Service Innovation Project Component 2: Social Inclusion Model Development Study

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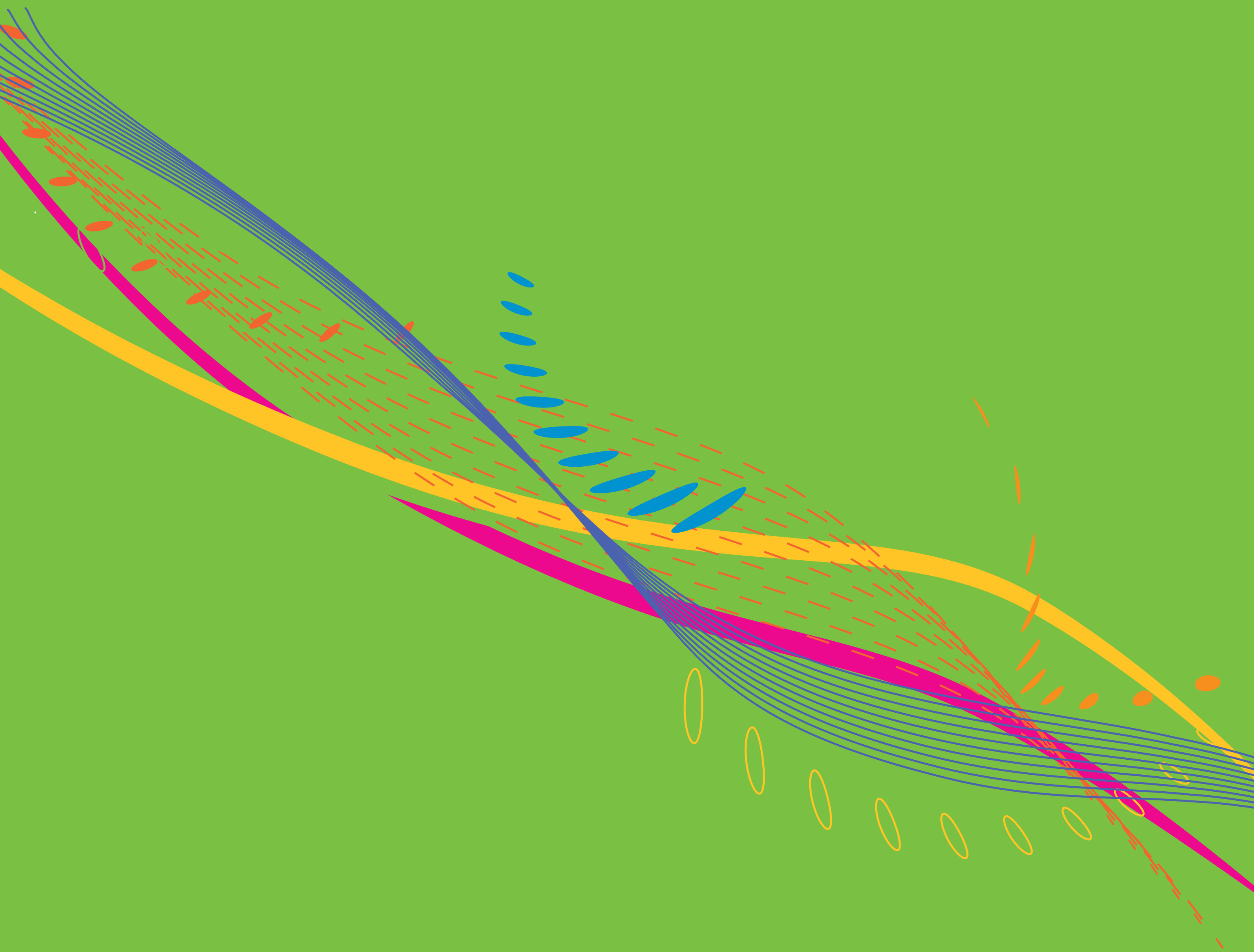
1. Background



1. Background

1.1 Service Innovation Project

The Service Innovation Project (SIP) aimed to identify, develop and trial innovative approaches to ensure that **headspace** centres are informed by the best current evidence and resources that support improving the quality and effectiveness of services to young people.

The SIP has three components: Components 1 and 2 aimed to develop the evidence base to inform centre practice and identify priority areas that the **headspace** centres need to focus on to improve service delivery to young people. Component 3 involved centres testing innovative and targeted approaches for improving engagement and outcomes for disadvantaged and excluded young people, to guide the development of resources and tools that could be rolled out nationally to enhance service provision. Together, these components inform development of the **headspace** model and build the evidence base, which will directly benefit the work of all existing and future **headspace** centres by enabling them to implement best practice approaches to working with all young people.

Component 1 – headspace Centre Best Practice Framework

This component comprised investigating views on implementation of the **headspace** centres to identify and document a best practice **headspace** framework. Identifying a best practice framework enables the sharing of effective practice and approaches across the centre network in order to optimise engagement and service outcomes for young people. This component has been completed and a report is available at http://headspace.org.au/corporate-and-governance/publications/

Component 2 – Social Inclusion Model Development Study

This component involved examining the facilitators and barriers for young people accessing and engaging with **headspace** services from specific population groups with high levels of need that are less likely to access mental health services – specifically young people who are: young males; lesbian, gay, bisexual, trans*[1], intersex, or questioning their sexuality or gender; Aboriginal and Torres Strait Islander; from culturally and linguistically diverse backgrounds; have co-morbid mental health and alcohol and other drug problems; or are homeless. This component enables the development of approaches that can ensure that **headspace** centres can effectively engage young people from more marginalised population groups to access required services and supports.

Component 3 – Centre Demonstration Projects

Centre based demonstration projects were implemented in Component 3, with grants provided to **headspace** centres through a submission process. These grants enabled interested centres to test innovative service approaches to target and engage specific at-risk groups of young people and identify best practice approaches and frameworks to be implemented nationally. Two rounds of grants were implemented from mid-2013 to mid-2015.

There were nine funded SIP grant projects:

- Linking carers through an innovative moderated online social therapy program (**headspace** Glenroy)
- 'All in' with the Inala Elders and the Suicide Prevention and Mental Health Program (**headspace** Inala)
- Training allied health professionals to deliver a brief physical activity intervention in addition to standard clinical care for young people with depression (**headspace** Collingwood)
- The **headspace** Family Inclusive Practice Model (**headspace** Murray Bridge)
- Responding to the impact of childhood trauma on the mental health and wellbeing of complex young people (**headspace** Midland)
- Training for Change – Improving the mental health outcomes for LGBTIQ youth (**headspace** Wagga Wagga)
- Choices about Healthcare Options Informed by Client Experiences and Expectations – The CHOICE Pilot Project (**headspace** Gosford)
- Refugee and Asylum Seeker Youth Mental Health Engagement Project (**headspace** Dandenong)
- my**headspace** – An online application to enhance engagement of young people with **headspace** centres (**headspace** Canberra)

A summary of the SIP Component 3 projects can be accessed at https://extranet.headspace.org.au/sites/centres/SIP/SitePages/Home.aspx

[1] Trans* is used as an inclusive term to capture transgendered and transsexual gender identities

1.2 The current report: Component 2 – Social Inclusion Model Development Study

This document reports the methodology and findings from Component 2 of the Service Innovation Project. The Social Inclusion Model Development study was undertaken between December 2013 and February 2015, and aimed to develop an understanding of the unique barriers and facilitators to accessing and engaging with **headspace** centres for young people from particular population groups. The population groups were those that have been shown to be less likely to access mental health care and **headspace** centres, and included young people who were: young males; lesbian, gay, bisexual, trans*, intersex, or questioning; Aboriginal and Torres Strait Islander; from culturally and linguistically diverse backgrounds; had co-morbid mental health and alcohol and other drug problems; or were homeless.

The focus of this study was on factors that affect *access to services*, or the initial approach by a young person to the service, and *engagement with services*, which comprises actions to remain with the service for the period that the young person requires support. The outcomes of this study will inform ways that the **headspace** model can be improved to better meet the needs of these young people. The identification of unique barriers or facilitators could be translated into modifications or enhancements to the **headspace** centre model that will empower young people from these groups to have greater access and engagement with required mental health services and supports.

This report is presented as a series of chapters that can be read collectively or independently, dependent on the reader's specific area of interest. Chapter 1 provides a brief overview of the study, the methodology and the rationale. Chapter 2 provides a summary of the overall findings and implications that have emerged across all groups. These findings are discussed in the context of the findings from all three components of the Service Innovation Project to inform the development of recommendations and potential strategies to enable **headspace** centres to better engage young people from each of these marginalised groups. Following this a comprehensive chapter on each of the six population groups, which includes a literature review, detailed results, a summary of the findings and recommendations specific to improving service delivery for the specific group, and references.

1.3 Methodology

There were four distinct methodological approaches applied throughout the Component 2 project. These were:

1. a systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care among young people from each population group – which aimed to determine how the current literature could inform understanding of barriers and facilitators
2. information on **headspace** clients derived from the **headspace** Minimum Data Set (April 2013 to March 2014) – which provided comparative data on service use characteristics of young people from each of the population groups and to total **headspace** client group
3. interviews and focus groups conducted with young people, family members and service providers relevant to each of the population groups – which aimed to provide rich qualitative information about the access and engagement experiences of young people in each of the population groups
4. clinical file reviews of young people from each of the population groups – which aimed to establish the barriers and facilitators that were evident in clinical files for young people from each of the population groups.

The combined methodology aimed to describe barriers and facilitators, needs and pathways to accessing and receiving care for young people from each of the population groups, and identify modifications or enhancements to the **headspace** centre model that would enable **headspace** centres to reduce the barriers and empower young people from these population groups to access and engage with required mental health services and supports.

A comprehensive Methodology is provided in Appendix A.

1.4 Rationale

In Australia, one in four young people have experienced a mental disorder in the previous 12 months, a higher prevalence than all other age groups (Australian Bureau of Statistics, 2008). Mental disorders account for almost 50 per cent of the burden of disease among 16-25 year olds (Australian Institute of Health and Welfare, 2011). Despite the high prevalence and significant disease burden, only 25 per cent of young people with a mental health problem had accessed a mental health service in the previous 12 months (Australian Bureau of Statistics, 2010).

Good mental health is fundamental to quality of life and wellbeing, and mental health problems can have a profound impact on young people, who developmentally are experiencing significant social, emotional, cognitive and physical changes (Hill, Pawsey, Cutler, Holt, & Goldfeld, 2011). Ongoing mental disorders affect people's living situation and quality of life (Eklund & Sandlund, 2012), impacting areas such as physical health, social development, educational and occupational opportunities and importantly the transition into adulthood (Rosier & McDonald, 2011).

Although help-seeking behaviours are fundamental to mental health and wellbeing, young people tend not to seek help. Rather, many young people need to be encouraged to seek help early and from appropriate sources (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Common barriers that impede the help-seeking process for young people include the following (Jorm, Wright, & Morgan, 2007; Rickwood, et al., 2005; Wright & Jorm, 2009):

– poor mental health literacy
– lack of knowledge about where to seek help
– negative attitudes towards professional help-seeking (often derived from negative past experiences)
– embarrassment or concern about what others think
– preference for self-reliance
– fear of stigma, and
– concerns regarding confidentiality.

While young people overall are reluctant to seek mental health care, there are some groups of young people for whom these common barriers are exacerbated and additional barriers exist, creating increased risk of untreated mental health problems and poorer outcomes (Jorm, et al., 2007; Rickwood, et al., 2005; Wright & Jorm, 2009).

Young people from the following population groups have been identified as having significant unmet need with respect to mental health care: young males (Rickwood, 2012); those who identify as lesbian, gay, bisexual, trans*, intersex, or questioning (Ciro et al., 2005; Nelson, 1997); Aboriginal and Torres Strait Islander people (Blair, Zubrick, & Cox, 2005; Silburn et al., 2009); people from a cultural or linguistically diverse background (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009); those who have alcohol and other drug problems (Anderson & Gittler, 2005); and those who are homeless (Crowley, 2012).

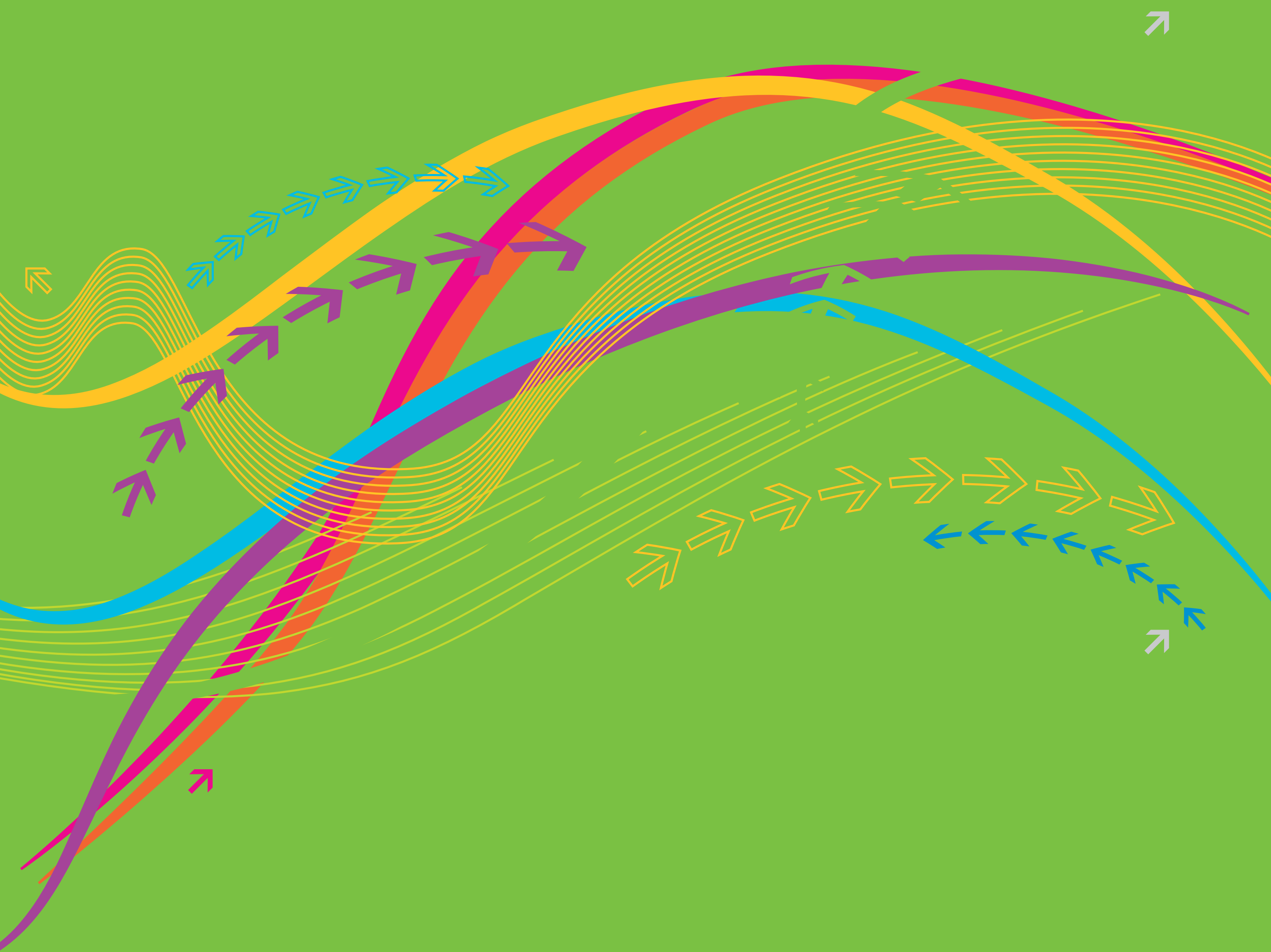
These groups are recognised as having significant unmet need with respect to mental health care. In particular, young people who are marginalised are at greater risk of lack of access to and engagement with appropriate health care. Marginalisation relates to individuals who are at a greater risk of social exclusion because of their limited access to the resources and opportunities needed to fully participate in society. Marginalised people experience a complex, mutually reinforcing mix of economic, social, health and early-life disadvantage, as well as stigma (Cruwys et al., 2008). Young people from marginalised groups seek help for mental health problems at a rate considerably less than others in the community (Lamb, Bower, Rogers, Dowrick, & Gask, 2012). While there is very little research on the help-seeking behaviours of young people in marginalised groups, for adults, the evidence shows that treatment access is often blocked by: cultural views of mental illness and therapy (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002); concerns regarding confidentiality (Palmer & Ward, 2007); stigma and feelings of shame (Chew-Graham, et al., 2002; Warfa et al., 2006); and a reluctance to understand their problems as mental health problems (Lamb, et al., 2012).

headspace recognises that entrenched prejudice and discrimination against members of many marginalised groups can seriously affect the health and wellbeing of those who are judged on the basis of their gender, ethnicity, health status, religion, sexuality or gender identity. **headspace** is committed to the celebration of diversity and raising awareness of the negative effects of culturally entrenched attitudes (**headspace**, 2011). **headspace** services aim to be accessible, acceptable, appropriate, and sustainable for all young people in Australia (Rickwood et al., 2014).

The aim of the current project was to determine the facilitators and barriers for young people accessing and engaging with **headspace** services from the following population groups. These groups were anticipated to have additional needs regarding access to **headspace** services, and this study aimed to identify any unique needs they might have in relation to their access and engagement. This knowledge will further inform **headspace** best practice to ensure the inclusion of young people from all population groups, including:

– young males
– young people who are lesbian, gay, bisexual, trans*, intersex, or questioning
– young people who are Aboriginal and Torres Strait Islander
– young people from culturally and linguistically diverse backgrounds
– young people with co-morbid mental health and alcohol and other drug issues, and
– young people who are homeless.

2. Key Findings and Implications



2. Key Findings and Implications

2.1 Summary of barriers and facilitators

A summary of the barriers and facilitators identified through the different research components is provided in Table 2.1, showing how they were endorsed across each of the population groups. The barriers/facilitators are presented in order of greatest to least endorsement across both the domains. The table shows that most barriers were endorsed by several population groups and there were very few that were unique. Barriers were mostly likely to be in the personal and interpersonal domains and there were somewhat fewer facilitators in these areas. The structural issues appeared to be more evenly spread across both barriers and facilitators.

The table also indicates which barriers and facilitators were specifically endorsed in the **headspace** Best Practice Framework report. It is important to note that the research from that report came from all young people accessing **headspace** services, and was not focused on young people from specific population groups. It is notable that many of the barriers and facilitators identified for young people from the more marginalised population groups in terms of service use were also identified as barriers and facilitators for all young people. This is particularly the case for structural barriers and facilitators, most of which are commonly endorsed. More personal barriers were evident for young people from the more marginalised population groups, which may be due to more in-depth probing, but may also reveal that these young people do experience a wider range of personal barriers to service access and engagement, and that they frequently experience multiple barriers.

This suggests that best practice in youth mental health care is similar for young people from all backgrounds, although additional effort and emphasis is required to ensure access and engagement for those for whom the barriers are even stronger, more personal and diverse, and who experience multiple barriers.

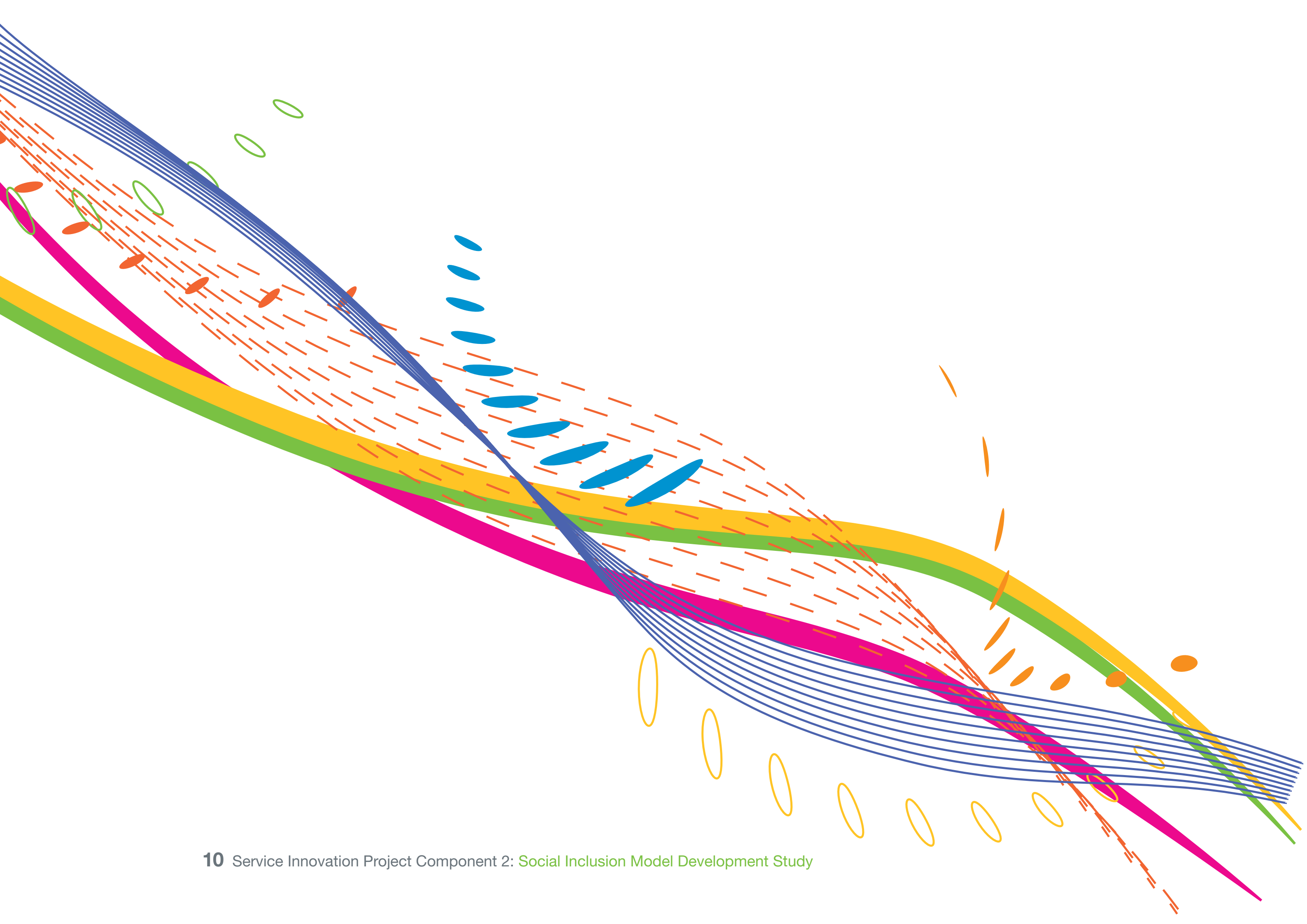


Table 2.1 Endorsement of barriers and facilitators by population group

Barriers	Males	LGBTIQ	Indigenous	CALD	AOD	Homeless	Facilitators	Males	LGBTIQ	Indigenous	CALD	AOD	Homeless
Personal & Interpersonal													
*Fears about being judged or not understood	•	•	•		•		*Openness and acceptance by staff and service	•	•		•	•	
*Confidentiality concerns		•	•	•	•		*Confidential service		•	•	•		•
Unfamiliar with therapy process or talking about emotions	•	•	•		•	•	*Good rapport and trust with staff		•		•	•	
*Stigma	•	•	•	•	•	•							
Community shame			•	•									
Lack of awareness and acknowledgement of need for mental health care	•	•	•	•	•		Targeted messaging	•			•		
Reluctance to seek help outside of family or culture			•	•			Strong relationships with families, communities			•	•		
Relationships with families and communities				•									
Rigid and culturally inappropriate approach to treatment			•				Flexible and culturally respectful approach to intake and treatment	•		•	•	•	
Lack of motivation to attend	•				•	•							
Negative past experiences with services					•								
Language difficulties				•									
More immediate basic needs						•							
Lack of family or social support						•							
Structural													
*Lack of awareness of available services	•	•		•		•	*Health and service promotion (and confidentiality)			•		•	•
*Uncomfortable physical environment (e.g. waiting area and service rooms intimidating)	•		•				Welcoming environment (e.g. displays of Indigenous art work, LGBTIQ flag)		•	•	•	•	
							Non-clinical environments (e.g. outdoor spaces)			•			
*Transport		•	•		•	•	*Support with transport		•	•			•
Negative experiences with intake process	•		•			•	*Positive initial contact	•					
*Long wait times					•		*Short wait times		•	•		•	
*Opening hours					•		*Extended opening hours					•	
Appointment-based					•	•	Drop-in					•	•
							Outreach services			•		•	•
Restricted resources and staff		•			•	•	*Collocation and links with other services, one-stop-shop	•	•		•	•	•
*Difficulty navigating the system	•						*Support in navigating the system				•		
*Availability of preferred worker demographic	•		•				*Availability of preferred worker demographic	•					
							*Low cost service		•				

* Also endorsed in the **headspace** Best Practice Framework report

Indigenous refers to Aboriginal and Torres Strait Islander people

Accepting, non-judgemental staff and good rapport with young people

One of the most common barriers was the fear of being judged or not understood, specifically by the service providers from whom the young person was seeking support. A corresponding facilitator was having open, accepting, friendly and non-judgemental staff. As either a barrier or facilitator, acceptance and judgement by staff was noted by all groups except the young people who were homeless. Staff attitudes and their approach to young people is clearly a service factor that is important for all young people, as it was raised as an essential service component by young people in the **headspace** Best Practice Framework report (Rickwood, et al., 2014). Nevertheless, while open and accepting staff is essential for all young people to feel comfortable accessing services, it seems to be even more critical for young people from more marginalised population groups, who may have additional concerns around being judged or not accepted.

A related facilitator was good rapport and trust with staff. This was especially noted by young people who were LGBTIQ, from CALD communities or had AOD problems. Not only is the initial contact with reception and intake staff critical, but also the ongoing rapport and trust developed with key service providers within the service. Staff attitudes and their ability to connect with young people are critical to initial and ongoing engagement.

Young people from almost all the groups identified being unfamiliar with the processes of therapy and having difficulties talking about emotions. These are well established barriers for most young people, and particularly young men. This means that staff need to be able to put young people at ease and help them overcome anxieties related to lack of knowledge of treatment practices and processes and difficulties expressing their concerns and emotions.

Additional ways to help young people know what is likely to happen during therapy and to help them identify and disclose their concerns are paramount. Ways to address this can include service additions and technological innovations. Component 3 of the SIP project comprised service innovations related to young people disclosing their concerns and treatment progress through the use of an online application called 'my**headspace**' (**headspace** Canberra[2]) and the 'Choice project' that developed a peer support approach around what to expect from services and support for shared decision making (**headspace** Gosford[2]). Additionally, the development of detailed virtual tours and targeted community awareness campaigns could assist in demystifying what happens during therapy for both young people and their family and friends.

For young people with alcohol and other drug problems, a unique barrier reported was negative past experiences with service providers. This may reflect unsuccessful prior help-seeking, where problems were either not taken seriously or where the young person was reluctant or in denial of need for professional help. Consequently, exceptional engagement skills are needed by staff to ensure good rapport and trust with young people with comorbid alcohol and other drug problems.

headspace has had a major focus on ensuring that centre staff are welcoming and accepting of all young people regardless of their presenting issues and personal characteristics. Recruitment and training must continue to prioritise this, as it is clear that the ability of staff to connect quickly with young people in an open and accepting way is fundamental to successful engagement. The importance of staff attitudes to young people cannot be overstated.

There is evidence that **headspace** centre staff are very effective in this regard. Service satisfaction data that are collected routinely from **headspace** young people at regular intervals during their service provision show that satisfaction with staff is very high. Furthermore, satisfaction with staff is the highest component of overall centre satisfaction (Rickwood et al., 2015), clearly demonstrating the critical role of having the right staff who excel at engagement with young people in **headspace** centres.

Confidentiality

It is unsurprising that the issue of confidentiality arose as a barrier/facilitator for almost all groups. Again the Best Practice Framework report notes that confidentiality is an essential issue for all young people. It is particularly relevant during adolescence and early adulthood because young people are growing in their independence, and increasingly expect and need their autonomy to be respected.

Young people are often not sure what is meant by a confidential service, however, or the ways that confidentiality is maintained. Several young people across different population groups raised the issue that **headspace** could promote the confidentiality of its services more strongly, so that young people were fully aware of this aspect of the service. It was argued that this was a critical aspect in determining whether young people would access services.

[2] https://extranet.headspace.org.au/sites/centres/SIP/SitePages/Home.aspx

Knowing that the service was confidential was essential to engaging young people from more marginalised groups. For service providers, training and orientation could reinforce how important confidentiality is to young people and remind them of the need to explore this thoroughly with each and every young person accessing their service.

The issue of confidentiality is somewhat more complex for parents and families, however, and many parents want to be very engaged in their young person's care. The role of the family and the information they are provided needs to be carefully negotiated throughout the episode of care and clearly conveyed to all parties. Families are important to the wellbeing of all young people, and especially for younger adolescents. The role of family and confidentiality for young people who are not considered mature minors must be carefully considered and clearly conveyed. Component 3 SIP project provides guidance on implementing a brief family inclusive approach within **headspace** services (**headspace** Murray Bridge[3]). The use of virtual tours and targeted information for family and friends could also assist in demystifying the therapy process and help family members feel more informed of the treatment process generally.

Stigma, community awareness and acceptance

Invariably, stigma was raised as a barrier by all groups. This comprised both the stigma of mental illness in general, as well as the stigma of seeking help. Young people from all groups were particularly keen to keep their service use from their social networks, but were also concerned about finding out that they were mentally unwell as this was not a label they were keen to take on. While **headspace** has put considerable effort into reducing the public and personal stigma of mental illness, continued effort in this area is clearly warranted.

Additional stigma elements were evident for young people from Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities. For young people from more collectively focused communities, the concept of community shame was an access and engagement barrier. This was mostly related to members of their community finding out that they had sought formal help for their personal problems, which was a source of personal and family shame in their community. In Aboriginal and Torres Strait Islander communities, and many culturally and linguistically diverse communities, there is a heightened sense of shame attached to not being able to deal with your personal problems yourself and an expectation of keeping problems within your family.

A related barrier for young people in these groups was reluctance to seek help outside the family or their own culture. Again, strong cultural mores are evident in many communities that work against professional help-seeking from mainstream services. The youth health service approach can be either unknown or viewed with suspicion by families and elders from non-Western communities. A facilitator to overcome such barriers is the development of strong relationships with the community and young people's family members. This requires becoming a visible and trusted service provider within the communities. Different communities will require different approaches, but identifying key people within the community and building trusted relationships with them are an important starting point. Two Component 3 SIP projects focused on engaging young people from Aboriginal and Torres Strait Islander (**headspace** Inala[3]) and the Afghan communities (**headspace** Dandenong[3]) and provide useful insights into improving access for young people from these communities.

Promotion of availability and confidentiality of services. A facilitator strongly related to the personal and interpersonal issues of stigma and awareness, was promotion of **headspace** services so that young people and their families and communities from all backgrounds were aware of **headspace** services and what they provided. This requires targeted media and community messaging about the availability of services. Importantly, explicit information about the confidentiality of services was shown to be essential information for young people from many of the marginalised groups.

Flexible, tailored, culturally appropriate approaches to engagement and treatment

An overarching lack of awareness of the need for mental health care was evident among almost all groups. This was exacerbated in some cultural groups that did not even recognise the existence of mental illness. Young men also showed a help-negation effect whereby traditional male role expectations worked against acknowledging mental health problems and the 'weakness' of seeking professional support. A facilitator identified for some of these groups was carefully targeted messaging that was tailored to the particular beliefs that were acting against seeking help. Generally, these messages needed to speak directly to the affected young people and show in a language that was meaningful to them that they did not need to put up with emotional distress and could obtain appropriate help that would not stigmatise and culturally disempower them.

[3] https://extranet.headspace.org.au/sites/centres/SIP/SitePages/Home.aspx

Many of the other barriers seemed to pertain to the need to provide a flexible and tailored approach to each individual young person; that addressed their particular demographic characteristics and presenting modes and issues. Clearly, each group of young people see their issues as unique – either as a population group or personally – even though many of their concerns are pervasive.

Intake processes. The intake process was both a personal and structural barrier and requires special mention. Intake could be either a negative or a positive experience, and this first impression was clearly critical for many young people, and particularly young males. The experience young people have when they first access a **headspace** centre, including the physical setting, needs to be positive, non-judgemental, accepting and hopeful. How to be this to young people from every possible background can be challenging, but the Component 3 SIP projects identified some very simple but powerful ways to promote acceptance and inclusiveness. This included having Aboriginal art and the Aboriginal and Torres Strait Islander flags on display (**headspace** Inala[4]). It also included having posters and messages that showed that the service acknowledged young people who were LGBTIQ (**headspace** Wagga Wagga[4]) and from different cultural groups (**headspace** Dandenong[4]).

For young people from Aboriginal and Torres Strait Islander communities, there were particularly strong barriers from rigid and culturally inappropriate approaches to treatment. Young Aboriginal and Torres Strait Islanders may need treatment approaches that are highly adapted from the usual conventions of Westernised treatment. This can include spending much longer on engagement and being less focused on assessment during initial sessions, and adopting less clinical approaches, including having therapeutic conversations outside clinical rooms in more natural and less clinical settings. Being aware of the cultural needs of young people who are Aboriginal and Torres Strait Islander is essential and require additional training as well as access to cultural advisors and expertise.

Lack of motivation to attend services was noted as a barrier for several groups, specifically young males, those with alcohol and other drug problems, and homeless young people. Focusing on motivational aspects within treatment is, therefore, likely to be key to ongoing engagement for these young people.

Obviously, language barriers can be significant for young people who are not English speaking. Enabling access to interpreters and working effectively through them with young people, and also with their families, can be a considerable challenge. This is particularly the case for young people from language groups where access to interpreters is lacking. Consequently, ways to help young people from culturally and linguistically diverse backgrounds improve their English, as well as access to interpreters, are important elements of the **headspace** model (see **headspace** Dandenong project).

The overarching message for services, however, is that young people need to be seen as individuals with unique needs that are acknowledged and addressed. Each young person comes with a particular socio-cultural context that needs to be acknowledged and addressed in a way that is accepting and non-judgemental.

Structurally, the availability of a service provider who matched their demographic characteristics (such as being from the same gender or cultural group) was noted as a barrier/facilitator for young men and young people who were Aboriginal and Torres Strait Islander. Some of the young people from these groups noted this as a potential preference that would help them to engage.

Homelessness

Young people who were homeless had some unique barriers and specific needs. For these young people, having more immediate basic living needs and a notable lack of family and other informal support were prominent barriers.

This reveals the importance of acknowledging the need to address the basic needs of housing, safety and daily living skills for homeless young people and using support for basic needs as ways to encourage them to access services. The lack of supportive social networks means that these young people need to be accessed directly through outreach and more flexible service delivery, including providing ways to meet their more immediate survival needs. Presently, this can generally only be achieved by working in close partnership with service providers specifically focused on homeless young people. Identifying such service providers within the local community and working with them is essential for **headspace** centres to effectively engage with young people who are homeless. Clearly describing this model to young people will assist in developing an understanding that additional service providers will be working in partnership with **headspace** centres to provide the care required.

A structural component that was a strong facilitator for homeless young people was the provision of a 'one-stop-shop' approach. Having a range of their needs met in one service setting was reported as important. With their additional access barriers related to lack of transport and need to focus on daily living challenges, not having to negotiate multiple service providers and multiple settings was a notable preference and advantage. Working through specifically targeted services for young people who are homeless and adding a **headspace** perspective to these services can be a good first step to better integrate services for homeless young people.

[4] See https://extranet.headspace.org.au/sites/centres/SIP/SitePages/Home.aspx

Instrumental factors that enable access

Many of the structural barriers related to enabling physical access in more flexible ways. Foremost was transport support to get to **headspace** services. Lack of access to low-cost transport was an issue in one way or another for most young people. Those without strong family support, their own transport or income to pay for transport were particularly vulnerable. The further young people lived from the **headspace** centre, the more problematic transport became.

The standard appointment-based 9 to 5 approach was also not appropriate, and many young people needed service access in other ways. This included extended opening hours, after 5pm and on the weekend. It also included availability of some drop-in options. This was noted mostly by young people who were homeless or had alcohol and other drug problems, for whom time management, daily hassles and crises, and transport made attending appointments difficult. Recognition of the real challenges these young people face in attending appointments and being more flexible in response are helpful. Outreach services were also proposed as a way to enable better access. Outreach was also valued by young people from Aboriginal and Torres Strait Islander communities, where this could help with transport problems and other inhibitors to attending at the centre.

Not surprisingly, short wait times were singled out by young people in many of the groups. Being able to access services when required and when they were ready to do so was a facilitator to service use and engagement, to capitalise on what can often be a fluctuating or fragile motivation to change.

Somewhat surprisingly, having a low cost service was only noted as a facilitator by a few young people in the LGBTIQ population group. This may be because the young people in the interviews and focus groups, as well as their service providers, were generally aware that **headspace** services are no or low cost.

Inviting physical setting

The physical environment of the **headspace** services was noted by young people in almost all the groups as an important aspect of access and engagement. In particular, the waiting room needed to be welcoming, safe and comfortable. To be welcoming of all young people, having art and poster work that acknowledged the diverse backgrounds of young people coming to **headspace** was needed. Simple gestures such as Aboriginal artwork and posters recognising different cultural groups and LGBTIQ young people helped young people feel accepted and at ease.

For some young people, having areas in the waiting area that were more private was also ideal. This was noted by young men and by young people transitioning gender. Options for greater privacy while waiting for services were pertinent for young people who felt particularly vulnerable to personal stigma.

Therapy rooms that did not look like a typical clinical environment, and options for services to take place outside the usual clinical rooms, including outside, were adaptations that could help engage some young people who found a traditional clinical environment particularly off-putting. Again, these features were noted by all young people in the Best Practice Framework, but were particularly pertinent to young people from the more marginalised service access population groups. Combined with the findings that low cost treatment and flexible appointment times are important to marginalised young people, this indicates the possible need for **headspace** centres to shift from more traditional models of healthcare service to be more adaptable and youth-friendly in general.

One-stop-shop

Having a range of their needs met in one service setting through a one-stop-shop approach was reported as important as a structural barrier and facilitator for all groups. With the additional access barriers that most young people in these groups had related to more complex service needs and additional risk factors for their mental health and wellbeing, not having to negotiate multiple service providers and multiple settings was a notable need and preference. Young men pointed out that they had difficulty navigating the mental health care system, and young people from culturally and linguistically diverse backgrounds identified such support as being a facilitator.

Similarly, having restricted resources available at the centre, and staff with limited skills and training, were identified as barriers. In contrast, collocation and strong links with other services were identified as facilitators. Such links worked both ways – as a pathway into the **headspace** services as well as essential ongoing referral points to address more complex issues for young people with additional needs. Working in strong partnership and collaboration with the more specialised services that some young people need because of homelessness, alcohol and other drug problems, or issues related to sexual identity and health, are essential components of an integrated platform of services for young people. Such integration is essential to effective engagement of young people from more marginalised population group in holistic service provision they require.

2.2 Recommendations for improving service access and engagement

The main recommendations where additional emphasis and more targeted approaches are required to improve service access and engagement for young people in each of the marginalised population groups are:

1. Build community awareness and promote **headspace** services (all groups)
2. Promotion of **headspace** centres as providing a confidential service (LGBTIQ, Aboriginal and Torres Strait Islander, CALD, AOD)
3. Increase service accessibility (through transport support and service availability options) (Aboriginal and Torres Strait Islander, AOD, homeless)
4. Provide a welcoming and accepting environment (physical setting and staff attitudes) (LGBTIQ, Aboriginal and Torres Strait Islander, CALD, AOD)
5. Appropriate intake, assessment and treatment (more flexibly provided for young males, Aboriginal and Torres Strait Islander, CALD)
6. Culturally respectful staff (Aboriginal and Torres Strait Islander, CALD)
7. Ensure integrated service links to enable referral in and out (young males, LGBTIQ, AOD, homeless)
8. Provide translation services (CALD)
9. Enhance the alcohol and other drug service stream throughout the centre network

These recommendations are presented in more detail in Table 2.2, identifying the specific strategies for young people in each population group who are more marginalised in their service access. This reveals which approaches are most pertinent to which population groups. Again, the overwhelming message is that good practice is common to all young people, but that additional emphasis or a more tailored approach is required to ensure a service element for young people from particular population groups.

The table shows that building community awareness and promoting **headspace** services is a high priority for all of the population groups. Community awareness messages need to be conveyed directly to these population groups in targeted ways that raise their awareness of **headspace** as a service that can meet their specific needs. The best ways of doing this may vary, however; for example, social media is considered to be effective for young males and working through community Elders as a useful strategy for Aboriginal and Torres Strait Islander young people.

Specifically promoting **headspace** as a confidential service needs added emphasis to encourage service access for young people who are LGBTIQ, Aboriginal and Torres Strait Islander, from CALD backgrounds, or who have alcohol and other drug problems.

Increasing service accessibility means improving instrumental support for young people who need it most. Transport support and more flexible appointment times and drop in options are relevant for young people who are Aboriginal and Torres Strait Islander, have alcohol or other drug problems, or are homeless.

A welcoming and accepting environment was even more important than usual for young people who are LGBTIQ, Aboriginal and Torres Strait Islander, from CALD backgrounds, or who have alcohol and other drug problems. Simple gestures that acknowledge the diversity of young people through artwork and posters help young people feel acknowledged and valued. Safe, welcoming and relaxed spaces and staff that are non-judgemental and accepting are essential.

Flexibility in intake, assessment and treatment is required to make these processes more appropriate to engage young men, young people who are Aboriginal and Torres Strait Islander, and those from CALD backgrounds. Progressing more slowly, recognising different levels of readiness and mental health literacy, and being responsive to different belief and value systems need to be incorporated into evidence-based assessment and treatment approaches, addressing young people's preferences to promote autonomy and choice.

Culturally respectful staff are critical to engage young people who are Aboriginal and Torres Strait Islander and those from CALD backgrounds. Cultural awareness, competence and safety training are essential and the employment of a culturally diverse workforce is of significant value and should be a priority, whenever possible.

Integrated service links work for young men and those who are LGBTIQ, have alcohol or other drug problems, or are homeless. Strong links with other services enable referral of young people to **headspace** and also build the capacity for more specialised youth services that these young people may need as an adjunct to their **headspace** care to address additional risk factors.

The availability of appropriate translation services is critical for young people with English language limitations.

Finally, the alcohol and other drug service stream of **headspace** is a core part of the model, where many young people are likely to have some level of co-morbidity even if it is not a main presenting issue, and this element needs to be strengthened across the board.

Table 2.2 **headspace** best practice model development for young people from more marginalised population groups – principles and potential strategies

Principle 1: Build community awareness and promote headspace services
Young males – Examine the effectiveness of setting-specific messaging and targeted digital campaigns (including messages that counter current narratives and male role expectations that impede help-seeking for young males). – Identify key influencers and consider broadening strategic partnerships with role models (male sporting figures, musicians) and influential organisations for young males. – Implement and evaluate targeted messaging in schools, sports clubs and other specific settings for young males (i.e., festivals, skate parks). – Utilise social media and websites attractive to young males.
LGBTIQ – Use the **headspace** brand to promote help-seeking in the community and break down perceived stigma and shame associated with accessing a mental health service. – Promote **headspace** to the community as a safe place where LGBTIQ young people can seek support.
Aboriginal and Torres Strait Islander – Build stronger relationships with community Elders and other trusted members of the community so young people do not feel apprehensive about accessing the service. – Promote **headspace** to Aboriginal and Torres Strait Islander families and the community to break down perceived stigma and shame associated with accessing a mental health service. – Provide culturally appropriate and relevant information and resources about mental health, and social and emotional wellbeing to young people, families and service providers.
CALD – Examine the effectiveness of setting specific messaging and targeted digital campaigns for CALD young people. – Use the **headspace** brand to promote help-seeking in CALD communities and break down perceived stigma and shame associated with accessing a mental health service. – Build relationships and awareness among leaders of local CALD communities.
AOD – Promote **headspace** to the community to break down perceived stigma and shame associated with accessing a mental health or AOD service. – Provide relevant information and resources about AOD and comorbid mental health issues to young people, families and service providers.
Homeless – Promote awareness of **headspace** ability to provide support and assistance to homeless young people's specific needs. – Provide clear promotion of all services and facilities that **headspace** centres can deliver to inform young people of how **headspace** can support homeless youth. – Promote the ability of **headspace** to link young people with other services including education, employment, and accommodation services.

Principle 2: Promotion as a confidential service

LGBTIQ

- Promote **headspace** as a confidential service.
- Communicate clear guidelines regarding confidentiality and circumstances in which it may have to be breached.
- Train all staff in the importance of client confidentiality.

Aboriginal and Torres Strait Islander

- Promote **headspace** as a confidential service.
- Communicate clear guidelines regarding circumstances in which confidentiality may have to be broken.
- Train all staff in the importance of client confidentiality, particularly for centres in smaller communities.

CALD

- Culturally appropriate promotional messages that **headspace** services are confidential and freely accessible to all young people.
- Clear guidelines regarding circumstances in which confidentiality may have to be broken.

AOD

- Promote **headspace** as a confidential service.
- Ensure the centre has clear policies regarding confidentiality and the circumstances in which confidentiality may have to be broken and communicate these to all service users in a timely manner.
- Train all staff in the importance of client confidentiality.

Principle 3: Increase service accessibility

Aboriginal and Torres Strait Islander

- Provide young people with vouchers for petrol or public transport fares, in order to access the centre.
- Greater provision and capacity for outreach into community, schools and community events to increase the likelihood of young Aboriginal and Torres Strait Islander people presenting to **headspace**.

AOD

- Provide flexible appointments and the ability for young people with AOD problems to 'drop-in'.
- Explore increasing opening hours past 5pm on some evenings and/or open on Saturdays.
- Provide young people with vouchers for petrol or public transport fares, in order to access the centre.

Homeless

- Provide flexible appointments and the ability for homeless young people to 'drop-in'.
- Greater provision and capacity for outreach services to increase the likelihood of homeless young people being able to access support.
- Enable earlier intervention around risk factors.
- Provide young people vouchers for public transport fares in order for them to access the centre.

Principle 4: Provide welcoming and accepting environment

LGBTIQ

- Ensure staff are friendly, non-judgemental and accepting of young people regardless of their sexual orientation or gender identity.
- Provide an open and friendly environment where LGBTIQ young people feel safe and accepted.
- Display the LGBTIQ rainbow flag and other appropriate imagery to promote **headspace** as safe and supportive for LGBTIQ young people.
- Ensure waiting room is welcoming and comfortable for all young people, including providing spaces that afford young people some level of privacy if desired.
- Ensure staff use respectful language, appropriate pronouns and preferred names for trans* and intersex young people.

Principle 4: Provide welcoming and accepting environment (continued)

Aboriginal and Torres Strait Islander

- Provide inviting, relaxed and safe environment for Aboriginal and Torres Strait Islander young people, possibly through displaying art work and the Aboriginal and Torres Strait Islander flags.
- Provide the option for the delivery of treatment in environments where Aboriginal and Torres Strait Islander young people feel comfortable such as in parks, local community venues or outdoor areas around the centre.

CALD

- Welcome signs in languages other than English in the **headspace** waiting area.
- Culturally appropriate information in the form of posters, pamphlets and leaflets, printed in languages other than English and available in the **headspace** waiting area.

AOD

- Provide a welcoming, relaxed and safe environment for all young people, including those with AOD problems.
- Ensure staff are friendly, accepting and non-judgemental of all young people.
- Provide options and flexibility with the choice of clinician for young people with AOD problems to ensure they can develop a strong rapport and remain engaged with the service.

Principle 5: Appropriate intake, assessment and treatment

Young males

- Where possible, provide young males with flexibility throughout the intake process, including less formal options, an initial introductory engagement-focussed session, and less initial emphasis on assessment at point of initial contact.
- Provide young males with options regarding the choice of clinician to ensure they can develop a strong rapport and remain engaged with the service.

Aboriginal and Torres Strait Islander

- Provide Aboriginal and Torres Strait Islander young people with a less formal intake process; options to complete the MDS on arrival or over subsequent visits; and the option of completing the data collection processes via paper, iPad or face to face.
- Ensure awareness of and appropriate responses to each young person's literacy level, at intake and throughout treatment.
- Provide culturally responsive treatment and service delivery suitable to the needs of Aboriginal and Torres Strait Islander young people; whereby kinship, social and family ties are considerations.
- Employ appropriate engagement approaches, such as playing board games or walking outside, while engaging in indirect therapy.

CALD

- Emphasise the focus on engagement and cultural understanding during the intake process with CALD young people.
- The development of culturally appropriate programs and treatment options – flexible enough to acknowledge and support different cultural values and beliefs.

Principle 6: Culturally respectful staff

Aboriginal and Torres Strait Islander

- Provide cultural awareness training for staff to ensure that they understand and respect cultural values, especially with reference to family and community ties and differences in how mental illness and help-seeking are perceived in Aboriginal and Torres Strait Islander-culture compared with non-Indigenous culture.
- Employ and retain a qualified and skilled Aboriginal and Torres Strait Islander workforce to promote culturally appropriate service delivery.
- Provide Aboriginal and Torres Strait Islander young people with the choice of an Aboriginal and Torres Strait Islander or non-Indigenous worker in their provision of care and treatment.
- Accept and respect cultural values, while ensuring that all young people are treated the same.

Principle 6: Culturally respectful staff (continued)

CALD

– Ensure that **headspace** staff understand and respect cultural values, especially with respect to different beliefs and understandings about what constitutes mental illness (compared with Western norms) – achieved through the provision of cultural awareness training.

– Employ and retain a qualified and skilled CALD workforce to promote culturally appropriate service delivery.

Principle 7: Integrated service links

Young males

– Centres to focus on strengthening and maintaining links to existing community groups, schools, and youth justice as these services are often critical in the pathway to care.

LGBTIQ

– Continue to develop strong working relationships with other local services in order to provide timely access to more specialised care (where needed) and to aid productive referrals.

AOD

– Develop flexible AOD outreach services in partnership with local youth agencies and programs to reach young people who are reluctant to seek help from a **headspace** centre.

– Develop strong collaborative relationships among relevant AOD services within the local community and provide warm referrals, where appropriate.

Homeless

– Continue to develop and value relationships with other agencies in the community that can effectively assist with the housing, education and employment needs of homeless young people.

– Encourage referrals to and from housing support services and **headspace** for homeless young people with mental health concerns.

– Provide greater provision for assistance with homelessness at each centre alongside other services to holistically meet young people's needs.

Principle 8: Translation services

CALD

– Adequate interpreter services for young people who have limited English proficiency.

Principle 9: Enhance alcohol and other drug service stream

AOD

– Provide appropriate AOD services onsite as a core part of the **headspace** model and promote these services to the community and other local services.

3. Young Males

3. Young Males

3.1 Background

Young Australian males experiencing mental health concerns are an important target group for **headspace** because they report the lowest rates of professional help-seeking of any demographic group across the lifespan (Rickwood, 2012), and have the lowest rates of awareness of available mental health organisations and services (Jorm, 2009; Morgan & Jorm, 2007). These disparities are especially pronounced for particular populations of young males, including young men who are Aboriginal and Torres Strait Islander (Hunter, 2007), young same-sex attracted males (King et al., 2008) and young males living in rural and isolated areas (Alston, 2012). The comparative low rates of help-seeking evidenced by young Australian males contribute to the range of poorer mental health outcomes of this group, including higher rates of risk-taking, antisocial behaviour, substance abuse and suicide (AIHW, 2007). In terms of suicide, young men are a known high-risk group, with suicide the second leading cause of mortality in young men after accidental mortality (Pitman, Krysinska, Osborn, & King, 2012).

For a variety of complex reasons, males tend to disconnect from healthcare services when they enter adolescence (Marcell, Ford, Pleck, & Sonenstein, 2007). For young males, the trajectory of disengagement with healthcare services often continues throughout early and middle adulthood (Smith, Braunack-Mayer, & Wittert, 2006). When males do access mental health services, they are less likely than females to remain engaged with these services (Cusack, Deane, Wilson, & Ciarrochi, 2004). At present, guidelines for engaging and working with young males are just beginning to be developed (Englar-Carlson, Marchetta, & Thelma, 2014).

Rates of psychological distress, substance abuse, risk-taking and antisocial behaviours remain high for young males within Australia (Reavley, Cvetkovski, Jorm, & Lubman, 2010; Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Between early adolescence and young adulthood, anxiety, depressive and attention-related disorders are the leading causes of disability for young Australian males (Mathews, Hall, Vos, Patton, & Degenhardt, 2011). Recent research indicates that within the last 12-months, up to one in 10 young Australian males experienced suicidal thoughts, with one in five young Australian males feeling as though life is barely worth living (Ellis et al., 2013). Further, males who experience adverse childhood events (e.g., neglect, abuse) are more likely to engage in antisocial behaviour in young adulthood than are females who experience similar such events (Schilling, Aseltine, & Gore, 2007). Hence, young males require priority mental health targeting, reconfiguring notions of help-seeking as un-masculine and reflective of personal weakness (Jorm et al., 2006). Low levels of mental health literacy and help-seeking competence must also be considered. Young males have significantly poorer recognition of symptoms of mental health problems than do young females (Cotton, Wright, Harris, Jorm, & McGorry, 2006) and corresponding lower levels of help-seeking preparedness (Jorm, et al., 2006; Rickwood, Deane, & Wilson, 2007; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Wilson & Deane, 2001; Yorgason, Linville, & Zitzman, 2008).

Relative to females, the level of access by young men to **headspace** centres is comparatively low (37.5%). This is problematic given the relatively high levels of psychological distress experienced by young Australian males (Young and Well CRC, 2013), the elevated suicide risk observed for this group, and the heightened likelihood of young males experiencing conduct, behavioural or psychotic disorders (Patel, Flisher, Hetrick, & McGorry, 2007). Further investigation is required, therefore, to ensure that preventable barriers are addressed and facilitators enhanced across the **headspace** centre network for young males.

3.2 Aim

Given the lower levels of engagement in services offered at **headspace** centres by young males in comparison to females, it is important for **headspace** to investigate the barriers and facilitators specific to these young people accessing the support they require. This chapter aims to identify approaches that can assist **headspace** centres to reduce the barriers and increase facilitators to ensure all **headspace** services are appropriate and accessible for young males.

3.3 Methodology

The following methodology was used to gain an understanding of the barriers and facilitators young males may encounter to accessing required services and supports through **headspace**.

1. Review and synthesis of relevant clinical and research literature related to barriers and facilitators to accessing and engaging with mental health care for young males.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Interviews and focus groups with 25 young males from three **headspace** centres. The three **headspace** centres involved were chosen to reflect a combination of a rural/regional centre with an above average engagement rate of young males (i.e., >45% males), a metropolitan centre with an above average engagement rate of young males (i.e., >45% males), and a centre that is actively working to engage young males.
4. Interviews with four **headspace** service providers from three **headspace** centres.

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews and focus group have been analysed according to the Consensual Qualitative Research Method (Hill et al, 2005) to determine the level of representativeness and frequency of responses (see Table 3.1). This type of analysis allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 3.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Table 3.2 outlines the focus group and interview participants, including the sex and age of young people involved.

Table 3.2: Participants

headspace centre 1 (NSW)	
Staff	
Clinical lead	
Young people	
Young male, aged 17	
Young male, aged 18	
Young male, aged 16	
Young male, aged 18	
headspace centre 2 (QLD)	
Staff	
Clinician	
Young people	
Young males (12-17 years) focus group (n=6, male)	
Young males (17-25 years) focus group (n=6, male)	
headspace centre 3 (QLD)	
Staff	
Centre Manager	
Community Engagement Officer	
Young people	
Young male, aged < 25	
Young males, 12-17 years, focus group (n=6, male)	
Young males, 17-25 years, focus group (n=2, male)	
Total staff	**4**
Total young males	**25**
Total	**29**

3.4 Literature review

A review of key studies related to barriers and facilitators for young men's mental health help-seeking was undertaken. While a large body of research has examined mental health help-seeking in young people (i.e., Gulliver, Griffiths, & Christensen, 2010), relatively few studies have focussed specifically on help-seeking barriers and facilitators for young men. Nonetheless, of the available literature, qualitative research reports a number of help-seeking barriers for this group, including a need to conceal vulnerability and maintain independence, lack of knowledge regarding available services, lack of time to access support, lack of perceived credibility of health care providers, fear and uncertainty regarding acceptance of differences (i.e., cultural, sexuality), and cost (Davies et al. 2000). Quantitative research supports many of these barriers, indicating that male role expectations frequently conflict with, and inhibit, young men's mental health help-seeking through increasing self-stigma and decreasing the likelihood of self-disclosure (O'Beaglaoich, Conway, & Morrison, 2015; Pederson & Vogel, 2007; Steinfeldt, Steinfeldt, England, & Speight, 2009). Furthermore, qualified mental health practitioners have been identified as the least accessible source of mental health support by young men (Russell, Gaffney, Collins, Bergin, & Bedford, 2004).

Potential facilitators for help-seeking nominated by young men include provision of free or low-cost services, training practitioners in strategies to encourage young males to seek help, use of peer advocates and role models, and targeted awareness raising in schools, universities and work settings (Davies et al. 2000; Russell, Gaffney, Collins, Bergin, & Bedford, 2004). Furthermore, societal institutions that specifically engage young men, including sporting clubs, may provide leverage for improving young men's help-seeking (Pringle & Sayers, 2004; Steinfeldt, Steinfeldt, England, & Speight, 2009). The use of technology and psychological interventions provided in online settings have been identified as important facilitators of engaging young males with mental health care (Ellis et al., 2013; Young and Well CRC, 2013). However, available evidence suggests that young females are significantly more likely to access web-based mental health chat services than are young males (Dowling & Rickwood, 2014). In possible explanation of this, research suggests that young Australian males prefer self-help and action oriented (rather than talk-based) strategies as ways of engaging with mental health care (Ellis et al., 2013).

While some attempts have been made to facilitate help-seeking engagement for adolescent boys (Kiselica, 2003) these interventions are yet to be empirically tested. The exception to this is the *Boys Forum* intervention (O'Neil, Challenger, Renzulli, Crapser, & Webster, 2013), the first gender-sensitive psychoeducation program specifically aimed at improving mental health outcomes of secondary school aged boys. A small scale (n=51) evaluation of the *Boy's Forum* intervention suggested positive changes to participant's anger, problem solving, and self-perception over a three-week period. For university aged males, a pilot randomised control trial (n=32) indicated that a gender-based motivational interviewing intervention improved young men's help-seeking behaviours (Syzdek, 2012).

The lack of focussed high-quality intervention-based research into overcoming young men's help-seeking barriers is of grave concern, leaving a significant gap in current knowledge and limiting innovation in service provision. It is generally agreed within the literature that any attempts to facilitate mental health help-seeking for young males must include consideration of masculine norms and stereotypes, which develop as the result of gender socialisation (Marcell, et al., 2007). Gender socialisation paradigms assert that males and females acquire gendered attitudes and behaviours from cultural values, norms, and ideologies that inform gender roles (Addis & Mahalik, 2003). Within Australia, the dominant masculine culture emphasises traits of stoicism, competitiveness, and inexpressiveness (Wilhelm, Brownhill, Harris, & Harris, 2006). While such traits can operate both positively and negatively, they are powerful barriers in the acknowledgement of mental health problems, and/or adaptive help-seeking processes for young men (Möller-Leimkühler, 2002). Indeed, relative to females, males tend to experience greater ridicule and social punishment for engaging in non-traditional gendered behaviours, such as displaying vulnerable emotions, seeking help, or expressing hurts (Courtenay, 2003). Furthermore, masculinity often operates as a social accomplishment to be defended or performed something that is hard won and easily lost (Vandello & Bosson, 2013), with experimental research in young males showing that perceived threats to masculinity activate compensatory and unhelpful displays of aggression, competition and strength (Vandello, Bosson, Cohen, Burnaford, & Weaver, 2008).

In summary, the current literature regarding barriers and facilitators for young men's mental health help-seeking indicates the importance of masculinity, stigma and specific preferences for help-seeking. Significant limitations affect the knowledge base, however, arising particularly from the common practice of analysing combined results for young males and females. In addition, at present the field is without empirically supported practices (i.e., supported when compared to an adequate control condition) for improving the engagement of young males with mental health interventions (Mahalik, Good, Tager, Levant, & Mackowiak, 2012).

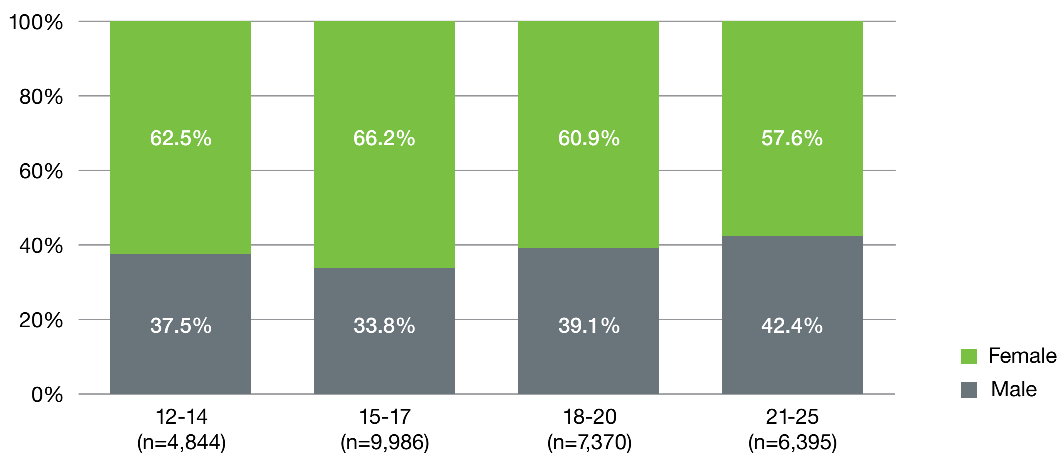
3.5 Results

Client profile

Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of young men accessing **headspace**, and provide an outline of how they compare with female services users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus excluded from the analysis).

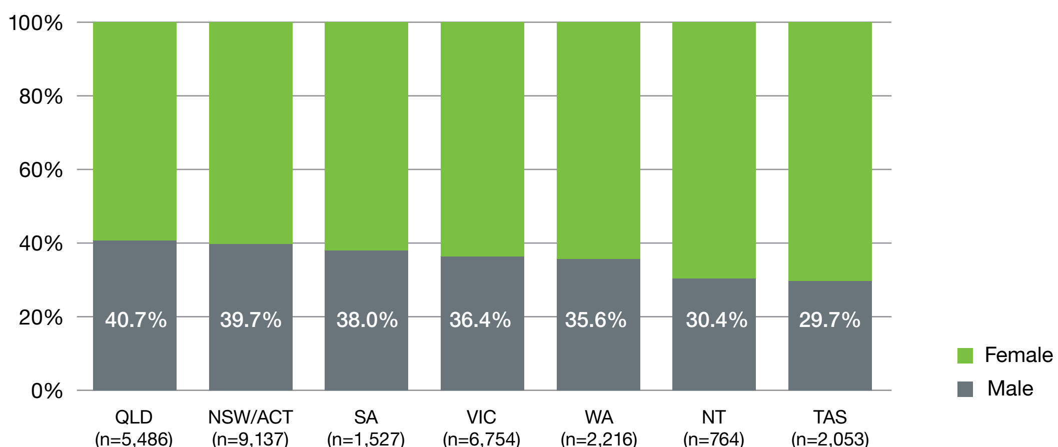
Of this sample, 10,800 were young men, representing 37.5 per cent of all **headspace** clients for whom data was available (28,792). A similar proportion was evident across the four age groups (see Figure 3.1), with just slight variations: the highest relative proportion of males (42.4%) was observed for the 21-25 year age group; and the lowest proportion (33.8%) was observed for the 15-17 year age group.

Figure 3.1: Percentage of male and female headspace young people by age group



Across all states, males were substantially less likely to present to **headspace** centres than were females. Comparison of male and female **headspace** young people at the state level was relatively similar across Queensland, New South Wales/Australian Capital Territory, South Australia, Victoria, and Western Australia (see Figure 3.2). Of note, comparatively lower rates of males presented at **headspace** centres in the Northern Territory and Tasmania.

Figure 3.2: Percentage of male and female headspace young people by state/territory



Noteworthy differences were observed between male and female **headspace** young people according to centre rurality (see Figure 3.3). The gender disparity was most noticeable for centres in remote areas, where only 28.2% of **headspace** young people were male.

Figure 3.3: Percentage of male and female headspace young people by centre rurality

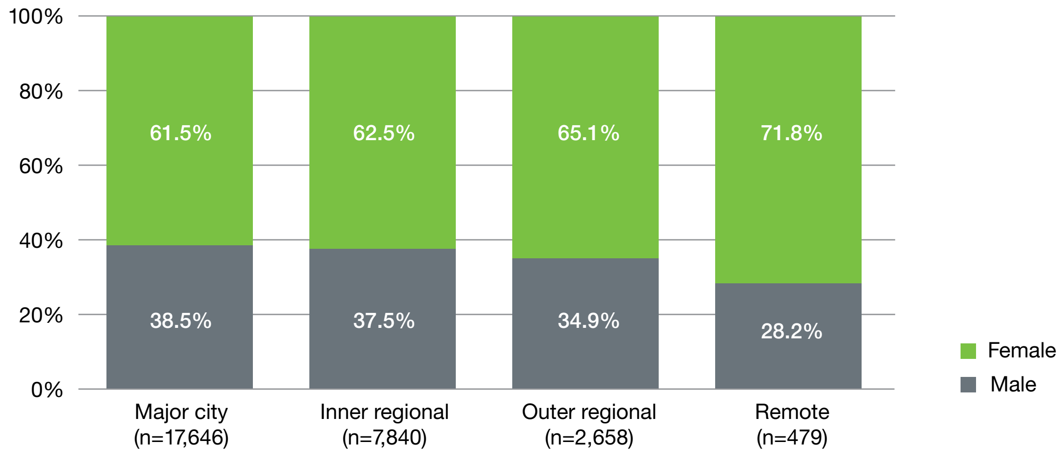
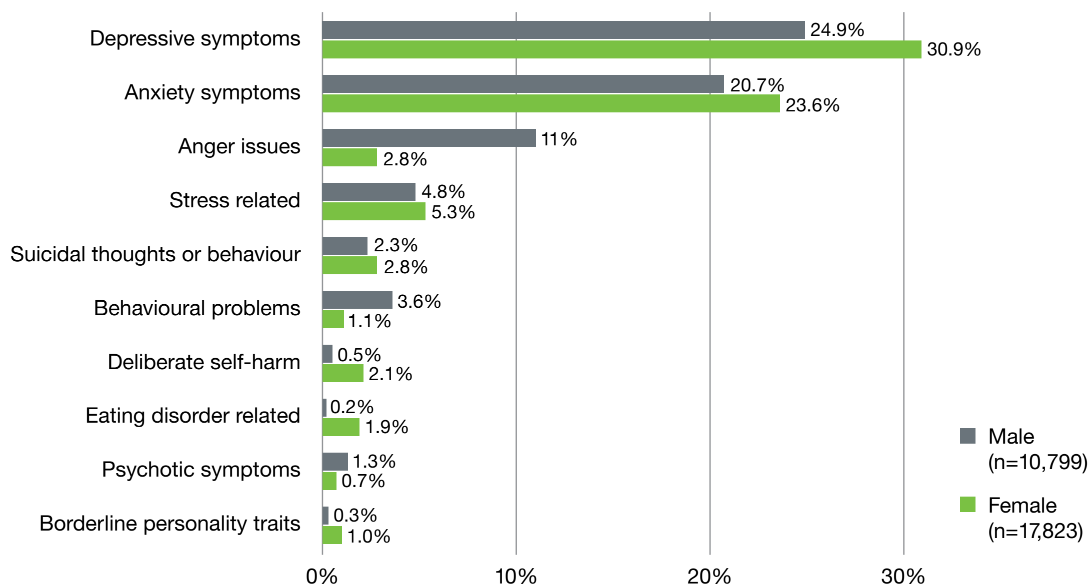


Figure 3.4 outlines the main presenting issues of young males compared to young females. Although the majority of both groups present with mental health issues followed by situational issues, there is some variation between groups. In general, young males were less likely to present for symptoms of depression, anxiety, self harm, eating disorder and borderline personality disorder. In contrast, they were substantially more likely than young females to present for anger issues and behavioural problems. Presentation for suicidal thoughts was relatively rare and roughly equivalent for young males and females. Chi-square analyses showed age and sex differences in presenting mental health issues, X2 (70) = 3300.57, $p < .001$. Younger males (12-14 and 15-17) had a greater proportion of presentations for anger issues and behavioural problems than other age and male/female groups.

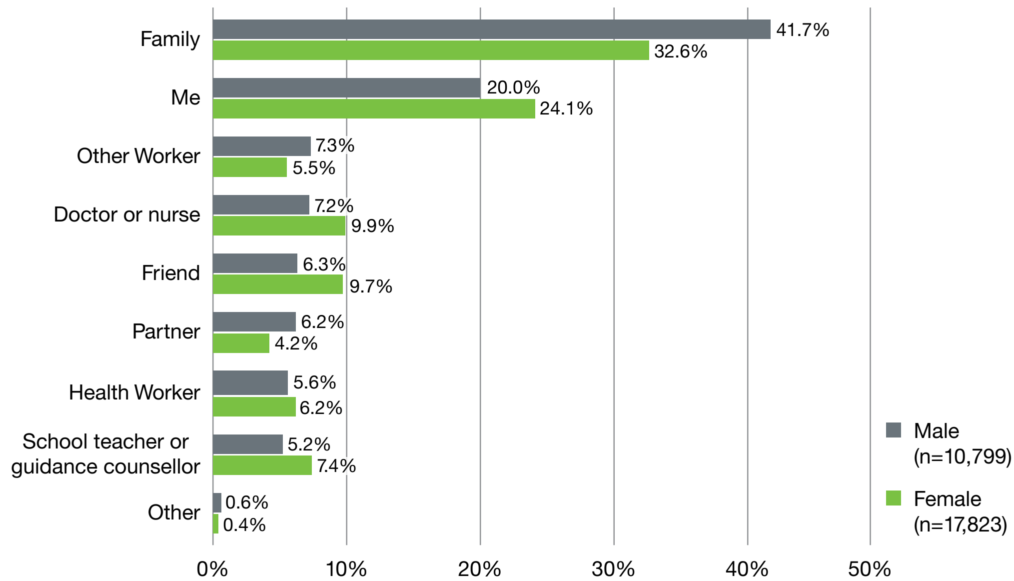
Figure 3.4: Main presenting mental health issue at headspace



Differences were observed regarding pathways to **headspace** care (see Figure 3.5). Males (41.7%) were more likely than females (32.6%) to be encouraged or influenced by a family member to attend a **headspace** centre. However, despite this sex difference, family members were the most frequently nominated source of encouragement for both young males and females. Young males (20.0%) were less likely to self-refer to a **headspace** centre than were young females (24.1%)[5]. Relatively small proportions of young males and females were encouraged to attend a **headspace** centre by medical professionals, friends, partners, health workers or school staff.

[5] Sex differences in young people's influence to attend were observed over and above any age effects.

Figure 3.5: Pathways to **headspace**

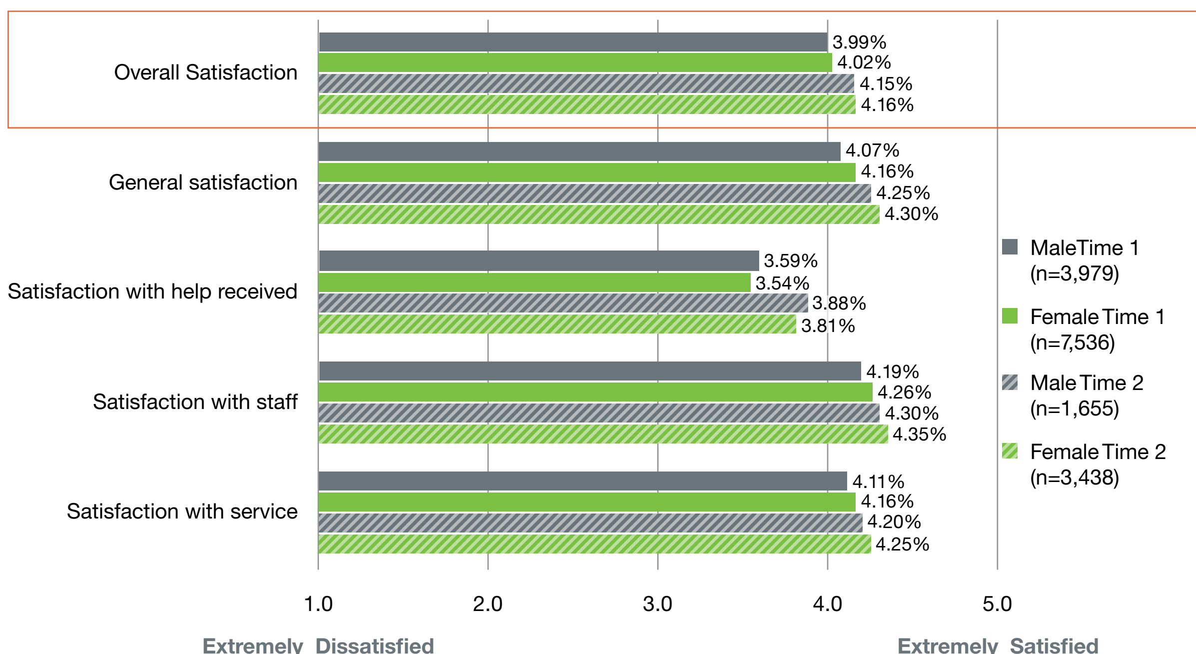


Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their time with service. During this period, over 12,000 young people completed a survey, and 4119 of these were young males (34%). The client satisfaction survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied.

Results are presented in Figure 3.6 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups. Analyses were undertaken separately for client satisfaction ratings at Time 1 and Time 2. Results indicated a statistically significant sex difference in overall satisfaction at Time 1 (females = 4.02, males = 3.99), however the effect size for this difference was very small (Cohen's d = 0.07). There was no sex difference in satisfaction ratings at Time 2. In practical terms, on average, client satisfaction was high and equivalent for both young males and females attending **headspace** centres.

Figure 3.6: Satisfaction for male and female **headspace** young people



Barriers and facilitators

Data from the interviews with young males and centre staff revealed a range of barriers and facilitators to service access and engagement. There were some important commonalities between the views of centre staff and young people, and some noteworthy differences within the sample of young males, underscoring heterogeneity of experience for this group.

The main barriers to accessing **headspace** services nominated by the young men included the effect of male role expectations on mental health help-seeking, therapy as an unknown and unfamiliar process that can be difficult for some young males, lack of awareness of **headspace** and available services, and negative experiences (either with the broader mental health system or with **headspace** itself). Most of the **headspace** staff concurred that male role expectations and the need to display stoicism may inhibit engagement with **headspace** and may impact on the nature of presenting problems for young males (i.e., greater likelihood of presenting with anger or substance use issues).

The primary facilitators of engagement identified by young males included a positive experience with initial **headspace** contact and the importance of non-judgemental staff, close collaboration and referral with other services that young males may be linked with including youth justice, a flexible and gender appropriate engagement and treatment process, role models and community attitudes. Targeted messaging and awareness was highlighted by almost all of the young males as an important facilitator, including more effective links and promotion with sports clubs and schools. Most of the service providers highlighted the importance of **headspace** centres having access to male clinicians, although it was acknowledged by them and also by some of the young males that there are instances where a female clinician is preferred. Most of the service providers highlighted the importance of flexible engagement, especially with young males showing greater ambivalence.

Although there was a long list of barriers and facilitators identified across the data, there were only a handful of barriers and facilitators that were common to staff and young people and mentioned by more than a few participants. These key barriers and facilitators are discussed in detail below and are categorised as either: *personal and interpersonal* which includes male role expectations, therapy as unknown territory, and positive initial contact; or *structural* which includes partnership within sector, difficulty navigating the system, negative experiences with the intake process and targeted messaging.

Personal and interpersonal barriers

Male role expectations

For young males, the process of help-seeking can conflict with internalised male role expectations. Such expectations exert a powerful effect on modifiable health risk behaviours especially during adolescence and emerging adulthood where peer group influence and acceptance dominate. Most of the young males discussed the impact of male role expectations negatively influencing the help-seeking process through a particular form of stigma, shame and a need to avoid being perceived as weak or vulnerable.

> *Yep, I think it is the stigma that society puts on guys to not cry and not show emotions; and that if you talk about your problems or acknowledge that you have problems in the first place, you are automatically gay or feminine or less of a man; and that's intimidating to - like, it just proves how insecure boys are to even acknowledging the fact that they are insecure in the first place.*
>
> —**headspace** young person, male, aged 16

> *Well, with young males, I know that they can be quite … they need to deal with things, themselves. Before* ***headspace*** *can reach out to kids and males, especially, who have mental health issues, we need to break the stigma of, "I'm a man, I can do it."*
>
> —**headspace** young person, male focus group [age not stated]

> *Maybe men are supposed to be the strong people in society. Not meant to have problems.*
>
> —**headspace** young person, male focus group 12-17yrs

> *Me, personally, I think there is always that, just "guys aren't supposed to feel" sort of mentality, which is always perpetuated, which is complete bullshit. It's like "boys don't cry; boys don't feel; they just are." That's just so stupid. It is a very hard issue to tackle because there's no real … it is in the upbringing of people, which sucks.*
>
> —**headspace** young person, male focus group 18-25yrs

Most service providers agreed that male role expectations impede the help-seeking process for young males.

I think it's a social thing, but I would imagine that would be the biggest reason why not … you know, potential for them being viewed as weak or … I don't know, girls are more open in talking about their feelings, generally, and are more open to the idea that sometimes you need support.

—**headspace** service provider

I think it's stigma. I think it's exacerbated for males. There's still the mental health stigma that is attached for anyone but then there's also the additional pride and "I should be strong. It shouldn't be getting at me." That whole perception that happens for people and that is the hard part, that it is magnified for young males and breaking down that stigma is challenging, to say "it's okay to talk".

—**headspace** service provider

In some instances, the shame associated with not matching up to male role expectations meant that emotional support could not be sought from same-sex friends.

I went to an all boys' school and it was just testosterone and "we are guys, we don't care", all this stupid crap. And so much stuff happened … they did such horrible things to each other because of that. Yeah, and they weren't allowed to show that they were hurt by it. So it just continued and perpetuated and it got worse until they left school.

—**headspace** young person, male focus group 18-25yrs

[Someone] I was friends with for a long time, but he … I thought he was really, like, collected and together and stuff, but all of his female friends knew that he was a wreck. So he would hide it from the other guys and he did that really well.

—**headspace** young person, male, aged 18

Service providers and some young males also noted an association between male role expectations and the nature of presenting problems. Service providers indicated that young males were more likely to report a greater incidence of externalising problems, including anger and substance use.

My guess would be that in general males are probably less likely to access support, in terms of what they are presenting with as well; that males might be presenting with anger and that isn't always necessarily labelled a mental health issue. So they are probably more likely to present with other anger issues but, actually, less likely to present and say, "Well, I am depressed".

—**headspace** service provider

It's a bit difficult with boys; it tends to come out in anger or drug and alcohol issues.

—**headspace** service provider

Therapy as unknown territory

Socialisation processes for males and females are distinct. For many young males, discussing painful or uncomfortable emotions is unfamiliar terrain. Therapy is something of an unknown and, at times, an unwelcome process. This may play out as a lack of confidence in sharing emotions, or not feeling 'ready' for the therapy process.

> *I think if a guy was to come to **headspace**, let them know that it's okay to talk about feelings and … like, I think it would have to be a long process, like, repetitive, to try and get it through their head that what they are doing is good for them and not gay and not being feminine; and that it's okay and that it's normal and that it is healthy; and that they are actually being more of a man acknowledging their feelings than being insecure.*
>
> —**headspace** young person, male, aged 16

> *Yeah, sure, they [young males] suck at talking about things.*
>
> —**headspace** young person, male, aged 18

> *I was a bit nervous. I wasn't really sure about the place.*
>
> —**headspace** young person, male focus group 12-17yrs

> *I didn't want to talk to people.*
>
> —**headspace** young person, male focus group 12-17yrs

Some young males discussed a misunderstanding of the therapy process and lack of motivation to attend **headspace**. One service provider referred to the importance of autonomy in the engagement process.

> *I didn't want to come. I thought … like, I didn't want to be helped. I thought I could deal with it, myself. That didn't really work.*
>
> —**headspace** young person, male focus group 12-17yrs

> ***headspace** has been really good but I guess I was just lazy and I just stopped coming in.*
>
> —**headspace** young person, male focus group 18-25yrs

> *I think having the autonomy to have the decision to actually be here is a huge one, for us, especially with the young males. A lot of the time with parents and things, it's about trying to get the young guys in the door to start off with and that can be done in an easier way.*
>
> —**headspace** service provider

All service providers expressed concerns about the perception of therapy amongst young males, and that a lack of an awareness of emotions, and/or lack of knowledge or discomfort associated with talk related to emotions, served as a significant barrier.

> *I think that is a gender/cultural issue in terms of how boys are raised and their emotional awareness.*
>
> —**headspace** service provider

> *Yeah, they don't have as much confidence to be able to say that and for a male to tell a female, "Look, I'm not feeling comfortable with you," yeah, it is not going to be easy.*
>
> —**headspace** service provider

The other thing, my perception is that we are asking them to come in and talk to someone. Sometimes that's not a treatment of choice for a young male to talk about. So often part of their challenge is about talking or sharing emotion or thoughts/feelings. So they automatically associate a talk therapy with something that is probably not going to resonate very much for them. So they will probably be my two … the two things for me that stand out.

—**headspace** service provider

Yes, I would agree with definitely being worried about talking about emotions and not being sure how to navigate that with maintaining this masculine appearance that they feel that they have to; I suppose that could be a big one, if they feel uncomfortable in that space.

—**headspace** service provider

Structural barriers

Difficulty navigating system

Lack of knowledge regarding available services, perceived lack of accessibility of services and difficulty navigating the mental health system (including **headspace**) were reported by some of the young males as significant barriers. This included a lack of inter-agency coordination.

When I wanted to see a psychologist, there were so many barriers. Like, I asked around. The school wasn't very supportive. Passed around until I found about ***headspace****; there wasn't any other service that I was eligible for.*

—**headspace** young person, male, aged 18

It was hard to navigate the system and it took me 10 and a half months.

—***headspace*** young person, male, aged 18

Uhm, one of the barriers is the government. They like to pass you around to other agencies, so you are not their problem; that's what it seemed like.

—**headspace** young person, male, aged 18

Oh, I had heard of it but didn't know what they did. I thought it was kind of like … I didn't know that they help out with jobs and you have to stop to come in ... So I didn't really know about it.

—**headspace** young person, male, aged 17

In some instances the difficulty navigating the system included a total lack of awareness of **headspace** services.

I got requested to come here by my school counsellor, and I came. Before that, didn't know.

—**headspace** young person, male focus group 12-17yrs

I didn't even know it existed. The police got me onto this, when my uncle bashed me.

—**headspace** young person, male focus group 12-17yrs

I was in hospital, in the mental ward a couple of years ago, and they didn't even tell me this place existed.

—**headspace** young person, male focus group 12-17yrs

But I never heard of this place until my dad recommended it. I didn't see anything on TV or anything like that.

—**headspace** young person, male focus group 18-25yrs

Intake

Some young males expressed that their initial experience with the intake process created a barrier to accessing and engaging with the service.

> *Yeah, I sat there for half an hour doing this survey.*
>
> —**headspace** young person, male focus group 12-17yrs

> *Originally, I was in …. I was seeing the … **headspace** and it was very hard to get an appointment. You had to wait very long.*
>
> —**headspace** young person, male focus group 18-25yrs

A few young males commented on the physical environment and location. Two young males from one of the older groups expressed feeling out of place.

> *It is a friendly layout. I wouldn't go as far as saying "it makes it too youthful" (laughs), but it is definitely … it makes you feel … I don't know, coming from a 22-year-old, I feel like I walk in here and it's like … sometimes I think, "Oh, I feel like I'm at a day-care centre, almost. (Laughs). Oh, God, I shouldn't be here".*
>
> —**headspace** young person, male focus group 18-25yrs

> *I know what you mean, like the vibe and the colours and all that. I just feel like I shouldn't be here, I'm too old.*
>
> —***headspace*** young person, male focus group 18-25yrs

> *It's off the street and all of that, but I think, yeah, you have got the big "**headspace**" screen sign out on the street and that might make people uncomfortable walking in.*
>
> —**headspace** young person, male, aged 17

> *They need more facilities. Instead of having just one that's, like … not being mean to this, but having small rooms and three larger rooms, they need to be a bit bigger.*
>
> —**headspace** young person, male focus group 12-17yrs

Some of the service providers commented that some young males may feel intimidated in the waiting room, impatient with data collection processes, and frustrated if there is a lack of male clinicians (if that is their preference).

> *In our service, there's no sort of area where they could just sit and not be noticed; so the reception area probably would be intimidating for them.*
>
> —**headspace** service provider

> *Yeah, yeah, I think so. A lot of males are resistant to, you know, filling in forms and completing the MDS; they find it difficult to sit and do those things.*
>
> —**headspace** service provider

> *I probably would have said, you know, having an all-female staff could be a barrier.*
>
> —**headspace** service provider

> *But in terms of the male coming in seeing other males, that they could talk to, I think that's something that really helps. I guess a barrier would be if we didn't have that; and we are quite lucky to have two male clinicians.*
>
> —**headspace** service provider

Personal and interpersonal facilitators

Initial contact and engagement

The importance of positive initial contact was highlighted by most young males and all service providers. This included factors relevant to all young people seeking support from **headspace** such as feeling understood by clinicians. A further theme was the use of a flexible process of engagement with young males and the need to be mindful of modifying practice and intervention to maintain initial engagement.

They listen. They actually take you seriously.

—**headspace** young person, male focus group 12-17yrs

I got asked by the person that I am seeing here if I wanted to, like, do runs and stuff, when I talked about everything; and if I wanted to go and do exercise and work-out and stuff outside because they know that I used to go to the gym and do my own stuff. So that's pretty good.

—**headspace** *young person, male focus group 12-17yrs*

They have a PlayStation, so they are doing one good thing.

—**headspace** young person, male focus group 12-17yrs

Some of the young males elaborated on specific factors that have maintained their engagement. These centred on themes of acceptance and helpfulness of clinicians.

The strategies that they have come up with to help my anger and my depression and stuff.

—**headspace** young person, male focus group 12-17yrs

I quite enjoy come here. It's very - not that I look forward to it every week, but it's definitely good knowing that I am coming here and talking about a lot of shit that's going on in my life with somebody.

—**headspace** young person, male focus group 18-25yrs

Well, they didn't really judge me, straight-up. That is a good word, too; no judgment. Nobody judges you here. Like, everyone believes everything you say.

—**headspace** young person, male focus group 12-17yrs

My psychologist, she's pretty good. I can trust her, I suppose. So there's a connection, I suppose.

—**headspace** young person, male focus group 18-25yrs

No, nothing's wanted me to make me stop. Far from it. I see the moments that I have found something that I need help with, more to the point (laughs).

—**headspace** young person, male [age not stated]

All service providers emphasised the need to actively focus on engagement when working with young males. This may include the need to emphasise autonomy and increase motivation of young males who may be initially referred by parents.

Yeah, definitely, if I am on the phone to a parent and they are trying to get their young fellow in, then that's something that I will suggest. If they say, "No, I don't think they are ready to come down. They are not agreeing to an appointment," or something - if they are meant to have an appointment booked in but then they call in and they say, "He's not going to come," then I will sort of suggest, "Just drop down and have a look around. We don't have to do an actual session. I can just say 'hey'".

—**headspace** service provider

I think having the autonomy to have the decision to actually be here is a huge one, for us, especially with the young males. A lot of the time with parents and things, it's about trying to get the young guys in the door to start off with and that can be done in an easier way; if it's just coming in and having a coffee or coming through for a visit, rather than having that initial first appointment. I think that's something that I find works pretty well when you are talking to parents and they are struggling to try and get that first appointment.

—**headspace** service provider

So even when they come in, we are very clear with them, "I know your mum said you need to come here, but, actually, if you don't want to stay" – and that, I find, works quite well. And then they usually do stay because they feel like they don't have to and, hopefully, in that first session we can make some sort of connection in terms of what's going on for them, what we might be able to offer.

—**headspace** service provider

Service providers also discussed the importance of working in a flexible manner from the intake process to the intervention and services that are offered. There was a theme of needing to bear in mind the preferences of young males.

Maybe a screening session first, a rapport building session and then getting some information. Not making it obvious that "this is an intake". "I'm sorry, we are just here to take all your information. So I am going to ask you question after question".

—**headspace** service provider

I think we have maintained that engagement by being able to offer something more flexible than other services are able to do; because they often have massive pressures in terms of the number of assessments that they need to do and they are predominantly doing assessment. So at that point, we would lose engagement with a lot of young males, which are a high-need group and don't access help easily. So when they do make that first step, we are quite keen to keep them engaged.

—**headspace** service provider

Something that we are keen to develop is maybe running a Rage group; so trying to access those young males who are presenting with anger issues and maybe not having any mental health problem but getting a foot in the door, so they see what the service is about and then maybe they are more likely to come back and go, "Actually, I do need some support with how I am feeling as well."

—**headspace** service provider

Structural facilitators

Partnership within sector

For some young males, engagement with the mental health system and **headspace** services occurred through cross-sector partnership and referral. Examples included hospitals, community organisations, and the youth justice system (lawyers, probation officer and court mandate) and in some instances from schools.

It was recommended highly to me by a lot of doctors that I went to.

—**headspace** young person, male focus group 18-25yrs

Yesterday, I had a young man walk in who was in his early 20s and he had been a previous client of JJ [Juvenile Justice] and had met up with his JJ worker and decided that now was a time that he wanted to access support.

—**headspace** service provider

It was the lawyer, after the court, from my family.

—**headspace** young person, male focus group 12-17yrs

I heard about this through a doctor. So I never knew about this place; and then through a friend who was already referred here, through a doctor.

—**headspace** young person, male focus group 18-25yrs

Oh, yeah. Look good for me in court, when I come here. They don't make me come here. Just, like, it looks good for me when I go to court. They say, "Oh, yeah, he's linked in with ***headspace*** *and that, yeah. He's doing something with himself. He's not just bumming around." That's another thing, like, when I come here, I'm not just walking around and shit; I don't really do anything else.*

—**headspace** young person, male focus group 12-17yrs

Service providers supported the importance of good linkage and partnership with the broader sector. Collocation with other services may have facilitated this process.

Yeah, because a lot of them, it will be a condition of their probation that they engage somewhere. Obviously, we are a voluntary service, so we make it clear to them that they can choose that this is the place that they need that requirement, but we are not going to be enforcing it and we are not going to be providing court reports.

—**headspace** service provider

Yes, collaboration with other services, particularly some of the really grassroots ones that go out and do a lot of outreach and then they will provide services in this nice, safe back area that you have just kind of seen. That's a pretty neutral space, so they know where it is. They do a lot of art workshops or drumming workshops and things like that, that are engaging; safe enough for people to see the space/people; some soft entry points as well. So I think that's one of them.

—**headspace** service provider

Male clinicians

Rapport between young males and service providers is critical in maintaining engagement. One of the key factors that emerged from the interviews and focus groups in relation to this was matching clinicians to the preferences of young males. Some of the service providers discussed the importance of having male clinicians on staff.

We started to see a different level of response when we would send two of our younger staff members out and a different response again when it was a young male and a young female. You have seen young males gravitate towards you in the school, just by seeing that there's a young male talking about this stuff.

—**headspace** service provider

What helps with that is having two male youth access clinicians … know that we have a lot of young males who have given us positive feedback about actually being able to see a male initially; and we also have one of our private psychologists who is male and that has helped us to retain the younger number of men who accessed initially and may have dropped off if it was predominantly female.

—**headspace** service provider

And our drug and alcohol workers were actually also both male. We only have one now, but I think that is another thing that has been quite helpful in maintaining engagement; just having some male staff. It is not typical but we are really lucky to have the ones that we do have.

—**headspace** service provider

However, while this theme also emerged from the young male data, it was not universal. One service provider highlights that the matching to preference was more important than matching to gender.

They [the male clinicians] are just good guys.

—**headspace** young person, male focus group 12-17yrs

More female staff; I don't talk to guys.

—**headspace** young person, male focus group 12-17yrs

Maybe give them more of an option of what therapist you see. Some people don't particularly like talking to guys.

—**headspace** young person, male focus group 12-17yrs

With our initial assessment, we try and match them up with probably one that's going to be a good match. It could be another male, if that's what works best; but sometimes they prefer a female as well. I guess being able to make that match helps, but we do that across the board.

—**headspace** service provider

Targeted messaging

Most young males discussed the importance of targeted messaging and advertising as a means to facilitating engagement with **headspace**. This included considering nuanced messaging relative to male role expectations. Key avenues for possible messaging included schools, sports clubs and organisations that appeal to males in general.

*I believe maybe an advertising campaign on the part of **headspace** might be good to break that myth of "men don't need help", because men do. And I have been in a domestic violent relationship and as a man, it's quite difficult to deal with those sorts of things because you don't know who you can go to. To break that myth of "a bloke don't need help."*

—**headspace** young person, male [age not stated]

Yes, more of a gender approach because men need to break that idea of, "I don't need it," or, "Someone else does and not me," because that's what holds us blokes back… When it comes to men, they really do need a kick in the teeth.

—**headspace** young person, male [age not stated]

I really like the posters, like Sam versus the smokescreen or whatever… You would have to make people feel like they weren't, like, a fuck-up, basically. Before they came in, make them feel like, you know, "You are not messed up or something because you are coming here."

—**headspace** young person, male, aged 18

*Well, I thought it was pretty cool that they had it in the Rehab Centre in Brisbane that I went to; they had advertising about **headspace**.*

—**headspace** young person, male focus group 12-17yrs

*Maybe, like, at our school, we have assemblies every Monday at the whole school. Maybe, like, sending – like, going to schools once a year just to, like, tell people what it's about; not just be, "Oh, **headspace**. We are at …, come on down." More like, "Yeah, we are **headspace**. You know, we provide this and this," and just sell, like, what **headspace** is to me; it's there for me, I guess; and not someone that's, like, "I've got problems, so I need to go and talk to them about it". It's more like, "they are there for me, when I need them".*

—**headspace** young person, male, aged 17

Maybe incorporating sport, somehow. Because sport, I think the type of guys that I am talking about, they mainly hang around - are part of the rugby scene and any sport in general sort of scene.

—**headspace** young person, male, aged 16

The importance of targeted messaging was also supported from interview data with the service providers.

In terms of getting a foot in the door: I think just continuing to do that, to build on what we have done. But maybe looking at even wider than the Education system; so maybe information to workplaces or other services that young men might access. Maybe work with Centrelink or employment agencies or – it's good that they are now advertising ***headspace*** *on the TV but it's still focussed on the younger end of it. I think that's something that we could look at doing… Yeah, and even wider than that. Looking at local rugby clubs, football clubs, where there's - it's good. A lot of sports players are coming out and talking about their experience. So I think it's becoming more acceptable to talk about it. If you are young, 17/18, at the start of your career, you are going to be worrying about "what's the impact on my team mates, if I have depression?"*

—**headspace** service provider

So they go out to schools together. In terms of accessing the male population – you know, having a male/female going out together is important. They do go to boys' schools and do talks. I am sure they love [female staff member], she's great, but it's actually nice to have a male there as well.

—**headspace** service provider

We started seeing a difference in response when we go and do communicate awareness in the schools … definitely, it makes a big difference in having young guys come up at the end of a talk/presentation at a school or something; sort of ask a few questions and grab some info.

—**headspace** service provider

The other strategy that we had was sort of link in with more male dominated sports, I suppose. So we had a connection to the skateboarding scene on the … So we did a bunch of different sort of skate comps and things around the place and kind of been seen at those. And their own environment makes it a less threatening point of engagement, I suppose, and somewhere where they don't expect to see a service like this.

—**headspace** service provider

The young males also highlighted the potential of online advertising, in particular social media, for raising awareness and promoting engagement.

I guess more advertising. If it is much more easier to find on Google and stuff, then probably more people will seek the help they need.

—**headspace** young person, male, aged 18

Do you have a Facebook page? They should advertise on the site, instead of all this other bull/crap that no-one wants to look at.

—**headspace** young person, male focus group 12-17yrs

Suppose social media is the way these days. So if there was more social media, to get around.

—**headspace** young person, male focus group 18-25yrs

I go with what he said, social media. I have never seen an ad for it on Facebook. Not even just Facebook. I think of You Tube, even. You Tube have 20-second ads that go in, if you could purchase it.

—**headspace** young person, male focus group 18-25yrs

The theme of targeted messaging included references to the importance of broader community awareness of young men's mental health, and the potential impacts of role models and peers.

…if, like, the girls that the tough guys hang around talked about it and then started conversation, I don't know, just like something to spark it, saying that "it's okay" in the circles and stuff. It's better than hurting themselves and eventually killing themselves.

—**headspace** young person, male, 16

*But my mate came here; he went to the school thing here, about Year 9 or whatever it is. [Did he tell you about **headspace**?] Yeah. [When he told you about it, did it kind of put your mind at ease and think, "Okay, I might check it out"?] No, I just went, "Oh, yeah, that's mad. I will go there. It is not school".*

—**headspace** young person, male focus group 12-17yrs

*There are a lot of young males out in the community, themselves, promoting **headspace** and making it okay and advocating for it; as well as the soft entry points and those practical engaging points that provide autonomy as well as a reason they can understand they want to be here, I suppose.*

—**headspace** service provider

The other thing is making it - if you are visible and you have this cool image, I suppose, it makes it okay for young people to say that they attend. So a lot of times we have young guys that come in and say, "Yeah, my friends come here," and things like that. I think that's pretty huge.

—**headspace** service provider

… having younger male workers to advocate for the service and make it okay. I know a lot of the time, if it's a youth worker, it will bring the young person in for the initial appointment and kind of sit with them and book them in and kind of go through that process with them. It makes it a lot easier.

—**headspace** service provider

3.6 Summary of main findings

Overall, MDS data indicate that the level of representation of young males at **headspace** centres is relatively low at 37.5 per cent. Rates of engagement with **headspace** centres were better for young males in the 21–25 age group (42.4%), though still significantly below service access rates for young females. Centres based in remote areas report particularly low rates of young male services users (28.2%). These figures are consistent with the existing literature, highlighting impeded help-seeking for males, and younger males in particular.

The two main presenting issues for young males were depressive symptoms, followed by anxiety symptoms – these are the same two main presenting issues for young females. Highlighting key areas of difference, however, substantially more young males presented for anger issues and behavioural problems than did young females. Young males were less likely than young females to present for deliberate self harm and disordered eating. In terms of pathways to **headspace** care, young males were more likely to be referred by family and less likely to self-refer than were young females. A relatively small proportion of young people were referred by health workers and school staff.

Analysis of client satisfaction data indicated broadly equivalent patterns of overall satisfaction with **headspace** services for young males and females. For young males, overall satisfaction ratings were high (rated on average as 4 as out of a possible 5). However, young males rated satisfaction with the help they received as markedly lower (3.59 at Time 1).

Interviews with young males and service providers at three centres with a relatively high proportion of young male clients identified a broad range of barriers and facilitators to accessing and engaging with **headspace** services. This report has concentrated on a smaller number of key personal and structural elements that were common to staff and young people or mentioned by more than a few participants. Unlike the other groups evaluated as part of this service inclusion report, this section on young males did not utilise data from a clinical file review.

The key personal and interpersonal barriers identified through the interviews included the impact of male role expectations and talking therapy as an unknown and unfamiliar process. Structural barriers included difficulty navigating the system and intake processes. Personal and interpersonal facilitators included positive initial contact and flexible engagement. Structural facilitators included effective partnership and collaboration with the broader sector and referral pathways, the availability of male clinicians and targeted messaging delivered in environments and settings where young males may be receptive to such messages.

Table 3.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young men.

Table 3.3: Barriers and facilitators to accessing and engaging with headspace for young men

Barriers	Facilitators
Personal & Interpersonal	
– Male role expectations around not being weak or vulnerable	– Positive, flexible initial contact – Non-judgemental staff – Being helped
– Externalising presenting issues	– Being able to try out before fully engaging
– Lack of awareness about therapy and not wanting to talk	– Early focus on engagement rather than assessment
Structural	
– Lack of awareness and difficulty navigating system	– Targeted awareness messaging
– Intake processes	– Collocation with relevant services
– Physical environment that engages young men (private wait spaces, not too ‘young’)	– Cross-sectoral referrals, particularly from justice system
	– Availability of male clinicians/intake workers

The main findings emerging from this research are:

- Many young males and service providers consider male role expectations to adversely influence the help-seeking process for young males, making it more difficult to seek and accept help for mental health concerns.
- Socialisation processes impact on the emotional vocabulary of many young males; this leaves many (but not all) young males feeling uncomfortable discussing negative emotional experiences and/or unmotivated for the therapy process.
- Navigating the mental health system and the intake process remains challenging for many young males.
- Centres adopting a flexible engagement and treatment approach may be able to engage and maintain higher numbers of young males in **headspace** care.
- Initial positive experiences with the intake process and rapport with staff are important in determining ongoing engagement for young males.
- Cross sector partnership and collaboration was identified as an important point of initial engagement for many young males.
- Availability of male clinicians was cited by many (though not all) as an important component of initial engagement with **headspace** care.
- Most young males discussed the need for greater awareness of **headspace** through targeted setting-specific messaging and advertising placed within the right environment, including social media.

An important caveat on these findings must be noted, however; the current data came from young males currently engaged with **headspace** services. Accordingly, the information does not reflect the experiences or opinions of young males who are unknowledgeable of, or are unwilling or unable to engage with **headspace**. Although there is greater complexity involved in obtaining such data, it would make for a valuable companion piece to the present findings and recommendations, and would help to contextualise next steps toward better engaging this cohort with available **headspace** services.

3.7 Recommendations

Table 3.4 details potential strategies to assist with improving service delivery for young males. It is further recommended that **headspace** consider developing an overarching policy framework for improving the help-seeking and engagement rates for young males.

Table 3.4 headspace model development for young males

Principles	Potential strategies
1. Community awareness and service promotion	– Examine the effectiveness of setting-specific messaging and targeted digital campaigns (including messages that counter current narratives and male role expectations that impede help-seeking for young males). – Identify key influencers and consider broadening strategic partnerships with role models (male sporting figures, musicians) and influential organisations for young males. – Implement and evaluate targeted messaging in schools, sports clubs and other specific settings for young males (i.e., festivals, skate parks). – Utilise social media and websites attractive to young males.
2. Appropriate intake, assessment and treatment	– Where possible, provide young males with flexibility throughout the intake process, including less formal options, an initial introductory engagement-focussed session, and less initial emphasis on assessment at point of initial contact. – Provide young males with options regarding the choice of clinician to ensure they can develop a strong rapport and remain engaged with the service.
3. Service links	– Centres to focus on strengthening and maintaining links to existing community groups, schools, and youth justice as these services are often critical in the pathway to care.

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4. Young People who are Lesbian, Gay, Bisexual, Trans*, Intersex, or Questioning

4. Young People who are Lesbian, Gay, Bisexual, Trans*, Intersex, or Questioning

4.1 Background

Between the ages of 12-25 is a critical period for the development of identity, and sexual identity is a major component of the overall sense of self. Uncertainty and questioning regarding sexual orientation is common, and concerns around gender identity become acute for young people for whom this is an issue. More complex identity formation than those with non-questioning heterosexual sexual orientation and the potential discrimination and social exclusion experienced by young people who are lesbian, gay, bisexual, trans*[1], intersex, or questioning (LGBTIQ) are risk factors for mental health, and these young people are, therefore, a population group of importance for **headspace**.

There is currently no national or population data available to accurately reflect the proportions of diverse sexual orientations and gender identities within the Australian population (McNair, Gleitzman, & Hillier, 2006; National LGBTQI Health Alliance, 2014). However, it is clear that the number of same-sex couples is increasing, with a growth of 32 per cent of same sex couples from 2006 to 2011, now representing one per cent of all couples in Australia (Australian Bureau of Statistics, 2013).

The National LGBTI Health Alliance indicates around nine per cent of adult men and 15 per cent of adult women in Australia report same-sex attraction or having had sexual contact with someone of the same sex, but only two per cent identify as lesbian, gay or bisexual (Smith, Rissel, Richters, Grulich, & de Visser, 2003). Among youth populations specifically, one large scale Australian population-based study, which drew on data from 9,260 young women (aged 22-27 in 2000) who provided information about their sexual attraction in the Women's Health Australia (WHA) longitudinal study (McNair, Kavanagh, Hillier, & de Visser, 2003), reported 7.4 per cent of women reported attraction to both men and women and a further one per cent identified as mainly or exclusively same-sex attracted. Similarly, a New Zealand-based study of 967 young people (aged up to 25) reported approximately three per cent were predominantly homosexual with up to 10 per cent having same-sex inclinations or experience (Fergusson, Horwood, Ridder, & Beautrais, 2005). More recently, the fifth national survey of Australian secondary students and sexual health found that 21 per cent of the more than 2000 students surveyed reported sexual attraction other than exclusively heterosexual. Eight per cent of young men and four per cent of young women reported sexual attraction only to people of the same sex. Five per cent of young men and 15 per cent of young women were attracted to people of both sexes. Around four per cent of young men and five percent of young women were unsure about their sexual attraction (Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014). Estimates of the prevalence of trans* people range from 1:500 to 1:11,500, and for intersex people range from 1:200 to 1:2000 (Blackless et al., 2000; Diamond, 2004).

LGBTIQ young people are at increased risk of experiencing mental health concerns (Shilo & Savaya, 2012; Toomey, Ryan, Diaz, Card, & Russell, 2010). People who identify as homosexual (lesbian or gay) or bisexual are more than twice as likely to have experienced a mental disorder in the previous 12 months (Australian Bureau of Statistics, 2008). Furthermore, rates of depression and anxiety among lesbian and bisexual women have been found to be at least twice that of heterosexual women (McNair, 2003). Lesbian or bisexual young women and gay young men also have a higher prevalence of suicidal thoughts than heterosexual young women and men (Needham & Austin, 2010).

Discrimination and exclusion are key causal factors of LGBTIQ young people's mental health problems (Rosenstreich, 2013). Difficulties associated with disclosure and community attitudes increase LGBTIQ young people's risk of experiencing mental health concerns (Toomey, et al., 2010). The psychological stressors of acknowledging, accepting, and disclosing same-sex attraction or nonconforming gender identity, which are intensified in adolescence and young adulthood, can also have a detrimental impact on their health and wellbeing (Shilo & Savaya, 2012). In 2004, a survey of 1,749 same-sex attracted young Australians found that almost half of these young people had experienced homophobia, manifest through verbal abuse and unfair treatment on the basis of sexuality (Hillier, Turner, & Mitchell, 2005). Most victimisation that young people experience due to their LGBTIQ status occurs within the school environment, and males experience significantly greater abuse than females

[6] Trans* is used as an inclusive term to capture transgendered and transsexual gender identities

(Toomey, et al., 2010). LGBTIQ young people from rural backgrounds reported feeling less safe in social occasions than those living in metropolitan areas (Hillier, et al., 2005). The stigma, victimisation, discrimination and isolation LGBTIQ young people often suffer as a result of homophobic attitudes and behaviour in the community has a significant impact on their health and wellbeing, and increases the likelihood of self harm and suicidal behaviour.

Studies of adults show that same-sex attracted people are more likely to access mental health services. Across all ages, homosexual women have been shown to be three and a half times more likely to report accessing a mental health service than heterosexual women (Cochran, Sullivan, & Mays, 2003; Razzano, Cook, Hamilton, Hughes, & Matthews, 2006) and homosexual and bisexual men are more likely to access a mental health service than heterosexual men (Cochran, et al., 2003). However, there has been little research into LGBTIQ young people's mental health service use, but what is available indicates that as a result of perceived judgements by health care providers and past negative experiences with other services, LGBTIQ young people actually access mental health services less readily than non-LGBTIQ young people (McIntyre, Daley, Rutherford, & Ross, 2011). Additionally, LGBTIQ young people tend not to discuss their sexual orientation with health care providers, and providers seldom enquire (Allen, Glicken, Beach, & Naylor, 1998; Kitts, 2010).

4.2 Aims

Given that LGBTIQ young people have elevated vulnerability for mental health problems and victimisation, and their tendency to not discuss issues related to LGBTIQ status with health professionals, it is important for **headspace** to investigate how to best enable access to and engagement with services for this population group. This chapter aims to identify approaches to assist **headspace** centres in reducing the barriers and increasing facilitators to ensure all **headspace** services are appropriate and accessible for LGBTIQ young people requiring support.

4.3 Methodology

The following methodology was used to gain an understanding of the barriers and facilitators that LGBTIQ young people may encounter to accessing required services and supports through **headspace**.

1. A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care for LGBTIQ young people.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Clinical file review for 20 young people across several centres who identity as LGBTIQ and who have accessed a **headspace** centre.
4. Interviews with seven LGBTIQ young people, one parent and nine **headspace** service providers from two **headspace** centres with high rates of LGBTIQ participation (centres were identified from MDS data over a 12 month period).

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews have been analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses (see Table 4.1). This type of analyses allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 4.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Table 4.2 outlines the interview participants, including the gender and age of young people involved.

Table 4.2: Participants

headspace centre 1 (NSW)	
Staff	
Centre manager	
Community development officer	
Intake clinician	
Intake coordinator	
Psychiatrist	
Young people	
Female, age 19	
Male, age 17	
Male, age 20	
Male, age 23	
headspace centre 2 (NSW)	
Staff	
Centre manager	
Case manager	
General practitioner	
Psychologist	
Young people	
Female, age 16	
Female, age 20	
Female, age 21	
Parents	
Mother of 16 yr old female	
Total staff	**9**
Total young people	**7**
Total parents	**1**
Total	**17**

4.4 Literature Review

A systematic review of the literature on barriers and facilitators to accessing and engaging in mental health services for LGBTIQ young people identified only four studies; two of which used a quantitative methodology and two used qualitative research methods. Three of the studies were conducted in the United States of America (USA) (Ciro et al., 2005; Sperber, Landers, & Lawrence, 2005; Williams & Chapman, 2011), and the other in Canada (Travers & Schneider, 1996). Three of these studies recruited young people from youth or health programs (these had very low sample sizes; n=14-17 participants) and one was a USA national survey of school-based youth (Williams & Chapman, 2011).

There were notable differences in sample characteristics between studies, with one being conducted with LGBQ young people (Ciro, et al., 2005), one with transgender and transsexual young people (Sperber, et al., 2005), one with gay and lesbian young people (Travers & Schneider, 1996), and one with sexual minority young people (defined as having had a same sex partner) (Williams & Chapman, 2011).Three of the studies explored help-seeking behaviour and motivation to talk about problems, while the fourth study examined feedback on addiction service improvement (Travers & Schneider, 1996).

Three studies investigated barriers to service access with common barriers (reported in at least two of the studies) including fear of harassment due to membership of a marginalised group as well as fear of being misunderstood and belief that this will result in their specific needs not being met (Sperber, et al., 2005; Travers & Schneider, 1996). Other barriers, identified in only one study, were: having low confidence in services capacity to help due to negative past experiences; confidentiality concerns (Travers & Schneider, 1996); and a tendency to access a GP rather than a mental health service (Williams & Chapman, 2011).

Two of the four studies investigated facilitators to service access. The facilitators identified by these studies were all unique and included: increased motivation to seek support (Ciro, et al., 2005); and seeking care for other reasons (Sperber, et al., 2005).

All studies were limited by small sample sizes, potential sampling bias (i.e., convenience sampling), and difficulties associated with categorising individuals' sexual identities. The lack of research in this area indicates the need for further examination of the barriers and facilitators for LGBTIQ young people accessing and engaging with mental health services.

4.5 Results

Client profile

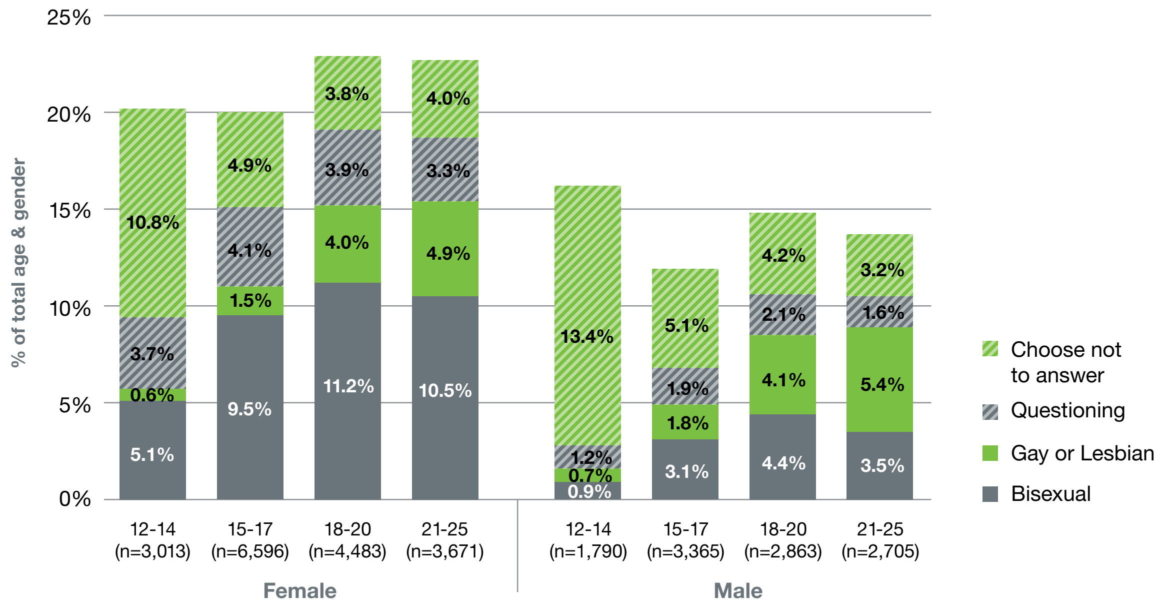
Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of the LGBTIQ young people who access **headspace** and provide an outline of how they compare with all service users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus were excluded from the analysis).

Of this sample, 3,861 young people identified as LGBTIQ, representing 13.5 per cent of all **headspace** clients for whom data was available (28,683). A further 1,586 (5.5%) elected not to disclose their sexual preference. This figure considerably exceeds the estimated national LGBTIQ population of one to three per cent, as reported by large scale studies (Fergusson, et al., 2005; McNair, et al., 2003; Smith, et al., 2003).

Overall, females (16.8%) more commonly identified as LGBTIQ than males (8.6%). Younger adolescents, and younger males in particular, were less likely to identify as LGBTIQ and more likely to choose not to disclose their sexual preference, with 13.4 per cent of 12-14 year old males and 10.8 per cent of 12-14 year old females electing not to disclose, compared to 4.3 per cent of females and males aged 15-25.

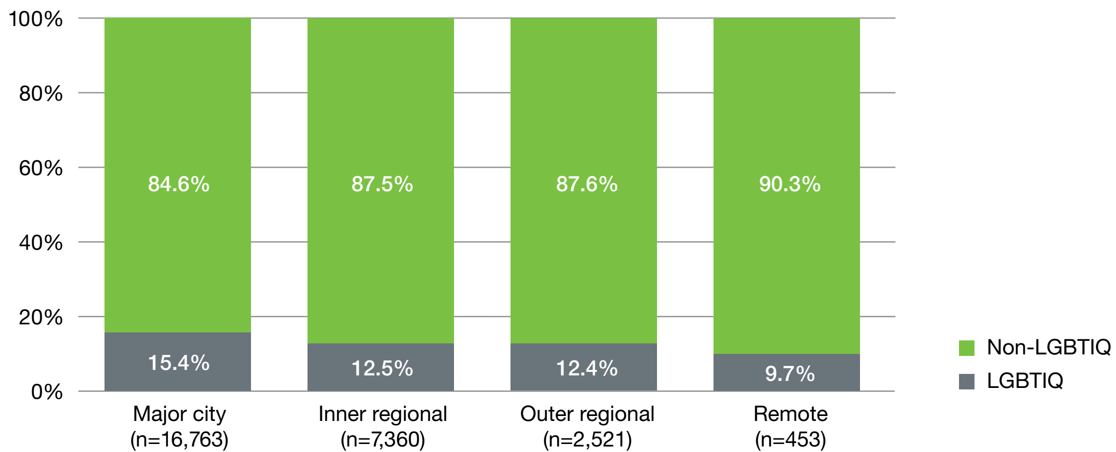
Over half (52.0%) of LGBTIQ young people identified as bisexual, comprising considerably more females (59.2% of LGBTIQ females) than males (39.3% of LGBTIQ males). More LGBTIQ males (38.6%) than females (16.8%) identified as lesbian or gay. Almost a quarter of young people who identified as LGBTIQ (24.0% of females and 22.1% of males) reported their sexual orientation as 'questioning', that is, unsure whether they are straight, lesbian, gay, or bisexual. Questioning sexuality peaked among young people aged 15-17 and 18-20. Trans* and intersex young people comprised only 4.2 per cent and 0.2 per cent of LGBTIQ young people respectively. Figure 4.1 illustrates the sexual orientation of LGBTIQ young people as a proportion of all **headspace** young people within each age group and gender.

Figure 4.1: LGBTIQ sexual orientation by gender and age group



There is wide variation in the level of access by LGBTIQ young people across **headspace** centres, ranging from 8.5 per cent to 23.8 per cent of all young people accessing a centre. Variablility is also evident across the States and Territories with centres located in Victoria and South Australia having the greatest proportion of LGBTIQ young people at 16.6 and 16.0 per cent, respectively, followed by Queensland (13.8%), New South Wales/Australian Capital Territory (13.6%) and Western Australia (13.2%). Centres located in Tasmania (11.9%) and the Northern Territory (10.7%) had the lowest proportions of LGBTIQ young people. Figure 4.2 shows that centres within major cities have the greatest proportion of LGBTIQ young people, while centres in remote areas are less commonly accessed by LGBTIQ young people.

Figure 4.2: Percentage of LGBTIQ young people by centre rurality



Figures 4.3 and 4.4 reveal the main presenting issues of LGBTIQ compared to non-LGBTIQ young people, as reported by their service providers. LGBTIQ young people have similar presenting issues to non-LGBTIQ young people, with most presentations being for mental health followed by situational reasons. LGBTIQ young people demonstrated a slightly higher rate of presentations for mental health issues, and specifically for depressive symptoms (34.5% versus 28.1% of all mental health presentations for LGBTIQ and non-LGBTIQ young people), as well as relatively lower situational presentations compared to non-LGBTIQ young people. Less prevalent mental health issues – such as deliberate self harm, suicical thoughts or behaviour, psychotic symptoms, and borderline personality traits had – relatively higher rates of presentation for LGBTIQ young people. Notably, when exploring LGBTIQ young people's self-reported main reason for presenting to **headspace**, only 1.9 per cent (n=72) reported attending primarily for concerns about their sexuality or gender identity.

Figure 4.3 Main reason for presentation at **headspace**

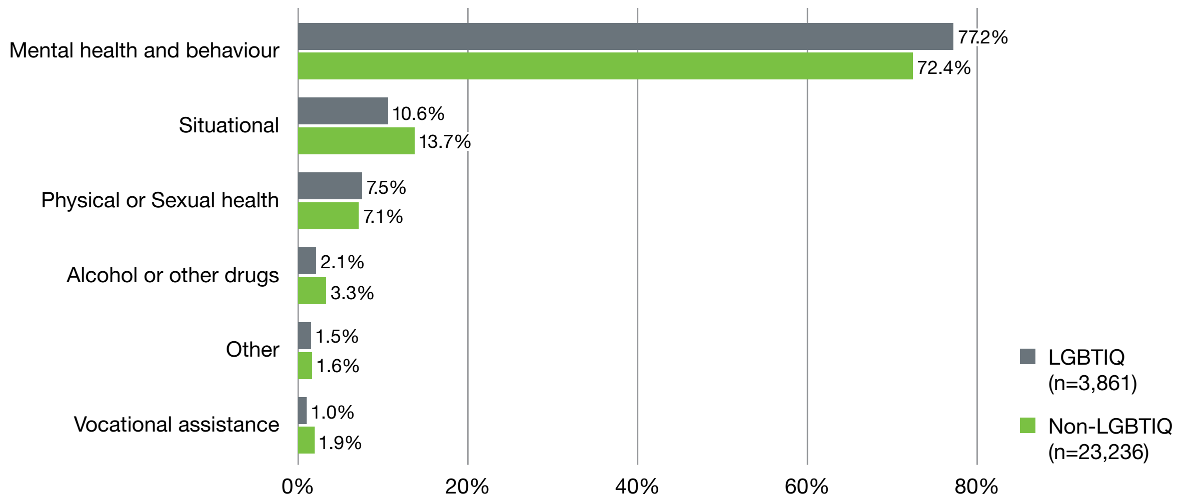


Figure 4.4 Main presenting mental health issue at **headspace**

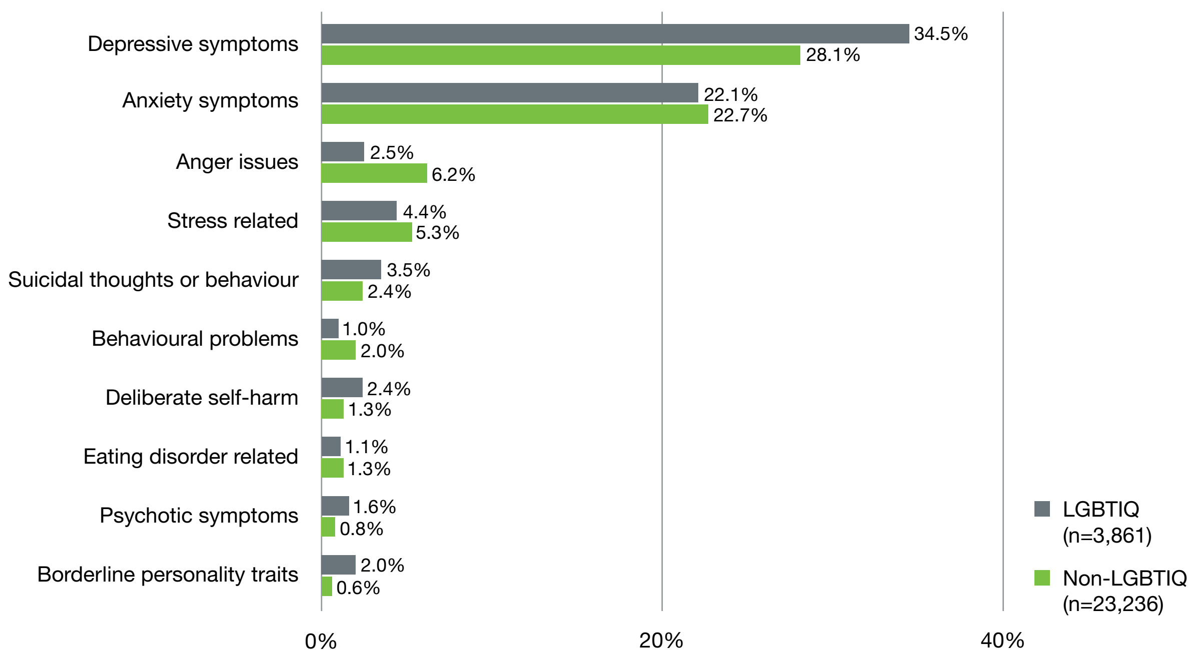
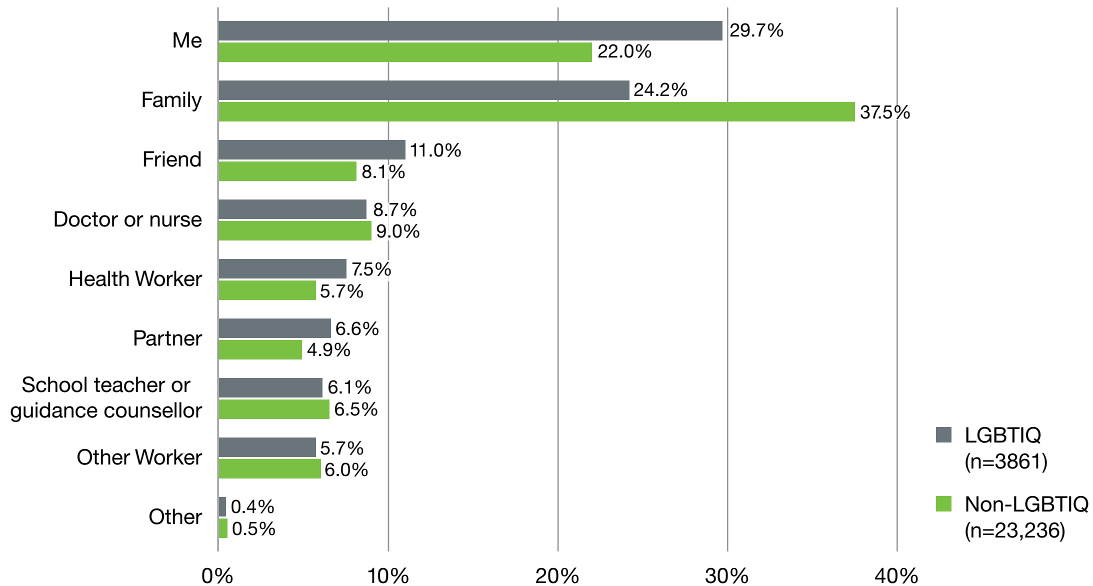


Figure 4.5 shows the different patterns of influence to attend **headspace** reported by LGBTIQ young people compared to non-LGBTIQ young people. In contrast to non-LGBTIQ, whose strongest influence is family members, LGBTIQ young people are most likely to self-refer and less commonly attend **headspace** due to encouragement from family members. Additionally, the influence of friends and partners is proportionally greater among LGBTIQ young people than non-LGBTIQ young people[7].These influence patterns are particularly strong for trans* and gay or lesbian young people specifically. They are far more likely to self-refer (trans* 38.9% and gay or lesbian 36.6%) than other young people.

[7] Differences between LGBTIQ and non-LGBTIQ young people's influence to attend were observed over and above any age effects.

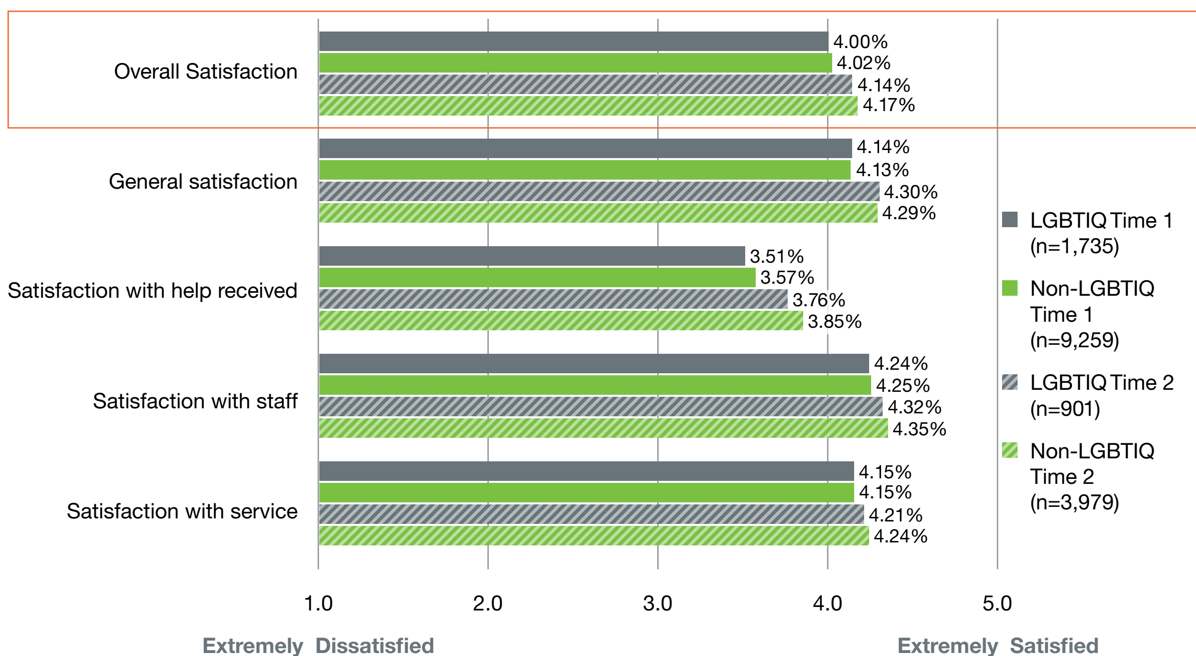
Figure 4.5 Pathways to **headspace**



Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their service. During this period, over 12,000 young people completed a survey and 1,811 of these identified as LGBTIQ (15.9%). The survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied. Results are presented in Figure 4.6 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups and results indicate that there were no significant differences in satisfaction between LGBTIQ and non-LGBTIQ young people.

Figure 4.6: Satisfaction for LGBTIQ and Non-LGBTIQ **headspace** young people



Barriers and facilitators

Data from the interviews with LGBTIQ young people, parents, and **headspace** centre staff and the clinical file review revealed a range of barriers and facilitators to service access and engagement.

The main barrier raised by both staff and young people was stigma and concern for acceptance. Young people also raised a lack of awareness among young people of their need for help or uncertainty of available services as barriers. Staff highlighted additional barriers such as: confidentiality concerns; service inaccessibility, including remoteness and transport issues; and long wait times.

The primary facilitators reported by staff and LGBTIQ young people included: being a confidential and trusted service; good rapport between young people and staff; the open and accepting approach of staff; providing a safe, welcoming and non-judgemental environment; service accessibility; and connections with other services.

The clinical file review identified the primary barriers for access and engagement to **headspace** as low motivation, poor rapport with the clinician, and negative past experiences with mental health services. Facilitators that were reported from the clinical file review included referrals from other services, family support, good rapport between young people and staff, belief in the service's ability to help, and service accessibility.

Although there were a variety of barriers and facilitators identified across the findings, there were only a handful of barriers and facilitators that were mentioned by more than a few staff and/or young people. These key barriers and facilitators are discussed in detail below and are categorised as either: *personal and interpersonal*, which includes stigma and acceptance, confidentiality issues, awareness of need for help and available services, relationship with staff; or *structural*, which includes service accessibility, safe and non-judgemental environment, and connections with other services.

Personal and interpersonal barriers

Stigma and concern for acceptance

Stigma was the most significant barrier for LGBTIQ young people accessing **headspace** services, discussed by most service providers and young people. The stigma associated with mental illness and seeking help for mental health problems was commonly highlighted as a concern for young people accessing **headspace**. However, specific to LGBTIQ young people, was the additional fear of judgement or not being accepted and stigma related to their LGBTIQ status. Stigma toward LGBTIQ young people was perceived to be particularly strong for gender variant young people.

> *That's what I thought when I first came here, would I be judged with what I say sort of thing?*
>
> —**headspace** young person, female, aged 16

> *There's a huge amount more issues for LGBT than there are for other people facing the stigma.*
>
> —**headspace** young person, female, aged 16

> *LGBTIQ have bigger barriers such as acceptance. Am I going to be accepted in this place? Are they going to look at me funny when I walk in with my boyfriend or girlfriend? Are they going to be accepting of this?*
>
> —**headspace** service provider

> *I think it is harder for a young person with gender dysphoria to present themselves at the moment than it is for a young person with issues around sexual orientations. I think there has been so much work done around that through all sorts of spheres including influential entertainers, pop stars and the media and all the rest of the antidiscrimination stuff. I think a lot of young people feel society as a whole, at least in [major city], is pretty much on their side and those who are not are in the wrong … but I think that the people with gender dysphoria are not near that place yet.*
>
> —**headspace** service provider

Some service providers also commented that stigma related to LGBTIQ status differed by location, with LGBTIQ young people located in regional and rural areas experiencing greater stigma than those in metropolitan areas.

> *[City] is well-known as quite a big community of gay and lesbian people so I don't think it's quite so stigmatised as it might be in a small rural town. It's pretty open here.*
>
> —**headspace** service provider

Confidentiality concerns

Concerns for confidentiality were raised by some service providers as a perceived barrier to young people accessing **headspace**. They indicated that there is a lack of understanding among young people about the confidential nature of **headspace** services.

> *I think the barriers are similar [to non-LGBTIQ young people]. It seems to be about … what is going to happen with my information, are you going to tell my parents, my teachers, my friends?*
>
> —**headspace** service provider

> *A lot of people are still frightened to come out as well so if they know that there is some way that it's confidential, people will understand it.*
>
> —**headspace** young person, female, aged 21

Lack of awareness of need for help or uncertainty of services

Some young people indicated that they were unaware that they needed help or support for what they were experiencing, or felt that support was not necessary.

> *I just didn't need it.*
>
> —**headspace** young person, male, aged 23

> *A lot of it was personal, I was always wanting to deal with the stuff on my own, and I always thought I could.*
>
> —**headspace** young person, male, aged 23

> *Feeling that maybe I couldn't think straight and I didn't know what help I needed.*
>
> —**headspace** young person, male, aged 17

Some staff and young people indicated young people do not always know about services in the community from which they could obtain help, and were uncertain about treatment processes and what would be involved in getting help from **headspace**.

> *I didn't really know about any services.*
>
> —**headspace** young person, male, aged 20

> *Me in that situation, stopping me is knowing about the place, knowing how it works, all that kind of stuff. Just knowing that it exists.*
>
> —**headspace** young person, male, aged 23

*The awareness of it, yeah. And it's [**headspace**] quite a different place to the usual. If you think about coming and getting help or seeing a counsellor or something, it's quite a different experience.*

—**headspace** young person, male, aged 23

*To some extent it's what we put out there. If they Google transgender or gender dysphoria adolescent … and something like **headspace** doesn't pop up because it's not on the **headspace** site, then they're not going to know that **headspace** might offer something.*

—**headspace** service provider

Structural barriers

Service inaccessibility

Service providers, and to a lesser extent young people, identified a number of structural barriers that affect the accessibility of **headspace** services. These barriers included transport and remoteness, waiting times and limited resources.

Transport was discussed by some service providers and some young people as a barrier contributing to service inaccessibility, in that centres could often be a long distance away from young people's homes or schools and finding and affording transportation can be difficult for some young people. Notably, this transport barrier was related directly to the remoteness or location of certain regional and rural **headspace** centres and impacted all young people rather than LGBTIQ young people specifically.

*It takes an hour and a half by a bus to [station] and then it's like another half an hour to here [**headspace** centre].*

—**headspace** young person, male, aged 20

I was talking on the phone [to a young person], he's in [town], it's 2 hours away. His options are come and catch up for a … appointment [and] take the day off, he's got to take the day off work to do that.

—**headspace** service provider

While some staff indicated that wait times were currently reasonable, long waiting times for an initial or subsequent appointment was raised by some staff and some young people as a barrier that can contribute to poorer service accessibility.

We have a six week waiting list to get into the service here. We're receiving 100 referrals a month.

—**headspace** service provider

The biggest barrier for us is the fact that we've got so many people coming in the door, from the day they get seen for counselling, for example, it may just be too long and sometimes for all young people when they're ready they're ready now and they need [to be seen].

—**headspace** service provider

Most staff discussed complexities related to the model of funding that many **headspace** service provider roles function through and that meeting the needs of LGBTIQ young people can be restricted by the parameters of this model and available resources. Specifically, service providers working under the Medicare Better Access Scheme, whereby they can provide up to 10 free sessions of evidence-based treatment to young people who have a Mental Health Care Plan, highlighted challenges in working in a 'fee for service' model.

*Myself, because of the way **headspace** works, not being on a salary, I'm limited by what the Medicare system will allow me to do and the fact that I need to earn a living in that 'fee for service' way so that puts certain time pressures on clinicians who are working under that scheme.*

—**headspace** service provider

Trying to work in this fee for service way is hard because there's certain things that need to be done that fall outside of that model. I try to do what the individual wants and what the individual wants is along quite a spectrum of possibilities.

—**headspace** service provider

We are free to a point of entry and then you're relying on Medicare and for a young person who is trying to work with anxiety, depression, at the same time their gender identity, who they are, plus schoolwork, 10 sessions is not an appropriate model of care to be slotting them in to.

—**headspace** service provider

Personal and interpersonal facilitators

Facilitating factors that have a positive influence on LGBTIQ young people's access and engagement with **headspace** services were also investigated. The key personal and interpersonal facilitators that were discussed by more than a few participants included being a confidential and trusted service, having good rapport between young people and **headspace** staff, an open and accepting approach by staff, and that young people's needs were being met.

Confidential and trusted service

The understanding that **headspace** is a confidential and trusted service was reported by most young people and some staff as a facilitator for accessing and engaging with **headspace** services. They discussed the importance of confidentiality in helping young people to feel more comfortable attending and disclosing their concerns.

[Being a confidential service] that makes me feel a lot more comfortable talking about things because I don't want to say it's embarrassing but there are things I don't want to bring up, [in] my everyday life.

—**headspace** young person, male, aged 17

It's good, don't have to worry about my personal details going everywhere, people finding out things.

—**headspace** young person, female, aged 16

*Certainly when they speak to friends, friends that might already have been to **headspace**, and … [coming] to a centre like this for a young person is difficult enough, let alone adding an identity thing. But when they come in and say I've spoken to a friend about it and often they will tell me that the friend said that the confidentiality is pretty strict so people that already know about a **headspace** centre and how it works and the confidentiality thing, are pretty pleased with how tight we are with information.*

—**headspace** service provider

Good rapport with staff

Most young people and some staff discussed the importance of having good relationships between each LGBTIQ young person and the **headspace** staff (including their intake worker, clinician, and all other staff members the young people come into contact with at the centre). These positive relationships were seen as key facilitators to young people's engagement with **headspace**.

I finally found people that I can actually talk to, which is good.

—**headspace** young person, female, aged 21

All the people here have been amazing.

—**headspace** young person, male, aged 23

I always encourage people to come back if they need to and make them very aware that the door is always open and that's regardless of what minority group they might come from.

—**headspace** service provider

Open and accepting approach of staff

The open, accepting and non-judgemental approach of **headspace** staff was discussed by most young people and most service providers as contributing significantly to their ability to build positive relationships, and was a major facilitator for LGBTIQ young people accessing and engaging with **headspace**.

The clinician that did my interview was amazing … she was just really open with everything.

—**headspace** young person, female, aged 19

They were easy to talk to, no judgement, none of it. It's been good … they were understanding.

—**headspace** young person, female, aged 21

Even being aware that all staff here are actually really good and not judgemental and everything … then just coming in and stuff is reassuring.

—**headspace** young person, female, aged 19

I think the first appointment is really important because if it's difficult to engage with a young person and they feel that you don't hear them, or that you don't accept them, they're less likely to come back, so I think it's really critical to be non-judgemental and very accepting and very open so I just listen openly and do what I can.

—**headspace** service provider

Routinely asking young people about their sexuality early in the help-seeking process was highlighted by some staff as a specific facilitator for LGBTIQ young people accessing **headspace** services and opens the door for young people to raise any issues related to sexuality or gender identification.

I think one of our strengths in this centre is that initial contact, so having someone who is confident in asking around sexuality and actually feeling confident to delve into that and making that a very normal conversation I think has been a plus.

—**headspace** service provider

They may not be coming because of their sexuality issues but I think the fact that it's routinely asked – every single person here we'll ask them about it, and I think the fact that we're fairly non-judgemental, it's a very welcoming space … That's where it gets identified and it will be asked if there are any concerns around that.

—**headspace** service provider

Using respectful language when addressing young people, particularly for trans* and intersex young people, including correct pronouns and preferred names, was identified by some staff as a facilitator to ongoing engagement with **headspace**.

> *The first time they're quite nervous and anxious, and that's understandable. Our admin are quite warm and friendly so once they fill out the paperwork they ask a few questions. We're very good at calling them [trans* young people] whatever they want to be called.*
>
> —**headspace** service provider

> *First things first, what do you want to be called? Especially with our trans*… Unfortunately with our systems you have to have your birth name in the system, but it's all over our notes, would you prefer to be called [name] or would prefer to be called whatever, and the pronoun. It's all documented so they [staff] take it really seriously.*
>
> —**headspace** service provider

> *I think language is a big thing, especially with trans* people, and if you put someone off it's hard for them to come back.*
>
> —**headspace** service provider

Structural facilitators

The structural facilitators that were identified included: providing a safe, welcoming and non-judgemental environment; service accessibility; and connections and referrals with other services.

Safe, welcoming, and non-judgemental environment

Linked to the open and accepting approach of staff, providing a safe and non-judgemental environment that is both youth and LGBTIQ friendly was identified as a facilitator by most staff and young people. Displaying the LGBTIQ rainbow flag was viewed as an important element to identifying **headspace** centres as a safe and welcoming environment for LGBTIQ young people.

> ***headspace** is particularly welcoming; there's always the rainbow flag in the window and a little sticker on the door saying safe space for LGBT and that kind of thing.*
>
> —**headspace** young person, female, aged 20

> *Cultivating a reputation that can be accepting and friendly and safe for LGBTIQ people, appropriate posters and signage around the place. Doesn't seem like much but it is important.*
>
> —**headspace** service provider

> *Some of the ones [young people] that we have had referred from other services … or from schools, have come to us because they know that we are youth-friendly and have an LGBTIQ friendly environment.*
>
> —**headspace** service provider

> *We've been pretty cognisant around the need to have posters in the waiting room that declare it to be an inclusive space and we've done lots of work on that and the feedback we've had … is that we are very inclusive but it has required a lot of work to send that message out, that this is inclusive as an LGBTIQ friendly space.*
>
> —**headspace** service provider

We used to have the signs up everywhere 'when did you tell your parents you were straight?' and I thought having all those signs up were good but our youth reference group … said we'd gone too far. All the community want to see is the flag out for support. So we removed everything on their advice and just put the flag up.

—**headspace** service provider

As well as the images and messages displayed, the lay out of the waiting room was also raised as a factor that contributed to young people's level of comfort in attending **headspace**. Some service providers indicated that this acted as a facilitator (or barrier) particularly for young people with gender identity concerns.

The waiting room. We used to have it as a very open space and I think we've now got little hubs so that people can feel like they can sit and be private rather than everyone looking at them, because we do have lots of kids transitioning and I think it can be a bit overwhelming just sitting there with everyone looking at you … We've tried to make it a really … safe space.

—**headspace** service provider

Young people, especially if they are transitioning, might not look the way that they would really like to be looking, and I guess maybe they get a bit self-conscious that people are staring at them, so I think it's better to have little spaces where people can [wait and] have a bit of privacy, where other people's parents and other kids aren't staring at them.

—**headspace** service provider

We reorganised furniture in the waiting area to afford somewhat more privacy to people, create some sense of confidentiality.

—**headspace** service provider

Service accessibility

Some staff and young people discussed service accessibility as a facilitator to attending **headspace**. This included service factors such as having short waiting times for appointments, providing a low cost service, providing financial assistance with transport.

I had to get my referral, which I did, but other than that I didn't really wait long.

—**headspace** young person, female, aged 21

The fact that it's free or very low cost, absolutely that's a big facilitator.

—**headspace** service provider

I also try and assist people to help seek so we will say we will pay one way, you've got to find the other way. So pay your [one way bus fare] and we will get you home.

—**headspace** service provider

Relationships with other agencies

The networks **headspace** centres build with other community services and assisting young people to access additional care by providing and receiving referrals to and from other services was identified by some service providers and young people as a facilitator to LGBTIQ people receiving appropriate care. Connections with services that have specialised knowledge in sexuality and gender identification issues were viewed as particularly valuable.

*I've been getting all my treatment here [**headspace**]. [But] I'm just about to get referred out to get some more help … and they've assisted me, I've actually got a referral …in case I need to go somewhere else.*

—**headspace** young person, male, aged 23

When I was seeing one of the [service providers] here I was telling them about some of the problems I was experiencing … so they arranged personally to help me get out to other places and see people that would be able to help me.

—**headspace** young person, male, aged 17

There are practical things you can do in more marginalised groups and a lot of it is working with other agencies and having good relationships with other agencies.

—**headspace** service provider

With community development, I try and pair up with local organisations that are specifically working with the LGBTIQ.

—**headspace** service provider

Clinical file review

A clinical file review was completed on the records of 20 LGBTIQ young people who had accessed services at a **headspace** centre to identify service use patterns as well as barriers and facilitators to service engagement.

Barriers to accessing or engaging in **headspace** services were identified in the clinical records of the majority of audited LGBTIQ young people. Primary barriers included low motivation or negative attitude to treatment or treatment options, poor family support, poor rapport with the clinician, negative past experiences with mental health services, premature termination of treatment, and having more immediate concerns or other priorities.

All of the LGBTIQ young people had evidence in their clinical records of one or more facilitators to attending **headspace**. Referrals and re-referrals from external services, support from external service providers, self-referrals, family support, good rapport between young person, clinician and service, belief in the service's ability to help, and service availability were all highlighted as facilitators to accessing or engaging in **headspace** services.

4.6 Summary of main findings

While up to one in five Australian young people may report sexual attraction to the same or both sexes (Mitchell, et al., 2014), only one to three per cent identify as LGBTIQ (Fergusson, et al., 2005; McNair, et al., 2003; Smith, et al., 2003). Overall, the level of representation of LGBTIQ young people accessing **headspace** services at 13.5 per cent well exceeds this estimated national LGBTIQ population. Nevertheless, given LGBTIQ young people's increased vulnerability to mental health concerns, stigma and discrimination it is important that **headspace** is working to reduce the barriers and increase the facilitators to make all **headspace** services attractive and appropriate for LGBTIQ young people.

Over half of LGBTIQ young people were bisexual and the majority were female. Almost one quarter of LGBTIQ young people identified as lesbian or gay, with another quarter who were predominantly younger adolescents reporting they were questioning their sexuality. Less than five per cent of LGBTIQ young people accessing **headspace** were trans* or intersex. Centres in major cities had the highest representation of LGBTIQ young people accessing their services and they presented for largely the same reasons as non-LGBTIQ young people. It was rare (less than two per cent) for a young person to access **headspace** primarily due to concerns about their gender or sexuality. LGBTIQ young people were equally as satisfied with the services they receive at **headspace** as non-LGBTIQ young people. However, trans* and gay and lesbian young people in particular showed different patterns of influence for attending **headspace**, suggesting they are more self-motivated and less often influenced by family than other young people.

Interviews with LGBTIQ young people and staff at two centres that have a high proportion of LGBQTI clients identified a wide range of barriers and facilitators to accessing and engaging with **headspace** services. This report has described the key personal and structural elements that were most common to staff and young people and mentioned by more than a few participants.

Many of the barriers experienced by LGBTIQ young people in accessing and engaging with **headspace** services reflect those experienced by all young people (as reported in **headspace** Best Practice Model) (Rickwood et al., 2014). This report has detailed many of these personal and structural barriers and has emphasised those barriers that may be intensified for LGBTIQ young people or that are specific to this minority group's experience.

The key personal and interpersonal barriers identified through interviews and the clinical file review were: stigma and concern for acceptance; confidentiality concerns; lack of awareness of need for help or uncertainty of services; low motivation or negative attitude to treatment; poor family support; poor rapport with the clinician; negative past experiences with services; and having more immediate concerns or other priorities. The key structural barrier was service inaccessibility which included transport and remoteness, waiting times and limited resources. The key facilitators mirrored these barriers and focused on: being a confidential and trusted service; good rapport with staff; the open and accepting approach of staff; providing a safe, welcoming and non-judgemental environment; service accessibility; self-referrals; family support; having connections and referrals with other services; and belief in the services ability to help.

The barriers emerging from this research were consistent with previous literature that had also identified fear of being misunderstood to LGBTIQ status, confidentiality concerns and negative past experiences with services as barriers for LGBTIQ young people. Other barriers identified by previous research that were not raised in relation to **headspace** service access were low confidence in services' capacity to help, belief that their specific needs will not be met, and a tendency to access a GP rather than a mental health service (Sperber, et al., 2005; Travers & Schneider, 1996; Williams & Chapman, 2011). In contrast, belief in the service's ability to help was identified as a facilitator in the current research. This finding may be a positive outcome that suggests **headspace** services have developed trust and confidence among young people regarding the effectiveness of the service and its ability to help, which is valued highly by young people.

The current research identified a greater number of facilitators than were evident in past literature. These included increased motivation to seek support and self-referral, which were consistent with Ciro, et al. (2005), as well as being a confidential and trusted service, good rapport with staff, the open and accepting approach of staff, providing a safe and non-judgemental environment, service accessibility, family support, having connections and referrals with other services, and belief in the service's ability to help, that had not been identified in previous literature. Notably, seeking care for other reasons as reported in Sperber, et al. (2005) was not identified as a facilitator to service access in this research.

Table 4.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young people who are LGBTIQ.

Table 4.3: Barriers and facilitators to accessing and engaging with headspace for young people who are LGBTIQ

Barriers	Facilitators
Personal & Interpersonal	
– Stigma and concerns about judgement and acceptance	– Non-judgemental staff – Respectful language
– Confidentiality concerns regarding mental health problems as well as disclosure of sexuality and gender identity	– Confidential and trusted services – Openness and asking about sexuality and gender identity by service providers
– Lack of awareness of services and need for support	
	– Positive relationships with staff
Structural	
	– Rainbow flag on display – Some private spaces in wait room
– Lack of accessibility	– Transport support, low cost, short wait times
	– Connections and referral to other local services for young people who are LGBTIQ

The main findings emerging from this research are:

- Many LGBTIQ young people are accessing **headspace** and a large proportion are females who identify as bisexual.
- The stigma associated with seeking help for mental health problems and for LGBTIQ status must be addressed as it is the major barrier for LGBTIQ young people attending **headspace**. This effect is worsened for trans* and intersex young people.
- An open, non-judgemental approach from staff, and providing a welcoming, safe environment at **headspace** is particularly important for LGBTIQ young people.
- Centres need to be known and trusted in the commuity for providing a comfortable and accepting environment where young people won't be judged, regardless of their sexual preference or gender identity.
- Centres need to ensure confidentiality and disclosure policies are clear, accessible and promoted to all young people to ensure they feel comfortable and safe to dicsuss any concerns.
- Centres need to continue to develop strong relationships with key local services to facilitate referrals and access to specialised care, including warm referrals (where required).

An important caveat on these findings must be noted, however; the current data came from young people currently engaged with **headspace** services. Accordingly, the information does not reflect the experiences or opinions of young people who are unknowledgeable of, or are unwilling or unable to engage with **headspace**. Although there is greater complexity involved in obtaining such data, it would make for a valuable companion piece to the present findings and recommendations, and would help to contextualise next steps toward better engaging this cohort with available **headspace** services.

4.7 Recommendations

Table 4.4 details potential strategies to assist with improving service delivery for young people who are LGBTIQ.

Table 4.4 headspace model development for young people who are LGBTIQ

Principles	Potential strategies
1. Community awareness	– Use the **headspace** brand to promote help-seeking in the community and breakdown perceived stigma and shame associated with accessing a mental health service. – Promote **headspace** to the community as a safe place where LGBTIQ young people can seek support.
2. Promotion of confidential service	– Promote **headspace** as a confidential service. – Communicate clear guidelines regarding confidentiality and circumstances in which it may have to be breached. – Train all staff in the importance of client confidentiality and its relevance in particular to LGBTIQ young people.
3. Welcoming and accepting environment	– Ensure staff are friendly, non-judgemental and accepting of young people regardless of their sexual orientation or gender identity. – Provide an open and friendly environment where LGBTIQ young people feel safe and accepted. – Display the LGBTIQ rainbow flag and other appropriate imagery to promote **headspace** as safe and supportive for LGBTIQ young people. – Ensure waiting room is welcoming and comfortable for all young people, including providing spaces that afford young people some level of privacy if desired. – Ensure staff use respectful language, appropriate pronouns and preferred names for trans* and intersex young people.
4. Service links	– Continue to develop strong working relationships with other local services in order to provide timely access to more specialised care (where needed) and to aid productive referrals.

4.8 References

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5. Young People who are Aboriginal and/or Torres Strait Islander

5. Young People who are Aboriginal and/or Torres Strait Islander

5.1 Background

Aboriginal and Torres Strait Islander young people are a population group of specific significance to **headspace**. The Aboriginal and Torres Strait Islander population of Australia is particularly young, with 57.5 per cent aged 25 years or under, which compares with 33.4 per cent of non-Indigenous population (Australian Bureau of Statistics, 2013). Aboriginal and Torres Strait Islander young people are disproportionately exposed to risk factors, such as grief, loss and discrimination, which greatly affect their social and emotional wellbeing, and they experience higher rates of suicide and risk of suicide compared with other Australian young people (Zubrick et al., 2005).

The Australia Government's definition of Aboriginal and Torres Strait Islander identity combines three elements: descent, identification and acceptance. An Aboriginal and/or Torres Strait Islander person is someone who is of Aboriginal or Torres Strait Islander descent, identifies as an Aboriginal person or Torres Strait Islander person and is accepted as such in the community where he or she lives or comes from (The Australian Council, 2010).

Aboriginal and Torres Strait Islander people, particularly those living in rural and remote Australia, have higher levels of psychological distress compared with other Australians, with 77 per cent indicating they have experienced at least one major stressor in the previous 12 months; the most common stressor reported was the death of a family member or close friend (Australian Institute of Health and Welfare, 2008). Aboriginal and Torres Strait Islander people also have higher rates of mental health problems, predominantly depression, comorbid mental health and substance abuse problems, and post-traumatic stress disorder (Australian Bureau of Statistics, 2008). Part of the reason for the higher rates of mental illness is the history of trauma, including intergenerational trauma, and grief that followed colonisation (Department of Families Community Services and Indigenous Affairs, 2009). High unemployment rates, and inequalities in other social determinants of health, also contribute to mental health and wellbeing problems for Aboriginal and Torres Strait Islander people (Thomson et al., 2010).

Despite much higher rates of mental health problems, Aboriginal and Torres Strait Islander young people's access to mental health services is considerably lower than that of non-Indigenous youth (Parker & Ben-Tovim, 2002). Studies that have examined the help-seeking behaviours of Aboriginal and Torres Strait Islander young people have concluded that they do not access mental health services at a level corresponding to their needs (Blair, Zubrick, & Cox, 2005; Hunter, 2007).

Barriers to help-seeking that may be more prominent for Aboriginal and Torres Strait Islander young people include intergenerational stigma, mistrust of mental health services and feelings of shame associated with help-seeking, particularly regarding mental illness (Rickwood, Gridley, & Dudgeon, 2010). Additionally, Aboriginal and Torres Strait Islander young people commonly report reliance on informal supports, poor service knowledge, and concerns about confidentiality as barriers to accessing support. Aboriginal and Torres Strait Islander young people may be more comfortable seeking support from family (i.e., parents, grandparents and elders) due to concerns about confidentiality, shame and lack of cultural competence from external sources of support (Mohajer, Bessarab, & Earnest, 2009; Westerman, 2004).

Furthermore, 19.7 per cent of Aboriginal and Torres Strait Islander youth (aged 12-25 years) live in rural and remote Australia compared to 1.4 per cent of non-Indigenous youth (Australian Bureau of Statistics, 2013), and geographic location, which contributes to lack of access to appropriate services among other issues, is therefore likely to be another barrier that is more pronounced for this group.

Facilitators to Aboriginal and Torres Strait Islander young people accessing services can include having information needs met, supportive clinicians, and perception of safety in treatment (Mohajer, et al., 2009; Price & Dalgleish, 2013).

5.2 Aims

Given the high level of unmet need, along with extensive variation across **headspace** centres in the engagement of Aboriginal and Torres Strait Islander young people, it is important for **headspace** to further investigate the barriers and facilitators specific to Aboriginal and Torres Strait Islander young people accessing the support they require. This chapter aims to identify approaches that can assist **headspace** centres to reduce the barriers and increase facilitators to ensure all **headspace** services are appropriate and accessible for Aboriginal and Torres Strait Islander young people requiring support.

5.3 Methodology

The following methodology was used to gain an understanding of the barriers and facilitators that Aboriginal and Torres Strait Islander young people may encounter to accessing required services and supports through **headspace**.

1. A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care for Aboriginal and Torres Strait Islander young people.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Clinical file review for 20 young people across several centres who identity as Aboriginal and Torres Strait Islander and who have accessed a **headspace** centre.
4. Interviews with six Aboriginal and Torres Strait Islander young people, three parents and nine **headspace** service providers from two **headspace** centres with high rates of Aboriginal and Torres Strait Islander participation (centres were identified from MDS data over a 12 month period).
5. Two focus groups with members of the **headspace** Aboriginal and Torres Strait Islander Youth Reference Group.

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews and focus group have been analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses (see Table 5.1). This type of analysis allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 5.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Ethical considerations

It is important to note that the research undertaken for this chapter was guided by the NHMRC *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NHMRC, 2003).*

Consequently, additional processes and consultation were involved to adhere to the values underpinning the guidelines and to ensure accountability to the Aboriginal and Torres Strait Islander community. Extensive consultation was undertaken with Aboriginal and Torres Strait Islander stakeholders within **headspace** to ensure the project was relevant and would benefit Aboriginal and Torres Strait Islander young people and communities. Specifically, the following groups were engaged at various points throughout the project cycle: the **headspace** Aboriginal and Torres Strait Islander Board Sub-Committee; the Aboriginal and Torres Strait Islander Youth Reference Group; and the Aboriginal and Torres Strait Islander Project Manager. These groups were involved in assessing the appropriateness of the methodology, participation in the research itself, and commenting and providing advice on the draft report.

Finally, any use of this research and its findings to drive service improvement across **headspace** centres will be overseen by the **headspace** Aboriginal and Torres Strait Islander Board Sub-Committee and the Aboriginal and Torres Strait Islander Project Manager.

Table 5.2 outlines the focus group and interview participants, including the gender and age of young people involved.

Table 5.2: Participants

headspace centre 1 (QLD)	
Staff	
Centre manager	
Intake clinician	
General practitioner	
Psychologist	
Young people	
Female, age 17	
Female, age 19	
Parents	
Mother of 21yr old male	
Mother of 15yr old male	
headspace centre 2 (NSW)	
Staff	
Centre manager	
Psychologist	
Aboriginal education officer	
Youth engagement officer	
Youth care coordinator	
Young people	
Female, age 14	
Female, age 16	
Male, age 18	
Male, age 20	
Parents	
Mother of female	
headspace Aboriginal and Torres Strait Islander Youth Reference Group	
Focus group 1 (n=6)	
Focus group 2 (n=6)	
Total staff	**9**
Total young people	**18**
Total parents	**3**
Total	**30**

5.4 Literature review

A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health services for Aboriginal and Torres Strait Islander young people identified only three studies; each used a qualitative research method.

Two of the studies were conducted in Western Australia (Hayward, 2009; Mohajer, et al., 2009); the third was a national study (Price & Dalgleish, 2013). One of the Western Australian studies (Hayward, 2009) and the national study (Price & Dalgleish, 2013) recruited Aboriginal and Torres Strait Islander school students, aged between 10 and 24 years, with no gender details recorded in the Western Australia study, and predominantly female participants (68%) in the national study. The other Western Australia study (Mohajer, et al., 2009) was conducted in two rural Aboriginal communities, with Aboriginal and Torres Strait Islander young people aged 11-18, and again the majority of participants were female (60%).

All three studies focused on help-seeking behaviour and sources of help, reporting barriers and facilitators to accessing services. A preference for seeking help from informal supports was a common barrier across studies. Poor service knowledge (Hayward, 2009; Price & Dalgleish, 2013), concerns about confidentiality, and stigma and shame around seeking help (Mohajer, et al., 2009; Price & Dalgleish, 2013) were common barriers in two of the three studies. Other barriers, identified in only one study were language or literacy concerns, having had a racist first experience with a service (Mohajer, et al., 2009), concerns about confiding in a person they don't know, and concern the service would not understand their needs (Price & Dalgleish, 2013).

The facilitators identified by these studies were all unique and included: an awareness of the availability of health services (Hayward, 2009); the service being seen as safe and supportive, and a place to meet and get information (Mohajer, et al., 2009); and having trained and qualified counsellors who listen, as there is less risk of judgment (Price & Dalgleish, 2013). This last study also found that participants were more likely to access formal help when informal sources were exhausted or inaccessible and the issues were of a more serious nature, such as bullying, grief and loss, and alcohol and other drug problems.

Although all the studies had good sized samples for qualitative studies (N=41,Hayward, 2009; N=99,Mohajer, et al., 2009; N=60,Price & Dalgleish, 2013), they provide limited information about the access and engagement needs of Aboriginal and Torres Strait Islander young people and further research is needed.

5.5 Results

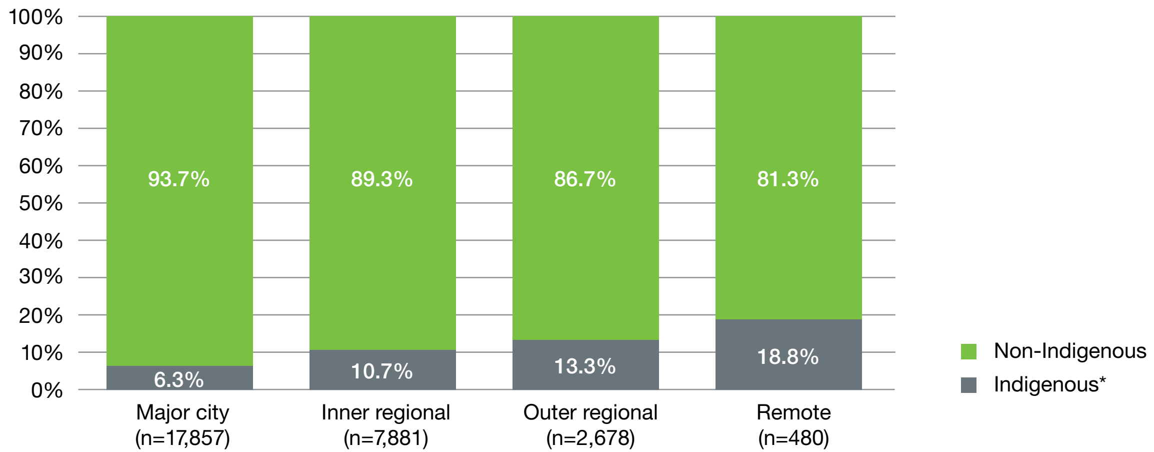
Client profile

Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of the Aboriginal and Torres Strait Islander young people who access **headspace** and provide an outline of how they compare with all services users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus excluded from the analysis).

Of this sample, 2,415 young people identified as Aboriginal and/or Torres Strait Islander, representing approximately 8.4 per cent of all **headspace** clients for whom data were available (28,896). This figure compares favourably with 2011 census data showing that four per cent of Australians aged 12-25 years identify as Aboriginal and/or Torres Strait Islander young people (Australian Bureau of Statistics, 2008).

Across the **headspace** centres there is wide variation in the level of access by Aboriginal and Torres Strait Islander young people, ranging from 28 per cent at one centre to less than two per cent at other centres. Similarly, there is large variation across the States and Territories, with centres located in the Northern Territory having the greatest proportion of Aboriginal and Torres Strait Islander young people at 18 per cent, followed by South Australia at 11.5 per cent, Queensland and New South Wales/ACT at 10 per cent, and Tasmania at 9 per cent. The two states where centres have the lowest proportion of Aboriginal and Torres Strait Islander young people are Western Australia at 5 per cent and Victoria at 4 per cent. Figure 5.1 shows that the centres with the greatest proportion of Aboriginal and Torres Strait Islander young people are in outer regional or remote areas.

Figure 5.1: Percentage of Aboriginal and Torres Strait Islander young people by centre rurality



*Indigenous refers to Aboriginal and Torres Strait Islander people.

Of the 2,451 Aboriginal and Torres Strait Islander young people, 61 per cent were female and 39 per cent were male, which is comparable with all clients (62% female versus 38% male). Across all clients, 8.2 per cent of females and 8.8 percent of males identified as Aboriginal and Torres Strait Islander. Figure 5.2 shows the proportion of young people identifying as Aboriginal and Torres Strait Islander across gender and age groups, with the largest proportion aged 12-14 years for both females and males (for males the age trend was strongest).

Figure 5.2: Percentage of Aboriginal and Torres Strait Islander young people by gender and age group

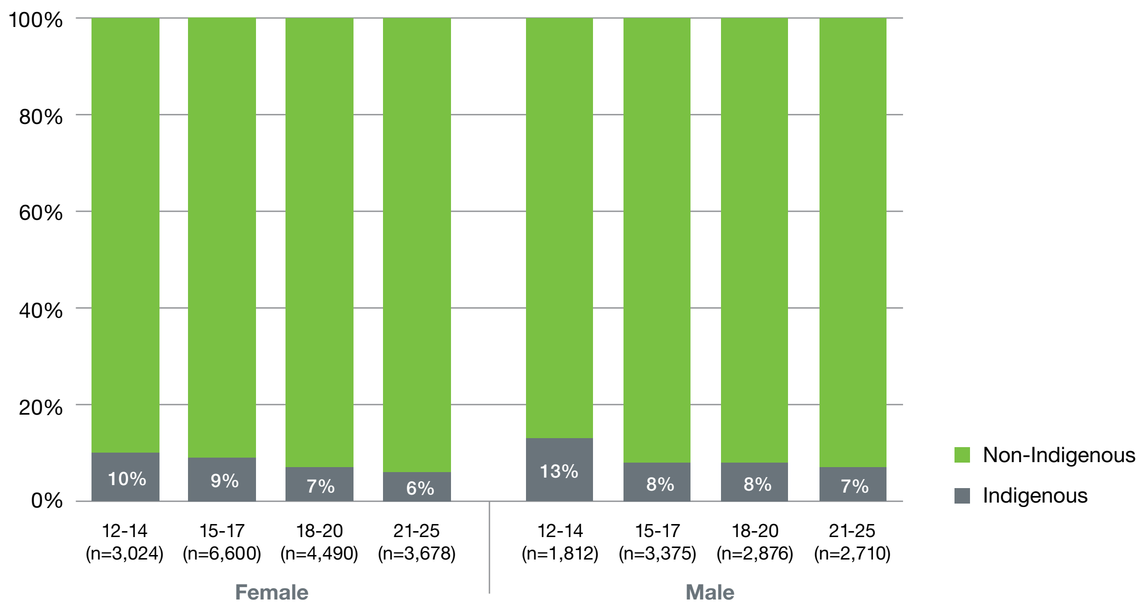
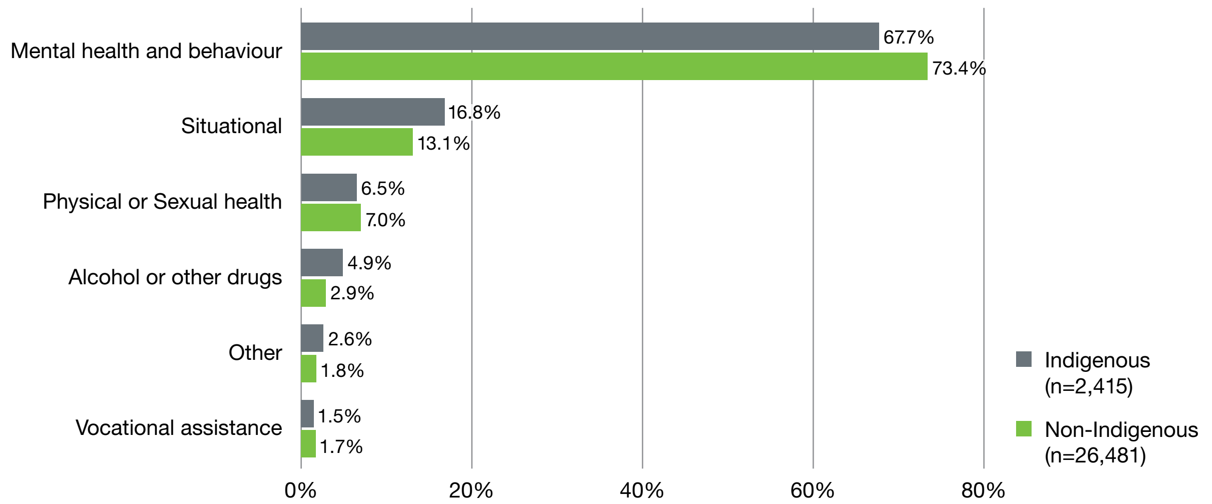


Figure 5.3 outlines the main presenting issues of Aboriginal and Torres Strait Islander compared to non-Indigenous young people, and although the majority of both groups present with mental health issues followed by situational issues there is some variation between groups. For example, Aboriginal and Torres Strait Islander young people are more likely to present for situational issues (17% versus 13%), and for issues related to alcohol and other drugs (5% versus 3%), and less likely to present for mental health issues than non-Indigenous young people (68% versus 73%). For Aboriginal and Torres Strait Islander young people, the primary situational issues were conflict at home, difficulties with personal relationships, bullying, grief, trauma and homelessness. The type of situational issues experienced varied considerably across groups, with Aboriginal and Torres Strait Islander young people proportionally more likely to present for situational issues related to trauma (11% versus 6%) and homelessness (10% versus 5%), and less likely to present with conflict at home (22% versus 31%) or difficulty with personal relationships (20% versus 25%) compared to non-Indigenous young people.

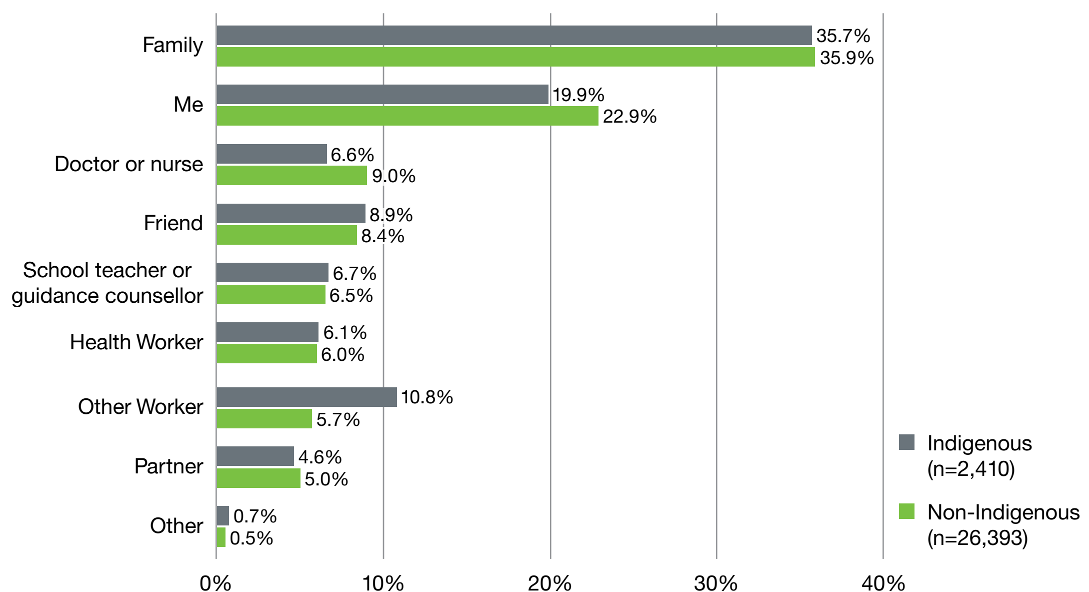
Similarly, there was variation in the types of mental health issues faced between groups. Although depression and anxiety make up the greatest proportion across both groups, Aboriginal and Torres Strait Islander young people were proportionally much less likely to present with anxiety (23% versus 32%), and more likely to present with anger issues (16% versus 7%) and behavioural problems (6% versus 2.5%).

Figure 5.3: Main reason for presentation at **headspace**



Aboriginal and Torres Strait Islander young people have similar patterns regarding who has encouraged or influenced them to attend a **headspace** centre as non-Indigenous young people. They are both most likely to be influenced to attend by a family member, followed by self-referral (see Figure 5.4). However, Aboriginal and Torres Strait Islander young people are less likely to be influenced by a doctor or nurse and are twice as likely to be influenced by other workers, such as welfare or community services workers and police, corrections or justice officers, compared with non-Indigenous young people[8].

Figure 5.4: Pathways to **headspace**

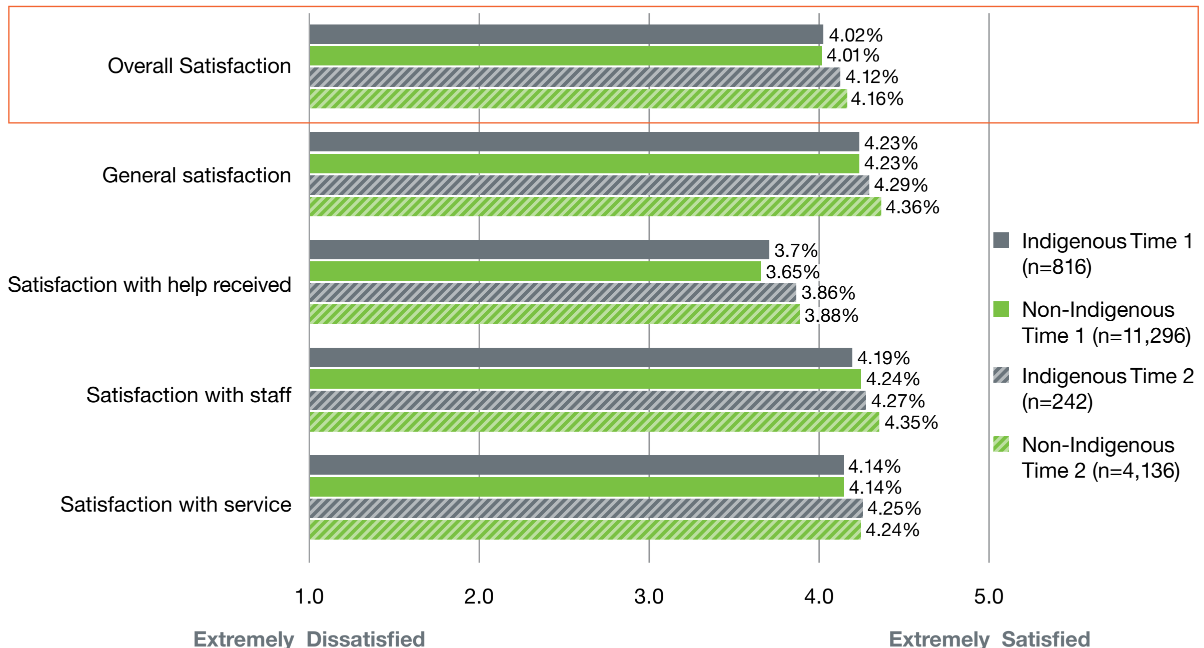


[8] Differences between Aboriginal and Torres Strait Islander young people and non-Indigenous young people's influence to attend were observed over and above any age and gender effects.

Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their service. During this period, over 12,000 young people completed a survey and 816 of these identified as being Aboriginal and Torres Strait Islander (6.7%). The survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied. Results are presented in Figure 5.5 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups and results indicate that there were no significant differences in satisfaction between Aboriginal and Torres Strait Islander and non-Indigenous young people.

Figure 5.5: Satisfaction for Aboriginal and Torres Strait Islander and Non-Indigenous headspace young people



Barriers and facilitators

Data from the interviews and focus groups with Aboriginal and Torres Strait Islander young people, parents and centre staff, and the clinical file review revealed a range of facilitators and barriers to service access and engagement.

The main barriers raised by young people included stigma, shame, confidentiality, fear, concerns about cultural awareness and appropriateness, remoteness and transport. Staff raised similar issues, but also highlighted barriers of anxiety, intake processes, and different help-seeking approaches.

The primary facilitators discussed by Aboriginal and Torres Strait Islander young people included confidentiality, service known and trusted within the community, culturally appropriate and safe service, easy to access services, and short waiting times. Additional facilitators that helped them to remain engaged included their needs being met, that they were listened to, and that their experience was positive. Staff raised a much wider list of facilitators, which in addition to those raised by young people included the service being youth friendly and culturally sensitive, providing family support, offering flexible appointments, and supporting young people to access other services where required.

Although there was a wide range of barriers and facilitators identified across the findings, there were only a handful of barriers and facilitators that were common to staff and young people and mentioned by more than a few participants. These key barriers and facilitators are discussed in detail below and are categorised as either: *personal and interpersonal*, which includes stigma and shame, confidentiality, cultural appropriateness, and community awareness; or *structural*, which includes welcoming environment, remoteness and transport, and intake processes.

Additionally, the clinical file review identified the primary barrier for access and engagement to **headspace** as reluctance to seek formal mental health treatment. A few additional barriers to accessing and remaining engaged in services were identified and included: more immediate concerns or work commitments; poor coping with symptoms; and limited family support (although the level of endorsement for each of these factors was low). Facilitators that were reported included: motivation for treatment; self-referral; re-referral, either internally or from an external source; previous mental health treatment; good fit between clinician and young person; a good relationship with the service; availability of the service; peer support; and improvements in mental health.

Personal and interpersonal barriers

Stigma and shame

The stigma attached to mental illness and shame in accessing help act as a significant barrier for many Aboriginal and Torres Strait Islander young people to seek mental health support and treatment. Some young people spoke about feeling a sense of shame in admitting that they had a mental illness and they also felt shame and embarrassment for seeking help for their problems. A key part of this was to do with seeking help and talking to people outside of their family or community.

> *Shame that I go to see someone. Shame to admit there is something wrong, it is going against your family. I don't want that.*
>
> —**headspace** young person, female, aged 17

> *A lot of stigma just around mental health.*
>
> —**headspace** Aboriginal and Torres Strait Islander reference group member

> *… they most likely will be ashamed to talk to someone like other than their family.*
>
> —**headspace** young person, female, aged 17

> *At first I was like that, when I went to my first session at a different service, like it was shame, I didn't really want to talk because it was like: who is this lady? Basically it's like one of those stranger things.*
>
> —**headspace** young person, female, aged 17

Parents interviewed as part of the research re-iterated that shame and stigma were key barriers for Aboriginal and Torres Strait Islander young people.

> *I do feel that Indigenous people are more shy and very shameful to open up to people that they don't know and I suppose just opening up to anybody in general.*
>
> —**headspace** parent

> *I think it's a stigma of - they think they're going to be discriminated against. I know a lot of them are shy, very shy, especially with eye contact. I think too a lot of them try and keep it within their family and work on it within their family.*
>
> —**headspace** parent

Most service providers also listed stigma and family shame as a barrier for Aboriginal and Torres Strait Islander young people accessing **headspace**. They felt that many Aboriginal and Torres Strait Islander young people who are affected by mental health problems often do not acknowledge their need for help, either to themselves or their family, and find it difficult to seek help. Also acknowledging that many Aboriginal and Torres Strait Islander young people perceive accessing help as shameful to their family or community and are worried how it will be perceived. As a strongly collectivist society, there is often a sense of responsibility to family and to the community before consideration of individual needs that can increase the stigma for Aboriginal and Torres Strait Islander young people (Dudgeon, Wright, Paradies, Garvey, & Walker, 2014).

> *I think it's this perception that going to* **headspace** *and talking to a counsellor means that you're crazy … so, there's a lot of perception around how am I going to look in my family or in my group if I do that.*
>
> —**headspace** service provider

> *If we look at the Aboriginal community, it's a big word [mental illness] within the Aboriginal community, it's the shame. They don't want to present with the shame of the help-seeking.*
>
> —**headspace** service provider

Unfortunately within our communities as a whole, there is a normalisation of mental health issues, so often someone either won't ever seek assistance and they'll live with it, without having that assistance or they'll seek help in a crisis when they've hit absolute rock bottom, or when the issue is too big.

—**headspace** service provider

The normality of mental health issues in our community and not even being able to recognise it yourself is a big barrier to accessing support if you think, well this is just normal, this is just life.

—**headspace** service provider

headspace staff also reported there were clear and observable outcomes attributable to these barriers in the number of Aboriginal and Torres Strait Islander young people failing to take up services when offered or referred.

We get quite a lot of referrals for Indigenous people but the amount that actually turn up or engage is fairly limited … If we can get them here then it's fine, once they've seen us, but it's actually getting the people to come in and have a look around and not feel ashamed, because there's a huge shame factor. And even if nobody is outside they perceive that people are going to see that they're going somewhere.

—**headspace** service provider

Somewhat related to the stigma and shame, nervousness, anxiety or fear about seeking help were raised as barriers by most staff and some young people.

I was a bit nervous; I was a bit scared to tell them about my own life and what I'd been through.

—**headspace** young person, male, aged 20

Nervous for me, I was a bit scared being around like people, no offense, talking to people from different cultures.

—**headspace** young person, male, aged 20

However, when questioned further half of the young people who raised fear as a barrier did not believe it was an issue specific to Indigenous young people and thought that all young people would be fearful with accessing this kind of help the first time, regardless of their cultural background.

Confidentiality concerns

Directly related to barriers raised around stigma and shame, most staff and some young people indicated that confidentiality concerns pose a considerable challenge for Aboriginal and Torres Strait Islander young people in seeking the advice and support they need. These concerns primarily revolved around whether the service is going to share confidential information with the young person's family or community, or whether they will find out that the young person is accessing mental health services.

Indigenous people, they're highly suspicious and dubious that you're going to tell other people and that their private, confidential information is going to get out somewhere.

—**headspace** service provider

Confidentiality is a real barrier … I can imagine word of mouth around family.

—**headspace** service provider

Similarly, some young people discussed concerns around confidentiality, indicating that they may be reluctant to seek help initially because of fear that their family, friends or community would discover they were attending a mental health service.

> *I don't want some family to know I come. They think it's 'white man' place. I went to the Aboriginal Medical Centre, and like all the family are actually talking about it … the girl at the front desk, she knew me and she told my family. I got wild about it.* ***headspace*** *won't tell, makes me come back.*
>
> —**headspace** young person, male, aged 20

Cultural appropriateness

Most staff and some young people raised concerns about cultural appropriateness of the service and the barrier this raises for Aboriginal and Torres Strait Islander young people. Cultural appropriateness was viewed from a number of different perspectives and participants raised multiple cultural barriers including uncertainty about what **headspace** is and what they will receive, cultural awareness of staff, appropriateness of the treatment approach, and environmental barriers. Each of these barriers is discussed below.

Appropriate service

Aboriginal and Torres Strait Islander young people feel a strong connection to their culture and may delay accessing **headspace** for the fear that it will not offer a safe and culturally respectful model of service. For some young people they are unsure around what to expect or how they will be treated when walking into a **headspace** centre.

> *… with Indigenous [young people] there's quite a bit of anxiety around help-seeking, uncertainty about acceptance, are they going to be comfortable here, are they going to be understood and is there someone who is going to be culturally aware?*
>
> —**headspace** service provider

Furthermore, staff indicated that some Aboriginal and Torres Strait Islander young people consider accessing help formally, or even from a non-Indigenous health service, as disrespectful to their family or community. A young person may have to seek permission or approval to access a mental health service, which for many becomes a significant barrier.

> *What I found was that the Aboriginal and Torres Strait Islander families had a lot more hurdles to step over before being able to access services and engage with services so they needed to speak with their auntie or whoever it was that is their … their role model … and they need permission in order to be able to engage with a service and sometimes they do need to bring people along with them.*
>
> —**headspace** service provider

> *Those communities might be more likely to seek help from one another and have a more inwardly directed help-seeking approach.*
>
> —**headspace** service provider

> *I don't know whether it is, like … you've got to stay within Community and get all your help within Community, there's definitely an attitude of that.*
>
> —**headspace** service provider

Treatment approach

Most staff indicated that standard treatment approaches can sometimes be culturally inappropriate and can become a real barrier to Aboriginal and Torres Strait Islander young people engaging with the services.

> *… we're taught under a Western framework however it's completely different to what it's like in communities so, you know, if clients go in and say I'm feeling depressed, I had a relationship breakdown, whereas for us it could be, I'm feeling depressed because I don't have a home, my family use drugs and alcohol, everything contributes to mental health whereas you know, in Western it's like one singular cause or one singular symptom of this so I think a lot of people don't understand that it's not just one thing it's everything.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

> *I think a massive cultural issue is that they shouldn't be like that and the upbringing for some, they might see, for example, their dad dealing with these issues by having alcohol or doing drugs so that's how they've learnt to deal with their issues and they don't need anybody else to intervene because that's what their culture might be, so just different techniques that they have with seeking help in their culture.*
>
> —**headspace** service provider

Most staff expressed that Aboriginal and Torres Strait Islander young people find it difficult to talk about their emotional and mental state, and therefore may not respond well to the standard treatment approaches offered at **headspace**.

> *They are just not confident in speaking out about saying I need help with this, I'm not really comfortable with this. So I find that quite tricky, you're just not sure when the last time that you're going to see them is and try to prevent that.*
>
> —**headspace** service provider

> *They do stop coming … because a white person in what they see as a government service, you know what I mean? I'm not going to tell you about my drug use or what's going on in my home.*
>
> —**headspace** service provider

> *I also notice that Aboriginal clients are very unlikely to speak up if they feel their needs aren't met so they will kind of disappear very quietly and not actually give you a reason as to why.*
>
> —**headspace** service provider

Structural barriers

Cultural awareness of staff and access to Aboriginal and Torres Strait Islander workers

Staff reported that not having Aboriginal and Torres Strait Islander workers on staff to provide young people with the option of talking to an Aboriginal and Torres Strait Islander person was a barrier to young people accessing the service. Staff felt that although many of them have completed cultural awareness training, actually having lived experience is something else that can be key in breaking down barriers for some young people.

> *I think barriers for Aboriginal and Torres Strait Islander clients, it's a service, it's a white service. It's very white service. We don't have any Aboriginal health workers, we don't have any black faces, we insist on appointment times.*
>
> —**headspace** service provider

> *I think the only way of engaging with that client group, to be really honest, is that we need to have a worker with lived experience of Aboriginality and so it's around having an identified position. It proves that we're culturally competent, it overcomes so many barriers that … prevents that group from engaging.*
>
> —**headspace** service provider

> *We have an Aboriginal liaison person at [**headspace** centre] but in terms of here we don't have anyone. We're all culturally trained but we're not actually from that cultural background, which is often a real barrier.*
>
> —**headspace** service provider

> *I'm not going to go and use that service, particularly if there's not an Indigenous person at the service. We do have Indigenous people that work here at the service so that's a big thing for any service really if there's like an Aboriginal person that people can go and see they will much more likely use the service than if they go and talk to somebody who is not because they feel sometimes inferior and not know what to expect or how to speak to them.*
>
> —**headspace** service provider

Some Aboriginal and Torres Strait Islander young people felt that the staff at **headspace** may not be welcoming or understanding of Aboriginal and Torres Strait Islander young people and the specific issues and cultural differences they faced.

> *Well, it all comes down to cultural awareness. Like, there's a lot of people who don't even know how to interview or even talk to Aboriginal and Torres Strait Islander people, like a lot of people ask direct questions, eye contact, things like that and that's going to put us off.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

> *… we know our own issues best, and so you know when we have non-Indigenous people tell us problems it's like, well do you really know these issues at heart. So, like if I was having employment problems, I'd rather go to … one of our organisations, that would look after our mob rather than going to a generic [employment agency] or whatever.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

On the other hand, a few staff and young people also suggested that having an Aboriginal and Torres Strait Islander worker at **headspace** can actually be a barrier to some Aboriginal and Torres Strait Islander young people engaging with the service because of community connections or family relationships.

> *If someone was to walk in and that Indigenous person [staff member] happened to be someone that they knew or someone they were related to, that could have an adverse effect.*
>
> – **headspace** Aboriginal and Torres Strait Islander youth reference group member

> *We found that previously when we had an Aboriginal worker, we couldn't talk to particular families.*
>
> – **headspace** service provider

Environment

For young people the cultural barriers identified were more about lack of outward displays of cultural awareness and acceptance that would contribute to a young person feeling comfortable and accepted when they walk in the door.

> *… when we went to [**headspace** centre], I didn't see anything that made me feel welcome that wasn't a person, there was no art … and it's just something small and easy to do that's kind of not even been thought about. I mean that doesn't go big tick on cultural awareness … but that just makes me feel a little bit more welcome … we know you're here and we want to talk to you.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

> *No flag to acknowledge the people, which is a very important thing … It's a little thing that makes a big difference.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

Additionally, a few staff and some young people indicated that receiving treatment in traditional settings, such as enclosed rooms with plain walls, can create anxiety or distress for many Aboriginal and Torres Strait Islander young people and becomes a barrier to engagement.

> *YP1: … like the rooms that they give their sessions in, they were just plain white walls with two lounge chairs in them, like you know a box of tissues in the corner of the floor …*
>
> *YP2: I know, really intimidating*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group members

Transport and remoteness

Most staff discussed location and transport difficulties as barriers to accessing services, particularly those living in remote communities. Some young people talked about the distance they had to travel to access the service, and the cost of petrol, bus tickets and/or taxis.

*There's no **headspace** in each region, you know, … like there's only two in the territory.*

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

The issue is actually getting to a booked appointment … if you don't have any money for the bus, or if you don't have a car, or your licence got cancelled.

—**headspace** young person, female, aged 19

Just in general, having no money and not having a car. People cancel appointments because they don't have petrol money … or transport money.

—**headspace** service provider

*Definitely there's lots of barriers, transport is one of them, especially as **headspace** is not in an area where a lot of Indigenous people in [town] live so getting here can be a little bit difficult, so that would definitely be one barrier.*

—**headspace** service provider

Staff highlighted that without support for transport or outreach services the barriers to service access for some young people are insurmountable, and this was more the case in outer regional or remote areas.

*I think additional to that, however, is that the disadvantaged groups are behind the eight ball when it comes to accessing the **headspace** service because we don't have any outreach currently and they are disadvantaged. A lot of the Indigenous young people live on the outer suburbs and also on Communities … which is close to an hour away … so for them to access means that it's really difficult.*

—**headspace** service provider

I think the other key barrier for people in this part of the world is obviously we're located at [town] so obviously distance, transport, if there is no informal supports to support people to get to the centre, and whilst we try and do as much in regional outreach as possible, that's a real barrier in regional areas.

—**headspace** service provider

Where we are, so a lot of our Aboriginal and Torres Strait Islanders are out in [town] or in other suburbs, so just getting here can sometimes be an issue, so we will use our services to help bring them.

—**headspace** service provider

Intake processes

Some staff and a few young people indicated that some Aboriginal and Torres Strait Islander young people feel bombarded with questions and forms when they first present to **headspace** and literacy was raised as an important issue for filling in forms. Young people indicated that they do not like being asked detailed questions about themselves or their history on each visit, with a few young people feeling the process is rude and that the questions should be completed later when they feel more settled.

People go in and see how long that form is, people want to be quick, straight to the point, and not, especially if someone can't read or write, answering what 35 odd questions, it's a big ask, for someone who's depressed and upset, or whatever else may be going on.

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

Being left in a waiting room, with a whole lot of pages to fill out, that can be daunting for some people. And not a lot of people are gonna admit they are illiterate.

—**headspace** young person, female, aged 17

So that's a major barrier, knowing that you have to fill out a big form, if you may not feel comfortable doing so but if literacy is a problem, they just won't bother.

—**headspace** young person, male, aged 18

Personal and interpersonal facilitators

The current research also investigated facilitating factors which have a positive influence on the help-seeking behaviours of Aboriginal and Torres Strait Islander young people. The facilitators that were common among staff and young people and discussed by more than a few participants were that the service needed to be confidential and trusted, culturally appropriate, well known and respected within the community, and could offer outreach services and transport assistance.

Confidential and trusted service

The importance of providing a confidential and trusted service was discussed by most staff and some young people as being a key facilitator to service access and engagement. Aboriginal and Torres Strait Islander young people need to feel confident that they can access **headspace** and that whatever is discussed is confidential and their family or community will not find out. The fact that **headspace** wasn't an Indigenous service was viewed as a facilitator in helping young people feel they could access the service confidentially.

It's around (having) somebody that they can trust … and young people actually value that perhaps there's not somebody (who is) part of that extended family.

—**headspace** service provider

*They actually wanted to come to **headspace** because it was separate from their community and I think there was a gathering place or something like that that was the alternative, and it was their aunties, so in some ways it would be a benefit that we are set up outside of those things.*

—**headspace** service provider

In order for **headspace** to gain that trust, young people, families, local services, schools and the wider community need to understand what the service provides and what it stands for. The centre needs to build relationships and reputation over time with all parts of the community, through mutually beneficial partnerships and meaningful and targeted community and youth engagement strategies, in order for **headspace** to be seen as a trusted service that people know, are comfortable with, and can confidently refer young people to.

It's going to take a while, you know, to build that relationship, you know, with an organisation that's not in the community.

—**headspace** young person, male, aged 18

*With my Indigenous kids I found a lot of them probably wouldn't have access to **headspace** without the general introduction like with myself because sometimes it needs to be seen as a safe environment, for Indigenous kids in particular it takes a little while to build trust. I've got really good relationships with all my Indigenous kids at my school, they trust me that, okay, she is taking me to a service that's going to help me so I will give it a try.*

—**headspace** service provider

Cultural appropriateness

In line with the barriers to service access, staff and young people raised the importance of cultural appropriateness as a facilitator for Aboriginal and Torres Strait Islander young people accessing services. Cultural appropriateness was viewed from a number of different perspectives and participants raised the following three key areas where cultural issues could act as a facilitator for service access and engagement: cultural awareness of staff; appropriateness of the treatment approach; and a welcoming environment. Each of these facilitators is outlined below.

Cultural awareness of staff

Some Aboriginal and Torres Strait Islander young people reported that culturally aware and competent staff, who understand their ties to kinship and community and who understand that mental health is viewed somewhat differently in Aboriginal and Torres Strait Islander culture, was a key facilitator to service access and engagement. Most staff also believed that cultural awareness was a key facilitator, but felt this should be driven through the involvement of Aboriginal and Torres Strait Islander staff who could ensure culturally responsive treatment and service delivery.

Making sure you have capable staff who have had training and know the population.

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

It was good to have someone to sit down and listen and not judge and give advice.

—**headspace** young person, male, aged 20

If we had an Indigenous worker here, it's going to make people more comfortable coming here, just because it's not all these white girls.

—**headspace** service provider

He just had experience and expertise working with Indigenous because he's done it for years and he's really good at it. He was just an asset. The same with our youth worker, so we had a youth worker who had a lot of connections in the Pacific Island community and he was well accepted by the Indigenous young people.

—**headspace** service provider

Linking back to service confidentiality, some staff believed it was important to give Aboriginal and Torres Strait Islander young people the choice about the involvement of Aboriginal and Torres Strait Islander worker in their provision of care and treatment as some young people enjoy the anonymity of being associated with a mainstream service and/or a non-Indigenous service provider.

*Some young Aboriginal and Torres Strait Islander young people actually like that **headspace** wasn't linked into the community because then it gave them anonymity, whereas going to an Aboriginal service, everyone knows.*

—**headspace** service provider

*There is a definite preference in using an organisation like **headspace** over Aboriginal medical services that are available because of confidentiality issues, because **headspace**, for our people that use it, is available and not connected to the community, so they're not gonna walk in and have their aunty listening in and passing on or divulging information that doesn't belong to them. So I think that separation is actually healthy in that it creates a safety for our people to go in and discuss things that are going on for them without fear of it spreading.*

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

A few young people also indicated that while they would like their culture to be respected and acknowledged, they do not want to be treated differently from non-Indigenous young people and do not want tokenistic treatment.

People want to be treated equally, they don't like special treatment, because that's, kind of makes us feel, you know, it's just a bit uneasy.

– **headspace** Aboriginal and Torres Strait Islander youth reference group member

Treatment and service approach

Providing culturally responsive treatment and service delivery were discussed by most staff as facilitators to service access and engagement for Aboriginal and Torres Strait Islander young people. Staff felt this could be achieved by providing practical support and treatment that is culturally suitable to the needs of Aboriginal and Torres Strait Islander young people, taking the time to build rapport and engage, and providing a flexible intake process.

> *I find it really good because, like I was saying, in the past I had a lot of issues with a lot of therapists and professionals in the past and one of the main things I really like about **headspace** is that they won't try to change me or anything like that, they actually encourage me as a person and my personality, especially my cultural background, they don't try to make out that my spiritual or cultural beliefs are the things that made me crazy, they actually encourage me to keep going with that as a part of my healing process, which is great encouragement because I don't ever plan on changing that; that's actually one of the main things that is helped me heal.*
>
> —**headspace** young person, female, aged 19

> *To be culturally sensitive … staff need to build a rapport.*
>
> —**headspace** young person, male, aged 20

> *I think all of our team are culturally sensitive, not just to Indigenous but to any cultures, and we get a vast array of cultures. I think what really helps is that we have implemented a pickup early scheme so that if somebody does come in or if they ring we will transfer it straight to a triage officer who has got all the skills, and all the clinical skills, rather than leaving it to reception to say we will make you an appointment, actually doing some work over the phone, if it's a phone call, or getting them in and actually doing a brief assessment of needs and building rapport.*
>
> —**headspace** service provider

Some staff indicated that greater flexibility is required in order to provide services in environments where young people feel comfortable such as in parks or local community venues. Not all young people feel comfortable in a clinical space and providing that flexibility can be key in helping them to engage.

> *I will play basketball with some clients if they're not engaging as much and it's a way if they're not concentrating on the actual therapy, and that's where a lot of conversations start, when they're doing something that's not directly asked.*
>
> —**headspace** service provider

> *It might be a bit of a, like, long shot, but even to offer that, for me when I was having counselling, I really liked that my counsellor offered that he would come to my house, for every single one of my counselling sessions I was in my comfort zone … I made so much progress with that counsellor, just because I was doing it in my home.*
>
> —**headspace** Aboriginal and Torres Strait Islander youth reference group member

> *Let's go for a walk. Just get out and talk that way. My best conversations in Community usually were with Indigenous people when we were driving. I was helping them get to a goal that they wanted so they needed to go and pick up a script or something, and I would drive them to their appointment to get that, and in the course of doing that we would be talking about everything and nothing but all relates.*
>
> —**headspace** service provider

Some staff spoke of the need for a more flexible intake process that provides options around collecting information over a number of visits, via paper, face to face or on the iPad.

> *Definitely with an Aboriginal client I wouldn't be using as many paper and pencil things at the start, I would be making it really just conversation, lots of questions about family and background and interests, as opposed to going through a checklist for me.*
>
> —**headspace** service provider

> *Maybe if they drop in and self-refer, the first thing they hit isn't the survey. Just some kind of provision for the survey not to be the first thing that they do, so they can actually have a good experience.*
>
> —**headspace** service provider

Community awareness and relationships

In order for the community to be aware of **headspace** it was important that the **headspace** centres have a presence at community events; are providing culturally appropriate and relevant information and resources about mental health, and social and emotional wellbeing to young people, families and service providers; and are developing relationships and connections with local Aboriginal and Torres Strait Islander services and communities.

Some staff spoke of the benefit of providing greater capacity for community engagement and having a presence at community events in raising awareness of the service and increasing the likelihood that Aboriginal and Torres Strait Islander young people will present to **headspace**.

> *We're attending community events to get our name out there, and we've got some engagement officers that go out into the community, they wear **headspace** shirts, and they're very active in putting their face out there.*
>
> —**headspace** service provider

> *We're just doing different things, we're going to a men's health expo next Thursday at the community centre, which is kind of in an area of higher [Indigenous] population … we had a meeting this morning with [Public School], which is part of the Connected Communities Program, and its population is 90 per cent Indigenous and they're looking at helping us decorate some of the walls in here.*
>
> —**headspace** service provider

> *It's just that you've got to get out there, which is what we are doing in the schools, in that 12 to 18 but it's that 18 to 25 that we've got to start targeting as well. We've formed an Are You Okay Day. We did it in pubs and clubs as well all over [town] so every pub and club (in town) had coasters and posters so that had **headspace** on it as well and contact numbers and all that sort of stuff. I guess that is a bit of an awareness as well that **headspace** is there.*
>
> —**headspace** service provider

Some staff also discussed the importance of raising awareness through developing and delivering health promotion programs for Aboriginal and Torres Strait Islander young people, their families and communities.

> *We have had family and friends nights, to let them know that **headspace** is there and get information on things such as bullying, anger, self harm, and all that sort of stuff. There are information nights on for parents and friends to come in and get information and how **headspace** can help them.*
>
> —**headspace** service provider

> *I think it's just continuing to promote **headspace** and I know that here in [town] they do that really well. They will hold youth nights and they've got different courses that young people can access and it hasn't got a stigma … I don't need to see a counsellor, there's nothing wrong with me. But once they realise that it's not about people think you're mad … but once they've seen that it is actually a service that, hang on, there's all young people not that much older than me and I get to talk to them and they help give me strategies on how to cope with different situations.*
>
> —**headspace** service provider

Some staff indicated that young people can feel a sense of distrust and suspicion toward institutions such as **headspace** and to overcome this staff were focussing on developing stronger relationships with community Elders and other trusted members of the community. A few young people also highlighted the role of building relationships with family members and the community and generally promoting the service as key in breaking down perceived stigma and shame associated with accessing a mental health service.

Our strategy has been around building stronger connections with the community … it's around building that trust in the community - they may be able to reach more of the young people.

—**headspace** service provider

I think family or friend recommendations are always helpful. I think a few of my Aboriginal clients usually know someone who has been at the service and that person talks it up for them.

—**headspace** service provider

They work in families, their family system is very important, they don't see themselves as individuals, they see themselves as part of a whole, of a group, and so to have other people come in with them and support I think is a very strong thing.

—**headspace** service provider

I actually knew about it and then my dad brought it up a couple of times, because he works at a mental health fellowship and he brought it up a few times and the first few times I let it slip and then I decided that it might actually be a good idea.

—**headspace** young person, female, aged 19

I guess our strategy has been around building stronger connections with the community, so talking to the Elders groups around town. There's also a number of groups that drop down, a men's group awareness group, so we've got plans to meet with those groups who obviously have contacts, and again it's around building that trust in the community; they may be able to reach more of the young people. I guess our strategy is more around targeting young people and they form a part of those groups that we would naturally go and be talking to anyone.

—**headspace** service provider

Structural facilitators

Welcoming environment

All staff discussed the importance of the centre providing an appropriate environment whereby Aboriginal and Torres Strait Islander young people feel relaxed, safe and welcomed. Some young people also discussed the physical environment and layout of centres, and welcomed displays of Aboriginal and Torres Strait Islander culture, such as art work throughout the centre, and the Aborignal and Torres Strait Islander flags in the waiting area.

We've had the three flags at the front desk from the beginning and the Sorry Statement, that's a new addition … into artwork as well too and we've been to an Aboriginal mums and bubs group to have them do some of our work for us … Then we've got the Deadly stickers in every room … we didn't want that to be a kind of in your face strategy, just enough so Indigenous people see it as a safe place.

—**headspace** service provider

I guess there would be a lot of anxiety around coming into a place that's mental health … being unsure about what to expect, so for all clients trying to alleviate that as much as possible just by being really relaxed, making it as informal as possible.

—**headspace** service provider

Something as little as having a board of scrabble, or a game … play a game and have a yarn at the same time.

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

One suggestion offered by both staff and young people to create an appropriate environment was to have outdoor spaces around the centre that could be used for intake and treatment.

Yes, just having a really relaxed laid-back feel to it. Sometimes doing a session outside, rather than being closed up in a room, or making sure they're in a room that they feel a little bit more comfortable in, so there's lots of light, or so they can see there's a way out of the room.

—**headspace** service provider

*I think if we could give them options with transport, options with having therapy outside of the **headspace** office, if we can make it a little bit more accessible, if we've got an outside area - a lot of youth like to be outside - if we can make it a little bit less restrictive I think we will access a whole variety of people that haven't come in here yet.*

—**headspace** service provider

Take it outside, you don't have to be in the office to do an intake or something like that, just go outside.

—**headspace** Aboriginal and Torres Strait Islander youth reference group member

Outreach services and transport assistance

Most staff spoke about how difficult it is to engage Aboriginal and Torres Strait Islander young people who traditionally do not use services such as **headspace**, or who are unable to commute to the centre. A few staff also indicated that providing young people with means of transportation, such as taxi vouchers or bus tickets would increase the likelihood of more young people attending **headspace**.

Transport is probably a huge one, so being able to have a transport facility, whether that be through taxi vouchers or a pickup system, and a drop home system, that enables people to be more engaged in the process.

—**headspace** service provider

I would say having some capacity for outreach to go and pick people up. Indigenous health workers would be really helpful. You can't be passive so you can't just make an appointment and if somebody doesn't come, that's it, because that's not how it works. You've got to know what's happening in the community and who is who and if someone doesn't come maybe you can go and find them.

—**headspace** service provider

The transport is a big one across the board so to assist with that I spoke to the Department of Transport and got $20,000 worth of funding to pay for taxis for our young people around this area to come in, so that's lot better.

—**headspace** service provider

In addition, providing Aboriginal and Torres Strait Islander young people with short waiting times was raised by a few young people.

When somebody is referred we would contact them within 24 hours to make an appointment and our waiting list generally is one week, at a time of their choice, they're offered a range of different times, what's suites them, what's going to happen. Depending on what they're presenting with is based on how long they wait.

—**headspace** service provider

We give priority to people who self-refer, again, because that's something new for us so we have a number of emergency appointments throughout the week for somebody who might be presenting with an urgent need.

—**headspace** service provider

Clinical file review

A clinical file review was completed on the records of 20 Aboriginal and Torres Strait Islander young people who had accessed services at a **headspace** centre to identify service use patterns and barriers and facilitators to service engagement.

As would be expected from an analysis of clinical files, the findings from this method were more clinical in nature, and it is important to note that they were observed and recorded by clinicians.

Barriers were evident in a quarter of the files and these were: poor support (i.e., family or other); social isolation or relocation; lack of readiness or reluctance to seek formal mental health treatment; more immediate concerns or work commitments; and poor coping with symptoms.

At least one type of facilitator was evident in nearly all the clinical file reviews. These included: motivation for treatment; self-referral; re-referral, either internally or from an external source; having had previous mental health treatment; good fit between clinician and young person; a good relationship with the service; availability of the service; peer support; and improvements in mental health.

5.6 Summary of main findings

Overall, the level of representation of Aboriginal and Torres Strait Islander young people accessing **headspace** service at 8.4 per cent is positive when compared to national data showing 4.0 per cent of young Australians identify as Aboriginal and Torres Strait Islander. However, while this may seem positive across the whole network, it needs to be considered in relation to the proportion of Aboriginal and Torres Strait Islander young people who reside in each community. The variation across centres ranges from less than two per cent to 28 per cent, and each centre needs to determine whether it is adequately engaging Aboriginal and Torres Strait Islander young people in proportion to their local population distribution. It is important that **headspace** is working to reduce the barriers and increase the facilitators to make all **headspace** services attractive and appropriate for local Aboriginal and Torres Strait Islander young people.

This report shows that Aboriginal and Torres Strait Islander young people who present to **headspace** services have similar pathways to non-Indigenous young people, their gender representation is comparable, and they are equally as satisfied with the services they receive. However, Aboriginal and Torres Strait Islander young people present with a slightly different range of issues which may require different treatment approaches and they make up a greater proportion of the younger service users, particularly boys aged 12-14.

Interviews and focus groups with Aboriginal and Torres Strait Islander young people and staff at two centres that have a high proportion of Aboriginal and Torres Strait Islander clients identified a broad range of barriers and facilitators to accessing and engaging with **headspace** services. This report has described the key personal and structural elements that were most common to staff and young people and mentioned by more than a few participants.

The key personal and interpersonal barriers were: stigma and shame; fear; confidentiality; cultural appropriateness – which includes appropriate service, appropriateness of the treatment approach; and community awareness. The key structural barriers included the physical environment, lack of Indigenous workers, transport and remoteness, and intake processes. The key facilitators aligned with these barriers and centred on the service being confidential and trusted, providing an appropriate treatment and service approach, well-known and respected within the community, providing a welcoming and safe environment, cultural awareness of staff and access to Indigenous workers, and could offer outreach services and transport assistance.

The barriers and facilitators revealed by this research were supported by the findings from the literature review which identified similar barriers around intergenerational stigma, feelings of shame associated with help-seeking, concerns about confidentiality, poor service knowledge, and geographic location. Comparable facilitators were also reported, including supportive counsellors and perception of safety in treatment, the service providing a place to meet and get information, and young people having an awareness of the availability of services.

Other barriers identified in the literature but not emerging as strongly from this research included Aboriginal and Torres Strait Islander young people having a greater reliance on informal supports or having had a racist first experience with a service.

Although the clinical file review identified fewer practical facilitators and barriers, its findings generally confirm the findings from the interviews and focus groups around the need for the service to be culturally appropriate, have a focus on relationship building, and achieve positive outcomes.

Table 5.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young people who are Aboriginal and Torres Strait Islander.

Table 5.3: Barriers and facilitators to accessing and engaging with headspace for Aboriginal and Torres Strait Islander young people

Barriers	Facilitators
Personal & Interpersonal	
– Stigma and shame, particularly family and community shame	– Community trust through presence at community events, and engagement with Elders and Aboriginal and Torres Strait Islander organisations
– Nervousness, fear, shyness	
– Confidentiality concerns, especially from family and community	– Confidential and trusted services
– Lack of cultural appropriateness: – Lack of safe and culturally appropriate model of service – Lack of culturally responsive treatment approach	– Cultural appropriateness: – Culturally aware and competent staff – Flexible, responsive treatment approach
Structural	
– Lack of welcoming reception environment and clinical rooms	– Art, flag on display – Service provision in non-clinical environments (outdoor spaces)
– Lack of Indigenous workers	– Access to Indigenous worker
– Transport problems and remoteness	– Transport support and outreach capacity
– Inflexible intake processes, particularly non-responsive to need to engage more slowly and literacy levels	– Flexible, responsive intake processes

The main findings emerging from this research are:

– A flexible approach is required for engaging and treating Aboriginal and Torres Strait Islander young people – involving flexibility in intake and engagement approaches, including the locations available to see young people, and flexibility in the implementation of information collection processes.

– Centres need to develop strong links with local Indigenous services and communities.

– Centres need to be known and trusted in the community as a safe place for Aboriginal and Torres Strait Islander young people, where confidentiality is paramount.

– For centres in outer regional areas, transport and outreach capabilities need to be explored.

– All **headspace** staff should receive cultural awareness training, to assist in building a culturally appropriate service.

– Where appropriate, employing Aboriginal and Torres Strait Islander workers may assist in building links to Indigenous communities and facilitating access and engagement for Aboriginal and Torres Strait Islander young people. However, in some instances due to community connections or family relationships, having an Aboriginal and Torres Strait Islander worker can be a deterrent, so flexibility and consultation with the young person is required.

– The environment needs to be comfortable and culturally welcoming to Aboriginal and Torres Strait Islander young people. This includes the reception area and treatment rooms as well as providing appropriate outdoor or informal spaces to engage and treat Aboriginal and Torres Strait Islander young people.

An important caveat on these findings must be noted, however; the current data came from young people currently engaged with **headspace** services. Accordingly, the information does not reflect the experiences or opinions of young Aboriginal and Torres Strait Islanders who are unknowledgeable of, or are unwilling or unable to engage with **headspace**. Although there is greater complexity involved in obtaining such data, it would make for a valuable companion piece to the present findings and recommendations, and would help to contextualise next steps toward better engaging this cohort with available **headspace** services.

5.7 Recommendations

Table 5.4 details potential strategies to assist with improving service delivery for young people who are Aboriginal and Torres Strait Islander.

Table 5.4: headspace model development for Aboriginal and Torres Strait Islander young people

Principles	Potential strategies
1. Community awareness and service promotion through engagement with local Aboriginal and Torres Strait Islander communities	– Build stronger relationships with community Elders and other trusted members of the community so young people do not feel apprehensive about accessing the service. – Promote **headspace** to Aboriginal and Torres Strait Islander families and the community to break down perceived stigma and shame associated with accessing a mental health service. – Provide culturally appropriate and relevant information and resources about mental health, and social and emotional wellbeing to young people, families and service providers.
2. Promotion of confidential service	– Promote **headspace** as a confidential service. – Communicate clear guidelines regarding circumstances in which confidentiality may have to be broken. – Train all staff in the importance of client confidentiality, particularly for centres in smaller communities.
3. Welcoming and culturally appropriate environments	– Provide inviting, relaxed and safe environment for Aboriginal and Torres Strait Islander young people, possibly through displaying art work and the Aboriginal and Torres Strait Islander flags. – Provide the option for the delivery of treatment in environments where Aboriginal and Torres Strait Islander young people feel comfortable such as in parks, local community venues or outdoor areas around the centre.
4. Culturally respectful staff	– Provide cultural awareness training for staff to ensure that they understand and respect cultural values, especially with reference to family and community ties and differences in how mental illness and help-seeking are perceived in Aboriginal and Torres Strait Islander culture compared with non-Indigenous culture. – Employ and retain a qualified and skilled Aboriginal and Torres Strait Islander workforce to promote culturally appropriate service delivery. – Provide Aboriginal and Torres Strait Islander young people with the choice of an Aboriginal and Torres Strait Islander or non-Indigenous worker in their provision of care and treatment. – Accept and respect cultural values, while ensuring that all young people are treated the same.
5. Culturally appropriate intake, assessment and treatment	– Provide Aboriginal and Torres Strait Islander young people with a less formal intake process; options to complete the MDS on arrival or over subsequent visits; and the option of completing the data collection processes via paper, iPad or face to face. – Ensure awareness of and appropriate responses to each young person's literacy level, at intake and throughout treatment. – Provide culturally responsive treatment and service delivery suitable to the needs of Aboriginal and Torres Strait Islander young people; whereby kinship, social and family ties are considerations. – Employ appropriate engagement approaches, such as playing board games or walking outside, while engaging in indirect therapy.
6. Increase service accessibility	– Provide young people with vouchers for petrol or transport fares, in order to access the centre. – Greater provision and capacity for outreach into community, schools and community events to increase the likelihood of young Aboriginal and Torres Strait Islander people presenting to **headspace**.

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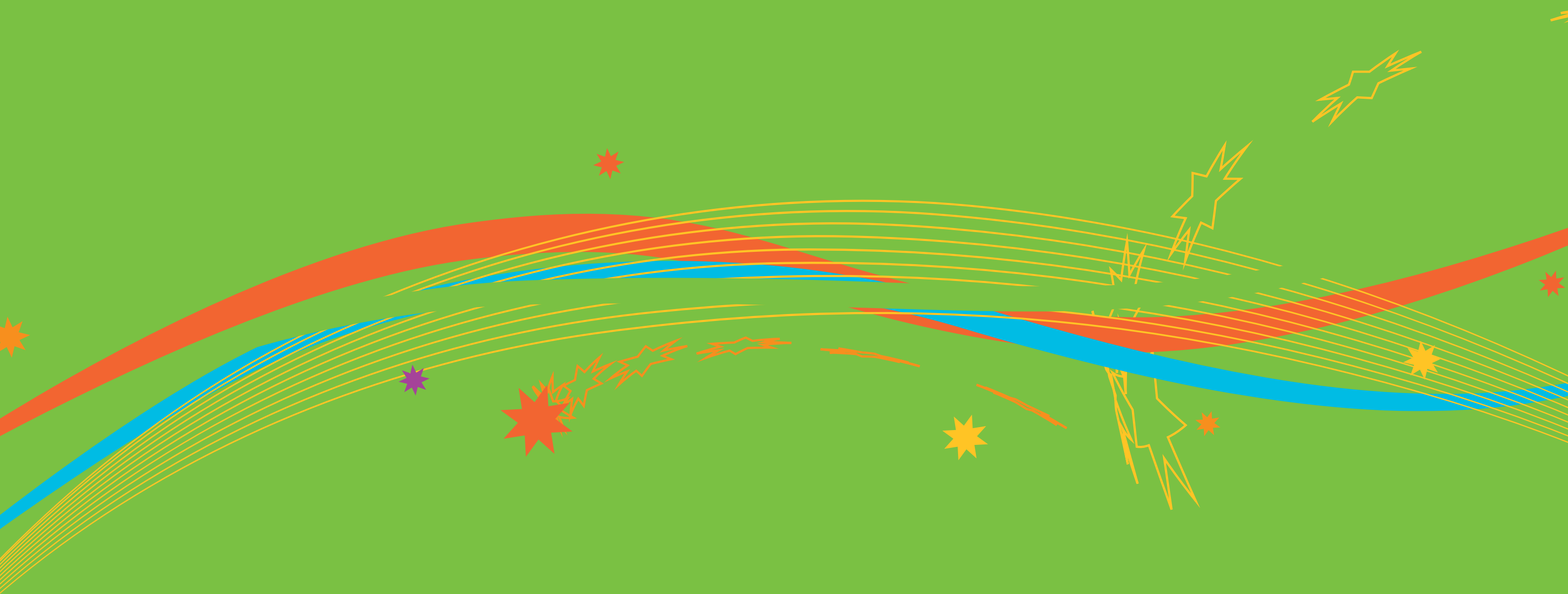
6. Young People from Culturally and Linguistically Diverse Backgrounds



6. Young People from Culturally and Linguistically Diverse Backgrounds

6.1 Background

The Australian population comprises people from a diverse mix of culturally and linguistically diverse (CALD) backgrounds and it is important for **headspace** to be culturally inclusive and aim to meet the needs of young people from all cultural and linguistic backgrounds.

Determining and understanding cultural and linguistic background status is complex, and the Australian Bureau of Statistics (2009) specifies four categories to describe the CALD status of individuals as those who are:

1. born in Australia and mainly speak English at home (non-CALD)
2. born in Australia and mainly speak a language other than English at home
3. born overseas and mainly speak English at home
4. born overseas and mainly speak a language other than English at home

The use of mental health services by young people from CALD backgrounds is generally low (McDonald & Steel, 1997; Queensland Program of Assistance to Survivors of Torture and Trauma, 2013). There are several reasons for this, including difficulty in understanding how the Australian health care system and mental health services operate, and uncertainty concerning how to access these services (Pirkis, Burgess, Meadows, & Dunt, 2001). Other factors include stigma related to having a mental health problem, limited English language, health beliefs and treatment expectations aligned with their culture (Chan & Parker, 2004; Hsiao, Klimidis, Minas, & Tan, 2006), and concerns about the suitability of treatment and the lack of cultural competency of therapists (Chiu, Wei, & Lee, 2006; Snowden & Cheung, 1990; Snowden & Yamada, 2005). This is further complicated by the fact that when people from CALD backgrounds do access services, they tend to do so at later stages in the development of mental illness than non-CALD young people, providing a further challenge for prevention and early intervention (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Mental Health in Multicultural Australia, 2014). Parents with a CALD background may be unaware of youth mental health services or view them with suspicion, making it unlikely that their children will access such services (Queensland Transcultural Mental Health Centre, 2001).

While young people from CALD backgrounds do not necessarily experience a higher rate of mental health problems (with the notable exception of young people who are refugees or victims of torture or trauma), many do experience additional risk factors for their mental health and wellbeing. In particular, they may experience uncertainty about where they fit into society, as they try to accommodate both their home and cultural background with the culture of their country of residence. Switching between these different cultures can result in emotional confusion and feelings of shame and self-blame (Vivero & Jenkins, 1999). They can experience stress and accompanying emotional and behavioural problems such as depression and anxiety, feelings of marginality and alienation, heightened psychosomatic symptoms, low self-esteem and identity confusion (Queensland Transcultural Mental Health Centre, 2001). Children and young people from immigrant backgrounds may be at particular risk of emotional and behavioural problems as a result of difficulty in establishing peer relationships, discrimination, post-migration settlement factors, and family conflicts resulting from discord between parental expectations and Australian cultural norms (Department of Human Services, 2006; Gorman, Brough, & Ramirez, 2003).

At particularly high risk are young people who are refugees or who have experienced torture or trauma; young people with these experiences are more likely to experience depression, anxiety and post-traumatic stress disorder than those without a trauma history (Hillin, McAlpine, Montague, & Markham, 2007). Child and adolescent mental health services report increasing numbers of young people from refugee backgrounds who have either been victims of torture or trauma or witnessed their parents as victims (Department of Human Services, 2006). More recently, the Centre for Multicultural Youth notes that “Many refugee young people have experienced and witnessed high levels of traumatic events and violence including war, persecution, sexual assault, the death and disappearance of loved ones and survival in a range of dangerous circumstances”(Centre for Multicultural Youth, 2014, p9). They further report that “Despite the prevalence of trauma amongst young refugees there are no systematic studies of the mental health of this group in Australia. No local data exists on the rate of referral of refugee children and young people to mental health services” (Centre for Multicultural Youth, 2014, p10).

Despite the heightened need for support, young people from CALD backgrounds face barriers associated with reliance on family and friends for support due to poor understanding of mental health services, concern over the cultural competence of external sources of support, cultural stigma impacting on help-seeking and explanatory models of illness (Gorman, et al., 2003; Pirkis, et al., 2001).

Facilitators to CALD young people accessing mental health services can include cultural competence of clinicians, information on treatment options and perceptions of mental health problems, and addressing issues of identity, self-worth and loss specific to this population of young people (Department of Human Services, 2006; Gorman, et al., 2003).

6.2 Aims

Given the low levels of access of CALD young people to mental health services and variations across **headspace** centres in engaging young people from CALD backgrounds, it is important for **headspace** to further investigate the barriers and facilitators specific to CALD young people accessing the assessment and treatment services they need. This chapter aims to identify the approaches that can guide and assist **headspace** centres to address the needs of young people from diverse cultural and linguistic groups by reducing identified barriers and increasing factors that facilitate access and engagement to ensure that all **headspace** services are appropriate for CALD young people who require mental health support.

6.3 Methodology

The following methodology was used to investigate the barriers and facilitators for young people from CALD backgrounds:

1. A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care for CALD young people, reviewing Australian-specific literature.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Clinical file review for 19 young people across several centres who identity as CALD and who have accessed a **headspace** centre.
4. Interviews and focus groups with 16 young people from CALD backgrounds and interviews with five **headspace** service providers from two **headspace** centres with high rates of CALD participation (centres were identified from MDS data over a 12 month period).
5. Focus group with two young people from CALD background (facilitated with the assistance of an interpreter) and interviews with two service providers from the Centre for Multicultural Youth[9].

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews and focus group have been analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses (see Table 6.1). This type of analysis allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 6.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Table 6.2 describes the focus group and interview participants, including the gender and age of young people involved.

[9] The Centre for Multicultural Youth supports young people from migrant and refugee backgrounds to build better lives in Australia. The organisation provides direct support and leadership opportunities that create individual and community change. Client support takes place in a number of settings including schools, sport and recreation centres, TAFEs and community hubs. Outreach is combined with one-to-one specialist case management and group work to support young people who are at risk to overcome issues, connect to community and settle well in Australia.

Table 6.2: Participants

headspace (VIC)	
Staff	
Centre manager	
Access team clinician	
Private allied health provider	
Clinical services manager	
Young people	
Female, age 18	
Female, age 17	
Female, age 17	
headspace (VIC)	
Staff	
Project Lead: Afghan refugee and asylum seeker youth mental health Engagement project	
Young people	
Young people focus group (n=13, male)	
Centre for Multicultural Youth (VIC)	
Staff	
CEO	
Senior case worker	
Young people	
Female, age 19	
Female, age 18	
Total staff	**7**
Total young people	**18**
Total	**25**

6.4 Literature review

A systematic review of the literature examining barriers and facilitators for access and engagement with mental health services for young people from a CALD background located only one study. This was a qualitative study conducted in South Australia that recruited an equal proportion of males and females. It explored help-seeking behaviour among refugee adolescents.

The study identified the following barriers to accessing services: shame, confidentiality concerns, sociocultural barriers that reduced motivation for treatment, and reliance on informal supports. While this study provides an indication of barriers affecting young people from CALD backgrounds, the study had methodological limitations relating to sampling technique, and limited generalisation and data reliability due to use of a single focus group (de Anstiss & Ziaian, 2010).

6.5 Results

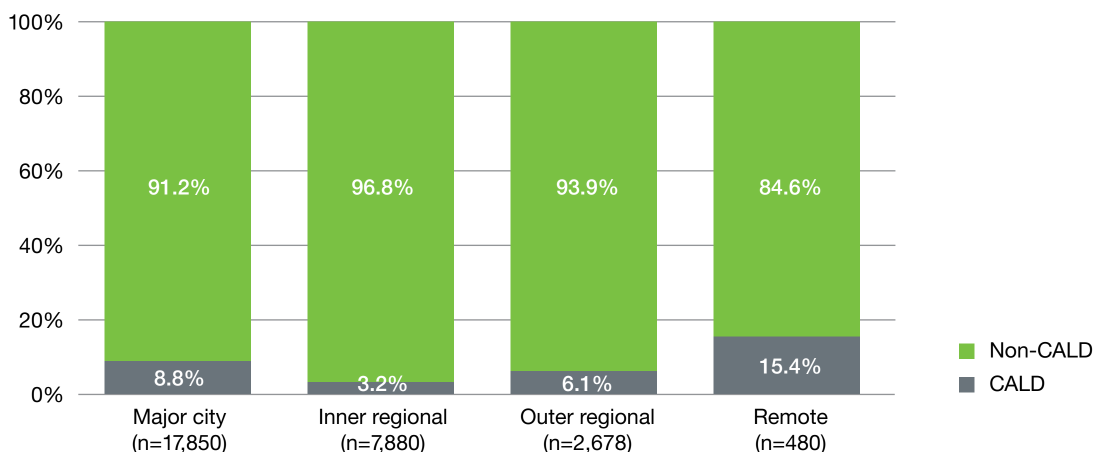
Client profile

Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of the CALD young people who access **headspace** and provide an outline of how they compare with all services users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus excluded from the analysis).

Of this sample, 2,050 young people identified as born in Australia or overseas and mainly speaking a language other than English at home (Categories 2 and 4 of CALD status, respectively) or born overseas and mainly speaking English at home (Category 3), representing approximately 7.1 per cent of all **headspace** clients for whom data were available (28,888). This figure compares poorly with 2011 census data showing that 25 per cent of Australians aged 12-24 years identify as CALD (Hugo, McDougall, Tan, & Feist, 2014), although this group is not fully comparable because the census includes young people whose parents were born overseas in a non-main English speaking country and these young people are not necessarily included in the **headspace** CALD categories.

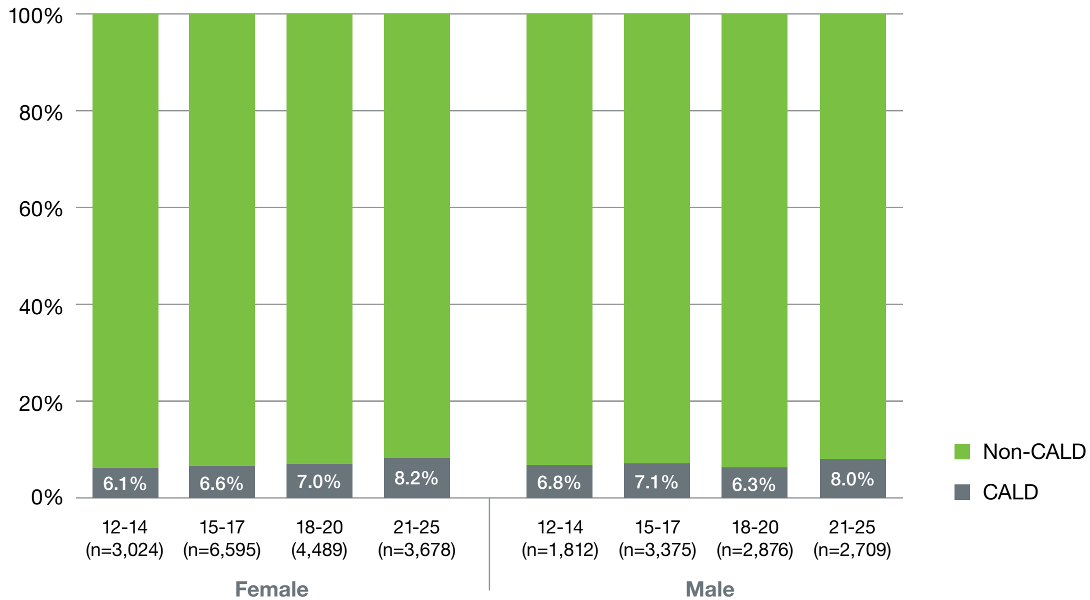
Across the **headspace** centres, there is wide variation in the level of access by CALD young people not born in Australia or English-speaking countries and not mainly speaking English at home, ranging from 29.7 per cent at one centre to one per cent at other centres. Similarly, there is large variation across the States and Territories, with centres located in the Northern Territory having the greatest proportion of CALD young people at 12.4 per cent, followed by Victoria at 8.4 per cent, and New South Wales/ACT at 8.0 per cent. The states with the lowest proportion of CALD young people are Western Australia at 5.8 per cent, South Australia at 5.2 per cent, Queensland at 5.0 per cent and Tasmania at 4.7 per cent. Figure 6.1 outlines that the centres with the greatest proportion of CALD young people are in major city or remote areas. The percentage of CALD young people was greatest in centres in remote areas, followed by those in major cities.

Figure 6.1: Percentage of CALD young people by centre rurality



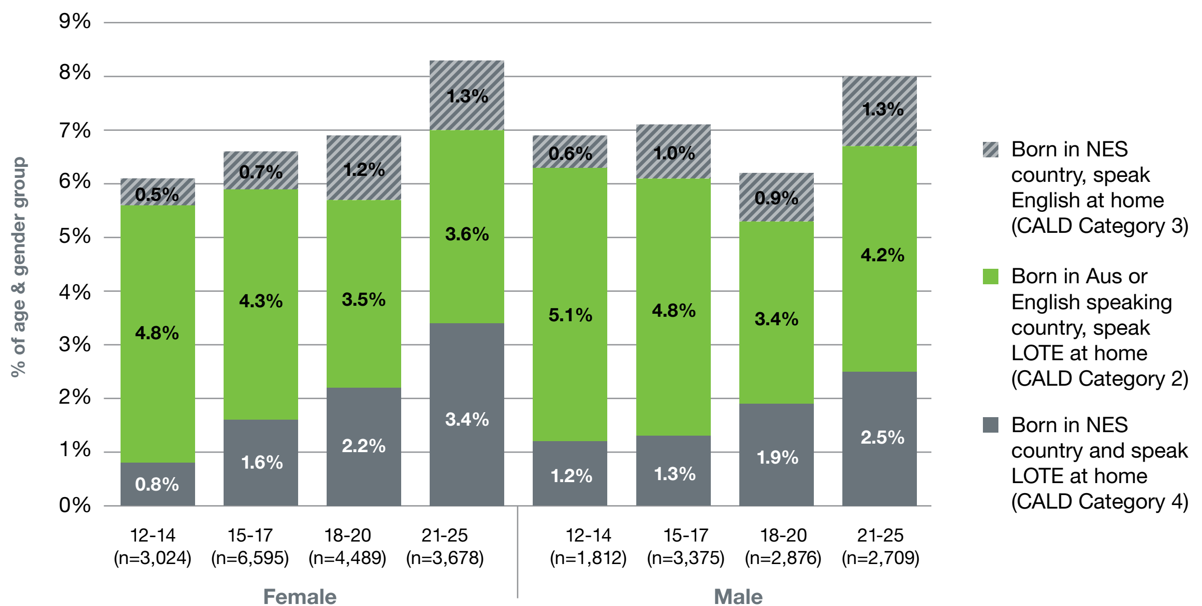
Of the 2050 CALD young people, 60.3 per cent were female and 39.7 per cent were male, which is comparable with all clients (62% female and 38% male). Across all clients, 7.5 per cent of females and 7.6 per cent of males identified as CALD. Figure 6.2 shows the proportion of young people identifying as CALD across age brackets and gender, with the greatest proportion being in the oldest age group for both males and females.

Figure 6.2: Percentage of CALD young people by gender and age group



Further breakdown of the CALD group is provided in Figure 6.3, which shows country of birth and main language spoken at home, by age group and gender. The majority of CALD young people were born in Australia (or other main English speaking country) and mainly speak languages other than English at home. It is more common for this group to be aged between 21 and 25 years (both male and female).

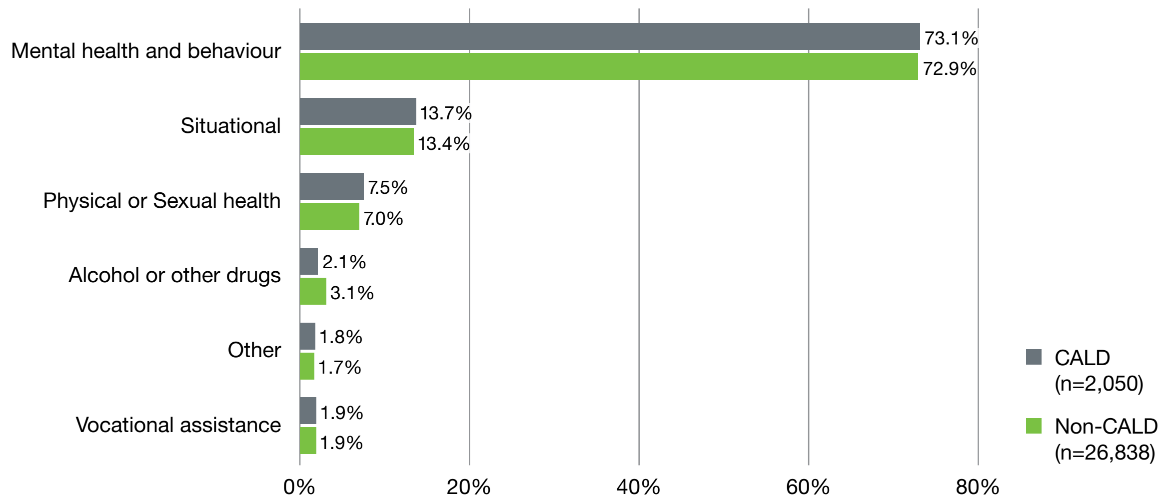
Figure 6.3: CALD categories by gender and age group



*LOTE-Language other than English
*NES-Non main English Speaking country

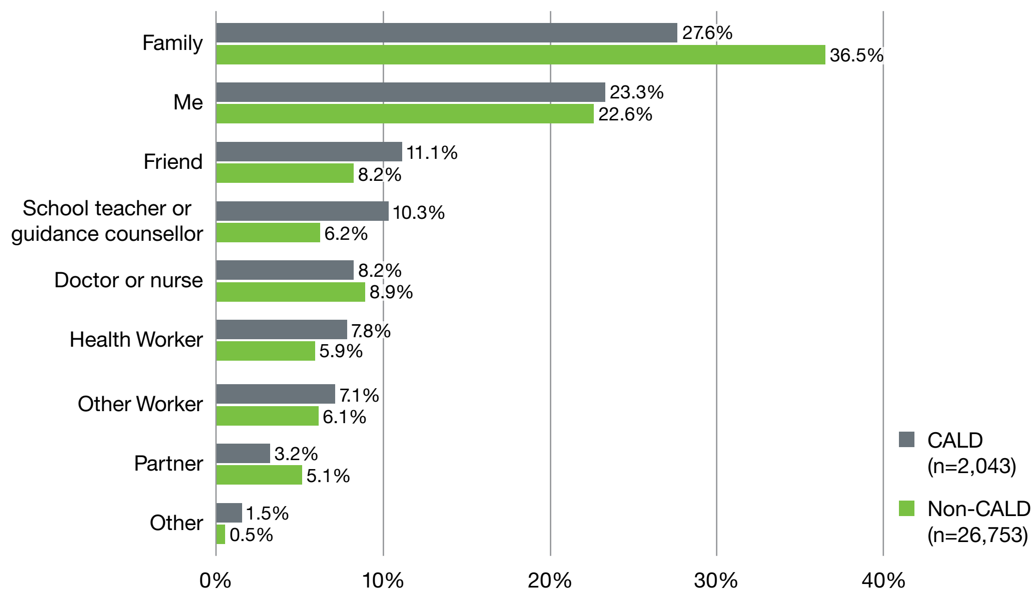
Figure 6.4 outlines the main reason for initial presentation at **headspace** for CALD compared to non-CALD young people. The majority of both groups present with mental health issues followed by situational issues, with little variation between groups apart from CALD young people being slightly less likely to present with problems with alcohol and other drugs. Depression and anxiety make up the greatest proportion of mental health issues faced by both CALD and non-CALD young people.

Figure 6.4: Main reason for presentation at **headspace**



As shown in Figure 6.5, CALD young people have different patterns regarding who has encouraged or influenced them to attend a **headspace** centre than non-CALD young people. CALD young people are much less likely to be influenced to attend by a family member or partner. They are more likely to be influenced to attend by a friend, school staff and health workers than are non-CALD young people. However, young people from CALD and non-CALD backgrounds are similar in terms of the likelihood of self-referral[10].

Figure 6.5: Pathways to **headspace**

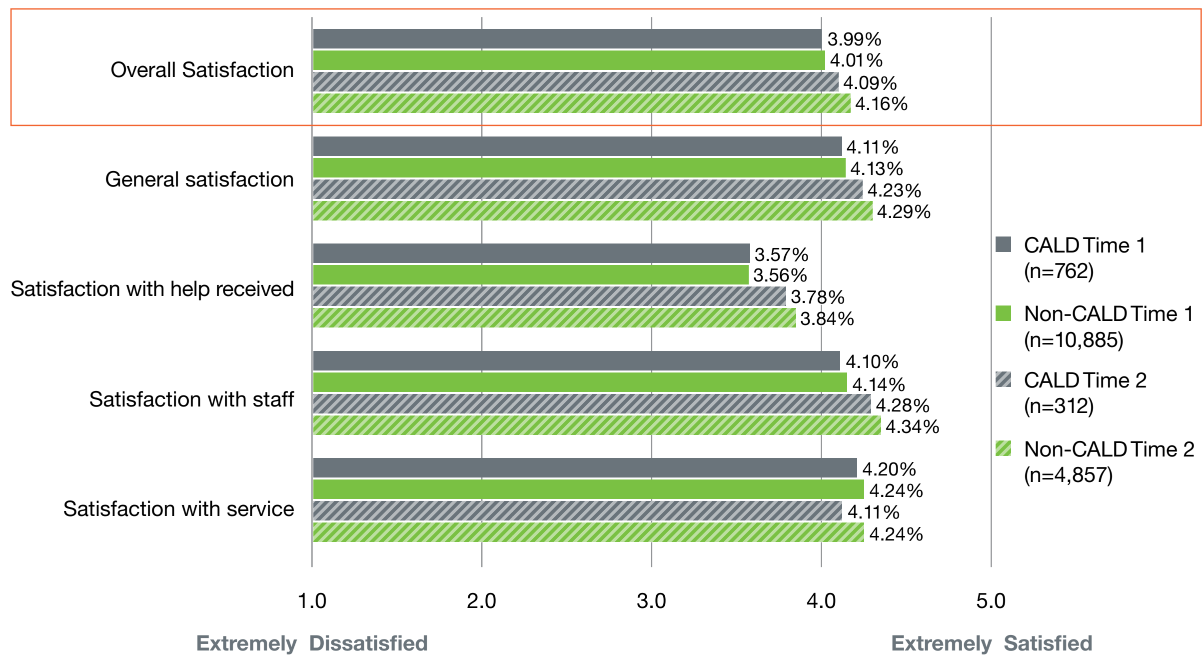


Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their service. During this period, over 12,000 young people completed a survey and 762 of these identified as being from CALD backgrounds (7.0%). The survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied. Results are presented in Figure 6.6 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups and results indicate that there were no significant differences in satisfaction between CALD and non-CALD young people.

[10] Differences between CALD and non-CALD young people's influence to attend were observed over and above any age and gender effects.

Figure 6.6: Satisfaction for CALD and Non-CALD headspace young people



Barriers and facilitators

Data from the interviews and focus groups with CALD young people, centre staff and service providers, as well as data from the clinical file review, revealed a number of barriers and facilitators to service access and engagement.

The main barrier raised by CALD young people was focused on language as a barrier, but some young people raised concerns over confidentiality and trust. Staff and additional service providers raised similar issues but also discussed barriers of concerns over cultural awareness of service providers, culturally appropriate service settings, stigma and family shame, lack of interpreter services, treatment expectations, and cost of services.

The main facilitators raised by CALD young people included promotion of **headspace** as a confidential service, ease of access, and culturally appropriate marketing/bilingual messaging. Staff and service providers raised similar issues but also added additional facilitators of building stronger community links, culturally appropriate treatment, culturally appropriate staff, and coordinated service provision.

Additionally, the clinical file review results identified the main barrier for CALD young people to service access and engagement as little or no family support in relation to mental health and a strong sense of shame associated with mental illness preventing them from disclosing their difficulties or their attendance at **headspace** to their family. Main facilitators identified from the clinical file review were staff who were respectful of the young person's cultural background.

Although there was a long list of barriers and facilitators identified across these data, there were only a handful of barriers and facilitators that were common to staff, service providers and young people and mentioned by more than a few participants. These key barriers and facilitators are discussed in detail below and are categorised as either: *personal and interpersonal*, which includes language barriers, confidentiality and trust, and culturally appropriate treatment; or *structural*, which includes lack of awareness of **headspace** services, culturally appropriate environments and marketing, stronger community links and coordinated service response.

Personal and interpersonal barriers

Language barriers

Most staff and young people indicated that language barriers can mean that young people are prevented from, or do not have the confidence to, seek out information about **headspace** or other services in the community from which they could benefit. It is common for CALD young people to feel frustrated when they cannot adequately communicate with reception and professional staff. A few young people indicated that sometimes they are reluctant to return to a service because of the language barriers. Some young people found that language barriers contributed difficulties in understanding and negotiating how to access a service that does not require formal referral processes.

The major thing is the language barrier. If we know the language it is easier for us to go everywhere and easier to communicate.

—**headspace** young person, focus group

We have a few people who have tried to approach this service, English isn't their first language, or they're not very strong at all with English.

—**headspace** service provider

I know that sometimes it can be difficult for young people to link in with services because either mum and dad can't speak English or don't feel comfortable talking about this kind of stuff. [It] can be quite difficult in terms of engaging over the phone and just that cultural understanding of shared language.

—**headspace** service provider

If they're not speaking the language that you speak, how are you supposed to communicate with them and families, what if she doesn't understand me, or doesn't get what I'm saying.

—**headspace** service provider

The hardest thing was the language, the language barrier, but if I had to come at reception I wouldn't know what I would have to say or how I would have to convey the message that I'm here for. It was very hard for me to convey the message to the right person and to seek assistance.

—**headspace** young person, focus group

Lack of acknowledgement and stigma of mental illness in many CALD groups

Although service providers were aware of cross-cultural differences, all staff indicated that young people coming from a range of cultures have additional barriers due to cultural beliefs and attitudes, such as: mental illness is only seen within Western cultures; negative attitudes and behaviours toward others within the culture who have mental health problems and their families; limited knowledge of mental health or an understanding of mental illness based on myths and inaccuracies about the cause and treatment (e.g, seen as taboo and a result of external forces such as weather, spirits or supernatural forces); mental illness is blamed on the person; they are perceived as weak, spiritually bad, or dangerous.

It's the parents' cultural understanding of mental health.

—**headspace** service provider

Psychosis, schizophrenia kind of thing … they (CALD population) will not accept that it's psychosis or schizophrenia. It is being punished by God, being possessed by a demon; it is a whole range of other things which bring incredible shame onto the families. The community's attitude toward mental illness is critical because families will hide it deliberately. They don't understand it, and then they hide it and it becomes a big shame.

—**headspace** service provider

*In the CALD community, young people will turn to you and say 'my parents don't understand mental health'. 'I won't talk to my parents about mental health.' 'I will hide my visits to **headspace** from my parents because they won't understand'.*

—**headspace** service provider

It actually impairs the capacity of services like us to help the young person, because they have this conflict going on where they paint one picture to us, but another to their community.

—**headspace** service provider

*I could never tell my parents I go to **headspace**, they see mental illness as evil spirits and being possessed by the devil. And they would think it is a bad reflection on their parenting and will bring shame to my family.*

—**headspace** young person, female, aged 18

Most staff revealed that young people from some cultural groups are less likely to seek help from mental health services because they associate mental illness as stigmatising and bringing shame on their family. In addition there is a reluctance to seek help outside the family.

There are also particular issues for certain cultures where maybe the stigma or their view on health/mental health might be discouraging, or at least supporting help-seeking from other community members, but certainly to an extent discouraging service seeking from us, particularly on mental health problems.

—**headspace** service provider

I've worked with people where the parents were saying they have to do their school work, that's the only thing that counts in our culture. And you're saying well, this school work and all that pressure is currently killing your daughter. So there is, I suppose, particular barriers to certain groups and I do wonder whether stigma and shame might be a higher prevalence in CALD groups than maybe in the Australian white community. There is no one-size-fits-all.

—**headspace** service provider

Some staff reiterated that in a few cultures there is not only a limited understanding of mental health, but there is no language, categorisation or definition for mental illness.

You keep in mind there's no equal concept to mental illness. For example, there's no language, there are no words in Dari that translate mental illness or mental health, let alone knowing what the difference is between mental health and mental health issues.

—**headspace** service provider

In Afghanistan and in Afghan communities, there is no equivalent language or concept that means mental health so we're not even talking about mental health having stigma, we're talking about mental health not having a concept so you've got to take three or four steps backwards. Normally in terms of talking about mental health you can start from a starting point of the concept and take that for granted and in this you can't. The concept of health being linked with what you think about in your head is not even understood. So that's the first barrier, actually defining mental health.

—**headspace** service provider

A few staff indicated that in some CALD backgrounds a mental illness does not evoke the same level of understanding as a physical illness because it is not visible and therefore young people feel it is taboo and delay accessing treatment.

For this group, a mental illness as an illness, is certainly a very different perception as opposed to physical illness and that it has, from varying understandings, from it being the devil to different religious perceptions on what that means, to just you being weak or get over it.

—**headspace** service provider

Concerns about confidentiality

Some CALD young people indicated that concern about confidentiality is a barrier that can affect service accessibility. Fears related to their family finding out about their mental health concerns, which could compromise the status of their family in the community.

> *I wasn't sure about the confidentiality and the privacy and that was worrying me at the time. So it was hard in those terms.*
>
> —**headspace** young person, female aged 18

> *I guess something like my parents have always been very nosey and I was afraid that they would go up and ask things and eventually they would give in, but apart from that, no. I guess it was something that I had to personally get over and I think the whole process of becoming an adult and turning 18, that sort of helped.*
>
> —**headspace** young person, female aged 18

Structural barriers

Unaware of **headspace** and other services

Some staff indicated that a lack of knowledge and understating by CALD young people about what services are available is a barrier to accessing treatment. Furthermore staff commented that **headspace** centres do not have well established links with multicultural communities to disseminate information about **headspace** and other existing services.

> *They won't know about* **headspace***. On top of that, if that person then is an asylum seeker or a refugee, you can pretty much guarantee they will not know, they won't know anything.*
>
> —**headspace** service provider

Some CALD young people indicated that they were specifically unaware that **headspace** is a mental health service and they had little or no knowledge about how to access a centre. For example, one CALD young person did not understand the name '**headspace**', while another thought it was a private business.

> *The word* ***headspace*** *doesn't give us any kind of meaning. Like if I go to a fruit shop … I know there is different kind of fruits available in that shop, whereas the word* ***headspace*** *for me it doesn't make sense. I don't know. It might have a meaning whereas it might not have a meaning, I don't know.*
>
> —**headspace** young person, focus group

> *The first time when I saw the monogram I thought it's kind of a place where the graphic designers.*
>
> —**headspace** young person, focus group

Personal and interpersonal facilitators

Staff and young people were also asked to discuss facilitating factors which have a positive influence on the help-seeking behaviours of CALD young people. The facilitators that were common among staff and young people and were discussed by more than a few participants were that the service needed to be confidential, culturally appropriate, offer translational services and coordinate well with additional community services.

Promotion of confidential service

A few young people and some staff stated that knowing the service is confidential and service providers are trustworthy as a facilitator to engaging with treatment. The fear that family find out that a young person is attending a mental health service is a barrier for some young people.

Once I came I've trusted it.

—**headspace** young person, focus group

…it kind of makes me feel a bit safer to talk to them, knowing that my information won't be told to other people.

—**headspace** young person, female, aged 18

I think it could be because there are some really strong cultural restrictions and expectations of behaviour so I'm sure if there's a strong cultural belief around what mental health means, to be able to go and access support for mental health without your community knowing about it, it could be really important.

—**headspace** service provider

Relationships with CALD community leaders

Some staff indicated that there can be a lack of trust by CALD young people toward institutions, and to overcome this limitation, some centres have tried to develop stronger relationships with trusted members of the CALD community so young people will not associate **headspace** as a stigmatising service.

Equivalent of Elders in Indigenous [culture] a young person will be a community leader because they just do things. They're kind of a champion. They're trusted. People go to them when they don't know what to do, so the community trusts them. The community listens to what they have to say and values what they have to say. So to increase the word out in the community you need to first plug into the community leader.

—**headspace** service provider

You could go to events and do all of that other stuff, but if you do not engage with the community leaders you're not going to get anywhere. But if you're at that particular festival and you have standing next to you the local Imam who is talking about the service or is talking about the issue, that's different. People will listen.

—**headspace** service provider

Accessing CALD communities, the best way to do that is through your community leaders. In CALD communities you will generally have people in those communities that are highly respected.

—**headspace** service provider

Culturally appropriate treatment

All staff stated that many young people do not understand Western cultural approaches to mental health care and in order to keep CALD young people engaged in services, greater understanding and education of the treatment options is required.

One of the biggest ways to learn about it, which is really an efficient way, is to hire a bicultural worker. Bicultural workers will teach everyone about the politics and the history.

—**headspace** service provider

So as a helper, whether it's a clinician, a doctor, if you have a greater understanding of the culture and the implications within that you can work towards that. Therefore you've got to make sure that you're not battling and you don't go at loggerheads with culture because you will get nowhere. You have to work within that culture and then you get to change the way people think about things.

—**headspace** service provider

So I guess on one level it's about understanding the system and treatment but there's also the individual stuff, personally what it means to them. There are all sorts of layers, cultural personal experiences.

—**headspace** service provider

Some staff stated that service provision needs to be flexible enough to acknowledge and support different cultural values and beliefs. A few staff stated that transcultural mental health approaches which recognise the significance of cultural factors in understanding mental health is important to ensure this group of young people remain engaged with the service. A few staff also indicated that as part of cultural competence, different forms of language need to be used that are more culturally congruent.

We have a range of things that we have known and do in order to be able to talk to a [CALD] young person and not necessarily do it in an office with four walls … they won't sit in a room with four walls and one door. I used to work in an area where you had to have at least two doors in the room and a window without the curtains ... it totally depends on their history.

—**headspace** service provider

***headspace** needs to think about the way in which they do therapy for common issues such as depression and anxiety, severe depression and anxiety, but nonetheless people from a CALD background don't understand that self-analysis stuff, so they don't understand counselling. The word counselling is not a good word so we don't say counselling either. We stay away from all the words that have got all of these kind of negative connotations and we interpret, we change the words.*

—**headspace** service provider

Emphasise the word 'health', talk about general wellbeing and those sorts of things.

—**headspace** service provider

Culturally safe and welcoming staff

Most staff indicated that CALD young people may have experienced torture and/or trauma in previous countries perpetrated by figures of authority. Therefore establishing communication and trust between the young person and service providers is important to ensure they remain engaged in a service.

Most staff indicated that their first concern is to ensure a young person is made to feel respected and welcomed which alleviates any distress they may have in relation to engaging with a mental health service.

You should see their face when you are welcoming, their faces light up because what you're showing them by simply understanding and respecting them. You've gone to the trouble of respecting and understanding how to properly welcome somebody from that culture, and they love it because it's welcoming. Yes, the way in which the service is presented is very, very, very important. And they will vote with their feet so if you're not engaging them you will know it.

—**headspace** service provider

I think having more training around different cultural backgrounds and how we can engage those young people more in terms of our language and understanding would be important, as well as maybe having to do less structured support.

—**headspace** service provider

… certainly we try to select [staff] here that have come with the right attitude, whether that then transpires as a good experience on the part of the young people and their families, that's something that they will hopefully tell us.

—**headspace** service provider

Some young people indicated that they return to **headspace** because staff make them feel welcome, comfortable and respected.

They [staff] are supporting us. For example, if we have a doctor's appointment we are not sure what to do so they give them a call the doctor and they make appointment.

—**headspace** young person, female, aged 18

I started seeing the GP there and she was awesome as well, there wasn't any dramas at all.

—**headspace** young person, female, aged 18

Structural facilitators

Culturally welcoming environment and branding/marketing

Most staff and young people stated that a centre which was culturally inviting and appealing to CALD young people would lead to greater service access and engagement. For example, the creation and dissemination of information in languages other than English via a variety of formats, including brochures and leaflets in waiting areas.

The first part is being able to communicate to CALD communities that the service is CALD friendly, that's the first point. The way you do that is through images … and in different languages.

—**headspace** service provider

We want some images around Islam, around Muslims, because it doesn't matter whether somebody comes from Somalia or Afghanistan or Iran or Iraq, the Muslim community here, Islam in this area is huge. So we need some images that resonate with the Muslim community. By just doing that we attract multiple different cultures into the centre.

—**headspace** service provider

On the front window we have "Welcome" written in Dari. We identify within our community what are the main demographic of our CALD community and we have "Welcome" written in those languages.

—**headspace** service provider

A few young people indicated that the **headspace** marketing posters need to resonate with their culture in order to facilitate greater access and engagement.

Personally, I would think when I enter an office and I see my language, maybe a sign in my language, maybe a word of welcome in my language, and that if it's a multicultural atmosphere and that is like an office which works for all the ethnic groups, for all the nationalities, so probably I would feel more welcome there and I feel more confident into going to there and I say there probably is either an interpreter available or there is something related to me because they have already written there something in my language, which means there are doing something for me too.

—**headspace** young person, focus group

I would say my experience culturally we didn't have this kind of posters back home and even for me, the posters for me are kind of meaningless. I don't understand anything from those posters, like the person with the big cloud over his head, I don't understand what the meaning lies behind that.

—**headspace** young person, focus group

Ease of access to **headspace** services

All young people indicated that ease of access to **headspace** centres was a facilitator to engaging in treatment. Support in negotiating the health service system was provided by a range of sources, including teachers and GPs, which facilitated the young people's knowledge of how to engage with **headspace**. Once contact with **headspace** was made, most young people reported the process to accessing services to be straightforward.

> *I called up a **headspace** centre and they told me to go to my GP to get a referral, and that's pretty much it; I went to my GP, got the referral, and then I was on the waiting list at **headspace** to speak to a psychologist … It was easy, it was pretty straightforward.*
>
> —**headspace** young person, focus group

> *It was pretty straightforward, give information and then make an appointment.*
>
> —**headspace** young person, focus group

Collaboration with local services

All staff indicated that a collaborative relationship among relevant services within the local community facilitated service access and engagement. A few young people commented that the support from other services to access **headspace** had made it easier for them to initially contact **headspace**.

> *Strengthening connections with the different services that we know already engage those young people really well … There are services that have a lot greater understanding of what those needs are and we could learn a lot from them.*
>
> —**headspace** service provider

> *Another thing we do, we do group projects with other services, or we'll go into a school with another service, so it's making that connection, having that overlap between a service that maybe is already working with a young person. There are some other groups that run from time to time with different services so it's just making that connection.*
>
> —**headspace** service provider

> *Contact with case managers to ensure that young people get the information from case managers that you have this service. Then the case managers tell every client that if you have any problems you should go to **headspace**.*
>
> —**headspace** young person, focus group

Clinical file review

A clinical file review was completed on the records of 19 CALD young people who had accessed services at a **headspace** centre to identify service use patterns and barriers and facilitators to service engagement.

As would be expected from an analysis of client case notes, the findings from this method were more clinical in nature, with the primary barriers reported by clinicians being: poor support (i.e., family or other); poor rapport with the clinician; negative past experiences with mental health services; and lack of readiness or reluctance to seek formal mental health treatment; more immediate concerns or work commitments; and poor coping with symptoms.

Nearly all of the young people within the CALD group had evidence in their clinical records of at least one type of facilitator to attending **headspace**, with the average number of unique facilitators higher than the average number of barriers. Facilitators that were reported by clinicians in client files included: motivation for treatment; self-referral; referral or re-referral from an external source; previous mental health treatment; good fit between clinician and young person; a good relationship with the service; availability of the service; family support; and improvements in mental health.

6.6 Summary of main findings

Overall, the level of representation of CALD young people accessing **headspace** services at 7.1 per cent is poor compared to the 2011 census data showing that 25 per cent of young people aged 12-24 years identify as CALD. The rates of access need to be considered in relation to the proportion of CALD young people who reside in each community. The variation across centres ranges from one per cent to 30 per cent, indicating that some **headspace** centres may be more adequately engaging CALD young people in proportion to their local population distribution, whereas others may not. It is important that **headspace** is working to reduce the barriers and increase the facilitators to make all **headspace** services attractive and appropriate for CALD young people.

This report shows that CALD young people who present to **headspace** services are equally as satisfied with services they receive as non-CALD young people and their gender representation is comparable. However, CALD young people marginally make up a greater proportion of older services users and have slightly different pathways to **headspace** services than non-CALD young people. CALD young people are less likely to be influenced by family or their partners and more likely to be influenced by friends, school staff and health workers to attend **headspace**.

Interviews and focus groups with CALD young people and staff at two centres with a high proportion of CALD clients, as well as an additional multicultural service, identified a broad range of barriers and facilitators to accessing and engaging with **headspace** services. This report has concentrated on a smaller number of key personal and structural elements that were common to staff and young people and mentioned by more than a few participants.

The key personal and interpersonal barriers were: language barriers; stigma and lack of acknowledgement of mental illness in many CALD groups; shame and keeping personal concerns within the family. The key structural barrier was lack of awareness of **headspace** and other services. The key facilitators aligned with these barriers and centred on: the service being confidential and trusted; culturally safe and appropriate, which includes being culturally welcoming, cultural awareness of staff, and providing an appropriate treatment and service approach; establishment of strong community links and coordinated services; and culturally appropriate marketing and materials.

The barriers and facilitators emerging from this research were reinforced by the findings from the literature review, which identified similar barriers around concerns about confidentiality and sociocultural barriers that reduced motivation for treatment.

Although the clinical file review identified fewer practical facilitators and barriers, its findings strengthen the findings from the interviews and focus groups around the need for the service to be culturally safe and welcoming, have a focus on relationship building and repairing negative past experiences with mental health services, leverage family support when possible, and achieve positive outcomes.

Table 6.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young people from CALD backgrounds.

Table 6.3: Barriers and facilitators to accessing and engaging with headspace for young people from CALD backgrounds

Barriers	Facilitators
Personal & Interpersonal	
– Language	– Confidential and trusted services
– Stigma and lack of acknowledgement of mental illness in many CALD communities	– Culturally safe and aware staff
– Shame, expectation to keep within family	
Structural	
– Lack of awareness of **headspace** and lack of cross-cultural understanding of **headspace** name, branding and marketing materials	– Relationships with leaders in CALD communities
	– Culturally welcoming environment (welcome signs in other languages, cross-cultural posters)
	– Connections with other local services (schools, health, community)

The main findings emerging from this research are:

- As CALD young people are more likely to be referred by school or health services, **headspace** centres need to establish strong coordination with other services and engage in culturally appropriate marketing of services.
- Centres need to be known and trusted in the community as a safe place for CALD young people, where confidentiality and trust is paramount, especially for the younger age groups.
- All **headspace** staff should receive cultural awareness training regardless of position, to assist in building a culturally appropriate service.
- The environment needs to be comfortable and culturally welcoming to CALD young people.
- Centres need to adequately provide translation/interpreter services, given that language was the greatest barrier identified by young people.

An important caveat on these findings must be noted, however; the current data came from young people currently engaged with **headspace** services. Accordingly, the information does not reflect the experiences or opinions of young people who are unknowledgeable of or are unwilling or unable to engage with **headspace**. Although there is greater complexity involved in obtaining such data, it would make for a valuable companion piece to the present findings and recommendations, and would help to contextualise next steps toward better engaging this cohort with available **headspace** services.

6.7 Recommendations

Table 6.4 details potential strategies for assist with improving the access and engagement with **headspace** services for young people who are from CALD backgrounds.

Table 6.4: headspace model development for young people from CALD backgrounds

Principles	Potential strategies
1. Community awareness and service promotion through engagement with local CALD communities	– Examine the effectiveness of setting-specific messaging and targeted digital campaigns for CALD young people – Use the **headspace** brand to promote help-seeking in CALD communities and breakdown perceived stigma and shame associated with accessing a mental health service and encourage help-seeking by family members – Build relationships and awareness among leaders of local CALD communities
2. Promotion of confidential service	– Culturally appropriate promotional messages that **headspace** services are confidential and freely accessible to all young people – Clear guidelines regarding circumstances in which confidentiality may have to be broken
3. Welcoming and culturally appropriate environment	– Welcome signs in languages other than English in the **headspace** waiting area – Culturally appropriate information in the form of posters, pamphlets and leaflets, printed in languages other than English and available in the **headspace** waiting area
4. Culturally respectful staff	– Ensure that **headspace** staff understand and respect cultural values, especially with respect to different beliefs and understandings about what constitutes mental illness (compared with Western norms) – achieved through the provision of cultural awareness training – Employ and retain a qualified and skilled CALD workforce to promote culturally appropriate service delivery
5. Culturally appropriate intake, assessment and treatment	– Emphasise the focus on engagement and cultural understanding during the intake process with CALD young people – The development of culturally appropriate programs and treatment options – flexible enough to acknowledge and support different cultural values and beliefs
6. Translation services	– Adequate interpreter services for young people who have limited English proficiency

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7. Young People who use Alcohol and Other Drugs

7. Young People who use Alcohol and Other Drugs

7.1 Background

headspace was set up to meet the needs of young people with alcohol and other drug problems (AOD) as well as those with mental health problems and co-occurring conditions. Consequently, young people with AOD concerns are one of the foremost target groups whose needs **headspace** services must address. AOD use is common among young people, with alcohol being the most frequently used substance. A nationally representative survey of Australian secondary students aged between 12 and 17 years found that 74.0 per cent of young people had tried alcohol, 14.8 per cent had used cannabis, 17.1 per cent had used tranquillisers (other than for medical reasons) and 17.3 per cent had used inhalants at some time in their lives (White & Bariola, 2012).

The 2013 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2014) investigated the use of alcohol and other substances and found that 27.6 per cent of young men and 14.4 per cent of young women aged 18-24 years reported engaging in risky/high risk drinking (i.e. consuming more than 4 standard drinks on a single occasion) at least once a week, with a further 2.1 per cent of males and 1.6 per cent of females in this age group engaging in risky consumption on most or all days during the last 12 months. Young people aged 18-24 were the most likely of any age group to exceed the single occasion drinking guidelines (National Health & Medical Research Council, 2009). Additionally, 17.6 per cent of young people aged 14-19 and 27.3 per cent aged 20-29 years had used illicit drugs during the last 12 months. The most common drug used by young people was cannabis (14.8 per cent of 14-19 year olds and 20.8 per cent of 20-29 year olds), followed by ecstasy (3.0 per cent of 14-19 year olds and 8.6 per cent of 20-29 year olds).

Substance use disorders are among the most common mental disorders experienced by young people and about half of people with substance use disorders first experience AOD issues by the age of 20 years (Kessler et al., 2005). In Australia, 12.7 per cent of people aged 16-24 are estimated to have a substance use disorder, with higher rates among young men (16%) than young women (10%)(Australian Bureau of Statistics, 2008). Harmful use of alcohol was the most commonly reported substance use disorder (at around 9%) (Reavley, Cvetkovski, Jorm, & Lubman, 2010).

People with substance use disorders often don't recognise the need for help nor seek help for the problem, and may not be screened for substance abuse when they seek treatment for other health conditions. This means that substance abuse and dependence disorders are often under-recognised and undertreated (Australian Bureau of Statistics, 2008).

Substance use disorders can result in significant short and long-term ill effects. These consequences arise from the type of substance and the way it is used (for example, respiratory problems resulting from smoking and spread of infections such as Hepatitis via injecting); from the immediate effects of intoxication (such as overdose, traffic accidents and falls, risky sexual behaviour, violence and aggression); from the longer term physical effects of the substance (such as brain damage, liver disease, and cancer) and the significant mental distress associated with drug dependence (Canadian Centre on Substance Abuse, 2007).

There is a close relationship between substance use disorders and other mental disorders, and use of some substances may increase the risk of developing certain disorders, however, it is often unclear whether one issue causes the other. It is common for young people with a substance use disorder to have one or more co-occurring mental disorders, such as anxiety, depression and schizophrenia (Armstrong & Costello, 2002).

The provision of targeted AOD services is one of four core pillars of the **headspace** model. The recent Best Practice Framework (Rickwood et al., 2014) identified the essential nature of each of the four core streams and also highlighted the importance of local, integrated approaches to meeting the needs of young people, particularly those with co-morbid mental health and AOD problems. This report identified that although in many centres the provision of an AOD service stream was viewed as important, it was not always implemented fully and effectively and needed considerable enhancement. Staff reported problems implementing an effective and consistent AOD stream due to difficulties in: engaging young people with AOD problems; coordinating with external organisations providing AOD services; identifying sufficient and appropriate external services; and overcoming young people's reluctance to attend targeted AOD services.

Consequently, the level of access by young people presenting to **headspace** with substance use issues is relatively low at just under seven per cent. Although there is likely some level of underreporting in this figure given the reluctance of young people to identify substance use as an issue, further investigation is required to ensure that preventable barriers are addressed and facilitators enhanced across the **headspace** centre network.

7.2 Aims

Given the difficulties identified by **headspace** centres in the delivery of the AOD service stream and relatively low levels of young people identifying AOD issues as a key reason for presenting to **headspace**, it is important for **headspace** to investigate the barriers and facilitators specific to these young people accessing the support they require. This chapter aims to identify approaches to assist **headspace** centres to reduce the barriers and increase facilitators to ensure all **headspace** services are appropriate and accessible for young people presenting with AOD issues.

7.3 Methodology

The following methodology was used to gain an understanding of the barriers and facilitators that young people using AOD may encounter in accessing required services and supports.

1. A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care for young people who use AOD.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Clinical file review for 20 young people across two centres who presented for ‘problems with alcohol and other drugs’.
4. Interviews with 10 young people, four parents and eight **headspace** service providers from two **headspace** centres with high rates of young people presenting for ‘problems with alcohol and other drugs’ (centres were identified from MDS data over a 12 month period).

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews and focus group have been analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses (see Table 7.1). This type of analysis allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 7.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Table 7.2 outlines the focus group and interview participants, including the gender and age of young people involved.

Table 7.2: Participants

headspace centre 1 (QLD)	
Staff	
Centre manager	
Psychologist	
General practitioner	
Intake team worker	
Young people	
Male, age 15	
Male, age 17	
Male, age 18	
Male, age 19	
Parents	
Mother of male	
Mother of male	
headspace centre 2 (VIC)	
Staff	
Centre manager	
Dual diagnosis clinician	
General practitioner	
Mental health nurse	
Young people	
Female, age 17	
Female, age 15	
Female, age 21	
Male, age 24	
Male, age 19	
Male, age 25	
Parents	
Mother of male	
Mother of female	
Total staff	**8**
Total young people	**10**
Total parents	**4**
Total	**22**

7.4 Literature review

The systematic review of studies examining barriers and facilitators for help-seeking by young people using AOD found 24 studies, 20 of which used a quantitative method, one qualitative, one randomised control trial, and two with a mixed methods approach. The majority of the studies (17) were conducted in the U.S.A., one in Australia, four in South Africa, and two in North America. Twelve of these studies recruited young people through services (mental health, substance use, social services) and two through shelters, five used school/university samples, and five were national surveys. The majority of participants in each study (for which gender information was available) were male.

One-third of these studies examined barriers to service access, with common barriers including: stigma, shame and embarrassment around seeking help for problems (Ballon, Kirst, & Smith, 2004; Grant, 1997; Johnson, Stiffman, Hadley-Ives, & Elze, 2001; Wu, Pilowsky, Schlenger, & Hasin, 2007); poor motivation for treatment (Ballon, et al., 2004; Grant, 1997; Johnson, et al., 2001; Myers, Louw, & Pasche, 2010; Wu, et al., 2007); cost (Grant, 1997; Johnson, et al., 2001; Myers, et al., 2010; Wu, et al., 2007); negative past experience resulting in low confidence in services capacity to help (Ballon, et al., 2004; Johnson, et al., 2001; Myers, et al., 2010); and lack of awareness of services (Grant, 1997; Johnson, et al., 2001; Myers, et al., 2010). Service inaccessibility, involving location and hours of operation (Johnson, et al., 2001; Myers, et al., 2010), and lack of support (Ballon, et al., 2004; Caldeira et al., 2009), were less common barriers identified in only two studies.

The majority of studies (14) explored facilitators to accessing services, with common facilitators being: socio-demographic factors (Burnhams, Dada, & Myers, 2012; D'Amico, 2005; Myers, Louw, & Pasche, 2011; Winstanley et al., 2008; Wu, Hoven, & Fuller, 2003; Yu, Evans, & Perfetti, 2003); increased severity of general or mental health problems (Caldeira, et al., 2009; Chan, Godley, Godley, & Dennis, 2009; Johnson, et al., 2001; Medeiros et al., 2004; Merikangas et al., 2011; Wu, et al., 2007; Wu, et al., 2003); motivation to change or seek support (Caldeira, et al., 2009; Medeiros, et al., 2004; Myers, et al., 2011); free service provision (Chan, et al., 2009; Myers, et al., 2011; Wu, et al., 2003); and easy accessibility, including no wait time, drop-in, extended opening hours, convenient location (Ballon, et al., 2004; D'Amico, 2005; Myers, et al., 2011). Less common facilitators, only identified in two studies, were family support (Winstanley, et al., 2008; Wu, et al., 2003), previous treatment (Chan, et al., 2009; Johnson, et al., 2001), service awareness (Ballon, et al., 2004; Berridge, Hall, Dillon, Hides, & Lubman, 2011), and confidence in treatment or providers (D'Amico, 2005; Myers, et al., 2011).

No barriers or facilitators to engagement were shared by multiple studies.

Several limitations were present in these studies, including: reliance on self-report data; the frequent use of cross-sectional data which does not demonstrate causal relationships; few studies examining actual service utilisation; reliance on sample recruitment from one school/service; and a preference for school samples, which limits the generalisability of these studies to young people who are not enrolled in school or clinical populations who may have greater needs or experience more difficulties accessing services.

7.5 Results

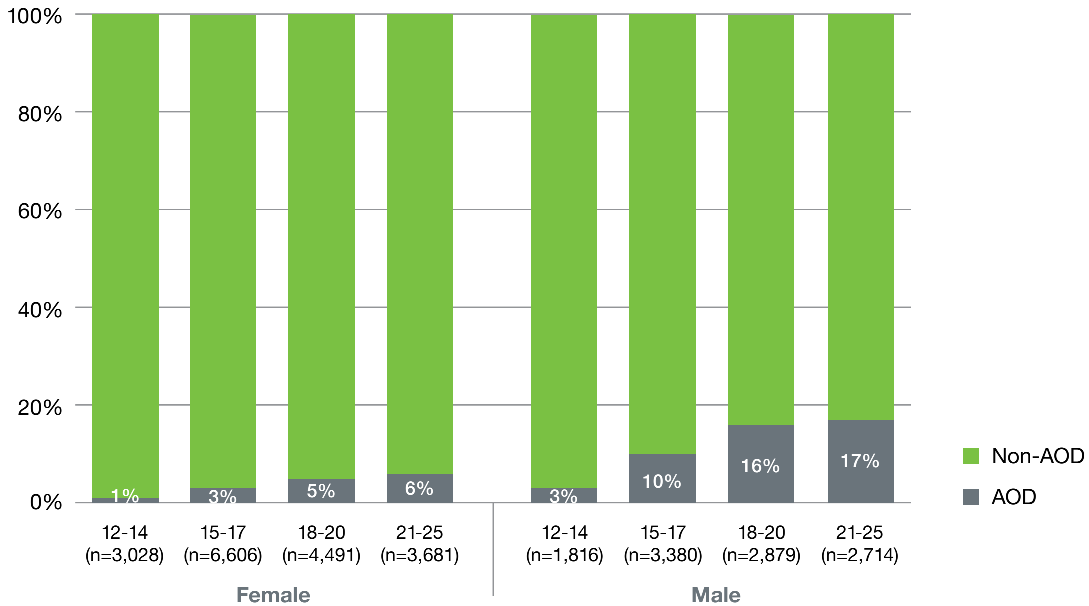
Client profile

Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of young people accessing **headspace** for 'problems with alcohol and other drugs' and provide an outline of how they compare with all services users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus excluded from the analysis).

Of this sample, 2,294 young people either self-reported 'problems with alcohol and other drugs' on their first visit or their clinician recorded a presenting issue of AOD, representing approximately 6.9 per cent of all **headspace** young people. This figure is likely to be an under-representation of the actual proportion of **headspace** clients with substance abuse problems, given young people may be seeking help from **headspace** for other issues or may not disclose or be aware of the extent of substance abuse problems on their initial visit. Regardless, it is well below reported national data, which estimates that 12.7 per cent of people aged 16-24 have a substance use disorder, with higher rates among young men (around 16 per cent), than young women (around 10 per cent) (Australian Bureau of Statistics, 2008). Limiting the analysis to **headspace** young people aged 16 years or above increases the proportion of young people presenting with an AOD issue to almost 9 per cent (15% of males and 5% of females).

Of the young people with AOD issues, young men were over-represented in comparison to all clients, with 66 per cent of those with AOD issues being male and 34 per cent female whereas the proportions for all clients show the reverse pattern with 38 per cent males and 62 per cent females. Figure 7.1 shows the proportion of young people with AOD problems across age brackets and gender, with males much more likely to have problems with AOD at all ages but especially those aged 18-25.

Figure 7.1: Percentage of young people with AOD issues by gender and age group



Across the **headspace** centres there is variation in the level of access by young people with AOD problems, ranging from 12 per cent at some centres to as low as 3 per cent at others. Across the states and territories there is also variation, with Queensland having the greatest proportion of young people with AOD problems at 8 per cent, followed by Victoria and Western Australia at 7 per cent, New South Wales/ACT and the Northern Territory at 6 per cent. The two states with the lowest level of access by young people with AOD problems were Tasmania and South Australia at 5 per cent. Figure 7.22 shows that the centres with the greatest proportion of young people with AOD problems are located in metropolitan areas.

Figure 7.2: Percentage of young people with AOD issues by centre rurality

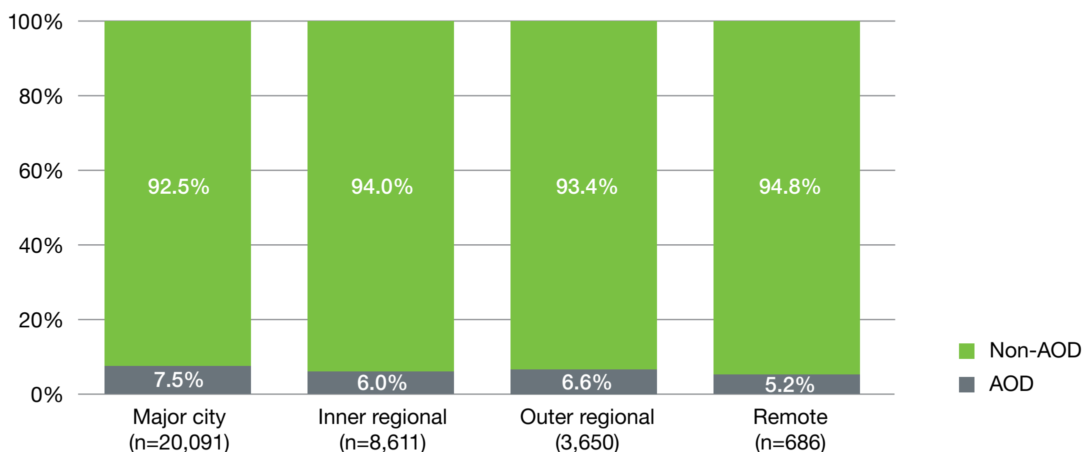


Figure 7.3 reveals the comorbidities recorded by **headspace** staff for those young people with AOD problems, with the majority having a mental health issue, followed by situational issues. For the young people presenting with comorbid AOD and mental health problems, the types of mental health issues recorded were primarily depressive symptoms (38%), anxiety symptoms (24%), anger issues (14%) and stress related (6%). These rates are consistent with the primary mental health issues recorded for all **headspace** young people. For the young

people presenting with comorbid AOD and situational problems, the types of situational issues included conflict in the home environment (29%), difficulty with personal relationships (20%), homelessness or at risk of homelessness (13%), and legal issues (13%).

Figure 7.3: Comorbidities of young people with AOD issues at **headspace**

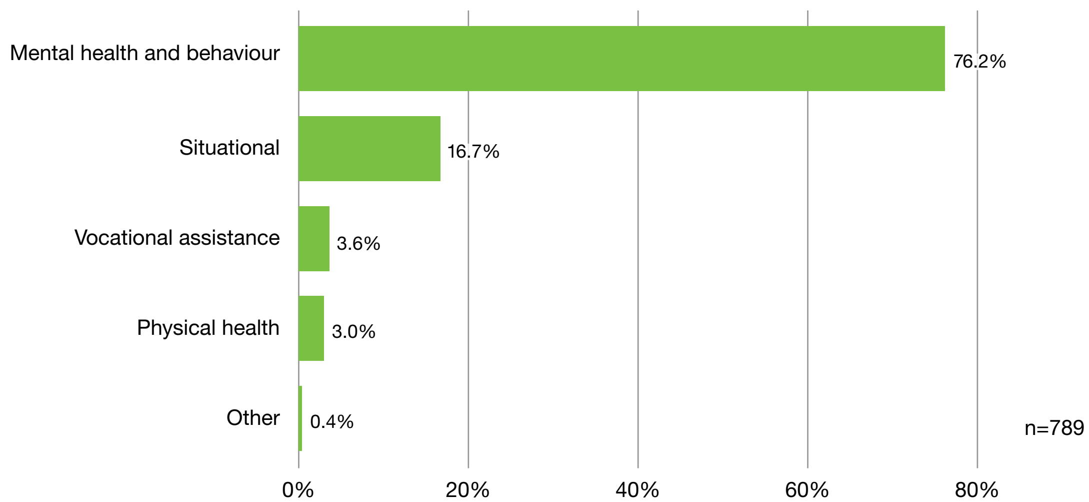
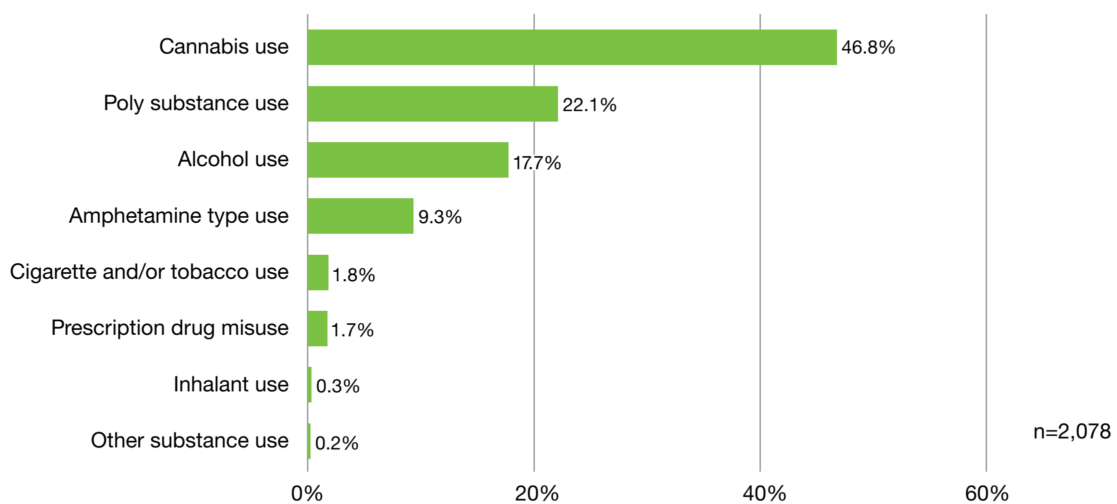


Figure 7.4 outlines the type of problems with AOD experienced by these young people. The majority reported cannabis use, followed by issues with poly substance use and alcohol use. The prevalence of cannabis use is higher for young males, representing 52 per cent of young males' problems with AOD, versus 39 per cent for young women. Young women are more likely to present with issues regarding poly substance use (24% of females versus 20% of males), alcohol use (19% females versus 16% males) and amphetamine use (13% females versus 7% males).

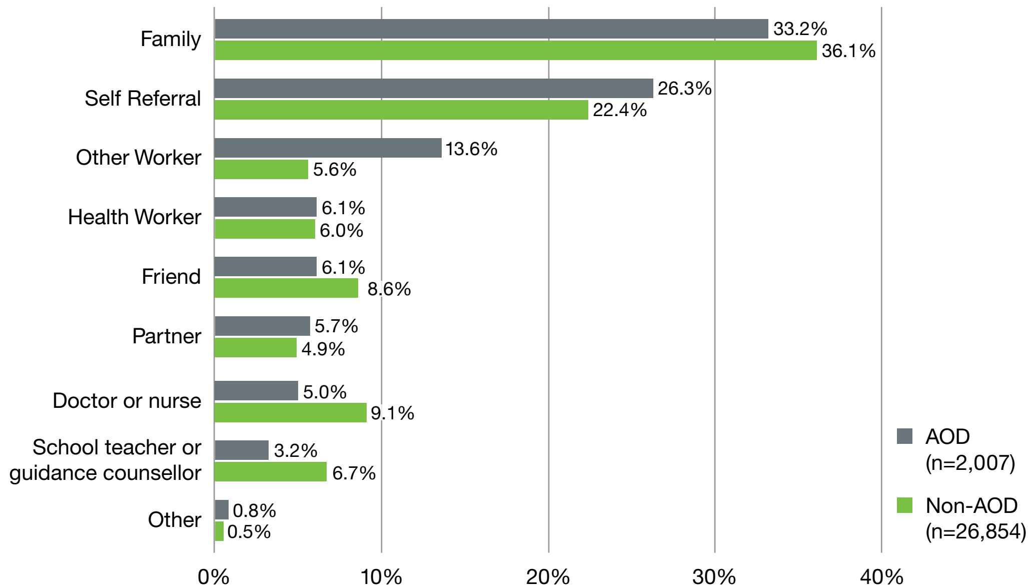
Figure 7.4: Main AOD issue for presenting at **headspace**



Young people with AOD problems are most likely to be influenced to attend a **headspace** centre by a family member or to be self-referred (see Figure 7.5). In comparison to young people who presented for reasons other than AOD, those with AOD problems are less likely to be influenced by friends or a doctor and more likely to be influenced by an 'other worker' ('other workers includes welfare or community services worker (8.6%), or police, corrections or justice officer (5.0%))[11].

[11] Observable differences in Figure 7.5 in the proportion of young people being influenced to attend **headspace** by family members, school staff, and self-referral in those presenting for AOD problems compared to reasons other than AOD were the result of age and gender effects, and do not represent AOD versus non-AOD group differences.

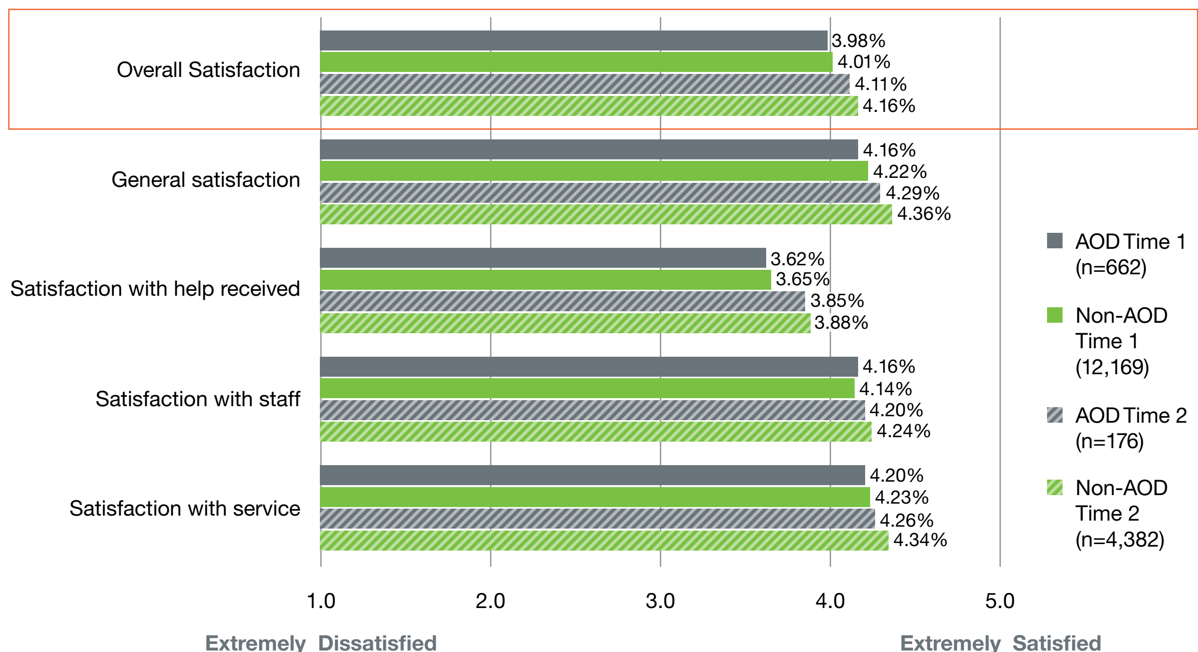
Figure 7.5: Pathways to **headspace**



Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their service. During this period, over 12,000 young people completed a survey and 662 of these presented with AOD problems (5.2%). The survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied. Results are presented in Figure 7.6 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups and results indicate that there were no significant differences in satisfaction between those presenting with AOD problems versus those presenting for reasons other than AOD.

Figure 7.6: Satisfaction for **headspace** young people with AOD issues and Non-AOD



Barriers and facilitators

Data from the interviews with young people presenting for problems with AOD and centre staff, and the clinical file review revealed a range of facilitators and barriers to service access and engagement.

The main barriers raised by young people included service accessibility (including remoteness and transport), stigma associated with help-seeking, negative past experiences, anxiety about seeking help and the possible consequences of disclosure, and denial that they have a problem or need help (poor motivation). Staff raised similar issues, but also highlighted barriers of confidentiality and limited personal support.

Issues around service accessibility, primarily remoteness, transport and centre opening hours, were also raised as barriers to ongoing engagement with the service by young people and staff. Other engagement barriers raised by staff were rapport with a worker and insufficient resources to meet service demand, which resulted in lengthy wait times.

The primary facilitators discussed by young people included easy to access services, short waiting times, comfortable services and accepting staff. Additional facilitators that helped them to remain engaged included their needs being met, having a good relationship with their clinician, and that the service was confidential. In addition to the facilitators raised by young people, staff also highlighted the importance of having supportive family and friends, providing flexible intake options, having strong relationships with referral agencies, and being able to provide outreach services.

Although there was a long list of barriers and facilitators identified across the data sources, there were only a handful of barriers and facilitators that were common to staff and young people or mentioned by more than a few participants. These key barriers and facilitators are discussed in detail below and are categorised as either personal and interpersonal or structural. Personal and interpersonal barriers include negative past experiences, stigma, denial of need for help, and anxiety and fear, while structural barriers focused on service inaccessibility. Although these barriers are primarily around initial service access, service inaccessibility was also highlighted as a barrier to ongoing engagement with the service.

The primary personal facilitator identified was good rapport with their clinician. Structural facilitators included service accessibility, comfortable and accepting environment, clear and upfront confidentiality policies, and relationships with other agencies. The majority of the structural facilitators were highlighted as facilitators to engagement.

Additionally, the clinical file review identified primary barriers for access and engagement to **headspace** as low motivation and negative past experiences with mental health services. Although less common, a few additional barriers to accessing and remaining engaged in services were identified and included dissatisfaction with treatment options, more immediate concerns or work commitments, and poor coping with symptoms. The facilitators identified through the clinical file review included motivation for treatment, referral from external service, good rapport between young person and clinician, and family support.

Personal and interpersonal barriers

Negative past experiences

Most staff and some young people explained how previous negative experiences with staff or with other services, or not being taken seriously, were barriers to overcome in relation to accessing **headspace**.

> *Like my first counsellor I had he was really difficult to talk to, and I think it's hard to find someone that it's easy to talk to, that you find to be comfortable with.*
>
> —**headspace** young person, female, aged 17

> *Because my [previous] therapist was a little bit too full-on and **headspace** was a bit more of a relaxed approach but still giving me the sort of support and therapy that I needed.*
>
> —**headspace** young person, male, aged 15

> *At the start I thought, because I had been to a few places before and I thought I was just getting shrugged off, but then the fact that they [**headspace**] said 'you're still actually coming back here every few weeks to check up with me.'*
>
> —**headspace** young person, male, aged 25

Often previous help seeking that hasn't been successful, for whatever reason. They haven't developed a good rapport when they've had previous contact.

—**headspace** service provider

… most of them have had experiences that haven't been that good.

—**headspace** service provider

Stigma

The stigma attached to mental illness and accessing help for problems with AOD was a key barrier identified by some young people in preventing them from accessing the care they required.

… you just don't want to get help because it makes you different.

—**headspace** young person, female, aged 21

I didn't like people finding out I was sick, so I just tried to hide it so I didn't really want to go and get help, I just wanted to be normal like everyone else.

—**headspace** young person, female, aged 21

I think there's a lot of people out there that probably should be coming to places like this but probably don't necessarily because … there's a negative stigma attached to it.

—**headspace** young person, male, aged 18

With me personally there was this big not wanting to deal with it, or I can do it myself, but I think there is this funny stigma about people who see professional people, they've got this weird attachment to it, and I think probably the biggest one is people don't want to maybe admit that they have problems.

—**headspace** young person, male, aged 19

Similar to young people, a few staff also indicated that stigma prevented young people with AOD problems from accessing help.

I think it's very hard and I think there are still some barriers, I think there's stigma around coming into a service.

—**headspace** service provider

The other thing a few of them said is still the stigma issue, even just the stigma of walking in the front gate.

—**headspace** service provider

The building is very small and lacks privacy. So if you sit in that very tiny waiting room mostly people know who the workers are so there is no anonymity with who you're going off to see.

—**headspace** service provider

Denial of problems or need for help

Most young people talked about how they refused to accept that they had a problem, with some saying they rationalised their behaviour and underestimated how much they used alcohol and other drugs. Often it is only when young people get to breaking point or they are made to come do they accept that there is an issue.

> *I know people that they can never admit that they have got really bad problems when it comes to smoking weed or other stuff but they wouldn't take the time to actually go and seek professional help because they don't see it as something that's going to help them, they just see it as another doctor who is probably going to try and push pills down their throat or something like that.*
>
> —**headspace** young person, male, aged 18

> *I didn't think there was anything wrong with me so that's why I didn't think I really needed to come.*
>
> —**headspace** young person, female, aged 21

> *Some people are just afraid to go and seek help and afraid to admit that they actually have a problem, especially younger people, they'd choose to be naive about the fact and wait until it gets so bad that they don't know what to do about it. Yeah, I don't see many young people actually taking the initiative to go and seek help, it's usually only when it gets to breaking point and they need to and then usually it's their parents trying to help them out.*
>
> —**headspace** young person, male, aged 18

Some staff also highlighted that if young people don't believe they have an issue and are forced to come to a **headspace** centre but aren't ready to deal with it they may lack that motivation to change which can be a key barrier to engaging with the service and working through their problems.

> *I see quite a few AOD people whose parents bring them in but it's generally to stay at school, they've been told that they have to be in treatment.*
>
> —**headspace** service provider

> *We have a lot of regular class kids who are dragged in by their parents … they're in that really pre-motivational stage … and generally they are here because they're being forced to, whereas when they're a little bit older you actually get the self-motivated and they want to do it so they turn up and they get a lot out of it.*
>
> —**headspace** service provider

> *They're probably the difficult group because they're forced and required to see us and obviously are not in a place to be considering change.*
>
> —**headspace** service provider

Anxiety and fear

In addition to the denial of need for help some young people and some staff raised that anxiety or fear prevented young people from accessing help for their problems with AOD. This anxiety and fear is related to the stigma associated with accessing a mental health service but was also due to fear of judgement, lack of understanding of what treatment involves, possible drug and alcohol withdrawal process, service confidentiality regulations, and a fear of legal ramifications for disclosing the use of illegal substances.

> *I was really scared because I had only had contact with a counsellor in a school setting so I was concerned about what they [**headspace**] would say about me, what they were going to do, would they send me off somewhere, or something like that. Scared of maybe a bit of judgment.*
>
> —**headspace** young person, male, aged 19

I think it's a very public space here regardless of it being a youth service; I think it's a very public space, a very public waiting room, and can be quite anxiety-provoking and I think you're less likely to seek treatment when people might know why you're going there.

—**headspace** service provider

I think it can be quite confronting to sit in a waiting room and access services but once they've done it the first time, that's fine, but initially I think that's a big barrier.

—**headspace** service provider

The added difficulty we have at this particular site is that we're in a shopping centre that is full of quite rough people, not across the board, but I know some of my young people are really anxious about coming to this centre in particular. We're tucked away, we're hard to find, so that's site specific stuff, I guess.

—**headspace** service provider

Most staff raised confidentiality concerns as a cause of fear or anxiety that was a key barrier for young people, indicating that there is a lack of understanding among young people that services are confidential and they often fear that the police or other legal services will be alerted that they are involved in the use of illegal substances.

They are very wary about confidentiality issues. Who are you going to tell? Who are you going to talk to?

—**headspace** service provider

Confidentiality, that's always an underlying concern, and obviously the younger the young person the more the potential issues.

—**headspace** service provider

On one hand they're involved in the (il)legal acts that can have really serious ramifications on their life, and they're all aware of that, so why would I tell you about my (il)legal activities?

—**headspace** service provider

However, these views around confidentiality were not strongly supported by young people, with only one young person reporting fears around confidentiality and legal consequences.

That could lead to their parents or the police or their school finding out that they have a substance problem. It's not something that you like to publicise … a lot worse for people with substance abuse problems because of the legality of it, no one wants to go and see a professional person because of the fear factor.

—**headspace** young person, male, aged 17

Structural barriers

Service inaccessibility

Staff and young people raised a number of structural barriers that impacted on the accessibility of the **headspace** centre; these barriers included remoteness and transport, waiting times, appointment based service approach, and service opening hours.

Remoteness and transport were discussed as being both a barrier to initial access but also ongoing engagement with **headspace**. Although it was raised as a barrier by most staff and some young people its level of importance may be confounded by the fact that both centres involved in the research were located in regional areas where there is a lack of public transport and it is often more difficult for young people to access centres independently than in metropolitan areas.

Before I had my licence if I had an appointment, I'd have to put an extra hour in front of it to get here so it would take a big chunk out of my day.

—**headspace** young person, female, aged 21

It's a nightmare. Public transport within [town] itself is bad enough, coupled with obviously these young people they're often substance using because of severe anxiety levels, or they're a bit paranoid or a combination of those things … but our public transport network is terrible and the further away you get from [town] the worse it is … you might have to rely on a once an hour service … then wait to see someone, and then you might miss the last bus back. It's awful.

—**headspace** service provider

Transport would definitely be a big barrier ... I've had a few clients from [town] and they've caught buses in and out or I've actually gone out to their schools and seen them for an after school appointment closer to their home and that has been easier for them.

—**headspace** service provider

Yes, basic transport issues, and I think that's specific to [town], but just in general having no money and not having a car. People cancel appointments because they don't have petrol money, when they do have cars, or because they don't have transport money. I'll give them money to get home; that's quite common.

—**headspace** service provider

Some staff and a few young people indicated that long appointment waiting times, for either an intake or a clinical appointment, is another accessibility barrier for young people on their first visit or with ongoing appointments.

I've had a few friends who have had to wait four or five weeks for an appointment.

—**headspace** young person, female, aged 15

When it first started it used to be a lot easier, you could walk in, nowadays, even when you go for a doctor, sometimes you've got to wait a week, a week and a half.

—**headspace** young person, male, aged 25

*You get to see [staff member] at **headspace** every two weeks sometimes, every three weeks, and sometimes if she goes away or it's very busy it's four weeks. What are you supposed to do in the meantime?*

—**headspace** young person, female, aged 21

Most staff also reported that they were not adequately resourced to meet the level of demand, which was a key reason for lengthy waiting periods for some services and young people.

*They're a complex cohort and given their stage of change it can be very difficult to support them at times. What I do find prohibitive in the support for that cohort is no brokerage; I can't believe that this is a youth service without brokerage. We are supposed to refer out for particular things but if you're trying to work with someone with substance use or comorbid diagnosis you often need to keep them contained and to do a lot of the work as case management, and we're not necessarily case managers at **headspace**.*

—**headspace** service provider

Our problem here is that we've got the people coming through the doors but we don't have enough clinicians. Every day at intake we're stuck with people that we don't know what to do with and we're just overloaded.

—**headspace** service provider

We've been running on really low staff levels all year, we've been a bit in kind of siege mode for a long period so we're really tight and we've been waiting for few staff members for four months.

—**headspace** service provider

Some staff indicated that centres' limited hours of operation is a prominent barrier to attending a **headspace** service, initially and ongoing. These staff talked about how young people with AOD issues often find morning appointments difficult to attend, and the **headspace** 9am to 5pm, Monday to Friday model leads to many young people missing appointments. A few staff suggested that appointments be scheduled at a more suitable time for this group (such as in the evening and weekends), as this would likely support young people to remain engaged in treatment.

We work in a 9.00 to 5.00 environment and often these young people work in a 5.00 to 9.00 environment.

—**headspace** service provider

They're often substance affected or hung over in the mornings and they really like afternoon appointments and I think probably by going until 6.00 would help with a lot of those young people in accessing services.

—**headspace** service provider

That particular group of people start their day late, they're more comfortable sometimes towards the end of the day, and we need to capture them when they need to come here. We can't offer it to people who are employed, and there are employed and people at school who are in that group.

—**headspace** service provider

We can't get parents to come in because they're working, and often when we're working with young people, particularly that group, we need a parent at least on board to change stuff at home and we can't do that if they're working. We can't get dads here because they've got to work. So we need extended hours, that is a huge barrier.

—**headspace** service provider

Probably the biggest thing is changing our hours, working 9.00 to 5.00 is not great. I didn't mention that but that's certainly a barrier for a lot of them. And particularly the rural kids, if they're at school until 3.00, 4.00 or so, they can't get here until a bit after 4.00 and we close at 5.00.

—**headspace** service provider

A barrier to engaging with **headspace** was noted as the limited hours of operation, with concern expressed for young people who work during business hours and are therefore unable to access a centre during these hours.

I think that they should have one night a week where they are open a bit later because there are so many people that aren't able to come because they have full-time jobs.

—**headspace** young person, female, aged 17

In addition to limited hours of operation being a barrier for young people with AOD problems the **headspace** model and structure of providing primarily appointment based services was reported by some staff as not being appropriate for this group and a key barrier to their engagement.

They're not within their experience or their ability to make an appointment and keep it, so that's quite an issue. Just that private practitioner model where if they're not turning up you don't get paid, you're not going to take clients on.

—**headspace** service provider

For both groups one of the issues is that they often have lots of psychosocial stress so actually getting to a booked appointment is really difficult so if you don't have any money for the bus, or if you don't have a car, or your licence got cancelled, all those kind of things.

—**headspace** service provider

So if someone turns up we can't see them and that's necessary, particularly for alcohol and other drugs. That whole appointment thing, but then when they actually turn up they're presented with all this paperwork and that is a barrier.

—**headspace** service provider

Often it's when it's in crisis. Yes, we tend to do the crisis intervention stuff so then I've had difficulty with maintaining that engagement. Look, that's true of all of these groups so I would say, in terms of substance use, for example, it's usually when bad things are happening they reconnect.

—**headspace** service provider

Personal and interpersonal facilitators

Staff and young people were also asked to discuss facilitating factors which have a positive influence on the help-seeking behaviours of young people with AOD problems.

Good rapport with clinician

Young people having a good rapport or relationship with their clinician was a key facilitator to accessing and engaging with a **headspace** centre and was reported by most staff and some young people and parents.

It was very awkward and it was a bit stressful and I got very anxious at the first couple of weeks but the worker I had was really, really lovely and she helped me a lot in the long run and I ended up seeing her for about a year and a bit in total.

—**headspace** young person, female, aged 15

Getting the dynamic right between the individual and the therapist, that's a big guessing game. It might not work with one and if you have an interaction that doesn't work then it's put you off potentially for a long, long time so first impressions are really, really important.

—**headspace** service provider

If I think about those people who are forced to come here to receive counselling or anger management, initially they come feeling quite resentful but I think if you can create that engaging place for them they can actually see that, hey, we can actually offer them unexpected things that they didn't even know.

—**headspace** service provider

I think knowing the skill sets of the practitioners involved is really, really helpful so if we had the perfect world - and also it goes beyond that because I can often also think about the personality fit, the gender fit, the location fit, who is going to be likely the best win.

—**headspace** service provider

And they never looked down at him, they never made him feel he was bad or anything like that. It was just: this is what you're going through now, it's your choice if you want to get off this road here. No one can make you get off it. It had something to do with [name] and my son's intellectual coming together that my son decided: I don't want to be drugged, bang, bang, bang. No. I am too smart for that. I don't want to go down that road. And you have to find someone that can mentally reach you.

—**headspace** parent

Structural facilitators

Service accessibility

Similar to the structural barrier of service inaccessibility, a key structural facilitator was service accessibility raised by most staff and most young people. Facilitators which were seen to improve service accessibility included flexibility in the appointment based approach of the service, a need for outreach services, and wider hours of operation.

Firstly, it was highlighted that for young people with AOD problems, a fixed appointment based structure used in most centres may not be the best fit and in order to engage these young people a flexible approach that includes drop-in ability and off-site appointment may be more effective.

> *I worked it out with my nurse, so we'd meet up places closer to my house, which was easier but still if I had to go to doctor I have to come here.*
>
> —**headspace** young person, female, aged 21

> *We've got people … who come quite regularly, come to any convenient appointed time slot, they come when they want to. And we make a time available for them. If they come in then we try and see them.*
>
> —**headspace** service provider

> *My most unwell, most dysfunctional clients are ones with severe drug and alcohol problems, at risk of everything, are heavy substance users and we have to be really flexible so we basically as a team have a list of people that we will see so we've given up making booked appointments and we've said to them: if you're in town and you want to see us, just come in, somebody will see you.*
>
> —**headspace** service provider

> *It's a really good team here and a lot of people engage and we work really hard where we can find space to be more flexible for people.*
>
> —**headspace** service provider

> *Just an undertaking with them that we are available for them and then we will rearrange our days. Where we have triage times we try, and [name] tries to be more flexible with her appointment times. If there is someone who is completely capable and able to make an appointment and turn up, there are strict boundaries there about appointment times and respect for them, but then we've just identified that for a subgroup, particularly the AOD and those dealing with more complex trauma and not such stable lives, that we try and work around it.*
>
> —**headspace** service provider

Some staff reiterated that young people often believe that they do not have problems with mental health or with AOD, or both, and therefore they do not actively seek help as freely as others might; the provision for greater outreach can assist those who might not access services.

> *There are still some barriers, there's stigma around coming into a service and hence why we do quite a bit of work on an outreach basis, particularly going out to schools, not just to educate but also engage with clients and work with them one-on-one … they much prefer an outreach based model as opposed to in-reach. Whilst we're not specifically funded to do outreach, we predominantly do it and it's just one of those things that is a positive thing because it helps to engage and overcomes that barrier.*
>
> —**headspace** service provider

> *It's actually easier for them to get to a service from school or after school in or around where they're attending school. Our [**headspace** centre] site is located out in front of [town] Secondary College so that's been really good for people.*
>
> —**headspace** service provider

And I think sometimes we get centre focussed instead of the fact that we can be flexible around how we deliver support services. Some of that might come down to variation due to different lead agencies having different views around whether they favour outreach or not.

—**headspace** service provider

As the mental health nurse it's very different to some of the other counselling roles in that I can actually do quite assertive outreach, I'm not limited to six to 10 sessions. I'm sure for some of the other clinicians, so ***headspace*** *as a general model being serviced predominantly with MBS and six to 10 sessions that would be a huge barrier whereas I can actually see them for up to two years. With assertive outreach I can go to their school, meet them in a cafe, whatever suits them, and there's that absolute flexible engagement arrangement where they come in and out of my care over a couple of years.*

—**headspace** service provider

Some staff said that extending the **headspace** hours of operation to some late weekday evenings and/or weekends, particularly Saturday would make it easier for young people to attend appointments and remain engaged in treatment.

Some young people mentioned that a shorter waiting time between appointments was a facilitator for them to remain engaged in treatment at **headspace**.

*I originally started at the [****headspace*** *centre] and, yeah, that was fine; got an appointment when I wanted to, I felt comfortable going in there.*

—**headspace** young person, male, aged 19

I remember the day that I rang up, because we had to do the intake, the day we rang up I was down here within an hour or something, so it was straightaway kind of thing.

—**headspace** young person, male, aged 18-25

Every time I've gone to make an appointment, like every now and then there will be the odd chance of someone is on leave or doing other stuff but besides that I've always been able to get an appointment when I've wanted it.

—**headspace** young person, male, aged 18-25

Comfortable and accepting environment

Most staff and some young people identified that a comfortable, accepting, non-judgemental and youth friendly environment was a key facilitator in young people with AOD problems accessing and then remaining engaged with the service.

With the substance using group … I think they would choose us because we're more relaxed and youth-friendly and we're non-judgemental and we don't look like a state health service.

—**headspace** service provider

I guess that we promote shame attenuation and we promote normalisation so we've known a lot of people that are in your circumstances and what you are going through is okay, it's normal for your situation and it doesn't mean it can't change.

—**headspace** service provider

Our greater strength is just our focus on engagement so everybody is treated with respect and welcomed and the place is nice and the reception staff are really friendly and welcoming and helpful and then the first clinician that they meet, or the youth worker or whoever, is interested in them and genuine.

—**headspace** service provider

Some young people also highlighted the importance of a comfortable and relaxed environment with staff who are accepting and non-judgemental of their use of AOD.

> *They don't make it feel like it's a clinical setting, they make it feel more like a community setting, which is nice.*
>
> —**headspace** young person, male, aged 19

> *I've always found the staff really friendly and they've always got a smile when they greet you and they use your name and tell you to take a seat. They make you feel like it's okay and that you're in a comfortable place. They've always been good.*
>
> —**headspace** young person, male aged 19

> *It's a comforting environment, it's not like [service] where you walk in and you're examined like an animal. You walk in there's (indistinct) on the walls, you can just go on Facebook, it's a real comfortable environment.*
>
> —**headspace** young person, male, aged 15

> *It's really easy and really comfortable and it didn't feel too awkward coming in to get what you need. I was in a really bad place at the time, but when I came here I still felt secure.*
>
> —**headspace** young person, male, aged 15

> *It's one of the most open places. You could rock up naked, they wouldn't care.*
>
> —**headspace** young person, male, aged 15

> *I tell people that they should come here and not worry about anyone else. You can be yourself and they don't talk the way they normally talk and stuff, it's just good. They're really accepting and you kind of get that feeling as soon as you walk in, so it's really good that way.*
>
> —**headspace** young person, male, aged 18

A couple of parents of young people who use **headspace** also highlighted the importance of the environment and the approach in facilitating access to **headspace**.

> *For children of today, they can get on Facebook while waiting for their appointment. My son tells everybody about* ***headspace****. In the olden days, if you had a doctor's appointment and one mate might see you, it's sort of like shame. These days at* ***headspace****, I watch them, they look at each other and wink like: you know how good this place is too, do you? My son speaks well of* ***headspace****. Because of the period of, shall we say, when he got off the beaten track, now that he's at least off that track.*
>
> —**headspace** parent

> *I had a small group of friends and they have got teenagers, do you know the thing I hear most, and I smile to myself? And that is the ladies will say things like: isn't it wonderful when the Government get it right? Look at* ***headspace****. And then I will have this big rah, rah, rah. This doesn't always happen. And I smile because I think: I've been to* ***headspace****, I know, and I speak very well of it. It came into my son's life when he needed it, and that's why I point out as a parent in our day there was nothing like this.*
>
> —**headspace** parent

> *I thought to myself, I was outside waiting, I thought: how do they do that? He spoke to my son for two hours. And I think: I can only get my son to grunt or to say "yes" or "no" or "I don't know". I was sitting outside thinking: at least he can relate to somebody.*
>
> —**headspace** parent

Clear and upfront confidentiality policies

Some young people mentioned they were more likely to continue to come to **headspace** once they were aware of the confidentiality policy as they no longer had concerns that anything they said in counselling sessions would be passed on to other people.

> *Because at first I wasn't 100 per cent sure, I was a bit hesitant on what I could say and what I could tell them without getting myself in trouble, but when I first came in they told me everything was confidential.*
>
> —**headspace** young person, male, aged 17

> *I can come here and let it out to whoever I am allowed to let it out to and then I know that it's not going to go back to anybody and that it's just my personal rant.*
>
> —**headspace** young person, female, aged 15

> *They always give me the option to, you know, if I feel like I don't want to say something in front of my parents, they can ask them to leave and I always feel like it's safe. Not going to go outside the walls or anything like that.*
>
> —**headspace** young person, male, aged 15

> *I tried to let him know, to make him aware that he actually does need the help, and I think talking to someone and knowing it doesn't go any further that's helped too.*
>
> —**headspace** parent

Although most staff raised confidentiality as a barrier to access rather than a facilitator the focus on overcoming this barrier and ensuring policies were clear and upfront was then viewed as a facilitator.

> *I think clients are always wary of legal implications of engaging with services, and I think that's something that we address straight up, very honest with people around that process, but once we've had that conversation with people, even the court order people who are involuntarily referred to our service, once they understand our harm minimisation ethos and the model that we work from they are happy to engage.*
>
> —**headspace** service provider

> *At intake I will say that I'm expecting you to tell me a lot of personal information today that you might not have ever told anybody else, and I'm going to treat it with the highest respect. Those kind of things so that they know that they can actually be quite honest and feel that that's safe so both groups actually have the same amount of paranoia, if you like, around confidentiality.*
>
> —**headspace** service provider

Relationships with other agencies

The importance of developing strong relationships with other agencies and services that can provide supported referrals in or out of the service was discussed as a key facilitator by most staff.

> *Particularly if I'm working with people that are both Indigenous and substance using, the only way I see them is because other agencies bring them in so we will have a good relationship with [service], for example, and they will go and get them and bring them in and the best way it works is if [service] ring up and say: we've got this one here, can you see them today? And we just squeeze them in and that's how I see them.*
>
> —**headspace** service provider

> *For the more marginalised people that have been referred by another agency it's often been helpful when the person they do know comes with them and shows them around and introduces them to whoever is around and they make an appointment and then they come back so they've already seen it, they know where it is, they know who we are. That works well.*
>
> —**headspace** service provider

Just being able to walk with them in that navigation rather than just saying: here is a number, follow this up. The more complex their presentation they're not going to be able to do that and there will be just too many barriers in the way.

—**headspace** service provider

Most of their needs would be met here and sometimes at other services. But, again, we've got pretty good linkages and we help them, walk them through with that. For a lot in the more moderate to severe mental illness I would actually take them to [external youth health service], if they needed a secondary consult, if they need psychiatry or whatever, GPs, take them in the car and go into the consult with them … it means they don't slip through the cracks.

—**headspace** service provider

The substance using group we work closely with another agency called [service], and the combination of [service] and us works well. [Service] is not collocated but we have a really good working relationship with them and that works well.

—**headspace** service provider

Clinical file review

A clinical file review was completed on the records of 20 young people with AOD issues who had accessed services at a **headspace** centre to identify service use patterns and barriers and facilitators to service engagement.

Although three quarters of these young people had evidence in their clinical records of at least one type of facilitator to accessing **headspace**, only a quarter of the group had a barrier to accessing listed. The documented barriers were personal in nature and included low motivation and negative past experiences with mental health services. Of the documented personal facilitators, most clinical records highlighted the importance of motivation for treatment and some listed the importance of family support. Common structural facilitators included referrals from external services (i.e., GP and school), and goodness of fit of young person with clinician/service options.

The majority of clinical files of the young people with AOD issues had evidence of at least one type of barrier and facilitator to engaging with **headspace**. Of the documented barriers to engagement, the majority of young people experienced personal barriers such as negative attitude to treatment, poor motivation or dissatisfaction with treatment options, or more immediate concerns. The file review revealed that the majority of the group experienced personal facilitators such as self-referral for assessment and treatment, good rapport with clinician and services, and rapport building and feelings of utility of service. Similarly, the majority of young people also experienced structural facilitators such as re-referral from external services, availability of services and support from external service providers, and goodness of fit of young person with clinician/service options.

7.6 Summary of main findings

Overall, the level of representation of young people self-reporting 'problems with AOD' on their first visit or their clinician recording a presenting issue of AOD, at 6.9 per cent of **headspace** young people is low when compared to national data showing that almost 13 per cent of 16-24 year olds have a substance use disorder. Limiting the analysis to young people accessing **headspace** aged 16 or above, the proportion increases to almost 9 per cent.

Young males are more likely to present at **headspace** for issues relating to their use of AOD, with young males accounting for two thirds of **headspace** AOD presentations, which is congruent with patterns from national survey data. This gender difference is particularly strong among young adults aged 18-25 for which 16.5 per cent of males present with AOD problems compared to only 6 per cent of females the same age.

Across the **headspace** centres there is variation in the level of access by young people with AOD problems, ranging from 12 per cent at some centres to as low as three per cent at others. This variation may indicate inconsistency across centres in their response to, and ability to provide appropriate services to, young people presenting with AOD issues. It is important that **headspace** is working to reduce the barriers and increase the facilitators across all **headspace** centres to ensure a consistent approach and message across the centre network.

The primary substance type recorded for young people accessing **headspace** with AOD problems was cannabis use (47%), followed by poly-substance use (22%), alcohol use (18%) and amphetamine use (9%). The majority (89%) also recorded comorbid issues, primarily depressive symptoms, anxiety symptoms, anger issues, or conflict in the home environment.

Interviews with young people with AOD issues, staff at two centres with a high proportion of clients presenting with AOD problems, and some parents identified a broad range of barriers and facilitators to accessing and engaging with **headspace** services. This report has concentrated on a smaller number of key personal and interpersonal and structural elements that were common to staff and young people or mentioned by more than a few participants.

The key personal barriers were negative past experiences, stigma, denial of need for help, and anxiety and fear. A structural barrier of service inaccessibility was also identified. The primary personal facilitator identified was good rapport with their clinician, and structural facilitators included service accessibility, comfortable and accepting environment, clear and upfront confidentiality policies, and good relationships with other agencies.

The barriers and facilitators emerging from this research were reinforced by the findings from the literature review, which identified similar barriers around stigma, poor motivation for treatment (denial of need for help), negative past experiences and service inaccessibility (including cost and awareness of the service). The literature also confirmed accessibility as a common facilitator. Other facilitators identified in the literature, but not emerging as strongly from this research, included socio-demographic status, severity of issues and motivation to change.

The common barriers and facilitators identified in the clinical file review also support the findings from the interviews that a negative past experience is a key barrier to service access and having strong referral pathways with external agencies can be a key facilitator.

Table 7.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young people with AOD issues.

Table 7.3: Barriers and facilitators to accessing and engaging with headspace for young people with AOD issues

Barriers	Facilitators
Personal & Interpersonal	
– Negative past experiences	– Good rapport with staff
– Stigma	– Motivation and family support
– Denial of need for help, pre-contemplation stage of change	
– Anxiety and fears of judgement	
– Confidentiality concerns, including related concerns related to illegal behaviour	
Structural	
– Lack of accessibility (transport, wait times, appointment-based, opening hours)	– Drop-in options – Extended opening hours (evenings, Saturday) – Outreach, off-site appointment – Short wait times
– Insufficient resources and staffing	– Comfortable, accepting, non-judgemental environment
	– Well promoted, clear confidentiality
	– Connections with and warm referral to other local services (particularly AOD services)

The main findings emerging from this research are:

– In order to improve service accessibility for young people with AOD problems a flexible approach is required to appointment scheduling and the option of drop-in should be encouraged. Prioritising shorter waiting times for young people with AOD problems should be considered.

– Outreach capabilities, especially for centres in regional or remote areas needs to be explored.

– Centres need to provide flexibility in the staff member seen and services provided to ensure goodness of fit.

– Centres need to develop strong relationships with key local services to facilitate referrals or access to AOD services (inward and outward), including providing warm referrals where appropriate.

– Centres need to be known and trusted in the community for providing a comfortable and accepting environment where young people won't be judged, regardless of their issue.

– Centres need to ensure confidentiality and disclosure policies are clear and accessible to all young people accessing the centre to ensure they feel comfortable and safe to discuss issues regarding their problems with AOD.

– Centres need to provide clear promotion of service options and approach so young people are aware of where they can get help for AOD issues and what's involved.

An important caveat on these findings must be noted, however; the current data came from young people currently engaged with **headspace** services. Accordingly, the information does not reflect the experiences or opinions of young people who are unknowledgeable of or are unwilling or unable to engage with **headspace**. Although there is greater complexity involved in obtaining such data, it would make for a valuable companion piece to the present findings and recommendations, and would help to contextualise next steps toward better engaging this cohort with available **headspace** services.

7.7 Recommendations

Table 7.4 details potential strategies to assist with improving service delivery for young people who have problems with AOD.

Table 7.4: **headspace** model development for young people with AOD issues

Principles	Potential strategies
1. Community awareness	– Promote **headspace** to the community to break down perceived stigma and shame associated with accessing a mental health or AOD service. – Provide relevant information and resources about AOD and comorbid mental health issues to young people, families and service providers.
2. Promotion of confidential service	– Promote **headspace** as a confidential service. – Ensure the centre has clear policies regarding confidentiality and the circumstances in which confidentiality may have to be broken and communicate these to all service users in a timely manner. – Train all staff in the importance of client confidentiality.
3. Welcoming and accepting environment	– Provide a welcoming, relaxed and safe environment for all young people, including those with AOD problems. – Ensure staff are friendly, accepting and non-judgemental of all young people. – Provide options and flexibility with the choice of clinician for young people with AOD problems to ensure they can develop a strong rapport and remain engaged with the service.
4. Enhance Alcohol and Other Drug service stream	– Provide appropriate AOD services onsite as a core part of the **headspace** model and promote these services to the community and other local services.
5. Increase service accessibility	– Provide flexible appointments and the ability for young people with AOD problems to 'drop-in' to match fluctuating motivation to seek treatment. – Explore increasing opening hours past 5pm on some evenings and/or open on Saturdays. – Provide young people with vouchers for petrol or public transport fares, in order to access the centre.
6. Outreach and service links	– Develop flexible AOD outreach services in partnership with local youth agencies and programs to reach young people who are reluctant to seek help from a **headspace** centre. – Develop strong collaborative relationships among relevant AOD services within the local community and provide warm referrals, where appropriate.

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8. Young People who are Homeless

8. Young People who are Homeless

8.1 Background

Young people who are homeless are a critical population group for **headspace** because homeless people are one of the most disadvantaged groups in the community and at particular risk for mental health problems (Australian Bureau of Statistics, 2012a). It is estimated that one quarter of all homeless people in Australia are aged between 12 and 24 years, with over 26,000 homeless people in this age range. The 2011 Census (Australian Bureau of Statistics, 2012a) reported that 56 out of every 10,000 Australian's aged 12 to 18, and 88 out of every 10,000 Australian's aged 19 to 24, were homeless. Furthermore, the Australian Bureau of Statistics cautioned that this was likely to be an underrepresentation of the proportion of homeless youth due to methodological difficulties in recording youth homelessness, especially where homelessness is masked by couch surfing or maintaining a record of a usual address.

The ABS defines a person as homeless if they do not have suitable accommodation alternatives and their current living arrangement is in a dwelling that is: inadequate; has no tenure, or their initial tenure is short and not extendable; or does not allow them to have control of, and access to, space for social relations (Australian Bureau of Statistics, 2012a). For the purpose of this report, **headspace** young people were similarly considered homeless if at the time of their first visit they reported their living situation to be homeless/sleeping rough or at risk of being homeless soon; for example, due to currently living in emergency accommodation or couch surfing.

Young people without stable accommodation frequently experience emotional and psychological problems related to the experience of homelessness. Mental health problems are highly prevalent in homeless populations, with around 90 per cent of homeless people experiencing a mental health problem (Krausz et al., 2013). Rates of alcohol and drug dependence, depression, anxiety, self-harming behaviour and suicidal ideation are substantially higher among young people experiencing homelessness compared with those who are in stable forms of accommodation (Krausz et al., 2013; National Youth Commission, 2008; Randall, Britten, & Craig, 2007).

Many of the causes of youth homelessness are also risk factors for the development of mental illness. Poverty, unemployment or poor job prospects, lack of affordable housing, financial distress, discrimination or victimisation, poor health, intellectual disability, drug and alcohol abuse, gambling, family and relationship breakdown, domestic violence, physical or sexual abuse, low social support, and hopelessness, all increase young people's vulnerability to both homelessness and mental health problems (Australian Institute of Health and Welfare, 2014; Crowley, 2012). Consequently, young people who are homeless tend to have increased exposure to many risk factors for mental illness, compounding the experience of homelessness itself.

Despite the high prevalence of mental health problems among young people who are homeless, the rate at which they access mental health services is low (Krausz et al., 2013). Young people who are homeless are confronted by a great number of barriers to accessing services, particularly as their basic essential needs, such as adequate food, shelter and safety, are often unmet. Consequently, young people who are homeless are even less likely to seek help than other young people. When they do seek help, they tend to fall through the gaps and may not receive adequate care due to their multiple complex needs (Orygen Research Centre, 2005; Solorio, Milburn, Andersen, Trifskin, & Rodríguez, 2006).

8.2 Aims

Given the complex needs of young people who are homeless and the low rate at which they effectively access services, it is important for **headspace** to further investigate the barriers and facilitators specific to these young people accessing the support they require. This chapter aims to identify approaches that can assist **headspace** centres to reduce the barriers and increase facilitators to ensure all **headspace** services are appropriate and accessible for homeless young people requiring support.

8.3 Methodology

The following methodology was used to gain an understanding of the barriers and facilitators that young people who are homeless encounter in accessing required services and supports through **headspace**.

1. A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care for young people who are homeless.
2. Information on **headspace** clients derived from the **headspace** Minimum Data Set (MDS; April 2013 to March 2014).
3. Clinical file review for 20 young people across two centres who are homeless and who have accessed a **headspace** centre.
4. Interviews with four young people, seven service providers from two **headspace** centres with high rates of homelessness (centres were identified from MDS data over a 12 month period) and one service provider from a collocated service that provides support for homeless young people.
5. Two focus groups, the first with four homeless young people from one **headspace** centre and the second with 10 homeless young people from the collocated service[12].

A detailed Methodology is provided in Appendix A. However, when reading this section it is important to note that the data collected via interviews and focus group have been analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses (see Table 8.1). This type of analysis allows for comparison across the participant types and provides a stable and common metric for communicating results. As such, the results in this section are discussed against the following four levels of response frequency.

Table 8.1: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Table 8.2 outlines the interview and focus group participants, including the gender and age of young people involved.

[12] Brophy Family & Youth Services is the collocated service, which is the primary provider for youth services in South West Victoria and offers a range of accommodation and support services to young people and individuals who are homeless or at risk of homelessness. The options range from kinship care/foster care through to independent supported accommodation. The service utilises an empowerment relationship-based approach to build on the strengths and skills of children, young people and individuals.

Table 8.2: Participants

headspace centre 1 (VIC)	
Staff	
Centre manager	
Access engagement intake team leader	
Dual diagnosis senior clinician	
Youth engagement officer	
GP	
Young people	
Male, age 23	
Female, age 16	
Female, age 19	
Female, age 17	
headspace centre 2 (VIC)	
Staff	
Centre manager	
Youth participation and community awareness officer	
Young people	
Focus group 1 (n=4)	
Collocated service (VIC)	
Staff	
Youth homelessness program team leader	
Young people	
Focus group 2 (n=10)	
Total staff	**8**
Total young people	**18**
Total	**26**

8.4 Literature review

A systematic review of the literature on barriers and facilitators to accessing and engaging with mental health services for young people who are homeless identified 14 studies (Brands, Leslie, Catz-Biro, & Li, 2005; Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Collins & Barker, 2009; Crowley, 2012; Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006; French, Reardon, & Smith, 2003; A. L. Hudson, Nyamathi, & Sweat, 2008; Angela L. Hudson et al., 2010; Angela L. Hudson et al., 2009; Nyamathi et al., 2007; Reid & Klee, 1999; N Slesnick & Prestopnik, 2009; N. Slesnick, Kang, & Aukward, 2008; Solorio et al., 2006). Three of these studies used a quantitative method, nine used qualitative and two had mixed method approaches. The majority of the studies (8) were conducted in the U.S.A., one in Canada, three in the U.K., and two in Australia. Most of these studies recruited young people through drop-in services or shelters and half of the studies involved young people who had substance use issues in addition to being homeless. The majority of participants in each study (for which gender information was available) were male.

The majority of these studies (11) examined barriers to service access or engagement, with common barriers including: poor motivation for treatment; stigma and shame around help-seeking; limited treatment options available; lack of service availability; negative past experience resulting in low confidence in services' ability to help; lack of awareness of services or where to seek help; and cost (including transport costs). Other less common barriers only identified in one or two studies were: poor mental health literacy; socio-demographic factors; poor organisational skills; low priority placed on mental health due to other immediate concerns; reliance on self and informal supports; fear of being misunderstood and that their specific needs will not be met; bullying; social isolation and lack of social support; confidentiality concerns; lack of coordination between services; lack of youth-friendly services; and service inaccessibility.

Over half (9) of the studies examined facilitators to accessing and engaging with services. Common facilitators to service access included: good rapport with staff; diversity of treatment options (e.g. outreach, home-based, phone, street-clinic); being a free service and located in in a familiar community-based setting. Other less common facilitators only identified in one or two studies were: being engaged with other activities; increased motivation to seek support; increased severity of problems; confidence in the treatment and service providers; availability of a mentor or support group; youth-friendly and relaxed environment; transport assistance; residential support; service accessibility with open door policy and capacity for drop-ins; providing resources and information about services; individual support; allowing choice in the level of disclosure; confidentiality; and using personal methods of contact (i.e. not contacted by letters).

Several limitations were present in these studies, including small sample sizes, sampling bias (convenience samples or samples limited to one service), and concerns about participant honesty due to existing relationships with interviewer, service, and/or focus group members.

8.5 Results

Client profile

Data for this section have been extracted from the **headspace** Minimum Data Set to provide a profile of homeless young people who access **headspace** and provide an outline of how they compare with all service users. Data provided are drawn from a sample of **headspace** clients who commenced an episode of care at a **headspace** centre between 1 April 2013 and 31 March 2014. This comprised data from 33,038 young people across 55 **headspace** centres (although a new round of centres had commenced operation during this period these were not fully operational and thus were excluded from the analysis).

Of this sample, the large majority (88.2%) of young people report their current living situation to be stable at the time of their first visit to **headsapce**, with a further nine per cent indicating some or low risk of homelessness (such as being unsure of how long they are able to stay in their accommodation, struggling to pay rent, or having major conflicts with other people in the house). A small but significant minority (2.1%) report high risk of homelessness (such as risk of being homeless soon due to living in emergency accomodation or currently couch surfing) or current homelessness (0.6%). National data estimate that less than one per cent (0.7%) of young people aged 12-24 are homeless, whereby they do not have suitable accommodation alternatives and their current living arrangement is in a dwelling that is: inadequate; has no tenure, or their initial tenure is short and not extendable; or does not allow them to have control of and access to space for social relations (Australian Bureau of Statistics, 2012a, 2012b). In order to most closely align with this national definition of homelessness, young people attending **headspace** who reported their living situation as either at high risk of homelessness or current homelessness are classified as homeless for the duration of this report. This means that 793 young people reported being homeless (including those at high risk of homelessness), representing 2.8 per cent of all **headspace** clients for whom data were available (28,623), which is greater than the reported national homeless population data.

A higher proportion of males accessing **headspace** services report being homeless than females (3.6% males versus 2.3% females). Homelessness is also more prevalent among young adults (aged 18-25) accessing **headspace** than in adolescents (aged 12-17). Figure 8.1 shows the proportion of young people who are homeless across gender and age groups and clearly highlights young men aged 18 to 25 as the most likely to be homeless.

Figure 8.1: Percentage of headspace young people who are homeless by gender and age group

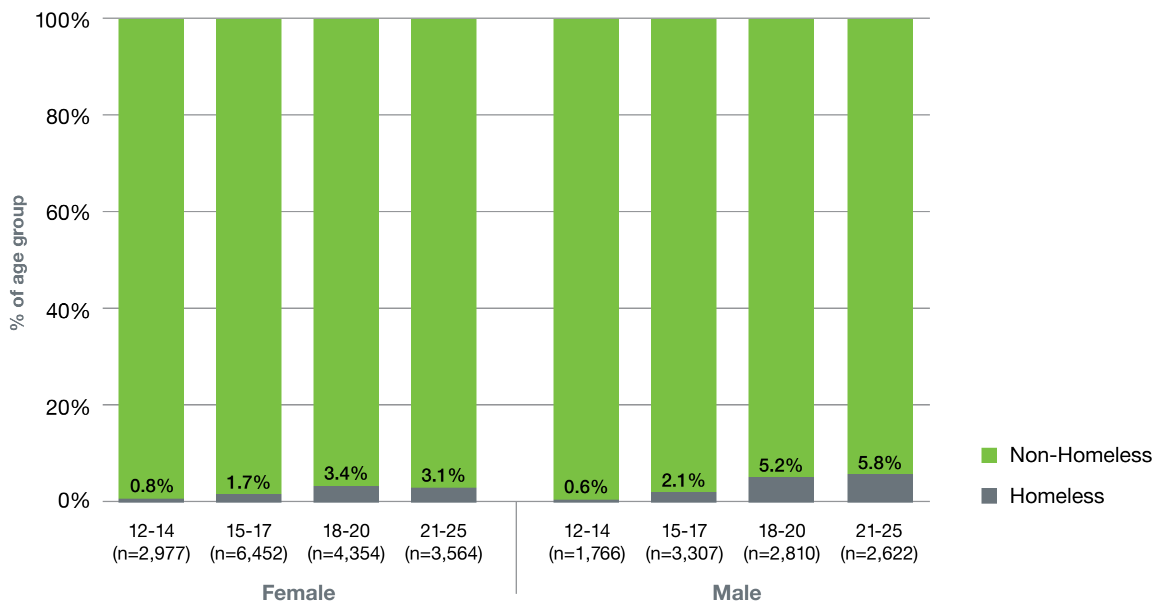
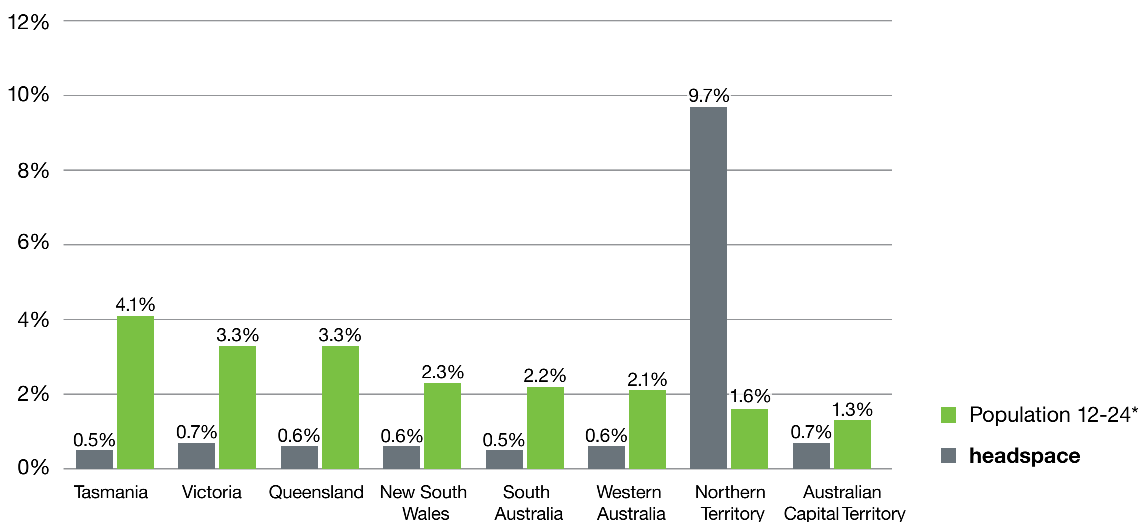


Figure 8.2 displays the representation of homelessness across states for the 12-24 year old population (Australian Bureau of Statistics, 2012b) and for **headspace** young people. As shown, with the exception of the Northern Territory, the level of representation of homeless young people accessing **headspace** services is far greater than the estimated populations. While this is a positive finding, as acknowledged by Australian Bureau of Statistics (2012a), it is likely that these population estimates underreport youth homelessness. The Northern Territory has a much greater homeless population than any other state but has near the least proportion of homeless young people accessing **headspace** services. Notably, only two **headspace** centres currently operate in the Northern Territory, which may in part account for the low rate of access for homeless young people in the region, however, this disparity clearly highlights the need to increase provision of accessible services for homeless young people in the Northern Territory.

Figure 8.2: Percentage of young people aged 12-24 who are homeless by state/territory for the Australian population and headspace young people



*Indicates the proportion of homeless people aged 12-24 across the state population as reported in the ABS 2011 Census.

As with state distributions, homeless young people's access to **headspace** services also varies widely by centre, ranging from less than one per cent of young people who are homeless in some centres up to 16.4 per cent at the centre accessed by the greatest proportion of homeless young people. Figure 8.3 shows that there is very little variation by level of centre rurality, but that the centres with the largest proportion of young people who are homeless accessing services are located in regional areas.

Figure 8.3: Percentage of **headspace** young people who are homeless by centre rurality

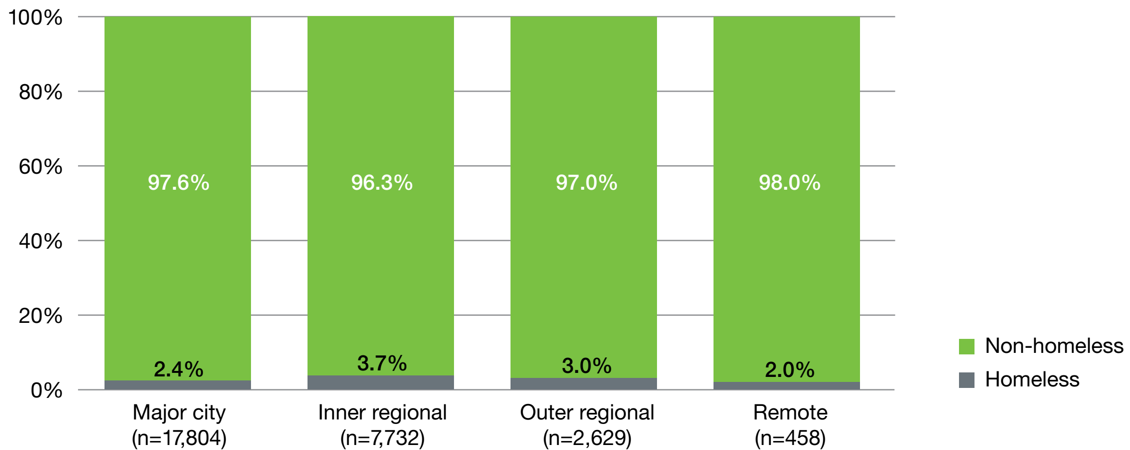


Figure 8.4 shows the main presenting issues for homeless compared to non-homeless young people accessing **headspace**. As for non-homeless young people, the majority of young people who are homeless accessed **headspace** for a mental health issue. However, proportionately fewer young people who are homeless present for mental health concerns and an increased number present for situational issues. This difference is largely accounted for by the 14.4 per cent of homeless young people accessing **headspace** services primarily for assistance with their homelessness, which is reported as a situational issue (indicated in red in Figure 8.4). Young people who are homeless also present more commonly for problems with alcohol or other drugs (AOD) than non-homeless young people. Whereas cannabis use is the most prevalent AOD problem for non-homeless young people accessing **headspace**, accounting for almost half of AOD presentations, among homeless young people AOD problems are more evenly distributed between poly substance use (34.5% of AOD presentations by homeless young people), cannabis use (30.9%) and amphetamine type use (21.8%).

Figure 8.4: Main reason for presentation at **headspace**

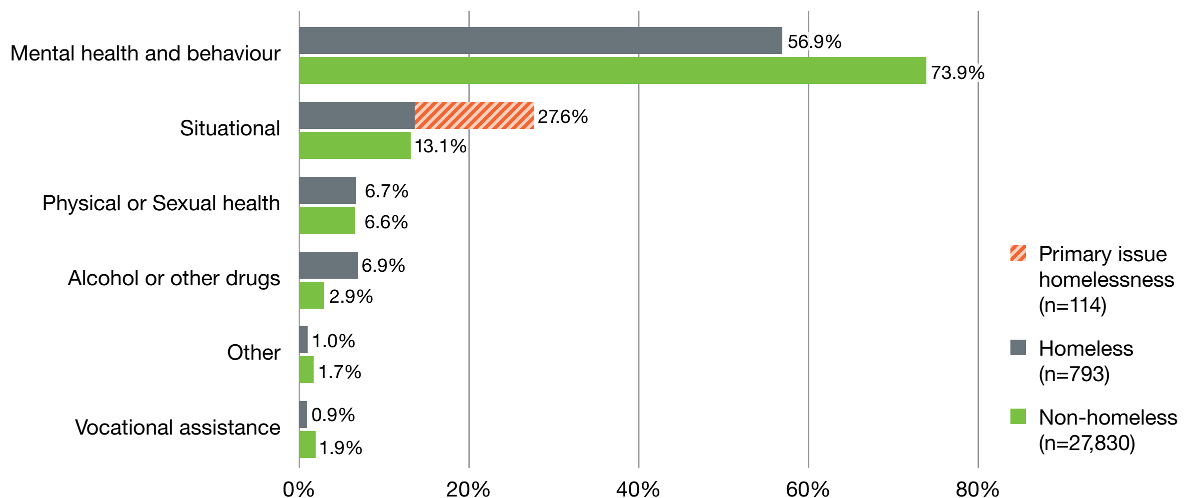
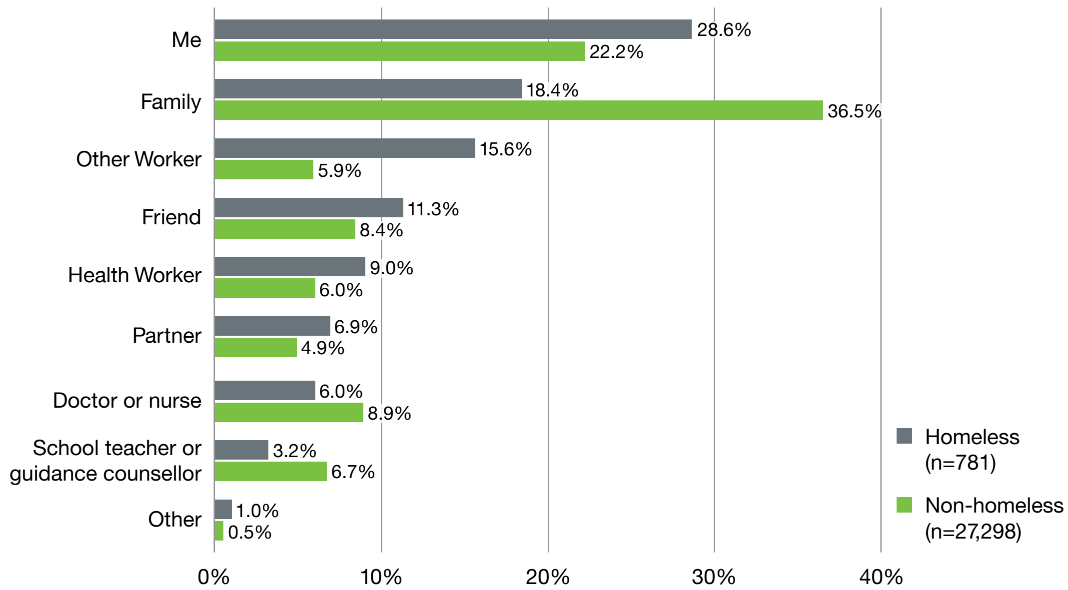


Figure 8.5 reveals the patterns of influence to attend **headspace** for homeless and non-homeless young people. Young people who are homeless are most likely to self-refer to **headspace**. This is in contrast to non-homeless young people who are most commonly influenced by family. The reduced influence of family for homeless young people is likely the result of most homeless young people generally losing contact or becoming separated from their family. This lack of family contact and support may be a significant help-seeking barrier for young people who are homeless. Additionally, homeless young people are much more likely to be influenced by other workers, such as welfare or community service workers, police, and corrections or justice officers, to attend **headspace** than are non-homeless young people[13]. This highlights the need for strong relationships with other agencies in order to increase referrals to **headspace** for homeless young people.

[13] Differences between homeless and non-homeless young people being influenced to attend by family members and 'other workers' were observed over and above any age and gender effects. However, the observable difference in Figure 8.5 between the proportion of homeless and non-homeless young people being self-referred was the result of age and gender effects, and does not represent a homeless versus non-homeless group difference.

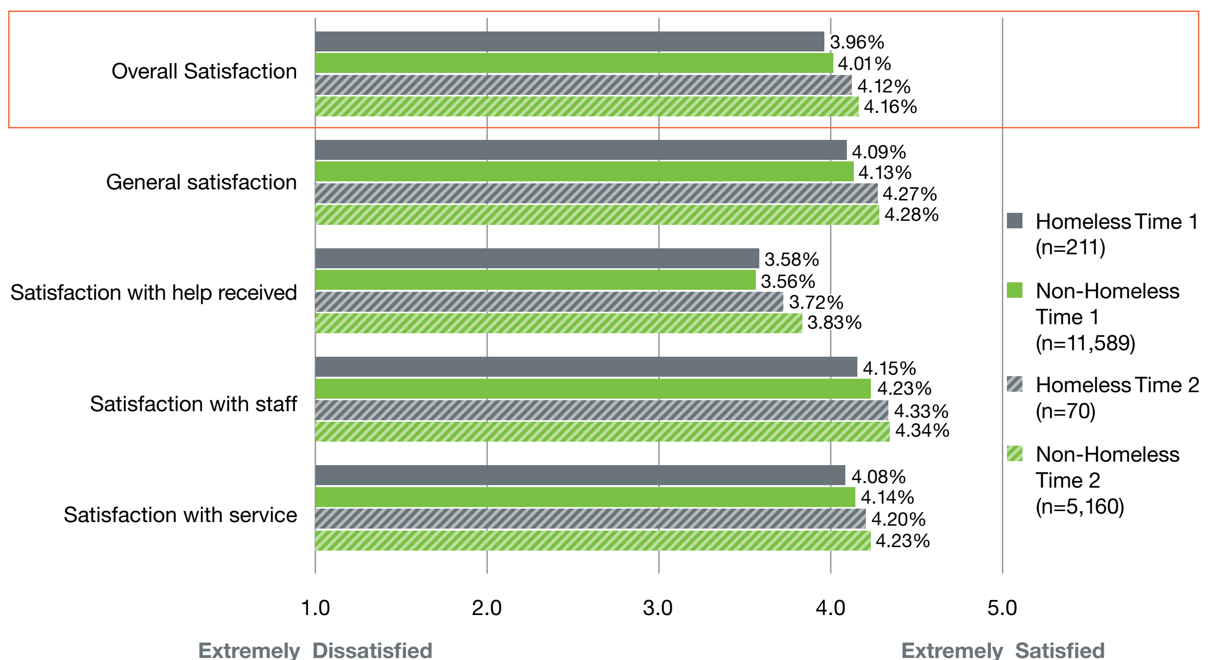
Figure 8.5: Pathways to **headspace**



Client satisfaction

All young people accessing **headspace** are invited to complete a client satisfaction survey at regular points throughout their service. During this period, over 12,000 young people completed a survey and 226 of these were homeless young people (1.8%). The survey asks young people to rate levels of satisfaction across 14 items within four key areas on a response scale of one to five, where one equals extremely dissatisfied and five equals extremely satisfied. Results are presented in Figure 8.6 and indicate very high levels of satisfaction across all categories. A one-way analysis of variance (ANOVA) was used to compare mean satisfaction across all categories between groups and results indicate that there were no significant differences in satisfaction between homeless and non-homeless young people.

Figure 8.6: Satisfaction for **headspace** young people who are homeless and Non-homeless



Barriers and facilitators

Data from the interviews and focus groups with young people who are homeless and service providers, as well as the clinical file review, revealed a range of barriers and facilitators to service access and engagement.

The key barriers raised by both staff and young people were the importance of meeting basic needs and priorities, lack of awareness of available help or uncertainty of services, limited social support and motivation, lack of belief in the service's ability to help, stigma, service inaccessibility, limitations of the type of services **headspace** can provide (service scope), and overwhelming intake processes.

The primary facilitators to service use reported by staff and young people included being a confidential service, service accessibility and need for outreach, relationships with other agencies, promotion of types of services provided, young people's needs being met, and providing a one-stop-shop and early intervention services.

The clinical file review identified the main barriers for service access and engagement as low motivation or negative attitude to treatment and prioritising more immediate concerns. Facilitators that were reported included self-referral and increased motivation for treatment, good rapport between young people and clinicians, and referrals to and from external services.

A large number of barriers and facilitators for homeless young people were identified across the data sources, and those that were reported by more than a few staff and/or young people are described in detail below. These barriers and facilitators are categorised as either: *personal and interpersonal*, which includes basic needs and priorities, lack of awareness of available help and belief in **headspace**'s ability to help, limited social support and motivation, and stigma as barriers, and confidentiality as a personal facilitator; or *structural*, which includes service inaccessibility, limitations of the types of services **headspace** can provide (service scope), and intake process as barriers, and service accessibility, relationships with other agencies, promotion of types of services provided, needs being met, one-stop-shop, and early intervention as structural facilitators.

Personal and interpersonal barriers

Basic needs and priorities

A key barrier to attending **headspace** that was identified by most staff was that homeless young people typically have more immediate concerns and competing needs. Staff discussed that the basic essential needs of this disadvantaged group – such as food, shelter and safety – are often unmet and meeting these needs from day- to-day must be their priority. A few staff likened this to 'Maslow's Hierarchy of Needs', whereby people are motivated to fulfil basic needs first before they progress to satisfying other needs such as cognitive needs (Maslow, 1943). Young people in this group are primarily focused on seeking help for their most basic physiological needs, which delays seeking help for their mental health needs. As a result, many homeless young people present to **headspace** in crisis and primarily seeking accommodation (which likely results in referrals to other services) rather than help for mental health issues.

> *Coming in when you're desperate for a roof over your head or some money to buy some food or something, the other stuff [mental health] is not really a priority.*
>
> —Service provider

> *Other priorities such as the basics of living, must be very difficult to just figure out the daily basics of living when you haven't got a home. Things like getting help with medical or mental health problems probably takes a much lower priority for them so that's a huge barrier because there's too much else to deal with.*
>
> —Service provider

> *With this group [homeless young people], as in Maslow's Hierarchy of Needs, first and foremost are their needs, their first needs are the very basic, their existence and support, and they are often very stressed to get those basics for life, to live.*
>
> —Service provider

For this group it also takes longer for us to address their mental health issues because when they come we are first and foremost trying to address their housing issues. It takes longer to address their mental health needs yet they are at higher risk and if it's raining they don't have appropriate clothes to wear and stand at the bus stop and get wet. Any number of things like this can interrupt their access because it means they won't make their appointment and then there is a sense of embarrassment to make another one. They think it is all too hard, it's all too much.

—Service provider

Lack of awareness of available help or uncertainty of services

Some staff reported that homeless young people may not be aware of services within the community from which they can obtain help. Similarly, a few young people indicated they were uncertain about the types of services **headspace** provides and whether support for homelessness was offered, as well as being unsure and fearful of what would be involved in getting help from **headspace**.

Stopping them [seeking help] would be awareness of services that are available, where to go to seek help. It's a fragmented service model, where to go and who to go to.

—Service provider

I just didn't know how the service worked and what it was and I was nervous about speaking to someone, fear about speaking to someone that I didn't know.

—Young person, female, aged 17

*I regret not getting help earlier – it wrecked everything, it wrecked school, it wrecked my family life which is what led me to be homeless. I was just scared to get help, I just didn't know what to expect at **headspace** so I put it off for too long – and all that stuff could have been prevented.*

—Young person, female, aged 17

Some homeless young people also reported uncertainty related to the utility of the service. They discussed a lack of belief in the ability of **headspace** to help and meet the specific needs of homeless young people. Additionally a preference for self-reliance, rather than seeking help from other people or services, was raised as a barrier by a few young people.

The motivation – for me I thought there was no point, I thought talking about your problems doesn't really change anything but it does because it helps you understand them more and find a solution.

—Young person, female, aged 16

*It's different being out on the street – the motivation to get up and go and do it is hard. You are living out on the street, in a bus shelter, a toilet, a train station – it's hard… Being on the street… you think to yourself 'what can **headspace** do to really help me? I am still going out on the street as soon as I leave here.' So the motivation is hard. It is hard to realise that there are people that can help – that is a barrier for me, believing people can help and that people care.*

—Young person, female, aged 19

Independence, because I don't like people helping me, but then I was homeless and I had to do it.

—Young person, female, aged 19

Limited social support and motivation

For many young people, family members play a significant role in encouraging and motivating them to seek help. However, young people who are homeless are often disconnected from family and socially isolated. Some staff and young people identified this lack of interpersonal support as a considerable barrier to homeless young people attending **headspace** as these young people must initiate their own help-seeking process and rely on self-motivation to remain engaged in services.

> *They do not have consistent support from anyone, not from parents, relatives or guardians and it is incidental people giving them a hand like the friend's parents might help them for a little while and couch surfing and living in your car.*
>
> —Service provider.

> *Not having the family support, who can support them to get to appointments, not having those people around them.*
>
> —Service provider

> *You have to be more independent and motivate yourself. You have to take control of yourself to want to do something. You don't have that parent there who cares about you telling you that you have to go and do this, you have to do it yourself.*
>
> —Young person, female, aged 19

> *You have to be more independent and motivate yourself.*
>
> —Young person, male, aged 23

Stigma (and self-stigma)

Most staff discussed that stigma, and self-stigma, associated with homelessness and with seeking help from mental health services is a barrier to service use. Notably, homeless young people did not raise stigma as a factor that impacted their attending **headspace** services.

> *Homelessness adds to the stigma because unless it's seen and recognised that it's actually happening, that's a key barrier to people being able to seek help.*
>
> —Service provider

> *The stigma that they feel on themselves but also the stigma of the services as well … a lot of the young people are a bit reluctant to go … Young people will not want to come in because it's a mental health service.*
>
> —Service provider

> *What the service represents may be a barrier to some people because they don't want to see themselves in that light.*
>
> —Service provider

Structural barriers

Service inaccessibility

Most service providers and young people discussed service inaccessibility as a major barrier for homeless young people. A number of components contributing to the accessibility of **headspace** services were identified, including challenges with transport, cost, appointment-based model and methods of contact.

Transport, in terms of distance and particularly in terms of cost of transport, was discussed by most staff and some young people in relation to the limited capacity of homeless young people to have means of transport or to afford public transport fares in order to physically attend a **headspace** centre. A few young people indicated it becomes increasingly difficult to afford the cost of transport to attend ongoing appointments, and that they would frequently miss an appointment and become less engaged in ongoing treatment at **headspace**.

That's very difficult for them because of the amount of time it takes them, the amount of petrol it costs them, these are poor families, so this is a major drain on their income.

—Service provider

Getting here! Because they're like 'Am I going to pay five bucks on the train or am I going to get a feed?'

—Service provider

Obviously distance, transport, if there is no informal supports to support people to get to the centre, and whilst we try and do as much in regional outreach as possible, that's a real barrier in regional areas.

—Service provider

You don't have mum or dad driving you, you have to get the bus.

—Young person, male, aged 17

That was the hardest thing, to travel an hour to get here.

—Young person, male, aged 23

As reported above, finances are a significant issue for homeless young people in attending **headspace** services. A few staff raised concern that many young people do not realise that **headspace** can provide free services and that this lack of knowledge can deter young people who are homeless from accessing services.

Finance is another barrier, they are unaware that ***headspace*** *is a free service. With this group they are loyal to the person giving them finances. The person who is giving them a roof over their head may ask for help with something and so they won't go to their appointment.*

—Service provider

Appointment-based services can be challenging for homeless young people. The methods of contacting young people that are typically employed by **headspace** staff, namely phone and text messages, was raised as a key barrier for homeless young people's ongoing engagement with services. Most staff indicated that young people are alerted about their upcoming **headspace** appointment via a text message; however, many homeless young people do not have a mobile phone, or have insufficient credit on their mobile phone (and usually do not have an alternative contact such as postal address or email that they regularly access). This causes difficulty in contacting and reminding young people about their **headspace** appointments. Staff reported that it is very common for homeless young people to miss scheduled appointments.

We also see practical concerns, we will send young people a text to alert them of their appointment … But with this group they don't have credit so they won't receive the message and they will miss their appointment.

—Service provider

Most of them don't have phones and are impossible to contact and can't make appointments either.

—Service provider

They get lost on the process between appointments and they just lose contact and you can't [contact] them again unless they actually drop in … that's probably the main barrier.

—Service provider

Limitations of the types of services **headspace** can provide (service scope)

Related to the key personal barrier of homeless young people's priority to meet their basic primary needs, some staff indicated that a significant structural barrier for engagement with **headspace** is limitations on the type of services **headspace** can provide. They discussed homelessness as a complex, multi-layered issue that requires specialist and dual services that not only meet the mental health needs of a young person, but also support structural concerns such as housing, unemployment and poverty. Some staff reported that the structure of the current service system does not recognise the urgent and complex needs of homeless young people affected by mental illness and that there is a shortage of such dual services that can assist young people in securing appropriate and affordable housing as well as offer mental health support. Staff indicated that **headspace** does not have the capacity to fully address these needs for young people within a centre.

> *The biggest barrier for them is there's just no funding. We can't help them; we have to refer them to housing services central intake. It's not good enough. That's the barrier … young people know that if they've been once and they've been told we have to ring the housing hotline, it's likely that not much is going to happen for them; they still end up back on the couch or on the street.*
>
> —Service provider

> *What is their priority? If their priority is homelessness, yes we will engage with them and we will refer them to a service that actually provides them housing, because that's their primary thing.*
>
> —Service provider

> *It's really difficult, because you've got large numbers of people with limited resources, so young people only come here so many times, and if they are told 'No' too many times they go 'I'm not going back, I've had a gutful.' And that's a barrier – not being able to meet young people's needs because we just can't, it's impossible.*
>
> —Service provider

Intake process

A comprehensive intake and assessment process, often with multiple service providers, is undertaken to inform the development of appropriate care plans for young people attending **headspace**. Some staff indicated that such an involved process can be a barrier to engagement as it may cause homeless young people to feel overwhelmed and subsequently be less likely to return to **headspace** for their next appointment.

> *I think sometimes there's too many layers to go through so you see an intake worker then you might see engagement, there's sometimes too many steps for them and I think that could be a bit of a barrier.*
>
> —Service provider

> *It's a disengaging thing. We just need to be aware of those sorts of things with assessment type models, that we don't become too presumptive about what the issues are for a young person.*
>
> —Service provider

Personal and interpersonal facilitators

Confidentiality

Facilitators for homeless young people accessing services were also explored. The only personal facilitator that was common among staff and young people and discussed by more than a few participants was confidentiality and trust.

> *You've got to build some credibility. You've got to be someone that the young person can have some faith in, some trust.*
>
> —Service provider

With any service where it's confidential, it's obviously the amount of information that you can share with the parent, obviously having your information consent form and getting that done straightaway with the young person and … being open and honest with them helps. There's not many young people who have had issues around their confidentiality.

—Service provider

*They [**headspace** staff] explained that it was confidential and it made me feel a little bit better that what I would say would not get me or anyone else into trouble.*

—Young person, female, aged 16

Structural facilitators

The structural facilitators that were identified by staff included: service accessibility and outreach; relationships with other agencies; needs being met; one-stop-shop; and early intervention. Homeless young people identified very few facilitators.

Service accessibility

Service accessibility was identified as a facilitator for homeless young people attending **headspace**. Factors that were highlighted as improving service accessibility included a need for outreach services and transport assistance.

Most staff stated that outreach services can be an effective facilitator for young people accessing **headspace** and remaining engaged with the service, particularly as homeless young people have limited transport options to attend appointments.

We need a hub and spoke model, we need to have visits to other rural areas, we need to be providing services one, two days a week somewhere, we need to partner with other community centres, where we can provide these services.

—Service provider

We should ideally be taking the services to where they are more likely to be, more in the frontline kind of areas.

—Service provider

We have the engagement team that go out into schools and stuff, and they will see young people where they want to be seen – but that young person has had to have made some initial contact.

—Service provider

A few young people and staff recommended that **headspace** should provide assistance with transport, in the form of public transport or taxi vouchers, to enable young people to attend appointments, and remain engaged in treatment.

Help with transport if someone is far away.

—Young person, male, aged 17

Having something [a car] that we can go out and grab them that would be great.

—Service provider

Relationships with other agencies

The development of strong relationships with other agencies was a key facilitator for accessing and engaging in **headspace** services. Most staff discussed that cooperation between services enabled the complex needs of more homeless young people to be met through supported referrals to and from **headspace**, as well as increasing capacity for outreach and transport assistance.

*Service partnerships and collocation of services is a facilitator to access. If they [young people] don't come to **headspace** directly they often get brought in through other pathways, which help with access … It helps them access **headspace** if they have someone in their corner, because these kids don't have anyone else.*

—Service provider

With the lead agency here and other programs that work outreach with homeless people, I think really good service coordination is a key and collaboration is a real key.

—Service provider

In this area there is concerted effort across services for a collaborative approach to try and create some more options for young people.

—Service provider

With the homeless young people we work closely with the homeless shelters for young people here, so they transport them in because they don't have transport.

—Service provider

We engage well with a lot of youth services, but coming into contact with people more on the edge, we need to make sure they are educated on what **headspace** *provides. We need to form partnerships across the housing support services, try and make it accessible to everyone.*

—Service provider

A few young people also commented that they appreciated the help they received from **headspace** to connect with other services that could help them with other needs.

***headspace** can connect you to other services and young people don't really know that.*

—Young person, female, aged 17

I'm just starting to get my help from them so they're telling me everything that's available around, like I'm just hearing what's available, and then there's the process of finding out what's going to fit me.

—Young person, female, aged 19

Promotion of types of services provided

Some young people indicated that they did not realise that **headspace** could assist them with their housing needs, and suggested that more young people would access **headspace** if they were more aware of the assistance the centre could offer.

*Make it known that it is not just for talking about your problems, there are other services and doctors – people don't really know that. **headspace** can connect you to other services and young people don't really know that. It's not well known that you can get other type of help here.*

—Young person, female, aged 16

*More people need to know about **headspace** – I think it is important to get more parents or teachers to know about **headspace**.*

—Young person, male, aged 17

One-stop-shop

Some staff and some young people discussed the one-stop-shop approach of **headspace** and collocated services as a facilitator to access and engagement. Likely due to the difficulty homeless young people have in accessing and physically attending services, they reported appreciation of being able to access a range of services within one location, such as counselling, general health and vocational support.

> *With the* **headspace** *model and our access engagement model here people don't have to shop around so once they present with something all of a sudden they realise they have access to all this.*
>
> —Service provider

> *The services I need are all here. I don't think I've fully utilised it all but when I needed them.*
>
> —Young person, male, aged 23

> *They help out with the GP and stuff like that as well and they can help make sure that you're linked up with your Medicare and everything. It just makes it a lot easier all in one spot.*
>
> —Young person, female, aged 16

Needs being met

While the priority of homeless young people in seeking to first and foremost meet their basic primary needs (such as food, shelter and safety) was identified as a barrier to this group accessing **headspace**, most staff also recognised that where they were able to assist in meeting homeless young people's holistic needs, this served as an important facilitator for continued engagement with **headspace**.

> *We will work on all the underlying issues, whatever they may be that are contributing to their homelessness, because we know homelessness doesn't just present on its own, there's underlying causes, so we will try and link the kids back into education, try and address their mental health needs, give them material assistance, whatever they identify, trying to do some work with families, reconciliation.*
>
> —Service provider

> *I think they are receiving the treatment for the problems they present with, and I think that then has an impact on the other things as well, and some of the young people that have successfully engaged have then found that their housing situation has eased a little bit and the relationship with parents is a little better.*
>
> —Service provider

> *Somewhere to sleep, somewhere to shower, so if we can tap into linking into those services. We are so fortunate here then at least you're showing you're willing to help them in some practical support and then at least they can think about that second layer really in terms of their emotional wellbeing.*
>
> —Service provider

Early intervention

The current research revealed that homeless young people tend to present to **headspace** at crisis point; many may have already been exposed to homelessness, mental health problems, drug use, limited access to medical care, and family violence. Some staff and a few young people discussed the importance of connecting with homeless young people earlier and maintaining contact to work with them to prevent an escalation of problems.

> *So outreach or I think early intervention like an at-risk of homelessness model or whether it's a little group model or something like that as an early engagement, peer support, catchment thing.*
>
> —Service provider

> *More promotion and also it's not about when a kid is struggling the most and that's when they get the help – so they know about the service before the problems get bad – it doesn't have to be something serious, it can be something little.*
>
> —Young person, female, aged 17

Clinical file review

A clinical file review was completed on the records of 20 homeless young people who had accessed services at a **headspace** centre to identify service use patterns as well as barriers and facilitators to service engagement.

Barriers to accessing or engaging in **headspace** services were identified in the clinical records of most audited homeless young people. The primary barriers reported from the files were low motivation or negative attitude to treatment or treatment options, and having more immediate concerns or other priorities. Less frequently recorded barriers included poor family support, poor rapport with the clinician, premature termination of treatment, limited availability of service, poor coping with symptoms, relocating and lack of transportation.

One or more facilitators to attending **headspace** were reported in the clinical records of most of the homeless young people. The most commonly recorded facilitators were: self-referral and increased motivation for treatment; good rapport between young person, clinician and service; and referrals and re-referrals from external services. Having received previous mental health treatment, family or peer support, service availability, support from external service providers, belief in the service's ability to help and transport assistance were also highlighted as facilitators to accessing or engaging in **headspace** services in up to half of the files reviewed.

8.6 Summary of main findings

Overall, the level of representation of young people who are homeless accessing **headspace** services at 2.8 per cent is positive when compared to national data showing less than one per cent of young Australians are homeless. While this is a favourable finding, it is likely that population estimates underreport youth homelessness due to methodological issues. The increased prevalance of mental health concerns among homeless young people, along with their complex needs and restricted means, highlight the need to reduce barriers and increase facilitators to accessing and engaging with **headspace** services for young people who are homeless.

Young men aged 18-25 are more likely than other young people accessing **headspace** to report being homeless. The proportion of homeless young people accessing **headspace** services varies by state, ranging from less than one per cent to 16.4 per cent homeless young people, with Tasmania having the highest proportion. The level of representation of homeless young people accessing **headspace** across each state exceeds population data with the exception of the Northern Territory which has, by far, the greatest population of homeless youth and near the least proportion accessing **headspace** services. Almost 15 per cent of homeless youth attend primarily for assistance with their homelessness and homeless young people are also more likely to present for problems with alcohol and drugs than non-homeless young people. Homeless young people were equally as satisfied with the services they receive at **headspace** as non-homeless young people. However, they showed different patterns of influence for attending **headspace**, indicating they rely more heavily on self-motivation and other services, and are less often influenced by family members.

Interviews and focus groups with homeless young people and staff from two **headspace** centres that have a high proportion of homeless clients and one collocated agency revealed that the ability of homeless young people to access and engage with **headspace** services is greatly impeded by a number of barriers.

The key personal and interpersonal barriers identified were: homeless young people have more immediate concerns and prioritise basic needs; lack of awareness of available help and uncertainty of services; limited social support and motivation; lack of belief in **headspace**'s ability to help; and stigma. The primary structural barriers were service inaccessibility (including issues with transportation or cost of transportation, challenges related to appointment-based service provision, and difficulties contacting homeless young people between sessions), limitations on the type of services **headspace** can provide, and the potentially overwhelming intake process.

The main facilitators that were identified reflected these barriers and centred on: being a confidential service; service accessibility including assistance with transport and a need for outreach services; relationships and referrals with other agencies; self-referrals and increased motivation for treatment; good rapport between young people and clinicians; promotion of the types of services **headsapce** can provide (including support for homelessness); providing a one-stop shop and early intervention services; and young people's needs being met.

The barriers emerging from this research were consistent with previous literature that had also identified poor motivation for treatment, stigma and fear of being misunderstood and that their specific needs will not be met, low confidence in services' ability to help (due to negative past experiences), lack of awareness of services or where to seek help, cost (including transport costs), low priority placed on mental health due to other immediate concerns,

social isolation and lack of social support, and service inaccessibility as barriers to service access and engagement for homeless young people. Facilitators included good rapport with staff, diversity of treatment options (e.g. outreach, home-based, phone, street-clinic), increased motivation to seek support, increased severity of problems, confidence in the treatment and service providers, transport assistance, service accessibility with open door policy and capacity for drop-ins, providing resources and information about services, and confidentiality.

Other barriers reported in previous research that were not raised in relation to **headspace** services were preference for reliance on self and informal supports, experience of bullying, confidentiality concerns, lack of coordination between services, lack of youth-friendly services, poor personal organisational skills, socio-demographic factors, and limited treatment options available. Facilitators identified by previous research that were not reported in this research included being located in a familiar community-based setting, being engaged with other activities, availability of a mentor or support group, youth-friendly and relaxed environment, individual support, allowing choice in the level of disclosure, and using personal methods of contact (i.e. not contacted by letters).

Table 8.3 provides a summary list of barriers and facilitators to accessing and engaging with **headspace**, identified across all data collection methods, for young people who are homeless.

Table 8.3: Barriers and facilitators to accessing and engaging with **headspace** for young people who are homeless

Barriers	Facilitators
Personal & Interpersonal	
– More immediate concerns around meeting basic needs	– Confidential and trusted service
– Lack of awareness of **headspace** and whether it provides suitable service options	
– Belief that the service won't be able to provide help	
– Lack of family for motivational and instrumental support	
Structural	
– Service inaccessibility (transport, cost concerns, appointment-based, contact difficulties for reminders and follow-up)	– Transport support and outreach capacity – Drop in
– Insufficient service scope to address needs like housing	– Service collaboration and referral – One-stop shop – Earlier intervention
– Overwhelming intake and assessment processes	– Awareness of service options to meet needs

The main findings emerging from this research are:

- In order to improve service accessibility for homeless young people a flexible approach is required.
- Flexibility in intake processes and appointment scheduling with the option of drop-ins should be encouraged.
- Providing assistance with transport and capacity for outreach services need to be explored.
- Centres need to continue to develop strong links with other community and housing services to facilitate referrals and coordinated care.
- Centres need to provide clear promotion of all services and facilities they can deliver so that local young people are aware of how **headspace** can support homeless youth.
- Centres need to ensure confidentiality policies are clear and accessible to all young people to ensure they feel comfortable and safe.

8.7 Recommendations

Table 8.4 details potential strategies to assist with improving service delivery for young people who are homeless.

Table 8.4: headspace model development for young people who are homeless

Principles	Potential strategies
1. Community awareness of service provision	– Provide clear promotion of all the services and facilities that **headspace** centres can deliver to inform young people of how **headspace** can support homeless youth. – Promote the ability of **headspace** to link young people with other services including education, employment, and accommodation services.
2. Increase service accessibility	– Provide flexible appointments and the ability for homeless young people to 'drop-in'. – Greater provision and capacity for outreach services to increase the likelihood of homeless young people being able to access support. – Enable earlier intervention around risk factors. – Provide young people vouchers for transport fares in order for them to access the centre.
3. One-stop-shop	– Provide greater provision for assistance with homelessness at each centre alongside other services to holistically meet young people's needs.
4. Service coordination and links	– Continue to develop and value relationships with other agencies in the community that can effectively assist with the housing, education and employment needs of homeless young people. – Encourage referrals to and from housing support services and **headspace** for homeless young people with mental health concerns.

8.8 References

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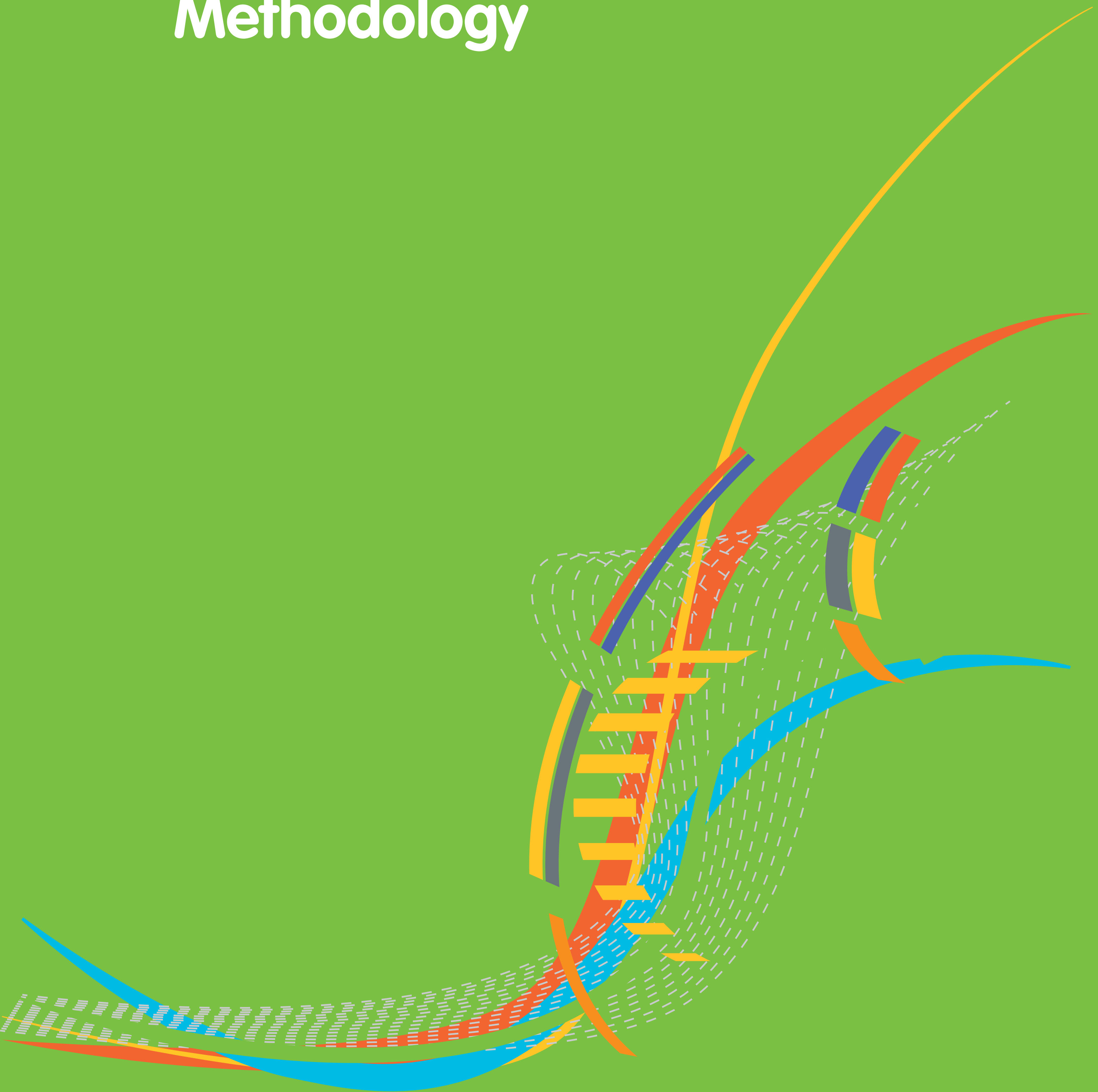
Appendix A: Methodology



Appendix A: Methodology

A.1 Overview

This research was undertaken between December 2013 and February 2015, and aimed to develop an understanding of the unique barriers and facilitators to accessing and engaging with **headspace** centres for young people from particular population groups. The population groups were those that have been shown to be less likely to access mental health care and **headspace** centres and included young people who were: young males; lesbian, gay, bisexual, trans*, intersex, or questioning; Aboriginal and Torres Strait Islander; from culturally and linguistically diverse backgrounds; had alcohol and other drug problems; or were homeless.

The focus was on factors that affect *access to services*, or the initial approach by a young person to the service, and *engagement with services*, which comprises actions to remain with the service for the period that the young person requires support.

There were four distinct methodological approaches applied throughout the project. These were:

1. a systematic review of the literature on barriers and facilitators to accessing and engaging with mental health care among young people from each population group – which aimed to determine how the current literature could inform understanding of barriers and facilitators
2. information on **headspace** clients derived from the **headspace** Minimum Data Set (April 2013 to March 2014) – which provided comparative data on service use characteristics of young people from each of the population groups and to total **headspace** client group
3. interviews and focus groups conducted with young people and family members and service providers relevant to each of the population groups – which aimed to provide rich qualitative information about the access and engagement experiences of young people in each of the population groups
4. clinical file reviews of young people from each of the population groups – which aimed to establish the barriers and facilitators that were evident in clinical files for young people from each of the population groups.

The combined methodology aimed to:

- describe barriers and facilitators, needs and pathways to accessing and receiving care for young people from each of the population groups, and
- identify modifications or enhancements to the **headspace** centre model that would enable **headspace** centres to reduce the barriers and empower young people from these population groups to access and engage with required mental health services and supports.

A.2 Systematic reviews of the literature

The purpose of the systematic literature reviews was to establish what information the current literature provided that could inform understanding of the barriers and facilitators to mental health care for each of the vulnerable population groups.

This included young people who were: lesbian, gay, bisexual, trans*, intersex, or questioning; Aboriginal and Torres Strait Islander; from culturally and linguistically diverse backgrounds; had co-morbid mental health and alcohol and other drug problems; or were homeless.

Note that young males were included as a group later in the project and were not a topic for the systematic reviews. A separate review was undertaken in 2014 related to young males.

Data sources and search strategy

Fourteen databases (Cochrane Reviews, DARE, CENTRAL, NHSEED, HTA, ACP Journal Club, APAIS, CINAHL, EMBASE, FAMILY, Medline, PsycINFO, TRIP, WoS) were searched in February 2013 for relevant articles. An iterative process was used to arrive at a final search strategy. This involved multiple search trials using varying search terms and strings in the Medline database. Each trial was compared to previous trials with respect to reliability in identifying relevant articles.

The following four central concepts (or search sets) were identified through this process: youth; mental health; vulnerable population characteristics; facilitators and barriers. Both MeSH thesaurus terms and free-text words were used. Following the confirmation of a final Medline strategy, the search was translated to the databases listed above. All searches were limited to 1990 onwards.

Two additional searches were conducted in the grey literature. First, an internet search was conducted to identify relevant websites and online evidence using a combination of the aforementioned central concepts. Second, a Google search was conducted to identify scholarly articles in the .org, . gov, and .net domains. This search combined terms for youth, mental health and vulnerable or marginalised populations, published in English in the last year.

Study selection

The database searches retrieved over 4000 articles and 17 websites were scanned for useful information and the first 100 most relevant Google references were reviewed (see Figure A.1 for study selection flowchart). Each article was assessed according to the specified selection criteria (outlined below) and those that did not meet these criteria were removed, arriving at a total of 42 relevant studies. The bibliographies of these relevant studies were then examined for additional articles that matched the selection criteria. Through this process an additional 20 articles were identified. The final number of studies included in this review from all searches performed was 62.

Interrater reliability was ensured by these researchers, who double-screened 10% of identified articles. This process achieved an interrater agreement of more than 95%, with consensus reached on any interrater differences. Authors were contacted if there was insufficient information provided to allow a judgement regarding inclusion in this review. A total of 46 authors were contacted. Of these, 20 responded and 11 additional articles were subsequently found to meet inclusion criteria. In cases where no reply was received, the article was excluded from the review due to not meeting inclusion criteria.

Selection criteria

Studies were included in the review if they met the following criteria:

1. Reported original data
2. Emerging young adults, 12-25 years (note that articles that report on other ages may be included as long as data for 12-25 years can be extracted or obtained from the authors)
3. Mental health care focus
4. Outlined experiences of at least one of the target groups (i.e., LGBTIQ, Aboriginal and Torres Strait Islander, CALD, AOD issues, homeless). Note CALD research was limited to that conducted in Australia, and the search on young males was not systematic).
5. Contained information on needs, pathways to care, barriers or facilitators to accessing and engaging with mental health care

Figure A.1. Literature search study selection flow chart

A.3 headspace Minimum Data Set

The purpose of examining the **headspace** Minimum Data (MDS) set was two-fold. Firstly, the MDS was used to determine which centres had higher proportions of young people from each of the vulnerable population groups, to inform which centres to work with for the interviews and focus groups; and secondly, the MDS was used to compare relevant service use characteristics of each vulnerable population group with the total **headspace** client population.

MDS data collection procedure

The **headspace** centre Minimum Data Set (MDS) supports reporting, monitoring, quality improvement and evidence-building requirements of the **headspace** initiative. It collects data on the young people presenting to **headspace** centres and the services they receive. The aims of this data collection are to describe the characteristics of **headspace** young people, the services they receive at **headspace**, and some of the outcomes attained. This information is used to inform and guide continuous quality improvement by knowing which young people **headspace** centres are servicing, some of the factors that influence their service use, what services are being provided, and how successful these are in improving outcomes for young people.

All **headspace** centres collect the MDS from all young people who agree to participate, which comprises the vast majority of clients. **headspace** centre clients are asked to fill in MDS information when they first present to the service and at subsequent service occasions. Young people are initially informed by the receptionist and provided either an iPad or given access to a private computer on which to enter their data while they are waiting in the waiting room.

A purpose-built, youth-friendly electronic form has been developed to collect information. The data collection application commences with a video that explains the data collection purpose and nature and the consent process. This information is also available in written form if required. If a young person is not thought to be fully able to understand and provide consent, the young person's intake worker explains the data collection procedure and takes the young person through the consent process (and possibly the questions if necessary).

Usually, however, the young person indicates their consent within the application, after which they are presented with the questionnaire items. Different sets of items are presented at different visits. Service providers also complete relevant information for each occasion of service through an online form. Service providers have access to online training regarding their online form.

The MDS covers:

- how young people become aware of **headspace**
- who clients are – age, gender, Aboriginal and Torres Strait Islander, country of birth, where live, education/employment
- why they present - Presenting Issues, Stage of illness, Diagnosis, Distress, Functioning
- what services they receive - Wait Time, Type of Service, Length, Funding Stream, Outcomes

All data are de-identified by encryption on extraction from the centre to the **headspace** data warehouse to ensure confidentiality. Responses have an identification number in the data warehouse, but the data can only be re-identified at the centre level and not from the combined data source.

Valid data are presented throughout this report and therefore although the total sample was 33,038, n values reported for each item may not sum to reported totals due to missing data.

Ethics approval

The MDS was approved through internal quality assurance processes, which comprised initial consideration and approval by the Clinical, Research and Evaluation Committee, and subsequent consideration and approval by the full **headspace** Board of Directors. The processes were also reviewed and endorsed by Australasian Human Research Ethics Consultancy Services in July 2013 (Dr Gary Allen, Prof. Colin Thomson, Winthrop Prof. Mark Israel). Ongoing review is undertaken by the Research and Evaluation Sub-Committee of the Board.

A.4 Interviews and focus groups

Information was collected directly from young people, some family members and service providers relevant to each of the vulnerable population groups.

The purpose of the interviews and focus groups was to obtain rich qualitative information about the barriers and facilitators to mental health care at **headspace** from young people in these population groups and their service providers.

Participants

Participants in the interviews and focus groups included **headspace** staff and young people from centres that were identified by the MDS as having higher proportions of young people from each of the population groups. These centres were identified by examining the MDS data to ascertain the proportion of young people from each of the population groups at each centre throughout Australia. The final centres were selected in collaboration with the **headspace** State Managers and included a mix of metropolitan and non-metropolitan centres.

The **headspace** centres and independent organisations selected to recruit staff and young people to participate in interviews and focus groups are described in Table A.1. At each of the nine **headspace** centres, the centre manager, staff who worked with young people from the population group, and young people who identified as belonging to one of the population groups, took part in an interview or focus group.

During data collection it became evident that few young people and staff were available to adequately represent the population groups of young people who were homeless and from diverse cultural and linguistic backgrounds. Consequently, in collaboration with staff at the Sunshine and Warrnambool **headspace** centres, the independent organisations of Brophy Family and Youth Services and the Centre for Multicultural Youth (CMY) were included to enable sufficient representation of these two hard to reach groups of potential **headspace** clients. Staff at these organisations who worked with young people from the population groups took part in an interview, and young people took part in a focus group.

Table A.1: headspace centres and independent organisations selected to recruit staff and young people to participate in interviews and focus groups

headspace centre	Location	Population group
Wagga Wagga	Inner regional, NSW	LGBTIQ
Camperdown	Major city, NSW	LGBTIQ
Cairns	Outer regional, QLD	Aboriginal and Torres Strait Islander & AOD
Tamworth	Inner regional, NSW	Aboriginal and Torres Strait Islander
Sunshine	Major city, VIC	CALD
Dandenong	Major city, VIC	CALD
Geelong	Major city, VIC	AOD
Warrnambool	Inner regional, VIC	Homeless
Frankston	Major city, VIC	Homeless
Independent organisation	**Location**	**Population group**
Centre for Multicultural Youth (Sunshine)	Major city, VIC	CALD
Brophy Family & Youth Services (Warrnambool)	Regional, VIC	Homeless

A detailed breakdown of the number of participants for each population group is provided in Table A.2 This shows that members of the **headspace** Aboriginal and Torres Strait Islander Youth Reference Group were also involved as participants for that population group. Overall, there were 149 young people, service providers and parents involved in the interviews and focus groups.

Table A.2: Number of participants in each population group

Population group	Number of participants
Young males	
headspace staff	4
Young people	25
Total young males	**29**
Lesbian, gay, bisexual, trans*, intersex, or questioning (LGBTIQ)	
headspace staff	9
Young people	7
Family members	1
Total LGBTIQ	**17**
Aboriginal and Torres Strait Islander	
headspace staff	9
Young people	6
headspace Aboriginal and Torres Strait Islander Youth Reference Group	12
Family members	3
Total Aboriginal and Torres Strait Islander	**30**
Culturally and linguistically diverse background (CALD)	
headspace staff	5
Young people	16
Centre for Multicultural Youth staff	2
Centre for Multicultural Youth young people	2
Total CALD	**25**
Alcohol and other drug problems (AOD)	
headspace staff	8
Young people	10
Parents	4
Total AOD	**22**
Homeless	
headspace staff	7
Young people	8
Brophy Family and Youth Services staff	1
Brophy Family and Youth Services young people	10
Total Homeless	**26**
Grand Total	**149**

Procedure

The interviews and focus groups were conducted between November 2013 and August 2014. All were facilitated by the same **headspace** researcher and were audio recorded. Young people were given a gift voucher in appreciation of their participation.

The staff interviews were 45-60 minutes in length, the young people interviews were 10-30 minutes in length and the young people focus groups were 30-45 minutes. Each interview or focus group was semi-structured and covered the following topics:

- What are the unique needs of young people from [the population group]?
- What are the pathways to care?
- What are the barriers and facilitators to accessing mental health care?
- What are the barriers and facilitators to service engagement?

Digitally recorded interviews and focus group sessions were transcribed verbatim by an external transcribing service and imported into NVivo 10 (QSR International, 2012) for analysis. NVivo is a qualitative data analysis software program that allows qualitative data to be sorted into themes, and relationships between themes and respondent characteristics to be examined.

Transcripts were de-identified to ensure the anonymity of responses prior to analysis. The initial coding and analysis of the transcripts was undertaken by a researcher who was not involved in the data collection.

Separate coding structures were created for staff and young people, with tree nodes initially informed by the topic of the interview questions. Branch nodes were created according to issues raised by respondents. For example, responses by staff concerning barriers to centre access were coded under the tree node 'Barriers to Centre Access', with branch nodes created in response to the various aspects of barriers to access, e.g. 'Concerns with confidentiality'; 'Lack of understanding of service delivery'.

To verify the accuracy of the coding process, all the interviews from one centre were re-coded by a second researcher. The NVivo10 coding comparison provides a calculation of Cohen's Kappa, which gives a measure of agreement beyond that which could be expected by chance. The inter-coder reliability was calculated as 97 per cent. Values above .80 are regarded as almost perfect agreement for qualitative data coding analysis (McGinn, Guyatt, Cook, Korenstein, & Meade, 2008).

Themes derived from the interviews and focus group were tabulated to assess the level of support. These tables were then analysed according to the Consensual Qualitative Research Method (Hill et al., 2005) to determine the level of representativeness and frequency of responses. This type of analysis also allowed for comparison across the participant types and provided a stable and common metric for communicating results. Four levels of response frequency were used in the analysis, as outlined in Table A.3.

Table A.3: Consensual qualitative research method

Level of support	Reported as	Frequency of responses from target group
General	All	91-100%
Typical	Most	51-90%
Variant	Some	21-50%
Rare	A few	10-20%

Ethics approval

Ethics approval for this research was obtained from Melbourne Health Human Research Ethics Committee: Protocol 2013.117.

A.5 Clinical file review

The purpose of the clinical file review was to determine what barriers and facilitators to accessing and engaging with **headspace** were evident within the clinical notes of young people from each of the vulnerable population groups.

Procedure

A clinical file review was undertaken at the **headspace** centres that were identified as having higher proportions of young people from the population groups. Client files were selected via the MDS and were included if the file had been: a) closed for a minimum of six months prior to the date of collection; and b) the young person had accessed **headspace** services a minimum of three times. Table A.4 shows that the files of about 20 young people who had previously been clients with the **headspace** centre were reviewed from each population group.

Note that young males were not included in the clinical file review, as this population group was added after this component of the research project had been completed.

Table A.4: Number of headspace centre client file reviews by population group

Population group	Total number of client files
Lesbian, gay, bisexual, trans*, intersex, or questioning	20
Aboriginal and Torres Strait Islander	20
Culturally and linguistically diverse	19
Alcohol and other drug problems	20
Homeless	20
Total	**99**

A clinical file review template was developed to record: 1) mental health needs of young people from each population group; 2) pathways to care for these young people; and 3) barriers and facilitators to service access and engagement, evident in the clinical file for each young person. The file review template was piloted using randomly selected files and two researchers initially extracted the same data until inter-rater reliability was established. Following this, the client files were reviewed by one researcher who accessed the clinical files while attending at the **headspace** centre. This information was recorded in a spreadsheet with no personally identifying information recorded.

Analysis explored the association of group membership with clinician recorded barriers and facilitators to access and engagement in services at **headspace**. The consensual qualitative research method shown in Table A.3 was used to describe and report the results.

Ethics approval

Ethics approval for this research was obtained from Melbourne Health Human Research Ethics Committee: Protocol QA2013123.

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