completers-only analysis, they should report the outcomes from the full cohort that received the service.

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IN REPLY: We welcome the correspondence from Jorm; much of it is consistent with the issues raised in the original study. We agree that the results highlight the need for ongoing research on who uses headspace-style services and what actual short- and longer-term benefits are derived. However, some of the concerns raised by Jorm do not appear to recognize that this report was focused only on a specific subpopulation of headspace clients, namely those with clinical presentations that met criteria for clinical stage 1b (attenuated syndromes of major mental disorders with significant impairment). That is, our cohort did not include individuals presenting with less severe, nonspecific syndromes or acute distress that are not typically associated with functional impairment. Consequently, this cohort is not comparable to other individuals attending our own services (1) or to those included in the national headspace cohort (2).

Jorm raises other substantive issues. First, are headspace-style services providing early intervention? In our view, it cannot be concluded that the service is failing to meet its early intervention goals simply because the stage 1b subpopulation had experienced symptoms for some time prior to accessing health care. The real test is whether attendees at headspace services have shorter duration of pre-existing symptoms than persons presenting to other traditional primary care or youth-designated mental health services. For most young people, early intervention has two goals—active management of the presenting syndrome and secondary prevention of progression to the next clinical stage. While interventions for those who present with stage 1b syndromes may initially focus on the management of acute symptoms, they also explicitly focus on preventing or delaying progression to persistent or recurrent major mental disorders. Consistent with the view expressed by Jorm, our recent study highlighted that there is indeed a need for an ongoing and specific focus on resolving current symptoms among those who present at stage 1b, promoting full recovery and preventing recurrence or progression to more severe disorders.

Although the independent review of headspace services was useful, in our view it is a far less relevant comparative study than other research reports (which we cited), which included over 10,000 headspace clients and used similar methodologies. Finally, our article excluded important information on follow-up assessments. To clarify, the model of care we use encourages young people to remain connected to care for 12 months and for clinicians to engage in proactive follow-up (3). Further, clinical ratings were undertaken at each assessment point for all study participants up to six months (including those who were no longer regularly attending services). We agree with Jorm that clinical studies that report or analyze data only from those who remain in care ("completers") can have major limitations. However, as with all such longitudinal cohort studies, we place a high priority on transparency in data reporting and analyses, as well as recognizing limitations on interpretation of the results.

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