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Implementation of Transdiagnostic Psychosocial Group Interventions and a Novel Peer Work Role in a Community Youth Mental Health Setting

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ABSTRACT

Aims: Group interventions can be an appropriate care option for young people with mental ill-health, yet there is a lack of research on their implementation within real-world settings. This paper aimed to explore the feasibility and acceptability of group interventions and a Group Coordinator peer work role in a community mental health service and the perspectives of young people, carers and staff on implementation.

Methods: A retrospective chart audit of 121 referrals to group interventions from January 2022 to June 2023 was conducted. Education, demographic and administrative data were collected to explore feasibility and acceptability. Survey data from 44 young people who participated was also used to explore acceptability. Semi-structured interviews (8 young people, 7 carers and 11 staff) explored perspectives on implementation, mapping barriers and facilitators to domains of the Comprehensive Framework for Implementation Research.

Results: Referrals made before the young person was involved in mental health treatment (i.e., at the stage of assessment) were less likely to result in engagement in a group, suggesting limited feasibility as a standalone care option. Young people reported overall positive experiences of group interventions, though attrition rates and qualitative interviews indicate they are perceived as less acceptable than individual options. The Group Coordinator role was viewed by staff as key to sustainability, with multiple benefits.

Conclusions: The current paper contributes to the scant literature on the implementation of group interventions with several practical implications for service planning. Further studies are needed to examine the implementation in other contexts, explore within-treatment variables and incorporate clinical outcomes.

1 | Background

Mental ill health is by far the principal source of the burden of disease for young people aged 10–24 years (Gore et al. 2011), with more than 50% impacted before the age of 25 (Copeland et al. 2011; Caspi et al. 2020; Gibb et al. 2010). Early intervention is crucial to prevent the progression of mental ill health and associated long-term negative outcomes, including premature

mortality, social exclusion and reduced educational and vocational achievement (McGorry et al. 2023).

Young people in Australia are seeking help for their mental health at an unprecedented rate and with rising levels of complexity (McGorry et al. 2023). It is evident that mental health services are experiencing major challenges in meeting demand, particularly, in primary care settings, with increased wait times and limited referral and open-door options creating major barriers for help-seeking young people and their families (Radez et al. 2021; McLaughlin et al. 2023; Headspace National 2019).

Group interventions are interventions delivered to a group of people rather than to individuals, can be clinical or non-clinical and may focus on mental health recovery, behaviour change, peer support, self-management and/or education (Biggs et al. 2020). Groups are commonplace for young people within mental health services, with many potential positive qualities (Erickson and Palmer 2004; Aronson and Haen 2017). They are developmentally appropriate and are as effective as individual interventions for a range of mental disorders (Cotton et al. 2011; Rosendahl et al. 2021; Kim et al. 2023; Bemmer et al. 2021; Chu et al. 2016; Gros et al. 2021). In theory, they are also efficient—allowing one or more mental health practitioners to see multiple young people (Whittingham et al. 2023). Recent changes under the Better Access initiative in Australia (Department of Health and Aged Care 2023)—a scheme providing rebates for people experiencing mental ill health to receive up to 10 individual and up to 10 group therapy services per calendar year—are designed to facilitate the implementation of group therapy, by reducing the number of people required to hold a session and introducing rebates for a range of session durations.

There is a substantial knowledge base for the implementation of evidence-based practice in youth mental health settings, though this has often lacked consideration of group interventions (Peters-Corbett et al. 2024). Literature on the implementation of groups in youth mental health real-world settings, outside of the confines of clinical trials, is scant. In an Australian context, Cotton et al. conducted a retrospective study of transdiagnostic group interventions within a community mental health setting (Cotton et al. 2011). They found that young people were less likely to engage if they had a psychotic disorder, were older, unemployed or had difficulties with time management or substance abuse. However, predictors of dropout and attrition rates were not examined—key information for service planning. Additionally, only quantitative data was collected, limiting understanding of barriers to and enablers of implementation (Cotton et al. 2011).

Another recent Australian study by Wood et al. (Wood et al. 2024) evaluated the implementation of two different group interventions in a community mental health service, cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) for self-harming and suicidal young people, respectively. A core strength of the study was the examination of implementation outcomes (Proctor et al. 2011), processes of implementation which are distinct from service and clinical outcomes, mapped to an implementation framework (RE-AIM) (Glasgow et al. 1999). The interventions were found to be clinically effective in reducing self-harm and suicidal behaviours. However, though the initial reach of referral to the interventions was good, the actual uptake was poor. Key barriers that were identified were a model of care within the service focussed on individual treatment, compared to a specific treatment pathway for group interventions, and low staff numbers and high staff turnover. Additionally, qualitative feedback gathered from group facilitators highlighted that facilitation required a significant amount of planning, and group coordinators felt that coordination negatively impacted their ability to carry out other clinical duties.

In a recent Irish qualitative study, Higgins et al. conducted interviews with young people, carers and group facilitators to gather rich information about their perspectives of the implementation of group psychoeducation about psychosis for families (Higgins et al. 2022). They found that engaged clinicians, peer co-facilitation and support all facilitated engagement, but that there were several barriers, including concerns related to stigma and confidentiality, issues with visibility of the programme and structural supports for clinicians—among others. While many of the themes are generalisable across settings, only young people and carers who had engaged were interviewed, limiting understanding of what inhibited others from engaging (Higgins et al. 2022). More broadly, there is a paucity of research investigating the implementation of group interventions within primary youth mental health services.

The headspace initiative is a network of nationally funded, enhanced primary care centres across Australia that are open-door and support young people aged 12–25 years with mild to moderate mental health challenges (Rickwood et al. 2023). In July 2021, headspace Bondi Junction initiated a clinical redesign quality improvement project to reduce wait times and increase participation of young people in care. As a result, three solutions were implemented: (i) an initial phone call for intake and triage with a clinician was replaced by self-directed intake using a health technology platform in January 2022, (ii) a peer worker role, acting as a 'Digital Navigator' to support intake and engagement with technology platforms, was implemented in July 2022 and (iii) a range of transdiagnostic, psychosocial group interventions, together with a peer worker Group Coordinator role, were implemented in January 2022. Group interventions were intended to be offered as an 'active waiting' care option following an initial assessment at the service, while young people were on waitlists for individual mental health care.

This study evaluates the implementation of the groups programme and Group Coordinator role. The specific aims were to: (i) evaluate the feasibility of group interventions as the key implementation outcome of interest, particularly, as an 'active waiting' solution to offer earlier access to care, (ii) evaluate the acceptability, appropriateness and adoption of group interventions and (iii) explore the barriers and facilitators to implementing group interventions and the Group Coordinator role from the perspectives of young people, carers and staff and to contextualise these within the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2022).

2 | Methods

2.1 | Design

This service evaluation used a mixed-method design, including a chart audit of routinely collected data, service experience survey and qualitative interviews, and is reported in line with SQUIRE guidelines (Greg et al. 2016). Implementation outcomes were conceptualised in line with Proctor et al.'s taxonomy, and barriers and facilitators were mapped to the CFIR (Damschroder et al. 2022). The CFIR was chosen due to its range of constructs and specification of causal mechanisms (Nilsen 2015). The intervention is reported using the TIDieR checklist (File SA) (Hoffmann et al. 2014).

2.2 | Setting

Headspace Bondi Junction is located in a large metropolitan area, servicing mainly the Eastern Suburbs catchment area of Sydney, Australia. It is part of the South Eastern Sydney Local Health District (SESLHD) and integrated with other local youth services including: the Comprehensive Assessment Service for Psychosis and At Risk (CASPAR), Early Psychosis Programme (EPP) and Child and Adolescent Mental Health Services (CAMHS). headspace Bondi Junction provided care to 1137 young people between 1 January 2022 and 30 June 2023.

2.3 | Intervention Development

The quality improvement programme was guided by the five-stage Accelerating Implementation Methodology (Agency for Clinical Innovation n.d.; Zolfaghari et al. 2022). Following initial stages defining project scope and mapping service pathways, three iterative solution brainstorming workshops were conducted (facilitated by P.R., L.T. and a Lived Experience lead). Workshop participants comprised a mix of staff at headspace Bondi Junction, members of the Youth Reference Group (young people involved in decision-making at headspace) and youth clinical service leads from SESLHD ($N = 20$). The workshops established the three solutions of the clinical redesign, with group interventions selected due to their effectiveness and efficiency (i.e., engaging multiple young people simultaneously) (Cotton et al. 2011; Rosendahl et al. 2021; Kim et al. 2023; Bemmer et al. 2021; Chu et al. 2016; Gros et al. 2021; Whittingham et al. 2023). Art therapy, educational skills, CBT- and DBT-based interventions were prioritised for implementation, given existing clinician expertise. Given the transdiagnostic nature of the groups, content was designed to be widely relevant—focussing on gaining personal insight, managing emotions and equipping young people with skills that could be applied to a range of issues, with less emphasis on psychoeducation about specific illnesses. Broadly, emotion regulation (Hernández-Posadas et al. 2023) and repetitive negative thinking (McEvoy et al. 2018) were targeted as shared underlying mechanisms across mental health issues. A youth peer worker Group Coordinator role was also identified for implementation, to co-facilitate groups and provide organisational support (Hannigan et al. 2018).

2.4 | Intervention Delivery

Young people were referred to group interventions by their clinician (e.g., key clinician or a clinician providing an initial assessment). The decision to refer to a group was based on the individuals' needs and stage in their recovery journey. Hence, while the primary aim was to provide support to those waiting for individual therapy at headspace, young people with established mental illnesses could also be referred from CASPAR, EPP and CAMHS. Prior to the commencement of the Group Coordinator, referral occurred through email contact between the referring clinician and group facilitator. This was subsequently replaced with a referral waitlist database managed by the Group Coordinator.

Group interventions were mostly co-facilitated, commonly by a clinician and a peer worker, and group content was developed by clinicians based on evidence-based interventions. For the first 9 months of the intervention, only art therapy was offered, due to delayed recruitment of the Group Coordinator and prioritisation of this group during workshops. Accordingly, an art therapy group was run multiple times while all other groups were run only once and introduced progressively over the evaluation period. Each group was run weekly in-person at headspace. An overview of the different kinds of group interventions is presented in Table 1.

To assist in implementing the group interventions, a youth peer worker acting in the role of a Group Coordinator was employed and commenced in June 2022. Peer workers are individuals with a lived experience comparable to those they are helping and youth peer workers work exclusively with young people (de Beer et al. 2024). Peer workers use their lived experience to provide socio-emotional support with functional goals of instilling social, vocational, and personal change (Tisdale et al. 2021). The Group Coordinator held a Bachelor of Music and enrolled in a Certificate IV in Peer Work upon commencing the role. They co-facilitated group interventions and provided organisational support. This support included waitlist management, data collection and reporting, coordinating supplies and communication materials and liaising with clinicians, young people and carers for recruitment about referrals.

2.5 | Participants and Recruitment

A chart audit was conducted on all young people who engaged with the groups programme. Service experience surveys were offered to all young people on completion of the groups programme. Qualitative interview participants formed three groups: (i) young people aged 16–25, (ii) carers of young people who had an episode of care at headspace Bondi Junction and (iii) clinical staff of headspace Bondi Junction.

Purposeful sampling was used to identify young people and carers of young people who did and did not attend group interventions for qualitative interviews, to increase heterogeneity. Potential participants were initially contacted by a clinician with whom they had prior contact, who provided them with information about the study and contact details for the research team. If they indicated interest (by directly contacting the

TABLE 1 | Overview of group interventions.

Group	Art therapy	Boost your mood	Introduction to exercise	In balance	My body, my narrative
Age range	12–17 and 18–25	12–17	18–25	12–17 and 18–25	12–17
Inclusion criteria	Young people experiencing mental health issues	Young people experiencing mental health issues, particularly, with, mood and anxiety	Young people experiencing mental health issues	Young people experiencing mental health issues, particularly, with mood and anxiety	Young people experiencing mental health issues around body image
Facilitators	1 art therapist; 1 peer worker[a]	1 psychologist; 1 social worker	1 exercise physiologist; 1 peer worker	2 social workers	1 psychologist; 1 peer worker
Focus	Creative expression for personal insight and coping skills	To help develop alternative ways of thinking to influence mood	Exercise for fitness and mental health	To help develop emotion regulation and interpersonal effectiveness strategies	Body image psychoeducation and confidence building
Duration	1.5 h	1.5 h	1 h	1.5 h	1.5 h
Length	6–8 weeks	6 weeks	4 weeks	6 weeks	7 weeks
Activities	Artmaking prompted by a weekly theme and shared reflection	Social interaction and introduction to different CBT skills to regulate mood each week, such as reframing, guided discovery and exposure therapy for social interactions	Progressive aerobic and strength training and psychoeducation on the relationship between exercise and mental health	Social interaction and introduction to different DBT skills to regulate mood each week, such as DEARMAN, 'opposite action' or STOP skills	Psychoeducation and critical reflection on advertising and social media use

[a]The peer worker was only co-facilitating groups after September 2022. Before this, the art therapist was the sole facilitator.

researchers or by informing their clinician), researchers OAY or PR provided them with an information and consent form and discussed the study in full. Participants were given at least 24h to consider the decision to consent before the interview was confirmed.

All staff at headspace Bondi Junction were eligible to participate in interviews. Similarly, a purposeful sampling approach was taken with regard to role and disciplinary background, to select information-rich participants. Staff were contacted by OAY, either in person or via email and were given equivalent information and minimum timeframes to consider participation.

2.6 | Data Collection and Outcome Measures

Service audit records provided information on demographics, administrative data, clinical characteristics and outcome measures. Demographic details extracted were gender, age and educational/employment status. Administrative data included: timepoint of referral within treatment journey, time delay between referral and engagement, uptake of group therapy, attrition and reasons for attrition. Clinical characteristics included: presenting mental health issue(s) and diagnosis. Clinical outcome measures were taken at the time of referral and included: the Kessler Psychological Distress Scale (K10), the Social and Occupational Functioning Assessment Scale (SOFAS) and clinical stage. The K10 is a self-report 10-item questionnaire on a scale from 0 to 50 (Andrews and Slade 2001). Higher scores on the K10 indicate greater distress. It is intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period. The SOFAS score is an overall score of psychosocial functioning on a scale from 0 to 100, assessed by clinicians (Iorfino et al. 2018). Higher scores on the SOFAS indicate better functioning. Clinical staging is a model of illness staging for youth mental health with four discrete categories (Stage 1a is 'help-seeking'; Stage 1b is 'attenuated syndrome'; Stage 2 is 'discrete disorder'; Stage 3 is 'persistent or recurrent illness' and Stage 4 is 'chronic debilitating illness'), rated by assessing clinicians (Hickie et al. 2013). For young people who were referred to group interventions multiple times, demographic and clinical details were extracted for the first period in which they were referred.

The 'Your Experience of Service' survey, a standardised survey used in Australian mental health services (InforMH and NSW Ministry of Health 2021), was adapted specifically for the group interventions and offered in the final session. This survey assessed feelings of respectfulness and safety participating in groups, inclusiveness of care, communication about the content and structure of groups, and overall experience. Respondents rated their level of agreement with statements on a 5-point Likert scale, anchored at '1 = *Never*' and '5 = *Always*' for the respectfulness and inclusiveness domains, and '1 = *Poor*' and '5 = *Excellent*' for the communication and experience domains. Mean values were calculated for each domain, with higher means indicating a more positive response. The survey and survey items that fit the three domains are provided in File SB.

Semi-structured interviews were conducted between July 2022 and September 2023 by OAY and PR, trained and experienced in qualitative research. Interviews lasted approximately 1h (range = 35–65 min) and were conducted in person in a consultation room within headspace Bondi Junction or virtually via Microsoft Teams. In-person interviews were audio recorded and transcribed verbatim in Microsoft Word. Virtual interviews were video recorded and automatically transcribed, with OAY or PR reviewing transcriptions for accuracy against the video recording. Interviews focused on the entire service redesign, with guides informed by discussion with the Youth Reference Group. Questions and prompts related to the groups programme and Group Coordinator are listed in File SC. To elicit any information the participants deemed important, open narrations were encouraged. After 11 interviews with staff, no new themes emerged related to experiences with the implementation of group interventions; at that point, it was concluded that data adequacy was achieved. After the combined 15 interviews with carers and young people, a pragmatic decision was made by the research team to cease recruitment given greater difficulties in recruitment for these groups.

Group data was categorised according to Proctor et al.'s (Proctor et al. 2011) taxonomy of implementation outcomes to answer the study aims. Feasibility outcomes were demand (number and timepoint of referral) and practicality (time delay between referral and engagement), as outlined by Bowen et al. (Bowen et al. 2009). Acceptability was measured by rates of attrition (defined as $< 75\%$ of sessions attended, as attending all sessions was not mandatory), reasons for attrition and 'Your Experience of Service' survey. Adoption was measured by uptake of the groups programme (referred young person attending at least one group session). Appropriateness was measured by rates of referral to the varying groups on offer. Themes identified from interviews informed barriers and facilitators to implementation of the groups programme and Group Coordinator.

2.7 | Analysis

Descriptive statistics were calculated for the demographic, clinical characteristics, and administrative chart audit data. Following Wolpert et al.'s recommendations for the use of data collected as part of routine care, analyses exploring adoption and attrition were kept simple (Wolpert and Rutter 2018). Shapiro–Wilk tests were conducted for continuous variables to inspect normality before using either the parametric independent samples t-test or non-parametric Mann–Whitney test. Categorical variables were analysed using the Pearson chi-square (χ^2) test and Cramer's V statistic was calculated to measure effect size. p values of less than 0.05 were considered statistically significant. Analyses were performed using SPSS Statistics (IBM Corp., Version 27, Armonk, NY).

Reflexive thematic analysis was employed for the analysis of interviews, adopting a constructionist epistemology (Braun and Clarke 2019). First, inductive semantic and latent line-by-line coding was conducted independently by OAY and PR on two transcripts from each participant group to develop a thematic framework. Divergence in coding and categorisation was

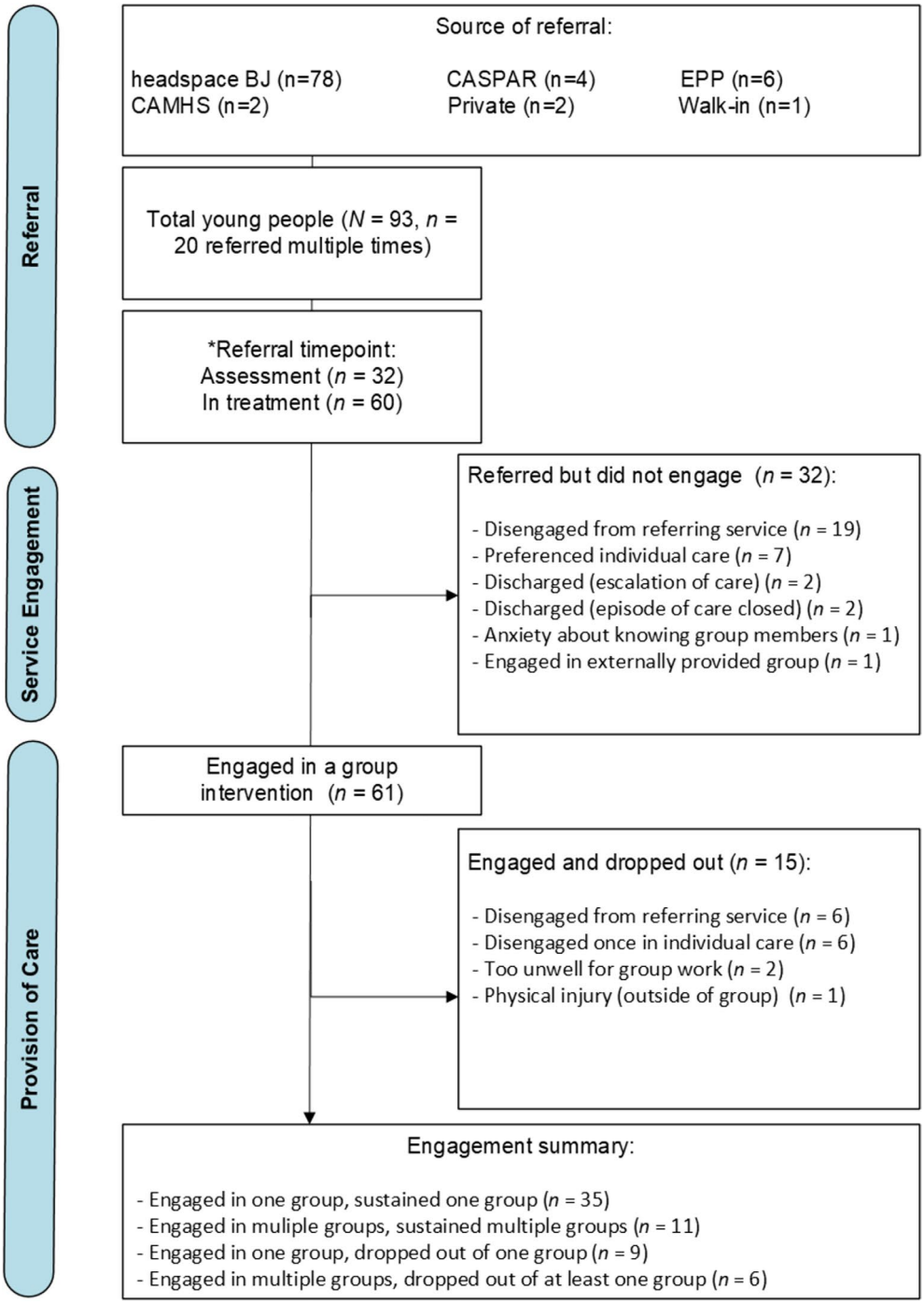

FIGURE 1 | CONSORT diagram of referral and engagement in group interventions. *Referral timepoint information was not available for $n = 1$ young person (the walk-in referral).

resolved through discussion at weekly meetings and was aided by the use of field notes (Byrne 2022). Once a framework was established, OAY and PR independently coded transcripts of interviews each had conducted in Nvivo 14 Software, resulting in 154 initial codes. This process was undertaken iteratively and concurrently with data collection. Following data collection, the framework was mapped onto domains of influence in a hybrid inductive/deductive approach informed by the CFIR (Damschroder et al. 2022), retaining the language of the inductive coding.

3 | Results

3.1 | Feasibility

3.1.1 | Demand

The chart audit identified 121 referrals made to the group programmes for 93 young people at headspace Bondi Junction; referrals to multiple groups were made for 20 of the young people. Of the 93 young people that were identified, 61 engaged in the groups

programme: 22 people between January and August 2022, and 39 between September and June 2023. Referral timepoint data was available for $n = 92$ young people: $n = 31$ were referred at the point of assessment, while $n = 61$ were referred once engaged in treatment. Figure 1 displays a CONSORT flow diagram overview of referral and engagement with group interventions.

Demographic and clinical details are presented in Table 1 of File SC. Briefly, for the 93 young people who were referred to the groups programme, the majority were referred internally from headspace (83.9%). Mean age was 16.4 ± 3.2 years, and the majority identified as female (76%) and were engaged in education, employment or training (83.9%). Most young people were experiencing multiple mental health issues (69.9%), with symptoms of depression (53.8%) and anxiety (49.5%) most frequent, but had not received an ICD-10 diagnosis of a mental disorder (81.7%) and 58.1% were engaged in (at least) one kind of treatment.

Clinical staging information was available for 91 of the 93 young people, and frequencies within each category were: Stage 1a (36.3%), Stage 1b (45.1%), Stage 2 (17.6%) and Stage 3 (1.1%). SOFAS ratings at the time of referral to groups were available for 84 young people, with the mean score (67.8 ± 12.4) indicating impairment in social and occupational functioning (scores < 69). K10 scores were available for 69 young people, with the mean rating (30.7 ± 8) indicating severe distress.

3.1.2 | Practicality

Data on the time (service) delay between referral and engagement in a group intervention was available for 81 (94.2%) of the total number of referrals. Twenty-six (30.2%) referrals were made at the stage of assessment, 48 (55.8%) while the young person was engaged in treatment and 12 (14%) as a 'warm' discharge pathway. In specific relation to aim (i), considering only the sample of 74 referrals from headspace, the mean time between referral and engagement in a group intervention was 19.8 calendar days (SD = 13.1, range = 1–63).

3.2 | Adoption

There were 32 people between September 2022 and June 2023 (45% of referrals in this timeframe) who were referred but did not take up the groups programme. The number of people who did not take up the groups programme for the first 8 months was not able to be retrieved. Statistical tests comparing uptake of group interventions based on demographics and clinical characteristics are presented in Table 1 of File SC. Young people with lower SOFAS scores were significantly more likely to engage, $t(83) = 2.1$, $p = 0.04$. However, young people referred at the stage of assessment were less likely to engage in a group intervention compared to referrals made once a young person was in mental health treatment, X^2 (1) = 5.84, $p < 0.02$, Cramer's $V = 0.25$. There were no significant differences between young people who engaged and did not engage with respect to K10 scores, SOFAS, age, clinical stage, gender, educational/employment status, whether they were diagnosed with a mental disorder, or had multiple presenting issues (all t's < 1.60, all p's > 0.11; all $X^2 < 4.23$, all p's > 0.20).

Of the 32 young people who did not engage in group interventions, the most common reasons for not engaging were disengagement from the referring service (59.4%), followed by a preference for individual care (21.9%). Among referrals that disengaged from the referring service and were not yet connected to ongoing care (i.e., were at the stage of assessment), none of these re-presented to the referring service within the data collection period.

3.3 | Appropriateness

Given the lack of available complete referral data between January and August 2022 and the fact that only one kind of group was run (art therapy), appropriateness was considered based on the referrals between September 2022 and June 2023 when there were multiple group offerings. Most referrals (33.7%) were for the DBT group, followed by art therapy (31.5%), CBT skills (18.5%), body image (12%) and exercise (4.3%).

3.4 | Acceptability

At the person level, 35 people (57.4%) engaged and sustained one group, 9 people (14.8%) engaged in one group and dropped out, 11 people (18.0%) engaged and sustained multiple groups, and 6 people (9.8%) engaged in multiple groups and dropped out of at least one group. The most common reasons for attrition were disengaging from the referring service (40.0%) and disengaging once connected to individual care (e.g., individual therapy or case-management) (40.0%). There were no significant associations between referrals which sustained engagement with at least one group intervention compared to those who dropped out with respect to K10, SOFAS, age, educational/employment status, whether the referral was made at the point of assessment or after commencing care, clinical stage, whether the person had a mental disorder diagnosis, referral pathway or whether the young person had multiple presenting issues or not (all t's < 2.0, all p's > 0.05; all $X^2 < 2.26$, all p's < 0.23). Full details on statistical tests are presented in Table 2 of File SC.

Survey data was only available for the period between September 2022 and June 2023 when it was introduced by the Group Coordinator. Of the 49 referrals who sustained engagement in a group intervention during this time, 44 (89.8%) completed the survey. Most (65.1%) respondents identified as female, 20.9% as male and 14% as other genders. The majority (69.8%) of respondents were aged less than 18 years old. Across all domains, the acceptability of the group interventions was rated highly. Young people felt group interventions were respectful and safe ($M = 4.8$, SD = 0.4), inclusive ($M = 4.6$, SD = 0.6), were communicated about with sufficient information ($M = 4.3$, SD = 0.8) and were an overall positive experience ($M = 4.1$, SD = 0.9).

3.5 | Semi-Structured Interviews

Twenty-six interviews were conducted in total, which included: 11 headspace staff (7 clinicians, 2 administrative staff and 2 peer workers—including the Group Coordinator), 8 young people and 7 carers. Demographics of carer and young person participants

TABLE 2 | Qualitative themes, quotations and descriptions.

Theme	*N* (%)	Quotation and description
Intervention characteristics		
Social nature	12 (46.2)	• **Young person [P4]:** 'I'm a very nervous person, so I was like "a whole thing where I have to go and talk [with others] about myself and my [mental health], like, do I really want to go?"' Participants identified potential discomfort with discussing mental health openly as a barrier to engagement, particularly, for those experiencing difficulties with social relationships. However, this was viewed as impermanent, seeing groups as beneficial once someone is well-engaged in care, with the social interaction and collective validation they provide acting as facilitators to sustained engagement.
Logistical compatibility	11 (42.3)	• **Clinician:** 'You've gotta wait until the next group starts next term. So, a group runs, a group is running every week. But … that utility to join a group doesn't run every week … so by the time that happens … [the young person is] 2–3 months down the track' Clinicians emphasised the closed nature of the groups as a barrier, yet were against the idea of open groups when probed—typically citing a need to manage group cohesion. Some clinicians suggested shorter clustered groups (e.g., 4 weeks instead of eight) as an alternative, although young people stated a desire for group interventions with a more extended duration.
Observable benefits for young people	12 (46.2)	• **Peer worker:** 'I think giving young people [the] opportunity to socialise and also do things that are functionally positive rather than sitting there and just talking about their mental health the whole time is really positive'. Witnessing improvements in young people that clinicians were working with in an individual modality was stressed as a catalyst for increased positive attitudes to referring to and facilitating groups. Young people also commented on a self-awareness of becoming more socially open or learning from others as key factors in continuing with groups.
Peer support	12 (46.2)	• **Young person [P2]:** '[The Group Coordinator helps] young people involved in those groups, be a little bit, I guess, on a personal level more comfortable because they are around people who have the sort of same experiences and same sort of goals going into the sessions' Clinical staff endorsed the unique peer worker aspect of the Group Coordinator role in being able to build rapport with young people to facilitate engagement. Young people also viewed the presence of a peer worker as comforting and as normalising sharing their mental health with others.
Relevancy	9 (34.6)	• **Young person [P1]:** 'There's never really been something I'm interested in' There was common agreement that a diversity of interventions needed to be offered and that planning took into account young people's preferences. Clinicians voiced divergent views on how targeted group interventions should be to a certain presenting issue but were unified in stating that groups should not be constrained to specific age brackets, as this would negatively impact referrals.

(Continues)

TABLE 2 | (Continued)

Theme	*N* (%)	Quotation and description
Organisational structure		
Dedicated time and infrastructure	12 (46.2)	• **Peer worker:** '[We changed groups to] fit into their KPIs. So people weren't having two hours of their time plus paperwork being used up without it showing for them. We sort of put in place that, actually, if you run a group, you're seeing six young people: that counts as six occasions of service for you. And that helped a lot. I think it made people more interested in running groups because prior to that it was, "that's just extra stress or something that's not helping me out at all"'. Staff identified dedicated time and infrastructure, both for the provision and organisation of group interventions, as fundamental—particularly, the restructuring of workloads for salaried clinicians to recognise group work. In addition, the contribution of the Group Coordinator to organisational components was seen as invaluable.
Staff turnover	5 (19.2)	• **Clinician:** '[Clinicians] just weren't asking because [group interventions] just came about all of a sudden. And it was like … I think it was the uncertainty, about when it was gonna start … the [new] clinicians didn't have it on the radar' Sole facilitation of group interventions and staff turnover of these clinicians was emphasised as a key barrier sustainability. A salient example of this was the departure of two clinicians due to deliver CBT- and DBT-based groups in January of 2022, with the result that these groups did not go ahead. Co-facilitation was suggested as a strategy to mitigate this and promote greater awareness of group interventions throughout the clinical team.
Organisational culture		
Beliefs about care	9 (34.6)	• **Clinician:** 'I remember a meeting where people expressed their angst about referring to groups and I was blown away … I think for a lot of them their interest was 1-on-1 work, and their only resolution for resolving mental health issues was 1-on-1 work. That resistance, it was their own sense of what their job was … the medical and psychological model are: 'there's a problem, I've got the expertise to fix it and then we send them out'. But mental health is a lot broader than that, and there's a lot of other strategies'. Latent devaluation of group interventions was common among clinicians. Senior clinicians commented that a culture shift emerged with the commencement of the Group Coordinator through their advocacy in clinical review meetings and over time, as more groups were implemented and clinicians received feedback from their clients.
Confidence	5 (19.2)	• **Clinician:** 'I don't have a good clinical sense of groups, how they're run, how sound they are … so, probably because of that I don't tend to prioritise them as a first referral'. Clinicians expressed a lack of confidence in facilitating or referring to groups stemming from a lack of training or experience. This was particularly the case for group interventions which were not based on approaches they used in individual therapy (e.g., art therapy or exercise).

(Continues)

TABLE 2 | (Continued)

Theme	*N* (%)	Quotation and description
Clinical team communication	9 (34.6)	• **Clinician:** '[When the Group Coordinator] came in that was really helpful … [they were] always telling us information about the groups in terms of times and different stuff like that and reminding us [about group interventions]. I think, to be honest, many of us didn't know what art therapy was until a couple of weeks ago when [the Group Coordinator] organised an in-service about art therapy'. Communication about groups was viewed as often missing prior to the Group Coordinator, contributing to a lack of confidence. In-services, mock brief sessions involving clinicians, and inclusion of facilitators in clinical review meetings were identified as positive strategies to enhance communication.
Community expectations of care		
Preference for individual care	8 (30.8)	• **Young person [P7]:** 'I don't think like it sounds so terrible, like so bad. But well, first of all, I wouldn't wanna have other people hear me speak about [my mental health] like I would just want my therapist to hear me speak about it'. Many young people and carers voiced a preference for individual care. As with clinicians, for some this was due to a belief in the superiority of individual care. For others, there were concerns around managing confidentiality or potential iatrogenic harm through varying degrees of distress among young people.
Communication with carers and young people	12 (46.2)	• **Young person [P3]:** 'I guess I just generally [was told] the times of those appointments and things like that, I wasn't really given much information about the groups. I was just told that there are groups—I wasn't told like what type of groups, like, they are, what are you [going to be] doing, things like that' Communication about the content and process of group interventions was reported across all groups as crucial but often not transmitted. The number of young people attending, age range and the cost and length of the commitment were highlighted as key information by young people. Among clinicians, the lacking communication was seen to arise from the cluster of sub-themes within the theme of organisational culture. Involving the Group Coordinator in recruitment and having clear written materials to give out were identified as important facilitators.

are presented in Table 3 of File SC. A thematic map is presented in Figure 2, denoting barriers to and facilitators of implementation. Themes, the number of participants who referred to the theme, illustrative quotes and descriptions are presented in Table 2.

4 | Discussion

Group interventions for young people experiencing mental ill-health are often offered in mental health services, yet little research has evaluated implementation outcomes and influencing factors. Key findings from the current paper are that: (i) there is demand for group interventions, but they may have limited feasibility as an 'active waiting' solution, (ii) group interventions are acceptable to young people, though viewed as inferior to 1:1 interventions, (iii) clinicians lacked confidence in implementing, referring to, or communicating about group interventions and (iv) the Group Coordinator role is a promising innovation for mental health services offering group interventions, conferring multiple benefits. More broadly, our findings align with the literature on implementation of evidence-based practice in youth mental health settings (Peters-Corbett et al. 2024). Staff turnover and consequent 'organisational forgetting' and loss of expertise was identified as a core barrier, while establishing dedicated infrastructure and staff training were key to implementation success. Practical implications for future implementation are summarised in Box 1.

4.1 | Feasibility

Overall, while there is demand for group interventions, this represents a small proportion of the total number of young people seeking care. To our knowledge, this is the first paper to examine referral to a group intervention in the context of a young person's care journey. In this sample, referrals that were made before the young person was involved in mental

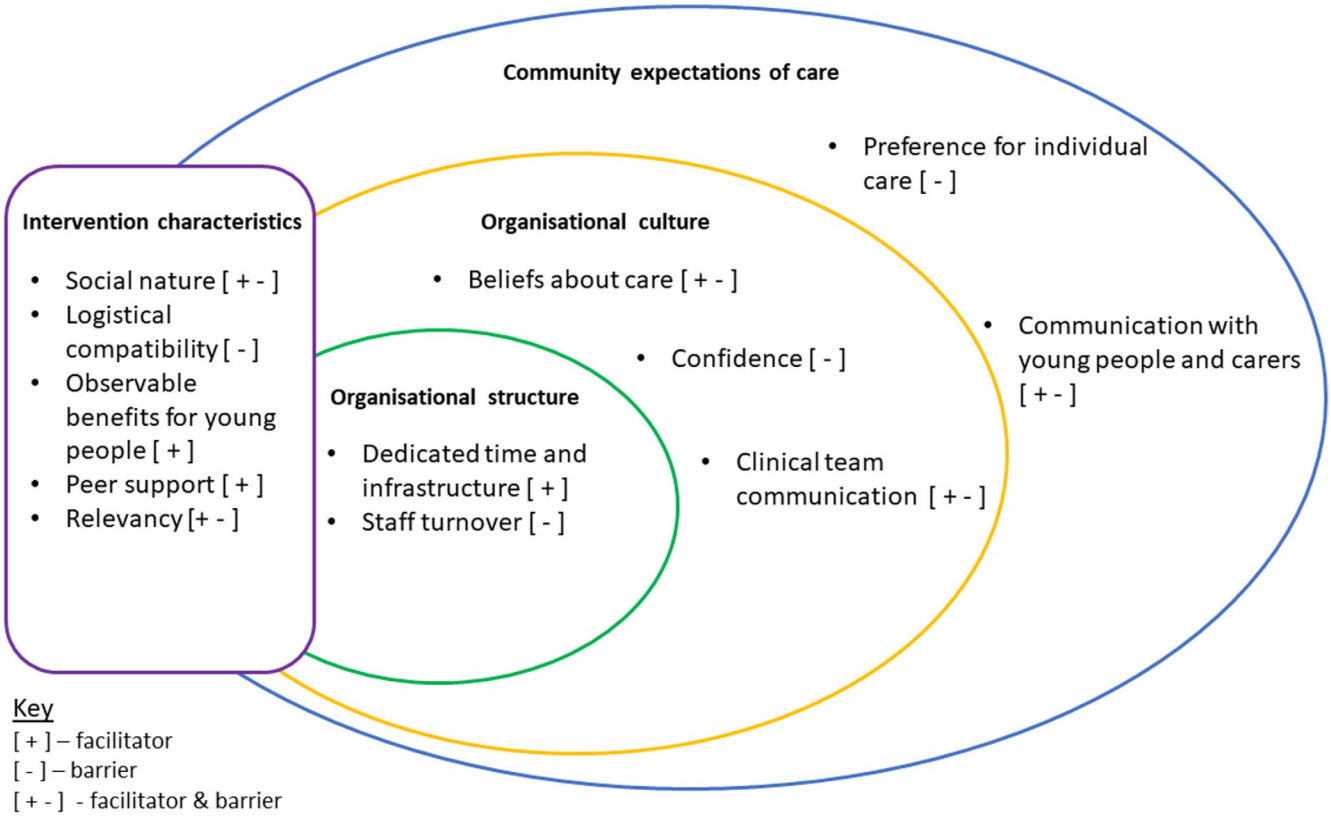

FIGURE 2 | Map of qualitative themes.

health treatment were less likely to result in engagement in a group. Various reasons may explain this finding; for instance, anxiety about the social nature of groups that young people voiced during interviews, stigma surrounding discussing mental health, low mental health literacy and confidentiality concerns (Beckman et al. 2023; Gulliver et al. 2010). Additionally, the most common reason for not engaging in a group intervention was disengagement from the referring service. The possibility of seeking care from external providers (i.e., private practices) at a particularly transitional time in care also likely contributes to this disengagement.

Regarding practicality, the delay between referral and engagement in a group intervention compared to individual care was markedly shorter for young people presenting to headspace (59.6%, or 13.4 days less). However, far more young people were seeking individual care, and clinicians reported making referrals to coincide with group start dates during the semi-structured interviews. Taken collectively, these findings suggest limited feasibility for group interventions as an 'active waiting' solution. As expressed during interviews, group interventions may be more feasibly implemented when blended into integrated care with individual therapy. Importantly, scaffolding care this way could still enhance access (Whittingham et al. 2023).

4.2 | Acceptability and Appropriateness

Acceptability of the group interventions was high across all survey domains assessed, with participants reporting that group interventions were respectful and safe, felt inclusive, were well communicated, and provided an overall positive experience. Caution is necessary for interpreting these results, however, as the survey was only offered in the last session of each group and results may be skewed due to the risk of selection bias (i.e., only those who enjoyed groups completed the survey). Additionally, given the stark difference in referral rates (e.g., 33.7% vs. 4.3% for DBT compared to exercise), reflections on DBT, art therapy and CBT groups are overrepresented, with strong limitations on drawing conclusions about the acceptability of exercise in this study. Referral rates are also a blunt measure of appropriateness and may reflect clinicians' belief about care and lack of confidence more than young people's perspectives, as there is a wealth of evidence supporting the acceptability and appropriateness of group physical activity interventions in these settings (Lederman et al. 2020; Czosnek et al. 2023; Klemmer et al. 2023). In general, given the shortage of research on this topic, there is a lack of age-appropriate data for comparison of attrition rates to complement understanding of acceptability and appropriateness.

Two randomised control trials examining transdiagnostic group therapy for young people observed attrition rates of 14% (Chu et al. 2016) and 29.6% (Gulamani et al. 2020), compared to 22.1% in our sample. However, trials generally have lower attrition rates than in real-world settings and these studies operationalised more liberal definitions of attrition: attendance of $< 66\%$ and $< 50\%$ of sessions, respectively. Further, a meta-analytic review on dropout from transdiagnostic therapy in child and adolescent community mental healthcare found an average treatment attrition rate of 50% (range = 17%–72%) in studies with effectiveness designs (de Haan et al. 2013). Holistically, the attrition rate and results of the survey support broad acceptability of the transdiagnostic group interventions in the current setting.

BOX 1 | Practical implications for future implementation.

Infrastructure	Ensure a Group Coordinator role and, where possible, employ a youth peer worker in this role.
	Restructure workloads of staff to recognise facilitation of group interventions as the provision of multiple occasions of service within any applicable key performance indicators.
	Ensure the opportunity for facilitators to participate in clinical review with referring clinicians, whether facilitators are internal or external.
	Establish ongoing meetings between coordinating and facilitating staff and share organisational responsibilities, to limit 'organisational forgetting'.
Content	For transdiagnostic groups, focus on content that emphasises skills development and facilitating social interaction. Keep psychoeducation brief and widely relevant, addressing underlying mechanisms such as emotion regulation and repetitive negative thinking.
	Offer a diversity of group interventions, based on the participatory involvement of young people. This may range from consultation to co-production (Guo et al.2024).
Referral and communication	Develop clear, youth-friendly written information about groups which includes what a group is, the focus of the group, what they will get out of it, the number of young people attending, age range, the cost, and length of the commitment.
	Consider prioritising referral to a group once a young person is engaged in care at the service. However, inform young people about groups early on in engagement with the service, and multiple times. Blending care this way may also decrease the load on individual therapy and provide a synergistic opportunity to work on issues identified in 1:1 sessions.
	Include the Group Coordinator in referral and communication about groups with young people.
Delivery	Ensure co-facilitation of group interventions, to increase capacity of including more young people, reduce the burden on individual facilitators and mitigate against staff turnover.
	Where possible, include a youth peer worker as a co-facilitator.

However, young people expressed perceived inferiority of the group compared to individual options in qualitative interviews, and being connected to individual care was the joint most common reason for disengagement. Possible explanations for this could be a reluctance to discuss deeply personal aspects of mental health among others or a desire for more personalised care (Gondek et al. 2017). These perceptions could also stem from the uncertainty in communication or the attitudes of clinicians in setting up expectations of care. Senior clinicians and peer workers commented on a culture among newer clinicians viewing group interventions as an adjunct, rather than part of integrated care. Addressing these perspectives and attitudes through the strategies identified by clinicians (e.g., in-services or mock participatory sessions) is a potential avenue to facilitate greater retention. Given some young people's reservations about sharing their personal mental health in groups, designing content—at least in the early stages of a group programme—to minimise this and emphasising the development of skills, both in content design and in communication during referral, are also strategies that may increase acceptability.

4.3 | Clinician Capacity and Confidence

The need to improve clinician capacity and confidence through structural and cultural change was a key finding from the qualitative interviews. A range of implementation enablers at a structural level was identified: recognising the provision of group interventions within the key performance indicators, protected time for organisational tasks, ensuring co-facilitation and shared organisational responsibilities. These findings echo barriers encountered by Higgins et al. and also feed into the ability of clinicians to effectively communicate with young people and carers (Higgins et al. 2022). These are simple, practical steps which were endorsed by clinicians as crucial for successful implementation. A notable barrier identified by a qualitative study of the implementation of CBT for young people with anxiety in the community, which did not emerge in our interviews, was a lack of support through clinical supervision (Ringle et al. 2015). However, all facilitators in our sample were engaged in regular supervision appropriate for their discipline, although the content of this supervision is unknown.

Cultural change, to improve clinicians' confidence in referring to, facilitating or communicating about group interventions also emerged as a core process across implementation. Some barriers to this, such as lacking intra-team communication, could be targeted with similarly practical steps (e.g., ensuring integration of facilitators within clinical review meetings). Others improved over time, such as beliefs devaluing group work changing through the positive feedback loop of clinicians observing tangible benefits in young people who were simultaneously engaged in group interventions. These insights underscore the significance of ongoing education and organisational support.

4.4 | Group Coordinator Role

The Group Coordinator role enhanced implementation across a range of domains. Advocacy for young people's engagement in group interventions within clinical review meetings and challenging clinician beliefs about care were aspects highlighted in interviews as contributing to cultural change. In their qualitative study of co-facilitation of group interventions by peer workers and clinicians, King and Simmons found that young people felt that peer workers encouraged young people's engagement in groups and sense of belonging, particularly, through the sharing of lived experience (King and Simmons 2023). Similar themes emerged in our setting, with clinicians and young people commenting on increased comfort and trust.

The peer workers in King and Simmons' study were reimbursed for sessions, rather than salaried staff and the benefit of further integration of group peer workers was evident at an organisational level. A role specifically coordinating waitlists, recruitment and communication—internally and externally—was seen as invaluable by clinicians for sharing organisational tasks. Particularly with recruitment and follow-up of young people, peer support was viewed as a key advantage, building rapport and accessibility.

4.5 | Limitations

The current paper has a number of limitations. First, as noted, data were missing for the total pool of referrals. Additionally, no service-level data was available for young people who were not referred to group interventions, so it is difficult to determine the representativeness of the sample. As the group interventions were conducted in the metropolitan suburbs of Sydney, generalisability to other contexts is also restricted. Because of delayed recruitment, fewer interviews were conducted with young people and carers than the 10 planned for each group and new themes were consistently emerging from interviews (Vasileiou et al. 2018). However, a key strength of the current paper is our exploration of the experiences and perspectives of these young people and carers who did not participate.

While effectiveness was not the focus of the paper, given qualitative responses emphasising observable improvements, it is a shortcoming that clinical outcomes were not measured. Additionally, while engagement did vary according to SOFAS score, the SOFAS is a pragmatic measure. It combines the independent domains of social and occupational functioning and may, therefore, occlude potential effects, limiting our inferential capacity—particularly, in the absence of any previous corroborating research (Lahera et al. 2018). Use of more targeted, self-report measures of social connectedness (Lee et al. 2001) and group readiness (Baker et al. 2013) may help more accurately predict engagement and, crucially, mentally frame group therapy for young people (Moore et al. 2023). Further, as Gulamani et al. found that within-treatment factors were important predictors of attrition in their setting, a lack of measures such as group cohesion, therapeutic alliance and the number of therapeutic techniques employed is a significant limitation (Gulamani et al. 2020). The use of an adaptable, validated measure of acceptability—such as that developed by Sekhon et al.—in addition to the adapted headspace survey would also have benefited the current evaluation (Sekhon et al. 2022).

4.6 | Conclusions

Despite these limitations, through the mixed-methods approach and ecological validity of implementation in a real-world setting, there are several useful implications of our findings for similar primary care youth mental health services—especially in light of the changes to the Better Access initiative (Department of Health and Aged Care 2023). Considering the impact of the Group Coordinator, a similar role is key to the sustainability of the intervention, as are co-facilitation and ongoing training for both clinicians and peer workers in delivering group interventions. Overall, our results indicate broad acceptability of transdiagnostic psychosocial group interventions within youth primary mental healthcare but limited feasibility as a standalone care option.

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Ethics Statement

This study was approved by the South Eastern Sydney Local Health District Human Research Ethics Executive Committee (2022/ETH00594).

Consent

Quantitative data was obtained from service audit records of routinely collected information and a routinely collected survey instrument. Qualitative data was obtained directly from participants who completed a written informed consent procedure.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.