

Why measuring mental health outcomes is not enough: lessons from the evaluation of headspace HSRAANZ Workshop

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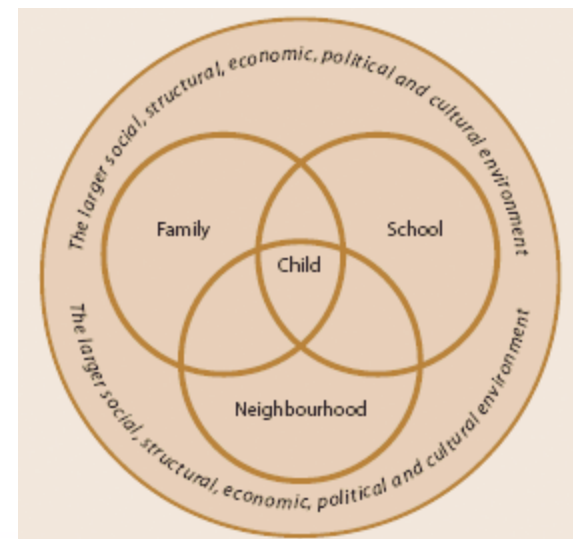
Context

- The Australian Government committed \$2.2 billion over 5 years for mental health in the 2011-12 budget (Australian Government, 2011)
 - \$197.3m for new headspace centres
 - +\$133.3m for a total 90 HS sites by 2014-15 (Senate, May 2011)
- Mental health investment aims to improve mental health prevention, diagnosis and treatment
- Research and evaluation are critical to demonstrating these outcomes
- **What's the best approach for collecting evidence to understand if we've met the aims, to inform and improve health services and to inform policy for further investment?**



To RCT or not?

- RCTs: gold standard (Veerman & Yperen, 2007; Susser, 1995; Leigh, 2003,09)
- **Why wouldn't we replicate clinical RCT models for MH evaluations?**
- RCTs have limitations:
 1. RCTs usually evaluate a single intervention. Limited when 'complex intervention' (Birckmayer & Weiss, 2000; Campbell et al. 2000, 2007)
 2. They fail to answer significant research questions – e.g. why/ why not?
 3. Don't replicate real world:
 - a) Daily practice (Weisz et al. 1992)
 - b) Context: intervention, community, individual (Pawson 1996; Veerman & Yperen 2007; Campbell et al. 2007; Bronfenbrenner 1979)
 - c) Processes & settings of care (Donabedian 2005)
 4. Youth specific issues (access, engagement, friendly)
 5. Ethics



Source: AIFS, 2009

Considering these limitations in regard to headspace: no single intervention and ?s

Headspace model

1. Communities of Youth Services

2. Community Awareness

3. Service Provider Education & Training

4. Centre of Excellence

5. headspace National Office



Young people seek assistance from accessible, quality, holistic, coordinated services

More, accessible & youth-friendly services (1,2,3,5)

Early identification & intervention (1,2,3,4,5)

Increased quality (inc. evidence based) services (1,2,3,4,5)

Increased workforce capacity (1,3,4,5)

Increased service coordination (1,3,4)

holistic support (1,3,5)



Improved outcomes for young people with or at risk of mental health and related issues

Mental health

Physical health

Alcohol and other drugs

Social participation

Economic participation



... Context



- 30 sites around Australia in very different geographic areas
- They worked in different state/territory health contexts
- Demographic differences in communities
- No precise single model
- No shared establishment and implementation timeframes
- Very different individual young people accessing headspace

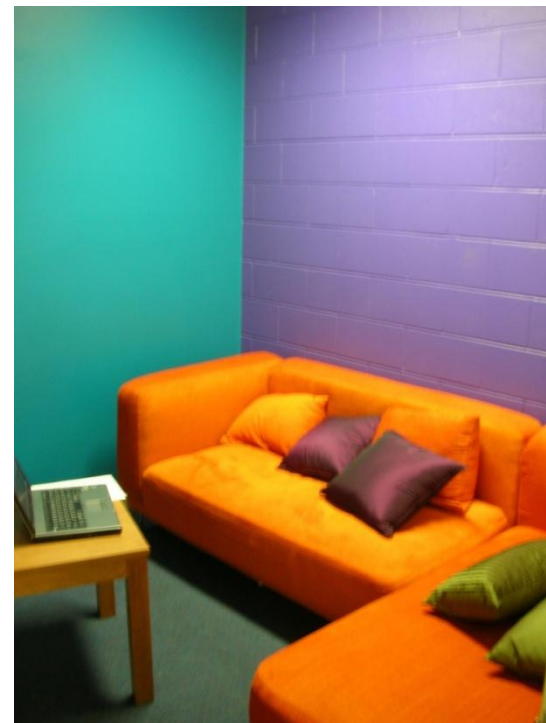
Alternatives to RCT: evaluation methods used to evaluate headspace

- Designed a program logic
- Mapped appropriate methods against the program logic
- 2 wave, mixed-method evaluation
- Policy document and report analysis
- Stakeholder interviews and surveys (YP, family/carers, site staff, external service providers, headspace central, government)
- *headspace* dataset (MHAGIC)
- Population service use: Medicare Benefits Scheme service use data
- Population mental health issues and compounding social and economic problems: 2007 ABS National Mental Health and Wellbeing Survey

Results

So, what did our methods tell us that would help inform improved mental health prevention, diagnosis and treatment for YP?

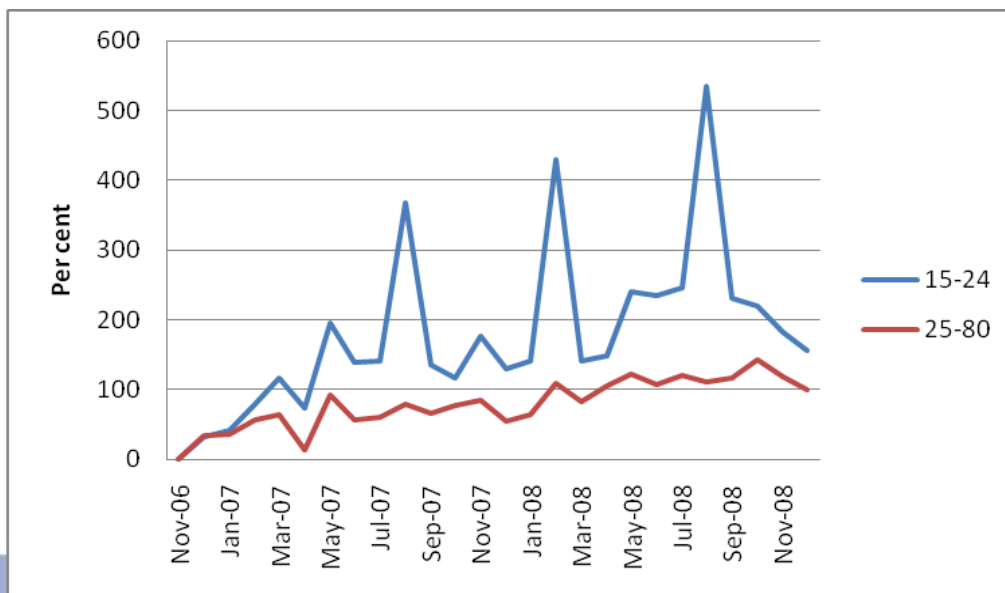
- Access
- Engagement
- Youth appropriate, holistic services
- headspace model and its implementation



Access: increased help-seeking

- MBS 2006-08: disproportionately large increase in young people accessing mental health services **medicare**
- headspace = the major national mental health policy change for YP during this period
- HS seen c. 14,000 YP by 30 June 2009

Relative change in the use of Medicare items associated with mental health by age group Nov 06 – Nov 08 (%), MBS



Access factors:

- ✓ Location
- ✓ Transport
- ✓ Referrals
- ✓ Affordability
- ✓ YP 12-17
- ✓ Males
- ✓ Low social support
- ✓ Low SEP
- × Opening hours
- × Older YP
- × NESB

Engagement of young people in mental health services

- Not only did YP access HS, but many remained engaged
- 95,000 occasions of service (c. 6.8 sessions each)

Why?

- minimal waiting times
 - staff skills to work sensitively with youth people
- “They really take the time and listen, they don’t stop trying”*
- privacy and confidentiality protected
 - young people given some control over service experience
 - youth access worker
 - Prompting: *“The phone call makes you want to go”*

Problems

- Do not attend rates
- ‘Too youthy’ and stigma



Youth appropriate, holistic, coordinated services

- Youth-friendly nature

- Non-clinical environment:

“It’s a friendly environment, you feel safe when you come in”

“The first time I was like really nervous and paranoid, but it looked like a real kid friendly place and that put me at ease. Today I was like, whatever.”

- 3 in 4 sites were providing at least 3 service types (primary health, mental health, alcohol and drug use, social and vocational support)

“they’re not attached to one bit [of your life], they don’t want to just stop violence at school...; they touch the home life, school life, work life, everything. ... that’s the best thing about ... the guys here at headspace”

- 68% of young people had seen at least 2 practitioners
 - usually GP and psychologist
 - whole of life approach (not just mental health)

headspace model lessons

- **Time:** establishment and implementation of sites took longer than expected to open and provide full complement of services (av. 7 months)
- **Practitioner gaps** were problematic, especially where no GP
- Capacity of **lead agency and consortium** were critical in informing, supporting and developing sites and providing resources
- **Funding** mix (*core*, MBS, private pract, other govt) = capacity & sustainability
- Need **clinical governance and business expertise**
- Co-location not enough for coordination (leadership, processes, roles, attitudes)
- Different engagement techniques needed for some **hard to reach groups**
- **Vocational support** needs integrating into the model
- **Warnings:** practitioner waiting lists, fees for young people
- **Families** require more support
- Opportunity for more collaboration between **components**

Future considerations and limitations

- The non-RCT evaluation findings are important for scaling up:
 - how can we make it work in other locations?
 - how do we know which parts of the intervention matter?
 - what factors made a difference?
 - how can we make it work elsewhere?
- Limitations: timeframes and data availability
 - Little evidence to conclude the extent to which services were evidence-based
 - Attribution not conclusive
 - YP outcomes and attribution: how do we know it wouldn't have happened anyway?



Conclusion

- Programs and policy makers require evaluations and research findings to inform program development and further investment
- RCTs play an important role in determining efficacy
- But they have limitations
- Broader program evaluations with mixed-methods make important contributions to answering the what, how and why questions and to help shape what's next
- **Full report:**
<http://www.sprc.unsw.edu.au/publications/reports>

