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# headspace Evaluation Report: Independent Evaluation headspace: The National Youth Mental Health Foundation

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Social Policy Research Centre

# Headspace Evaluation Report

## Independent Evaluation of headspace: the National Youth Mental Health Foundation

Kristy Muir, Abigail Powell, Roger Patulny, Saul Flaxman, Shannon McDermott, Ioana Oprea, Sandra Gendera, Joaquin Vespignani, Tomasz Sitek David Abello and Ilan Katz

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# Abbreviations

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACT | Australian Capital Territory |
| AGPN | Australian General Practice Network |
| AHW | Allied Health Worker |
| AIHW | Australian Institute of Health and Welfare |
| AOD | Alcohol and other drugs |
| APS | Australian Psychological Society |
| ASGC | Australian Standard Geographical Classification |
| ATAPS | Access to Allied Psychological Services |
| BMRI | Brain and Mind Research Institute |
| CA | Community Awareness |
| CALD | Culturally and linguistically diverse |
| CATI | Computer-Assisted Telephone Interview |
| CAMHS | Child and Adolescent Area Mental Health Services |
| CEO | Chief Executive Officer |
| CLN | Collaborative Learning Network |
| COAG | Council of Australian Governments |
| CoE | Centre of Excellence |
| CYS | Communities of Youth Service |
| DGP | Division of General Practice |
| DoHA | Australian Government Department of Health and Ageing |
| EIPYP | Early Identification of Psychosis in Young People |
| FEC | Foundation Executive Committee |
| FTE | Full-time Equivalent |
| FSO | Working with Families and Significant Others |
| GP | General practitioner |
| hNO | headspace National Office |
| hYNRG | headspace Youth National Reference Group |
| K10 | Kessler 10 Psychological Distress Scale |
| MAHS | More Allied Health Services program |
| MBS | Medicare Benefits Scheme |
| MCB | Managing Challenging Behaviour in Young People |
| MHAGIC | Mental Health Assessment Generation and Information Collection |
| MHCP | Mental Health Care Plan |
| MIBCT | Motivational Interviewing and Behavioural Change Techniques |
| NGO | Non-government organisation |
| NHMRC | National Health and Medical Research Council |
| NSW | New South Wales |
| NT | Northern Territory |
| NYPCS | National Youth and Parent Community Survey |
| ORC | ORYGEN Research Centre |
| PASS | Promoting Access and Support Seeking in Young People |
| PSST | Problem Solving Skills Training |

| | |
|---|---|
| PWI | Personal Wellbeing Index |
| QLD | Queensland |
| SA | South Australia |
| SEE | Screening-Engaging-Early Young People |
| SMHWB | National Survey of Mental Health and Wellbeing |
| SPET | Service Provider Education and Training |
| SPRC | Social Policy Research Centre |
| TAFE | Technical and Further Education |
| TAS | Tasmania |
| UNSW | University of New South Wales |
| UoM | University of Melbourne |
| VIC | Victoria |
| WA | Western Australia |
| YMHI | Youth Mental Health Initiative |

# 1 Executive Summary

## 1.1 Background

headspace, the National Youth Mental Health Foundation, was launched in 2006 as part of the Australian Government's commitment to the Youth Mental Health Initiative (YMHI). It was established to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young people aged 12-25-years-old. headspace aims to achieve this by:

- Providing holistic services via Communities of Youth Services (CYSs);
- Increasing community capacity to identify young people with mental ill-health and related problems as early as possible;
- Encouraging help-seeking by young people and their carers;
- Providing evidence-based, quality services delivered by well-trained professionals; and
- Impacting on service reform in terms of service coordination and integration within communities and at an Australian and state/territory government level.

A number of headspace components contribute towards these aims alongside the CYSs, including headspace national office (hNO), a research and dissemination component (the Centre of Excellence, CoE), a Service Provider Education and Training Program (SPET), a Community Awareness program (CA) and a youth national reference group (hY NRG).

In 2008, the Social Policy Research Centre (SPRC) was contracted by headspace and the University of Melbourne (UoM) to conduct the first independent evaluation of headspace. The evaluation is a longitudinal, mixed methods research project, established to examine the achievements, limitations and future directions of the headspace program. The evaluation draws on qualitative and quantitative data from primary and secondary sources collected over two waves. The main methods used were:

- Policy, procedure and documentary analysis;
- Interviews and surveys with key stakeholders, including CYS staff, local service providers, headspace training participants, staff from the national headspace components, government representatives, carers and young people using CYS services;
- Service coordination study;
- Sustainability instrument;
- Secondary analysis of existing datasets, including the headspace dataset, medicare data, the National Youth and Parent Community Survey (NYPCS) and the National Survey of Mental Health and Wellbeing (SMHWB);
- Meta-analysis.

The data is analysed thematically to address service provision, service access and service quality within the CYSs, as well as examining the impact of headspace on broader service reform, the implementation of the national headspace components - hNO, CA, CoE, SPET and hY NRG - and a meta-analysis of the extent to which the program has met its objectives. Key findings from each of these sections are outlined below, followed by lessons and recommendations emerging from the research.

## 1.2 Key findings

### Service provision

headspace aims to provide multidisciplinary services to young people with mental health issues in 30 CYSs throughout Australia across four key areas: primary health, mental health, alcohol and drug use, and social and vocational support. Service provision is analysed to address the extent to which CYSs have achieved this, with a particular focus on factors impacting on their establishment, implementation and sustainability. The findings show that by June 2009:

- On average it took CYSs seven months to open their services to young people and longer to provide a full complement of services, with no substantial differences between urban and regional CYSs.

- More than three quarters of CYSs were providing services across three of the four core areas, although only a third were covering all four areas.

- Practitioner gaps were less common at Wave 2 than Wave 1, although six CYSs were yet to recruit GPs and engagement of psychiatrists was limited.

- A range of factors, structural and operational, had impacted on the establishment, implementation and potential sustainability of CYSs.

- Factors that impacted on establishment included the tight-timeframe for establishment, the experience of lead agencies in delivering services, capacity of the consortium to provide resources and support CYS managers, headspace core funding and YMHI workers, the ability to obtain, rent and renovate appropriate premises and support from hNO.

- Effective implementation depended on the consortium's ability to provide strategic direction, flexibility in the role of the consortium to reflect CYS needs, a mix of funding including Medicare Benefits Schemes (MBS) and private practice fees, practitioners representing all four areas, software to manage consultations, billing and reporting to hNO, appropriate space (with room to expand and soundproof clinical rooms) and support from hNO, CA, CoE and SPET.

- Key factors contributing to sustainability include effective clinical governance to develop appropriate policies and procedures, a diverse range of funding sources, a full complement of staff and a large number of young people accessing services.

**Service access**

headspace aims to attract and engage young people with mild to moderate mental health issues and promote help-seeking behaviour. In order to address the extent to which headspace is meeting these objectives, this section of the report explores the issue of young people's access to headspace. It found that:

- To achieve its objectives, headspace has, among other things, developed local and national community awareness activities and campaigns, developed youth-friendly, accessible service sites and promoted appropriate referral pathways.

- headspace has used a variety of national and local community awareness activities, including advertising campaigns, school visits and forums with community service providers, to encourage help-seeking, promote its services and to raise awareness of youth mental health.

- Medicare data, showing substantial increases in the numbers of 15-24 year olds accessing mental health services, and referrals to headspace from health, education and community services, as well as self-referrals, suggest community awareness has been effective.

- Across Australia, headspace has provided services to almost 14,000 young people who, on average, have accessed CYS services 6.8 times each.

- The characteristics of young people using headspaceare varied in terms of demographics, mental and physical health characteristics, work and education, relationship characteristics and alcohol, tobacco and drug use.

- Comparison with young people in the population at large suggests that CYSs are attracting young people with higher than average psychological distress and who also need support in other areas of the life, such as economic participation and substance use.

- The most frequently occurring diagnoses for young people attending headspace were anxiety and depressive disorders. Almost half of those with a primary diagnosis had received at least one other diagnosis, highlighting the high prevalence of co-morbidity in young people attending headspace.

- headspace has been effective achieving its goal of early intervention: 53% of those using headspace services had no, low or medium levels of psychological distress. Nonetheless, CYSs are also successfully engaging many young people with high levels of distress: they constituted almost 47% of headspace clients, compared to an incidence of 2.6% in the general population of young people.

- Young people using headspace services were also more likely than those in the population at large to have poor physical health, be neither studying nor working, have poor or no contact with family members (even when living at home), and be higher than average users of alcohol, tobacco and other drugs.

- Young people access and remain engaged with headspace because of its youth friendly nature. Aspects of youth friendliness include the non-clinical

environment, the good location of most CYSs, non-judgemental and trusting relationships between young people and their practitioners, a sense of control over service experiences, low or no cost services, and appointment reminders.

- Barriers to service use, which most CYSs are attempting to address, are mainly psychological, but also include perceived costs, opening hours, inappropriate physical space and waiting times to see practitioners.

- CYS practitioners were concerned that they were not attracting appropriate proportions of young people from particular backgrounds. Depending on their CYS location, this included young people with limited family support systems, those with lower socio-economic status, and those from Indigenous or refugee backgrounds.

**Service quality**

headspace aims to maximise outcomes for young people and their families by providing holistic, high quality services. This section addresses the extent to which headspace has achieved this, as well as examining how service quality factors have impacted on these outcomes. The findings indicate that:

- Both the qualitative and the quantitative data showed that most young people surveyed reported improvements in their mental health, with reduced levels of psychological distress. Young people also found that headspace helped them develop strategies to manage their mental health, as well as greater insight into their own behaviour.

- More than half the young people surveyed reported improved physical health since using headspace. There were also significant decreases in the frequency of AOD use and almost 80% of young people stating that their ability to manage their emotions without AOD had improved.

- Approximately 50% of young people believed that headspace had improved their ability to go to school, TAFE or university, or to work or find work. Improved willingness to engage with work or education was largely attributed to psychological support received through headspace, rather than support from vocational service providers.

- Most young people described improved relationships with family and friends since accessing headspace services, although this was dependent on the nature of individual relationships. These changes were attributed to improved communication, increased self-awareness and the development of coping strategies to deal with challenging relationships.

- The findings indicate that headspace may be more impact on young people presenting with mild to moderate mental health problems, with whom early intervention is possible. These people are more likely to be aged 12-17 than older youths aged 18-25.

- The impact of headspace did not differ greatly between men and women, or between service users in regional and urban locations.

- Families and significant others generally felt that headspace had had a positive impact on the mental health of the young people they cared for and consequently on their own lives as well. However, there was some criticism concerning the lack of support available for carers through CYSs.

- Good practice 'episodes of care' are seamless and coordinated from the time a young person is referred to headspace through to their exit. An episode of care usually begins when a young person is referred to headspace. They are then assessed and further referred to different practitioners within and outside headspace and access services (that are coordinated and case reviewed) until they are ready to exit.

- Holistic services were also a positive experience for young people. 68% of those surveyed had seen at least two headspace practitioners, most commonly a GP and psychologist. The multidisciplinary nature of headspace increased the accessibility of services for young people, and enabled young people to address issues across their whole life.

- headspace has improved the quality of services by using evidence-based practices, providing appropriate training and supervision for staff, and by informally evaluating services, although the extent of these activities has varied between CYSs.

- Service quality was particularly visible where there was strong clinical governance, including a champion to promote the use of evidence-based practice, regular clinical and case review meetings and additional training opportunities beyond those delivered by the SPET.

- Service integration and coordination within each CYS also helped to maintain service quality. Coordination activities have been facilitated through shared infrastructure, clear governance, and individual leadership and attitudes. The barriers to coordination were time and funding constraints and prohibitive organisational cultures.

**Broader service reform**

headspace aims to promote broader service reform and increased awareness around youth mental health across Australia at a local level in CYS communities and at a national level, by engaging state, territory and federal governments. This section describes the extent to which headspace has been successful in this. It showed that:

- CYSs have coordinated services in their communities by working with organisations to promote referral pathways both into and out of headspace and to provide training for service providers about youth mental health in order to improve outcomes for young people.

- Factors impacting on the success of coordinated services are shared respect for and understanding of the mental health needs of young people, and a common working culture that includes the goal of cooperation, as well as sufficient time and resources and commitment from high-level stakeholders.

- The effectiveness and appropriateness of referral pathways improved between Waves 1 and 2 of the evaluation, largely as a result of increased communication about the role of headspace and its target population.

- Cross-disciplinary training and involving external providers in case review meetings were also effective in building relationships, reducing overlap, selecting the most appropriate care for young people, coordinating care for young people and generally creating a shared understanding of how to work effectively with young people.

- Barriers to referral pathways included staff turnover, client confidentiality and competition between service providers.

- hNO has effectively engaged with governments to increase knowledge and awareness of youth mental health issues among state/territory and federal health officials. This is most evident in DoHA's commitment to fund headspace for a further three years, as well as the many close relationships between state mental health services and some CYS sites.

- Most states and territories that are undergoing, or have recently completed, reform of their mental health policies have at least some focus on young people and early intervention issues, and some have also addressed issues of holistic and coordinated service provision.

- Government stakeholders perceived that the headspace initiative had provided guidance and vision in the reform and development of mental health services, although it had not substantially changed the direction of these processes. Only one state disputed the headspace approach of developing specialist youth mental health services.

- Further coordination activities at a government level are restricted by the diversity of the CYS focus, operational differences, and the numbers of CYSs in some states.

**Implementation of the national components**

headspace national components aim to support the CYSs through the provision of CA strategies and materials (hNO and BMRI CA), evidence based information (CoE), appropriate training (SPET) and strategic and operational support (hY NRG and hNO). Key achievements and challenges are outlined below:

- hNO has played a critical role in establishing headspace as a primary reference point for youth mental health. It has played an active role in the marketing of headspace, contract management of the CYSs, establishing hY NRG, and engaging government.

- The Brain and Mind Research Institute (BMRI) have primarily been involved in developing the NYPCS to monitor help-seeking behaviour and CA around youth mental health. They also played a role in developing the first national awareness campaign with hNO.

- hNO have implemented two national awareness campaigns via television, print and electronic media, developed the headspace website and developed marketing tools for CYSs to use.

- The CoE have reviewed existing research on psychological disorders to produce evidence maps, evidence summaries and 'mythbuster' factsheets for use by practitioners and young people. Accessibility and useability of these resources has improved between Waves 1 and 2 of the evaluation.

- SPET has developed seven training modules as a result of a training needs assessment. Roll out of these training packages was initially slow and there are many CYSs who have yet to utilise the training resources.

- The youth reference group, hY NRG, was established to support the youth friendliness of headspace. hY NRG have represented headspace at community events, provided advice to headspace on policies, procedures, training and marketing and participated in media activities about youth mental health.

**Meta-analysis**

The success of headspace is premised on the contribution of each headspace component and the program as a whole. This section compares the goals of headspace with the contributions of each of the headspace components and outcomes achieved thus far. It found that:

- The findings support the evaluation hypothesis: headspace has been effective in promoting and facilitating improvements in some young people's mental and physical health, AOD use and their social and economic participation.

- These results are likely to have occurred because young people increasingly sought assistance from services that were accessible, affordable, quality based, holistic and coordinated.

- As the hypothesis predicted, help seeking and service based outcomes were likely to be a result of an interaction of funding and other contributions from the various components of headspace.

- Increased access and increased help-seeking among young people was supported by funding (hNO), service availability (CYSs), youth friendliness (CYSs and hY NRG) and community awareness (CA).

- It appears that CYSs have been successful in attracting young people at an early intervention stage, with many young people coming to headspace with no, low or medium levels of psychological distress.

- The headspace logic model indicates there should have been a strong coordinated effort between most components to achieve quality, evidence based services. However, while the evaluation found that services were generally high quality, there is little tangible evidence to conclude the extent to which services are evidence based.

- CYSs only received valuable tangible support from CoE and SPET in regard to service quality well into the implementation of headspace. CoE resources were most valuable for CYSs that had a staff member responsible for supporting the strong clinical governance.

- hNO has tried to support service quality largely via the collaborative learning network (CLN), which has had some success in enabling shared practice between CYS sites.

- Service quality largely occurred independently from the other headspace components. It occurred within CYSs with strong clinical governance (including regular clinical care reviews with independent expert input, review of case notes and supervision, and access to training).

- Similarly, service coordination was largely driven by CYSs and not directly supported by other components. However, the headspace model and hNO have been important in ensuring that services are coordinated and funds are available for paid staff to act as facilitators for coordination (largely the YMHI workers).

### 1.3 Lessons and recommendations

Key lessons and recommendations emerging from the evaluation are outlined below. Some of these recommendations have the potential to improve headspace existing operations, while others are useful lessons for headspace should the CYSs be further rolled-out to other locations in the future.

**Service provision**

- CYSs require 9-12 months to become fully operational, including 6-7 months for set-up and establishment and 3-6 months to recruit a full complement of staff and refine policies and procedures.

- Access to psychiatric services should be increased, or made available where there is currently no or limited provision, within CYSs in order to further support young people and to provide expertise and support to other practitioners.

- During establishment and early implementation, CYSs require high proportions of core funding, but beyond this some core funding is still essential for most CYSs. However, it is also important for sites to diversify their funding mix to increase the likelihood of sustainable services.

- The largest sites are likely to be able to cope with the reduction in funding between 2009 and 2012 by diversifying funding sources, and to become increasingly more sustainable over time.

- It is unlikely that CYSs would be able to adopt a business model that requires no core funding. This is especially the case if headspace is to remain a public service, which is accessible to all young people.

- CYSs in remote areas will require a very high proportion of core funding.

- Rent free and fee free periods are important for recruiting private practitioners, but initial findings indicate that fears around losing private practitioners if fees are charged are largely unfounded and could be an important source of revenue.

- Effective co-location requires collaboration and coordination between CYSs and the co-locating service. To ensure this, co-location should be beneficial to both parties and for young people, and may require additional resources to guarantee that services do not become divergent.

- CYSs require expertise in business and clinical governance to operate effectively. CYS that do not have the capacity to employ a business and clinical manager may require greater support from their lead agency and/or hNO.

**Service access**

- headspace needs to undertake regular reviews of the appropriateness and effectiveness of its marketing and community awareness activities, with a particular focus on whether and how they reach out to marginalised groups of young people.

- A second National Youth and Parent Community Survey is required to enable detailed analysis of the wider impact of community awareness activities by headspace.

- As CYSs have now established themselves as service providers within their communities, it is important that they ensure their services are engaging 'hard to reach groups', for example, young people in the lowest socio-economic status groups, those with limited family support, refugee communities and Indigenous young people.

- Largely as a result of their own success, many CYSs now have waiting lists for practitioners. This needs to be addressed in order that headspace does not miss the 'window of opportunity' to support young people ready for help and that further help-seeking is not negatively affected.

**Service quality**

- CYSs must improve data compliance, particularly around demographic characteristics and psychological distress (K10) at initial and subsequent assessments, in order to obtain a realistic view of the impact of headspace and the type of young people it is most effective for.

- CYS sites should consider strengthening services that may have a positive impact on young people's body image, especially for women. Satisfaction with feelings about bodily appearance were, on average, rated somewhat negatively, and yet only 46% of service users perceived that headspace had improved these feelings.

- Improvements in young people's economic participation were largely attributed to psychological support, not to vocational providers, suggesting that vocational service providers require further integration into the headspace model to be effective.

- headspace has been effective in both regional and remote locations as well as urban areas.

- Greater support for families and significant others should be developed. Where this is not possible or desirable within CYSs, referral pathways for carers should be promoted and extended.

- All CYSs should have staff supervision structures in place to support practitioners.

**Broader service reform**

- Co-location does not automatically result in effective coordination of services and care. Where co-location occurs, CYSs need to ensure that there is collaboration and that the co-located service(s) are coordinated as part of the headspace model.

- Government representatives indicated the need for more consistency by headspace in engaging governments.

- The impact of headspace on policy development is more tangible where strategic partnerships have been created between CYSs and the state mental health system.

**Implementation of the national components**

- hNO has faced a number of challenges as a result of the initial governance structures, a lack of resources, and an unanticipated demand for support from CYSs.

- Funding constraints may mean that the CoE cuts back on printed resources. However, given the popularity of these resources, it is recommended that resources are directed towards producing hard-copy posters and flyers.

- SPET needs to ensure that evidence collated by the CoE is incorporated and reflected in training materials.

- Collaboration and support between all components should be increased to add value to the headspace initiative and to ensure that the work of each of the components is ultimately to the benefit of young people using headspace services.

**Meta-analysis**

- Sites seeing the most young people are largely carrying out the headspace model advocated by hNO:

    - they holistically offer all four key service areas (mental health, physical health, AOD, social/vocational);

    - they have private practitioners; and

    - they have a strong leadership with both clinical and business expertise.

- These sites are also likely to have a particular governance structure: they are more likely to be led by a GP based agency and have smaller numbers of consortium

members. These sites suggest that the above factors may be important for a successful CYS.

- headspace will benefit from hNO adopting a clear consistent role: either as contract managers implementing a flexible program driven by community needs and resources; or as facilitators, supporters and contract managers for the implementation of a specific headspace model with context flexibility. If a defined model is adopted, it will require minimum standards with some local flexibility.

- It is not sufficient for CYSs to merely co-locate services and some service providers currently co-located may not have the expertise needed to support young people attending headspace.

- Components individually added value to CYSs, but SPET, CoE and CA did not work effectively together to integrate, coordinate and strengthen their support.

- Components should work together to ensure that awareness campaigns and provision of services are inclusive of young people currently under-represented among headspace clients (these groups will be context-specific, but may include those in low socio-economic groups, those with limited support systems, refugee communities and Indigenous young people).

- The challenge for 2009-2012 is to make the headspace system more integrated and ensure that the value added by the other components makes the national branding of headspace CYSs worthwhile and demonstrably valuable.

### 1.4 Conclusion

It is evident that there are some ongoing challenges for headspace. These have been highlighted above, but key aspects include:

- The sustainability of CYSs, which will only be achieved with strong clinical governance, cost-effective models that draw on a diverse range of funding sources, some core funding, engagement within the community and demand for the service from young people.

- Engaging young people who are not currently using headspace services, but are in need of mental health support, by addressing some of the barriers to service use and developing engagement strategies for hard to reach groups.

- Improving data compliance (through the headspace dataset) in order that the effectiveness of services can be monitored.

- Ensuring all headspace services, including those that are co-located, are coordinated to benefit young people and ensure they receive holistic care.

- Ensuring that the national components continue to support the CYSs, but also each other, in order to provide added value to the headspace model.

Nevertheless, the headspace initiative has promoted and facilitated improvements in young people's mental health, social well-being and participation in education, training and employment. Outcomes have been particularly positive for young people

with early onset and early intervention needs, who are predominantly aged 12-17 years. This has been achieved through effective engagement of young people via good CA and high quality, youth-friendly services. These achievements have also been supported by the national headspace components: hNO, CA, CoE, SPET and hY NRG. headspace also has wide recognition in CYS communities and at a national level, demonstrated through the effectiveness and improvements in referral pathways locally and government commitments to youth mental health nationally.

# 2 Introduction

The National Youth Mental Health Foundation, *headspace*, was launched in 2006. It is an Australian Government initiative first funded as part of the Federal Budget commitment to the Youth Mental Health Initiative (YMHI) (2005-06 to 2008-09). Funding has since been extended from 2009-2012. headspace aims to promote and facilitate improvements in the mental health, social wellbeing and economic participation of Australian young people aged 12–25 years.

In 2008 the Social Policy Research Centre (SPRC) was contracted by the University of Melbourne (UoM) to conduct the first independent evaluation of headspace. The evaluation, conducted between 2008-2009, is a longitudinal, mixed methods research project, established to examine the achievements, limitations and future directions of the program. This report collates and analyses qualitative and quantitative data from primary and secondary sources collected over two waves. Most Wave 1 data was collected between July-September 2008 and most Wave 2 data was collected between April-June 2009.

The report uses the logic model of headspace to provide an understanding of how headspace operates, its achievements and outcomes thus far, and the factors that have facilitated and hindered establishment, implementation and sustainability. In order for headspace to meet its objectives, it is critical that headspace is delivering the required services, that young people are accessing these services, and that the services are appropriate and of quality. It is also important that headspace has started the process of establishing referral pathways beyond the CYSs, and that it is having some impact on broader service reform.

Throughout the report, Wave 1 data is analysed to determine baseline data and understand early implementation issues around the establishment of headspace, while Wave 2 data is examined to address longer-term implementation issues, potential for sustainability, change over time and outcomes of the headspace program.

The report begins with a description of the headspace initiative and the evaluation methodology before exploring service provision, service access and service quality within the CYSs. Finally the report examines the impact of headspace on broader service reform, the implementation of the national headspace components and the relationship between them, a cost analysis of the headspace initiative and a meta-analysis that summaries the extent to which the program has met its objectives and why.

The report has been written in order that each of the chapters can be read independently, but it is important to note that many of the findings are inter-related and mutually reinforcing.

# 3 headspace initiative

The mission of headspace is to promote and facilitate improvements in the mental health, social wellbeing and economic participation of Australian young people aged 12–25 years[1]. headspace aims to do this by: providing holistic services; increasing the community's capacity to identify young people with mental health and related problems as early as possible; encouraging help-seeking by young people and their carers; and providing quality services that are evidenced-based, and delivered by well trained, appropriate professionals. headspace also aims to have an impact on service reform in relation to service coordination and integration within communities, and at an Australian and state/territory government policy level. The core element of the headspace initiative consists of 30 service delivery sites across Australia, called Communities of Youth Services (CYS), that provide services for young people. The CYSs are supported by a number of other headspace components: the headspace National Office (hNO), a research and information dissemination component (the Centre of Excellence, CoE), a Service Provider Education and Training Program (SPET), and a Community Awareness program (CA).

**The roles of the headspace components**

*CYSs*

CYSs aim to promote early help-seeking and provide early intervention, and to use evidence-based treatment and care for young people aged 12–25 years who are at risk of developing mental health and substance-use disorders. They are hubs or one-stop-shops, which provide holistic, coordinated, evidence-based and youth-friendly treatment in the areas of primary health, mental health, alcohol and other drug (AOD) use, and social and vocational participation.

CYSs were selected through a competitive process administered by the headspace Grants Committee. The CYSs collectively received $34.2 million between 2006 and mid-2009, and will be receiving at least $500,000 each per year between 2009 and 2010 as ongoing core funding. Service delivery is supported by the Youth Mental Health Initiative (YMHI) Allied Health Worker (AHW) program,[2] which assists in the payment of practitioners, such as psychologists, social workers, mental health nurses, occupational therapists, Aboriginal and Torres Strait Islander health workers, AOD counsellors, and youth workers.

Each CYS is directed by a lead agency on behalf of a consortium of government agencies and non-government organisations (NGOs) from a range of sectors (see Section 5.3). This arrangement is intended to encourage a whole-of-community approach and engage key stakeholders in the development, establishment, implementation and coordination of headspace services.

Consultations with private practitioners, such as General Practitioners (GPs) and psychologists, are an important part of the CYS model. Consultations are either bulk-billed through the Medicare Benefits Scheme (MBS) or paid for by the young people

[1] For further information regarding the headspace initiative see *headspace Strategic Plan* (headspace, 2008).

[2] DoHA allocated $15million for the YMHI AHW program between 2006-2009.

who are reimbursed by private health insurance or the MBS. From 2009, it is intended to charge gap payments (i.e. fees charged over and above the MBS scheduled fee), for those young people or their families who can afford them, as a way of contributing to the sustainability of CYSs beyond that date. Services are also provided by co-located organisations.[3] The consortia models, and the organisations involved and the contributions they make to the CYSs vary across the 30 sites.

CYSs further support young people by networking and establishing clear referral pathways with other relevant services in the community. Through shared training and CA programs with the broader community, the CYSs also aim to increase the community's capacity to identify, refer and work with young people at risk of problems related to mental health and other issues.

*hNO, CoE, CA and SPET*

Between 2006 and 2009, the headspace components were separate entities managed by different organisations. hNO was administered within the UoM; the CoE was established within the ORYGEN Research Centre (ORC) at the University of Melbourne; the CA program was run by the Brain and Mind Research Institute (BMRI) at the University of Sydney; and the SPET program was undertaken by the Australian Psychological Society (APS) and the Australian General Practice Network (AGPN).

The governance structure of headspace has recently changed after headspace became a company by limited guarantee with charitable status (not for profit) in 2009. Between 2006 and mid-2009, headspace was funded by the Australian Government Department of Health and Ageing (DoHA) and governed by the UoM, ORC and Foundation Executive Committee (FEC) (which consisted of the organisations who originally tendered for the foundation: ORC, UoM, BMRI, APS and the AGPN) and overseen by an Advisory Board. The headspace Chief Executive Officer (CEO) was employed by UoM and was accountable to all the governing parties.[4] Under the new governance arrangements, the company is funded by DoHA and is governed by a board . The board members include a representative from UoM, ORYGEN Youth Health, BMRI, APS, AGPN, and the Australian Indigenous Doctors Association and Principals Australia and four independent directors (including the Chair who was nominated by DOHA.

The funding for headspace has also been renewed from 1 October 2009 – 30 June 2012. The headspace model was not fundamentally changed, that is, it continues to rely on the CYSs, CA, SPET, CoE and hNO. However, while the CoE continues to be run by ORC at the University of Melbourne, the CA and SPET programs are now administered within the hNO, which also continues to oversee, support and contract manage the 30 CYSs.

[3] Organisations or agencies funded by government or NGO sources that are physically located in CYS hubs.

[4] The interim report examined the previous governance structure. During Wave 2 of the evaluation the transition between governance structures was underway and therefore this report neither continues to evaluate to old governance structure nor is in a position to evaluate the new structure.

As this report is based on data collected between June 2008 and July 2009, its findings relate to the earlier structure of headspace. The individual roles of hNO, CoE, CA and SPET, as undertaken between 2006 and mid-2009, are described in Table 3.1. They are also discussed in Section 9.

**Table 3.1: Roles of headspace components (2006-09)**

| Component | Role and funding |
|---|---|
| headspace National Office | hNO received almost $4.6 million (2006-09) to: contractually manage and support the implementation of the CYSs; coordinate and oversee the headspace initiative; manage the contracts of the CYSs, the CoE, and the CA and SPET programs; provide accountability to DoHA, FEC, the Advisory Board, ORC and UoM, and the wider community; and represent headspace and lobby government at all levels. hNO has also taken on the responsibility for communications and marketing. |
| Centre of Excellence | The CoE, run by ORC at UoM, received almost $2.9 million (2006-09) to conduct three main activities: evidence mapping; evidence translation and dissemination; and evidence implementation. The CoE was established to improve outcomes for young people by collecting, generating and disseminating evidence about 'what works' for managing mental health problems and substance-use issues in young people. |
| Community Awareness | The CA program, run by BMRI, received a total of $3.9 million (2006-09) to plan and conduct CA campaigns, develop and produce CA resources, review existing evidence and programs, and fill gaps in knowledge. CA was established to create awareness about headspace services, encourage early help-seeking, and reduce the stigma associated with mental health problems. Awareness-raising activities at the national level were primarily the responsibility of hNO with input from BMRI.[5] BMRI's primary role was reviewing evidence and conducting research. |
| Service Provider Education and Training | SPET, run by APS and AGPN, received almost $3.5 million (2006-09) to improve the community's capacity for early identification and increase the use of evidence-based interventions for young people experiencing mental health problems and substance-use issues.[6] The APS was responsible for determining training needs and design and development, and the AGPN was responsible for the promotion and dissemination of training. |

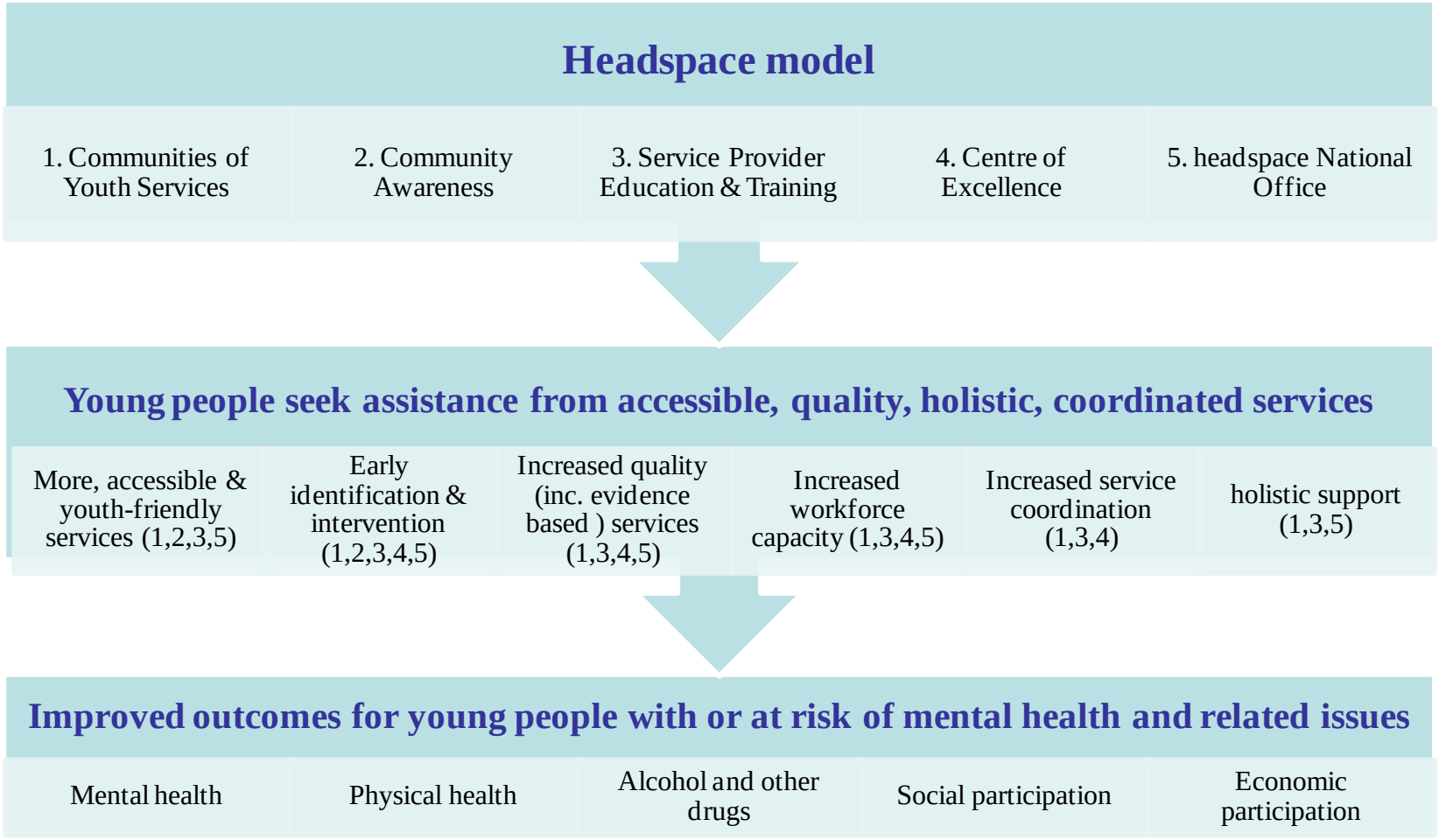
## headspace logic model

Each component of headspace works to increase the number of young people who receive support from accessible, quality, holistic and coordinated services. These services aim to improve outcomes for young people who have or are at risk of mental health problems and related issues. Figure 3.1 provides an illustration of the headspace logic model.

[5] This work was supported by the Marketing and Communications Subcommittee of the Advisory Board.

[6] The training is primarily targeted towards the workforce of GPs, allied health professionals, drug and alcohol workers, education and youth sector professionals, and staff in emergency, police and juvenile justice roles.

**Figure 3.1: headspace model**



The five components aim to work together to enable young people to get assistance from accessible, quality, holistic and coordinated services. The CA program, for example, is intended to assist CYSs to attract young people to headspace, while hNO supports a headspace youth national reference group (hY NRG) as a way of making services youth-friendly.

The CYSs aims to support early identification of those young people who are at risk of mental health problems and related issues, but so too do the other headspace components. CA aims to increase early help-seeking; SPET aims to support service providers to identify early-onset mental health problems; and the CoE aims to assist practitioners to identify young people early by devising a psychosocial screening tool.

Once young people access a headspace CYS, it is intended that they will receive quality, holistic and coordinated services. Improving service quality within and outside the CYSs is primarily the responsibility of the CoE, but it is also facilitated by SPET and hNO. SPET, CoE and hNO also aim to assist CYSs to increase workforce capacity. Service coordination is the primary role of the CYSs, but it is also indirectly supported by CoE and SPET. Finally, the holistic focus of headspace is ensured by the fact that each CYS is a hub where young people can access several practitioners with expertise in mental and physical health, substance use, and social and economic participation, and who can provide services that are integrated and coordinated.

# 4 Evaluation methodology

## 4.1 Aims of the evaluation

The independent evaluation of headspace (2008–2009) is a longitudinal, mixed methods research project, established to examine the achievements, limitations and future directions of the program. The main objectives of the evaluation are:

1. To review the efficiency and effectiveness of headspace as an initiative, and of its individual components (including hNO, the CoE, CA, and SPET programs);

2. To assess the efficiency, effectiveness and performance of the CYSs, particularly around increasing young people's help-seeking behaviour, increasing rates of early detection and early intervention, increasing evidence-based interventions, increasing the economic participation of young people, improving service coordination and developing sustainable business models;

3. To evaluate the extent to which the headspace initiative has influenced government policy, CA and knowledge of evidence-based approaches to youth mental health issues; and

4. To contribute to the ongoing development of headspace and the evolution of the CYS models.

Much of the evaluation is, necessarily, focused on the CYSs, as these are the main points of service delivery for young people. However, the evaluation also aims to assess how the individual components interact and add value to the model, in order to build a picture of how headspace operates as a whole. A detailed evaluation methodology is available in the *Independent Evaluation of headspace: Evaluation Plan* and further details on the methodology can be found in Appendix B: Additional methodological details.

The evaluation will assess the following hypothesis:

> That the headspace initiative has promoted and facilitated improvements in young people's mental health, social well-being, and participation in education, training and employment, particularly through:
>
> - its financial and other support for a reformed approach to mental health services for young people which emphasises early intervention;
> - its engagement with young people and its promotion of information about youth mental illness and related disorders, and about services available; and
> - its advocacy with all levels of government for reforms to the funding of youth mental health services.

In addition to the evaluation hypothesis, the evaluation also intended to answer a wide range of evaluation questions (see Muir et al., 2008). These questions have, where possible, been addressed throughout the report. A number of questions could not be answered due to the evolving nature of the research process, which needed to be

adapted to take account of data availability and the time it took to establish the headspace CYSs and components.

## 4.2 Methods

This report analyses many sources of data, much of which was collected over two waves. Data has been triangulated in order to meet the evaluation objectives, to measure change over time where possible, and to recommend possible areas for improvement. The methods are briefly described below.[7]

### Policy, document and report analysis

Policies, documents and reports were analysed to clarify the current resources and implementation of each of the headspace components. Federal and state/territory government policies on youth mental health and substance use were also reviewed.

### Stakeholder interviews and surveys

Key stakeholders were surveyed and interviewed at Waves 1 and 2 of the evaluation. Wave 1 data collection (2008) aimed to obtain baseline findings and to understand early implementation issues, while Wave 2 (2009) aimed to address longer-term implementation issues, the potential for sustainability, change over time, and outcomes. Stakeholders included representatives from CYSs, CYS consortiums and service providers in CYS communities, hNO, the Advisory Board, the CoE, and the CA and SPET programs, and from federal and state/territory governments, as well as young people using headspace and their carers. CYS staff, members of consortium partners, community-based service providers, and young people and their carers were interviewed during visits to ten CYS sites (the in-depth sites). A list of the CYSs included in the in-depth study can be found in the appendix (Table B.2).

*The Young People study*

The Young People study combined data from a number of sources (see below) to give a picture of the young people who access headspace: their characteristics; their service experiences; baseline data on a range of life domains (such as mental and general health, social and economic participation, and AOD use); and the initial outcomes for young people in terms of their levels of psychological distress and their own reports on the impact headspace has had on them.

The data sources for this study included both interviews and surveys with young people in the ten in-depth CYS locations, and analysis of the headspace dataset, which is compiled using the Mental Health Assessment Generation and Information Collection software (MHAGIC). At Wave 1, 91 young people participated in interviews, and 93 were interviewed at Wave 2. There were 16 young people who were interviewed at both Waves. There were 169 young people who completed the survey at either Wave 1 or Wave 2 of the data collection, 28 of whom were ‘repeats’, i.e. they completed the survey twice, at Wave 1 and at Wave 2.

[7] In addition to the following methods, the evaluation intended to conduct a cost analysis. The data from this analysis was not included because it did not properly reflect the true establishment and recurrent cost of the program. Only budgeted revenue and expenditure data for the 2008-2009 financial year and the actual revenue and expenditure for the six months from 1 July to 30 December 2008 was available to the researchers for analysis.

The original evaluation plan included the collection of longitudinal survey data from a sample of young people who accessed headspace both in 2008 and in 2009, and involved treating the Wave 1 and 2 cohorts of young people as separate samples. However, the response rate of young people who participated in both Waves was poor (n=28), and those who completed the survey at Wave 1 had been coming to headspace for similar periods of time to those who completed it at Wave 2, so the cohorts were combined. The demographics of the small number of young people in the longitudinal group (the 'repeats') closely reflect those of the larger sample (Table 4.1).

The headspace dataset included data for 7,022 young people attending 24 of the 30 headspace sites.[8] Demographic characteristics of the young people in the headspace dataset are detailed in Table 4.1. The original plan was to collect most of the longitudinal outcome data from the headspace dataset, but the database took longer to finalise and operationalise than expected, and as a consequence this evaluation contains very little longitudinal data (see Appendix B: Additional methodological details for further information).

**Table 4.1: Demographic characteristics of young people attending headspace (headspace dataset and Young People's survey)**

| Characteristics | | YP headspace dataset (n=7022) | | YP survey (n= 169) All young people | | YP survey (n=28) Repeats | |
|---|---|---|---|---|---|---|---|
| | | n | % | n | % | n | % |
| Sex | Male | 2798 | 42.6 | 66 | 39.8 | 10 | 35.7 |
| | Female | 3768 | 57.4 | 100 | 60.2 | 18 | 64.3 |
| Age | 12–17 years | 2709 | 53.8 | 70 | 42.2 | 10 | 35.7 |
| | 18–25 years | 2328 | 46.2 | 96 | 57.8 | 18 | 64.3 |
| Location | Urban | 4639 | 67.5 | 57 | 33.7 | 8 | 28.6 |
| | Regional/remote | 2236 | 32.5 | 112 | 66.3 | 20 | 71.4 |
| Indigenous status[a] | Non-Indigenous | 3394 | 90.5 | 149 | 88.7 | 26 | 92.9 |
| | Indigenous | 355 | 9.5 | 19 | 11.3 | 2 | 7.1 |
| Country of birth | Australian | 5867 | 89.6 | 153 | 90.5 | 26 | 92.9 |
| | Overseas | 680 | 10.4 | 14 | 95 | 2 | 7.1 |
| Main language | English | 2576 | 98.1 | 154 | 91.7 | 25 | 92.6 |
| | Others | 51 | 1.9 | 14 | 8.3 | 2 | 7.4 |
| Living arrangements | Family | 3354 | 73.8 | 109 | 64.5 | 16 | 57.1 |
| | Others | 1190 | 26.2 | 60 | 35.5 | 12 | 42.9 |

Note: The proportions of young people in headspace dataset are not representative of the population of young people attending headspace.

a. Young people from Indigenous backgrounds were over-represented at headspace compared with the general population, but this result was skewed by a small number of sites with high proportions of Indigenous young people (ABS, 2008).

As data collection from the CYSs improves, better longitudinal evidence will become available for understanding the impact of headspace on young people's outcomes. But

[8] Although 26 sites are using MHAGIC, at the time of data collection, the headspace dataset only included data from 24 sites.

for this evaluation, what outcome data there is is only suggestive, and is drawn from a number of sources: the headspace dataset (where available); the interviews with young people, their families and service providers; and the survey data from the 169 young people in the ten in-depth CYSs.

### Service coordination study

This study investigated the type and extent of service coordination between practitioners within CYSs, and between CYSs and service providers in the broader community. Questions relating to service coordination were incorporated into the CYS and consortium/service provider surveys.

### Sustainability

As with the coordination study, questions relating to the risk and protective factors contributing to sustainability were incorporated into the CYS and service provider surveys and interviews. The sustainability findings can be found predominantly in Section 5.

### Secondary data analysis

A number of secondary data sources other than the headspace dataset were analysed in the evaluation. The National Youth and Parent Community Survey (NYPCS) was used to investigate the types of young people using headspace and attitudes towards mental health. Data collected about the MBS was analysed to assess changes in mental health service-use through the Scheme since headspace's inception. Both the 2006 Census of Population and Housing, and the 2007 National Survey of Mental Health and Wellbeing (SMHWB), were used as sources of information about the general population of 12-25-year-olds, in order to compare the young people using headspace with those of the same age in the general population. These datasets, and their use in the evaluation, are described in Appendix B: Additional methodological details.

### Meta-analysis

The meta-analysis addresses the headspace program as a whole. It compares the headspace logic model and evaluation hypothesis to the actual outcomes and contributions of the various headspace components. It brings together the findings from the evaluation to explore the extent to which headspace has met its objectives and why, as well as highlighting key lessons and recommendations in regard to the headspace model.

# 5 Service provision

headspace aims to improve young people's mental health, social wellbeing and economic participation. It intends to do this by providing youth-specific services and increasing the number of young people who receive these services (DoHA, 2008). Providing youth-specific services is critical to meeting headspace's broader aim because of the high prevalence of mental health disorders in this age group, the barriers they experience to accessing appropriate services, and the disabling nature of mental health problems.

The onset of adult-type mental disorders is most likely to occur between 15 and 24 years, with one in four 15-24-year-olds experiencing a mental disorder. Mental health problems are the leading cause of disability among young people (AIHW, 2007; Kessler et al., 2005). Yet adolescents with mental health problems are under-represented in their use of health services (Sawyer et al., 2007). Only around a quarter of young people with mental health problems access treatment, and fewer than 2 per cent receive help from mental health specialists (Sawyer et al., 2000).

The current mental health system largely caters for children (under 18 years) or adults (over 18 years) with diagnosed complex mental health problems that require intensive support. Where support is available, young people rarely receive holistic services even though mental health problems often coexist with other physical, social and emotional problems for young people, including substance abuse, long-term physical health issues, exclusion from education and/or employment, unstable housing and limited social support (AIHW, 2007; Hickie et al., 2004).

For these reasons, the headspace service model is multidisciplinary and aims to provide a range of services within one hub or physical location. The CYSs are the cornerstone of headspace, and they target four key areas – primary health, mental health, AOD treatment, and social and vocational support.

This section of the report examines the establishment of the CYSs, the services they provide, and the factors impacting on their establishment, implementation and sustainability, as well as addressing how these issues changed between Waves 1 and 2 of the evaluation.

## 5.1 CYSs establishment and opening

headspace established and opened 30 CYSs around Australia between 2007-2008. While all headspace sites were established and seeing young people by the end of 2008, they varied in the time they took between receiving funding, establishing their services, opening to young people, and becoming fully functional.

The first 10 CYSs were announced in February 2007 (Round 1) and the remaining 20 in January 2008 (Round 2).[9] All of the CYSs had opened and were providing services to young people by December 2008. The establishment of the CYSs took longer than

[9] A list of CYSs by name, location and opening dates can be found in Appendix C. Using the Australian Standard Geographical Classification (ASGC) Remoteness Structure, 18 CYS are in regional or remote areas and 12 are in urban locations. This distribution was a deliberate strategy from headspace, which was adopted to improve service access for young people in regional and remote locations.

anticipated and, at the time of the second wave of the evaluation, a number of sites were still in the process of implementing some aspects of the model. According to audit data,[10] Round 1 sites saw their first client on average 8.5 months after the funding announcement.[11] Round 2 sites had a shorter average establishment period of 6.6 months.[12] The Round 2 sites were established within a shorter time period because the model had become more embedded, funding guidelines and contractual requirements were clearer, and hNO was able to provide additional support. Regional and remote CYSs on average took approximately one month longer than urban sites to open (6.8 months and 7.6 months respectively, regardless of the funding Round).

While on average it took sites approximately seven months from announcement of their selection to the opening of their service to young people, it took sites longer to develop and provide a full complement of services. In fact, some CYSs had not yet reached this goal by Wave 2 of the evaluation. While some sites were expanding services by Wave 2, others were still recruiting practitioners as part of their initial attempts to become fully operational.

It would seem that sites need at least six months to become established, but a longer time period before they are fully operational.[13] It is likely that sites require 9-12 months to become fully operational, with 6-7 months needed for initial set-up and establishment and a further 3-6 months to recruit a full complement of staff and to refine and finalise policies and procedures. The evaluation found that, on average, the initial establishment phase did not vary markedly between urban and regional CYSs. However, it did find that remote sites required longer to recruit staff, and this was also the case in regional and rural areas where there were local shortages of particular practitioners.

## 5.2 Services provided within CYSs

This section uses audit data collected from all sites, and information from the in-depth CYS visits, to show that CYSs are developing multi-disciplinary teams of primary health and mental health practitioners, AOD workers, and social recovery support. As Table 5.1 shows, more than three-quarters of the CYSs provide at least three of the four core services. However, only a minority of sites (33%) have providers in all four areas, with expertise in physical health, mental health, alcohol and other drugs, and social/vocational participation.

[10] headspace Centre's Summary Briefing – Commercial in Confidence. February 2009.

[11] See Appendix C. Four of these sites saw their first client within six months, another three sites took between eight and nine months, and the remaining three sites 13-16 months to see their first client.

[12] Twelve sites took six months or less to see their first client, six sites took 7-8 months and two sites took 10 and 11 months.

[13] This will depend on the particular situation of each CYS. See Section 5.3.

**Table 5.1: Proportion of CYSs offering core service components by funding round (March 2009, %)**

| | Round 1 % (n=10) | Round 2 % (n=20) | All % (n=30) |
|---|---|---|---|
| Physical health | 80 | 80 | 80 |
| Mental health | 100 | 100 | 100 |
| Alcohol and Other Drugs (AOD) | 70 | 60 | 63 |
| Social/Vocational | 80 | 85 | 83 |
| At least three of four core components | 80 | 75 | 77 |
| All components | 40 | 30 | 33 |

## Primary health providers

The integration of primary health-care providers is central to the CYSs. Young people must receive a Mental Health Care Plan (MHCP) to enable them to receive MBS-funded psychological services. General Practitioners (GPs) have the responsibility for devising these Plans, which also help achieve a more seamless integration between primary and allied health providers. In addition, general medical services provide a pathway to service access for young people, as well as promoting early identification and intervention for those experiencing early-onset mental health problems.

In March 2009, audit data[14] showed that eight Round 1 CYSs and sixteen Round 2 CYSs had engaged GPs using the private practitioner model. Of those CYSs that had engaged GPs (and where data was available), the average full-time equivalent (FTE) was 0.4, ranging from 0.01 FTE to 2.1 FTE. These figures show that, over time, the CYSs have increasingly engaged GPs, since only nine CYSs had done so by June 2008. However, six CYSs had not yet recruited a GP by March 2009. Some of these were still struggling to attract available and appropriate practitioners because of the difficulty of recruiting GPs in particular regions. But it was also clear that, at least for one or two of these sites, recruiting a GP was not a priority.

## Mental health providers

By March 2009, all 30 CYSs had engaged mental health professionals (although to varying degrees). Mental health providers were either YMHI-funded AHWs, private practitioners funded through other sources, or co-located. As Table 5.2 shows, many sites had a combination of funding sources for their mental health practitioners providing services to young people.

[14] Ref: Reassessment reports, March 2009

**Table 5.2: Proportion of CYSs with mental health practitioners by type, funding source and funding round (March 2009, %)**

| Funding source | Type of mental health practitioner | Round 1 % (n=10) | Round 2 % (n=20) | All % (n=30) |
|---|---|---|---|---|
| YMHI AHWs | Psychologist | 80 | 85 | 83 |
| | Other mental health clinician | 80 | 70 | 73 |
| Private practitioners | Psychologists | 90 | 35 | 53 |
| | Psychiatrists | 50 | 30 | 37 |
| Other | Mental health clinicians | 50 | 40 | 43 |
| Co-located | Mental health | 50 | 35 | 40 |

Nine Round 1 sites and seven Round 2 sites had successfully engaged private clinical and/or counselling psychologists for between 0.05 FTE to 3.9 FTE (an average of 1.23 FTE for Round 1 and 1.06 FTE for Round 2 sites). By March 2009, psychiatrists had also been engaged by 11 of the CYSs for between 0.02 FTE to 0.3 FTE (an average of 0.11 FTE for Round 1 and 0.06 FTE for Round 2 sites), a substantial increase since June 2008, when only four sites had engaged psychiatrists.

The majority of CYSs utilised the YMHI AHW funding to engage mental health clinicians. By March 2009, 25 CYSs had engaged psychologist AHWs (ranging from 0.4 FTE to 3.6 FTE) and 22 CYSs had engaged other mental health clinicians[15] (ranging from 0.2 FTE to 2.2 FTE).

At thirteen CYSs mental health services were co-funded by other sources, for example, the Mental Health Nurse Incentive, Access to Allied Psychological Services (ATAPS), the More Allied Health Services program (MAHS), the Police and State mental health services. Twelve CYSs (40%) also had co-located mental health services[16].

### AOD workers

headspace has a strong focus on improving interventions in substance-use-related disorders and on promoting early intervention for young people experiencing substance use problems. Substance use disorders are particularly high in 18-24 year olds of both genders (ABS 1998; ABS 2006a) and mental illness and the use of alcohol and other drugs often coexist (Ministerial Council on Drug Strategy, 2004; NSW Health, 2008; Teesson and Byrnes, 2001). Service providers with expertise in this area are therefore an important asset for CYSs.

At March 2009, nineteen CYSs (63%) had AOD counsellors. Fifteen of these sites had their AOD counsellors co-located and the remaining four were employed with YMHI funding. This represents a substantial improvement since Wave 1 of the evaluation, when only nine sites had co-located AOD services.

[15] Other mental health clinicians included social workers, nurses, Indigenous workers, family support workers, occupational therapists, and group workers.

[16] See section on co-location in Section 5.3.

The audit data identified eleven sites with no AOD counsellors. This overestimates the number of sites without any expertise, since the audit data does not capture the AHWs and private psychologists with experience in AOD counselling who are employed in broader roles. The Wave 2 interviews showed that some sites do not have any expertise in AOD counselling. But it also showed that other sites are still in the process of negotiating arrangements, and that others have established local referral pathways for young people requiring this type of support.

**Social recovery and vocational support**

A central feature of the CYS model is the co-location of vocational assistance, welfare and other social recovery services. By March 2009, 25 of the 30 CYSs (83%) were providing social and/or vocational support within their service hubs.

Both the audit data and the in-depth interviews suggested that greater emphasis was being placed on vocational support than on social support. By March 2009, fourteen CYSs had co-located vocational assistance providers.[17] One CYS employed a vocational worker through headspace core funding, while others provide vocational support on an ad-hoc basis through YMHI-funded youth workers.

In the case of social recovery, a number of CYSs provided non-clinical recreational activities in cooperation with co-located services for young people. Four CYSs reported co-located social services, and YMHI AHW youth workers provided social support services as part of their role (24 CYSs had AHW youth workers).

As in Wave 1 of the evaluation, recreational programs and activities were regarded as an important early-identification strategy to engage young people (especially those under 16 years, the marginalised, those most 'at risk', and those reluctant to access health services) and for their social recovery (Davidson et al., 2001; Sane Australia, 2005). Yet there were still some CYSs with no group social support programs.

**Practitioner gaps**

CYS staff and practitioners were generally satisfied with the configuration of providers in their sites. There were, however, some challenges across the sites, and in both waves of the evaluation the most commonly reported was the need for more psychiatric services. Psychiatric expertise was important because the primary providers (the GPs) lacked expertise in the area of youth mental health, and they needed assistance to determine the appropriate medication for young people experiencing acute mental health problems.

Other practitioner gaps were less common, but more problematic. Sites without GPs, for example, were unable to provide MHCPs for young people, which meant they were not eligible for MBS-funded counselling sessions. While all sites had mental health practitioners by March 2009, those who only had YMHI-funded practitioners had very limited capacity to support the young people coming into the CYS with mental health problems.

[17] Usually one or two providers (with varying hours) supporting young people's economic participation and career planning.

At Wave 2, many of the gaps discussed in the in-depth interviews involved a scarcity of specialist practitioners[18] to enhance service provision, or limited numbers of existing practitioners (e.g. psychologists) to cope with the demand and reduce waiting-list times. This suggests that, by Wave 2, many CYSs were moving beyond the establishment phase and into further development as client numbers grew, as well as addressing ways of engaging hard-to-reach groups within the CYS communities.

## 5.3 Factors impacting on CYS establishment, implementation and sustainability

A range of factors have impacted on the establishment of CYSs and the implementation of the headspace service model. Qualitative and quantitative findings from both waves of the evaluation indicate that these factors can be broadly categorised as follows:

- the timeframe for establishment;
- local governance;
- funding;
- staffing;
- infrastructure;
- software; and
- the support available from the other headspace components.

These factors can be further characterised as:

- those affecting different phases of headspace (establishment, implementation and sustainability of CYSs);
- those which are operational (a result of how the model is delivered) ; and
- those which are structural (a result of the headspace model).

Dividing the factors up in a matrix specifying these three aspects of CYSs is important for future service provision and development. Table 5.3 lists the most important factors that help facilitate effective establishment, implementation and sustainability.

[18] For example, practitioners specialising in the younger age group (especially 12-14-year-olds), Indigenous and/or refugee youth workers, family counselors, sexual health workers, practitioners of both genders.

## Table 5.3: Most important factors for CYS establishment, implementation and sustainability

| | Phase | | | Type | |
|---|---|---|---|---|---|
| | **Establishment** | **Implementation** | **Sustainability** | **Operational** | **Structural** |
| **Timeframe for headspace (2006-09)** | ✓ | ✓ | | ✓ | ✓ |
| **Local governance** | | | | | |
| Consortium | ✓ | ✓ | ✓ | ✓ | |
| Lead agency | ✓ | | | | |
| Ability to provide resources | ✓ | ✓ | ✓ | ✓ | |
| **Funding** | | | | | |
| headspace core funding | ✓ | ✓ | ✓ | | ✓ |
| YMHI funding | ✓ | ✓ | ✓ | | ✓ |
| MBS funding | | ✓ | ✓ | ✓ | |
| Private practitioner fees | | ✓ | ✓ | ✓ | ✓ |
| Co-location fees | | | ✓ | ✓ | |
| Alternative sources (Government, charity, business) | | | ✓ | ✓ | |
| **Staff and practitioners** | | | | | |
| Administrative/business manager | ✓ | ✓ | ✓ | ✓ | |
| Clinical services manager | | ✓ | ✓ | ✓ | |
| Range of practitioners | | ✓ | ✓ | ✓ | |
| Private practitioners | | ✓ | ✓ | ✓ | |
| YHMI workers | ✓ | ✓ | ✓ | ✓ | |
| **Other resources** | | | | | |
| Infrastructure | ✓ | ✓ | | | ✓ |
| Software | | ✓ | | | ✓ |
| **Support from components** | | | | | |
| headspace National Office (hNO) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Community Awareness (CA) | | ✓ | | ✓ | ✓ |
| Centre of Excellence (CoE) | | ✓ | | ✓ | |
| Service Provider Education and Training (SPET) | | ✓ | | ✓ | |

## Time

As the Interim evaluation report showed, the original three-year funding agreement with DoHA for headspace establishment, implementation and sustainability, placed substantial pressure on CYSs. This was largely because the establishment phase was more time-consuming than originally estimated. As the Interim report described, this phase took approximately seven months because of the number of tasks involved, including locating and furnishing buildings, employing staff, recruiting private practitioners, engaging co-located services, developing agreements, policies, procedures and clinical governance frameworks, and establishing effective working relationships between the lead agency, the consortium (see below) and the CYS manager.

The pressure to open as quickly as possible had a negative impact on CYSs with fewer resources in relation to the type and availability of services, the turnover of staff, and/or the environment in which services were delivered. CYSs that coped well with the short establishment phase were those who were able to access additional resources and supports from their lead agencies and consortium partners. Sites with fewer resources to draw on early in the establishment phase continued to be considerably disadvantaged during implementation.[19] They took longer to establish a holistic, coordinated, evidence-based, youth-friendly service across all four key areas of service provision.

The initial three-year government funding timeframe was a structural constraint. This was further compounded by operational delays in the start-up of the initiative. Together these factors placed pressure on CYSs until further funding for 2009-2012 was announced by DoHA in December 2008.

## Lead agencies and consortiums

*Lead agencies*

At Wave 2 of the evaluation, eighteen of the CYSs had the local Division of General Practice (DGP) or the General Practice Network (GPN) or Association (GPA) as their lead agency. The remainder were led either by NGOs (n=8), by groups within universities (n=3), or by local government (n=1). Two of the CYSs changed their lead agencies between Waves 1 and 2 of the evaluation, thus demonstrating that this is possible (e.g. if an organisation withdraws support, or if circumstances or needs change).

As the Interim Report outlined, lead agencies with experience delivering services and who were not just organising bodies (such as NGOs), had an advantage in the establishment phase because they had access to the knowledge and resources necessary to develop appropriate policies and procedures.[20] However, once sites were established, these traits became less important. Strength in organisational governance, and access to financial resources and experience with attaining them, became more

[19] Each of these issues is discussed in the relevant Sections below.

[20] As the Interim Report recommended, it is important for hNO to have the capacity to assist newly established CYSs with the development of policies, procedures and frameworks.

valuable to CYSs during implementation and in their efforts to remain sustainable. Thus by Wave 2 of the evaluation, sites with a GP-related organisation as their lead agency had an advantage over those led by a NGO. Overall, however, it was the traits of the organisation, and the commitment and support it provided to the CYS, rather than the type of organisation, that was most important.

CYSs continued to receive very different levels of support from their lead agencies (depending on the lead agency's capacity, availability, skill-set and generosity). At Wave 2 of the evaluation, CYSs were generally less dependent on lead agencies, but they still played a critical role in supporting the CYSs, especially in the provision of resources. Some lead agencies took substantial financial risks, for example, by renewing staff contracts for six months towards the end of the headspace funding period and before new funding had been announced.

Other lead agencies struggled as the needs of the CYSs changed over time. Some became more aware of the responsibilities involved in their role and increasingly uncertain about their capacity to continue. At Wave 2 of the evaluation, for example, some lead agencies had only recently learned that they shouldered full legal responsibility for the CYS, a fact that had not been clearly understood when they originally took on the role.

*Consortiums*

From a governance and strategic perspective, the smooth, efficient running of a CYS (particularly in the establishment phase), and promoting collaboration within CYS communities, required a highly functional consortium of partners which could make quick decisions about money, staffing and service philosophy. Having a consortium with a strategic, rather than an operational, focus had a positive impact on implementation and the development of a sustainable model.

The audit data showed that the size of the consortiums varied considerably between the CYSs, from four to 20 partners, with an average of 9.2 partners.[21] These partners were from a range of sectors – general health, mental health, education, youth, vocational and social welfare – and from both government and NGOs. The most highly functioning consortiums were those who had members representing a range of sectors. They were also those who did not have too many partners, since a large number of partners could hinder efficient decision-making.

In Wave 1, the following characteristics were found to facilitate effective consortiums and enable them to provide valuable support for the CYSs:

- a pre-existing relationship between key stakeholders;
- members representing state/territory government agencies, NGOs and the local DGP;
- roles that were clearly defined and transparent, together with a shared understanding of the CYS model and goals;
- a lead agency that encouraged the consortium to participate in decision-making;

[21] March 2009

- small steering groups in large consortiums, to facilitate effective and timely decision-making;
- formalised institutional agreements (to ensure that changes in membership did not significantly affect how the consortium members worked together);
- provisions for the CYS manager to make day-to-day operational decisions without constant oversight from the lead agency or the consortium; and
- the provision of adequate resources (infrastructure, policies and procedures for the operation of CYSs, and/or service delivery supports – clinicians, clinical governance, training).

Wave 2 of the evaluation found that these characteristics were still important, but two other important and related factors emerged:

- flexibility to modify or revise the consortium's terms of reference, their role or even the membership, to reflect the changing needs of the CYS; and
- changing the role of the consortium from the operational focus it needed in the establishment phase, to a more strategic focus on the future direction of the CYS.

At the end of the first contract period (June 2009), eighteen CYSs were considering reviewing the membership of their consortiums. Sometimes this was to ensure that the consortium membership and focus effectively matched the changing needs of the CYS, and sometimes it was to improve the effectiveness of the consortium (and sometimes it was both). This was particularly important because CYS needs changed with the shift from the establishment and implementation phases to sustainability.

Challenges and difficulties regarding the consortium arose for a number of reasons:

- if members were not fully engaged with the headspace initiative;
- if the lead agency did not enable the involvement of other consortium partners;
- if the lead agency micro-managed the CYS or did not display confidence in the CYS manager;
- if the lead agency did not have a health background or clinical knowledge; and
- finally, if there was confusion between the role of the lead agency and the CYS manager, in terms of accountability and responsibilities.

The majority of CYS staff who responded to the survey reported that they were satisfied with the governance of their consortium, but satisfaction decreased over time (the decrease was slight but significant – $p<0.05$). Seventy per cent of Wave 1 respondents (n=106) were satisfied compared with only 64 per cent of Wave 2 respondents (n=153). There was a higher level of satisfaction among CYS managers than among staff, with 77 per cent of managers (n=26) stating they were satisfied with consortium collaboration in Wave 1, increasing marginally to 78 per cent (n=27) in Wave 2 (Table 5.4). Dissatisfaction reflected the absence of some of the key facilitating characteristics listed above, as well as the need to revise the role of the consortium once the CYS had progressed from the establishment phase to implementation.

**Table 5.4: Satisfaction with collaboration between the consortium and CYS (CYS survey, %)**

| Resource | Wave | n | Very / somewhat unsatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| All CYS staff | Wave 1 | 106 | 16.9 | 13.2 | 69.8 |
| | Wave 2 | 153 | 15.7 | 20.3 | 64.0 |
| CYS managers only | Wave 1 | 26 | 15.4 | 7.7 | 76.9 |
| | Wave 2 | 27 | 7.4 | 14.8 | 77.8 |

Lead agencies and consortium partners played a critical role in providing resources to the CYSs. This role was important in both Waves of the evaluation and supported CYSs through the establishment and implementation phases, as well as increasing their potential for sustainability. Such resources included infrastructure, human resources and administrative support, operation of the sites and service delivery (such as providing clinicians 'on loan' to CYSs), clinical governance, training opportunities and financial assistance. Approximately half the survey respondents were satisfied with the resources provided by the consortium partners. At Wave 2, 60 per cent (n=139) were satisfied with facilities and infrastructure, 56 per cent (n=117) with electronic equipment, 52 per cent (n=115) with technical support, and 53 per cent (n=120) with software systems. These satisfaction rates are all slightly higher than those reported in Wave 1 (Table 5.5).

**Table 5.5: Satisfaction with resources from consortium partners (CYS survey, %)**

| Resource | Wave | n | Very / somewhat unsatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| Facilities/ infrastructure | Wave 1 | 101 | 25.8 | 22.8 | 51.5 |
| | Wave 2 | 139 | 20.9 | 18.7 | 60.4 |
| Electronic equipment | Wave 1 | 84 | 21.5 | 31.0 | 47.7 |
| | Wave 2 | 117 | 17.9 | 26.5 | 55.6 |
| Technical support | Wave 1 | 83 | 25.3 | 28.9 | 45.8 |
| | Wave 2 | 115 | 24.4 | 23.5 | 52.2 |
| Software systems | Wave 1 | 81 | 29.7 | 29.6 | 40.8 |
| | Wave 2 | 120 | 23.4 | 24.2 | 52.5 |

## Funding

In both waves of the evaluation, CYSs were found to use a range of funding streams, mainly headspace core funding, YMHI AHW, MBS and private practitioners, and co-location. A diversity of funding sources is important for CYS sustainability, but the extent to which sites relied on funding sources varied. Some funding streams were more integral to the type of headspace model being implemented than others (Table 5.9).

The extent to which sites relied on any one funding source varied, and some funding streams were more integral to the headspace model than others (Table 5.9).

At Wave 1 almost two-thirds of CYS survey respondents (64%, n=119) reported that they were satisfied with the amount of funding (Table 5.10). However, by Wave 2 this had decreased to just over half (55%, n=167). Similarly, the proportion of those dissatisfied with the funding increased from Wave 1 (15%) to Wave 2 (36%) (the remainder were neutral).

The significant difference ($p<0.01$) between Wave 1 and Wave 2 responses reflects the timing of Wave 2 data collection, which occurred when CYSs were waiting to find out whether their contracts would be renewed and what the new funding allocations would be. Many CYS staff thought that their funding had been cut between the first contract period (2006-09) and the second (2009-12). However, total funding allocations were actually very similar for 2006-09 and 2009-12. What changed, and placed CYSs under pressure, was that the delay in funding announcements and slow establishment phase meant CYSs had a relatively shorter period of time in which to spend their 2006-09 funding. Thus the new funding may require CYSs to review and change their business models.

Although different funding sources are more or less useful depending on the model adopted by each site (Table 5.9), a mix of funding sources increases the likelihood that services will be diverse and sustainable. While the financial data is currently limited to a six month period, preliminary findings show that the ten sites seeing the largest numbers of young people are attracting higher total revenue and have a wider variety of funding sources than CYS sites in the moderate or low categories (Table 5.7). As a consequence, this group tended to be less reliant on hNO core funding than the moderate to low sites. This is largely a result of implementing the private practitioner model and attaining funding from the MBS.

**Table 5.6: Proportion of revenue by source (July-Dec 08) for CYSs by the number of young people seen since opening**

| | **High (n=10, %)** | **Moderate (n=9*, %)** | **Low (n=8*, %)** |
|---|---|---|---|
| headspace National funding | 38.5 | 76.0 | 69.6 |
| MBS rebates - patient consultations | 7.3 | 0.0 | 0.0 |
| YMHI (Allied Health Services) | 16.2 | 9.3 | 19.8 |
| Rollover | 33.2 | 9.6 | 8.8 |
| Other | 4.8 | 5.1 | 1.9 |
| Total | 100 | 100 | 100 |

* The only sites included are those for which detailed financial data was available for July-Dec 08

As long as they diversify their funding sources, the sites seeing the largest numbers of young people will probably be able to cope with the reduction in core funding for the 2009-2012 funding period, and they are likely to become increasingly sustainable over time. However, it is unlikely that CYSs would be able to adopt a business model

requiring no core funding at all. This is especially the case if headspace is to remain a public service accessible to all young people.

These findings also have implications for smaller and remote sites. Remote sites require a different funding structure, since they do not have the opportunity to diversify their funding sources and attract high numbers of young people like urban and regional locations. These sites will require ongoing high proportions of core funding.

By Wave 2 of the evaluation, qualitative and quantitative data showed that CYSs were using a slightly wider range of funding sources, including funding and in-kind support from consortium partners, especially lead agencies (see also Section 5.3), and state/territory government departments. Some sites were also using a wider range of MBS items than in Wave 1, not just Better Outcomes in Mental Health, but also items such as case conferencing (which require GPs to coordinate and maintain involvement in young people's care). Finally some sites were also exploring alternative sources such as Australian Government and philanthropic grants.[22] A number of CYS managers thought that additional funding could be obtained by charging external service providers training fees. However, several CYS practitioners in the in-depth evaluation believed hNO was not in favour of this option. Given that some sites have not managed to acquire alternative funding sources, it may be appropriate for future training to target effective use of resources and improved integration with key national primary care projects such as the Closing the Gap initiative.[23]

*headspace seed and YMHI funding*

headspace seed money and YMHI funding are essential for CYS establishment and implementation. Core funding was used to physically establish the CYS and to fund the CYS manager and other administrative staff. YMHI funded AHWs provided CYSs with practitioners to carry out core service delivery and staff who could perform essential activities, such as administration, clinical governance and service integration. YMHI-funded positions act as an essential link between young people and other staff and services, particularly headspace private practitioners, and as such, are seen by staff as a critical part of CYS sustainability.

At Wave 1, the evaluation team found that YMHI funding presented a challenge in regard to its allocation via the DGP regardless of whether or not they were the lead agency. In sites with a lead agency other than the local DGP, the arrangement whereby funding was split between the DGP and the other lead agency was not easy to implement in practice and resulted in some difficult relationships within the consortiums.[24] However this was not a significant issue at Wave 2 after the allocation of funding was complete. Changes to the funding model, whereby YMHI funding will be directed to the CYSs via hNO, should solve this problem.

*Private practitioners*

[22] Grant applications were made to The Myer Foundation, The Victorian Women's Trust, the Department of Veterans Affairs, and The Tobin Brothers Foundation.

[23] For additional information on training, see also Section 7.4 and Section 9.4.

[24] The role of the DGP was also important for engaging GPs in headspace.

Private practitioner fees (through rent or other administration costs) may contribute to a long term sustainable business model. While this is suggested by hNO, it is also acknowledged that not all sites will have the workforce availability to charge private practitioners. The only comprehensive financial data available (July – December 2008) does not record any revenue from private practitioners, but by mid-2009 some sites had started charging private practitioners rent and administration fees. While eight of the CYSs involved in the in-depth evaluation were using private practitioners, only two were generating income by charging rent and/or an administrative fee. The other sites either paid private practitioners through the MBS system, or directly employed private practitioners and reclaimed these wages via MBS fees. The former decreased CYS overheads, but the latter secured practitioners (by ensuring stable hours for CYSs and income for private practitioners if young people did not show up). However, employing private practitioners was only financially sustainable for those CYSs with large numbers of young people or sites able to attract large numbers of young people.

Many sites had offered 'rent free' or 'fee free' periods to attract and engage private practitioners in headspace. Most continued with this practice into 2009 fearing that private practitioners might leave to go to more lucrative practices, or that fees would be transferred to clients. These fears proved groundless for the sites that started charging private practitioners between evaluation waves. Both the managers and the private practitioners within the two CYSs charging fees reported that this model had benefits. It benefited the CYSs by providing steady income, and hence assisted with sustainability and defrayment of increasing administration costs. The private practitioners benefited from the infrastructure (building and administration), the collegial team atmosphere, and the steady stream of young people, while at the same time paying fees that were much less than those charged by other private practices.

Indeed, both the fee-paying and the non-fee-paying private practitioners working in the eight in-depth evaluation sites identified positive factors and motivators for their ongoing affiliation with headspace. These included:

- a general interest in young people's mental health and a commitment to the headspace philosophy;
- an opportunity to work outside their usual/core area of work;
- a collaborative style of working (coordinating services with other headspace staff);
- engaging with a different client group (young people, early intervention);
- more space and time to think about the links between physical and mental health (particularly for GPs); and
- an attractive business proposition, with few overheads, an existing client load and administrative support.

Nonetheless, rent-free and fee-free periods were important for initially engaging private practitioners in Wave 1 of the evaluation, while headspace was building its capacity and reputation. This was less important by Wave 2 because the benefits of working in headspace CYSs had been demonstrated. Further evaluation in a number of different sites will be required to understand the longer-term impact of charging private practitioner fees, but the case studies suggest that fears around charging private practitioners small fees may be unfounded.

*Co-location*

The audit data indicated that almost all the CYSs (29 sites) had co-located with other services to varying degrees. The number of services co-located with any one CYS ranged from one to nine, with an average of 3.1 across all CYSs (Table 5.7). The number of sessions available also varied considerably. Two sites had only sessional services, while co-located services at the other 27 sites varied from 0.05 FTE to 45 FTE.[25]

**Table 5.7: Co-located services by round and type**

| | Round 1 (n=10) | Round 2 (n=20) | All (n=30) |
|---|---|---|---|
| Average no. co-located services | 2.8 | 3.25 | 3.1 |
| Proportion of CYSs with following types of co-located service providers: | | | |
| Physical health | 30% | 30% | 30% |
| Mental health | 50% | 35% | 40% |
| Alcohol and other drugs | 50% | 50% | 50% |
| Vocational | 40% | 50% | 47% |
| Social | 0% | 20% | 13% |
| Other | 50% | 50% | 50% |

As Table 5.7 shows, agencies specialising in alcohol and other drugs, and vocational services and mental health, were the ones most likely to be co-located. Mental health co-located services usually specialised in a specific area, such as family counselling. Almost one in three sites had a service co-located with a physical health focus, mainly sexual health. The 'Other' co-located organisations included Centrelink, youth homelessness services and youth legal services.

Co-location took different forms, with most CYSs sub-letting space in their buildings to other service providers. However, some CYSs rented space that was shared with other service providers and managed by another service. Both of these models had advantages and disadvantages. For example, CYSs renting shared space did not need to seek out other services for co-location, but they had limited control over infrastructure issues or the services they shared their space with. Furthermore, some respondents in the in-depth study interpreted co-location in terms of individual practitioners, who were often staff provided or funded by consortium partners. This was important in terms of additional resources and effective integration of services, but it did not constitute a whole service co-locating with headspace.

Over two-thirds of CYS staff and around half of the service providers believed that co-location was mostly or always helpful. Survey respondents' views did not change

[25] 10 CYSs had less than 1 FTE co-located, 9 CYSs had 1-10 FTE, 3 CYSs had 11-20 FTE, 3 CYSs had 20-45 FTE, 2 CYSs had sessional co-location and for 1 CYS there was no information about time.

substantially between Waves 1 and 2.[26] In both Waves, the benefits of co-location were perceived in terms of additional resources and an added diversity of skills and services. It was felt to be particularly effective if the co-located services were integrated into headspace and referral pathways were strong (both into and out of headspace) and to the benefit of young people. Staff in the in-depth study suggested young people were more likely to go to the on-site services they were referred to or that were recommended to them, than to services further afield.

However, for a range of reasons co-location was sometimes problematic and challenging:

- if there was a shortage of space for the co-located services;
- if relationships between headspace and the co-located services were weak (just because services were co-located did not necessarily mean practitioners collaborated or coordinated their services);
- where the expectations of the co-locating services were too high (e.g. for administrative support); and
- where the CYS had limited control over the shared space (in terms of how the building could be used and accessed).

It is important that headspace provides resources (financial and/or personnel) to ensure that co-location is mutually beneficial and that it does not become merely another siloed service.

*Sustainability and funding*

The diversification of funding sources assisted to increase the number of CYS managers who believed that their site was sustainable. Overall, however, sustainability of sites was still largely reliant on core funding.

Almost one in three CYS managers (32%, n=28) felt that funding from sources other than headspace were somewhat or very sustainable, compared to 23 per cent of Wave 1 CYS managers (n=26). Although this shows that potential for sustainability has increased between Waves 1 and 2 of the evaluation, 39 per cent of managers responding to the survey still felt that other funding sources were unsustainable at Wave 2 (Table 5.8).

**Table 5.8: Sustainability of funding for headspace site (i.e. getting funding from sources other than headspace, e.g. private practice) (CYS managers, %)**

| Wave | n | Very / somewhat unsustainable | Neutral | Somewhat / very sustainable | Don't know |
|---|---|---|---|---|---|
| Wave 1 | 26 | 53.8 | 11.5 | 23.1 | 11.5 |
| Wave 2 | 28 | 39.3 | 21.4 | 32.1 | 7.1 |

[26] 73 per cent of CYS staff in Wave 1 perceived that co-location was mostly or always helpful, decreasing to 70 per cent in Wave 2. Among service providers, 49 percent thought co-location was helpful in Wave 1, compared to 48 per cent in Wave 2.

Without ongoing core funding to cover unfunded activity, such as administrative costs, rents and outreach work, the financial sustainability of CYSs would be threatened.

*Funding models*

The funding model adopted by CYSs depended on a number of factors, including: the capacity and background of the lead agency (e.g. service delivery focus); the composition of the CYS consortium; the availability of and knowledge about resources; and the geographic area (i.e. urban, or regional, rural or remote).

Whatever the funding model adopted, core funding from headspace is essential for CYS management, administrative and overhead expenses. However, the level of importance of the different funding sources varies according to the type of model implemented. For example, CYSs providing the one-stop-shop clinical and non-clinical service model advocated by hNO rely on all the sources of funding (core, private practice/MBS, co-location and YMHI). CYSs implementing a health-based service model are less reliant on co-location. Similarly, in remote and some rural areas where CYSs predominately offer outreach services, co-location is less important, but so too is the private practitioner component (the travel costs make an MBS-funded private practitioner model prohibitive) (Table 5.9).

**Table 5.9: Implementation of the CYS model and the extent to which funding sources are part of the model**

| | headspace core funding | Private practice/ or appropriation of MBS funding | Co-location | YMHI funding |
|---|---|---|---|---|
| One-stop-shop (clinical and non-clinical service focus) | ✓✓ | ✓✓ | ✓✓ | ✓✓ |
| Multi-disciplinary youth health centre | ✓✓ | ✓✓ | ✓ | ✓✓ |
| Psychological outreach services | ✓✓ | - | ✓ | ✓✓ |

✓✓ - funding stream is central to the model; ✓ - funding source is less important to the model, (-) - funding source is marginal to the model.

## Staff/ practitioners

As already indicated, the number, range and skills of staff and practitioners had a significant impact on the establishment and implementation of CYSs.[27] The majority of CYS respondents (Wave 1, 81%, n=127; Wave 2, 88%, n=203; Table 5.10) were satisfied with the staff skill-set within their site. A further 58 per cent of Wave 1 (n=128) and 69 per cent (n=202) of Wave 2 CYS respondents were also satisfied with their staff numbers.

[27] See Section 4.2 for the role and mix of staff.

**Table 5.10: Satisfaction with resources (CYS survey, %)**

| Resources | Wave | n | Very / somewhat unsatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| Amount of money allocated* | Wave 1 | 119 | 15.1 | 21.0 | 63.9 |
| | Wave 2 | 167 | 36.0 | 9.6 | 54.5 |
| Skill set of staff | Wave 1 | 127 | 13.4 | 5.5 | 81.1 |
| | Wave 2 | 203 | 7.4 | 4.9 | 87.7 |
| Number of staff | Wave 1 | 128 | 36.7 | 5.5 | 57.8 |
| | Wave 2 | 202 | 26.2 | 5.0 | 68.8 |
| Facilities/infrastructure** | Wave 1 | 129 | 35.6 | 7.0 | 57.3 |
| | Wave 2 | 205 | 22.9 | 4.4 | 72.7 |
| Electronic equipment | Wave 1 | 124 | 16.1 | 8.9 | 75.0 |
| | Wave 2 | 195 | 12.3 | 6.2 | 81.6 |
| Software systems (including MHAGIC) | Wave 1 | 126 | 33.3 | 8.9 | 54.8 |
| | Wave 2 | 189 | 28.0 | 6.2 | 59.2 |
| Technical support | Wave 1 | 122 | 23.7 | 16.4 | 59.8 |
| | Wave 2 | 177 | 18.1 | 17.5 | 64.4 |

*p<0.01; **p<0.05 (Chi-square test)

Although the difference between Wave 1 and Wave 2 responses is not statistically significant on either of these measures, the increase in satisfaction with both staff skill-sets and numbers reflects real increases in both staff numbers and types, which have occurred as CYSs have become more established.

*Management*

Waves 1 and 2 of the evaluation showed that having highly skilled CYS managers was crucial for efficient and effective establishment and implementation. CYSs varied in the type of manager they employed. As Table 5.11 shows, three in four CYSs had a clinical manager or coordinator (usually a Clinical Services Integration Manager), and two in three had a business manager.

**Table 5.11: CYS managers by type and round (March 2009, %)**

| | Round 1 (n=10) | Round 2 (n=20) | All (n=30) |
|---|---|---|---|
| Business Manager only | 80% | 60% | 67% |
| Clinical Manger/Coordinator only | 100% | 65% | 77% |
| Business manager and clinical manager | 80% | 30% | 47% |

Almost half the CYSs had both clinical and business managers. Due to the expense of employing two managers, this most frequently occurred in the larger sites. Sites with both managers benefited from the two distinct skill-sets. Sites with only one manager, whether clinical or business, often struggled to fulfill the governance needs of the CYS effectively, since both forms of management are essential to the successful implementation and sustainability of a site. The in-depth study, for example, showed that administrative managers were particularly effective at implementing management and financial systems, developing partnerships, and liaising with the consortium,

while clinical managers were more successful in developing clinical governance, promoting evidence-based practice and integrating private practitioners into the headspace team. The evaluation has shown that, where feasible, sites should have expertise both in business and in clinical governance. Where capacity does not support two roles, the CYS may require greater support from hNO.

Without business skills such as staff management, change implementation, relationship building and negotiation with partners, and financial management and the ability to meet contractual agreements, CYSs struggled in the establishment and implementation phases (in both Waves of the evaluation). In some cases, where these skills and the appropriate support did not come from the consortium and hNO, high stress levels ensued and staff retention was poor.

Wave 2 also showed that the role of the manager was critical for the development of both internal and external relationships, and for shaping the local headspace culture, for example, how valued and supported staff felt. Approximately three-quarters of service providers felt that leadership from the manager of their local CYS promoted effective partnerships (72% in Wave 1 increasing to 75% in Wave 2).[28] These factors are subsequently likely to impact on the CYSs' capacity for sustainability, highlighting the significant contribution managers can make to the ongoing development of CYS sites.

*Recruitment of practitioners and AHWs*

To enable CYSs to provide the intended range of services, it is essential that they be able to recruit key practitioners and staff members. Most sites opened without a full complement of staff, but they continued to employ additional staff as the need arose. As implementation progressed between Waves 1 and 2 of the evaluation, most CYSs continued to increase the number and range of staff at their sites. However, sites in remote areas and in some regional areas continued to find the recruitment of certain specialist staff more difficult than sites in metropolitan locations.

The most successful sites were those with a mix of GPs, psychologists, social workers and AHWs with a range of expertise (such as AOD, family therapy, anger management or Cognitive Behavioural Therapy). Sites with fewer staff were disadvantaged in their capacity to provide appropriate, effective and/or holistic support for young people, especially when they did not have access to GPs and/or psychologists. As noted earlier, many CYSs also reported needing more psychiatric expertise to support primary providers to determine appropriate medication and referral pathways for young people experiencing acute mental health problems.

YMHI-funded AHWs were also a critical to the success of CYSs. They were a stable resource because they were readily available to provide continuity of care and assist with service accessibility (engagement, assessment and intake), and service provision and integration. They were also active in establishing referral pathways and conducting outreach. They provided the essential link between young people and other staff and services, particularly headspace private practitioners, and as such, were seen by staff as a critical part of CYS sustainability. The AHW access and

[28] 72 per cent in Wave 1 (n=232) increasing to 75 per cent in Wave 2 (n=212).

coordination role is a core component of the headspace model, and sites benefit most when the AHWs have a background in mental health.

**Other resources**

*Infrastructure*

Infrastructure, especially the ability to obtain, rent and appropriately renovate premises, was a major issue for CYSs, impacting primarily on the establishment phase and the time it took for sites to open. At Wave 1, almost all the CYSs in the in-depth study had been successful in obtaining accessible and youth-friendly locations by occupying buildings in key streets or community areas. However, this was usually at substantial cost, mainly for rent, and sometimes accounted for a large proportion of the core funding. Where this was the case, CYSs were concerned about their ability to sustain these high rents. Other CYSs were able to benefit from co-location, but these buildings were not always adequate in size or location.

While infrastructure was primarily an establishment issue, lack of appropriate space impacted on CYSs' capacity for ongoing effective implementation. For example, a number of the CYS sites in the in-depth evaluation were in buildings already at capacity, leaving no room for future expansion or co-location. Moreover, initial building fit-outs were not always sufficient for service delivery. A lack of sound-proofing of consultations rooms was reported by practitioners in a number of sites, and one site had opened without an appropriate GP fit-out. These issues were valid in both Waves of the in-depth evaluation, although satisfaction with facilities and infrastructure increased significantly ($p<0.05$) between Wave 1 of the evaluation (57% of CYS respondents, n=129) and Wave 2 (73% of respondents, n=205) (Table 5.10).

*Software*

As clinical primary health centres, CYSs require electronic software systems as an important part of their daily operation. CYSs face more challenges than other health service clinics because the nature of the work requires software for a number of different purposes, not only GP and allied health consultations and billing but also reporting to hNO. At Wave 1, the headspace electronic medical record and data collection tool, MHAGIC (used to compile the headspace dataset), had been installed in 22 of the 30 CYSs. By Wave 2, 26 CYSs were using MHAGIC. The remaining four sites used alternative software.[29] At least twelve of the sites were using MHAGIC in combination with other software, for example, for GP billing.[30]

By Wave 2 almost two-thirds of CYS respondents were satisfied with the available software systems (Wave 1, 55%, n=126; Wave 2, 59%, n=189) and technical support (Wave 1, 60%, n=122; Wave 2, 64%, n=177) (Table 5.10). While satisfaction did increase slightly over time, some CYSs were still experiencing challenges in establishing feasible processes for data entry and data checking. There was also a

[29] Alternative software used at the CYSs included Profile, The Care Manager and Communicare

[30] Additional software, used in combination with MHAGIC, included Medical Director, PracSoft, Mediflex, Communicare, Best Practice, Medical Message Exchange (MMEx) and Practix

need for ongoing affordable training in the use of the systems, both for new staff and for building the skills of current staff. Another problem reported by CYS staff involved delays in establishing MHAGIC. This impacted on implementation and left some CYSs with a back-log of data entry. Other challenges reported by several sites in Wave 2 of the evaluation included incompatibility between MHAGIC and other software programs, concerns about its confidentiality, and the time-burden of data entry. The slight increase in satisfaction from Wave 1 to Wave 2 of the evaluation, however, suggests that challenges around software systems are being slowly improved.

The challenges people were experiencing with MHAGIC were reflected in the fact that there was substantial missing data from some sites and for certain variables. For example, at Wave 2, data was only available from 24 of the 26 sites using MHAGIC and 29 per cent of MHAGIC data was from just two CYS sites. A sizable amount of data was missing for basic demographics such as country of birth, accommodation status and educational achievement. Substantial data was also missing from important variables concerned with involvement in headspace, such as occasions of service, source of referrals, diagnosis and the Kessler 10 psychological distress scale (K10). Even basic information, like age and sex, were missing in some records. If these challenges can be addressed and consistent data is collected and entered into MHAGIC, this software will be an important tool and a valuable evaluation resource. Introducing a new data software system to a large number of sites always involves complexities, especially when it requires some refining. As a result, the data quality could not be expected to be high within the initial contracting period of headspace, but should improve with time.

By Wave 2, some CYSs had begun to see the tangible benefits of MHAGIC. In particular, it assisted sites with the integration of services. For example, practitioners had started to use MHAGIC for client history and information about other headspace services a young person received. The future success of MHAGIC will depend on the availability and quality of training and support, as well as the commitment of CYS staff. This should be significantly assisted by the new data management role within hNO and the supply of individual site reports to CYSs (which will help to demonstrate the value of data collection).

### Support from components[31]

The components played varying roles at the establishment, implementation and sustainability stages of headspace. hNO played a key role in funding, establishment and implementation of the CYSs. At Wave 1 of the evaluation, CYSs overwhelmingly reported receiving little or no practical support from the CoE, the CA (BMRI) and SPET programs. By Wave 2, the role of the other components in supporting the CYSs had developed substantially.

[31] For additional information about the role of the headspace components at the national level, see Section 9.

**Table 5.12: Satisfaction with headspace components (CYS survey, %)**

| | Wave | n | Very / somewhat unsatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| headspace National office | Wave 1 | 103 | 25.2 | 25.2 | 49.5 |
| | Wave 2 | 140 | 37.1 | 25.0 | 37.9 |
| Service Provider Education & Training* | Wave 1 | 101 | 32.7 | 18.8 | 48.5 |
| | Wave 2 | 169 | 15.4 | 17.2 | 67.5 |
| Community Awareness** | Wave 1 | 115 | 19.1 | 13.9 | 67.0 |
| | Wave 2 | 178 | 8.4 | 15.7 | 75.8 |
| Centre of Excellence | Wave 1 | 90 | 23.3 | 32.2 | 44.4 |
| | Wave 2 | 144 | 13.9 | 27.8 | 58.3 |

*p<0.01; **p<0.05 (Chi-square test)

*National Office (hNO)*

hNO played a vital role in the establishment and early implementation of the CYSs. They developed the funding and assessment guidelines, negotiated contracts, developed reporting structures and key performance indicators, and provided supports, policies and tools (such as partnership documentation, memorandums of understanding, governance and clinical governance guidelines and a business model guide). They also provided some of the youth and carer participation resources.

At Wave 1 of the evaluation, 68 per cent of CYS managers (n=25) reported that they were satisfied with hNO collaboration (Table 5.13). At this time, a number of managers said that this relationship had improved substantially since the beginning of the initiative, although sites that had experienced difficulties in establishment and implementation tended to report strained relationships with hNO. By Wave 2, tensions had developed in the relationship between CYS managers and hNO, in part as a result of funding issues, and reports of satisfaction with the collaboration had decreased to just 42 per cent (n=26). CYS managers identified problems such as poor communication from hNO (too much, not enough, inappropriate), an authoritarian approach to management, an unequal partnership that was not conducive to collaboration, and arduous reporting requirements without feedback.

In both waves, there were CYS staff and managers who criticised hNO for pushing standardisation across all CYSs. These stakeholders wanted hNO to recognise the particularities of their local situations and the contexts within which they were working (e.g. urban/regional, the socio-economic status of the area, the availability of other services and practitioners, the extent of government support). At the same time, there were other sites whose staff and managers called for more standardised guidance from hNO in terms of policies, procedures and clinical governance. These tended to be those sites which had struggled in the opening and implementation phases. Furthermore, tension existed between managers and hNO when the managers felt they were being criticised for not complying with the headspace model, despite the lack of an explicitly defined model to conform to. However, in Wave 2 there was a consensus on the part of both CYS managers and government representatives that hNO needed to adopt more flexible approaches which maintained minimum standards but which also enabled CYSs to shape their own directions in response to their local contexts.

It is inevitable in any new program that there will be conflict between local providers and central managers. The challenge for hNO is to communicate the benefits of being part of a national initiative and find a balance between defining a model and maintaining context specific flexibility.

**Table 5.13: Satisfaction with headspace components (CYS managers, %)**

| | Wave | n | Very / somewhat unsatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| headspace National office | Wave 1 | 25 | 20.0 | 12.0 | 68.0 |
| | Wave 2 | 26 | 46.2 | 11.5 | 42.3 |
| Service Provider Education & Training | Wave 1 | 26 | 38.5 | 23.1 | 38.5 |
| | Wave 2 | 28 | 25.0 | 14.3 | 60.7 |
| Community Awareness | Wave 1 | 25 | 20.0 | 16.0 | 64.0 |
| | Wave 2 | 28 | 21.4 | 32.1 | 46.4 |
| Centre of Excellence | Wave 1 | 23 | 21.7 | 43.5 | 34.8 |
| | Wave 2 | 28 | 21.4 | 35.7 | 42.9 |

Overall, hNO will continue to play an important role in the continued implementation and sustainability of headspace CYSs. Improving the relationship between hNO and CYSs will substantially assist both parties to achieve the goals of the headspace initiative in a timely and most effective manner.

*Community Awareness (CA)*[32]

The CA activities of the CYSs were an important part of the implementation phase, and were supported by the CA component at BMRI and by the hNO Media, Communications and Marketing team. After Wave 1 of the evaluation, the BMRI continued to assist CYSs in planning local awareness activities and by providing feedback on CA strategy drafts. Interestingly, managers' satisfaction with collaboration between CA and CYSs decreased between Waves 1 and 2, from 64 per cent (n=25) to 46 per cent (n=28) (Table 5.13), as did satisfaction among repeat respondents (Table D.13). Although in the case of CYS staff, satisfaction increased from 67 per cent (n=115) to 76 per cent (n=178) (Table 5.12). Indeed, most staff and managers still felt they were able to effectively utilise the materials provided by hNO and CA, with 81 per cent of CYS managers (n=26) believing their site had effectively done so at Wave 1, increasing to 93 per cent of managers (n=28) by Wave 2 of the evaluation (Table 5.15).

The in-depth interviews revealed a mixed response regarding the branding and national marketing of the headspace initiative. Both managers and staff indicated that they were happy to be part of a national campaign and praised the usefulness and appropriateness of resources such as information sheets for young people and the national headspace website. However, a number of respondents said they had found that there was a need to tailor promotional materials to local populations, particularly in areas with high numbers of Indigenous youth. Some staff also thought it would

[32] For further information about the effectiveness of the community awareness campaigns in attracting young people to headspace, see Section 6.

have been beneficial to share resources and engage with other CYS sites in joint marketing across their state or territory. Moreover, there were a number of respondents who believed that there had been limited CA support provided to headspace sites. In some cases, national material was received after the sites had developed their own CA strategies and resources, making the national material limited in its usefulness.

**Table 5.14: Effectiveness of CYSs in utilising resources provided by headspace (CYS survey, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective | Not received resource yet |
|---|---|---|---|---|---|---|
| Utilising communication materials (hNO & CA) | Wave 1 | 116 | 13.8 | 9.5 | 71.6 | 5.2 |
| | Wave 2 | 186 | 5.9 | 8.6 | 82.3 | 3.2 |
| Utilising evidence-based information (CoE) * | Wave 1 | 113 | 13.3 | 21.2 | 52.2 | 13.3 |
| | Wave 2 | 175 | 5.1 | 12.6 | 80.0 | 2.3 |
| Utilising training packages (SPET) * | Wave 1 | 111 | 13.5 | 20.7 | 55.0 | 10.8 |
| | Wave 2 | 184 | 9.2 | 8.7 | 79.3 | 2.7 |

*p<0.01 (Chi-square test)

*Centre of Excellence (CoE)*[33]

By Wave 2 of the evaluation, CYSs had started to substantially benefit from CoE. Most stakeholders who had seen or used CoE resources praised the CoE outputs and the work that had gone into producing them. Respondents generally agreed that CoE resources were well researched, evidence-based and useful.

There was a significant increase in the perceived effectiveness of CYSs utilising CoE materials between Waves 1 and 2 of the evaluation. Only 52 per cent of staff (n=113) in Wave 1 had thought their sites effectively utilised evidence-based materials, compared with 80 per cent of staff (n=175) in Wave 2 (p<0.01) (Table 5.14), while only 39 per cent of managers (n=26) agreed with this in Wave 1, increasing to 79 per cent (n=28) in Wave 2 (p<0.05) (Table 5.15).

CoE resources have helped a number of sites engage with external practitioners and clinicians in CYS communities. They have enabled staff to inform other service providers about youth mental health and about what headspace has to offer them. Consequently, they have better equipped external providers to work sensitively and effectively with young clients, and made it more likely that other providers will refer clients to headspace where appropriate.

[33] For further information about how CYSs have implemented evidence-based services, see Section 7.4.

**Table 5.15: Effectiveness of CYSs in utilising resources provided by headspace (CYS managers, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective | Not received resource yet |
|---|---|---|---|---|---|---|
| Utilising communication materials (hNO & CA) | Wave 1 | 26 | 3.8 | 15.4 | 80.8 | - |
| | Wave 2 | 28 | 7.1 | 0 | 92.9 | - |
| Utilising evidence-based information (CoE) ** | Wave 1 | 26 | 15.4 | 26.9 | 38.5 | 19.2 |
| | Wave 2 | 28 | 10.7 | 10.7 | 78.6 | - |
| Utilising training packages (SPET) * | Wave 1 | 26 | 3.8 | 26.9 | 57.7 | 11.5 |
| | Wave 2 | 28 | 7.1 | 0 | 92.9 | - |

*p<0.01; **p<0.05 (Chi square test)

Despite increases in the effectiveness and usefulness of CoE resources, satisfaction with collaboration between CoE and CYSs was not strong, although it increased between Waves 1 and 2 of the evaluation (from 44% to 58% of staff satisfaction (Table 5.12), and from 35% to 43% of manager satisfaction (Table 5.13). Although respondents found interactions with CoE staff at collaborative learning network (CLN) meetings useful, in-depth data suggests some would have liked more input into the content of resources at the outset.

The main challenges around CoE materials centred on their usability. Some CYS practitioners were concerned that the target audience of many CoE resources was too broad. However, it is extremely difficult to target resources in a program like headspace which serves such a diverse range of practitioners, clients and carers with varying degrees of prior knowledge and capabilities. For example, younger headspace clients (12-13 years) are likely to have very different language and comprehension skills to older clients in the late teens or early twenties. Given the diversity both between and within these groups, it is difficult to find a balance between clarity and ensuring that resources are sufficiently detailed to be useful to those with prior knowledge of the subject. Staff working in sites with a high proportion of Indigenous service users, for example, felt that the materials were not well tailored to their clients. A focus on diversifying the 'translation' of CoE materials would therefore be useful for CYSs.

*Service Provider Education and Training (SPET)*[34]

Evidence from the sites involved in the in-depth evaluation indicates that the relationship between CYSs and the SPET component improved substantially between Waves 1 and 2. Satisfaction with collaboration with SPET increased from 49 per cent of staff and 39 per cent of managers in Wave 1, to 69 per cent of staff and 61 per cent of managers at Wave 2 (Table 5.12; Table 5.13). Managers' agreement that their sites' effectiveness at utilising SPET resources had improved also increased significantly

[34] For further information about the training and supervision of CYS staff, see Section 7.

($p<0.01$) between Waves 1 and 2 (from 58% to 93%) (Table 5.15). This is because SPET training modules were largely rolled out between Waves 1 and 2 of the evaluation.

The main concern expressed about SPET resources was the lack of flexibility to adapt the content and methods of delivery to local circumstances and needs. CYS staff also felt that the quality of individual training modules and specialist facilitators varied considerably; they were also concerned about the sites' future capacity to provide regular training. This is an important requirement due to high staff turnover. Staff from several CYSs in the in-depth study also perceived the training as a resource for bringing together a range of community providers, and for bonding with consortium partners and discussing referral pathways, as well as a 'great starting point' for challenging traditional ways of working and fostering service integration, with the eventual aim of promoting service reform.

## 5.4 Conclusion

This section has described the establishment of headspace CYSs and the range of services they provide to improve the mental and physical health, social wellbeing and economic participation of young people with mental health and substance use issues in their local communities. It has shown that the management, governance and resourcing of CYSs, along with hNO, have a critical impact on the time it takes to establish sites, the effectiveness of their implementation and their potential for sustainability. The other national components, CA, CoE and SPET, offered limited support to CYSs during the establishment phase, when they were also in the process of establishment. This support has increased through the sustainability phase and has been valuable for most sites. At this stage, sustainability is one of the main challenges facing CYSs and will only be achieved if sites have strong clinical governance to develop effective policies and procedures; a cost-effective model, that uses resources effectively and draws on a diversity of funding sources; some core funding, particularly to fund YMHI workers who play a crucial role in coordinating services; engagement within the community, particularly from other service providers and referrers; and demand for the service from young people. The following section examines this demand and factors impacting upon it in more detail.

## 5.5 Summary

*Key findings*

- headspace aims to provide multidisciplinary services to young people with mental health issues in 30 CYSs throughout Australia across four key areas: primary health, mental health, alcohol and drug use, and social and vocational support.
- On average it took CYSs seven months to open their services to young people and longer to provide a full complement of services, with no substantial differences between urban and regional CYSs.
- More than three quarters of CYSs were providing services across three of the four core areas, although only a third of sites had the full provision of services.
- Practitioner gaps were less common at Wave 2 than Wave 1, although six CYSs were yet to recruit GPs and engagement of psychiatrists was limited.

- A range of factors, structural and operational, have impacted on the establishment, implementation and potential sustainability of CYSs.

- Factors impacting on establishment included the tight-timeframe, the experience of lead agencies in delivering services, the capacity of the consortium to provide resources and support CYS managers, headspace core funding and YMHI workers, the ability to obtain, rent and renovate appropriate premises and support from hNO.

- Effective implementation depended on the consortium's ability to provide strategic direction, flexibility in the role of the consortium to reflect CYS needs, a mix of funding including MBS and private practice fees, practitioners representing all four areas, software to manage consultations, billing and reporting to hNO, appropriate space (with room to expand and soundproof clinical rooms) and support from hNO, CA, CoE and SPET.

- Key factors contributing to sustainability included effective clinical governance to develop appropriate policies and procedures, a diverse range of funding sources, and a full complement of staff.

*Lessons and recommendations*

- CYSs required 9-12 months to become fully operational, including 6-7 months for set-up and establishment and 3-6 months to recruit a full complement of staff and refine policies and procedures.

- Access to psychiatric services should be increased, or made available where there is currently no or limited provision, within CYSs in order to further support young people and to provide expertise and support to other practitioners.

- headspace seed funding is essential for most CYSs, but it is also important for sites to diversify their funding mix to increase the likelihood of sustainable services.

- The largest sites are likely to be able to cope with the reduction in funding between 2009 and 2012 by diversifying funding sources, and to become increasingly more sustainable over time.

- It is unlikely that CYSs would be able to adopt a business model that requires no core funding. This is especially the case if headspace is to remain a public service, which is accessible to all young people.

- CYSs in remote areas will require a very high proportion of core funding.

- Rent free and fee free periods were important for recruiting private practitioners, but initial findings indicate that fears around losing private practitioners if fees are charged are largely unfounded and fees could be an important source of revenue.

- Effective co-location requires collaboration and coordination between CYSs and the co-locating service. To ensure this, co-location should be beneficial to both

parties and for young people, and may require additional resources to guarantee that services do not become divergent.

- CYSs require expertise in business and clinical governance to operate effectively. CYS that do not have the capacity to employ a business and clinical manager may require greater support from their lead agency and hNO.

# 6 Service access

headspace aims to provide multidisciplinary services to young people predominantly in the early onset stages of mental health issues. This aim is part of a broader objective to prevent mental health disorders in young people becoming more severe (McGorry, Parker et al., 2007) and to fill a major service gap for 12-25 year olds in the existing mental health system. In an effort to fulfill this, headspace aims to attract young people at risk by targeting its services at all young people. A further goal of headspace is to promote help-seeking behaviour, since research has shown that many young people are reluctant to get help for mental health problems (DoHA, 2004; Rickwood et al., 2007).

In order to address the extent to which headspace is meeting these objectives, this section of the report explores the issue of young people's access to headspace. It starts by looking at the ways in which headspace is trying to attract young people and discusses what is known about the effectiveness of its community-awareness strategies. It goes on to examine the numbers of young people using headspace services, and their characteristics – mental and physical health, work and education status, relationships, and alcohol and other drug use – as well as what is known about those groups of young people who do not access the services. This section also investigates the factors that facilitate young people's access to headspace (e.g. community-awareness strategies, referral processes) and their ongoing engagement with it (e.g. youth-friendly services), as well as factors that could be discouraging young people from accessing and engaging with headspace (e.g. psychological barriers to help-seeking, the cost and opening hours of services, and waiting times to see practitioners).

## 6.1 Attracting young people to headspace

National and local CA strategies and campaigns are a key platform of headspace. They aim, not only to increase the number of young people accessing mental health services, but also to increase awareness of youth mental health problems more generally and to brand and market headspace.[35]

headspace has been active in national and local CA activities since its inception. At the national level there is the headspace website, the advertising campaigns via television and print and electronic media, and the provision of promotional materials and CA support to all CYSs. At the local level, each CYS has its own headspace page within the main website, which includes local contact details, awareness activities and newsletters. The national website is particularly important, as it has the capacity to reach and inform young people who do not have a CYS in their region.

At Wave 1, all the in-depth evaluation sites had conducted some CA activities, but this varied according to the implementation stage each had reached. By Wave 2 of the evaluation, most CYS sites had increased their involvement in CA activities since Wave 1. Twenty-five headspace CYSs were actively promoting headspace in local schools; this was seen to be one of the most important CA activities because it helped to access the target group (headspace, 2009a). Other CA strategies included: attending

[35] Further information about the role of hNO and BRMI in developing the national campaign and supporting local CYSs with their CA can be found in Section 5 and Section 9.

meetings and organising forums with service providers in the community; holding public forums on issues affecting young people (such as bullying); organising weekly radio programs; linking in with existing sporting events and programs; and having a presence at music and other festivals that attract young people. Nonetheless, word of mouth remained an important way of attracting young people to headspace in 2008 and 2009.

There are signs that CYSs will be able to engage in fewer CA campaigns in the future. In the 2009–2012 funding round, sites received a smaller amount of money than they had anticipated and, as a result, they now have to make some difficult decisions about which activities to reduce. Audit data indicates that 16 of the 30 CYSs are planning to decrease funding for CA activities (headspace, 2009a). This may have adverse longer-term effects on the sustainability of sites and make it increasingly difficult for headspace to meet its national objectives for raising awareness of headspace and increasing help-seeking on the part of young people in the community.

## 6.2 Effectiveness of community awareness strategies

There is little data currently available on the broad impact of the CA campaigns throughout Australia. However, there is some information about the broader community's awareness of headspace, and there is data showing increases in young people's access to mental-health services and attendance at headspace, and changes in awareness within the communities where the headspace sites are situated.

*National community awareness changes*

There is some information about levels of broader CA of headspace during its establishment and early implementation phases from the headspace NYPCS conducted by BMRI between January and June 2008. Almost one in five respondents over the age of 12 (18%; n=3961) had heard of headspace, while 6.5 per cent (n=709) had visited the headspace website. The 18-25-year-old age group were slightly more likely to have heard of headspace (19%) and to have visited the website (7.6%). Females aged 12-25 were slightly more likely than males to have heard of it and visited the website. As this data was collected during the establishment phase of headspace, it offers only an early insight into the general public's knowledge of the program. Repeating the survey would give a more accurate picture of the broader national effectiveness of these campaigns.

There is an increasing amount of traffic to both the national and the local websites. This is a good indication that awareness of headspace continues to grow. On average there were there were just under 5,000 website visits per month in 2007, increasing to over 38,000 visits per month in 2008 and over 54,000 visits per month in 2009.

*National changes in mental health service use*

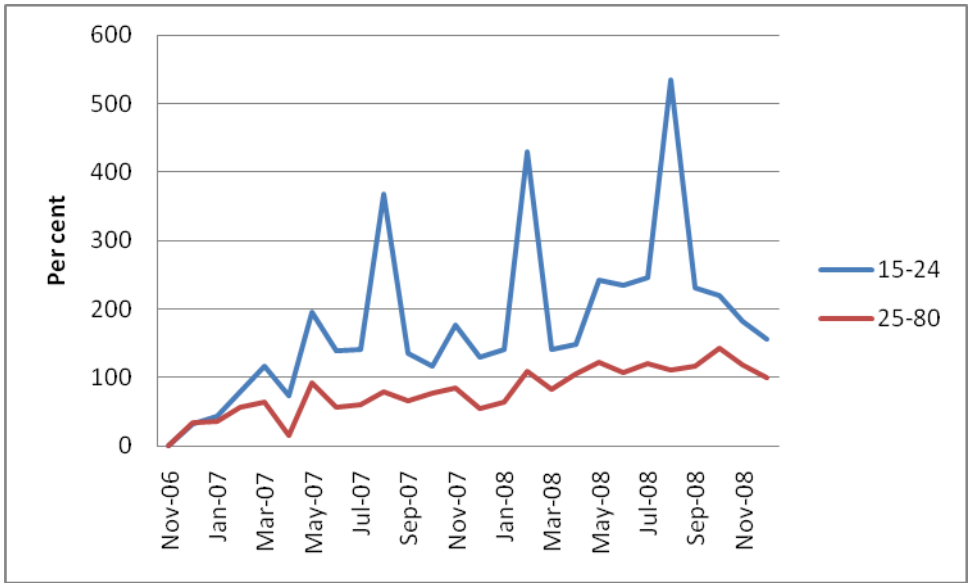
Medicare data for the two years from November 2006[36] to November 2008 does suggest that young people are not only accessing mental health services in greater

[36] On 1 November 2006, the Australian Government Department of Health & Ageing changed the Medicare Benefits Scheme (MBS) by introducing the Better Access to Mental Health Care initiative. This initiative allowed certain mental health care services, such as access to psychiatrists and psychologists to be funded under the MBS.

numbers, but that they are doing so at higher rates than the Australian population in general (Figure 6.1). It was expected that mental health service usage would steadily increase as a result of the changes to the MBS system, and there has been a steady increase nationally in the numbers of people accessing mental health services. However, this change has not occurred uniformly across the population. Although young people are traditionally less likely to seek help, they do have higher rates of mental health problems. Since 2006 there has been a steady increase in the use of Medicare items associated with services provided by psychologists and mental health services in general, but use by 15-24-year-olds has grown much faster than use by those over 25 years (note the trend in Figure 6.1).

headspace CYSs started opening from May 2007 and the majority (22) had opened by July 2008. It was during this period that the greatest increases occurred in 15-24-year-olds' usage of mental health services provided through MBS items, in comparison with the service usage of those 25 years and over (Figure 6.1 and Figure 6.2). For example, between November 2006 and May 2008 15-24-year-olds' usage of MBS GP Mental Health Care items[37] had increased by 241 per cent (if a baseline of 0 is used from November 2006), whereas the usage by adults 25 years and over had increased only by 126 per cent. Even in periods where the peaks did not occur, the gap between the younger and older age groups consistently increased, especially between May and August 2008 (Figure 6.1).

**Figure 6.1: Relative change in the use of Medicare items associated with mental health by age group between November 2006 and November 2008 (%)**



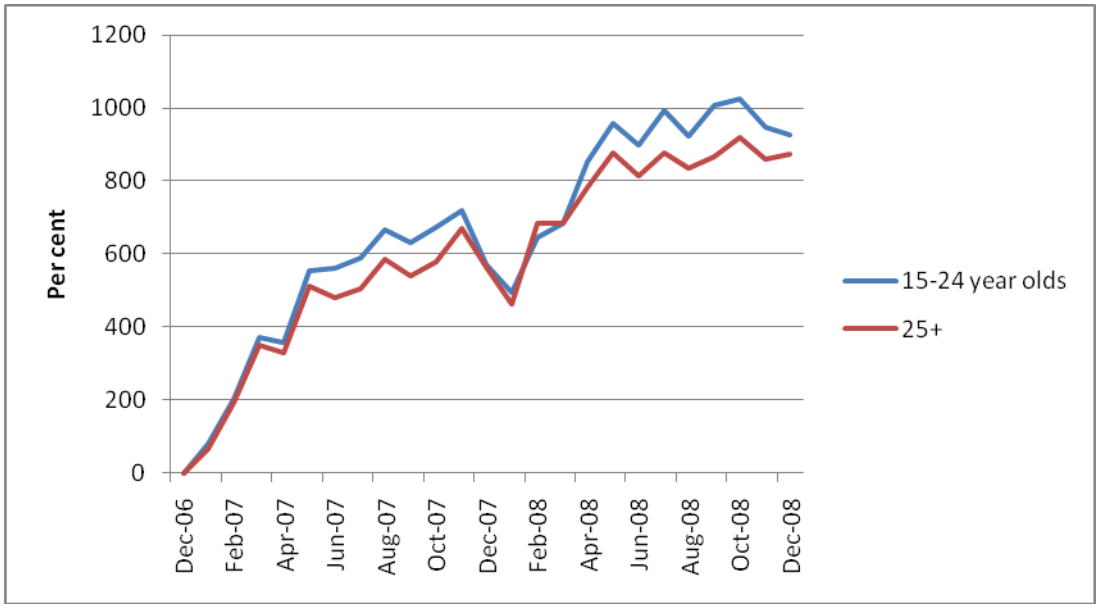

Source: MBS data, November 2006-November 2008.

In addition to the changes in the use of Medicare items associated with mental health, young people also had greater increases than older adults in the use of services

[37] The services defined by the GP Mental Health Care items 2710, 2712 and 2713. These are services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers.

provided by psychologists. While the use of psychological services reimbursed through the MBS[38] increased markedly for all age groups, for 15-24-year-olds it increased to a greater extent (Figure 6.2). By July 2008 when most CYSs were open and seeing young people, this difference had been firmly established and remained till the end of the year.

**Figure 6.2: Relative change in the use of services provided by psychologists through the MBS by age group between December 2006 and December 2008 (%)**




Source: MBS data, November 2006-November 2008.

While these changes could have been a result of a range of strategies between 2006 and 2008, headspace was the major national mental health policy change for young people aged 15 to 24 years during this time. Thus, it is likely that headspace community-awareness campaigns have had an impact on the help-seeking behaviours of young people.

*Changes in community awareness within CYSs*

Most participants in the in-depth sites reported that the CA activities in their sites were effective. The majority of CYS staff and practitioners surveyed reported that communication strategies had created recognition of headspace in the community (91%; n=209), increased awareness of mental health issues (94%; n=208), and encouraged young people to attend headspace services (95%; n=211; Table 6.1, All CYS respondents).

Belief in the effectiveness of campaigns to increase CA of mental health issues and of headspace in particular was lower among the small sample of repeated respondents (although the difference was not significant and rates of agreement about effectiveness were still high, Table 6.1). This could be because some long-standing stakeholders felt their CYS had reached a level of saturation in terms of increasing

[38] Psychological therapy (items 80000 to 80020) provided by eligible clinical psychologists.

CA. However, it could also have been a reflection of perceived limitations of the national campaign.

**Table 6.1: Effectiveness of communication strategies used by CYS (CYS survey, %)**

| A. All CYS respondents | Wave | n | Very or somewhat ineffective | Neither effective nor ineffective | Somewhat or very effective |
|---|---|---|---|---|---|
| Increase awareness of mental health issues | Wave1 | 131 | 3.8 | 7.6 | 88.5 |
| | Wave2 | 208 | 3.8 | 2.4 | 93.8 |
| Encourage young people to attend headspace services * | Wave1 | 129 | 6.2 | 7.8 | 86.0 |
| | Wave2 | 211 | 3.8 | 1.4 | 94.8 |
| Create recognition of headspace in your community | Wave1 | 131 | 6.1 | 3.8 | 90.1 |
| | Wave2 | 209 | 3.8 | 4.8 | 91.4 |
| *p<0.01 (Chi square test) | | | | | |
| **B. Repeated CYS respondents** | **Wave** | **n** | **Very or somewhat ineffective** | **Neither effective nor ineffective** | **Somewhat or very effective** |
| Increase awareness of mental health issues | Wave1 | 44 | 2.3 | 6.8 | 90.9 |
| | Wave2 | 44 | 6.8 | 6.8 | 86.4 |
| Encourage young people to attend headspace services | Wave1 | 44 | 6.8 | 4.5 | 88.6 |
| | Wave2 | 44 | 6.8 | 2.3 | 90.9 |
| Create recognition of headspace in your community | Wave1 | 44 | 4.5 | 0 | 95.5 |
| | Wave2 | 44 | 6.8 | 9.1 | 84.1 |

Several service providers, for example, reported that the messages contained in the 'Someone else to go to' advertising campaign were inappropriate for young people (especially for Indigenous young people); and some young people, both in the local reference groups and in the interviews, did express confusion and concern over the campaign's message. Consequently, a few sites did not use national advertising materials for this reason. Furthermore, television advertising campaigns were broadcast on channels that were unavailable in some areas and so some sites did not benefit from the televised campaigns. In addition, while most stakeholders believed that CA was an important part of headspace, a few sites were concerned that the high level of CA activities could increase demand for the services to an unsustainable level.

*Referrals to CYSs*

However, the referral numbers and sources also suggest that headspace has been broadly successful with its CA strategies, both national and local. The headspace dataset suggests that young people are increasingly likely to arrive at headspace under their own volition or with the help of family members and friends, and less likely to rely on referrals from professionals. At Wave 2, the headspace dataset indicates that referrals were most likely to be self-referrals and from family members (41%), followed by health providers (28%) (Table 6.2). This is an important change since Wave 1, when only 25 per cent of referrals were via family, friends or self, and 46 per cent of referrals were via health providers. The increase in self-referrals between

Waves 1 and 2 of the evaluation reflects the success of community-awareness campaigns in promoting headspace services.[39]

**Table 6.2: Primary referral sources for a sample of young people (headspace dataset)**

| Referral source | Wave 1* | | Wave 2** | |
|---|---|---|---|---|
| | n | Percent | n | Percent |
| Family, friend, self | 300 | 25 | 1085 | 40.7 |
| Health provider | 547 | 45.9 | 735 | 27.6 |
| Community service organisation/agency | 135 | 11.3 | 405 | 15.2 |
| Education provider | 60 | 5 | 232 | 8.7 |
| Other/unknown | 156 | 13.1 | 206 | 7.7 |
| Total | 1198 | 100 | 2663 | 100 |

This data should be used cautiously. It reflects only a sample of young people accessing CYSs.
*There were 1481 records without a listed referral source at Wave 1.
**There were 4359 records without a listed referral source at Wave 2.

The main indication of success in CA is the increasing numbers of young people who have accessed and used headspace services. This is discussed below.

## 6.3 Young people attending headspace

By 4 June 2009, the 30 CYS sites had collectively seen approximately 13,917 young people since opening, and had provided over 95,000 occasions of service.[40] This means that, on average, each young person attended 6.8 sessions at headspace.

The headspace dataset and the surveys of the young people who participated in the in-depth CYS evaluation provide an understanding of the characteristics of a large proportion of the almost 14,000 young people who had attended CYSs by that date. The headspace dataset relates to samples of up to 7,022 young people (depending on the demographic characteristic) attending 24 of the 30 CYSs.[41] The survey data relate to a sample of 169 young people in ten CYSs, who were attending headspace at either Wave 1 or Wave 2 of the evaluation. The demographics of the young people in both data sources are similar.

The demographic data (Table 6.3) shows that headspace is attracting young people of both genders, from the two age groups (12-17 and 18-25), and of Indigenous and non-Indigenous backgrounds. The headspace dataset shows that headspace attracts a slightly higher proportion of females (57%) and 12-17-year-olds (54%). Around 10 per cent of service users are Indigenous and almost three in four (74%) live with their families.

[39] This data is based only on a proportion of young people accessing headspace (see the notes to Table 6.2), and more comprehensive data is required before referral trends can be more fully understood.

[40] Unpublished hNO data, July 2009.

[41] The data are not representative across all these 24 CYSs (for further information, see methodology).

**Table 6.3: Demographic characteristics of young people (12-25 years) attending headspace compared to young people in the population**

| | | YP headspace dataset[a] | | YP survey | | YP in the population[b] |
|---|---|---|---|---|---|---|
| **Characteristics** | | **n** | **%** | **n** | **%** | **%** |
| Total | - | 7022 | 100 | 169 | 100 | 100 |
| Gender | Male | 2798 | 42.6 | 66 | 39.8 | 51 |
| | Female | 3768 | 57.4 | 100 | 60.2 | 49 |
| Age | 12–17 | 2709 | 53.8 | 70 | 42.2 | 44 |
| | 18–25 | 2328 | 46.2 | 96 | 57.8 | 56 |
| Location | Urban | 4639 | 67.5 | 57 | 33.7 | - |
| | Regional/remote | 2236 | 32.5 | 112 | 66.3 | - |
| Indigenous status | Non-Indigenous | 3394 | 90.5 | 149 | 88.7 | 97 |
| | Indigenous | 355 | 9.5 | 19 | 11.3 | 3 |
| Country of birth | Australian | 5867 | 89.6 | 153 | 90.5 | 80 |
| | Overseas | 680 | 10.4 | 14 | 9.5 | 20 |
| Main language | English | 2576 | 98.1 | 154 | 91.7 | 79 |
| | Others | 51 | 1.9 | 14 | 8.3 | 21 |
| Living arrangements | Family | 3354 | 73.8 | 109 | 64.5 | - |
| | Others | 1190 | 26.2 | 60 | 35.5 | - |

a. The numbers of young people in the headspace dataset represent approximately half the population of young people who attended headspace.
b. From the Census of Population and Housing (ABS, 2006).
c. This data is for 12-24 year olds.

Young people attending headspace are not entirely representative of the broader population of 12-25-year-olds in Australia (Table 6.3, last column). Comparing the headspace dataset and Census data, women, 12-17-year-olds and Australian-born young people appear to be using headspace services at a higher rate than might be expected from their proportions in the general population. These differences might be because these groups are more likely to experience psychological distress (see below) or because they are more likely to seek help.[42] The data also indicate that a high proportion of young people from Indigenous backgrounds are using headspace, but this result is skewed by the fact that there are a number of sites with high proportions of Indigenous young people.

As headspace aims to assist young people in the areas of mental health, AOD use, physical health, and social and economic participation, it is important to know how the young people accessing headspace are faring across these areas. The mental and physical health, economic and social participation, and alcohol and drug use, of a sample of young people attending headspace across ten sites, are detailed below, along with information about how this population of young people compares with the wider population, using data from the SMHWB survey (ABS, 2007).[43]

[42] For example, existing research states that males (Booth et al., 2004; Jorm et al., 2007; Weich et al, 2005), 18–25-year-olds (Jorm et al., 2007) and overseas-born young people or those from CALD backgrounds (Rickwood, 2007) are less likely to seek help.

[43] Information about the impact attending headspace has had on these issues can be found in Section 7.1.

## Mental health characteristics

The headspace dataset (where available), together with information from the interviews with CYS staff and practitioners and young people in the ten in-depth sites, suggests that young people are presenting at headspace with a range of types and degrees of severity of mental health issues.

*Diagnosis*

The headspace dataset indicated that the most frequently occurring disorders for young people attending headspace (n=811) were anxiety and depressive disorders.[44] Thirteen per cent of clients had a primary diagnosis of an unspecified anxiety disorder, 13 per cent were diagnosed with mixed anxiety and depressive disorders, and 10 per cent were diagnosed with a mild depressive episode. Almost half (45%; n=237) of those with a primary diagnosis had received at least one other diagnosis, indicating the high prevalence of co-morbidity in young people attending headspace. The total range of diagnoses was vast (i.e. 148 separate diagnoses) and included post-traumatic stress disorder, agoraphobia, suicidal ideation, eating disorders, adjustment disorders, irritability and anger, drug use, and Asperger's syndrome.

*Severity: psychological distress*

Not surprisingly, headspace is attracting young people with degrees of psychological and psychiatric distress that exceed the levels in the general population. The scores of a large sample of young people on the K10[45] on their first assessment at headspace (n=2222), demonstrate that young people's psychological distress levels vary significantly (Table 6.4). Less than 1 in 10 young people come to headspace with no or low levels of psychological distress, 44 per cent show medium levels of distress and 47 per cent show high levels of distress. This diversity suggests that headspace is attracting a range of young people: those who are mentally healthy, as well as those who are at risk of mental health problems, those in the early stages, and those with more severe mental health symptoms.

On the basis of these findings, it can be assumed that headspace is achieving two of its objectives. It is engaging a range of young people, while at the same time it is attracting young people with higher levels of psychological distress than the general population of 12-25-year-olds (a mean score of 28.1, compared with 15.1; Table 6.4).

[44] Diagnoses were classified using the International Classification of Disease and Related Health Problems, 10th Revision, 2007 (ICD-10).

[45] This is a ten-item, validated questionnaire designed to measure psychological distress through questions about levels of nervousness, agitation, fatigue and depression. The K10 score is calculated by summing the responses to each of the ten questions, to provide a total score (between 10 and 50), which is indicative of the degree of psychological distress, and therefore the severity of the young person's mental health disorder. A score between 10 and 19 indicates little or no distress (mental health), 20-24 indicates mild psychological distress, 25-29 indicates moderate distress, and 30-50 indicates severe distress.

**Table 6.4: K10: psychological distress scale[1] (%)**

| | n | Mean Score (range 10-50) | Low or no distress (score 10-15) | Medium distress (score 16-29) | High distress (score 30-50) |
|---|---|---|---|---|---|
| SMHWB survey[2] | 1552 | 15.1 | 64.8 | 32.6 | 2.6 |
| headspace dataset | 2222 | 28.1 | 9.4 | 43.7 | 46.9 |

Note: [1] Based on the Clinical Research Unit for Anxiety and Depression (CRuFAD) K10 scale.
[2] SMHWB, ABS, 2007, data on 16-25-year-olds

Furthermore, the headspace dataset showed that 47 per cent of young people had signs of high psychological distress, much higher than in the general population of 16-25-year-olds, only 2.6 per cent of whom had severe levels of psychological distress, according to the SMHWB survey.

The findings from the SMHWB survey demonstrate that there are certain groups of young people who are more likely to be at risk of, or experiencing, mental health problems, and who would therefore benefit from the support of headspace. On average, young people not engaged in work or education have significantly higher K10 scores than their counterparts (Table 6.5). headspace was successful in engaging young people from this group. The headspace dataset showed that on assessment young people coming to headspace who were not engaged in work or education had significantly higher K10 scores ($p<0.01$). Furthermore, when controlling for age, gender and participation in work or study, K10 scores were also significantly higher for young people who had not completed education levels appropriate to age (OLS regression, n=700; $p<0.05$; Table 6.5).

In the regression analysis, males were shown to have significantly better mental health (lower K10 scores) on assessment ($p<0.01$),[46] when controlling for age, educational attainment and participation in work and study. Thus the slightly higher numbers of females attending headspace is consistent with the incidence of psychological distress within each sex in the broader community.

[46] While the gender – K10 cross tab showed males having a higher K10 score, the regression results are more rigorous and should be used to draw conclusions around the impact of gender. Interestingly, the young people's survey results were consistent with the regression analysis: young men reported higher satisfaction levels with their mental health than women.

**Table 6.5: K10: Psychological distress by demographic characteristics**

| Demographic | Sub-category | SMHWB survey (n=1552) Mean K10 score | headspace dataset (crosstabs) n | headspace dataset (crosstabs) Mean K10 score | headspace dataset (OLS regression)[a] | |
|---|---|---|---|---|---|---|
| All young people | - | 15.1 | 2222 | 28.1 | - | - |
| Gender | Males | 14.2 | 1704 | 30.0*** | -3.618*** | (0.569) |
| | Females | 15.8*** | | 25.9 | | |
| Age | 12-17 (16-17) | 14.9 | 1385 | 22.2 | | |
| | 18-25 | 15.1 | | 32.8*** | 7.929*** | (0.687) |
| Engagement in work or education | Engaged | 14.9 | 1142 | 27.7 | | |
| | Not engaged | 16.7*** | | 29.6*** | -0.730 | (0.706) |
| Educational attainment | Completed education appropriate to age | 14.8 | 1877 | 31.42* | | |
| | Not completed education appropriate to age | 16.6*** | | 28.64 | 0.409** | (0.191) |
| Indigenous | Indigenous | - | 1082 | 27.3 | ∧ | ∧ |
| | Non-Indigenous | - | | 27.9 | ∧ | ∧ |
| Language spoken at home | English | 15.1 | 945 | 27.7 *** | ∧ | ∧ |
| | Other than English | 15.5 | | 24.1 | ∧ | ∧ |
| Living arrangement | Family | - | 1193 | 27.7 | ∧ | ∧ |
| | Other | - | | 30.4 | ∧ | ∧ |

*p<0.1;**p<0.05; ***p<0.01

a) Dummy variable for each site were included in the regressions but not reported.

∧ The variables 'language spoken at home', 'living arrangement', 'indigenous group' and 'country of birth', have been tested in both models above and are excluded as these are statistically insignificant at conventional levels.

Across all the datasets, the 18-25-year-olds had poorer mental health (higher K10 scores) than the younger age group. While the difference between the age groups in the population data is not significant, in the headspace dataset (both cross-sectionally and in the OLS regression analysis) the K10 scores of the older group were significantly higher than those of their younger counterparts. This suggests that headspace has been successful in attracting younger teenagers with earlier onset mental health problems.

The K10 data suggests that headspace is successfully attracting young people with mental health problems, and that most of these are relatively early intervention cases, having either no, low or medium levels of psychological distress (53%), although there is also a sizeable number presenting with high levels of distress.

The high incidence of young people presenting with only mild to moderate levels of psychological distress is important, given that Wave 1 of the evaluation highlighted some challenges around operationalising early intervention. Reasons for this included the high demand for mental health services, the lack of services for young people combined with the high threshold of severity to qualify for entry into the state mental health system, and a lack of clarity around the meaning of early intervention. While these difficulties had not been completely resolved at Wave 2, it is likely that increased CA and education around appropriate referrals have played a key role in

alleviating these issues. Factors which either facilitate young people's access and engagement, or discourage them from engaging, are discussed further below.

### Physical health characteristics

Physical health services (particularly GP services) are part of the headspace model. They are intended to provide access points into headspace for young people, as well as addressing the co-morbidity of physical and mental health.

Young people attending headspace who completed the in-depth survey rated their satisfaction with their physical health slightly higher than their mental health, but satisfaction with physical health was mixed (Mean=5.80; n=157; Table D.1). When controlling for age, gender and educational attainment, young people who were not working or studying were 19 per cent more likely to be dissatisfied with their physical health than those who were in work or education ($p<0.01$, n=153; logit regression; Table 6.6). [47]

These findings suggest that headspace is engaging young people who have a range of issues, not just mental health problems. They might also suggest that headspace may be having an impact on young people's understanding and identification of their physical health problems.

**Table 6.6: Marginal effect after logit regression of demographic characteristics on young people's dissatisfaction with life domains (Young People's survey)**

| | **Dissatisfied with...** | | | | | | |
|---|---|---|---|---|---|---|---|
| **Coefficient** | **Work** | **School** | **Physical health** | **Mental health** | **Family relationships** | **Friendships** | **Community** |
| 18-25 years | 0.172* (0.097) | -0.030 (0.085) | 0.033 (0.102) | 0.158** (0.073) | -0.029 (0.103) | -0.001 (0.031) | 0.174* (0.095) |
| Male | -0.036 (0.090) | -0.083 (0.086) | -0.675 (0.063) | -0.116 (0.062) | -0.038 (0.069) | -0.006 (0.044) | 0.081 (0.092) |
| Not completed education appropriate to age | -0.091 (0.105) | -0.038 (0.068) | 1.326 (0.392) | 0.050 (0.051) | 0.119*** (0.036) | 0.063** (0.042) | -0.079 (0.085) |
| Not working or studying | 0.383*** (0.086) | 0.329*** (0.074) | 0.185*** (0.066) | 0.093 (0.076) | -0.008 (0.047) | -0.048 (0.036) | 0.044 (0.074) |
| n | 141 | 140 | 153 | 157 | 161 | 160 | 146 |
| Pseudo R2 | 0.144 | 0.085 | 0.037 | 0.058 | 0.016 | 0.036 | 0.036 |

*p<0.1;**p<0.05; ***p<0.01

Note: The impact of each site was also tested in these regressions. There were no significant findings, suggesting that the results are not skewed by particular locations.

[47] Marginal effects after logit are reported instead of odds ratios because they are easier to interpret. Each of the marginal effects displayed in this table (the coefficients) represent the change in the predicted probability (0-100) of being dissatisfied with one aspect of life or another following a one-unit change in any of the independent variables (dy/dx). For eg, the coefficient of 0.033 for those who are older (18-25 years) says that they are 3% more likely to be dissatisfied with their physical health when compared to those who are younger (12-17 years).

### Work and education characteristics

The in-depth evaluation showed that many of the young people accessing headspace were also experiencing problems in other areas of their lives, such as economic participation. The headspace dataset indicates that around a quarter of all young people accessing headspace services were neither studying or working (26%), compared with only a tenth (9%) in the general population of 16-25-year-olds (Table 6.7; n=4040). While figures from the headspace dataset cannot be broken down by main activity status, the results of the in-depth evaluation suggest that headspace is attracting a relatively high proportion of young people who are either unemployed (36%) or in caring roles (32%), compared with the general population of 12-24-year-olds (5% and 15% respectively; Table 6.7).

**Table 6.7: Economic participation of young people (full- or part-time, %)**

| | n | Working or studying | Not working or studying | Paid work | Studying | Volunteering | Caring | Unemployed (looking for work) |
|---|---|---|---|---|---|---|---|---|
| SMHWB survey | 1552 | 90.9 | 9.1 | 73.4 | 53.0 | - | 14.6 | 5.3 |
| headspace dataset | 4040 | 73.8 | 26.2 | - | - | - | - | - |
| Young People's survey | 169 | 68.6 | 31.4 | 36.4 | 52.4 | 23.0 | 31.5 | 36.2 |

Given that the economic participation of the young people attending headspace is starkly different from the average situation for most young people (Table 6.7), it would appear that headspace is engaging young people who are most at risk.

The young people's survey also indicated that young people were not particularly satisfied with their ability to work or find work (Mean=6.01; n=144; Table D.1), or their ability to go to school, technical and further education (TAFE) or university (Mean=6.57; n=142; Table D.1). Older service users (aged 18-25 years) were significantly less likely than 12-17-year-olds to be satisfied with their ability to work or find work ($p<0.01$, cross-tab, Table D.2; $p<0.1$, logit regression, Table 6.6).

Unsurprisingly, young people who were not working or studying were also significantly more likely to be dissatisfied with their ability to work, find work or study than those who were working or studying ($p<0.01$, logit regression, Table 6.6).

The level of and capacity for economic participation by young people attending headspace reinforces the importance of a holistic service that focuses not only on mental health issues, but also on other critical areas of young people's lives.

### Relationship characteristics

As noted above, almost three-quarters of the young people using headspace lived with their families. However, not all the young people had contact with their families and not all of those who were in contact had strong relationships with their family members.

Those young people who were not in contact with family members they do not live with were most likely to be males and/or those who were not working or studying. Males coming to headspace were 19 per cent less likely than females to have contact with family members they do not live with, and 17 per cent less likely to be able to rely on their family members for small favours ($p<0.05$).[48] Young people who were not working or studying were 12 per cent less likely to have contact with family they do not live with ($p<0.1$; logit regression; Table 6.8). Young people who had not completed education appropriate to their age were 21 per cent less likely to be able to have family who they could ask for small favours, and 22 per cent less likely to have family who could support them in times of crisis, than their counterparts ($p<0.1$). Finally, 18-25-year-olds were 26 per cent less likely to be able to rely on family for support in a time of crisis than 12-17-year-olds ($p<0.01$). These findings suggest that males and those young people who are not in work or study are particularly at risk of social exclusion, and that this risk may increase with age.

**Table 6.8: Marginal effect after logit regression of demographic characteristics on contact with family and friends and ability to ask family for small favours and support in times of crisis[49] (Young People's survey)**

| Coefficient | No contact with family they do not live with | No contact with friends | Cannot ask family for small favours | Cannot ask family for support in crisis |
|---|---|---|---|---|
| 18-25 years | 0.048<br>(0.088) | -0.018<br>(0.032) | -0.002<br>(0.112) | 0.261***<br>(0.066) |
| Male | -0.190**<br>(0.079) | -0.108*<br>(0.059) | -0.168**<br>(0.08) | -0.021<br>(0.088) |
| Has not completed education appropriate to age | 0.021<br>(0.116) | 0.057<br>(0.048) | 0.208**<br>(0.087) | 0.218***<br>(0.082) |
| Not working or studying | 0.121*<br>(0.074) | 0.056<br>(0.048) | -0.026<br>(0.110) | 0.018<br>(0.091) |
| n | 150 | 155 | 164 | 164 |
| Pseudo R2 | 0.035 | 0.068 | 0.041 | 0.104 |

*p<0.1;**p<0.05; ***p<0.01

Note: The impact of each site was also tested in these regressions. There were no significant findings, suggesting that the results are not skewed by particular locations.

Given the above findings, it is unsurprising that young people's satisfaction with their family relationships were generally neither good nor bad (Mean=6.28; n=165; Table D.1). They were more likely to be satisfied with their friendships than with their families (Mean=7.54; n=164). Teenagers (12-17-year-olds) had a significantly higher satisfaction rate ($p<0.05$) with their friends than 18-25-year-olds (Table D.2). When controlling for age and gender, young people who had not completed education appropriate to their age were less satisfied with their relationships with both their families and their friends ($p<0.01$ and $p<0.05$ respectively; Table 6.6). This suggests

[48] This finding is not unique to young people with mental health issues however; previous research suggests Australian men are typically less likely to maintain contact and have support than Australian women in general (ABS 2006).

[49] See footnote pg 42 for interpretation of marginal effects after logit.

that young people not in work or education may be particularly socially excluded and that some of these young people are accessing headspace.

### Alcohol, tobacco and drug characteristics

headspace has also attracted young people with higher than average consumption of alcohol, tobacco and some drugs. Alcohol consumption can be measured in two ways. The first addresses the frequency of consumption (i.e. how many days a week a person drinks alcohol), while the second addresses the quantity of consumption (i.e. how much a person drinks on a single occasion). The latter is particularly important given the 2009 National Health and Medical Research Council (NHMRC) guidelines on drinking.[50] This analysis includes both these measures.

In terms of frequency of consumption, almost 15 per cent of young people in the in-depth evaluation (n=163) had been high-risk drinkers (drinking 2-3 days or more a week) in the previous 12 months, compared with 13 per cent of 16-25-year-olds in the broader population (SMHWB survey, Table 6.9).

**Table 6.9: Frequency of alcohol consumption in last 12 months (%)**

| | n | Does not drink | Low risk drinker (drinks 1-2 days a week) | High risk drinker (drinks 3 or more days a week) |
|---|---|---|---|---|
| SMHWB survey | 1552 | 25.4 | 61.4 | 13.2 |
| Young People's survey | 163 | 18.4 | 66.9 | 14.7 |

In terms of the quantity of alcohol consumed (number of drinks on a single occasion), young people attending headspace are much more likely to be high-risk drinkers (five or more drinks on a single occasion) than young people in general (44% and 26% respectively, Table 6.10). Interestingly, while headspace males are only slightly more likely to be high-risk drinkers than young men in the general population (43% and 34% respectively), headspace females are much more likely to be high-risk drinkers than young women in general (45% and 19% respectively, Table D.4). Moreover, being male increased the likelihood of drinking by 34 per cent (when tested within a logit regression).

[50] The NHMRC (2009) recommends that young people under the age of 18 should avoid drinking alcohol completely and that the safest option for teenagers aged 15-17 is to delay the onset of drinking for as long as possible. However, for healthy men and women aged 18 and over, it recommends drinking no more than two standard drinks on any day to reduce the lifetime risk of harm from alcohol, and no more than four standard drinks on a single occasion to reduce the risk of alcohol-related injury arising from the occasion.

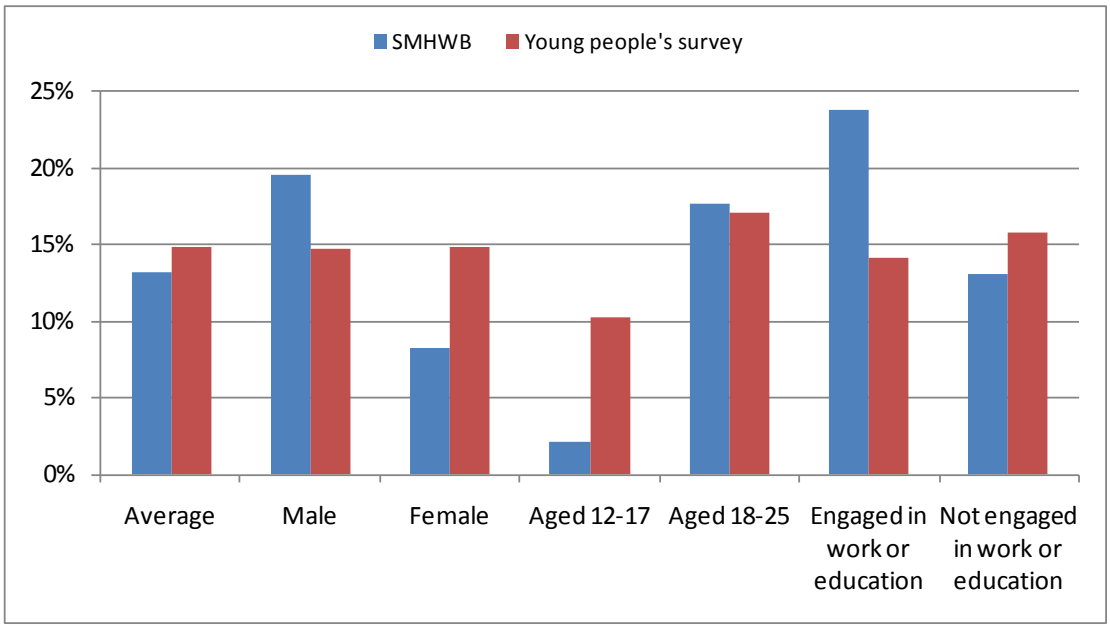
**Table 6.10: Quantity of alcohol consumption in last 12 months (%)**

| | n | Does not drink | Low risk drinker (drinks 1-4 drinks on single occasion) | High risk drinker (drinks 5 or more drinks on a single occasion) |
|---|---|---|---|---|
| SMHWB survey | 1552 | 41.7 | 32.5 | 25.8 |
| Young People's survey | 162 | 18.5 | 37.7 | 43.8 |

Comparing alcohol consumption by frequency and quantity shows that young people attending headspace are at greater risk of binge drinking (drinking large quantities on a single occasion) than of sustained drinking behaviour (drinking on frequent occasions), but that this risk is much higher than for young people overall. These findings highlight the need for holistic treatment of mental health and substance use within headspace sites.

As with alcohol consumption, smoking tobacco was much more prevalent among young people (16-25) receiving headspace services than among the general population, and they were more likely to smoke every day. For example, 76 per cent of the 16-25-year-olds in the SMHWB survey did not smoke at all, compared with only 52 per cent of respondents to the young people's survey. Furthermore, 39 per cent of young people attending headspace said they smoked every day, compared with 18 per cent of 16-25-year-olds overall. As in the general population, women were less likely than men to smoke every day, while 12-17-year-olds using headspace were at much greater risk of smoking every day than 16-17-year-olds in the general population (40% and 3% respectively) (Figure 6.3; Table D.5).

**Figure 6.3: Young people who smoke cigarettes, cigars, pipe or other tobacco everyday (%)**



In total 58.6% (n=169) of young people attending headspace had used illicit drugs in the previous twelve months. The young people's survey (Table 6.11) showed that cannabis was the most commonly used drug (50%), followed by ecstasy (32%), the inappropriate use of pain killers (25%), methamphetamines and amphetamines (21%), and tranquillisers and sleeping pills that had not been prescribed (18%).

**Table 6.11: Frequency of substance use in the previous 12 months (Young People's survey %)**

| Substance type | n | % |
|---|---|---|
| Marijuana/Cannabis | 143 | 50.3 |
| Ecstasy | 135 | 31.9 |
| Pain killers/Analgesics | 134 | 24.6 |
| Methamphetamines/Amphetamines (speed) | 137 | 21.2 |
| Tranquillisers/Sleeping pills[a] | 133 | 18.0 |
| Cocaine | 134 | 11.9 |
| LSD/Synthetic or natural hallucinogens | 133 | 9.8 |
| Inhalants | 131 | 8.4 |
| Heroin, methadone, morphine or pethidine[b] | 133 | 6.0 |

a. Not prescribed by a doctor.
b. Not supplied as part of a medical program.

The young people reported using AOD to alleviate mental health symptoms and numb their feelings, but they also recognised that substance use had negatively affected their relationships, and their education and work. The level of substance use of young people attending headspace reinforces the perception that headspace is attracting young people with higher than average use, and that support in this area is an important part of headspace's suite of services.

### Young people who are not accessing headspace

Figures from the headspace dataset indicate that headspace is attracting young people from across its target group, but that there may be some difficulties around supporting certain groups. In-depth data also shows that CYS practitioners were concerned about young people who were not accessing headspace, particularly because of the reluctance to seek help regarding mental health issues. These groups varied according to the location of each headspace site, because the reasons why some young people were hard to reach were context-specific, but among them were young people in the lowest socio-economic status, those with limited support systems (especially family support), refugee communities, and Indigenous young people.[51]

At a national level, headspace aims to create an Indigenous Strategy Group, although this is yet to occur[52]. Some sites appeared to be more successful than others in attracting and retaining clients from Indigenous and culturally and linguistically diverse (CALD) backgrounds. Sites that effectively engaged Indigenous and CALD

[51] The proportion of Indigenous young people represented at headspace appears high according to MHAGIC data (9.5%), but this is probably skewed by the fact that some CYSs are located in regions with high Indigenous populations.

[52] See also Section 9.1.

service users generally had active contact with, and support from, local Indigenous or CALD community-based services, and implemented culturally appropriate strategies of engagement. Where these strategies have been successful, they should be shared with other CYSs.

## 6.4 Factors that keep young people coming back to headspace: youth-friendly services

The characteristics of headspace which keep young people engaged and encourage them to keep returning for subsequent appointments have an impact on young people's access to headspace. The in-depth survey found that these factors all revolved around the youth-friendly nature of headspace, including the CYS environment, cost, accessibility, the mutual respect and trust between young people and headspace practitioners, young people being informed about the processes of headspace, and the specific strategies used by CYSs to encourage appointment attendance. It is notable, for example, that 86 per cent (n=166) of the young people in the in-depth evaluation said that headspace had met their needs, and 99 per cent (n=167) said they would recommend headspace to friends.

### Environment

> I like the friendly atmosphere. Everyone says "g'day, how are you going?" and it's generally just a very nice place to be. I can sit there and just read magazines while I wait, and they have music going there sometimes. It's really cool ... Everything is really cool. It's a friendly environment; you feel safe when you come in. (Female, 22 years old)

Most of the young people interviewed perceived the CYS environment as youth-friendly because of the colourful walls, the non-clinical environment, the comfortable lounges and the activities (such as music, games, computers and internet access). These perceptions generally improved between Waves 1 and 2 of the evaluation as CYSs had largely completed their renovation works by Wave 2. Occasionally clients said they felt that CYSs were too 'youthy' and aimed at people younger than themselves, but these were usually people at the upper end of the headspace age bracket. Young people also reported that headspace staff were friendly and approachable and had made them 'at home', and that it was a place they could come to not only for their appointments but also to 'hang out'.

### Accessibility

At Wave 2, young people stated that headspace services were generally well located. This was particularly the case where CYSs were located near public transport and other services frequented by young people (e.g. youth centres, internet cafes). Proximity to other services was important because young people did not want it to be obvious that they were using mental health services, because of the stigma associated with this. Proximity to transport services was easier to achieve in urban than regional areas, where public transport was sometimes limited and expensive. However, some sites had the capacity to collect clients or offer them taxi vouchers if transport was problematic. While this was perceived as a very effective strategy for ensuring

engagement,[53] only 50 per cent of CYSs had used it by Wave 2 (14 of 28 CYSs) (Table D.6). The in-depth evaluation indicated a possible reluctance on the part of some sites to use this strategy, possibly because of the financial burden. But it should at least be considered given how effective it is, particularly at CYSs where public transport is limited.

### Relationships with staff

> I didn't want them to speak to anyone else, because it's just me, I want this [headspace] confidential because there's just stuff that I don't, not even my partner knows fully. (Female, 18 years old)
>
> They really take the time and listen, they don't stop trying. They are really caring. (Female, 17 years old)

The young people who participated in the in-depth evaluation were overwhelmingly content with their relationships with headspace staff. The vast majority of the service users felt they were treated with respect and dignity by headspace workers (98%; n=139) (Table 6.12). Young people also felt able to talk to headspace workers about their concerns (91%; n=138) (Table 6.13).

**Table 6.12: Treatment by headspace workers (Young People's survey, %)**

| | n | Never / not often | Sometimes | Nearly always / always |
|---|---|---|---|---|
| To what extent were you treated with respect and dignity by headspace workers? | 139 | 0.7 | 1.4 | 97.8 |

These findings were supported by what the young people said in the interviews. They said they felt comfortable returning to appointments with practitioners whom they perceived to be friendly, good listeners, able to 'relate to kids', and non-judgemental, and whom they trusted to keep their information confidential. This meant that young people became more engaged, felt more in control of their service experience, and had better relationships with their workers.

**Table 6.13: Ability to communicate concerns to headspace workers (Young People's survey, %)**

| | n | Not at all / a little | To some extent / definitely | Had no concerns |
|---|---|---|---|---|
| To what extent were you able to talk to headspace workers about your concerns? | 138 | 0.7 | 91.3 | 8.0 |

Having said this, it should also be noted that there were a few young people who were critical of staffing issues. In particular, there were complaints that the CYS staff member they were working with had left headspace, or that they were unable to see

[53] 92 per cent of managers (n=26) felt this was somewhat or very effective at Wave 1, increasing to 100 per cent of managers (n=28) at Wave 2.

either a male or female practitioner.[54] This highlights the importance of ensuring clients do not become dependent on individual staff, of maintaining clear hand-over periods wherever possible when staff leave, and recruiting both male and female practitioners.

### Control over service experiences

In both Waves of the evaluation, young people said that they valued the information they received about their care. They also reported that positive relationships with service providers were crucial for de-bunking misconceptions about accessing services. Most young people (94%; n=136) felt that headspace workers had given them an appropriate level of information about their condition or treatment (Table 6.14).

**Table 6.14: Information about condition (Young People's survey, %)**

| | n | None or not enough | Some or right amount | Too much |
|---|---|---|---|---|
| How much information about your condition or treatment was given to you by headspace workers? | 136 | 4.4 | 94.1 | 1.5 |

Young people clearly showed that they valued the control they were given over their care. Most of them felt that they definitely had enough say in decisions about the care and treatment they received from headspace (79%; n=136), while a further 20 per cent felt they had enough say to some extent (Table 6.15).

**Table 6.15: Involvement in decisions about care and treatment (Young People's survey, %)**

| | n | No | Yes, to some extent | Yes, definitely |
|---|---|---|---|---|
| Overall, did you have enough say in decisions about the care and treatment you received from headspace? | 136 | 0.7 | 19.9 | 79.4 |

However, at Wave 2, there was a minority of young people who had still not fully engaged with headspace because they were unclear about its processes and structure. These may be particularly confusing for young people who have experienced other mental health services, because they can operate quite differently from the ways in which headspace operates. It is therefore advantageous for services to be clearly explained to young people from the outset. This should include information about the range of different services available, the number of visits young people are entitled to, and whether there are costs associated with these services.

[54] For example, young people sometimes had a preference to see a male or female practitioner because they were uncomfortable with people of a particular gender due to previous experiences.

### Appointment reminders

> That phone call [reminder] makes you want to go to the appointment. (Male, 25 years old)

Given that appointment attendance rates did not improve between the two waves of the evaluation, it appears that some young people continue to face barriers to accessing services (Freed et al., 1998; Irwin et al., 1993; West et al., 1993). At Wave 2, two-thirds of CYS managers (67%; n=24) reported that approximately one in five young people or fewer did not show up for their appointments.[55] The in-depth data suggest that these were usually people who were still engaged with headspace, but who had simply forgotten to attend or to cancel their appointment if they had something else happening. This was a challenge for CYSs because it led to unused appointment times that could have been given to other clients. It also meant that private practitioners were not paid for this time, as they can claim MBS fees only for clients who attend their appointments.

CYSs implemented a range of strategies to maximise attendance, including: sending reminder phone calls or text messages the night before or on the day of the appointment; charging either the young person or the service provider for unattended appointments; and scheduling appointments at appropriate times for the young person (e.g. after school, not early in the morning). Information from the CYS managers indicates that the use of these strategies increased between Waves 1 and 2 The most commonly used methods at Wave 1 were telephone reminders the night before the appointment (62%) and on the day (54%), and at Wave 2, they were scheduling appointments at appropriate times for young people (89%), text message reminders the night before (82%), and phone calls on the day (82%) (Table D.6). Young people undoubtedly found these reminders useful. It was also important to provide multiple methods for young people to contact headspace, e.g. by text or free phone number, and the option for headspace to call young people back if necessary.

### Youth participation

The success of headspace's youth-friendly approach is, in part, a result of the fact that young people themselves participated in the processes, policies and campaigns, both at a national and at the local levels. hNO has recruited and established a national youth reference group[56] (hY NRG), and CYS sites have been encouraged to establish youth reference groups locally. According to the audit data, by March 2009, 22 CYSs had established local youth reference groups. The role of local youth reference groups varies from site to site, but information from the in-depth evaluation shows that they have been instrumental in supporting the effective establishment and implementation of the CYSs. They have been involved in various activities, including: organising social events for young people; helping develop local youth participation policies; contributing to the look and feel of headspace service provision environments and advice materials; participating in CYS staff recruitment; helping to address gaps in service provision and access; working with other local organisations to promote headspace; and advising and participating in local CA campaigns. Most of the CYSs

[55] This was not substantially different to Wave 1, when 65% (n=26) managers reported that one in five young people or less failed to show up for their appointments.

[56] See Section 9.5 for further information.

that do not already have youth reference groups have plans to establish them, and in the interim, they have been consulting with young people through existing youth groups or at one-off events.

## 6.5 Factors that discourage young people from accessing and engaging with headspace

In order to improve service access and engagement it is necessary to address the factors that have been discouraging young people from using headspace, as well as the strategies CYSs are using to overcome these barriers. Information from the in-depth evaluation suggests that the main factor involves psychological barriers to help-seeking. Cost, transportation, opening hours and waiting times to see practitioners were also mentioned.[57]

### Psychological barriers to help-seeking

> I noticed something wasn't quite right long before I spoke to anyone about it. I tried to hide it from everyone for months and months. Then I had a psychotic episode and thought I should maybe seek some help. (Male, 25 years old)

> Mental barriers, mine were negative experiences in the past and thinking how can somebody else that has no relation to you change my life, how is he going to improve my life. Young people, they think, "I'm strong and I can do this myself. And coming here could be a sign of weakness". (Female, 17 years old)

Psychological barriers are a major deterrent to people seeking help for mental health problems. The NYPCS, for example, found that, while 76 per cent (n=1874) of young people thought it was appropriate to seek help for a physical health problem within four weeks of the problem presenting, only 66 per cent (n=1825) thought the same for a mental health problem (Table 6.16).

**Table 6.16: Proportion of young people who think a person should seek help for a physical or mental health problem within 4 weeks of the problem presenting**

| | Mental health | | Physical health | |
|---|---|---|---|---|
| | n | % | N | % |
| Young people 12-25 | 1825 | 66 | 1874 | 76 |
| 12-17-year-olds | 913 | 70 | 938 | 75 |
| 18-25-year-olds | 912 | 62 | 936 | 76 |
| Males 12-25 | 907 | 67 | 933 | 67 |
| Females 12-25 | 918 | 65 | 941 | 78 |

Source: BMRI, NYPCS, 2008

The young people interviewed for this evaluation said that they had experienced psychological barriers to help-seeking prior to coming to headspace. They had been concerned about their friends knowing they were using headspace services because they did not want to be seen as 'mental'. However, it would appear that headspace is

[57] The in-depth evaluation sample comprised only those young people who engaged with the service, and not those who visited headspace once but did not return, or who did not access headspace at all.

challenging this barrier, because some of the young people had found out about headspace from their friends, and were accessing it because their friends were.

Other psychological barriers involved negative experiences with counsellors and mental health services in the past, or inaccurate perceptions of mental health services or of the practitioners they would see (e.g. concerns about confidentiality, being judged and not being respected), or scepticism that mental health services could actually help them.

A further psychological factor impacting on access and engagement was young people's willingness and 'readiness' to seek and accept support. CYS staff suggested that the young people who failed to engage or to return for further appointments were often those who were not at headspace voluntarily (e.g. their parents had persuaded them to attend, or they were attending as part of a juvenile justice program).

### Cost

At Wave 1, concern was expressed by a number of young people, as well as by carers and service providers, about the fact that they could not afford mental health consultations once their MBS bulk-billed sessions had been used for the year. This seemed to be less of a concern at Wave 2 as few CYSs were charging young people gap fees, and clients seemed able to keep seeing practitioners at no personal cost for as long as staff felt it was necessary. Young people also said that they were more inclined to seek help at headspace, rather than elsewhere, because they knew the service was free of charge.

### Opening hours

Most CYS sites provided clinical services during business hours. This made accessing services difficult for those young people who needed to take time off work or school to attend appointments. Even for young people who did not study or work, early morning appointments were a challenge, especially for young people with poor sleep patterns. One young person reported that it was difficult to be 'ready for an interview at 9 am in the morning … if you have depression'. Service providers commented that, to make headspace services more youth-friendly, longer and youth-friendly opening hours were important, although this would be difficult to implement because of workforce implications. By Wave 2, several in-depth evaluation sites had extended their service hours, at least on one or two days a week, and believed that this was contributing to improved accessibility and 'youth friendliness'.

### Physical space

The buildings in which CYSs are located vary greatly in how pleasing and welcoming they look, and in the amount of space they have. Many are located in converted houses and service delivery environments and few buildings are custom-built for the delivery of services to young people. Most of the sites in the in-depth evaluation had reached physical capacity by Wave 2, and in most cases, lack of physical space prevented sites from taking on more practitioners or clients. Few sites had large enough areas to work with groups, and that limited their capacity to undertake the social recovery components of the headspace model. Most sites managed the limited space well, but at Wave 2 there were a small number of sites that still had significant physical and spatial problems. While most sites had resolved sound-proofing issues, a

small number had still not sound-proofed all the consultation rooms by Wave 2. Physical accessibility was also an issue. Some of the buildings in which the CYSs were located were not accessible to people with physical disabilities because they had stairs. A small number of sites were also located in buildings that required service users to use an intercom or to sign to gain access, and this may present a barrier for some young people.

There was generally insufficient space available for practitioners to have their own dedicated offices and they usually had to use any available room. A small number of service providers commented that some young people found it disconcerting and disruptive to move rooms. However, GPs seemed to be able to manage any potential anxiety about this, because none of the young people interviewed for the in-depth evaluation reported it as a problem.

### Waiting time to see practitioners

Waiting lists for practitioners also presented a barrier to accessing services for some young people. The proportion of services with waiting lists increased markedly between Waves 1 and 2 of the evaluation for all services – GPs, psychologists, psychiatrists, AOD workers, and others (Table 6.17). This reflects the increase in demand for services as awareness about headspace has grown in CYS communities. As well as the increases in the proportions of services with waiting lists, the range of waiting times increased. For example, in the case of GPs, the waiting times at Wave 1 ranged from one week to four weeks, and at Wave 2 they ranged from 0.2 of a week to five weeks. However, the average waiting time decreased for all services between Waves 1 and 2, and this suggests that, between the two Waves, sites developed more effective strategies for addressing waiting times. The longest waiting times were for psychiatrists (an average wait of 4.7 weeks at Wave 2). This reflects the shortage of psychiatrists identified earlier (see section 5.2).

**Table 6.17: Waiting lists for CYS service providers (CYS managers)**

| Service | Wave | n | % | | | Weeks | |
|---|---|---|---|---|---|---|---|
| | | | Yes | No | N/A | Range of waiting time | Average waiting time |
| GP | Wave 1 | 26 | 23.1 | 42.3 | 34.6 | 1-4 | 2.65 |
| | Wave 2 | 27 | 42.9 | 32.1 | 22.2 | 0.2-5 | 2.0 |
| Psychologist | Wave 1 | 26 | 38.5 | 34.6 | 26.9 | 0.1-6 | 2.85 |
| | Wave 2 | 26 | 61.5 | 26.9 | 11.5 | 0.2-7 | 2.56 |
| Psychiatrist | Wave 1 | 26 | 11.5 | 11.5 | 76.9 | 2-6 | 5 |
| | Wave 2 | 24 | 20.8 | 8.3 | 70.8 | 2-8 | 4.69 |
| Drug & Alcohol Worker | Wave 1 | 26 | 3.8 | 50.0 | 46.2 | 2-4 | 3 |
| | Wave 2 | 23 | 13.0 | 65.2 | 21.7 | 1-7 | 2.94 |
| Other | Wave 1 | 12 | 33.3 | 41.7 | 46.2 | 1-6 | 2.83 |
| | Wave 2 | 12 | 50.0 | 16.7 | 33.3 | 0.2-6 | 1.94 |

Waiting times are counter-productive, primarily because young people need to be supported when they are 'ready' to accept help. CYS staff indicated that this 'window of opportunity' to provide support was often short-lived, and therefore it was crucially important to take advantage of it at the time the young person first sought help. CYSs did attempt to reduce waiting times by recruiting more practitioners and by using YMHI-funded access workers to maintain regular contact with clients in the interim.

Young people highly valued this support, and it helped to keep them engaged and attending appointments.

## 6.6 Conclusion

This section has explored the strategies headspace has used to attract young people, the numbers and characteristics of young people using CYS services and factors facilitating and discouraging young people's service access and engagement. It has shown that CA strategies are having a positive impact on help-seeking behavior, with increasing numbers of self-referrals and high numbers of service users, and have promoted youth mental health and referral pathways into headspace with community service providers. Importantly, CYSs are attracting young people in need of mental health support, as well as support in other life areas, such as physical health, substance use and social and vocational support. Most of these young people are at an early intervention stage, experiencing no, low or medium levels of psychological distress, particularly those aged 12-17, although CYSs are also supporting some young people with more severe or complex mental health needs. The main challenge for CYSs now is to engage those young people who are not currently using headspace services, but may be in need of mental health support. This will involve addressing some of the barriers to service use that have been identified as well as developing engagement strategies for hard to reach groups. The next section of the report explores the impact headspace is having on the young people using CYS services and examines strategies being used to ensure the quality of services is high.

## 6.7 Summary

*Key findings*

- headspace aims to attract and engage young people predominantly in the early onset stages of mental health disorders, presenting with mild to moderate mental health issues. It also aims to promote help-seeking behaviour among young people.
- To achieve its objectives, headspace has, among other things, developed local and national community awareness activities and campaigns, developed youth-friendly, accessible service sites and promoted appropriate referral pathways.
- headspace has used a variety of national and local community awareness activities, including advertising campaigns, school visits and forums with community service providers, to encourage help-seeking, promote its services and to raise awareness of youth mental health.
- Medicare data, showing substantial increases in the numbers of 15-24 year olds accessing mental health services, and referrals to headspace from health, education and community services, as well as self-referrals, suggest community awareness has been effective.
- Across Australia, headspace has provided services to almost 14,000 young people who, on average, have accessed CYS services 6.8 times each.

- The characteristics of young people using headspace are varied in terms of demographics, mental and physical health, work and education, relationships and alcohol, tobacco and drug use.

- Comparison with young people in the population at large suggests that CYSs are attracting young people with higher than average psychological distress levels and who also need support in other areas of the life, such as economic participation and substance use.

- The most frequently occurring diagnoses for young people attending headspace were anxiety and depressive disorders. Almost half of those with a primary diagnosis had received at least one other diagnosis, highlighting the high prevalence of co-morbidity in young people attending headspace.

- headspace has been effective in achieving its goal of early intervention: 53% of those using headspace services had no, low or medium levels of psychological distress. Nonetheless, CYSs are also successfully engaging many young people with high levels of distress: they constituted almost 47% of headspace clients, compared to an incidence of 2.6% in the general population of young people.

- Young people using headspace services were also more likely than those in the population at large to have poor physical health, be neither studying nor working, have poor or no contact with family members (even when living at home), and be higher than average users of alcohol, tobacco and other drugs.

- Young people access and remain engaged with headspace because of its youth friendly nature. Aspects of youth friendliness include the non-clinical environment, the good location of most CYSs, non-judgemental and trusting relationships between young people and their practitioners, a sense of control over service experiences, low or no cost services, and appointment reminders.

- Barriers to service use, which most CYSs are attempting to address, are mainly psychological, but also include perceived costs, opening hours, inappropriate physical space and waiting times to see practitioners.

- CYS practitioners were concerned that they were not attracting appropriate proportions of young people from particular backgrounds. Depending on their CYS location, this included young people with limited family support systems, those with lower socio-economic status, and those from Indigenous or refugee backgrounds.

*Lessons and recommendations*

- headspace needs to undertake regular reviews of the appropriateness and effectiveness of its marketing and community awareness activities, with a particular focus on whether and how they reach out to marginalised groups of young people.

- A second National Youth and Parent Community Survey is required to enable detailed analysis of the wider impact of community awareness activities by headspace.

- As CYSs have now established themselves as service providers within their communities, it is important that they ensure their services are engaging 'hard to reach groups', for example, young people in the lowest socio-economic status groups, those with limited family support, refugee communities and Indigenous young people.

- Largely as a result of their own success, many CYSs now have waiting lists for practitioners. This needs to be addressed in order that headspace does not miss the 'window of opportunity' to support young people ready for help and that further help-seeking is not negatively affected.

# 7 Service quality

headspace is intended to maximise outcomes for service users, primarily for young people but also for families and significant others. This section addresses the extent to which headspace has improved young people's mental and physical health, their economic participation, their relationships, and their alcohol and other drug use, as well as the ways in which these may differ according to age, gender and the location of each site. It also considers the impact of headspace on young people's families, and discusses how they perceive headspace services affecting the young people they care for.

headspace strives to achieve improved outcomes for young people and their families by providing quality, holistic and coordinated services. Quality services can be achieved by ensuring that they are evidence-based, and by increasing workforce capacity in the area of youth mental health through supervision and training. Another key contributor to improving young people's outcomes is integrating and coordinating services that come from a variety of different disciplines. (The holistic approach of headspace was discussed in Section 5). This section also examines how each of these factors has impacted on effective outcomes for young people, and how these factors changed between Waves 1 and 2 of the evaluation.

## 7.1 Outcomes for young people

> [headspace] helped me a lot. I'm coming here for my anger problem ... Since coming here I've improved 100%. My mum also says I've improved heaps, which makes me keep coming back. Before coming here my school work was really bad but lately it's improved a lot and I've been getting on better with my friends. Coming here has basically improved everything not just my anger. (...) This is only due to headspace because nothing else has changed outside. (Male, 15 years old)

This section investigates the impact headspace has had on young people across the four domains of mental health, physical health, social and economic participation, and alcohol and other drug use. The data sources used are the headspace dataset (compiled using MHAGIC software), the young people's survey, and the in-depth interviews with all the evaluation respondents. There is also some limited longitudinal information available from the young people's survey and the in-depth interviews.[58]

Due to the limitations of the data at this stage in the evaluation, it is not possible to draw any firm conclusions about the outcomes for the population of young people accessing headspace. This evaluation endeavoured to collect longitudinal survey data from a sample of young people who accessed headspace both in 2008 and in 2009. However, the response rate from those who participated in the evaluation in 2008 was poor (n=28), so the survey results from Wave 1 and Wave 2 have been combined. The 28 young people who completed the survey twice, and longitudinal interviews with 16 young people, are used as case studies to indicate possible trends and trajectories;

[58] Due to the small sample size, the longitudinal data is not statistically representative, and hence is used simply to indicate trends.

observed differences and changes over time are not statistically significant. For the longitudinal aspect, the evaluation originally intended to primarily use the headspace dataset, but this was not possible due to the data currently available (see Appendix B: Additional methodological details for further information). As data collection from the CYSs improves, better longitudinal evidence will become available for understanding the impact of headspace on young people's outcomes. In the meantime, this section draws on data from the headspace dataset (where available), qualitative findings from interviews with young people, their families and service providers, and data from the young people's survey. Taken together, these data do suggest that headspace has generally had a positive impact for service users.

Young people's perceptions of the impact of headspace services are summarised in Table 7.1 and discussed in more detail in the following sections.

**Table 7.1: Young people's perceptions of the impact of headspace services (Young People's survey, n=169)**

| | n | Worse | Neither better nor worse | Better |
|---|---|---|---|---|
| Mental Health | 147 | 0 | 6.8 | 93.2 |
| Physical health | 131 | 2.3 | 35.1 | 62.6 |
| Sexual/Reproductive health | 68 | 2.9 | 61.8 | 35.3 |
| Drug and Alcohol Use | 79 | 1.3 | 31.6 | 67.1 |
| Feelings about bodily appearance | 121 | 3.3 | 50.4 | 46.3 |
| Involvement in social/community activities | 123 | 0.8 | 50.4 | 48.8 |
| Being able to work or find work (paid/voluntary | 99 | 1.0 | 49.5 | 49.5 |
| Being able to provide care (for family members, children or other people | 76 | 0 | 31.2 | 68.8 |
| Being able to go to school, TAFE or university | 108 | 1.9 | 38.9 | 59.3 |
| How you get on with family | 145 | 2.1 | 20.0 | 77.9 |
| How you get on with friends | 142 | 0 | 30.3 | 69.7 |
| How you sleep | 142 | 3.5 | 43.0 | 53.5 |
| Being able to care for yourself and your home, perform daily activities | 136 | 0.7 | 27.9 | 71.3 |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 121 | 1.7 | 19.8 | 78.5 |
| The place where you live | 129 | 3.9 | 42.6 | 53.5 |
| Being able to see doctors or health workers when you want | 142 | 0.7 | 21.1 | 78.2 |
| General happiness | 153 | 2.0 | 11.8 | 86.3 |

## Mental health

> Before coming to headspace I thought no one could help me, no one ... When I first started [at headspace] I was a bit stubborn but then I started to relax a bit and open up and I'm really doing good today, I'm actually walking in public with my head up. I still feel a bit weird but it's much better. (Female, 17 years old, longitudinal participant)

> [The impact of headspace] is small but you can see it. Like learning to be more positive, that's something I never did before, I was always a negative person. I've got really bad stress for no reasons sometimes. She's helped me deal with it, like giving me some techniques... it's a big difference. Everything counts. (Female, 19 years old)

Almost all the young people surveyed as part of the in-depth evaluation (93.2%; n=147) reported that their mental health had improved since coming to headspace. Improved mental health outcomes were distributed uniformly across all groups of service users and there were no statistically significant differences in mental health outcomes for young people based on age or geographic location, although women were more likely to think that their mental health had improved (97%; n=86) than men were (88%; n=56) (Table D.8).

However, fewer respondents felt that headspace had improved their feelings about bodily appearance (46%; n=121) or how they slept (54%; n=142). The 12-17-year-olds were significantly more likely to feel better about bodily appearance as a result of headspace (58%; n=50), than the 18-25-year-olds were (39%; n=70) ($p<0.05$; Table D.7). This suggests that body image may be a focus requiring attention within CYSs.

All of the 6.8 per cent of young people who did not report mental health improvement said their mental health was neither better nor worse since coming to headspace. Most of these young people were continuing to see practitioners at headspace and were hopeful that they would see some improvement in the future. A small number of these respondents, however, said that headspace had not helped alleviate their symptoms and were unsure whether sustained treatment would have any beneficial effect.

The headspace dataset gives some indication that young people's psychological distress decreased over time, from their initial headspace assessment throughout their additional visits (Table 7.2). Although the number of records is limited, when K10 scores in the headspace dataset (n=2222) were compared with the scores on subsequent headspace visits, average scores decreased from 28.1 to 26.9.[59] If it is to be at all possible to obtain a realistic view of the impact of headspace on young people's mental health, it is important that practitioners continue to measure and record psychological distress at young people's subsequent assessments.

**Table 7.2: Change in mean psychological distress (K10) levels between first assessment at headspace and later assessments (headspace dataset)**

| Assessment period | n | Mean | Range |
|---|---|---|---|
| First assessment at headspace | 2222 | 28.1 | 10-50 |
| Other assessments | 889 | 26.9 | 10-50 |

Note: change is not statistically significant using model.

The fact that there is a multitude of other influences on young people's lives makes it difficult to attribute any changes directly to the use of headspace services. But many young people themselves thought that headspace had had a substantial impact on their

[59] Note that the smaller average score still denotes a moderate level of psychological distress.

lives. They believed that, without it, they might not have progressed as far as they did. On the whole, young people interviewed in the in-depth study reported gradual improvements in their symptoms and behaviours. In most cases, young respondents reported that headspace provided them with strategies to manage their mental health issues and gave them greater insight into their own behaviour. They also indicated that they were more confident, tolerant, rational, assertive and positive and that they had better self-esteem and were calmer and generally happier than before they started visiting headspace.

**Physical health**

> I feel comfortable talking to him [the GP]; that's hard to find in a GP. Every time I go to a medical centre they give you a doc certificate, ask you three times if you are on pot and ask you to leave. For some reason they think I'm a stoner because I have this sleep problem. It's in and out. Here [at headspace] it's more conversational, they take more time to talk to you, you have the 30 minute appointment ... I don't sleep, so there is heaps of different factors and you need to talk that through. (Female, 21 years old)
>
> Having a counsellor and GP in same service is excellent. It's obvious that they prepare before she comes and read their notes. (Female, 22 years old)

Physical health services are an important part of the headspace model. They provide access points into headspace for young people, as well as continuity of care for those using the mental health services. They also go some of the way towards addressing the co-morbidity of physical and mental health problems.[60] Physical health services were popular with the young people who used headspace. They were particularly important in sites in regional and remote areas, where access to GPs and other primary health care providers was often limited.

More than half the young people surveyed as part of the in-depth evaluation (62%) reported improved physical health since using headspace services. Responses did not vary significantly with age or sex (Table D.7; Table D.8).

As discussed earlier, most CYSs had GPs on site and respondents found it extremely useful to have medical and counselling services co-located. This co-location not only encourages young people to seek help for physical health problems, it also increases the likelihood that they will follow the medical advice they are given. Young people said they would be more likely to take advice from headspace clinicians than from other doctors. They also said they felt confident about advice when it came from a number of different, trusted practitioners (from both a GP and a psychologist, for example). The interviews with the young people supported the findings in the literature that physical and mental health issues were often related (AIHW, 2007; Phelan et al., 2001). For example, for some of the young people interviewed, depression or addiction to prescription drugs was the result of long-term physical illness or injury.

[60] Further information about the provision of these services is available in Section 5.2.

### Economic participation

> headspace has been helping me, I was laid off because I had a car accident and I was really stressed out. We've been working on my career choices. (…). I have enrolled in courses with TAFE so hopefully I will be starting them next session. (Female, 20 years old)

> I'm not a case at work. I can keep a lot calmer at work in certain situations I used to freak out and stress out pretty easily at times. (Female, 25 years old)

Young people experience multiple benefits from engagement in education or work, one of which includes better mental health and well-being than those who are not engaged (Fergusson et al., 2001; Fryer, 2001; Reine et al., 2004). However, people with mental health disorders are less likely than the general population to be engaged in work and/or education (ABS. 2006a). A key part of the headspace model is therefore to support young people in their work or education and to support the re-engagement of young people who have become disengaged from economic participation.

Although supporting young clients to engage in work and education was secondary to improving young people's mental health, CYS practitioners did provide such support. In some cases, service providers recommended that young people remove themselves from stressful work or educational environments, particularly if these were exacerbating mental health issues, to enable them to focus on improving their mental health. Over half of the young people who answered this question in the survey (59%; n=108) said that headspace had improved their ability to go to school, TAFE or university, while 50 per cent (n=99) said it had improved their ability to work or find work (Table 7.1). Teenagers (12-17-year-olds) were more likely than 18-25-year-olds to feel that headspace had had a positive impact on their ability to participate in education (71%, n=51, compared to 49%, n=57) and on their ability to work or find work (61%, n=38 compared to 43%, n=60).[61]

Qualitative data from the in-depth study uncovered a number of factors affecting young people's ability or willingness to engage with work or education. These included caring responsibilities, physical health constraints, and mental health issues such as anxieties around interacting with colleagues and customers, pressures of work/education, difficulties concentrating, and lack of confidence. In many of these cases, young people were encouraged to take up casual or part-time work or education if full-time engagement was too challenging. Some who experienced difficulty finding appropriate paid employment were encouraged to become involved in voluntary work. Despite these challenges, respondents were generally positive about the impact of headspace on their social and economic participation. Young people who had regularly truanted, or who had been disengaged from education before coming to headspace, reported that they were now attending school more often or studying again. Many young respondents said they were thinking more about long-term future goals since attending headspace. Most of these young people attributed their improvements to the psychological support they obtained at headspace, rather than to

[61] These differences were only significant at the 10 per cent level ($p<0.1$), see Table D.7.

any help they received from vocational providers.[62] This suggests that vocational service providers need to be further integrated into the headspace model in order to be effective.

### Relationships with family and friends

> A lot of respect has come from my friends because of this place teaching me how to get that respect out of the people I'm involved with. I didn't know how to talk to people openly and as easily as I am today, I couldn't do this 12 months ago. Now I'm fairly confident about myself, I know a lot more about myself. (Female, 17 years old)

> I don't shut them [family] out any more. I used to shut them down before. Before, I just locked myself in my room and read or listened to music. (Female, 15 years old)

The quality of young people's relationships with family and friends can be crucial to their emotional well-being, mental health and socialisation (AIHW, 2007; Needham, 2008; Smart and Vassallo, 2008). CYS practitioners generally encouraged young people to engage or reconnect with family members when their relationships were strained or estranged. However, the degree to which practitioners encouraged family engagement depended on the nature of the individual relationships. In a minority of cases, practitioners had to discourage young people from engaging in relationships when those relationships were violent or abusive.

Just over three-quarters of the young people who answered this question in the survey (78%, n=145) believed that relationships with their families had improved since participation in headspace (Table 7.1). This differed by age and the difference was significant. In the case of the 12-17-year-olds, 89 per cent said they were getting on better with their families as a result of headspace, compared with 71 per cent of the 18-25-year-olds (Table 7.3). Most young people (70%, n=142, Table 7.1) also said that their friendships had improved since attending headspace. There were no significant differences by age.

**Table 7.3: Young people's perceived impact of headspace services on relationships with family by age (Young People's survey, %)***

| | n | Worse | Neither better nor worse | Better |
|---|---|---|---|---|
| 12–17 years | 61 | 1.6 | 9.8 | 88.5 |
| 18–25 years | 83 | 2.4 | 26.5 | 71.1 |

*$p<0.05$ (Chi square test).

On the whole, the young people who participated in interviews described better communication with parents, partners and friends. CYS staff encouraged them to discuss their concerns and feelings, either working with young people one-to-one, or using a family therapy approach to re-engage young people with their families. The

[62] By Wave 2, a number of CYSs had successfully engaged vocational providers, but several were still trying.

young people generally reported that involvement with headspace had made them more accepting of others, and that it had provided them with coping strategies to deal with relationship challenges. Many of the young people also said that headspace had given them more insight into their own emotions, and that it was this greater insight that enabled them to have better relationships with their families and friends. One service provider remarked that improvements in a young service user's mental health could improve all the relationships in the family, because the reduced pressure on parents meant that they were able to give more attention to their other children.

Sometimes it was young people's mental health problems – such as depression or anxiety – that made it difficult for them to establish and maintain relationships with friends and/or family members. At other times, it was the improvements that caused problems in relationships with friends. Stopping using alcohol or other drugs, for example, could cause problems with those friends with whom they had previously engaged in these activities. There were a few interviewees who expected that the quality of their friendships would further improve as they addressed their mental health issues, but several respondents with social anxiety or depression felt that it would be some time before they would be able to participate socially.

**Alcohol and illicit drug use**

> I've cut down my pot use from $50 to $25 a week since coming to headspace. Now I seem more able to wake up in the morning without feeling I need the cone to get through the day. I deal with things better. From drugs you always will be recovering, so it is a long process I will continue through my whole life. (Male, 25 years old)

As mental health and alcohol and other drug misuse often coexist, headspace also aims to reduce young people's alcohol and drug consumption. Although many CYSs had not yet reached their optimum capacity for supporting young people with AOD problems at Wave 2 of the evaluation, capacity has increased since Wave 1 and qualitative and quantitative data from the in-depth evaluation did suggest there had been substantial reductions in alcohol and illicit drug use.

According to the young people's survey, 67 per cent (n=79) of young people perceived that their use of AOD had got better since engaging with headspace. A further 79 per cent (n=121) believed that their ability to manage their emotions without the use of AOD had also improved (Table 7.1).

Young people's estimates of their alcohol and drug intake over the previous 12 months and in the last month before the survey also indicated that headspace had had a positive impact on reducing consumption. The proportion of high-risk alcohol users (according to frequency of alcohol consumption) declined from 15 per cent in the previous 12 months to 8 per cent in the previous one month (Table 7.4). This shows that almost half of all those who were high risk drinkers in the previous 12 months, were no longer high risk drinkers.

**Table 7.4: Change in frequency of young people's alcohol consumption (n=169, Young People's survey)**

| Alcohol consumption | Previous 12 months | | Previous 1 month | |
|---|---|---|---|---|
| | n | % | n | % |
| Does not drink | 30 | 18.4 | 60 | 38.5 |
| Low risk (drinks 2 days a week or less) | 109 | 66.9 | 83 | 53.2 |
| High risk (drinks 3 or more days a week) | 24 | 14.7 | 13 | 8.3 |

The survey results also indicated substantial decreases in the numbers of young people using illicit drugs(Table 7.5). These figures vary by substance type, but show, for example, that almost half of young people who consumed cannabis in the previous 12 months had not done so in the last month and almost all young people who had consumed either cocaine, inhalants, heroin or methamphetamines in the previous 12 months had not done so in the previous month. The Australian Illicit Drug Reporting System classifies illicit drugs into four main classes: i) heroin and other opioids; ii) methamphetamine; iii) cocaine; and iv) cannabis (Stafford et al., 2009). The sharpest decreases registered in the survey were for drugs in the first three categories, although it should be noted that the numbers of young people taking these drugs were very low. Cannabis was the most commonly used drug, and it had the smallest percentage decrease in the number of young people consuming it, although there was still a decrease of 48 per cent.

**Table 7.5: Change in frequency of young people's substance use (n = 169; Young People's survey)**

| Substance type | Consumed previous 12 months | | Consumed previous 1 month | |
|---|---|---|---|---|
| | n | % | n | % |
| Marijuana/Cannabis | 72 | 50.3 | 37 | 27.4 |
| Ecstasy | 43 | 31.9 | 11 | 8.6 |
| Pain killers/Analgesics | 33 | 24.6 | 16 | 12.5 |
| Methamphetamines/Amphetamines (speed) | 29 | 21.2 | 5 | 3.9 |
| Tranquillisers/Sleeping pills[a] | 24 | 18.0 | 14 | 11.0 |
| Cocaine | 16 | 11.9 | 1 | 0.8 |
| LSD/Synthetic or natural hallucinogens | 13 | 9.8 | 3 | 2.4 |
| Inhalants | 11 | 8.4 | 1 | 0.8 |
| Heroin, methadone, morphine or pethidine[b] | 8 | 6.0 | 1 | 0.8 |

a. Not prescribed by a doctor.
b. Not supplied as part of a medical program.

Interviews with young people revealed that respondents who had used alcohol or other drugs did so to relieve anxiety, to numb their emotions or to fit in with their friends. While most young people had not stopped using substances altogether, they believed that headspace had given them a greater understanding of how AOD affected their emotions and relationships, as well as providing them with strategies to cope without the use of drugs. This encouraged young people to change their alcohol and drug use behaviour, and as a result, it reduced the risks they face.

## Longitudinal case studies

Analysis of the subset of the 28 surveys and 16 interviews completed by young people in both Waves of the evaluation provides an interesting picture of trends in involvement in headspace over time for this small group of case studies. These 28 longitudinal participants were a diverse group of young people reflecting a range of demographic characteristics and levels of psychological distress, and with very different mental health needs. Half of them were no longer using headspace services. Because of the small size and the diversity of the sample, most differences are not statistically significant,[63] although results are generally positive and these respondents reported increased satisfaction in most life domains. This positive trend was generally stronger for the younger respondents (12-17 years).

**Case Study 1: Engaging young people**

Josie, a 24-year-old, has been attending headspace since she moved interstate with her partner in late 2008. She had been seeing a psychiatrist in private practice in the area where she was previously living.

When she arrived in the area in which she currently lives, she sought to make contact with psychological practitioners in order to have a point of call if she experienced any mental health problems. She initially contacted the area mental health service and found them uncommunicative and unresponsive. In contrast, she found headspace helpful and flexible, and far more focused on her needs than any of the previous mental health practitioners she had used in the past.

She believed that her mental health had improved since Wave 1, but noted that progress was gradual and non-linear. Highlighting the cyclical nature of mental health issues, Josie reported that she had had another 'major upheaval' in the months preceding the Wave 2 interview. At Wave 2, she reported that support she had received at headspace, and their advice about cognitive behavioural management techniques and lifestyle changes, had helped her to deal with her problems. Although she was still volatile, she said, she also reported that she was coping well.

Josie had not been working for several months prior to the Wave 1 interview, because she had found her previous job too stressful. By Wave 2, she was doing part-time voluntary work and was about to begin a paid job in new industry.

*Mental health and well-being*

Longitudinal respondents generally were more positive about their mental health at Wave 2 than they had been at Wave 1. However, some had had mixed outcomes, and said that some aspects of their lives had improved while others had not or had actually deteriorated. For example, a 20-year-old male said that his physical health had improved considerably between the Waves and that his mental health was improving gradually. He also said that, although his mental health state was noticeably better at Wave 2, he had been hospitalised for depression three months before the second

[63] Statistical significance is only reported where it occurred.

interview. There was also a small number of cases who reported that their situation had declined between the two Waves.

The younger respondents reported increased satisfaction across all seven of the domains in the Personal Wellbeing Index (PWI), while the older respondents reported increased satisfaction on only five of the PWI domains (Table D.9; Table D.10).[64]

The qualitative data from the interviews with the longitudinal respondents supported these survey findings. Although fieldwork observations suggested that several longitudinal respondents were in better physical and mental health at Wave 2, respondents' self-assessments did not always correspond with these observations.

**Case Study 2: Severe mental health problem**

Daniel, a 19-year-old living in one of the urban sites, was much more positive about his life circumstances at Wave 2 than he had been at Wave 1, when he had been suffering from depression and severe anxiety and had found it difficult to go outside his home. He had been disengaged from work and education for several months and was not actively looking for work.

At his first interview for the evaluation (2008), Daniel's demeanor was subdued and it was difficult to engage him in conversation. At Wave 2 (2009), he appeared to be physically healthier than at Wave 1 and was noticeably happier and more engaged. He confirmed that his mental and physical health had improved significantly between Waves and that he no longer felt anxious about going outside.

Since Wave 1, Daniel had made several life changes. Significantly, he had started working again and had begun composing music – something that he had not done for several months. He had not yet found work in his chosen field but felt optimistic that he was able to work towards achieving his goals.

He attributed many of the positive changes in his life to his involvement with headspace. Although he emphasised that improvements required a great deal of effort on his part, he acknowledged that headspace had helped to change his direction in life: '[Now] I have incentive, goals ... ideas about what I want to achieve ... It's a big change'.

*Satisfaction with areas in life*

Longitudinal respondents reported slightly increased satisfaction with a number of areas of life, including being able to provide care for others, being able to participate in education, relationships with family and friends, and general happiness (Table D.11). Only one increase was significant, and that was in the ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs. This corresponded to a slight decrease in reported satisfaction with AOD use (Mean=7.44 to 6.28; n=18). This paradoxical combination of indicators suggests that participants had begun to recognise that their substance use patterns were problematic but, as yet,

[64] The older respondents reported increases in satisfaction with: standard of living; achievement; safety; feeling part of the community; and future security; and decreases in satisfaction with health and personal relationships. All the differences were slight and none was significant.

had insufficient time to make substantial changes to their behaviour by ceasing to use alcohol or drugs altogether.

These longitudinal respondents also reported slight decreases in satisfaction in a number of other domains (as well as their alcohol and drug use): mental health; physical health; sexual/reproductive health; feelings about bodily appearance; involvement in social/community activities; being able to work or find work; how they slept; being able to care for themselves and their homes; and being able to see doctors or health workers when they wanted to. A possible explanation for this is that participants become increasingly self-aware as their involvement with headspace progresses, and hence that decreased satisfaction in some of these areas may not necessarily be a negative outcome, but rather, might reflect more 'realistic' views of their lives.

*Engagement in education, work and volunteering*

The proportion of longitudinal respondents engaged in education or work did not change substantially between the Waves, although there were increases in the proportion of those volunteering (26% to 41%) and those unemployed and looking for work (26% to 48%; Table D.12). This is a consequence of the fact that many of the young people who classified themselves as 'unemployed and looking for work' in Wave 2 had previously been disengaged from the labour market and had not been actively looking for work at Wave 1. This suggests that the young people increasingly felt able to work, even though they had not found appropriate work by Wave 2.[65]

*Impact of headspace services*

As noted in the previous section, the survey data from the longitudinal respondents recorded increased participation in education, work and volunteering, and increased satisfaction and personal well-being between Waves 1 and 2. There were no significant changes in satisfaction with any of the life domains between the Waves, although there were slight increases in some domains and slight decreases in others, including mental and physical health.

It is not known whether these changes resulted from the impact of headspace services. But information from the interviews with the longitudinal respondents suggests that it was those who had engaged with the program for less than six months and were no longer using headspace services at Wave 2, who were the least likely to report positive changes. Respondents who had engaged with the program for longer periods, and/or who had disengaged only after they and their practitioner felt that further treatment was unnecessary, generally reported more positive results.

In addition, the diversity of factors affecting young people's lives made it difficult for many respondents to definitively attribute the changes to their involvement in headspace. Overall, however, longitudinal respondents – like respondents more generally – were largely positive about their well-being at Wave 2, with many reporting increased self-awareness and greater motivation.

[65] This follows the ABS definition of unemployment: actively looking for work in the four weeks up to the end of the survey reference week (Australian Bureau of Statistics (2006b), *Labour Statistics: Concepts, Sources & Methods*, Cat No. 6102.0.55.001, ABS, Canberra. .

**Case Study 3: Early Intervention**

Sam, a 20-year-old, had been thinking about seeing someone for a couple of months before coming to headspace. After completing high school, moving away from home, and breaking up with his girlfriend, Sam had felt very down and was fearful of engaging with strangers in conversation. Motivated by friends, he finally started seeing a psychologist at headspace.

He reported 'trying to talk [himself] out of going to headspace' because he 'initially thought [he] would be taking services away from … someone who needed them more'. By Wave 2, Sam was confident that the services had helped him to deal with some of the issues he was facing and to gain an insight into himself, although there were issues that still hadn't been addressed. He did not reveal everything to counsellors, he said, because 'the right questions haven't been asked'.

Sam reported that he is now more confident interacting with others and that headspace had helped him address his problems differently. 'Now if I have a panic attack I use the strategies I have learnt here, [and think] "OK, what am I going to do about it?" rather than worrying about the event that has caused the attack'.

At Wave 2, Sam was in his final year of undergraduate study and was planning to continue to study the following year. He was continuing to use headspace services, but was seeing his practitioner less regularly as his need for support was decreasing.

**The effectiveness of headspace for different young people**

The target group for headspace services is young people aged 12-25, but it is important to consider whether headspace is having a more significant impact on some groups of young people than others, and why this might be the case, in order to target resources more effectively and identify areas where service provision needs to be improved.

Age: Although there was a diversity of opinion among service providers about which group of young people could potentially benefit most from headspace, many believed that the initiative had been most effective in engaging 12-17-year-olds and that this group had the greatest potential to benefit from the services. The survey data from both Waves found that headspace was generally effective for all service users regardless of age, but that 12-17-year-olds reported better outcomes than 18-25-year-olds on almost all indicators. This difference was significant in the domains of sexual/reproductive health, AOD use, feelings about bodily appearance, involvement in social/community activities, ability to work or find work, ability to go to school, TAFE or university, and getting on with their families (Table D.7). Physical health and sleep were the only indicators for which older service users had better outcomes than their younger counterparts, but these differences were not statistically significant. These findings are particularly important given that service access data shows that the 12-17-year-olds using headspace generally have a much higher satisfaction rate than 18-25-year-olds across most life domains (except AOD use), as well as experiencing lower levels of psychological distress. This is supported by other research showing that the prevalence of mental health disorders increases with age (Ford et al., 1999). This suggests that headspace may be most effective at supporting early intervention cases or young people with relatively mild mental health symptoms.

Sex: Both Waves of the survey found that headspace was generally effective for all service users regardless of sex. Although female service users did report better outcomes on almost all indicators, the differences were not statistically significant except for sexual/reproductive health (Table D.8).[66] Men and women using headspace services did not differ significantly, as shown in Section 6.3, except for feelings about their bodily appearance (Table D.3). This is important because while women were much less likely to be satisfied with their body image, they reported that headspace had a positive impact on this in similar proportions to men. This may suggest gender and body image is an area where headspace could focus more.

Location: According to the survey results, headspace was generally effective regardless of whether service users lived in urban, regional or remote areas. However, those in regional and remote areas[67] reported better outcomes than those in urban areas on all indicators except how they got on with their friends, how they slept, and their ability to care for themselves. These were not statistically significant differences, but the fact that headspace can be effective both in regional and remote locations and in urban areas, despite using different models, is an important finding.

Further analyses of the effectiveness of headspace for different groups of young people will become possible as the quantity and quality of data in the headspace dataset improves.

## 7.2 Outcomes for families and significant others

> I'm very happy that I rang them up [headspace]. I was almost ready to kick her out, not that I wanted to, and now it's liveable again. My daughter was just out of control. She wouldn't listen to me, she swore terribly and hit her smaller brother and we would all argue. It was crazy. And now that she's at headspace she has stopped bashing her brother, she listens again when I speak to her, it's just like magic, it's really good. I'm so, so happy. From having a war zone here, and that was bringing me down and everyone else, it's so much better (parent of young person receiving headspace assistance).

> The young person's mental health problems are often embedded in family difficulties. For this reason it is very important to work with families (CYS staff member).

This section discusses parents' and carers' involvement in headspace, their perceptions of the impact of headspace on the young person they care for and directly on themselves, and their satisfaction with headspace services. It uses interview data

[66] This may be because women are more likely to visit primary health services for sexual health reasons than men are (for example, for contraceptive services or pap smears).

[67] Due to the small number of headspace sites in remote areas, data from regional and remote was combined to preserve respondents' anonymity and increase data reliability.

from 41 carers (of whom, 4 were interviewed at Waves 1 and 2) and survey data from 40 carers who completed the survey at either Wave 1 or 2 of the evaluation.[68]

### Carer involvement in headspace

Parents and carers were most likely to become involved with headspace through referrals from another agency (46%, n=16). Other sources of information were: word of mouth; the young person in their care; and the internet, newspapers and television[69].

Practices relating to the acceptance of carer referrals varied from site to site and depended on the individual situation. Most services required the young people to refer themselves, but all services worked with parents/carers in supporting young people seeking help. The involvement of carers in the referral and assessment of and assistance to their young people varied, depending on the nature of the relationship between the family and the young person, and whether or not the family posed any difficulties for the young person, and taking into account the need to empower young people to take control of their own situations and treatment. The needs of the young person were not always congruent with what the carer/parent wanted.

Of those parents and carers surveyed, 61 per cent were involved in the referral process and 78 per cent were involved in the assessment process (Table 7.6).

**Table 7.6: Carers' involvement in referral and assessment processes (Carers survey, %)**

| | n | Yes | No |
|---|---|---|---|
| Did headspace involve you in the referral process? | 38 | 60.5 | 39.5 |
| Did headspace involve you in the assessment process? | 40 | 77.5 | 22.5 |

Almost all parents and carers expressed satisfaction with the opportunity to be part of the care provided to their young person (97%, n=38), with the level of information they received from headspace sites (95%, n=37), and with the communication between themselves the headspace worker(s) (97%, n=37).

### Carers' perceptions of headspace's impact on their young people

Most parents and carers believed that headspace had an important impact on the person they cared for. Carers overwhelmingly agreed that headspace had improved the mental health of the young person (92%, n=37), as well as their general happiness (85%, n=40) and their family relationships (80%, n=40). They also perceived that headspace had a positive impact in all other areas of the young person's life (Table 7.7). The low number of responses to some of the questions in this table indicates that

[68] There is no longitudinal analysis due to the small sample size.

[69] See also Section 6.2 Effectiveness of community awareness strategies and Section 8.1 which discuss referral processes.

carers had limited knowledge about the sexual health, and the AOD use, of the young person they cared for.

**Table 7.7: Carer perceptions about whether headspace has improved aspects of young people's lives (Carers survey, %)**

| | n | Disagree | Neither | Agree |
|---|---|---|---|---|
| Mental health | 37 | 0 | 8.1 | 91.8 |
| Physical health | 30 | 3.3 | 40 | 56.7 |
| Sexual/reproductive health | 12 | 0 | 41.7 | 58.3 |
| Drug and alcohol use | 14 | 0 | 42.9 | 57.1 |
| Bodily appearance | 27 | 3.7 | 51.9 | 44.4 |
| Involvement in social and community activities | 36 | 0 | 36.1 | 63.9 |
| Finding paid or unpaid work | 21 | 4.8 | 33.3 | 61.9 |
| Attending education or training | 34 | 0 | 29.4 | 70.6 |
| Relationships with family | 40 | 0 | 20 | 80 |
| Relationships with friends | 39 | 2.6 | 30.8 | 66.7 |
| General happiness | 40 | 0 | 15 | 85 |

Overall, carers and parents were positive about the effectiveness of headspace in helping the person they cared for (98%; n=40). They also reported high levels of satisfaction with specific aspects of headspace services, including the quality of the support their young person was receiving, the amount of support, the appropriateness of services received and the length of time they received them, referrals to other services, and the outcomes for their young people.

A minority of parents/carers were dissatisfied with some aspects of headspace. They reported poor services and lack of follow-up of their young person. They felt excluded from their young person's relationship with headspace staff, and believed that headspace's individual orientation happened at the expense of family. A number of carers had concerns about GPs increasing the quantity of psychiatric medications their child was taking, and others did not know how they would support their young person's treatment in the longer term.

**Impact of headspace on carers**

> At headspace they help me as well, and I'm just happy that my daughter is better and she seems so happy. (...) now I know how to get along with me kids, I used to do everything for them but now I ask them to help me with the washing and the shopping and they'll do it, they won't argue with me. headspace has shown me to ask for help (parent of young person receiving headspace assistance).

An individual's mental health commonly impacts upon the well-being of their closest friends and family (Gubman, 1987). Most carers (85%, n=39) said that their quality of life declined when their family member started to develop mental health symptoms. In contrast, 93 per cent (n=40) said that their quality of life had improved since the young person had been attending headspace, thus acknowledging the wider impact improving the mental health of young people can have.

In the interviews, parents and carers described a number of positive outcomes for themselves and their families. These included feeling better in general, sleeping better, feeling less depressed, getting on top of household chores and being better able to look after other family members, being able to cope better in the parenting role, and feeling less judged or blamed for their child's problems. Carers also said that their own relationship with the young person had improved, as had the young person's relationship with other family members (e.g. siblings), largely as a result of better communication. Carers said they found it useful to receive feedback from headspace practitioners about the young person's progress, and to learn about opportunities to support such progress at home.

Few carers and families had received family counselling, either within headspace or through referrals to other support agencies. Only 28 per cent of the carers surveyed had received family counselling (Table 7.8), although not always from within headspace. One of the main criticisms carers had of headspace was the lack of support for carers. Although carers acknowledged that it might not be appropriate for them to receive support from headspace itself, they felt that headspace practitioners lacked awareness of support services available to carers. The main carer supports desired were family counselling (55%), and guidelines for managing emotional distress (53%), challenging behaviour (47%) and mental health problems (38%).

**Table 7.8: Supports that carers currently receive and would like to receive (Carers survey, Wave 2 only, n=19, %)**

| | Currently receive | Do not receive, but would like to receive |
|---|---|---|
| Peer support | 3.5 | 22.2 |
| Individual counseling | 8.7 | 11.8 |
| Family counseling | 27.6 | 54.5 |
| Access to information about mental health and related issues | 30.0 | 40.0 |
| Information about mental health and related issues | 22.2 | 23.1 |
| Guidelines for the management of emotional distress | 16.0 | 53.3 |
| Guidelines for the management of challenging behaviour | 16.0 | 46.7 |
| Guidelines for the management of mental health problems | 12.5 | 37.5 |
| Other | 8.7 | 5.9 |

## 7.3 Practitioner perceptions of service quality

The generally positive outcomes reported by young people attending headspace and their families were reinforced by reports from service providers, both those from outside headspace and CYS practitioners themselves. Most external service providers whose clients had used headspace services were positive about the quality and appropriateness of those services for their clients, with demonstrable improvements between Waves 1 and 2 of the evaluation (Table 7.9).

**Table 7.9: Satisfaction with headspace services (Service provider survey, %)**

| | Wave | n | Very / somewhat dissatisfied | Neutral | Somewhat / very satisfied |
|---|---|---|---|---|---|
| Quality of support client is receiving from their headspace worker | Wave 1 | 126 | 7.1 | 14.3 | 78.6 |
| | Wave 2 | 161 | 5.6 | 7.5 | 87.0 |
| Appropriateness of headspace services for client | Wave 1 | 134 | 4.5 | 10.4 | 85.1 |
| | Wave 2 | 167 | 7.2 | 5.4 | 87.4 |

CYS staff responding to the survey also perceived headspace services to be of high quality, with significant improvements between Waves 1 and 2 of the evaluation. Staff believed headspace was effective as an early intervention strategy for 12-25-year-olds, because it targeted youth at risk of developing mental health problems, provided youth-friendly services, and targeted the needs of young people in each local area. These results suggest that CYSs were effectively tailoring services to local and individual needs (Figure 7.1).

**Table 7.10: Effectiveness of headspace CYSs (CYS survey, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective |
|---|---|---|---|---|---|
| As an early intervention strategy for 12-25 year olds ** | Wave 1 | 130 | 3.8 | 9.2 | 86.9 |
| | Wave 2 | 208 | 2.4 | 2.9 | 94.7 |
| Targeting youth at risk of developing mental health problems * | Wave 1 | 131 | 5.3 | 14.5 | 80.2 |
| | Wave 2 | 207 | 4.8 | 3.9 | 91.3 |
| Providing youth friendly services * | Wave 1 | 131 | 3.8 | 9.9 | 86.3 |
| | Wave 2 | 212 | 1.9 | 0.9 | 97.2 |
| Targeting the needs of young people in local areas * | Wave 1 | 131 | 5.3 | 9.2 | 85.5 |
| | Wave 2 | 209 | 4.3 | 1.9 | 93.8 |

*p<0.01; **p<0.05 (Chi square test)

A small number of stakeholders interviewed in the in-depth sites said that the reliance of the CYS model on MBS items and private providers limited the reach of headspace services, and this could be detrimental to the outcomes for young people in remote areas. This is a structural issue, indicating that the model requires some flexibility/changes for different geographic areas.

## 7.4 Factors impacting on effective outcomes

The CYSs have generally provided a smooth, coordinated, high-quality service experience for young people from referral to service exit. They have done this as part of their implementation of the headspace model, but also with support through the research work of the CoE and through training and supervision.[70] CYS practitioners

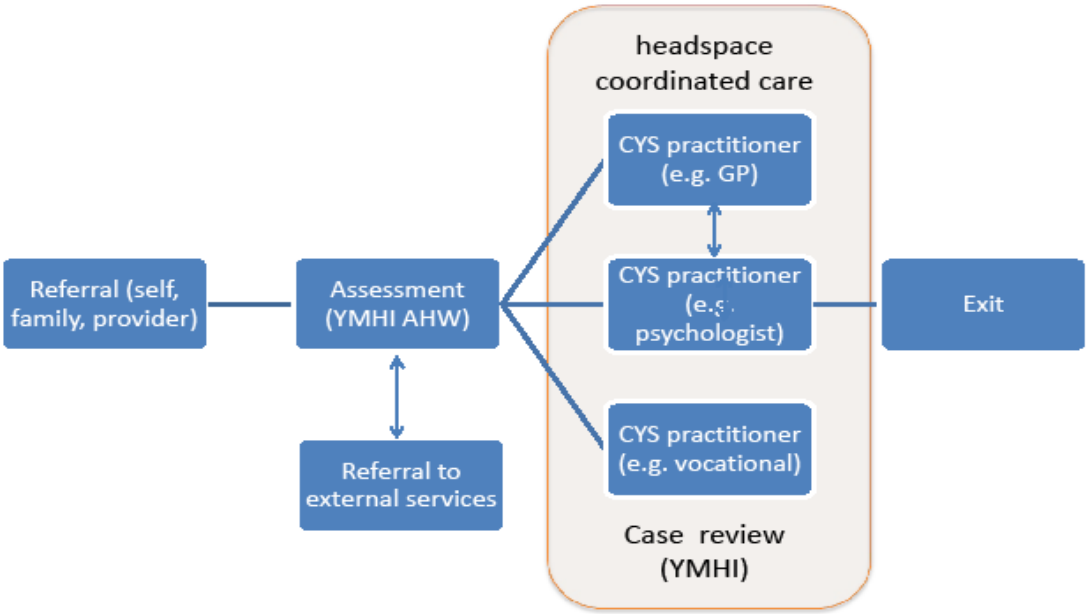
[70] See also Section 5.3 and Section 9.3.

and external service providers also reiterated the impact of these factors on effective outcomes, along with strong clinical governance.

*A seamless episode of care*

Good practice 'episodes of care', which were seamless, coordinated and supported service experiences from referral through to the last visit, were important for young people's continued engagement in headspace, and, in turn, their outcomes. While episodes of care were often tailored to individual needs and the service model implemented at each site, generally most CYSs had a similar broad episode of care. A young person is referred to headspace, is assessed and further referred to different providers within and outside of headspace, accesses services (which are coordinated and case reviewed); and, once the young person is ready, exits headspace. This is illustrated in Figure 7.1.

**Figure 7.1: Good practice episode of care for young people attending CYSs**




While this process appears relatively linear and step-wise, the steps may differ depending on the CYS and/or young person's trajectory of care. For example, young people may access a social or recreational service within a CYS and then be assessed for further services. Alternatively, a young person's first contact with headspace may be via a GP who then refers the young person for a more substantial assessment and/or directly refers them to a psychologist within the headspace site.

Where episodes of care were seamless and good practice, the following steps occurred:

- A young person self refers or is referred from another provider in the community.

- Within approximately one week the young person is assessed on their first appointment by a YMHI AHW with expertise in mental health to determine their individual needs and the types of services and supports that may be most appropriate for them, both within and outside of the CYS.

- The assessment is reviewed as part of broad case reviews of all new assessments to maintain consistency and ensure good clinical governance. The case review team consists of CYS staff/practitioners and an external expert (such as a psychiatrist or an experienced state/territory mental health clinician).

- If the assessment determines that the young person is best supported by services in the broader community, they are referred outside of the CYS. However, the YMHI worker may continue to support the young person and/or work with the external provider. The young person may also return to headspace at a later time or be supported by headspace and external providers simultaneously.

- If the young person requires mental health support, they will be referred to a GP within headspace to have a MHCP completed[71] and six MBS funded sessions will be initially set up with a psychologist or another mental health worker. The needs of the young person will be matched to the expertise of the particular skill set of the psychologist.

- A further 6 to 12 appointments may occur if the GP and psychologist determine that this is in the best interest of the young person and the GP renews the MHCP. These appointments occur once a week while need is high and decrease in frequency as the young person improves.

- The young people will attend headspace and have a number of appointments with different types of providers on an individual needs basis (e.g. primary health, mental health and vocational provider). These services are directly or indirectly coordinated by YMHI AHWs who also are often responsible (with key stakeholders) for individually reviewing a young people's care and facilitating team reviews.

- The young person exits headspace services when they no longer require support. While this is generally agreed between the headspace practitioners and the young person, the young person often discontinues their attendance at headspace at least one session prior to the full completion of an episode of care – that is, before their full 6, 12 or 18 sessions are completed.

- The young person re-enters headspace at a later point in time (if required) and repeats the above process.

The in-depth evaluation found that episodes of care were mostly good practice. The seamless nature of episodes of care were compromised when YMHI AHWs did not have expertise in mental health, when waiting lists were long and young people were

[71] If they were not already initially referred to headspace with a MHCP by an external GP.

not supported by a YMHI worker in the interim and where cases were not reviewed. For positive outcomes to occur it is important that the actual services received are of high quality.

**Service quality**

*Evidence-based services*

Evidence-based practice refers to scientifically rigorous research findings and knowledge applied to service delivery to improve patient care and outcomes (Lubman et al., 2007; McGorry, Killackey et al., 2007). Within headspace, all CYSs are expected to use evidence-based interventions to improve young people's health and their economic and social outcomes.

At Wave 1, most CYS managers agreed that their focus was on successfully establishing their CYSs, rather than tracking the use of evidence-based interventions. While there was some confidence that best practice was being implemented, there were few procedures in place to check that this was occurring. By Wave 2, there were stronger perceptions across the in-depth study sites that evidence-based practice was being implemented. Although some interviewees still found it difficult to provide examples, most CYS respondents were confident that the headspace initiative was effectively encouraging and incorporating evidence-based interventions in their work with youth mental health (Table 7.11). At Wave 2, 85 per cent (n=199) of CYS respondents said that their CYSs were effective at encouraging the use of evidence-based interventions, compared with 78 per cent (n=130) at Wave 1; and 87 per cent (n=194) reported that their site was effective at incorporating evidence-based practice into service delivery at Wave 2, compared with only 74 per cent (n=131) at Wave 1.

**Table 7.11: Including evidence-based practices in headspace sites (CYS survey, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective |
|---|---|---|---|---|---|
| Encouraging evidence-based interventions in youth mental health | Wave 1 | 130 | 4.6 | 17.7 | 77.7 |
| | Wave 2 | 199 | 5.5 | 9.0 | 85.4 |
| Incorporating evidence-based practice into work practices * | Wave 1 | 131 | 3.8 | 22.1 | 74.0 |
| | Wave 2 | 194 | 2.6 | 10.8 | 86.6 |

* $p<0.05$ (Chi square test)

These improvements may be in part a result of the support provided by the CoE and SPET between Waves 1 and 2 of the evaluation. The CoE became increasingly proactive in directly supporting CYSs by responding to their requests, and by assembling the available research evidence on youth mental health, including evidence-based treatments, and disseminating it to the CYSs. This included the production of detailed evidence maps, evidence summaries and 'mythbuster' overviews about a range of mental health conditions aimed at young people, families and practitioners. Also between Waves 1 and 2 of the evaluation, all seven of the SPET training packages were rolled out, and given that this training had a focus on

evidence-based services, it may have assisted CYSs to improve their evidence-based practice (see below).[72]

Evidence-based services were more visible in those CYS sites with strong clinical management, where clinical or case review team meetings took place on a regular basis (usually weekly or monthly) and involved state mental health psychiatrists, and where reviews of client case notes occurred (this was ongoing in at least one in-depth site). Service providers and CYS practitioners most commonly reported that the main problem with evidence-based practice was a lack of evidence about the efficacy of early interventions.

*Training*

Training is important both for practitioners and for non-clinical staff, and to ensure increased workforce capacity within and outside of the CYSs. Most headspace training was delivered via SPET, but there were other opportunities for staff training and up-skilling within some of the CYS communities. These opportunities varied over time, but there was a significant improvement in CYS staff views on the effectiveness of training opportunities provided between Waves 1 and 2 of the evaluation (from 63% to 87% for all respondents, and from 68% to 86% for the repeated sample[73]) (Table 7.12).

**Table 7.12: Effectiveness of CYSs in providing training opportunities (CYS survey, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective |
|---|---|---|---|---|---|
| All respondents * | Wave 1 | 131 | 16.0 | 20.6 | 63.4 |
| | Wave 2 | 199 | 8.5 | 4.5 | 86.9 |
| Repeated sample only ** | Wave 1 | 44 | 20.5 | 11.4 | 68.2 |
| | Wave 2 | 44 | 6.8 | 6.8 | 86.4 |

* p<0.01 (Chi square test); **p<0.05 (Mcnemar test for repeated samples)

Training participants who answered both of the online pre- and post-training surveys (n=123)[74] reported that they had increased their understanding, knowledge, skills and confidence in a number of domains as a result of undertaking SPET training workshops. After the training, these respondents were more likely than before the training to report that they had a good understanding and knowledge of a range of areas relevant to working with and/or supporting young people with mental health problems (and the differences in all areas were significant). Those areas were:

- the psychosocial development of young people and the purpose of aggression (strongly agreed: 7% at pre-training, 44% at post-training);

[72] For further information on the role of the CoE and SPET see Section 5.3 and Section 9.

[73] The repeated sample refers to those survey respondents who completed the survey at both Waves 1 and 2 of the evaluation.

[74] It is important to note that this only accounted for a small proportion of people who completed the SPET training.

- how to identify young people at risk of suicide and deliberate self-harm (strongly agreed: 20% at pre-training, 38% at post-training);
- the role of policies and procedures in managing challenging behaviours and preventing staff burnout (7% and 19%);
- the Comprehensive Assessment of At Risk Mental State tool and its application (13% and 38%);
- motivational interviewing principles to prepare young people for cognitive-behavioural treatment interventions (0% and 42%); and
- when to apply Problem Solving Skills Training (PSST) as an appropriate and effective strategy for addressing issues associated with emerging mental health and substance use problems in young people (0% and 17%).

Respondents who attended SPET training were also significantly more likely after the training than before to report that they had the following skills and the confidence to apply them:

- conducting a risk assessment of suicide and self-harm (strongly agreed: 7% at pre-training, 44% at post-training);
- implementing key strategies to prevent and manage crisis situations when young people became aggressive (14% to 44%);
- developing, implementing and monitoring a safety plan with a young person at risk of suicide or self-harm (7% to 56%);
- effectively engaging and communicating with young people at risk of developing psychosis, in order to assess symptoms, and risk and protective factors (13% and 75%);
- identifying psychotic symptoms and disorders and at risk mental states in young people (13% and 75%);
- discussing potential treatment interventions with young people at risk of psychosis (0% and 50%);
- involving carers/families in the assessment and management of ‘at risk’ clients (0% and 50%); and
- providing information to families and significant others caring for young people with emergent or recent-onset mental or substance use disorders (0% and 40%).

According to the in-depth evaluation, the availability and accessibility of additional training opportunities over and above the SPET training varied between CYS sites. Sites with the most opportunities usually had a lead agency with a strong focus on training, and staff were able to attend their training sessions. Some sites had undertaken internal professional development for YMHI workers to review the role of

the Access team, and some allowed staff to identify their own training needs appropriate to their roles and interests.

It is an APS requirement that psychologists attend professional development, but respondents expressed a number of concerns about training, including: the time constraints of attending, particularly for part-time staff; the lack of incentives to attend, especially for private practitioners who were unable to see clients whilst on training; a lack of training opportunities that were clinically relevant; and the difficulty for staff of committing themselves to training before the funding announcement for 2009/2010 was made.

*Staff supervision*

Supervision, for both staff and practitioners, was another key area of service improvement and way of ensuring service quality. The in-depth study at Wave 1 had found that some CYSs encouraged staff members to ask for supervision as a way of talking through workplace stress and developing particular skills. At Wave 2, both formal and informal supervision procedures had improved in the in-depth sites, although they were still not consistent across all the CYSs. One-on-one supervision and group supervision where staff could debrief and discuss problems were important, but both were not always available. Around two-thirds of staff perceived supervision to be effective, increasing to 69 per cent at Wave 2 from 60 per cent at Wave 1 (Table 7.13). Interestingly, a slightly higher proportion of the repeated sample found supervision effective (71% in Wave 1 and 81% in Wave 2). This is in line with findings in the literature showing that ongoing support for practitioners increases staff retention (Harvey and Hurworth, 2006; Larson et al., 1998; Wanous et al., 1979).

**Table 7.13: Effectiveness of CYSs in providing supervision (CYS survey, %)**

| | Wave | n | Very / somewhat ineffective | Neutral | Somewhat / very effective |
|---|---|---|---|---|---|
| All respondents | Wave 1 | 131 | 22.1 | 17.6 | 60.3 |
| | Wave 2 | 188 | 16.5 | 14.4 | 69.1 |
| Repeated samples only | Wave 1 | 41 | 19.5 | 9.8 | 70.7 |
| | Wave 2 | 41 | 7.3 | 12.2 | 80.5 |

Practitioners were often provided by CYSs with formal one-to-one supervision, but occasionally they had to arrange (and pay for) their own supervision externally. Clinical review meetings sometimes operated as forms of group supervision. As noted above, these aimed to improve services for clients, but they also facilitated shared practice between practitioners. In four of the in-depth sites, these meetings were facilitated by psychiatrists, whose time was often donated voluntarily or whose services were provided by a consortium partner. Most sites also had informal supervision and peer debriefing. This was beneficial, but it depended on the organisational culture. It is important for all sites to have supervision structures in place as part of common practice.

*Service evaluation/review*

Local evaluation and review of practices within CYSs were another mechanism to support service quality. At Wave 1, most sites were cognisant of the need to review

and improve the set-up and delivery of services, but it was too early for any major local evaluation. Instead, the focus was on collecting data and reviewing structures and procedures. In a number of CYSs, for example, AHWs had the responsibility for following up with young people about their service experiences. Sites with local youth advisory boards were also using this mechanism to obtain input from young people as a way of improving services.

By Wave 2, sites were still obtaining informal feedback from service users, but they had also developed more formal methods of feedback through exit surveys and from their youth advisory boards. They were also sharing practices amongst each other to improve policies and procedures. A number of the in-depth evaluation sites had visited at least one other CYS and made improvements to their own service as a result. These changes varied from site to site, and ranged from updating the initial assessment form to more substantial changes such as implementing case review meetings. Shared practice was viewed very positively among the in-depth study sites, and it was usually reported that it was an initiative of the management or staff within the CYS, and not something actively promoted by hNO. Although the CLN is intended to promote shared practice, the managers interviewed in the in-depth study said that the content of the CLN face-to-face seminars was predetermined by hNO and did not allow for local variations. The online CLN forum was largely regarded as positive, but using it effectively required time that many practitioners could not afford.

Staff at most in-depth sites were aware of the need to put more formal evaluation procedures in place. At one CYS, it was even suggested that local evaluations address the views of young people who do not want to attend headspace or who drop-out. The challenge for CYSs will be finding the resources to properly implement and conduct local evaluations.

**Service integration and coordination within CYS sites**

If headspace CYS sites are to be successful at providing multi-disciplinary, joined-up services to young people at a single location, it is essential that practitioners from different backgrounds not only work together, but work together effectively so that young people receive integrated packages of care. CYS sites are not intended to be places where young people visit multiple practitioners independently of each other. This section therefore analyses a young person's episode of care and the extent to which practitioners within headspace work together and whether this results in the effective integration of services for young people.

*Changes to service integration and coordination*

Both the level of service coordination activities undertaken at headspace CYS sites, and their usefulness, were reported to have increased between Wave 1 and Wave 2. Ninety-one per cent of respondents in Wave 2 (n=213), compared with 82 per cent (n=131) in Wave 1 reported that services are coordinated within CYS sites ($p<0.05$). Almost all the respondents surveyed in Wave 2 (n=212) were working together in various ways: referring clients to agencies outside headspace (90%); exchanging information (90%); and conducting joint service delivery or case management (89%). In the case of most coordination activities, the proportion of respondents involved had increased by Wave 2, with significant increases in the proportions of people involved in joint service delivery and of those involved in joint staff training (Table 7.15). Joint case management also increased between Waves 1 and 2 of the evaluation, although

joint planning decreased, probably because the integration of services moved beyond the establishment phase and into implementation. These changes indicate that service providers within CYSs were more likely to be working together across a range of activities by Wave 2.

**Table 7.15: Involvement in service coordination activities within CYSs (CYS survey, %)**

| Service coordination activity | Wave 1 (n=131) | Wave 2 (n=213) |
|---|---|---|
| Joint planning | 82.4 | 75.5 |
| Referring clients to other agencies outside of headspace | 86.3 | 89.6 |
| Joint service delivery or case management * | 80.9 | 88.7 |
| Exchanging information (about clients, projects, funding sources, etc) | 91.6 | 90.1 |
| Joint staff training for professionals from different backgrounds * | 77.1 | 87.7 |
| Meetings between professionals from different backgrounds | 86.3 | 90.1 |

*p<0.05 (Chi square test)

Not only did CYS practitioners increasingly work together between Waves 1 and 2, they also reported that working together had become more helpful (Table 7.16). Service delivery and case management were the two areas where perceptions of the usefulness of a coordinated approach increased the most between Wave 1 (84%) and Wave 2 (91%), while the most useful coordination activities at Wave 2 were meetings between professionals from different backgrounds (93%) and exchanging information (92%). There were no significant differences between Waves 1 and 2 for the repeated sample. This could be the result of small sample sizes, but it could also have been the case that, while working together had become more entrenched in CYSs overall, certain individuals continued working largely in isolation within their sites.

**Table 7.16: Perceived helpfulness of service coordination activities within CYSs (CYS Survey, %)**

| Service coordination activity | Wave | n | Never or rarely helpful | Sometimes helpful | Mostly or always helpful |
|---|---|---|---|---|---|
| Joint Planning | Wave1 | 108 | 2.8 | 20.4 | 76.9 |
| | Wave2 | 160 | 1.3 | 13.1 | 85.6 |
| Referring clients to other agencies outside of headspace | Wave1 | 113 | 3.5 | 20.4 | 76.1 |
| | Wave2 | 191 | 0.5 | 17.3 | 82.2 |
| Joint service delivery or case management * | Wave1 | 106 | 2.8 | 13.2 | 84.0 |
| | Wave2 | 189 | 0 | 9.0 | 91.0 |
| Exchanging information (about clients, projects, funding sources, etc) | Wave1 | 120 | 0 | 12.5 | 87.5 |
| | Wave2 | 192 | 1.0 | 6.8 | 92.2 |
| Joint staff training for professionals from different backgrounds | Wave1 | 102 | 1.0 | 13.7 | 85.3 |
| | Wave2 | 187 | 2.1 | 7.5 | 90.4 |
| Meetings between professionals from different backgrounds | Wave1 | 113 | 0 | 9.7 | 90.3 |
| | Wave2 | 192 | 1.0 | 5.7 | 93.2 |

*p<0.05 (Chi square test)

The young people who used the multiple services within headspace were positive about this experience in both Waves of the evaluation, and 68 per cent of those taking part in the survey reported that they had seen at least two practitioners, the most common combination being a GP and a psychologist. Young people said they found the holistic service beneficial. It increased the accessibility of services because visiting an additional service at a place they were already familiar with was less intimidating than going elsewhere, and because it was convenient to be able to see multiple practitioners in one visit. In addition, young people felt that it reduced the burden of having to repeat their stories and background, when clinicians collaborated and exchanged information. They also believed that the multi-disciplinary services and the coordination between practitioners assisted them to address issues in all aspects of their lives: from their mental and physical health to their home life and work or school experiences.

Wave 1 uncovered a range of factors that facilitated the integration and coordination of practitioners within headspace CYS sites, including shared infrastructure, clinical governance and the kinds of policies and procedures in place, and differences in leadership and attitudes. At Wave 2, shared infrastructure and clarity around the governance of CYS sites remained important precursors of internal service coordination. Respondents reported that policies relating to the governance of CYS sites had been further developed between the two Waves, and that the roles and responsibilities of providers at the sites had been clarified, which indicates that the integration of services within CYS hubs continued to improve. It is likely that this is a result of the fact that, by Wave 2, the CYSs had had more time to implement and refine these procedures (see Section 5 for more information regarding establishment and implementation issues).

Simply placing services together in one location does not automatically result in services that are well-coordinated internally (Leutz, 1999; May et al., 2008), so practical activities bringing all CYS staff together in a formalised way, such as case review meetings, remain important for developing coordination between service providers. At Wave 2, some of the sites that had been paying private practitioners to attend formal meetings using headspace grant funding were considering ending this arrangement due to lack of resources. Some private practitioners will remain engaged in coordination activities, either because of their commitment to headspace, or because they find the activities useful in terms of learning, sharing and debriefing, or because of negotiated memorandums of understanding. However, it is possible that provision of the same amount of funding over a longer period of time may lead to cut-backs in the extent to which internal coordination activities will continue in future. At some CYSs, GPs coordinated the young people's care so that the activity could be charged as a Medicare item. However, while this is not a direct cost for the headspace sites, it remains a headspace cost because it transfers it back to DoHA who fund headspace. It is also far less cost-effective, and possibly less effective generally, than to have AHWs coordinating care.

Due to the lack of resources for engaging private practitioners in formal service coordination activities, communication between headspace staff and the private providers about the young people's situations is done informally in some of the in-depth sites. According to one provider, this is a problem because:

> the model is designed to be holistic and, while it brings together practitioners [from different backgrounds], the communication still tends to be in silos. We continue to work individually.

Barriers to coordination between practitioners within each CYS site often involve practical considerations such as time and funding constraints, individual attitudes, and organisational culture. Table 7.17 lists a range of factors related to developing partnerships with other practitioners rated by CYS staff according to the extent to which each was seen as a problem.

**Table 7.17: Factors hindering service coordination in CYS sites (CYS survey, %)**

| Hindering factors | Wave | n | Always/ Often a problem | Occasionally a problem | Rarely/Never a problem |
|---|---|---|---|---|---|
| Time constraints | Wave1 | 121 | 41.3 | 42.1 | 16.5 |
| | Wave2 | 196 | 36.7 | 42.9 | 20.4 |
| Differences in funding sources to pay for professionals | Wave1 | 102 | 23.5 | 27.5 | 49.0 |
| | Wave2 | 153 | 13.1 | 27.5 | 59.5 |
| Territoriality between professionals | Wave1 | 120 | 13.3 | 31.7 | 55.0 |
| | Wave2 | 201 | 6.5 | 27.4 | 66.2 |
| Historical differences between professionals (e.g. terminology, service mandates, or practices) * | Wave1 | 112 | 16.1 | 35.7 | 48.2 |
| | Wave2 | 183 | 8.7 | 27.9 | 63.4 |
| Disagreement between professionals about funding sources and allocation | Wave1 | 98 | 14.3 | 23.5 | 62.2 |
| | Wave2 | 152 | 5.9 | 20.4 | 73.7 |
| Absence of effective leadership in promoting professionals working together | Wave1 | 118 | 11.9 | 25.4 | 62.7 |
| | Wave2 | 196 | 10.2 | 26.5 | 63.3 |
| Absence of a common vision for how to meet the needs of young people with mental health problems | Wave1 | 120 | 11.7 | 18.3 | 70.0 |
| | Wave2 | 199 | 8.5 | 15.6 | 75.9 |

*$p<0.05$ (Chi square test)

Time constraints were by far the most common practical hindrance to service coordination, with almost 80 per cent of staff in both Waves reporting it to be a problem ‘always’ or ‘occasionally’. The second most common factor hindering internal service coordination in Wave 2 was the absence of effective leadership in promoting professionals working together (it is ‘always’ or ‘occasionally’ a problem for 37% of respondents). All the constraints listed in Table 7.17 were seen as less of a problem at Wave 2 than at Wave 1, although only the difference relating to historical differences between professionals was significant ($p<0.05$, Table 7.17). These issues were affirmed by CYS staff who were interviewed. It would seem that relationships between practitioners developed over time, and that trust and respect between staff from different professions increased. Once coordination systems are established (such as clinical review meetings) and the benefits have been demonstrated, it is easier for staff to work together effectively.

## 7.5 Conclusion

This section examined the quality of headspace services in terms of their impact on service users, including young people and their families. It also analysed the strategies CYSs have used to promote successful outcomes and the factors that have impacted on the effectiveness of these strategies. CYSs have increasingly addressed service quality issues between Waves 1 and 2 of the evaluation, improving their use of evidence-based practices to support young people, and coordinating care to provide young people with a holistic service. This has not only resulted in improved mental health outcomes for some young people, but also improvements in their physical health, economic participation, social relations, and alcohol and drug use. Data from the small sample of young people indicate that headspace may be particularly beneficial for young people with early onset and early intervention needs, who are predominantly those aged 12-17 years. It is now critical for CYSs to improve data compliance in order to continue monitoring the effectiveness of headspace and to ensure that all headspace services, including those that are co-located, are coordinated to benefit young people and ensure they receive holistic care. While this section assessed the impact of headspace directly on service users, the next section analyses the impact headspace has had on the wider community by examining broader service reform.

## 7.6 Summary

*Key findings*

- headspace aims to maximise outcomes for young people and their families by providing holistic, high-quality services.
- Both the qualitative and the quantitative data showed that most young people surveyed reported improvements in their mental health, with reduced levels of psychological distress. Young people also found that headspace helped them develop strategies to manage their mental health, as well as greater insight into their own behaviour.
- More than half the young people surveyed reported improved physical health since using headspace. There were also significant decreases in the frequency of AOD use and almost 80% of young people stating that their ability to manage their emotions without AOD had improved.
- Approximately 50% of young people believed that headspace had improved their ability to go to school, TAFE or university, or to work or find work. Improved willingness to engage with work or education was largely attributed to psychological support received through headspace, rather than support from vocational service providers.
- Most young people described improved relationships with family and friends since accessing headspace services, although this was dependent on the nature of individual relationships. These changes were attributed to improved communication, increased self-awareness and the development of coping strategies to deal with challenging relationships.

- The findings indicate that headspace may be more beneficial for young people presenting with mild to moderate mental health problems, with whom early intervention is possible. These people are more likely to be aged 12-17 than older youths aged 18-25.

- The impact of headspace did not differ greatly between men and women, or between service users in regional and urban locations.

- Families and significant others generally felt that headspace had had a positive impact on the mental health of the young people they cared for and consequently on their own lives as well. However, there was some criticism concerning the lack of support available for carers through CYSs.

- Good practice 'episodes of care' are seamless and coordinated from the time a young person is referred to headspace through to their exit. An episode of care usually begins when a young person is referred to headspace. They are then assessed and further referred to different practitioners within and outside headspace and access services (that are coordinated and case reviewed) until they are ready to exit.

- Holistic services were a positive experience for young people. 68% of those surveyed had seen at least two headspace practitioners, most commonly a GP and psychologist. The multidisciplinary nature of headspace increased the accessibility of services for young people, and enabled young people to address issues across their life.

- headspace has improved the quality of services by using evidence-based practices, providing appropriate training and supervision for staff, and by informally evaluating services, although the extent of these activities has varied between CYSs.

- Service quality was particularly visible where there was strong clinical governance, including a champion to promote the use of evidence-based practice, regular clinical and case review meetings and additional training opportunities beyond those delivered by the SPET.

- Service integration and coordination within each CYS also helped to maintain service quality. Coordination activities have been facilitated through shared infrastructure, clear governance, and individual leadership and attitudes. The barriers to coordination were time and funding constraints and prohibitive organisational cultures.

*Lessons and recommendations*

- CYSs must improve data compliance, particularly around demographic characteristics and psychological distress (K10) at initial and subsequent assessments, in order to obtain a realistic view of the impact of headspace and the type of young people it is most effective for.

- CYS sites should consider strengthening services that may have a positive impact on young people's body image, especially for women. Satisfaction with feelings

about bodily appearance were, on average, rated somewhat negatively, and yet only 46% of service users perceived that headspace had improved these feelings.

- Improvements in young people's economic participation were largely attributed to psychological support, not to vocational providers, suggesting that vocational service providers require further integration into the headspace model to be effective.

- headspace has been effective in both regional and remote locations as well as urban areas.

- Greater support for families and significant others should be developed. Where this is not possible or desirable within CYSs, referral pathways for carers should be promoted and extended.

- All CYSs should have staff supervision structures in place to support practitioners.

# 8 Broader service reform

In addition to providing specific services for young people, headspace aims to promote broader service reform around youth mental health in Australia. headspace has striven to accomplish this through effective service coordination at a local and national level. In the broader context, service coordination in the community can be characterised as a range of working relationships that includes superficial agency interaction, altering how agencies work, sophisticated relationships between agencies and the structural relocation of services within a common governance structure. Using this definition it is evident that in communities in which headspace services are offered cooperation, coordination, collaboration and integration is occurring. This section describes the extent to which headspace has been successful in achieving a continuum of working relationships within CYS communities and in engaging government, as well as the factors impacting on this and any changes since Wave 1 of the evaluation.

## 8.1 Coordination in CYS communities

Service coordination within the communities in which the CYSs are situated is crucial if young people are to receive the most effective care to address their needs. This requires the integration of multi-disciplinary services within CYSs (as discussed in Section 5, but also across other community services, particularly in cases where headspace may not be able to provide all the support a young person requires. At a local level, CYSs have worked with organisations to promote referral pathways both into and out of headspace, developed working relationships with other organisations, primarily consortium partners but also other agencies, educated organisations such as schools and GPs to improve outcomes for young people presenting with mental health issues, and co-located services provided by other organisations at the same location as headspace services.

Since Wave 1, headspace has been effective in strengthening partnerships between existing services and developing new partnerships in CYS communities, and the improvement in both domains is significant ($p<0.05$; Table 8.1).

**Table 8.1: Development of partnerships in CYS regions (Service provider survey, %)**

| All agencies | Wave | n | Very ineffective | Somewhat ineffective | Neither effective nor ineffective | Somewhat effective | Very effective | Don't know |
|---|---|---|---|---|---|---|---|---|
| Strengthening partnership between existing services * | Wave 1 | 131 | 4.6 | 1.5 | 9.9 | 52.7 | 32.8 | 0.0 |
| | Wave 2 | 213 | 3.7 | 2.8 | 5.6 | 32.4 | 55.9 | 2.3 |
| Developing new community partnerships * | Wave 1 | 131 | 5.4 | 3.1 | 11.5 | 45.8 | 37.4 | 0.0 |
| | Wave 2 | 213 | 2.3 | 1.9 | 4.7 | 33.8 | 52.1 | 5.2 |

*p<0.01 (Chi square test)

The reported difference between Waves 1 and 2 in the extent to which services in the broader community were coordinated was also significant. While 70 per cent of service providers in Wave 1 believed that services in their communities were somewhat or completely coordinated, 80 per cent of respondents in Wave 2 did (Table 8.2).

**Table 8.2: Service coordination in CYS regions* (Service provider survey, %)**

| | n | Completely/somewhat Uncoordinated | Neither | Completely/somewhat Coordinated |
|---|---|---|---|---|
| Wave 1 | 232 | 15.5 | 14.2 | 70.3 |
| Wave 2 | 211 | 8.1 | 11.8 | 80.1 |

*p<0.05 (Chi square test)

There were many factors which influenced the degree of coordination between service providers in CYS communities, but the most important was perceived to be respect for and understanding of the mental health needs of young people, closely followed by a common working culture (Table 8.3). Government mandates were perceived to have the least impact on coordination. Among repeat respondents, a number of factors decreased in importance between Waves 1 and 2, i.e. the willingness of stakeholders to work together, leadership from headspace manager, and government mandates. This difference may be a result of the fact that coordination activities had moved out of the establishment phase and into the implementation phase. For example, CYS managers may have played an important role in establishing coordination activities, but once these relationships were successfully established, other staff, such as AHWs and YMHI workers, have increasingly taken on the role of implementing coordination.

Information from the in-depth evaluation also indicated that successful coordination was dependent on a number of factors: the leadership of key stakeholders; commitment from high-level stakeholders; an organisational and working culture that supported the work of headspace; sufficient time and resources; effective communication; and individual willingness. Co-location is a further aspect of the headspace model. However, shared premises do not necessarily result in effective coordination of services and care for young people (for further information about co-location, see Section 5).

**Table 8.3: Factors that promote coordination between service providers in CYS communities (Repeated service provider respondents, %)**

| Repeated respondents | | n | Never/rarely contributes | Occasionally contributes | Often/always contributes |
|---|---|---|---|---|---|
| Respect for and understanding of the mental health needs of young people | Wave1 | 117 | .9 | 8.5 | 90.6 |
| | Wave2 | 117 | .9 | 6.0 | 93.2 |
| Willingness among stakeholders to work together | Wave1 | 117 | 1.7 | 7.7 | 90.6 |
| | Wave2 | 117 | 2.6 | 11.1 | 86.3 |
| Common working culture that includes the goal of cooperation | Wave1 | 117 | 2.6 | 12.8 | 84.6 |
| | Wave2 | 117 | 1.7 | 11.1 | 87.2 |
| Leadership among agency administrators | Wave1 | 116 | 5.2 | 13.8 | 81.0 |
| | Wave2 | 116 | 2.6 | 11.2 | 86.2 |
| Headspace providing a forum to work together | Wave1 | 108 | 9.3 | 13.9 | 76.9 |
| | Wave2 | 108 | 11.1 | 10.2 | 78.7 |
| Leadership from the manager of your local headspace site * | Wave1 | 111 | 4.5 | 19.8 | 75.7 |
| | Wave2 | 111 | 13.5 | 11.7 | 74.8 |
| Common goals among agencies to secure funding | Wave1 | 109 | 8.3 | 22.0 | 69.7 |
| | Wave2 | 109 | 10.1 | 18.3 | 71.6 |
| Government mandates for more efficient and effective service provision | Wave1 | 112 | 16.1 | 26.8 | 57.1 |
| | Wave2 | 112 | 17 | 27.7 | 55.4 |

*p<0.05 (Mcnemar test for repeated samples)

## Referral pathways

In Wave 2, service providers in the CYS in-depth study reported that service coordination activities in the broader community were focused on the development of effective referral pathways. This is in fact the most common service coordination activity involving organisations in the regions surrounding the CYS sites. Developing seamless referral pathways is crucial for ensuring that young people who seek help are directed to the appropriate services and remain engaged until help is received, regardless of whether or not the young person fits the headspace target group, and whether the CYS is able to provide support or not.

At Wave 1, the CYSs were at different stages in the development of referral pathways because they were at different stages of implementation. Most of the sites that opened in the second round of funding were still focused on promoting headspace in the broader community, building understanding of the model both within and outside the CYS, establishing key contacts, and referring clients. Both internal and external participants in Wave 1 reported that the development of referral pathways could be hindered by one or more of the following: lack of understanding about how headspace fits in with the service network; lack of knowledge about the headspace target group among service providers in the community (this is crucial for making appropriate referrals to headspace); limited knowledge about services for young people in the broader community; and few support processes for engaging young people until they reached the appropriate service.

As discussed in Section 6, at Wave 2 referrals to headspace continued to come from a variety of sources and the number of referrals had increased since Wave 1, particularly from community service organisations and education providers. This points towards an increased awareness in CYS communities of the existence of headspace. The evaluation findings also indicated that there were more early intervention headspace services users at Wave 2 than there had been at Wave 1. This suggests that, over time, headspace has come to receive more appropriate referrals from service providers. Most of the service providers interviewed in Wave 2 said that they were actively involved in addressing the barriers to developing effective referral networks identified in Wave 1.

As well as the CA activities, there was an increased focus by the CYSs on communicating the role of headspace and its target group to service providers in the community. This was achieved through activities such as regular attendance at and organisation of interagency meetings. This also provided opportunities for headspace staff to build their own knowledge of other services to which they could refer young people. One CYS, for example, organised a meeting that not only exchanged information about what agencies did in the community but also involved discussing cases. This gave the participating organisations the productive opportunity to discuss how each might contribute in real-life situations. Knowledge of existing services was reported to be particularly important for urban sites because there were so many services in those areas. People in rural areas were more likely to report that they knew about the other services in the community to which young people could be referred.

headspace training events were also recognised as an important way of developing clear referral pathways. Cross-disciplinary training provided by headspace allowed providers to gain a better understanding of the headspace initiative, and to make new contacts, build existing relationships and, most importantly, create a common ground of understanding about how to work effectively with young people.[75]

Clarifying where headspace sits in the broader service system is an important aspect of developing clear referral pathways. Most of the CYS staff in the in-depth evaluation had increased their engagement with state mental health services by Wave 2, so that they could pass referrals quickly and seamlessly on to the appropriate mental health service provider. They had found this to be especially important in the case of those young people who had more severe mental health problems and required formal support from their state/territory mental health system, but who were not yet ready to access this support, or who had had difficulty accessing this support in the past, or who felt distrustful of the state system. The majority of sites were involved in developing joint case plans and attending case review meetings with state or territory government child and adolescent mental health services by Wave 2. This was seen as a useful strategy for building relationships, reducing overlap, deciding on the most appropriate service, and coordinating care for young people with more complex needs.

There were a number of factors that impacted on the numbers and appropriateness of referrals. Staff turnover could hinder the development of clear referral pathways

[75] Further information about perceptions of headspace training can be found in Section 7.4 and Section 9.4.

because organisational commitments risked losing momentum when key personnel moved on. Practical considerations in relation to information sharing and client confidentiality had been identified as barriers at Wave 1, and these still existed at Wave 2. In contrast, gaining client consent, which enabled information sharing across agencies, was believed to be central to promoting smooth referral pathways for young people. Finally, some service providers in both Waves had found that referral pathways could be blocked if people felt as though their organisations were in competition with headspace for clients and funding. As headspace increases its emphasis on social recovery, which is more likely to be offered in the community than mental health or AOD services, it is possible that competition between headspace and other NGOs in some CYS areas will increase. This would be particularly the case if the headspace model maintained its strong focus on integrating services in one location.

## 8.2 Service reform beyond the CYSs: engaging government

A central aim of headspace is to impact on policy development and investment in youth mental health at all levels of government. hNO has proactively engaged with government representatives at both the federal and the state/territory level in order to achieve this. This section uses data from interviews with government representatives, as well as policy analysis, to determine the extent to which this has been effective.

The evaluation has found high levels of awareness of headspace within national and state/territory governments, and an overall commitment to the principles practiced and advocated by headspace: that care for young people is early intervention, multi-disciplinary and coordinated. The impact of headspace on broader service reform is most evident in DoHA's commitment to refunding headspace for a further three years (2009-2012), and in the National Health and Hospitals Reform Commission's recommendation to expand the headspace program by establishing another 30 'youth friendly community-based services' accessible to all young Australians (National Health and Hospitals Reform Commission, 2009: 100-271). Furthermore, headspace has been discussed at the Council of Australian Governments (COAG); and the links established at Wave 1 between headspace and other Australian Government initiatives, such as the Mind Matters program, have been strengthened and more clearly defined by Wave 2.

At the state/territory level, key health officials perceived headspace as a valuable initiative and had some contact with CYSs in their jurisdiction and often with hNO. While this contact appeared more regular and consistent at Wave 2 of the evaluation, overall government stakeholders expressed the need for more regular meetings and a more structured engagement approach. Of particular interest to government stakeholders were new models of the provision of care, such as: public-private partnerships and their cost-effectiveness; integrated service delivery models; evidence-based interventions in youth mental health; and strategies of appropriately engaging with and responding to the needs of young people.

In both Waves of the evaluation, government stakeholders expressed the belief that headspace had the potential to influence several policy areas, particularly around promoting early intervention and youth-friendly services, reducing young people's need for public mental health services, and supporting young people with limited access to care. The potential to impact on policy and discourse development was

stronger in states/territories that have recently undergone mental health reform (Victoria, Tasmania, South Australia) and/or are planning or undergoing mental health reform (Western Australia and the Australian Capital Territory). In these states headspace had provided a platform for refining new ways of working together across different sectors and services, and continuing to challenge traditional models of care.[76]

Victoria and Tasmania's recent reforms, for example, have a strong youth and multi-disciplinary approach. *Because Mental Health Matters: Victorian Reform Strategy 2009-2019* identifies children, young people and families as primary reform areas, and aims to provide accessible, multi-disciplinary support to 12-25-year-olds with emerging mental health issues. It also endorses working closely with headspace CYSs wherever possible (Department of Human Services (Vic), 2009). In Tasmania, the *Youth Health Service Framework 2008-2011* states that services should strive to provide an integrated service model, with multi-disciplinary teams working in partnership, and in collaboration with headspace, to support young people's health and wellbeing (Department of Health and Human Services, 2008). While the Northern Territory (NT) has not undergone mental health reforms, they have incorporated young people's needs in other recent policies. For example, the NT Suicide Prevention Action Plan 2009-2011 focuses on promoting wellbeing and resilience among young people and their families (NT Department of Health and Families, 2009: 9).

The South Australian government has also identified young people and early intervention as important areas for future investment in *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*. *Stepping Up* shows that the South Australian Government does not believe the headspace model of a specialist youth sector is the right approach. Rather it recommends focusing on resolving service boundaries through 'integrated catchments' as a better transition between the adult, and the child and adolescent, mental health sectors (Department of Health (SA), 2008: 64).

Western Australia and the Australian Capital Territory are at very early stages in developing and implementing Mental Health policies and reform.[77] Interviews with government stakeholders suggest that young people and their different developmental needs, as well as mental health promotion and early intervention, have been identified as priority areas for these reforms.

Overall, while state/territory representatives did not believe headspace had changed the direction of the reform process, they nevertheless felt that the initiative had provided some guidance and vision on how to improve mental health services to the benefit of young people.

States and territories that were already working under existing or recently renewed mental health policy frameworks prior to headspace, had already focused their policies on young people and their needs to varying degrees. In Queensland, the *Plan for Mental Health 2007-2017* identifies prevention and early intervention (with

[76] For example, services provided in isolation rather than a holistic approach to care.

[77] As at August 2009.

particular reference to young people), coordinating care and inter-departmental partnerships as central priorities (Queensland Health, 2008: 7). In New South Wales, *NSW: A New Direction for Mental Health Plan 2006* outlines the Government's commitment of $28.6 million for the development of new youth mental health services for 14-24-year-olds, focusing on early intervention and multi-disciplinary teams in a 'one-stop shop' (NSW Department of Health, 2006: 9). While the overall reforms were not influenced by headspace in these states, Queensland and New South Wales child and adolescent mental health services have worked in collaboration with headspace.

The active engagement of policy makers was visible in various partnerships between headspace and state/territory governments even though the government focus was a broader mental health reform agenda. At Wave 2, two states were planning to include headspace representatives in the development of their reform strategy plans around mental health and early intervention for young people. Another state had involved a headspace representative on their Youth Mental Health Advisory Group. Several officials stated that they were considering using indicators from the national evaluation in future policy development and planning, while two states had already closely aligned their policy programs with headspace or referred to the initiative in their strategy and planning documentation. In states where the reform process was in the very early stages or had not yet commenced, government representatives reported that the commitment to youth mental health and early intervention at the national level had highlighted these priorities on their agendas.

Despite these advances, a number of challenges prohibited further coordination with government. For government stakeholders these challenges included the diversity of the CYS focus, operational differences, and the numbers of CYSs across states limiting a coherent integration with state services. At Wave 1, there had also been some frustration that states/territories had not been included in early discussions around the distribution of funds. However, at Wave 2, representatives mainly argued that headspace would have a real impact on policy making at this level only if there were more consistency in engaging governments.

Although hNO have actively engaged with government representatives, there is scope for further improvement. While headspace has had some impact on policy development within a number of states and territories, this influence is more tangible where strategic partnerships are being created between the state service system and headspace CYSs (as in Victoria and Tasmania). In other states/territories, the influence appears to have been minimal or absent(for example, in South Australia). Nevertheless, among government stakeholders there is also growing acknowledgement of the substantial potential for headspace to provide direction in the field of youth mental health and to affect government policy. The establishment and implementation of the 30 CYSs around Australia has also supplied an operational platform with which the strategic directions of governments can connect. Government has taken a number of key lessons from headspace including the need for appropriate, youth-friendly services as well as the integration of mental health, AOD, and primary care services.

## 8.3 Conclusion

This section has explored the impact headspace has had on broader service reform around youth mental health. It has shown that headspace now has wide recognition in the community. At both the local and the national level, there is increased awareness of youth mental health issues, and this has resulted from service provider training and awareness activities in CYS communities, collaboration between CYSs and state mental health services, and the engagement of government by hNO. Locally, the extent of service coordination is most clearly demonstrated through the effectiveness and improvements in referral pathways. However, a key challenge for CYSs will continue to be managing service integration for the benefit of young people where there are perceptions of competition between headspace and other services.

Nationally there is clearly a commitment to youth mental health and the most substantial impact of headspace can be seen in the refunding of the initiative for a further three years and the recommendations by the National Health and Hospitals Reform Commission for its expansion. At a state/territory level, while hNO has lobbied and worked with various government representatives to shape the direction of mental health policies, it is likely that reform was already on the right track, and that headspace made some contribution in those states/territories where plans have recently or are currently being updated.

## 8.4 Summary

*Key findings*

- headspace aims to promote broader service reform and increased awareness about youth mental health across Australia, both at the local level in CYS communities and at the national level, by engaging governments at federal and state/territory level.

- CYSs have coordinated services in their communities by working with organisations to promote referral pathways both into and out of headspace and to provide training for service providers about youth mental health in order to improve outcomes for young people.

- Factors impacting on the success of coordinated services are shared respect for and understanding of the mental health needs of young people, and a common working culture that includes the goal of cooperation, as well as sufficient time and resources and commitment from high-level stakeholders.

- The effectiveness and appropriateness of referral pathways improved between Waves 1 and 2 of the evaluation, largely as a result of increased communication about the role of headspace and its target population.

- Cross-disciplinary training and involving external providers in case review meetings were also effective in building relationships, reducing overlap, selecting the most appropriate care for young people, coordinating care for young people and generally creating a shared understanding of how to work effectively with young people.

- Barriers to referral pathways included staff turnover, client confidentiality and competition between service providers.

- hNO has effectively engaged with governments to increase knowledge and awareness of youth mental health issues among state/territory and federal health officials. This is most evident in DoHA's commitment to fund headspace for a further three years, as well as the many close relationships between state mental health services and some CYS sites.

- Most states and territories that are undergoing, or have recently completed, reform of their mental health policies have at least some focus on young people and early intervention issues, and some have also addressed issues of holistic and coordinated service provision.

- Government stakeholders perceived that the headspace initiative had provided guidance and vision in the reform and development of mental health services, although it had not substantially changed the direction of these processes. Only one state disputed the headspace approach of developing specialist youth mental health services.

- Further coordination activities at a government level are restricted by the diversity of the CYS focus, operational differences, and the numbers of CYSs in some states.

*Lessons and recommendations*

- Co-location does not automatically result in effective coordination of services and care. Where co-location occurs, CYSs need to ensure that there is collaboration and that the co-located service(s) are coordinated as part of the headspace model.

- Government representatives indicated the need for more consistency by headspace in engaging governments. This suggests that headspace may need to adopt a more structured engagement approach, with regular meetings, that can be rolled out in a similar way across all states and territories that wish to be involved.

- The impact of headspace on policy development is more tangible where strategic partnerships have been created between CYSs and the state mental health system.

# 9 Implementation of the national components

Strategies for improving the mental health of young people require not only the delivery of integrated services (through the CYSs), but also strengthening and supporting the capacity of the CYSs through the provision of CA strategies, evidence-based information, appropriate training, and strategic and operational support. This is the rationale behind the establishment of the CA, SPET, CoE, hY NRG and hNO components of headspace. The activities of each of the components are framed around the following four priority areas, identified in the *headspace Strategic Plan* (headspace, 2008):

- Setting direction: promoting reformed policy at all levels of government to achieve better access, care and outcomes for young people;
- Community support: strengthening community understanding and support for young people with mental health issues;
- Stronger services: establishing integrated multidisciplinary service sites in local communities that provide more effective systems of mental health and other care; and
- Youth and carer participation: working with young people and carers at all levels of headspace to inform service development (headspace, 2008b).

This Section outlines the components' deliverables against their strategic work plans, together with some of the challenges they have faced.

## 9.1 headspace National Office (hNO)

hNO has worked towards establishing headspace as a primary resource for youth mental health, through awareness-raising activities (detailed below), supporting headspace services in CYSs, and engaging government. It has played a major role in branding and marketing headspace and in the CA activities (see Section 9.2 below). hNO has been actively engaged in selecting and establishing the 30 CYSs, funding them, setting up headspace, and supporting them. hNO support has involved contract management and strategic guidance, facilitating shared learning across the sites (through the CLN), and providing operational and technical support[78]. hNO support for headspace services has also involved face-to-face events (such as the CLN events in Adelaide, Melbourne and Sydney) and e-forums (such as the CLN website). As well, hNO has played a role in providing evidence-based information and identifying effective strategies for ensuring the uptake of evidence within the CYSs through the CLN workshops (see also Section 9.3 below). hNO has ensured the involvement of young people in headspace by developing resources for their participation and establishing and supporting the hY NRG (see Section 9.5 below). However, hNO has yet to identify the most appropriate strategies for responding to the needs of particular groups of young people, such as Indigenous young people or young people from

[78] See also section 5.3 .

different cultural groups. It is also yet to implement a family/carer strategy for headspace.

hNO has also played a key role in working with government on youth mental health policy and funding. This has included meeting with mental health directors from each state and territory, as well as policy responses to a number of reviews, inquiries, commissions and strategies.[79] Audit data (March 2009) indicates, however, that hNO is yet to establish a policy unit which would serve as an advocate for the development of appropriate policy and funding at the national and state/territory levels. This is most likely because of limited time and resources.

hNO is also tasked with establishing a Trust to provide for corporate sponsors and donations. This will be possible as Deductible Gift Recipient status was received in September 2009. Finally, the evaluation of headspace, the minimum dataset, and the contracting of the independent evaluator, is supported by hNO. At Wave 2 of the evaluation, hNO was still in the process of establishing headspace as a company limited by guarantee, and finding new locations for itself and for the CoE.

The work of hNO has been central to headspace's implementation, both of the CYSs and of the other headspace components. Despite an initial limited budget, without hNO it is unlikely that the initiative would have progressed as far as it has. Many of the challenges faced by hNO are the result of the previous governance structures and a lack of resources, coupled with the fact that the CYSs required higher than anticipated levels of support. The new governance structure and funding restructure should help to address these past challenges.

## 9.2 Community Awareness (CA)

Deliverables involving CA activities as outlined in the *headspace Strategic Plan* (headspace, 2008) are focused around supporting local community campaigns, building strategic partnerships, and developing greater national awareness of headspace and youth mental health. At Wave 1 of the evaluation, most of the intended CA activities were shared between the CA component at the BMRI, and the Media, Communications and Marketing Team at hNO.

### BMRI CA

At Wave 1 of the evaluation, the BMRI CA was focused on reviewing evidence and conducting original research on CA and the help-seeking behaviours of young people with mental health problems. It conducted a Computer Assisted Telephone Interview (CATI, NYPCS) about CA and help-seeking, and at that time it played a minor role in the actual development and production of CA resources.

Since Wave 1, the BMRI has prepared a draft report on the first NYPCS (CATI-I), which has been reviewed by the hNO and submitted for peer review (although it had not been published by headspace at the time of writing). The team at the BMRI is also preparing six journal articles on the data to be published in a supplementary issue of the *Medical Journal of Australia* in 2010. The report on the second NYPCS (CATI-II)

[79] These include the ATAPS Review, the Inquiry into the Bullying of Children and Young People, the national Health and Hospitals Reform Commission, Towards a National Primary Health Care Strategy, the National Mental Health Plan and the new Victorian Mental Health Strategy.

was being rolled out at the time of writing. The delay in reporting on this survey was attributed to the extensive consultation required on its format and content. In addition to the CATI surveys, the BMRI has published two peer-reviewed journal articles based on qualitative research with young people at headspace, submitted two additional articles to academic journals, and run consultation meetings with CA workers.[80] The BMRI also funded airfares, food and venue hire for three face-to-face consultations with CA workers from headspace CYSs. The first event involved 30 workers from 17 CYS sites across the country, and the other two events were initiated by CA workers in Victoria and in Queensland.

At Wave 1 of the evaluation, BMRI was funding all the marketing and communication strategies, and this required the BMRI and hNO to work together to accomplish CA deliverables. In the review of funding allocations for 2009-2012, BMRI did not receive funding to conduct CA activities after 30 June 2009. While the BMRI will remain on the headspace board, all future CA activities will be managed by the Media, Communications and Marketing team at hNO. Without the research expertise of the BMRI, hNO may experience some challenges around creating evidence-based marketing campaigns. Nevertheless, the change in funding allocations is likely to contribute to more efficient and effective use of headspace resources. Communication with the hNO team about CA activities within the CYS sites will be streamlined, and the team will have more control over funding for these activities.

**hNO Media, Communications and Marketing team**

At Wave 1 of the evaluation, hNO was focused on developing national CA strategies to increase awareness of youth mental health problems, to brand and market headspace, and to encourage young people to access CYS sites. At that time, hNO had created a headspace website, developed and conducted one national marketing campaign, and branded and marketed headspace through advertising campaigns via television, print and electronic media.

Since Wave 1, hNO has implemented a second national campaign called, 'headspace: someone else to go to'. The campaign comprises three television advertisements (run on Channels 7 and 10), supplemented by advertisements placed strategically in other media. From early November 2007 until the end of January 2008 the advertisements were featured:

- 441 times on Channels 7 and 10;
- 150 times on the radio;
- online on Ninemsn, Fox Interactive, Yahoo, and Fairfax Digital sites;
- in shopping centres across five states;
- on message boards at 21 universities;
- on seven billboard locations in five states;

[80] See also Sections 5.3 and 6.2.

- in S-Press and Australian Teacher Magazine; and
- at the Rugby World Cup.

With the exception of the advertisements in the education magazines, the advertising resources were pro bono. As well as the national campaign, hNO provided CYS sites with implementation plans and advertising tools that could be adapted for each local site.

Data provided by the hNO Media, Communications and Marketing team do indicate that more people are becoming aware of headspace as a result of the social marketing strategies it has employed. For example, during the second campaign the number of visits to the website increased in proportion to the number of advertisements played on radio and television. The average number of pages viewed per visit also went up during that period. More importantly, the average number of young people visiting headspace services has steadily increased over time. In 2007 there were an average of just under 5,000 website visits monthly, compared with over 38,000 visits per month in 2008 and over 54,000 visits per month in 2009.

It is less clear whether the advertising campaigns have been effective in challenging the stigma associated with mental health, or in increasing young people's awareness of mental health issues, or in changing their help-seeking behaviours. Changes in these areas can only be assessed with research data such as the BMRI NYPCSs. However, the high numbers of website hits and the increasing numbers of young people accessing CYSs do suggest that the CA campaigns are having some impact.

The hNO Media, Communications and Marketing team also provides ongoing support for CYS sites (see also Section 5.3), the most important of which is the provision of the CA resources that can be tailored to the local needs of each CYS. When the second campaign was released, hNO provided all CYSs with a CD that included television, radio and print advertisements that could be modified with information relevant to each local CYS site. Included with this was a campaign dissemination packet which gave instructions and tips on how to use local media outlets to promote headspace. In addition, hNO continued to provide on-call support and to produce promotional products such as pens, post-it notes and t-shirts. Staff spoke positively about the promotional materials, and said that they were useful in promoting headspace at community events.

### 9.3 Centre of Excellence (CoE)

At Wave 1, the CoE's primary focus was on assembling the available research evidence about young people and mental health, with the aim of producing comprehensive Cochrane-style[81] Evidence Maps of research findings from 1980 onwards for seven psychological conditions. By June 2008, CoE researchers had reviewed more than 105,000 articles to produce their resources (headspace, 2009b). In addition, the CoE aimed to translate this evidence into a format that could be easily used by practitioners in CYS sites and beyond. By Wave 2, the CoE had completed

[81] The Cochrane Collaboration is an international, independent organisation which produces and disseminates systematic reviews of health-care interventions, and promotes the search for evidence in the form of clinical trials and other studies of interventions.

four Evidence Maps, and were still working on another two.[82] More importantly for the staff in CYS sites, the CoE had shifted its focus to 'evidence translation' and had produced several resources for service providers and young people.

The CoE has adapted its structure by moving from a primary focus on research to making translation and dissemination a more central part of their work. By Wave 2, CoE outputs had more practical relevance to CYS practitioners and were less heavily weighted towards lengthy Evidence Maps and academic papers.[83] By that time, CoE staff had become more interactive with CYS sites and more responsive to their requests.[84]

In addition to the Evidence Maps, the CoE has begun to produce 'Mythbusters' (brief, plain language overviews written to counter misperceptions about various psychological conditions),[85] and Evidence Summaries (brief summaries of research findings made available online and also produced as wall charts).[86] At Wave 2, one Mythbuster and two Evidence Summaries and had been produced and a further two were in the final stages of production (headspace, 2009b).[87] All published materials are available on the headspace website, and most of the resources have also been produced in hard copy or as wall charts.

The CoE has had its budget cut for the period 2009–2012. This will have some impact on the quantity of material CoE will be able to produce and on its ability to meet the individual needs of the CYS sites. Furthermore, CoE staff believe they will be unable

[82] At 30 June 2009, evidence maps had been completed on depression, psychosis, self-harm and suicide, and eating disorders, and maps were under way for anxiety disorders and substance use (headspace, 2009). By Wave 2, CoE staff had begun updating the evidence maps for two disorders (depression and psychosis), and expected that all maps would be updated at 6- or 12-month intervals, depending on the available resources.

[83] The CoE is, however, continuing to present their findings at academic conferences, and CoE staff are aiming to produce academic journal articles on each of the evidence maps.

[84] After Wave 1, the CoE hired an administrative assistant to respond to telephone calls and emails from sites and deal with specific queries. They also presented findings from the Evidence Mapping exercises at a CLN meeting in late 2008. Moreover, CoE staff intended to have face-to-face visits with each site in 2009, in order to look at the needs of each local community and the barriers and facilitators to effective service provision in each site. By Wave 2, they had visited one site and had several additional visits planned. However, it was uncertain whether they would be able to visit all 30 sites, partly because of budgetary constraints, but also because several sites were reluctant to arrange visits. The issue of their ongoing funding had not yet been resolved and they felt that there was little point in planning future work when their future was uncertain. Further information about how useful CYSs found CoE is available in Section 5.3 and Section 7.4.

85 hY NRG had considerable input into many CoE outputs, but they were particularly involved in the production of the Mythbusters series.

[86] Twenty copies of each of these branded Evidence Summaries were distributed to each CYS site. headspace practitioners were encouraged to use these resources themselves and also asked to distribute them to professionals working in their communities, such as GPs and psychologists.

[87] By Wave 2, the CoE had produced a Mythbuster on suicidal ideation, and Evidence Summaries on the use of Selective serotonin reuptake inhibitors for treating depression in young people, and on the effectiveness of motivational interviewing. Evidence Summaries on the effectiveness of brief interventions, and on the diagnosis and treatment of personality disorders in young people, were in the final stages of production (headspace, 2009).

to pay for designing and printing resources in the future, and they are intending to publish most new products only on the website in order to cut costs. Given the popularity of hard-copy resources and their important role in promoting headspace and in influencing service practice, it seems important to continue to produce hard-copy posters and flyers. This may be a role that hNO can take forward through other funding sources or pro bono support.

Information technology issues created another challenge for the CoE. The Knowledge Centre on the headspace website, initiated and managed by the CoE, has limited search functionality, and this detracts from the overall usability of the Evidence Maps and other resources. headspace staff have investigated modifications to increase this functionality, but the financial cost of including them retrospectively would be considerable.

Further refinement of CoE resources will be difficult with the reduced budget for the period 2009–2012. Nonetheless, the CoE has achieved a considerable amount in a relatively short period of time. They have summarised a wealth of academic literature and gone a considerable way towards making these materials easily accessible to a wide range of audiences, including from headspace clients to CYS service providers and practitioners in the wider community.

### 9.4 Service Provider Education and Training (SPET)

SPET was formed by the APS and AGPN , and funded to assess what training packages were currently available, to analyse training needs, and to develop and deliver seven evidence-based training packages (headspace, 2008). At Wave 2, the assessment and development had been undertaken, and the training packages had been piloted and rolled-out to most CYSs.

In order to identify training needs, the AGPN and APS consulted with peak bodies and CYS stakeholders (12 site visits and focus groups at six Round 1 sites). The APS collected and analysed this data, completed a literature review and audit report on existing training packages, and developed four of the seven training modules, and contracted out the remaining three modules for development.[88] They also piloted the training packages. The training modules include:

- Screening-Engaging-Early (SEE) Young People;
- Early Identification of Psychosis in Young People (EIPYP);
- Managing Challenging Behaviours in Young People (MCB);
- Motivational Interviewing and Behavioural Change Techniques (MIBCT);
- Problem Solving Skills Training (PSST);
- Working with Families and Significant Others (FSO);
- Promoting Access and Support Seeking in Young People (PASS).

[88] To the ORC and the Illawarra Institute for Mental Health.

The AGPN, whose primary role was training delivery, sought accreditation with relevant professional bodies, developed quality-assurance strategies and contracted trainers to conduct training. All seven headspace training modules had been rolled out to most of the CYSs by the end of June 2009. Furthermore, with the help of external funding the AGPN had provided CYSs with an existing module, the 'CAN DO' training, while the SPET training packages were still in development.

Delays in the development of the training packages impacted on the roll-out of the modules to the CYSs. The delays left some of the sites which opened early without training and education resources for a significant period of time. However, for sites that opened later, this delay had less of an impact.

The capacity to provide training sessions, both for headspace staff and for the local community, varied considerably across the CYS sites, although by Wave 2 some of the CYSs were in a better position to conduct training because they had more staff and/or had recruited specific training coordinators. But this time, too, SPET had completed the training manuals and had become more responsive to the needs of CYSs. In total, by March 2009 there were 2,016 people, including headspace staff and community service providers in all 30 CYS sites, who had participated in all seven of the training modules developed by SPET.

Nevertheless, the numbers of training sessions per module varied considerably. While the SEE module (in both its initial and final format) had been delivered the most frequently (48 times), eight of the sites had still not utilised the package by March 2009 (Table 9.1). The MCB training was delivered 11 times; the MIBCT training used 9 times and the FSO training delivered 8 times across all CYSs.

Up to 22 sites (depending on the module) had either not yet received or not yet delivered the training packages by March 2009. Only one CYS had delivered the PASS training at the time the data were collected. However, the audit data indicated that many CYSs had training events planned between for between March and June 2009. These sessions were to be delivered by headspace staff, in collaboration with consortium partners, and/or by SPET specialist trainers. As data were not available for this evaluation, the information is not captured in Table 9.1.

**Table 9.1: Total number of training modules and participants**

| Training modules | Round 1 CYS | | | Round 2 CYS | | |
|---|---|---|---|---|---|---|
| | Training Sessions | Participants | Not utilised training | Training Sessions | Participants | Not utilised training |
| SEE | 28 | 541 | 1 | 20 | 450 | 7 |
| MIBCT | 2 | 46 | 8 | 7 | 191 | 14 |
| MCB | 3 | 74 | 7 | 8 | 194 | 12 |
| EIPYP | 1 | 20 | 9 | 4 | 109 | 16 |
| PSST | 2 | 46 | 8 | 3 | 72 | 17 |
| FSO | 2 | 21 | 8 | 6 | 122 | 14 |
| PASS | 4 | 130 | 9 | 0 | 0 | 0 |
| **Total** | 42 | 878 | - | 48 | 1138 | - |

Source: hNO audit data March 2009

The high proportion of CYSs yet to utilise the training and education resources is related to several structural issues. Firstly, the delays in the development and roll-out of the training modules (as discussed in the Interim Report). Secondly, the training was designed to be incremental, with general training needs being covered by the SEE and FSO packages, and more specific and specialised training needs being covered by other modules at a later period. Thirdly, while the SEE, FSO, and PASS modules were delivered to CYSs in a train-the-trainer format which gave them the autonomy to decide when and how often they could roll-out the modules, the remaining modules have to be delivered by specialist trainers/facilitators. These are commonly allocated by SPET, not by the individual CYSs. Some CYSs had professionals within their own communities (e.g. psychiatrists) who were capable of rolling-out the specialist modules and willing to do so. But the need for specialist trainers meant the roll-out was generally slow. Fourthly, the delay in the development of several modules (such as the PASS training) meant that, by March 2009, the majority of CYSs had not attended the train-the-trainer events which would have enabled them to deliver the training to their community. The capacity of the sites to distribute the modules on a regular basis is also at risk, particularly those with high staff turnover, since the train-the-trainer process must be repeated whenever a facilitator leaves.

There have been substantial changes to the SPET component since Wave 1. The responsibility for the APS is to transform some of the training materials into online modules which can be made more accessible to a broader audience and thus increase long-term sustainability. Roll-out of the training, previously organised by the AGPN, is now the responsibility of hNO. SPET will need to ensure that the evidence collected by the CoE is incorporated and reflected in training materials. Information from the in-depth study has highlighted the value of developing optional training packages to support CYSs in less clinical and more operational and strategic areas, such as managing interdisciplinary teams and implementing change management.

## 9.5 headspace Youth National Reference Group (hY NRG)

> We started out with some ideas about having a diverse group and we succeeded in getting one, in terms of who we got, where they came from and their backgrounds and experience (hY NRG member).

In 2007 headspace established its youth reference group, hY NRG, with 28 members. It was established as part of the headspace priority area, youth and carer participation, and it aimed specifically to establish a national reference group of young people, to build the skills of young people and carers to promote mental health awareness, and to promote the development of effective participation models.[89] The first hY NRG finished on 30 June 2009, although there are plans to establish another group by the end of 2009.

hY NRG members were required to be directly or indirectly affected by mental health issues, and passionate about mental health issues and/or their work in the youth or mental health sector. The group comprised both males and females, although more females than males were recruited and males were harder to recruit and retain. It also included Indigenous young people and members from metropolitan, rural and remote areas. Because of the complexities of duty of care, no one under the age 15 of was

[89] headspace WorkPlan 08-09 Progress Report

recruited. Over time some representatives left the group, leaving a core group of 20 members by June 2009. Those who left did so for a range of personal reasons that impacted on their ongoing availability for participation.

The chairperson of hY NRG also sat on the headspace Advisory Board to provide youth representation and updates on hY NRG activities. hY NRG has met five times since its establishment as well as engaging in regular teleconferences and communicating via facebook and email. The face-to-face meetings involved being updated on headspace, contributing opinions regarding the direction and policies of headspace, and participation in training.

hY NRG members were provided with training in their role as group members. They were also supported by a youth participation officer, and later given clinical support to enable young people with their own mental health problems to participate. The need for this clinical support had become evident as the group evolved. hNO employed a clinical manager to support the national youth participation process, and particularly the capacity of individuals to attend the national meetings. Members have also been able to engage clinical or other supports they need from practitioners in local headspace sites, although not all members have access to a headspace site where they live and other arrangements have been made. hNO has reviewed hY NRG processes and training to gather feedback on the direction of hY NRG.

hY NRG has made an important contribution to developing a youth-friendly communication strategy for headspace and is an effective model of youth participation. Specific activities of the group include:

- advocating for and representing headspace at CYS launches and community events;
- informing headspace stakeholders about the importance of youth participation (via factsheets and presentations);
- providing advice on headspace policies and procedures, training sessions and marketing;
- participating in the design of communication campaigns and CA development (e.g. the CoE Mythbuster series);
- liaising with local youth reference groups;
- producing communication bulletins for the headspace website;
- participating in media activities (such as radio and magazine interviews) about youth mental health issues and headspace, and acting as role models to other young Australians by sharing aspects of their own stories;
- providing advice to organisations outside headspace who work in the youth mental health sector (e.g. Youth Beyond Blue);
- promoting the importance of providing mental health material in schools; and

- advocating the importance of an early intervention framework.

hY NRG has been supported and valued by hNO. Interviewees from both hY NRG and hNO felt that involvement of the group was meaningful and that it had added vitality to the initiative, increased headspace's relevance and appeal to young people, and informed the direction and work of headspace.

As already noted, the first hY NRG ended on 30 June 2009, although it was involved in the further development of a youth participation model, with plans to start another hY NRG later in 2009. Informants felt that the model would change fairly substantially, depending on funding and the availability of resources. One option proposed for the model is to draw hY NRG representatives from within the CYSs. This would lessen the need for the group itself to provide clinical support, with individuals receiving clinical support from the sites instead.

## 9.6 Conclusion

This section has described the role and activities of the national headspace components: hNO, CA, CoE, SPET and hY NRG. These components were established to promote better care and outcomes for young people in local communities and within government policy, to provide stronger, quality services within CYSs, and to increase youth and carer participation. While all of the components are now established and meeting many of their goals, they have faced various challenges in achieving this. These have primarily revolved around the fast establishment phase which occurred in parallel with the CYS establishment, and was often the period CYSs required most support, but there have also been funding limitations. Problems from the establishment phase have largely been resolved now, as establishment is complete and the components are able to be more responsive to CYS needs. Nevertheless, the future success of the national components will depend on greater collaboration if they are to fulfil their deliverables effectively. Funding limitations are, as with many major initiatives, likely to be an ongoing problem, which will only be addressed through the effective use of resources and the acquisition of diverse funding sources, such as sponsorship and pro bono work. The latter has already been used with some success.

The following section provides a detailed analysis of the investments into and costs associated with each of the headspace components, while further information about how each of the components have worked together can be found in the meta-analysis.

## 9.7 Summary

*Key findings*

- headspace national components aim to support the CYSs through the provision of CA strategies and materials, evidence-based information, appropriate training and strategic and operational support.
- hNO has played a critical role in establishing headspace as a primary resource for youth mental health problems. It has played an active role in the marketing of headspace, the contract management of the CYSs, establishing hY NRG, and engaging government.

- BMRI have primarily been involved in developing the NYPCS to monitor help-seeking behaviour and CA around youth mental health. They also played a role in developing the first national awareness campaign with hNO.

- hNO have implemented two national awareness campaigns via television and the print and electronic media, developed the headspace website and devised marketing tools for the use of the CYSs.

- The CoE have reviewed existing research on psychological disorders to produce evidence maps, evidence summaries and 'Mythbuster' factsheets for use by practitioners and young people. Accessibility and useability of these resources improved between Waves 1 and 2 of the evaluation.

- SPET has developed seven training modules as a result of a training needs assessment. Roll out of these training packages was initially slow and there are many CYSs who have yet to utilise the training resources.

- The youth reference group, hY NRG, was established to develop the youth-friendliness of headspace. hY NRG have represented headspace at community events, provided advice to headspace on policies, procedures, training and marketing, and participated in media activities about youth mental health.

*Lessons and recommendations*

- hNO has faced a number of challenges as a result of the initial governance structures, a lack of resources, and an unanticipated demand for support from CYSs.

- Funding constraints may mean that the CoE cuts back on printed resources. However, given the popularity of these resources, it is recommended that resources are directed towards producing hard-copy posters and flyers.

- SPET needs to ensure that evidence collated by the CoE is incorporated and reflected in training materials.

- Collaboration and support between all components should be increased to add value to the headspace initiative and to ensure that the work of each of the components is ultimately to the benefit of young people using headspace services.

# 10 Meta-analysis and conclusion

The success of headspace is premised on the contribution of each headspace component and the program as a whole. This section returns to the program logic model of headspace and compares this with the actual contributions of each component and the outcomes headspace has achieved thus far. It also addresses the extent to which goals contained in the evaluation hypothesis were met. Importantly, the major focus of this section is to provide an overview of why headspace has or has not met these goals and its individual objectives, and how the components have contributed individually and collectively to this. Finally, it highlights key lessons and recommendations in regard to the headspace model.

**Table 10.1: Evaluation hypothesis by headspace's key objectives**

| Hypothesis | headspace key objectives |
|---|---|
| That the headspace initiative has promoted and facilitated improvements in young people's mental health, social well-being, and participation in education, training and employment, particularly through: | • Improve young people's outcomes: mental health, social well-being and participation in education/training and employment |
| its financial and other support for a reformed approach to mental health services for young people which emphasises early intervention; | • Service provision/service reform within CYSs (youth-focus, service coordination, evidence-based, appropriate services, quality of service)<br>• funding and other support for the CYSs to achieve above<br>• sustainability |
| its engagement with young people and its promotion of information about youth mental health and related disorders, and about services available; and | • Increase numbers of YP accessing services and seeking help (CA, youth participation, HS profile) |
| its advocacy with all levels of government for reforms to the funding of youth mental health services | • Government policies support early identification and early intervention for YP with mental health issues |

## 10.1 The evaluation hypothesis: summary of young people's outcomes

While results are limited to a sample of young people who have attended headspace so far, the evaluation findings support the evaluation hypothesis. That is, headspace has been effective in promoting and facilitating improvements in young people's mental health, AOD use, and their social and economic participation.

The domain in which the young people in the in-depth evaluation were most likely to report improvements since coming to headspace was that of mental health. Almost all the young people surveyed (93.2%) said their mental health had improved since coming to headspace, and this was supported by the fact that they also reported decreased symptoms, increased confidence, and changed emotions and behaviours. While mental health outcome data in the headspace dataset is still limited, the change in K10 scores between first assessment and subsequent assessments also supports this finding.

Comparisons between young people's consumption of alcohol and use of illicit drugs 12 months ago and their use within the last month show that substance use decreased significantly. The proportion of high-risk alcohol users declined from 15 to 8 per cent, and at least half of all young people who had used drugs in the previous 12 months had not done so in the last month. Almost all young people who had consumed either cocaine, inhalants, heroin or methamphetamines in the previous 12 months had not done so in the previous month. Cannabis use declined the least.

headspace is also having an impact on young people's participation in education, employment and training. When they first come to headspace, young people are more likely to be disengaged from work and study than their counterparts in the general population (one in four and one in 10 respectively; the headspace dataset and ABS 2006). Over half the young people surveyed said that headspace had improved their ability to study, and 50 per cent reported improvement in their ability to work or to find work since starting headspace. Importantly, reports from the small sample of young people involved in both Waves of the evaluation indicate that headspace is helping some young people previously disengaged from the labour force to start looking for work.

Finally, most young people surveyed also reported improvements in their relationships with family members and friends (78% and 70% respectively). This was further reinforced by young people's responses to questions about how their relationships have changed on an emotional and practical level and by family members who also perceived that relationships with the young people they care for had improved as a result of headspace.

The subsequent sections of the meta-analysis consider reasons why these improvements occurred, and the extent to which the outcomes were a result of the program logic and the causes hypothesised (Table 10.1).

## 10.2 Contribution of headspace components to young people's outcomes

The evaluation found that the program logic was correct: young people did increasingly seek assistance from services that were accessible, of good quality, evidence-based, holistic and coordinated. As the hypothesis predicted, these help-seeking outcomes were likely to be the result of funding and other contributions from the various components of headspace.

### Increased access to mental health services

headspace has increased young people's access to mental health services. By June 2009, the CYS sites had seen almost 14,000 young people and provided over 95,000 occasions of service. Furthermore, during the headspace initiative, 12-25-year-old's use of MBS funded mental health services and psychologists increased substantially across the country and far more than for those over 25-years.

headspace has been successful in attracting young people at social and economic risk. In addition to poor mental health, headspace clients were more likely than young people in the general population to have poor physical health, be disengaged from work and education, have challenging relationships with their family and friends, and above average substance use levels. The headspace dataset indicates that females, 12-17-year-olds and Australian-born young people are accessing headspace services at a

greater rate than might be anticipated. This may be due to these groups having higher levels of psychological distress, being more likely to seek help or because headspace has greater appeal to these groups than their counterparts.

CYSs should be aware of and supported to attract young people from particular groups who live in the local area who are not accessing headspace services. The young people who were not represented at headspace services varied by location, but were primarily thought to be those with low socio-economic status, those with limited support systems (especially family support), refugee communities and Indigenous young people. Moving forward headspace needs to ensure that strategies (which are likely to be context-specific) are in place to attract and engage potential service users from these groups.

The overall increased access to mental health services and increased help-seeking among young people was supported by the CYSs, CA and hNO through funding, service availability, youth-friendliness and CA. The characteristics of the model implemented by the CYSs were also instrumental in attracting young people to headspace.

The 30 CYSs were crucial resources for young people's increased access to mental health services in the communities in which they were based. Without funding, CYSs could neither be established, nor kept open, although funding situations varied according to the size of the CYS. Sites seeing the largest numbers of young people cost less per young person, attracted higher total revenue and acquired their funding from more sources than those sites with low to moderate numbers of young people. hNO played a leading role in the distribution of funding and in the establishment phase. It has also been effective in its advocacy to the federal government for extending the headspace funding for another three years.

Once services were available, the CYSs, hNO and CA engaged in national and local CA campaigns about youth mental health and help-seeking that actively encouraged young people to seek help. The engagement of young people through the local and national youth reference groups (supported by each CYS and hNO respectively) was also likely to have contributed to increased help-seeking, by helping to keep the CYSs youth-friendly and by supporting the CA campaigns. Importantly, CYSs were also highly accessible to young people because of their affordability (services were bulk-billed with Medicare).

Despite only a short operational period, headspace is attracting large numbers of young people, although numbers vary from site to site. This is partly a function of the length of time services have been opened. For example, the ten CYSs who have been seeing the highest numbers of young people have been opened for an average of 15.3 months, in comparison with 13.1 months for all 30 sites. An extra two months would assist to further build clientele. However, time was not the only explanation for the higher numbers of young people attending certain CYSs. The characteristics of the CYSs also had an influence on the numbers of young people accessing services.

*CYS characteristics*

The sites that were successful at consistently attracting large numbers of young people all had similar qualities and characteristics. Table 10.2 categorises the CYSs into three

groups of ten (high, moderate, low) based on the number of young people they have seen on average per month since first opening their services, and compares the groups on the basis of a number of characteristics.

Sites seeing the highest average numbers of young people (57.6 young people per month) were more likely to have the four core headspace services, than the sites seeing moderate to low numbers of young people. All the CYSs within the 'high' group had physical and mental health providers, and almost all offered alcohol and other drug services (80%) and social/vocational services (90%). They also had a higher average number of other headspace-funded staff. Furthermore, all these sites had private practitioners and, when the private practitioners were grouped by service type, they outscored the other groups across four of six areas (private psychologists, GPs, social workers and occupational therapists).

The largest CYSs also had a specific governance structure. They were more likely to have both a business manager and a clinical manager on site. Eight of the top ten sites were led by a GP-related group (the DGP, GPN or other GP association), compared with six and four of the CYSs from the moderate and low groups. NGO-led agencies were over-represented in the low group – 50 per cent of these sites had an NGO as a lead agency, compared with 27 per cent of all CYSs. Interestingly, the largest CYSs had the lowest average number of consortium partners (7.9, in comparison with 11 for the moderate groups and 9.4 for the low groups).

On the whole, urban or regional geographic location did not influence the numbers of young people seen. However, it was the two remote sites who had seen the least number of young people, as might be expected given their small populations and the difficulties in establishing and implementing services in remote areas.

The degree of co-location did not have any influence on whether a CYS belonged in a high, moderate or low category; neither did the proportions of different types of YMHI workers (largely because the proportions of all types were high in all the categories). Finally, the funding round also had little impact on which category a CYS belonged to.

These findings carry a number of important lessons for the headspace model. Specifically, the CYSs that attract the largest numbers of young people are those with the greatest capacity to apply the headspace model advocated by hNO: they holistically offer all four key service areas (mental health, physical health, AOD, social/vocational); they have private practitioners; and they have a strong leadership with both clinical and business expertise. Furthermore, it appears that, once services are implemented, those with GP-based lead agencies are likely to have the greatest capacity. This may be related to access to additional funding sources. The findings around governance also suggest that CYS consortiums may be more beneficial and more effective when they consist of a smaller, more cohesive and more actively engaged, group of members.

## Table 10.2: Average characteristics of CYSs grouped by the number of young people seen since they opened*

| | | High (n=10) | Moderate (n=10) | Low (n=10) | All (n=30) |
|---|---|---|---|---|---|
| Young people | Young people seen per month | 57.6 | 27 | 17.1 | 33.9 |
| CYS funding round, opening and site numbers | Months since opened to young people | 15.3 | 10.7 | 13.3 | 13.1 |
| | Funded Round 1 | 5 | 1 | 4 | 10 |
| | Funded Round 2 | 5 | 9 | 6 | 20 |
| | Number of sites per CYS | 1.8 | 2.2 | 1.4 | 1.8 |
| Core components | Proportion CYSs with following services: | | | | |
| | Physical health | 100% | 70% | 70% | 80% |
| | Mental health | 100% | 100% | 100% | 100% |
| | AOD | 80% | 70% | 40% | 63% |
| | Social/Vocational | 90% | 90% | 70% | 83% |
| | Average no. core components | 3.5 | 3.2 | 2.75 | 3.1 |
| Private practice | Proportion of CYS with private practice(s) | 100% | 60% | 80% | 80% |
| HS funded staff | Proportion CYSs with: | | | | |
| | Business Manager | 70% | 70% | 60% | 67% |
| | Clinical Manger/Coord | 90% | 60% | 80% | 77% |
| | Average no. managers (business/clinical) | 1.6 | 1.3 | 1.4 | 1.4 |
| | Average no. other HS funded staff | 2.7 | 2.3 | 1.9 | 2.3 |
| YMHI-AHWP funded staff | Proportion CYSs with: | | | | |
| | YMHI Clinician - Psychologist | 80% | 90% | 80% | 83% |
| | YMHI Youth worker | 90% | 60% | 90% | 80% |
| | AOD | 10% | 10% | 10% | 10% |
| | Clinician - MH | 70% | 80% | 70% | 73% |
| Proportion of CYSs with other funding sources | | 90% | 30% | 10% | 43% |
| Private practitioners | Proportion of CYSs with following types of private practitioners: | | | | |
| | Psychologists | 70% | 40% | 50% | 53% |
| | GPs | 100% | 70% | 70% | 80% |
| | Psychiatrists | 40% | 30% | 40% | 37% |
| | Social Workers | 30% | 20% | 10% | 20% |
| | Occupational Therapists | 20% | 10% | 10% | 13% |
| | Other | 10% | 10% | 0% | 7% |
| | Average no. of different types of private practitioners | 2.7 | 1.9 | 1.8 | 2.1 |
| Co-located services | Average no. co-located services | 3.2 | 3.2 | 2.9 | 3.1 |
| | Proportion of CYSs with following types of co-located service providers: | | | | |
| | Physical health | 30% | 30% | 30% | 30% |
| | Mental health | 30% | 40% | 50% | 40% |
| | AOD | 50% | 40% | 60% | 50% |
| | Vocational | 50% | 40% | 50% | 47% |
| | Social | 30% | 10% | 0% | 13% |
| | Other | 60% | 50% | 40% | 50% |
| Geographic area (ASGC | Urban | 5 | 3 | 4 | 12 |
| | Regional | 5 | 7 | 4 | 16 |

| | | | | | |
|---|---|---|---|---|---|
| Classification, no. of sites) | Remote | 0 | 0 | 2 | 2 |
| Governance | No. consortium partners | 7.9 | 11 | 9.4 | 9.3 |
| | No. of CYSs by lead agency type: | | | | |
| | DGP | 8 | 6 | 4 | 18 |
| | NGO | 1 | 2 | 5 | 8 |
| | University | 1 | 1 | 1 | 3 |
| | Local government | 0 | 1 | 0 | 1 |

*Source: Compiled from March 2009 reassessment data hNO

One of the challenges for headspace thus far has been to balance a prescriptive approach to the headspace model with flexibility for each individual site. Sometimes, the relationship between hNO and a particular CYS has been substantially stressed by an inconsistent approach. hNO has not taken a definite stand on this issue, neither acting as a manager facilitating flexible programs driven by community needs and resources, nor contractually requiring CYSs to implement a specific model. It was difficult for hNO to develop a consistent approach around either of these options while the model was being rolled-out, piloted and developed. However, headspace will benefit in future if hNO adopts a clear consistent role. If a defined model is adopted by hNO, it should probably involve minimum standards with some local flexibility.

**Early intervention**

It appears that CYSs were successful in attracting young people at the early intervention stage, who were predominantly those in the younger age group (12-17-year-olds). This is supported by the number of young people coming to headspace with no, low or medium levels of psychological distress and reinforced by the survey and interview data.

There are a number of possible reasons for the early intervention focus: because the services are available to all young people via the CYSs; because young people discuss the positive impact of headspace on their lives to their friends and encouraging attendance at headspace; and because of the local and national CA campaigns and the information included on the headspace website about mental health symptoms and help-seeking. Therefore, hNO, CA and CoE were likely to have had some impact on early intervention.

There is no evidence from the SPET evaluation or the qualitative data to suggest that SPET made any significant contribution to increasing early intervention, although two of the SPET modules – SEE and PASS – have early intervention components. The SEE training has been used widely, with 48 sessions comprising 891 people in 22 of the 30 CYS locations, but there is no evaluation data available. Furthermore, the initial SEE module required redesigning after an unsuccessful initial rollout. There is potential for the training component of headspace to work more closely with the CA component to increase the number of young people attending headspace at an early intervention stage, and to be developed and updated by CoE.

The small sample of young people who participated in the in-depth evaluation suggest that headspace may be most beneficial for young people who are at early stages of mental health problems. For example, 12-17-year-olds with lower levels of

psychological distress and higher satisfaction rates across life domains were more likely to report better outcomes across life domains as a result of headspace, than 18-25-year-olds.

**Service quality and coordination**

The evaluation findings generally suggest that services were of high quality. The majority of CYS staff surveyed (87%), for example, stated that their CYSs were effective at incorporating evidence-based practice into service delivery. Overall, however, there is little tangible evidence at this point in time to come to any definite conclusions about the extent to which services are evidence-based. This should become clearer over time as the headspace dataset improves in quality and becomes more complete.

CYSs are expected to provide quality, evidence-based services, and they are meant to be supported in this task primarily by the CoE, but also by SPET and hNO. CoE's review of the literature around evidence-based services, and its subsequent production and dissemination of evidence-based maps and other supporting materials, has made some contribution to ensuring that services within the CYSs are evidence-based. However, the tangible contribution of the CoE to the CYSs largely became evident only once materials had been distributed. By Wave 2, the contribution of CoE was becoming increasingly valuable to a number of CYSs. Those CYSs that found these resources most valuable were those that had a staff member who was responsible for supporting the strong clinical governance of the site and for championing the importance of evidence-based practice.

SPET also made some contribution to increasing service quality in the CYSs through the development and conducting of relevant training modules (particularly EIPYP, MCB, Motivational Interviewing and Behavioural Change Techniques, and Problem Solving Skills Training). As in the case of the CoE, the value of SPET was only starting to become evident by Wave 2 of the evaluation, as the number of training sessions increased across the country.

Although there are only small numbers of people who have attended training and completed the pre- and post- online surveys, early findings are encouraging. The skills and confidence of people who attended training have significantly improved in a number of areas relevant to service quality, such as the following abilities: to develop, implement and monitor a safety plan with a young person at risk of suicide or self-harm (7% to 56%); to engage effectively and communicate with young people at risk of developing psychosis in order to assess symptoms, risk and protective factors (13% and 75%); to identify psychotic symptoms and disorders and at-risk mental states in young people (13% and 75%); and to discuss potential treatment interventions with young people at risk of psychosis (0% and 50%). These positive findings indicate that well-developed, tailored training modules are an important component of headspace, and that they can add substantial value to the skills of CYS practitioners and of service providers in the broader community.

Finally, hNO has aimed to support CYS service quality both directly and indirectly, by hosting forums, events and the CLN, and by providing evidence-based information and identifying effective strategies for ensuring that these are taken up. It is difficult

to assess the impact on service quality of these activities at this stage.[90] The in-depth evaluation suggests that the main benefit of the CLN has been the opportunity for CYS managers and CYS Clinical Service Integration Managers to share best-practice.

Service quality was also supported independently within the CYSs themselves. Strong clinical governance, including regular clinical care reviews (with independent expert input), review of case notes and supervision, and access to other relevant local training opportunities, were all factors that supported evidence-based quality services.

According to the logic model of headspace, to achieve quality, evidence-based services the components should have combined in a strong coordinated effort. However, service coordination was largely driven by the CYSs and not directly supported by the other components. However, the headspace model itself, and hNO, have been important in ensuring that services are coordinated within CYSs, and that funds are available for paid staff to act as facilitators for coordination (largely the YMHI workers). YMHI AHWs with mental health expertise were most effective in this role.

While service coordination has occurred within CYSs, sites have been more successful at integrating some services than others. For example, mental and primary health supports were more likely to be coordinated than vocational providers with any of the other services. This reinforces two important lessons: firstly, it is not sufficient merely to co-locate services; and secondly, vocational providers with expertise in supporting young people in the general public may not provide the types of support young people at headspace require. An example at one site involved a standard vocational provider helping a young person with depression to get a job. But the required support, psycho-social and step-wise did not occur, and there was no coordination between the young person's psychologist and the vocational provider. Within a short period of time the employment failed. It is important that sites do not merely tick off aspects of the headspace model one by one, and that they continue to have the resources and commitment to ensuring ongoing coordination within and between sites.

The contribution each headspace component made to increasing the quality of the services highlights a key finding that came up a number of times: while the components individually added value to the CYSs, they did not work effectively together to integrate, coordinate and strengthen their support. For example, while the CoE and SPET individually supported CYSs, they did not work together to ensure that the evidence collected was translated and reflected in training materials; instead, the training module development was contracted out to CoE.

### 10.3 headspace as a whole

The evaluation found that the headspace components added different types and levels of value to the initiative in its first three years, and that headspace has not been as integrated as the initial model was intended to be.

[90] This is largely because there was no separate evaluation of these activities, but also because CYS staff and practitioners were preoccupied with funding issues at the time of Wave 2 evaluation, as well as with other relationship challenges they were experiencing with hNO.

Overall, CA, CoE and SPET had limited working relationships with each other in the early stages of the initiative, despite the inherent links between them. Stakeholders from all components were interested in working together in a more meaningful way and willing to do so, but there were substantial barriers to effective working relationships in factors such as the speed of implementation, the simultaneous development of components, the separation of the headspace components, and governance issues. While there were some reports of relationships improving between Waves 1 and 2, overall the evaluation found no substantial interaction between the components that resulted in tangible, beneficial outcomes for headspace. This is reflected in Table 10.3, which shows that collaboration occurred between the CYSs and all the other components of headspace, and between hNO and all other components, but that interaction between SPET and CA, SPET and CoE, and CA and CoE was limited.

**Table 10.3: Collaboration between components that produced tangible positive outcomes for headspace**

| | CYSs | SPET | CA | CoE | hNO |
|---|---|---|---|---|---|
| CYSs | - | ✓ | ✓ | ✓ | ✓ |
| SPET | ✓ | - | × | × | ✓ |
| CA | ✓ | × | - | × | ✓ |
| CoE | ✓ | × | × | - | ✓ |
| hNO | ✓ | × | × | × | - |

The limited interaction may be a reflection of the timing of Wave 2. Since then, the structure of the headspace components has changed, with hNO being responsible for CA and SPET and a closer working relationship between hNO and CoE. This is likely to assist in overcoming the lack of coordinated input. However, effective coordination will still require planning and effort.

The challenge for 2009-2012 will be to make the headspace system more integrated and ensure that the value added by the other components makes the national branding of headspace CYSs worthwhile and demonstrably valuable.

## 10.4 Conclusion

Each individual component of headspace has made a contribution to the initiative and has helped to achieve the broad program objectives. Despite the complexity of the model and the short time period, the evaluation has found evidence to support the headspace hypothesis: that headspace has promoted and facilitated improvements in young people's mental health, their AOD use, and their social and economic participation. The program has also been successful in attracting young people at an early intervention stage. These results have occurred largely because, together, the components of headspace have provided accessible service delivery sites around Australia (CYSs, hNO), and offered affordable services (CYSs, hNO, DoHA), that are good quality (including evidence-based) (CYSs, CoE, SPET, hNO), and holistic and coordinated (CYSs and hNO).

However, while there is evidence of valuable contributions by all of the headspace components, much of the success of the CYSs stems from their individual

characteristics. The CYS model has worked most efficiently, and arguably most effectively, in sites where there is both clinical and business management expertise, where there is strong clinical governance, and where there are service providers covering all four core areas (mental health, physical health, alcohol and other drugs, and social/vocational), a private practitioner component, and sound referral pathways into and out of headspace. Service coordination is also an important part of effective support for young people, and this has been found to be strongest between the mental and physical health service providers within each CYS, and between mental health providers within the CYSs and those outside. Because headspace involves trusted service providers, it has been able to assist young people to access other community-based services (including state/territory mental health services), although it has not always been successful at achieving effective service coordination between mental health services and vocational services.

CYSs are becoming more cost-effective over time. However, core funding will still be required to ensure, both that headspace remains accessible to all young people, and that remote sites, which require high proportions of core revenue, will continue to receive adequate funding.

One of the great benefits of headspace thus far has been its universal access. Introducing a fee for service for young people would decrease the overall cost of the program for government, but it would also significantly affect the impact of the initiative by changing the cohort of young people accessing headspace. This would especially be the case as CYSs reach their capacity and waiting lists grow.

The CYSs have been supported by the other components of headspace in a number of different ways, but on the whole the components did not work together effectively to complement their individual expertise and thus strengthen their support to CYSs. The changed governance structure for 2009-2012 should help to address this, but hNO will need to set up specific processes if it is to deliver a more integrated system.

In summary, the headspace initiative has shown that it is possible to more effectively promote and facilitate improvements in young people's mental health, social well-being and participation in education, training and employment. This has been achieved through effectively engaging young people via good community awareness and high quality, youth-friendly services. These achievements have been supported to varying degrees by each of the national headspace components: hNO, CA, CoE, SPET and hY NRG. headspace has also achieved wide recognition in the communities where the CYS sites are located, as well as at a national level. This is demonstrated by the effectiveness of referral pathways in local regions and improvements in those pathways during the life of headspace, and through government commitments to youth mental health nationally.

The quantitative and qualitative data from this evaluation has demonstrated that headspace has achieved much in a relatively short time and has substantial potential. The next three years should bring further evidence of the extent to which headspace improves outcomes for young people aged 12-25 years.

## 10.5 Summary

*Key findings*

- The success of headspace depends on the contribution of each headspace component and of the program as a whole.
- The evaluation findings support the hypothesis: headspace has promoted and facilitated improvements in some young people's mental and physical health, AOD use, and their social and economic participation.
- These results occurred because services were increasingly accessible, affordable, of good quality, evidence-based, holistic and coordinated.
- As the hypothesis predicted, help-seeking and service-based outcomes were likely to be the result of an interaction between funding and other contributions from the various components of headspace.
- Increased access and increased help-seeking by young people were supported by funding (hNO), service availability (CYSs), youth-friendliness (CYSs and hY NRG), and CA campaigns.
- CYSs were successful in attracting young people at early intervention stages, with many of the young people coming to headspace with no, low or medium levels of psychological distress.
- The evaluation found that services were generally of high quality, but there was little tangible evidence of the extent to which services were evidence-based.
- CYSs received valuable tangible support from CoE and SPET, but not until well into the implementation of headspace. The CoE resources were most valuable for those CYSs with a staff member responsible for supporting the strong clinical governance.
- hNO has supported service quality largely via the CLN, and this has had some success in enabling shared practice between CYS sites.
- Service quality largely occurred within those CYSs with strong clinical governance, including regular clinical care reviews (with independent expert input), review of case notes and supervision, and access to other relevant local training opportunities.
- Service coordination was largely driven by the CYSs themselves and not directly supported by the other components. However, the headspace model and hNO have been important in ensuring that services are coordinated and that funds are available for paid staff to act as facilitators for coordination (largely the YMHI workers).

*Lessons and recommendations*

It is the sites which are seeing the most young people that are most successful at carrying out the headspace model advocated by hNO:

- they holistically offer all four key service areas (mental health, physical health, AOD, social/vocational);
- they have private practitioners; and
- they have a strong leadership with both clinical and business expertise.

These sites are also likely to have a particular governance structure: they are more likely to be led by a GP-based agency and they have smaller numbers of consortium members. Their success suggests that the above factors may be important for a successful CYS.

- headspace will benefit when hNO adopts a clear consistent role: acting either as contract managers facilitating flexible programs driven by community needs and resources, or as facilitators, supporters or managers for the implementation of a specific headspace model (although still with context flexibility). If a defined model is adopted, it will require minimum standards with some local flexibility.
- It is not sufficient for CYSs merely to co-locate services, and some service providers currently co-located may not have the expertise needed to support young people attending headspace.
- Components individually added value to CYSs, but SPET, CoE and CA did not work effectively together to integrate, coordinate and strengthen their support.
- Components should work together to ensure that awareness campaigns and provision of services are inclusive of young people currently under-represented among headspace clients (these groups will be context-specific, but may include those in low socio-economic groups, those with limited support systems, refugee communities and Indigenous young people).
- The challenge for 2009-2012 is to make the headspace system more integrated and ensure that the value added by the other components makes the national branding of headspace CYSs worthwhile and demonstrably valuable.

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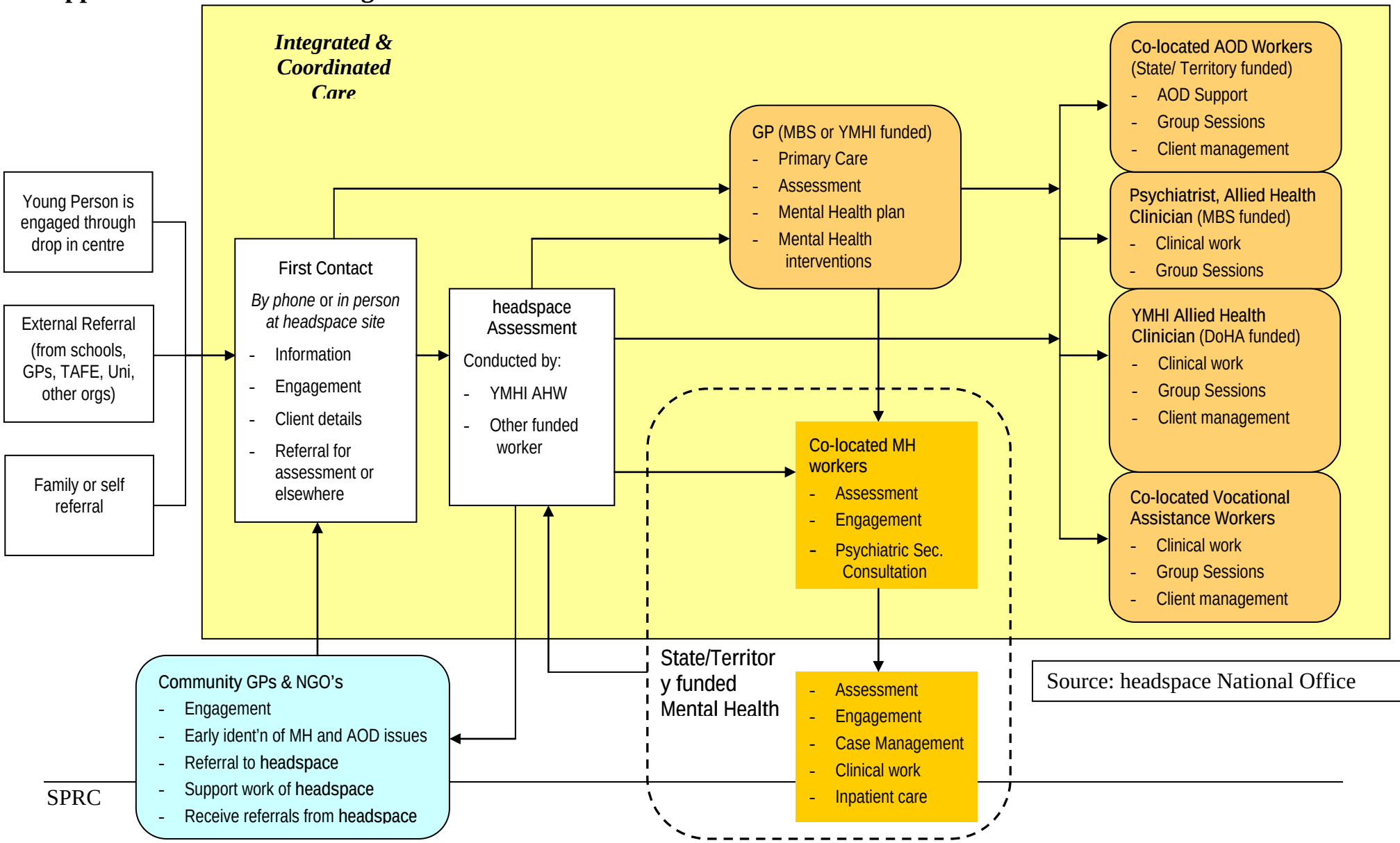
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# Appendix A: CYS model diagram




Source: headspace National Office

# Appendix B: Additional methodological details

As outlined in the Evaluation methodology, the research methods used were designed to address the evaluation questions and headspace objectives. The research used a longitudinal mixed methods approach, with data collected over two Waves. These methods included:

- Policy, procedure and documentary analysis;
- Interviews and surveys with key stakeholders, including CYS staff, local service providers, headspace training participants, headspace components, government representatives, and young people using CYS services and their carers;
- Service coordination study;
- Sustainability study;
- Secondary analysis of a number of datasets: the headspace dataset (compiled using MHAGIC); MBS data; the NYPCS; and the SMHWB;
- Meta-analysis.

More information about the selection of these methods, recruitment and response rates, ethics and quality assurance can be found below. Where possible, respondents from all groups were interviewed and surveyed in both Waves of the evaluation in order to track change over time.

## B.1 Policy, procedure and documentary analysis

Policies, documents and reports were analysed to clarify the resources, processes and implementation of each of the headspace components. Analysis of these resources was an important part of the evaluation, and helped to clarify the nature and extent of the support offered, the services, and the information, training and communication strategies. The documents analysed included CYS audit data collected by hNO, and headspace work-plans and marketing strategies (amongst others). The only program documentation the researchers had access to was that which had been selected by component stakeholders and most documentation came through hNO. There may be other documents that were withheld deliberately or inadvertently overlooked, and so it is necessary to be cautious in making inferences based on documentation.

Government policies (federal and state/territory) on mental health and substance use were also reviewed in order to determine the extent to which government recognises the importance of youth mental health, early intervention and multi-disciplinary services, as well as any impact headspace may have had on government policies in these areas.

## B.2 Interviews and surveys with stakeholders

### Research instruments

Interviews and surveys were conducted with all stakeholders and were the primary form of data collection. The researchers developed a number of qualitative and

quantitative instruments for this purpose. The content of these instruments was informed in the first place by the evaluation questions and objectives, as well as by a review of key literature, existing data collected for headspace, and other comparative secondary data sources. The instruments and the stakeholder groups they targeted are summarised in the table below.

**Table B.1 Evaluation instruments**

| Stakeholder Group | Interview schedules | Surveys |
|---|---|---|
| hNO | hNO questionnaire | - |
| CoE | CoE questionnaire | - |
| SPET | SPET questionnaire | - |
| CA | CA questionnaire | - |
| FEC | FEC questionnaire | - |
| Advisory Board | Advisory Board questionnaire | - |
| hYNRG | hYNRG questionnaire | - |
| CYS managers | CYS managers questionnaire | CYS survey |
| CYS staff members/ practitioners | CYS staff questionnaire | CYS survey |
| CYS affiliates [a]<br>Government representatives [b] | CYS affiliates and government representatives questionnaire | Service provider/coordination survey |
| Young people | Young people questionnaire | Young people survey |
| Carers | Carers questionnaire | Carers survey |
| headspace training participants | - | SPET training evaluation surveys |

a. CYS affiliates include consortium partners and community-based providers.
b. Government representatives include federal and state/territory government representatives.

*In-depth study*

As part of the evaluation, ten CYS sites were selected for in-depth analysis (Table B.2). The sites were selected to include a range of characteristics: located in all states and territories (if possible); located in urban, regional and remote areas; and located in communities with different socio-economic and cultural backgrounds. Other factors relevant to the choice of site were: accessibility of standardised data; and open and seeing young people by August 2008. The ten headspace sites chosen to participate in the evaluation are listed in Table B.2.

**Table B.2: In-depth evaluation sites**

| Site Name | Location | State/ Territory [a] |
|---|---|---|
| Riverina headspace | Wagga Wagga | NSW |
| Illawarra headspace | Wollongong | NSW |
| headspace Top End | Palmerston, Darwin | NT [b] |
| Gold Coast headspace | Gold Coast | Qld |
| Townsville headspace | Townsville | Qld |
| Murraylands headspace | Murray Bridge | SA |
| Northern Tasmania headspace | Launceston | Tas. |
| Southern Melbourne headspace | St Kilda, Melbourne | Vic. |
| Western Melbourne headspace | Sunshine, Melbourne | Vic. |
| Kimberley headspace | Broome | WA |

a. The ACT was not included because the one site in this territory was not open and seeing young people in time for the evaluation.
b. It was originally intended to include the site in Alice Springs, NT, because of the particular issues experienced in the NT that are important for the evaluation to capture. But its opening was delayed by staff recruitment problems and it was replaced by headspace Top End (Darwin/Palmerston, NT site).

The manager of each of these CYS sites was contacted and asked about the range of staff and practitioners at the site and the service providers in the broader community, and who consortium partners were. Fieldwork took place at each of the sites in both Waves of the evaluation, and qualitative and quantitative data was collected from managers, CYS staff and practitioners, consortium partners and other service providers, and young people using services and their carers. More details about the numbers of respondents and type of data collected from each of these groups can be found below. At Wave 1, fieldwork in nine of the ten CYS sites took place in August/September 2008.[91] At Wave 2, fieldwork took place in all the sites in April/May 2009.

*Interviews (qualitative instruments)*

Semi-structured interviews with young people, carers and other stakeholders were chosen as a key qualitative data collection instrument. Interviewing allowed the research team to identify issues and insights into headspace that would not be captured by the surveys. A semi-structured format was used to ensure that all relevant topics were discussed and to assist in identifying trends and key issues for particular stakeholders. Care was taken to ensure that, over the course of the interviews, questions flowed naturally and language was of appropriate complexity and detail for each stakeholder group. Audio recordings were made with the participants' permission to the ensure accuracy of information gathered; all interviews were then transcribed for analysis (Bryman, 2004). Data was thematically analysed using a coding framework.

[91] The visit to the tenth site, Darwin/Palmerston, NT, was delayed until late November 2008. The original plan was to interview 10 young people at each site, but only 71 young people initially participated in the nine sites because of the low numbers at some of the CYSs, and because young people did not show up at the interviews (as well as other recruitment difficulties). A further seven young people were interviewed in a return visit to one site (December 2008). An additional 14 young people also were interviewed at the tenth site in November.

*Surveys (quantitative instruments)*

Electronic surveys were used to collect large amounts of data across stakeholder groups in a cost- and time-effective manner. As responses are standardised, surveys allow for accurate comparisons to be made across headspace sites and across time. The researchers developed six survey instruments (Table B.1). Evaluation Solutions, a web-survey company, was contracted to host the surveys on-line, with the exception of carers and young people, respondents were emailed links to electronic surveys, which were completed online. Carers and young people who provided email addresses and who participated in Wave 1 of the evaluation were also emailed links to on-line surveys in Wave 2.

Respondents were sent hyperlinks to personalised survey forms which were completed electronically. Results were amalgamated automatically, which removed the possibility of errors introduced through manual data entry. The survey hosting software will ensure correct matching of Wave 1 and 2 data for applicable respondents to enable longitudinal comparisons.

Inclusion of a control group was precluded by the timing, budget and funding requirements for the evaluation, coupled with the introduction of the new model and delayed implementation of the initiative. This limits the validity of the outcomes because it is not possible to determine what would have occurred if young people had not received the headspace intervention. Wherever possible, however, the evaluation findings are compared with existing population data.

Comparability with other data sources

The researchers used several existing survey instruments when constructing the evaluation surveys to increase comparability of results with other datasets. The headspace dataset and the survey data can be compared with all of the following: the Kessler 10 (K-10) scale[92] (ABS 2001); the Personal Wellbeing Index (PWI) scale[93] (ITG 2006); the Australian School Students Alcohol and Drugs Survey 2005 (DoHA 2006a); the General Social Survey 2006 (ABS 2006a); the National Drug Strategy Household Survey 2004 (AIHW 2005); and the National Health Surveys 1995, 2001 and 2004-05 (ABS 2003), 2006c).

Scale Construction

Five-point scales were used in the majority of the likert scale questions as they minimise complexity and allow for neutral/undecided responses (Jamieson, 2004); Jacoby and Mantell, 1971).

**Recruitment and response rates**

As described above interviews and surveys were carried out with CYS staff, service providers, headspace training participants, representatives of the headspace components and government, and young people and carers. Information about how

[92] The K-10 scale measures non-specific psychological distress in the anxiety-depression spectrum.

[93] The PWI scale measures subjective self-evaluations across eight domains representing the first level deconstruction of the overall question 'How satisfied are you with life as a whole?'

each of these groups were recruited and their response rates is detailed below and summarised in the tables below.

**Table B.3: Number and type of research informants surveyed**

| | Wave 1 | | | Wave 2 | | |
|---|---|---|---|---|---|---|
| **Name of survey** | **Number surveys distributed** | **Number surveys completed** | **Response rate (%)** | **Number surveys distributed** | **Number surveys completed** | **Response rate (%)** |
| CYS | 299 | 131 | 43.8 | 437 | 213 | 48.7 |
| Service providers | 479 | 232 | 48.4 | 431 | 212 | 49.2 |

**Table B.4: Number and type of research informants interviewed**

| **Stakeholder Group** | **Wave 1 interviewees** | **Wave 2 interviewees** | **Repeats** |
|---|---|---|---|
| National Office | 7 | 5 | 5 |
| Advisory Board | 3 | 2 | 2 |
| Foundation Executive Committee (FEC) | 3 | 2 | 2 |
| Centre of Excellence (CoE) | 3* | 3* | 3* |
| Community Awareness (CA) | 2* | 2* | 2* |
| Service Provider Education and Training (SPET) | 3 | 2 | 2 |
| CYS practitioners and staff | 43 | 43 | 18 |
| CYS Managers | 10 | 10 | 7 |
| CYS affiliates[b] | 36 | 31 | 15 |
| Young people using CYS[b] | 91 | 93 | 16 |
| Carers of young people using CYS [b] | 21 | 24 | 4 |
| Australian Government | 2 | 2 | 2 |
| State and Territory Government | 9 (7 states/territories) | 7 (6 states/territories) | 4 |
| hYNRG | 1 | 1 | 1 |
| **Total** | **232** | **225** | **81** |

*One respondent was involved in two stakeholder groups, but is counted only once in the total number of interviews.

*CYS staff and managers*

hNO provided the evaluators with contact details for all CYS managers, who in turn provided email contact details for all their staff and practitioners, and for consortium members and community-based service providers. This data was used to invite individuals to complete an online survey about their experiences of headspace in Wave 1. CYS managers update the contacts list prior to the collection of Wave 2 data. The survey response rates for CYS staff and practitioners was 44% at Wave 1 of the evaluation and 49% at Wave 2 (Table B.3). Sixty-one respondents completed both

Wave 1 and Wave 2 surveys.[94] These response rates are sufficient for gaining an understanding of service provider perceptions and behaviours.

At Wave 1 of the evaluation, several CYS were not yet operational. This had an effect on the response rate from some of the CYS sites, and only 23 sites participated in this first Wave. At Wave 2, all 30 CYS sites participated in the data collection. An average of 7.1 people from each CYS responded in Wave 2, compared with 4.7 people from 23 CYS in Wave 1. Similarly as in Wave 1, there was some variability between numbers of respondents per site (ranging from one to twelve people), the distribution across CYS was however largely consistent. Respondents' main roles in the headspace initiative across both Waves is detailed in Table B.5.

**Table B.5: CYS survey – respondents' roles (%)**

| Main role in the headspace initiative | **Wave 1 (n=131)** | **Wave 2 (n=213)** |
|---|---|---|
| Clinical services integration manager/CYS Manager | 19.9 | 13.1 |
| Community liaison officer | 3.8 | 3.8 |
| Drug and alcohol worker | 5.3 | 4.7 |
| General practitioner (GP) | 9.9 | 8.5 |
| Health worker/Nurse | 3.1 | 1.9 |
| Mental health worker/Nurse | 6.1 | 6.6 |
| Psychologist | 9.2 | 16.4 |
| Psychiatrist | 0.8 | 1.9 |
| Social Worker | 2.3 | 2.8 |
| Vocational Assistance Provider | 1.5 | 1.9 |
| Youth Worker | 9.2 | 9.4 |
| Other | 29 | 29.1 |
| Total | 100 | 100 |

In addition to the quantitative data collection from the surveys, there were interviews with managers, staff and practitioners at the ten in-depth CYSs. Managers were interviewed at all the sites, while other staff were interviewed depending on which services were provided in each CYS. Fifty-three staff and managers were interviewed in each Wave, of whom 25 were interviewed at both Waves (Table B.4).

*Service providers*

Service providers were also invited by email to complete an online survey about their experiences of headspace. The response rate for service providers was 48% at Wave 1 and 49% at Wave 2. 120 respondents completed surveys in both Waves.

The range of numbers of service provider responses within any one CYS site was similar in both Waves, from one to 27 in Wave 1 and two to 28 in Wave 2. This variation largely reflects the number of service providers that each CYS manager nominated as contacts. Most respondents were either service coordinators/managers or senior managers within their organisations, or frontline workers, and the majority were involved in headspace as consortium members or referring agencies (Table B.6).

[94] The number of people who completed both surveys is lower than 61 in many tables, because not all 61 respondents answered all the questions.

**Table B.6: Service providers' roles in organisation/agency and in headspace (%)**

| Role in organisation/agency | Wave 1 (n=232) | Wave 2 (n=212) | Agency's role in headspace CYS | Wave 1[a] | Wave 2[a] |
|---|---|---|---|---|---|
| CEO | 7.8 | 9.4 | None | 0.9 | 1.4 |
| Senior/Area Manager | 22.4 | 26.4 | Consortium member | 38.4 | 39.6 |
| Service Coordinator/Manager | 33.2 | 30.2 | Provides headspace CYS with accommodation/building | 2.6 | 0.9 |
| Frontline worker | 21.6 | 19.8 | Services funded by headspace | 2.6 | 0.9 |
| Other | 15.1 | 14.2 | Services co-located with headspace | 3.0 | 4.2 |
| Total | 100 | 100 | Referring agency | 18.5 | 17.5 |
| | | | Joint care | 14.2 | 20.8 |
| | | | Other | 19.8 | 14.6 |

a. Responses do not add to 100% as some agencies had more than one role in a headspace CYS.

Service providers and consortium partners also participated in the in-depth study. Thirty-six CYS affiliates were interviewed at Wave 1, and 31 at Wave 2, of whom 15 participated in both Waves of the study (Table B.4).

*headspace components, Advisory Board and Foundation Executive Committee*

headspace hNO also provided the evaluators with the contact details of people involved in the national headspace components (hNO, CoE, SPET and CA), and the Advisory Group and the FEC. The researchers selected a number of potential respondents from this list and invited them to participate in interviews at both Waves of the evaluation. In total 20 individuals participated in Wave 1 interviews and 14 in Wave 2. All Wave 2 participants were repeat respondents, having also participated in Wave 1 (Table B.4).

*Government representatives*

The evaluators also invited key policy makers from each state and territory and from the Australian Government (DoHA) to participate in interviews. Eleven interviews were conducted with state/territory and federal representatives in Wave 1, and nine interviews in Wave 2. Seven states and territories were represented in interviews in Wave 1, and there were six represented in Wave 2. Six interviewees took part in interviews both in Wave 1 and in Wave 2 (Table B.4).

*Young people*

Young people using headspace services at each of the ten in-depth study sites were invited to participate in the evaluation research with the help of flyers, information sheets and requests from CYS staff. The original plan was to recruit 10 young people at Wave 1, and an additional eight young people, two of them repeated interviews, at Wave 2. Young people experiencing the more serious mental health issues, or those who had had negative experiences with headspace, are unlikely to have participated in the evaluation. As a consequence, the in-depth evaluation results could be overestimating the effectiveness of the headspace program, and should not be used in isolation. However, researchers also requested interviews with young people with different levels of mental health severity and who were more and less challenging to support for CYSs.

Ninety-one young people were interviewed at Wave 1 and 93 at Wave 2, and 16 were interviewed in both Waves (Table B.4). The interviewees were also asked to complete online surveys once they had completed their interviews, in order to maximise response rates. In case some young people had difficulties with language or comprehension or computer literacy, a researcher was available to provide support and clarification to respondents if necessary. Although this was not strict adherence to quantitative research methods (and hence might have compromised the results), it did enable young people with poor literacy to be included. Respondents were reassured about the confidentiality of their responses in order to minimise the effects of social desirability bias.

At Wave 1, all young people completed the survey. At Wave 2 of the evaluation, young people who had participated in Wave 1 of the evaluation and who had agreed to take part in the second phase of the evaluation (but who were not selected for a second face-to-face interview), were invited by email to complete another survey. At Wave 2 all interviewees completed the survey after their interview, but only 41.2 per cent of those who provided their email addresses at Wave 1 completed the online survey. Demographic characteristics of the young people who responded to the survey can be found in the Section 6.

Young people were reimbursed for their participation in the research. Those who took participated in both interview and survey each received a $40 voucher, and those who completed only the online survey received a $20 voucher.

*Carers*

Carers participated in the evaluation in all ten of the in-depth sites. They were recruited in the same way the young people were, and also completed interviews and surveys. All the carers who were interviewed completed the survey (21 Wave 1 respondents and 24 Wave 2 respondents). Four carers were interviewed in both Waves, and 12 carers completed the survey in both Waves (Table B.4). Carers were interviewed only if the young person they were caring for gave their consent. Carers were predominantly the young people's mothers (Table B.7)

**Table B.7: Carers' relationship to headspace client (%)**

| Relationship | Wave 1 (n=21) | Wave 2 (n=31) |
|---|---|---|
| Mother | 76.2 | 74.2 |
| Father | 14.3 | 9.7 |
| Foster parent | - | 3.2 |
| Sibling | 4.8 | 3.2 |
| Grandparent | - | 6.5 |
| Friend | 4.8 | - |
| Total | 100 | 3.2 |

*headspace training participants*

One of the main features of the headspace CYS model is to enhance the community's capacity to work with young people and their carers through the provision of training and education resources. As part of Wave 2 data collection, training participants

(including participants from community providers and agencies, and headspace staff and practitioners) were asked to complete an online survey before and after the training session. The surveys were administrated by a CYS. In total, 366 respondents completed the pre-training survey and 123 respondents completed the post-training survey.

### B.3 Service coordination study

A service coordination study was devised to address the level of cooperation and collaboration between services, both within CYS sites and between CYS sites and service organisation in their surrounding communities. The questions in this study were incorporated into the CYS and service provider surveys, and are reported in the sections relating to Section 7 and Section 8.

### B.4 Sustainability Study

The sustainability instrument was designed to address the potential for headspace and the CYSs to be sustainable, and the risk and protective factors contributing to sustainability. As with the coordination study, the sustainability instrument was incorporated into the CYS and service provider surveys and interviews. The findings from the sustainability instrument are predominantly found in the Service Provision section.

### B.5 Secondary data analysis

A number of secondary data sources were analysed in the evaluation. The headspace dataset and the National Youth and Parent Community Survey were analysed to investigate the types of young people using headspace and attitudes towards general health. The other datasets were analysed to compare the young people using headspace with the general population of 12-25-year-olds. These datasets, and their use in the evaluation, are described below.

#### The headspace dataset

The headspace dataset, compiled using MHAGIC software, contains administrative records on referrals and service use by headspace clients, and demographic and clinical information about the young people who accessed CYS services. Amongst other things, it contains information about headspace clients' mental health, substance use patterns, and economic participation.

The original evaluation plan was to use the headspace dataset for a number of purposes: to determine the numbers of young people accessing headspace services; to assess the uptake of services by young people within CYS sites; to investigate the demographics of the young people assessed by CYSs in order to find out whether this group reflects young people known to be at risk of mental health issues in the population; and to identify any changes in mental health, substance use and economic participation for the young people who receive services.

However, data recorded in the headspace dataset is neither complete nor representative. The numbers of unique clients (n=7022) and visits to headspace (n= 10604) recorded in MHAGIC underestimates the total number of young people and occasions of service within CYSs. At the time of the evaluation, only 24 of the 30 CYS sites had any data at all recorded in MHAGIC, and just two of these 24 sites

accounted for 29 per cent of the recorded data. Some of the reasons for the missing data include: a delay in the development of MHAGIC; delays in the roll-out of the system (some sites were established before MAHGIC was ready); incompatibilities with existing software systems; and minimal staff training. The headspace dataset will become increasingly useful as the quantity and quality of data continues to improve. This will assist to draw clear conclusions from it about the population of young people receiving headspace services in the future.

### National Youth and Parent Community Survey

The first National Youth and Parent Community Survey (CATI-I) was conducted by the Brain and Mind Research Institute (BMRI) at the University of Sydney from January to June 2008.[95] The survey aimed to assess awareness, knowledge and attitudes regarding mental health and substance use among young people. It was a cross-sectional, computer-assisted telephone interview (CATI) conducted with a stratified sample of 4,000 people from around Australia.[96] Participants were randomly selected using random digit dialing, and included 2,000 young people aged 12-25 years,[97] 1,000 parents or carers of at least one child aged 12 to 25 years, and 1,000 adults from the general population. The sample was stratified according to age, gender and geographic location across all states and territories by selecting respondents to match appropriate current Australian Bureau of Statistics demographic profiles. Participants were excluded if they had English language difficulties or if they were uncomfortable with the interview being conducted in English.

The late timing of this survey means that it does not capture a true baseline of community perceptions. As a result, the evaluation team has limited data on which to base any assessment of the effectiveness of the headspace community awareness campaign. A second National Youth and Parent Community Survey (CATI-II) has been commissioned, but was not completed at the time of Wave 2 data collection. The second survey aims to assess any change in perceptions of help-seeking and mental health in headspace communities in comparison with control communities.

### Medicare Benefits Scheme data

MBS data from Medicare Australia[98] was used to assess any changes in early detection and intervention in the general population of young people experiencing mental ill-health. Changes in the use of MBS items associated with mental health between November 2006 and November 2008 were compared by age (15-24-year-olds and 25-80-year-olds). The data were also used to determine whether there had been any change between 2006-2008 in the use of Medicare services provided by

[95] Hickie, I.B., Davenport, T.A., Luscombe, G.M. and Fogarty, A.S. (2009) *Findings from the headspace National Youth and Parent Community Survey 2008*. Unpublished report to headspace.

[96] The survey was designed by the investigators at BMRI, but the telephone interviews were conducted by an independent contract company, The Social Research Centre (Melbourne).

[97] Existing protocols for telephone interviews with people aged under 18 were used, and the study had institutional ethics committee approval from The University of Sydney Human Research Ethics Committee (08-2007/10336).

[98] This data is publicly available and can be accessed from: http://www.medicareaustralia.gov.au/provider/medicare/mbs.jsp

psychologists, both by 15-24-year-olds and by the general population, in order to assess any impact of headspace on help-seeking behaviour.

### Census of Population and Housing

The 2006 Census of Population and Housing was used to compare the demographic characteristics of young people using headspace with young people of the same age in the general population.

### National Survey of Mental Health and Wellbeing

The 2007 SMHWB was conducted by the Australian Bureau of Statistics (ABS) from August to December 2007. The survey collected information from approximately 8,800 Australians aged 16-85 years.

The survey provides information on the prevalence (lifetime and 12-month) of selected mental disorders in three major categories: anxiety disorders (e.g. social phobia); affective disorders (e.g. depression; and substance use disorders (e.g. alcohol harmful use). It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, and social networks and care-giving, as well as demographic and socio-economic characteristics (ABS, 2008).

For the purpose of comparison with the other surveys used in this evaluation, the SMHWB sample was confined to Australians aged 16-25 (1552 observations), and person weights were used in the statistical analysis to account for the probability of that person being selected for the survey.

The SMHWB is based on a widely-used international survey instrument, thus making it compatible with similar surveys elsewhere. Experts and key stakeholders in the field of mental health provided ABS with advice on survey content such as the most appropriate topics for collection and associated concepts and definitions, and assisted with issues that arose during the field work.

## B.6 Meta-analysis

The meta-analysis addresses the headspace program as a whole. It compares the headspace logic model with the actual contributions of the various headspace components. It brings together the findings from the evaluation to explore the extent to which headspace has met its objectives and why, as well as highlighting key lessons and recommendations in regard to the headspace model.

## B.7 Ethics

The researchers maintained high standards of ethical practice and respected the confidentiality and privacy of all research participants. The evaluation methods were approved by the University of New South Wales (UNSW) Human Research Ethics Committee in April 2008. The researchers implemented a number of ethical safeguards, including using arms-length, voluntary recruitment, informed consent, and opportunities to revoke consent at any time (see Muir et al., 2008 for more details).

Furthermore, several measures were taken in the design and administration of the evaluation in order to maximise factors such as reliability, validity, cost-effectiveness and the ability to generalise results.

# Appendix C: CYS sites by round, location and opening date

## Table C.1: CYS sites by round and opening date

| Round 1 sites | | Round 2 sites | |
|---|---|---|---|
| **CYS** | **Date opened** | **CYS** | **Date opened** |
| Adelaide Northern | May-07 | ACT | Sep-08 |
| Barwon | Jul-07 | Central Australia | Nov-08 |
| Central Coast | Jun-07 | Central Sydney | Aug-08 |
| Great Southern | Oct-07 | Central West Gippsland | Jul-08 |
| Illawarra | Nov-07 | Fraser Coast | Jun-08 |
| MCHS | Jul-07 | Fremantle | Jul-08 |
| Mid North Coast | Mar-08 | Gold Coast | May-08 |
| Southern Melbourne | Mar-08 | Hunter | Sep-08 |
| Top End | Jun-08 | Kimberley | Aug-08 |
| Western Melbourne | Nov-07 | Mt Druitt | Aug-08 |
| | | Murraylands | Jun-08 |
| | | Northern Melbourne | Dec-08 |
| | | Northern Tasmania | Jul-08 |
| | | NSW Central West | Jul-08 |
| | | Peninsula | Jun-08 |
| | | Riverina | Jul-08 |
| | | Riverland | Sep-08 |
| | | Southern Downs | Jul-08 |
| | | SW Victoria | Jun-08 |
| | | Townsville | Jun-08 |

Source: headspace Centre's Summary Briefing – Commercial in Confidence. February 2009.

# Appendix D: Topic specific tables

## D.1 Satisfaction with life areas

### Table D.1: Satisfaction with life areas (Young People's survey)

| | N. | Mean |
|---|---|---|
| Mental health | 161 | 5.64 |
| Physical health | 157 | 5.80 |
| Sexual/Reproductive health | 111 | 7.00 |
| Drug and alcohol use | 107 | 6.94 |
| Feelings about bodily appearance (how I look to others) | 157 | 5.26 |
| Involvement in social/community activities | 150 | 5.99 |
| Being able to work or find work (paid/voluntary) | 144 | 6.01 |
| Being able to provide care (for family members, children or other people) | 126 | 6.94 |
| Being able to go to school, TAFE or university | 142 | 6.57 |
| How you get on with family | 165 | 6.28 |
| How you get on with friends | 164 | 7.54 |
| How you sleep | 165 | 5.32 |
| Being able to care for yourself and your home, perform daily activities | 163 | 6.95 |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 143 | 5.56 |
| The place where you live | 163 | 6.72 |
| Being able to see doctors or health workers when you want | 161 | 7.49 |
| General happiness | 163 | 6.17 |

## Table D.2: Satisfaction with life areas by age group (Young People's survey)

| Satisfaction with life areas | 12-17 year olds | | 18-25 year olds | | Independent Samples Test |
|---|---|---|---|---|---|
| | n | Mean | n | Mean | |
| Mental health | 67 | 6.16 | 92 | 5.20 | p<0.05 |
| Physical health | 63 | 6.25 | 92 | 5.40 | p<0.05 |
| Sexual/Reproductive health | 31 | 7.19 | 79 | 6.89 | - |
| Drug and alcohol use | 35 | 6.20 | 71 | 7.30 | p<0.1 |
| Feelings about bodily appearance | 64 | 5.59 | 91 | 4.98 | - |
| Involvement in social/community activities | 60 | 6.82 | 88 | 5.36 | p<0.01 |
| Being able to work or find work (paid/voluntary) | 55 | 6.98 | 87 | 5.34 | p<0.01 |
| Being able to provide care (for family members, children or other people) | 48 | 7.92 | 76 | 6.30 | p<0.01 |
| Being able to go to school, TAFE or university | 65 | 6.69 | 76 | 6.42 | - |
| How you get on with family | 68 | 6.57 | 95 | 6.04 | - |
| How you get on with friends | 69 | 7.93 | 93 | 7.19 | p<0.05 |
| How you sleep | 69 | 5.83 | 94 | 4.90 | p<0.1 |
| Being able to care for yourself and your home, perform daily activities | 67 | 7.66 | 94 | 6.38 | p<0.01 |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 57 | 5.93 | 84 | 5.29 | - |
| The place where you live | 66 | 7.29 | 95 | 6.26 | p<0.05 |
| Being able to see doctors or health workers when you want | 66 | 8.00 | 93 | 7.13 | p<0.05 |
| General happiness | 67 | 6.97 | 94 | 5.59 | p<0.01 |

## Table D.3: Satisfaction with life areas by gender (Young People's survey)

| Satisfaction with life areas | Male | | Female | | Independent Samples Test |
|---|---|---|---|---|---|
| | n | Mean | n | Mean | |
| Mental health | 60 | 5.88 | 99 | 5.54 | - |
| Physical health | 60 | 5.98 | 95 | 5.69 | - |
| Sexual/Reproductive health | 41 | 7.00 | 68 | 7.03 | - |
| Drug and alcohol use | 43 | 6.77 | 63 | 7.14 | - |
| Feelings about bodily appearance | 58 | 6.02 | 97 | 4.79 | $p<0.05$ |
| Involvement in social/community activities | 55 | 5.64 | 93 | 6.18 | - |
| Being able to work or find work (paid/voluntary) | 53 | 5.94 | 90 | 6.04 | - |
| Being able to provide care (for family members, children or other people) | 49 | 6.88 | 75 | 6.92 | - |
| Being able to go to school, TAFE or university | 54 | 6.57 | 87 | 6.54 | - |
| How you get on with family | 64 | 6.61 | 99 | 6.03 | - |
| How you get on with friends | 63 | 7.76 | 99 | 7.39 | - |
| How you sleep | 64 | 5.80 | 99 | 4.99 | - |
| Being able to care for yourself and your home, perform daily activities | 63 | 7.03 | 98 | 6.89 | - |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 58 | 5.45 | 84 | 5.65 | - |
| The place where you live | 63 | 6.46 | 98 | 6.88 | - |
| Being able to see doctors or health workers when you want | 60 | 7.53 | 99 | 7.41 | - |
| General happiness | 64 | 6.41 | 97 | 6.01 | - |

## D.2 Alcohol and tobacco consumption

### Table D.4: Quantity of alcohol consumption

| | SMHWB | | | | Young People's survey | | | |
|---|---|---|---|---|---|---|---|---|
| | n* | Does not drink | Low risk drinker (drinks 1-4 drinks on single occasion) | High risk drinker (drinks 5 or more drinks on a single occasion) | n | Does not drink | Low risk drinker (drinks 1-4 drinks on single occasion) | High risk drinker (drinks 5 or more drinks on a single occasion) |
| Total | 1552 | 18.4 | 66.9 | 14.7 | 163 | 18.5 | 37.7 | 43.8 |
| Male | 710 | 33.1 | 33.2 | 33.7 | 63 | 23.8 | 33.3 | 42.9 |
| Female | 842 | 48.9 | 31.8 | 19.2 | 97 | 14.4 | 40.2 | 45.4 |
| 12-17 (16-17) | 378 | 66.4 | 15.6 | 18.0 | 67 | 34.3 | 29.9 | 35.8 |
| 18-25 | 1174 | 33.7 | 37.9 | 28.4 | 93 | 7.5 | 41.9 | 50.5 |

*Although 'n' shows the actual number of respondents, the analysis was applied using person weights, considerably enlarging the observations number on which the percentages were drawn.

### Table D.5: Tobacco consumption

| | SMHWB | | | | | Young People's survey | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | n* | Does not smoke | Smokes less than weekly | Smokes weekly | Smokes everyday | n | Does not smoke | Smokes less than weekly | Smokes weekly | Smokes everyday |
| Total | 1552 | 75.5 | 2.9 | 4 | 17.6 | 164 | 51.8 | 4.9 | 4.3 | 39 |
| Male | 710 | 70.4 | 3.8 | 5.5 | 20.3 | 66 | 54.5 | 1.5 | 1.5 | 42.4 |
| Female | 842 | 80.8 | 2 | 2.3 | 14.9 | 96 | 51 | 7.3 | 6.3 | 35.4 |
| 12-17 (16-17) | 378 | 91.7 | 2.9 | 2.2 | 3.2 | 67 | 52.2 | 6 | 1.5 | 40.3 |
| 18-25 | 1174 | 70.5 | 2.9 | 4.5 | 22 | 95 | 51.6 | 4.2 | 6.3 | 37.9 |

*Although 'n' shows the actual number of respondents, the analysis was applied using person weights, considerably enlarging the observations number on which the percentages were drawn.

## D.3 Service Access: Strategies to promote engagement

### Table D.6: Strategies used by CYS to address DNAs (CYS managers, per cent)

| | Wave | Percentage used | Very ineffective | Somewhat ineffective | Neither effective nor ineffective | Somewhat effective | Very effective | n (total) | n (used) | Sig. (Chi square test) |
|---|---|---|---|---|---|---|---|---|---|---|
| Phone call reminder the night before the appointment | Wave1 | 61.5 | - | 6.3 | 6.3 | 56.3 | 31.3 | 26 | 16 | - |
| | Wave2 | 67.9 | - | 5.3 | 10.5 | 68.4 | 15.8 | 28 | 19 | |
| Phone call reminder the day of the appointment | Wave1 | 53.8 | - | - | 7.1 | 64.3 | 28.6 | 26 | 14 | - |
| | Wave2 | 82.2 | - | - | 8.7 | 69.6 | 21.7 | 28 | 23 | |
| Text message the night before the appointment | Wave1 | 50.0 | - | - | 7.7 | 46.2 | 46.2 | 26 | 13 | - |
| | Wave2 | 82.1 | - | - | 4.3 | 56.5 | 39.1 | 28 | 23 | |
| Text message reminder the day of the appointment | Wave1 | 38.5 | - | - | 10.0 | 50.0 | 40.0 | 26 | 10 | - |
| | Wave2 | 39.3 | - | - | - | 52.9 | 47.1 | 28 | 17 | |
| Pick the young person up | Wave1 | 46.2 | - | - | 8.3 | 33.3 | 58.3 | 26 | 12 | - |
| | Wave2 | 50.0 | - | - | - | 42.9 | 57.1 | 28 | 14 | |
| Charge the young person for unattended appointments | Wave1 | 11.5 | 33.3 | - | 66.7 | - | - | 26 | 3 | p<0.1 |
| | Wave2 | 14.3 | 100.0 | - | - | - | - | 24 | 4 | |
| Charge the service provider for unattended appointments | Wave1 | 7.7 | 50.0 | - | 50.0 | - | - | 26 | 2 | - |
| | Wave2 | 14.3 | 100.0 | - | - | - | - | 28 | 4 | |
| Schedule appointments at appropriate times for the young person | Wave1 | 15.4 | - | - | 25.0 | 25.0 | 50.0 | 26 | 4 | - |
| | Wave2 | 89.3 | - | - | 4.0 | 52.0 | 44.0 | 28 | 25 | |

## D.4 Impact of headspace

### Table D.7: Impact of headspace by age group (Young People's survey)

| Impact of headspace on | 12–17 years n | Worse | Neither better or worse | Better | Total | 18–25 years n | Worse | Neither better or worse | Better | Total | Sig. (Chi square test) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | 59 | 0.0 | 6.8 | 93.2 | 100.0 | 87 | 0.0 | 6.9 | 93.1 | 100.0 | - |
| Physical health | 52 | 1.9 | 36.5 | 61.5 | 100.0 | 78 | 2.6 | 34.6 | 62.8 | 100.0 | - |
| Sexual/Reproductive health | 18 | 0.0 | 44.4 | 55.6 | 100.0 | 49 | 4.1 | 69.4 | 26.5 | 100.0 | p<0.1 |
| Drug and alcohol use | 26 | 3.8 | 15.4 | 80.8 | 100.0 | 52 | 0.0 | 38.5 | 61.5 | 100.0 | p<0.1 |
| Feelings about bodily appearance | 50 | 2.0 | 40.0 | 58.0 | 100.0 | 70 | 4.3 | 57.1 | 38.6 | 100.0 | p<0.05 |
| Involvement in social/community activities | 48 | .0 | 37.5 | 62.5 | 100.0 | 74 | 1.4 | 58.1 | 40.5 | 100.0 | p<0.05 |
| Being able to work or find work (paid/voluntary) | 38 | 2.6 | 36.8 | 60.5 | 100.0 | 60 | 0.0 | 56.7 | 43.3 | 100.0 | p<0.1 |
| Being able to provide care (for family members, children or other people) | 36 | 0.0 | 22.2 | 77.8 | 100.0 | 56 | 0.0 | 37.5 | 62.5 | 100.0 | - |
| Being able to go to school, TAFE or university | 51 | 2.0 | 27.5 | 70.6 | 100.0 | 57 | 1.8 | 49.1 | 49.1 | 100.0 | p<0.1 |
| How you get on with family | 61 | 1.6 | 9.8 | 88.5 | 100.0 | 83 | 2.4 | 26.5 | 71.1 | 100.0 | p<0.05 |
| How you get on with friends | 59 | 0.0 | 28.8 | 71.2 | 100.0 | 82 | 0.0 | 30.5 | 69.5 | 100.0 | - |
| How you sleep | 61 | 1.6 | 50.8 | 47.5 | 100.0 | 80 | 5.0 | 36.3 | 58.8 | 100.0 | - |
| Being able to care for yourself and your home, perform daily activities | 57 | 0.0 | 26.3 | 73.7 | 100.0 | 78 | 1.3 | 28.2 | 70.5 | 100.0 | - |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 50 | 2.0 | 14.0 | 84.0 | 100.0 | 70 | 1.4 | 22.9 | 75.7 | 100.0 | - |
| The place where you live | 57 | 3.5 | 36.8 | 59.6 | 100.0 | 71 | 4.2 | 46.5 | 49.3 | 100.0 | - |
| Being able to see doctors or health workers when you want | 59 | 1.7 | 18.6 | 79.7 | 100.0 | 81 | 0.0 | 23.5 | 76.5 | 100.0 | - |
| General happiness | 65 | 1.5 | 6.2 | 92.3 | 100.0 | 87 | 2.3 | 16.1 | 81.6 | 100.0 | - |

## Table D.8: Impact of headspace by gender (n= 169; percent, Young People's survey)

| Impact of headspace on | Male n | Male Worse | Male Neither better or worse | Male Better | Male Total | Female n | Female Worse | Female Neither better or worse | Female Better | Female Total | Sig. (Chi square test) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | 59 | 0.0 | 11.9 | 88.1 | 100.0 | 86 | 0.0 | 3.5 | 96.5 | 100.0 | p<0.1 |
| Physical health | 54 | 1.9 | 42.6 | 55.6 | 100.0 | 76 | 2.6 | 30.3 | 67.1 | 100.0 | - |
| Sexual/Reproductive health | 26 | .0 | 80.8 | 19.2 | 100.0 | 41 | 4.9 | 51.2 | 43.9 | 100.0 | p<0.05 |
| Drug and alcohol use | 35 | 2.9 | 34.3 | 62.9 | 100.0 | 44 | .0 | 29.5 | 70.5 | 100.0 | - |
| Feelings about bodily appearance | 46 | 2.2 | 54.3 | 43.5 | 100.0 | 74 | 4.1 | 48.6 | 47.3 | 100.0 | - |
| Involvement in social/community activities | 49 | 0.0 | 59.2 | 40.8 | 100.0 | 73 | 1.4 | 45.2 | 53.4 | 100.0 | - |
| Being able to work or find work (paid/voluntary) | 43 | 0.0 | 55.8 | 44.2 | 100.0 | 56 | 1.8 | 44.6 | 53.6 | 100.0 | - |
| Being able to provide care (for family members, children or other people) | 38 | 0.0 | 36.8 | 63.2 | 100.0 | 54 | 0.0 | 27.8 | 72.2 | 100.0 | - |
| Being able to go to school, TAFE or university | 42 | 2.4 | 47.6 | 50.0 | 100.0 | 65 | 1.5 | 33.8 | 64.6 | 100.0 | - |
| How you get on with family | 62 | 1.6 | 19.4 | 79.0 | 100.0 | 82 | 2.4 | 20.7 | 76.8 | 100.0 | - |
| How you get on with friends | 58 | 0.0 | 32.8 | 67.2 | 100.0 | 83 | 0.0 | 32.8 | 67.2 | 100.0 | - |
| How you sleep | 56 | 3.6 | 50.0 | 46.4 | 100.0 | 84 | 3.6 | 39.3 | 57.1 | 100.0 | - |
| Being able to care for yourself and your home, perform daily activities | 42 | .0 | 25.0 | 75.0 | 100.0 | 53 | 1.3 | 30.8 | 67.9 | 100.0 | - |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 54 | 1.9 | 20.4 | 77.8 | 100.0 | 66 | 1.5 | 19.7 | 78.8 | 100.0 | - |
| The place where you live | 53 | 3.8 | 49.1 | 47.2 | 100.0 | 75 | 4.0 | 38.7 | 57.3 | 100.0 | - |
| Being able to see doctors or health workers when you want | 52 | .0 | 30.8 | 69.2 | 100.0 | 88 | 1.1 | 15.9 | 83.0 | 100.0 | p<0.1 |
| General happiness | 63 | .0 | 12.7 | 87.3 | 100.0 | 88 | 3.4 | 11.4 | 85.2 | 100.0 | - |

## D.5 Young people's longitudinal case study data

### Table D.9: Personal Well being Index, 12–17-year-olds (Young People's survey, repeat sample)

| | Wave 1 | | Wave 2 | |
|---|---|---|---|---|
| **Satisfaction with...** | **n** | **Mean** | **n** | **Mean** |
| Life as a Whole | 10 | 8.10 | 10 | 8.40 |
| Standard of Living | 10 | 8.30 | 10 | 8.70 |
| Health | 10 | 6.70 | 10 | 7.40 |
| Achievements | 10 | 6.80 | 10 | 7.90 |
| Personal Relationships | 10 | 9.10 | 10 | 9.20 |
| Safety | 10 | 8.20 | 10 | 8.90 |
| Feeling part of the Community | 10 | 10.20 | 10 | 9.60 |
| Future Security | 10 | 7.90 | 10 | 9.20 |

### Table D.10: Personal Well being Index, 18–25-year-olds (Young People's survey, repeat sample)

| | Wave 1 | | Wave 2 | |
|---|---|---|---|---|
| **Satisfaction with...** | **n** | **Mean** | **n** | **Mean** |
| Life as a Whole | 16 | 6.44 | 16 | 7.13 |
| Standard of Living | 17 | 7.59 | 17 | 7.41 |
| Health | 16 | 6.19 | 16 | 6.13 |
| Achievements | 17 | 6.12 | 17 | 6.53 |
| Personal Relationships | 17 | 6.88 | 17 | 6.71 |
| Safety | 17 | 7.71 | 17 | 7.82 |
| Feeling part of the Community | 17 | 6.53 | 17 | 7.00 |
| Future Security | 17 | 6.76 | 17 | 6.88 |

## Table D.11: Satisfaction with areas in life (Young People's survey, repeat sample)

| Satisfaction with... | Wave 1 | | Wave 2 | | Sig. |
|---|---|---|---|---|---|
| | n | Mean | n | Mean | |
| Mental health | 25 | 6.20 | 25 | 6.00 | - |
| Physical health | 25 | 5.64 | 25 | 5.48 | - |
| Sexual/Reproductive health | 13 | 6.54 | 13 | 6.00 | - |
| Drug and alcohol use | 18 | 7.44 | 18 | 6.28 | - |
| Feelings about bodily appearance | 23 | 5.57 | 23 | 5.43 | - |
| Involvement in social/community activities | 25 | 6.28 | 25 | 6.12 | - |
| Being able to work or find work (paid/voluntary) | 24 | 6.63 | 24 | 6.29 | - |
| Being able to provide care (for family members, children or other people) | 16 | 7.38 | 16 | 7.56 | - |
| Being able to go to school, TAFE or university | 22 | 6.91 | 22 | 7.41 | - |
| How you get on with family | 24 | 6.79 | 24 | 7.17 | - |
| How you get on with friends | 28 | 7.57 | 28 | 7.96 | - |
| How you sleep | 25 | 6.04 | 25 | 5.64 | - |
| Being able to care for yourself and your home, perform daily activities | 26 | 7.58 | 26 | 7.31 | - |
| Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs | 22 | 5.91 | 22 | 7.32 | $p<0.05$ |
| The place where you live | 25 | 7.36 | 25 | 7.36 | - |
| Being able to see doctors or health workers when you want | 27 | 7.41 | 27 | 7.19 | - |
| General happiness | 23 | 6.39 | 23 | 6.74 | - |

## Table D.12: Engagement in education, work and volunteering (Young People's survey, repeat sample)

| | **Wave 1** | | **Wave 2** | |
|---|---|---|---|---|
| **Engagement** | **n** | **%** | **n** | **%** |
| Engaged in education or work | 28 | 67.9 | 28 | 71.4 |
| Engaged in Volunteering | 27 | 25.9 | 27 | 40.7 |
| Unemployed and looking for work | 27 | 25.9 | 27 | 48.1 |

## D.6 Repeat data for CYS and Service provider respondents

### Table D.13: Satisfaction with headspace components (CYS survey, %)

| B. Repeated agencies | | n | Very or somewhat unsatisfied | Neither satisfied nor unsatisfied | Somewhat or very satisfied |
|---|---|---|---|---|---|
| headspace National Office | Wave1 | 41 | 26.8 | 29.3 | 43.9 |
| | Wave2 | 41 | 41.5 | 22.0 | 36.6 |
| Service Provider Education and Training | Wave1 | 40 | 32.5 | 17.5 | 50.0 |
| | Wave2 | 40 | 27.5 | 10.0 | 62.5 |
| Community Awareness | Wave1 | 41 | 19.5 | 14.6 | 65.9 |
| | Wave2 | 41 | 17.1 | 24.4 | 58.5 |
| Centre of Excellence | Wave1 | 34 | 23.5 | 32.4 | 44.1 |
| | Wave2 | 34 | 20.6 | 26.5 | 52.9 |

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