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Young people's participation in their own mental health care: Session-by-session feedback in youth mental health services (headspace)

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Abstract

Aim: Young people's participation in their own mental healthcare requires ways for them to provide feedback to their clinicians on how they are experiencing their treatment. Key dimensions of session experience are willingness to attend, feeling listened to and understood, working on issues important to them, feeling hopeful for the future and feeling that things are improving in their lives. This study reports on young people's session experiences over time and by key demographics for headspace youth mental health services.

Methods: The sample comprised 16 484 young people aged 12–25 years who commenced an episode of care at one of the 150 headspace centres between 1 July 2021 and 30 June 2022 and who had attended at least two services. Data were collected via the routinely collected headspace minimum data set.

Results: Overall, young people reported very positive session experiences over all the session dimensions. Few demographic differences were found: session ratings were more positive for young adults (18+ years) compared with adolescents (under 18 years). Scores on all five dimensions improved with more visits, and willingness to attend and working on issues important to the young person were strong predictors of service engagement. Better session experience scores were associated with more positive ratings of quality of life.

Conclusions: Young people experience their headspace sessions very positively, and more positive experiences are associated with better service engagement and quality of life. Routinely collecting session feedback gives young people a valuable way to participate in and inform their own care.

KEYWORDS
adolescent, mental health services, patient engagement, patient reported outcome measures, young adult

1 | INTRODUCTION

An international movement to design and implement integrated youth mental healthcare services tailored to the needs of adolescents and young adults has occurred in response to the high and growing need for more effective mental healthcare for youth (McGorry et al., 2022). These services aim to redress the many barriers to access and the traditional reluctance of young people to seek help from the mental healthcare system. Countries such as Australia, Ireland, Canada, Israel, Norway, New Zealand and a growing number of others have invested in reorienting their mental health service system to focus specifically on the needs of young people aged 12–25 years to attempt to reduce their high burden of disease from mental health problems (Hetrick et al., 2017).

headspace is Australia's National Youth Mental Health Foundation, founded in 2006 and funded by the Australian Government (McGorry, Purcell et al., 2007; McGorry, Tanti et al., 2007). headspace is the largest national network of youth mental healthcare services worldwide, currently with over 154 centre-based services across Australia and a suite of other programmes, including digital services (headspace National, 2023a). The foundation of the headspace system is the headspace centre, which is a primary care, community-based, integrated service hub providing highly accessible, youth-friendly services that deliver evidence-based interventions to young people to support their holistic mental health needs (Rickwood et al., 2019). Since establishment, the headspace national network of centres and online programmes has supported more than 865 000 young Australians, providing 6.7 million services to help them to manage their mental health (headspace National, 2023b). The headspace centre model has been shown to be cost-effective through independent evaluation (KPMG, 2022), and internal evaluations reveal that 86% of centre clients report being satisfied with headspace and 71% achieve improvements in either psychological distress, social and occupational functioning, or quality of life (Rickwood, Albrecht et al., 2023; Rickwood, McEachran et al., 2023).

Like other youth mental healthcare services internationally, headspace prioritises young people's voices and experiences (McGorry et al., 2022). The first principle of the headspace model is youth participation, which occurs at three levels: (1) in young people's own care, (2) in young people's input to their headspace centre's service development and (3) in young people's involvement in the broader headspace initiative at the national governance level (Rickwood et al., 2019).

At the national governance level, youth participation occurs in two main ways. The first is through the headspace Youth National Reference Group (hYNRG), which is made up of young people from diverse backgrounds and from each jurisdiction across Australia. hYNRG plays a crucial role in ensuring that headspace initiatives will make a positive difference in the lives of young people and that the resources headspace receives from government and corporate partners are used optimally. The second form of youth participation at the national governance level is via Youth and Family Advisors to the headspace National Executive team and two Youth Advisors who

sit on the headspace National Board. These young people are active board members who bring the youth voice and contribute to the strategic leadership of the organisation.

At the headspace centre level, youth participation also occurs in two main ways. First, each centre is expected to have an active Youth Reference Group (YRG) to provide opportunities for young people to have a voice within the operation, evaluation and development of the headspace centre service. Second, and more critical, is young people's participation in their own mental healthcare. It is essential that young people are enabled to provide feedback on their service experiences, to be able to check in regarding engagement and whether they are achieving outcomes that are meaningful to them. To understand and improve young people's experience and outcomes, headspace has implemented a comprehensive routine data capture and outcome measurement system for all young people at every visit to obtain session-by-session feedback about their service experience and how their mental health and wellbeing is changing (Rickwood et al., 2014).

headspace uses three main measures to determine the impact of its services on client outcomes. These include: the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002)—a self-reported measure of psychological distress that is mandated for collection by the Australian Government as the headspace service funders; the Social and Occupational Functioning Assessment Scale (SOFAS) (Goldman et al., 1992)—a clinician rating of current functioning; and MyLifeTracker (MLT) (Kwan et al., 2018)—a brief self-reported quality of life measure used to support measurement-informed treatment. MLT was developed specifically for youth mental health services, co-designed with young people to ensure it measured outcomes that were meaningful to them.

The need for youth-specific and youth-designed measures for youth mental health services is now well-recognised (Cotton et al., 2023; Ding et al., 2023). Along with youth-specific outcome measures, there is also need for youth-specific session experience measures. Yet, similar to outcome measures, there are few youth-specific measures currently available despite routine monitoring of individual session experience, along with outcomes, being critical for measurement-based care (Prescott et al., 2017). Such measurement can improve engagement, retention and client experience, as well as clinical outcomes (Chiauzzi, 2021). Real-time feedback from young people about their session is essential to young people participating in their own care. It provides a way for clinicians to be aware of how the young person is experiencing their care on key dimensions. This then enables clinicians to adapt their approach, if needed, to better target the services they provide to support the young person's engagement in treatment and the outcomes they achieve. Such routine monitoring is empowering for clients, supports shared decision-making, is helpful for collaboration and provides valuable information for service evaluation (Jacob & Edbrooke-Childs, 2022).

To enable such routine feedback within its youth mental healthcare services, headspace co-designed, with young people and service provider input, a session-by-session experience measure—My youth mental health Session Experience (MySE) (Rickwood, Albrecht et al., 2023; Rickwood, McEachran et al., 2023). This measure was

implemented in all headspace centres in July 2019. It is routinely measured at the beginning of each service session, asking young people to reflect on their last session. The responses are made immediately available electronically to clinicians so they can be used to inform, adapt and improve the service that the young person receives.

1.1 | The current study

The aim of this study was to describe young people's session-by-session experiences at headspace youth mental health services and examine how these varied over time and for different demographic groups. We were interested in how willing young people were to attend, whether they felt listened to and understood, whether they were working on issues important to them, and whether they felt hopeful and that things were improving in their lives. We anticipated improvements over time in each of these areas and expected more positive session experiences to be associated with continuing engagement with the service. We also explored whether session-by-session experiences varied across key headspace priority demographic groups (i.e., by age, gender, First Nations, LGBTIQA+, rurality).

2 | METHODS

2.1 | Participants

Data came from all young people who commenced an episode of care for any type of presentation at a headspace centre service between 1 July 2021 and 30 June 2022 ($n = 64\,484$) and who attended at least two visits and had a valid MySE measurement at visit 2, which comprised 16 484 young people. Amongst them, 29.8% were in early adolescence (12–14 years), 30.9% in mid-adolescence (15–17 years), 24.7% in late adolescence (18–21 years) and 14.6% were young adults (22–25 years). The majority were female (65.2%), 30.1% were male and 4.7% were gender diverse. Geographically, 50.1% were from metropolitan areas, 31.3% from inner regional areas, 14.9% from outer regional areas and 3.8% from remote areas across Australia. First Nations young people comprised 8.2% of the participants, 9.7% had culturally and linguistically diverse backgrounds and 28.6% identified as LGBTIQA+.

The main reasons for seeking help at headspace were related to mental health and behaviour issues, accounting for 80.9% of presentations. Situational issues were reported by 13.9% and 5.2% presented with a variety of other problems. The most common primary presenting issues were anxiety (38.4%) and depressive symptoms (23.0%). Other primary reasons for seeking help included stress-related issues (5.2%), anger problems (4.3%), difficulties with personal relationships (3.3%), conflict in the home environment (3.0%), suicidal thoughts or behaviour (2.6%), trauma (2.1%) and other situational stressors or mental health symptoms (less than 2% each). Over 85% (86.6%) of young people received a stage-of-illness assessment (McGorry, Purcell et al., 2007; McGorry, Tanti et al., 2007) on

presentation, with 3.5% being Stage 0 with no symptoms of mental disorder, 48.3% being Stage 1a with mild to moderate general symptoms, 25.1% being Stage 1b with a sub-threshold diagnosis, 14.2% reaching a Stage 2 threshold diagnosis, 2.9% being Stage 3 with periods of remission, and 6.1% being Stage 4 with ongoing severe symptoms. The data encompass a total of 16 747 episodes of care, with 63.1% of participants receiving their first episode of care at headspace, and 24.4% being in their second episode (the remainder was in their third or later episode). Each episode consisted of individual occasions of service (visits). The majority of episodes comprised seven or fewer visits (two visits: 20.0%; three visits: 19.0%; four visits: 14.3%; five visits: 11.0%; six visits: 8.7%; seven visits: 7.5%); 8.1% of episodes extended to more than 10 visits.

2.2 | Procedure

When young people visit a headspace centre, they are given access to an electronic tablet or a desktop computer to answer a series of questions. They provide consent for the collection and use of their data primarily for the purpose of service provision and outcome monitoring, but also for service-related evaluation and research purposes.

The specific questions presented vary depending on the visit. For the initial visit in each episode of care, a comprehensive questionnaire is administered, encompassing demographic information, background details, and a question about their willingness to be at headspace, which constitutes the first item of MySE. Baseline information for outcome measures related to psychological distress and quality of life is also gathered during this first visit. Subsequent visits involve the completion of all five items of MySE as well as outcome measures. In addition to the young people's responses, service providers contribute to the data collection by providing information about each occasion of service.

The data collection process received ethics approval through the headspace Board Research subcommittee. An independent body, the Australasian Human Research Ethics Consultancy Services, also reviewed and endorsed the consent procedures. The primary purpose of data collection is to enhance service provision and inform quality improvement. Parental consent is not a standard requirement for those under 18 years unless explicitly indicated, provided they are assessed as mature minors. Young people also have the choice to opt-out of data collection.

2.3 | Measures

Session experience was measured by 'My youth mental health Session Experience' (MySE) (Rickwood, Albrecht et al., 2023; Rickwood, McEachran et al., 2023). This comprises five items tapping different but related dimensions of care designed to be used every session to determine whether the young person felt: willing to be there (Willingness), listened to and understood (Understood), that they are working on issues important to them (Importance), hopeful for the

future (Hopefulness) and that things are improving in their lives (Improving). Items are rated on a 1–10 scale using a slider anchored by a sad emoji to a happy emoji. Item 1 is asked at each visit and the other four items are asked from the second visit onwards. The average of the five items is calculated as a summary measure of service session experience, and ranges from 1 to 10 with higher scores indicating more positive experience. Both the total and individual item scores are graphically displayed for clinicians. The measure showed strong internal consistency ($\alpha = 0.900$).

Client outcomes for this study were measured using MLT (Kwan et al., 2018), which is a self-report quality of life measure comprising five items designed specifically for youth mental health services. The MLT items ask about essential aspects of young people's lives, including their overall wellbeing, daily activities, relationships with family and with friends, and ability to cope with life during the past week. Responses are via a slider scale ranging from 0 to 100. A total average score is calculated, with higher scores indicating better quality of life. The measure showed strong internal consistency ($\alpha = 0.849$).

The demographic characteristics assessed in the study included gender (female, male, gender diverse), age group (early-, mid-, late-adolescence, and early adulthood), First Nations background, cultural and linguistic background (CALD), LGBTIQA+ identity and rurality (major city, inner regional, outer regional, remote).

2.4 | Data analysis

Descriptive statistics were derived for MySE for different demographics at initial service and across time (visits). Linear regression analyses explored the relationships between MySE items individually and jointly with demographic characteristics and client outcomes. These analyses used available data from all visits while controlling for the visit number as fixed effects. Dependency in the data by young person was accounted for by clustering standard errors at the young-person level. The length of stay in headspace centre services was examined through a survival analysis, drawing on non-parametric Kaplan–Meier survival estimates and the parametric discrete time proportional hazard model to characterise how session experience relates to the length of stay.

Analyses were conducted using Stata Version 18. To facilitate interpretation and cross-comparison, regression coefficients were reported on standardised variables for continuous variables. For in-text reporting a threshold statistical significance of $p < .001$ and $d > 0.1$ and $\beta > 0.1$ was applied to exclude trivial effects.

3 | RESULTS

Descriptive statistics for the MySE summary measure and the quality of life measure MLT after the first occasion of service (measured at the beginning of the second visit in an episode of care) for different demographic characteristics are provided in Table 1. All subgroups report an overall positive initial session experience (between 7 and

8 on the 10-point scale), but older age groups have a more positive experience than younger age groups ($\eta_p^2 = 0.036$, $p < .001$). There is a very small, but significant, difference between gender groups with gender diverse young people reporting slightly less positive session experience ($\eta_p^2 = 0.001$, $p < .001$). First Nations status, CALD background and LGBTIQA+ identity are not associated with initial session experience, although young people in remote locations report slightly better initial session experience ($\eta_p^2 = 0.001$, $p = .002$). In terms of quality of life, the youngest age group, males, non-LGBTIQA+ young people, and those in remote locations provide more positive ratings than their respective counterparts ($p < .001$). Young people with no symptoms of mental disorder (Stage 0) report a higher session experience ($\eta_p^2 = 0.004$, $p < .001$) and quality of life ($\eta_p^2 = 0.020$, $p < .001$) than those in later stages or with missing stage-of-illness data (with the exception of those in Stage 3 with periods of remission, who also report highly on their session experience). Although significant, the effects are weak.

Figure 1 plots average MySE scores by visit, separately for adolescents (12–17 years) and young adults (18–25 years) who received 10 or more occasions of service (to rule out a possible selection effect from a changing sample over time). This demonstrates that all dimensions of session experience increase with a higher numbers of visits, and that adolescents rate session experience lower than young adults for all dimensions and across visits. The change in ratings over time, however, is similar between the age groups. The difference between age groups is largest for Willingness and smallest for Understood. Overall, while all ratings improve over time, feeling that things are Improving shows the steepest increase.

Table 2 shows how different demographic groups experience their sessions at headspace across their entire episode of care, derived from linear regressions using all available data (from visits 1 to 10). Willingness is slightly lower for males than for females (by 0.136 of a standard deviation), but other service dimensions are largely comparable. In contrast, gender diverse young people have a similar willingness to be at the service but feel somewhat less positive about other service dimensions than females. Older age groups are substantially more willing to be at headspace (by up to 0.656 of a standard deviation for young adults aged 22–25 compared with young adolescents aged 12–14) and report higher scores on each of the MySE dimensions compared with younger age groups. In terms of feeling listened to and understood, feeling that they are working on issues that are important to them, feeling that things are improving and being hopeful for the future, young people, 18 years and over, report a better session experience than those aged under 18 years. There are neither regional differences in session experience, nor consistent significant differences for harder-to-reach service groups including First Nations and CALD young people. First Nations young people rate working on issues important to them, feeling that things are improving and hopefulness slightly more positively than non-indigenous young people (between 0.083 and 0.100 of a standard deviation) and do not differ in willingness, feeling listened to and understood, and in the overall measure. LGBTIQA+ young people rate feeling understood, working on issues important to them, feeling that things are improving and

TABLE 1 Summary statistics of measures at initial service.

	MySE		MLT	
	Mean	SD	Mean	SD
Full sample (n = 16 747)	7.42	1.75	53.89	20.70
By age group				
12–14 (n = 4984)	7.09	1.86	57.63	20.94
15–17 (n = 5196)	7.25	1.73	52.91	20.33
18–21 (n = 4134)	7.76	1.58	51.45	20.22
22–25 (n = 2425)	7.89	1.58	52.32	20.67
	$\eta_p^2 = 0.036, p < .001$		$\eta_p^2 = 0.011, p < .001$	
By gender group				
Female (n = 10 880)	7.44	1.74	52.25	20.23
Male (n = 4999)	7.41	1.75	58.41	21.08
Gender Diverse (n = 787)	7.20	1.72	46.26	18.68
	$\eta_p^2 = 0.001, p < .001$		$\eta_p^2 = 0.014, p < .001$	
By First Nations status				
Is Not Indigenous (n = 15 295)	7.42	1.74	53.82	20.54
Is Indigenous (n = 1358)	7.51	1.79	53.72	22.20
	$\eta_p^2 = 0.000, p = .098$		$\eta_p^2 = 0.000, p = .045$	
By CALD background				
Is Not CALD (n = 15 022)	7.42	1.75	53.84	20.65
Is CALD (n = 1615)	7.47	1.68	53.45	20.94
	$\eta_p^2 = 0.000, p = .846$		$\eta_p^2 = 0.000, p = .526$	
By LGBTIQA+ identity				
Is Not LGBTIQA+ (n = 10 637)	7.47	1.75	55.74	20.82
Is LGBTIQA+ (n = 4257)	7.39	1.68	48.71	19.18
	$\eta_p^2 = 0.000, p = 142$		$\eta_p^2 = 0.010, p < .001$	
By rurality of young person				
Major Cities (n = 8365)	7.41	1.72	53.34	20.17
Inner Regional (n = 5252)	7.38	1.77	53.9	20.95
Outer Regional (n = 2487)	7.48	1.76	54.59	21.29
Remote (n = 636)	7.71	1.79	58.11	22.34
	$\eta_p^2 = 0.001, p = .002$		$\eta_p^2 = 0.002, p < .001$	
By stage of illness at presentation				
Not applicable/missing (n = 2466)	7.53	1.76	55.24	20.77
Stage 0 No symptoms of mental disorder (n = 493)	7.69	1.80	63.98	22.17
Stage 1a Mild to moderate general symptoms (n = 6895)	7.43	1.71	56.31	20.26
Stage 1b Sub-threshold diagnosis (n = 3584)	7.34	1.76	51.62	19.85
Stage 2 Threshold diagnosis (n = 2029)	7.37	1.78	49.79	20.67
Stage 3 Periods of remission (n = 415)	7.76	1.64	51.45	20.68
Stage 4 Ongoing severe symptoms (n = 865)	7.22	1.80	45.18	20.77
	$\eta_p^2 = 0.004, p < .001$		$\eta_p^2 = 0.020, p < .001$	

Note: Sample sizes for MLT differ slightly from the stated numbers due to individual missing responses. The table reports means and standard deviations, as well as partial eta-squared and statistical significance from a factorial ANOVA model.

Abbreviations: CALD, cultural and linguistic background; MLT, MyLifeTracker; MySE, My youth mental health Session Experience.
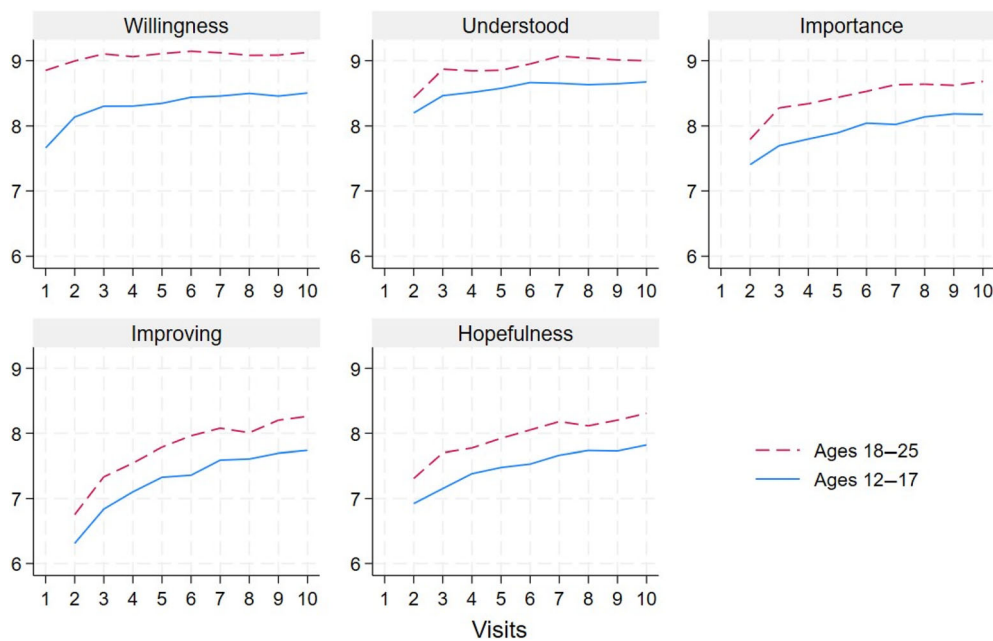
FIGURE 1 Averages of MySE dimensions across visits by age group.

hopefulness slightly more negatively (between 0.056 and 0.111 of a standard deviation), even though they are more willing to attend the service (by 0.080 of a standard deviation).

Compared with the largest group of headspace clients (young people with mild to moderate general symptoms (Stage 1a)), those with no symptoms of mental disorder (Stage 0) rate feeling hopeful and that things are improving higher (by up to 0.182 of a standard deviation). Those who reached the threshold of mental illness (Stage 2) report a 0.120 standard deviation lower session experience overall, which is particularly driven by hopefulness and feeling that things are improving. For those with ongoing severe symptoms (Stage 4), this pattern is somewhat stronger (with effect sizes ranging from −0.166 to −0.254 of a standard deviation). These differences by severity of illness are expected in self-report scales and relatively minor in size.

Overall, with increasing visit numbers, all MySE measures improve. The most notable increase is seen in feeling that things are improving: from visit four onwards, young people rate that things are improving more than 0.4 standard deviations higher than when they started their service journey. Robustness checks on a subsample of young people with at least seven visits, show that this is not due to a selection effect (not reported in Table 2).

The relationship between MySE (total score and individual dimensions) and quality of life as measured by MLT (at each occasion of service and as an outcome [i.e., change]) are shown in Table 3. In regressions controlling for demographic characteristics and visit as fixed effects, there was a sizeable association between the MySE total score and MLT: a one standard deviation increase in session experience (relating to the previous visit) is associated with a 0.455 standard deviation increase in (current) quality of life (column 1). Session experience is also positively, but less strongly, associated with positive change in quality of life since the previous session (column 2). Individually, the MySE dimensions Improving and Hopefulness are most

strongly correlated with MLT: a one standard deviation increase on these measures is associated with a 0.332 and 0.245 standard deviation increase in quality of life, respectively. Other MySE dimensions are more weakly associated with MLT (column 3). Feeling that things are improving is the most strongly associated with a positive change in quality of life (column 4).

3.1 | Survival analysis

The survival analysis shows to what extent individual dimensions of session experience are related to length of stay in the youth mental health service. Willingness is a key dimension of session experience that captures new information and is somewhat distinct from other dimensions (Rickwood, Albrecht et al., 2023; Rickwood, McEachran et al., 2023). A one-point higher willingness score at the first visit is associated with a 4.5% increase in the likelihood of returning for subsequent visit(s) (result of logistic regression, not reported in table[i]). This difference also appears in the main sample: comparing those who are above-median for Willingness at presentation (rating Willingness between 9 and 10 in at least one of the first two visits) with those with below-median willingness at presentation (rating Willingness between 1 and 8) in a non-parametric survival analysis (Figure 2), the first group's survival rate (i.e., the cumulative probability of remaining in the service) is consistently higher than that of the second group. Between visits 3 and 6, the gap in 'survival' is largest between these groups. Overall, the difference between these two groups is highly significant ($p < .001$, log-rank test).

Table 4 presents the results of a multivariate parametric survival analysis. We compare estimates from discrete time proportional hazards models with only the MySE total score (column 1) or individual MySE dimensions (column 3) as predictor variables of service exit to

TABLE 2 Linear regression showing standardised coefficients (and standard errors) of demographic characteristics on individual MySE dimensions.

	Willingness (SD)	Understood (SD)	Importance (SD)	Improving (SD)	Hopefulness (SD)	MySE (SD)
Baseline: Female						
Male	−0.136***	−0.085***	−0.087***	0.011	−0.075***	−0.082***
	(0.016)	(0.018)	(0.018)	(0.018)	(0.019)	(0.019)
Gender diverse	−0.088*	−0.168***	−0.144***	−0.100*	−0.162***	−0.149***
	(0.036)	(0.040)	(0.040)	(0.039)	(0.042)	(0.042)
Baseline: 12–14 years old						
15–17	0.245***	0.070**	0.102***	0.043*	0.061**	0.117***
	(0.020)	(0.021)	(0.022)	(0.021)	(0.022)	(0.023)
18–20	0.526***	0.214***	0.312***	0.233***	0.273***	0.356***
	(0.021)	(0.024)	(0.024)	(0.024)	(0.025)	(0.025)
21–25	0.656***	0.297***	0.410***	0.334***	0.361***	0.475***
	(0.020)	(0.022)	(0.023)	(0.023)	(0.024)	(0.024)
Baseline: Metropolitan						
Inner regional	−0.057***	−0.038*	−0.030	0.009	−0.013	−0.030
	(0.016)	(0.019)	(0.019)	(0.018)	(0.019)	(0.020)
Outer regional	−0.068**	−0.036	−0.035	0.013	0.002	−0.025
	(0.021)	(0.024)	(0.024)	(0.024)	(0.024)	(0.025)
Remote	0.018	−0.009	0.014	0.054	−0.027	0.014
	(0.037)	(0.042)	(0.042)	(0.043)	(0.045)	(0.045)
Baseline: Is not Indigenous						
Is indigenous	0.033	0.044	0.099***	0.083**	0.100***	0.078*
	(0.027)	(0.029)	(0.029)	(0.029)	(0.029)	(0.030)
Baseline: Is not LGBTIQA+						
Is LGBTIQA+	0.080***	−0.066***	−0.056**	−0.100***	−0.111***	−0.066***
	(0.016)	(0.019)	(0.019)	(0.019)	(0.020)	(0.020)
Baseline: Is not CALD						
Is CALD	−0.056*	−0.056*	−0.033	−0.011	0.010	−0.034
	(0.023)	(0.028)	(0.027)	(0.026)	(0.028)	(0.029)
Baseline: Stage 1a Mild to moderate general symptoms						
Not applicable/missing	0.019	−0.007	0.022	0.029	−0.008	0.007
	(0.021)	(0.024)	(0.024)	(0.025)	(0.026)	(0.026)
Stage 0 No symptoms of mental disorder	0.029	0.065	0.121*	0.175***	0.182***	0.132**
	(0.043)	(0.048)	(0.049)	(0.046)	(0.048)	(0.051)
Stage 1b Sub-threshold diagnosis	−0.036	−0.032	−0.048*	−0.063**	−0.071**	−0.061**
	(0.018)	(0.021)	(0.021)	(0.021)	(0.022)	(0.022)
Stage 2 Threshold diagnosis	−0.071**	−0.082**	−0.084**	−0.116***	−0.134***	−0.120***
	(0.024)	(0.027)	(0.027)	(0.026)	(0.027)	(0.028)
Stage 3 Periods of remission	−0.027	−0.009	−0.023	0.041	−0.068	−0.017
	(0.040)	(0.046)	(0.048)	(0.051)	(0.055)	(0.050)
Stage 4 Ongoing severe symptoms	−0.166***	−0.204***	−0.191***	−0.190***	−0.254***	−0.243***
	(0.034)	(0.040)	(0.040)	(0.039)	(0.041)	(0.042)
Adj. *R*-squared	0.087	0.034	0.054	0.076	0.049	0.070
N (Visits)	53 971	41 954	41 952	43 069	41 951	43 078
Episodes	14 876	14 582	14 582	14 873	14 581	14 877
Young people	14 643	14 355	14 355	14 640	14 354	14 644

Note: SD: variable has been standardised.

Abbreviations: CALD, cultural and linguistic background; MySE, My youth mental health Session Experience.

***p < .001.**p < .01.*p < .05.

**TABLE 3** Linear regression showing standardised coefficients (and standard errors) of individual MySE dimensions on client outcomes measure MLT.

	MLT (SD)	MLT change (SD)	MLT (SD)	MLT change (SD)
MySE (SD)	0.455***	0.150***		
	(0.007)	(0.005)		
Willingness (SD)			−0.060***	−0.015
			(0.009)	(0.008)
Understood (SD)			0.029***	−0.000
			(0.009)	(0.008)
Importance (SD)			−0.036***	−0.062***
			(0.009)	(0.010)
Improving (SD)			0.332***	0.197***
			(0.009)	(0.010)
Hopefulness (SD)			0.245***	0.050***
			(0.009)	(0.010)
Adj. *R*-squared	0.246	0.028	0.301	0.041
N (Visits)	42 345	35 937	41 936	35 845
Episodes	14 780	13 049	14 577	13 005
Young people	14 549	12 851	14 350	12 808

Note: SD: Variable has been standardised.
Abbreviations: MLT, MyLifeTracker; MySE, My youth mental health Session Experience.
***$p < .001$.
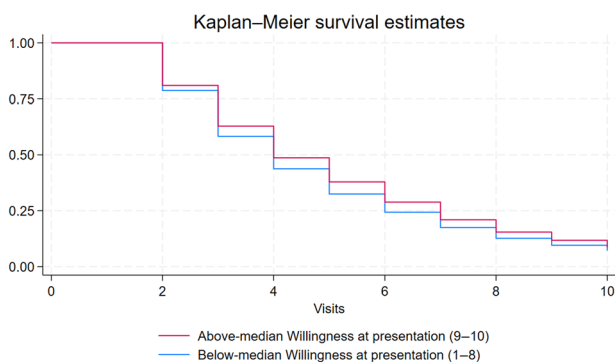
FIGURE 2 Kaplan–Meier survival estimates by Willingness at initial presentation. The sample at presentation (considered as visits 1 and 2) is split by the median willingness to be at the youth mental health service. Those with above-median willingness reported Willingness between 9 and 10 at presentation (average Willingness = 9.3) and are represented in the red line. Those with below-median willingness at presentation (average Willingness = 6.1) are represented in the blue line.

gauge the importance of session experience for continuing visits. In columns 2 and 4, we additionally control for MLT ratings. Coefficients are reported as hazard ratios on unstandardised variables. The results show a one-point increase in overall session experience is associated with a 4.2% reduction in the likelihood of exiting the service (Model 1), or a 9.4% reduction when controlling for MLT ratings (Model 2). The largest contribution to this overall measure comes from the willingness to be at the service and from working on issues that are important to the young person (Model 3): a one-point increase in these individual dimensions reduce the likelihood of exiting by 7.8% and 5.7%, respectively. In contrast, feeling that things are improving

TABLE 4 Proportional hazard model for discrete time.

	Model 1	Model 2	Model 3	Model 4
MySE	0.958***	0.906***		
	(0.007)	(0.007)		
Willingness			0.922***	0.926***
			(0.007)	(0.007)
Importance			0.943***	0.945***
			(0.009)	(0.009)
Improving			1.083***	1.058***
			(0.011)	(0.011)
Hopefulness			1.005	0.986
			(0.010)	(0.010)
MLT		1.009***		1.007***
		(0.001)		(0.001)
N (Visits)	43 099	42 366	41 966	41 958
Episodes	14 884	14 787	14 586	14 585
Young people	14 651	14 556	14 359	14 358

Note: The table shows hazard ratios for MySE variables and MLT on the hazard of leaving the youth mental health service, from clog-log regressions with standard errors clustered at the young-person level. All regressions control for gender, age group, rurality, First Nations status, LGBTIQA+ identity and CALD background.
Abbreviations: CALD, cultural and linguistic background; MLT, MyLifeTracker; MySE, My youth mental health Session Experience.
***$p < .001$.

increases the likelihood of exiting the service (by 8.3%; Model 3), which is expected given that this is correlated with more positive quality of life (cf. Table 3). Model 4 underscores that part of the

information captured in the MySE dimensions reflects clients' ratings of quality-of-life: when controlling for MLT scores, the effect of feeling that things are improving is now lower at 5.8%, but other dimensions are relatively unchanged (Model 4). Feeling hopeful about the future has no significant impact on whether the young person remains in the service.

4 | DISCUSSION

This study investigated how MySE, a brief five-item routine session-by-session experience measure for youth mental health services, is distributed amongst different client demographics, how it changes over time and impacts on ongoing service engagement, and how it correlates with the brief routine client outcome measure, MLT, capturing quality of life. MySE was developed to fill a gap in the availability of a young people-specific measure for session-by-session experience monitoring, which is a crucial aspect of the feedback young people can provide during mental health service provision. The information is made available immediately to headspace clinicians at the start of the session, thereby providing a way for young people to participate in their own care by informing their clinician of potential need to adapt their approach in response to feedback on key dimensions of service delivery.

Overall, these results show positive session experiences for young people at headspace. Older age groups experience their service sessions more positively than younger age groups. The young adults were substantially more willing to attend their headspace services and also rated other dimensions of session experience more positively. These findings emphasise that additional effort is required to engage younger adolescents in mental health care, a finding that has been previously demonstrated (Baruch et al., 2009).

A smaller difference in session experience is evident between different gender groups. While young males are least willing to be at their session, it is gender diverse young people who rate other dimensions of session experience somewhat lower than male and female young people, although these differences are very small. Other headspace priority demographic groups (First Nations young people, LGBTIQA+ young people and those with CALD backgrounds) rate service session experience similarly to other population groups.

While MySE captures five different dimensions of service experience, reflecting what was identified as being important to young people in its co-designed development, the total MySE score and dimensions of hopefulness for the future and a sense of improvement are most strongly correlated with client quality of life ratings (as measured by another youth co-designed measure, MLT). The fact that the item measuring sense of improvement is significantly associated with a change in quality of life is important as a validation of the measure, as it shows that experiencing a sense of improvement is associated with more positive client outcomes. This effect is also evident in the association between MySE scores and stage of illness, with those experiencing current ill health having lower experience scores, although the effects were quite weak. Differences in how

individual dimensions of session experience are associated with a shorter or longer episode of care underscore the need to report individual items separately and for clinicians to consider each dimension as well as the total score.

As a routine measure of service experience, MySE is useful in predicting whether young people will return for additional services. Notably, a one-point improvement in session experience increases the likelihood of returning for additional services by 9.4%. The items asking about willingness to be at the service and whether they are working on issues that are important to them were the most strongly associated with returning to the service. Since MySE feedback reflecting on the previous session experience is made available immediately to clinicians at the beginning of a new session, this provides scope for adjusting service delivery promptly to promote ongoing engagement and, thus, achieve better mental health outcomes.

An important limitation of our study is that we do not have information on young people who attended only once, as the experience measure is administered at the second visit (with the exception of the willingness item, which is also measured at visit 1). Given that a large proportion only attend once, this is a major knowledge gap. Premature 'drop-out', including after just intake or one session, is typical of all mental health services and particularly community-based services (Gibbons et al., 2019). However, disengagement and early 'drop-out' are particular concerns for youth mental health, especially for younger adolescents and young males (Seidler et al., 2020). While it is difficult to follow up clients who have attended only once, this is a research gap that needs attention; better understanding of the factors affecting engagement is critical for services.

The clinical implications of these findings are that the five dimensions of session experience assessed in MySE are associated with both service engagement and quality of life. Clinicians should note that willingness to attend and working on issues that are important to the young person are critical dimensions for engagement. Hopefulness for the future and a sense of improvement are the most strongly associated with quality of life. Lower scores on these items may indicate risk of service disengagement. Reviewing young people's scores at the start of each session provides a way for the clinician to engage the young person in a conversation about what is and is not working for them. This could become part of routine practise supporting shared decision-making (Simmons et al., 2015). Note, however, that this study had no access to information on how clinicians are using MySE in practise, including whether or how it is integrated within shared decision-making. How clinicians use the MySE items in practise is a key direction for future research.

Although this study has several strengths, particularly the large sample of help-seeking young people from over 150 youth services across Australia, a limitation is generalisability to other contexts. Being the first study on the newly developed routine session experience measure, it is unclear to what extent these findings may translate to youth mental health contexts outside of Australia or the headspace context. Reassuringly, we found no differences in session experience for young people from culturally and linguistically diverse backgrounds or First Nations young people, but more research is required to

compare these results with other integrated youth mental health services nationally and internationally.

How clinicians use such client feedback in practise and how useful they, and the young people themselves, find the items also needs to be investigated. Prior research into implementation of the session-by-session mental health outcome measure, MLT, across headspace centres in Australia, identified clinician characteristics, clinician attitudes, and organisational supports as important predictors for clinicians' use of measurement feedback systems (Kwan et al., 2021). This study concluded that given young people have high rates of deterioration during therapy, treatment drop-out, and missed appointments, such routine measurement feedback systems are a critical service support. Implementation of a routine service experience measure, such as MySE, alongside routine outcome measurement is likely to further enhance the benefits of measurement-based care.

5 | CONCLUSION

This study shows that young people at headspace youth mental health services experience their session-by-session care positively, and that more positive service experience is associated with better service engagement and more positive quality of life ratings. This routine measure for session-by-session monitoring gives young people an important way to participate in their own care by providing regular feedback to clinicians about important dimensions of their mental healthcare session.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available from headspace National Youth Mental Health Foundation. Restrictions apply to the availability of these data, which were used under license for this study. Data are available from the author(s) with the permission of headspace National Youth Mental Health Foundation.

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ENDNOTE
[i] For this analysis, the sample was extended to include those young people who attended a single session only, yielding a sample of 28 596 young people in 29 838 episodes of care.

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