

More smoke and mirrors: Fifteen further reasons to doubt the effectiveness of headspace

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Abstract

Objective: Commentary on the debate concerning the effectiveness of headspace, including the most recent independent evaluation of its services.

Conclusions: The available evaluations indicate that headspace does not deliver therapy of adequate duration that results in clinically significant improvement. Most evaluations have used either short-term process measures or uncontrolled satisfaction surveys, and where there have been data on outcomes using standardised instruments, findings have been disappointing. Costs are poorly quantified and probably underestimated. Even so, headspace as a primary care intervention costs twice as much as a mental health consultation by a general practitioner and, depending on the assumptions, may not be cost effective.

Keywords: Headspace, evaluation, outcome measures, cost effectiveness

Headspace has been central to the federal government's approach to mental healthcare for young people since 2006. In September of 2022, the Medical Journal of Australia (MJA) published a viewpoint by Kisely & Looi¹ questioning the evidence for the continued and expanding funding of headspace, and associated services, given the limited evidence of effectiveness. This highlighted that many of the studies had used either process measures or uncontrolled satisfaction surveys and that where there were data on outcomes using standardised instruments, findings have been disappointing.^{2–5} Limitations included low rates of follow-up, especially up to 90 days, and disappointing levels of clinically significant improvement. These concerns were reinforced by the most recent study published by the MJA in the previous year of 1,510 young people where only 35% had good functional outcomes after 2 years.⁶ This paper also reported concerns about both

the effectiveness of *headspace* services and their integration with other community, private and state government services in reports from both the Productivity and National Mental Health Commission.¹

Headspace's response

Headspace responded with a press release alleging fifteen 'erroneous' or 'misleading' claims within the Kisely & Looi paper. Table 1 presents these along with rebuttals, documenting 15 further reasons to question

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Table 1. Responses to headspace's claims

Alleged "erroneous/misleading claim" (sic)	Alleged "fact"	Response
1. Misrepresentation of information <i>"Of the \$2.3 billion allocated in the 2020–21 federal budget on new mental health expenditure, \$765.8 million was directed to headspace, as well as related services for older age groups in Head to Health centres."</i>	The amount reported (\$765.8M) adds together separate funding for headspace (\$278.6M) and Head to Health (\$487.2M), which are separate services and government initiatives. Head to Health is not a youth mental health initiative. The headspace funding comprises only 8.25% of the \$2.3B	Head-to-health was described as associated, not part of, headspace. It is an adaptation of the model to older age groups with the same problems of limited evaluation and poor integration with other services. It is therefore legitimate to question the value of such expenditure in the same article. These figures also do not take into account Medicare billings and state funding, which are likely to be substantial. There is also additional funding from state governments. For example, last year, headspace received \$20 million from the New South Wales Government (headspace welcomes record \$20m NSW Government investment in youth mental health workforce. https://headspace.org.au/our-organisation/media-releases/headspace-welcomes-record-20m-nsw-government-investment-in-youth-mental-health-workforce/ (accessed 14 Sep 2022). That is just one announcement in 1 year in one state out of 8 jurisdictions
2. Error of omission <i>"This expansion has occurred despite limited evidence of effectiveness, with many studies using either process measures or uncontrolled satisfaction surveys."</i>	No citations are provided for this assertion, which fails to acknowledge the three independent quantitative evaluations commissioned by the Australian Government, ^{2,3} a comparison outcome study with better access, ⁸ two major reports of client outcomes, ^{4,10} and a longitudinal follow-up study ⁹	Kisely and Looi actually cited four of the relevant studies, all of which had issues with low rates of follow-up particularly up to 90 days ^{2–5} This means data on outcomes were restricted to highly selected and possibly unrepresentative groups. Of the other three, one had a follow-up rate of a similarly unrepresentative sample of 7.6%, ⁸ one was an unpublished non-peer-reviewed report from headspace's website (9.2% inclusion rate), ⁹ and the third a non-peer-reviewed pre-print published after the final acceptance the Kisely & Looi paper and three weeks before it appeared. ¹⁰ Concerning the latter, changes in symptoms were only available in 50%, and follow-up in approximately 4% ¹⁰

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (sic)	Alleged “fact”	Response
		Claims to the media that this article showed that more than 70% of 50,000 people surveyed reported improved outcomes are substantially inaccurate according to headspace’s reported data. (https://www.abc.net.au/news/2022-09-13/headspace-mental-health-support-questioned-report/101433630). The 58,233 refers to the number of people at baseline. As described above, there were two or more ratings and thus some measure of change on 26,010, less than half.¹⁰ The non-peer-reviewed pre-print acknowledges that the respective sample sizes declined dramatically with each time point, although by how much it’s impossible to tell as the relevant figures are missing. However, by 90-days follow-up, the study only had 4.08% ($n = 1574$) of eligible young people who responded to the survey¹⁰
3. Misrepresentation of results “A small uncontrolled study from Sep 2012 to Jul 2017 ($n = 77$) did report statistically significant benefits on the K10. However, the proportion of participants in a lower clinical stage of illness at the end of treatment was not statistically significant.”	This is a very small study of a brief intervention conducted by graduate students in a few headspace centres.⁵ Kisely and Looi dig deeply into the results of this paper to find the one non-significant result, failing to report the main findings which show a medium effect sized change, and that significantly more young people scored in the non-clinical range after the intervention	Kisely and Looi acknowledged that there were significant findings in favour of headspace. However, Schley et al.,⁵ authors of the study reported upon, also thought the non-significant finding important enough to highlight it in the text. Notably, follow-up scores were missing in almost 40% of participants (46 out of 123), again raising doubts about the representativeness of the sample.⁵
4. Misleading claim “These findings are reflected in a more recent study of 1510 young people that found only 35% had good functional outcomes after 24 months in the period 2008–2018 (Iorfino et al., 2021)”	This study is not from a headspace client group (and does not claim to be), as clarified in a letter to the editor and accompanying the paper (Rickwood et al., 2022).^{6,11}	The original paper by Iorfino et al. (2021) stated clearly that their study covered headspace attendees. An accompanying editorial by the founding director of headspace published in the same issue of the MJA as the Iorfino paper also supported the view that the study involved headspace attendees.¹⁶ This is a direct quote from the editorial

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (<i>sic</i>)	Alleged “fact”	Response
5. Error “The available evidence is further limited by the relatively small sample sizes, the highest of which was 2222 participants from 2008–09, less than 0.5% of the 700 000 young people seen by headspace since 2006.”	The statement uses a numerator from a 1-year period when there were only 10 headspace centres initially opened (2008–2009) and a denominator from a 16-year period (2006–2021) to derive the very small (and non-sensical) (<i>sic</i>) percentage reported. This statement is also incorrect as there are outcome data publicly reported for 15,496 (Rickwood et al., 2015) and 58,233 (Rickwood et al., 2022) young people. ^{4,10} These studies are of census samples of all young people attending headspace for mental health care in their specified time frames	<i>“The findings reported by Iorfino and colleagues in this issue of the MJA are sobering, and clearly illustrate what else is needed. Over a 2-year period, only 35% of a large sample of 1510 young people aged 12–25 years who visited headspace and linked services at the Brain and Mind Centre in Sydney had good functional outcomes, while nearly two-thirds experienced either persistent functional impairment or deteriorating and volatile functional trajectories”</i> The letter to which headspace refer did not accompany the paper but was published 3 months later.¹¹ The letter does not specify the proportion of the study sample that might not have been headspace attendees. None of the letter writers were authors on the original Iorfino et al. (2021) paper but appear to be either employed, or associated with headspace even though they declared they had no competing interests.¹¹ It is therefore unclear whether Iorfino & colleagues actually agreed with headspace’s assertions about their study Kisely and Looi were making the point that outcome data are only available on a small proportion of total headspace attendees over the years. Kisely and Looi should have been clearer that the 90-days follow-up sample of 3.1% in the paper by Rickwood et al.⁴ (2015), was different from the roughly 8000 (under half of the original relevant sample), of whom 78.9% experienced no clinically significant benefit on two or more K-10 ratings. However, that means even more people were not clinically better. The choice of which sample is more relevant can be debated, but even if the larger figure were added to the proportion of headspace attendees where outcomes were evaluated this would amount to 1.5%

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (sic)	Alleged “fact”	Response
		The 2022 paper of Rickwood et al. ⁴ was a non-peer-reviewed pre-print published that was covered under point #2. As noted previously, the 58,233 participants in this non-peer-reviewed pre-print referred to the number of people at baseline. ¹⁰ There were two or more ratings and thus some measure of change on 26,010, less than half. Only 4% supplied data at 90-days follow-up ¹⁰
6. Misrepresentation of quote “ <i>For instance, in 2014, the National Mental Health Commission noted that the creation of headspace mental health centres was conducted without sufficient consultation, leading to “duplication of, and competition with, other community, private and state government services”.</i> ”	The full reference for this quote is, “While headspace has been enthusiastically received by many communities, there also have been clear indications that problems can arise due to a lack of local planning, along with duplication of, and competition with, other community, private and state government services in some regions.” (National Mental Health Commission, 2014 p.82). Further, this is a 9-year-old report; the National Mental Health Commission (NMHC) publishes a report every year (see https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports)	It is irrelevant whether headspace services were welcome or not – the point the NMHC was making is that there was a lack of local planning, along with duplication of, and competition with, other community, private and state government services in some regions. In addition, the NMHC report was a substantial once-off review of the organisation of mental health services, not an annual report as claimed by headspace. There has been no subsequent review by the NMHC on this topic
7. Misrepresentation of results “ <i>This is despite the fact that conventional headspace centres may be ill-equipped to manage this population as just under 40% of clients have no recorded diagnosis.</i> ”	This percentage seems to come from the following statement, “29 per cent of clients were estimated by clinicians to have full-threshold, remission, or serious and ongoing disorder, yet almost a third of these had no actual clinical diagnosis recorded at presentation, and a further 6.7% were reported as diagnosis not yet assessed” (Rickwood et al., 2018); a misrepresentation of these results	The quoted statement does not come from Rickwood (2018) but from Rickwood (2014), as correctly cited by Kisely & Looi. ¹⁷ The 2014 paper is very unclear regarding what is meant by people with a full-threshold, remission or serious and ongoing disorder who do not have a diagnosis. An alternative data point from the same paper would have been the percentage who had neither a sub- nor full-threshold diagnosis, which was even higher at 54.2%. ¹⁷ These proportions are reflected in the most recent evaluation of headspace where only 35.3% of attendees had a psychiatric diagnosis. ¹⁰ There was a similar proportion after excluding people with only one visit. Although it is possible that the lack of lack of diagnoses could reflect a philosophy of not labelling young people, this would not explain findings that clinically significant changes were only seen in 17% of episodes using the K10 ⁷

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (sic)	Alleged “fact”	Response
8. Error <i>“should return to evidence-based care delivered in public and private settings”</i>	No evidence is provided to support the claim that ‘evidence-based’ care was the previous norm. Headspace was set up to address the well-acknowledged failings of the previous system for youth mental health	This assertion is made without any supporting citation
9. Misrepresentation of evidence <i>“based on existing early episode psychosis services, already linked to headspace and said to have a strong evidence base. However, in comparison with treatment as usual, the advantages of these services are restricted to the initial 2 years with limited evidence beyond that.”</i>	Cites a non-peer-reviewed report ¹³ rather than the 22 peer-reviewed studies of early intervention in psychosis that show strong cost effectiveness (McGorry & Mei, 2020) ¹⁴	This statement is untrue – Kisely & Looi cited a peer-reviewed 15-page systematic review (the most robust form of evidence) in an accepted journal without any obvious conflict of interest. ¹³ By contrast, the cited paper by McGorry & Mei (2020) is a four-page opinion-piece, not a systematic review, with a potentially undeclared conflict of interest ¹⁴
10. Irrelevant comparison <i>“Most information on effectiveness concerns inpatient settings and data from the Australian Institute of Health and Welfare and the Private Psychiatric Hospitals Data Reporting and Analysis Service suggest high effect sizes that easily exceed those of headspace.”</i>	Data on inpatient services are not comparable with headspace, which is community-based primary care and focused on mild-moderate presentations within an early intervention context –very different to an inpatient population	Kisely & Looi acknowledged the limitation that these routine data were largely restricted to inpatients and that a nationwide assessment of Better Access was under way
	The ‘high effect sizes’ noted here come from analysis of all adult inpatients in private psychiatric hospitals using measures that cannot be sensibly compared to headspace clients in any possible way	The suitability of measures is covered under point # 12
11. Misleading inference <i>“At a minimum, headspace services should be situated and funded within state/territory publicly provided mental health services with established systems for clinical governance and subject to a similar level of accountability”</i>	This inference that headspace centres do not have established systems for clinical governance is incorrect. As part of the headspace trademark licencing process, all headspace centres must demonstrate sound clinical governance, which is the responsibility of the lead agency and commissioning PHN. Clinical governance is checked regularly through the headspace Model Integrity Framework and the headspace Trade Mark Licence Deed process	Kisely & Looi referred to the overall governance of mental health services and how headspace fits very poorly into the system. We note that the latest evaluation of headspace, published after the piece by Kisely & Looi, also recommended improvements in clinical governance and the quality control of interventions given that the relative improvement and clinically significant change outcomes were worse than expected ⁷

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (sic)	Alleged “fact”	Response
12. Irrelevant comparator <i>“In particular, the routine use of standardised clinician and patient reported outcome measures, such as the Health of the Nation Outcome Scales, would enable comparisons to existing public and private sector services”</i>	The HoNOS is an inappropriate measure for the headspace client group. The HoNOS is a clinician-rated tool developed by the United Kingdom Royal College of Psychiatrist’s Research Unit to measure change in the health and social functioning of adults experiencing severe mental illness in secondary care mental health services. ¹² headspace includes the K10+ as a mandated outcome measure for PHN-funded mental health services, as well as the SOFAS, and also developed a purpose-built routine outcome measure (MyLifeTracker) for its centre services after undertaking a systematic review of outcome measures for youth mental health and finding few suitable measures. ¹⁰	This statement is untrue. HoNOS was developed to assess a wide range of psychiatric disorders. Importantly, there was a version that was specifically designed for use in children & adolescents, the HONOS-CA. They cited a paper that makes no mention of this. By contrast, MyLifeTracker is a bespoke outcome measure developed by headspace that has not gained widespread acceptance, and the use of which seems largely restricted to headspace centres. Use of clinician-completed measures such as HoNOS and HoNOS-CA would facilitate comparison with other health services’ outcomes, as well as address the issue of asking young people to complete outcome measures
13. Irrelevant comparator and error of omission <i>“In addition to the integration of existing centres into mainstream mental health services, alternatives to headspace include the diversion of proposed future funding to public sector mental health services where there is better evidence for improved outcomes, or to private psychological and psychiatric services through the Better Access program.”</i>	No evidence or citations are provided to support claims made in relation to the effectiveness of community-based public mental health services for young people. The reference given here is to the Australian Government’s website, which lists its initiatives. Furthermore, a comparative study of young people accessing headspace and Better Access [that] showed comparable outcomes is not cited ⁸	See response to point # 10. Kisely & Looi acknowledged that the nationwide assessment of Better Access was under way & had not been completed. It should be highlighted that the paper by Bassilios et al., ⁸ 2017 had an unrepresentative follow-up rate of 7.6%
14. Irrelevant comparator and error of omission <i>“In 2019–2020, baseline psychiatric symptoms for new outpatient referrals as measured by the Health of the Nation Outcome Scales were 11.1 (standard deviation, 6.2) for 15–24-years-olds compared with 7.4 (standard deviation, 5.8) at discharge to no further care.²¹ This approximates an effect size of 0.62, which represents a change of medium magnitude”</i>	Again, the HoNOS is not an appropriate outcome measure for the headspace client service group; they do not have severe mental illness. Further, it is expected that those with more severe scores on outcome measures demonstrate greater change. For example, a meta-analysis of depression treatment reported posttreatment effect sizes were much greater for high-severity patients ($d = 0.63$) than for low-severity patients ($d = 0.22$)	See answer to point 12 on HoNOS. It is unclear how the high-severity patients & low-severity patients in the cited paper relate to headspace attendees. It is also possible that headspace is conceding that an explanation for their disappointing findings in comparison to other psychiatric services is that the majority of attendees have neither a sub- nor full-threshold diagnosis (see point # 7)

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Table 1. (Continued)

Alleged “erroneous/misleading claim” (sic)	Alleged “fact”	Response
15. Error of omission <i>“It is time for a national discussion about youth mental health in the context of declining mental health outcomes in young people, rather than doing the same thing repeatedly and expecting different results.”</i>	There is robust ongoing national discussion of youth mental health in Australia and has been for some time. Australia is acknowledged as a global leader in youth mental health research and treatment development (see https://www.internationalaffairs.org.au/australianoutlook/australia-must-take-the-lead-in-global-youth-mental-health/). Headspace, itself, provides a platform for national discussion and this is a major part of its remit. Australia also has many more major initiatives all focused on understanding and improving youth mental health and providing platforms for discussion (eg, ReachOut, Orygen Youth Health, Youth Beyondblue, BlackDog). The International Association of Youth Mental Health was set up and is auspiced from Australia to facilitate discussion around youth mental health, internationally. Its 6th biennial conference commences Sep 29th this year	The fora described are restricted to like-minded individuals. Discussion within headspace and similar related programmes on their need for greater funding is not a debate about how best to deliver youth mental health services

the effectiveness of headspace. Broadly, Kisely & Looi were accused of inflating the costs of direct federal grants to headspace by also including related ‘head-to-health’ centres. However, as outlined in Table 1, head-to-health centres were described as associated, not part of, headspace, but are a model adaptation to older people, with the same problems of limited evaluation and poor integration with other services. It is therefore legitimate to question the value of such expenditure in the same article. Furthermore, direct federal grants only accounted for 43% of headspace funding in 2019–2020, and do not include Medicare billings and state/territory funding.⁷

The second broad criticism was that Kisely and Looi failed to cite all the available literature on the effectiveness of headspace. However, the paper actually cited four of these, all of which had issues with low rates of follow-up as noted above.^{2–5} This meant data on outcomes were restricted to highly selected and probably unrepresentative groups. Of the other three, one paper had a follow-up rate of a similarly unrepresentative sample of 7.6%,⁸ one was an unpublished non-peer-reviewed report from headspace’s website (9.2% inclusion rate),⁹ and the third a non-peer-reviewed pre-print.¹⁰ Concerning the latter, changes in symptoms were only available in 50% of the total sample of 58,223 (Table 3 in the pre-print), and 4.08% ($n = 1,574$) at 90-days follow-up. There was also reliance on a composite measure that had not been pre-specified.¹⁰ Other

objections included the most appropriate instrument to measure outcomes or choice of systematic review, as well as the applicability of the findings of one study to headspace (Table 1).^{6, 11–17} The final issue was the use of scarce resources for people without a clinically significant illness (Table 1). In the largest survey of headspace attendees to date ($n = 58,233$), only 35.3% had a psychiatric diagnosis (See point 7 in Table 1).¹⁰

Findings from the latest evaluation of headspace

Subsequent to the Kisely & Looi paper, the most recent headspace evaluation reported Australia-wide data from 1 July 2015 to 30 June 2020.⁷ As previously, most benefits were restricted to process measures, while outcomes were less favourable. Although there were some psychosocial improvements, the majority of attendees did not report clinically significant changes on standardised measures such as the Kessler-10 (K-10), Social and Occupational Functioning Assessment Scale (SOFAS) or MyLifeTracker (MLT). Reliable changes in scores were only observed in 16, 23 and 25% of episodes using the K10, SOFAS and MLT outcome measures, respectively, while clinically significant changes were seen in 17, 44 and 31% of episodes using the same measures. In this regard, K-10 is the most important clinical indicator given that the MLT is a bespoke measure developed by headspace, the use of

which appears restricted to the service. Crucially, data on sustained outcomes at 90-days follow-up were only available on 4.6% (p 310).⁷

Another area of concern was cost.⁷ Although described as primary care, the average cost of a headspace consultation (AUD\$230) was double a typical mental health consultation with a general practitioner. (p20). Although this was slightly lower than the Australian Psychological Society's recommended fee for a 46-to-60-min session of \$260, only 50% of headspace service providers are psychologists (p62). Apart from the 8% who are doctors, most other providers would likely cost less than a psychologist raising doubts on value for money. Furthermore, the average cost per finished episodes of care was much higher at \$842 (p 334).

The headline incremental cost-effectiveness ratio (ICER) for headspace services was AUD\$44,722 per quality-adjusted life-year (QALY), which was quoted as lower than the cost-effectiveness threshold used to assess similar healthcare services (AUD\$50,000).⁷ However, the report also conceded that it was impossible to ascertain the full costs of headspace services as there was no consistent collection of Medical Benefits Scheme (MBS) billings or other indirect and in-kind costs (p15). Consequently, the full cost of headspace activity could well have been underestimated. (p337). Adding estimates of these costs increased the ICER to AUD\$54,693 per QALY gained, which is above the AUD\$50,000 cost-effectiveness threshold. Similarly, the headline ICER analysis assumed that three occasions of service (OOS) represented minimally adequate treatment (MAT). However, as the report concedes, this assumption favours headspace given findings that a minimum of four sessions is effective and considered adequate.⁷ This results in a considerably higher ICER of \$56,894 (p122).

Another limitation of the ICER in the report is the use of an algorithm to convert the K10 scores into a Quality of Life (QoL) measure - the Assessment of Quality of Life – Eight Dimension Scale (AQoL-8D).⁷ Ideally, the calculation of a QALY measure should be based directly on a multi-attribute utility instrument (MAUI) that includes measures of physical health, pain or social functioning. The use of algorithms to indirectly derive QoL scores from disease-specific measures such as the K-10 is therefore less preferable.¹⁵

In the light of these many issues, the report recommends improvements in clinical governance and the quality control of interventions given that the relative improvement and clinically significant change in outcomes were worse than expected. It also recommended improved data on funding, costs and long-term outcomes. Since 36% of care episodes were restricted to single visit, it recommended further investigation to better understand whether care episode closures were planned or unplanned. It also highlighted the need to better serve hard-to-reach groups. As in the Kisely & Looi paper, the report recommends greater integration with other services.^{1,7}

Discussion/Conclusions

This article's scope is largely limited to published evaluations on a limited range of outcomes and costs, commissioned by the Australian federal government or conducted by headspace, not independent randomised controlled trials. These findings lack information on preventative effects, satisfaction levels and benefits in service access, referral or for particular subgroups. Outcomes might also vary by age, stage of illness, diagnosis and social settings. Future studies should therefore include linked data sets to evaluate different cohorts across services and clinical pathways. Finally, headspace's real-world data will show smaller effect sizes than experimental studies. However, equally, studies without controls may overestimate effects.

Given concerns about the limited resources to meet the increasing need for psychiatric care, services should focus on people with clinically significant symptoms, deliver appropriate therapy of adequate duration, and result in sustained improvements in mental health that are clinically, as well as statistically, significant. There should also be adequate follow-up so that results are generalisable. Evaluations of headspace have failed on all five of these key performance indicators. Concerns about effectiveness, integration with other services and value for money cannot be ignored.

Declaration of Conflicting Interests

Two current authors (SK and JL) wrote a key referenced paper that has formed part of the debate. The other authors declare that there is no conflict of interest.

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