

COMMENTARY

Headspace, an Australian Youth Mental Health Network: Lessons for Canadian Mental Healthcare

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Abstract

Objective: To describe political advocacy and scientific debate about headspace, a non-governmental organisational (NGO) substantially funded by the Australian federal government that has significantly impacted the youth mental healthcare landscape. Access Open Minds is a Canadian clinical research initiative for youth mental health partially based on headspace. Lessons from the Australian experience may thus prove useful for Canadian stakeholders. **Method:** The Australian healthcare system, mental health policy and governance for youth mental healthcare are contextually described. The structure and promulgation of the headspace NGO is detailed, as a parallel provider of primary mental healthcare outside of existing public and private mental health services. A review of the existing research on the evaluation of headspace was conducted. **Results:** Headspace has expanded rapidly due to successful political advocacy on behalf of the youth early intervention model, with limited coordination in terms of governance, planning and implementation with existing mental health services. In spite of consuming considerable resources, there has been limited evidence of effectiveness. **Conclusions:** Canadians should be wary of large youth programs that operate outside mainstream mental healthcare because of similar dangers such as poor co-ordination with existing government-funded services, duplication of care, the substantial consumption of resources, and limited evaluation of outcomes. As Access Open Minds is a clinical research project, there is the opportunity for Canada to evaluate the efficacy of the model before further adoption by governments.

Key Words: *headspace, youth mental health, NGO, evaluation, Australia*

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Résumé

Objectif: Décrire le plaidoyer politique et le débat scientifique au sujet de headspace, une organisation non gouvernementale (ONG) substantiellement financée par le gouvernement fédéral australien qui a eu un effet significatif sur le paysage des soins de santé mentale chez les jeunes. **Access esprits ouverts** est une initiative canadienne de recherche clinique qui est en partie fondée sur headspace. Les leçons de l'expérience australienne peuvent ainsi se révéler utiles aux intervenants canadiens. **Méthode:** Le système de santé australien, la politique de santé mentale et la gouvernance des soins de santé mentale jeunesse sont décrits en contexte. La structure et la promulgation décrivent l'ONG headspace comme étant un fournisseur parallèle de soins de santé mentale de première ligne hors des services de santé mentale publics et privés existants. Une revue de la recherche existante sur l'évaluation de headspace a été menée. **Résultats:** headspace a eu une croissance rapide en raison du plaidoyer politique réussi au nom du modèle d'intervention précoce chez les jeunes, de la coordination limitée en matière de gouvernance, de la planification et de la mise en œuvre avec les services de santé mentale existants. Malgré la consommation considérable de ressources, les preuves d'efficacité ont été limitées. **Conclusions:** Les Canadiens devraient être prudents devant ces vastes programmes jeunesse qui fonctionnent hors des soins de santé mentale dominants en raison de dangers semblables à une mauvaise coordination avec les services publics existants, de la duplication des soins, de la consommation substantielle de ressources, et de l'évaluation limitée des résultats. Comme **Access esprits ouverts** est un projet de recherche clinique, le Canada peut y trouver la possibilité d'évaluer l'efficacité du modèle avant que les gouvernements ne l'adoptent plus avant.

Mots clés: *headspace, santé mentale des jeunes, ONG évaluation, Australie*

Introduction

Canada has introduced the Access Open Minds network to address shortfalls in youth mental health (Access Open Minds, 2020). The Access Open Minds model is based, in part, on the headspace program developed in Australia (Malla et al., 2019). As Australians, we have direct experience of non-governmental organisations (NGOs) like headspace and their consequences for our mental healthcare system (Looi et al., 2019). In this commentary, we describe the context, as well as our concerns, about the model and its consequences. Finally, we highlight the implications for Canadian mental healthcare, if the emerging youth mental health sector follows the path of headspace-like programs.

Many mental health conditions begin in childhood, adolescence and emerging adulthood; and youth mental health services for patients from 12 to 25 years are a response to concerns about how the majority of patients seen by child and adolescent mental health services fail to transition to their adult counterpart. Australia is a leader in youth mental health initiatives (McGorry & Mei, 2020), and political advocacy has made youth early intervention into a dominant mental health policy issue in Australia over the last decade (Whiteford et al., 2016). Political advocates have successfully lobbied the Australian Federal government to seize opportunities for headspace as their preferred policy solution (Whiteford et al., 2016). The Federal government first announced substantial funding for headspace in 2006, and funding continues to increase, fuelled by the recognition of headspace as a national 'brand' (Rickwood et al., 2019). The network of 115 headspace early intervention centres

provide treatment for both early psychosis and high prevalence disorders amongst young people aged 12-25 years, with 37 in New South Wales (NSW), 28 in Victoria, 22 in Queensland, 12 in Western Australia, 10 in South Australia, 3 in the Northern Territory, 2 in Tasmania and one in the Australian Capital Territory (headspace, 2020). These centres are primarily situated along the most populous coastal areas of Australia, in both metropolitan and regional areas (headspace, 2021a). Accordingly, we have previously described headspace as an Australian NGO of leviathan-like dimensions, based on its size and political reach (Looi et al., 2019).

Proponents argue that headspace centres meet the needs of an under-serviced population for whom the age boundary between child and adult mental health services at 18 years is inappropriate, because it disrupts continuity of care for psychosis and high prevalence disorders. There is a focus on early intervention, based on the belief that many mental health issues arise in this age range. Headspace centres act as a 'youth-friendly' one-stop-shop for young people who need help with mental health, physical health (including sexual health), alcohol and other drugs, as well as work and study support (headspace, 2021b).

However, there have been persistent questions about the effectiveness of the headspace centres. In response, a media and political campaign on behalf of headspace has changed the terms of the debate from a scientific discussion of the evidence to a partisan contest (Whiteford et al., 2016). Concerns about the efficacy of youth early intervention model have been compared to doubting the consensus on climate

change or tobacco smoking (McGorry & Mei, 2020). The Australian policy debate has thus been framed as a contest between doubt and optimism (Allison et al., 2020; McGorry et al., 2020); the unusually adversarial nature of which may have discouraged contributions to the scientific discourse in Australia (Looi et al., 2020a).

In the current article, we explore how headspace has altered the landscape of mental health service delivery in Australia with major impacts on the resourcing and roles of public sector child and adolescent mental health services, and adult mental health services. The age range for headspace (12-25 years) overlaps both public sector youth and adult mental health services. In Australia, this has led to the diversion of Federal funds from struggling State mental health services.

The context: Australia's health system

Australia's healthcare system is governed by the Federal (Commonwealth) and State/Territory (hereinafter the States) jurisdictions. There is a vertical fiscal imbalance in Australia where the Federal Government raises most of the tax revenue while the States provide most public sector hospital and community mental healthcare (See Table 1). The Federal Government has increasingly been involved in healthcare provision, primarily in funding of private sector and NGO health and social services, but also has the financial capacity to fund discretionary programs such as headspace, and gain the political credit from doing so.

In Australia, child and adolescent mental health services are provided up to the age of 18 years in the public sector by State children's hospitals and associated community services, and in the private sector by the analogous services. The Australian healthcare system is a relatively unique combination of public health services, managed by the States through block allocations of funding from the Federal government and private health services, also partially-funded by the Federal government. In turn, States allocate funding to hospital and community services, such as mental health services. There is a rebate for Australian permanent residents (including landed immigrants, citizens and New Zealanders) when consulting privately practising health care practitioners, including medical specialist, general practitioners and psychiatrists at privately owned practices, hospitals, disability and aged care facilities. Finally, admissions to private hospitals and procedures, as a day or inpatient, are covered by private health insurance. There may be out-of-pocket costs as private practitioners and hospitals can charge more than the scheduled Medicare fee or private insurance rebate, with these costs accruing to the patient (AMA, 2019). The only parts of the system that are free at the point of delivery are state-run public hospitals, outpatient clinics and community services.

In addition, in Australia, there are several NGOs that are largely block-funded by the Federal government. These include headspace, for young people from adolescence into their mid-twenties, and Beyond Blue, for anxiety and depression (Looi et al., 2019). Apart from the very substantial funding from the Federal government, headspace centres also host private mental health practitioners such as psychiatrists and psychologists, whose patients can also claim Federal government Medicare rebates for mental healthcare

Healthcare NGOs in Australia: headspace and related organisations

NGOs such as headspace and Beyond Blue have grown rapidly in size, scope and influence in the mental health space. Their roles include policy, advocacy, media visibility, self-evaluation, and provision of healthcare (Looi et al., 2019; Looi et al., 2020b).

Furthermore, the government's response to crises such as the Australian 2020 bushfires and COVID-19 pandemic has been to allocate still further funding to headspace. In addition, there are plans to extend the model beyond children and youth, with the Federal Government funding Adult Mental Health Centres in a headspace-style model parallel to public and private mental health services (Department of Health, 2020b).

NGOs of the size and influence of headspace raise several challenges for Australian public and private mental healthcare. These include a poor coordination between NGOs and State health services resulting in both providing parallel services for both young people and adults. There is also the concern that resources are being diverted from State-run child and adolescent mental health services, and adult mental health services, given the limited funding pool across the Federal and State governments. Confusion also arises for patients and families from the differing age ranges for public sector mental health services and the NGO headspace, which has introduced more transition points for patients. For example, patients treated for early psychosis at headspace usually face a transition to adult mental health services at age 26. Furthermore, headspace centres frequently refer to State mental health services before age 25 for more severe and complex mental illnesses, resulting in a duplication of effort and intake assessments with additional burdens on young people. Finally, evidence of effectiveness has been limited and deserves further investigation (Looi et al., 2019; Looi et al., 2020b). We further discuss each area of concern in the following sections.

Table 1. The Australian Health System

Funder	Responsibilities	Services
Federal Government (The Commonwealth of Australia)	Block funding to State/Territory Governments for provision of health services	Funding for States/Territories
	Funding of Federal health and social programs	NGO health services, including mental healthcare, such as headspace Disability support services provided via NGOs
	Funding of Primary Health Networks	Funding for Primary Care – GP networks to commission health services, including mental healthcare e.g., these networks have been directed by the Federal government to purchase services from headspace
	Funding of Medicare patient rebates for private consultations	Private medical and allied health care, including outpatient and hospital inpatient care – this includes private sector mental healthcare Patients of private healthcare practitioners situated in headspace are entitled to Medicare rebates
	Funding for Australian Defence Force Veteran’s private healthcare	Private medical and allied health care, including outpatient and hospital inpatient care – this includes private sector mental healthcare
	Funding for Aged Care Services	Aged care services, including Aged Care Assessment Teams, provision of in-home Aged Care via (Non-governmental-organisation) NGO health services and provision of Private Sector/NGO-managed Residential Aged Care Facilities
	State/Territory Government	Funding of State/Territory health services
Private Health Insurance	Funding of private hospital inpatient treatment, services and procedures	Outpatient and inpatient health professional consultations, services (optical, wellness, exercise programs etc.) funding for privately insured patients as determined by the respective private health insurers schedule of fees
Private Sector Patients (out-of-pocket costs)	Co-payment of consultation and procedural fees not covered by private health insurance	Outpatient and inpatient health professional consultations, services (optical, wellness, exercise programs etc.) as well as procedures not covered by private health insurance

Lack of coordination of governance, planning and implementation

There has generally been a lack of coordination and consultation between the Federally-funded headspace program and State mental health services. A major review of mental health care by the Australian National Mental Health Commission highlighted that the creation of headspace mental health centres was conducted without sufficient consultation, leading to:

“...duplication of, and competition with other community, private and state government services....”
p.82 - (National Mental Health Commission, 2014).

More recently another independent Federal agency, the Productivity Commission recommended that if States and the Federal Government ever do pool their funds for mental health it should be possible to.....

“redirect funding hypothecated to headspace centres and other particular providers to alternative services, subject to these services demonstrably not meeting the service needs identified in regional plans.” (Productivity Commission, 2020)

Consumption of finite resources

The Federal government funding for headspace has been substantial. This includes 35 million Australian Dollars (AUD) in 2017-2018 and over AUD263 million in the

Federal Budget of 2019-2020 for future spending over 7 years for headspace and AUD109.7 million for early psychosis intervention, also run, in part, through headspace (Looi et al., 2019). During the COVID-19 pandemic the Federal government committed still more funds: AUD24 million to reduce waiting times at headspace centres because of potential increased demand (Department of Health, 2020a). These totals do not take into account services billed by headspace-based clinicians through Federally-funded Medicare. These are less easily quantifiable, but are substantial given there are over 115 headspace centres that will potentially have private practitioners.

Limited evidence of efficacy

Much of the evaluation of headspace has relied on process measures or uncontrolled basic surveys of attendee's satisfaction with services (Muir et al., 2009; Rickwood et al., 2014). Data on outcomes using standardised instruments are less common and show limited efficacy. Importantly, most of the studies were uncontrolled and thus subject to other potential biases.

An early uncontrolled evaluation of the high prevalence disorder program that used the Kessler-10 (K-10) reported that mean baseline scores in 2222 participants of 28.1 had only decreased to 26.9 on subsequent headspace visits (Muir et al., 2009). Furthermore, attrition was significant with data only available on 889 subjects (40%). It is possible that these were cases with the best prognosis. The authors themselves acknowledged that

“...it is difficult to attribute any of these changes to the use of headspace services.” (Muir et al., 2009)

A subsequent evaluation found that only 21.1% of headspace attendees experienced clinically significant change on the K-10, meaning that 78.9% of clients had no clinically significant benefit (Rickwood et al., 2015). Furthermore, only 37% showed clinically significant psychosocial improvement on the Social and Occupational Functional Assessment Scale (SOFAS). An observational study (Hilferty et al., 2015) reported effect sizes for improvements in psychological distress of -0.11 compared to no treatment, and -0.16 compared to other treatments, results which were statistically but not clinically significant (Goldney, 2020). Another non-experimental study relied on the absence of clinical deterioration as an indicator of effectiveness (Cross et al., 2018). As a result of this low bar, the rather disappointing finding that most patients showed no reliable change, and only a quarter to a third reliable improvement, was seen as evidence of success (Jorm, 2018). A further small study without controls (n=77) reported statistically

significant benefits of moderate effect size on the K10. However, the number of participants identified as being in a “lower” clinical stage of illness by the end of their treatment was not statistically significant (Schley et al., 2019). In consequence, other authors have concluded that this

“...expansion has occurred in the absence of any evidence that headspace services are actually effective in improving youth mental health.” (Jorm, 2015).

This is especially of concern given that

“Resources for mental health services are finite, and new treatments and innovative programmes should be rigorously tested with convincing outcome data, rather than simply process data, before being introduced widely, no matter how much superficial appeal they have.” (Goldney, 2020)

Advocates of headspace have claimed that their programs will positively impact youth population mental health outcomes, which has likely contributed to their increased government funding allocations. However, despite the significant increase in youth mental health service funding and provision through headspace, youth mental health outcomes have worsened since 2015. For instance, rather than decreasing with the expansion of headspace, the prevalence of very high and high psychological distress levels in youth populations has increased from 15% in the decade from 2003 and 2014 to 22% since 2015 (Jorm & Kitchener, 2020). However, it remains possible that recent public interest and discourse regarding youth psychological distress may increase self-reported distress.

Nevertheless, the public health evidence so far suggests that the headspace program has failed to deliver on its initial and ongoing promise of improving youth mental health outcomes.

Contexts for Canadian mental healthcare

The Australian experience with headspace may provide an early warning for Canadian governments, about the need for better integration of the emerging youth service sector, given similarities in the health care systems of both countries and the similar Australian population, of 25 million. Canadians should be hesitant about large programs that operate outside mainstream mental health services leading to similar dangers of poor co-ordination with existing services, duplication of care, overlapping age ranges, the substantial consumption of funding and resources, and limited evaluation of outcomes (Looi et al., 2019), as well as the potential for politically adversarial advocacy by proponents that can deter scientific debate (Looi et al., 2020a).

If such programs are widely introduced in Canada, there are potential examples of good practice from Melbourne where headspace centres have been successfully integrated into public mental health services (Looi et al., 2020b). The key aspect of this model is that the public mental health service is the lead agency, allowing for harmonisation of processes, avoiding additional age cut-offs for services, and inter-operability of care provision, as headspace is an integrated part of the public system. For example, there is a single point of entry for youth mental health that flows through to coordinated services.

Access Open Minds is an introductory model, jointly funded by the Canadian Institutes of Health Research (the Canadian equivalent of the Australian National Health and Medical Research Council) and the Graham Boeckh Foundation as an embedded clinical research project (Goldbloom, 2019). This is in contrast with Australian Federal government funding for headspace where resources have been allocated in the absence of rigorous evaluation.

Access Open Minds has published a detailed research protocol (Iyer et al., 2019). Although the primary objectives are focused on process measures, such as early case identification and reducing treatment delay, improved outcomes are mentioned as a secondary measure (Iyer et al., 2019). Comprehensive clinical outcome evaluation of the Access Open Minds is thus possible and recommended, before further adoption of the model, in contradistinction to headspace.

In recommending consideration of clinical outcomes, it remains important to be aware that there are other outcome measures that may be of significance, such as a youth voice in co-design, engagement and patient satisfaction, and accessibility for youth that have been historically marginalised (e.g., indigenous people, ethnic diversity, gender diversity, people with disabilities) (Hawke et al., 2019).

There are also other initiatives in Canada, not based on headspace, such as the Toronto-based YouthCan IMPACT project, that aims to implement an integrated youth service model, with an embedded pragmatic randomised control trial as part of the evaluation (Henderson et al., 2020). Accordingly, Canadians may soon have more comprehensive data on the effectiveness of local youth mental health interventions.

The space agency, NASA, has an unofficial motto in the Johnson Space Center, “*In God we trust – All others bring data*” (Kohut, 2012). Based on the Australian experience, Canadians are encouraged to tune into the evidence, drop into the debate, and check-out the most useful youth mental health interventions, thus potentially escaping the perils of headspace-like NGOs.

Conflicts of Interest

The authors have no financial relationships to disclose.

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