Parliamentary committee on suicide and self-harm in children and young people

RESPONSES FROM HEADSPACE NEWCASTLE

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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?

headspace Newcastle services a wide range of regional, urban and rural areas across the Hunter region (approx. 30,000sq km; approx. 600,000 people). Referrals come primarily from 4 LGAs – Newcastle (54%), Lake Macquarie (34%), Port Stephens (6%) and Maitland (6%).

The data presented below relate to our service summary data for financial year 2016-2017. Source: **headspace** National, Centre Activity Report.

As depicted below, **headspace** Newcastle is significantly busier than the national average, seeing almost 50% more young people than most centres.

Table 1:
Headspace Newcastle: Data for previous 12 months, compared to national average.
Source: headspace National, Centre Activity Report.

Newcastle	2015	2016	2017	Current reporting period (FY 2016/17)
Occasions of Service	4,309	4,170	4,762	4,762
Serviced Young People	989	1,009	1,123	1,123
New Young People	686	688	722	722
Returning Young People	164	243	292	292
Average visit frequency	4.4	4.1	4.2	4.2

National (Centre Average)	2015	2016	2017	Current reporting period (FY 2016/17)
Occasions of Service	3,019	3,164	3,350	3,350
Serviced Young People	683	744	791	791
New Young People	464	504	507	507
Returning Young People	163	185	216	216
Average visit frequency	4.4	4.3	4.3	4.3

Headspace Newcastle also sees a greater level of complexity than the national average. **headspace** Newcastle has almost twice the rate of stage 2 (threshold diagnosis) presentations compared to national average (33.4% vs 17.6%) and, commensurately, lower rate of young people presenting with 'nil or mild symptoms' (stage 0-1a) (31.8% vs 50.1%).

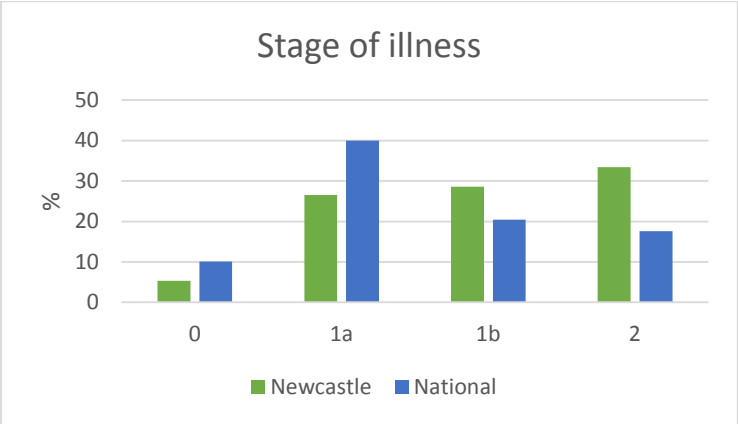

Figure 2: Clinical stage of illness, headspace Newcastle 2016-2017. Source: headspace National, Centre Activity Report.

Headspace Newcastle clients are mostly female (62%), and primarily (90%) present for mental health issues or mental health assessment. Most clients are aged 15-17 (35%) or 18-20 (27%). homelessness or at risk of homelessness is reported by 2.6% (compared to 1.8% nationally). Average scores for emotional distress (K10 scale) at initial presentation are higher for headspace Newcastle (29.2) than the national average (28.4)

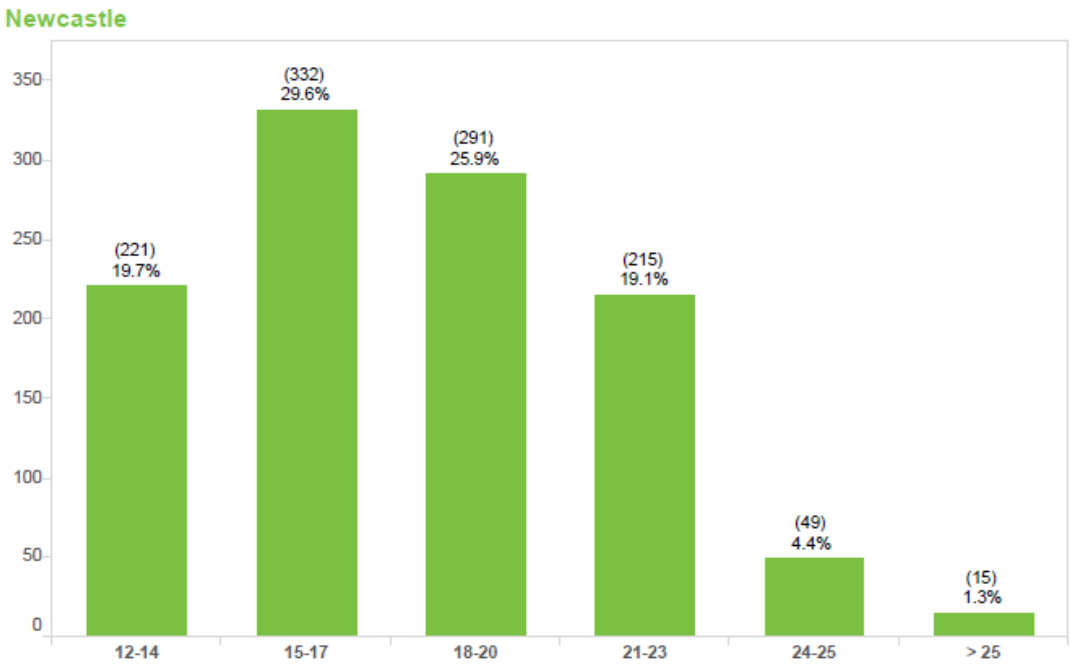

Figure 1: Demographics, headspace Newcastle 2016-2017. Source: headspace National, Centre Activity Report.

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

Clients are assessed / triaged by phone by our intake team, or face to face for more complex referrals. Clients who meet headspace eligibility criteria (mild to moderate mental health concerns that would benefit from a brief / early intervention model of care) are then allocated to a clinician within 2-3 weeks on average.

There remains a significant sector gap for complex / chronic / sub-acute mental health presentations in young people. **headspace** is under ever increasing demand to see young people who are outside of our early intervention scope – complex personality disorders, complex trauma, psychosis, recurrent self-harm and suicidal ideation. **headspace** Newcastle has almost twice the rate of stage 2 (threshold diagnosis) presentations compared to national average (see question 1, above) and, commensurately, lower rate of young people presenting with 'nil or mild symptoms'. **headspace** Newcastle is significantly busier than the national average, compounding the demand on the service to manage this high level of complexity.

Other local **headspace** services have accepted such referrals for ongoing care, resulting in large volumes of clients with long-term care needs, long waiting times for service, and reduced capacity to provide early intervention. **headspace** Newcastle has managed to keep waiting times within targets, but this requires significant time and resources from our intake team, to find suitable alternatives for complex and chronic referrals. We anticipate further increase in demand due to overflow from another local **headspace** centre, and increasing rate of referrals from Calvary Mater Newcastle and Mater Mental Health, particularly following deliberate self- harm /suicide attempts. We have advocated and continue to work with HNECC PHN on this issue to be addressed as a priority.

Geographical challenges are also pressing. **headspace** Newcastle services not only the Newcastle urban area, but also areas with greater than one hour travelling time, including Port Stephens/Tomaree peninsula and Lake Macquarie areas including Morisset and Swansea, which have limited access to public transport. **Headspace** Newcastle is frequently petitioned by community groups from these areas, requesting outreach services. Early in 2017, HNECC PHN invited us to submit an expression of interest to establish a satellite clinic in the Port Stephens / Nelson Bay area, but have been advised that this proposal did not obtain funding in the recent expanded funding round from the Commonwealth Government.

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?

Each headspace has minimum standards of 'model integrity' that must be adhered to (eg must provide, mental health, drug and alcohol, vocational, and physical health care; must deliver community awareness activities, must have a youth reference group involved in service delivery, must have co-located partnerships with other community agencies / NGOs).

However, each headspace centre can decide how to allocate its funding, how to manage intake and referral processes, the length of service provided for clients, the nature of any group programs or service innovation projects. This can lead to considerable variances in the clients accepted for service, waiting times, and range of interventions provided.

Additionally, different lead agencies can also lead to varying levels of support and resources, such as the robustness of clinical governance processes, donation of in-kind staffing, and financial contribution to funding shortfalls.

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

We have a well-recognised community development officer, who links with a wide range of community organisations, including schools, councils, youth development officers, radio stations, aboriginal and multicultural health agencies, community fundraisers, and other not for profit organisations. Recent initiatives have included Waves of Wellness surfing program, national anti-bullying campaign workshops, Walk a Mile Koori Style (domestic violence awareness program), multicultural youth group, and producing a video resource in collaboration with HeadJam media, aimed at encouraging young people to seek help, utilising funding donated by a range of community individuals and groups.

Formally, headspace Newcastle has service level agreements with the following agencies, to provide input or direct staffing on-site at our centre:

- Child and Adolescent Mental Health Service (CAMHS)
- Flourish Australia
- Relationships Australia
- Wesley youth services
- Centrelink
- APM employment

We are also collaborating closely with the Black Dog Institute and Everymind, with to deliver Youth Aware Mental Health (YAM) workshops to local catholic and independent schools commencing in Term 3, as part of the Newcastle Lifespan suicide prevention research trial.

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?

I am not aware of such a trial taking place. This would be of great benefit to headspace services, to trial specific evidence-based interventions for self-harm.

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

We need services that are set up to see clients with chronic and complex but sub-acute difficulties, such as youth with borderline personality disorder and complex trauma. The majority of these young people have chronic self-harm or suicidal risk, but are ‘bounced’ from one service to another once the risk becomes too high, or they have exhausted their available sessions (eg via Medicare or ATAPS). The result is greater numbers of people being forced to present at emergency departments. The headspace model of early and short-term intervention is not set up for such young people, who require intensive and sustained intervention and a long-term therapeutic relationship. Addressing this gap requires either enhanced funding directly to services

(for enhanced roles in care coordination and wrap-around support), or different items via Medicare, such as complex / chronic mental health disorders.

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 particularly affects young people from rural and regional areas. Not only are young people living in rural / remote areas less likely to seek help from clinical services following self-harm compared to young people living in major cities (Fadum et al., 2013), young people aged 15–24 years living in remote areas have twice the rate of hospitalisation for self-harm compared to young people living in major cities. (Australian Institute of Health and Welfare, 2008).

Many young people do not present for help or disclose their self-harm due to fear of negative responses from others, feelings of shame and guilt, or school staff discouraging students to talk openly for fear of contagion effects. For rural young people there are also likely to be other cultural factors related to social isolation, which reduce the reach and impact of stigma reduction campaigns.

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

Comprehensive evidence-based school and community education programs.
Greater wrap-around support to schools, to help marginalised students manage the stigma responses from peers.
Enlisting respected key members of the local community (eg sports coaches, school counsellors, Aboriginal elders, respected artists / musicians to promote mental health.
Improved data collection and monitoring, to building our understanding of the nature and prevalence of self-harm.