half of young people with severe impairment never receive services directed at their disorders. The rates of service utilization are highest for ADHD and (59.8%) and behavioural disorders (45.4%). Fewer than one in five of affected adolescents received services for anxiety, eating or substance use disorders (Merikangas et al. 2011).

Kessler and colleagues (2005 a, b) reported on the National Co-morbidity Survey Replication (NCS-R) study in the United States. This study administered the World Health Organization’s Composite International Diagnostic Interview to 9,282 individuals in a nationally representative sample of individuals to estimate the likelihood of anxiety, mood, impulse-control, and substance use disorders to occur during the lifetime of an individual. It was found that about 26.2% of the population was likely to have experienced a diagnosable mental disorder within their lifetime, and that of these the most prevalent were major depressive disorder (16.6%), alcohol abuse (13.2%), specific phobia (12.5%), and social phobia (12.1%). Anxiety disorders were found to be the most prevalent class of lifetime disorders (28.8%), followed by impulse-control disorders (24.8%), mood
disorders (20.8%), and substance use disorders (14.6%).

Kessler et al. (2005) note that the onset patterns for mental ill-health are quite opposite from most chronic physical health problems (which typically increase with age, peaking in middle or old age). Psychiatric disorders are rooted in youth and risk gradually decreases as people mature into adulthood. The authors conclude:

“Given the enormous personal and societal burdens of mental disorders, these observations should lead us to direct a greater part of our thinking about public health interventions to the child and adolescent years and, with appropriately balanced considerations of potential risks and benefits, to focus on early interventions aimed at preventing the progression of primary disorders and the onset of comorbid disorders.”

(Kessler, et al, 2005, p.601)

Highly similar findings are found in the World Health Organization study of mental health disorders (Kessler, et al. 2007), which was based on face-to-face community surveys conducted with 85,052 individuals in seventeen countries in Africa, Asia, the Americas, Europe, and the Middle East. In sum, epidemiologic data confirm that the average age at onset for a variety of behavioural and emotional difficulties is within the teen and early adult year timeframe (12-25). In fact, it appears that approximately 75% of mental disorders emerge before the age of 25 (Kessler et al., 2005a).

The ability to negotiate the emotional, behavioural, and social challenges that occur during adolescence and young adulthood has a substantial impact on the trajectory and subsequent severity of these problems (McGorry & Purcell, 2009). It is therefore quite troubling that extensive research shows access to and utilisation of mental health services by young people is poor (Booth, Bernard, Quine, Kang, Usherwood, Alperstein, G., et al., 2004; Samargia, Saewyc, & Elliott, 2006). The system of mental health services and supports appears to be weakest at the exact point where research suggests it needs to be strongest (McGorry, 2007). To add fuel to the fire, research has also documented a significant rise over the past 25 years in emotional and behavioural difficulties among adolescents (Collishaw, Maughan, Goodman, & Pickles, 2004).

An Irish View

Positive Mental Health

Mental health is not the absence of distress or mental illness, and general satisfaction with life does not necessarily connote well-being. Nonetheless, it should be first noted that on various measures of life satisfaction and well-being, the majority of Irish young people indicate their general satisfaction and happiness. On the most recent Health Behaviour Survey for Children (HBSC) (nic Gabhainn, Kelly, & Molcho, M. 2007), for example, within the 12-14 year age range, boys and girls reported similar levels of feeling very happy about their lives (54.3% & 53.1%, respectively), although these groups diverged at the 15-17 year range, when girls were much less likely (34.3%) than boys (43.6%) to indicate being “very happy”. Feeling happy appeared to occur at much
higher rates when young people lived with both parents, found it easy to talk with parents and friends, had opportunities for socialisation, liked school, and did not feel pressured academically. Notably, social class did not appear to be have a moderating effect. In terms of overall life satisfaction Irish 15-year olds ranked 19th among 39 countries in Europe and North America with 70% reporting high life satisfaction (generally below most Scandinavian and western European countries, but above countries in central and eastern Europe).

A cross-national study showed that most Irish adolescents reported life satisfaction with family, friends, self and living environment as generally positive, at levels similar to cohorts in the United States, South Korea, and China, although less so with respect to school experiences (Gilman, et al, 2004). More recently, McGrath, Brennan, Dolan, & Barnett (2009) compared Irish and American adolescents with regard to predictors of subjective well-being, finding that informal social support and school satisfaction were the strongest predictors across both locations, and peer and parental support were especially critical for a sense of well-being. Liking school and perceived school success appeared more important to school satisfaction in Ireland than Florida (in Florida, student cameraderie and bullying were stronger predictors of school satisfaction).

Some interesting health-related patterns were evident from the 2006 HBSC (nic Gabhainn, Kelly, & Molcho, 2007), which enabled examination of overall Irish rates as well as comparisons with other European and North American countries. While these patterns showed positive results for a substantial portion of the youth population, they also implied considerable need and risk. For example, Ireland experienced a significant decrease between 2002 and 2006 in the number of young people living with both parents, (although still ranking in the top third of European countries).

Whereas 74% of fifteen-year olds reported they found it easy to talk with their mothers (30th among 40 countries), only 59% reported they found it easy to talk with their father (13th among 40 countries). Only 50% of 15-year olds reported positive relationships with classmates (21st among 41 countries). When considered together, these data showed that a substantial portion of Irish adolescents did not find it easy to talk with either their parents or with peers. In terms of liking school, Irish 15-year olds ranked 29th among 41 countries, with 61% responding positively. 57.2% of Irish boys and 55.9% of Irish girls aged 15-17 years indicated that they had been drunk at some point in their lives (23rd among 39 countries), and Ireland ranked 21st among 39 countries in student reports of having been bullied (23% for age 15).
Mental Ill-Health

Despite these generally positive findings, there is extensive scientific evidence that Irish young people are experiencing high levels of mental ill-health. A rigorous population study of 1,589 adolescents in Clonmel (County Tipperary) found that 21.1% of 12–18 year olds met the criteria for at least one psychological disorder (Martin, Carr, et al., 2006). Of these, about one-fifth had problems associated with clinical risk (e.g., thoughts of death, being suspended or expelled from school). The majority of adolescents who were identified as either being at-risk or meeting the criteria for a psychiatric disorder were receiving no professional help, and fewer still had had contact with the child and adolescent mental health services.

Lynch, Mills, Daly, and Fitzpatrick (2004, 2006) assessed 723 12–15 year olds in eight Dublin schools and found that 19.4% were at-risk for developing a mental health disorder. Within this at-risk group, 12.1% expressed possible suicidal intent and 45.7% expressed suicidal ideation. Of the total sample, 15.6% met the criteria for a psychiatric diagnosis, including 4.5% for affective disorder, 3.7% for anxiety disorder, 3.7% ADHD, 1.9% with past suicidal ideation, and 1.5% with a history of parasuicide. Very few had come to the attention of the Child and Adolescent Mental Health Services (CAMHS).

The Lifestyle and Coping Survey (Sullivan et al., 2004), was administered to over 3,830 school students aged 15–17 in 39 randomly selected schools in Counties Cork and Kerry. Based on self-report, it was discovered that serious personal, emotional, behavioural or mental health problems were experienced by 26.9% of those surveyed, but of these only 17.8% were able to access help. Within this sample, 12.2% reported having harmed themselves at some stage in their lives, and 21.6% indicated that they had thought of harming themselves in the past year.

The strongest, most recent, and most compelling evidence regarding the mental health of young people in Ireland comes from Headstrong’s My World Survey (MWS), administered to a stratified and representative sample of almost 14,500 young people across Ireland in 2011. The adolescent version of the scale was given to a representative sample of 6,085 individuals ages 12-19 and a non representative (skewed toward third-level) version was completed by 8,221 young adults. The samples included young people from all of the 26 counties in Ireland and all of the universities. A particular strength of the MWS is that it incorporates scales that measure both risk and resilience factors.

2012 My World Survey Findings

While the findings are far too extensive to fully describe here (and are available in National Study of Youth Mental Health, 2012), some of the more prominent findings were:

- About 8% of adolescents and 14% of young adults experience depressive
symptoms classifiable as severe or very severe. An additional 22% of adolescents and 26% of young adults experience mild to moderate depression. At a population level, this equates to almost 270,000 young people experiencing depressive symptomatology.

- About 11% of adolescents and 14% of young adults experience anxiety symptoms classifiable as severe or very severe, and an additional 21% of adolescents and 23% of young adults experience mild to moderate anxiety. At a population level, this equates to around 240,000 young people experiencing difficulty with anxiety.

- 6% of adolescents and 20% of young adults are classifiable as hazardous or dependent drinkers, and an additional 15% of adolescents and a stunning 41% of young adults engage in occasional problem drinking. At a population level, this equates to around 325,000 young people experiencing difficulty with alcohol consumption.

- The population equivalent of about 225,000 young people report that they have used cannabis.

- About 4% of adolescents (the equivalent of 14,000 students) report that they have been suspended or expelled from their school at some point.

- About 21% of young adults (the population equivalent of 220,000) report that at some point in the last year they have deliberately hurt themselves without wanting to take their life (deliberate self-harm).

- A remarkable 7% of the young adult sample indicated that they had made an attempt to take their own life, 24% of which had been in the last year. For this age range alone, this equates to around 18,000. Even more sobering, 51% (population equivalent of 209,000) said that they had at some point thought about taking their life.

- Nearly 42% of adolescents (equivalent to 150,000 young people nationally) reported that they had been bullied at some point.

- Given the dominant research finding that having a trusted and caring adult is a strong predictor of outcomes, participants were asked about the support they had available to them. 16% (about 56,000 equivalent) of adolescents and 18% (about 75,000 equivalent) of young adults reported low or very low adult support.

When these findings are considered alongside similar information about hospitalisations, suicide and self-harm rates, school adjustment, early school leaving, antisocial behaviour, crime, and related indicators, there should be little doubt that mental ill-health among Irish young people has reached epidemic proportions.
How Responsive is the Irish Mental Health System to the Need?

Throughout much of the 20th century, the Irish public’s understanding of mental ill-health was limited. “Mentally ill” people were consigned to mental hospitals or asylums, isolated from their family and community, “out-of-sight” of the general population, and treated by specialists. As recently as 1972, there were 15,856 “in-patients” in Irish psychiatric hospitals. The least prevalent “mental illnesses” (schizophrenia, bipolar disorders, mania) dominated the public’s perception of mental illness and mental disorders, and the perceived distance between “normal” and “abnormal” was vast.

In 2006, A Vision for Change described the “old” institution-based mental health system as broken and provided a blueprint for transformative systems change with a focus on community- and evidence-based care and support. A Vision for Change explicitly acknowledged the pressing need to change the way Ireland thinks about mental health and reduce the stigma associated with mental ill health. It envisioned a recovery-oriented system that was accessible, consumer-friendly, and more broad-based.

While vestiges of the old “attitudes” may remain, Irish knowledge and attitudes about mental health have changed steadily. Thus, in 2010, there were far less patients in Irish psychiatric units and hospitals (2,812), and the Mental Health Commission (2011) was recommending a public health approach that emphasizes building “mental capital” and improvement of well-being as a long-term investment approach.

Nonetheless, community-based mental health services that are specifically designed for young people are either non-existent or difficult to access (Vision for Change, 2006). While there are fine examples of best-practice interventions in communities around Ireland, they are sparse and tend to operate in isolation. Service delivery is, at best, fragmented, and even in very small communities, not integrated. As a result, young people often have negative experiences of help-seeking and services struggle to retain them.

Referral criteria for accessing services can serve to exclude young people in distress. For example, if a young person has a mild intellectual disability, a history of substance misuse, a diagnosis of a personality disorder, is homeless or between the ages of 16-18, they are prone to “fall between the cracks”. Moreover, the minority of young people who manage to engage with specialist services must enter the service by referral to either child or adult services. The settings and interventions offered within them can be inappropriate to a young person’s needs and desires because they are exclusively child or exclusively adult focused, there is a lack of choice regarding the types of interventions offered, and many perceive (or fear) an over-reliance on psychototropic medication and crisis intervention.
In light of these deficiencies, Ireland’s regulatory body, the Mental Health Commission (2008), stated:

“It is obvious that in Ireland there is a major discrepancy between the services provided and the identified needs of children and adolescents with mental health problems. The frustration of parents and staff is apparent, and children and adolescents who require assessment and interventions lose valuable time while waiting for essential services.”

Given that current mental health systems of services and supports are not attending to the unique needs of adolescents and young adults, systems change is required. The core solution requirement of change is that the transformed system must be comprised of an integrated array of youth-focused, community-based, and evidence-based prevention, early intervention, and treatment services. It must insure that young people can obtain more responsive support when they need it, where they need it, and at the level of support intensity required (Patel, Flisher, Hetrick, & McGorry, 2007).

It should be noted that some progress has been made in implementing the Vision for Change recommendations as they relate to young people, despite the serious economic limitations brought by austerity. For example, A Vision for Change stipulated the need for 99 12-person multidisciplinary child and adolescent mental health services (CAMHS) teams across Ireland to establish basic coverage for specialized mental health services (Health Service Executive, 2006). As of 2011, 61 of these teams had been established, 56 of which were community-based. Within these 61 teams (comprised of 464.74 FTEs), staffing was only at 63.8% of the recommended level, with considerable variability and disciplinary composition across teams and regions. While trending in a positive direction, there were still a significant number of young people on waiting lists to be seen (1,897 in September, 2011), and 10 teams had a waiting list of 50 to 99 (the remaining 2 community-based teams had waiting lists of 100-149 young people). The non-attendance (no-show) rate for CAMHS appointments had increased over prior years to 19.6% (12% for new cases). Fully implementing A Vision for Change is clearly a marathon, not a sprint.
What is Being Done about Youth Mental Health in Other Countries?

**Australian System Development**

Deployment and validation of a youth-focused model of early intervention and treatment is well underway in Australia (McGorry, 2007; McGorry, Parker, & Purcell, 2007; Patton, Hetrick, & McGorry, 2007). Much of Headstrong’s work has been modelled after the Australian system developed by Professor Patrick McGorry, an internationally acclaimed psychiatrist and acknowledged founder of the youth mental health movement. A native of Ireland, Dr. McGorry has been a member of Headstrong’s Board of Directors from its founding in 2007.

Due to the leadership of Professor McGorry and his colleagues, the Australian government has invested extensively in youth mental health services. The primary vehicle for the implementation of the Australian youth mental health system is community-based youth mental health centres operated by headspace, the National Youth Mental Health Foundation. As of 2012, there are 55 such centres operating across the country (with 5 more anticipated during the year). To date, more than 62,000 young people have been served through these programmes. According to the Australian government website:

“The 2011-12 Budget allocated $197.3 million over five years, on top of a current commitment of $133.3 million to 2013-14, to expand existing and establish new youth focused mental health services through the headspace program. Specifically, the 2011-12 Budget measure provides funding for 90 fully sustainable headspace sites across Australia by 2014-15. This will be achieved through boosting funding to the 30 current and 10 developing headspace sites and ensuring a robust funding base for the further 50 sites to be established by 2014-15. Once all 90 sites are fully established, headspace will help up to 72,000 young people each year.”


An independent evaluation of the initiative by the Social Policy Research Centre at the University of New South Wales (Muir, Powell, et al., 2009) found that it was highly successful in engaging young people with significant psychological distress, and that most service recipients reported reduced stress and were satisfied with the services they received.
Similar to the situation in Ireland, suicide and self-harm among young people were driving concerns for Australian young people. As can be seen in the graph below, coincident with the deployment of the youth mental health system around 2005/2006, suicide rates among young people began to drop. Currently, the 15-19 year old age group has the lowest rate of suicide for both males and females (compared to all other age ranges). The rate of suicide deaths in young males has fallen by 29% in the last decade and the rate for females has dropped by 46%.

A unique component of the Australian system of care is Orygen Youth Health, led by Professor McGorry. It is comprised of the world’s largest youth mental health research centre, a clinical service for young people with emerging serious mental health and substance disorders, and a training and communication programme designed to share knowledge and enhance service system functioning.

To a significant extent, the Australian approach of integrating elements of service delivery with on-going research, training, and communication has informed the approach taken by Headstrong in developing areas of work such as community-based service development, My World (research), and national-level support activities (education & training, communication, service evaluation, & fundraising). A powerful addition, unique to Headstrong, has been the systematic development of youth engagement, enablement, and leadership across all areas of work through activities such as local and national youth advisory panels (YAPs) and youth-led mental health promotion (Think Big).

**Other Youth Mental Health Systems of Care Initiatives**

In the United Kingdom, a tiered model of care was introduced in 1995 following several reports emphasising the need to better integrate primary and specialised mental health care within the Child and Adolescent Mental Health (CAMH) system. In this model, Tier 1 is defined as services provided by professionals who are not necessarily mental health specialists, such as GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. These individuals receive training and support from mental health professionals, and can refer children and young people to more specialist services. Tier 1 interventions can include early identification, general advice for mild-moderate problems, and mental health promotion and prevention provided by primary care and other front-line services. Tier 2 services are provided by mental health specialists who work in community-based settings such as GP practices, paediatric clinics or schools. The development and implementation of a primary mental health care worker at the interface between Tier 1 and Tier 2 level in a particular catchment area is described by Gale and Vostanos (2006), with anecdotal evidence of the utility of this role (which is quite similar to Headstrong’s concept of a youth support worker). These components of the service array are similar to the role that Headstrong is intended to play within the Irish system of mental health care and support.
Research on the effectiveness of the Tier 1 component in the UK system of care has been limited, but what evidence is available seems to show that the system has not been fully implemented. Gowers, Thomas, and Deeley (2004) found in a survey of 291 schools that while teachers had great interest in mental health and improving the liaison with CAMH, little training had occurred, pathways to care had not been clarified, and communication was insufficient. These findings point to the importance of achieving full implementation and sustaining support in an early intervention approach such as this.

In Canada, England, Scotland, and Wales, considerable effort has recently gone into replicating a youth mental health first aid training program at community level similar to the validated Australian model (Kitchener & Jorm, 2006; Jorm, 2011). This training is targeted toward people who live with, work with or care for young people aged 11-18. It encompasses two days of work geared toward promoting mental and emotional wellbeing and supporting young people who experience mental and emotional distress. The specific goals for the course are to identify early signs of distress, enhance confidence about help-giving, provide help on a first aid basis, prevent self-harm, ameliorate the course of mental illness, facilitate recovery, guide young people toward the right support, and reduce stigma. These activities are highly consistent with a major component of the community training model being implemented through Headstrong, which is also aimed at a broad audience of care-givers, youth workers (e.g., coaches, hairdressers), parents, and other interested community members.

In the United States, extensive work over a two-decade period has gone into transforming child and adolescent mental health services for individuals with significant emotional and behavioural disorders. The majority of this work has been focused on children and families, but there are several “systems of care” initiatives focused on adolescents and young adults. One of the most prominent is the Transition to Independence Process (TIP) Model, an evidenced-based promising practice developed by the National Network on Youth Transition (NNYT). It emphasizes training for front-line and supervisory staff to enable young people with significant behavioural and emotional difficulties to transition into adulthood through an individualised process, engaging them in planning their own future and accessing developmentally appropriate services and supports. The core skills of the training include strength discovery, needs assessment, futures planning, rationales, in-vivo teaching, social problem solving, prevention planning related to high-risk behaviours and situations, and mediation (Clark, Belkin, et al. 2002). Headstrong engaged the programme’s originator (Prof. Hewitt Clark) to provide core training in these areas to site staff in 2011, and is examining the feasibility of incorporating the training model into its training sequence for front-line providers.

Canada is rapidly moving into systems development for youth mental health as a consequence of widely reported studies by the Kirby Commission (Kirby
& Keon, 2006) and the Mental Health Commission of Canada, and a national report to the Minister of Health about child and youth mental health called Reaching for the Top (Leitch, 2007). All of these reports delineated extensive unmet need and called for both systemic reform and a significant infusion of new resources. Much of the effort to date has gone into advocacy for young people and training for mental health practitioners and other front-line staff who serve young people, as exemplified by the work of the Ontario Centre of Excellence for Child and Youth Mental Health. In Quebec, a major systems transformation of mental health from hospital care to primary care in communities has begun as a function of the Plan d’action en santé mentale (PASM) (Mental Health Action Plan). Changes to child and youth mental health (CYMH) are at the core of the work. A recent process evaluation (Nadeau, Jaimes, Rousseau et.al., 2012) responded to several challenges, including establishing a common culture of care across hospital and community settings, despite strong progress toward partnership. Continuous communication was seen as key, and was fostered by numerous opportunities for clinical discussions, dialogue on models of care, harmonising administrative and clinical priorities, and involving key actors and structures.

The rapid expansion of international efforts in youth mental health resulted in the creation of a worldwide, bi-annual conference called the International Youth Mental Health Conference, the first of which was held in Melbourne in 2010. Headstrong participated in the conference and provided one of the keynote addresses (Illback & Bates, 2011).

What Does a Typical Jigsaw Site Look Like?

Profiling a typical Jigsaw site operating at full capacity is useful for two key reasons: (1) it establishes a framework for standardisation of the Jigsaw model (a key enabler of successful replication), and, (2) it communicates an understanding of the operational resource requirements for bringing a site to scale and maintaining it over time.

It should be noted at the outset that each Jigsaw site will have unique solution requirements as a function of local needs and circumstances. The application model in each site is the same, but the way the components are organized and delivered may vary due to the heterogeneity of Ireland’s communities. Local design and ownership of Jigsaw is critical to its success.
It should also be noted that the Jigsaw model, as described here, is conceived as encompassing: (1) all of the community-based components that involve direct and indirect services to young people, and (2) the full array of developmental supports that are required to sustain these local efforts, to include Jigsaw’s direct programme work (e.g., training, planning, evaluation), and Headstrong’s wide-ranging, national-level activities designed to create the environment within which youth mental health programmes and services can flourish (e.g., communications, research, youth advocacy and support).

**Core Elements of a Jigsaw Programme Site**

There are several core elements and processes which a community must commit to in order to be considered a Jigsaw programme. These include:

- the availability of a premises and staffing to provide person-centred and accessible support to young people;
- comprehensive training for front-line providers and other staff;
- a systematic planning process that features a comprehensive needs and resource assessment;
- an interagency management structure;
- clinical governance processes;
- meaningful youth engagement and participation;
- integration with the primary and specialty mental health system, and commitment from the local HSE; and
- use of the Headstrong online information management system for tracking and evaluation, and evidence-based approaches to practice.

The Jigsaw model can be adapted to the needs and circumstances of each community. In communities where Jigsaw programmes are currently operating, a range of additional programme elements have been integrated into agreed strategies, including public awareness campaigns, whole-school change initiatives, parent-carer support programmes, youth spaces and youth cafes, mentoring programmes, awareness and prevention strategies, and a range of
<table>
<thead>
<tr>
<th>Core Concepts Underlying the Jigsaw Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every young person has the capacity to get through tough times, make a difference, and be an asset to their community;</td>
</tr>
<tr>
<td>The developmental needs of young people for socialisation, recreation, adult mentoring, and leadership opportunities are an essential element of mental health, and have been neglected by communities and society as a whole;</td>
</tr>
<tr>
<td>The absence of mental illness is not mental health - all young people have mental health needs, not just those in distress or at risk;</td>
</tr>
<tr>
<td>Young people's thoughts, feelings, and behaviour are influenced by multiple factors (e.g., families, peers, media &amp; culture) and systems (e.g., youth work, primary care, sports &amp; recreation, schools), requiring a holistic approach when planning change efforts;</td>
</tr>
<tr>
<td>The current community-based system of mental health services is inadequate, and adding more positions, services, and programmes will not necessarily improve the current system - systemic transformation is needed;</td>
</tr>
<tr>
<td>Communities need to become more aware of their existing strengths and resources so that they are better positioned to develop solutions for young people;</td>
</tr>
<tr>
<td>Supports and services need to focus on the development of the strengths and resilience of young people, rather than focusing on young people as 'problems that have to be fixed';</td>
</tr>
<tr>
<td>Young people need to be actively engaged in the design, implementation and review of programmes, to ensure that these programmes are accessible and non-stigmatising for young people;</td>
</tr>
<tr>
<td>Service providers need to be supported in making evidence-based, best practice approaches become more available and accessible to young people, and by providing clear pathways to appropriate information, support, and expertise;</td>
</tr>
<tr>
<td>Young people in distress must be engaged when their needs first become identified - there may be only one chance to safely connect them with appropriate expertise and support;</td>
</tr>
<tr>
<td>Partnerships among services engaged in promoting positive youth mental health should be fostered;</td>
</tr>
<tr>
<td>A transformed system of services and supports should be rigorously evaluated, on an on-going basis, to ensure that its intended benefits are being achieved.</td>
</tr>
</tbody>
</table>
The “Hub” and the Youth Centred Practice (YCP) Network

Jigsaw Hub sites are neutral, youth-friendly locations placed strategically in the community where young people can be seen by a trained youth mental health support worker. These are called “Hubs” because they serves as the focal point for the Jigsaw youth mental health initiative in the community, and are therefore the platform from which all of the aspects of the approach described above operate. A fully functioning but basic Hub site requires core staffing as follows:

1 - Project Manager
1 - Clinical Co-ordinator
3 - Support Workers
1 - Youth Engagement Officer (may be part-time)

As the programme becomes embedded in a community, opportunities for growth in the staffing complement emerge through new resources, re-allocation of staff from other programmes, and integration of programme elements. Headstrong’s experience has been that Hub sites become “magnets” for youth-focused resources due to their centrality, integrated nature, and leadership. As they develops over time, Hubs can have a synergistic effect on a community’s service array in terms of re-focusing current resources and attracting new ones, enabling growth in the scope of the programme.

In addition to a centrally located and accessible Hub, a core component of the direct service delivery system involves the development of a network of front-line providers and practitioners who have been trained in Youth Centred Practice (YCP). This eight-day training is targeted at individuals already working within the system and embedded in organisations across the community. Participation requires a commitment by the host organisation to support the on-going direct support activities of the newly trained individuals, facilitate their participation in networking and clinical support work, and document their work through Headstrong’s online data management system.
Capacity Strengthening & Community-Level Activities

In addition to providing direct supports to young people in distress (or linking them with support), Jigsaw has an important role to play in strengthening service system components as they strive to meet the mental health needs of young people. These may include creative efforts to engage young people across the socioeconomic spectrum, establishing clear management and governance structures to insure proper and effective use of resources, facilitating interagency cooperation and collaboration, re-engineering pathways in and out of care, school-based prevention programming, specialised training for mental health professionals, and peer and family support programmes.

Jigsaw also strives to help communities take responsibility and leadership in youth mental health, and supports work such as creating opportunities for young people to have a voice and to take the lead, mental health promotion, education and awareness programmes, enabling help-seeking, and stigma reduction.

Governance, Linkages with Statutory and Voluntary Services

The HSE statutory mental health and related services are key to the success of a Jigsaw project. The HSE is considered the Lead Agency in each community. Given its mission, the HSE plays a major role in establishing proper clinical governance for the activities of the direct services provided through Jigsaw. The clinical co-ordinator serves as a link to more specialised mental health services. The HSE Area Manager (or designee) is expected to Chair the Management and Planning Teams, and is often also the Chair of the local Children’s Services Committee, ensuring clear and direct management controls for the Jigsaw effort. HSE employees may also be involved in a variety of capacities, such as support workers, sessional staff, and administrative support.

Role of Community Partners

Also required in every Jigsaw site are community partners comprised of representatives from local schools, youth services, family support services, probation services, community services, and other youth-serving statutory and voluntary agencies. Community partners are essential for the promotion of Jigsaw to young people and are also part of the programme’s support network. These community partners engage with young people every day as their core job. Community partners give staff time for selected individuals to be trained in Youth Centred Practice (YCP).

Following training, these individuals dedicate part of their working week to support young people’s mental health utilising the training they have received. These partner workers also link with each other and with the clinical coordinator (based in the hub) and collect data via an online data management system (ODM).
Processes for referring young people to the Hub and to traditional mental health services are in place. This ensures that the partner workers deal with issues that they have been training to deal with and if something more serious comes up with a young person, that they feel is beyond their ability to deal with, they can get the young person to the support they need through.

**From Installation to Full Implementation**

Headstrong has refined a comprehensive strategy for bringing a community’s initiative from site selection to full implementation. In general, it is anticipated that this process will take approximately three (3) years from the point of site selection to attainment of a steady state of operation. Within this timeframe, it is anticipated that the Hub will begin seeing young people within a year of site selection, followed by the addition of other components and continuous refinements.

**Evidence Base for Programme Components**

Headstrong’s overall strategy has been informed by extensive empirical and descriptive literature about comprehensive community initiatives (Aspen Institute, 1997); complex community change (Fulbright-Anderson, 2006); systems of care (Huang, Stroul, Friedman, Mrazek, Friesen, & Pires, 2005); integrated services (Illback, Cobb, & Joseph, 1997); programme planning and evaluation (Illback, Kalafat, & Sanders, 1997); youth engagement and participation (Camino & Zeldin, 2002); developmental asset building (Scales & Leffert, 1999); and positive youth development (Larsen, 2000).

Many of the specific interventions for young people employed by Headstrong have well-developed evidence bases, including person-centred planning and wraparound (Burns, Schoenwald, Burchard, Faw, & Santos, 2006); service coordination (Illback & Neill, 1995); cognitive-behavioural interventions for anxiety, depression, and trauma (Birmaher, Brent, Kolko, Baugher, Bridge, Holder, et al., 2000); multi-systemic therapies (Henggeler, Rowland, Randall, Ward, Pickrel, Cunningham, et al.,1999); brief, problem-focused therapies (Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996); family behaviour therapy (Donohue, & Azrin, 2001); family support and parent training (Spoth, Redmond, & Shin, 2001); and school mental health models (Bond, Glover, Godfrey, Butler, & Patton, 2001), among others.
What Impact Will the Jigsaw Programme Have in a Typical Community?

The figure below provides a perspective on the scale and scope of the Jigsaw programme in a given community, its reach and penetration.

In sum, a fully implemented Jigsaw programme can reasonably be expected to provide “direct” support services to approximately 1,500 young people a year and “indirect” support for an additional 10,500 young people a year through its outreach and awareness activities.
How Does Jigsaw Fit Into the Broader “Landscape” of Youth Mental Health?

When fully operational, Jigsaw programmes can occupy an important space in the community mental health services “landscape”. Jigsaw is not intended to supplant other forms of mental health care and support, but rather to complement and help integrate them. In reality, a typical project is designed to have capacity to provide direct support for only about 5-6% of a community’s youth population aged 12-25 years in a given year. Jigsaw cannot be expected to meet the needs of all of the young people in Ireland through direct services and supports, but fortunately it does not need to in order to fulfil its complementary and integrative role of prevention and early intervention.

- Given an average Jigsaw location population size of 152,000, the typical size of the youth population (12-25) is about 25,000 (based on a national population proportion of 16.6%). Assuming that about 20% of young people will experience significant distress in a given year, the target population of concern (for mental ill-health) would be about 5,000 young people “at risk” (in need of support), per community.

- Not all of these “at risk” young people need direct support from Jigsaw or other formal mental health programmes. Based on 2011 My World Survey data, it seems likely that perhaps 50% of these (about 2,500 young people) will have family, friends and community resources available to provide necessary supports. In these instances, Jigsaw’s role is to empower natural supports to deal more comfortably and capably with the needs of young people.

- Another 35% (about 1,750 young people) may have mild to moderate concerns but not have available supports. In these instances, Jigsaw can serve as a vehicle for the delivery of direct and timely support through its drop-in centre (the Hub) or the YCP-trained provider network. At full implementation, Jigsaw projects that a fully developed programme would have the capacity to provide brief support and early intervention for 1,500 young people per year (taking into account both Hub and YCP network direct supports).

- Most of the remaining individuals (perhaps 750 in a given catchment area) are likely to already have come to the attention of one or more service systems, and some will already be engaged with more specialized services (CAMHS, AMH, hospital-based programmes). Some of these individuals may come to the attention of Jigsaw, either in the drop-in centre (Hub) or in some other venue. Preliminary data from Galway suggests that in a given year, perhaps fifty (50) individuals in need of higher levels of care seek assistance at Jigsaw, and these are linked with the appropriate services. Jigsaw’s role in these instances is to facilitate pathways in and out of care.
What Has Been Accomplished to Date?

The figure below shows what has been accomplished as of early 2013. Six communities (Counties) have opened Hubs and are providing direct support to young people (Donegal, Galway, Kerry, Meath, Offaly, & Roscommon), and five others are due to open shortly in (Limerick, Dublin 15, North Fingal, Clondalkin, & Tallaght). County Mayo) has completed planning and programme development processes and expects to open in the near term, pending resourcing. A number of other communities are engaged in training through the Headstrong Learning Network to become more ready for implementation when funds are available.

Can Jigsaw be Scaled Up for Full National Coverage?

As of 2013, eleven (11) sites are underway. Comprehensive coverage can be achieved by installing, operating, and sustaining thirty (30) sites across Ireland.
References


