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ABSTRACT

This document contains issues eight and nine of the 1999 Australian Early Intervention Network for Mental Health in Young People newsletters for health professionals. The newsletters disseminate information about the national and local initiatives for intervention and prevention of mental health problems in young children and youth. The issues feature information on the evaluation and effectiveness of several programs; consumer involvement in health care; available resources; and news on upcoming conferences. Guest editorials include: "Suicide Prevention: Changing the 'Tipping Point'" (Robert Goldney); "Indigenous Health and Early Intervention--Addressing and Acknowledging the Influences of the Past" (Shane Merritt); "Early Intervention and Perinatal Mental Health" (Stephen Matthey); and "Early Intervention: From Rhetoric to...?" (Cathy Davis). (Contains 19 references.) (JDM)

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Guest Editorial

Professor Robert Goldney

Suicide Prevention: Changing the "Tipping Point".

We all know there are no simple answers to the challenge of suicide prevention. However, sometimes opinions about one approach as opposed to another are held with considerable conviction, albeit with little evidence for their effectiveness.

A concept which may allow us to reconcile and accept the contribution of opposing views is that of the "tipping point", first postulated by Tittle and Rowe in 1973 and more recently applied to suicidal behaviour (Goldney, 1998). The "tipping point" implies that there is a background base rate of a phenomenon, which results from many factors, and that there is a threshold or "tipping point" which once breached allows for a dramatic increase in the phenomenon. It has been used in other contexts, for example to explain variations in crime rates where there have been marked changes over relatively short periods of time, such as the dramatic decrease in crime in New York City in recent years. Quite clearly there is no simple answer to this change: it must be the result of a number of factors which have tipped the balance towards a safer society.

Drawing an analogy with the increase in young male suicide in Australia, the question can be posed: could relatively minor changes in some sociological factors suddenly result in a breaching of the "tipping point" for suicide, with a resultant dramatic increase? For example, have there been changes in how our society views and rewards young males? Have there been changes in early parenting practices towards males? Have there been changes in societal attitudes to the acceptability of recreational drug use? Have there been changes in the delivery of health care to young males? Has there been a change in the perceived willingness of our society to accept and treat young males with emotional problems by the closure of places of "asylum", i.e. - de-institutionalisation? Have there been societal changes in regard to the acceptability of euthanasia? Has there been undue publicity about suicidal behaviour?

The answer to each of these questions, and others which could also be posed, is probably yes, but no one factor could reasonably be considered sufficient to have produced the increase in young male suicides. Therefore it appears useful to invoke a concept such as the "tipping point" to assist our understanding of this worrying phenomenon.

It is important to note that the "tipping point" is consistent with the public health model that focusing on so-called high risk preventive/treatment strategies may not be the most effective way of tackling a community problem such as suicide. Thus, when there is mass exposure to risk, as is the case with the well established but unfortunately non-specific risk factors for suicide, even if there is only a low level of risk there is an opportunity for broader measures of control to exert an influence. For example, a small shift in one of the contributing sociological factors to suicide, a shift which just influences the "tipping point" to such behaviour in a large population, may have a far more wide-reaching effect on overall suicide rates than a more specific intervention aimed, for example, at treating those afflicted with depression or substance abuse. This is consistent with the public health "prevention paradox" that "a preventive measure that brings large benefits to the community offers little to each participating individual" (Rose, 1992).

Possible broad population early interventions which could change the "tipping point" away from suicide would include addressing the previously noted issues which could influence young male suicide, such as providing a climate where "time out" or "asylum" was readily available and not seen as inappropriate - in a sense countering the de-institutionalisation at all costs thrust observed in some Such issues are controversial, as are suggestions for the need for individuals to develop more resilient and personally responsible coping patterns, rather than attributing difficulties to external events. Another possibility could be to change the perception of suicidal behaviour from the

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"cry for help", with the expectation of assistance, to a "cry of pain", which is a more accurate description of those who are suffering and feel driven to suicidal behaviour, but which denotes suffering rather than the expectation of care. This has been well described by Mark Williams (1997) in his book appropriately titled "The Cry of Pain".

It must be emphasised that the "tipping point" concept is drawn not to denigrate individual treatment programs, as clearly they must continue to reduce the personal morbidity and mortality associated with suicidal behaviour. Rather, it is raised to illustrate how sociological factors may have a significant impact on rates of suicide in a given society by influencing many persons, albeit in an almost imperceptible individual manner.

The "tipping point" may seem too vague and lacking in specificity by some to be useful. However, in terms of early intervention, particularly from the broad public health perspective, it is worthy of the closest consideration in our attempts to integrate and accept the importance of different approaches to one of Australia's major health and social challenges, that of suicide, particularly in young males.

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Guest Editorial

Mr Shane Merritt

Indigenous Health and Early Intervention - Addressing and Acknowledging the Influences of the Past.

I am of Aboriginal descent from the Kamilaroi People of Northern New South Wales. Currently I am a University Lecturer, and the Bachelor of Health Science Co-ordinator (Aboriginal Health & Community Development) at Yooroang Garang: School of Indigenous Health Studies, The University of Sydney. My areas of specialty are psychology and mental health. I am a member of the Consultative Group for AusEinet, representing NSW and indigenous peoples. In addition, I am on the Steering Committee for the upcoming AusEinet conference, "Risk, Resilience & Results".

The area of indigenous health is of concern. Obviously, there is no simple answer to these health problems, as they are both multi-layered and extremely complex. I will not be so bold as to pretend I will offer the answer to these concerns within this editorial. I do, however, hope to outline why Indigenous Health, and in particular Indigenous Mental Health, is an issue that has to be addressed.

Early Intervention is a concept that is kept in mind in all teaching at Yooroang Garang. We see education as the key to making a difference in Indigenous Health, and we do not see a vast difference between other aspects of health, such as community development and primary health care, and Indigenous Mental Health. Indigenous communities tend to be holistic, looking at the whole, not only the individual parts. Early intervention thus becomes broader, in a sense, and incorporates prevention, cultural awareness, the strengthening of culture, self esteem, and the support that these factors can give. Early intervention, then, incorporates addressing the past, and the recognition of the past for its role in the problems with health now.

Historically, the Indigenous People of Australia and the Torres Strait Islands have been subjected to displacement from their traditional land. It is very important to understand that land and spirituality are very closely linked.

The land was declared 'vacant' by the British, thus allowing the invasion. In order for this to happen, the Indigenes were thought of, and treated as, sub-human, and as such were to be eradicated or controlled.

This mindset led to a racist base, where to be Indigenous was to be second class. Socio-economic factors and status kept the Indigenes in a position where culturally and economically they were disadvantaged. This, over the longterm, led to health problems to do with hygiene, nutrition and poverty. Death and illness became much more widespread than in the general population.

Psychologically, both the racism and the inequality took their toll, especially in the long term. Self-esteem, and surrounding issues, became associated with substance abuse, suicide, hopelessness, and depression, while broader health issues added to this anxiety and stress. This, in turn, further impacted upon the feelings of dispossession, bereavement and loss. These issues included the loss of culture, land, spirituality, and more immediate losses, such as the loss of loved ones, due to morbidity and mortality.

A psychiatrist, John Cawte studied Aboriginal responses to what he described as the "catastrophic upsets caused by Western influence" (Cawte, J. 1974, xiv, as cited in Saggers,

S. & Gray, D., 1991). Cawte investigated "how individual behaviour is determined by the social and physical environment, and in turn how the disturbed behaviour of an individual may have an adverse reflexive effect upon the group in which he lives" (Cawte, J., 1974, xvii ibid). Cawte saw three main causes of high levels of mental illness among the Indigenes:

1. Problems associated with one culture needing to adapt into a more technological society.
2. Oppression and exclusion resulting from the colonisation process.
3. Exclusion from opportunity (including geographic isolation).

In Cawte's studies he found stress often resulted in mental illness. He considered that the behaviour of those mentally ill contributed to a breakdown in social cohesion, as did tension-reducing devices like alcoholism and addictions. Saggers & Gray (1991) took this further to agree with Cawte's assertion that there is an unacceptable rate of mental illness in the Indigenous Population, and that the high levels of mental illness were "one of the injuries suffered by them as a consequence of their exclusion from the wider society and their lack of an economic base" (p 11).

Historical influences, society and culture, stereotypes, power, and personal history all combine to influence the individual. Indigenes have, in the last 211 years been subjected to various influences, and these experiences have had their impact on a number of levels. The recognition of the factors that accumulate to bring stress and other psychological problems is critical. Accumulated stress can lead to psychological problems, which in turn can manifest in physical maladies, and vice versa. The effects of this history can be current, handed down transgenerationally.

An understanding of the issues surrounding Indigenous Health, Indigenous Culture and Spirituality, is important for the future of health provisions. Indigenous autonomy and input into decisions affecting Indigenes is also vital.

In order to address these issues, it is important to consider the influences of the past, and the manifestations of these influences today, and in the future. The courses at Yooroang Garang: School of Indigenous Health Studies aim to give a broad overview of the issues involved in Indigenous Health. We provide expertise in primary health care, health promotion, management, community development, research, counselling and Indigenous Mental Health. Our ethos is to facilitate positive change in Indigenous Health. We are perfectly placed to make a big difference. Most of our studies are undertaken in block mode. Our students are usually mature, mostly Indigenous, and probably already working in the health field in their respective communities. Yooroang Garang has the chance to facilitate positive change in a number of different Indigenous Communities. Our subjects are based on holism: we strive for empowerment through culturally appropriate delivery of the subject streams.

Early intervention in mental health aims to 'intervene' at a time when a possible problem might be stopped or minimised and can consider the social, emotional, cultural and spiritual. We can attempt to address the influences of the past, and try to resolve these, and the associated stressors that can have an impact on mental health. We can aim to strengthen community, culture, self-esteem and support. We can look at the whole picture. We can help our students understand these issues, and hopefully they will modify the concepts for use in their own communities. I consider this to be a valid form of early intervention.

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Guest Editorial

Stephen Matthey

Early Intervention and Perinatal Mental Health

Intervention and Home Visits

Considerable efforts are being made to provide the best possible start to a family's life by intervening early where there is risk of the mother experiencing significant distress in the perinatal period. Early on, work focused on detecting mothers with anxiety or depression and providing a home visiting intervention. Barnett and Parker (1985) demonstrated the effectiveness of a year-long support program on anxious mothers' distress levels using professional or lay people to do home visits (professionals resulted in superior improvement over lay people). Holden et al., (1989) also provided depressed women with a home visitation service over 13 weeks, and demonstrated that non-directive counselling was effective in alleviating their distress. This study has been replicated by Wickberg & Hwang (1996), with similar encouraging results.

Both of these programs illustrate that not only can such interventions be effective but that, by offering such assistance to women who are experiencing difficulty in the early postpartum weeks, many accept such help. However, it would be a mistake to think that simply sending people to visit women with postpartum depression or anxiety (PNDD) will solve their difficulties. All three studies had extensive training for the home visitors, both prior to the commencement of the programs, and with ongoing supervision. Simply sending visitors to a new mother is not sufficient if we are to make an impact on her, and the family's, psychosocial adjustment. For many years all new parents have had a Health Visitor in Britain, with visits lasting up to a year. However, even with this service the rate of maternal depression in British studies was never lower than in countries where the new mother did not receive such home visiting. Thus careful consideration must be given to the aims of the visit, the skill of the visitor, the model of intervention to be provided, and the training and back-up support that is given. Indeed, Families First, a program commencing in New South Wales in the near future, which aims to visit all new parents, augurs well for families providing that these issues are adequately addressed. It is all too easy to assume that programs which provide 'home visiting' must be beneficial - but as with any intervention, the content and process issues must be routinely monitored and adjusted if we are to ensure that what looks good on paper is actually good in practice, and demonstrated to be so (or not) by proper evaluation.

The success of such programs, together with the increased acknowledgment of the extent of difficulties faced by new parents, has lead to the recommendation in NSW that all new mothers be given the Edinburgh Postnatal Depression Scale at their initial visits to the Early Childhood Clinics (PND Services Review, 1994). This is a self-report instrument used as a screen, and sensitive for postnatal depression, which is brief and has high acceptability to the women. Thus the move is towards the health services taking a proactive role in detecting women with PNDD.

Screening & Prediction

There is also now a move towards attempting to predict which parents will become depressed or anxious, and thereby either provide them with a service in their pregnancy, or provide extra support, if needed, in the early postpartum weeks. Initiatives in this area include those by Appleby et al (1994), Beck (1995), Cooper et al., (1996), and more locally by ourselves and colleagues in South West Sydney ('MINET' project) and also in South East Sydney.

The benefits of trying to predict who will become depressed are in one sense obvious. If we are 'correct' in our predictions, then considerable effort and expense can be spared by knowing who to target once the baby is born. Information can be transferred to Early Childhood services so that at a mother's (or father's / couples') first few visits with the baby, sensitive inquiring about how she is managing can be undertaken with the knowledge of the risk factors identified in her pregnancy (such as lack of support or feeling depressed). Appropriate intervention can then be offered, and the family's adjustment can be monitored, so as to maximise the opportunity for a good beginning for the family.

But what if we are not 'correct' in our predictions? To date these studies, utilising many risk factors for PNDD, have not shown high accuracy in predicting antenatally those women who will develop PNDD. A consideration of some factors could provide an explanation for this low hit rate.

Around half of women with PNDD have experienced depression either during their pregnancy, or have had a history of depression in their life. Whether screening measures, such as those discussed above, will have differential accuracy at predicting these two categories of PNDD, known as 'Recurrent' or 'De Novo' (Cooper & Murray, 1995), is yet to be tested. It may be that if studies determine the accuracy of prediction instruments for each of these two groups, then the success rate of the instrument (adjudged by its receiver operating characteristics) may be found to be good for at least one of them.

Another consideration is whether different stressors associated with PNDD are more predictive than others. Thus while it is easy to read the research into risk factors, build up a picture of what seems to 'cause' PNDD (which should more correctly be read as being 'associated' with), and conclude, for example, that complications in delivery will *not* 'result' in PNDD (as the majority of studies show little association between this and PNDD), such an interpretation is clearly incorrect when one moves from the overall descriptive statistics of quantitative research, to the individual stories of women themselves. Thus for most women, having a caesarean will not be associated with feeling depressed. However, but there are instances where having a natural birth is valued so highly by a woman that not having this, in conjunction with other factors, will result in a high level of postpartum distress. Because of these idiosyncrasies in human behaviour and emotions, screening based upon a simple presence/absence of certain risk factors cannot be expected to be 100% accurate. The prediction formula may well have to be considerably more sophisticated than a simple algorithm which sums different risk factors. It may need to weight different stressors, or combinations of stressors, if it is to be useful. But if such predictive instruments remain poor in predictive power, should such screening be abandoned, at least in the antenatal period?

The argument *for* screening antenatally or postnatally if we can't develop a highly predictive instrument is, I would argue, strong. We are not just interested in the woman's wellbeing after the birth. Antenatal care is just that - care for <u>all</u> aspects of the woman's health during the antenatal period. Screening therefore has the dual purpose of predicting and providing a clinical service at the same time. Asking not just about possible risk factors, but also about how she is feeling now, will be of enormous benefit for her and her family. A woman who is struggling emotionally during her pregnancy needs support, in whatever form, at this point. By providing this some mothers may adjust better, and better utilise services and supports before and after the birth - thereby reducing the accuracy of our predictions in the best possible way.

There are also other benefits to such early screening. By inquiring of all mothers in their pregnancy on such issues as likely support after the birth, whether or not there has been a history of anxiety or depressive conditions previously, and

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current mood and feelings towards the pregnancy, we are showing that we care about not just the infant, nor just about her physical wellbeing, but also about a mother's psychosocial adjustment to her situation. There are a significant number of women who experience postnatal depression without any of the risk factors during their pregnancy. For these women, similar follow-up questions at the Early Childhood Clinic will remind the mother of our interest in her wellbeing. It is possible that this will result in these 'de novo' depressed or anxious women being more willing to seek appropriate support at this time.

Another consideration, if our screening instruments are not particularly successful at prediction, are those women who are predicted as being of low risk of becoming postnatally depressed. The temptation would be not to offer these women a screening service in the postnatal period, and to assume that because they were 'low-risk' in pregnancy they do not need the resources in comparison to 'high-risk' women. This is a risky strategy. Women's circumstances change - while there may have been support during the pregnancy with no major stressors, for a fair number of women other issues will have arisen since the pregnancy that now would put them at risk of having difficulty coping. The birth may not have gone according to plan, close relationships may have changed, or other major life events could have occurred. Thus screening all women postpartum is necessary to ensure such women are quickly detected and offered help if required.

Of course, and this is a personal (and I'm sure some would say male!) view, if the screening is used to subtly make a woman feel guilty if she has any thoughts of not breastfeeding then it will have the effect of driving women away from health services. I have spent the last three years interviewing many new mothers and fathers, and understand the effects of the hospital 'baby friendly' policy on some of these parents. The stress that they report at the inability of health services to respect their informed decision to bottle feed is substantial. As one father said to me, having expressed his anger at the intolerance of many staff at their decision not to breastfeed: "Are we actually allowed to bottle feed our baby?".

Interventions for 'at-risk' women

This move towards identifying high-risk women in the antenatal period has lead to studies examining the effectiveness of providing support to those considered to be 'at-risk' in their pregnancy. Several investigators have examined the efficacy of running groups or individual counselling at this time, and sometimes extending these to continue into the postpartum period (e.g., Elliott et al, 1988; Stamp et al, 1995). Some studies show benefits, while others do not. Of interest in such work in one sense is the assumption that one intervention should be effective for all at-risk women. Undoubtedly we shall soon move in the direction of attempting to compare different early interventions for different types of women - whether the types differ in their risk factors, or in their personality or coping styles, are just some of the considerations that may be worthwhile to pursue. For some women, interventions that provide non-directive support may be most beneficial while, for others, practical ways that increase the sense of competence at caring for an infant may be more appropriate. Our own research (Matthey et al., in preparation) in providing interventions antenatally to couples suggests that a woman's self-esteem is an important variable that plays a part in how effective certain interventions are in the antenatal period, and this finding ties in well with the evidence of the role of self-esteem in the aetiology of depression (cf. Brown et al., 1990). Another consideration, which is again being explored in our research, is the role of the woman's partner. It is likely that interventions will differ in their effectiveness (for both the woman and man) depending upon the quality of the couple's relationship. Thus when and how to include the partner in antenatal or postnatal interventions, or screening interviews, needs to be empirically determined. Up to now such considerations appear to be based more upon practical considerations than well-supported theory.

Conclusions

In the next few years I expect that we shall see continued advances in the use of screening instruments antenatally and postnatally for women, and an advance in our thinking of the overall benefits of such screening. Research is likely to inform us further as to the matching of interventions to different types of difficulties or aspects of the parents in the perinatal period. Increasingly the role of men in all of these aspects will be explored.

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EVALUATION OF FIRST NATIONAL STOCKTAKE REPORT OF EARLY INTERVENTION PROGRAMS

First Report of the National Stocktake

The First Report of the National Stocktake of Early Intervention Programs was completed in July 1998 with printing and dissemination (to 2500 people) taking a further 6 weeks. In order to obtain feedback on this report and to assist in the development of the Second Stocktake Report, an evaluation form was included in each Stocktake Report. Findings from those completed, and returned to AusEinet, are summarised.

The response to the First Report has been overwhelmingly positive. . Fifty four (54) completed evaluation forms were received. In addition, AusEinet project staff received a number of favourable phone calls. A further 135 copies of the Stocktake have been disseminated following requests from interested individuals and organisations.

As can be observed in the summary below, the feedback received on the First National Stocktake Report of Early Intervention Programs was overwhelmingly positive

1. Overall response to the report (n=54)

50 positive responses were received. A number of respondents commented that the report was an 'excellent resource', was 'informative and easy to read', 'comprehensive and clear' and provided a useful 'snapshot of services'. The report was also considered to be a valuable tool in that it demonstrated a range of approaches, and the theoretical bases underlying them. One new service commented that 'as a service just setting out, (the report) has been invaluable in regard to networking, information gathering and gaining insights into how others solve the problems faced.' The division of programs into different prevention orientation levels was seen as a positive attribute of the report as were the chronological frameworks and indexes.

One criticism of the report was that it was difficult to ascertain credibility and how effective programs are. (It should be noted, however, that the stocktake report was not able to assess 'effectiveness' of the early intervention programs reported on due to lack of evaluation data reported by the programs themselves).

Most respondents reported finding the report easy to understand, well presented and very relevant to their work context. Several respondents were critical of the layout of the report. Responses varied in terms of whether the ideas presented in the report would change their way of working.

2. Strengths of the report

Strengths of the report identified by respondents included the standardised format used in the report, the use of graphs, the comprehensive details of programs provided and the multifaceted approach employed. The report's potential for dissemination of information and networking across agencies were also highlighted. Other comments included:

- I like the size of the book, easy to handle; also nice to feel, clear print and headings.
- An excellent inventory of programs and projects; enough information to make a decision about contacting specific people about these programs and projects

3. Omissions or limitations of the report

A number of early intervention programs were identified as not included in the report. This was in part because many programs had not completed stocktake forms. However, where possible, information on these programs will be included in the second report.

It was suggested that some type of 'evaluative hurdle' was needed to allow programs to be included. However, given the difficulties involved in evaluating early intervention programs, AusEinet project staff believe it is preferable to allow programs to decide whether or not to include themselves in the stocktake. Another respondent commented that it was unfortunate that information on some programs was incomplete. Again, it should be noted that the project team was, (and is) reliant on the information provided to them by programs. It was also pointed out that like any stocktake, the information presented in the report requires continual updating.

4. Suggested possible inclusions in subsequent report

A range of suggestions were received for possible inclusions of information in subsequent stocktake reports. These included:

- A clear identification of regions, services which need targeting for programs
- Other services for survivors of torture and trauma services in NSW, VIC, QLD, SA and TAS
- Some necessity for agencies to show evidence for success and have these separated from other programs reported
- The impact the report would have on funding resources – to gain more funds for more programs and rural sector of Australia misses out
- Fees charged; planned program modifications; an inclusion in the chapter introductions outlining current service gaps
- Active search for programs aimed at integrating at risk groups into the workplace
- Perhaps define "risk" a bit more.
- Reply-paid envelopes for feedback
- Perhaps a national rating scale
- A section on rural early intervention projects and the problems they face
- Book is too heavy - not easily transported
- More information on indigenous programs. A separate strategy and report required to do this justice. Some excellent preventive initiatives are under way but are not in this report. Phone interviews with OATSIHS and NACCSCO in first instance would be a good start (sending questionnaires may not be appropriate)

5. Possible beneficiaries of the report

A range of potential beneficiaries of the report were identified. These included:

- Any people involved in the mental health area for the 0-25 year olds (and others who need a referral/contact reference). All major community mental health agencies should have a copy. (mental/health and illness, community information centres, education regional offices, probably a number of psychiatrists and psychologists would also be grateful).
- All medical therapeutic educational and welfare personnel who have contact with young people on a regular basis
- Children and young people, all who work in the field
- Parents/ teachers/ psychologists/ social workers/ nurses, general practitioners
- Practitioners in mental health, consumer groups, educators in mental health
- Program managers and policy bodies, school/youth/theatre groups or church groups working to help better lifestyle choices, harm minimisation, etc. and to encourage better awareness of services in region, funding bodies to map out gaps in services.
- Community child health units, community health centres, child and adolescent mental health units, schools, community centres
- Service providers, consumer groups, information services
- Program evaluators, child and adolescent workers
- All those concerned with youth suicide and others
- Everybody who works, lives with, or is a young person. "I'd like to see a state by state 'friendly' booklet of programs given to young people so they are not left in the dark."
- Anybody who works with young people and young people themselves
- People trying to initiate new programs
- Obviously anyone working in early intervention programs (professionals) and those persons hoping to get local programs up and running (community workers, volunteers) and those clients who benefit from the assistance of such programs and workers.
- Service providers, families
- Hopefully those people at risk of becoming marginalised and consequently hindered in their development. Smaller services who don't have the resources to design programs.
- Referring agencies, health professionals, school staff, young people/families (possibly), researchers
- Agencies investigating early intervention strategies
- All CAMHS; consumer peak bodies; state mental health administrations

Other comments

A number of other comments were made by respondents which covered a range of areas including layout of the report, the need for regular updating of information and congratulatory information. More specific comments related to the perceived need (by one respondent) to take into account religious, moral and ethical teachings. The AusEinet project staff has carefully noted all comments and will make changes as appropriate in the Second Report.

Second Report of the National Stocktake

Over 2000 questionnaires have been distributed to obtain information for the Second Stocktake Report. It is currently anticipated that the report will be printed and disseminated in April 1999. Feedback from the First Report has been noted and as a consequence, some minor changes will be made to the layout of the Second Report and a glossary will be included. The indexing will also be improved.

For further information contact Ms Cathy Davis, AusEinet on telephone 08 8357 5788, facsimile 08 8357 5484 of email: cathy.davis@flinders.edu.au

Into the Depths and Back

This is the title of the opening, during Mental Health Week in Canada, May 3-7th 99, of the Artist's Loft in Sudbury, Ontario, Canada, to which I have been invited to bring my art work. One of my pieces was called 'Into the Depths', a place most of we bipolar sufferers have been. I was not diagnosed as bipolar 2 till May 1998, at the age of 61. Unaware of the presence of this syndrome affecting me, I had managed to accumulate B.Agr.Sc., M.Sc., Ph.D at Harvard, entry to Harvard's Society of Fellows as the first Australian ever so honoured, a D.Sc. from Monash, 70 research papers, 3 books, and had worn out two good women over 34 years in the process. I had also driven many, but by no means all, of my colleagues, to distraction, and some of them had in turn made sure I would never make Professor by blocking a promotion that should have been automatic.

I was a troublemaker. I said it as I saw it. Worse, I was often correct, but blunt forthrightness is not all that well liked in Academia Australiensis, though it was the stuff of life in Harvard, my second alma mater.

Six serious depressive episodes punctuated that career, all triggered by serious, but common, life path emotional challenges (divorces, infidelities, abortions - the usual stuff). Hypomanics who don't know they are hypomanics stress themselves with overwork, and the manic depression does the rest when the next serious challenge arises to ones emotional stability.

My first escape from depression was "aided" by nortryptyline; I got better rapidly because it made me feel so lousy I wanted to escape from it! Later depression episodes lasted longer, and the fourth one I seriously contemplated suicide; it lasted 12 months. The last one was prompted by my sister muttering "manic depression". I managed to get a referral to a psychiatrist in the middle of it and he diagnosed bipolar 2 (manic/depression type 2) in 30 minutes. Helped out of depression by Zoloft (great for your sex life!), I have been off all medications for more than 2 months.

I use self-discipline to control the hypomania (no more than five active projects at once, absolutely rigorously enforced), days off whenever I feel tired, sleep whenever I need it for as long as I need it (embarrassing but necessary in boring meetings, or at dinner parties, the opera etc., since I also snore!) and so far so good. My work at a Psychoaesthetics Group meeting each week also helps dramatically, as does my marvellous, superbly permanently hypomanic, totally dedicated psychiatrist, who might not want me to name him just at this moment!

For further information contact Dr Teri O'Brien, D.Sc., F.A.I.Biol. Former Reader in Botany, Monash University Honorary Research Fellow, La Trobe University Visiting Research Fellow, University of Hong Kong

Consumer Involvement

A particular challenge of the AusEinet project and of course, of all services providing direct or indirect treatment and intervention to children and young people is that of facilitating meaningful consumer participation. Indeed, the National Mental Health Policy and Plan specified consumer rights as one of the 12 policy areas for reform under the strategy, as well as defining specific objectives and strategies for implementation. Significantly, the recently released report of National Stakeholders Consultations contained in the Evaluation of the National Mental Health Strategy (Manderscheid and Pirkis 1997) stated that consumer empowerment was considered to have improved substantially under the Strategy, particularly at a national (and to a slightly lesser extent, State/Territory) level. Consumer involvement on bodies such as NCAG were applauded as were opportunities for networking and information-sharing at venues such as the THEMHS Conference (ibid, page 5). It was notable, however, that the 'trickle down' effect to the local level was 'still patchy, with many consumers still feeling disempowered, for example, when it came to influencing their own treatment' (ibid, page 5). The Strategy was felt to have achieved less with regard to the rights of carers.

In attempting to explore how to encourage 'meaningful' consumer participation in the AusEinet project, the project have examined the following questions:

- why is consumer involvement needed?
- what is 'meaningful' consumer involvement?
- what strategies facilitate meaningful/effective consumer involvement?
- How can the needs of both consumers (young people) and carers be represented?

We are still grappling with these questions. Some of our thoughts appear here and we welcome your comments and suggestions.

Why consumer involvement? - the importance of finding a voice

> *Finding a voice means that you get your own feeling into your own words and that your words have the feel of you about them* (Seamus Heaney 1980:17).

One of the major changes occurring in human service agencies in general is a long overdue shift away from a disproportionate focus on service providers to clients/ consumers of services. Effective consumer feedback systems have long been seen as providing benefits to the business sector by means of customer satisfaction surveys (Hirschman 1970). More recently, however, it has been postulated that effective client/customer feedback systems can provide benefits to managers and clients of human service programs including mental health services. Unfortunately, however, national policy does not state how this is to be supported and encouraged at the local level. Client/consumer participation can be part of strategic planning; service planning; policy development; service delivery; quality management; and review and evaluation (Donabedian 1992). Additionally, writers such as Draper (1997) and Jones and May (1992) have asserted that consumer participation can enable better functioning of human service teams and create more open culture in agencies whereby consumers/ clients become allies in service delivery.

The move towards the development of client / consumer feedback systems in human service agencies has not been without criticism. Some writers have questioned whether the concept of 'consumer satisfaction' which comes from the business sector can be applied to the non profit social service sector, given the differing perspectives and backgrounds of people in these systems. Particular difficulties in relation to giving clients/consumers 'a voice' have also been raised. It has been suggested that the uneven power relationship existing between human service workers and clients will give rise to problems in staff collecting data (Wilhite and Sheldon 1997). Moreover, it has been suggested that clients who receive human services such as child protection services or mental health services are often unlikely to be seen as critical of service providers and experience difficulty in bringing into language a critique of existing services (Ringma and Brown 1991).

Despite these challenges, it is argued that clients of human service agencies such as mental health services need to be given a 'voice'. The rationale for this comes from a range of theoretical frameworks which have an ethical, rights-based or consequentialist basis:

- The ethical framework stresses the concept of client autonomy and self determination. Consumer research continually elicits from consumers the comment that they want to be 'treated with respect, like a person' (Entwhistle 1997:426).
- The rights-based approach incorporates the notion that clients/consumers have rights, for example, to information, choice, safety, fair treatment and redress
- The consequentialist approach judges the rightness of the approach from the point of view of the consequences. This approach underpins the attempts to provide evidence, based on research, that outcomes are improved by developing partnerships with clients/consumers or services

What is consumer involvement?

The concept of consumer involvement or consumer participation embraces a number of areas including participation at the individual level, policy, planning and decision making processes as well as service delivery levels.

Considerable work has been undertaken on the development of client feedback mechanisms and other mechanisms to give clients 'a voice' in the health and mental health systems. (See for instance Draper 1997 and National Mental Health Plan 1998). Despite this, however, actual operationalisation of this still has a long way to go. A recent discussion concerning consumer involvement on the EINET email discussion list noted that while national policies state that consumer participation in services is a 'must', policies lack information on how this is to be supported and encouraged at the local level.

Particular questions which have been aired on the EINET site are as follows:

- What is 'meaningful' consumer representation?
- What strategies can be employed to encourage consumer participation?
- Who determines who should represent whom?
- How do you ensure the representativeness of consumers?
- How do you support and encourage consumers at the local level?

What strategies facilitate meaningful/effective consumer involvement?

An interesting paper on consumer and carer involvement presented at the 1997 THEMHS conference by Sozemenou et al (1997) highlighted some of the facilitators of and barriers to participation."

Consumers	Carers	Staff/Management
Resources	Resources	Structure and process
Supportive group facilitator	Supportive environment	Knowledge and skills of consumers
Wider supportive environment	Knowledge and skills	Support and resources
Knowledge and skills of consumers	Structure and forms	Attitudes, commitment and responsivity of staff
Attitudes and characteristics of consumers	Attitudes of carers	Responsibility on the part of consumers
Issues specific to NESB	Issues specific to NESB	Issues specific to culture and ethnicity

Table 1: Facilitators of and barriers to participation (Source: Sozomenou et al., 1997). *Weaving diverse partnerships: bringing together the threads of consumer and carer involvement*

A lack of space in this issue precludes further discussion of strategies identified from the literature. However further discussion of consumer involvement will appear in June's issue of AusEinetter. Your suggestions and contributions would be welcomed!

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For further information contact Ms Cathy Davis, Senior Project Officer, AusEinet, ph. 08 8357 5788, fax 08 8357 5484, email: cathy.davis@flinders.edu.au

MENTAL HEALTH CONSUMER PARTICIPATION IN A CULTURALLY DIVERSE SOCIETY

The Transcultural Mental Health Centre of NSW has completed a national research project examining innovative strategies that have successfully involved consumers and carers in partnership in mental health service development and evaluation. The project was funded by the Australian Transcultural Mental Health Network under the Mental Health Strategy.

Mental health and health services often find it difficult to involve consumers, carers and communities from marginalised groups in society in partnership in the development, management and evaluation of services. A major objective of the research was to identify factors that are critical to success in engaging disadvantaged and marginalised groups such as individuals from linguistically and culturally diverse backgrounds, women, the elderly and young people.

Original data collection involved three components:

(i) a national survey examining consumer and carer participation strategies

(ii) in-depth case studies of innovative initiatives within 8 organisations/services

(iii) a broad consultation with consumers, carers and community members

On the basis of the findings of the national survey, eight (8) initiatives judged to be best practice examples of consumer and carer participation were selected to be studied in-depth. The eight sites were selected from four different states around Australia and included a variety of community participation initiatives spanning: national; state; area/regional; local mental health services; non-government organisations; acute in-patient units and employment services.

The findings from the eight organisations which included over 80 interviews with consumers, carers and health professional focuses on the results relating to four key areas:

- definitions of 'partnership' held by staff, management, consumers and carers
- the barriers and facilitators to achieving genuine consumer and carer partnerships with people from linguistically and culturally diverse backgrounds; and
- issues related to consumer and carer representativeness

Suggestions are also made regarding the development of partnerships that embrace the social, linguistic and cultural diversity of consumers and carers, and the need for participation strategies to be Flexible, Diverse and Supportive.

The monograph Mental Health **Consumer Participation in a Culturally Diverse Society** *will be available by the end of March. For more information please contact Andrew Sozomenou at the Transcultural Mental Health Centre, Cumberland Hospital, Locked Bag 7118, PARRAMATTA BC NSW, phone (02) 9840 3800 or fax (02) 9840 3755.*

SPA (Suicide Prevention Australia) 6th National Conference

Melbourne: 25th –27th March, 1999

SPA will be hosting a conference on suicide prevention titled "Suicide Over the Lifespan: What Works Across the Country?" at the Melbourne Convention Centre from the 25th-27th March, 1999. Key note speakers include Professor Ian Webster, Chair, National Advisory Council, National Youth Suicide Prevention Straetgy; Dr Annette Beautrais; Professor Robert Goldney; Dr Chris Cantor; Ms Kerryn Neulinger; Dr Michael Dudley, Richard Eckersely and Wayne Sanderson.

A range of papers are being presented across themes including: professional collaboration; risk factors; indigenous suicide; rural research; general practice; clinical intervention research; resilience; schools, empowering young people; community development; therapeutic story telling; self and society, and same sex attraction.

The next issue of AusEinetter will contain a summary of highlights from the conference.

AusEinet

The Australian Early Intervention Network for Mental Health in Young People

CONFERENCE

"Risk, Resilience & Results"

to be held at

Adelaide Convention Centre
6th - 8th June 1999

Expressions of Interest
Contact: SAPMEA
68 Greenhill Road
PARKSIDE SA 5063
Phone 08 8274 6060
Fax 08 8274 6000

Invited Speakers include:

Professor Mark Fraser (USA)
Assoc Prof David Fergusson (NZ)
Professor Beverley Raphael
Professor Patrick McGorry
Dr Alan Rosen
Dr Ian Shochet
Ms Sharon Cruse
Mr Tim Keogh
Consumer (tba)
Dr Anne Sved-Williams

Email conv@sapmea.asn.au
For further information visit the Conference website:
http://www.sapmea.asn.au/auseinet.htm

The program committee encourages abstract submissions on early intervention in all its forms as applied to a range of mental health problems, issues and disorders. Papers may be theoretical in nature, or address practice/clinical management, training, research or policy issues.

Early Intervention Conference

The AusEinet hosted international conference on early intervention titled "Risk, Resilience and Results" promises to be an exciting and innovative event. A range of key note speakers will be presenting including:

- Professor Mark Fraser of the School of Social Work, University of North Carolina
- Associate Professor David Fergusson from the Christchurch Health and Development Study, Christchurch University New Zealand
- Professor Beverley Raphael, Director of the Centre for Mental Health, NSW Health
- Professor Patrick McGorry, Centre for Young People's Mental Health, Parkville
- Mr Tim Keogh, Director of Psychology & Special Programs, Dept of Juvenile Justice
- Dr Anne Sved Williams, Helen Mayo House Integrated Service
- Dr Alan Rosen, Director of Psychiatry, Royal North Shore Hospital
- Ms Sharon Cruse, Lecturer, Community Mental Health, Yunggorendi, Flinders University of SA
- Dr Ian Shochet, Griffith Early Intervention Program, Griffith University
- Associate Professor Graham Martin and Professor Robert Koskey, Joint Project Directors, AusEinet

Professor Fraser's areas of specialisation include the aetiology, prevention and treatment of aggressive behaviour in childhood and adolescence and services for children and families.. His publications include "Risk and resilience in childhood; an ecological perspective" (1997); "Evaluating family-based services" (1995) (with Percora, Nelson, McCroskey and Meezan); Families in crisis: the impact of intensive family preservation services" (1991) (with Pecora, and Haapala); and "Making choices: social problem-solving for children" (in press) (with Nash, Galinsky and Darwin).

Presentations include:

- "Early intervention: risk. Resilience and results" (Professor Beverley Raphael)
- "Realistic prevention: youth mental health model" (Professor Patrick McGorry)
- "Early intervention in young offenders: a second chance" (Mr Tim Keogh)
- "Early intervention mindset: system rebuilding for early intervention" (Dr Alan Rosen)
- "The resourceful adolescent program (RAP): a comprehensive approach to the prevention of adolescent depression" (Dr Ian Shochet)
- "Darwin to Adelaide: Out Back or In Front?" (Dr Anne Sved-Williams)
- "Antecedents in contemporary Indigenous Mental Health: What now?"

Abstracts for the conference are still being accepted. Please contact SAPMEA, 68 Greenhill road, Wayville 5034, South Australia.

Telephone:	+61 8 8274 6060
Facsimile:	+61 8 8274 6000
Email:	conv@sapmea.asn.au
Web:	www.sapmea.asn.au

A limited number of funded registration places are available for consumers. Please contact Cathy Davis, Senior Project Officer, AusEinet, Phone 08 8357 5788 for further information.

EINET

Have you subscribed to the AusEinet early intervention email mailing list? To subscribe, please email majordomo@auseinet.flinders.edu.au In the text, write "subscribe einet" in the mail message body.

AusEinet Database

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Please let us know if we have incorrect address details.

Name: ....

Organisation: ....

Address: ....

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Telephone:........................Facsimile:.............................

Email: ....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN JUNE. DEADLINE FOR MATERIAL WILL BE **FRIDAY 11TH JUNE 1999.** PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.
AUSEINET WEBSITE ADDRESS http://auseinet.flinders.edu.au

This issue will incorporate a summary of the AusEinet Early Intervention Conference "Risk, Resilience & Results".

AusEinet

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Guest Editorial

EARLY INTERVENTION: FROM RHETORIC TO...?

The last three months has seen a lot of activity by the AusEinet project staff. One of the main activities, was the staging of the international conference on early intervention, *Risk, Resilience and Results* at the Adelaide Convention Centre from 6th-8th June. From the range of presentations from both national and international speakers, it is clear that early intervention is very much on the agenda. What is less clear, however, is a consensus view on what 'early intervention' actually is when we think in terms of the mental health of children and young people. More work is also needed in terms of identifying specific early intervention strategies that are effective in intervening in the developmental trajectory of specific mental health problems, in matching these strategies to the characteristics of an individual and in judging the appropriate time to implement these strategies. Essentially then, if we are to move from the rhetoric of early intervention, much more research and synthesis of the existing literature is required to address the questions:

What works, with **whom** and **when?**

AusEinet has been provided with additional funding to complete a number of its deliverables over the next 6 months. During this time, the project staff will be attempting to move much more from the rhetoric of early intervention to its reality – that is, there will be an increased focus on addressing how early intervention can be practised in relation to the mental health of children and young people. This will be evidenced in the completion of the Stream II and II activities and in the publication and dissemination of the *Second Report of the National Stocktake of Early Intervention Programs*, the literature review and a publication designed to assist with training in early intervention.

Cathy Davis, Senior Project Officer, AusEinet

AUSEINET UPDATE : STREAMS II and III

Stream II: Reorientation

The reorientation placements were completed at the end of May. All the agencies met their original objectives (several achieved more than planned) and all have put sustainable strategies in place. Over the next month or so I'll be working on the Orientation AusEikit. This will be a summary of the objectives and outcomes of each placement, an overview/analysis of the outcomes from a capacity building perspective and a description of the strategies used to manage the placements. We expect the AusEikit to be ready for distribution in September or October.

The AusEinet team wishes to thank the Stream II mental health workers and their agency supervisors. They did a terrific job and we've enjoyed working with them.

Stream III: Projects

AusEinet has funded six projects which will make a contribution towards the development of good practice in early intervention. Several of the projects are completed and the others are very close to completion. We'll place summaries of the projects on the AusEinet website by the end of September. The researchers will be encouraged to publish the full account of their work in scientific journals.

Stream III: Guidelines

AusEinet has commissioned guidelines for early intervention in ADHD, anxiety, chronic conditions, conduct disorder, delinquency and depression. Work is still in progress, though several are very close to completion. We expect to make the guidelines available in October. Keep an eye on our website for more information closer to that time.

For further information on Stream II and III activities, contact me via e-mail aohanlon@health.adelaide.edu.au or phone (08) 8204 6802. Anne O'Hanlon, Senior Project Officer

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

FAMILIES AND MENTAL HEALTH NETWORK

An intersectoral group promoting the wellbeing of families with dependent children where parents have a mental illness.

This multidisciplinary group started six years ago in Melbourne, as the "Children's Interest Group," and was involved in organising two conferences on this them in 1995 and 1996. Throughout, the purpose of the group has been to lobby for improved service structure and service delivery for parents with mental illness and their children through exchanging information about program, policy and service developments, providing peer support and professional development, bringing into focus, raising consciousness and advocating for the rights of families where one or both parents have a mental illness, fostering intersectoral linkages, encouraging and facilitating involvement of an consultation with family members and consumers. The monthly meetings provide a valuable forum through which information can be exchanged and networks established and maintained. People unable to attend meetings may receive twice yearly updates.

For further information please contact the current Convenor, Vicki Cowling, Maroondah Child and Adolescent Mental Health Service, 21 Ware Crescent, Ringwood East, Victoria 3135, Phone: 03 9870 9788, Fax: 03 9870 7973.

ACHIEVING THE BALANCE: A RESOURCE KIT FOR AUSTRALIAN MEDIA PROFESSIONALS FOR THE REPORTING AND PORTRAYAL OF SUICIDE AND MENTAL ILLNESSES

Achieving the balance - a resource kit for Australian media professionals for the reporting and portrayal of suicide and mental illnesses was launched on Tuesday 22nd June, 1999 by the Honourable Dr Michael Wooldridge, Minister for Health and Aged Care. The kit is the result of an extensive collaborative effort between the Federal Government , the industry and the community and is an initiative that brings together the efforts of key players to lessen the threat of imitation suicide and reduce the stigma currently faced by people with a mental illness.

In launching the program Dr Wooldridge said the media could play a central role in suicide prevention.

> *"This information will assist journalists who face sorting fact from myth and misinformation"* (Dr Wooldridge said).
>
> *"While the media has generally shown a sensitive and responsible approach to suicide, in an attempt to minimise copycat attempts, improvements can still be made".*

The resource kit has six elements(outlined below) and aims to depict and report suicide and mental health issues in context, with relevance and sensitivity to those who may be affected by it. The kit offers an insight into how dangerous irresponsible reporting and portrayal can be. It also suggests ways to ensure that newsworthy stories are reported in a sensitive manner.

Suicide

- a Media Resource for the reporting and portrayal of suicide
- a Life Promoting Media Strategy
- a Media quick reference card on mental illness

Mental Illnesses

- a Media Resource for the reporting and portrayal of mental illnesses
- a Mental Health Promoting Media Strategy
- a Media quick reference card on mental illnesses

The two Media Resources aim to promote awareness of the issues relating to mental illnesses and suicide and how they are addressed by the media, recognising the important influence the media have on the perceptions and behaviours of the wider community.

The Mental Health Promoting Strategy aims to support the media to report and portray mental illnesses sensitively and to encourage the media to educate the community on issues relating to mental health and mental illnesses.

The Life Promoting Strategy aims to encourage the media to portray suicide in a responsible way to minimise the possibility of imitation suicide, or to avoid the risk of normalising or glamorising suicide. The Strategy is an overarching framework that reinforces the partnership between the Federal, State and Territory Governments, the media industry; the youth, health and education sectors; and non-government organisations to help reduce suicide.

The Media quick reference cards aim to provide media professionals with easily information on mental illnesses and suicide. The quick reference cards are based on the acknowledgment that realistically, in an environment of urgent deadlines, media professionals would not always find the time to refer to both resources before running or broadcasting a story. The quick reference cards provide useful tips, checklists and contacts at the fingertips of media professionals.

The Development of the Resource Kit

The Resource on the reporting and portrayal of suicide was developed by Suicide Prevention Australia and the Australian Institute for Suicide Research and Prevention, and written by expert authors. Workshops were held with media industry leaders and consultations took place with many suicide prevention project workers and organisations, along with the media and mental health policy units of the National Advisory Council on Youth Suicide Prevention.

The Resource on the reporting and portrayal of mental illnesses was developed by the Mental Health Branch of the

Department of Health and Aged Care. The initial version of this resource underwent the same consultation process as the resource on suicide. The resource was subsequently revised and circulated to mental health experts for comment. It has been considered by the Australian Health Ministers' Advisory Council's National Mental health Working Group and endorsed by the Commonwealth Mental Health Promotion and Prevention Working Party.

Availability of Resource Kit

Copies of the Resource Kit for Australian Media Professionals and portrayal of suicide and mental illnesses can be obtained by contacting the Mental Health Branch, Department of Health and Aged Care. The documents are also available on the Mental Health Branch Website http://www.health.gov.au/hsdd/mentalhe

EVALUATION OF *OUT OF THE BLUES* PROJECT

The *Out of the Blues* project, funded under the Youth Suicide Prevention Initiative, was developed as a treatment centre for young people aged 15-24 years suffering from a mood disorder. This service was designed as a Suicide Prevention Strategy given that depression is the most common feature of those who complete suicide. It closed in December 1998 and the Evaluation and Final Reports are currently being written.

The unit was located at Southern Child and Adolescent Mental Health (CAMHS), at the Flinders Medical Centre site and comprised a small team of clinicians, (approximately 1.7 FTE generic mental health and 1.0 FTE psychiatry) research officer (0.5 FTE) and administrative officer (0.5 FTE).

The aims and objectives of *Out of the Blues* were as follows:

AIMS

- To add to the existing service Southern Child and Adolescent Mental Health Services (Flinders Medical Centre), a high quality clinical, teaching, research and publishing unit focused on affective disorders, which will:
    - develop, promote and disseminate good practice locally and nationally;
    - actively explore issues of mental health promotion, early detection and intervention, treatment and management, as well as relapse prevention;
    - promote a national focus on these issues through professional publication, national bulletins, media discussion and all electronic means;
    - promote education in good practice for affective disorders in young people through national conferences, seminars and workshops focused on affective disorders;

OBJECTIVES

- Promote access to and participation in the service by young people.
- Optimal care and treatment for young people
- Strategic alliances within the community
- Integration and influence
- Evaluation

In less than 2 years the unit took in excess of 180 referrals of which 104 clients were assessed. Of these 104 clients, 98 were offered ongoing treatment for a depressive disorder as a primary or secondary diagnosis.

As the project evolved, through hindsight and continuous evaluation the project team found evidence indicating that they could meet their objectives, and fine tune the way in which they approached and delivered mental health services to young people. These ideals or 'good practice' methods of service delivery developed into 4 main themes:

1. Access and Alliance
2. Customer Service
3. Suicide Prevention Training
4. Qualitative Evaluation

1. Access and Alliance

Optimum access to mental health requires the agency to attempt to provide a service that is as easy as possible for the client to use. When the symptoms of depression and the developmental features of adolescence are considered, it stands to reason that this service will need to be adaptable, flexible and respectful to young people . The way referrals are taken and processed will affect the types of clients and problems that are presented. As a consequence, provision of home visits, 'community' outreach and transport will impact on attendance. Further, the atmosphere of the centre, both the physical environment and the approach of staff (be they clinical staff or cleaners) will impact on the client's level of comfort and consequent compliance.

The concept of "Therapeutic Alliance" is well documented and recognized as being strongly associated with outcome or usefulness of therapy. Agencies need to actively promote this by supporting alliance development in policies and regular practices within their services . Indeed, the 'care' of our clients must be reflected in our practice. *Out of the Blues* has achieved this by addressing non-attendance and non-compliance with methods that demonstrate care.

Reference:

Wright, S. & Martin, G. (1998) "Young People and Mental Health - Access and Alliance". *Youth Studies Australia*, December 1998.

2. Customer Service

Service delivery must be actively worked on if the treatment is to arrive at a mutual conclusion. Young people can be more difficult to treat due to the developmental, cultural and social stages they are negotiating. Interagency collaboration and community linkage is vital to promote holistic treatment that addresses the often multiple needs of the young person. Promoting resilience in young people and their families requires a co-operative and collaborative approach that values all sectors of the community and the resources they can offer. Hence, the way program staff deliver service from the initial crisis to the closure of therapy needs to be examined and practices that promote agreement, transparency and respect need to be employed.

Reference:

Wright, S. & Martin, G. "Young People and Mental Health - Customer Service". (Awaiting Publication)

3. Suicide Prevention Training

This training format provided as part of the *Out of the Blues* project introduced participants to the signs of suicide and depression in young people. As such, it provided education in risk assessment, initial management and appropriate referral to the mental health sector. Primarily, training was aimed at the non-health sector but was also used to train health professionals and students.

Reference:

Wright, S. & Martin, G. "Young People and Mental Health - Suicide Prevention Training". (Awaiting Publication)

4. Qualitative Evaluation

The Telephone Evaluation Project was developed from a Narrative Therapy Project that invited clients to discuss what was helpful and unhelpful in therapy . *Out of the Blues* employed two young people to follow this process using the telephone. Clients reported that they preferred this process of evaluation. As the interviewer's skills improved and as the process was refined the quality of information consequently became more informative.

Reference:

Wright, S., Pattison, C., Williams, K. & Martin, G. "The Telephone Evaluation Project". (Awaiting Publication)

SUMMARY OF EVALUATION

Out of the Blues received 186 referrals over 15 months of clinical activity. This represents an underestimate of the need given that referrals to the unit had to be closed on at least 2 occasions because clinicians were unable to take on new assessments. The majority of referrals were from parents (59), with the Adult Crisis Service referring on 25 occasions, Southern CAMHS on 20, the Youth Sector on 18 and General Practitioners on 18. 12 young people referred themselves and following a careful triage process only 104 young people met criteria or agreed to be seen.

More than 50% were young men – an unusual finding for Youth Mental Health Services. The mean age was 18.2 years (range 14.8 – 24 years). This suggests that program staff reached the target of servicing young people at the crossover between child and adult services. The majority (42%) were students, though nearly 30% were employed in some capacity, 22% were unemployed.

All diagnosis were made on DSM IV criteria and indicated that nearly 75% had a primary diagnosis of an affective disorder. If they did not have a first degree diagnosis of depression then they were likely to have a secondary diagnosis of a depressive disorder. On all parameters (self report and clinician rated) this was a severely depressed group. Co-morbidity was a serious problem in 70%.

Although only 57 of the program's sample of young people have complete data at Time 2 and only 37 are complete at Time 3, it is clear that for those who have data, substantial change occurred throughout assessment and therapy. Both the quantitative and qualitative data reflect this.

While only 39 (45.3%) of the program's young people reported having attempted suicide prior to Time 1 assessment, 15 of these were in the previous month. Overall the group rated very highly on our measure of suicidality confirming the link between serious affective disorder and suicidal behaviours. By Time 2 and 3 assessments, only a few young people had re-attempted, there were no fatalities in the 15 months, and the suicidality scores had reduced considerably.

At the end of the unit's life, eight of the young people remained severely depressed. As a group they reported marked ongoing family dysfunction, past histories of major abuse, and of note they had high ongoing levels of anxiety. They consumed disproportionate amounts of the service resources despite their relative lack of complete recovery. However they were manageable in an outpatient setting and did not need impatient care. These matters are detailed in the Evaluation Report.

The Telephone Evaluation shows that young people appreciated the dedicated focus on young people, the response to their expressed needs, the ambience of the unit, the easy access and the therapeutic style of the clinician.

KEY RECOMMENDATIONS

The Evaluation Report has identified a number of recommendations related to access issues, clinical practice and research.

These include recommendations that:

- Clinical services should reflect the culture, expressed needs and developmental context of young people and maintain an atmosphere that promotes ease of use by the clients. Feedback mechanisms need to be put in place to ensure clients feel well treated and respected when attending for treatment.
- Clinical Services should be accessible; barriers to service need to be actively minimised.
- Clinical Services should be inclusive (holistic) with regard to issues of co-morbidity, rather than exclusive; young people 'referred on' (hand-balled) are less likely to attend and become engaged in a therapeutic alliance.
- Clinical Services need to be high profile and/or well known and promoted to the young client group; services buried in generic services are less likely to be accessed, as are those identified explicitly with 'mental health'.
- Clinical Services should have strong and meaningful interagency and intersectoral linkages to ensure the widest possible collaboration; while direct management of the depression may be the key to better personal functioning, a range of education, employment, accommodation and other issues must be dealt with at this key developmental age.

LETS TALK MENTAL HEALTH PAMPHLETS

NESB Resource Development Project

As part of the Transcultural Mental Health Centre's goal of developing a collection of appropriate Mental Health resources which will effectively address the information needs of NESB communities in NSW about Mental Health, the Centre has recently completed Stage 3 of the Project, the development of a series of pamphlets which aim to demystify mental illness and tackle issues of stigma, highlight the need for early intervention, as well as family and community support. 280,000 pamphlets in 15 community languages on four Mental Health topics per language are now available for distribution. The pamphlets are titled:

1. About Mental Health
2. Stigma and Anxiety
3. Depression
4. Psychotic Disorders: Schizophrenia and Delusions

Community languages are: Arabic; Bosnian; Cantonese; Croatian; Filipino; Greek: Italian; Khmer; Korean; Maltese; Serbian; Spanish; Turkish; Vietnamese.

This pamphlet series has been developed from the transcripts of the professional recordings of the multicultural radio campaign developed by the Transcultural Mental Health Centre, in conjunction with SBS Radio during Mental Health Week.

Copies of the pamphlets are available free of charge by contacting the Resources Officer, Transcultural Mental Health Centre, Locked Bag 7118, PARRAMATTA BC NSW 2150

The implementation of the Transcultural Mental Health Centre's goal of developing a collection of appropriate mental health resources commenced in October 1997 and includes six individual stages: the mass media method of broadcasting through radio segments; the production of audio tapes; the development of written materials/ pamphlets; the loading of the pamphlets onto the internet tmhc@magna.com.au the production of compact disks for each language; and finally, a free call 1800 telephone caller information service in 15 community languages.

AVAILABLE NOW

- The NSW Health Department has released its *"Caring for Mental Health in a Multicultural Society: A Strategy for the Mental Health needs of People from Culturally and Linguistically Diverse Backgrounds".* This document addresses the Health Department's strategic plan in the area of multicultural health. To obtain a copy please contact: the Better Health Centre on 02 9816 0452
- *"Nobody Wants To Talk About It: Refugee Women's Mental Health".* This document is available at a cost of $20 from the Transcultural Mental Health Centre, Cumberland Hospital, Locked Bag 7118, PARRAMATTA BC NSW
- *"Hear Our Voices: Trauma, Birthing and Mental Health among Cambodian Women".* This document is available at a cost of $25 from the Transcultural Mental Health Centre, Cumberland Hospital, Locked bag 7118, PARRAMATTA BC NSW

Transcultural Mental Health Centre: 1998 Awards for Excellence

Readers of AusEinetter may be interested to learn of some of the 1998 Awards for Excellence awarded by the Transcultural Mental Health Centre

Early Intervention

Joe Chuong

Joe Chuong provides a specialist case management and community development services for the Vietnamese community. He is currently working on a project to promote the early identification and intervention for depression among the Vietnamese community in the South Western Sydney Area.

Early Intervention Program

The NSW Spanish and Latin American Association for Social Assistance

Hijos del Sol (Children of the Sun) Hispanic Youth Program This is an Association formed for Spanish speaking youth. It is run by young people and provides a range of services to assist young refugees to adjust to Australian life. The project provides a week long camp which addresses various issues. The Hispanic Youth program is highly effective in addressing resettlement, emotional and psychological issues. The project has attracted attention and increased in popularity and the workers have provided papers to organisations interested in adapting it for their own service.

AUSEINET CONFERENCE: "RISK, RESILIENCE AND RESULTS"

AusEinet's international conference on early intervention, "Risk, Resilience and Results" was held at the Adelaide Convention Centre from 6th-8th June, 1999. An average of 180 participants attended each of the three days and were generally positive in their comments about the conference, including the quality of the speakers and their presentations, the suitability of the venue and the conference organisation. (Approximately 80% of those participants completing the evaluation form rated these items as 'good' or 'excellent'). A number of participants commented on the challenges of both organising and staging a conference that would appeal to a wide range of participants – this was certainly a major challenge for the conference organisers! As with many conferences, time was also a major constraint with many of the speakers having insufficient time to present.

A majority of respondents reported that their participation at the conference gave them an improved understanding of the concepts of early intervention, risk and resilience respectively. Interestingly, a minority of respondents reported that that the material presented at the conference would change their approach to their work.

A number of leading national and international speakers in the field of early intervention presented at the conference. These included:

Professor Mark Fraser - *Risk & Resilience: A Development and Ecological Perspective on Aggressive Behaviour in Childhood.*

Associate Professor David Fergusson - *Risk, Resilience and Early Intervention.*

Professor Patrick McGorry - *The Scope for Early Intervention in Potentially Serious Mental Illness and Common disorders in Young People.*

Professor Beverley Raphael - *Early Intervention: Risk, Resilience and Results.*

Mr Darren Bowd - *Caring for All Regardful of Race, Colour and Creed - Valuing Diversity for Better Mental Health Services for All.*

Dr Anne Sved-Williams - *Darwin to Adelaide: Out Back or in Front?*

Mr Tim Keogh - *Early Intervention with Serious Repeat Juvenile Offenders: A Second Chance.*

Dr Ian Shochet - *The Resourceful Adolescent Program (RAP): Towards a Comprehensive Approach to the Prevention of Adolescent Depression.*

Dr Allan Rosen - *Early Intervention Mindset: System Rebuilding for Early Intervention.*

Associate Professor Graham Martin - *A Stitch in Time .....*

Ms Wendy Goodwin & Ms Tracy Hill - *Consumer and Carer Presentation.*

Unfortunately, it has been difficult to obtain copies of many of the speakers' presentations. Those that are available (including Professor Mark Fraser and Associate Professor David Fergusson) will appear on the AusEinet website in the near future. We would welcome copies of any other conference presentations.

OTHER CONFERENCES OF INTEREST

1. "Home and Away". NSW Child and Family Health Conference. Monday 16th August 1999. The Masonic Centre, 279 Castlereagh Street, SYDNEY

Highlights:

Professor David Olds, one of the world's foremost researchers in Child and Family Health will present two papers:

"Prenatal and infancy home visiting by nurses". Participants in the pioneering Elmira home visitation trial have now been followed up for 15 years and the long term follow up confirms the cost-effectiveness of this form of intervention in promoting maternal and infant health.

"Program replications: linking research with practice". The Elmira study is now being replicated in many non-research settings. Data is now available from nearly 100 sites in the US involving hundreds of nurses and thousands of families, enabling important questions about the effectiveness of roll-our from a pilot study to a large scale inetervention to be addressed

Dr Ken Nunn, Chair of Division of Psychological Medicine, New Children's Hospital. *"Finding a focus treatment in the multi problem family"*

Professor Jake Najman, Professor of Sociology, University of Queensland. *"Poverty and its consequences for child health and development*". There is an emerging interest in the extent to which adult health inequalities have their origin in the extent to which adult health inequalities have their origin at or around birth and early childhood. Social inequalities influencing the mental and physical health of the child are assessed, and their relevance for community and population health initiatives are considered.

Cost $85

For further information, please contact: Lindy Danvers Phone: 029414 0281; Fax: 029411 6493

2. "The MHS 9th Annual Mental Health Services Conference: Whose Realities?" 22nd-24th September, 1999 Melbourne Convention Centre

The conference aims:

- to provide a forum for the presentation and exchange of ideas about best ways on ensuring high quality mental health services for people seriously affected by mental illness and disability
- promote positive attitude about mental health and mental illness
- provide a forum for professional development of people associated with mental health services, i.e., an opportunity to present current innovations, strategies, research, policies and future directions
- provide a forum for professionals, consumers, carers and managers to meet and debate mental health services
- stimulate debate which will challenge the boundaries of present knowledge and ideas about services for people with mental health disabilities

For further information, please contact Conference Secretariat THEMHS PO Box 192, BALMAIN NSW 2141. Phone: 02 9926 6057; Fax: 02 9926 7078; email: enquiries@themhs.org website www.themhs.org

International Conference: Culture, Race and Community

Theme: *Making it work in the new millennium.*

Venue: Crest Hotel, Melbourne
19-21 August 1999

Conference Program Highlights

Thursday 19 August 1999

DAY ONE - BELIEFS & THEORY

- About cultural and racial difference
- About ethnic and cultural identity
- About racism and inter-group relations

8.00 am	Registration
9.00 am	Welcome & Official Opening Ceremony
9.40 am	**OPENING ADDRESS** The Hon Phillip Ruddock Federal Minister for Immigration and Multicultural Affairs, Canberra
10.00 am	**KEYNOTE ADDRESS** Multicultural Societies: Concepts and Issues Professor John Berry, Queensland University, Canada
10.30 am	Morning Tea
11.00 am	**KEYNOTE ADDRESS** Race and Difference: Myths and Facts Professor Emeritus Marshall Segal, Syracuse University, New York, USA
12.00 pm	Exhibition and Cultural Performance
12.30 pm	Luncheon
1.30 pm	Concurrent Sessions - Papers & Workshop Discussion
3.30 pm	Afternoon Tea
4.00 pm	Plenary Panel Discussion Chair: Associate Professor Harry Minas, Vic.
5.00 pm	Welcome Reception

Friday 20 August 1999

DAY TWO - EFFECTS & REALITIES

- Living with cultural diversity in all walks of life
- Developing services and programs in accommodating difference
- Increasing equity and access

9.00 am	**KEYNOTE ADDRESS** Professor Henry Reynolds
10.00 am	Response Professor John Berry and Professor Emeritus Marshall Segal
10.30 am	Morning Tea
11.00 am	Concurrent Sessions - Papers & Workshop
12.30 pm	Luncheon and Poster Display
2.00 pm	Concurrent Sessions - Papers & Workshop
3.30 pm	Afternoon Tea
4.00 pm	Plenary Session Panel Discussion Chair: Mr Haas Dellal, Executive Director, Australian Multicultural Foundation
5.00 pm	Close

Saturday 21 August 1999

DAY THREE - PRACTICALITIES & POSSIBILITIES

- Encountering the issues in managing difference
- Promoting good practice for the benefit of multicultural communities
- Forging links for successful cohesion

9.00 am	**KEYNOTE ADDRESS** Mr Nigel Milan, Managing Director, SBS Australia
9.30 am	**KEYNOTE ADDRESS** Mr John Cook, Managing Director, Berri Limited, Australia
10.00 am	Response Professor John Berry and Professor Emeritus Marshall Segal
10.30 am	Morning Tea
11.00 am	Concurrent Sessions - Papers & Workshop
12.30 pm	Luncheon & Cultural Performance
2.30 pm	Plenary Session Panel Discussion Chair: Mr John Cook
3.00 pm	Visionary Statement - Where to From Here?
3.30 pm	Closing Ceremony & Refreshments.

ENQUIRIES

For further details regarding the conference, please contact:

The Conference Organiser
PO Box 214, Brunswick East, Victoria, Australia, 3057
Telephone: (61) (03) 9380 1429
Fax: (61) (03) 9380 2722
Email: conorg@ozemail.com.au

CONSUMER FORUM ON EARLY INTERVENTION

AusEinet is currently considering the feasibility of conducting a consumer forum on early intervention. The project team is keen to identify key consumer groups and individuals who may be interested in having input into such a forum Any suggestions would be most gratefully appreciated. Please contact: Cathy Davis at AusEinet. Email: **C.Davis@signadou.acu.edu.au** fax: 08 8357 5484; phone: 041 120 8484.

SOUTH AUSTRALIAN SIBLING PROJECT

A new project has been established at the Adelaide Women and Children's Hospital to develop and co-ordinate resources and services for siblings of children with disabilities and chronic illness. Specific activities planned include:

- Networking with other people around Australia
- Conducting focus groups with parents of children with disabilities and chronic illness
- Planning and undertaking workshops with young siblings of children with disabilities and chronic illness
- Development of a discussion paper with recommendations

The development of this project highlights the increasing awareness of the importance of early intervention in this area. Chronically ill/disabled children have a profound impact on the family. Although there is no complete consensus about the effect of chronic childhood illness/disability on a family, the bulk of the evidence seems to suggest that ongoing physical illness or disability may disrupt the entire fabric of a family and have significant psychological and financial costs as well as costs to interpersonal relationships (Jessop and Stein 1989; Drotar and Bush 1985). Researchers including Steinhauer and colleagues (1974) have discussed sibling reactions to chronic physical illness. They have identified as important, jealousy and resentment toward the child who gains the attention and energies of the family unit. The parental preoccupation with the sick child and their own reactions to his/her illness may result in their experiencing a certain degree of emotional deprivation. Feelings and expression of jealousy, resentment and hostility that are not allowed to be adequately expressed often result in withdrawal, school problems, adolescent delinquency, and behavioural problems or other acting-out behaviour among the physically intact siblings (Silverman and Koretz 1989). Existing literature suggests that if mechanisms are developed to provide support for the siblings of children with disabilities and chronic illness, the mental health status of these children is enhanced and they are able to provide ongoing support to their disabled/chronically ill sibling.

At this stage, the project has funding through until October 1999 through Community Benefit SA but it is hoped to secure longer term funding.

References

Drotar, D. & Bush, M. (1985) Mental health issues and services. In N. Hobbs & J.M. Perrin (Eds.) *Issues in the care of children with chronic illness.* San Francisco: Jossey Bass, pages 517-527.

Jessop, D.J. & Stein, R.E. (1989) Meeting the needs of individuals and families. In R.E. Stein (Ed.) *Caring for children with chronic illness: issues and strategies.* New York: Springer Publishing Co, pages 63-74.

Silverman, M.M. & Koretz, D.S. (1989) Preventing mental health problems. In R.E. Stein (Ed.) *Caring for children with chronic illness: issues and strategies.* New York: Springer Publishing Co, pages 213-229.

Steinhauer, P.D., Mushin, D.N. & Rae-Grant, O. (1974) Psychological aspects of chronic illness. In *The Pediatric Clinics of North America. 21* Philadelphia: Saunders, pages 825-840.

For further information contact the Project Officer, Ms Kate Strohm, C/- Dept of Psychological Medicine, Women's & Children's Hospital, 72 King William road, North Adelaide, SA, 5006, Ph. 08 8204 7227, fax 08 8204 7032, or Email: sibproject@wch.sa.gov.au

AUSEINET DATABASE

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Please let us know if we have incorrect address details.

Name: ....

Organisation: ....

Address: ....

....P/C...............

Telephone:............................Facsimile:.............................

Email: ....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN SEPTEMBER. DEADLINE FOR MATERIAL WILL BE **FRIDAY 10TH SEPTEMBER 1999.** PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.

AUSEINET WEBSITE ADDRESS http://auseinet.flinders.edu.au