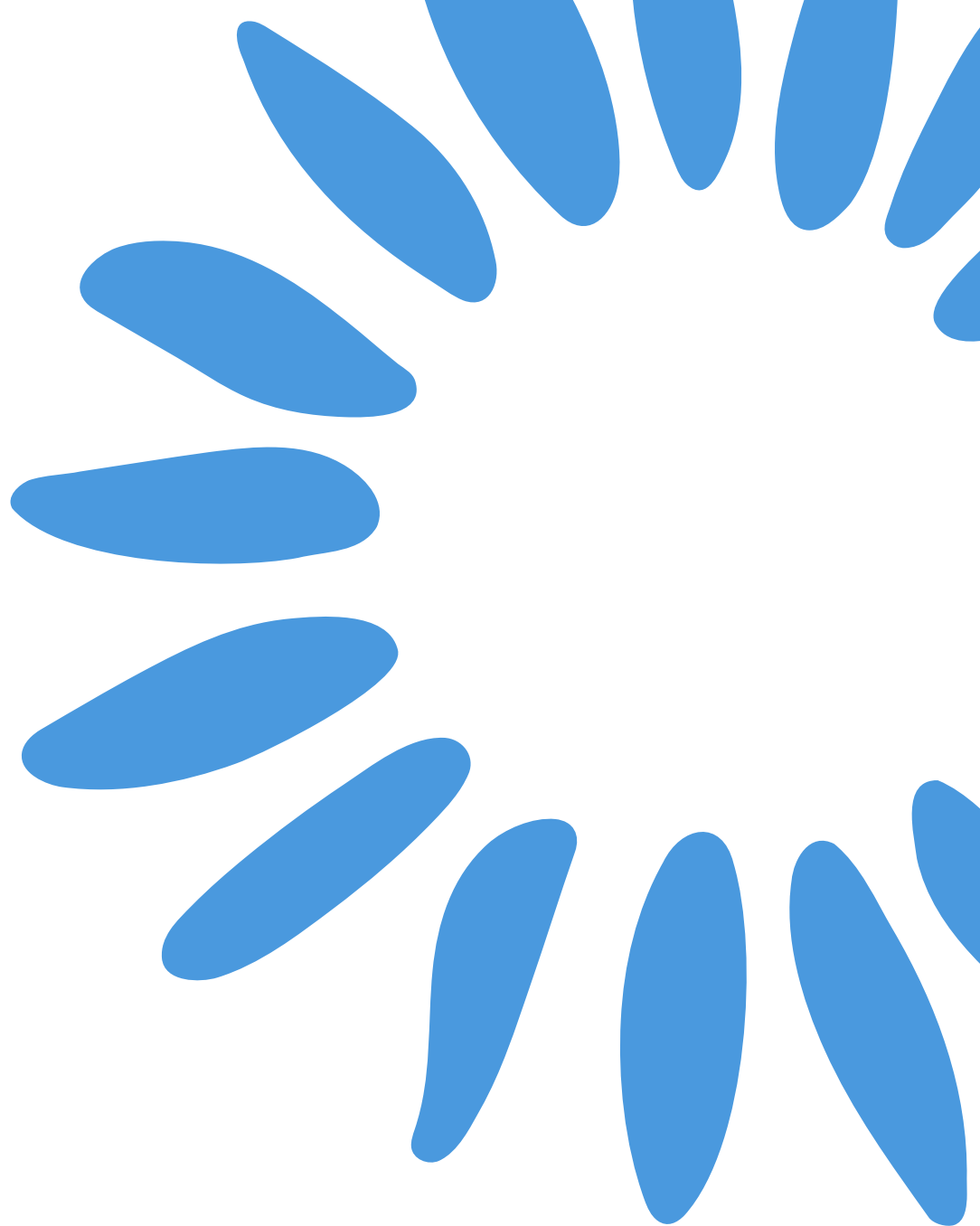


JUNE 2026

Evaluation of the MOST digital mental health platform for young people in Western Australia

Prepared for the Mental Health & Suicide Prevention Team, WA Primary Health Alliance



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Executive Summary

Background

MOST is a multi-faceted digital mental health service for young people aged 12 to 25 providing access to evidence-based psychoeducation, remote clinician support, peer support, vocational support, and access to a moderated social community. Operated by Orygen Digital, the digital division of **Orygen - Australia's Centre of Excellence in Youth Mental Health**, MOST was launched in Western Australia with the support of the **WA Primary Health Alliance (WAPHA)** through the Australian Government's Primary Health Networks (PHN) Program. In the first phase, MOST was made available for referral from headspace services to young people in WA in a staggered rollout. Despite this delivery model, MOST remains a standalone service and is not developed for or connected to headspace.

In 2024, WAPHA commissioned the **Human Development and Community Wellbeing** team at **The Kids Research Institute Australia** on behalf of the Centre for Child Health Research at the University of Western Australia to undertake an evaluation of the implementation of MOST in WA, with a focus on the impact and effectiveness of MOST on participants and the system of care.

Service focus and aims of the evaluation

headspace is Australia's National Youth Mental Health Foundation, established in 2006 to address the high prevalence of mental health difficulties, low service uptake, and poor outcomes among young people in Australia aged 12 to 25 years of age. While young people can access MOST through a variety of pathways, this report exclusively focuses on the Western Australian service implementation of MOST in headspace.

Four aims were established for the evaluation: 1) Stakeholder's usage and engagement with MOST; 2) Perceived outcomes of MOST; 3) User and clinician attitudes towards MOST's service delivery model; and 4) Patterns in usage, engagement, and outcomes based on demographic profiles.

Method of evaluation and ethical approval

A mixed-methods line of inquiry was used to evaluate MOST. This evaluation integrated both quantitative and qualitative approaches to collecting data. Ethical approvals for this research were sought and granted through the University of Western Australia Human Research and Ethics Committee (Ref: 2024/ET001036 and Ref: 2024/ET001040).

Quantitative and qualitative samples

Quantitative data was provided by Orygen Digital on 986 (85%) consenting Western Australian users.

With respect to the qualitative analysis, interviews with youth who used MOST, and their parents/carers were intended to be data sources for this evaluation. However, despite best endeavours, due to the very low response rates of youth and parents/carers of youth, the qualitative analysis is confined to interviews with 13 clinicians from nine headspace sites across metropolitan and regional sites in Western Australia.

Youth access and engagement with MOST

MOST is made available by referral from headspace services. headspace clinicians typically use MOST as an early-intervention and post-discharge form of support, commonly offering it at a client's commencement with the service (at triage or intake) and occasionally as the service concludes.

From the time of referral, a young person (e.g. a user) typically takes around five days to sign up and onboard to MOST with 90.2% of young people signed up and onboarded within two weeks. Some

41% of young people onboarded within one day of referral. Among young people who had signed up, 93.5% onboarded on the same day. The typical user of MOST engaged with the app across 10 sessions totalling approximately 56 minutes. Gender diverse users engaged with MOST to a higher degree when compared to cisgender male and female users. Regional users spent more time on MOST relative to metropolitan users.

Perceived outcomes of MOST

Findings on youth outcomes are derived from both MOST data from the young people themselves as well as headspace clinician perceptions regarding the potential impact of MOST.

Sampling and design restrictions limit these observations to correlational associations and findings cannot be interpreted as causal outcomes resulting from young people's use of MOST. headspace clinician perceptions of perceived youth outcomes are interpretative and speculative in nature and reflect their views rather than measured outcomes.

Quantitative results and statistical tests demonstrate a positive association between use of MOST and measured improvements on standardised scales of depression and anxiety symptoms and the mental wellbeing of young people.

headspace clinicians perceive that MOST can support young people to develop emotional literacy, which in part, may be one mechanism implicated in the relationship between observed mental health improvements. headspace clinicians also observed that MOST may provide young people with a sense of psychological safety, which may support peer disclosure and validation, and therefore increased social connectedness.

headspace clinicians were also interviewed for their perceptions of the system and service-level impacts of MOST. They positioned MOST as a form of support that bridges system gaps by expanding access to mental health support for young people requiring out-of-hours care but not acute care. They viewed MOST as an early intervention model that provided almost instantaneous access to a mental health support platform following referral. They were more cautious in their opinions of system level impacts from MOST, perceiving MOST as having some capacity to address young people's needs, noting that in its current form MOST does not substantially influence young people's engagement with headspace or the broader mental healthcare system.

Clinician attitudes towards implementation of MOST

All interviewed headspace clinicians viewed MOST as an accessible mental health support option, particularly due to its perceived ability to reduce traditional barriers to care. MOST's around-the-clock access was seen as critical for supporting young people. headspace clinicians valued MOST as it extends mental health support reach to underserved populations such as those facing geographic and situational barriers to access headspace.

Interviews with headspace clinicians found that their knowledge of the MOST platform varies substantially, with many clinicians navigating the platform from a position of uncertainty. Limited content knowledge, minimal exposure to the youth interface, reliance on initial implementation training, and difficulties with clinician portal usability, collectively undermined their confidence to implement MOST into practice.

While headspace clinicians generally recognise the potential value of MOST, strengthening clinician understanding and improving platform usability is likely to support greater confidence and more consistent implementation of MOST into care. headspace clinicians compared MOST, headspace, and eheadspace to assess MOST's novelty and grappled with uncertainty over the purpose of MOST, and when to use it, in the context of headspace's additional services. They consistently valued MOST as an addition to in-person care rather than a treatment replacement, perceiving a blended care approach as ideal albeit with improved communication between headspace and MOST clinicians, allowing a young person to experience the "best of both worlds".

Meaningful inclusion of MOST into clinical care appears to be most feasible for headspace clinicians in counselling roles operating within multi-session episodes of care, where there is greater opportunity for follow-up, monitoring, and therapeutic use of the platform. Clinicians suggested that inclusion of clearer and more well-defined therapeutic journeys in MOST may indirectly support clinicians' implementation of MOST into their practise. Training that focuses on how MOST can be used alongside routine clinical work – beyond the provision of a referral – would enhance clinicians' confidence and uptake of the platform.

headspace clinicians largely perceive MOST as a safe and well-governed mental health support platform, with appropriate risk-escalation protocols in place. However, some concerns were raised regarding privacy, duty of care, and timeliness of communication with MOST clinicians within a shared care model.

Importantly, the implementation of MOST within headspace appears to be influenced by both system level factors and clinicians' attitudes, as well as by how visible young people's engagement with MOST is to staff. Client usage data does not consistently match clinicians' perceptions, suggesting clinicians have limited insight into how young people actually use the platform. Overall, these findings indicate that the effectiveness of integrating MOST into headspace care is shaped by a combination of system level conditions and clinician level factors.

Evaluation limitations

While the data provides valuable insights into the implementation of MOST in WA, several limitations should be noted.

The evaluation is based on a non-experimental research design, meaning causal relationships cannot be established. There is no like-for-like comparison to causally attribute changes in user outcomes over time to MOST.

The quantitative sample only includes young people who onboarded to MOST and did not capture those who were referred but chose not to sign up or onboard. Follow up data at 6-, 12-, and 24-weeks are more limited than baseline data, reflecting MOST's recent implementation in WA. In addition, some variables on the quantitative analysis contains incomplete data, including key stratification proxies such as gender and work/study status.

The qualitative findings are based on interviews with headspace clinicians. While these perspectives offer valuable contextual insights, they may not reflect the broader clinician workforce. The absence of input from young people themselves and parents/carers further limits the interpretation of quantitative youth engagement and outcome findings. To add further contextual information, headspace clinician perspectives have been used cautiously and primarily for illustrative purposes and may not be representative of young people's views.

Recommendations

Based on report findings, several recommendations relating to the implementation of MOST have been put forward. These recommendations include further training for headspace clinicians, clearer expectations about how MOST should be implemented in the headspace service, the provision of supplementary documentation about MOST to aid implementation, and a consistent streamlined referral procedure across all headspace centres. This report also presents suggestions to improve MOST's designed responsiveness including the expansion of content and features on MOST.

Introduction

10

1.1 Context

1.1.1 MOST Background

Over the last two decades the prevalence of mental health disorders among young people has increased (Australian Institute of Health and Welfare, 2026). While prevalence estimates vary by study design including age group, methodology, and data source, national Australian data consistently demonstrate that adolescence and early adulthood are peak times for the onset of mental health disorders (Australian Institute of Health and Welfare, 2026). During this time, mental health service use is also high (Australian Institute of Health and Welfare, 2026), and young people may also experience service limitations such as long wait times and limited time with a professional (headspace 2019a, 2019b).

1.1.1.1 Why was MOST developed?

MOST is a mental health intervention for young people aged 12-25 operated by Orygen Digital– the digital brand of Orygen to address these ongoing challenges of mental health care in Australia and to improve the access, engagement, and treatment effectiveness of mental health support (Alvarez-Jimenez et al., 2025). MOST is a digital service funded to be available and free for young people. It was designed to complement existing youth mental health services by providing an accessible support option for youth to engage with at all stages of their care journey – before receiving care, during care, or after their treatment (Cross et al., 2023; Orygen, 2026).

As MOST is designed to be blended into existing mental health services, mental health professionals can refer young people to MOST (Cross et al., 2023). Importantly, MOST remains a standalone service and does not claim to be a substitution for mental health services but is purpose-built and has the overall mission to personalise mental health care for young people in Australia by integrating digital health technology with professional human support (Cross et al., 2023; McGorry et al., 2022).

1.1.1.2 How was MOST developed?

MOST was designed with a multidisciplinary team of researchers, clinical psychologists, software engineers, young adult novelists, comic artists, and digital designers (McGorry et al., 2022). MOST was co-designed with young people with lived experience of mental ill health and is supported by over 15 years of clinical research (MOST, 2025). While MOST originally emanated from a research project in Australia, designed for people who have been discharged from psychosis services, it is a digital mental health service supporting young people across Australia with a wide range of conditions (Alvarez-Jimenez et al., 2021; McGorry et al., 2022). As such, MOST is constantly evolving and has been adapted for a range of populations through a range of different MOST platforms including, but not limited to Moderated Online Social Therapy+ (e.g., Alvarez-Jimenez et al., 2020), Q-MOST (e.g., Carpenter et al., 2024), ENYOY (e.g., van Doorn et al., 2023), HORYZONS (e.g., Ludwig et al., 2021), Affinity (e.g., Bailey et al., 2021), Entourage (e.g., Rice et al., 2020), and Rebound (e.g., Rice et al., 2018). MOST is also being tested and implemented across the European Union, Canada, and United States of America (Orygen Digital, 2024b).

1.1.1.3 What are the key features of MOST?

MOST delivers care through a multi-component digital platform, providing youth with access to a range of resources such as:

- 1. Psychotherapeutic content:** Evidence-based information focused on a range of mental health difficulties. This self-paced content is delivered in the form of psychotherapeutic journeys, tracks, or individual items, and activities that young people can engage in. Young people can save their favourite pieces into their 'Toolkit' for easy access, or access discrete psychoeducation through an 'explore' function.
- 2. Clinical support:** MOST clinicians are accredited mental health professionals that provide one-on-one, text-based support to young people on MOST. If a young person is already engaging in face-to-face care, a shared care approach is taken. MOST clinicians also conduct regular safety checks on the platform.

3. **Peer support:** Peer workers are paid and trained employees aged between 18 and 30 who have lived experience of mental ill health. Peer workers moderate the social network and can provide constructive peer support to young people in the social community, or through one-on-one text-based support on MOST.
4. **Career consultant support:** Vocational workers are tertiary-qualified career specialists that can provide one-to-one text-based support for young people on MOST whose education or career path has been impacted by mental ill health, to help them achieve their work and study goals.
5. **Access to an online community or social network:** A moderated space which allows young people to connect with other young people with similar experiences. Young people can create a post, react, or comment on other's posts. This component was developed to address loneliness and self-stigma.

A key component of MOST is its flexibility. Young people can choose the parts of MOST with which they want to engage with, and the extent of engagement (Cross et al., 2023). In this way, two people can be using MOST in completely different ways.

1.1.1.4 How is MOST expected to shape youth outcomes?

Cross et al. (2023) developed a theory of change model outlining a hypothesised framework for how MOST can be integrated within youth mental health services to improve service delivery and ultimately, improve outcomes for young people and the healthcare system. The authors postulated a range of short- (e.g., reduced wait times between service entry and treatment allocation, increased reach of young people accessing mental health support, improved health and wellbeing), medium- (e.g., a higher number of people serviced within the mental healthcare system per annum and improved quality-adjusted life years), and longer-term (e.g., reduced annual health care costs, decreased burden of mental illness in young people, and improved accessibility, effectiveness, and appropriateness of youth mental health care) outcomes (Cross et al., 2023).

A recent evaluation of MOST across Victoria, Queensland, New South Wales, and the Australian Capital Territory found MOST to be a promising mental health intervention across a large cohort of young people (Alvarez-Jimenez et al., 2025). This evaluation indicated that young people tended to report positive feedback about MOST, were satisfied and demonstrated sustained engagement with the platform, demonstrated improvements to clinical outcomes such as anxiety and depressive symptoms, psychological distress, and wellbeing. Other research across Australia investigating the effectiveness of a range of MOST platforms such as Entourage (O'Bree et al., 2021, Rice et al., 2020), Affinity (Bailey et al., 2021), and Rebound (Rice et al., 2018) demonstrate potential therapeutic and social benefits of the MOST platforms, with them often perceived as acceptable and helpful, though evidence of its effectiveness remains preliminary and mixed.

1.1.2 headspace Background

headspace is Australia's National Youth Mental Health Foundation, established in 2006, and funded by the Australian Government, focusing on providing youth-friendly, early-intervention, free mental health care for people aged 12 to 25 years of age, experiencing mild to moderate distress (headspace, 2026a). headspace provides support on a range of experiences including mental health, alcohol and other drug services, physical health, sexual health, and work and study support (headspace, 2026a). Across Western Australia alone, there are 21 headspace locations, typically operating during standard business hours (headspace, 2026b; MOST & Orygen Digital, 2025).

WAPHA commissions lead agencies to run headspace centres across Western Australia. Lead agencies are community health enterprise entrusted to manage and operate headspace centres. The lead agencies have a responsibility for the delivery of headspace, its daily operations, and governance. To ensure quality and consistency of care across headspace, centres must adhere to headspace's fidelity model.

headspace provides face-to-face support for young people and their families through its centres and online and telephone support through eheadspace from 3pm to 10pm each day (headspace, 2026c). headspace also provides access to online communities and group chats (headspace, 2026d). More recently, WAPHA has funded the MOST service to be available for referral from headspace sites, as a complementary digital option in the headspace service ecosystem to enhance the headspace care model.

WAPHA has also funded the MOST service to be available for referral from headspace services, Medicare Mental Health Phone service, selected general practices, and more recently Early Psychosis and Youth Enhanced services (Orygen Digital, 2024a; MOST & Orygen Digital, 2025). A staggered implementation approach has been used across these service settings. Specifically, MOST was made available for referral from all 21 headspace services in WA through a three-phase rollout conducted between April 2024 and May 2025 (MOST & Orygen Digital, 2025). MOST received additional funding from the WA Mental Health Commission to expand its presence in WA through state-funded mental health services, building on the foundation established by WAPHA in 2025 (MOST & Orygen Digital, 2025). Additionally, the Federal Government has funded MOST to be directly accessible to young people (MOST & Orygen Digital, 2025).

As WAPHA commissioned the evaluation of the rollout of the MOST service to headspace services, this evaluation exclusively focuses on the MOST as an independent service, operating within headspace.

1.2 About the Evaluation

In 2024, The Kids Research Institute Australia on behalf of the Centre for Child Health Research at the University of Western Australia, was commissioned by the WA Primary Health Alliance (WAPHA) to conduct this evaluation based on secondary quantitative data provided by Orygen Digital and primary qualitative data collected by the evaluation team.

1.3 Aims of the Evaluation

This evaluation aimed to assess the implementation of MOST in Western Australia focused on the impact and effectiveness of MOST on participants and the system of care. The specific key lines of enquiry were to explore:

1. Stakeholder's usage and engagement with MOST
2. Perceived Outcomes of MOST
3. Attitudes towards MOST's service delivery model
4. Any patterns to usage, engagement, and outcomes based on demographic profiles

These four key lines of enquiry were developed by The Kids Research Institute Australia in consultation with WAPHA and comprise the scope of this evaluation. The evaluation also includes system diagnostics, theory of change, and design responsiveness.

Per the Terms of Reference developed by WAPHA, the purpose of this evaluation is not to compare the implementation of MOST in WA to that in other states, but to build on place-based knowledge to enhance the effectiveness of MOST for WA users.

Data Sources

20

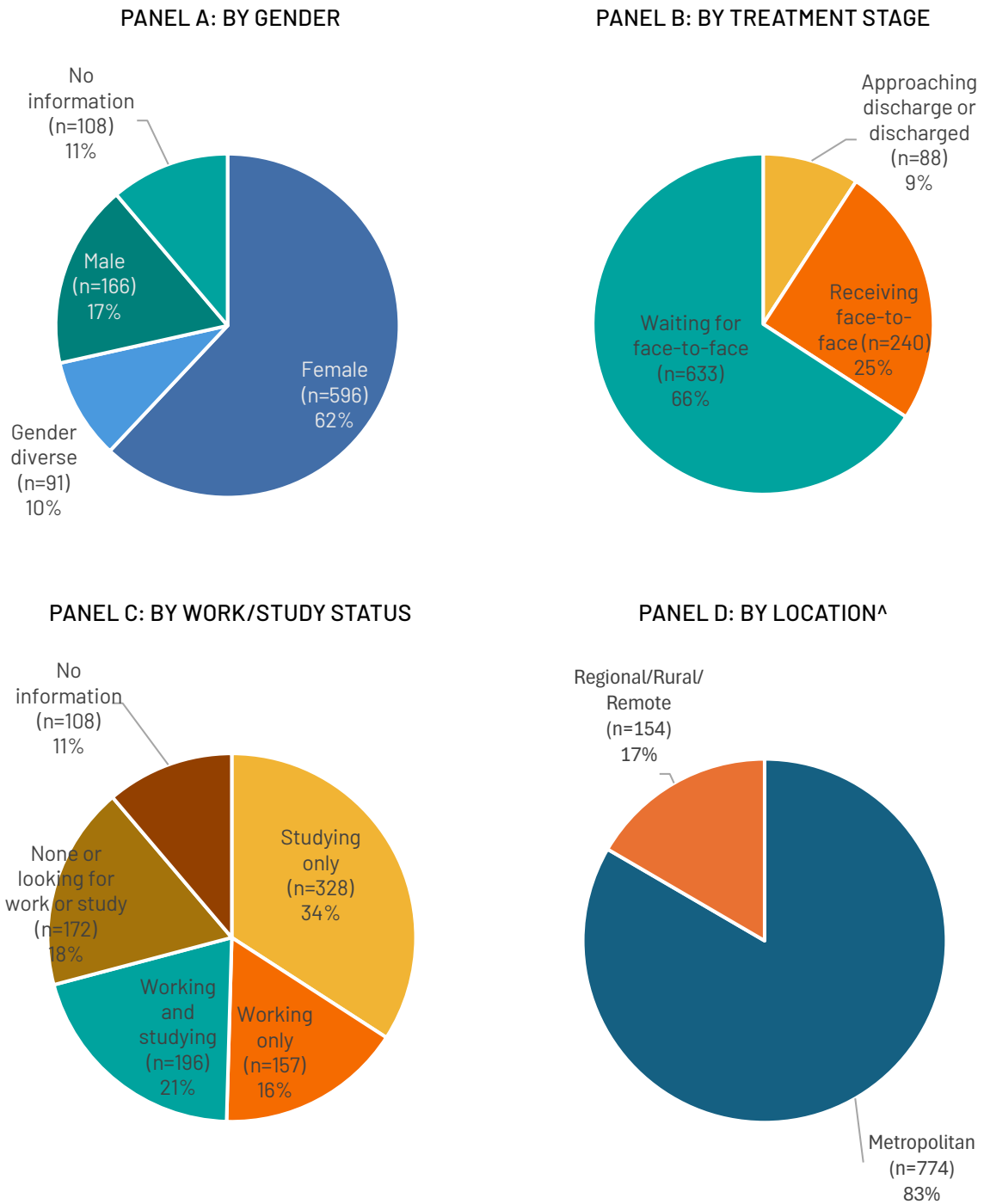
The evaluation was conducted using a mixed method approach employing quantitative data provided by Orygen Digital and qualitative data collected by the evaluation team. More details on the methodology including information on ethics are provided in Appendix A1.

A summary of data sources can be found in [Table 1](#), with further characteristics of the study samples provided in [Figure 1](#), [Figure 2](#), [Table 2](#) and [Table 3](#). More detailed characteristics can be found in Appendix A1.

Table 1. Summary of Evaluation Data Sources

Description	Type of participants	Type of data	Source	Note
MOST platform use and engagement data	Young people who use MOST	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025; Sample characteristics presented in Figures 1 and 2
User outcomes and satisfaction data	Young people who use MOST	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025; Sample characteristics presented in Figures 1 and 2
headspace service clinician and service leader satisfaction survey data	Clinicians	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025; Sample characteristics presented in Table 2
Interviews with headspace clinicians	Clinicians	Qualitative	Primary data collected for evaluation	Interviews conducted July 2025 to November 2025; Sample characteristics presented in Table 3
Interviews with youth between the ages of 18-25 who use MOST	Young people who use MOST	Qualitative	Primary data collected for evaluation	Interview conducted, however minimum sample for analysis not met. Data excluded due to ethical considerations.
Interviews with parents of youth aged 12-17 who use MOST	Parents of young people who use MOST	Qualitative	Primary data collected for evaluation	Interview conducted, however minimum sample for analysis not met. Data excluded due to ethical considerations.

Figure 1. Characteristics of Quantitative User Sample



Note: [^]From here on, "Regional/Rural/Remote" will be referred to as "Regional"

Figure 2. Maximum Usable Quantitative User Sample by Section

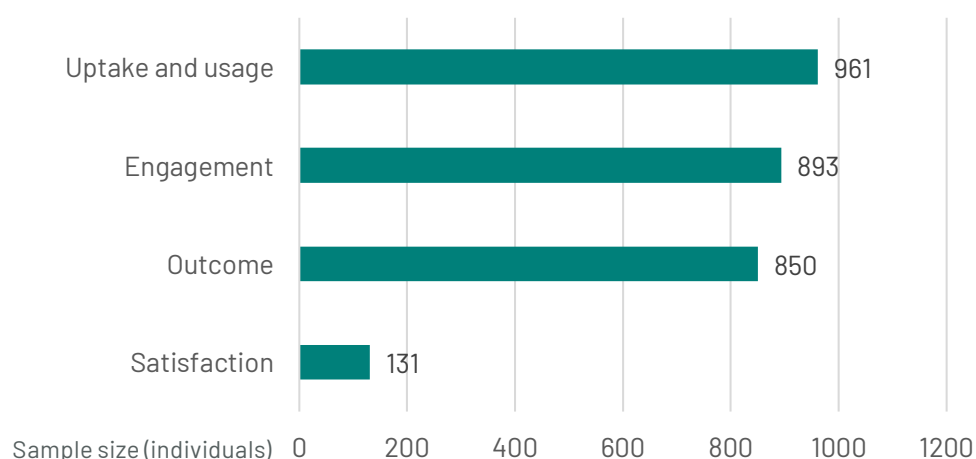


Table 2. Role of Clinicians in the Quantitative Clinician Sample

	Summary
Number of clinicians	95
Deliver therapeutic treatment to young people	
No	12 (14.8%)
Yes	69 (85.2%)
Primary role	
Intake/triage role	7 (7.4%)
Service clinician role	60 (63.2%)
Service lead* (e.g. Clinical Manager/Lead, Team Leader, Program Manager)	13 (13.7%)
Other	15 (15.8%)

Note: *The clinician survey incorporated questions targeted at service leads. Due to the small sample size and to ensure respondent anonymity, exact counts and percentages are not reported when presenting the findings from these questions.

Table 3. Qualitative Clinician Sample Demographics

Clinician Number	Clinician headspace Position	Summary
1	Senior Youth Access Worker	Metropolitan
2	Not reported	Metropolitan
3	Youth Counsellor	Metropolitan
4	Clinical Educator	Regional
5	Clinical Lead	Regional
6	Clinical Lead	Regional
7	Program Manager	Metropolitan
8	Duty Officer and Youth Counsellor	Metropolitan
9	Youth Access Clinician	Regional
10	Mental Health Occupational Therapist	Regional
11	Counsellor	Regional
12	Senior Access Clinician	Metropolitan
13	Duty Officer	Metropolitan

Youth Access & Engagement with MOST

3.0

This chapter provides an overview of how young people access and engage with MOST in the headspace context. It outlines the referral process and explores how young people onboard and use MOST, with clinician perspectives about MOST integrated throughout.

3.1 The MOST Referral Process

HIGHLIGHTS

- The MOST referral process is standardised, however its implementation across headspace sites differs.
- headspace clinicians in a range of positions can provide a MOST referral by completing a brief online referral form.
- Referrals can occur at multiple phases across a person's engagement with headspace – most commonly at triage, intake, during counselling sessions, approaching exit or at exit.
- While headspace clinicians exercise their clinical judgement on a case-by-case basis, there are a range of factors that may encourage or discourage them from providing a MOST referral.
- headspace clinicians appeared to primarily use MOST as a form of interim support for young people awaiting face-to-face headspace care, as well as a means of maintaining continuity of care for those approaching exit from the service.

This section outlines how young people obtain a MOST referral from headspace. It comprises headspace clinician accounts describing what a referral involves, when headspace clinicians offer a referral to MOST, how frequently headspace clinicians perceive the need to offer a referral, and factors that shape whether a clinician decides to provide a referral.

While MOST is an independent service, examining the referral process within headspace provides insight into how headspace clinicians integrate MOST into clinical care. Although the referral form itself is standardised, headspace clinicians emphasised that the way referrals are operationalised differs across centres, reflecting variation in service structures:

The process is standardised. How it's operationalised in each centre is different. I think it's mostly to do with like how each centre is set up. — HEADSPACE CLINICIAN 4, REGIONAL SITE

While there are various ways in which young people can access MOST, this evaluation exclusively focuses on MOST's availability within headspace services, rather than broader population use.

3.1.1 What is a MOST Referral?

A MOST referral occurs when a headspace clinician formally directs a young person to MOST, enabling them access. To provide a referral, headspace clinicians complete a brief online form through MOST's clinician web portal. headspace clinicians enter their own name, select the headspace site they work at, enter basic demographic information for the client they are referring – such as the client's name, contact details, stage of care journey – and confirm the youth's suitability for MOST. Once the referral is submitted, the young person receives a text message from MOST prompting them to create an account and begin the onboarding process.

3.1.2 When Can a Referral Occur?

headspace clinicians can provide a MOST referral at any point in a youth's engagement with headspace. Referrals typically occur at one of four phases – at triage, intake, treatment, and at exit from the headspace service, though some referrals may be provided at outreach. As referrals can occur at multiple phases, referrals can be initiated by headspace clinicians in a range of roles including intake workers, duty officers, clinical leads, and counselling clinicians. The following sections outline when and how a MOST referral can be provided across the headspace service.

3.1.2.1 Referrals During Triage

Triage is the first point of contact that a young person has with headspace. This can be initiated through a walk-in, phone call, online enquiry, or external referral to the headspace service. Triage is a brief screening session (approximately 15 minutes) in which headspace clinicians assess youth risk, determine their suitability for the service or need for an on-referral, and provide an overview of headspace and its services:

At triage, we decide if they're suitable for service, if they want an assessment and depending on the outcome of that triage, the clinician or the triage officer they may just say ... "We've also got the MOST app that you can be signed up to". So, the triage clinician will just use a simple online form to sign them up. — HEADSPACE CLINICIAN 7,

PROGRAM MANAGER, METROPOLITAN SITE

For some headspace clinicians, triage is the initial opportunity to introduce MOST, although this is largely dependent upon clinician role. At some centres, triage is primarily conducted by duty officers or dedicated triage workers. However, at other sites, headspace clinicians across roles may lead triage in the case of walk-ins. Overall, triage emerged as a key opportunity for headspace clinicians to offer MOST, contributing to its use as an early-intervention support service within headspace.

3.1.2.2 Referrals During Intake

Intake signifies a person's formal entry into headspace. Here, headspace clinicians undertake a comprehensive assessment to understand the young person's difficulties. In this session, headspace clinicians typically conduct a biopsychosocial assessment, develop a care plan, and allocate youth to a headspace clinician. While intake represents the second opportunity for MOST to be integrated into headspace care, for most counselling headspace clinicians, it appears that intake is the first opportunity they have to mention MOST:

The most common time that I talk about MOST is during an intake assessment ... And then I'll show them. I'm always showing them the app on my phone before they agree to it. So, then I would just do a referral after I speak with them. — HEADSPACE CLINICIAN 1,

SENIOR YOUTH ACCESS WORKER, METROPOLITAN SITE

We will always offer a MOST referral at our initial clinical contact with a young person, so, during an intake call. And so, if that happens, the young person just gets referred that way. And then you go online and do the online referral form. — HEADSPACE CLINICIAN 10,

MENTAL HEALTH OCCUPATIONAL THERAPIST, REGIONAL SITE

At some headspace centres, clinicians are expected to offer MOST to all clients during intake because a MOST referral is embedded within the assessment form. However, this practice is not consistent across all sites, reflecting differences between the implementation of MOST across headspace sites (see Section 5.4.5 for further detail).

3.1.2.3 Referrals During Episodes of Care

Treatment or episodes of care refers to the counselling sessions young people have with their treating clinician at headspace. While less common, a subset of headspace clinicians described offering a MOST referral during this stage, if they perceive MOST as relevant or helpful for clients. This is particularly the case for clients who may have previously decided against accepting a MOST referral who are discussing themes in-session that headspace clinicians perceive can be supported through MOST, or if a client is seeking more support in addition to face-to-face sessions.

If I felt that a young person who was coming in for counselling was wanting more than the work that we were doing in session and that they were really eager to engage in doing counselling work in between sessions, then I would definitely be thinking about MOST as a referral and I would be discussing with them at that time. — HEADSPACE CLINICIAN 9, YOUTH ACCESS CLINICIAN, REGIONAL SITE

If they've said no and we think there's an opportunity for it later, we would present that and say, "Well, you know, I know you said no to the MOST referral at the start, but do you think that that might be really helpful now?" — HEADSPACE CLINICIAN 11, COUNSELLOR, REGIONAL SITE

3.1.2.4 Referrals at Exit

Another stage that headspace clinicians can provide a MOST referral is at exit – when a young person works with their headspace clinician to plan their exit from the headspace service. As exit involves ensuring that young people have the skills and tools necessary to support their wellbeing outside of the service, headspace clinicians often offer MOST as a part of their exit strategy to ensure youth can continue to receive some support. As exit appointments typically last around 50 minutes, a minority of headspace clinicians mentioned that in this appointment, they will provide a more thorough description of MOST and a demonstration of the platform:

I'm regularly hearing people say, "Oh, have you thought about MOST?" ... I would have to be honest and say it is a part of our exit strategy more so than ongoing work. — HEADSPACE CLINICIAN 9, YOUTH ACCESS WORKER, REGIONAL SITE

We usually do that at our initial appointment, but also at the end of our sessions at headspace ... they complete our six sessions with us, they get discharged and, then they can continue with MOST. — HEADSPACE CLINICIAN 12, SENIOR ACCESS CLINICIAN, METROPOLITAN SITE

Overall, it seems that headspace clinicians typically use MOST as an early-intervention and post-discharge form of support, commonly offering it at a client's commencement with the service (at triage or intake) and conclusion with the service.

3.1.2.5 Referrals Through Outreach

While less common, some clinicians described engaging in outreach activities such as school-based or community outreach. These practises varied, with some headspace clinicians providing a MOST referral during outreach encounters, while others focused on raising awareness of MOST. This variation demonstrates how MOST can be introduced outside of standard intake pathways.

3.1.3 headspace Clinician Referral Frequency

While there are multiple opportunities for headspace clinicians to offer MOST, this does not appear to be a standardised process between sites and the frequency with which headspace clinicians offer a referral varies. While the following is intended to provide contextual information, it is based upon headspace clinician *estimations* rather than a calculated observation and may not accurately reflect referral frequencies. Some headspace clinicians suggested they offer MOST to around 30–40% of their clients, while others described routinely offering MOST to every young person, reflecting variation in headspace clinician preferences and site-level practise:

Part of our headspace model here ... is that every young person that attends the service gets a referral to MOST. — HEADSPACE CLINICIAN 12, SENIOR ACCESS CLINICIAN, METROPOLITAN SITE

I'll 100% suggest it, just because it's another kind of tool that they can use. — HEADSPACE CLINICIAN 11, COUNSELLOR, REGIONAL SITE

3.1.4 Factors Influencing the Provision of a MOST Referral

headspace clinicians described a range of factors that shape whether they offer a MOST referral. These included factors that encourage or remind them to suggest MOST with young people, as well as factors that discourage them from offering a referral. Together, these perspectives illustrate how clinical judgement, youth characteristics, and contextual considerations influence referrals.

3.1.4.1 Factors Encouraging a Referral

headspace clinicians outlined some characteristics that may make them more likely to offer a MOST referral. These typically relate to the phase of care a client is in at headspace, the client's motivation, interpersonal difficulties, and demographic considerations.

HEADSPACE WAIT TIMES PROMPTING MOST REFERRAL

headspace clinicians commonly refer young people to MOST at triage and intake, to provide youth with interim support while they are on a waitlist to receive face-to-face headspace care. These waitlists appeared to be a key driver in encouraging headspace clinicians to offer MOST as a support service, often conceptualised as a holding space that allows young people to be supported while waiting to receive face-to-face care. This practise closely aligns with MOST's development – which aims to provide young people with immediate access to evidence-based care and social support while waiting to be formally admitted into care (Cross et al., 2023):

Especially when I have like a long wait list – it's usually like a three-month wait, that's when I reinforce MOST ... for them [clients] to have some kind of resource until they come back to see us. — HEADSPACE CLINICIAN 8, METROPOLITAN SITE

MOST AS A MEANS TO MAINTAIN CONTINUITY OF CARE

It appears that headspace clinicians commonly provide a MOST referral when a young person is approaching discharge to maintain continuity of care, following their exit from the headspace service. In this way, headspace clinicians offer MOST to provide young people with further support if they wish, to ensure they have resources to support them, once they no longer require headspace support. This is confirmed by survey results where the majority of headspace clinicians ($n = 48$, 72.7%) indicated that MOST helps them discharge young people from their care while ensuring they can still receive support (see Appendix A4, item 1):

I see it more as a value to those that are closing who won't have that ongoing therapy ... if they want to have something that they can keep touching base with and keep on doing their own self-guided learning. — HEADSPACE CLINICIAN 5, REGIONAL SITE

YOUTH READINESS: MOTIVATED YOUTH

The development of MOST was guided by the self-determination theory of motivation (Cross et al., 2021). In the context of MOST, this theory suggests that a person's motivation and desire for growth shapes their willingness to engage with MOST. Consistent with this model, headspace clinicians described being more likely to offer a MOST referral to young people who appear motivated, proactive, or who are actively seeking additional strategies and resources:

I've had a few young people that they're like, "I really am motivated for change" and "I really wanting to be proactive in creating change in my life". And then we're like, "Well have I got the program for you!" — HEADSPACE CLINICIAN 9, REGIONAL SITE

YOUTH EXPERIENCING SOCIAL DISCONNECTION

headspace clinicians also described interpersonal difficulties such as youth at risk of, or currently experiencing social disconnection as a factor that would influence them to offer a referral. headspace clinicians often viewed the social networking component of MOST as being particularly helpful in building up a support network for these youth and helping them to feel more connected to other young people:

I think definitely young people who are more socially isolated. I definitely will recommend because again, that community aspect. — HEADSPACE CLINICIAN 3, METROPOLITAN SITE

YOUTH WHO MAY BENEFIT FROM AFTER-HOURS SUPPORT

headspace clinicians also noted they were more likely to provide a referral to young people seeking additional support outside standard business hours, when the need was non-acute but still meaningful:

I might say, “Hey, do you think that MOST might be better for you now because you are saying at 2-3 o’clock in the morning you’re a bit lost, but you don’t want to ring emergency [and] you just kind of want to reach out or have a safe platform?”

— HEADSPACE CLINICIAN 11, REGIONAL SITE

3.1.4.2 Factors Discouraging a Referral

In addition to discussing factors that may make headspace clinicians more likely to provide youth with a MOST referral, sometimes headspace clinicians consider MOST as inappropriate for young people. The factors that may influence a headspace clinician to omit a MOST referral typically relates to a young person’s lack of access to technology, disengagement with headspace, and if youth are experiencing complex difficulties or require more acute support. headspace clinicians also described exerting clinical judgement on a case-by-case basis.

LIMITED ENGAGEMENT READINESS: UNMOTIVATED YOUTH

As previously mentioned, MOST is guided by the self-determination theory of motivation and assumes that youth have a desire for growth. Therefore, headspace clinicians are less likely to provide a MOST referral to youth who seem unmotivated or are less engaged with headspace. This can involve youth who are detached or disengaged with face-to-face sessions, youth who do not want to be at headspace, or youth who are not seeking additional strategies and resources:

Young people who seem really kind of detached, I suppose, who aren’t that interested in even coming in person. Or, their referrals aren’t really like young person-driven [and] if they’re more by other people or another service provider, or they really just wanted to come here so that they can get a letter to give back to their community corrections officer, then that’s probably when I’d be less inclined to refer them to MOST.

— HEADSPACE CLINICIAN 4, REGIONAL SITE

CLINICAL APPROPRIATENESS: YOUTH REQUIRING ACUTE SUPPORT

Like headspace, MOST is not a crisis support service. Therefore, headspace clinicians reported being less likely to provide a MOST referral to people who are requiring more urgent, acute support, in order to protect the safety of both the young person accessing MOST and other young people using the platform. In some cases, clinicians may still discuss MOST as a supplementary resource but would prioritise immediate referral to crisis or acute care and would clearly explain the bounds of the MOST service.

Young people who are in acute risk, I wouldn’t really refer. I mean, even if I refer, I’ll let the young person know that “Oh, you know, this app is not a crisis service. It’s just for additional help. You still need to go to the hospital or get more acute support that you need”. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

CLINICAL APPROPRIATENESS: YOUTH EXPERIENCING COMPLEX DIFFICULTIES

headspace clinicians described they are less likely to offer a MOST referral to young people presenting with complex, multifaceted, or highly specific difficulties. Although MOST contains over 600 individual therapy items, headspace clinicians perceived the material as too generalised to adequately support youth whose needs require more tailored, intensive, or specialised intervention. In these situations, headspace clinicians felt that face-to-face therapeutic work or a referral to a more specific service is more appropriate and relevant than directing youth to MOST, discouraging them from offering a referral.

If there was something that maybe that they were coming in for that wasn’t addressed in MOST. That’s also a time where I wouldn’t consider necessarily that MOST was appropriate ... for example, if they’re coming in saying, “Look, I’ve got a sleep disturbance, I’m not sleeping really well”, then *absolutely* I would weave it in. If they’re coming in and they’re saying, “I’ve got issues at home, and it all feels all tangled up and I’m not coping at school”. I probably wouldn’t weave MOST into that situation. — HEADSPACE CLINICIAN 9, REGIONAL SITE

CLINICAL JUDGEMENT CONSIDERATIONS

Across interviews, headspace clinicians emphasised that decisions about offering a MOST referral were ultimately made on a case-by-case basis. Beyond specific youth characteristics discussed above, that may encourage or discourage headspace clinicians from offering a referral, these factors are not regulations, and headspace clinicians exert clinical judgement to consider the appropriateness of a referral for a young person. For example, some headspace clinicians considered how a referral might impact the therapeutic relationship, whether the referral would be perceived as supportive or pressuring:

It would be on an individual basis. So, I can't say this as a rule, but I'd be considering whether MOST would be appropriate in terms of; is it good? Are they gonna feel pressured? Is it going to damage the rapport that I've built with them? Are they gonna feel like there's something wrong with them? I would just have to be really mindful of what I think therapeutically would be best for that young person at that time. — HEADSPACE CLINICIAN 9, REGIONAL SITE

3.2 Youth Uptake and Usage of MOST

HIGHLIGHTS

- Over 90% of young people signed up and onboarded within two weeks from referral.
- On average, a young person took 5.1 days from the time of referral to onboard to MOST.
- Female users averaged faster at 4.5 days, while male and gender diverse users took longer at respectively 6.4 and 6.2 days. Under-15 users took more time to onboard, at 6.7 days compared to those who were over 15 (4.4 days).
- Most people who signed up and onboarded to MOST did so immediately, were female, resided in a metropolitan location, and were over the age of 15.
- Not all youth who receive a referral decided to sign up and onboard to MOST.

Once youth are provided with a MOST referral from a headspace clinician, they are not automatically onboarded to the platform. Following referral, young people receive communication providing them instructions for signing up and logging into MOST. Here, the young person has the option to decide if they want to continue with the onboarding process. To be able to use MOST, young people must complete two processes:

- a. Sign up to MOST** – This occurs once a young person has created a MOST account
- b. Onboard to MOST** – This occurs once a young person has logged into MOST and completed onboarding questionnaires and has full access to MOST.

Some young people will complete both steps, others may sign up but not complete onboarding, and some may not engage with either process. This section describes uptake of MOST.

3.2.1 Youth Uptake of MOST

Figure 3 shows that the majority ($43.2 + 31.1 = 74.3\%$) of young people (714 users) signed up to MOST within one week of receiving a referral. Overall, 90.2% of young people who were referred to MOST signed up, and 90.1% onboarded within two weeks. Some 41% of young people onboarded within one day of referral. Among young people who had signed up, 93.5% onboarded on the same day.

On average, a young person took 5.1 days from the time of referral to onboard to MOST, providing timely access to support (details reported in [Table 12](#) in Appendix A6). This figure indicates that MOST is serving its intended purpose as an adjunct treatment that allows young people to access care nearly instantly while waiting for traditional treatment, which, as reported by Subotic-Kerry et al. (2025), took 100.1 days on average with psychologists (for young people aged 13-17 years).

Female users averaged faster at 4.53 days, while male and gender diverse users took longer at respectively 6.42 and 6.24 days ([Figure 5](#) below and [Table 12](#) in Appendix A6). Clients using the Under-15 platform took more time to onboard, at 6.68 days compared to those who used the Over-15 platform (4.37 days) ([Figure 6](#)). These differences are statistically significant at the 95% confidence level.

[Table 12](#) to [Table 16](#) in Appendix A6 provide a detailed breakdown of this average time gap by gender, treatment stage, work/study status, location and age group.

Figure 3. Time Gaps Between Referral, Sign Up and Onboarding

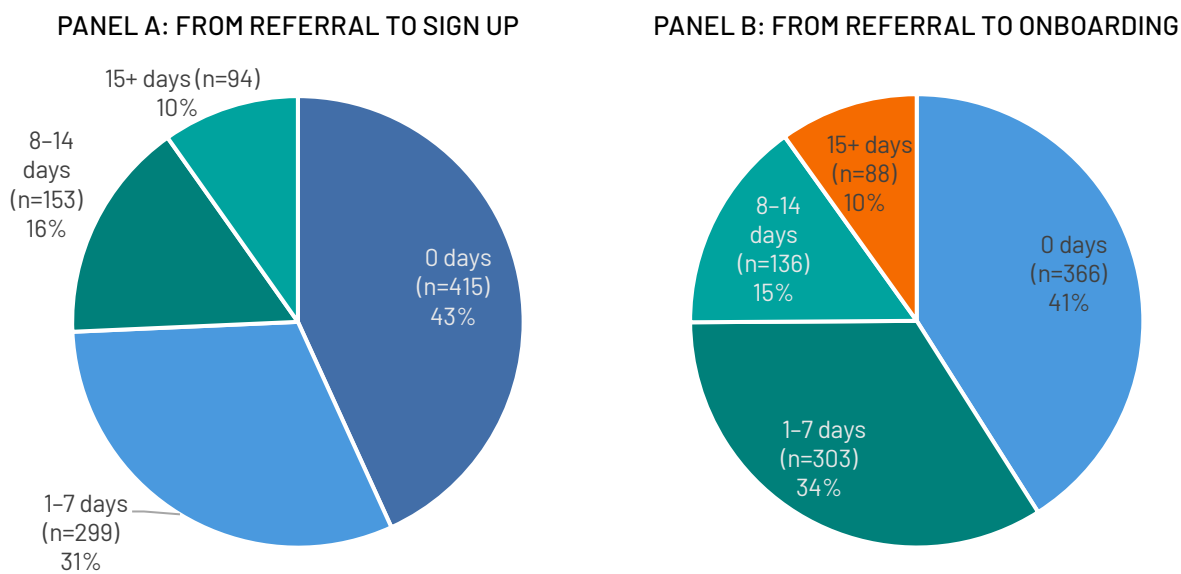
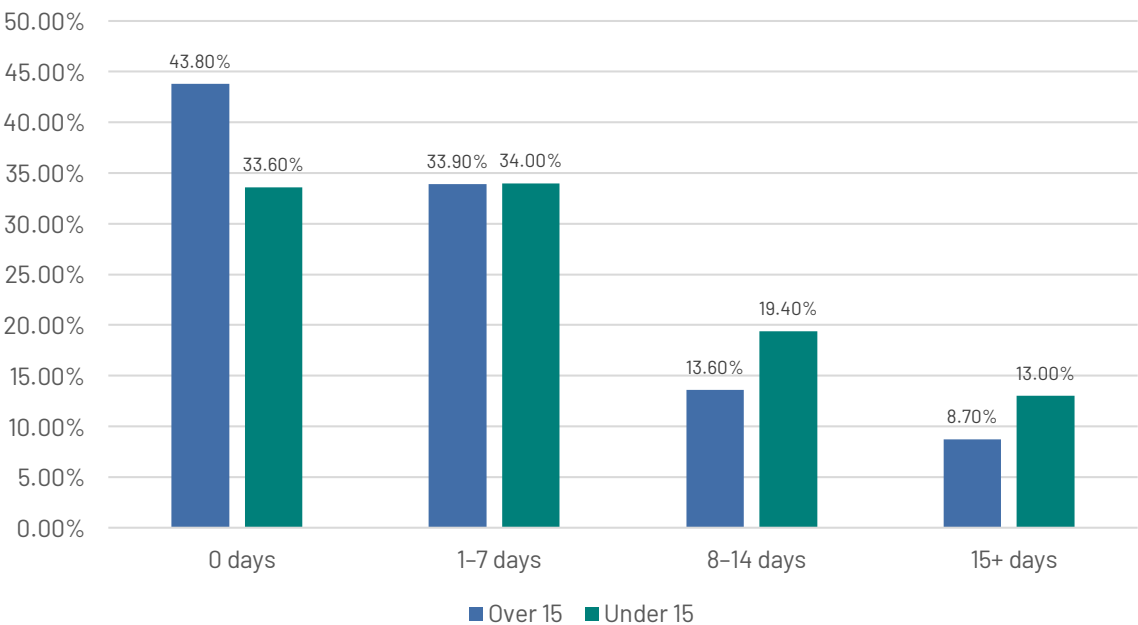


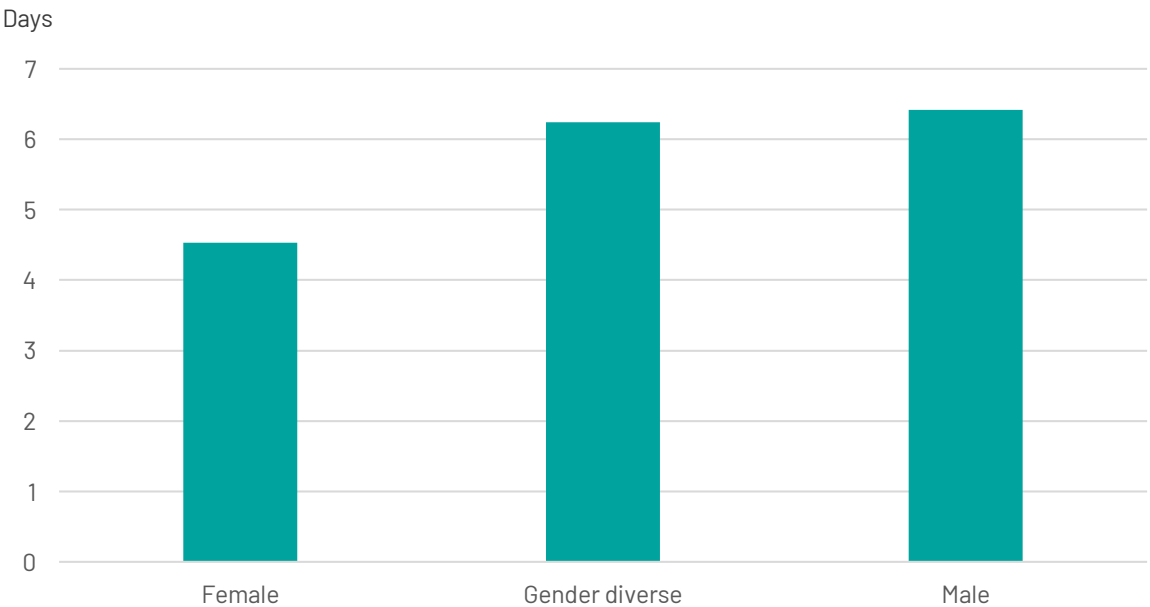
Figure 4. Time Gaps Between Referral and Onboarding, by Age Group



Note: Only items with statistically significant differences are presented in this figure.

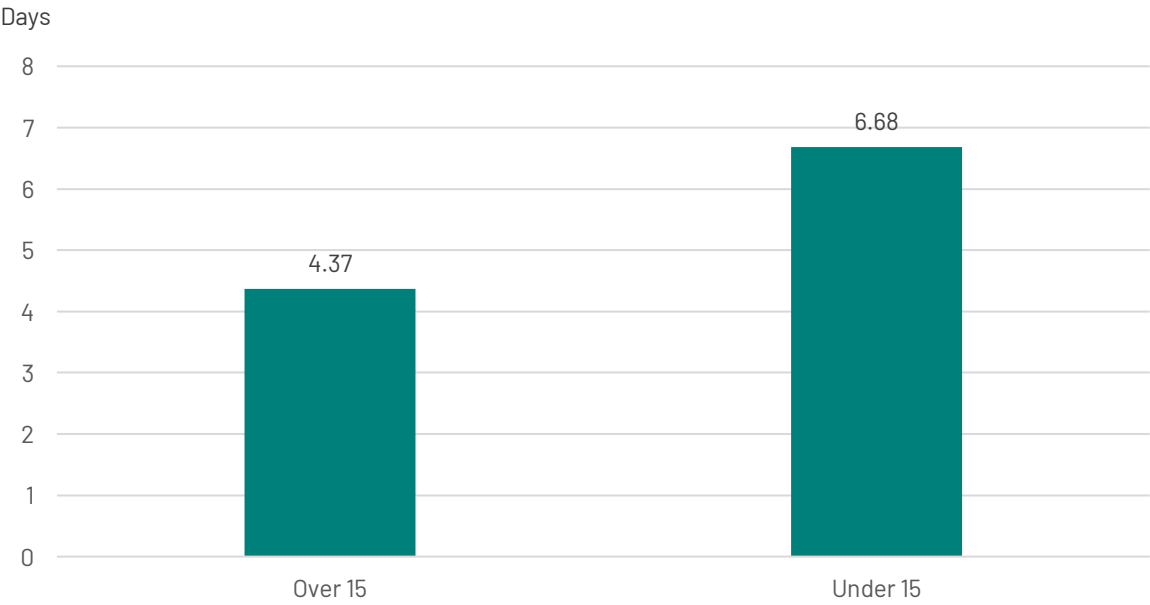
Following a MOST referral, headspace clinicians generally described taking a hands-off approach, resulting in limited oversight of whether and when young people complete the sign up and onboarding process. Only one headspace clinician reported routinely monitoring the onboarding process. This headspace clinician reflected that a prolonged time to onboarding may indicate disengagement with the platform rather than delayed uptake. Although the quantitative data only captures people who onboard, this perspective aligns with the observed pattern that onboarding becomes less likely after the first seven days following referral.

Figure 5. Number of Days Between Referral and Onboarding, by Gender



Note: Only items with statistically significant differences are presented in this figure.

Figure 6. Number of Days Between Referral and Onboarding, by Age Group



Note: Only items with statistically significant differences are presented in this figure.

3.2.2 Clinician Perceptions of Referral-to-Onboarding Uptake

While the available quantitative data demonstrates quick sign-up and onboarding times among young people who completed the onboarding process, from the available dataset it was not possible for the evaluation team to calculate the proportion of young people who did not uptake MOST despite receiving a referral.

headspace clinicians reported receiving quarterly reports from Orygen Digital that included site- and state-specific data on referral rates among other statistics for MOST (see Section 5.6.7.). However, from memory, headspace clinicians were unable to recall the exact proportion of uptake at their site, though consistently estimated that approximately 30 to 50% of referred youth ultimately sign up and log in to the platform:

I think at the moment it's about 50%. And I say that because we can see when they actually commence with MOST through our MOST clinician portal. Maybe it's 50, maybe it's 30 ... Generally, it's about half. Half of them will actually link in and log on.

— HEADSPACE CLINICIAN 13, METROPOLITAN SITE

A minority of headspace clinicians who held quite favourable attitudes toward the platform, expressed confusion about the misalignment between referral and onboarding rates. These headspace clinicians found it difficult to reconcile young people's apparent enthusiasm at the point of referral with subsequent decisions not to onboard. One headspace clinician reflected that onboarding rates appeared higher when MOST was first introduced at their site, noting uncertainty about what has changed over time:

In the beginning I was getting really good referral to onboarding. But I don't know, maybe I've lost my touch on convincing people of it because they sound so keen and then they don't onboard. I'm not really sure what that disconnection is?

— HEADSPACE CLINICIAN 1, METROPOLITAN SITE

There may be an opportunity for Orygen Digital to further highlight the uptake rate when sharing reports with headspace clinicians. This may help overcome referral hesitancy.

3.3 Youth Engagement with MOST

HIGHLIGHTS

- On average, a user engaged with MOST across 10.03 sessions, totaling 55.97 minutes.
- Gender diverse users engaged more with MOST compared to cisgender male and female users. Regional users spent more time on the app than metropolitan users.
- MOST users stayed active on the app for 41.52 days after onboarding, with the number of unique days with access being 6.59 days on average.
- On average, MOST users posted 0.76 posts and 1 comment and made 1.40 interactions in the MOST social network. Gender diverse users interacted more with the social network than cisgender male and female users. Under-15 users were also more active than Over-15 users, and rural/regional/remote users were more active compared to metropolitan users.
- MOST users sent on average 1.99 messages to and received 2.92 messages from peer workers. They sent 0.75 messages to and received 1.98 messages from MOST vocational workers.

headspace clinicians referred to MOST as a “one stop shop”, highlighting the multi-faceted nature that provides youth with evidence-based psychotherapeutic content and activities, a peer-led social network community, remote clinician support, peer support, and vocational or career consultation support. This section describes how youth are engaged with MOST overall and each of the components. Importantly, headspace clinician perceptions are often based on their thoughts and hypothetical scenarios rather than observations. In this section, headspace clinicians’ observations about young people’s engagement with MOST, reported alongside quantitative findings, are provided for illustrative purposes.

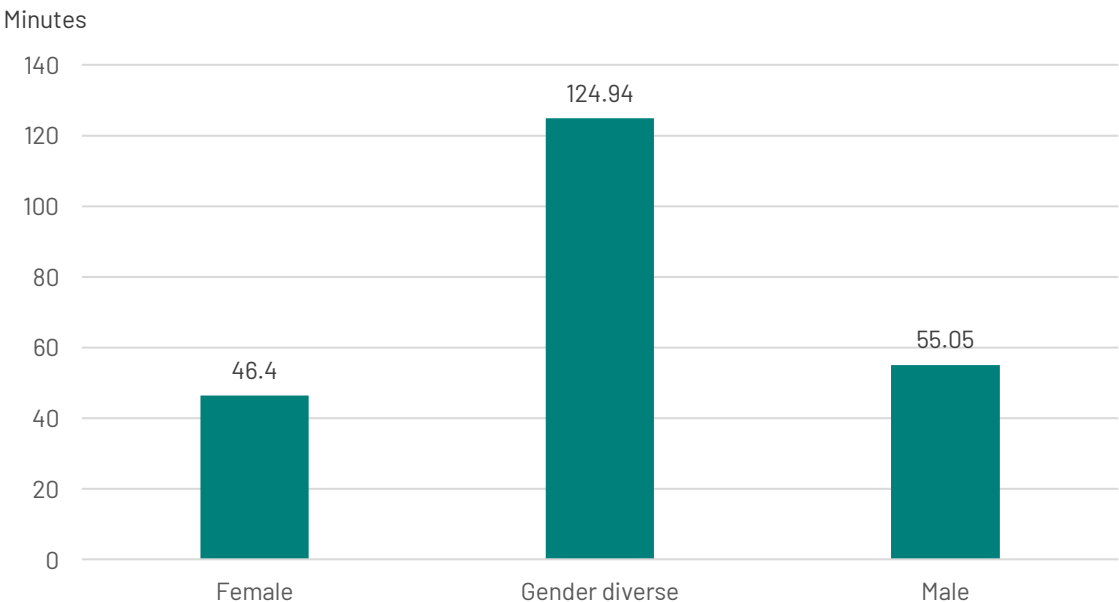
3.3.1 Overall Platform Engagement

On average, a user engaged with MOST across 10.03 sessions, totalling 55.97 minutes.

3.3.1.1 Overall Platform Engagement by Gender

As reported in **Figure 7** (detailed results can be found in Appendix A6, **Table 17**) gender diverse users had the most engagement, with 21.89 sessions and 124.94 minutes of app use. These figures exceeded those of users who identified as female (8.47 sessions & 46.40 minutes) and male (9.83 sessions & 55.05 minutes). Statistical tests suggest that there is a statistically significant difference across genders.

Figure 7. Total Session Time (minutes) by Gender



Note: Only items with statistically significant differences are presented in this figure.

Across genders overall engagement with MOST varied substantially, with large standard deviations indicating highly uneven patterns of platform use between individuals rather than consistent engagement across users. This suggests that overall engagement may be better characterised as polarised – where young people either use the platform intensely or minimally, rather than overall use being conceptualised as evenly distributed across users. This pattern was most pronounced among gender diverse youth, who showed the highest average engagement and greatest variability. This pattern aligns with headspace clinicians’ observations that engagement with MOST tends to be uneven, with headspace clinicians describing young people as “highly engaged” or “not engaged at all” rather than moderately engaged. One headspace clinician described observing this pattern particularly among young men, for example:

The interesting thing to me is boys seem to be really engaged or not at all ... Like I’ve had quite a few boys in their 20s [and] I just see they’re like doing all of the things. They’re talking all the time. And I’m like, that’s amazing ... and I just thought that was really interesting that sometimes people are really, really engaged ... but I’ve had females do the exact same thing, like very, very interested ... And then other times, not at all, but I would say on average, women are more receptive. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

Notably, headspace clinician perceptions of gendered engagement did not align with observed platform use. While several headspace clinicians perceived cisgender females to be more engaged with MOST overall, quantitative data indicates that cisgender females have the fewest average number of sessions and spend the least amount of time on the platform, on average. This misalignment between headspace clinician perceptions and quantitative data suggests headspace clinicians may hold biases toward traditional help-seeking behaviours when forming assumptions about engagement.

Although gender diverse young people demonstrated the highest average engagement, only one headspace clinician explicitly reflected on this group’s usage of the platform. This absence of qualitative commentary may reflect limited clinician visibility into gender-diverse engagement or implicit assumptions about who engages with digital interventions.

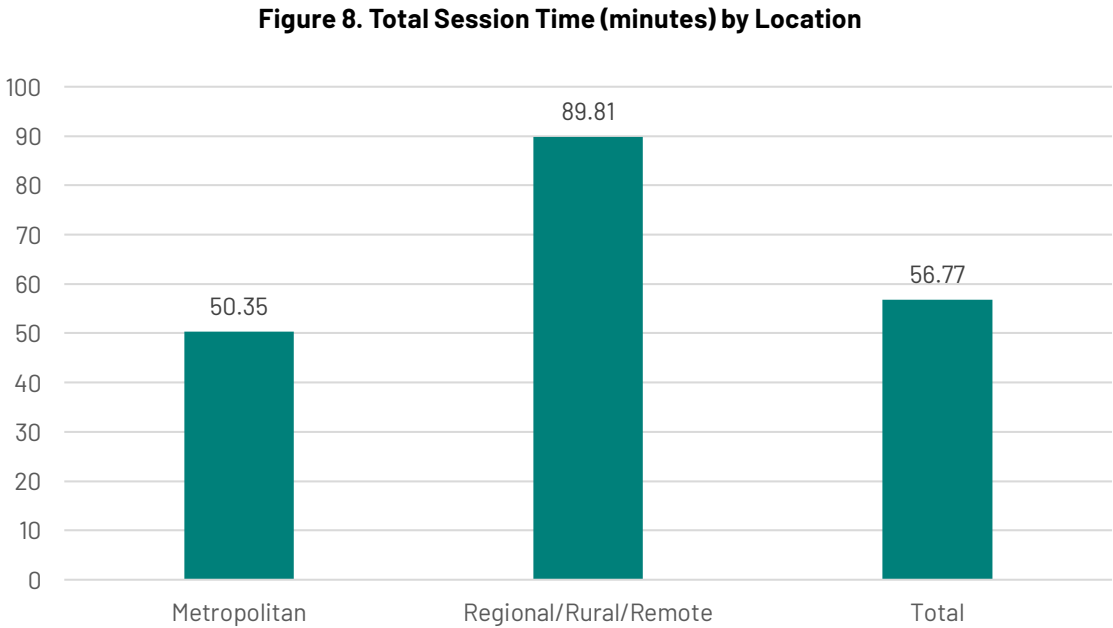
3.3.1.2 Overall Platform Engagement by Age

The over-15 user group spent 10.93 sessions, or 62.06 minutes on MOST, while the under-15 group averaged at 7.70 sessions or 40.03 minutes. The differences across age groups, however, are not statistically significant. Detailed results are reported in [Table 19](#) in Appendix A6.

The lack of a statistically significant difference across age groups demonstrates that young people engage with MOST similarly regardless of age.

3.3.1.3 Overall Platform Engagement by Location

The results [Figure 8](#) (details in Appendix A6, [Table 20](#)) indicate that regional users spent more time on MOST than users from metropolitan areas. The average number of sessions among regional users was 14.80 sessions, with a total session time of 89.81 minutes. Meanwhile, metropolitan users averaged 9.29 sessions and 50.35 minutes. These differences are statistically significant.



Note: Only items with statistically significant differences are presented in this figure.

Overall engagement differed substantially by location, with young people in regional, rural, and remote areas spending more time on the platform and engaging in a greater number of sessions than their metropolitan counterparts. These findings suggest that MOST may play a particularly important role for young people living in regional areas.

Notably, headspace clinician reflections did not initially align with this pattern. headspace clinicians working in regional locations frequently emphasised youth resistance, hesitancy, or disengagement from mental health interventions, and rarely described observing high levels of digital engagement. This misalignment between the expectations of headspace clinicians and observed platform use highlights a potential blind spot in how engagement is conceptualised in regional contexts. These findings suggest that although headspace clinicians may perceive resistance to online mental health interventions in regional areas, young people in these settings appear to engage more intensely with digital platforms, and higher engagement may reflect a greater reliance on digital platforms in contexts where offline support, privacy, and choice are constrained.

3.3.1.4 Overall Platform Engagement by Treatment Stage

There are no statistically significant differences among users at different treatment stages (detailed results can be found in [Table 21](#) in Appendix A6). In contrast to these findings, headspace clinicians held varied expectations about when young people would be most engaged with MOST. Many clinicians anticipated that engagement would be highest while young people were waiting for their first appointment or approaching discharge, perceiving these periods as particularly challenging due to limited support or the loss of structured care. However, these expectations contrast with usage data, which indicates that overall engagement is broadly similar across treatment stages.

3.3.1.5 Overall Platform Engagement by Work/Study Status

There are large variations in the level of engagement of users with different work/study status. The differences are however not statistically significant. Detailed results can be found in [Table 22](#) in Appendix A6).

headspace clinicians were somewhat aware of young people's use of MOST while they were engaged with headspace, but they reported having limited knowledge of how youth used each component—especially those not currently active in care, waiting for face to face support, or nearing discharge.

3.3.2 Psychotherapeutic Content

The psychotherapeutic content refers to the evidence-based information that youth can access on MOST. This content is derived from cognitive behaviour therapies that can include – but is not limited to – cognitive distortions such as repetitive negative thinking styles, cognitive and affective biases, emotional dysregulation, and avoidance (Alvarez-Jimenez et al., 2025; Cross et al., 2023; MOST & Orygen Digital, 2025). There are more than 600 individual therapy items available on MOST that can be accessed as standalone resources, grouped within themed 'tracks'. These tracks target a key mechanism that may maintain or exacerbate a targeted mental health difficulty (Alvarez-Jimenez et al., 2025). Multiple tracks are combined to create broader 'journeys' (Alvarez-Jimenez et al., 2025).

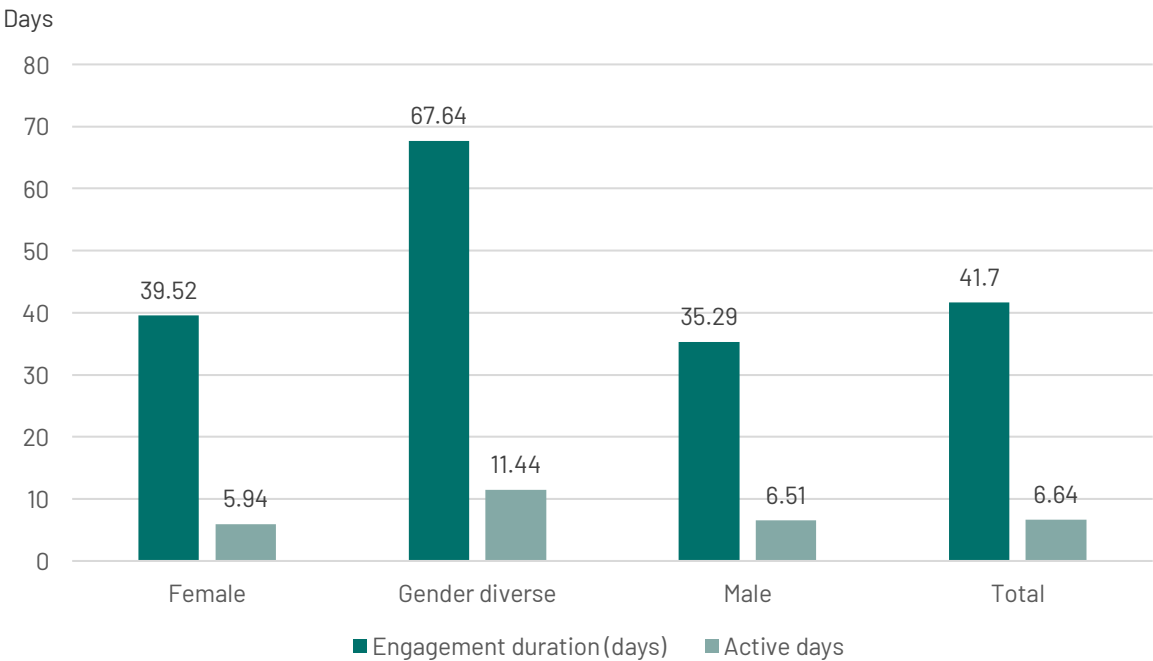
Each journey comprises key psychotherapeutic concepts, debunking myths, themed narrative-driven comics, reflective activities, behavioural experiments, audio and audio-visual content, and questions embedded within each track that encourage young people to share and discuss their experiences with other people – referred to as 'talking points' (Alvarez-Jimenez et al., 2025). Young people can save any activities they find helpful to their personalised 'toolkit' allowing them to re-locate and re-engage with these activities for later reference (Alvarez-Jimenez et al., 2025). headspace clinicians can assign journeys to a young person, or the young person can explore and select the journeys they deem as appropriate and relevant to themselves.

Data from MOST indicated that MOST users on average had six distinct therapy item views and eight views of any items. On average, they stayed engaged with MOST for ~41 days after onboarding, with ~7 active days of access across that period. This aligns with clinician perceptions as they consistently described the psychotherapeutic content as a central driver of young people's engagement with MOST and frequently identified it as one of the components with which young people engage most readily and consistently. In contrast to clinical, peer, and vocational support offered on the platform, clinicians perceived the psychotherapeutic resources as a primary way that young people interact with MOST.

3.3.2.1 Psychotherapeutic Engagement by Gender

There were no statistically significant gender differences regarding therapy item views (details reported in Appendix A6, [Table 23](#)). However, gender diverse users stayed engaged with MOST for an average duration of 67.64 days, accessing MOST on 11.44 of those days. These figures are much higher than that of cisgender female (39.52 days engaged/5.94 days active) and cisgender male users (35.29 days engaged/6.51 days active).

Figure 9. Engagement with Psychotherapeutic Content by Gender



Note: Engagement duration is the number of days between completing onboarding and last access to MOST; Active days refers to the number of days MOST was accessed by the client during their engagement period. Only items with statistically significant differences are presented in this chart.

3.3.2.2 Psychotherapeutic Engagement by Age

While there are no statistically significant differences across age groups, it is important to note a potentially lower level of engagement among under-15 users. If the statistical significance threshold was lowered to 90%, the difference in the number of unique therapy views would be considered significant (4.34 views among the under-15 group compared to 6.64 views of the over-15 group). Detailed results are reported in [Table 25](#) in Appendix A6.

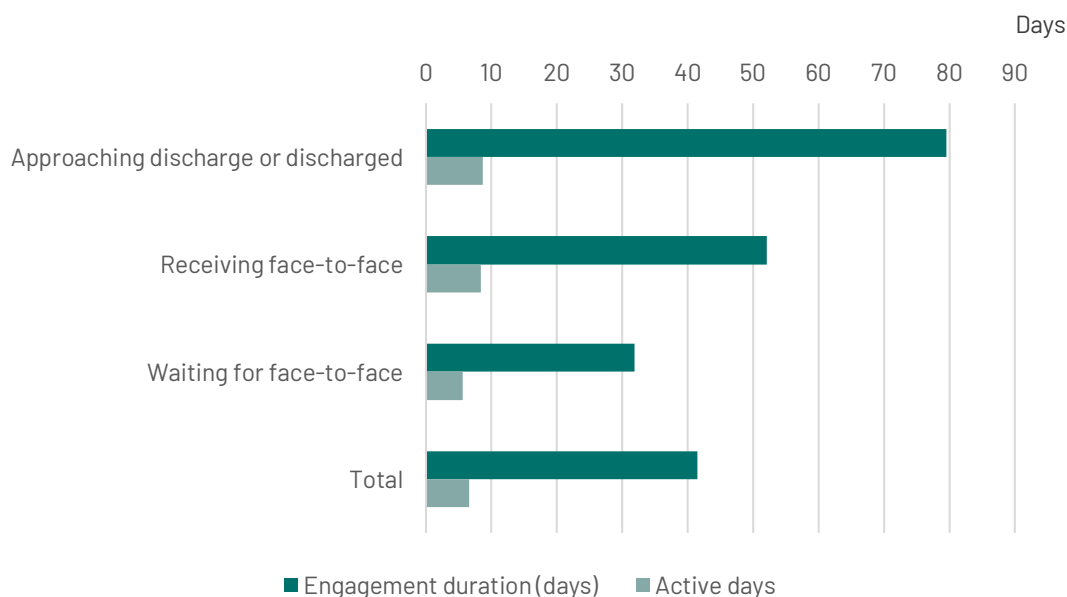
3.3.2.3 Psychotherapeutic Engagement by Location

There are no statistically significant differences in therapy views, engagement duration or the number of active days on MOST between users in metropolitan areas and regional locations. Detailed results are reported in [Table 26](#) in Appendix A6.

3.3.2.4 Psychotherapeutic Engagement by Treatment Stage

There were no statistically significant differences in therapy views between users in different treatment stages (Appendix A6, [Table 27](#)). However, those who were close to, or had already been discharged, remained engaged with MOST for a statistically significantly longer period of time (79.59 days in total, with 8.65 days with access) than those who were receiving face-to-face treatment (52.12 days in total, with 8.41 days with access), and those who were waiting for face-to-face (31.87 days in total, with 5.59 days with access). This suggests that while some young people engage with psychotherapeutic content to a similar extent across stages, sustained engagement with the platform varies depending on where people are in their care journey.

Figure 10. Engagement with Psychotherapeutic Content by Treatment Stage



Note: Engagement duration is the number of days between completing onboarding and last access; Active days refers to the number of days with access. Only items with statistically significant differences are presented in this figure.

headspace clinicians described observing some young people engaging with self-guided therapy content alongside face-to-face care, between headspace sessions. However, headspace clinicians acknowledged limited insight into how this pattern compares across treatment stages, reflecting limited visibility into young people's engagement beyond active headspace involvement.

3.3.2.5 Psychotherapeutic Engagement by Work/Study Status

There are no statistically significant differences in therapy views, engagement duration or the number of active days on the app between users with different work/study status. Detailed results can be found in [Table 28](#) in Appendix A6.

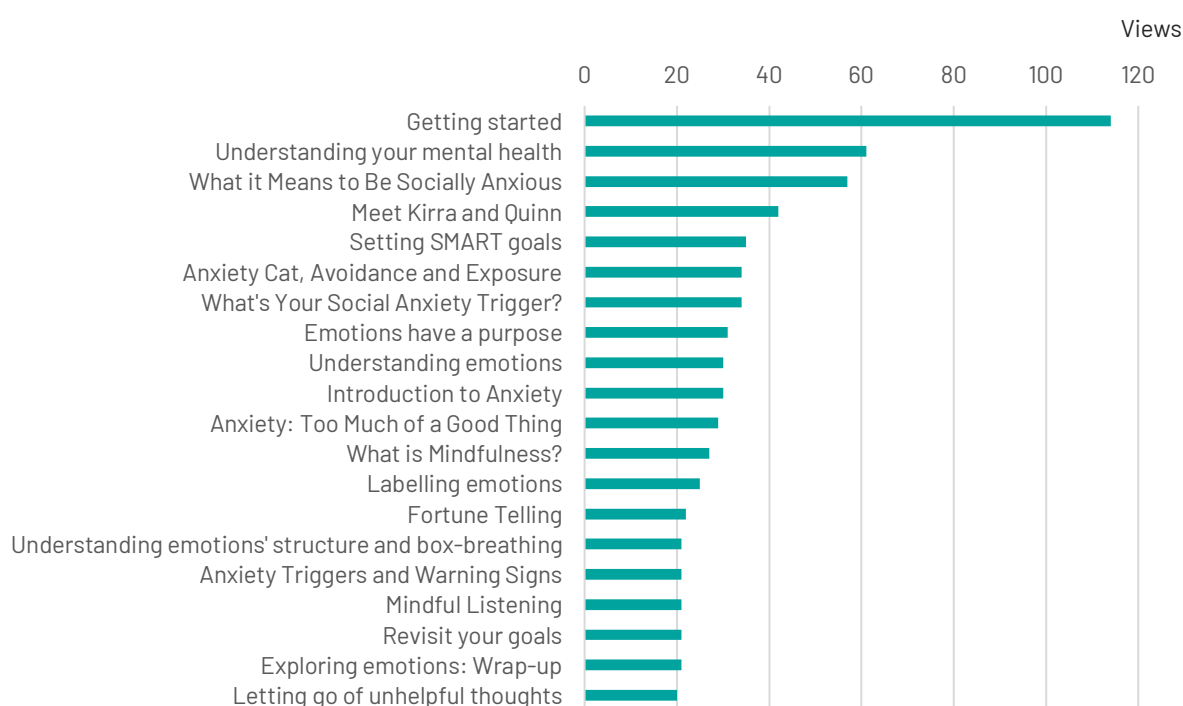
3.3.2.6 Psychotherapeutic Engagement by Therapy

Given the centrality of the psychoeducation component to young people's engagement with MOST, the following figures describe which psychotherapeutic content items were most frequently viewed by young people on the platform.

Figure 11. 20 Most-viewed Therapies in Over-15 Platform



Figure 12. 20 Most-viewed Therapies in Under-15 Platform



headspace clinicians consistently perceived the psychotherapeutic content delivered on MOST to be well-matched to concerns that youth commonly present to headspace with such as anxiety, depression, self-esteem, low confidence, low body image, and sleep hygiene. Notably, headspace clinicians' identification of anxiety as a particularly salient and relevant concern is reinforced by platform data showing that approximately a quarter of the most-viewed therapies across age groups relate to anxiety.

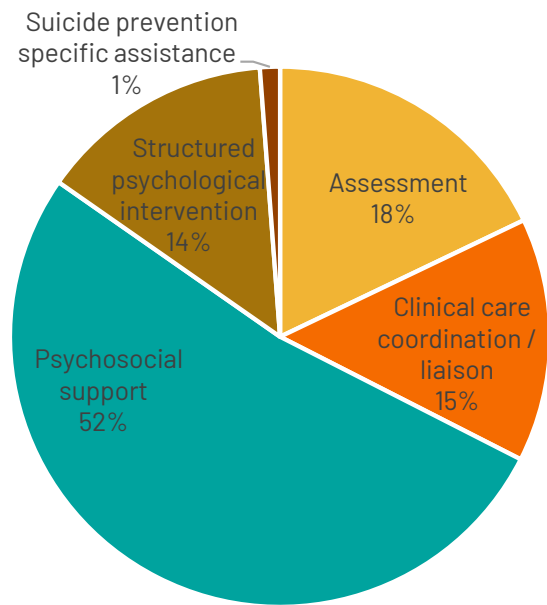
3.3.3 MOST Clinician Support

MOST clinicians are accredited mental health professionals that provide direct support to the youth. MOST clinicians use treatment manuals that are standardised and aligned to the psychotherapeutic content on MOST (Alvarez-Jimenez et al., 2025; MOST & Orygen Digital, 2025). MOST clinician support includes an initial phone call, scheduled contact, and text-based interactions with the youth. A MOST clinician is available to anyone on the platform, however young people aged 15 to 25 are encouraged to use the provided clinician support on MOST, whereas young people aged 12 to 14 are assigned a MOST clinician (Alvarez-Jimenez et al., 2025). This section describes how youth engage with clinician support on MOST.

Quantitative data indicates that on average, MOST users sent 1.14 messages to MOST clinicians and received 3.75 messages from clinicians. An average user had 2.96 contacts with MOST clinicians, during which the clinicians spent 22.84 direct minutes with the young person and 27.92 minutes preparing for the contact, completing necessary follow-up tasks, and engaging with others.

Figure 13 reports the primary purposes of contacting a clinician (allocated clinician, clinical lead or duty clinician) by a young person. The largest category is psychological support which accounts for ~52%, followed by assessment (~18%) and clinical care coordination/liaison (~15%). Detailed results are provided in Table 29 in Appendix A6.

Figure 13. Primary Purposes of Contacting an Allocated Clinician, Clinical Lead, Duty Clinician



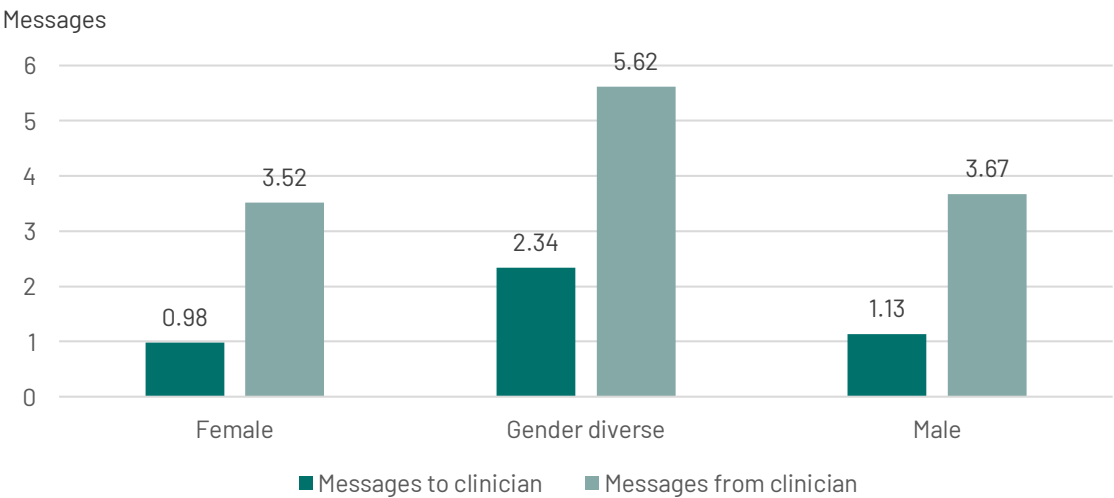
3.3.3.1 Interactions with a MOST Clinician by Gender

Detailed results in Appendix A6, [Table 30](#) shows that the gender differences in interactions with a MOST clinician are statistically significant. The results are visualised in [Figure 14](#) and [Figure 15](#).

Gender diverse users sent and received the greatest number of messages to and from MOST clinicians (2.34 and 5.62 messages respectively). Cisgender male users sent 1.13 messages and received 3.67 messages on average. Cisgender female users sent 0.98 messages and received 3.52 messages.

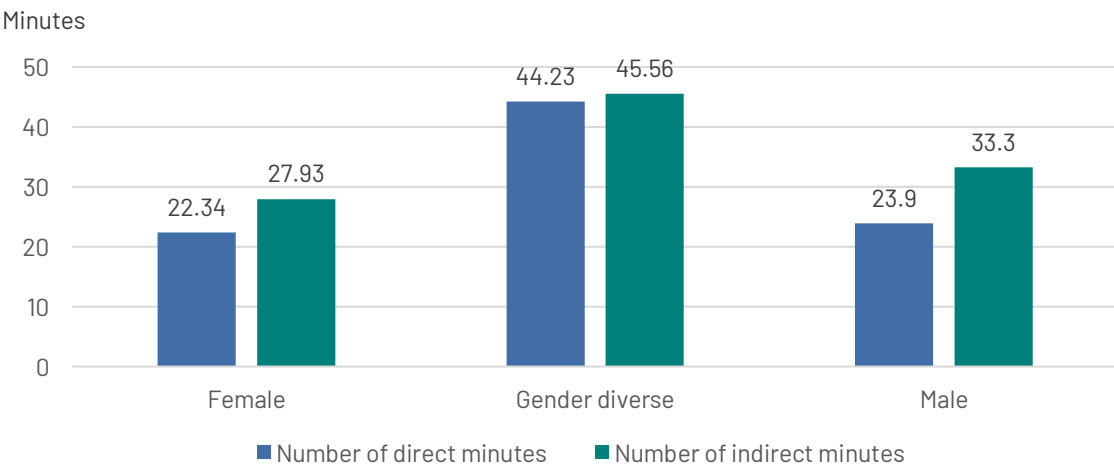
Gender diverse users also had the most contacts with a MOST clinician, at 4.16 contacts. MOST Clinicians sent nearly twice as many direct and indirect minutes with a gender diverse young person than an average user.

Figure 14. Number of Messages to and from a MOST Clinician, by Gender



Note: Only items with statistically significant differences are presented in this figure.

Figure 15. The Amount of Time MOST Clinicians Spent for Contact with Young Person, by Gender

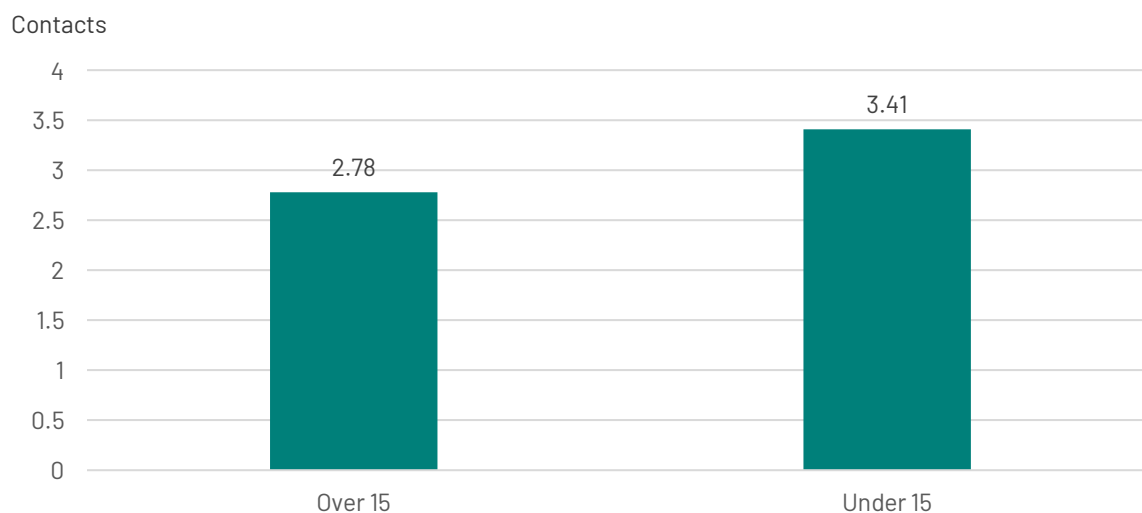


Note: Direct minutes refer to the amount of time MOST clinicians spent in direct contact with the young person. Indirect minutes refer to the amount of time MOST clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others. Only items with statistically significant differences are presented in this figure.

3.3.3.2 Interactions with a MOST Clinician by Age

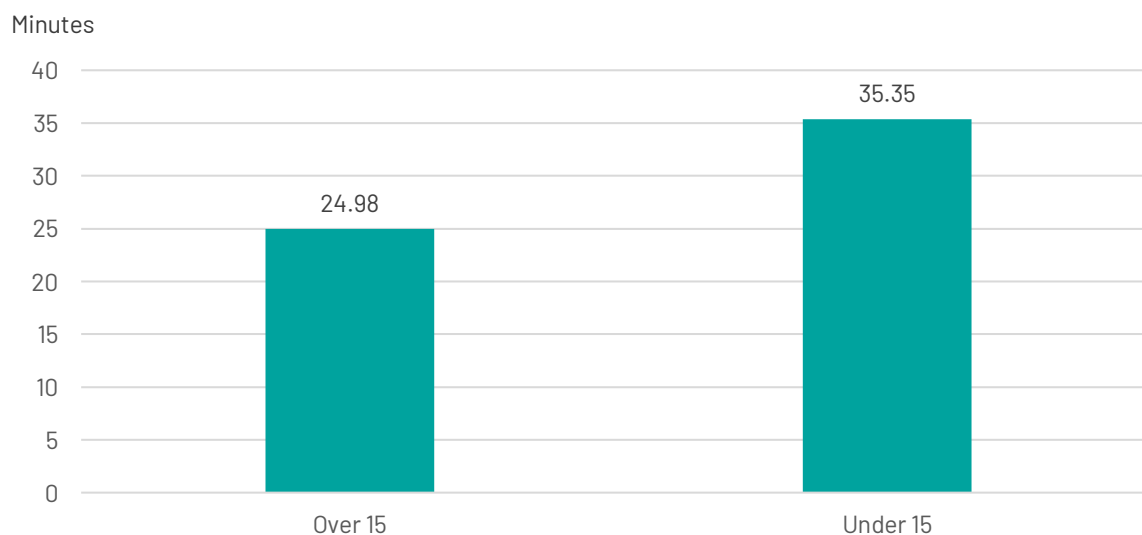
The Under-15 age group had more contacts with MOST clinicians (detailed results reported in [Table 32](#) in Appendix A6). MOST clinicians also spent more time preparing for the contact with Under-15 users. There are no statistically significant age group differences in the number of messages or the amount of time clinicians spent in direct contact with the young person.

Figure 16. Number of Contacts with a MOST Clinician, by Age Group



Note: Only items with statistically significant differences are presented in this figure.

Figure 17. The Number of Indirect Minutes MOST Clinicians Spent for Contact with Young Person, by Age Group



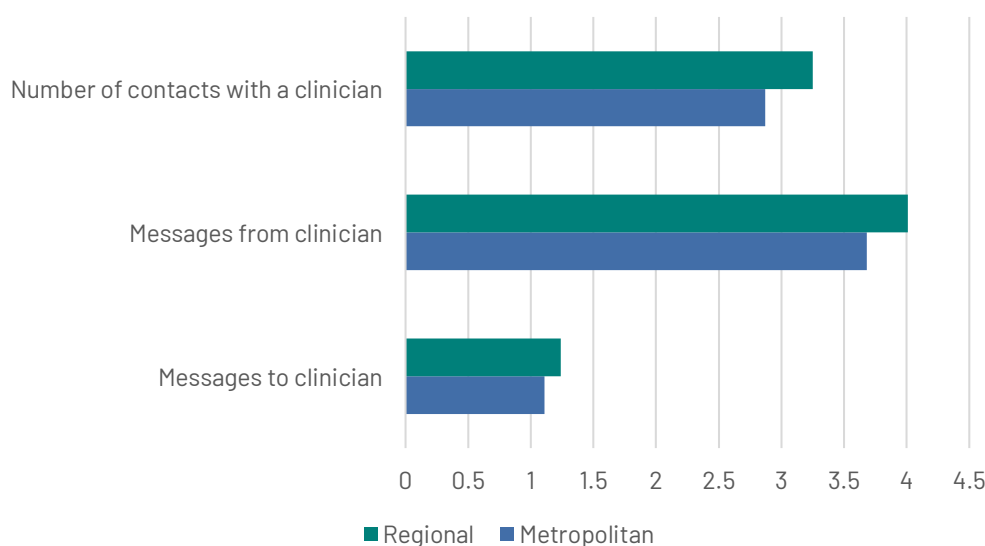
Note: Indirect minutes refers to the amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others. This difference is statistically significant. The difference across age groups in terms of direct minutes is not statistically significant and therefore not presented in this chart.

3.3.3.3 Interactions with a MOST Clinician by Location

There were no statistically significant differences in the number of interactions with a MOST clinician by location. Detailed results are reported in [Table 33](#) in Appendix A6.

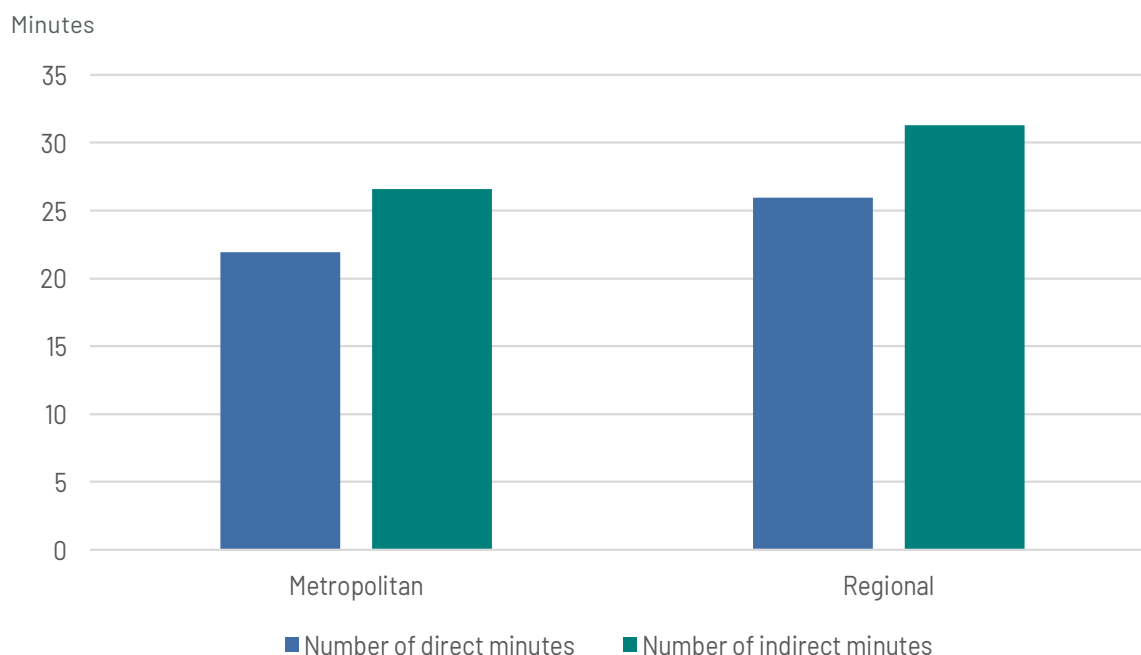
The results are presented in [Figure 18](#) and [Figure 19](#). Note that the differences between regional and metropolitan areas shown in these graphs are not statistically significant.

Figure 18. Number of Contacts and Messages with a MOST Clinicians by Location



Note: The differences between regional and metropolitan areas presented here are **not statistically significant**.

Figure 19. The Amount of Time MOST Clinicians Spent for Contact with Young Person by Location



Note: Direct minutes refer to the amount of time MOST clinicians spent in direct contact with the young person. Indirect minutes refer to the amount of time MOST clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others. The differences between regional and metropolitan areas presented here are **not statistically significant**.

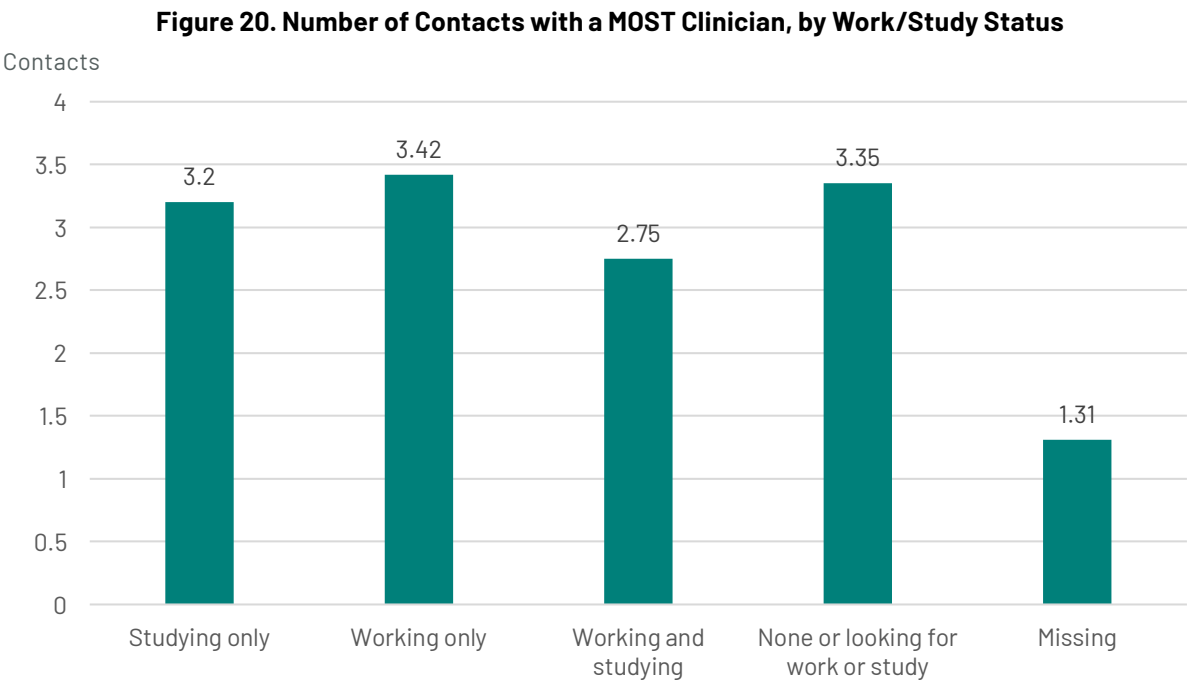
3.3.3.4 Interactions with a MOST Clinician by Treatment Stage

There were no statistically significant differences in the number of interactions with a MOST clinician by treatment stage.

Although engagement differences by treatment stage were not statistically significant, the trend toward higher engagement with MOST clinicians around headspace discharge contrasts with some headspace clinician expectations that young people would be less likely to seek clinical support when exiting headspace care. While some headspace clinicians recognised discharge as a difficult transition for young people, when discussing post-discharge support options, clinicians most often referenced psychotherapeutic or social networking features, rarely mentioning clinical support. This suggests that MOST’s clinical support component may be under-positioned within referral conversations.

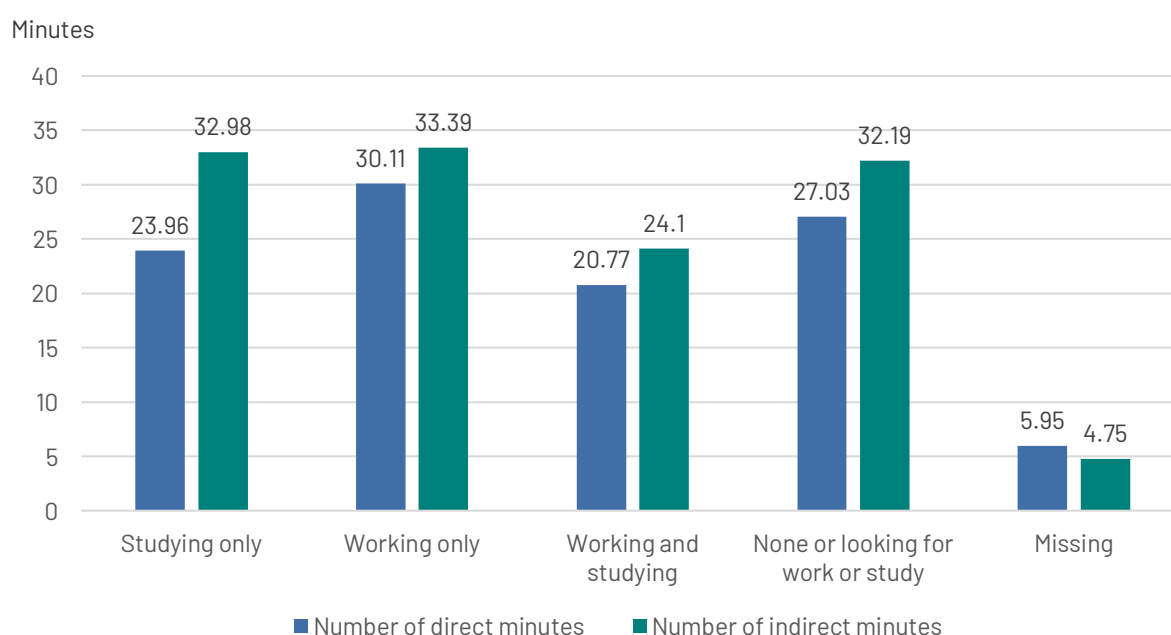
3.3.3.5 Interactions with a MOST Clinician by Work/Study Status

Figure 20 and Figure 21 (with detailed results reported in Table 35 in Appendix A6) show that users who were working and studying had fewer contacts with MOST clinicians than those who were studying only or working only. Users with missing information on their work/study status had the least contact with MOST clinicians. There are no statistically significant differences in terms of the number of messages.



Note: Only items with statistically significant differences are presented in this figure.

Figure 21. The Amount of Time MOST Clinicians Spent for Contact with Young Person, by Work/Study Status



Note: Direct minutes refer to the amount of time MOST clinicians spent in direct contact with the young person. Indirect minutes refer to the amount of time MOST clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others. Only items with statistically significant differences are presented in this figure.

Despite the availability of clinician support on MOST, quantitative data indicates that youth engagement with this component was consistently low across demographic groups.

3.3.3.6 headspace Clinician Understanding of MOST Clinical Support

Across interviews, headspace clinicians reported having limited insight into whether, and how young people engage with MOST clinicians. While MOST clinicians may contact headspace clinicians about shared clients, when necessary, headspace clinicians noted that this communication is sometimes delayed (see Section 5.6.6 for further information). In contrast to the psychotherapeutic content, which young people appeared more willing to actively discuss with their headspace clinician, interactions with MOST clinicians were rarely raised in session. Notably, not a single headspace clinician reported young people discussing their engagement with MOST clinical support.

Several headspace clinicians expressed uncertainty about the nature of clinician support on MOST (see Section 5.6.3 for further information). Additionally, clinicians held inconsistent understandings about the provision of clinical support – with some clinicians believing that young people can access as much clinical support as needed, while others believing that clinical support was limited or not offered to everyone. This lack of clarity appeared to reduce clinicians' confidence in explaining the feature to young people and setting realistic expectations, which may further limit youth awareness and uptake of this component. Taken together, these findings suggest that headspace clinician understanding plays an important role in shaping the uptake of MOST's clinical support.

3.3.4 Engagement in MOST Social Network

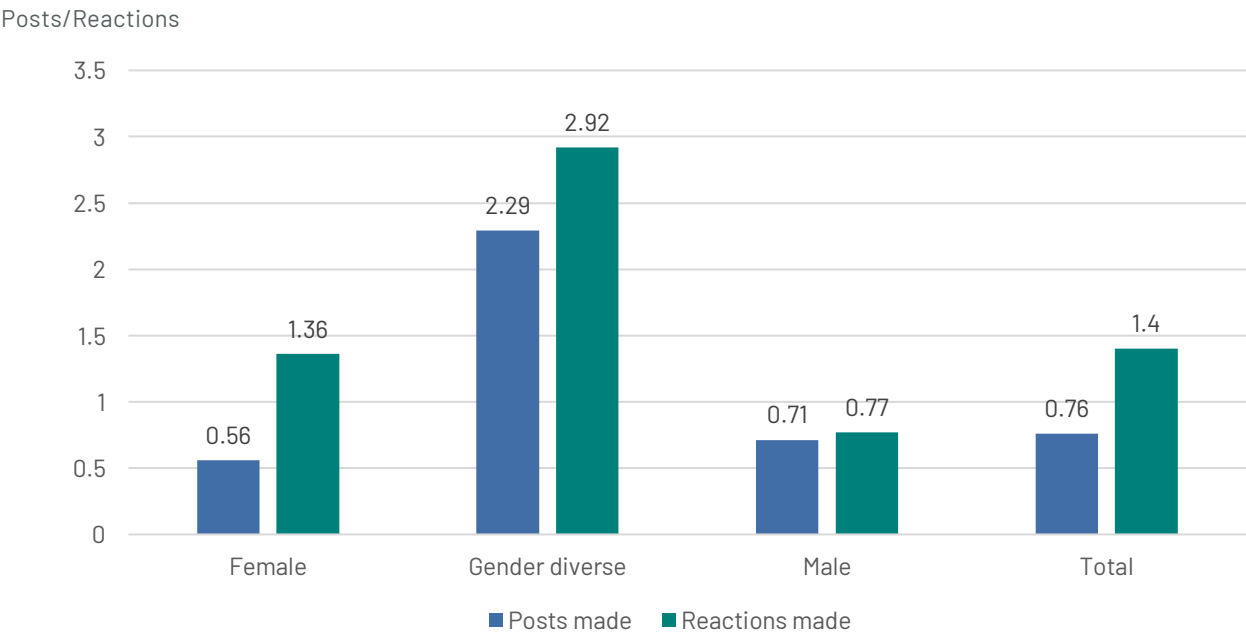
MOST’s moderated online social network allows young people to connect with other young people, which can occur through three ways. First, MOST offers “The Community” which is a space for young people to share their general experiences, resources and support. Second, “Talk it Out” is a space for young people to share their difficulties and collaboratively work to address them. Last, “Talking points” are embedded within psychotherapeutic journeys that guide young people to discuss topic-based items in the social network. In the social network space youth can create a post and engage with other people’s posts by reacting and commenting. This space was designed to encourage hope, agency, and address loneliness and self-stigma (Alvarez-Jimenez et al., 2025) and is moderated by peer workers who foster healthy discussion and protect youth’s safety.

While headspace clinicians consistently perceived the moderated social network as one of the components that young people are most engaged with, observed levels of active participation were relatively low. On average, MOST users posted 0.76 posts and 1 comment and made 1.40 interactions in the MOST social network.

3.3.4.1 Engagement in the Social Network by Gender

There are statistically significant gender differences in the number of posts and interactions made (but not the number of comments) in the social network among MOST users. Particularly, gender diverse users had the greatest level of interaction, with 2.29 posts and 2.92 interactions. These are higher than that of cisgender male (0.71 posts and 0.77 interactions) and cisgender female (0.56 posts and 0.91 interactions) users. The full results are reported in [Table 36](#) and [Table 37](#) in Appendix A6, with statistically significant differences presented graphically in [Figure 20](#).

Figure 22. Number of Posts and Reactions Made in the Social Network by Gender

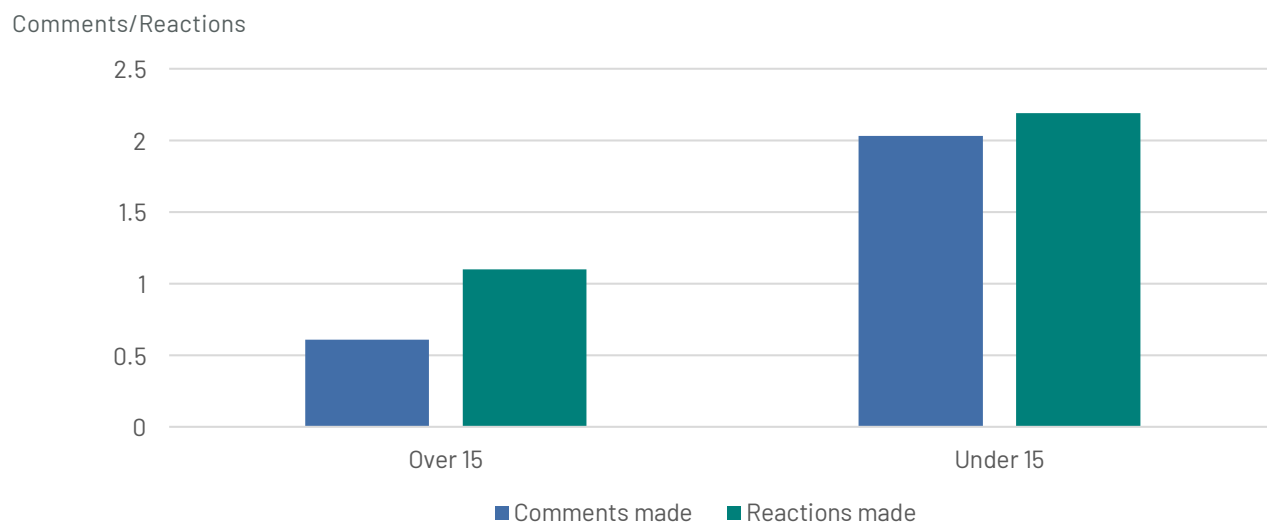


Note: Only items with statistically significant differences are presented here.

3.3.4.2 Engagement in the Social Network by Age

Over-15 and under-15 age groups differ in terms of the number of comments and interactions made in the MOST social network. A statistically significant higher level of engagement was observed among under-15 users, with 2.03 comments and 2.19 interactions made on average, compared to 0.61 comments and 1.10 interactions of over-15 users. The difference in the number of posts was not statistically significant (detailed results reported in [Table 38](#) in Appendix A6).

Figure 23. Number of Comments and Reactions Made in the Social Network by Age Group

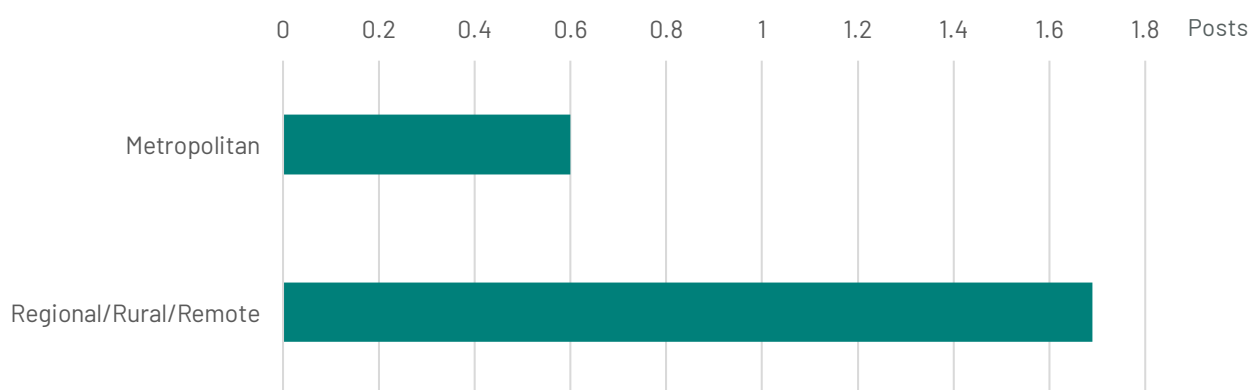


Note: Only items with statistically significant differences are presented here.

3.3.4.3 Engagement in the Social Network by Location

Regional users posted statistically significantly more than metropolitan users in the MOST social network (1.69 posts and 0.61 posts respectively). However, the number of comments and interactions are not statistically significantly different among these two groups of users (detailed results reported in [Table 39](#) in Appendix A6).

Figure 24. Number of Posts Made in the Social Network by Location



Note: Only items with statistically significant differences are presented in this figure.

3.3.4.4 Engagement in the Social Network by Treatment Stage

MOST users who were approaching discharge or had been discharged made statistically significantly more interactions in the social network (2.59 interactions), compared to that of users who were receiving face-to-face treatment (1.80 interactions) and those waiting for face-to-face treatment (1.08 interactions). The differences in terms of posts and comments were not statistically significant (detailed results reported in [Table 40](#) in Appendix A6).

3.3.4.5 Engagement in the Social Network by Work/Study Status

There were no statistically significant differences by work/study status in terms of the level of engagement in the social network (detailed results reported in [Table 41](#) in Appendix A6).

3.3.5 Engagement with MOST Peer Workers

Youth can also receive peer support on MOST from peer workers. Peer workers are young people aged between 18 and 30 who have lived experience of mental ill health. Peer workers and paid, trained employees, delivering peer support within an international peer support framework (MOST & Orygen Digital, 2025). On the social network, peer workers constructively respond to posts, share resources and discussion starters, and moderate the platform. Young people can also receive individual peer support at any time through direct messaging on the platform (MOST & Orygen Digital, 2025).

3.3.5.1 Overall Engagement from Quantitative Data

Quantitative data suggests that, on average, MOST users sent 1.99 messages to and received 2.92 messages from peer workers. There are no statistically significant differences by gender, age, location, treatment stage or work/study status. Detailed results are reported in Appendix A6 from [Table 42](#) to [Table 47](#).

3.3.6 Engagement with MOST Vocational Workers

MOST also provides vocational support for young people whose education or career path has been affected by mental health (MOST & Orygen Digital, 2025). These career consultants are tertiary-qualified career specialists (MOST & Orygen Digital, 2025). Young people can receive one-to-one support for achieving their work and study goals and navigating their career decisions via direct messaging (MOST's vocational workers (MOST & Orygen Digital, 2025)).

headspace clinicians generally perceived that MOST's vocational support was rarely used by young people engaged with headspace. Quantitative data aligns with these perceptions, showing low overall levels of engagement with vocational support. On average, engagement with this component was low as MOST users sent 0.75 messages to and received 1.98 messages from MOST vocational workers.

Despite limited observed use, headspace clinicians perceived vocational support as a valuable component of the platform, viewing it as an important part of a holistic support offer.

3.3.6.1 Interactions with Vocational Workers by Gender

There were no statistically significant differences in the number of interactions with a MOST vocational worker by gender. For results, see [Table 48](#) and [Table 49](#) in Appendix A6.

3.3.6.2 Interactions with Vocational Workers by Age

Over-15 users sent and received a greater number of messages to and from vocational workers (1.04 and 2.70 messages respectively) compared to under-15 users (0.01 and 0.10 messages respectively). These differences are highly statistically significant (reported in [Table 50](#) in Appendix A6).

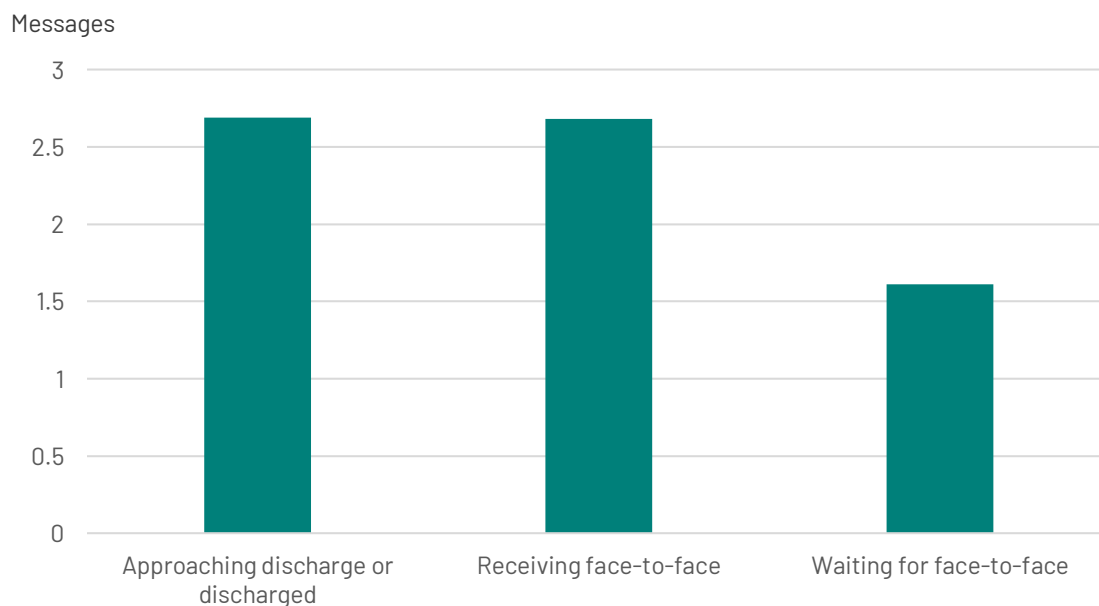
3.3.6.3 Interactions with Vocational Workers by Location

There were no statistically significant differences in the number of interactions with a MOST vocational worker by location (see [Table 51](#) in Appendix A6).

3.3.6.4 Interactions with Vocational Workers by Treatment Stage

MOST users who were approaching discharge or had been discharged or were receiving face-to-face treatment received statistically significantly more messages from vocational workers than those who were waiting for face-to-face treatment (2.69, 2.68 and 1.61 messages respectively). There was a similar pattern when it comes to the number of messages sent to vocational workers from MOST users though not statistically significant (see full results in [Table 52](#) in Appendix A6).

Figure 25. Number of Messages Sent to a Young Person from Vocational Workers by Treatment Stage



Note: Only items with statistically significant differences are presented here.

While young people messaged vocational workers to a similar extent regardless of treatment stage, headspace clinicians consistently perceived that young people receiving headspace care rarely engaged with MOST vocational workers as they perceived young people's vocational needs may already be met by the headspace service. These findings suggest that low engagement with MOST's vocational support reflects the presence of an embedded vocational service within headspace rather than an absence of vocational need among young people. In this context, MOST's vocational feature may function as a supplementary option, with uptake shaped by local service configurations rather than youth relevance and interest.

3.3.6.5 Interactions with Vocational Worker by Work/Study Status

There were no statistically significant differences in the number of interactions with a MOST vocational worker by work/study status. For results, see [Table 53](#) in Appendix A6.

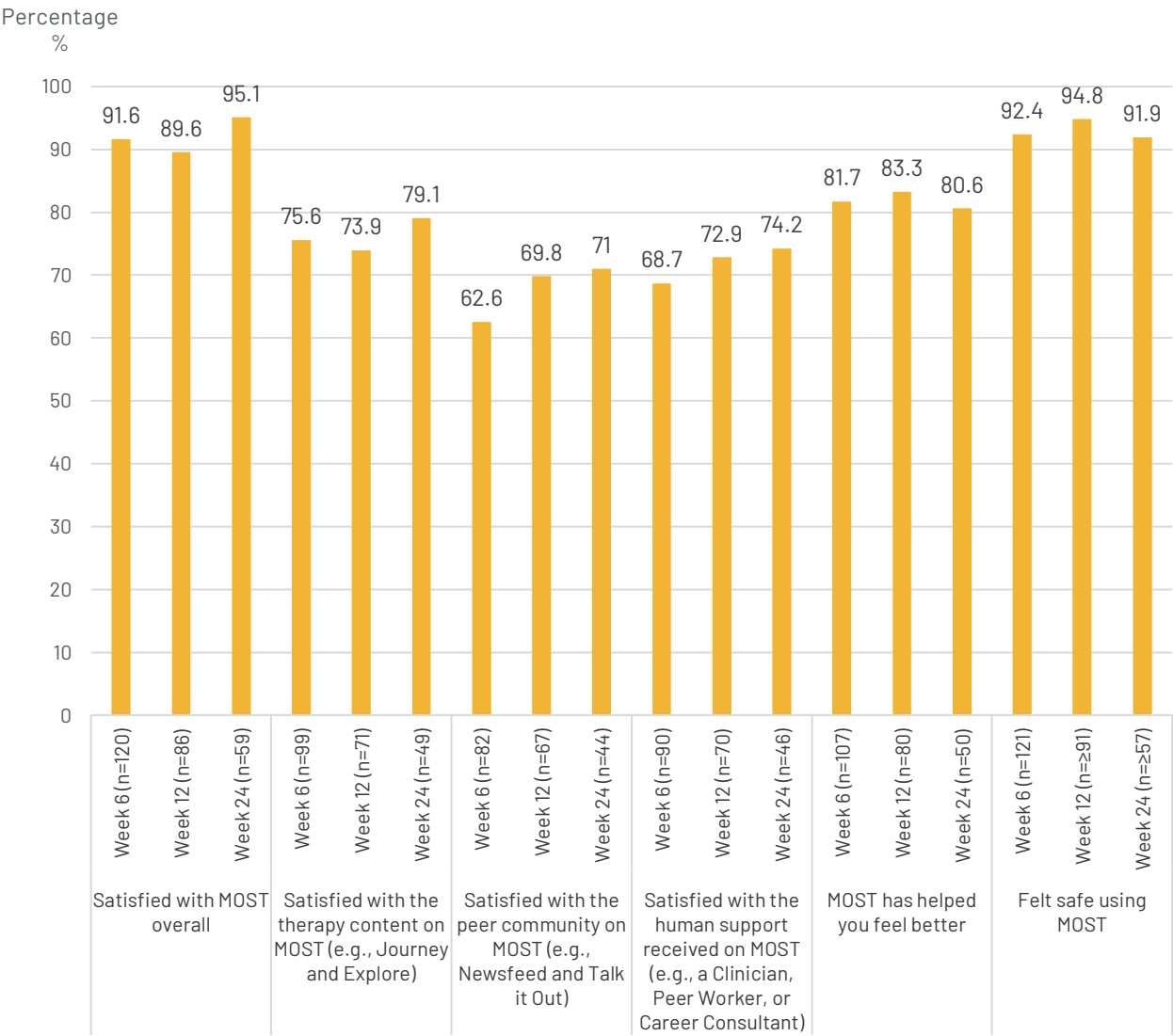
Across components on MOST, headspace clinicians reported having limited visibility over young people's engagement. Some headspace clinicians indicated they were only aware of engagement when young people chose to disclose it in-session, and although some engagement data were available within the platform (for example, psychotherapeutic content and posts on the social network), few clinicians reported accessing it.

This limited visibility appears to contribute to a misalignment between headspace clinician perceptions and observed youth usage data, with clinicians seemingly forming views based on informal feedback or conversations with the youth rather than actual usage patterns. These discrepancies suggest that headspace clinicians may not have a complete understanding of how young people engage with MOST, particularly across demographic groups, which may pose implications for its effective implementation within headspace care.

3.3.7 Youth Satisfaction with MOST

A total of 131 youths at 6 weeks, 96 youths at 12 weeks and 62 youths at 24 weeks answered questions regarding their satisfaction with MOST. More than 90% were satisfied with MOST overall, and more than 90% felt safe using MOST after 24 weeks. About 80% said that MOST had helped them feel better. Satisfaction with the therapy content, peer community and human support was between 60% and 80%. Full results are reported in [Table 54](#) in Appendix A6.

Figure 26. Youth Satisfaction with MOST



3.4 Chapter Summary

- headspace clinicians in a range of positions have multiple opportunities to provide young people with a referral to MOST.
- headspace clinicians were most likely to provide a referral at intake and when a young person is approaching discharge from the headspace service.
- headspace clinicians' decisions to offer a MOST referral appear to be shaped by a range of individual and contextual factors.
- The majority of young people completed sign up and onboarding within two weeks of referral, averaging 5.1 days. Cisgender females and those aged over 15 onboarded more quickly than other cohorts.
- In general, gender diverse users and regional users engaged more with MOST than other user groups, both in terms of app use and interaction in the MOST social network.



Perceived Outcomes of MOST

4.0

This chapter examines the potential impact of MOST on young people and on the broader care system. The first half presents quantitative data, while the second half reflects clinicians' perceptions, which are interpretive and speculative rather than measured outcomes.

4.1 Observed Youth Mental Health and Wellbeing Outcomes

HIGHLIGHTS

- There were statistically significant improvements in depression and anxiety symptoms and mental wellbeing over time among MOST users.
- Some outcome measures saw a greater improvement among cisgender female and gender diverse users (compared to male users), rural/regional/remote users (compared to metropolitan users) and users under the age of 15 (compared to users aged 15 or above).
- Due to the lack of a control group, it is not possible to conclude whether these changes over time are attributable to MOST. However, the results suggest that there is a positive association.

This section focuses on mental health and wellbeing outcomes associated with a young person's engagement of MOST. This section demonstrates how MOST may be related to depressive symptoms, anxiety symptoms, distress, health-related quality of life, mental wellbeing, and empowerment. Importantly, the observational data in this section are correlational and *cannot* be interpreted to suggest that these outcomes are a direct result of young people using MOST. Rather, the findings *suggest* how MOST may be *related* to mental health and wellbeing outcomes.

Orygen Digital collected a number of clinical measures in weeks 0, 6, 12 and 24 after the user onboarded to MOST. Only measures with a sufficient number of observations were analysed and reported in this evaluation, with the main analysis being the Generalised Estimating Equations (GEE) regression models. This methodology allows the data to be an unbalanced panel, meaning that a MOST user does not need to have data available for all time points at 0, 6, 12 and 24 weeks to be included in the regression sample. The methodology also accounts for correlation between data points from the same user, which if not corrected can cause standard errors to be underestimated.

Table 55 in Appendix A6 presents a list of clinical measures used in the quantitative analysis. **Table 56** in Appendix A6 provides the count and proportion of users with improved, the same or deteriorated outcomes after 6, 12 and 24 weeks. Across the instruments, between 30% and 60% of users experienced an improvement. Due to small sample sizes, the exact values of several cells are suppressed to protect the privacy of MOST users.

A summary of statistically significant results from GEE models and their interpretation is provided in **Table 4**. Detailed results are reported in **Table 57** in Appendix A6.

As reported in **Table 4**, there were statistically significant improvements in depression and anxiety symptoms as indicated by changes in the GAD-2 scores, with users using the Under-15 platform seeing greater improvements at weeks 6 and 12 than the Over-15 group. Female and gender diverse users also had greater improvements at week 6 than male users.

In terms of mental wellbeing (measured by the SWEMWBS scale), improvements were observed at 12 and 24 weeks, with greater effects among female and gender diverse users (in week 12, compared to male users), and regional users (in week 12, compared to metropolitan users).

Due to the lack of a control group, it was not possible to conclude whether these changes over time were attributable to MOST. However, regression results and statistical tests suggest that there is at least a positive association between MOST and improvements in depression and anxiety symptoms and the mental wellbeing of young people.

Table 4. Interpretation of Regression Results

Instrument	How to interpret	Meaning of regression results*	Difference by subgroups ^
GAD2	Lower scores indicate a lower likelihood of anxiety symptoms	Improvements at 12 and 24 weeks	Under-15 group had greater improvements at weeks 6 and 12 than Over-15 group. Female and gender diverse users had greater improvements at week 6 than male users.
GAD7	Lower scores indicate fewer anxiety symptoms and lower severity	Improvements at 6, 12 and 24 weeks	
K10	Lower scores indicate lower distress	No statistically significant improvements	
Mini-SPIN	Lower scores indicate a lower severity of social anxiety symptoms	Improvements at 6, 12 and 24 weeks	
PHQ2	Lower scores indicate a lower likelihood of having major depression	No statistically significant improvements	
PHQ9	Lower scores indicate fewer depressive symptoms and lower severity	Improvements at 6, 12 and 24 weeks	Under-15 group had greater improvements at week 6 than Over-15 group.
CHU9D	Higher scores represent higher health related quality of life	No statistically significant improvements	
DTS	Higher scores indicate a greater capacity to withstand negative emotional states	No statistically significant improvements	
PGIS	Lower scores indicate a better health state as symptoms are perceived as less severe	Improvements at 12 and 24 weeks	
SWEMWBS	Higher scores indicate greater positive mental wellbeing	Improvements at 12 and 24 weeks	Female and gender diverse users had greater improvements at week 12 than male users. regional users had greater improvements at week 12 than metropolitan users.

Note: *Only statistically significant findings are reported. See full results in [Table 57](#) in Appendix A6.

^The differences reported in this column are identified based on additional Generalised Estimating Equations (GEE) models where the time indicator is interacted with gender, age group and regional status (in separate models).

4.2 headspace Clinician-Perceived Youth Outcomes

HIGHLIGHTS

- headspace clinicians perceive that MOST can support young people to develop emotional literacy, which in part, may be one mechanism implicated in the relationship between observed mental health improvements.
- headspace clinicians perceived that MOST empowers young people in their mental health journey through three interrelated dimensions – timing, intent, and focus.
- headspace clinicians perceive that MOST may provide young people with a sense of psychological safety, which may support peer disclosure and validation, and therefore supporting increased social connectedness.

This section briefly describes some of the perceived outcomes of MOST on a young person, from headspace clinicians' perspective. **Importantly, these findings are illustrative and are presented in the absence of quantitative data.**

4.2.1 Perceived Mental Health Outcomes

4.2.1.1 MOST Supporting the Development of Emotional Literacy

headspace clinicians perceive that the psychotherapeutic component is particularly supportive in educating young people about mental health and mental health treatment. Clinicians described that initially, some young people may have low emotional literacy, or ability to understand what they are experiencing. In this way, clinicians perceive the platform may be insightful in helping young people to recognise and understand what difficulties they are experiencing and how to cope with it:

*I think not knowing what's going on is a big thing for young people, like explaining that what they're feeling is probably anxiety, is sometimes *revolutionary* for some of these people just to have an understanding and words for what they're experiencing. So, I think MOST can provide that... which is cool 'cause, sometimes all people need is just that understanding and some basic tools and then they're golden.*

— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

Some headspace clinicians thought that developing emotional literacy may be particularly conducive for young people waiting to enter the counselling space. headspace clinicians described that MOST could help young people to develop a foundational understanding of mental health and mental health treatment, which can then be expanded upon in face-to-face counselling sessions – potentially optimising the limited face-to-face time they have with clients, for example:

I think it's really great for young people who have maybe limited emotional literacy to be able to develop that in a safe space. Even just before they come to counselling, because then they can really utilise counselling to its biggest benefit if they already have some awareness of what they're experiencing. I think MOST plays a big, big role in that.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

4.2.1.2 MOST Supporting Autonomy and Empowerment

headspace clinicians consistently perceive that MOST facilitates a sense of autonomy and empowerment among young people. Most saliently, headspace clinicians described how the platform's self-directed features allow young people to take an active role and feel a sense of ownership in their mental health care. This sense of empowerment was described as operating through three interrelated dimensions: *"timing and focus and intent"*.

There's lots of ways that that can really empower a young person to take control of you know, so through timing and focus and intent. I think those three things particularly.

— HEADSPACE CLINICIAN 9, REGIONAL SITE

In relation to *timing*, clinicians emphasised that MOST facilitates agency as it allows young people to access support when they identify themselves as requiring further support, rather than only seeking support during scheduled appointments. When it comes to *focus*, clinicians referred to MOST allowing the young person to decide which components of MOST to engage with and how deeply to engage. Finally, when clinicians spoke about *intent*, they described how meaningful engagement with MOST requires young people to actively choose to log in and interact with the platform. Together, these features were perceived to place control and initiative with the young person, positioning young people as active participants in their own care, rather than passive recipients of an intervention.

4.2.1.3 A Psychologically Safe Outlet

headspace clinicians consistently framed MOST as providing a psychologically safe outlet for young people to disclose their mental-health related experiences, emotions, and thoughts. "The Community" appeared to be a low-pressure environment where young people can vent, share daily frustrations, and express their emotions. headspace clinicians identified that youth would reveal experiences that they may not bring up in their headspace sessions, further reinforcing the strong sense of psychological safety young people may experience from the platform:

Sometimes they'll post in community and say "I had a crappy day today, this and this happened" ... And I feel like it's been interesting that there's things that I didn't even know they had frustration about, that they've just vented on the community page.

— HEADSPACE CLINICIAN 1, METROPOLITAN SITE

4.2.1.4 Perceived Social Connection and Peer Validation

headspace clinicians perceived that MOST enables young people to connect with peers, providing opportunities to openly share experiences that are recognised and understood by others with similar backgrounds and lived experiences. headspace clinicians consistently perceived that MOST may help to normalise a young person's experiences and help them to *"feel connected. Like they're not the only one in the world who is going through this"* (headspace Clinician 6). headspace clinicians frequently described peer validation as a key social outcome of MOST, supporting young people on their mental health journey:

[On the] Talk it out/Community page ... I find a lot of young people [find] having their experience validated is very, very impactful. So, seeing other people who've gone through similar things or being able to post stuff they're going through and have that, understood and experienced by others I find is impactful.

— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

There are certain things that we just really don't necessarily talk about with other people or maybe, [in] our culture, our friendship group, it's not appropriate or we don't feel safe to do that. So, to be able to see that somebody else is saying, "Yeah, I'm not coping today". And then to be able to have that opportunity to say, "Yeah, I'm not coping either". I think that's really valuable and important.

— HEADSPACE CLINICIAN 9, REGIONAL SITE

I think there's such value in knowing you're not alone in your journey. And I think for young people who are experiencing mental health challenges for the first time, it can be really, really isolating. And I think that knowing that there's other young people who are experiencing or have experienced similar things to them could be really powerful. — HEADSPACE CLINICIAN 10, REGIONAL SITE

One headspace clinician positioned the psychotherapeutic component as also validating young people's experiences, comparing the experience to diagnostic validation – a situation that can occur when a person receives a diagnosis which helps them recognise their experiences are real and legitimate. In this way, MOST was perceived to be very supportive by helping normalise young people's experiences:

[If] you've not had a diagnosis for something and you're suffering, and then suddenly you get a diagnosis [and] you're like, "Oh!" ... "That's it!" ... "I have something going on and oh! it's called anxiety, right? I didn't know why I was sweating and my heart's racing and why I am freaking out when I'm around other people at a social event?" And they go, "Oh, it's social anxiety" and "how can I deal with that?" You know, "Oh, there's some ways to decrease that" ... So, I think that's really powerful. — HEADSPACE CLINICIAN 11, REGIONAL SITE

4.3 Perceived System and Service-Level Impacts

HIGHLIGHTS

- headspace clinicians positioned MOST as a form of support that bridges system gaps by expanding access to mental health support for young people requiring out-of-hours care but not acute care.
- headspace clinicians perceived that MOST supports an early intervention model by providing almost instantaneous access to a mental health platform following referral.
- headspace clinicians speculated that the early intervention model afforded by MOST has the potential to reduce risk escalation.
- headspace clinicians positioned MOST as a helpful supplementary resource that young people can access between headspace sessions when additional support is needed.
- headspace clinicians held mixed perceptions regarding the potential system-level impact of MOST. While clinicians perceive MOST has some capacity to address young people's needs, most clinicians believed that, in its current form, MOST does not substantially influence young people's engagement with headspace or the broader mental healthcare system.

This section describes perceived outcomes that MOST may have on the headspace service and mental healthcare system more broadly. In line with MOST's development, headspace clinicians primarily positioned MOST as an accessible, supplementary form of support that can be used while young people are waiting for care, during engagement with headspace services, and following exit from the service. While MOST was perceived to support early intervention and expand access, headspace clinicians generally viewed its current impact on service demand and broader system as limited, with benefits largely confined to providing an additional support option.

4.3.1 MOST Addressing System Gaps and Extending Support Options

headspace clinicians commonly positioned MOST as an additional form of mental health support that broadens the range of options available to young people across the care pathway. In the context of high service demand and prolonged wait times, clinicians appeared to value the MOST for its capacity to expand support choice within an overstretched system. Clinicians expressed appreciation for having *something* available, particularly when existing services are constrained, framing MOST as a supplementary resource:

Particularly when services are stretched and we've got bigger wait times I think the clinicians are just happy and grateful that we've got *something*.

— HEADSPACE CLINICIAN 7, METROPOLITAN SITE

headspace clinicians also perceived MOST as addressing a gap between existing service tiers, providing accessible, immediate support for young people experiencing mild to moderate distress, providing evidence that MOST is serving its intended purpose of increasing the accessibility of services (Cross et al., 2023):

There's this gap at the minute we've just got either Tier 2 services or we've got crisis services when you're at the absolute point of, "I need a crisis number". So, to have that sort of in between platform available is great and I think there is a gap, generally in the healthcare system for those sorts of platforms.

— HEADSPACE CLINICIAN 7, METROPOLITAN SITE

4.3.2 Expanding Access and Reach

headspace clinicians perceive MOST as an accessible service, bypassing limitations of traditional service pathways, therefore increasing the reach of young people who are able to receive mental health support. headspace clinician perspectives are in direct alignment with the purpose and perceived short-term outcome of MOST (Cross et al., 2023). headspace clinicians spoke about a range of circumstances where the online nature of MOST may be particularly beneficial for increasing reach to young people who have to travel long distances to get to a centre, family beliefs that hinder access to mental health services, or mental health difficulties that may make attending headspace appointments challenging, for example:

I have clients who live in country areas. They don't have access to all these things. That includes headspace as well. Some clients have to travel two hours ... it is the home stability as well. The client may not be able to leave their home to access headspace. — HEADSPACE CLINICIAN 8, METROPOLITAN SITE

We've been able to do referrals for people that have agoraphobia and struggle to get to the centre. We'll suggest an online platform or even try to do it in conjunction with us building them up to coming face to face. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

For a further description on the components of MOST's accessibility, see Section 5.5, which outlines clinician perceptions of MOST's accessibility.

4.3.3 Perceived Impacts Across the Care Pathway

headspace clinicians frequently positioned MOST as supporting continuity of care, by allowing young people to access mental health support across all stages of the care pathway. The following sections illustrate that MOST is operating as per its intended purpose in the theory of change model.

4.3.3.1 MOST as an Early Intervention Resource

headspace clinicians frequently described extended waiting lists as a defining feature of the current mental health landscape, reflecting high demand and limited-service capacity. Across both metropolitan and regional locations, headspace clinicians typically reported wait times of one to three months for in-person headspace support. headspace clinicians perceived these delays were constraining opportunities for early intervention. In their accounts, prolonged wait times were understood to contribute to the escalation of mental health difficulties, with young people often presenting with more severe concerns to headspace by the time they were able to access support.

Within this context, a subset of headspace clinicians positioned MOST as a potential preventative or early intervention resource. As mentioned in Section 3.2.1, onboarding to the platform can be imminent, with most young people having access to MOST within a week of receiving a referral. headspace clinicians viewed that enabling young people access to support almost immediately, bypasses the temporal barriers associated with traditional service entry, further indicating that MOST is serving its intended purpose. headspace clinician perspectives also align with the expectation that MOST will reduce waiting times for access to mental health interventions (Cross et al., 2023).

headspace clinicians also emphasised MOST's capacity to keep young people actively engaged with mental health support while they remained on waitlists for in-person headspace care. These perspectives align with clinician survey results where 77.2% of headspace clinicians ($n = 61$) agreed that MOST ensures clients are supported while they wait for in person care (see Appendix A4, item 2).

4.3.3.2 MOST Providing Between-Session Support

headspace clinicians also perceived MOST as providing between-session support for clients. Given the limited face-to-face contact and short, infrequent episodes of care, headspace clinicians viewed existing headspace services as insufficient for young people who have explicitly requested more frequent support. Consistent with MOST's development as an additional service that can offer further support between face-to-face sessions (Cross et al., 2023), in this context, MOST was positioned as helping to bridge system gaps by offering additional support between headspace episodes of care:

I've had some young people who call in weekly to have appointments and I'm like, that's just not feasible. And then I see that they're chatting someone's ear off on MOST. I'm like, hell yeah, I'm glad that you're getting that support that like headspace isn't really able to provide. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

Some headspace clinicians also described MOST as complementary in supporting their limits to clinical care. One headspace clinician framed MOST as being a helpful supplement to counselling, particularly for helping them to address topics they may feel less confident with broaching authentically while being relatable to youth:

Developmentally most social relationships are the only thing in the world I find, for teenage girls, so any kind of interpersonal stuff is really hard to do 'cause I don't wanna cause waves or seem weird or be cringe or all of those things ... So having that gap bridge I find is helpful. — CLINICIAN 3, METROPOLITAN SITE

4.3.4 Perceived Impact on headspace Services

While MOST was not developed to impact upon headspace episodes of care, it is anticipated that in the short-term, MOST would lead to fewer face-to-face sessions (blended care) with established youth mental health services such as headspace (Cross et al., 2023). headspace clinicians held mixed views about MOST's capacity to influence the number of headspace sessions. A small minority of headspace clinicians perceive that MOST may help to reduce headspace service demands as it facilitates entry into a mental healthcare platform. These headspace clinicians regarded the psychoeducational materials offered on MOST as having the capacity to influence a young person's engagement with headspace if they are highly motivated, as speculated by some:

With the early intervention model, having that baseline ... anxiety and depression skills can potentially mean that young people that would be on waitlists to see clinicians like at headspace might not need to. — CLINICIAN 3, METROPOLITAN

One headspace clinician recalled a rare but notable case in which a young person became emotionally supported through MOST to the point that they no longer required ongoing headspace care. The clinician explicitly referred to this client as an outlier – recognising this is an uncommon experience and that experiences between people can drastically vary:

I actually had one young person that was incredibly out of our scope, like he was on the higher end and we gave him the MOST referral because he was like, “I really want the resources”. And when I spoke to him next time, he was like, “I just came here to like, thank you guys, but, actually I don’t need support anymore”. Because he had literally done every module on MOST ... I think he was a bit of an outlier to be honest. But I’ve had females do the exact same thing, like very, very interested and no longer needing support through us. And then other times, not [interested] at all.

— HEADSPACE CLINICIAN 1, METROPOLITAN SITE

These headspace clinician perspectives suggest that for highly engaged and motivated users, MOST may have the capacity to influence a young person’s engagement with the headspace service. However, this experience appears to be an exception rather than the norm. Across interviews, it appeared that the dominant view was that while MOST can be beneficial for youth, it does not significantly influence the frequency or intensity of a young person’s engagement with headspace:

I don’t think there’s really much impact that MOST has on the length that they’re engaged, length of time that they’re engaged with headspace.

— HEADSPACE CLINICIAN 4, REGIONAL SITE

Across all interviews, there appeared to be a consensus among headspace clinicians that MOST serves as a supplement to therapy and **not** a determinant of service engagement, emphasising that core therapeutic work still takes place within session. Taken together, these perspectives indicate that MOST may influence service utilisation for a small subset of highly motivated people with clear goals.

4.3.5 Broader System-Level Implications and Scepticism

While some headspace clinicians believe in MOST’s capacity to influence the headspace service, most headspace clinicians were less optimistic about its capacity to influence the mental healthcare system. These clinicians perceived that MOST’s clinical support would have the largest influence on the healthcare system as it would help to reduce demand, however, viewed this component as relatively small, viewing the platform as a largely psychoeducational resource. Consequently, headspace clinicians are largely sceptical about MOST’s ability to help with managing the demand for mental health services.

I think at this stage, because that clinician support isn’t offered to everyone that accesses MOST, then it probably isn’t reducing demand as much as it says that it might be in the information that they’re giving us.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

I think it would need to be tweaked as we’ve discussed ... Essentially at the moment it’s psychosocial Ed with access to a counsellor. I don’t know. I think it would need to level up a little bit in order to be what you’re asking it to be.

— HEADSPACE CLINICIAN 9, REGIONAL SITE

Some headspace clinicians’ scepticism regarding MOST’s ability to influence the healthcare system extended beyond the platform itself, reflecting a broader sense of frustration and perceived powerlessness to effect change at a system level:

Influence the healthcare system? [laughs] I’m only laughing ‘cause I’m like, wouldn’t it be great to actually be able to influence the healthcare system? I mean, we certainly try heaps, but it hardly ever goes anywhere most of the time. So, I don’t quite know how to answer this question. Can I skip?

— HEADSPACE CLINICIAN 4, REGIONAL SITE

4.3.6 MOST Speculated to Prevent Risk Escalation

In line with the anticipated outcome that MOST may lead to lower rates of mental health hospital admissions and visits to emergency services (Cross et al., 2023), a small subset of headspace clinicians speculated that MOST may have the potential to indirectly reduce crisis presentations to emergency services and hospital admissions. From this perspective, MOST was speculated as having the potential to reduce the escalation of distress by offering timely, low-intensity support that may prevent some young people from requiring more acute services. Importantly however, headspace clinician perceptions are speculative and reflect preventative intentions rather than observed reductions:

Young people knowing that they've got *something* is really important and especially if they've waited a while or have been struggling for a while, having a thing I think, can definitely help maintain people and potentially decrease the chance of risk increasing. — CLINICIAN 3, METROPOLITAN

I think it perhaps helps with reduction of escalation of risks for sure.
— CLINICIAN 14, METROPOLITAN

One headspace clinician further speculated that access to MOST, and the associated experience of feeling heard, may help to alleviate distress that could otherwise contribute to help-seeking through emergency or acute pathways:

It can help with reduction of self-harm and suicide, like feeling heard so they don't feel like they're alone and no one cares 'cause a lot of them ... Would wanna hurt themselves just to go into the hospital just so someone can listen to them and help. So it's reducing that ... work. — CLINICIAN 6, NON-METROPOLITAN

4.4 Chapter Summary

- Quantitative results showed that there were statistically significant improvements in depression and anxiety symptoms and mental wellbeing over time among MOST users, with some user groups experiencing a greater improvement.
- Due to the lack of a control group, it is not possible to conclude whether these changes over time are attributable to MOST; however, the results suggest that there is at least a positive association.
- headspace clinicians perceived MOST has the capacity to enhance young people's mental health literacy and empowerment in their mental health journey.
- headspace clinicians also viewed MOST as a psychologically safe platform that may promote social connectedness and provide a validating space for peer interaction
- headspace clinicians held varied views about the potential service and system-level impact of MOST. Most commonly, they perceive MOST provides an additional form of mental health support, supporting an early intervention model, which may be particularly beneficial for people who have been on long waiting lists.
- While headspace clinician perceptions around MOST's capacity to influence young people's engagement with the headspace service varied, typically, clinicians did not perceive MOST as impacting the broader healthcare system.

Attitudes Toward the Implementation of MOST

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A staggered approach to the implementation of MOST in WA across headspace services, Medicare Mental Health Phone service, selected general practises, and more recently Youth Enhanced Support Services (in 2025) and Early Psychosis Services (in 2026; (MOST & Orygen Digital, 2025) was used. As headspace is a large part of the youth mental health system, the rollout of MOST began with headspace in 2024 in a phased approach as an efficient means to reach young people (MOST & Orygen Digital, 2025). The WA MOST Implementation team works proactively with services to support the effective implementation of MOST and uptake of MOST by service clinicians (MOST & Orygen Digital, 2025).

This chapter focuses on headspace clinicians' reflections and attitudes toward MOST and its implementation in headspace. This chapter discusses headspace clinicians' knowledge, familiarity, and confidence to use MOST, as well as clinician acceptability. headspace clinicians' attitudes toward the accessibility, implementation, and feasibility of MOST are also discussed. This chapter ends with headspace clinician attitudes around platform governance. While this section largely comprises data from headspace clinician interviews, survey results with headspace clinicians and clinical leads are also embedded throughout this section, where appropriate.

5.1 Clinician Knowledge, Familiarity, and Confidence with MOST

HIGHLIGHTS

- headspace clinicians' knowledge of the MOST platform varies substantially, with many clinicians navigating MOST from a position of uncertainty.
- Limited content knowledge, minimal exposure to the youth interface, reliance on initial implementation training, and difficulties with using MOST's clinician portal, appears to collectively undermine headspace clinicians' confidence to use MOST.
- While headspace clinicians generally recognise the potential value of MOST, strengthening clinician understanding and improving platform usability are likely to support greater confidence and more consistent integration of MOST into care.

headspace clinicians' familiarity and knowledge with MOST forms the foundation for them to implement, use, and access MOST. headspace clinician knowledge and familiarity with MOST substantially varied. While all clinicians understood that MOST provides psychoeducational content and supplementary support for youth across all stages of the care pathway, many clinicians described a surface-level understanding of the platform's full functionality. These gaps in foundational knowledge appeared to influence how confidently clinicians introduced MOST to youth, how accurately they explained its components to youth, and how they used MOST.

5.1.1 Varied Understanding of MOST

There was considerable variability in headspace clinicians' knowledge with MOST. Their knowledge ranged from a solid conceptual understanding of MOST and each of its components to a far more simplified conceptualisation, with some headspace clinicians reducing it to a primarily psychoeducational tool rather than a multi-component digital intervention:

There's different parts, so there's self-help resources, there's a community chat group and then there's also one part where it's a career mentor ... They also have the clinical side as well... — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

It's more psychoeducational based. That's what I am aware of.
— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

With regards to the psychoeducational component on MOST, headspace clinicians understanding drastically varied – from an absence of knowledge of the type of content and Journeys available on the platform to extensive knowledge. Generally, most headspace clinicians had some knowledge about the content offered on MOST, which allowed them to guide their clients toward topics. Importantly, headspace clinicians noted they were operating within their window of knowledge and were unable to recommend psychotherapeutic content that fell outside their knowledge base, operating from a position of incomplete understanding:

I think similarly because I'm not wholly familiar with what contents on there, I'm only really recommending based on this window of what I know.
— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

One headspace clinician, who appeared to be an outlier, had a very in-depth understanding of the psychotherapeutic content. This clinician described how they completed each Journey on MOST during a quiet holiday period, with the intent to help their colleagues better implement MOST. This clinician acknowledged their comprehensive understanding about the psychotherapeutic journeys and nothing else on the platform, reinforcing the pattern that headspace clinicians typically have a more in-depth but narrow understanding of MOST, or a broader and more superficial understanding of MOST:

... my supervisor and I worked together to make the decision to have a look at the MOST journeys and for me to like maybe write a bit of a summary of each of the journeys to help the clinicians understand what was in them and when they might be good ... the idea was if you had a summary, you could look at it and go, "Oh yeah, that's exactly what I need for the young person" ... I think that's probably unique to me.
— HEADSPACE CLINICIAN 9, REGIONAL SITE

Similarly, headspace clinicians appeared to have varied knowledge about the other components on MOST. Most headspace clinicians indicated they understood the peer worker role on MOST (70.9%, $n = 56$), with fewer headspace clinicians reporting an understanding of the career consultant role on MOST ($n = 51$, 64.6%)(see Appendix A4, items 3 and 4). Importantly, headspace clinicians did not claim to have an extensive understanding of the platform and were forthcoming about limitations to their knowledge about MOST. Clinicians also commonly mentioned they lacked familiarity with MOST, describing an infrequent, surface-level exposure to it, for example:

I've only had very, very surface level go over of MOST.
— HEADSPACE CLINICIAN 2, METROPOLITAN SITE

All but one headspace clinician consistently reported a lack of understanding of the MOST's interface for the young person, despite often providing referrals to MOST. This gap in knowledge between headspace clinicians' expectations and knowledge of the youth interface can limit headspace clinicians' ability to accurately explain the platform to young people and may have implications for clinicians' willingness/engagement with MOST, implementation into existing care, and referral decisions/consistent referrals:

The biggest thing for me, which I'm sure you've heard pretty much every clinician you've spoken to say is that I don't really understand what it looks like from a young person's perspective [and] I don't really understanding how to use it from their perspective. So I can't be like "This is what it looks like, and these are all the things [you can do]". — HEADSPACE CLINICIAN 10, REGIONAL SITE

If they ask me "How do you explore it?" "Where do you go?" ... I'm really trusting that it's a very easy kind of process for them to access what they want to access. So relatively unaware of how they navigate it. That would be my truth.

— HEADSPACE CLINICIAN 11, REGIONAL SITE

Across interviews, several headspace clinicians sought clarification about the terminology and operational components surrounding moderation and the accessibility of clinical support on MOST, potentially illustrative of their lack of familiarity with it, for example:

I don't even know if clinicians are available after-hours ... I don't know about the hours for that. Do you know about the hours for that? — HEADSPACE CLINICIAN 11, REGIONAL SITE

The forum, is that what you called it? The forum? Is that what it's called? The feed?

— HEADSPACE CLINICIAN 10, REGIONAL SITE

Some headspace clinicians also held small misunderstandings about the platform. Most saliently, they were not aware that MOST is available as a phone application for the older cohort, commonly under the assumption that MOST is not available to download on a smartphone, consistently bringing it up as something they would like to see:

Once again, harping on this, I would like to see it as an app that you can download.

— HEADSPACE CLINICIAN 9, REGIONAL SITE

While small, and seemingly inconsequential, these consistent misunderstandings and gaps in headspace clinician knowledge shapes their ability to accurately implement MOST. This variability may shape headspace clinicians' ability to recommend content, assess the relevance of MOST for youth, implement MOST into care, and accurately explain MOST to young people. Seemingly, knowledge gaps about the content and functionalities of MOST appear to undermine headspace clinicians' confidence (see Section 5.1.5) and limit consistent implementation of the platform into routine practise.

5.1.2 Clinician Reliance on Training from MOST

Prior to MOST being implemented across headspace sites, headspace clinicians receive formal training from the MOST implementation team. This training is intended to support service-based clinical staff and support the service to integrate MOST into the clinical pathway (Cross et al., 2023).

It appears almost all headspace clinicians relied entirely on this training session to build their knowledge about MOST and confidence to implement MOST into care. While the vast majority of surveyed headspace clinicians reported the provision of sufficient training to enable staff to implement MOST ($n = 58$, 77.3%) (see Appendix A2, item 1), almost all interviewed clinicians unanimously discussed being disappointed with the content and structure of the training session. Some headspace clinicians also felt as though the training was misdirected toward general clinical skills, rather than training them about the platform and how to practically use it. Most headspace clinicians described the training as brief, overly administrative, and too superficial to build the depth of familiarity needed to confidently use and understand the platform.

It was mostly about setting us up around logins and very basic admin stuff and not so much around unpacking what MOST was about ... we do really rely on that sort of initial walkthrough to really help us in how to identify how it can help our young people 'cause we might not get the time. So, I think it was helpful the snippets that they've shown us, but it would be great to have maybe more of an in-depth walkthrough.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

In addition, there seemed to be an inconsistency in the delivery of training between sites. One headspace clinician who offered a unique perspective of having worked in both a metropolitan and non-metropolitan headspace site had noticed a discrepancy in the quality of training offered between sites. One stark difference is that all but one participating headspace sites in this evaluation, had face-to-face training sessions with the MOST implementation team. A headspace clinician from the only interviewed site who received a virtual training session described having to remotely dial in to another site's training session via Microsoft Teams. They described how this experience was less-than-ideal and confessed this introduction has negatively shaped the clinical team's ongoing attitudes and implementation of MOST more broadly:

To be honest, the training was actually kind of a bit tricky for our team. One, because they were talking to headspace [other location] and not really us. So, our team got left behind a bit when they were trying to sign up and do things ... one of the clinicians sort of gave up and put their laptop down and was just like, "OK, well I don't even have a user account and they're talking about what to do next." So, it wasn't the greatest introduction ... [the uptake of MOST] has still tanked with a few of the clinicians because of that introduction. — HEADSPACE CLINICIAN 5, REGIONAL SITE

The majority of clinicians reported that after the training session, they still felt confused and uncertain about the overall platform, its usability, how to implement into clinical care, and ultimately lacked confidence to use MOST. Consequently, few headspace sites requested an additional training session to improve their understanding, confidence, and competency with the platform. Even with the additional training, clinicians' needs were still not met. Clinicians described the additional training as too passive, further reinforcing a sense of unpreparedness and uncertainty about the purpose, functionality, and clinical use of MOST:

The last person that came, we were really excited about this as clinicians that we would be presented with some more training or more insight into MOST. But the lady came and just sort of, put on a board, "What's your questions?" We were all expecting that she would do a live [walkthrough], we would see her navigating the system showing us where we can go and where we can access, so it was a little bit disappointing because it wasn't interactive and we did feed that back and say we're very time poor, just asking questions and feedback isn't as great as someone leading you through the process. — HEADSPACE CLINICIAN 11, REGIONAL SITE

Taken together, headspace clinician perspectives overwhelmingly suggest that the current training model may be too passive and brief to build or sustain the level of familiarity required for them to confidently use and navigate MOST. The perception of inadequate training appears to permeate into their implementation behaviours and adoption attitudes. It appears headspace clinicians need more assistance to implement MOST into the clinical pathway.

5.1.3 Clinician Portal Usability

headspace clinician usability reflects the extent to which MOST's Clinician Portal can be used effectively and efficiently by headspace clinicians with minimal burden. While 70.9% of surveyed headspace clinicians ($n = 56$) reported being able to log into MOST without experiencing any issues (see Appendix A4, item 5), usability appears to be low as all but one headspace clinician described difficulty with using and navigating the clinician portal:

I don't really know how to navigate the MOST app ... to be honest with you, I'm still really unsure about how to see that back end of mine. — HEADSPACE CLINICIAN 11, REGIONAL SITE

These challenges included navigating the MOST system, locating the psychotherapeutic content, and accessing client engagement information through the clinician portal. In some cases, headspace clinicians were uncertain about the functionality offered in the clinician portal, contributing to reduced confidence in their ability to effectively use the platform:

I don't know if it's cause I haven't had the time to really look into it or if I'm just a bit technologically challenged, but I haven't been able to find the modules to look at.

— CLINICIAN 13, METROPOLITAN SITE

Some headspace clinicians who had more familiarity with the platform described the cumbersome and impractical routes they have to take to get to their target destination, describing MOST's usability as clunky and time consuming. Notably, difficulty with navigating the MOST clinician portal appeared to frustrate headspace clinicians who were already time-limited (see Section 5.4.3), acting as a barrier to the clinician themselves and their broader headspace team utilising MOST:

How you find a young person is so clunky and time-consuming ... especially at the moment with the way it's being with the clinician interface, I think it's really hard. It takes time to navigate it that we don't have I suppose. I think it's a big one.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

Accessing it on the clinician side is really, really clunky and really user unfriendly and I think that is a huge barrier to at least a lot of my team using it and engaging with it more. I could spend ages getting into the technical things.

— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

Overall, clinicians appear to have difficulty navigating the clinician portal, which could influence their usage. Clinicians highlighted high usability as a key facilitator in their uptake of MOST, reinforcing the importance of clinician usability and efficiency in the context of limited time (see Section 5.4.3):

Just accessibility on clinician end to be able to navigate the site is probably the main thing ... if MOST looks like the way I can see it, I can't imagine it would take that long or that much out of my day to check in on that before a session.

— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

5.1.4 Clinician Confidence Implementing MOST

Confidence with MOST among headspace clinicians was related to their knowledge about the platform, exposure to youth interface, training experiences, and their ability to navigate the clinician portal. Confidence with MOST appears to be most strained when headspace clinicians attempt to translate their conceptual understanding about the platform into clinical practise.

For example, while headspace clinicians appeared to be most confident in completing the referral form, they reported greater difficulty implementing MOST into daily practise. This seems to reflect a broader lack of procedural and content-specific knowledge about MOST, leading clinicians to rely on external prompts such as promotional materials or pre-prepared scripts. Consequently, headspace clinicians identified their limited understanding of MOST impacting their confidence to implement MOST:

I think that my understanding of MOST is a bit of a barrier...I feel like I don't have a very good understanding and I'm not very good at explaining what it is. I don't have a nice little spiel about it. I just kind of bumble my way through it and I feel like then they're like, "What are you saying?" And I'm like, "I don't know".

— HEADSPACE CLINICIAN 10, REGIONAL SITE

I'm just not very confident in how to phrase it, frame it to them without giving them unrealistic expectations. So I think we do rely heavily on the pamphlet information to share with young people and encourage them to have a look for themselves. But in terms of really going through it with them, I don't feel very confident in explaining what it is ...

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

headspace clinicians' lack of confidence to implement MOST seemingly ties in with clinicians' training and knowledge of MOST. While headspace clinicians were most confident with providing the referral and handing it over to MOST to instigate the onboarding process, clinicians consistently mentioned they were "not confident" with using MOST. Clinicians often described the clinical integration of MOST as difficult and the part that "needs work":

I'm confident with that they can access [MOST] once we hand over that referral.

— HEADSPACE CLINICIAN 11, REGIONAL SITE

Again, there's some lack of knowledge around MOST ... I think there's still that idea of, how to integrate it in service can be difficult.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

I think the clinical integration is the part that needs work.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

Ultimately, however, it appears that clinicians' low confidence in using MOST may directly shape how clinicians implement MOST into clinical care, positioning confidence as a critical factor influencing clinician uptake:

Just with the way that I work, it doesn't. It'd feel a bit clunky to me ... I wouldn't be so keen on using it so closely with my intervention because I'm very free flowing with how I wanna go about the sessions ... And maybe it's just cause I'm not really too sure in how necessarily I would go about bringing that up.

— HEADSPACE CLINICIAN 2, METROPOLITAN SITE

5.2 Clinician Acceptability of MOST

HIGHLIGHTS

- headspace clinicians were generally accepting of, and satisfied with MOST as a platform, but held some resistance integrating MOST into practice beyond providing a referral, commonly viewing it as a separate, disparate service youth can engage with in their own time.
- headspace clinicians consistently valued MOST as an addition to in-person care rather than a treatment replacement, perceiving a blended care approach as ideal, allowing a young person to "experience the best of both world".
- headspace clinicians perceived MOST has the capacity to meet some young people's needs, but not all of them, viewing it as a "good starting point", noting areas for improvement to better meet youth's needs.
- headspace clinicians' acceptability toward the platform appeared to be negatively shaped by the perception of there being an abundance of digital mental health interventions that appear to be a quick fix to addressing the mental health burden.

Clinician acceptability refers to headspace clinician perceptions of the appropriateness and satisfaction with MOST. headspace clinician acceptability with MOST varied depending on how the platform was viewed. For example, headspace clinicians were largely acceptable of MOST as an intervention to be used in addition with in-person support rather than as a replacement. While headspace clinicians were comfortable and appeared to have high acceptability of digital interventions more broadly including MOST, some headspace clinicians appeared somewhat resistant to implementing MOST into clinical care. Understanding headspace clinicians' acceptability is important as it appears to shape how clinicians use, implement, and access MOST.

5.2.1 Clinician Comfort and Acceptability Toward Digital Environments

To understand headspace clinician attitudes toward MOST, it is first helpful to understand headspace attitudes toward online spaces and digital mental health interventions more broadly. Almost all headspace clinicians appear to be quite accepting of digital interventions, recognising their increasing presence and society's broader reliance on digital technology in daily life. As a result, headspace clinicians reflected on the necessity of developing competency with online environments to meet youth where they are, strengthening headspace clinicians' acceptability of online environments:

I feel like for an old lady, I'm pretty like tech literate. I don't feel scared of technology at all. I feel like young people have not lived in a world without tech, so it is really important for us to be tech literate ... I don't understand everything, but I think that is where young people are. They're online, they're using their devices, and if we're going to help them, we need to go where they are. — HEADSPACE CLINICIAN 9, REGIONAL SITE

headspace clinicians' accounts suggest that comfort with technology – their confidence using digital tools – often underpins their broader acceptability of online environments for mental health support. headspace clinicians who described prior experience and familiarity with implementing digital interventions in headspace care appeared to feel more comfortable and therefore accepting toward online environments:

I think they're great. We work with a lot of different digital interventions like Brief BEeT's [Binge Eating eTherapy] eating disorder training [and] other online resource platforms ... They've all been found to be really useful for young people.

— HEADSPACE CLINICIAN 13, METROPOLITAN SITE

However, headspace clinicians who have less experience and feel less apt to use technology, appeared to feel less comfortable and accepting toward broader online environments, holding a strong preference for face-to-face support, albeit recognising the potential value of online spaces for youth:

I am not very IT literate, so keeping up with everything that changes in the world of IT scares me. And again, I think we're just moving away a little bit from that person-centred, face-to-face sort of model of care that I prefer. Again, that's just a very personal thing to me, how there might be heaps of benefits to that, to the young people or people who need that method of intervention, but I'm just not quite there yet.

— HEADSPACE CLINICIAN 7, METROPOLITAN SITE

Despite clinician experience with online platforms, a consistent finding across interviews was the limitations of online platforms, particularly around rapport and lacking human interaction, leading headspace clinicians to view online platforms as a supplement rather than a replacement for mental health.

We know that 80% of therapeutic intervention success is related to the rapport that the counsellor has with the young person, and that can't happen in a digital space unless... it's one-on-one. Even then you know you're missing a lot of those little subtle [cues]. — CLINICIAN 9, REGIONAL SITE

Overall, headspace clinicians seem quite accepting of online spaces, recognising it as a way to enrich and enhance support available to young people. Despite the broad acceptability of digital environments, clinician attitudes and acceptability of MOST does not seem to be as straightforward.

5.2.2 Clinician Acceptability Toward MOST as an Online Platform

Overall, headspace clinicians seemed broadly accepting of MOST. In principle, clinicians expressed support for the idea of MOST as a free, safe, accessible, and well-governed digital mental health resource for young people. However, in practise, clinicians' acceptability of the platform was shaped by multiple considerations. This included their understanding of the platform, the perceived capacity of MOST to meet young people's needs, the appropriateness of MOST for young people, the depth to which clinicians implement MOST, and attitudes toward other digital interventions within the contemporary mental health landscape.

5.2.2.1 Clinician Experience with MOST Shaping Acceptability

headspace clinicians with limited exposure to and understanding of MOST were generally accepting of the platform at an abstract level. In these cases, acceptability appeared to be grounded in the *idea* of MOST as a digital mental health intervention, rather than based on their own experience using the platform. As a result, headspace clinicians' acceptability was often tentative, superficial, and high-level, accompanied by explicit acknowledgements of limited knowledge and familiarity:

From my limited understanding of what it is, I love that it's a mental health platform ... It's not specifically MOST, because I don't know as much around MOST that I potentially should. — HEADSPACE CLINICIAN 11, REGIONAL SITE

This suggests that headspace clinicians hold broadly positive attitudes toward MOST despite minimal engagement with it. From a similar perspective, one headspace clinician described an attitude shift once gaining more direct experience and familiarity with MOST:

I think that I was a bit hesitant at first, like, I'm not really sure what this looks like. Will people like it? We're already kind of providing a service. Would an additional service be helpful? But I feel like since I've been working with it for a fair bit now, I do feel like there's a lot of value to not only the digital model on its own, but also integrated with our service. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

5.2.2.2 Clinician Satisfaction with MOST

Across interviews and surveys, headspace clinicians generally held positive views about MOST and considered it to be supportive for young people. However, clinician satisfaction with MOST varied, and all interviewed headspace clinicians noted features for improvement. A minority of headspace clinicians were highly satisfied and enthusiastic about MOST. Seemingly, these clinicians appeared to be more likely to use MOST in practise:

I think it's great. I'm a huge MOST advocate. I think it's a good kind of like, I don't know if one stop shop's the right word, but the concept is fantastic. I think there are a lot of wrinkles that could get ironed out, but as a whole. Yeah, I'm a big fan. — HEADSPACE CLINICIAN 3, METROPOLITAN SITE

More generally, however, headspace clinicians were moderately satisfied with the platform and expressed quite generalised statements about the supportive nature of MOST. These headspace clinicians appeared to have more gaps in their understanding, appeared less confident to implement MOST into care, and appeared to use MOST to a lesser extent:

I mean, there's some really great things about MOST. If you ask me, how do I feel about it? Generally, I really like it, but there are some flaws and some problems for me with it. But I'm definitely going to be encouraging young people to use it under the right circumstances. — HEADSPACE CLINICIAN 9, REGIONAL SITE

I think it's a brilliant idea, but it's just sort of ironing out the bugs of that. — HEADSPACE CLINICIAN 11, REGIONAL SITE

Some headspace clinicians expressed a clear preference for MOST positioning it as their primary online service:

It's a free online service. It's the free online service that I would be referring people to.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

One headspace clinician seemed to dislike the platform. However, this perspective appeared to be largely tied to the introduction of MOST and organisational pressures surrounding its adoption, rather than the platform itself. This view seems to be shared by the clinical team at that particular headspace site:

It felt like pressure, like almost an ad campaign from MOST. It felt like an advertisement. That was something my other clinician said ... it's like we're being branded or trying to make sure we use it. And then it felt like even more pressure to use it from our funding bodies. — HEADSPACE CLINICIAN 5, REGIONAL SITE

Another headspace clinician perceived themselves as being the most passionate one at their site about MOST. This clinician positioned themselves as a champion of MOST, with the hope of influencing broader clinician uptake:

I think that I'm probably the most passionate about that in the team that I really believe in integrating the two and I'm always talking about it. I hope that that is giving other people inspiration ... I do think that people [clinicians] are interested in it, but I don't know if they're as enthusiastic as myself. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

Interestingly, 73.3% of surveyed headspace clinicians ($n = 55$) reinforced this sentiment, agreeing that there are key individuals who play a central role in advancing MOST and encouraging others' involvement (see Appendix A2, item 2).

5.2.2.3 Clinician Trust in MOST as a Credible, Evidence-Based Platform

headspace clinicians unanimously described the platform as a valid and well-researched platform for young people – a key factor underpinning its acceptability to headspace clinicians. headspace clinicians contrasted the evidence-base on MOST to misinformation youth are commonly exposed to from social media. Across surveys ($n = 55$, 83.3%, see Appendix A4, item 6) and interviews, headspace clinicians indicated that the evidence-based psychotherapeutic content also helps reinforce what they are working on with youth, further reinforcing its acceptability.

I think the thing that's always helpful about modules is that you can see that this has been something that's been taught. That's it's just not the practitioner making it up ... And so it kind of legitimises what you're saying ... a lot of the information they are getting on TikTok and other devices you can't be sure that, that's real evidence-based practice, and I think MOST does that well. The evidence-based practice is interwoven fully so you can trust the information that you get.

— HEADSPACE CLINICIAN 5, REGIONAL SITE

5.2.2.4 Perceived Capacity of MOST to Meet Young People's Needs

headspace clinicians perceived the platform has some capacity to meet young people's needs; however, they did not think that MOST can comprehensively address the full range or complexity of a young person's needs. MOST was frequently described as a good starting point, particularly in relation to the self-guided learning, but headspace clinicians expressed reservations about its ability to support sustained cognitive, and behaviour change in the absence of more structured activities and deeper therapeutic content or for young people with more complex difficulties, requiring more one-to-one clinical support than what is available on MOST:

I think that they [MOST] have capacity to support young people with learning and resources and psychoeducation. I don't know if it's going to completely meet the needs of young people cause young people do a lot of one-on-one support to really have a space to talk about what's concerning them, because, a lot of their concerns might not be captured in those resources or areas, especially a lot of our vulnerable cohort. But I think it's a good starting point. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

Alongside these views, other headspace clinicians articulated a different perspective, suggesting that the platform's capacity to support change is less about the features of MOST itself and more about the motivation, self-efficacy and readiness of the young person using it. From this perspective, MOST was framed as a tool whose potential impact depends on how individuals engage with the platform, rather than as mechanism in and of itself that has the ability to drive change:

The capacity is not in the app, I don't think. I think the capacity is in the young person ... If the young person is coming to look at that content with the intention and the desire for motivation for change, then *absolutely* the app can be a tool to do that. But the app in and of itself ... it's just information. It's really up to the person what they do with that and how reflective that they're willing to be.

— HEADSPACE CLINICIAN 9, REGIONAL SITE

This view was further reinforced by clinicians who highlighted that engagement with MOST is voluntary, meaning that people who are less motivated to engage with the platform may find it more difficult to benefit from self-directed, digital interventions:

A lot of the people that I see are really not motivated and, the idea of doing that [MOST], as good as I think it would be for their mental health, is really challenging for them.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

5.2.2.5 Clinician Acceptance Tied to the Perception of the Platform's Appropriateness for Youth

headspace clinicians' acceptance of MOST appears to be related to their perceptions of its appropriateness for young people. Overwhelmingly, 91.1% of clinicians ($n = 72$) agreed with the sentiment that MOST is appropriate for young people at some point in their care journey, with *no* clinicians disagreeing with this sentiment (see Appendix A4, item 7). Clinicians commonly evaluated MOST's acceptability based on whether they perceived it to align with young people's preferences, communication, and digital styles.

headspace clinicians frequently drew on MOST's design features including its interface, visual design, and use of informal, non-clinical language as indicators of MOST's suitability. These elements were interpreted as signals that the platform had "*obviously [been] designed with young people in mind*" (headspace Clinician 3), which in turn appeared to support headspace clinicians' acceptability and willingness to offer and endorse the platform, for example:

I think it's great. I think it's very much got a young person focus on it. I think young people will relate to, how it looks visually. Again, I'm only speaking from my perspective, but I think it's set out well, I think it's done well, I like. I like the comic style, videos and pictures on there. The colours are good well.

— HEADSPACE CLINICIAN 7, METROPOLITAN SITE

Importantly, headspace clinicians perceived MOST to be an appropriate and useful resource within the contemporary mental health landscape. Many headspace clinicians perceive that young people generally spend a considerable amount of time in digital environments, positioning MOST as a platform capable of meeting young people where they already are – online – further shaping headspace clinicians' acceptance of MOST:

I think it's very appropriate and applicable to our cohort of young people here in terms of allowing them that space online. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

5.2.2.6 Preference for a Blended Care Approach

Clinicians consistently valued the blended approach where MOST is used alongside care. They perceived it allows youth to experience the relational therapeutic presence and safety from in-person sessions as well as the flexibility, and around the clock support of the digital platform in between headspace sessions. Clinicians positioned the combination of modalities to allow young people to "*experience the best of both worlds*", while also highlighting that neither modality alone may fully meet the needs of youth:

I imagine the collaboration between in-person and digital is probably ideal ... because then they have the best of both worlds, that connection with a real person, in-person and also access to 24-hour support through community pages and through resources. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

If you're asking me as a clinician how I feel about it, look, I'm all for face-to-face interventions myself personally. However, I do feel, young people have a better connection with online supports ... So I think it has to be both it can't be one or the other ... I wouldn't want someone to solely rely on an online platform, because I feel there's real value and connection in that one-to-one time, in person. But it's a nice additional support I guess. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

5.2.2.7 Acceptability at a Distance: Clinician Reluctance to Implementing MOST into Practise

Across interviews it became clear that headspace clinician's acceptability and comfort with MOST appears to be influenced by the depth to which MOST is implemented into care. Around half of the interviewed headspace clinicians view MOST as a great platform from afar yet hold some resistance toward closely integrating it into clinical practise. headspace clinicians consistently viewed MOST as a disparate service that youth can engage with in their own time outside of headspace sessions, viewing it as an optional, self-directed resource rather than a tool to be embedded within their therapeutic practise, for example:

I feel comfortable with it in the sense that it's like a separate thing. I don't really see it as integrated into my practice, like in-session, that is. I see it as something that the young person can access in their own time outside of the therapeutic space, because my approach is that when you're here, you're here and we'll talk about things in the time that we have set aside, right? And I don't want to pull up MOST during this time, when you can access it yourself outside of the space, I want you to make the most of this space, because it's just all about you at the moment.

— HEADSPACE CLINICIAN 4, REGIONAL SITE

In addition to wanting to optimise the value of limited face-to-face sessions, headspace clinicians described other attitudes underpinning their attitudes toward the acceptability of MOST. They discussed their therapeutic preferences, valuing relational presence, authenticity, and a distraction-free therapeutic space, with some clinicians perceiving MOST as a tool that may impose a structure on their counselling sessions, creating a sense of inauthenticity, resulting in integration perceived as 'clunky'.

Some senior clinicians spoke about their dislike for using external prompts in counselling session, describing already having established their therapeutic approach and clinician toolkit. These clinicians positioned MOST as a potentially helpful resource for early-career clinicians who may need some more guidance and are still forming their own clinician toolkit:

I'm not a tool-based clinician It's never been my forte to use homework sheets or things like that. So for me personally, it's not something that I would [use] ... But my early career clinicians, they do want that scaffolding of what to do, how to say it.. and I've been a clin psych (clinical psychologist) for nearly 19 years now, so I kind of have that toolkit in my mind. — HEADSPACE CLINICIAN 5, REGIONAL SITE

5.2.2.8 An Oversaturation of Digital Interventions

Some headspace clinicians' acceptability toward MOST as an online mental health intervention was influenced by the broader digital mental health ecosystem. Some headspace clinicians advocated for the adoption and funding of a single overarching mental health intervention. They spoke about the abundance of digital mental health platforms in the current landscape. While headspace clinicians recognised the impracticalities of a single platform, they questioned the need for MOST perceiving it as one of many, albeit recognising its novelty:

I think that it would be great to have kind of a one-stop, just one really. I feel like there's twelve thousand. And MOST is doing something a bit different for sure, but I think that having one overarching one would be great ... But like, that's a huge job and it's probably not actually realistic now that I say that. — HEADSPACE CLINICIAN 10, REGIONAL SITE

Other headspace clinicians reflected on the funding distribution across the mental health sector, expressing frustration with the current allocation of resources across Tier 1, Tier 2, and Tier 3 services. These clinicians described a healthcare system that is unable to meet existing mental health demand, viewing the proliferation of digital mental health interventions as a “quick fix” rather than a sufficient response to the burden placed on the system. These clinicians perceived that a re-distribution of funding toward front-facing, acute services should be more of a priority than funding additional online interventions in an already saturated environment. While this perspective appears to be tied to lower clinician acceptability of the platform, these perspectives did not reflect ill-feelings toward MOST itself, but rather broader concerns about the digital mental health ecosystem.

I think we need to stop putting a lot of money into digital services and put more into the acute care facilities, the Tier 3, like Tier 1, Tier 2 ... I feel like some of that money is almost like a quick fix to give all these digital services when actually we just need more services in the hospitals, in the community clinics, in clinicians on the ground. We've got a shortage of clinicians. So I personally think there's no dilemma of digital services, but ... I think putting money into some of one digital service maybe and then the rest can go into funding community health and increasing acute care services and mid-tier services. — HEADSPACE CLINICIAN 5, NON-METROPOLITAN SITE

5.2.2.9 Clinician Acceptability Shaped by a Range of Factors

headspace clinicians' attitudes toward the acceptability of MOST appeared to be shaped by an interconnected set of factors. Alongside the factors discussed in this section, challenges outlined elsewhere related to clinician usability (see Section 5.1.4), implementation (see Section 5.3), feasibility (see Section 5.4), and confidence (see Section 5.1.5) also appeared to shape headspace clinician attitudes toward the acceptability of MOST.

5.3 The Implementation of MOST in headspace

HIGHLIGHTS

- MOST can be used at multiple points across the care pathway, though it appears to be commonly positioned as an interim support service while people wait for headspace services and as a resource offered at discharge to maintain continuity of care.
- While some headspace clinicians implement MOST alongside face-to-face headspace sessions, implementation was inconsistent and considerably varied between clinicians. Only one headspace clinician appeared to deeply integrate MOST into care.
- headspace clinicians reflected on an aspirational view as to how MOST could be embedded alongside ongoing care, recognising its potential value which, often contrasted with their actual patterns of use.
- headspace clinicians compared MOST, headspace, and eheadspace to assess MOST's novelty and grappled with uncertainty over the purpose of MOST, and when to use it, in the context of headspace's additional services.

This section brings together headspace clinicians' knowledge, attitudes, and experiences with implementing MOST into routine headspace practise – beyond the referral process. This includes *how* and *why* headspace clinicians integrate MOST into clinical care.

5.3.1 How Clinicians Integrate MOST

headspace clinicians described clear opportunities to integrate MOST during triage, intake, episodes of care, and at exit (as detailed in Section 3.1.2). Some headspace clinicians perceive that MOST was most important for youth at the start and end of their engagement with headspace, whereas other headspace clinicians perceive that each stage is equally important.

Interestingly, there appears to be a discrepancy between the perceived value of MOST and headspace clinicians' integration behaviours. In practise, headspace clinicians seem to engage with it minimally, while consistently emphasising its potential value if further integrated.

5.3.1.1 How Clinicians Typically Integrate MOST

Clinicians described varying levels of integration, ranging from using MOST as a fully separate adjunct to incorporating MOST into treatment sessions. While MOST is designed to be a tool that can be used alongside face-to-face care, it appears that clinicians are not deeply engaged with MOST and rarely integrate MOST into headspace episodes of care:

I would really like to incorporate it more than I am. Like, I don't really incorporate it. It's not because. I don't know. I haven't had time to look into it. — HEADSPACE CLINICIAN 10, REGIONAL SITE

I think the general vibe that I've got from our team here is that we're happy to use it as something to offer them and another thing that can support them. But we're not so keen on, and I'll speak for myself, I'm not so keen on deeply integrating it into ongoing intervention sessions. — HEADSPACE CLINICIAN 2, METROPOLITAN SITE

The depth of integration of MOST among interviewed headspace clinicians largely appears to be limited to the provision of a referral (see Section 3.1 for a description of the MOST referral process). This pattern also appears among surveyed headspace clinicians, with headspace clinicians most consistently reporting recommending MOST to young people due to upcoming leave or service closures with other behaviours reported more infrequently (see Appendix A3 for a summary on how surveyed headspace clinicians typically use MOST).

For headspace clinicians who use MOST in session, the ways they engage with and integrate the platform varies. Like most interviewed headspace clinicians, only a small minority of surveyed headspace clinicians reported often or always discussing MOST content in session ($\leq 15.20\%$, $n \leq 10$, see Appendix A3, item 1), with interviewed clinicians describing lower integration. These headspace clinicians described they may reference MOST content or guide youth toward psychotherapeutic content, but not monitor their client's engagement on MOST, for example:

The way we are using it is within session, showing them tools and maybe some homework, but we're not doing referrals necessarily because it's just something that young people haven't been interested in. — HEADSPACE CLINICIAN 5, REGIONAL SITE

On a handful of occasions, I've recommended certain articles to them, or I've used the send SMS to young person feature on the platform to kind of gently remind them that it exists. ... But yeah. That's it ... in terms of me pulling up the resources from MOST, I don't do that. — HEADSPACE CLINICIAN 4, REGIONAL SITE

Some headspace clinicians who appear to integrate MOST a bit more, described discussing MOST during episodes of care. However, it is not clear whether these conversations emanate from the headspace clinicians or client themselves. One headspace clinician described clients as active agents who, on their own accord, bring questions, concerns, or salient experiences encountered on MOST into the clinical room. This dialogue appears to be valuable for clinicians, providing a natural starting point to further explore these experiences in greater depth and clarity any uncertainties:

They seem to enjoy those [psychotherapeutic resources] and they'll often bring them up in session with us as well. It's very specific things like 'Don't change your life at 3am in the morning' or something ... quite often, it can lead us to exploring things more in depth and then also bringing in other sort of therapeutic tools and activities based upon that. So it kind of helps them identify what's a concern for them and then we can unpack that further and I think that's been helpful. — HEADSPACE CLINICIAN 12, METROPOLITAN SITE

One of them said that the peer worker was a bit invalidating. So we spoke about why she felt that was a bit invalidating. It was interesting, like, it wasn't invalidating, but I could see how ... someone who doesn't know her saying that, perhaps feels invalidating. But that led to a bigger conversation. — CLINICIAN 1, METROPOLITAN SITE

One headspace clinician appeared to be part of the minority who actively and consistently integrates MOST into their headspace care. This clinician largely uses MOST to assign content or 'homework' that they perceive as being helpful and relevant to their clients. This clinician also reported following-up with the client about their experience with the 'homework' in following sessions. This clinician undertook a more active role and reported looking at their clients posts in the social networking component as further insight into what the young person is experiencing, to then discuss in-session.

Sometimes they'll post in Community ... and then I'll be like, "well, I saw that you spoke about this" ... So I'll talk to them about that. I like to set them activity and ask how they felt about it. If it was helpful. so trying to integrate the online with the in person and kind of get an idea of how they're tracking ... So, it gives me a bit more feedback around them, not just the hour that they're telling me, but throughout the week I can see how they're travelling. It is a great talking point at times. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

Despite great variability in clinicians use of MOST, 53 clinicians (70.6%) value the effects that MOST has had on their work (see Appendix A2, item 3) and 44 clinicians (66.6%) indicated that integrating MOST into clinical work benefits their practice (see Appendix A4, item 8), further reinforcing the value of MOST.

5.3.1.2 How MOST Could Be Integrated

Across surveys and interviews, most headspace clinicians recognised the potential value of MOST, though did not seem to routinely integrate MOST into their clinical care. The majority of surveyed clinicians viewed the potential value of MOST in their work ($\geq 93.3\%$, $n \geq 70$; See Appendix A2, item 4) and agreed that integrating MOST into practise would make it more effective (68.1%, $n = 45$; See Appendix A4, item 9). Likewise, interviewed clinicians seemed to value MOST and recognise how it *could* be integrated into care, commonly describing hypothetical scenarios demonstrating the complementary nature of MOST on headspace care, yet seldom integrated MOST, for example:

I think it's so invaluable. Let's say a young person is coming in for support around anxiety and maybe we're looking at unhelpful thinking styles around anxiety ... so we'd be doing that work and then ... they're going home to MOST and they're looking [at] the anxiety journey and are like, "Oh yeah, that's what [Clinician 9] was saying" or "Oh, I can see how that fits and relates and I can see maybe the same thing from a different perspective." So I think that can be absolutely invaluable for sure. — HEADSPACE CLINICIAN 9, REGIONAL SITE

Ideally ... the clinician then would go on to MOST, see what kind of experience and engagement they've had. "Oh, they've looked at that thing about sleep" [and then] talk to them about it. Like that would be great. I wish that's how it worked ... but we just don't do that. — HEADSPACE CLINICIAN 10, REGIONAL SITE

5.3.2 Navigating the Overlap Between MOST, headspace and eheadspace

headspace clinicians frequently situated MOST within the broader ecosystem of headspace services, including eheadspace, using these existing supports as a benchmark to evaluate the role and novelty of MOST. In doing so, they often compared services and expressed uncertainty about how MOST fits within the headspace fidelity model and when it should be used alongside or instead of other services.

5.3.2.1 Uncertainty When to Use MOST

Almost half of the interviewed headspace clinicians drew direct comparisons between MOST, headspace, and eheadspace, pointing out the relative strengths and weaknesses of each service. Across accounts, headspace clinicians perceived considerable overlap between MOST, and other supports offered within headspace (including headspace episodes of care, eheadspace and headspace Connect), noting that each offers psychoeducation, clinical support, moderated online environments, and community forums.

This perceived overlap between MOST and headspace contributed to uncertainty about MOST's purpose within the existing headspace service model and ecosystem, posing implications for the implementation, uptake, and referral pathways for MOST. Some headspace clinicians described the addition of MOST as contributing to service saturation, as multiple services within the headspace ecosystem offer similar types of support and team structures, leading some to question the necessity of MOST within the broader service landscape:

I feel a bit confused, at least about how MOST sits within the headspace model, because In terms of digital mental health support, I thought headspace, eheadspace was able to provide that ... And then there's MOST and I'm like, I don't get it. Why is there an eheadspace *and* a MOST as well? I know MOST was developed by Orygen, which works, really closely with headspace, and they're both based in Melbourne ... they support each other, but I think it's just a bit odd. — HEADSPACE CLINICIAN 4, REGIONAL SITE

Uncertainty was further compounded by inconsistent expectations across services. Some headspace clinicians reported encouragement to prioritise MOST, while others described pressure to increase engagement with eheadspace. These mixed signals may shape whether headspace clinicians use MOST:

We've got eheadspace saying you need to uptake us a bit more. We're starting to change it. — HEADSPACE CLINICIAN 5, REGIONAL SITE

We definitely have a culture here where we would be expected to be referring to MOST when it's appropriate. — HEADSPACE CLINICIAN 9, REGIONAL SITE

Overall, the seemingly absence of clear guidance regarding the distinct role of each service may hinder headspace clinicians' implementation of MOST in practise.

5.3.2.2 Prioritising the headspace Fidelity Model

In the context of this uncertainty, headspace clinicians tended to prioritise services more clearly aligned with the headspace fidelity model. While MOST was often perceived as an external or additional platform, headspace services (including headspace Connect, eheadspace, and headspace Individual Placement and Support Team) were viewed as default, integrated extensions of existing headspace care:

We do put headspace first because it's part of our fidelity model. So, we use their digital services, we are actually audited on that ... But we prompt headspace digital services more than we prompt MOST ... I think because we can guarantee it similar sort of vibe in the headspace land ... Young people can have us from during hours, so 9 to 5, but after school you can have headspace at home, which is the eheadspace from 3:00pm to 10:00pm.... [and] my understanding is the eheadspace is looking to make our electronic medical records speak together.... making it really streamlined that it's one service, one look, *one*. — HEADSPACE CLINICIAN 5, REGIONAL SITE

5.4 Perceived Feasibility of Implementing MOST into headspace

HIGHLIGHTS

- The feasibility of implementing MOST into headspace is highly variable across sites and is shaped by multiple interacting factors including clinician role, episode of care models, and overall workload pressure.
- Meaningful implementation of MOST into clinical care appears to be most feasible for headspace clinicians in counselling roles operating within multi-session episodes of care, where there is greater opportunity for follow-up, monitoring, and therapeutic use of the platform.
- High workloads, limited resources, and high staff turnover, may limit opportunities for clinicians to implement MOST into care, reinforcing a reliance on individual clinicians, which may lower feasibility.

This section describes the practicality of headspace clinicians implementing MOST within the existing headspace structures, resources, and workflows. This section focuses on a range of factors that impact the feasibility of incorporating the MOST service into clinical care.

While the majority of surveyed clinicians indicated they can easily integrate MOST into their existing work (77.4%, $n = 58$, see Appendix A2, item 5), interviewed clinicians provided a different perspective, discussing a range of factors that may impact the ease and feasibility of integration. This includes clinician roles, the headspace episode of care model, time constraints, the degree to which MOST is embedded into headspace procedures, and high staff turnover impacting newer clinicians onboarding with, and knowledge of MOST. While previously discussed factors such as clinician knowledge, confidence, and comfort with MOST (see Section 5.1) may also impact the feasibility of integrating MOST into care, this section focuses on additional factors that may shape its feasibility.

5.4.1 Clinician Role Impacting Extent of Integration

While all headspace clinicians can implement MOST to some extent, the depth of feasibly integrating MOST is dependent upon their role at headspace. For example, the program managers, duty officers, and intake workers appear to undertake more administrative responsibilities whereas counsellors appear undertake more client-focused, counselling responsibilities.

In the case of duty officers, intake workers, access clinicians, and clinical leads who largely interact with clients at intake, it does not seem feasible for clinicians in these positions to integrate MOST beyond the provision of a referral. Often, these clinicians do not have ongoing contact with the young person, and do not provide counselling or ongoing monitoring of the young person. Therefore, while it is feasible for clinicians in these types of roles to describe MOST and provide a referral, it does not seem realistic or practical for clinicians to further embed MOST:

If I do clinical work, it's triage and assessment, so I don't do long-term counselling in my role ... The clinicians may well [integrate MOST], and that's a good question to ask them, but I've not had the opportunity to do that. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE, PROGRAM MANAGER

We're aware if they're accessing MOST, but all of the other features of it are not things that we are in the position to use. So, things like recommending resources to young people or following them on their journey that's actually out of our scope at headspace to sort of interact with them outside of our initial role.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE, SENIOR ACCESS CLINICIAN

On the contrary, it appears more feasible for clinicians engaged in ongoing counselling to embed MOST into clinical care. When headspace clinicians see clients across multiple sessions, they are better positioned to introduce and follow up on MOST and incorporate it into their ongoing interactions with clients. As one clinician noted, opportunities to engage with MOST is reduced when care is transferred, limiting the ability to follow up or reinforce its use:

The first time I talk to a young person about MOST is during an intake appointment and, because of the way I practice, I tend to continue on with the young person just because I've built the rapport with them already. Otherwise, if they are allocated to a different clinician, then I'm less inclined to kind of follow up on MOST or I really don't have any other opportunity to follow up on MOST. — HEADSPACE CLINICIAN 4, NON-METROPOLITAN, CLINICAL EDUCATOR

5.4.2 headspace Episodes of Care Model

In addition to clinician role shaping the extent of implementation, the headspace episodes of care model also appear to meaningfully shape the depth to which counselling clinicians can integrate MOST into routine clinical practise. In particular, clinicians spoke about a single session (*"one at a time"*) model and a multi-session model, with clear implications for implementation.

5.4.2.1 The Single Session Therapy Model

Some headspace clinicians described working within a single-session therapy framework, commonly referred to as *"one at a time"*. Under this model, clinicians conduct a 90-minute targeted session to focus on a singular, client-identified issue. One to two weeks later, headspace clinicians provide a follow-up phone call to assess whether the young person would like further support for the same issue, a different concern, or whether they feel no further support is required:

While MOST could be briefly introduced within these sessions, the feasibility appears to be constrained within the single-session model. The absence of ongoing sessions limits headspace clinicians' capacity to assign and review homework, monitor young people's engagement with the moderated platform, or follow up on activities completed between sessions. As a result, opportunities to integrate MOST as part of an ongoing therapeutic process are reduced.

In addition, when young people select highly specific or situational concerns to focus on in their single session, these issues may not closely align with the psychotherapeutic content available on MOST. As one clinician explained, clients may choose to speak about specific difficulties – for example *"I don't know how to talk to dad or mum about X or my foster parents about Y"* (headspace Clinician 11) or *"I've got exams coming up. I'm going to feel really stressed. Could we talk about that?"* (headspace Clinician 9). This may further limit the applicability of MOST resources within a single-session format. Collectively, these constraints suggest that the episodic nature of the 'one at a time' model may restrict headspace clinicians' ability to establish sustained engagement with MOST.

5.4.2.2 Multiple Episodes of Care Model

In contrast, the integration of MOST into clinical care appears to be more feasible for headspace clinicians operating within a multi-session episode of care framework. Within this model, headspace clinicians reported greater capacity to integrate MOST into ongoing treatment. This session framework allows headspace clinicians to introduce the platform, assign homework activities, and meaningfully review young people's engagement between sessions, to further inform their episode of care. One headspace clinician described routinely embedding MOST into care for young people who they see more regularly:

I'm also doing it a lot [integrating MOST] when I see someone more regularly. So, I'll send my homework on there. I'll say "Hey, I want to give you these resources for us for you to look at between our appointments". — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

This suggests that the depth of MOST integration is closely linked to the structure of care delivery. While single-session models may allow for an introduction to MOST, multiple sessions provide the flexibility necessary to build routines, monitor engagement, and integrate MOST into clinical practise to complement headspace sessions.

5.4.3 Clinician Time Constraints

One of the most consistent findings raised by all headspace clinicians, regardless of clinician role and episodes of care model, is the time constraints they experience. headspace clinicians often positioned time as a finite and competing resource, describing MOST as taking up additional time they do not have.

5.4.3.1 Time as a Competing Resource

The feasibility of headspace clinicians practically integrating MOST appears to be constrained by the volume of work and available resources. For example, counselling headspace clinicians described some typical daily activities – 45-minute counselling sessions, with a 60-minute break in between clients to complete a range of tasks such as case notes, writing safety plans, getting in touch with a client’s care team such as school counsellors, while also preparing for the following client. headspace clinicians often spoke about a misalignment between what was expected of them and what is practically achievable. While some headspace clinicians appear enthusiastic to integrate MOST to a greater extent into care, it seems less feasible to do so with their already constrained workload:

I’m supposed to go in and have all this wonderful time to go and see how they’re going and look at what they’re doing in MOST. And to me, we just simply wouldn’t have time to facilitate that. It’d be nice to think, you know, in a perfect world, yes. But we just don’t have that much time, unfortunately. — HEADSPACE CLINICIAN 11, REGIONAL SITE

Interestingly, a broadly equivalent number of surveyed headspace clinicians both agreed ($n = 27$, 40.9%) and disagreed ($n = 29$, 44%) that they struggle to use MOST to the extent that they would like because of their other clinical priorities (see Appendix A4, item 10 for agreed responses – disagreed responses not shown). This constrained workload was consistent across roles and settings, with clinicians describing competing priorities that relegated integrating MOST into care, sometimes leading to clinicians forgetting about MOST:

Usually, I always offer it [MOST] regardless. Sometimes I forget because it’s not at the top of my priority list within the assessment session ... like the session is so packed with making sure I’m addressing everything else. — HEADSPACE CLINICIAN 2, METROPOLITAN SITE

We’re getting so strained ... That we kind of forget about it. Put it on the second planning. — HEADSPACE CLINICIAN 8, METROPOLITAN SITE

Interestingly, the majority of headspace service leads also contended with the challenge to keep MOST at the front of their mind with all of their other clinical priorities (detailed results not reported due to small sample size). While headspace Clinician 2 explicitly mentioned forgetting to offer a MOST referral during intake assessment, this was contended by a minority of surveyed headspace clinicians who agreed with the sentiment that other clinical priorities interfere with referring young people to MOST ($n = 11$, 13.9%, see Appendix A4, item 11).

5.4.3.2 Navigating MOST Takes Additional Time

It appears that the volume of work exceeds headspace clinicians’ time, making time a restrictive resource, exemplified by one headspace clinician describing their time as *“really quite valuable to be searching another app”* (headspace Clinician 11). Low clinician portal usability compounded existing time pressures by increasing the time and effort required to locate and access clinically relevant information about their clients (as discussed in Section 5.1.4). Consequently, headspace clinicians have to spend more time navigating the platform. headspace clinicians described the need for an efficient, and easy-to-navigate platform to integrate into the face-paced, time-limited clinical care, with some providing an example of how they could feasibly see MOST being integrated into headspace care:

For me as a clinician, I need something easy to refer to, which it is – very easy. Then I need to know how to navigate it ... If I could just go “Right, Sally’s coming in today, her Happy [score] doesn’t really tell me much. Let’s have a look at what she’s posting on MOST. Oh, that’s concerning. I’ll bring that up in today”, [it’s], just as simple as that. — HEADSPACE CLINICIAN 11, REGIONAL SITE

The need for time-efficient systems was further reinforced by headspace clinicians' greater perceived uptake of MOST when processes are straightforward and efficient, with the referral pathway frequently cited as a key enabler:

MOST is a recent thing I've been referring because the referral form is so easy.

— HEADSPACE CLINICIAN 13, METROPOLITAN SITE

5.4.3.3 Limited Capacity to Learn About MOST

In addition to time constraints reducing the opportunity for headspace clinicians to integrate MOST into care, headspace clinician knowledge about MOST also appears to be related to the feasibility of integrating it into care. Most headspace clinicians appeared to have a limited understanding of MOST (see Section 5.1.1 for further detail) and recognised the need to dedicate time toward understanding MOST and how to navigate the clinician portal in order to develop their capability and confidence with MOST. As headspace clinicians appear to be overwhelmingly time-constrained, it is perhaps unsurprising that they have not had the time to dedicate toward learning about MOST, thereby reinforcing their lack of confidence in integrating it:

The onus is sort of on us to look further into it. But again, time constraints can make that really difficult. So we do really rely on that sort of initial walkthrough to really help us in how to identify how it can help our young people 'cause we might not get the time.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

It's a lack of time. I haven't had time to like sit down for a couple of hours and explore the program. I just haven't. Which isn't on MOST, it's on the mental healthcare system.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

5.4.3.4 High Staff Turnover Impacting New Clinician's Onboarding to MOST

The majority of interviewed headspace clinicians described high staff turnover as common across headspace sites, framing this as a normative feature of the service context. Many headspace clinicians noted that a substantial proportion of staff at their site are relatively new and had commenced with headspace after MOST's implementation team delivered on-site training. However, it seems there is no consistent, standardised onboarding process for new staff, which may directly undermine the feasibility of integrating MOST into care.

Some sites reported that newly employed headspace clinicians are onboarded with MOST. These clinicians described new staff are assigned to complete MOST's online training course suggesting the presence of a more standardised approach:

Whenever we hire new people, very quickly they'll be added to get the training on how to use MOST so it's pretty well within headspace.

— HEADSPACE CLINICIAN 3, METROPOLITAN SITE

However, this experience was not universal. Other headspace clinicians were not aware of any formal training processes and described having to independently onboard and train new staff on MOST. This informal, peer-led approach shifts responsibility for the MOST training onto the headspace clinicians themselves, adding to an already constrained workload:

We cannot provide a proper training for the new staff ... to bring me another clinician [to train] is hard for me ... No [we have no support to help train clinicians]. That's part of the frustration with MOST and the headspace material. We try to pair [the material] with new clinicians but [we] also [have] a lack of time as well. We [clinicians] just had a short amount of time to do the training.

— HEADSPACE CLINICIAN 8, METROPOLITAN SITE

As headspace clinician training about MOST seems fundamental for developing clinician knowledge, confidence, and implementation behaviours of MOST (see Section 5.1), this peer-training model appears particularly problematic. New headspace clinicians may inherit incomplete, inconsistent, or inaccurate understandings of MOST, which may further compromise their understanding of, and engagement with MOST. Other interviewed headspace clinicians reported that newer team members may not be aware of MOST or had not been onboarded to the platform at all:

Most of our clinicians are quite new. And I still I think two of them are like yet to be onboarded onto MOST... but I think a fair few of the new clinicians didn't even know what it was. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

The site-level variation in training processes appears to directly impact the feasibility of newer headspace clinicians integrating MOST into care. Insufficient training may undermine headspace clinician knowledge, confidence, and capability reducing the likelihood that MOST will be meaningfully implemented in practise. Establishing a standardised onboarding session with clear ongoing support may be critical for improving headspace clinician engagement with MOST, enhancing its feasibility across sites.

5.4.4 Embedding MOST in headspace Procedures Supports Feasibility

headspace clinicians described variability in the extent to which MOST was embedded into headspace procedures across sites. The feasibility of integrating MOST into clinical care seems bolstered when MOST is clearly incorporated into established headspace procedures and documentation. headspace clinicians spoke about the various ways in which MOST is procedurally embedded into the headspace service, most commonly through its inclusion the headspace's Welcome Pack (which provides young people with an overview of the supports offered at headspace), and through prompts within clinician documents. Some headspace clinicians described how MOST was explicitly integrated into intake assessment via a direct prompt on mandatory fields, encouraging a MOST referral at this stage, for example:

After we've done the triage call, we'll do a more thorough assessment and we offer them MOST within that session ... We've got this document that we're needing to fill out, and part of the document is like "Is a MOST referral being completed? Yes or no". So really, we should be doing it regardless in every single one of those [intake assessments]. — HEADSPACE CLINICIAN 2, METROPOLITAN SITE

On the back page [of the referral form, there are] some further support options that young people can read through and tick. It includes things like eheadspace, some groups that we run, etcetera, and there's also one for MOST too. — HEADSPACE CLINICIAN 4, REGIONAL SITE

headspace clinicians reported greater satisfaction with the feasibility of implementing MOST when MOST was clearly embedded into routine headspace procedures. In these contexts, integration was perceived as "really easy" (headspace Clinician 13) and supportive of clinician workflow, clarifying expectations around clinician's use of MOST, thereby likely contributing to implementation feasibility:

[Here, MOST] seems to be working pretty seamlessly ... Integrating it into the first contact process has made it really easy because in the end every young person gets a referral and if they want to. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

It's kind of just really embedded in practice here. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

These headspace clinician accounts are also contended by the majority of surveyed headspace service leads who agree that MOST is part of their service's routine care (count and percentage not reported due to small sample size). Notably, however, MOST is not consistently embedded within headspace procedures across sites. Some headspace clinicians perceive that MOST is not integrated into the headspace service as well as it could be. At these sites, the implementation of MOST appears to be more reliant on clinician initiative and willingness to use MOST, rather than embedded into clinician procedures which may impact the feasibility of integrating MOST into care.

I don't think it's [MOST] embedded in our practice as much as it could be ... I think most of the time it's just people taking the initiative as they feel, like "Oh, this might be helpful". We have had conversations about incorporating into our intake process, so offering it to every young person, but ... it's not happening from like a busyness aspect and staff turnover. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

headspace clinicians highlighted organisational factors – namely busyness and staff turnover, as key barriers to embedding MOST more systematically into headspace procedures. These factors were reinforced by a range of headspace clinicians and appear to constrain clinicians ability to prioritise the implementation of MOST. High workloads, limited resources, and high staff turnover, may further limit opportunities for clinicians to implement MOST into care, reinforcing a reliance on individual headspace clinicians. Taken together, time constraints and staff turnover emerge as interrelated structural factors with downstream effects on the feasibility of implementing MOST across sites.

5.5 Perceived Accessibility of MOST

HIGHLIGHTS

- All headspace clinicians viewed MOST as an accessible mental health support option, particularly due to its perceived ability to reduce traditional barriers to care.
- The online format allows young people to access across devices and locations, allowing young people to engage with MOST “wherever they go”
- Continuous, around-the-clock access was seen as critical for supporting young people outside business hours and during periods of heightened distress.
- headspace clinicians valued MOST as it extends mental health support reach to underserved populations – e.g., young people facing geographic and situational barriers to access headspace.
- The youth friendly design, particularly the non-clinical language supports usability of the platform across varying literacy levels.
- Despite MOST being viewed as a largely accessible platform, digital inequities persist and headspace clinicians mentioned lack of devices, internet access or phone numbers as barriers to young people’s access.

Accessibility refers to how MOST can be used and understood by the widest range of young people. All headspace clinicians perceived MOST to be an accessible mental health support option (discussed in further detail below), which aligns with the intent of MOST to increase the reach of young people accessing mental health support (Cross et al., 2023).

5.5.1 Digital Accessibility: Being Able to Access MOST “Wherever you go”

headspace clinicians valued the online format of MOST, noting that young people could readily access MOST from a range of portable devices. This was perceived as particularly beneficial given that most young people already have regular access to personal devices such as a phone, laptop, or tablet, and a stable internet connection, enabling engagement with MOST:

You can access it wherever you go ... If it’s on your phone and you move around, you go with it [and] it moves with you, right? ... And you can access it, as long as you have internet, a phone or laptop, you can access it anywhere. — HEADSPACE CLINICIAN 6, REGIONAL SITE

While the online nature may be accessible for some youth, this modality of support can be a barrier for other young people who do not have access to a personal device or stable internet connection. Although young people who do not own a personal device may be able to create an account and access MOST via a parent's device, this can be challenging in households with multiple young children, as the same phone number cannot be used to create multiple accounts:

I think that's pretty accessible. The only problem that we've come in contact with is, if there's multiple kids that are a bit younger so they don't have their own phone, they have to use like mum's phone number and there's only one phone number that they can use. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

MOST is accessible to anyone as I say, unless you've got no means of IT [Information Technology] or the Internet's rubbish out there in the country. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

5.5.2 Continuous Day-and-Night Support

headspace clinicians appreciated the around-the-clock support offered on MOST and its ability to bridge gaps in the traditional therapy landscape. A subset of headspace clinicians described that MOST allows young people to access care outside of business hours and when they are not able to see a headspace clinician. The continuous platform allows young people to access care when they need it:

All those different areas of support within their life, at any point, whether they're at home and it's the middle of the night and they're just looking for a bit of a rant or something, I think that's a fantastic sort of thing that doesn't really, necessarily exist in many other places. — HEADSPACE CLINICIAN 2, METROPOLITAN SITE

I think it's very accessible for sure, as compared to like, "Oh, I need to call like this organisation and I still need to wait for an appointment". Whereas the app, it's just there when you need. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

I think it's a great service. You know, being a digital online [is] wonderful because people at three o'clock in the morning, they can't ring headspace, they don't really want to call emergency services, Lifeline's a bit too hectic. They just want to kind of talk to someone. — HEADSPACE CLINICIAN 11, REGIONAL SITE

5.5.3 Accessible for Harder to Reach Populations

A subset of headspace clinicians identified that the online nature of MOST enables mental health care access to a broader range of individuals who may be hard to reach and disengaged from traditional service pathways. headspace clinicians described a range of circumstances that may prohibit a person from leaving their home to access the headspace service, including people experiencing geographic barriers (such as those living in rural or regional country areas) who have to travel long distances to get to the centre. headspace clinicians also described situational factors that may hinder a youth's ability to seek headspace mental health support including familial beliefs about mental health, the experience of family and domestic violence, or more severe mental health difficulties limiting a person's capacity to get to headspace. In this way, MOST was perceived as being accessible and as having the capacity to reach some young people who may otherwise be missed, for example:

I think it's such an important way to reach young people and to reach young people who don't have access to mental healthcare ... [in terms of] location but also it could be family wise if their parents don't believe in accessing mental health support. — HEADSPACE CLINICIAN 10, REGIONAL SITE

I have clients who live in country areas. They don't have access to all these things. No, that includes headspace as well. Some clients, they have to travel two hours. Sometimes they cannot make. So the logistics. It is the home stability as well. The client may not be able to leave their home to access, we don't know their situation or where they live. It [MOST] is for their easy access as well. — HEADSPACE CLINICIAN 8, METROPOLITAN SITE

5.5.4 Accessible for a Range of Literacy Levels

Most headspace clinicians perceived the language used on MOST to be an important facilitator of its accessibility, allowing people with a range of English- and mental-health literacy levels to understand and use the platform. Clinicians often reference the language used in terms of the therapeutic content. The casual, non-clinical, lay language and informal tone of information was perceived to present mental health support in a way that is approachable and non-stigmatising for young people. They felt the language and tone used facilitates engagement as it is casual and relatable – which, they often contrasted with more clinical resources:

The stuff I have read through is obviously youth friendly, easy to understand and non-clinical which I think is very important for young people they don't want to feel, pathologised. I guess it feels again accessible like it would be explained [as] if you're talking to a mate ... so I think the language is good. — HEADSPACE CLINICIAN 3, METROPOLITAN SITE

I think the wording and everything is really clear. It's really easy to read ... there's no like jargon or any therapeutic terms or anything like that. — HEADSPACE CLINICIAN 9, NON-METROPOLITAN

5.5.5 Flexibility Perceived to Enhance MOST's Acces

As MOST was developed to be a flexible service that can be adapted to a range of different service contexts, preferences, and needs (Cross et al., 2023), flexibility appears to be a core component that enhances its accessibility. headspace clinicians consistently perceived this flexibility as a key asset, contributing to its potential impact. In direct alignment with its development (Cross et al., 2023), headspace clinicians described how young people can use MOST on their terms – by choosing which components to engage with, when and how frequently to engage with MOST, the depth of their involvement, and the level of personalisation– features that support youth to be actively involved in their care plan, rather than passive recipients. In this way, the flexibility of MOST was perceived as a key facilitator in increasing its reach to young people:

Being able to use it in whatever way a person wants is good. Some people will only use The Community page, others will only have it for the toolkit. I think it being targeted that way makes it more accessible, which makes it easier to access and then therefore impactful. — HEADSPACE CLINICIAN 3, METROPOLITAN SITE

Two different people that are referred to MOST can be using it in two completely different ways. Like some people might want to talk in Community, some people might want to text clinicians, other people just want my resources that I send through. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

People can just go in and be like, "If I don't want support today, it's ok I can go tomorrow if I need" ... I feel like the flexibility and just the customised personal kind of like thing ... it's not that you need to follow like a customised thing. It's like, *you* are the young person, so *you* actually create what you want to do that is helpful for you. — HEADSPACE CLINICIAN 14, METROPOLITAN SITE

5.6 Perceptions Around MOST's Governance Structure

HIGHLIGHTS

- headspace clinicians largely perceived MOST as a safe and well-governed platform, with this perception underpinned by safeguards such as moderation, established risk escalation pathways, and age segmentation.
- Some concerns were raised regarding aspects of the MOST model, including moderation hours, privacy, and duty of care responsibilities.
- While headspace clinicians were generally satisfied with communication from MOST regarding risk escalation procedures, headspace clinicians held mixed perceptions about the timeliness of communication with MOST clinicians undertaking a shared care approach.
- headspace clinicians perceived a misalignment between the MOST model and the headspace fidelity model that prioritises a one-at-a-time approach, creating potential tension in implementation
- Implementation support from Orygen Digital and headspace was viewed positively with clear monitoring and feedback mechanisms identified as facilitating ongoing implementation

This section describes headspace clinician attitudes toward the formal structures, processes, and safeguards on MOST. headspace clinicians largely perceive MOST as a safe, low-risk, well-governed platform but express ethical concerns about youth safety in terms of the timeliness of flagging risk, privacy of information, duty of care, and sometimes a lack of knowledge about governance systems.

5.6.1 Perceived Safety and Risk

Overall, headspace clinicians largely perceived MOST as a safe and well-governed platform. Nearly all surveyed headspace clinician ($n \geq 75$, $\geq 93.75\%$) agreed that MOST is safe for their clients to use (see Appendix A5, item 1). The perception of safety appeared to be underpinned by a range of structural safeguards on MOST. headspace clinicians unanimously valued the moderation component. They perceived moderation as a core component to ensuring safety, providing a gateway for risk flagging, and reducing the possibility of online harms, with one headspace clinician comparing the safety on MOST to the lack of safety in non-monitored online gaming communities:

All the community stuff is moderated, so any things that are risky get flagged. Obviously, I know that if we have young people assigned to us as clinicians and they disclose something to their MOST clinician, they get in touch with us, so I think a lot of bases are covered. — HEADSPACE CLINICIAN 3, METROPOLITAN SITE

There is some sort of moderation around what's posted so that people aren't sort of saying "Yes, go out and hurt yourself" ... which in the gaming community ... they can say, "yeah, go get wrecked basically to someone". It's not looked at all, not modified [moderated]. So ... there's quite a lot of hurtful, bullying that can occur in the cyber communities. — HEADSPACE CLINICIAN 11, REGIONAL SITE

headspace clinicians also viewed the age segmentation and private message restrictions as other safeguards enhancing the safety on MOST. Clinicians like that two platforms of MOST exist – one for young people aged 12 to 14, and another for young people aged 15 to 25, to protect the safety of the younger cohort. The private message restrictions were also perceived to enhance safety as it ensures that all direct communication between young people having to be posted on the moderated community page:

[On] the community chat group, even if people talk, you can't exchange numbers, it's very private. You can only post, you cannot comment about other stuff. I think MOST have done such a great job in trying to avoid ... bullying or anything in this kind of chat group ... I think it's very safe for everyone using it. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

I think how it's broken down into the two age groups is excellent. You've obviously got your one for your 12 to I think 15-year-olds and then 15 and above. So I think they've broken it down well to allow young people to engage at the age appropriate level. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

Some headspace clinicians expressed no concern about potential risk on MOST, reinforcing perceptions around MOST as a safe platform:

I've not come across any barriers or any concerns using the platform. Certainly not heard any from the team. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

From everything that I've seen, it's been a supportive platform, especially around resources and supporting young people to learn more about that in a safe space. So, no concerns. — HEADSPACE CLINICIAN 12, METROPOLITAN SITE

While MOST is not a crisis service, some headspace clinicians expressed concern about the timeliness of moderators detecting and responding to risk. These concerns were often shaped by limited understanding and visibility into the moderation process (see Section 5.6.3), with headspace clinicians drawing on hypothetical worst-case scenarios when describing potential harm. For example, one headspace clinician described a potential situation in which a young person posts alarming content outside of active moderation hours, raising concerns that delay in review or content filtering could lead to the escalation of risk:

I would just worry about that harm to themselves, harm to others kind of aspect, from a safety planning point of view. If the young person reaches out to MOST and no one else, right? They're not ringing Lifeline, they're not ringing anyone else. They post something and I don't know how MOST works but potentially they, there might be certain words that trigger that they don't post it. So they're talking about suicide or self-harm or harming someone else. They [MOST] don't post it. They don't get to see it till 9 o'clock in the morning. That person's now "nobody cares about me. They haven't even posted it. No one's got back to me". And they act on that. That could be potentially life-threatening. — HEADSPACE CLINICIAN 11, REGIONAL SITE

5.6.2 Satisfaction with Known Risk Escalation Pathways

When content that indicates potential risk (for example around self-harm and suicidality) is posted on MOST's moderated social network or discussed in one-on-one conversations with a MOST clinician or peer worker, it is flagged and escalated to the young person's headspace clinician.

68.4% of surveyed headspace clinicians ($n = 54$) agreed that the safety procedures on MOST are adequate (see Appendix A4, item 12), and interviewed headspace clinicians generally viewed these processes positively, highlighting the moderation and risk escalation procedures on MOST creates a "safety net" for young people. headspace clinicians described that the process largely enabled timely identification of risk, and supports them to undertake safety planning and appropriate follow up care, further reinforcing their confidence in MOST as a safe platform:

I've had a young person who's had a bit of an incident posting something on MOST and I was very happy with how MOST handled that and the support that the young person received and the communication between them and us and like it was all very, very professional and clear and quick. so. I'm very happy with that and very comfortable with the people that I see feeling and being safe on that sort of platform.

— HEADSPACE CLINICIAN 2, METROPOLITAN SITE

I do really love that if you have a young person who's kind of talking about their risk or their thoughts of suicide or whatever it might be, that is flagged. Like I don't know how they flag it, [but] then they tell the clinician. I really like that element. I think that is really, that's really, really helped me in a couple of situations actually.

— HEADSPACE CLINICIAN 10, REGIONAL SITE

Similar to headspace clinician accounts that emphasised efficient communication between MOST and headspace, the majority of headspace clinical leads agree that communicating with MOST's clinical team about shared client risk has been easy (the exact count and percentage are not reported due to the small sample size).

Importantly, however, a handful of headspace clinicians were uncertain about risk escalation protocols on MOST. It appears that knowledge about risk escalation pathways appear to emanate from clinician experience rather information received in training:

I'm uncertain as to what the escalation protocols are if a young person were to disclose risk to a MOST clinician that is connected with the young person that I referred to MOST Are they going to contact me? Are we gonna share notes? Are you gonna share notes? Am I part of the care team ongoing? I don't really know.

— HEADSPACE CLINICIAN 4, REGIONAL SITE

I guess if someone disclosed something. really intense to one of the clinicians, I imagine that they would reach out to me. It's not a situation that I've had.

— HEADSPACE CLINICIAN 1, METROPOLITAN

5.6.3 Limited Detailed Knowledge About Governance Systems

While headspace clinicians may understand *what* is included on MOST, they expressed uncertainty about the governance systems across different components. For example, several clinicians expressed uncertainty around the nature of moderation and clinical support on MOST including *how* posts are flagged, the hours of moderation, the modality in which young people can speak to a MOST clinician, any limitations to accessing clinical support, and whether there are waiting lists on the platform to talk to a clinician, for example:

I'm a bit concerned if they have a clinician looking at it 24/7 ... [because] if a young person talks about suicidality, is there someone [that] is flagging and is it something that someone looks at? Because I'm not sure about that. — HEADSPACE CLINICIAN 11, REGIONAL SITE

I'm not sure how their counselling is in their clinical team, whether it's phone or telehealth [or] whether chatting could be an option. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

Limited knowledge of governance systems may directly shape headspace clinicians' engagement, communication, and implementation of MOST.

5.6.4 Privacy Concerns About the Accessibility of Youth Information

Some headspace clinicians also expressed concern about young people's privacy on MOST. Specifically, these clinicians were concerned about their own ability to view all young people's engagement on the platform, personal content, and client case notes on MOST from other clinicians at their headspace site. This appeared to be particularly problematic to headspace clinicians as they do not have the young person's consent to view their content, nor have to know the young person, yet are privy to their information:

It seems like MOST doesn't allow you to see *your* clients. I think you can see everyone ... which is a bit of a privacy concern, isn't it? ... if you're seeing your own, you've got their consent to see that, and we've got a release of information form that we sign and then we can see what they're posting or doing. So, that's really important. Whereas ... [you can see] young people who don't know who you are, and don't have that connection with you. — HEADSPACE CLINICIAN 11, REGIONAL SITE

Say there's four of us who are clinicians here, I think the case note is visible ... So if I have a client ... and I don't want the other clinician to know about it, they can see it. They can access it. — HEADSPACE CLINICIAN 6, REGIONAL SITE

5.6.5 Ambiguity Around Duty of Care

headspace clinicians described instances where there may be an ambiguity around duty of care and responsibility. They described two scenarios around a misaligned allocation of clients on MOST, both related to the frequent turnaround of headspace clients and the inability to remove clients from clinicians' caseload on MOST.

One scenario described by headspace clinicians is when a triage clinician submits a MOST referral for a young person and, by default, becomes listed as that young person's clinician on MOST. This occurs even though the young person is later assigned to a different counselling clinician once they come off the waitlist. As a result, the original allocation on MOST quickly becomes outdated.

Because triage clinicians do not appear to have the ability to reassign the young person to their actual treating clinician on MOST, the counselling clinician is unable to fully integrate MOST into the young person's care. This creates ambiguity around role clarity and information ownership, and limits the effectiveness of MOST as part of the counselling process.

Relatedly, other headspace clinicians described the general inability to remove young people from their caseload on MOST, for example:

If they disengage [from headspace] there's no option ... [to] remove young person from my caseload or from my list of allocated young people. — HEADSPACE CLINICIAN 4, REGIONAL SITE

The inability to formally cease responsibility for a client is particularly problematic for headspace clinicians as they have a continued attribution of responsibility for young people who have been exited from the headspace service. As the listed clinician on MOST, MOST clinicians will continue to contact the headspace clinician, under the assumption that they are still the young person's current treating clinician. This creates an ethical uncertainty when risk escalates for a past client, leading to ethical, legal, and duty of care ambiguity.

A lot of my young people that I was seeing regularly, I no longer see. So if someone reached out and was like "this person is talking about this", I'd be like, "Okay. They're not even like an active client of mine. They're welcome to re-refer and we can chat". Obviously, if there was high risk, I could reach out ... But I think like headspace moves quite fast. — HEADSPACE CLINICIAN 1, METROPOLITAN SITE

As a result, some headspace clinicians avoid integrating MOST into practise and engaging with the social network component on MOST, to avoid seeing posts from exited clients, highlighting the need for better privacy controls:

I try not to check too much in on my young people because I've exited them [and] they're on there. So, I feel like ethically I wanna be careful about that. — HEADSPACE CLINICIAN 9, REGIONAL SITE

5.6.6 Various Views About the Shared Care Approach

As MOST is designed to be used across all stages in a person's care journey, it is intended to be used alongside face-to-face care. This means that young people may be seeking clinical support from a MOST clinician and headspace clinician at the same time. When a young person is engaged in with clinical support from MOST and headspace concurrently, MOST undertakes a shared care approach with the client's headspace clinician (Alvarez-Jimenez et al., 2025). Shared care refers to a collaborative approach where a person's care is jointly managed by treating mental health professionals, allowing people to receive specialised care.

5.6.6.1 Clinician Preference for the headspace Fidelity Model

headspace clinicians described tension between MOST's shared care model and headspace's fidelity model, commonly positioning the headspace fidelity model preferencing young people to see one clinician at a time, rather than being treated by two clinicians at the same time:

If we're spending six sessions on this subject, but they're also spending six sessions on this subject with another clinician somewhere else, then that's not quite using the headspace model in a way that's going to be useful for the young person.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

headspace clinicians' preference around shared care often aligned with headspace's fidelity model. Clinicians described this preference in terms of protecting the young person's safety, avoiding potential risk of conflicting therapeutic approaches and ideas, while also allowing more resources and availability to see other young people:

We really try to steer away from someone being engaged with two therapists at once ... And I think it could be, could be difficult 'cause you can get conflicting thoughts and ideas. And I think it could be problematic. — HEADSPACE CLINICIAN 10, REGIONAL SITE

Within this headspace, the sort of vibe seems to be like we wouldn't see someone who's also seeing another therapist because we wouldn't really want to clash in in how we're approaching the problems that are in their life. — HEADSPACE CLINICIAN 2, METROPOLITAN SITE

5.6.6.2 Clinician Recognition of Potential Value of Shared Care

Although headspace clinicians were often reluctant to undertake a shared care approach as it clashes with the headspace model, some clinicians expressed conditional acceptance of it, recognising that there may be certain circumstances where shared care is valuable. Clinicians described that shared care can be helpful when clinicians are addressing separate but related challenges, undertaking a complementary approach. These clinicians discussed that shared care must protect the safety of the young person, be in the best interest of the young person,

Say if there's a need identified through MOST ... [and] they're aware that they're [young person is] engaging with headspace ... if they decide to work concurrently with the young person, as long as they're not working on the exact same issues and concerns that we are to prevent re-traumatisation that's also fine. If they're working with the young person around anxiety or risk when we're also working with them around trauma, then that can be very supportive. — HEADSPACE CLINICIAN 12, METROPOLITAN SITE

Some headspace clinicians reported on their shared care experience with MOST clinicians. Few headspace clinicians were satisfied with this approach, framing it as a positive experience that provided them with further insight into the young person's difficulties, allowing them to jointly manage their clients' treatment. In a similar manner, most surveyed headspace clinicians agree that it is helpful to collaborate with MOST clinicians when undertaking a shared care approach ($n = 48$, 72.7%, see Appendix A4, item 13):

I have had a few situations where MOST clinicians actually contacted me and my staff members just to update us on like a young person[s] mental health and what's been going on ... So, there's that partnership as well, which is really helpful, just so that we are all on the same page supporting the young person. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

However, headspace clinicians did not always report a positive experience with the shared care framework, noting instances of communication breakdown between headspace and MOST clinicians (discussed below).

5.6.6.3 Communication Breakdowns in Shared Care

Some headspace clinicians were dissatisfied with the shared care approach undertaken by MOST. These shortcomings were most evident in inconsistent and delayed communication from MOST clinicians during concurrent care, reflecting failures in shared care collaboration. headspace clinicians described instances where they were informed of MOST's involvement in concurrent care *after* multiple sessions had already occurred – sometimes, at the end of a client's engagement with a MOST clinician – limiting opportunities for genuine, coordinated care. As headspace clinicians are often unaware as to when a client is engaging in concurrent clinical care on MOST, headspace clinicians rely on timely communication, and delays creates risks for the young person including duplicated intervention and potential re-traumatisation:

The incidence that I'm talking about is when a young person was accessing MOST and also accessing headspace at the same time for counselling ... and MOST only communicated this to us at the end of their sixth session with MOST. It would have been helpful to have that communication so we could work collaboratively because otherwise we might be re-traumatising the young person ... We really wanna make sure that the young person's as safe as possible ... it can just cause a lot of distress for the young person or a lot of exhaustion around talking about their concerns and history that perhaps is not necessary. So even just discussion around what they're working on with that clinician and then we can work on something different that could also be suitable. But again, that wasn't communicated, and I think that's something that we'll probably be looking at further on, to ensure that doesn't happen.

— HEADSPACE CLINICIAN 12, METROPOLITAN SITE

While other headspace clinicians did not draw on direct experience, they consistently spoke about the importance of timely and efficient communication when undertaking a shared care approach, to ensure clinicians have the opportunity to collaborate:

[It's] very good for us to know because we don't see young people every week ... if they're seeing a clinician on MOST [and] then if MOST update us, [it] is really helpful because we may not know certain things that might have happened within that week ... as a clinician is good to know ... especially [if it] has to do with risk ... and then you know we both work together ... then at least they're on the same page. It's just a duty of care. I think it's really helpful in terms of partnership.

— HEADSPACE CLINICIAN 13, METROPOLITAN SITE

Similar to headspace clinicians gaining an understanding of MOST's risk escalation procedures through direct experience, headspace clinicians seem to develop an understanding of shared care directly. headspace clinicians who have not yet been in a shared care situation are largely unaware of this process. This can create some ambiguity around the expectations for the communication pathways between MOST and headspace. Consequently, headspace clinicians may be confused about role boundaries, and may not recognise that MOST clinicians have the capacity to instigate a collaborative, shared care approach, potentially reinforcing headspace clinicians' general attitudes that view MOST as a separate entity, rather than a partnership:

I haven't had any contact with any of the clinicians there beyond the people that actually came to do the training.

— HEADSPACE CLINICIAN 4, NON-METROPOLITAN SITE

I don't talk to any of these clinicians [on MOST] and the clinicians have never reached out to me. So I would say there's quite a disconnect like, this is what I provide, this is what they can provide. I don't think there's a great deal of communication. I don't think there's any communication between the two of us.

— HEADSPACE CLINICIAN 1, METROPOLITAN SITE

Across interviews, it seems as though approximately half of the sample had not had a direct experience with MOST clinicians regarding shared client care. For the headspace clinicians who had, they often spoke about isolated instances of communication, demonstrating this may be an infrequent experience. These accounts align with quantitative survey results demonstrating that the majority of surveyed headspace clinicians have never communicated with the clinical team on MOST about a specific client (59.1%, $n = 39$), with a substantial minority reporting this as a rare occurrence ($n = 19$, 28.8%; see Appendix A3, item 2).

5.6.7 Monitoring and Feedback Systems

headspace clinicians identified clear monitoring and feedback mechanisms supporting the implementation of MOST, particularly through regular data reporting and informal reports from coworkers and clients. headspace clinicians consistently cited reports from Orygen Digital and ongoing discussion in headspace team meetings as key systems. These reports include both state-wide and site-specific data on platform engagement, referral rates, and user activity. All headspace clinicians who mentioned these reports valued these updates, particularly due to the use of data and evidence to maintain visibility over MOST and inform their practise. These reporting systems appear to strengthen the implementation of MOST within headspace by increasing clinicians' awareness of youth uptake and engagement patterns.

In our team meetings, we have regular MOST updates and we talk regularly about MOST. So, I think that's really fantastic I do love that ... mostly it's about data. So like, "these are how many people were referred", "these are how many people are still continuing on with their MOST journey", that kind of stuff. We don't have that data at every meeting, but there is an allowance for that if it's relevant. — HEADSPACE CLINICIAN 9, REGIONAL SITE

[The report] it's just a general overview of what MOST looks like in WA in terms of [how] the young people are engaged. It's got some really nice statistics and what content they're engaging with mostly on the app. ... it really lets you know what the app's being used for and I share that with the team at the meeting every month in terms of how we're doing. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

I am very type A, I love stats, but, that was just great to see. You know, who was referring the most and what the percentage of like presenting issues and like demographics of the users that was great! — HEADSPACE CLINICIAN 4, REGIONAL SITE

In addition to more formal reporting systems, some headspace clinicians described receiving informal feedback from other headspace clinicians and the young people themselves, although this was mentioned less consistently.

5.6.8 Implementation and Ongoing Support

headspace clinicians generally described positive experiences with the implementation support and ongoing support provided by Orygen Digital and headspace. Most headspace service leads reported receiving adequate support from Orygen Digital to implement MOST (detailed counts and percentages are not reported due to the small sample size), and interviewed headspace clinicians highlighted Orygen Digital's responsiveness throughout both implementation and ongoing delivery. Support was described as timely, hands-on, and transparent, particularly in addressing technological issues, assisting clinicians with MOST, and communicating updates about the platform:

Overall the governance, it's really good. Even recently I had. Issue with my login [and] they were really helpful and it was just really quick like I never feel like I needed to wait or anything like in terms of their structure and everything. Very, very, efficient team. — HEADSPACE CLINICIAN 13, METROPOLITAN SITE

They're keeping us updated with the monthly updates, they come in every time we've got new clinicians are always there, visible, "come in", "let's talk about it", any changes, any updates. — HEADSPACE CLINICIAN 7, METROPOLITAN SITE

However, this experience was not consistent across sites. Some headspace clinicians in non-metropolitan areas reported feeling less supported, noting disparities in face-to-face engagement. One headspace clinician who had worked across both metropolitan and non-metropolitan sites also noted this inconsistency, describing fewer opportunities for in-person support and tailored communication in non-metropolitan locations:

I remember a time in [metropolitan site] one of the people came back and did a little presentation about what the uptake was ... We haven't had that in [rural site] and I've raised this with the people that came for their first training session. They'll probably deliver it at some point through Teams. — HEADSPACE CLINICIAN 4, REGIONAL SITE

Survey findings suggest moderate organisational support overall, with 64.0% of headspace clinicians ($n = 48$) agreeing that management adequately supports MOST (see Appendix A2, item 6), and 76.0% ($n = 57$) indicating that sufficient resources are available to support MOST (see Appendix A2, item 7). While the majority of surveyed clinicians indicated they know where to go if they have questions or want to access resources/information about MOST ($n = 61$, 77.2%, see Appendix A4, item 14), interviewed clinicians reported more uncertainty about how to access further information, for example:

I think [MOST] it's a really great idea, but I think that it has not been communicated sufficiently ... I just feel like ... I don't have enough information about it, and I'm not really sure how to get it. — HEADSPACE CLINICIAN 10, REGIONAL SITE

5.6.9 Organisational Partnership and Oversight

Albeit an inconsistent finding, some headspace clinicians – particularly those in leadership roles – perceived strong organisational partnerships between Orygen Digital, WAPHA. These headspace clinicians described collaboration as a strength of MOST implementation, with some feeling informed and involved in governance processes:

I feel like from a governance perspective, we are very much involved, in what's going on there, in terms of the implementation and how that was embedded as I say, I wasn't here at that time, but certainly from here on in, I feel like there's a good partnership with MOST and headspace and certainly as program manager there is with me as well. — HEADSPACE CLINICIAN 7, PROGRAM MANAGER, METROPOLITAN SITE

However, other headspace clinicians reported a desire for greater clarity around governance and expectations of MOST from WAPHA. Some headspace clinicians expressed uncertainty about what is required of individual centres, particularly in relation to roles, responsibilities, and performance expectations of headspace clinicians use of MOST:

I think it'd be good if the governance between the funding body, which I believe is WAPHA, Orygen and headspace, were a little bit clearer about what they expect of centres. — HEADSPACE CLINICIAN 5, CLINICAL LEAD, REGIONAL SITE

This inconsistency suggests that governance clarity may be unevenly communicated, potentially shaping variable engagement with MOST across sites.

5.7 Chapter Summary

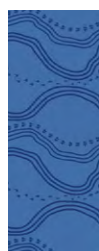
- headspace clinicians' (content-specific and platform-specific) knowledge about MOST varies substantially, with many headspace clinicians navigating MOST from the position of partial uncertainty
- Limited content knowledge, minimal exposure to the youth interface, reliance on initial implementation training, and difficulties with clinician platform usability, collectively undermine headspace clinicians' confidence to integrate MOST into practice
- Generally, headspace clinicians saw the potential value of MOST. Despite this, headspace clinicians did not seem to consistently integrate MOST into clinical care (beyond the provision of a referral – though integration practices varied), with headspace clinicians often conceptualising MOST as a distinct entity that young people can engage with in their own time, rather than as a component of care that could be actively integrated into clinical work
- headspace clinicians compared MOST, headspace, and eheadspace to assess MOST's novelty and grappled with uncertainty over the purpose of MOST, and when to use it, in the context of headspace's additional services
- The feasibility of implementing MOST into headspace is highly variable across sites and is shaped by multiple interacting factors including clinician role, episode of care models, and overall workload pressure
- All headspace clinicians view MOST as an accessible mental health support option, particularly due to its perceived ability to reduce traditional barriers to care. Despite MOST being viewed as a largely accessible platform, digital inequities persist
- headspace clinicians were largely satisfied with the safeguards and risk escalation procedures on MOST, often perceiving MOST as safe and well-governed. Despite this, headspace clinicians expressed concern around some governance structures

Limitations

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The evaluation is based on a non-experimental research design using descriptive quantitative data and qualitative interviews with headspace clinicians. While the data has provided valuable insights into the implementation of MOST in WA, the following limitations are acknowledged:

- The changes in outcome measures reported in this evaluation are descriptive and correlational because the design of the evaluation limits the capacity to attribute a causal relationship between MOST and user outcomes. Such an analysis would require a like-for-like comparison to isolate the effects of MOST from changes in outcomes over time which are not caused by MOST.
- Due to MOST being launched in WA relatively recently, the quantitative component of the evaluation has a fewer number of users who have completed the 6-, 12- and 24-week follow-ups compared to the number of those with week-0 data. This may cause small sample sizes in descriptive tables that report sub-groups. Where the sample size is fewer than or equal to five participants, the affected cells have been suppressed to protect the privacy of participants, in line with the project ethics agreement.
- Due to the nature of the surveys being optional, some variables used in the quantitative analysis have incomplete information, including those that are used to stratify the results such as gender and work/study status.
- The quantitative data only included users who onboarded to MOST and did not capture those who received a referral but decided not to sign up and onboard.
- The qualitative component of the evaluation was based on interviews with headspace clinicians and therefore the results were reported from a clinician's perspective, which may not be representative of young people's views.
- Interviews with headspace clinicians were conducted with one to two clinicians across nine sites in a range of roles. headspace clinician views may not be representative of all headspace clinician views.
- The qualitative interviews with headspace clinicians were primarily focused on the operational running of MOST and its implementation into headspace, with a smaller focus on youth engagement and outcomes. A limitation here is the absence of complementary qualitative perspectives from young people and parents/carers, which constrains the interpretation of engagement and outcome findings derived from quantitative data.



Recommendations

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The report indicates that MOST is most effective when its implementation is active, structured, and embedded within headspace services, rather than reliant on individual clinician discretion. The following recommendations, addressing key human, operational and organisational factors are provided to enhance the effectiveness of the implementation of MOST in WA. All recommendations are based on feedback received by evaluation participants and synthesise consistently identified strategies proposed by headspace clinicians to address key barriers to implementation.

7.1 System-level Recommendations for the Implementation of MOST

LIST OF RECOMMENDATIONS

1. headspace clinicians should receive further training with MOST's implementation team to enhance their knowledge about MOST. It is recommended that this training:
 - a. Provides headspace clinicians with a visual walkthrough of MOST from a young person's perspective
 - b. Demonstrates how headspace clinicians can navigate the Clinician Portal
 - c. Provides practical guidance on how MOST can be used alongside routine clinical work (beyond the provision of a referral)
 - d. Is also provided to new headspace clinicians to provide them with a structured onboarding process, with clear ongoing support to support clinician engagement
 - e. Provides headspace clinicians with an understanding of governance
 - f. headspace clinicians should receive clearer expectations about their use of MOST
2. Clear expectations should be provided around headspace clinicians' use of MOST, particularly outlining when it is appropriate to direct young people to, or utilise, MOST within the context of the headspace ecosystem
3. headspace clinicians should be provided with a supplementary document clearly outlining the thematic content covered on MOST, to aid their implementation of MOST into clinical care
4. MOST referrals should be embedded within existing headspace procedures across all sites to reduce reliance on clinician discretion and improve consistency of care

1. This evaluation **recommends further training sessions be provided to headspace clinicians**. This addresses the key finding from clinician interviews that the initial training for MOST was perceived as too brief, overly administrative, and insufficiently practical, leaving headspace clinicians feeling inadequately equipped to use and implement MOST effectively, and at times, operating with uncertainty. To support improved implementation, the following elements are recommended to be included in further training with MOST's implementation team:

- a. Structured Visual Walkthroughs from a Youth Perspective:** headspace clinicians will benefit from visual demonstrations of a young person's experience on MOST. This could include mock demonstrations of the user interface and how young people can navigate MOST, including how each component and its features are experienced.
 - b. Demonstrating how headspace clinicians can use MOST's Clinician Portal:** The training session should cover a walk-through demonstration of how clinicians themselves can use the Clinician Portal, including the capabilities clinicians have on the portal – what they can view and how to get to the destination.
 - c. Practical guidance on how headspace clinicians can use MOST alongside routine clinical work (beyond the provision of a referral).** headspace clinicians reported difficulty integrating MOST into care programs, despite their conceptual understanding of MOST. It is important that training demonstrates how MOST can be used alongside routine clinical care to enhance headspace clinicians' confidence and uptake of MOST. Such guidance on implementation should be situated within the realities of the headspace service model, recognising constraints related to time, workflow, and role boundaries. If headspace clinicians are expected to meaningfully incorporate MOST into care, it is important to allow clinicians to prioritise and dedicate time to learn about MOST.
 - d. Ensure there is a structured onboarding process that new headspace clinicians are allocated to, with clear ongoing support of clinician engagement with MOST.** headspace clinicians described variability with onboarding processes, with some taking training matters into their own hands. Providing standardised training is important to reduce burden on headspace clinicians and potentially improving the feasibility of integrating MOST into standard care, whilst ensuring new clinicians are developing a complete and accurate understanding of MOST, allowing for more consistent implementation.
 - e. Provide headspace clinicians with an understanding of governance procedures.** headspace clinicians reported they developed their understanding of risk escalation and shared care procedures through direct experience. Greater transparency with headspace clinicians may help improve attitudes towards their implementation of MOST.
- 2. Clear expectations should be provided around headspace clinicians' use of MOST,** particularly outlining when it is appropriate to direct young people to, or utilise, MOST within the context of the headspace ecosystem. headspace clinicians understanding about MOST within the headspace ecosystem yields implications for its implementation in headspace
- 3. headspace clinicians should be provided with a supplementary document clearly outlining the thematic content covered on MOST, to aid their implementation of MOST into clinical care.** Many headspace clinicians lacked a full understanding of the breadth of available topics. This document may help increase their confidence and likelihood of recommending specific journeys that are relevant for their client.
- 4. MOST referrals should be embedded within existing headspace procedures across all sites.** This will potentially reduce the reliance on the discretion of individual headspace clinicians to refer to MOST, leading to improved consistency of implementation across the service.



7.2 App-related Suggestions to Support Design Responsiveness

Throughout interviews with headspace clinicians, a number of suggestions were put forward to support MOST's design responsiveness. These suggestions are summarised in the figure below and are discussed in more depth in the main text.

LIST OF APP-RELATED SUGGESTIONS

- **Expanding content and features:**
 - Expanding the breadth and depth of information on MOST
 - Topics covered, rural-specific information, psychotherapeutic content
 - More interactive activities on MOST (as opposed to observation activities)
 - Further divide the 15–25-year-old cohort into two separate age groups
- **Continuity of care**
 - 'Record keeping' function
 - On-referral pathways
 - Family inclusive practise
 - Timely, consistent communication between headspace and MOST clinicians
- **Increasing Youth Safety**
 - Increasing hours of moderation on MOST
 - Functionality to allow headspace clinicians to remove clients from their caseloads
 - Add safety planning functionality

EXPANDED CONTENT AND FEATURES:

- More in-depth psychotherapeutic content for young people who rely on MOST as their sole support outside of headspace
- Expanding the breadth of available content
For example – content on disordered eating, substance misuse, neurodiversity, and sexual health
- Further psychoeducation about therapy
For example – information about the therapeutic relationship, the different roles of people in a young person's care team (e.g., peer worker role), an introduction to different therapeutic treatment approaches
- Inclusion of content that is specific to young people living in regional locations
For example – relevant statistics, modules addressing unique challenges such as physical isolation, and activities accessible to young people in regional areas
- Increased use of interactive activities, including skill-building, goal setting, and behaviourally oriented activities – rather than primarily observational tasks (e.g., "Go and observe...")
- Potential to further divide the 15–25-year-old cohort into two separate age groups

CONTINUITY OF CARE FEATURES:

- 'Record keeping' function that young people can use as a prompt in headspace sessions rather than having to rely on memory
For example – young people being able to log certain events or feelings that occurred between headspace sessions or being able to create a list of topics they want to discuss in their next headspace session
- On-referral pathways to guide young people toward more specialised support from MOST
- Family inclusive practise
For example – making it so that trusted support people can view the young person's safety plan and relevant coping strategies triggered by the emotion they record on MOST
- Timely, consistent communication processes between headspace and MOST clinicians when a young person is receiving concurrent care (shared care approach)

INCREASING YOUTH SAFETY:

- Increasing hours of moderation on MOST
- Functionality to allow headspace clinicians to remove clients from their caseloads upon a client's exit from headspace, or to re-allocate them to their counselling clinician
- Add safety planning functionality



Conclusion

8.0

This report discusses the effectiveness of MOST in WA using a mixed-method approach combining quantitative and qualitative data. The evaluation utilised quantitative platform and user survey data supplied by Orygen Digital and primary qualitative data collected by the evaluation team via interviews with headspace clinicians.

MOST provides early access to mental health support and is associated with improvements in mental health symptoms: This evaluation reported a number of findings suggesting MOST has a positive impact on users. The quantitative results show that young people who received a referral to MOST onboarded within an average of 5.1 days. Compared to the average 100-day wait for traditional treatment, this much shorter timeframe means young people can access support earlier and at any point along their care journey. MOST users overall experienced a statistically significant improvement in depression symptoms, anxiety symptoms and mental wellbeing after 6 to 24 weeks of using the platform (depending on the outcome measures). Note that the findings relating to user outcomes are suggestive only and did not account for the effects of external contributing factors unrelated to MOST which are out of scope of this evaluation.

MOST was perceived as an accessible service, increasing the reach of young people who can access mental health support: Overall, platform engagement was statistically significant higher amongst regional users (compared to metropolitan users), and gender diverse users (compared to cisgender males and females), suggesting that MOST may be particularly effective in extending access to underserved populations and enhancing the geographical reach of mental health support. Consistent with these findings, headspace clinicians perceived MOST as having the capacity to reduce traditional barriers to mental health care and extend mental health support to young people who may be unable to physically access headspace services.

Clinicians were supportive of MOST, but there are opportunities for better training and service implementation: The qualitative findings demonstrate that headspace clinicians largely perceive MOST as a safe, accessible, and well-governed mental health platform. While headspace clinicians demonstrated a reasonable conceptual understanding of MOST, there were notable gaps in their knowledge and application. In particular, there were challenges integrating MOST into routine clinical care beyond its use as a referral option. It is important to note that these findings are indicative rather than representative and may not reflect the perspectives and experiences of all headspace clinicians, and these perceptions cannot be interpreted to represent causality.

The integration of MOST into headspace care appears to be shaped by both system factors and clinicians' visibility into how young people engage with the platform: The report demonstrates that the implementation of MOST appears to differ across headspace sites and clinician roles, with differences evident in headspace clinicians' training on MOST, knowledge about MOST, usability with MOST, and perceived workflow fit. Beyond these considerations, the report also identifies important mismatches between headspace clinician perceptions and observed youth usage data, particularly across demographic characteristics such as age, gender, location, and treatment stage. Generally, clinicians appeared to have limited insight into how young people engage with MOST, and their perceptions did not consistently align with observed engagement data. Together, these findings suggest that systemic variability and gaps in clinician visibility may constrain the effectiveness of the implementation of MOST within routine care.

Recommendations for improving MOST uptake and implementation: Based on the findings in this report and WAPHA's priorities, this report has put forward several recommendations relating to the implementation of MOST and its implementation into the system of care in WA, including further training for clinicians, clearer expectations about how MOST should be implemented, the provision of supplementary documentation about MOST, and a more streamlined referral procedure. The report also presents direct suggestions from respondents for WAPHA and their stakeholders to consider as MOST is further developed as a resource within WAPHA commissioned services.



References

Alvarez-Jimenez, M., Koval, P., Schmaal, L., Bendall, S., O'Sullivan, S., Cagliarini, D., D'Alfonso, S., Rice, S., Valentine, L., Penn, D. L., Miles, C., Russon, P., Phillips, J., McEnery, C., Lederman, R., Killackey, E., Mihalopoulos, C., Gonzalez-Blanch, C., Gilbertson, T., Lal, S., Cotton, S. M., Herrman, H., McGorry, P.D. and Gleeson, J. F. M. (2021). The Horyzons project: A randomized controlled trial of a novel online social therapy to maintain treatment effects from specialist first-episode psychosis services. *World Psychiatry*, 20, 233–243. <https://doi.org/10.1002/wps.20858>

Alvarez-Jimenez, M., Nicholas, J., Valentine, L., Liu, P., Mangelsdorf, S., Baker, S., Gilbertson, T., O'Loughlin, G., McEnery, C., McGorry, P. D., Gleeson, J. F., & Cross, S. P. (2025). A national evaluation of a multi-modal, blended, digital intervention integrated within Australian youth mental health services. *Acta psychiatrica Scandinavica*, 151(3), 317–331. <https://doi.org/10.1111/acps.13751>

Alvarez-Jimenez, M., Rice, S., D'Alfonso, S., Leicester, S., Bendall, S., Pryor, I., Russon, P., McEnery, C., Santesteban-Echarri, O., Da Costa, G., Gilbertson, T., Valentine, L., Solves, L., Ratheesh, A., McGorry, P. D., & Gleeson, J. (2020). A novel multimodal digital service (Moderated Online Social Therapy+) for help-seeking young people experiencing mental ill-health: Pilot evaluation within a national youth e-mental health service. *Journal of Medical Internet research*, 22(8), Article 17155. <https://doi.org/10.2196/17155>

Australian Institute of Health and Welfare. (Updated 12 May 2026). Young people's mental health (12-24 years). <https://www.aihw.gov.au/mental-health/topic-areas/populations/young-people-s-mental-health>

Bailey, E., Robinson, J., Alvarez-Jimenez, M., Nedeljkovic, M., Valentine, L., Bendall, S., D'Alfonso, S., Gilbertson, T., McKechnie, B., & Rice, S. (2021). Moderated online social therapy for young people with active suicidal ideation: Qualitative study. *Journal of Medical Internet Research*, 23(4), e24260. <https://doi.org/10.2196/24260>

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications.

Carpenter, M., Patel, M., Luebke, A., Gadenne, K., Whiteford, H., & Rutherford, Z. (2024). *An independent evaluation of the Q-MOST pilot: Final report - May 2024*. Brisbane: Queensland Centre for Mental Health Research. <https://doi.org/10.14264/c588917>

Cross, S., Nicholas, J., Mangelsdorf, S., Valentine, L., Baker, S., McGorry, P., Gleeson, J., & Alvarez-Jimenez, M. (2023). Developing a theory of change for a digital youth mental health Service (Moderated Online Social Therapy): Mixed methods knowledge synthesis study. *JMIR Formative Research*, 7, e49846. <https://doi.org/10.2196/49846>

headspace. (2019a). *Increasing demand in youth mental health: A rising tide of need*. <https://headspace.org.au/assets/Uploads/Increasing-demand-in-youth-mentalh-a-rising-tide-of-need.pdf>

headspace. (2019b). *headspace centre young person follow up study*. <https://headspace.org.au/assets/headspace-centre-young-person-follow-up-study-Sept-2019.PDF>

headspace. (2026a). *Who we are*. <https://headspace.org.au/our-organisation/who-we-are/>

headspace. (2026b). *Find a centre*. <https://headspace.org.au/headspace-centres/>

headspace. (2026c). *Connect 1-on-1 for support*. <https://headspace.org.au/online-and-phone-support/connect-with-us/>

headspace. (2026d). *Information about headspace Online Communities and group chats*. <https://headspace.org.au/online-and-phone-support/join-the-community/chats-by-peers/>

- Ludwig, K. A., Browne, J. W., Nagendra, A., Gleeson, J. F., D'Alfonso, S., Penn, D. L., & Alvarez-Jimenez, M. (2021). Horyzons USA: A moderated online social intervention for first episode psychosis. *Early intervention in psychiatry*, 15(2), 335–343. <https://doi.org/10.1111/eip.12947>
- McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 21(1), 61-76. <https://doi.org/10.1002/wps.20938>
- MOST. (2025). MOST. <https://www.most.org.au/>
- MOST & Orygen Digital. (2025). MOST in WA Primary Health Settings: Progress Report.
- O'Bree, B., Walton, C. C., Bendall, S., Wilson, M., Valentine, L., McEnery, C., D'Alfonso, S., Alvarez-Jimenez, M., & Rice, S. (2021). Perceived helpfulness of a moderated online social therapy network for young people experiencing social anxiety. *International Journal of Environmental Research and Public Health*, 18(6), e2796. <https://doi.org/10.3390/ijerph18062796>
- Orygen. (2026). MOST for clinicians. <https://www.orygen.org.au/Clinical-Care/Clinical-services/most/MOST-for-clinicians>
- Orygen Digital. (2024a). *Orygen Digital and MOST: Revolutionising youth mental health care*.
- Orygen Digital. (2024b). *World-first digital mental health intervention shows outstanding engagement rates, bridges gaps in healthcare system*. <https://www.orygen.org.au/About/News-And-Events/2024/World-first-digital-mental-health-intervention-sho>
- Rice, S., Gleeson, J., Davey, C., Hetrick, S., Parker, A., Lederman, R., Wadley, G., Murray, G., Herrman, H., Chambers, R., Russon, P., Miles, C., D'Alfonso, S., Thurley, M., Chinnery, G., Gilbertson, T., Eleftheriadis, D., Barlow, E., Cagliarini, D., ... Alvarez-Jimenez, M. (2018). Moderated online social therapy for depression relapse prevention in young people: Pilot study of a 'next generation' online intervention. *Early Intervention in Psychiatry*, 12(4), 613–625. <https://doi.org/10.1111/eip.12354>
- Rice, S., O'Bree, B., Wilson, M., McEnery, C., Lim, M. H., Hamilton, M., Gleeson, J., Bendall, S., D'Alfonso, S., Russon, P., Valentine, L., Cagliarini, D., Howell, S., Miles, C., Pearson, M., Nicholls, L., Garland, N., Mullen, E. McGorry, P. D., & Alvarez-Jimenez, M. (2020). Leveraging the social network for treatment of social anxiety: Pilot study of a youth-specific digital intervention with a focus on engagement of young men. *Internet Interventions*, 20, e100323. <https://doi.org/10.1016/j.invent.2020.100323>
- Subotic-Kerry, M., Borchard, T., Parker, B., Li, S. H., Choi, J., Long, E. V., Batterham, P. J., Whitton, A., Gockiert, A., Spencer, L., & O'Dea, B. (2025). While they wait: A cross-sectional survey on wait times for mental health treatment for anxiety and depression for adolescents in Australia. *BMJ Open*, 15(3), e087342. <https://doi.org/10.1136/bmjopen-2024-087342>
- van Doorn, M., Monsanto, A., Boeschoten, C. M., van Amelsvoort, T., Popma, A., Öry, F. G., Alvarez-Jimenez, M., Gleeson, J., Jaspers, M. W. M., & Nieman, D. H. (2023) Moderated digital social therapy for young people with emerging mental health problems: A user-centered mixed-method design and usability study. *Frontiers in Digital Health*, 4, e1020753. <https://doi.org/10.3389/fdgth.2022.1020753>



Appendices

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A1. Evaluation Methodology

A1.1 Research Design

A convergent parallel mixed methods design was employed for this research. The quantitative and qualitative data were collected and analysed separately and integrated at the interpretation stage:

- The quantitative data comprised young people in WA who used MOST and have provided consent for their data to be used for research purposes.
- The qualitative data sought to include the young people who used MOST, parents and carers of young people aged 12-17 who use the platform, and headspace referring clinicians in WA. However, final data only reports on interviews with headspace clinicians (see Section 2.4 Qualitative Interview Sample).

Our approach is built on the indicators outlined in MOST's Theory of Change (Cross et al., 2023) and the lines of inquiry requested by WAPHA and informed by past evaluations (Alvarez-Jimenez et al., 2025; Bailey et al., 2021, Carpenter et al., 2024, O'Bree et al., 2021).

A multi-informant approach was chosen to provide more comprehensive insights about MOST, while acknowledging that young people and the broader system of care each bring distinct perspectives.

A1.2 Ethics Approval

Ethics approval to conduct this project was sought in two separate stages. An ethics exemption for the quantitative research design and protocol that used pre-collected data from Orygen Digital was granted on the 8th of January 2025 from the University of Western Australia Human Research and Ethics Committee (Ref: 2024/ET001036). A data transfer agreement was signed between the evaluation team and Orygen Digital for the secure provision of quantitative MOST platform data and related user and clinician surveys.

Ethical approval for the qualitative research design and protocol was granted on the 14th of April 2025 from the University of Western Australia Human Research and Ethics Committee (Ref: 2024/ET001040).

A1.3 Data Sources

This evaluation drew upon both quantitative and qualitative data. The quantitative data were drawn from sources that had existed prior to the evaluation, and the qualitative data were primary data collected for this evaluation. The data sources are presented below:

Table 5. Summary of Evaluation Data Sources

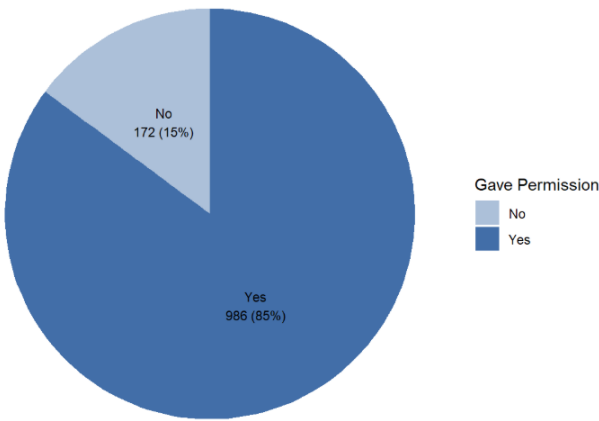
Description	Type of participants	Type of data	Source	Note
MOST platform use and engagement data	Young people who use MOST	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025
User outcomes and satisfaction data	Young people who use MOST	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025
headspace service clinician and service leader satisfaction survey data	Clinicians	Quantitative	Provided by Orygen Digital	Cut-off date: September 2025
Interviews with headspace clinicians	Clinicians	Qualitative	Primary data collected for evaluation	Interviews conducted July 2025 to November 2025
Interviews with youth between the ages of 18-25 who use MOST	Young people who use MOST	Qualitative	Primary data collected for evaluation	Interview conducted, however minimum sample for analysis not met
Interviews with parents of youth aged 12-17 who use MOST	Parents of young people who use MOST	Qualitative	Primary data collected for evaluation	Interview conducted, however minimum sample for analysis not met

A1.4 Quantitative Sample

A1.4.1 MOST User Sample

Quantitative data on MOST users was provided to the evaluation team by Orygen Digital. Individuals who did not provide consent for research were removed from the data, resulting in a sample of 986 users (85% as reported in Figure).

Figure 27. Proportion of MOST Users in WA who Provided Consent for Research



The maximum usable sample has been further reduced to 961 MOST users due to incomplete information for some participants in the app uptake and usage data. The usable sample for each analysis may be smaller depending on the availability of each data component. A summary of the analytical sample is provided in Table 6.

Table 6. Characteristics of the Quantitative Sample of MOST Users

	Count (%)
Number of users	961(100.0%)
Gender	
Female	596(62.0%)
Gender diverse	91(9.5%)
Male	166(17.3%)
No information	108(11.2%)
Treatment stage	
Approaching discharge or discharged	88(9.2%)
Receiving face-to-face	240(25.0%)
Waiting for face-to-face	633(65.9%)
Work/Study status	
Studying only	328(34.1%)
Working only	157(16.3%)
Working and studying	196(20.4%)
None or looking for work or study	172(17.9%)
No information	108(11.2%)
Location	
Metropolitan	774(83.4%)
Regional/Rural/Remote*	154(16.6%)
Maximum usable sample by section	
Uptake and usage	961
Engagement	893
Outcome	850^
Satisfaction	131

Note: * Referred to in the report as "Regional"

^Based on the maximum sample size for Generalised Estimating Equations(GEE) regression models with unbalanced panel where the outcome is the total score from the Kessler Psychological Distress(K10) scale. The sample for GEE regression models includes all individuals with at least one available data point. The sample size is lower for other analyses. In most cases, the sample size varies between 100 to 300 individuals in regression models. The reportable sample for descriptive tables may be lower as these tables require at least two available time points to enable a comparison.

A1.4.2 Clinician Sample

The majority of respondents in the quantitative clinician sample were in a service clinician role and delivered therapeutic treatment to young people. A summary of the characteristics of the sample can be found in Table 7.

Table 7. Descriptive Statistics of Quantitative Clinician Sample

	Summary
Number of clinicians	95
Gender	
Female	68 (71.6%)
Gender diverse	≤5 (≤5.3%)
Male	16 (16.8%)
No information	≤10 (≤10.5%)
Primary role	
Intake/triage role	7 (7.4%)
Service clinician role	60 (63.2%)
Service lead* (e.g. Clinical Manager/Lead, Team Leader, Program Manager)	13 (13.7%)
Other	15 (15.8%)
Deliver therapeutic treatment to young people	
No	12 (14.8%)
Yes	69 (85.2%)

Note: *The clinician survey incorporated questions targeted at service leads. Due to the small sample size and to ensure respondent anonymity, exact counts and percentages are not reported when presenting the findings from these questions.

A1.5 Qualitative Sample

A1.5.1 Recruitment Process

The Kids Research Institute Australia, in consultation with WAPHA devised the recruitment strategy for the qualitative component. Participant recruitment was managed by WAPHA and undertaken by six headspace Lead Agencies.

Sixteen headspace sites across the Perth, Peel, Wheatbelt, Mid-West, Gascoyne, Goldfields-Esperance, South-West, and Great Southern regions were sampled from. Lead Agencies distributed recruitment materials to headspace clinicians and to parents of eligible young people aged 12 to 17. headspace clinicians also informed eligible youth about the study through routine therapeutic contacts.

For representation across headspace sites, per site soft quotas were used. This included one clinician per headspace site (N ~ 16), two to three youth per headspace site (N ~ 45), and one parent/carer per headspace site (N ~ 16). Participation was voluntary and informed consent was obtained from all participants. Parental consent and consent from the young person themselves were obtained for children aged 12 to 17. Recruitment took place over six months from June 2025 to December 2025.

Throughout the recruitment period, WAPHA and The Kids Research Institute Australia communicated routinely to monitor participant recruitment. In response to lower than anticipated participation, particularly among youth and parents/carers, several enhancement strategies were introduced. This included:

- WAPHA sending follow up emails and making personal contact with Lead Agencies
- Ethically approved follow-up emails with consenting but unresponsive individuals
- The introduction of a \$50 reimbursement for youth and parents/carers, and
- Postponing the recruitment end date from August 2025 to December 2025.

Despite these efforts, overall recruitment remained substantially lower than expected, resulting in clinicians forming the only usable qualitative sample for analysis. Consequently, attitudes toward the implementation and effectiveness of MOST in headspace is limited to headspace clinician perceptions, and quantitative data cannot be complemented with youth perspectives.

A1.5.2 Final Qualitative Sample

Interviews were conducted with 13 headspace clinicians, one young person between the ages of 12 to 17, one young person between the ages of 18 to 25, and one parent/carer.

Clinicians were sampled from nine headspaces across metropolitan, rural, and regional sites in Western Australia. headspace clinicians were individuals who worked with young people and referred them to MOST. headspace clinicians held a range of positions, including clinical leadership and managerial roles, to frontline clinician roles, intake and duty roles, specialist allied health, and educational roles. There was a roughly equal split between clinicians who worked at a metropolitan (n = 7) and non-metropolitan (n = 6) headspace site. Table 8 presents demographic information of the 13 clinicians.

Table 8. Clinician Sample Demographics

Clinician Number	Clinician headspace position	Location
1	Senior Youth Access Worker	Metropolitan
2	Not reported	Metropolitan
3	Youth Counsellor	Metropolitan
4	Clinical Educator	Regional
5	Clinical Lead	Regional
6	Clinical Lead	Regional
7	Program Manager	Metropolitan
8	Duty Officer and Youth Counsellor	Metropolitan
9	Youth Access Clinician	Regional
10	Mental Health Occupational Therapist	Regional
11	Counsellor	Regional
12	Senior Access Clinician	Metropolitan
13	Duty Officer	Metropolitan

Young people who use MOST, and parents/carers of MOST users, were ethically approved to provide data for this evaluation, however, due to the low response rate of youth (N = 1) and parents/carers of youth (N = 1), their data were excluded from this evaluation to protect the identity of participants.

A1.6 Qualitative Data Collection Procedures

A1.6.1 Interview Guide Development

In consultation with WAPHA, The Kids developed separate interview guides for each participant group to collect complementary data from different stakeholders. Each interview guide was aligned to the overall evaluation aims, with topics tailored to the perspectives and expected knowledge of each stakeholder group. All interview guides were approved as part of the ethics process.

A1.6.2 Clinician Interviews

All headspace clinicians provided written informed consent prior to participation and confirmed verbal consent at the commencement of each interview. Semi-structured interviews were conducted online via Microsoft Teams. Interviews were video-recorded and transcripts were generated using the inbuilt functionality on Microsoft Teams.

The headspace clinician interview guide explored:

- headspace clinicians' experiences with the MOST referral process
- Perceived outcomes of MOST on youth and the system of care more broadly
- headspace clinician attitudes toward MOST
- headspace clinician attitudes toward the service delivery model, and perceived

Interview duration ranged from 26.40 minutes to 48.14 minutes, with an average interview duration of 34.57 minutes. Interviews took place between July 2025 and November 2025.

One researcher conducted all interviews, with a second researcher always present to support the process and strengthen consistency. All transcripts were checked for accuracy and anonymised by the same two members of the research team. Due to low participation from youth and parents/carers, interviews with headspace clinicians became the primary qualitative data source. Quotes have been edited for readability and grammar; however, their meaning has not been altered.

A1.7 Data Analysis Techniques

The evaluation adopted a mixed-method approach, combining analyses of quantitative data with a thematic analysis of qualitative interviews.

A1.7.1 Quantitative Analysis

Using user demographic and outcome data provided by Orygen Digital, the averages of measured outcomes and how they vary by user demographics in Western Australia (including stratifications by gender, age, location (metropolitan and regional/rural/remote), stage of treatment, and work/study status, depending on the sample size and the completeness of the data) are reported. Two-sample t-tests and ANOVA tests were conducted where appropriate to test the statistical significance of the differences across groups.

To measure the changes in clinical outcomes over time, the evaluation team adopted the Generalised Estimating Equations (GEE) with unbalanced panel method. The methodology allows for the inclusion of MOST users who did not have data available for all time points (0, 6, 12 and 24 weeks).

A1.7.2 Thematic Analysis

Data were analysed using NVivo version 15.3.1. A thematic analysis was conducted broadly following Braun and Clarke's (2022) six-step process.

1. Data familiarisation
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining, and naming themes
6. Writing up

A2. NoMad: Measures based on Normalisation Process Theory

ITEM	N	Agree/ Somewhat agree - Count	Agree/ Somewhat agree - Proportion
1 Sufficient training is provided to enable staff to implement MOST.	75	58	77.3%
2 There are key people who drive MOST forward and get others involved.	75	55	73.3%
3 I value the effects MOST has had on my work.	75	53	70.6%
4 I can see the potential value of MOST for my work.	75	≥70	≥93.3%
5 I can easily integrate MOST into my existing work.	75	58	77.4%
6 Management adequately support MOST.	75	66	88.0%
7 Sufficient resources are available to support MOST.	75	57	76.0%
8 I can distinguish MOST from usual ways of working.	75	55	73.3%
9 Staff in this organization have a shared understanding of the purpose of MOST.	75	66	88.0%
10 I understand how MOST affects the nature of my own work.	75	62	82.7%
11 I believe that participating in MOST is a legitimate part of my role.	75	52	69.4%
12 I'm open to working with colleagues in new ways to use MOST.	75	66	88.0%
13 I will continue to support MOST.	75	70	93.4%
14 MOST disrupts working relationships.	75	≤5	≤6.7%
15 I have confidence in other people's ability to use MOST.	75	53	70.7%
16 Work is assigned to those with skills appropriate to MOST.	75	27	36.0%
17 I am aware of reports about the effects of MOST.	73	51	69.8%
18 The staff agree that MOST is worthwhile.	75	65	86.7%
19 Feedback about MOST can be used to improve it in the future.	75	69	92.0%
20 I can modify how I work with MOST.	75	61	81.3%

Note: These items were collected by Orygen Digital as part of a clinician survey. Items are presented based on the order they are discussed in the report. Not all items are mentioned in the report.

A3. Clinicians Who Deliver Treatment's Use of MOST

ITEM		N	Never (N %)		Rarely (N %)		Sometimes (N %)		Often (N %)		Always (N %)	
1	Discussed MOST content with a client in session	66	15	22.70%	16	24.20%	28	42.40%	≤10	≤15.20%	≤10	≤15.20%
2	Communicated with the clinical team on MOST about a specific client	66	39	59.10%	19	28.80%	≤5	≤7.60%	≤5	≤7.60%	≤5	≤7.60%
3	Recommended MOST to clients due to upcoming leave or service closures	66	8	12.10%	6	9.10%	20	30.30%	22	33.30%	10	15.20%
4	Logged in to MOST	66	≤5	≤7.60%	24	36.40%	23	34.80%	13	19.70%	≤5	≤7.60%
5	Asked a client in session about their use of MOST	66	≤10	≤15.20%	12	18.20%	32	48.50%	14	21.20%	≤10	≤15.20%
6	Supported a client to troubleshoot any barriers to use of the MOST platform	66	33	50.00%	17	25.80%	≤15	≤22.73%	≤10	≤15.20%	≤10	≤15.20%
7	Suggested completion of MOST content to a client as homework	66	33	50.00%	17	25.80%	11	16.70%	≤5	≤7.60%	≤5	≤7.60%
8	Considered MOST as part of your treatment plan	66	≤10	≤15.20%	15	22.70%	23	34.80%	15	22.70%	≤10	≤15.20%

Note: These items were collected by Orygen Digital as part of a clinician survey. Items are presented based on the order they are discussed in the report. Not all items are mentioned in the report.

A4. Clinicians' Opinion on MOST and Their Work

	Statement	N	Agree / Strongly agree - Count	Agree / Strongly agree - Proportion
1	MOST helps me discharge young people from my care while ensuring they can still receive support	66	48	72.7%
2	MOST ensures young people in my service are supported while they wait for in-person care	79	61	77.2%
3	I understand the role of peer workers on MOST	79	56	70.9%
4	I understand the role of career consultants on MOST	79	51	64.6%
5	I can log on to MOST without any issues	79	56	70.9%
6	Content on MOST complements and reinforces what I am working with young people on in sessions	66	55	83.3%
7	At some point throughout their care journey, MOST is appropriate for the young people I see	79	72	91.1%
8	Integrating MOST in my clinical work benefits my practice	66	44	66.6%
9	Integrating MOST in my practice would make it more effective	66	45	68.1%
10	I struggle to use MOST with my clients to the extent that I'd like because of my other clinical priorities	66	27	40.9%
11	My other clinical priorities interfere with referring young people to MOST	79	11	13.9%
12	The safety procedures on MOST are adequate	79	54	68.4%
13	It is helpful to collaborate with MOST clinicians regarding my young people's safety and risk	66	48	72.7%
14	If I have questions or want to access resources/information about MOST I know where to go	79	61	77.2%
15	I remember to refer young people to MOST	79	52	65.8%
16	I understand how the content on MOST links to common presenting problems	66	≥61	≥92.4%
17	The MOST community provides a valuable opportunity for young people to give and receive support among peers	79	≥74	≥93.7%
18	MOST is a resource that supports my young people and allows me to space out our sessions, where appropriate	66	37	56.1%
19	The support MOST provides to YP after discharge may reduce their likelihood of rejoining services	66	39	59.1%
20	MOST provides me with one place to access evidence-based resources to use in and between sessions	66	41	62.1%
21	Integrating digital and face-to-face services is important for the mental health system	79	73	92.4%
22	I can easily access the MOST referral form	79	72	91.1%
23	The role of a MOST clinician is complementary to my own	66	51	77.2%
24	I understand how the content on MOST links to common presenting problems	66	≥61	≥92.4%

Note: These items were collected by Orygen Digital as part of a clinician survey. Items are presented based on the order they are discussed in the report. Not all items are mentioned in the report.

A5. Clinicians’ Opinion on Recommending MOST to Other People

	Statement	N	Yes - Count	Yes - Proportion
1	MOST is safe for my client(s) to use	80	≥75	≥93.75%
2	I would recommend MOST to a colleague working in youth mental health	80	≥75	≥93.75%
3	I would recommend MOST to eligible young people	80	≥75	≥93.75%

Note: These items were collected by Orygen Digital as part of a clinician survey. Items are presented based on the order they are discussed in the report. Not all items are mentioned in the report.

A6. Supplementary Tables

Table 9. Time Gaps Between Referral, Sign Up and Onboarding

	Total
N	961(100.0%)
Days from referral to sign up	
0 days	415 (43.2%)
1-7 days	299 (31.1%)
8-14 days	153 (15.9%)
15+ days	94 (9.8%)
Days from referral to onboarding	
0 days	366 (41.0%)
1-7 days	303 (33.9%)
8-14 days	136 (15.2%)
15+ days	88 (9.9%)

Table 10. Categories of Time Gaps Between Referral, Sign Up and Onboarding by Location

	Metropolitan	Regional	Total	p-value^
N	774 (83.4%)	154 (16.6%)	928 (100.0%)	
Days from referral to sign up				
0 days	342 (44.2%)	63 (40.9%)	405 (43.6%)	0.113
1-7 days	229 (29.6%)	57 (37.0%)	286 (30.8%)	
8-14 days	132 (17.1%)	17 (11.0%)	149 (16.1%)	
15+ days	71 (9.2%)	17 (11.0%)	88 (9.5%)	
Days from referral to onboarding				
0 days	303 (42.0%)	53 (37.9%)	356 (41.3%)	0.239
1-7 days	238 (33.0%)	52 (37.1%)	290 (33.7%)	
8-14 days	116 (16.1%)	17 (12.1%)	133 (15.4%)	
15+ days	64 (8.9%)	18 (12.9%)	82 (9.5%)	

Note: ^From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

Table 11. Categories of Time Gaps Between Referral, Sign Up and Onboarding by Age Group

	Over 15	Under 15	Total	p-value^
N	688 (71.6%)	273 (28.4%)	961(100.0%)	
Days from referral to sign up				
0 days	323 (46.9%)	92 (33.7%)	415 (43.2%)	<0.001
1-7 days	209 (30.4%)	90 (33.0%)	299 (31.1%)	
8-14 days	99 (14.4%)	54 (19.8%)	153 (15.9%)	
15+ days	57 (8.3%)	37 (13.6%)	94 (9.8%)	
Days from referral to onboarding				
0 days	283 (43.8%)	83 (33.6%)	366 (41.0%)	0.008
1-7 days	219 (33.9%)	84 (34.0%)	303 (33.9%)	
8-14 days	88 (13.6%)	48 (19.4%)	136 (15.2%)	
15+ days	56 (8.7%)	32 (13.0%)	88 (9.9%)	

Note: ^From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

Table 12. Time Gaps Between Referral, Sign Up and Onboarding by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Days from referral to sign up	4.22 (6.51)	5.51 (14.39)	6.17 (9.54)	4.74 (8.35)	0.018
Days from referral to onboarding	4.53 (6.96)	6.24 (14.89)	6.42 (9.66)	5.08 (8.72)	0.020
Days from sign up to onboarding	0.31 (2.38)	0.74 (4.78)	0.24 (1.00)	0.34 (2.57)	0.290

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

Table 13. Time Gaps Between Referral, Sign Up and Onboarding by Treatment Stage

	Approaching discharge or discharged (N=88)	Receiving face- to-face (N=240)	Waiting for face-to-face (N=633)	Total (N=961)	p-value [^]
Days from referral to sign up	4.77 (6.36)	5.70 (15.47)	4.89 (8.98)	5.08 (10.79)	0.591
Days from referral to onboarding	5.65 (8.08)	4.88 (7.34)	4.96 (9.14)	5.01 (8.62)	0.763
Days from sign up to onboarding	0.79 (5.44)	0.34 (2.15)	0.26 (1.88)	0.33 (2.51)	0.189

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

Table 14. Time Gaps Between Referral, Sign Up and Onboarding by Work/Study Status

	Missing (N=108)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=961)	p- value [^]
Days from referral to sign up	7.81 (21.95)	5.10 (7.88)	5.01 (9.96)	4.59 (7.18)	3.95 (6.30)	5.08 (10.79)	0.059
Days from referral to onboarding	3.42 (5.82)	5.20 (7.88)	5.28 (10.08)	5.16 (7.90)	4.45 (7.47)	5.01 (8.62)	0.652
Days from sign up to onboarding	0.05 (0.32)	0.09 (0.74)	0.27 (1.29)	0.57 (3.44)	0.50 (4.11)	0.33 (2.51)	0.318

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

Table 15. Time Gaps Between Referral, Sign Up and Onboarding by Location

	Metropolitan (N=774)	Regional (N=154)	Total (N=928)	p-value [^]
Days from referral to sign up	5.17 (11.52)	4.40 (6.69)	5.04 (10.87)	0.426
Days from referral to onboarding	4.91 (8.73)	5.17 (7.93)	4.96 (8.60)	0.746
Days from sign up to onboarding	0.24 (2.06)	0.84 (4.24)	0.34 (2.55)	0.011

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

Table 16. Time gaps Between Referral, Sign Up and Onboarding by Age Group

	Over 15 (N=688)	Under 15 (N=273)	Total (N=961)	p-value [^]
Days from referral to sign up	4.44 (10.33)	6.71 (11.76)	5.08 (10.79)	0.003
Days from referral to onboarding	4.37 (6.97)	6.68 (11.76)	5.01 (8.62)	<0.001
Days from sign up to onboarding	0.38 (2.88)	0.19 (1.02)	0.33 (2.51)	0.313

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

Table 17. Overall Engagement by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value [^]
Total sessions ^a	8.47 (16.98)	21.89 (71.31)	9.83 (22.00)	7.20 (16.19)	10.03 (28.68)	<0.001
Total session time (minutes) ^b	46.40 (115.78)	124.94 (456.66)	55.05 (122.95)	45.40 (94.19)	55.97 (183.62)	0.002

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 18. Overall Engagement by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Total sessions ^a	8.47 (16.98)	21.89 (71.31)	9.83 (22.00)	10.17 (29.14)	<0.001
Total session time (minutes) ^b	46.40 (115.78)	124.94 (456.66)	55.05 (122.95)	56.46 (186.79)	<0.001

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 19. Overall Engagement by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p-value [^]
Total sessions ^a	10.93 (32.11)	7.70 (16.53)	10.03 (28.68)	0.132
Total session time (minutes) ^b	62.06 (207.29)	40.03 (96.18)	55.97 (183.62)	0.109

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 20. Overall Engagement by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Total sessions ^a	9.29 (18.92)	14.80 (58.15)	10.19 (29.16)	0.041
Total session time (minutes) ^b	50.35 (117.66)	89.81 (377.41)	56.77 (186.61)	0.022

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 21. Overall Engagement by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face- to-face (N=223)	Waiting for face- to-face (N=584)	Total (N=893)	p-value [^]
Total sessions ^a	12.35 (20.50)	12.65 (28.22)	8.69 (29.82)	10.03 (28.68)	0.158
Total session time (minutes) ^b	72.62 (136.48)	69.83 (169.54)	48.22 (194.30)	55.97 (183.62)	0.222

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 22. Overall Engagement by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p- value [^]
Total sessions ^a	7.20 (16.19)	8.61 (16.53)	10.48 (21.56)	7.24 (13.67)	14.88 (55.62)	10.03 (28.68)	0.124
Total session time (minutes) ^b	45.40 (94.19)	47.43 (113.30)	53.99 (118.77)	43.00 (106.85)	88.32 (362.34)	55.97 (183.62)	0.172

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of sessions per each user after signup - sessions are defined as at least two consecutive events or actions on the platform (e.g., page visits) that are no more than 30 minutes apart (idle time standard)

b. Cumulative total of session durations in minutes for each user after signup

Table 23. Engagement with Psychotherapeutic Content by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value [^]
Number of therapy items ^a	6.40 (21.14)	6.43 (10.90)	4.76 (10.97)	4.35 (12.32)	6.00 (18.42)	0.707
Therapy views ^b	8.45 (27.15)	8.68 (15.25)	6.08 (14.30)	5.58 (15.60)	7.91 (23.76)	0.620
Engagement duration (days) ^c	39.52 (72.94)	67.64 (104.37)	35.29 (73.20)	37.70 (79.27)	41.52 (77.42)	0.007
Active days ^d	5.94 (10.27)	11.44 (23.67)	6.51 (12.48)	5.58 (11.39)	6.59 (12.81)	0.002

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 24. Engagement with Psychotherapeutic Content by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Number of therapy items ^a	6.40 (21.14)	6.43 (10.90)	4.76 (10.97)	6.08 (18.66)	0.597
Therapy views ^b	8.45 (27.15)	8.68 (15.25)	6.08 (14.30)	8.02 (24.08)	0.512
Engagement duration (days) ^c	39.52 (72.94)	67.64 (104.37)	35.29 (73.20)	41.70 (77.38)	0.003
Active days ^d	5.94 (10.27)	11.44 (23.67)	6.51 (12.48)	6.64 (12.88)	<0.001

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 25. Engagement with Psychotherapeutic Content by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p-value [^]
Number of therapy items ^a	6.64 (20.52)	4.34 (11.08)	6.00 (18.42)	0.095
Therapy views ^b	8.68 (25.94)	5.88 (16.67)	7.91 (23.76)	0.115
Engagement duration (days) ^c	43.00 (78.86)	37.64 (73.54)	41.52 (77.42)	0.355
Active days ^d	7.02 (13.66)	5.47 (10.19)	6.59 (12.81)	0.106

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 26. Engagement with Psychotherapeutic Content by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Number of therapy items ^a	5.86 (19.00)	6.79 (14.94)	6.01 (18.40)	0.584
Therapy views ^b	7.76 (24.20)	8.99 (22.37)	7.96 (23.91)	0.578
Engagement duration (days) ^c	42.20 (79.32)	39.41 (72.76)	41.74 (78.26)	0.701
Active days ^d	6.43 (11.40)	7.87 (19.24)	6.67 (13.00)	0.230

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 27. Engagement with Psychotherapeutic Content by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face-to-face (N=223)	Waiting for face-to-face (N=584)	Total (N=893)	p-value [^]
Number of therapy items ^a	8.40 (17.94)	5.83 (12.12)	5.72 (20.38)	6.00 (18.42)	0.448
Therapy views ^b	11.26 (24.04)	7.82 (18.56)	7.45 (25.43)	7.91 (23.76)	0.382
Engagement duration (days) ^c	79.59 (107.48)	52.12 (92.49)	31.87 (62.28)	41.52 (77.42)	<0.001
Active days ^d	8.65 (13.05)	8.41 (16.07)	5.59 (11.18)	6.59 (12.81)	0.006

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 28. Engagement with Psychotherapeutic Content by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p-value [^]
Number of therapy items ^a	4.35 (12.32)	4.91 (12.38)	5.72 (13.46)	7.23 (30.44)	6.69 (13.88)	6.00 (18.42)	0.719
Therapy views ^b	5.58 (15.60)	6.37 (16.76)	8.04 (22.28)	8.80 (33.67)	8.78 (19.94)	7.91 (23.76)	0.809
Engagement duration (days) ^c	37.70 (79.27)	40.90 (70.14)	44.29 (82.89)	34.44 (64.52)	46.22 (87.17)	41.52 (77.42)	0.602
Active days ^d	5.58 (11.39)	6.00 (9.61)	7.06 (12.55)	5.13 (8.67)	8.34 (19.33)	6.59 (12.81)	0.163

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. The number of distinct therapy items viewed

b. The number of therapy views with multiple views of the same item counted separately

c. Number of days between completing onboarding and last access

d. Number of days with access

Table 29. Primary Purposes of Contacting an Allocated Clinician, Clinical Lead, Duty Clinician

	Summary
Number of contacts	2,363
Primary purpose of contact	
Assessment	377 (17.9%)
Clinical care coordination / liaison	307 (14.6%)
Psychosocial support	1,099 (52.2%)
Structured psychological intervention	298 (14.1%)
Suicide prevention specific assistance	26 (1.2%)

Table 30: Interactions with a MOST Clinician by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value ^a
Messages to MOST clinician ^a	0.98 (3.20)	2.34 (6.64)	1.13 (3.42)	0.78 (2.17)	1.14 (3.72)	0.012
Messages from MOST clinician ^b	3.52 (5.96)	5.62 (9.79)	3.67 (5.04)	3.17 (4.65)	3.75 (6.28)	0.027
Number of contacts with a clinician ^c	3.01 (3.73)	4.16 (5.82)	3.19 (3.45)	1.31 (1.22)	2.96 (3.81)	<0.001
Number of direct minutes ^d	22.34 (52.38)	44.23 (93.86)	23.90 (42.19)	5.95 (21.65)	22.84 (54.41)	<0.001
Number of indirect minutes ^e	27.93 (43.31)	45.56 (72.45)	33.30 (45.85)	4.75 (15.89)	27.92 (46.25)	<0.001

Note: ^aFrom an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 31: Interactions with a MOST Clinician by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value ^a
Messages to clinician ^a	0.98 (3.20)	2.34 (6.64)	1.13 (3.42)	1.15 (3.77)	0.006
Messages from clinician ^b	3.52 (5.96)	5.62 (9.79)	3.67 (5.04)	3.77 (6.34)	0.013
Number of contacts with a clinician ^c	3.01 (3.73)	4.16 (5.82)	3.19 (3.45)	3.17 (3.97)	0.035
Number of direct minutes ^d	22.34 (52.38)	44.23 (93.86)	23.90 (42.19)	24.98 (56.89)	0.003
Number of indirect minutes ^e	27.93 (43.31)	45.56 (72.45)	33.30 (45.85)	30.86 (47.98)	0.004

Note: ^aFrom an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 32: Interactions with a MOST Clinician by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p- value [^]
Messages to MOST clinician ^a	1.21(4.03)	0.95(2.75)	1.14(3.72)	0.344
Messages from MOST clinician ^b	3.79(6.76)	3.64(4.79)	3.75(6.28)	0.752
Number of contacts with a MOST clinician ^c	2.78(3.73)	3.41(3.96)	2.96(3.81)	0.021
Number of direct minutes ^d	22.14(56.24)	24.60(49.56)	22.84(54.41)	0.528
Number of indirect minutes ^e	24.98(43.98)	35.35(50.87)	27.92(46.25)	0.002

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 33: Interactions with a MOST Clinician by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Messages to clinician ^a	1.11(3.60)	1.24(4.44)	1.13(3.74)	0.706
Messages from clinician ^b	3.68(6.01)	4.01(7.78)	3.74(6.33)	0.579
Number of contacts with a clinician ^c	2.87(3.48)	3.25(5.13)	2.93(3.80)	0.252
Number of direct minutes ^d	21.95(49.17)	25.95(75.57)	22.62(54.42)	0.406
Number of indirect minutes ^e	26.57(42.14)	31.29(61.15)	27.35(45.84)	0.243

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 34: Interactions with a MOST Clinician by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face-to- face (N=223)	Waiting for face-to-face (N=584)	Total (N=893)	p- value ^a
Messages to MOST clinician ^a	1.70 (3.23)	1.48 (4.54)	0.92 (3.41)	1.14 (3.72)	0.054
Messages from MOST clinician ^b	4.65 (5.51)	4.18 (7.29)	3.45 (5.95)	3.75 (6.28)	0.122
Number of contacts with a MOST clinician ^c	3.25 (3.24)	3.38 (4.86)	2.76 (3.39)	2.96 (3.81)	0.071
Number of direct minutes ^d	27.41 (51.44)	26.84 (67.75)	20.69 (48.82)	22.84 (54.41)	0.234
Number of indirect minutes ^e	37.44 (49.53)	30.20 (53.31)	25.74 (42.64)	27.92 (46.25)	0.057

Note: ^aFrom an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 35: Interactions with a MOST Clinician by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p-value ^a
Messages to clinician ^a	0.78 (2.17)	0.82 (2.61)	1.24 (3.55)	1.18 (4.33)	1.31 (4.50)	1.14 (3.72)	0.689
Messages from clinician ^b	3.17 (4.65)	3.61 (4.84)	3.76 (5.88)	3.72 (7.01)	4.06 (7.75)	3.75 (6.28)	0.939
Number of contacts with a clinician ^c	1.31 (1.22)	3.35 (3.55)	3.20 (3.95)	2.75 (2.95)	3.42 (5.31)	2.96 (3.81)	<0.001
Number of direct minutes ^d	5.95 (21.65)	27.03 (50.15)	23.96 (53.12)	20.77 (46.27)	30.11 (79.19)	22.84 (54.41)	0.005
Number of indirect minutes ^e	4.75 (15.89)	32.19 (42.51)	32.98 (48.29)	24.10 (34.26)	33.39 (64.50)	27.92 (46.25)	<0.001

Note: ^aFrom an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST clinicians from a young person

b. Number of direct messages sent to a young person from MOST clinicians

c. Contacts/services and other work related to directly supporting a young person

d. The amount of time clinicians spent in direct contact with the young person

e. The amount of time clinicians spent preparing for the contact, completing necessary follow-up tasks, and engaging with others

Table 36: Interactions in the Social Network by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value [^]
Posts made ^a	0.56 (3.05)	2.29 (10.48)	0.71 (3.42)	0.53 (0.93)	0.76 (4.44)	0.007
Comments made ^b	0.91 (6.73)	1.27 (4.52)	1.25 (5.38)	0.72 (2.03)	1.00 (6.15)	0.880
Reactions made ^c	1.36 (6.33)	2.92 (7.51)	0.77 (2.70)	1.20 (3.53)	1.40 (5.89)	0.044

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 37: Interactions in the Social Network by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Posts made ^a	0.56 (3.05)	2.29 (10.48)	0.71 (3.42)	0.77 (4.54)	0.003
Comments made ^b	0.91 (6.73)	1.27 (4.52)	1.25 (5.38)	1.02 (6.28)	0.755
Reactions made ^c	1.36 (6.33)	2.92 (7.51)	0.77 (2.70)	1.41 (5.97)	0.020

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 38: Interactions in the Social Network by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p-value [^]
Posts made ^a	0.60 (4.15)	1.18 (5.12)	0.76 (4.44)	0.081
Comments made ^b	0.61 (2.71)	2.03 (10.79)	1.00 (6.15)	0.002
Reactions made ^c	1.10 (4.44)	2.19 (8.55)	1.40 (5.89)	0.014

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 39: Interactions in the Social Network by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Posts made ^a	0.61 (2.89)	1.69 (9.07)	0.79 (4.52)	0.010
Comments made ^b	0.98 (6.33)	1.27 (5.92)	1.03 (6.26)	0.619
Reactions made ^c	1.35 (5.66)	1.96 (7.46)	1.45 (5.99)	0.267

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 40: Interactions in the Social Network by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face-to-face (N=223)	Waiting for face-to-face (N=584)	Total (N=893)	p-value [^]
Posts made ^a	0.57 (1.68)	1.22 (5.45)	0.62 (4.29)	0.76 (4.44)	0.207
Comments made ^b	1.55 (6.91)	1.64 (10.57)	0.68 (2.84)	1.00 (6.15)	0.095
Reactions made ^c	2.59 (9.86)	1.80 (7.14)	1.08 (4.36)	1.40 (5.89)	0.042

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 41: Interactions in the Social Network by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p-value [^]
Posts made ^a	0.53 (0.93)	0.82 (4.84)	0.84 (3.30)	0.39 (1.56)	1.07 (7.80)	0.76 (4.44)	0.667
Comments made ^b	0.72 (2.03)	1.48 (11.09)	1.20 (5.30)	0.44 (2.26)	0.83 (3.79)	1.00 (6.15)	0.517
Reactions made ^c	1.20 (3.53)	1.70 (7.82)	1.70 (6.43)	0.66 (2.48)	1.45 (5.71)	1.40 (5.89)	0.348

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of posts made in the newsfeed, or on an individual users' wall

b. Number of comments made in response to 'talking point' therapy items or other's posts (other users and peer workers)

c. Number of reactions made on any post or comment

Table 42: Interactions with MOST Peer Workers by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value [^]
Messages to peer worker ^a	1.70 (13.73)	5.24 (30.59)	1.51 (8.34)	0.82 (3.93)	1.99 (15.33)	0.196
Messages from peer worker ^b	2.63 (14.22)	5.80 (29.74)	2.52 (13.18)	2.42 (10.78)	2.92 (16.20)	0.361

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 43: Interactions with MOST Peer Workers by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Messages to peer worker ^a	1.70 (13.73)	5.24 (30.59)	1.51 (8.34)	2.04 (15.66)	0.118
Messages from peer worker ^b	2.63 (14.22)	5.80 (29.74)	2.52 (13.18)	2.95 (16.41)	0.214

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 44: Interactions with MOST Peer Workers by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p-value [^]
Messages to peer worker ^a	2.35 (17.56)	1.05 (6.48)	1.99 (15.33)	0.259
Messages from peer worker ^b	3.25 (17.77)	2.06 (11.03)	2.92 (16.20)	0.325

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 45: Interactions with MOST Peer Workers by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Messages to peer worker ^a	2.00 (16.49)	2.20 (9.72)	2.04 (15.59)	0.892
Messages from peer worker ^b	2.98 (17.32)	2.99 (10.99)	2.98 (16.45)	0.992

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 46: Interactions with MOST Peer Workers by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face-to- face (N=223)	Waiting for face-to-face (N=584)	Total (N=893)	p- value [^]
Messages to peer worker ^a	1.98 (8.28)	3.15 (19.65)	1.55 (14.20)	1.99 (15.33)	0.416
Messages from peer worker ^b	3.03 (9.69)	4.12 (17.74)	2.45 (16.34)	2.92 (16.20)	0.423

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 47: Interactions with MOST Peer Workers by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p- value [^]
Messages to peer worker ^a	0.82 (3.93)	1.65 (14.37)	2.25 (16.66)	1.76 (18.67)	2.41 (9.75)	1.99 (15.33)	0.967
Messages from peer worker ^b	2.42 (10.78)	2.73 (19.06)	3.20 (17.74)	2.16 (14.32)	3.63 (12.43)	2.92 (16.20)	0.926

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST peer workers from a young person

b. Number of direct messages sent to a young person from MOST peer workers

Table 48: Interactions with MOST Vocational Workers by Gender

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	NA (N=40)	Total (N=893)	p-value [^]
Messages to vocational worker ^a	0.59 (2.91)	0.92 (2.60)	0.93 (5.11)	2.08 (11.05)	0.75 (4.08)	0.129
Messages from vocational worker ^b	1.82 (4.80)	2.56 (5.29)	1.99 (4.49)	2.98 (14.22)	1.98 (5.55)	0.432

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 49: Interactions with MOST Vocational Workers by Gender (excluding NA)

	Female (N=596)	Gender diverse (N=91)	Male (N=166)	Total (N=853)	p-value [^]
Messages to vocational worker ^a	0.59 (2.91)	0.92 (2.60)	0.93 (5.11)	0.69 (3.42)	0.416
Messages from vocational worker ^b	1.82 (4.80)	2.56 (5.29)	1.99 (4.49)	1.93 (4.79)	0.389

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 50: Interactions with MOST Vocational Workers by Age Group

	Over 15 (N=646)	Under 15 (N=247)	Total (N=893)	p-value [^]
Messages to vocational worker ^a	1.04 (4.76)	0.01 (0.13)	0.75 (4.08)	<0.001
Messages from vocational worker ^b	2.70 (6.38)	0.10 (0.32)	1.98 (5.55)	<0.001

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 51: Interactions with MOST Vocational Workers by Location

	Metropolitan (N=721)	Regional (N=140)	Total (N=861)	p-value [^]
Messages to vocational worker ^a	0.84 (4.46)	0.20 (0.65)	0.74 (4.09)	0.089
Messages from vocational worker ^b	2.10 (6.04)	1.31 (1.56)	1.97 (5.57)	0.121

Note: [^]From a two-sample t-test. A p-value of <0.05 (boldfaced) indicates that there is a statistically significant difference between two groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 52: Interactions with MOST Vocational Workers by Treatment Stage

	Approaching discharge or discharged (N=86)	Receiving face-to- face (N=223)	Waiting for face-to- face (N=584)	Total (N=893)	p- value [^]
Messages to vocational worker ^a	1.28 (4.04)	1.14 (5.66)	0.53 (3.27)	0.75 (4.08)	0.072
Messages from vocational worker ^b	2.69 (6.25)	2.68 (8.75)	1.61 (3.46)	1.98 (5.55)	0.023

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 53: Interactions with MOST Vocational Workers by Work/Study Status

	Missing (N=40)	None or looking for work or study (N=172)	Studying only (N=328)	Working and studying (N=196)	Working only (N=157)	Total (N=893)	p- value [^]
Messages to vocational worker ^a	2.08 (11.05)	0.73 (2.86)	0.71 (4.17)	0.62 (2.92)	0.69 (2.82)	0.75 (4.08)	0.343
Messages from vocational worker ^b	2.98 (14.22)	2.12 (4.60)	1.74 (5.50)	1.87 (4.26)	2.21 (4.01)	1.98 (5.55)	0.673

Note: [^]From an ANOVA test. A p-value of <0.05 (boldfaced) indicates that there is at least one statistically significant difference in the mean across groups.

a. Number of direct messages sent to MOST vocational workers from a young person

b. Number of direct messages sent to a young person from MOST vocational workers

Table 54. Youth Satisfaction with MOST

	Week 6		Week 12		Week 24	
	Count (N=131)	%	Count (N=96)	%	Count (N=62)	%
Satisfied with MOST overall	120	91.6	86	89.6	59	95.1
Satisfied with the therapy content on MOST (e.g., Journey and Explore)	99	75.6	71	73.9	49	79.1
Satisfied with the peer community on MOST (e.g., Newsfeed and Talk it Out)	82	62.6	67	69.8	44	71
Satisfied with the human support received on MOST (e.g., a Clinician, Peer Worker, or Career Consultant)	90	68.7	70	72.9	46	74.2
MOST has helped you feel better	107	81.7	80	83.3	50	80.6
Felt safe using MOST	121	92.4	≥91	≥94.8	≥57	≥91.9

Table 55. Description of Clinical Measures Used in the Quantitative Analysis

Instrument	Abbreviation	Description	Interpretation
Kessler Psychological Distress Scale	K10	A 10-item self-report instrument measuring non-specific psychological distress.	Lower scores indicate lower distress
Child Health Utility instrument 9D	CHU9D	A 9-item self-report instrument used to measure health-related quality of life in children and adolescents (11 to 17 years old). Preference weights for Australian youth were used to calculate the total score.	Higher scores represent higher health related quality of life
Generalized Anxiety Disorder 2-item	GAD2	A brief 2-item self-report screening instrument used to detect potential generalised anxiety disorder. Contains the first two items of the GAD7	Lower scores indicate a lower likelihood of anxiety symptoms
Generalized Anxiety Disorder 7-item	GAD7	A 7-item, self-report instrument measuring screening and assessing the severity of generalised anxiety disorder	Lower scores indicate fewer anxiety symptoms and lower severity
Brief Distress Tolerance Scale	DTS	A single-item, self-report instrument assessing a person's capacity to withstand negative emotional states (or distress).	Higher scores indicate a greater capacity to withstand negative emotional states
Mini Social Phobia Inventory	Mini-SPIN	A brief 3-item, self-report instrument screening and assessing the severity of generalised social anxiety disorder (social phobia).	Lower scores indicate a lower severity of social anxiety symptoms
Patient Global Impression of Severity	PGIS	A single-item, self-report instrument used to measure the current severity of mental health symptoms.	Lower scores indicate a better health state as symptoms are perceived as less severe
Patient Health Questionnaire-2	PHQ2	A very brief 2-item, self-report screening instrument used to detect potential depression. Contains the first two items of the PHQ9.	Lower scores indicate a lower likelihood of having major depression
Patient Health Questionnaire-9	PHQ9	A 9-item, self-report instrument measuring the presence and severity of depression.	Lower scores indicate fewer depressive symptoms and lower severity
Short Warwick-Edinburgh Mental Wellbeing Scale	SWEMWBS	A 7-item, self-report instrument measuring positive mental health (happiness and psychological functioning)	Higher scores indicate greater positive mental wellbeing

Table 56. Changes in Clinical Outcomes at 6, 12 and 24 Weeks

	After 6 weeks	After 12 weeks	After 24 weeks
K10	N=104	N=68	N=51
Improved	59 (56.7%)	33 (48.53%)	32 (62.7%)
The same	10 (9.6%)	≤5	≤5
Deteriorated	35 (33.7%)	≤35	≤20
CHU9D	N=71	N=46	N=34
Improved	35 (49.3%)	19 (41.3%)	13 (38.2%)
The same	≤5	≤5	≤5
Deteriorated	≤35	≤25	≤20
GAD2	N=103	N=67	N=50
Improved	53 (51.5%)	32 (47.8%)	31 (62.0%)
The same	28 (27.2%)	26 (38.8%)	10 (20.0%)
Deteriorated	22 (21.4%)	9 (13.4%)	9 (18.0%)
GAD7	N=113	N=75	N=54
Improved	62 (54.9%)	46 (61.3%)	35 (64.8%)
The same	15 (13.3%)	10 (13.3%)	≤5
Deteriorated	36 (31.9%)	19 (25.3%)	≤20
DTS	N=109	N=75	N=52
Improved	26 (23.9%)	20 (26.7%)	15 (28.8%)
The same	48 (44.0%)	25 (33.3%)	21 (40.4%)
Deteriorated	35 (32.1%)	30 (40.0%)	16 (30.8%)
Mini-SPIN	N=111	N=75	N=53
Improved	46 (41.4%)	35 (46.7%)	28 (52.8%)
The same	30 (27.0%)	23 (30.7%)	12 (22.6%)
Deteriorated	35 (31.5%)	17 (22.7%)	13 (24.5%)
PGIS	N=117	N=81	N=58
Improved	45 (38.5%)	36 (44.4%)	26 (44.8%)
The same	45 (38.5%)	26 (32.1%)	19 (32.8%)
Deteriorated	27 (23.1%)	19 (23.5%)	13 (22.4%)
PHQ2	N=103	N=67	N=49
Improved	32 (31.1%)	28 (41.8%)	19 (38.8%)
The same	41 (39.8%)	17 (25.4%)	14 (28.6%)
Deteriorated	30 (29.1%)	22 (32.8%)	16 (32.7%)
PHQ9	N=113	N=75	N=53
Improved	61 (54.0%)	42 (56.0%)	36 (67.9%)
The same	15 (13.3%)	8 (10.7%)	≤5
Deteriorated	37 (32.7%)	25 (33.3%)	≤20
SWEMWBS	N=111	N=75	N=53
Improved	49 (44.1%)	38 (50.7%)	31 (58.5%)
The same	17 (15.3%)	6 (8.0%)	≤5
Deteriorated	45 (40.5%)	31 (41.3%)	≤25

Note: Outcomes at weeks 6, 12 and 24 are compared to the baseline at week 0 to determine the direction of the change (where data are available at both time points).

Table 57. Results from Regression Models Measuring Changes in Clinical Outcomes

Outcome	Covariates	6 weeks	SE	12 weeks	SE	24 weeks	SE	N	Wald chi2	Wald p-value
GAD-2	No	-0.011	(0.149)	-0.353*	(0.178)	-0.488	(0.256)	847	6.875	0.076
GAD-2	Yes	-0.042	(0.154)	-0.425*	(0.180)	-0.531*	(0.266)	815	51.927	0.000
GAD-7	No	-0.879*	(0.373)	-1.291**	(0.486)	-2.310***	(0.679)	256	16.932	0.001
GAD-7	Yes	-0.832*	(0.380)	-1.369**	(0.494)	-2.328***	(0.700)	247	25.205	0.003
K10	No	0.701	(0.962)	0.098	(1.126)	-1.340	(1.179)	850	3.214	0.360
K10	Yes	0.572	(0.985)	-0.102	(1.139)	-1.239	(1.202)	818	64.072	0.000
Mini-SPIN	No	-0.485*	(0.247)	-0.948**	(0.316)	-0.878*	(0.429)	250	10.469	0.015
Mini-SPIN	Yes	-0.456	(0.250)	-0.980**	(0.316)	-0.785	(0.439)	241	28.838	0.001
PHQ-2	No	0.135	(0.158)	0.003	(0.196)	-0.007	(0.219)	846	0.878	0.831
PHQ-2	Yes	0.081	(0.161)	-0.027	(0.202)	-0.094	(0.224)	814	30.653	0.000
PHQ-9	No	-1.108**	(0.402)	-1.536**	(0.524)	-2.891***	(0.736)	254	21.731	0.000
PHQ-9	Yes	-1.058**	(0.407)	-1.565**	(0.539)	-3.012***	(0.753)	245	27.423	0.001
CHU-9D	No	0.006	(0.719)	-1.160	(0.934)	-0.949	(1.462)	164	2.163	0.539
CHU-9D	Yes	0.064	(0.732)	-0.894	(0.924)	-1.204	(1.523)	158	11.934	0.217
DTS	No	-0.106	(0.096)	-0.178	(0.122)	-0.128	(0.136)	248	2.734	0.434
DTS	Yes	-0.115	(0.097)	-0.204	(0.124)	-0.110	(0.140)	239	7.819	0.553
PGI-S	No	-0.182	(0.093)	-0.446***	(0.132)	-0.463**	(0.152)	286	14.472	0.002
PGI-S	Yes	-0.180	(0.095)	-0.433**	(0.136)	-0.449**	(0.157)	277	18.662	0.028
SWEMWBS	No	0.549	(0.402)	1.377*	(0.556)	1.708*	(0.698)	251	9.636	0.022
SWEMWBS	Yes	0.596	(0.406)	1.443*	(0.573)	1.811*	(0.730)	242	13.765	0.131

Note: The table reports results from Generalised Estimating Equations (GEE) models with unbalanced panel. Outcomes at 6, 12 and 24 weeks are compared to the baseline in week 0. Covariates include gender, age group, treatment stage and location. To test the effect of gender, age group, work/study status and location on changes in outcomes over time, we interacted the time indicator with these variables in separate models (the results of which are not reported here).

Significance levels: *** <0.001, **<0.01, *<0.05.

