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Author:
Muir, K; McDermott, S; Gendera, S; Flaxman, S; Patulny, R; Sitek, T; Abelló, D; Oprea, I; Katz, I

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Independent evaluation of headspace: the National Youth Mental Health Foundation: interim evaluation report

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

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Telephone: +61 (2) 9385 7802 Fax: +61 (2) 9385 7838 Email: sprc@unsw.edu.au

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Research team

Social Policy Research Centre, University of New South Wales

Professor Ilan Katz, Director

Dr Kristy Muir, Senior Research Fellow

Dr Roger Patulny, Research Fellow

Dr Shannon McDermott, Research Associate

Sandra Gendera, Research Associate

Saul Flaxman, Research Associate

David Abelló, Research Officer

Ioana Oprea, Research Officer

Tomasz Sitek, Research Officer

Authors

Muir, K., McDermott, S., Gendera, S., Flaxman, S., Patulny, R., Sitek, T., Abello, D., Oprea, I. and Katz, I.

Contact for follow up

Dr Kristy Muir, Social Policy Research Centre: ph. 9385 7818; fax: 9385 7838; email: k.muir@unsw.edu.au

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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
APS	Australian Psychological Society
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
CoE	Centre of Excellence
CYS	Communities of Youth Service
DGP	Division of General Practice
DoHA	Australian Government Department of Health and Ageing
FEC	Foundation Executive Committee
GP	General practitioner
hNO	headspace National Office
hYNRG	headspace Youth National Reference Group
K-10	Kessler 10
MBS	Medicare Benefits Scheme
MHAGIC	Mental Health Assessment Generation and Information Collection
MHCP	Mental Health Care Plan
NGO	Non-government organisation
NSW	New South Wales
NT	Northern Territory
ORC	ORYGEN Research Centre
PWI	Personal Wellbeing Index
Qld	Queensland
SA	South Australia
SEE	Screening-Engaging-Early
SPET	Service Provider Education and Training
SOFAS	Social and Occupational Functioning Assessment Scale
SPRC	Social Policy Research Centre
Tas.	Tasmania
UNSW	University of New South Wales
UoM	University of Melbourne
Vic.	Victoria
WA	Western Australia
YMHI	Youth Mental Health Initiative

1 Introduction

headspace, the National Youth Mental Health Foundation is an Australian Government initiative first funded as part of the Federal Budget commitment to the Youth Mental Health Initiative (2005–06 to 2008–09), and launched in 2006. It aims to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young Australians aged 12-25 years.

The Social Policy Research Centre (SPRC) was contracted by headspace and the University of Melbourne (UoM) to conduct the first independent evaluation of headspace in early 2008. It is a longitudinal evaluation with two Waves of data collection (2008 and 2009). This interim report presents data from the first Wave (2008). Most of the Wave 1 data were collected between late July and September 2008, at a time when many of the Communities of Youth Services (CYSs) had only recently opened and the components were still developing resources and refining support. A brief overview of this document (Muir et al., forthcoming) has also been produced.

This report largely contains baseline information, but it also raises some preliminary questions around trends and issues introduced by early experiences of implementation. Many of these issues, along with an assessment of whether or not headspace has made further progress towards meeting its objectives, will be further explored in Wave 2 of the evaluation after the CYSs have been open for a longer period of time, and the headspace components have provided more resources to support the CYSs.

This interim report is structured around the logic model of headspace to provide an understanding of how headspace works, the progress achieved thus far, and the factors that have facilitated and hindered establishment and implementation. For headspace to achieve its aims, it is critically important 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.

After briefly covering the headspace model and evaluation methodology, this report is structured around the four areas of: service provision, access and quality, and broader service reform. It concludes by describing the relative contributions of the headspace components, the relationship between them and the governance of the initiative.

2 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. 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, and 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 headspace model consists of 30 CYSs that provide direct service delivery to young people across Australia. The CYSs are supported by: the headspace National Office (hNO), the headspace Centre of Excellence (CoE), the Service Provider Education and Training Program (SPET), and the Community Awareness Program (CA). headspace will receive $51.8 million from the Department of Health and Ageing (DoHA) between 2006 and 2009. The governance of headspace involves:

- ORYGEN Research Centre (ORC) and the UoM: accountable to DoHA for the delivery on the contract;
- Foundation Executive Committee (FEC): provides strategic direction. It is made up of five consortium members, ORC, UoM, Brain and Mind Research Institute (BMRI), Australian Psychological Society (APS) and the Australian General Practice Network (AGPN);
- Advisory Board (appointed by the Government): provide recommendations on the strategic direction of headspace; and
- Chief Executive Officer (employed by UoM): accountable to all of the above parties.

A diagram of the headspace model can be found in Appendix A.

The roles of the headspace components

Role of hNO, CoE, CA and SPET

The roles of hNO, CoE, CA and SPET are described in Table 2.1. They are also discussed in Section 8.

Table 2.1: Roles of headspace components

Component	Role and funding
headspace National Office	hNO will receive almost $4.6 million to: contractually manage and support the implementation of the CYSs; coordinate and oversee the headspace initiative; manage the contracts of the CYSs, CoE, and CA and SPET programs; provide accountability to DoHA, FEC, 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, will receive almost $2.9 million 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, will receive a total of $3.9 million to plan and conduct community awareness campaigns, develop and produce community awareness resources and 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 are primarily the responsibility of hNO with input from BMRI.[1] BMRI's primary role is reviewing evidence and conducting research.
Service Provider Education and Training	SPET, run by APS and AGPN, will receive almost $3.5 million 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.[2] The APS is responsible for determining training needs and design and development, and the AGPN is responsible for the promotion and dissemination of training.

Community of Youth Services (CYSs)

CYSs aim to promote early help-seeking, provide early intervention, and 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 across primary health, mental health, drug and alcohol use, and social and vocational participation.

CYSs were selected through a competitive process via the headspace Grants Committee. The CYSs will collectively receive a total of $34.2 million (2006–2009) for establishment and management. Service delivery is funded by the Youth Mental Health Initiative Allied Health Workers (YMHI AHWs[3]), which pays the salaries of practitioners, such as psychologists, social workers, mental health nurses, occupational therapists, Aboriginal and Torres Strait Islander health workers, drug and alcohol counsellors and youth workers.

1 This work is supported by the Marketing and Communications Subcommittee of the Advisory Board.

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

3 $15million has been allocated by DoHA for the YMHI AHW program.

Each CYS is directed by a lead agency on behalf of a consortium (government agencies and NGOs from a range of sectors; see Section 4.3). This arrangement intends to encourage a whole-of-community approach and engage key stakeholders in the development, establishment, implementation and coordination of headspace services.

Private practitioners, such as GPs and psychologists, are an important component of the CYS model. Consultations with private practitioners are paid for by bulk billing the Medical Benefits Scheme (MBS) or by young people who are reimbursed by private health insurance or by MBS. Gap payments, contributed by young people or their families who can afford them, are intended to contribute to the sustainability of CYSs beyond 2009. Services are also provided by co-located organisations.[4] The consortia models, organisations involved and contribution to the CYSs varies 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 community awareness programs, the CYSs also aim to increase the capacity of the broader community to identify, refer and work with young people at risk of mental health and related problems.

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

3 Evaluation methodology

The independent evaluation of headspace (2008–2009) is a longitudinal, mixed methods research project. It aims to review the efficiency and effectiveness of headspace as a whole and of its individual components; assess the efficiency and effectiveness of the performance of the CYSs; evaluate the extent to which headspace has influenced government policy; ascertain the extent of community awareness of issues related to youth mental health and the extent of evidence-based approaches to these issues; and contribute to the ongoing development of headspace and to the evolution of the CYS models. The evaluation's main focus is on CYSs, but it also aims to evaluate headspace as a whole and how the individual components interact and contribute to the model. A detailed evaluation methodology is available in the *Independent Evaluation of headspace: Evaluation Plan* (Muir et al., 2008) and further details on the methodology can be found in Appendix B.

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 health 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.

Methods

This report includes baseline and early implementation data from Wave 1 of the evaluation. Wave 2 will be conducted in 2009 and will track changes over time. The key evaluation questions will be answered using both Waves of data in the final evaluation report. These key questions include:

- What impact has headspace had on the mental health, social well-being and economic participation of the young people who access CYSs?
- What impact has headspace had on community awareness, the youth service sector, and the government response to youth mental health in Australia?
- How beneficial is headspace as an early intervention strategy for 12-25 year olds?
    - For which young people is headspace most effective?
    - What aspects of the headspace model are most effective?
- How effectively have headspace resources been used?
- What lessons have been learnt on how to efficiently and effectively support young people with mental health and substance-use-related problems?

The evaluation methods to answer these questions were designed using a program logic model (Cooksy et al., 2001). These methods are briefly described below.

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 (n=392) and interviewed (n=198) to obtain baseline findings and to understand early implementation issues (Table 3.1). Stakeholders included representatives from CYSs, CYS consortiums and service providers in CYS communities, young people using headspace, carers, and federal and state/territory governments, as well as representatives from hNO, Advisory Board, CoE, CA and SPET programs. Interviews with CYS, consortium partners, community based service providers, young people and carers occurred within nine in-depth CYS visits. Further methodological details are available in Appendix B.

Table 3.1: Number and type of research participants

	Number contacted	Number completed survey	Response rate (%)	Number interviewed
headspace components (hNO, Advisory Board, hYNRG, CoE, CA, SPET)	20	13	65	20
CYS*	193	107	55	47
Consortium/ service providers**	312	182	58	29
Young people	71	70	99	71
Carers	20	20	100	20
Government	13	n/a	n/a	11
Total	616	392	64	198

*23 of the 30 CYSs. 6 of these sites were not operational at the time. **24 of the 30 CYSs are represented.

Service co-ordination 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. The questions in this survey were incorporated into the CYS and consortium/service provider surveys.

Young people study

The young people study examined the demographic characteristics of young people accessing headspace, their service experiences, baseline data on a range of life domains (such as mental and general health, social and economic participation, and drug and alcohol use), and some preliminary self-reported outcomes in regard to young people's perceived impact of headspace at this early stage.

The data sources for this included 71 in-depth interviews with young people in nine CYS locations around Australia, and analysis of the headspace dataset – the Mental Health Generation and Information Collection (MHAGIC). The nine CYS sites

include: Illawarra and Riverina, NSW; Gold Coast and Townsville, Qld; Southern Melbourne and Western Melbourne, Vic; Kimberley, WA; Northern Tasmania, Tas; and Murraylands, SA. SPRC endeavored to interview 10 young people each site. The visit to the tenth site, Darwin/Palmerston, NT, was delayed until late November 2008. Only 71 young people initially participated in the nine sites because of the low numbers at some of the CYSs, and because of young people not showing up to the interviews and 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. The data from the extra 21 young people will be incorporated into the final report.

Most of the information on young people contained in this report is based on the in-depth interviews and surveys. The MHAGIC dataset is still being rolled out to the last four CYSs. The development of this tool took longer than anticipated and many sites have only recently had it installed. Staff have only recently been trained to use it and many are still learning how to use it effectively. Hence at this stage, information from MHAGIC is not representative of all the CYSs nor of all the young people the CYSs are seeing. It is useful, however, to establish some basic demographic information and to provide preliminary understanding of some possible trends that will be further explored and confirmed in Wave 2 of the evaluation.

4 Service provision

Increasing the numbers of young people receiving youth-specific services is a primary objective of headspace (headspace, 2008b). The provision of youth-specific services is critical if headspace is to contribute to the improved mental health, social wellbeing and economic participation of young Australians, for a number of reasons: the prevalence of mental health disorders in this age group, current barriers to accessing 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 of age, with one in four 15 to 24-year-olds experiencing a mental disorder. Mental health problems are the leading disease burden for this age group (Australian Institute of Health and Welfare, 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 two per cent receive help from mental health specialists (Sawyer et al., 2000).

The current mental health system largely caters for children (under 18 years of age) 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 substance-use disorders, and their social and economic participation is often limited (Australian Institute of Health and Welfare, 2007; Hickie et al., 2004).

For these reasons, the headspace model indicates that for young people's mental health, social, and economic outcomes to improve, youth-specific services at the CYSs need to target four key areas – primary health, mental health, drug and alcohol treatment, and social and vocational support. Thus the CYSs are the cornerstone of headspace. This Section of the report examines the establishment of the CYSs, the services they provide, and the factors impacting on their establishment and early implementation.

4.1 CYSs established

The first ten CYSs were funded in February 2007 (Round 1) and the remaining twenty in January 2008 (Round 2). Twenty-eight of these thirty CYSs had opened by November 2008 and were providing services to young people.[5]

The establishment of the CYSs has taken longer than anticipated and many sites are still in the early stages of implementation. According to audit data, Round 1 sites opened on average 8.6 months after the funding announcement.[6] The 18 sites that, at the time of writing, had opened in Round 2 had a shorter average establishment period of 6.1 months.[7] The Round 2 sites were established within a shorter time because the

[5] The two remaining sites were funded in Round 2. A list of CYSs by name, location and opening dates can be found in Appendix C.

[6] See Appendix C. Four of these sites opened within six months, another four sites took between 8-9 months to open, and the remaining 2 sites between16 and 22 months.

[7] Eleven of the 20 sites were opened within six months and the remaining sites opened within 7 or 8 months.

model was more embedded by that time, funding guidelines and contractual requirements were clearer, and hNO was able to provide additional support.

At Wave 1, some open sites did not have a full complement of staff/practitioners. Most Round 2 sites, for example, were continuing to recruit practitioners and still developing and refining policies and procedures. The varying lengths of the establishment phases of the CYSs indicate that sites need at least six months to become established, but a longer time period before they are fully operational.[8] It is too early as yet to make an accurate assessment of the time required between funding announcement and full operation.

4.2 Services provided within CYSs

As noted above, the CYS model intends to provide a range of services within one hub or physical location. Audit data collected from 9 Round 1 and 15 Round 2 sites[9] in June 2008, and information from the in-depth CYS visits, shows that CYSs are beginning to develop multi-disciplinary teams of primary health and mental health practitioners, drug and alcohol workers, and social recovery support.

Primary health and mental health providers

The integration of primary health-care providers (GPs) is pivotal to the CYSs. GPs have the responsibility for devising the Mental Health Care Plans which entitle young people to receive MBS funded psychological services. These Plans also help achieve a more seamless integration between primary and allied health providers. As well, the provision of general medical services increases service accessibility for young people, and promotes early identification and intervention for those experiencing early-onset mental health problems. By the end of June 2008, all the opened Round 1 sites (n=9) had engaged GPs. The extent of GP support differed by site from 1.5 to 18.5 hours per week. Six Round 2 sites were open at this time and only two of these had GPs (Table 4.1).

Eight of the nine Round 1 sites had also engaged mental health professionals (either clinical or counselling psychologists) to deliver services; while three of the Round 2 sites had clinical and/or counselling psychologists available for consultations (Table 4.1). Clinical psychologists were engaged for between 8 and 48 hours per week and counselling psychologists between 6 and 19 hours. Psychiatrists were also engaged in four sites for an average of 3.5 hours in Round 1 sites and 2.8 hours in Round 2 sites.

[8] This will depend on the particular situation of each CYS. See Section 4.3.

[9] It is important to note that only 6 of these Round 2 sites were opened by or in June 2008. The rest of the sites provided information based on where they were at in the establishment of their site.

Table 4.1: Practitioners in CYS Round 1 and 2

	Round 1 CYS Data for 9 sites		Round 2 CYS Data for 15 sites[a]	
	Number of CYSs with providers	Average working hours/ week (per CYS engaged)	Number of providers engaged in...	Average working hours/ week (per CYS engaged)
General Practitioners	9	11.8	2	11.3
Clinical psychologists	5	24.2*	3	19.8*
Counselling psychologists	5	9.8	1	8.0
Clinical or counselling psychologist	8	17	3	13.9
Psychiatrists	3	3.5	1	2.8

[a] Only 6 of the 15 sites from which data was obtained had opened by June 2008.

* There averages are high because of a small number of sites that engaged psychologists for large numbers of hours.

Other clinical providers engaged by CYSs by June 2008 included occupational therapists, clinical social workers, mental health nurses, and sexual-health and family therapists.

Allied Health Workers

A number of CYS mental health workers are funded through YMHI as AHWs. CYS stakeholders reported that these AHWs are a critical component of the model. They provide CYSs with practitioners who, because they are salaried, are stable and readily available to provide continuity of care and assist with service accessibility, service provision and service coordination. They are also active in establishing referral pathways and conducting outreach. By June 2008, all opened Round 1 and Round 2 CYSs had engaged AHWs.

A number of AHWs are appointed as youth access workers by CYSs. These access workers are an essential part of the model. They ensure service accessibility and continuity of care, and promote the coordination of service providers in the community around headspace. In the in-depth evaluation CYS sites, youth access workers were involved with: engaging young people, assessment and intake; the provision of brief and targeted interventions; family and carer support; coordination of the young person's care with community providers; as well as referral to external services and outreach. By June 2008, all Round 1 CYSs and six of the fifteen Round 2 CYSs that completed audit data had engaged youth access workers (in total 20.2 FTE for Round 1 and 10.9 FTE for Round 2 sites).

Drug and alcohol workers

Substance use disorders are particularly high in 18–24 year olds of both genders (ABS 1998; ABS 2006b) and the link between excessive use of alcohol, drugs and mental illness is widely recognised (Ministerial Council on Drug Strategy, 2004; NSW Health, 2008; Teesson and Byrnes, 2001; Australian Government, 2001).

headspace has a strong focus on improving interventions in substance use related disorders and promoting early intervention for young people experiencing substance use problems. Therefore service providers with expertise in this area are an important asset for CYSs.

By June 2008, five Round 1 and four Round 2 CYSs had co-located drug and alcohol workers providing services on-site. The number of drug and alcohol counsellors is under-reported in the audit data, as some AHWs and private psychologists also have expertise in drug and alcohol counselling. But there were sites where there were no specialists in this area, and this was reported to be a significant gap in service delivery. At the time of the Wave 1 interviews, several CYS managers were in the process of negotiating arrangements to co-locate alcohol and drug services.

Social recovery support

The co-location of vocational assistance, welfare and other social recovery services is a central feature of the CYS model. By June 2008, six Round 1 and two Round 2 CYSs had engaged vocational assistance providers.[10] Several CYSs provide non-clinical recreational activities in cooperation with co-located services for young people. Recreational programs and activities were important as an 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 social recovery (Davidson et al., 2001; Sane Australia, 2005). CYSs that did not have group social or vocational support programs acknowledged their potential benefit, and some had started to plan group activities.[11]

Practitioner gaps

Most CYS staff and practitioners were satisfied with the configuration of providers in their sites. There were, however, some challenges across the sites, the most commonly reported was the need for more psychiatric services. Due to the lack of expertise in the area of youth mental health, psychiatric expertise was considered important to assist primary providers to determine appropriate medication for young people experiencing acute mental health problems. Sites also struggled when they opened without key clinicians such as GPs and psychologists. The two CYSs in the in-depth evaluation without a GP at the time of the evaluation were attempting to recruit these practitioners. Without a GP, these sites were unable to conduct in-house mental health care plans, which meant these young people were not eligible for MBS counselling sessions.[12] Sites that opened without a psychologist or clinically trained staff did not have the capacity to appropriately support young people coming into the CYS with mental health problems. Without qualified mental health staff, sites would not be able to meet the broad objectives of the initiative.

4.3 Factors impacting on CYS establishment and effective early implementation

A number of factors impacted on the establishment and effective early implementation of CYSs. According to findings from the surveys with CYS providers (n=107) and in-depth interviews conducted in the nine CYSs (n=47) and with other relevant headspace stakeholders (hNO, Advisory Board, CYS lead agencies and consortium members; n=49), these factors include time, the consortium and lead agency, funding, staffing, infrastructure, software, and the support available from the other headspace components.

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

[11] Some sites reported that they did not have the space for group activities.

[12] Unless they were referred by an external GP.

Time

Within a three-year funding period, headspace has an extremely short period of time to achieve a significant amount. The CYSs had 2.2 years (Round 1) or 1.4 years (Round 2) in which to establish, implement and sustain services between the announcement and conclusion of funding.[13] The establishment phase took up a substantial portion of this time. Once sites were finally seeing young people, they had an average of 1.6 years (Round 1) or 0.9 years (Round 2) left before the end of the contract.

The establishment phase was time-consuming because it involved locating and furnishing buildings, employing headspace staff, recruiting private practitioners and engaging co-located services. In addition, this phase involved developing agreements, policies, procedures and clinical governance frameworks, as well as establishing effective working relationships between the lead agency, consortium and CYS manager. Some sites opened even though some of these requirements were not yet finalised.

The tight timeframes and contractual agreements between hNO and CYSs were essential because of the DoHA funding timelines and the need to demonstrate the viability and benefits of the initiative before the conclusion of the funding. Most CYSs struggled under the tight contractual deadlines: less than one-third of CYS staff/practitioners (29%) who completed this question (n=89) felt the timeframes were realistic.

The fast establishment phase and the consequent pressure to open had an impact on some CYSs in relation to the types 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 able to access additional resources, policies and supports from their lead agencies and consortium partners. Sites with fewer resources, policies, local governance procedures and supports to draw from early in the establishment phase were considerably disadvantaged by the speed of implementation.[14]

Consortium partners and lead agencies

From a governance and strategic perspective, a highly functional consortium was important for the smooth, efficient running of CYS platforms and to promote service coordination. Having the right people available to make quick decisions about money, staffing and service philosophy was reported to be critical to the establishment and further development of the CYSs.

The size of the consortiums varied considerably between the CYSs involved in the in-depth evaluation, from 4 to 20 partners. These partners were from a range of sectors – general health, mental health, education, youth, vocational and social welfare – and they are from both government and NGOs. The number of partners is of less importance than the breadth of sectors they represent and how actively they are

[13] This is prior to the announcement in December 2008 that funding for headspace would be extended.

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

involved. Indeed, too many partners without clear leadership hindered efficient decision-making.

Within most consortiums, the lead agency was a medical association. Seventeen of the CYSs have the local Division of General Practice (DGP) as their lead agency. The remaining are lead by local medical associations (e.g. Aboriginal Medical Services), youth, mental health or drug and alcohol agencies, academic institutions, local government and NGOs.[15]

Those lead agencies that were not just organising bodies, but which had experience delivering services, were at an advantage because they had access to the knowledge and resources necessary to develop policies and procedures. Overall, the resources, skills and capacity of the lead agency, and its commitment to supporting the CYS, were more important than whether it was a government or non-government organisation, and more important than the nature of its core business, e.g. primary health or another area.

The following characteristics helped to facilitate effective consortiums and, in turn, provided valuable support for the CYSs:

- pre-existing relationships between key stakeholders;
- representatives from state/territory government agencies, NGOs and the local DGP;
- clearly defined roles and a shared understanding of the CYS model and goals;
- a lead agency that encouraged the consortium to have input into decision-making;
- small steering groups when consortiums were large;
- 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/consortium; and
- provision of resources (infrastructure, policies and procedures for the operation of CYSs, and/or service delivery supports – clinicians, clinical governance, training).

The CEO of a lead agency included a number of the above points in describing why the consortium in their site worked so well:

> We have actually worked really hard on relationships for 20 years so we invited people that were really important, gave them the role, were really clear about the role, set ourselves up as an executive. They get to discuss the issues, and I guess it's just incredible respect. I think we train them well to be good consortium members.

The majority of CYS survey respondents were satisfied with the governance of their consortium (69% of those who had an understanding of the role of the consortium, n=87). Almost one in five were dissatisfied (the remaining felt neutrally), which reflected an absence of some of the key facilitating characteristics listed above.

[15] Based on reports received from hNO.

In addition to governance, lead agencies and consortium members played an important role in providing resources. These included infrastructure, human resources, operation of the sites and service delivery (such as providing clinicians 'on loan' to CYSs while additional staff were recruited). They also assisted with clinical governance and training opportunities and some contributed additional financial assistance. CYSs received very different levels of support from their lead agencies. This was based on the capacity, availability, skill set and generosity of the lead agency and consortium members. Approximately half of all CYS respondents who were aware of resources provided by the consortium partners, were satisfied with the supply of facilities/infrastructure, electronic equipment and technical support (Table 4.2).

Table 4.2: Satisfaction with resources from consortium partners (CYS respondents, per cent)

	Very / somewhat unsatisfied	Neutral	Somewhat / very satisfied
Facilities/ infrastructure (n=82)	19.5	24.4	56.1
Electronic equipment (n=69)	18.8	31.9	49.3
Technical support (n=67)	23.9	29.9	46.3
Software systems (n=66)	28.8	28.8	42.4

When consortium partners did not provide policies, procedures and frameworks, CYSs struggled to establish and implement services. In a model like headspace, it is important that either consortiums have the capacity to develop the necessary policies, procedures and frameworks, or that hNO provide the resources to support consortiums without this capacity (particularly those without a health-service delivery background).

Funding

Sites used a combination of the funding streams, including headspace core funding, YMHI AHW, MBS, private practitioners and co-location funding. 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 4.3).

headspace seed money and YMHI funding were essential for CYS functioning. Core funding was used to physically establish the headspace CYS and fund the CYS manager and other administrative staff. YMHI funded AHWs provided CYSs with practitioners to carry out core service delivery and staff who can perform essential activities, such as administration, clinical governance and service coordination. YMHI funded positions act as the essential link between young people and all clinical and non-clinical services.

The challenge around YMHI funding is in regard to its allocation via the DGP regardless of whether or not they were the lead agency. This split funding

arrangement was not an easy one to implement in practice and resulted in some difficult relationships within the consortia.[16]

Although a core requirement of headspace, the extent to which CYSs relied on private practitioners varied. This was partly dependent on availability of private practitioners within the region (more challenging for regional/rural sites), attracting practitioners to work for CYSs and the service model used (e.g. if private practitioners were not appropriate for outreach in rural locations).

The engagement or retention of private practitioners willing to draw largely on MBS funding is especially challenging for those in regional or remote areas where the pool of practitioners is small or scarce and there may be low or fluctuating demand for services. Two regional sites, for example, maintained that the establishment of a hub or one-stop-shop for young people was not appropriate to support marginalised young people in surrounding rural areas. They advocated for and implemented the 'hub and spoke' model where the shop front located in a regional area has numerous outreach centres in surrounding rural locations (Kurrajong Early Intervention Service, 2008). This involves fully funded psychologists providing services in very small communities. With the need to travel, private practice based sessional funding would not be attractive or sustainable for practitioners.

Although private practitioner fees are envisaged as part of the sustainable business model of the CYSs, very few CYSs were charging private practitioners rent or fees at Wave 1 of the evaluation. Many had offered 'rent free' or 'fee free' periods to attract and engage private practitioners in headspace. CYS managers and consortium members largely believed that if fees were implemented, private practitioners would leave to work in more lucrative practices. The extent to which private practitioners can be engaged and retained and other sustainability issues will be followed up in Wave 2 of the evaluation.

The degree to which CYSs had co-located services also differed. Six of the nine in-depth evaluation sites had integrated community providers (state/territory mental health services, other government agencies and NGOs) as part of their service delivery model. This was beneficial for sites because it provided additional resources and added a diversity of skills and services. For staff in two of the CYSs in the in-depth study, co-location has proved extremely challenging. It is important that headspace provides resources (financial and/or personnel) to ensure that co-location is mutually beneficial.

The funding models adapted by CYSs depended on a number of factors. These included 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 (e.g. the pool of resources differed between urban and regional, rural and remote locations). Almost two-thirds of CYS survey respondents (62% of n=92; Table 4.4) reported that they were satisfied with the amount of funding allocated. Although different funding sources are more or less instrumental depending on the CYS model adopted by the sites (Table 4.3), a mix of funding sources within CYSs is important for increasing the likelihood of diverse and sustainable services.

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

Table 4.3: Implementation of the CYS model and extent funding sources are part of the model

	Private practice/ or appropriation of MBS funding	Co-location of State/ Commonwealth/ Local Government funded providers and NGOs	YMHI funding allocated through DGP
One-stop-shop (clinical and non-clinical service focus)	xx	xx	xx
Multi-disciplinary youth health centre	xx	x	xx
Psychological outreach services	-	x	xx

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

Staff/ practitioners

Closely tied to funding is staffing. The number and skills of staff and practitioners had a substantial impact on the establishment and early implementation of CYSs.[17] The majority of CYS respondents (82% of n=104; Table 4.4) were satisfied with the staff skill set within their site. However, 37 per cent of CYS respondents (of n=105) were dissatisfied with their staff numbers.

Having highly skilled CYS managers was crucial for efficient and effective establishment and early implementation. Skills involving staff management, change implementation, negotiation with partners, financial management and the ability to meet contractual agreements were particularly important. In sites where CYS managers did not have these skills, or where they did not have sufficient resources or strong practical support from the lead agency, significant stress and delays ensued. High stress levels resulted in poor staff retention in some sites.

The recruitment of key practitioners was essential if CYSs were to provide the range of intended services. CYSs that had a mix of GPs, psychologists, social workers and AHWs with a range of expertise (such as drugs and alcohol, family therapy, anger management or Cognitive Behavioural Therapy) worked well.

Most sites opened without a full complement of staff, which enabled CYSs to employ additional staff based on experience and need. However, this also hindered some CYSs' capacity to provide appropriate, effective and/or holistic support for young people, especially when GPs and/or psychologists were not engaged. Most CYSs reported needing more psychiatric expertise to support primary providers to determine appropriate medication and referral pathways for young people experiencing acute mental health problems.[18]

The recruitment of clinical and non-clinical staff with certain skill sets was more difficult in regional and remote areas than in metropolitan areas. GPs, for example, are in short supply in many regional, rural and remote areas, making it difficult for CYSs to compete with other agencies for their services. Some sites had difficulty

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

[18] Two sites had already engaged a psychiatrist.

attracting private practitioners because of the possible instability of payments (from young people not showing for appointments) and relatively lower paid work compared with non-MBS private practice fees.

Table 4.4: CYS respondents' satisfaction with resources (per cent)

	n	Very / somewhat unsatisfied	Neutral	Somewhat / very satisfied
Amount of money allocated	97	17.5	20.6	61.9
Skill set of staff	104	12.5	5.8	81.7
Number of staff	105	37.1	5.7	57.1
Facilities/infrastructure	105	36.2	7.6	56.2
Electronic equipment	102	15.7	8.8	75.5
Software systems	106	32.7	11.5	55.8
Technical support	102	24.5	16.7	58.8

Other resources

Infrastructure

The ability to obtain, rent and appropriately renovate a building also affected the time sites took to open and deliver services. Almost all CYSs in the in-depth study were successful in making their buildings accessible and youth-friendly by occupying buildings in key streets or community areas.[19] However, this was usually at substantial cost, mainly for rent, and accounted for a large proportion of the core funding in some sites. 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.

A number of CYS sites in the in-depth evaluation were in buildings that were already filled to capacity, leaving no room for future expansion or co-location. Finally, the 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 also opened without an appropriate GP fit-out.

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: GP and allied health consultations and billing. In most sites, GPs use Medical Director and PracSoft for billing. At Wave 1, MHAGIC (the headspace electronic medical record and data collection tool) had been installed in 22 of the 30 CYSs to collect data on young people attending headspace.[20]

[19] This is discussed in further detail in the Section 3.3 below.

[20] Four are yet to be supplied with MHAGIC and the remaining four CYSs negotiated use of alternative software (data will be amalgamated).

Just over half of the CYS respondents were satisfied with the software systems (56% of n=106) and technical support (59%) available to them. Important challenges included the need for change management in learning new software, determining processes for data entry that were sometimes time consuming, having few procedures to check the completion of MHAGIC and the need for more training.

The challenges people were experiencing with MHAGIC were reflected in the substantial missing data from some sites and for certain variables. For example, at the time of the analysis (October 2008), 69 per cent of data within MHAGIC had been completed by five sites and 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. Even some 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 for sites and a valuable evaluation resource.

Training and ongoing support will be essential to improve data collection and recording in MHAGIC, but other strategies may also assist. Emphasising which variables are most important for CYSs to accurately record for the duration of the program may improve the validity, representativeness and usability of the data. In addition, some data with numerous entry points could be collapsed into specific time periods to increase the likelihood of it being recorded and the possibility of time series analysis. Finally, sites which find the software beneficial should be encouraged to share this with other CYSs.

Support from components

hNO has played a key role in the funding, establishment and early implementation of the CYSs. At Wave 1 of the evaluation, the other components had had little operational contact with the CYSs.

hNO developed the funding and assessment guidelines, negotiated contracts, developed reporting structures and key performance indicators, 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 youth and carer participation resources.

The interaction, support and assistance provided by hNO was generally reported by CYS managers to be positive.[21] A number of CYS managers reported that this relationship had improved substantially since the beginning of the initiative. Sites that experienced challenges in establishment and implementation were more likely to report strained relationships with hNO. Some sites criticised hNO for pushing standardisation across CYSs. These sites wanted further understanding and recognition of the local situation and the context in which they were working. In contrast, other sites which had struggled to open and effectively implement services, called for more standardised guidance from hNO in terms of policies, procedures and

[21] 72% of CYS managers (n=18) reported being somewhat or very satisfied with their relationship with hNO.

clinical governance. It is inevitable in any new program that there will be some conflict between local providers and central managers. The challenge for hNO is to communicate the benefits of being part of a national initiative, while at the same time recognising community context and resources. Strained relationships between CYS stakeholders and hNO were also related to the time demands within their contracts and the slow roll-out of MHAGIC.

At the time of Wave 1 data collection, CYSs overwhelmingly reported having little contact with the CoE, the CA (BMRI) and SPET programs. A number of CYS general staff and practitioners interviewed were not aware of other national components. This was largely because these components had not yet provided much practical support to CYSs.[22]

Summary

Key elements

- 28 of the 30 CYSs have opened and are seeing young people. CYSs are the cornerstone of headspace and essential to meeting the objectives of the initiative.
- CYSs funded in Round 1 took an average of 8.6 months to establish and Round 2 sites 6.1 months. Many sites were still in the early stages of implementation.
- CYSs are beginning to develop multi-disciplinary teams of practitioners in the core areas of primary health, mental health, social and vocational support and alcohol and other drugs.
- AHWs are a critical part of the headspace model. They are stable practitioners who provide services and facilitate youth access and service coordination.
- The resources, capacity and commitment of the lead agency and consortium affect the efficiency and effectiveness of CYS establishment and early implementation.
- Highly functional consortiums have partners with pre-existing working relationships, stakeholders from different sectors, and clearly defined, formalised roles.
- CYS managers with the skills to manage staff, implement change, negotiate and work with partners, manage finances and meet contractual arrangements, are an asset to CYSs.
- A diversity of funding streams is important for CYSs to deliver a range of services and to work towards some sustainability.

Early challenges/ possible issues for follow-up

- CYSs without GPs or mental health professionals will not meet the model's objectives. There were also some service gaps in the area of drug and alcohol and social recovery.
- The short funding period, the time taken to select CYSs, and the complex establishment requirements, left CYSs with very little implementation time before the contract expired.

[22] This is discussed in more detail in Sections 8 and 9.

- CYSs require policies and procedures from their consortiums or alternatively hNO will require the resources to provide templates of this documentation.
- Lead agencies that were organising bodies were at a disadvantage, compared to those with service delivery experience.
- Not all CYSs had private practitioners at Wave 1. Attracting private practitioners was difficult for some sites (especially those in rural and regional areas).
- Co-location was occurring in some sites, but was only effective when it was perceived as mutually beneficial.
- MHAGIC will be a valuable tool, but only if all CYSs regularly collect and record data.

5 Service access

Research has shown that young people are, in general, reluctant to get help for mental health problems (DoHA 2004; Rickwood et al., 2007). Encouraging help-seeking among young people is one of the key objectives of the headspace initiative. This is supported by a broader community awareness strategy that aims to increase the community's capacity for early identification of young people with emerging mental health and related problems, and to market headspace as a service where all young people 12–25 years can access support (headspace, 2008c). Access to headspace services is also encouraged by ensuring that services are youth-friendly and easy to enter. This Section of the report examines the accessibility of headspace in regard to attracting young people to CYSs, use of services and facilitators and barriers to access.

5.1 Attracting young people to headspace

National and local community awareness strategies have been developed to increase awareness of youth mental health problems, to brand and market headspace, and to encourage young people to seek help generally and to access CYSs in particular. hNO has been responsible for the majority of the operational community awareness activities at a national level. The BMRI has worked with hNO in some of these operational aspects and has provided funding for a number of these campaigns and activities.[23]

At a national level, hNO developed marketing and communications plans, developed a new headspace website (which receives an average of 2,000 visits per day), developed and conducted two national marketing campaigns ('What's in your headspace?' and 'headspace centres: someone else to go to'),[24] branded and marketed headspace through advertising campaigns via television, print and electronic media (almost $1 million of this was pro-bono), and established and consulted with the headspace Youth National Reference Group (hYNRG) to ensure communication was youth friendly. Furthermore, headspace has been promoted within state and territory mental health services (hNO), through journal articles (hNO, CA, CoE), conference papers (CA, CoE, hNO), and other events and meetings (all components). The headspace website also contains a knowledge centre (CoE), with useful summaries compiled by CoE on the burden, onset, risk factors and treatment models of depression, anxiety, substance-use disorders, bipolar disorders and psychosis.

At a local level, hNO and BMRI have provided some resources and assistance to CYSs for localised community awareness campaigns and marketing. The BMRI has a staff member available to assist CYSs in planning local awareness activities, and has developed DVDs (with a resource guide) of young people discussing their experiences of mental health care. The hNO Media, Communications and Marketing team supports the CYS awareness activities through on-call support, the development of local media release templates, promotional products such as pens, post-it notes and t-shirts, and a branding guide and media and communications policy to establish the

[23] The BMRI's focus has been on conducting research in relation to community awareness of mental health and related issues. This is discussed in more detail in Section 8.

[24] There was a 580% surge in website visits during the first national campaign and a doubling of headspace mentions in the media from 2007 to 2008.

same look and feel across all 30 sites. hNO also surveyed CYS staff to determine the types of products that would work best as local campaign materials, and developed media training.

Most CYSs that participated in the evaluation conducted some community awareness activities, but this varied according to their stage of implementation. Seven of the nine sites in the in-depth evaluation actively promoted headspace in local high schools. Other strategies included monthly meetings with school officials, advertising on local radio and television stations, in school newsletters and/or email networks, attending youth social events, running information sessions, and speaking to TAFE and university students. Word of mouth was also important for increasing attendance and normalising help-seeking.

There is not enough information yet to determine whether any of these community awareness activities are making a difference in help-seeking behaviour in the sites, and if so, which activities. However, the high number of visits to the headspace website, and of media mentions, and the numbers of young people accessing headspace as a result of self- or family-referral (discussed below) suggests that these community awareness activities are important. Furthermore, the majority of CYS staff and practitioners surveyed (n=107 from 23 CYSs) reported that communication strategies had created recognition of headspace in the community (90%), increased awareness of mental health issues (88%), and encouraged young people to attend headspace services (84%).

5.2 Young people attending headspace

Based on data collected by hNO, approximately 5,000 young people had accessed headspace CYSs by June 2008. As most Round 2 CYSs only opened during or after June, the number of young people using headspace services is likely to be much higher. If the preliminary data within MHAGIC is more broadly representative, young people attending CYSs had accessed an average of 4.2 sessions each.[25]

Referrals

The interviews with CYS staff and practitioners (n=47) and young people (n=71) and preliminary MHAGIC data, suggest that referrals to headspace are coming from a range of sectors: health, education, community-service and criminal justice sectors. They also reported a large number of self-referred young people who became aware of headspace through advertising, family members and friends.

Preliminary data from MHAGIC indicates that referrals were most likely to come from health providers (46% of all reported referrals),[26] followed by young people themselves and their family members (25% of all reported referrals). Approximately one in ten referrals came from other types of community organisations/agencies and one in twenty from an education provider (Table 5.1). This referral data is based on a

[25] This is based on responses for 2,229 young people entered into MHAGIC with between 1 and 44 occasions of services (st dev = 4.4). This data should be used cautiously because of its limited representativeness.

[26] The high rates of referrals from health providers is understandable, given the requirement for GPs to complete mental health care plans to facilitate access to MBS covered mental health consultations.

small proportion of young people accessing headspace. More comprehensive data entry regarding referral sources is required before representative referral trends across all CYSs can be understood.

Table 5.1: Preliminary referral sources for a sample of young people (MHAGIC)

Category of referral source	Frequency	Percent
Health provider	547	45.9
Family, friend, self	300	25
Community service organisation/ agency	135	11.3
Education provider	60	5
Other/ unknown	156	13.1
Total	1198	100

Note: There were 1481 records without a listed referral source. This data should be used cautiously. It reflects only a sample of young people accessing CYSs.

To promote referrals from all sources, CYSs sites that were part of the in-depth evaluation used a range of communication strategies in their local communities. These included, promoting headspace in schools; meeting with school officials; placing advertisements on local radio and television stations, in school newsletters and/or email networks; going to youth social events; running information sessions and speaking to TAFE and university students.

Referral processes appear to be working well in most of the nine CYS sites that were part of the in-depth evaluation. Referrals to CYSs were commonly assessed and either allocated to a provider within headspace or referred to another provider in the community. The majority of service providers surveyed in the CYS communities who had referred a client to headspace were content with the referral process (84% of n=108). Interviews with service providers in the in-depth CYSs suggest that the reasons why the minority of providers were unsatisfied may have involved concern about unclear referral pathways and/or that transition between services might risk continuity of care. This reinforces the importance of clear communication channels between service providers in the broader community and CYS practitioners. It also highlights the crucial role of the AHWs.

Demographics of young people attending headspace

Further data is required to get a more comprehensive and representative picture of the demographics of the young people who are accessing CYSs. Preliminary MHAGIC data and the surveys of young people who participated in the in-depth CYS evaluation provide an interim understanding of the characteristics of a sample of young people attending CYSs. The MHAGIC data is based on between 1,663 and 2,656 young people (depending on the characteristic) attending 22 of the 30 CYSs,[27] and the survey data on 70 young people attending nine CYSs. The demographics of young people in both samples are similar.

Table 5.2 is based on this preliminary sample. It shows that attendance at CYSs by males and females was roughly similar, as was the attendance by 12–17 and 18–25-year-olds. The proportion of young people born overseas was the same for young people in both samples (10%) and a similar proportion identified as Indigenous or

[27] The data are not representative across all these 22 CYSs – 5 sites account for 69% of the data.

Torres Strait Islander in MHAGIC and the evaluation (9% and 7% respectively). The young people were also likely to be living with their parents.

Table 5.2: Demographic characteristics of a sample young people in a sample of CYSs (MHAGIC and evaluation data)

Characteristic		Per cent YP with data entered into MHAGIC (n=2,679)	Per cent YP who completed evaluation survey (n=70)
Sex [a]	Male	56.2	47.1
	Female	43.8	52.9
Age [b]	12–17	55.0	44.3
	18–25	45.0	55.7
Indigenous status [c]	Indigenous[28]	9.2	7.1
	Non-Indigenous	90.8	92.9
Country of birth [d]	Australian	90.5	90
	Overseas	9.5	10
Main language	English	-	92.9
Living arrangements[e]	Family	77	71

Notes: Proportions of young people from MHAGIC data do not represent the population of young people attending headspace. Missing data for the above characteristics are as follows: a - 23; b - 152; c - 1,016; d – 765; e 683; f – 891.

At this stage, comprehensive data on the type and severity of mental health disorders young people were experiencing is not available. Interviews with CYS staff and practitioners and young people in the nine in-depth sites suggest that young people are most likely to be presenting with high prevalence anxiety or mood disorders. This is also supported by the small sample of young people for whom data is available in MHAGIC (n=293). The young people in the in-depth evaluation (n=70) rated low levels of satisfaction with their mental health (mean score was 3.28 on a scale of 0–10, with 0 representing very dissatisfied). In future, MHAGIC will be an important source for understanding the types and severity of mental health disorders with which young people are presenting to CYSs.

The surveys and the interviews with young people show that in the nine CYSs involved in the in-depth evaluation were attracting at least a sample of young people experiencing problems across different areas of their lives including: economic participation, family relationships and friendships.

For example, almost half of the young people involved in the evaluation were not studying and approximately two-thirds were not in paid work (Table 5.3).

Table 5.3: Economic participation of young people in the in-depth evaluation (per cent; n=70)

	Paid work	Studying	Volunteering	Caring	Unemployed (looking for work)

[28] Young people from Indigenous backgrounds were overrepresented at headspace compared with the general population, but this result was skewed by a small number of sites in areas with high proportions of Indigenous young people; Australian Bureau of Statistics (2008).

Full time/ or part-time	34.2	51.4	24.3	28.6	41.5
Not at all	65.7	48.6	75.7	71.4	58.6

One in five of the 70 young people who completed the survey, reported not being engaged in any economic activity – work, education, volunteering or caring.[29] Many of the young people interviewed attributed their socio-economic problems to their mental health problems. It will be important to examine MHAGIC data in Wave 2 of the evaluation to understand the extent of economic participation of young people when they first access headspace and at the end of their period of care.

headspace has also attracted young people with high frequency alcohol and some drug use. According to the Australian Alcohol Guidelines for safe drinking (NHMRC 2001), 44 per cent of the males and 54 per cent of the females in the in-depth evaluation were high-risk drinkers.[30] And almost two-thirds had used at least one illicit drug in the last year (use ranged from 1 to 7 substances). Marijuana was the most common illicit drug used, followed by ecstasy, the abuse of pain killers and methamphetamines. Many young people reported that substance use had affected their relationships and interfered with education and/or work.

Early intervention target group

As discussed previously, a priority area for headspace is to provide young people with access to services at an earlier stage of onset. The aim is to prevent mental disorders from becoming more severe (McGorry et al., 2007), and to fill a major service gap in the mental health system. This involves targeting services to young people with mental health disorders that are mild to moderate, and providing services to all young people in an effort to identify at risk cases. The community awareness campaigns discussed above, the 'expert consensus statements on early intervention' developed by the CoE, and training from SPET, are intended to support the CYSs in this area (headspace, 2008b).

The overwhelming majority of CYS staff and practitioners surveyed (83% of n=107) reported that the headspace model was effective at successfully targeting youth at risk of developing mental health issues. At Wave 1, it is difficult to assess the extent to which young people in the early onset stages of mental health disorders or at risk of mental health problems are accessing CYSs. The available data suggests that CYSs are supporting young people with a range of severities – from those in the early stages to more severe disorders. Further analysis will be undertaken in this area for the final report, but this analysis relies on higher completion rates of variables such as the Kessler 10.

[29] Of these 14 young people, 8 were looking for work. For further details on educational participation, see Appendix D.

[30] The difference between males and females may be partly due to the stringency of the regulations for women, but this is a relatively high level of alcohol consumption among female respondents, and it is consistent with reports of higher levels of drinking and alcohol dependence among younger cohorts of women Grucza, R., K. Kathleen, J. Bucholz, l. Rice and J. Bierut (2008), 'Secular Trends in the Lifetime Prevalence of Alcohol Dependence in the United States: A Re-evaluation', *Alcoholism: Clinical and Experimental Research*, 32 (5), 763-770..

Interviews with CYS staff and practitioners in the nine in-depth CYSs indicate that there have been some shared challenges around operationalising early intervention. Reasons for this include: the high demand for mental health services; the lack of services for young people; and the high threshold of entry into the state mental health system (which for some results in more severe presentations at the CYS) and a lack of clarity around the meaning of early intervention. Challenges in this area are not surprising. Young people with all levels of severity accessed CYSs and most CYSs had not yet received the 'expert consensus statements on early intervention' from CoE. Moreover, the training on early intervention from SPET had only recently been rolled out to the CYSs.[31] Future resources provided by hNO and CoE should also be useful in assisting sites to develop shared understandings of early intervention, and educating service providers in the community about their key target groups.

5.3 Facilitators and barriers to accessing headspace

The young people interviewed described psychological and practical barriers to help-seeking prior to coming to headspace. Psychological barriers focussed primarily around negative health-service experiences in the past and false perceptions about the nature of mental health services or the practitioners they would see (e.g. concerns about confidentiality, being judged and not being respected). Practical barriers, such as service accessibility, availability and cost, also emerged but to a lesser extent. The young people overcame these barriers to attending headspace because of the support from family, friends or carers and/or the practical ease of access to, availability and affordability of headspace services. They remained engaged in headspace because of the youth-friendly approach.

Facilitators – accessible, youth-friendly services

headspace services were accessible to young people for practical reasons and youth-friendliness. Effective elements of the youth-friendly approach included: the provision of low- or no-cost services, transportation, proximity to other facilities young people frequently accessed, timeliness of response to young people's request for help, and contact before and after appointments to assist young people to turn up to appointments, provide feedback and keep them engaged.

The youth-friendliness of CYSs also helped young people to initially access headspace and then to remain engaged. Youth-friendly services were those that were physically appealing to young people and appropriately structured, and ensured young people felt comfortable in their relationships with service providers and in control of their service experiences.

Overwhelmingly, service providers in the general community, CYS staff and practitioners, stakeholders from other headspace components, and most importantly, the young people themselves, reported that the CYSs were youth-friendly. Eighty-six per cent of CYS and service providers surveyed (n=107 and 182 respectively) rated CYSs as either 'somewhat' or 'very' effective in providing youth-friendly services.

[31] This training module was the Screening-Engaging-Early (SEE). It was delayed because it needed to be re-designed after proving to be unsuitable when piloted with CYSs. After receiving the training, a number of CYS practitioners reported that, although they gained useful information, they felt overwhelmed and stressed.

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 (e.g. music, games, computers and the internet). They reported that headspace had made them 'feel quite at home' and that it was a 'happy environment' and a place they could come to not only for their appointments but also to 'hang out':

> The first time I [came to headspace I] was like really nervous and paranoid, but it looked like a real kid friendly place and that put me at ease. ... It's not like other places. It's got young people here, there are things on the walls, like this music room. You won't get that at another doctor's surgery or where other counsellors are. (Female, 15 years)

Young people also liked the informal set up of the services, which were 'not like a doctor's place where it's boring, smells funny and only sick people go there'. Young people also emphasised the importance of not feeling 'judged':

> When someone comes in it doesn't matter what they look like, whether they're drug or alcohol addicts, they'll [headspace staff] put a smile on their face. It's very good for young people. (Female, 13 years)

headspace was also youth-friendly because young people accessing CYSs generally felt in control and informed. Most young people involved in the in-depth evaluation reported that they had received at least some information about what headspace was and what kind of services could be provided for them (98%, n=48).[32] Some received a comprehensive induction. Overall, these young people reported that they had enough say in decisions around their care, and that they were given sufficient information about the care and treatment they received from headspace (91%, n=47).

Young people valued the control they were given over their care, and the positive relationships they had with service providers were critical in terms of de-bunking misconceptions about accessing services:

> They [headspace staff] explained everything, what is going to happen at the next appointment and why they are doing things ... They're always telling you exactly what is going on and what they can do ... They always give me my options. (Female, 19 years)

Young people who participated in the in-depth evaluation were overwhelmingly content with their relationships with headspace staff. The majority of the service users who had been in contact with GPs, mental health workers, psychologists and/or social workers, reported that they were satisfied with their interactions with these workers (91% to 100%).

[32] The sample size is smaller for this question and the following example because they were added after some fieldwork had already occurred. The questions were added late to increase the cross-over between this survey and BMRI's CATI I.

Young people felt comfortable returning to appointments with practitioners that they perceived as friendly, good listeners, able to 'relate to kids', and non-judgemental. This resulted in young people becoming more engaged, feeling more in control of their service experience, and having a better relationship with their worker.

Youth participation

hYNRG and local youth reference groups assisted headspace to be youth-friendly, keep focused on their target group, and ensure that the views of young people were represented. The participation of young people in the processes, policies and campaigns of headspace is a priority for the organisation. To fulfil this, hNO recruited 28 young people to form hYNRG. hYNRG members have been directly or indirectly affected by mental health problems, are passionate about mental health issues and/or work in the youth or mental health sector.

The group meets face-to-face once every three months to be updated on the initiative, contribute opinions regarding the direction and policies of headspace and participate in training. The Chair sites on the headspace Advisory Board to contribute to represent young people and provide an update of recent hYNRG activities. In addition to quarterly meetings, the hYNRG members are active in advocating for and representing headspace in 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 and communication campaigns; 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 providing advice to organisations outside of headspace who work in the youth mental health sector.

It appears that hYNRG has had an important impact on headspace. hNO and hYNRG interviewees reported that the role of the youth advisory group has been extremely important in adding vitality to the initiative, increasing headspace's relevance and appeal to young people and informing the direction and work of headspace. As a hNO representative explained:

> [hYNRG] is a voice of the people who are experiencing it [the mental health sector]... we've tapped into some of what they see, what they hear and what they need, and we know what they're feeling and what they're seeing out in the community and they bring it back to us which helps inform what headspace is doing. Without them we could be seen as not representing the views of young people, which is what we need to do as an organisation.

While hNO has taken the views of hYNRG seriously and acted upon the members' advice, running the group has been a financial commitment and, at times, an organisational challenge. One element of the youth reference group that was not foreseen in the initial establishment was the need to support the young people involved with their own mental health problems. hYNRG require support structures for young people within the group who experience mental health problems. This was acknowledged by hNO and they were planning to invite a clinically trained practitioner to future hYNRG face-to-face meetings.

At a local level, some CYS sites had developed their own youth participation policies, which included consultations with young people and/or local youth reference groups. In some of the in-depth evaluation CYSs young people had been consulted in regard to designing counseling rooms, being involved in community awareness campaigns, instigating new ideas and directions for the CYS, and sitting on interview panels for staff. The youth participation aspect of headspace at a national and local level is important in contributing to the youth friendliness of the initiative.

Barriers to service access

Some of the barriers to young people's access to headspace were practical difficulties such as cost, transportation, opening hours and waiting lists. Concern was expressed by a number of young people, as well as their 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. CYSs that were not close to public transport could be difficult for young people to access. Some CYSs addressed this barrier by picking young people up, negotiating arrangements with local transport providers, and giving out taxi vouchers.

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 9am 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.

Waiting lists for practitioners also presented a barrier to accessing services for some young people. Approximately one in three CYSs (of the 18 CYS managers surveyed) had waiting lists for psychologists (44%), GPs (33%) and other practitioners (29%; this group predominantly included mental health nurses, occupational therapists and youth workers; Table 5.4).[33] Aspects of the service environment, such as a lack of soundproofing, also created difficulties for young people. In sites which did not have a youth reference group in place, service users also complained about the environment being too clinical, and the lack of colours and/or paintings or posters inside practitioners' rooms.[34]

[33] The average waiting time to see a GP was 1.9 weeks and 4.8 weeks to see a psychologist.

[34] It is difficult to determine other barriers to accessing headspace CYSs because the evaluators were not able to interview any of the young people who came to headspace once and then did not to return.

Table 5.4: Waiting lists for CYS service providers (CYS managers; n=18)

Service provider	No (per cent)	Yes (per cent)	Range of waiting time (weeks)	Average waiting time (weeks)	Not applicable (per cent)
GP	38.9	33.3	0.4-3	1.9	27.8
Psychologist	27.8	44.4	0.1-8	4.8	27.8
Psychiatrist	11.1	5.6	6-12	8	83.3
Drug & Alcohol Worker	44.4	11.1	0.4-4	2.3	44.4
Other (n=11)	42.9	28.6	0.2-0.4	0.3	28.6

CYSs developed strategies to give young people some support and reduce the negative impact of long waiting periods. YMHI funded access workers, for example, were used in some sites to provide young people with an appointment in a short period of time (usually less than a week) and to maintain contact between appointments. Young people highly valued this in between support, and it helped to keep them engaged and attending appointments.

Rates of young people not showing up for appointments demonstrate that some young people face ongoing barriers to accessing services. Most CYS managers surveyed (72% of n=18) and other CYS respondents (70% of n=106) reported that approximately one in five young people do not show up for their appointments. The rates and reasons for young people not showing up for their appointments will be further explored in Wave 2 of the evaluation.

To minimise the number of young people not showing up for appointments, CYSs implemented a range of strategies. The two most common and most effective methods reported by CYS staff and practitioners were calling or texting the young person the night before their appointment. Other strategies used included prioritising referrals, rescheduling shorter appointments, assisting with transportation, providing social and recreational activities and avoiding early appointments. The least popular and least effective strategies reported were charging young people for unattended appointments and double booking appointments. On the whole, respondents reported proactive reminders as more effective than reactive strategies.

At this stage, it is difficult to come to any conclusions about the types of young people who are not accessing headspace. Some consistent trends uncovered in the in-depth CYS interviews in Wave 1 suggest that young people with limited family support or who are living alone may be less likely to access headspace. Although not supported by the MHAGIC data at present, some CYS managers interviewed also reported experiencing challenges in engaging young people of Indigenous or culturally and linguistically diverse (CALD) backgrounds. Sites that did not have these access problems had active contact with and support from local Indigenous or CALD community-based services, and culturally appropriate strategies of engagement. At a national level, headspace has created an Indigenous Strategy Group to assist in this area. CYSs may still require local strategies to reach specific sub-groups of young people who are not accessing headspace.

Summary

Key elements

- National and local community awareness strategies have branded and marketed headspace and worked to increase awareness of youth mental health and help-seeking.
- Approximately 5,000 young people had accessed CYSs by June 2008 (before the majority of CYSs were open).
- Referrals have come from a range of sectors (medical, education, community and juvenile justice service providers), young people themselves and family members.
- Young people accessing CYSs were from both genders and age groups (12–17 years; 18–25 years), and were most likely to be Australian-born, living with their parents, experiencing symptoms of high prevalence mental health disorders, relationship and study/work problems. Half were high-risk drinkers, and almost two-thirds had used at least one illicit drug in the last year (based on a sample of young people).
- CYSs were generally perceived as easy to access and youth-friendly because of a range of practical factors.

Early challenges/possible issues for follow-up

- In a minority of cases, referral pathways were unclear for service providers and there was some concern about continuity of care between service transitions.
- Further data is required to get a comprehensive picture of young people attending CYSs.
- Reliance on MBS items and private practitioners may limit the reach of headspace for young people in rural and remote areas.
- Challenges around early intervention include a higher number of young people accessing headspace than anticipated; educating the community about the target group; and a lack of clarity about the definition of early intervention.
- hYNRG requires support structures for members experiencing mental health problems.
- Cost, limited transportation, and opening hours (too early or within school/work hours) could hinder young people's access to CYSs.
- Waiting lists and clinical environments could also affect young people's ongoing engagement in CYSs.
- Preliminary trends suggest that young people with limited or no family support may be less likely to access headspace. Some CYSs also reported having difficulty recruiting young people from specific groups (e.g. Indigenous and CALD). CYSs require support for localised community awareness strategies to engage specific sub-groups of young people.

6 Service quality

Maximising outcomes for young people through effective and high quality services is a primary objective of headspace (headspace, 2008b). This includes increasing the capacity of the workforce by providing the latest evidence to inform the quality of their practice (CoE), and providing appropriate training for CYS staff and practitioners and those working with young people in the broader community (SPET). More specifically, it means providing young people with high quality and well-coordinated services. CYSs are also expected to undertake some local evaluation and focus on ongoing service improvement. While it is difficult to determine at this early stage whether or not quality services have resulted in positive outcomes, some preliminary exploration of young people's perceived changes are included at the end of this Section.

6.1 Evidence-based services

Through the CoE and SPET, headspace aims to collect the latest evidence about the presentation and treatment of mental health disorders and disseminate this evidence to the CYSs to improve service quality. As part of their model, CYSs are expected to use evidence-based interventions when providing support for young people.

The CoE has conducted a number of systematic reviews of the evidence regarding interventions for mental health and substance-use disorders in young people, and that process is ongoing (headspace, 2008a). The CoE intends to make this and forthcoming evidence-mapping research accessible to CYS and other practitioners by producing simple, easy-to-use guides to treating various mental health disorders. As this has not yet occurred, at this early stage in headspace the work of the CoE is not yet relevant to the day-to-day use of evidence-based interventions by CYS practitioners.

However, the CoE has produced some service-improvement frameworks, and a clinical assessment tool and peer-support guides, and they do respond to requests from CYSs. The majority (61.5%) of CYS staff who have received these resources reported using them effectively. Even without the translated evidence from CoE, 75 per cent of CYS managers, staff and practitioners surveyed (n=107 from 23 CYSs) reported that the CoE resources were 'somewhat' or 'very' effective in helping them incorporate evidence into their work practice. Future data from MHAGIC and the use of findings from the CoE should assist in understanding the extent to which CYSs use evidence-based interventions.

CYS managers interviewed across the nine in-depth sites said that, at this early stage, most sites had been focused more on setting up the service than on actively tracking the use of evidence-based interventions. Some interviewees expressed confidence that best practice was in fact being used, because it had been an essential criterion in the recruitment process. Others had put checks in place by seeking support from universities or from established providers in the field; one site had even established a committee on best practice. Several of the respondents at the in-depth study sites stated that they would like to be more up-to-date about the progress of other sites, and to work more closely together and share resources to better incorporate evidence into work practice. The Collaborative Learning Network (CLN) and the intranet are effective forums for this to occur.

SPET training modules are also intended to increase CYS use of evidence-based interventions. Seven training modules have been developed, but only two had been rolled out across the CYSs by November 2008.[35] Because most of the training sessions that relate to using evidence-based interventions have not yet been rolled out, it is not possible to assess whether and to what extent SPET will impact on the use of evidence-based interventions.

Training is important both for practitioners and for non-clinical staff. There was some concern among CYS staff interviewed about a lack of training in emergency procedures and strategies to manage at-risk clients. A SPET training module covers these areas and will be rolled out to CYSs in 2009.

6.2 Service coordination and integration

Having well-coordinated services within CYS sites is a key part of the logic model of headspace. Section 4.2 discussed the multi-disciplinary service environment within CYSs. Working to integrate these different disciplines is an important aspect of creating holistic support for young people.

Staff and practitioners who were surveyed overwhelmingly reported that services within the sites were coordinated and integrated (85%; n=107). Over three-quarters (77%; n=107) stated that staff from different professional backgrounds work in partnership 'a lot' or 'all the time' when providing services for young people. Professionals and practitioners within CYSs actively worked together on a range of activities that focused around the client. Over three-quarters of all CYS staff surveyed (n=107) reported that they were actively involved in these coordinating activities, and that participation in these was 'mostly' or 'always' helpful (Table 6.1).

[35] SPET's role and the training modules are further discussed in Section 6.

Table 6.1: Service coordination activities and helpfulness within CYSs (per cent)

	Per cent of CYS staff respondents conducting activity (n=107)	Level of helpfulness for staff participating in the activities		
		Not at all / rarely helpful	Sometimes helpful	Mostly / Always helpful
Joint planning	83.2 (n=93)	0	3.2	96.8
Referring clients to other professionals within headspace	86.9 (n=97)	0	9.3	90.7
Referring clients to other agencies outside of headspace	86 (n=95)	0	8.4	91.6
Joint service delivery or case management	80.4 (n=91)	1.1	11.0	87.9
Exchanging information (about clients, projects, funding sources etc)	90.7 (n=86)	2.3	10.5	87.2
Joint staff training for professionals from different backgrounds	78.5 (n=84)	1.2	11.9	86.9
Meetings between professionals from different backgrounds	88.8 (n=92)	3.3	17.4	79.3
Co-location	85 (n=89)	2.2	20.2	77.5

Almost all CYS staff coordinated around the client by exchanging information (91%), participating in joint meetings (89%), referring clients between each other and to other professionals in the community (87% and 86% respectively), planning together (83%) and conducting joint service delivery or case management (80%; Table 6.1). Of the CYS staff who participated in joint planning, 97 per cent stated that this was mostly or always helpful. This was the highest rated activity for helpfulness, which demonstrates that, despite it requiring a greater time commitment, staff found this to be a worthwhile investment. Client referral between professionals within and outside of headspace was also common and over 90 per cent rated this activity as mostly or always helpful. The other client centred coordination activities were also rated as mostly or always helpful by the majority of CYS staff who were involved in these activities (between 79% and 88%; Table 6.1).

The focus on a coordinated approach to supporting young people was also reflected in the young people who took part in the in-depth evaluation. Most of these young people (61%; n=70) reported seeing at least two different types of practitioners at their CYS. And in the majority of cases, practitioners worked together to support them. Young people and their carers were extremely positive about this holistic approach and the active coordination, because it increased accessibility, improved timeliness of service response and reduced the need to repeat information:

> because everything is done at the one place you feel comfortable**.** … most other places … you would have to first see [a doctor], get a referral and then go and find a psychologist yourself, and you never have that in-between support. … I think it's really good the whole set-up. I love it. (Female, 19 years)

The holistic, coordinated approach worked particularly well for those young people experiencing mental health and substance-use issues who required support for social, educational and/or economic participation. As a 19 year-old male explained,

> They're not attached to one bit [of your life], they don't want to just stop violence at school; they touch the home life, school life, work life, everything. They try to help out in every aspect, that's the best thing about [my psychologist] and the guys here at headspace.

Facilitators for coordination and integration within CYSs

A range of factors facilitated the coordination and integration of practitioners and service providers within headspace CYS sites, including shared infrastructure, policies and procedures, and individual leadership and attitudes. Table 6.2 lists a range of factors that CYS staff perceive as important for service coordination and partnerships.

Table 6.2: Factors that promote partnerships/coordination (CYS respondents; per cent; n=107)

	Never/ rarely contributes	Occasionally contributes	Often/ always contributes	Not applicable
Respect for and understanding of the mental health needs of young people	0.0	5.6	90.7	3.7
Willingness among stakeholders to work together	2.8	9.3	84.1	3.7
Common working culture that includes the goal of cooperation	0.9	14.0	82.2	2.8
headspace provides a forum to work together	0.9	13.1	80.4	5.6
Leadership from individual professionals working in your headspace CYS site	3.7	11.2	80.4	4.7
Leadership from the manager in your headspace CYS site	2.8	9.3	75.7	12.1
Shared agreement between professionals about funding sources and allocation	6.5	25.2	46.7	21.5
Government mandates for more efficient and effective service provision	12.1	28.0	43.0	16.8

Shared infrastructure helped to place different practitioners in the same physical location. However, because many providers worked at different times, it was also important to implement other practical coordination activities, such as having a forum or team meeting that brought all staff together at one time. The attendance of private practitioners at these forums and team meetings was highly dependent on whether or not they were paid to attend. Some sites generated funding for this through MBS items (where meetings fulfil strict criteria for case-conferencing) or through headspace grant funding.

Other practical activities, such as training, helped to facilitate good working relationships as these sessions helped to increase understanding of different service providers' expertise and ways of working with young people. Stakeholders reported inter- and cross disciplinary trainings to be beneficial to service integration within the CYSs, because they provide a level of consistency around skills important for

working in effective partnerships, such as report writing, identification of mental health issues and making appropriate referrals.

Policies and procedures that encourage collaboration and integration and clarify roles and responsibilities were also important. In sites where policies were not yet formalised, coordination was sometimes haphazard and incidental. As Table 6.2 shows, policies and procedures need to exist in conjunction with a cultural and attitudinal commitment to working together and with strong leadership from individual practitioners (e.g. AHWs) and CYS managers.

Barriers to service coordination and collaboration within CYSs

Barriers to coordination between service providers within CYS sites involved practical considerations such as time and funding constraints, and individual attitudes and organisational culture. Table 6.3 lists a range of factors that CYS staff rated as either problematic or not in relation to developing partnerships with other practitioners in their site.

Table 6.3: Factors hindering partnerships (CYS respondents; n= 107)

	Always/ Often a problem	Occasionally a problem	Rarely/ never a problem	Not applicable
Time constraints	39.3	37.4	15.9	7.5
Differences in funding sources to pay for professionals	17.8	22.4	36.4	23.4
Territoriality between professionals	12.1	26.2	54.2	7.5
Historical differences between professionals (e.g. terminology, service mandates, or practices)	11.2	32.7	42.1	14.0
Disagreement between professionals about funding sources and allocation	10.3	17.8	45.8	26.2
Absence of effective leadership in promoting professionals working together	10.3	18.7	61.7	9.3
Absence of a common vision for how to meet the needs of young people with mental health problems	9.3	15.0	68.2	7.5

Time constraints were by far the most commonly reported practical hindrance, followed by differences in funding sources for professionals (40% reported it was always or occasionally a problem). Funding caused problems for effective working relationships in three areas. Firstly, different funding sources for staff and for practitioners could blur lines of accountability and create divisiveness. Secondly, funding could hinder service integration because co-located services were reluctant to commit resources to an untested and time-limited new program. Thirdly, and perhaps most commonly across headspace sites, service coordination was particularly problematic where there was no established system to pay private practitioners for coordination activities.

Fragmented working relationships and/or limited coordination were also evident in CYS sites where the manager did not actively encourage working relationships, where there was no central staff member responsible for facilitating coordination, and when staff turnover was high. Differences between the scope, boundaries and practices of different disciplines were also barriers to effective coordination.

The latter barriers are likely to be related to the early stage of implementation of headspace. Solutions to the barriers associated with funding, however, may require the model to be changed or adapted.

6.3 Service improvement and evaluation

It is too early in the establishment and implementation phases of headspace for most sites to focus on local evaluation, but they were collecting data and reviewing structures and procedures in order to support staff and improve service delivery. Hence, despite a lack of formalised local evaluation, most sites were cognisant of the need to review and improve the set-up and delivery of services, and to find out how individual young people reacted to practitioners. In a number of CYSs, AHWs had the responsibility for following up with young people about their service experience. Sites with local youth advisory boards were also using this mechanism to obtain input from young people in order to improve services.

Supervising practitioners was another key area of service improvement. The provision of one-on-one and group supervision where staff could debrief and discuss problems was important for staff and practitioners, but was not always available in CYSs.[36] Some CYSs encouraged staff members to ask for supervision as a way of talking through workplace stress and developing particular skills, but it is important for all sites to have such structures in place as part of common practice, rather than only on request.

6.4 Stakeholder perceptions of service quality

headspace services were generally perceived to be of high quality by key stakeholders. All those surveyed and interviewed, whether service providers in the broader community, CYS staff and practitioners, or young people accessing services, were overwhelmingly positive about the quality and appropriateness of headspace services. Of the 101 service providers surveyed, 81 per cent were either 'satisfied' (19%) or 'very satisfied' (62%) with the quality of services their clients had received. All but one of the 71 young people interviewed in the nine in-depth evaluation CYSs rated the quality of services they received highly.

Almost all CYS respondents (90%; n=106) believed that the sites were effective in addressing the needs of young people relevant to their geographic location. This suggests that CYSs were tailoring services to local and individual needs. The majority of young people interviewed and surveyed (n=70) believed the services they received were appropriate for them.[37] They also reported that they received the kind of service they wanted from headspace (94%), that the services had helped (96%), and that they would return to headspace if needed in the future (97%). A small number of stakeholders interviewed in the in-depth sites argued that the reliance of the CYS model on MBS items and private providers limited the reach of headspace services and may, therefore, negatively affect the outcomes for some young people in rural and remote areas.

[36] Almost two-thirds of CYS staff surveyed reported being satisfied with the supervision arrangements provided (64%, n=107).

[37] All the carers interviewed (n=20) were also satisfied with the quality of the support provided by headspace.

6.5 Preliminary young people outcomes

headspace aims to provide quality, evidence-based treatment to young people, to help facilitate improvements in their mental health and social and economic participation. At this early stage in the evaluation, definitive conclusions cannot be reached on the impact of headspace on young people's outcomes. A small sample of young people surveyed as part of the in-depth evaluation (n=70), however, reported some preliminary outcomes.

Mental health

Almost all young people surveyed as part of the in-depth evaluation (92%) reported that their mental health had improved since coming to headspace. This was despite the fact that more than three-quarters of young people (67%) had been using headspace services for less than three months.[38] No statistically significant differences were found between the different age groups (12–17 years; 18–25 years), sexes, geographic areas (urban, regional, rural/remote), or type of headspace worker, in these reports of improved mental health (see Appendix D for more detail).

The 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 mental health symptoms and were unsure whether sustained treatment would have any beneficial effect. Many young people interviewed explained that their symptoms had lessened or alleviated since they began attending headspace services.

Economic participation

Young people were also positive about the impact of headspace on their social and economic participation. Younger respondents (those aged 12–17 years) who were or wanted to be engaged in education or work were more likely than 18 to 25-year-olds to report improvements in their ability to study or work. 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. In contrast, just under half of the 18 to 25-year-olds who were at school, TAFE or university reported educational improvement – the majority stated it was neither better nor worse (Table 6.4).

[38] Although the sample size was small, the majority of carers (89%, n=20) agreed that their family member/ward's mental health had improved since they had been attending headspace.

Table 6.4: Young people's perceived impact of headspace services on ability to participate in education by age (n =47; in-depth evaluation)*

	Worse (per cent)	Neither better nor worse (per cent)	Better (per cent)
12–17 years	0	20.8	79.2**
18–25 years	0	52.2	47.8

*This only includes the young people who stated that education was applicable to them. **p<0.05

Over two-thirds of the 14–17-year-old respondents, and half the respondents aged 18–25 years, who were or wanted to work, believed their ability to find and retain work had increased since using headspace services. Most of these young people attributed their improvements to the psychological support they obtained at headspace, rather than help from vocational providers. A number of CYSs were still trying to engage vocational providers at the time of the evaluation (Table 6.5).

Table 6.5: Young people's perceived impact of headspace on ability to find and retain work by age (n = 50; in-depth evaluation)*

	Worse (per cent)	Neither better nor worse (per cent)	Better (per cent)
14–17 years*	0	28.6	71.4
18–25 years	0	44.8	55.2

*This only includes the young people who stated that work was applicable to them. Therefore those under 14 years and nine months are not included in this analysis.

Relationships with family and friends

A high proportion of young people interviewed reported that their family relationships had improved following participation in headspace. This difference was more marked amongst younger respondents (81% aged 12–17 years compared to 58% aged 18–25 years, p<0.05; Table 6.6). Although to a lesser extent, young people also reported improved friendships.

Almost three-quarters of 12-17-year-olds (72%) reported improvements in their relationships with friends compared to 60 per cent of those aged 18 to 25 years. A few respondents expected that the quality of their friendships would further improve as they addressed their mental health issues, although several respondents with social anxiety or depression felt that it would be some time before they would be able to participate socially (Table 6.6). There were no statistically significant differences between young people of varying ages, gender, geographic location or the type of practitioner they saw at headspace in regard to their change in relationships with friends (see Appendix D for more detail).

Table 6.6: Young people's perceived impact of headspace services on relationships with family and friends by age (n = 70; in-depth evaluation)

	Worse (%)	Neither better nor worse (%)	Better (%)	Not Applicable (%)
Relationships with family members				
12–17 years	0	3.1	81.3*	15.6
18–25 years	2.6	28.9	57.9	10.5
Relationships with friends				
12–17 years	0	15.6	71.9	12.5
18–25 years	0	31.6	57.9	10.5

*p<0.05

headspace practitioners worked either one-on-one with young people or using a family therapy approach to reengage young people with their families. Many young people reported that headspace gave them more insight into their own emotions and this in turn improved their relationships with family and friends:

> I used to try to run away from my family so I didn't have to get involved with anything but now I'm not afraid to go home anymore. I can sit around the house and just hang out with my brother and sister and talk. Now I'm on talking on terms again with my mum ... and we are very close again (Female, 15 years old).

Carers also noted improvements in their relationships with their children/ wards who used headspace services. As the mother of one 16 year old service user noted:

> I've got a better understanding [now]. Before we came here [to headspace] I thought she [daughter] would just be a typical teenager going through typical adolescent problems, but there was a lot more there... Coming here made [our family] understand her and give her some time and space so she can sort herself out... That's also helped her feel more connected to me and my husband.

One service provider explained that improvements in a young service users' mental health could have a positive flow-on effect on all relationships in their family as the reduced pressure on parents meant that they were able to give more attention to their other children.

Although headspace encouraged many respondents to reconnect with estranged family members, some of those who had experienced significant turmoil in their relationships in the past were justifiably reluctant to reengage with family. headspace CYSs only supported reengagement where appropriate.

Physical health

More than half of all young people surveyed as part of the in-depth evaluation (54%) reported improved physical health since using headspace services. Responses did not vary significantly according to age or sex (Table 6.7).

Table 6.7: Impact of headspace on physical health by age group (n = 70)

	Impact of headspace services on physical health			
	Worse (per cent)	Neither better nor worse (per cent)	Better (per cent)	Not Applicable (per cent)
12–17 years	0	18.8	59.4	21.9
18–25 years	2.6	31.6	50	15.8

As discussed earlier, most CYS sites had GPs on site and respondents found it extremely useful to have medical and counselling services collocated. This collocation appears to not only encourage young people to seek help for physical health problems, but may also increase the likelihood of medical advice being adhered to. Young people talked about being more likely to take advice from headspace clinicians, than other independent doctors, and of feeling confident about advice when it came from a number of different, trusted practitioners.

Alcohol and illicit drug use

Many CYSs have still not reached their optimum capacity for supporting young people with drug and alcohol problems. However, many of the young people interviewed in the nine in-depth evaluation sites reported reductions in the frequency and volume of alcohol and illicit drug use.

The proportion of frequent and high risk alcohol users declined from 16 per cent in the previous 12 months to 9 per cent in the previous month (Table 6.8). Twelve months prior to the evaluation, 63 per cent of all young people surveyed (n=70) were using at least one illicit substance. This had decreased to 40 per cent one month prior to the evaluation (Table 6.9). Three-quarters of the young people who had previously used substances reported that they could better manage emotions without using alcohol or drugs since attending headspace.

Many of these young people gave headspace the credit for helping them to change their drug and alcohol use. The services had given them a greater understanding of how alcohol and drugs affected their emotions and relationships, and this had encouraged them to change their substance-use habits. Several had reduced the frequency or the quantity of the alcohol or drugs they consumed, although they had not ceased using substances altogether. However, in most cases, these reductions minimised the risks young people faced.

Table 6.8: Young people's frequency of alcohol consumption in previous month (n = 69; in-depth evaluation)

	Frequency of alcohol consumption*	
	12 months before (%)	1 month before (%)
High risk[b]	2.9	0
Frequent use[c]	13	9.1
Less frequent use[d]	66.7	54.5
None[e]	17.4	36.4
Total	100	100

* Definitions based on Australian Alcohol Guidelines.

a. Consumed alcohol every day in previous month.
b. Consumed alcohol 3 to 6 days a week in previous month.
c. Consumed alcohol 1-2 days a week or less in previous month.
d. Did not consume alcohol in previous month.

Table 6.9: Young people's frequency of substance use in the previous 12 months and previous month (n = 70; in-depth evaluation)

Substance type	Had used substance ever	Consumed previous 12 months	Consumed previous month	Change (12 months to 1 month)
	%	%	%	%
Marijuana/Cannabis	55.7	50.0	22.9	-27.1
Ecstasy	30.0	27.1	4.3	-22.9
Pain killers/Analgesics	30.0	22.9	11.4	-11.4
Tranquillisers/Sleeping pills[a]	24.3	21.4	11.4	-10.0
Methamphetamines/Amphetamines (speed)	22.9	20.0	2.9	-17.1
Heroin, methadone, morphine or pethidine[b]	10.0	5.7	0.0	-5.7
Cocaine	11.4	10.0	0.0	-10.0
LSD/Synthetic or natural hallucinogens	10.0	8.6	1.4	-7.1
Inhalants	10.0	5.7	1.4	-4.3

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

Young people's backgrounds and the effectiveness of headspace

Further data collection is required to find out which young people headspace will be most effective for. Some specific areas that will be followed up in Wave 2 of the evaluation include: whether headspace has been more effective for 12 to 17-year-olds than for those aged 18–25 years; whether headspace is more effective for some types or severities of mental disorders than others; whether headspace has been successful at engaging and supporting young people from particular groups (e.g. those with Indigenous and CALD backgrounds); and whether the types of service providers seen, or the geographic locations, have a differential effect on young people's outcomes.

Although there was a diversity of opinion about which group of young people could potentially benefit most from headspace, at Wave 1 most service providers agreed that the initiative had been most effective in engaging 12 to 17-year-olds and this group had the greatest potential to benefit from the services. Most agree that some groups of young people were failing to access services in many areas and sustained, strategic effort was needed to engage additional sub-groups.

6.6 Preliminary involvement of and impact on carers

Although young people are the focus of headspace's services, many of their family members or other carers were involved in their treatment.[39] Some carers initiated help from headspace for their children/ wards and were actively involved from the intake and assessment phases of their treatment. Others carers became engaged in treatment after headspace staff requested their involvement. These roles are an important reflection on the successful promotion of headspace as a service option and may assist to raise broader awareness of mental health issues and, in turn, reduce stigma.

As discussed in Section 5.2, more than two-thirds of young people interviewed for the evaluation (71%) lived with family members. Very few carers participated in Wave 1 of the evaluation (this only occurred with young people's consent). Of the 20 carers interviewed and surveyed, most were mothers (75%). Other respondents were fathers (15%), a sibling (5%) and a legal guardian (5%).

Carers interacted with headspace in a variety of ways. The carers of many service users had no involvement in the children/ wards' care at headspace; others were quite actively engaged. Unsurprisingly, the carers of younger service users were more likely to be involved in their treatment than were older service users' carers. Most carers and family members said that they were involved in the referral process and their child/ward's assessment at headspace. Family-related interventions typically initiated by headspace clinicians included: family relationship mediation; developing alternative supports where family remediation was not an option; and addressing specific family dynamics involving anger or violence.

All surveyed carers were happy with the quality and amount of support provided; the friendliness of services and their appropriateness for their child/ ward. All of those involved in referrals were satisfied with the referral process and all who had had direct contact with headspace workers were satisfied with the quality of communication and with the opportunity to be part of the care provided to their child/ ward. Almost all carers were very satisfied (85%) with the outcomes from their child/ ward's involvement with headspace.

Preliminary impact of headspace on carers' quality of life

An individual's mental health commonly impacts upon the well-being of their closest friends and family (Gubman, 1987). More than three-quarters of all carer respondents (79%) said that their child/ ward's mental illness had adversely affected their own quality of life. Half (50%) stated that their quality of life declined 'a lot' as result of

[39] It is important to note that some young service users who were interviewed for the evaluation had caring responsibilities of their own and a number of them cared for their children, parents or siblings. In this section, 'carers' refers to parents, siblings or legal guardians of young service users unless otherwise stated.

their child/ ward's mental health issues. In contrast to this, almost all carer respondents (95%) said that their quality of life had improved since their child/ ward started receiving help from headspace.

Summary

Key elements

- Service quality within CYSs is based on the premise that services will be evidence-based, coordinated, evaluated and improved.
- Service coordination and integration within CYSs is working well. This reduced repetition, filled service gaps and simplified accessibility.
- Service coordination and integration was facilitated by shared infrastructure, policies and procedures, clearly defined and understood roles and responsibilities, leadership from AHWs and CYS managers, individual willingness, and funding for private practitioners.
- CYSs were working on improving service quality through staff training and supervision and through feedback from young people.
- Young people and carers perceived the services to be of high quality. Community-based service providers (81%) were also satisfied with the quality of services young people received at headspace.
- Preliminary outcomes from a small sample of young people attending headspace suggest that services are assisting young people in regard to mental health, physical health, drug and alcohol use and social and economic participation.
- The small sample of carers interviewed and surveyed reported improvements in their child/ ward's mental and physical health and in their own well-being.

Early challenges/possible issues for follow-up

- CYSs report that they are using evidence-based practice in their work, but have been largely focused on establishment and implementation rather than actively tracking the extent of evidence-based interventions.
- CoE and SPET's work on evidence-based interventions had had limited practical applicability for CYS practitioners by Wave 1 of the evaluation (findings were not yet translated into user-friendly guides and training packages had not yet been rolled out).
- CYS staff/practitioners were keen to share resources to better incorporate evidence into work practice. The CLN may help facilitate this.
- Service coordination and integration was hindered by time and funding constraints.
- Staff supervision, where practitioners could debrief and discuss cases and problems, was not always formally available within CYSs. This is an important area for staff development, staff retention and quality service delivery.
- Future consistent data collection in MHAGIC will assist in understanding the outcomes for young people accessing headspace. The impact on service outcomes of age, sex, country of birth, indigeneity, geographic area, and type and severity of mental health problems needs to be followed up.

7 Referral Pathways and Broader Service Reform

If headspace is to be successful in becoming the primary reference point for youth mental health and set the direction for reforming government policy to achieve better access, care and outcomes for young people, it is important to have an impact beyond the CYSs. To achieve this broader service reform, headspace aims to establish referral pathways, encourage service coordination in the wider community and promote policy reform at a state/territory and federal level. This Section discusses the referral pathways and service coordination within communities where CYSs are based and provides an overview of the ways in which headspace is engaging government.

7.1 Policy context

The service system for young people with mental health needs is commonly described as having three service tiers, which are targeted differently depending on the severity and complexity of the young person's mental health problems (DoHA 2004). The target group and providers of care in each of these tiers is described in Table 7.1.

Table 7.1: Australian service system for young people with mental health needs

	Level of support		
	Tier 1 **Informal Support**	**Tier 2** **Individualised Support**	**Tier 3** **Intensive Support**
Target Group	Young people with **minimal** mental health care needs	Young people with **moderate** mental health care needs	Young people with **diagnosed disorders** or **complex** mental health problems
Providers	- family and friends - the education sector - welfare and other community services - primary health care providers	- professionals with specific training (psychological, psychiatric etc) who work alone and are not part of a team	- specialists working in multidisciplinary teams in the public or private sector

The public provision of mental health care in Australia has traditionally been provided for people with the most complex mental health needs. Across Australia, young people up to age 18 with diagnosed disorders are eligible for services provided by the state-funded Child and Adolescent Mental Health Services (CAMHS). Before headspace, the predominant publicly available support for young people over 18 years of age was provided by Adult Mental Health Services (AMHS), which provide primarily intensive (tier three) supports (DoHA, 2004). Thus young people have historically faced barriers to accessing mental health services because of the artificial division between the child-adolescent and the adult service stream and because services are targeted at people with the most severe disorders (Meadows and Gribb, 2007).

The provision of mental health services in Australia is guided by a series of national frameworks and action plans concerning mental health, various elements of mental health (such as suicide prevention), and service reform strategies (such as inter-agency collaboration).[40] The principal policy framework is the National Mental

[40] All states and territories have their own mental health frameworks. A large number of these frameworks and other strategic documents were used to compile this section of the report. See Appendix E for a full list reference sources.

Health Strategy and implementation is based on the five-year National Mental Health Plans (covering the periods 1993-1998, 1998-2003 and 2003-2008[41]). These national frameworks lay out a set of directions and themes in order to guide the development of individual state/territory policies. All policies have increasingly focused on mental health promotion, evidence based prevention and collaborative approaches. This was further reinforced by the 2006 Council of Australian Governments' National Action Plan on Mental Health 2006-2001, which also identified children, young people and their carers as important target groups for mental health promotion and early intervention. Most states and territories also include early intervention as part of their mental health policies, but only the NSW, Victorian and Tasmanian governments specifically have youth mental health as a strategic focus.

While a number of frameworks and strategies are in place, at a practical level, young people with early onset mental health problems have had little opportunity to access professional mental health support in a coordinated, multidisciplinary environment. The National Youth Mental Health Foundation, headspace, has started to change this situation in 30 communities around Australia. Future analysis will focus on whether policies at the national, state and territory levels change to focus more explicitly on young people between the ages of 12-25, early intervention, evidence based services and collaborative practice due to the advocacy and awareness of headspace.

7.2 Pathways and coordination of care

While the services within CYSs are multidisciplinary, headspace was designed to complement, rather than replace, existing services. Young people presenting at headspace will have a diversity of needs and CYSs will not always be able to provide the support and care required. Thus having a sound understanding of other services available in the community, establishing referral pathways, and coordinating with these services, are integral aspects of the CYSs' role.

Almost all CYS staff and practitioners surveyed reported that headspace had been effective in developing some new community partnerships and at strengthening existing partnerships (87% and 80% respectively, n=107). Moreover, the CYSs involved in the in-depth evaluation were establishing or building relationships with a range of government agencies and NGOs in the community. State/territory mental health services (Child and Adolescent Youth Mental Health Services for 12 to 17-year-olds, and Adult Mental Health teams for those over 18 years) are a key resource for headspace because of the need to refer young people with severe mental health problems. But these partnerships are also a critical pathway of care for young people moving between area mental health services to headspace and vice versa. CYSs are also working with agencies and organisations from other sectors, such as specialist health services (e.g. dentists, sexual-health providers, etc), juvenile justice services, education providers, social/welfare agencies, and community specific organisations (e.g. Indigenous and CALD organisations).

According to the service coordination study and the interviews with service providers, CYS staff and practitioners, CYSs are at different stages in the development of clear referral pathways and in the extent to which they coordinate with other services. This

[41] In July 2008, Australian Health Ministers agreed to develop a *Fourth National Mental Health Plan* and this *Plan* is currently being drafted.

is largely because of the different establishment and implementation periods. Most CYS respondents and other service providers[42] reported that they worked in partnership with other agencies to support young people at least some of the time (95%; n=107 and 89%; n=182 respectively). But it is not known to what extent all possible youth-based organisations in communities are coordinated. Some CYSs were advanced enough to conduct regular inter-agency meetings, actively use referral pathways, and work together to provide coordinated support and care for young people. However, those in the early stages of implementation were still primarily focusing on promoting headspace, building service-provider understanding of the headspace model, learning about the scope and capacity of other services in the community, establishing key contacts, and referring clients.

Promoting effective referral pathways and service coordination

Community-based service providers and CYS practitioners commonly reported such crucial factors affecting service coordination in the broader community. These included the leadership role of key stakeholders (especially headspace personnel), organisational culture and individual willingness and communication.

Key stakeholders, both within the CYS (such as the managers and AHWs) and within community organisations/agencies (such as lead-agency representatives and consortium members), played important leadership roles in facilitating service coordination at an operational level. In a number of sites, for example, CYS-based AHWs worked with service providers from other agencies to co-support or to facilitate young peoples' transitions. CYS practitioners and staff found this to be especially important in the case of young people with more severe mental health problems, who required formal support from their state/territory mental health system but who were not yet ready to access this support. Engaging leaders from external agencies like the state/territory mental health services or DGP was made easier when they were allocated meaningful roles in the headspace initiative.

An organisational culture that supports coordination and a willingness to work collaboratively was reported as an important condition for effective working relationships in both the survey and the interviews. The willingness and commitment were easier to achieve in communities where there were strong pre-existing relationships. Communities that did not have pre-established, collaborative networks faced considerable challenges in developing strong collaborative partnerships in the three-year time period. Organisational support for working together was important, particularly for state/territory government representatives.

Effective working relationships also hinged on clear communication to outside service providers and consortium partners, of the scope, capacity and limitations of headspace. Community-based service providers, for example, were reluctant to refer clients to headspace when there was insufficient clarity about which organisation would take responsibility for the client. Overall, there was a good understanding among service providers from external organisations and agencies about key aspects of the headspace model, but almost two-thirds of service providers working with

[42] Service provider respondents included organisations identified by CYS managers as having some involvement with headspace. As such, these findings are useful for validating the CYS reports.

CYSs believed that headspace services were providing care only to young people with severe mental health problems. Further communication about the scope and aims of headspace CYSs may be required.

Finally, for partnerships and collaborative networks to work well, it was considered essential for activities to be purposeful, relevant and mutually beneficial. It was also crucial that the relationships be reciprocal, especially since staffing and funding limitations were commonly reported barriers to service coordination.

7.3 Engaging government

A central aim of headspace is to impact on strategic planning and investments in youth mental health at all levels of government. To accomplish this, senior managers from hNO proactively liaised with government representatives at the federal and state/territory levels.

Interviews with government officials indicated that there is an awareness of headspace in high levels of government at both the national and the state/territory levels. At the national level, awareness of headspace extended beyond DoHA because the Australian Health Ministers' Council were familiar with the initiative. Links had also been established between headspace and other Australian Government initiatives. Key health representatives from all state/territory governments also reported contact with headspace and expressed interest in the initiative. This indicates the importance key stakeholders accord to supporting early intervention in youth mental health. Of particular interest to these interviewees were new models of the provision of care, including: public-private partnerships and their cost-effectiveness; evidence-based interventions in youth mental health; and strategies of appropriately engaging with and responding to the needs of young people.

At Wave 1, government stakeholders identified several policy areas which they believed headspace had the potential to influence, including raising the profile of early intervention services more broadly; reducing the number of young people accessing the public mental health system; and supporting young people who did not otherwise have access to care. One state was considering involving a headspace representative on their Youth Mental Health Advisory Group and two others reported that headspace was contributing to ongoing reform in their states to include a stronger focus on young people and revise CAMHS' age criteria.

There were challenges to the closer collaboration between the state/territory health services and headspace, as reported by government representatives, including the diversity of the CYS focus, and operational differences. There was also some frustration that states/territories had not been included in early discussions around the distribution of funds.

Although hNO staff actively engaged with government representatives, it is too early for headspace to have made any significant impact on policy development. Nonetheless, the establishment and implementation of the 30 CYSs around Australia has supplied an operational platform with which the strategic directions of governments can connect, and interviewees acknowledged that headspace does have substantial potential to affect government policy.

Summary

Key elements

- The majority of surveyed CYS staff reported that headspace had been effective at developing new and strengthening existing partnerships.
- CYSs are working with state/territory mental health services, specialist health services, social/welfare agencies and community or interest-group-specific organisations.
- CYSs are at varying stages of service coordination.
- Coordination and integration between CYSs and community providers has been facilitated by key stakeholders, strong pre-existing relationships, clear communication about the scope and capacity of headspace, and mutually beneficial activities.
- Federal and state/territory health officials have been engaged by hNO and the CYSs.
- It is too early for headspace to have impacted on government policy, but headspace has provided an operational platform for the strategic directions of some governments.

Early challenges/possible issues for follow-up

- Sites with few strong pre-existing relationships face considerable challenges in developing effective partnerships before the end of the funding period.
- A number of service providers may not understand the target group for headspace.
- Closer collaboration between state/territory health services and headspace requires government support at strategic and operational levels.

8 Implementation of the national initiative

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 community awareness strategies, evidence-based information, appropriate training, and strategic and operational support). This was the rationale behind the establishment of the CA, SPET, CoE and hNO components of headspace. This Section outlines the components' deliverables against the strategic and work plans, the interaction between them, and the overarching governance of headspace.

8.1 Deliverables and challenges experienced by the national components

Community Awareness

According to the *headspace Strategic Plan 2008-2009* (headspace, 2008b), the Community Awareness deliverables are focused around supporting local community campaigns, developing national awareness, and establishing strategic partnerships that build increased awareness. The intended activities included planning community awareness campaigns (CA, hNO), conducting community awareness activities (CA, hNO), developing and producing resources (including kits for CYSs, CA) and reviewing existing evidence and programs, conducting surveys, and filling research gaps in knowledge (CA). The latter activity is the responsibility of BMRI, and the former activities have largely been the responsibility of hNO.

The BMRI CA component has primarily focused on reviewing evidence, and conducting original research on community awareness and help-seeking through two sets of Computer Assisted Telephone Interviews (CATI-I and CATI-II). These are the primary headspace activities of the BMRI. CATI-I aimed to assess current levels of community awareness together with attitudes to accessing care for mental health and substance abuse problems; CATI-II (not yet finalised) will compare the rates of appropriate service use in headspace communities with those in non-headspace communities. There have been some considerable delays in the CATI surveys. The first survey, for instance, was developed to inform headspace CA activities, but the findings will only be available well after the establishment of CYSs. However, the survey may subsequently be useful in assisting CYSs to develop more appropriate marketing strategies. The report on the results of this survey has not yet been released. Other research conducted by BMRI includes focus groups and interviews with young people and their families.

At this stage, the BMRI has played a minor role in the actual development and production of community awareness resources. Of these activities, the BMRI was primarily responsible for a DVD with a guide for CYSs and worked with hNO on six segments for Eclipse television.

BMRI has focused on conducting research on help-seeking. Therefore, hNO took the lead on promoting headspace to the broader community and producing community awareness resources.[43] These marketing and communication strategies (listed in Section 5.1) are funded by the BMRI. The relationship between the BMRI and hNO has been maintained by their mutual belief that headspace is an important initiative,

[43] Marketing & Communications Subcommittee also supported hNO.

although governance issues (discussed below), conflicting visions about how the CA money should be spent, and time pressures in the establishment phase of the initiative, have resulted in work that is largely siloed and possibly an inefficient use of resources. Marketing headspace to the wider community is essential for the initiative to succeed, and so decisions need to be made about what proportions of the CA budget should be used for research and communication/marketing purposes.

Centre of Excellence

The CoE's intended deliverables focus on strengthening services and setting directions. This includes conducting and disseminating research about the treatment of young people with mental health problems, and providing practical support to service providers and CYSs. The CoE has met its deliverable regarding conducting research and has disseminated some of the findings, but is still working towards the wider dissemination of evidence on treatments of mental disorders for CYSs.

The CoE has conducted and published systematic reviews of evidence (or evidence maps) regarding interventions for depression, psychosis and bipolar disorders in young people aged 12–25 years. The evidence maps for substance use, anxiety disorders, eating disorders, and suicide and self-harm, are still being completed. The component has also established the knowledge centre within the headspace website (see Section 5.1), which includes information on mental disorders and substance-use issues affecting young people.

At this early stage in headspace's implementation, little work has been done as yet on the translation and dissemination of these evidence maps. Thus, CoE's work on evidence-based treatment has not to date practically supported the CYSs. The CoE has, however, produced a clinical assessment tool, a service improvement framework, and a peer-support guide, and responded to the CYSs requests for information. CoE plans to expand its focus on translation in future by disseminating reviews to CYS sites via the CLN, and then later to a wider audience through print and internet publications.

Service Provider Education and Training

SPET's intended deliverables include assessing current training packages that are available, analysing training needs, and developing and delivering seven evidence-based training packages (headspace, 2008b). At Wave 1, the assessment and development deliverables have been met, but the training had only partially been delivered.

The AGPN and APS consulted with peak bodies and CYS stakeholders (12 site visits and focus groups at 6 Round 1 sites) to identify training needs. The APS also collected and analysed this data, and completed a literature review and audit report on existing training packages. The APS developed four of the seven training modules, contracted out the remaining three modules (these have now been developed),[44] and piloted the training packages. The training modules include: Screening-Engaging-Early (SEE) Young People, Early Identification of Psychosis in Young People, Managing Challenging Behaviours in Young People, Motivational Interviewing and

[44] By ORYGEN Research Centre and the Illawarra Institute for Mental Health.

Behavioural Change Techniques, Problem Solving Skills Training, Working with Families or Significant Others, and Youth Mental Health Access.

The AGPN, whose primary role is training delivery, has sought accreditation with relevant professional bodies, developed quality-assurance strategies, and contracted trainers to conduct training. Only two of the seven training modules (SEE and Working with Families of Significant Others) had been rolled out to the CYSs by the end of November 2008. The other five training programs will be rolled out over the next 12 months, but the delays have left some CYS Round 1 sites without training and education resources for a period of time.

SPET's delivery of the modules was slowed because of subcontracting, the complexity of the shared leadership, delayed role out of the CYSs and other reasons beyond the control of the headspace components. Subcontracting arrangements brought in additional expertise, but also added time in terms of tendering, selection, coordination and management. The effectiveness of SPET will only become known after training sessions have been conducted by the CYSs. The shared leadership between the AGPN and APS was believed by interviewees to be positive, but it has nevertheless added complexity to this component. The initial lack of clarity around roles, responsibility and accountability, the time-consuming nature of maintaining effective working relationships, and a high turnover of staff, were challenging for stakeholders.

headspace National Office

hNO's deliverables are to establish headspace as the primary reference point on youth mental health and related issues, establish and develop CYSs, coordinate the headspace evaluation, and involve young people and carers in headspace (headspace, 2008b). The activities undertaken by hNO are working towards meeting these deliverables.

hNO has worked towards establishing headspace as a primary reference point on youth mental health through awareness-raising activities. They have played a major role in branding and marketing headspace and in the community awareness campaign and assisting CYSs with local community awareness activities (see Section 5.1). They have also held meetings with mental health directors from each state and territory. hNO has been actively engaged in setting up headspace and supporting CYSs. The 30 CYSs have been selected and established (two are yet to open). hNO supported these CYS though contract management, providing strategic guidance, facilitating shared learning across the sites, and providing operational and technical support (see Section 4.3). hNO has involved young people and carers in headspace by developing a strategy and resources for their participation and establishing and supporting hYNRG. Finally, the evaluation of headspace and minimum dataset and contracting the independent evaluator, is supported by hNO.

The work of hNO has been central to headspace's implementation. Despite an initial limited budget, without hNO it is unlikely that the initiative would have progressed as far as it has.

Interactions between components

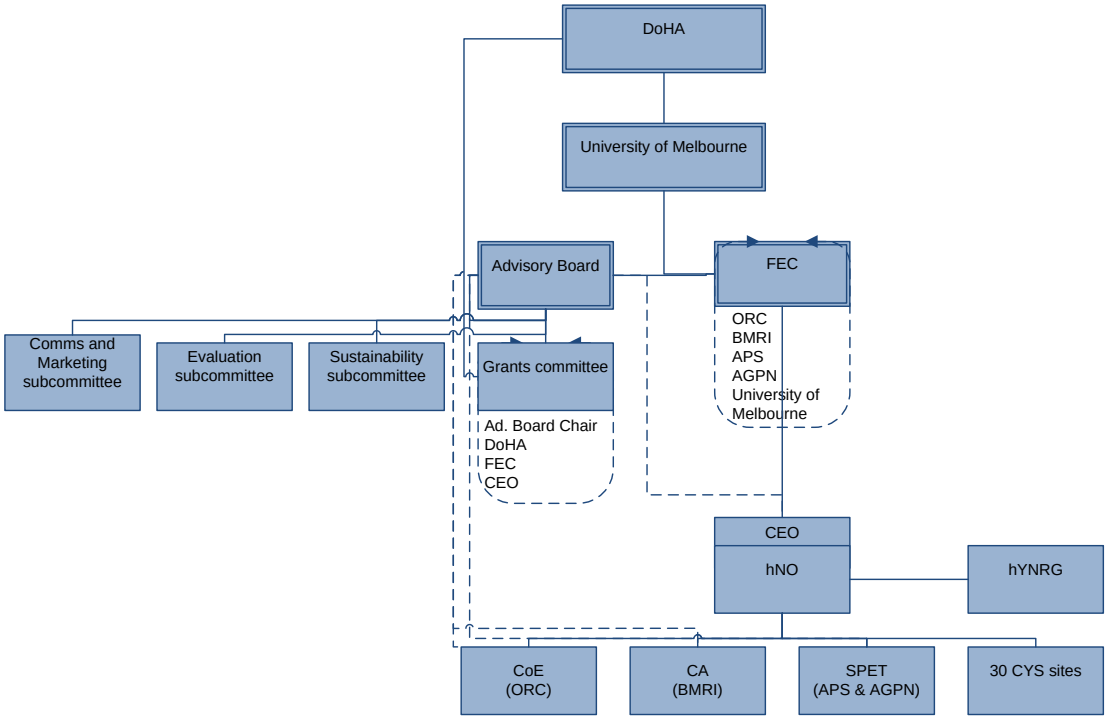
The relationships between the national components of headspace were largely driven by the hNO, which has tried to foster a consistent vision of headspace across the organisation and coordinate all components. Stakeholders reported that hNO has been partly successful in guiding and coordinating the national components.

Overall, however, CA, CoE and SPET had limited working relationships with each other in the early stages of the initiative, despite the inherent links between these components. Stakeholders from all components were interested and willing to work together in a more meaningful way, but there were substantial barriers to effective working relationships (the speed of implementation, the simultaneous development of components, the separation of the core functions, and governance issues). Still, component stakeholders reported that these relationships were improving as the roles and responsibilities became clearer.

8.2 Governance

The current governance structure is illustrated in Figure 8.1. The FEC and the Advisory Board make up the primary governing bodies of headspace. The FEC is composed of representatives from five founding organisations: ORYGEN, BMRI, APS and AGPN and UoM. The Advisory Board is comprised of community members with a range of expertise. The Board provides guidance around the strategic direction of headspace. If there is a serious dispute between the Advisory Board and the FEC or CEO, the Advisory Board consults with DoHA for a decision. The CEO is also central to the governance of headspace. This position reports to the FEC and the Advisory Board on the progress of the initiative. The CEO is responsible for overseeing the hNO and all other subcontracts (CoE, CA, SPET, CYSs).

Figure 8.1: headspace Governance Structure



A conflict of interest within the governance structure has challenged headspace since its inception. Consequently, headspace is currently in the process of restructuring the governance arrangements. As has been indicated previously, FEC members, with the exception of UoM, have held contracts that total more than $13 million. The current structure means that the headspace CEO is accountable to the FEC and is also required to manage the contracts of each of the FEC member organisations (see Figure 8.1). The conflict of interest has caused confusion around the roles and responsibilities of the governing agencies. The hNO experienced difficulties due to its dual role of being accountable to the FEC and holding the member organisations of the FEC to account for their performance as national components.

Due to these challenges, governance was identified as the single most problematic factor for headspace at the national level, and this impacted on staff in all the national components. The governance problems resulted in tension and stress and also compromised trust among staff in some components. This reportedly affected working relationships and, in some cases, led to high levels of staff turnover. Despite the challenges of the governance structure, the headspace initiative was still implemented. It is unknown if these governance problems have affected the initiative's outcomes and, if so, to what extent.

The governance problems have been recognised by all key senior stakeholders in headspace, including DoHA who commissioned an independent audit of the structure. The restructure, which is currently underway, will establish a company with a constitution and a board with an independent chair. Effective governance is essential to the long-term success of headspace and the constitution of the new company and board members will have substantial influence over the future of direction of the initiative.

Summary

- Each of the headspace components is central to the logic model of the initiative.
- CA was working towards meeting its deliverable on reviewing existing evidence and programs and conducting surveys and filling research gaps (primarily with the CATI).
- CA had met its other deliverables – planning and conducting community awareness campaigns and developing resources – with the support and work of hNO.
- CoE had met its deliverable of conducting research into engaging and treating young people with mental health problems (primarily through evidence mapping), but had only disseminated this to a limited extent by November 2008.
- SPET had met its deliverables for auditing and assessing training needs (APS and AGPN), and for developing seven training modules (APS). SPET had started to meet its deliverable for rolling out these training modules to the CYSs.
- hNO had conducted activities that meet its deliverables of establishing and developing the CYSs, establishing headspace as a primary reference point, involving young people and carers in headspace, and the evaluation of headspace.

Early challenges/possible issues for follow-up

- Governance decisions need to be made about what proportion of the CA budget should be allocated for research and community awareness resources and marketing.
- CYSs require the evidence-mapping research translated into user guides. CoE is working towards this.
- SPET experienced some delays with the development and roll-out of training packages.
- CA, CoE and SPET have largely worked in isolation, despite links between the three components. Interaction was affected by the governance problems and time.
- Conflict of interest has challenged the headspace governance structure since its inception.
- Effective governance is essential to the long-term success of headspace. This will largely be determined by the board members and constitution.

9 Conclusion

headspace has achieved a substantial amount in a short period of time. The initiative was launched in July 2006 and had only three years to fund, develop, establish and implement 30 service delivery sites, three major programs (CA, CoE and SPET) and a national office. This was particularly challenging because headspace is a new model which aims to change the culture and provision of services to young people (12–25 years) across Australia. This overview presents interim trends and issues around establishment and early implementation. The following findings need to be confirmed in Wave 2 of the evaluation.

What's worked and why

Twenty-eight of the CYSs have been established and are making progress towards developing multi-disciplinary teams of practitioners in the core areas of primary health, mental health, drug and alcohol, and social and vocational support. Practitioners within CYSs are starting to work actively together to provide support to young people and to establish relationships with service providers in the broader community. National and local community awareness strategies have branded and marketed headspace, and are working to increase awareness of youth mental health and help-seeking behaviours. headspace CYSs around Australia have seen at least 5,000 young people with mental health, substance-use, and/or social and vocational problems. Young people, carers and community-based providers have been satisfied with the quality of headspace support, and preliminary outcomes from a small sample of young people suggest that services are in fact supporting young people in all the areas where they are experiencing problems.

These achievements occurred because of a range of factors. The successful establishment of CYSs was assisted by the provision of funding (headspace seed money, and YHMI and MBS funding) and through the tangible resource support provided by lead agencies and consortium partners. Highly skilled CYS managers and support from the hNO were also important in the implementation of CYS sites. Young people's access to headspace services was facilitated by the low cost of services, physical accessibility and the youth-friendly environment.

The national components are central to the logic model of headspace, and each has been successful as far as possible given the early stage at which headspace was evaluated. SPET has developed training packages to support the CYSs; CA conducted a major survey of community awareness of youth mental health; and the CoE has mapped evidence of treatment interventions for three mental-health disorders, and established a knowledge centre. hNO has facilitated the interaction between these components and has been critical to the establishment and implementation of the CYSs.

Challenges and areas for improvement

A number of challenges emerged during the establishment and implementation of headspace. The biggest challenges for the initiative – governance and timeframes – are structural. Governance has been problematic due to the conflict of interest built into the structure of the model; and the underestimation of the amount of time needed to select and establish CYSs left insufficient time to implement services before the end of the funding period. It is too early to tell whether the reliance on private

practitioners to sustain service provision is another structural problem of the model, especially for regional and rural areas. This will be followed up in Wave 2 of the evaluation.

Other challenges may have occurred because of the early stage of the initiative and/or timing of the evaluation. At Wave 1, some CYSs still had gaps in the provision of drug and alcohol, general health and social recovery services. A few were still without GPs, and if this persists, they will not be able to meet the objectives of the headspace model. In addition, some CYSs faced challenges in relation to accessibility (because of waiting lists and business-based opening hours), to targeting services at early intervention, and to providing formalised practitioner supervision. Wave 2 will follow up on whether these challenges are transitional or ongoing.

From a strategic and program logic perspective, all national components have the potential to play a crucial role in headspace. At an operational level, however, support for CYSs from SPET, CoE and CA was limited at this early stage. Five of seven SPET training sessions had not yet been rolled-out, and CoE's evidence maps had not yet been translated into usable formats for the CYSs. CA provided little formalised assistance in relation to local community awareness activities; most local support, as well as the national branding and marketing activities, were provided by hNO. Integration and outputs from the components have been challenged by governance arrangements, unclear roles and responsibilities, staff turnover, and the early stages of the initiative. At this stage of headspace, it is not possible to assess the potential value that each component will add to the initiative.

Summary

headspace has made inroads into changing the culture of mental-health service-provision to young people by integrating primary health, mental health, drug and alcohol and social recovery services. Despite some challenges, headspace has achieved a substantial amount in regard to service provision, access, quality and reform. Whether and how headspace has met its objectives will be further explored in Wave 2 of the evaluation.

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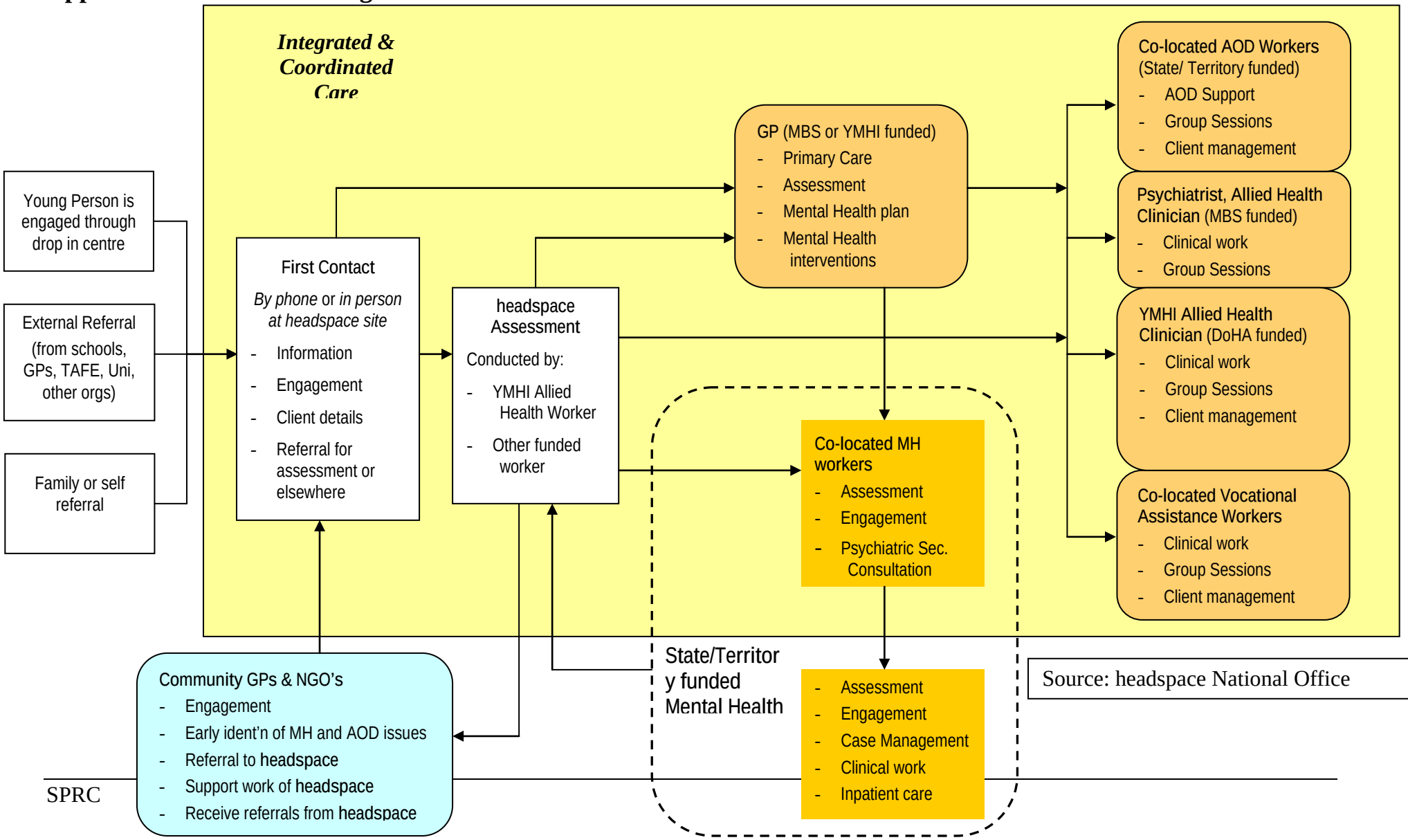
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Appendix A: CYS model diagram



Source: headspace National Office

Appendix B: Additional methodological details

Research Instruments

The researchers developed a number of qualitative and quantitative instruments for this evaluation (Table B.1). Development of the qualitative interview schedules and survey instruments was based on the evaluation questions, objectives, a review of key literature, existing data collected for headspace, and other comparative secondary data sources.[45]

Table B.1: Evaluation instruments

Stakeholder Group	Interview schedules	Surveys
hNO CoE SPET CA FEC Advisory Board	hNO questionnaire CoE questionnaire SPET questionnaire CA questionnaire FEC questionnaire Advisory Board questionnaire	headspace components survey
hYNRG	hYNRG questionnaire	-
CYS managers CYS staff members/ practitioners	CYS managers questionnaire CYS staff questionnaire	CYS survey
CYS affiliates [a] 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 [c]

a. CYS affiliates include consortium partners and community-based providers.
b. Government representatives include Australian, state and territory government representatives.
c. Training participants will be surveyed before and after training is delivered. These surveys will be rolled out in 2009 with the training modules.

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, explanations and insights into headspace that would not be captured by the surveys. A semi-structured format was used to ensure that all

[45] Such as literature on interagency cooperation and collaboration (Himmelman, 2004; Alkema et al., 2003; Bloxham, 1997; Okamoto, 2001 in Friedman, S., Reynolds, J., Quan, M. A., Call, S., Crusto, C. A. and Kaufman, J. S. (2007), 'Measuring Changes in interagency collaboration: An examination of the Bridgeport Safe Start Initiative', *Evaluation and Program Planning*, 30(1), 294-306.; O'Looney, J. (1993), 'Beyond Privatisation and Service Integration: Organizational Models for Service Delivery', *Social Service Review* . 67(4), 501-534.; Fine, M., Pancharatnam, K. and Thompson, C. (2000), *Integrated Human Service Delivery: A report prepared for the New South Wales Cabinet Office and Premier's Department*, , Addington, D. E., McKenzie, E., Addington, J., Patten, S., Smith, H. and Adair, C. (2007), 'Performance measures for evaluating services for people with a first episode of psychosis', *Early Intervention in Psychiatry*, 1, 157-167.; and Thompson, D., Socolar, R., Brown, L. and Haggerty, J. (2002), 'Interagency Collaboration in Seven North Carolina Counties', *Journal of Public Health Management Practice*, 8(5), 55-64. and sustainability (Shediac-Rizkallah and Bone, 1998 in Harvey, G. and Hurworth, R. (2006), 'Exploring program sustainability: identifying factors in two educational initiatives in Victoria', *Evaluation Journal of Australasia*, V o l . 6(No. 1), 36 – 44.

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 participant's permission to the ensure accuracy of information gathered; all interviews were then transcribed for analysis (Bryman, 2004).

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 one set of instruments, the SPET Training Evaluation Surveys, was still being developed at time of writing and is therefore not analysed in this report. Evaluation Solutions, a web-survey company, was contracted to host the surveys on-line; respondents to the first three surveys (the headspace components survey, CYS survey and Service provider/ coordination survey) were emailed links to electronic surveys, which were completed online.

Young people and carers were asked to complete electronic surveys directly after they completed their interviews to maximise response rates. A number of procedures were put in place to help these respondents complete their surveys and maximise data quality. As some young people were likely to exhibit difficulties with language/comprehension, a researcher was available to provide support and clarification to respondents if necessary. Respondents were reassured about the confidentiality of their responses to minimise the effects of social desirability bias.

Recruitment and response rates by group

Table B.2: Number and type of research informants interviewed (n = 198)

Stakeholder Group	Number of people interviewed
hNO	7
Advisory Board and hYNRG	4
FEC	3
CoE	3[a]
CA	2[a]
SPET	3
CYS[b]	47
CYS affiliates[b]	29
Young people[b]	71
Carers[b]	20
Australian Government	2
State and Territory Government (ACT, NSW, NT, SA[c], Tas., Vic., WA[c])	9
Total	**198**

a. One respondent involved in two stakeholder groups. Each of these respondents was counted once only
b. From nine of the CYS sites
c. Two respondents interviewed from these states

CYS and service providers

headspace hNO provided the SPRC with the contact details of all CYS managers, who were then asked to provide lists of CYS staff and practitioners, consortium members and other community based service providers. Based on the details provided by CYS managers, 193 CYS staff and practitioners and 312 consortium members and community based service providers were invited to complete on-line surveys about their experiences of headspace and of working together in the community. Just over half of both groups completed the survey (107 CYS, 55%; and 182 providers, 58%; Table B0.3).

CYS survey

CYS managers and staff members from 23 of the 30 sites responded to the CYS survey. Therefore results presented in this report are based on responses from only two-thirds of the CYSs. Six of the seven CYS sites that did not take part in the survey were not operational at the time of Wave 1 data collection. These sites will be surveyed in December to capture baseline responses. Of the 23 CYS sites that participated, 4.7 people responded from each CYS. While there was some variability between the number of respondents per site (the number ranged from one to nine respondents), the distribution was largely consistent. Respondents' main role in the headspace initiative is detailed in Table B0.3.

Table B.3: CYS survey – respondents' role (n = 107)

Main role in the headspace initiative	Respondents (per cent)
Clinical services integration manager/ CYS Manager	16.8
Community liaison officer	4.7
Drug and alcohol worker	6.5
General practitioner (GP)	10.3
Health worker/Nurse	10.3
Mental health worker/Nurse	14.0
Psychologist	8.4
Psychiatrist	1.9
Social Worker	4.7
Vocational Assistance Provider	1.9
Youth Worker	12.1
Other	8.4
Total	100.0

Service provider survey

An average of 7.6 CYS affiliates from 24 of the 30 sites responded to the service provider survey.[46] The number of people who submitted completed surveys varied between sites, ranging from 27 respondents in one location to a single respondent in another. The variation reflected the number of service providers that CYS managers nominated as contacts to the SPRC. The average response rate was 39 per cent for service providers contacted across CYS sites that were established. Most respondents were frontline workers, service coordinators/managers or senior managers within their organisation or agency and the majority were involved in headspace as consortium members or referring agencies (Table B0.4).

[46] This number differs from the previous section because in one site no CYS staff completed the CYS survey, but an external service provider in the same location completed the service provider survey.

Table B.4: Service providers' role in organisation/agency and in headspace (n = 182)

Role in organisation/agency	Respondents (per cent)	Agency's role in headspace CYS	Respondents [a] (per cent)
CEO	6.6	None	1.1
Senior/Area Manager	20.3	Consortium member	60.4
Service	33	Provides headspace CYS with	9.9
Frontline worker	25.3	Services funded by headspace	7.1
Other	14.8	Services co-located with	14.8
Total	100	Referring agency	39
		Joint care planning/Counselling	18.7
		Other	20.9

c. Responses do not add to 100 per cent as some agencies have more than one role in a headspace CYS.

headspace components and government stakeholders

headspace hNO provided SPRC researchers with the contact details of people involved in headspace hNO, CoE, SPET and CA and the Advisory Group. The researchers selected a number of potential respondents from this list and invited them to participate in two interviews (first in 2008, and again in 2009). Twenty stakeholders from these groups were approached, 20 were interviewed and 13 filled out the on-line survey (a 65% response rate; note, one woman was on maternity leave). The affiliation of the survey respondents' roles are described in Table B0.5. The quantitative results from this survey were not used throughout this report because of the skewed response rate. The qualitative findings are more representative and have been drawn on for the report.

Table B.5: headspace components survey – respondents' role (n = 13)

Component	Respondents (per cent)
hNO	38.5
CoE	23.1
SPET	15.4
CA	7.7
Executive Committee	7.7
Advisory Board	15.4
Total	100

In addition to stakeholders within headspace components, the SPRC invited key policy makers from each state and territory to participate in interviews and surveys. Ten interviews were conducted with states and territory government representatives and, apart from Queensland, all states and territories took part.[47]

In-depth evaluation sites

As part of the evaluation, ten CYS sites were selected for more in-depth analysis (Table B0.6). The sites were selected to include CYSs with a range of characteristics, including: most Australian states and territories; urban, regional and remote locations;

[47] The Qld representative agreed to participate in the process by providing written responses to the interview questions, but was not forthcoming in providing a response by the time this report was prepared.

communities with different socio-economic and cultural backgrounds; accessibility of standardised data; and those that were open and seeing young people by August 2008. The ten headspace sites chosen to participate in the evaluation are listed in Table B0.6.

Table B.6: 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 site in this territory was not open and seeing young people in time for the evaluation. Despite being in a similar situation, it was initially decided to include the Alice Springs, NT, site because of the particular issues experienced in the NT that are important for the evaluation to capture.

b. The Alice Springs site was replaced by headspace Top End (Darwin/Palmerston, NT site) in the in-depth evaluation as the opening of the Alice Springs site was delayed by staff recruitment problems. Fieldwork in Darwin/Palmerston was conducted in late November 2008 and results will be incorporated into the final evaluation report.

SPRC researchers contacted CYS managers in each of the in-depth evaluation sites to understand the range of CYS staff and practitioners and consortium members/partners/service providers in the broader community. From these initial conversations, approximately five CYS staff members and practitioners and one to three CYS affiliates (external providers/consortium members) were invited to participate in an interview. With the use of flyers, information sheets and requests from CYS staff, the researchers also endeavoured to recruit ten young people using headspace services and five family members/carers in each of the ten sites.

Fieldwork in nine of the ten CYS sites was conducted in August/ September 2008.[48] During these site visits, face-to-face interviews were conducted with young people and carers, most CYS staff and some CYS affiliates. Additionally, the researchers conducted site observations, collected policy documents for analysis and administered

[48] SPRC endeavoured to interview 10 young people each site. The visit to the tenth site, Darwin/Palmerston, NT, was delayed until late November 2008. Only 71 young people initially participated in the nine sites because of the low numbers at some of the CYSs, and because of young people not showing up to the interviews and 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. The data from the extra 21 young people will be incorporated into the final report.

surveys to young people and carers. Seventy-one young people, 20 carers, 37 CYS staff and 29 CYS affiliates were interviewed (Table 3.1).[49]

Table B. 7: Young people survey – respondents by age and gender, Wave 1 (n = 70)

Respondents	Age group				
	12–14 years	15–17 years	18–20 years	21+ years	Total
	per cent	per cent	per cent	per cent	per cent
Male	15.2	24.2	45.5	15.2	100
Female	8.1	40.5	24.3	27	100
Total	11.4	32.9	34.3	21.4	100

Carers were only interviewed if the young person provided consent and contact details for their relative or guardian. Three-quarters of carers interviewed were young people's mothers (Table B0.7).

Table B. 8Carers' relationship to headspace client, Wave 1 (n = 20)

Relationship	Respondents (per cent)
Mother	75
Father	15
Sibling	5
Friend	5
Total	100

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 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).

Quality assurance

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.

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. Once data

[49] In each fieldwork site, two young people who are interviewed in Wave 1 will be interviewed again in Wave 2 in order to provide twenty some longitudinal case studies. An additional eight young people will be recruited in each site in Wave 2. The remaining Wave 1 young people will be contacted and asked to complete a survey in Wave 2.

is available in both Waves of evaluation, MHAGIC and/or survey data can be compared to Kessler 10 (K-10) scale[50] (ABS 2001); Personal Wellbeing Index (PWI) scale[51] (ITG 2006); and Social and Occupational Functioning Assessment Scale (SOFAS)[52] (APA 2000); Australian School Students Alcohol and Drugs Survey 2005 (DoHA 2006a); Australian Secondary School Students' Use of Over-the-counter and Illicit Substances Study 2005 (DoHA 2006b); General Social Survey 2006 (ABS 2006a); National Drug Strategy Household Survey 2004 (AIHW 2005); and National Health Survey 1995, 2001 and 2004-05 (ABS 2003); (ABS 2006c).

Scale Construction

The researchers considered literature on likert scale construction in developing instruments which collect ordinal data (Jamieson, 2004); (Jacoby and Mantell, 1971). Five-point scales were used in the majority of likert scale questions as they minimise complexity and allowing for a neutral/undecided responses.

Online Questionnaires

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.

Methodological limitations

Due to the nature and scale of headspace, several compromises were made to allow the evaluation to proceed within the time and budget constraints. The limitations on data quality limitations relevant to the evaluation are discussed below.

Survey completion

For young people with poor literacy skills, surveys are not usually appropriate (Bryman, 2004). To address this limitation, researchers were present when young people completed the surveys to clarify questions and to physically assist respondents to complete the surveys when participants were not computer literate. This enabled young people with poor literacy to be included in the results, however, strict quantitative methods would suggest that this may have compromised the results.

Self-selection bias

Young people experiencing more serious mental health issues or who had negative experiences with headspace may have been likely to participate in the evaluation

50 The K-10 scale measures non-specific psychological distress in the anxiety-depression spectrum.

51 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?"

52 The SOFAS is a relatively new scale derived from the Global Assessment of Functioning (GAF) scale, which measures of impairment in an individual's social and occupational functioning.

because they might not have been identified by service providers and asked to participate in the evaluation or because they had disengaged from the service and could not be contacted. As a consequence, the effectiveness of the headspace program could be overestimated if the in-depth evaluation survey results are used in isolation.

Lack of a control group

The timing, budget and funding requirements for the evaluation, coupled with the new model and delayed implementation of the initiative, precluded the inclusion of a control group. This limits the validity of the outcomes, as it is not possible to determine what would have occurred if young people had not received the headspace intervention. Wherever possible, however, evaluation findings will be compared to existing population data.

Missing data

The researchers only had access to program documentation that was selected by participants. Some documents may have been withheld deliberately or by chance, and so it is necessary to be cautious in making inferences based on documentation.

The MHAGIC minimum dataset contains administrative records on referrals and service use. There is potential to use this data to investigate the demographics of 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. The dataset will be used to assess the uptake of services by young people within CYS sites and the changes in mental health, substance use and economic participation for the young people who receive services.

MHAGIC data was only received in late October 2008. As a result, analysis of this data has only been conducted on a small portion of this data; a more detailed analysis will be included in the final report. The data that is in MHAGIC represents only 22 of the 30 CYS sites and 5 of these 22 sites account for 69 per cent of recorded data. Some of the reasons for the missing data include: a delay in the development of MAHGIC; delay in the roll out of the system (some sites were established before MAHGIC was ready); incompatibilities with existing software systems, leading to non-compliance; and lack of staff training. If data continues to be missing and unrepresentative, the usefulness of the MHAGIC dataset will be significantly compromised and a broad understanding of headspace participants and their outcomes will be lost.

CATI-I data was used to assess awareness of mental health and substance use issues among a sample from the Australian population.[53] CATI-I is a representative sample of 4,000 people from around Australia.[54] Participants were randomly selected using

[53] There is an additional CATI-II survey, which will be conducted with a random sample of people living in CYS locations and in control sites, but data for this survey was not available at time of writing.

[54] 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).

random digit dialling, and included young people aged 12–25 years,[55] parents or carers of at least one child aged 12 to 25 years; and, the general population. The CATI-I 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.

Only a small selection of BMRI CATI-I data was received due to the timing of BMRI's analysis and the interim report. The full dataset will be provided to SPRC by BMRI in 2009 and so the final report will include further analysis of this data. Due to the late timing of the CATI-I, this survey does not capture a true baseline of community perceptions. The CATI-II survey, which aims to assess the change in perceptions of help seeking and mental health in headspace communities as compared to control communities, has not yet been conducted by the BMRI. As a result, the SPRC will have limited data upon which the effectiveness of the headspace community awareness campaign can be assessed.

Data presentation

The conclusions drawn in this report are based on a range of methodologies. In most Sections, analysis is drawn on the mix of qualitative data and quantitative data from the interviews and surveys conducted with stakeholders and young people. When administrative, policy or document data is used, the source is explicitly acknowledged.

Next steps

Wave 2 of the evaluation will be conducted in 2009. This will include findings from all methodologies used in the evaluation (including an economic evaluation). The final report will be submitted in late 2009.

[55] Existing protocols for telephone interviews with people aged below 18 years of age were used. See BMRI *'headspace: National Community Survey 2008'* report (forthcoming) for more details.

Appendix C: CYS sites by round, location and opening date (as at November 2008)

Round 1 Sites			Round 2 Sites		
CYS	**Shopfront location**	**Date/month opened**	**CYS**	**Shopfront location**	**Date/ month opened**
Adelaide Northern headspace, SA	Shopfront	30-May-07	Fremantle headspace, WA	Fremantle	30-Jun-08
	Second Story	30-May-07	headspace ACT, ACT	University of Canberra, Bruce	10-Sep-08
	Paralowie	8-Oct-07	headspace Central Australia, NT	Alice Springs	10-Nov-08
headspace Barwon, VIC	Jigsaw	Nov-07	headspace Central Sydney, NSW	Youthblock Camperdown	21-Jul-08
	Clockwork	Aug-07		Redfern/Waterloo	1-Sep-08
	Bellarine	Not opened		Marrickville	25-Aug-08
headspace Central Coast, NSW	Ycentral, Gosford	Jun 07: interim; Jun 08: full	headspace Central West Gippsland, VIC	Warragul	Jul-08
headspace Great Southern, WA	Albany	31-Oct-07		Morwell	Not opened
headspace Illawarra, NSW	Wollongong	6 Feb 08	headspace Fraser Coast, QLD	Maryborough	16-Jun-08
	Wollongong CBD (2nd site)	Not opened		Hervey Bay	2-Dec-08
	Shell Harbour	Not opened	headspace Gold Coast, QLD	Southport	Apr-08
headspace MCSH, NSW	Campbelltown	17-Jul-07	headspace Kimberley, WA	Broome	4-Jul-08
	Tahmoor	Not opened	headspace Northern Tasmania, TAS	Launceston	Mar 08: GP; 1 Jul 08: full
headspace Mid North Coast, NSW	Nambucca	5-Nov-07	headspace Southern Downs, QLD	Warwick	Jul-08
	Coffs Harbour	Nov-07	Hunter headspace, NSW	Maitland	16-Sep-08
	Bellingen	Aug-08	Mt Druitt headspace, NSW	Mt Druitt	Aug 08: interim; Nov 08: full
headspace Top End, NT	Palmerston	23-Jun-08	Murraylands headspace, SA	Murray Bridge	Apr-08
Southern Melbourne headspace, VIC	Highett	14-Apr-07	Northern Melbourne headspace, VIC	Preston	Not opened
	St Kilda	13-Mar-08		Broadmeadows	Not opened
Western Melbourne headspace, VIC	Sunshine	21-Nov-07		Brunswick (outpost)	Not opened
	Werribee	Not opened		Mill Park	Not opened
			NSW Central West headspace, NSW	Bathurst	7-Aug-08
			Peninsula headspace, VIC	Frankston	5 Jun 08: GP; Jan 09: full
			Riverina headspace, NSW	Wagga Wagga	1-Jul-08
			Riverland headspace, SA	Berri	4-Sep-08
			South West Victoria headspace, VIC	Warrnambool	Sep-08
			Townsville headspace, QLD	Townsville	10-Jun-08

Appendix D: Topic specific tables

Table D.1: Service providers in nine Round 1 CYS sites by category, number and time committed (as at June 2008)

Category	Service	Number sites with service	Range of hours/FTE	Average hours/FTE
Private Clinician	Clinical psychologists	5	8–48 hours	17.5 hours
	Counselling Psychologists	5	6–19 hours	10 hours
	Clinical social workers	3	7–20 hours	12.5 hours
	Clinical Ots	3	10–24 hours	15 hours
	Psychiatrists	3	2–4.5 hours	3.5 hours
	General Practitioners	9	1.5–21 hours	11 hours
	Mental health nurse	2	6–24 hours	15 hours
	YMHI worker (DOHA funded)	9	1.4–4 FTE	2 FTE
	Alcohol and Drugs	0	0	0
	BOMHI psychologist	1	0.8 FTE	0.8 FTE
Co-located Practitioners	Mental health workers	4	0.05 FTE–40.8 FTE	12 FTE
	AOD workers	5	1 –54.5 hours	14.5 hours
	General Practitioners (state funded)	1	1 hour	1 hour
	Child protection workers	0	0	0
	Youth worker	1	12 hours	12 hours
	Nurse	0	0	0
	Psychologist	0	0	0
	Psychiatrists	0	0	0
	Vocational assistance providers	6	3–76 hours	27 hours
	Family planning/midwife	2	3–4 hours	3.5 hours
	Family □ounselor/ therapist	0	0	0
	Vocational	5	7–21 hours	14 hours
	PCYC	1	35 hours	35 hours
	ART	0	0	0
	Legal Support	1	1.5 hours	1.5 hours
	Housing Worker	2	38 hours	38 hours
	Sex Health	1	1 hour	1 hour

Source: Audit data, provided by hNO

Table D.2: Young person participation in headspace recorded using MHAGIC by CYS

Organisation Name	CYS Site	Frequency	Percent
Riverland	Berri	25	1.1
Fremantle	Fremantle	20	0.9
Kimberley	Broome	33	1.5
Murraylands	Murray Bridge	70	3.1
Gold Coast	Gold Coast	306	13.7
MidNorth Coast	Bellingen, Coffs Harbour, Nambucca Heads	116	5.2
Central Coast	Gosford	264	11.8
Central West	Morwell	1	0.0
Gippsland			
Central Sydney	Redfern/Waterloo	38	1.7
NSW Central West	Bathurst	125	5.6
Adelaide Northern	(3 sites) Salisbury, Elizabeth, Paralowie	551	24.7
Southern Melbourne	(2 sites) Highett, St Kilda	190	8.5
Peninsula	Frankston	5	0.2
Macarthur	Campbeltown	206	9.2
Fraser Coast	Hervey Bay	96	4.3
Great Southern	Albany	66	3.0
Top End	Darwin	45	2.0
Riverina	Wagga Wagga	5	0.2
Western Melbourne	Sunshine	7	0.3
ACT	Canberra	24	1.1
Southern Downs	Warrick	36	1.6
Other		1	0.0
Total		**2,230**	**100.0**
Missing		449	
Total MHAGIC Organisations		22	
Total CYS Sites represented		27	
Missing Sites*		9	
Total CYS Sites		36	

*Missing sites: Geelong (Barwon), Corio (Barwon), Launceston, Preston (North Melbourne), Wollongong, Warrambol (SW Victoria), Townsville, Alice Springs, Mt Druitt

Table D.3: Proportion of young people in education by age (n=70; in-depth evaluation)

Age (years)	Studying		Not Studying		Total	
	n	%	n	%	n	%
12-14	8	89	1	11	9	100
15-16	10	67	5	33	15	100
17-18	8	42	11	58	19	100
19-20	4	31	9	69	13	100
21+	6	43	8	57	14	100
Total	36	54	34	46	70	100

Table D.4: Impact of headspace by age group (n=70; in-depth evaluation)

Impact of headspace on	12–17 years				18–25 years				Asymp. Sig.
	Worse	Neither better or worse	Better	Total	Worse	Neither better or worse	Better	Total	
Mental health	-	3.8	96.2	100	-	11.1	88.9	100	.3
Physical health	-	24	76	100	3.1	37.5	59.4	100	.337
Sexual/Reproductive health	-	20	80	100	4.5	68.2	27.3	100	.020
Drug and alcohol use	-	23.5	76.5	100	-	45.8	54.2	100	.144
Feelings about bodily appearance	-	38.5	61.5	100	6.7	66.7	26.7	100	.021
Involvement in social/community activities	-	39.1	60.9	100	-	69	31	100	.031
Being able to work or find work (paid/voluntary)	-	28.6	71.4	100	-	44.8	55.2	100	.242
Being able to provide care (for family members, children or other people)	-	20	80	100	-	45	55	100	.091
Being able to go to school, TAFE or university	-	20.8	79.2	100	-	52.2	47.8	100	.025
How you get on with family	-	3.7	96.3	100	2.9	32.4	64.7	100	.011
How you get on with friends	-	17.9	82.1	100	-	35.3	64.7	100	.126
How you sleep	-	44.4	55.6	100	6.3	37.5	56.3	100	.394
Being able to care for yourself and your home, perform daily activities	-	32.1	67.9	100	3.1	31.3	65.6	100	.641
Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs	-	19	81	100	-	29	71	100	.415
The place where you live	-	28.6	71.4	100	3.3	40	56.7	100	.372
Being able to see doctors or health workers when you want	-	13.3	86.7	100	-	26.5	73.5	100	.192
General happiness	-	3.4	96.6	100	2.7	24.3	73	100	.038
N	32				38				

Table D.5: Impact of headspace by gender (n=70; in-depth evaluation)

Impact of headspace on	12–17 years					18–25 years					Asymp. Sig.
	Worse	Neither better or worse	Better	Total	N	Worse	Neither better or worse	Better	Total	N	
Mental health	-	13.3	86.7	100	30	-	3.1	91.9	32	100	.140
Physical health	3.1	33.3	63	100	27	-	30	70	30	100	.531
Sexual/Reproductive health	-	75	25	100	12	5	40	55	20	100	.144
Drug and alcohol use	-	35	65	100	20	-	38.1	61.6	21	100	.837
Feelings about bodily appearance	4	56	40	100	25	3.2	51.6	45.2	31	100	.942
Involvement in social/community activities	-	57.7	42.3	100	26	-	53.8	46.2	29	100	.780
Being able to work or find work (paid/voluntary)	-	48.1	51.9	100	27	-	26.1	73.9	23	100	.109
Being able to provide care (for family members, children or other people)	-	40.9	59.1	100	22	-	22.2	77.8	18	100	.209
Being able to go to school, TAFE or university	-	31.9	60.9	100	23	-	33.3	66.7	24	100	.679
How you get on with family	3.2	25.8	71	100	31	-	13.3	86.7	30	100	.266
How you get on with friends	-	33.3	66.7	100	30	-	21.9	78.1	32	100	.312
How you sleep	3.6	42.9	53.6	100	28	3.2	38.7	58.1	31	100	.942
Being able to care for yourself and your home, perform daily activities	-	33.3	66.7	100	30	3.3	30	66.7	30	100	.591
Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs	-	32.1	67.9	100	28	-	16.7	83.3	24	100	.199
The place where you live	-	46.4	53.6	100	28	3.3	23.3	73.3	30	100	.131
Being able to see doctors or health workers when you want	-	26.7	73.3	100	30	-	14.7	85.3	34	100	.235
General happiness	-	18.8	81.3	100	32	2.9	11.8	85.3	34	100	.471

Table D.6: Impact of headspace by geographic area (n=70; in-depth evaluation)

Impact of headspace by geographic area	Worse			Neither better or worse			Better			Total (%)	N	Asymp. Sig.
	Geographic Area			Geographic Area			Geographic Area					
	Rural	Regional	Urban	Rural	Regional	Urban	Rural	Regional	Urban			
Mental health	-	-	-	-	1.6	6.5	1.6	33.9	56.5	100	62	.702
Physical health	-	1.8	-	-	10.5	21.1	1.8	19.3	45.6	100	57	.597
Sexual/Reproductive health	-	3.1	-	-	9.4	43.8	-	15.6	28.1	100	32	.144
Drug and alcohol use	-	-	-	-	12.2	24.4	-	17.1	46.3	100	41	.664
Feelings about bodily appearance	-	1.8	1.8	-	16.1	37.5	1.8	16.1	25	100	56	.725
Involvement in social/community activities	-	-	-	-	13.5	42.3	1.9	17.3	25	100	52	.233
Being able to work or find work (paid/voluntary)	-	-	-	2	10	26	-	24	38	100	50	.323
Being able to provide care (for family members, children or other people)	-	-	-	-	7.5	25	2.5	20	45	100	40	.687
Being able to go to school, TAFE or university	-	-	-	-	10.6	25.5	2.1	23.4	38.3	100	47	.630
How you get on with family	-	-	1.6	-	6.6	13.1	1.6	27.9	49.2	100	61	929
How you get on with friends	-	-	-	-	12.9	14.5	1.6	24.2	46.8	100	62	.530
How you sleep	-	1.7	1.7	-	15.3	25.4	1.7	16.9	37.3	100	59	.868
Being able to care for yourself and your home, perform daily activities	-	1.7	-	-	11.7	20	1.7	21.7	43.3	100	60	.654
Ability to manage emotions and feelings like anxiety and anger without using alcohol/drugs	-	-	-	-	11.5	13.5	1.6	25	48.1	100	52	.625
The place where you live	-	1.7	-	-	12.1	22.4	1.7	22.4	39.7	100	58	.670
Being able to see doctors or health workers when you want	-		-	-	4.7	15.6	1.6	32.8	45.3	100	64	.398
General happiness	-	1.5	-	-	7.6	7.6	1.5	30.3	51.5	100	66	.672

Appendix E: Government sources

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