

headspace — Australia's innovation in youth mental health: who are the clients and why are they presenting?

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headspace National Youth Mental Health Foundation is the Australian Government's major investment in the area of youth mental health.¹ The National Survey of Mental Health and Wellbeing (NSMHW) revealed that one in four young people experience a clinically relevant mental health problem within any 12-month period, compared with one in five in the general population.² Half of a cohort of young people were shown to suffer diagnosable mental ill health at some point during the transition from childhood to adulthood, which reduces fulfilment of their potential and increases likelihood of disability and premature death.³ Australian data are consistent with international trends and the adolescent and early adult years are periods of peak prevalence and incidence for most mental disorders.^{4,5} Yet, despite having the highest prevalence, young people have the lowest level of professional help-seeking for mental health problems across the lifespan.²

headspace was initiated in 2006 to address the concerning mismatch between level of need and amount of mental health service use among adolescents and young adults.¹ The initiative is innovative in targeting the age range from early adolescence through early adulthood, maintaining that the traditional child and adolescent versus adult service divide creates a disjunction at precisely the time when there is greatest need for continuity.⁶ There are now 55 *headspace* centres across Australia, scaling up to 100 centres in 2016.

The approach to service delivery has been described elsewhere,^{1,7} but briefly, *headspace* centres aim to create highly accessible, youth-friendly, integrated service hubs that provide evidence-based interventions and support to young people aged 12–25 years around their mental health, health and wellbeing needs. Each centre is directed by a lead agency on

Abstract

Objectives: To provide the first national profile of the characteristics of young people (aged 12–25 years) accessing *headspace* centre services — the Australian Government's innovation in youth mental health service delivery — and investigate whether *headspace* is providing early service access for adolescents and young adults with emerging mental health problems.

Design and participants: Census of all young people accessing a *headspace* centre across the national network of 55 centres comprising a total of 21 274 *headspace* clients between 1 January and 30 June 2013.

Main outcome measures: Reason for presentation, Kessler Psychological Distress Scale, stage of illness, diagnosis, functioning.

Results: Young people were most likely to present with mood and anxiety symptoms and disorders, self-reporting their reason for attendance as problems with how they felt. Client demographic characteristics tended to reflect population-level distributions, although clients from regional areas and of Aboriginal and Torres Strait Islander background were particularly well represented, whereas those who were born outside Australia were underrepresented.

Conclusion: *headspace* centres are providing a point of service access for young Australians with high levels of psychological distress and need for care in the early stages of the development of mental disorder.

behalf of a local partnership of organisations responsible for the delivery of services, comprising mental health, alcohol and other drug, primary care, and vocational services. The main aim is to improve outcomes for young people by addressing the major barriers to service use for young people,^{8,9} and enabling better access to and engagement in early intervention services that provide holistic and integrated care.

The current study provides the first comprehensive profile of *headspace* clients across the entire national network of the current 55 centres. It is timely to investigate the demographic characteristics of young people presenting to *headspace* centres and their reasons for presentation to determine whether *headspace* is providing early service access for adolescents and young adults with emerging mental health problems.

Method

Participants and procedure

Participants were all *headspace* clients who received a centre-based service

between 1 January and 30 June 2013. This comprised data from 21 274 clients across the 55 current *headspace* centres. The centres have been operational for varying periods of time, including 10 round 1 centres (established in 2007), 20 round 2 centres (2009), 10 round 3 centres (2011), and 15 round 4 centres established in the past 12 months.

A major review in 2012 of routine data collected by *headspace* found that beyond basic demographics, the information was generally of poor quality. Consequently, a new minimum dataset was implemented from the beginning of 2013. This requires young people accessing *headspace* centres and their service providers to enter data into an electronic form about each occasion of service. Data are de-identified by encryption and extracted to the *headspace* national office data warehouse.

Measures

Client demographic characteristics comprised age in years, sex, Aboriginal and Torres Strait Islander background, country of birth, living situation and current occupation.

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1 Proportion of *headspace* clients reporting each main reason for presentation, by sex and age group

	Male				Female			
	12–14 years	15–17 years	18–20 years	21–25 years	12–14 years	15–17 years	18–20 years	21–25 years
Proportion of total male or female clients	13.4%	30.4%	27.3%	28.9%	11.5%	36.8%	27.1%	24.7%
Reason for presenting								
Feelings	62.3%	66.7%	73.8%	76.3%	67.5%	71.9%	70.2%	72.6%
Relationships	19.6%	14.1%	9.3%	8.0%	19.6%	13.3%	8.7%	7.8%
School/work	16.2%	10.2%	4.2%	3.9%	9.9%	6.2%	3.4%	4.0%
Physical health	1.1%	3.4%	4.6%	5.5%	2.4%	5.2%	12.0%	11.8%
Alcohol/drugs	0.6%	3.6%	4.8%	4.3%	0.2%	0.5%	0.9%	1.1%
Vocational	0.1%	1.6%	3.1%	1.9%	0.1%	0.4%	0.9%	0.6%
Sexual health	0	0.4%	0.3%	0.1%	0.3%	2.6%	3.9%	1.6%

Client clinical presentation characteristics were measured through self-reported reason for presentation, as well as by clinician diagnosis according to relevant World Health Organization ICD-10 classifications of mental and behavioural disorders. Level of psychological distress was measured by self-report using the 10-item Kessler Psychological Distress Scale (K10),¹⁰ while stage of illness was estimated by clinicians using the categories of no mental disorder, mild to moderate symptoms, subthreshold symptoms not reaching full diagnosis, diagnosed disorder, periods of remission, or serious and ongoing disorder without periods of remission.¹¹ Days out of role were self-reported,¹² and overall functioning was assessed by clinicians using the Social and Occupational Functioning Assessment Scale (SOFAS).¹³

Results

Client demographic characteristics

The proportion of male and female clients in each age group is shown in Box 1. The peak age of presentation was 15–17 years, and relatively more males presented in the youngest (12–14 years) and oldest (21–25 years) age groups. Overall, 63.7% of clients were female and 35.6% were male, with only 0.7% reporting that they were intersex, transgender or transsexual. The NSMHW showed that 30% of young women and 23% of young men had experienced mental disorder in the past 12 months.¹⁴

There were 7.7% of clients who identified as Aboriginal or Torres Strait Islander, compared with 2011

census data showing that 4.0% of Australians aged 12–25 years identify as Aboriginal or Torres Strait Islander.¹⁵

Clients who reported being born outside Australia comprised 7%, compared with 15% of the population aged 10–24 years in 2007–2008.¹⁶ Consistent with population trends, the most common places of birth outside Australia for *headspace* clients were England and New Zealand. Ninety-four per cent reported speaking only English at home, which compares with 80.3% in the general population aged over 5 years.¹⁷

Over half the clients (57.1%) lived in major cities, while 31.2% lived in inner regional areas, 9.6% in outer regional, and 2.1% in remote or very remote areas. This compares with 2012 estimates from the Australian Bureau of Statistics that 70% of the youth population lived in major cities, 18% in inner regional areas, 9% in outer regional and 2% in remote or very remote areas.¹⁸

Most *headspace* clients had stable accommodation (86.6%), but there were 10.3% for whom accommodation was an issue, 2.4% who reported that they were at risk of being homeless, and 0.7% who were currently homeless. This compares to 0.7% of the Australian population aged 12–24 years who were estimated as being homeless or in marginal housing in the 2011 census.¹⁹ Security of housing decreased markedly with age among *headspace* clients, from 94.0% of those aged 12–14 years to 81.5% of those aged 21–25 years.

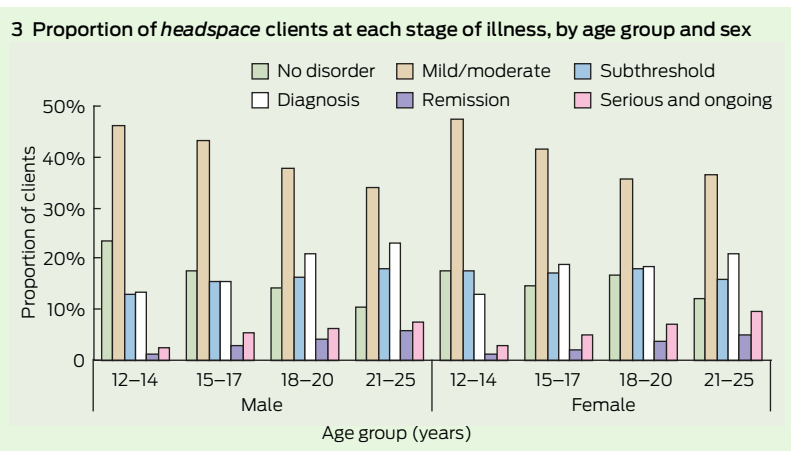
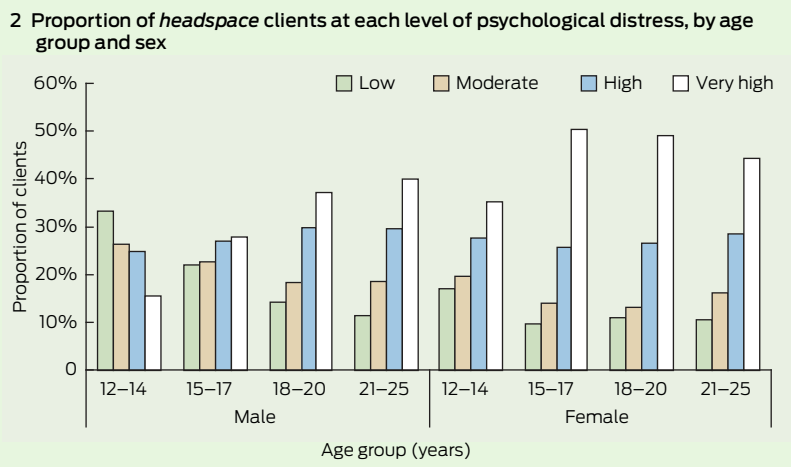
Many clients were currently engaged in education, with 46.7% at school and 21.0% in higher education.

Among those aged 18–25 years, 29.0% were not engaged in employment, education or training, which compares with 27.3% in the population.²⁰

Presentation characteristics

Overwhelmingly, the main self-reported reason for young people presenting at *headspace* centres was having problems with how they felt (71.6%); specifically, almost a quarter first presented feeling sad or depressed (24.9%) and 12.7% were feeling anxious. The next most common reason was having relationship problems (11.4%), followed by physical health issues (6.6%), school/work problems (6.0%), alcohol or other drug problems (1.7%), sexual health issues (1.6%) and vocational concerns (1.0%). Reasons for presenting varied by age and sex (Box 1). Relationship and school issues decreased with age, while problems with feelings increased, especially for males. For females, health and sexual health reasons for presentation increased with age, while alcohol and other drug and vocational issues become more pressing for males.

Over half (69.3%) of the young people attending *headspace* did so with high or very high levels of psychological distress (Box 2). This compares with only 9% in the general community aged 16–24 years, and 21% of young people diagnosed with mental disorder in the NSMHW.¹⁴ Males aged 12–14 years were most likely to present with the lowest levels of psychological distress, while females aged 15–20 years were most likely to present at the highest level of distress. By early adulthood, the distress levels of males and females con-



verged. These patterns were reflected in the mean K10 scores. For males, these increased from 20.7 (standard deviation [SD], 8.2) for those aged 12–14 years to 26.9 (SD, 9.0) for those aged 21–25 years. The increase for females was less pronounced, from 25.7 (SD, 9.4) to 27.7 (SD, 9.1) for those aged 12–14 years and 21–25 years, respectively. Only the younger boys had a mean in the moderate range for the K10; means for all other age groups were in the high-distress range.

Stage of illness development reflected the expected age-related trajectory using a population health approach based on the spectrum of mental health interventions²¹ (Box 3). Overall, there were 14.6% of clients with no mental disorder, 39.6% with mild to moderate symptoms, 16.9% with subthreshold diagnosis, 18.8% with full-threshold diagnosis, 3.5% with periods of remission, and 6.4% with serious and ongoing mental disorder. With increasing age, there were

fewer clients in the no mental disorder and mild to moderate groups, relative stability in the subthreshold group, and increased proportions in the full-threshold diagnosis, remission, and serious or ongoing disorder categories.

These trends were confirmed by self-report of whether prior mental health care had been received. Overall, a third of clients reported never previously seeing a mental health professional. The proportion declined with age: 51.6% of 12–14-year-olds, 41.9% of 15–17-year-olds, 31.5% of 18–20-year-olds, and 26.4% of 21–25-year-olds.

Twenty-nine per cent of clients were estimated by clinicians to have full-threshold, remission, or serious and ongoing disorder, yet almost a third of these had no actual clinical diagnosis recorded at presentation, and a further 6.7% were reported as diagnosis not yet assessed. The most common diagnoses recorded were mood disorders (28.2%), followed by

anxiety disorders (17.3%), adjustment disorder (4.3%), personality disorders (2.7%), developmental disorders (2.3%), substance use disorders (1.8%), psychotic disorders (1.6%) and eating disorders (1.2%).

Self-reported days out of role in the previous 2 weeks revealed a trend of increasing disability due to mental health problems with age. This was most pronounced for males, who were most likely to report no days out of role when aged 12–14 years (55.5%), decreasing to 44.5% for those aged 21–25 years. For females, this decrease was less pronounced, from 41.2% for those aged 12–14 years to 38.4% for 21–25-year-olds. Overall, 40.6% of *headspace* clients reported no days out of role, 22.8% reported 1–3 days, 17.8% reported 4–6 days, 6.2% reported 7–9 days, and 12.5% reported more than 10 days out of role in the past fortnight.

Social and vocational functioning, as reported by service providers, showed a similar pattern. The proportions of clients with serious or major impairment (SOFAS scores <50) were 11.2%, 11.9%, 17.0% and 19.4% for males in each of the ascending age groups, respectively; and 8.1%, 10.0%, 12.3% and 12.6% for females. The mean SOFAS scores were similar across age and sex and closest to the anchor defined as “Moderate difficulty in social, occupational, or school functioning (eg, few friends, conflicts with peers or co-workers)”.

Discussion

These are the first data that describe the young people presenting to *headspace* centres across Australia. Such information is timely, as the initiative is now established and attracting national and international interest. Therefore, it is important to examine whether *headspace* centres are being accessed by their intended target group.

The results show that almost two-thirds of *headspace* clients are female, which partly reflects the sex difference in the distribution of mood and anxiety disorders for this age group within the Australian population.¹⁴ However, in the future, *headspace* will need to respond more effectively to mental ill

health in young men, which typically manifests through substance misuse and behavioural problems, conditions that can mask underlying emotional disorders. The higher proportion of Aboriginal and Torres Strait Islander clients, compared with their proportional representation in the overall population, indicates the need for mental health support in this population group and that the youth-friendly focus of *headspace* centres may be attractive to young Aboriginal and Torres Strait Islander people. In contrast, there is a lower proportion of clients born outside Australia compared with their proportional representation in the overall population, which suggests that some of these demographic groups may still experience significant barriers to service use.

That a third of the young adult *headspace* clients were not engaged in education, employment or training indicates the vulnerability of youth with mental health issues to disengagement from vocational opportunities. This is a situation that must be addressed, particularly during the current period of growing unemployment.²²

headspace is serving young people outside major metropolitan areas — an excellent outcome for Australia, which struggles to provide an effective mental health service response in regional and rural areas.²³ There has been a deliberate strategy to locate *headspace* centres in regional areas, with the aim of eventually providing national coverage so that all young people have reasonable access to services.

The presenting issues for young people attending *headspace* centres are primarily problems with how they feel, mostly related to feeling depressed or anxious. The initiative was set up to better respond to the need for care for such high-prevalence mental ill health in young people. However, formal diagnosis of mental disorder by an appropriately qualified clinician is available for only a small proportion of clients. This partly reflects the multidisciplinary nature of the *headspace* workforce, many of whom are not trained in formal diagnosis and who use psychotherapeutic approaches that are

not diagnosis driven. It also suggests the need for an expanded diagnostic approach that incorporates clinician assessment of at-risk and subthreshold conditions.²⁴ Over half the young people presenting were in the early stages of the development of mental disorder, having mild to moderate or subthreshold symptoms, as specifically targeted by the initiative. Nevertheless, almost 20% had an established disorder and about 10% had a serious ongoing disorder, showing the wide range of clinical presentations that *headspace* centres need to accommodate.

This description of the presenting characteristics of young people accessing *headspace* centres suggests that the initiative is mostly achieving its aim to improve service access early in the development of mental illness, although there are demographic groups where access needs to be improved. Further analyses of the new minimum dataset are planned, to examine the types of services that *headspace* clients are receiving and to determine whether the approach is making a difference to their mental health and wellbeing. Importantly, a process to obtain follow-up data 3 months after young people have received their last service was implemented several months after the initial implementation of the new minimum dataset, and these outcome data will be available for analysis early in 2014. Such analyses, and other evaluation efforts, are required to determine whether *headspace* is delivering on the aims of this innovative initiative.

Competing interests: We are all employed by or directly involved with *headspace* National Youth Mental Health Foundation.

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