

## Headspace (Maitland and Newcastle)

### *Headspace model*

1. We understand that Headspace is geared towards those with mild to moderate mental health difficulties. Could you please comment generally on the types of young people that present at your centres and the severity of their mental distress when they first arrive?

*We certainly do have young people that present with mental health in the Mild-Moderate space and this group would represent up to 50% of our client group and referrals.*

*We also have a large proportion that present in the moderate-acute stages of mental health. Now that CAMHS services have tightened their criteria, it is a constant conversation with services and referrers about transitioning young people back to our service (from CAMHS), which other services can be referred to and wait times which maintain a young persons risk, heighten the risk due to the wait or the need for co-management of a young person due to services being stretched.*

*Several referrals a week are not accepted or referred straight to the Mental Health Contact Centre due to their severity and recent suicidal attempts or suicidal thoughts with a plan. We do not have the resources to support young people at this stage of mental health and give the referrer, parents/supports phone numbers for services to access and information about what to do next, where to go. We advise a young person/family to present to their GP if they are not at an emergency level, so that the GP can do a thorough assessment and make appropriate decisions re care. We provide numbers for services with appropriate skill sets if the young person will require a higher level of intervention – e.g. clinical psychologists or ATAPS funded services*

2. After a young person presents at a Headspace centre, what pathways are then followed? Where are the main gaps in services?

*If a young person is appropriate for our service we book them in for a full assessment – 9 domains of their life to see where their strengths areas and support lie and where difficulties are arising – to make a plan, etc. Some strategies can be given during this appointment – sleep hygiene and general self care such as diet and exercise. Mindfulness for anxiety etc.*

*Young person is asked to go to their GP and obtain a Mental Health Care Plan (MHCP). This ensures the primary care professional is aware of what is going on for young person and can follow treatment plans etc.*

*Young person is then linked for ongoing counselling/psychological support.*

*If a young person has more intensive needs, a referral the Mental Health Line (MHL) is made by our service and we encourage the family to make a referral also. If the young person is with us and has higher needs and are we unsure of safety but not at emergency response level, we make the referral to the MHL while they are with us to assist the triage process. We then can walk through the process of what comes next/what to expect to the family and young person.*

*If during the call to the MHL we are told the young person does not meet their criteria – we suggest checking in with the GP regularly until linked with a service – clinical psychologist, ATAPs provider or one of our psychologists.*

*We ensure all supports are in place to support a young person while waiting for appointments – if they are engaged with a school counsellor, we speak with them and let them know what is going on so they can “hold” them until appointments are available.*

*All referrers are notified about the outcome of a referral so they can assist the young person as needed.*

*Main gaps in services exist in the moderate-acute mental health stages. There are not services funded or with capacity to provide for the needs in these areas. Moderate-acute young people may present with persistent symptoms that impact on areas of their life and have behaviours such as regular self harm, suicidal thoughts without current plan, recent suicidal attempt (within 2-8 weeks) but with no current plan. These stages of mental health are not acute enough to meet CAMHS criteria, are too high risk for headspace centres (although if there was capacity and lower wait times Maitland sees these young people). If wait times were less at headspace Maitland, we would see these young people more frequently. The complexity for us is that our wait times contribute to*

*increasing risk of these symptoms for young people and the potential for them to become acutely unwell is high. This is not what young people should experience.*

*We endeavour to have them access other services with shorter wait times, such as Hunter Primary Care, Clinical Psychologists and ATAPS funded services. Otherwise, we will endeavour to have their symptoms recognised and picked up by CAMHS wherever possible or co-manage a client between our clinicians and CAMHS. Our interventions with young people in these circumstances are not what we are funded for and resourcing then becomes an issue for access by mild-moderate clients. We have a no wrong door and do not wish for young people's mental health to decline so do what we can, whenever we can as we often have no other choice.*

3. We understand that Headspace's Maitland and Newcastle offices are run by different service providers. Does this result in different approaches to the delivery of Headspace services? If so, how?

*Maitland and Newcastle are run by different service providers, as are most centres Nation wide – only a few have the same lead agencies.*

*Headspace Maitland has Samaritans Foundation as its lead agency.*

*Anecdotally, Maitland will see a broader range of presentations in regard to mental health symptoms and complexity as we have fewer other services in the community to assist or refer to, due to geographical location and funded services available in our draw areas. Family capacity to access private services also impacts service provision.*

*headspace Maitland is funded at a lower level, so we have less capability for employing staff to meet demand etc which impacts things such as wait times and community awareness and engagement. Maitland's demand is high due to the geographical areas that referrals and clients come from. We also have large numbers of socio-economically disadvantaged clients which can contribute to factors such as: - ability to access other supports, recovery time, complexity of presentations and the like.*

*There are not figures shared between centres to see what our occasions of service are in comparison of the two centres or referral numbers etc.*

*Each centre has its own Clinical Governance Framework that assists to manage risk and informs policies and procedures of the centres. This would affect client engagement and referrals in and out.*

*If sticking heavily to the guidelines for funding being mild-moderate only – which excludes working with clients with severe or persistent mental health – our centres may work differently in this space. Headspace Maitland will see a client if they need to return after a period, depending on circumstances – it may be a young person's 2<sup>nd</sup> or 3<sup>rd</sup> episode of care over the span of 12-25 years as different life stages bring up different circumstances to deal with.*

4. How does Headspace link up with other services in the community to provide ongoing support to young people?

*headspace Maitland has strong community partnerships and formal networking arrangements in place with many stakeholders to provide a wrap around service to clients. We have in-kind working arrangements with agencies who sit on our Consortium and these services are provided at our site for young people to access. Services include – Wesley Mission and HNEALHD for AOD counselling, HENEALHD for our CAMHS Partnership for complex case reviews and co-management of clients, Mental Health Carers ARAFMI for carer support and counselling, TAFE NSW for vocational counselling and enrolment assistance. We also have other services that come to site and provide appointments for young people such as: APM employment, Centrelink, GP, Midwife. Our lead agency, Samaritans Foundation has funded services that co-locate with us to provide extra supports – Specialist Homelessness Services, Adolescent and Family Counsellor, Youth Development Officer, Emergency Relief and such.*

*There are many services we have working relationships with that assist our clients. Our working knowledge of these services make them more readily accessed by young people through a shared understanding of environment and process.*

*In areas we cover but cannot provide direct services we partner with organisations and agencies to assist to provide information, referral advice and community education in the communities – e.g. Relationship with Upper Hunter Community Services, Where There's A Will, Dungog High School.*

5. The 2016 Orygen report *Looking The Other Way: Young People and Self-Harm* recommended that a two year trial be conducted in 10 Headspace centres across the country focusing on young people who self-harm. Are you aware of such a trial taking place? If not, do you see benefit in such a trial?

*headspace Maitland has not been aware of this trial.*

*There would be a massive benefit to this trial taking place and these young people being worked with in a consistent manner and some information gathered about effective treatments options and effectiveness – as per client feedback.*

6. More generally, are there opportunities to improve how service providers assist young people who present with self-harm?

*Perhaps there could be generalized questioners developed for practitioners that help to assess if the self harm is for self-regulation of emotions or for suicidal intent. Our service is confident in asking questions around this to ascertain the difference.*

*The questionnaires may be helpful for other professions – teachers, GP's etc who do not deal with this as a frequent occurrence so that it may take the fear out of the behaviour. More education everywhere on self harm and why it may be utilised by a person who be a massive help in reducing stigma, fear and potentially promote conversations between people engaging in self harm.*

### *Stigma*

7. What role does stigma play in regional areas in the context of youth suicide and self-harm, noting also that young people in rural and regional areas are less likely to seek help for self-harm?

*Stigma plays a huge role for youth suicide and self harm and also seeking help at all, in many areas. The fear of admitting a problem, needing help, etc can be extremely off-putting in sharing a personal experience to gain assistance. If the education can be across all of life that everyone has Mental Health, like we all have physical health is important. Sometimes Mental Health is not great, like physical health – if that can be acknowledged and accepted then perhaps stigma will decrease and talking about worries and circumstances will be less frightening and “out of the ordinary”.*

*Different areas would have differing circumstances for the role that Stigma plays.*

8. How can the stigma associated with mental health in children and young people in rural and regional areas be reduced?

*We would say that stigma could be reduced through conversation about feelings, coping and help seeking from early days in education and health settings to make it a “normal” part of what could be done. Similar to dental visits and immunisations.*

*Elements of mental health education could be embedded in the curriculum across the nation and a focus on maintaining mental health being as important as healthy eating and cleaning your teeth. Ad campaigns for general mental health an ongoing focus as a reminder.*