

Treatment and support



Evaluation of the National Youth Suicide Prevention Strategy

Penny Mitchell



Australian Institute of Family Studies

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About the author

Penny Mitchell (BSc, MPH) is a Research Fellow at the Australian Institute of Family Studies where she has worked on the National Communications Project and the Evaluation of the National Youth Suicide Prevention Strategy since March 1998. Penny has worked as a researcher in psychology, public health and mental health since 1987 with a focus on service development and evaluation research, transcultural mental health, and youth suicide prevention.

Evaluation format

The Australian Institute of Family Studies was commissioned by the Commonwealth Department of Health and Aged Care to evaluate the National Youth Suicide Prevention Strategy, which ran from 1995 to 1999, with the aim of identifying lessons from the Strategy to carry forward for the future.

The Institute's evaluation results are presented in five separate reports – an overview of the Strategy entitled *Valuing Young Lives*, and four technical reports which present detailed information about what was achieved and learned by projects within each of the particular approaches adopted by the Strategy. The five volumes in the series are as follows.

- **Valuing Young Lives.** This volume provides an overview of the Strategy, what the Strategy achieved and what was learned from the Strategy as a whole. The report includes administration, policy context, conceptual basis and a description of activities within each of the main approaches adopted by the Strategy. It presents the evaluation methodology and a summary of major achievements and good practice findings.
- **Building Capacity for Life Promotion: Technical Report, Volume 1.** This report describes the Strategy's system level activities which aimed to build capacity and assist the adoption of evidence-based practice in all service systems relevant to youth suicide prevention. Activities described in this volume include research and evaluation, communications, education and training, networking and intersectoral collaboration, and community development.
- **Primary Prevention and Early Intervention: Technical Report, Volume 2.** The goal of primary prevention is to prevent the development of problems (risk factors) that place people at risk of suicide. Primary prevention also includes mental health promotion, which aims to promote wellbeing, optimism, resilience and interconnectedness between people and communities. Primary prevention activities of the National Youth Suicide Prevention Strategy were concentrated in four areas: parenting education and support; school-based programs; media education; and access to means/injury prevention. The goal of early intervention activity is to reduce the prevalence of risk factors for suicide among young people who have begun to develop early signs of disturbance or who are exposed to environments known to be harmful. What has been learned about early intervention aspects of Strategy projects is collated and synthesised in this volume.

- **Crisis Intervention and Primary Care: Technical Report, Volume 3.** Crisis intervention activities are often short-term activities directed at young people who may be at immediate risk of suicidal behaviour. Crisis intervention aims to respond quickly to crises that could result in self-harm or suicide attempts. Crisis intervention activity of the National Youth Suicide Prevention Strategy focused in two areas: telephone counselling services; and hospital accident and emergency department protocols. This volume also describes projects set in general practice and other primary health care settings.
- **Treatment and Support: Technical Report, Volume 4.** In keeping with the guiding principle that attention should be paid to the needs of young people who are marginalised from mainstream society, a number of projects were based in organisations helping these young people. The term ‘marginalisation’ refers not only to the stigma and social rejection associated with the experiences or risk factors of conditions such as homelessness or drug misuse, but also to the fact that young people with multiple problems are generally poorly catered for by most services. This volume also describes projects aimed at young people with mental health problems.

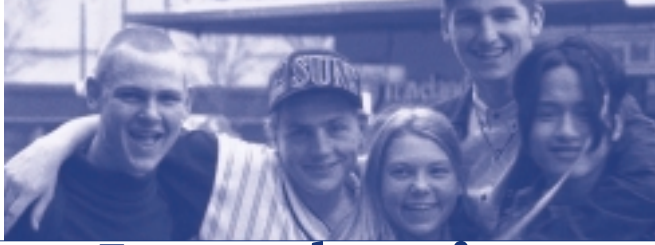
Note on the recommendations

As part of its evaluation of the National Youth Suicide Prevention Strategy, the Australian Institute of Family Studies was required to make recommendations to inform future efforts in suicide prevention. The Institute put forward a total of 36 recommendations, and these are published in the Recommendations chapter (pp. 10–21) of the overview volume *Valuing Young Lives*.

These recommendations appear again at the end of chapters throughout the four technical reports – as they pertain to findings and discussion in each chapter.

As they appear throughout the technical reports, recommendations are numbered according to their position at the end of each chapter. (The corresponding original number that is attached to each recommendation in *Valuing Young Lives* is also shown, in brackets.)

In addition to the recommendations, the technical reports include “further suggestions” which complement and elaborate upon the basic recommendations.



Introduction

Treatment and support are medium to long-term activities aimed at individual young people with ongoing problems which place them at sustained risk of suicide. This group includes young people with mental health problems as well as young people experiencing other sustained risk factors such as exposure to neglect and abuse, homelessness, substance misuse, contact with the juvenile justice system, or sexual identity issues, which can lead to their being marginalised from the wider community.

This volume, the fourth in the Technical Report series, presents the results of a meta-analysis (or meta-evaluation) of the evaluations of projects that addressed the support needs of young people who are identified as marginalised and disaffected, and projects based in mental health services.

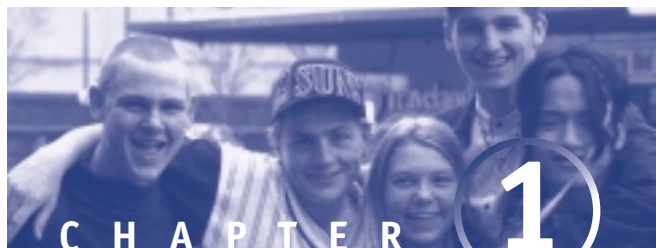
The National Youth Suicide Prevention Strategy funded seven projects based in agencies (including youth health services as well as a range of non-government agencies) that provide services to young people identified as marginalised and disaffected. A major focus of these projects was exploration of strategies for engaging marginalised young people with helping services.

The term “marginalisation” refers not only to the stigma and social rejection associated with the experiences or risk factors listed above, but also to the fact that young people with multiple problems are generally poorly catered for by most services. They are widely considered extremely challenging to work with. The specialist nature of most services means that their problems tend to be dealt with in isolation from each other. These young people tend to be shunted between services, with less than adequate follow-up, and they frequently fall through the gaps. As a result of their negative experiences in the service system many of these young people are highly suspicious of professional service providers.

Two of the projects in this group focused specifically on providing intensive support to young people who have attempted suicide.

Three demonstration projects were based in specialist child and adolescent mental health services. These aimed to improve access to, and engagement with mental health services as well as the quality of treatment and ongoing care provided to young people with mental disorders. One project focused on depression, one focused on early psychosis and substance misuse, and one developed interventions to identify young people at high risk of suicide and provide therapy specifically tailored to reduce identified suicide risk factors among young people with mental disorders.

The sources of information used in the evaluation of the National Youth Suicide Prevention Strategy, and the methods used to analyse these data, are described in detail in the overview volume, *Valuing Young Lives*.



Support for young people who are marginalised and disaffected

This chapter presents and analyses information about the projects funded under the National Youth Suicide Prevention Strategy that focused on young people identified as being “marginalised and disaffected”.

These terms generally refer to young people exposed to multiple risk factors for suicide such as homelessness, substance misuse, contact with the justice system, sexual identity issues, mental health problems, self harming behaviour, previous suicide attempts, violence, physical and sexual abuse. Many of these young people also suffer severe physical illness. The experience of being exposed to these multiple risk factors tends to be associated with the experience of disconnection or marginalisation from the key institutions of mainstream society such as family, school and work.

The goal of this group of projects was to reduce the disadvantage and enhance the wellbeing of young people exposed to multiple risk factors for suicide and who are marginalised and disaffected.

The main aim of the individual projects funded under this category was to identify ways to enhance service delivery to young people who are marginalised and disaffected. Specific aims and objectives common across the projects included: (i) engaging this group of young people with services and other support structures; and (ii) improving health, welfare and wellbeing outcomes.

Projects of the Strategy that provided support to marginalised and disaffected young people

The projects in this group include: Connexions, based at Jesuit Social Services in Melbourne; Limelight Productions, based at the Bridge Youth Health Service in Shepparton Victoria; The Young Women’s Project, based in Melbourne; Belong’s Haven, at Kinchela Creek in rural NSW; High Street Youth Health Service, in

Western Sydney; Cellblock Youth Health Service, in Central Sydney; and the Centacare Youth Suicide Intervention Program (CYSIP), based at Centacare in Adelaide.

ConneXions

ConneXions is a program for young people run by Jesuit Social Services in inner Melbourne. The Strategy Project based at ConneXions involved trial and evaluation of strategies aimed at enhancing the quality of care provided to young people experiencing complex problems of drug use, mental illness and self-harming behaviour, including suicide. The project target group was young people aged 16–25 years. Young people can come to the ConneXions program through a variety of means including self-referral or referral via other services.

The specific strategies employed by the ConneXions project were to: provide skilled professional services to the target group of young people; increase the capacity of outreach workers to identify and respond more effectively to the emotional and psychological health needs of marginalised young people; create pathways for marginalised young people into mainstream health, welfare and

TABLE 1 Projects of the Strategy providing support to marginalised young people

Program name	Organisation	Main intervention	Evaluation design
ConneXions	Jesuit Social Services, Melbourne	Long term therapy provided within a holistic service	Ethnographic research
Limelight Productions	The Bridge Youth Health Service, Shepparton VIC	Drama and arts program	Standardised instruments and interviews
The Young Womens Project	The Young Womens Project, Oakleigh VIC	Accommodation and other practical support	Variety including interviews, analysis of service utilisation and outcomes data
Benelong's Haven	Benelong's Haven, Kinchela Creek NSW	Rehabilitation for substance misuse	Ethnographic research
High Street	High Street Youth Health Service, Western Sydney	Counselling provided within a holistic youth health service	Standardised instruments and interviews
Cellblock	Cellblock Youth Health Service, Central Sydney	Counselling provided within a holistic youth health service	Standardised instruments and interviews
Centacare Youth Suicide Intervention Program (CYSIP)	Centacare, Adelaide	Consultation service and training for workers in non-government agencies	Interviews with staff in target agencies

community services; and establish a model of intervention with marginalised young people and frameworks for collaboration between professional services and outreach workers.

Strategies used by ConneXions to increase the competency of professionals in mainstream services were supervision, formal and informal training, secondary consultation, the publication of papers and information dissemination about successful models of intervention. Linkages between ConneXions and the broader service community were also a priority. These linkages took the form of co-case management of clients and ConneXions staff acting as consultants to workers in other agencies.

Ethnographic research (the study of a group of people for the purpose of describing their sociocultural activities and patterns) was used to evaluate the project.

Limelight Productions

Limelight Productions was an initiative of The Bridge Street Youth Service and the Goulburn Accommodation Project based in the rural Victorian town of Shepparton. The Limelight Productions model is a form of self-development program intended to run parallel with other sources of support and direct assistance services. Limelight One, a drama group run for young people at risk of becoming homeless in 1996, formed the basis of the Limelight Two project, which was funded under the Strategy and undertaken in 1997. The evaluation of Limelight One made it possible to redesign the model for Limelight Two in order to allow more time for therapeutic discussion and enable participants to explore factors contributing to young people's despair, and work with the imagery that expresses this.

The philosophy underlying the Limelight program is that creative arts enable self-expression and have greater appeal to young people than more structured, discussion-focused groups. Involvement in the creative arts is thought to unite young people in similar circumstances around art and youth culture, develop a sense of comradeship, build self-esteem and reduce feelings of isolation. A fundamental assumption of the program is that a drama group can effectively engage vulnerable young people who are usually reluctant to be involved in other youth programs. Further assumptions underlying the design of the program were that: workers would enhance their expertise while working with the client group; participating in Limelight Productions would be a therapeutic experience for young people who had attempted suicide in the past or had suicide ideation; and that the finished documentary and video could be effective tools for increasing general practitioners', youth workers' and teachers' understandings of young people's perceptions of their struggle for mental health.

Twelve project workers from a variety of agencies were recruited to Limelight Two to provide positive role models, support and encouragement for the young people attending the program. The workers were also instrumental in recruiting

the young people to the program. The following three themes were examined in workshops: the isolation of adolescence; rites of passage and change; and constraints of male and female stereotypes. These themes were developed and used in the production of the rock music video, *Dance of Death*, and through the forms of mask movement, improvisation, dance, chanting, drumming, art work, song writing, music, body art and storytelling. These skills culminated in a live performance for a local audience of over a hundred people.

Young Women's Project

The Young Women's Project is an ongoing initiative of the Oakleigh Youth Housing Project which is funded through the Supported Accommodation Assistance Program (SAAP). The Young Women's Project provides in-crisis medium term accommodation support and a range of other support services to young women who are homeless or at risk of homelessness including case management; a sexual assault outreach service; advocacy; and referral to other support services.

Funding was provided by the National Youth Suicide Prevention Strategy to document and evaluate the Young Women's Project service model. The task was to assess the impact of service provision on young women's mental health and to produce a document that described the model of service provision.

The Young Women's Project service model is based on literature and practice wisdom which notes links between homelessness, mental illness and suicide. It has been found that many young homeless women leave home early to escape physical, sexual or emotional abuse. The Young Women's Project approach uses a feminist empowerment frame of reference. It is believed that the unique structures of the project's team environment constitute a positive example to young women, of women working together to do things differently.

Belong's Haven: Alternative to Gaol Program

The need for a rehabilitation program, rather than gaol, for young Aboriginal people with drug and alcohol problems is emphasised in the report of the Human Rights and Equal Opportunity Commission inquiry into *Aboriginal Deaths in Custody* (Johnston 1991). This report showed a direct link between custodial sentencing and Aboriginal suicide. Belong's Haven provides an alternative to gaol for young Aboriginal people facing drug and alcohol related charges and with high levels of suicidal ideation.

Belong's Haven was founded in 1974 as the first rehabilitation service for indigenous people in Australia and is an ongoing service. It is situated on the mid-north coast of Australia and consists of a property of thirty acres including a men's dormitory, family units, meeting hall, dining, kitchen, medical and administration facilities. The Haven provides a six-strand program: an Alcoholics Anonymous-based group; psychotherapy; recreation; culture; food/rest; and personal problem-solving for health, legal and housing issues.

The client group consists of young Aboriginal people on drug and alcohol related charges, three-quarters of whom are under 26 years of age (average 21 years). Over half of the clients have high levels of suicide ideation and one-third have previously attempted suicide. Almost all male clients at the centre have spent time in gaol, with over half having served more than six months. The intended outcome of the Haven's programs is that clients have more knowledge about relevant issues, experience an improvement in their mental wellbeing and achieve a life free of alcohol and drugs. It is hoped that the program will enable clients to see their options and be able to make informed decisions. A key objective is that clients will experience a change in their attitude and adopt a more positive interpretation of life events.

The project funded under the National Youth Suicide Prevention Strategy was integrated into the existing infrastructure and aimed to increase access to Belong's Haven for young Aboriginal people at risk of going to gaol. These young people received treatment along with clients of other age groups. Funding under the Strategy was also provided to appoint a researcher/evaluator to conduct an evaluation and assist in the ongoing development of the program delivery. The evaluation used an ethnographic-style methodology. However, the project managers reported that the demands of running a 24-hour service limited the time available to write up the evaluation, and as a consequence only a few real achievements are documented soundly.

High Street Youth Health Service

Based in mid-western Sydney, the High Street Youth Health Service is a community based youth health service. The agency offers a holistic service for young people which includes medical and personal care services, counselling, a drop-in centre and creative and educational programs. It aims to promote optimal health of young people, with an emphasis on those at risk of being homeless.

High Street Youth Health Service received funding under the Strategy for three different projects. The project reported here in this chapter involved a study of a group of young people using High Street's medical and counselling services.

Cellblock Youth Health Service

Cellblock Youth Health Service is located in inner city Sydney and offers a multi-disciplinary approach to the care of marginalised young people, including counselling and medical services, and arts and health promotion programs. Cellblock's service approach seeks to understand young people's social circumstances and the impacts of these on health.

Similarly to High Street, three suicide prevention projects were funded at Cellblock. The project reported here involved a study of a group of young people using Cellblock's medical and counselling services.

Centacare Adelaide

The Centacare Youth Suicide Intervention Program (CYSIP) was developed to enhance the support services available to young people at high risk of suicide and promote best practice. The project focused on enhancing the capacity of non-government welfare services to provide an appropriate service to young people with mental health problems. The major activities of the project included: provision of mobile assessment and consultation; input into case planning and management; training in suicide risk assessment; development of links between mental health and community-based services; and development of support networks and resources, including both peer and family supports.

The Centacare CYSIP team comprised two clinicians who worked in collaboration with agencies supporting young people at risk of suicide. Assessment and consultation services provided by the team included: primary assessment (one-to-one with the young person) and secondary assessment (with the agency worker). About 250 primary and secondary consultations (essentially broad psycho-social assessments) were undertaken with a range of agencies including Supported Accommodation Assistance Program services, health services, sexuality services and schools, both public and private. Consultation took place wherever the young person was located.

Other major activities of the Centacare project included development of a Suicide Risk Assessment training package and provision of in-service training to a total of 409 participants; as well as establishment of four peer support courses with approximately twenty participants from supported accommodation agencies.

The Centacare project also had a strong focus on enhancing networking and interagency collaboration. Networking activities additional to those described above included: a seminar on mental health issues for young people; participation in the development of the Supported Accommodation Assistance Program (SAAP) Suicide Intervention Guidelines; consultations on developing a formal protocol between non-government and mental health services assisting young people; and participation in three committees operating to improve service delivery and interagency linkage.

Results of the evaluation

The results of the qualitative meta-analysis of the evaluations of the projects in this group are organised into three main domains:

- engaging marginalised young people with services and other support structures;
- improving health, welfare and wellbeing outcomes; and
- capacity building.



What works to engage this group of young people with services and other support structures?

The problem of engaging marginalised young people at high risk of suicide with services was the major focus of this group of projects. The projects used a variety of different evaluation methods and some were better suited than others to addressing the question of whether the interventions were effective in engaging marginalised young people with services. Unfortunately, none of the projects used a control group of any sort in order to assess whether or not the interventions under scrutiny were more effective than other types of interventions such as “standard” or “usual” treatments. The variation in evaluation designs makes it difficult to draw comparisons between the projects and precludes the possibility of using the projects as controls for each other. Nevertheless, the projects and the evaluations have generated some important insights into the problem of engagement including some promising ideas for service development and hypotheses for future research.

In general, the services involved in the current group of projects appear to have been successful in engaging a highly marginalised group of young people at high risk of suicide with supportive and therapeutic services. Many of the young people from whom data were collected had been engaged with these services for a considerable length of time and were committed to ongoing therapy and the task of overcoming the complex range of problems that currently limited their progress in life. In contrast, a substantial number of the young people from whom data were collected had experienced considerable difficulties and expressed strong dissatisfaction with other services they had used in the past.

While the evaluations did not generate quantitative data capable of demonstrating higher levels of engagement effectiveness for this group of services, however, there is currently no evidence available to indicate that the young people concerned will access mainstream services. The available qualitative data collected from staff and young people as well as other stakeholders is highly consistent in identifying the service characteristics that are predictive of strong engagement.

These include:

- relationship;
- time, patience, space and commitment;
- self determination and empowerment;
- a holistic approach that includes provision of basic needs;
- being non-judgemental and demonstrating respect; and
- outreach.

► ***Relationship***

The strongest theme to emerge from the qualitative evaluation data is that the quality of the relationship between a young person and a particular worker in a service is the most critical factor determining engagement of the young person with therapeutic services. The critical importance of relationship was identified explicitly by project staff and evaluators – it also emerged as an overarching theme or framework for understanding the other factors identified as important to engagement.

In a sense it could be said that engagement is the same as relationship – a relationship that is founded on trust, acceptance, respect, and commitment. Being accepted in a respectful relationship is seen as a key to creating an openness to exploring positive, self caring solutions, including therapy.

► ***Time, space, commitment and flexibility***

Engagement with marginalised and disaffected young people is a long term process. Young people with multiple problems have almost always had a number of negative experiences with other services that have made them extremely wary of professional service providers. It takes considerable time and patience to build up an adequate level of trust with these damaged young people. Being seen to be committed to the young person over the long term is extremely important.

Thorough assessment with marginalised young people usually requires an extended period of time getting to know them and interacting with them in a variety of environments. Kelk (1999a and 1999b) has argued that the reliability and validity of assessment of alienated young people is much lower than the assessment of people who identify with society. Kelk suggests that we can't expect services for these young people to be as good at detecting suicidality as services for other people.

Consistent with the principle of self-determination (discussed below), young people must be allowed to proceed at their own pace. Providing time and space for this process to unfold while maintaining contact with the young person is the key. Non-clinical components of holistic service provision such as art and vocational programs as well as provision of a physical “space” such as a drop in centre were observed to fulfil a valuable function in this regard. Participation in these activities allowed young people to acclimatise to the environment. With the safe interaction provided in these programs, their defences relaxed over time and clients slowly revealed the difficulties in their lives to the workers, opening up to the exploration of various solutions. Having clinical workers located in the same building as the other programs also allowed young people to meet and chat with them in an informal, non-threatening manner. This opportunity to “check out” the therapists informally from a safe place was perceived as a major enhancer of engagement.

► *Self determination and empowerment*

The third key factor identified as critical to the engagement of young people at high risk of suicide is self determination. Self determination and empowerment as operationalised in most of these projects involved ensuring that every intervention is aimed at building up the young person's power to act for themselves and take control of their own life. Key practical aspects of self determination include: involving the young person in the development of their case plan; making the plan available for their scrutiny; and asking their permission before divulging information about them to others. Several services in this group also involved young people in decision making processes relevant to service planning and evaluation. More generally the philosophy of the service is one of validating the particular experience of each young person and encouraging staff to ensure that they are not imposing their own values and opinions on clients.

For many young people involved in these services life has been chaotic and “out-of-control”. Providing young people with a range of activities to choose from, and choice about when and how they approach particular workers to obtain services is identified as an important means of helping them feel in control.

The evaluators of the ConneXions Program (Ridge et al. 1999) note that self harming behaviours are often one of the only forms of control that many marginalised young people have been able to exercise in their lives. Showing young people that they can have control in their interaction with a service and other positive activities is a critical learning exercise. It demonstrates to them that they have the capacity to learn the skills necessary to exercise control in their lives more generally.

Art programs are frequently used by youth oriented services to channel empowerment and facilitate self determination of young people. This perception of the capacity of art was expressed directly and passionately by several young people at Cellblock: “It's great there is a place that offers young people an opportunity to express themselves in a comfortable and respecting environment. Art is an expression of a person's individuality and can speak all languages and cuts through all barriers here; we have the opportunity to be heard” (Kelk 1999b: 18).

► *Being non-judgemental*

Being non-judgemental is a characteristic that was frequently identified by young people as differentiating the current group of services from others. Key informants viewed the services in the current group as very accepting of young people with challenging behaviours, and generally available to take on clients that other services would not accept. Being non-judgemental also requires that service providers be uncritical of factors affecting many young people over which they have little control. For example homeless young people can find it difficult to organise and keep appointments or to take medication. They may not be able to

afford medication or public transport to attend appointments. They may have poor or highly sub-culturally specific clothes. Lacking access to washing facilities, homeless people can often be dirty and smelly.

Many young people who are affected by difficult behaviours and who have failed to comply with strict service rules and requirements or treatment plans are subject to “black lists” which effectively preclude them from gaining access to other services, particularly accommodation services. Many of these young people would be given a diagnosis of personality disorder by mental health services.

Resourcing is an important factor in an organisation’s ability to cope with difficult behaviours and to overcome the lack of resources possessed by their clients. For example the Young Women’s Project is able to provide accommodation to young women on their own or with one other person. This arrangement reduces the impact that disruptive behaviours will have on other clients. Small caseloads are also necessary in order for staff to find the time to work with young people experiencing severe behavioural problems. This work is much more difficult for most mental health services where staff have caseloads of 30 to 40 clients. In services where staff and resources are highly stretched, rules of conduct tend to be more tightly enforced and the acceptable ranges of behaviour are narrower.

However, despite being non judgemental, youth health agencies do have and need strict rules, but they tend to be rules that other agencies would rarely think of stating, let alone trying to enforce, such as no violence and not being on the premises under the influence of drugs.

► **Respect**

A theme that underlies a number of the other themes discussed above is that of respect. Respect for the young person is one the most important ingredients for developing a sound relationship.

Respect is a central concept in self determination. True respect enables providers to let clients make decisions for themselves and to make, and learn from, their own mistakes. Evaluators found that many young people had never before felt respected by adults, especially service providers. “In many cases, it was the first time that the client had felt respected and in control, rather than judged, interrogated and pushed” (Ridge et al. 1999: 69).

Respect is critical if therapists are to be capable of really listening to young people without judging them, of validating their subjective experience, and allowing them to make their own decisions.

Evaluators identified genuine respect for young people as widely present among the staff of most of the agencies hosting the current projects. Conversely, a lack of respect from other service providers was identified several times as characterising young peoples’ experience.

► *Holistic service provision*

People who are not functioning well in a large proportion of their social roles need more holistic services. For example, older people whose physical and mental health is starting to deteriorate also benefit from increasingly holistic services.

Most of the agencies hosting this group of projects described themselves as offering a holistic range of services, and staff and evaluators identified the holistic approach to service provision as important for engaging young people who have experienced difficulties accessing and engaging with other agencies.

As mentioned earlier, providing young people with a diverse range of programs and activities in addition to clinical services also enhances engagement by giving young people the space and opportunity to make choices about how they become involved and therefore, sufficient time to get to know the clinicians. In other words, providing a flexible range of services helps enhance self determination and gives young people time to build up a relationship.

Holism is not just about service structure and diversity, it is also a philosophy or theoretical approach which views human beings as greater than the sum of their parts (that is, the biological, psychological, social, emotional, spiritual) and which sees these elements as inseparable. This philosophy or theory is directly at odds with “dualism” which separates experience into polarities and tends to lead to binary thinking (for example, mental health problem or drug problem; suicide risk or not a suicide risk) and mutually exclusive perspectives. As such, a holistic approach tends to place much greater emphasis on the validity of alternative perspectives – especially the client’s.

Validation of subjective experience through self-expression is one of the major rationales behind the creative arts approaches that are widely advocated and practiced by youth services. Another major rationale is “art as work” (Wyder and Kelk 1997) which underscores yet another critical dimension of holistic service provision for marginalised young people.

► *Outreach*

Outreach can provide an accessible path to services for young people with complex problems.

A good illustration of the way in which outreach can enhance access and engagement is provided by Benelong’s Haven (Nolan and Chenhall 1999). One of the most important strategies undertaken by Benelong’s Haven is to increase outreach to young Aboriginal people by assisting them during court proceedings. This work involves developing professional relationships with solicitors and magistrates to inform them about the program and encourage them to consider ordering treatment at Benelong’s Haven rather than imprisonment. By attending court proceedings, Benelong’s Haven staff can also speak on behalf of the client and provide immediate transport to the Centre if this is required. Benelong’s Haven

is also able to pick up clients who are being released from gaol. When clients are not provided with this assistance, they are perceived to be much less likely to make contact with the Centre and to continue drifting through the system.



What works to improve health, welfare and wellbeing outcomes for this group of young people?

The evaluation designs were not well suited to determining whether the young people experienced more positive outcomes than they would have without the service or if they had accessed an alternative service. Only one of the project evaluations provided data that could be used to compare the effectiveness of the intervention with those used in other services. The projects also used very different evaluation methods and this makes it difficult to draw comparisons between the projects and precludes the possibility of using the projects as controls for each other. However, some useful information has been generated that could be used to guide the direction of service development and inform further evaluation research.

Three sources of data were used in the High Street study: clinical interviews focusing on risk factors for suicide; a self completed version of the Inventory of Suicide Orientation (ISO-30) which provides a measure of suicidal ideation, hopelessness, low self esteem, social isolation and withdrawal, and inability to cope with emotions; and the ISO-30 Clinician Rating Form.

Each of the twelve young people from High Street Youth Health Service who were assessed at baseline were found to have a range of serious long-term problems. The evaluator reports that they were a very high risk group even compared to other youth health client samples with whom the evaluator had contact (Kelk 1999c). Most had made multiple suicide attempts and four were suicidal at the time of the assessment. Most had engaged in self harm without the intention of killing themselves and most knew people who had completed or attempted suicide including close relatives and friends. Nine of the twelve young people had an ISO-30 risk classification of high. Five of the twelve had a psychiatric diagnosis including psychosis, major depression or personality disorder. Based on the interview data, Kelk (1999a) believes that several others had undiagnosed personality and anxiety disorders. Six reported a history of sexual abuse. They all reported difficulties in managing their emotions – for example, most reported feeling crazy or abnormal most of the time and all reported experiencing intense anger regularly.

Only two of the twelve young people involved in the High Street study reported having a relationship with their family which was likely to be supportive. The remainder described chronic and severe problems with multiple members of their

families. Despite this, half the group were still living with their parents. Four of the twelve had experienced homelessness. Seven of the twelve had quite restricted peer friendship groups. This was a long-term tendency for all except one of these. Only half of them reported having someone outside of High Street or other counsellors to whom they could turn for support.

Few were engaged in any established patterns of leisure activity. The group as a whole appeared to have a significant level of physical health problems in addition to the psychiatric problems mentioned above. Seven were unemployed and had been so for at least 18 months. Three were in high school and two were attending university – one of these by distance education. The young people in education were generally struggling to remain involved.

Only six of the twelve young people were available for the follow-up assessment that took place an average of 5.6 months later. A case study methodology was used to explore the changes that occurred. Three of the six showed a small reduction in ISO-30 scores over the months between the two assessments, and all of the young people reported positive changes in their lives. The major changes reported included: increased ability to deal with emotions (four); improvements in their self perception (three); improvements in their management of their education (three); satisfactory management of major life changes (three); improvements in relationships with parents or partner (two).

Although it is not possible to attribute any of these changes to the interventions provided by High Street, the young people themselves are reported as attributing certain changes to the agency. Unfortunately, except for one, the case studies do not provide sufficient detail about the particular interventions received to allow any speculation about the factors that may have been most important in promoting positive changes for these young people.

Three sources of data were used in the Cellblock study: the Inventory of Suicide Orientation (ISO-30) which provides a measure of suicidal ideation, hopelessness, low self esteem, social isolation and withdrawal, and inability to cope with emotions (King and Kowalchuk 1988, cited in Kelk 1999b); the Beck Depression Inventory II (Beck, Steer and Brown 1987, cited in Kelk 1999b); and a series of questionnaires devised partly by the evaluator and partly by Cellblock staff to evaluate clients' views about the medical, counselling and arts programs offered by Cellblock.

Baseline data for the ISO-30 and the BDI-II were obtained from 43 young people (18 males and 25 females). It is not possible to determine the extent to which the sample is representative of the wider client group. Scores indicated that over half of the young people were at either high or moderate risk of suicide and that nearly half were either severely or moderately depressed. Ten young people (eight females and two males) completed a second assessment with the

ISO-30 and the BDI-II approximately 5.6 months after their first assessment. Nine of the ten had positive changes on the raw scores of the ISO-30 and the total score on the BDI-II.

The Young Women's Project (YWP) evaluation included collection of information about satisfaction with the program and the sense of wellbeing experienced by the young women as well as data about the objective situation of clients on entry and exit from the program (Success Works 1998). Data were collected from clients in 1997 and 1998 using focus groups as well as a survey questionnaire, and involved a total of 63 young women. The inclusion of young women from non-English-speaking backgrounds and those with low literacy was facilitated by offering telephone interviews conducted with an interpreter as well as face-to-face interviews with or without an interpreter.

A number of instruments exploring different issues were distributed to service users via the service workers throughout the project. A "service entry form", a "personal information form" and an "exit evaluation" form were completed only once and a "research form" was completed by participants at four weekly intervals. The research form measured hopelessness (Beck Hopelessness Scale) and self esteem. A total of 31 women participated in the research. All completed the research form once (Stage 1), 17 completed it a second time (Stage 2) and nine completed it a third time (Stage 3). The question of whether or not these 31 women were representative of the whole client population is not discussed in the report (Success Works 1998).

The satisfaction and wellbeing data are very positive. All of the clients interviewed reported that their situation had improved since becoming involved with the Young Women's Project. This improvement centred primarily around mental health and wellbeing, life in general and physical health. Seventy-seven per cent of respondents also reported that they believed their situation would have worsened if they had not become involved with the Young Women's Project. Fifty-seven per cent of respondents reported that the Young Women's Project had met most of their needs, and 21 per cent reported that all of their needs had been met. No respondents said that none of their needs had been met. Other benefits reported by a majority of clients in the 1998 evaluation included: making new friends (70 per cent), a feeling of improved wellbeing (65 per cent), having become more responsible (60 per cent), learning new ways to avoid becoming homeless (55 per cent).

Data about the objective situation of the clients of the Young Women's Project also reveal some improvements. The report provides comparison data referring to other Supported Accommodation Assistance Program (SAAP) funded services. The improvements found for clients of the Young Women's Project do not appear to be any greater than those achieved by other SAAP funded services.

There was a drop in the proportion of clients with no income between entry (25.3 per cent) and exit (3.8 per cent). There was a slight increase in the proportion of clients earning a wage or salary (2.5 per cent on entry up to 5.1 per cent on exit). Data about accommodation status in the 1995–96 period did not reveal any real improvements. The income and accommodation outcomes achieved by the Young Women’s Project were no better or worse than those of SAAP generally.

Mean scores on the Beck Hopelessness Scale and the Self Esteem Scale changed only slightly over time for the sample overall. However, respondents whose “situations had improved” were reported to be a lot more optimistic than respondents whose situations had worsened at all three time points (Success Works 1998). This could be interpreted as indicating that optimism predicts improvements in the person’s objective situation.

One of the major outcomes observed for clients from the Connexions ethnographic research was the development and improvement of social relations with peers, relatives and other adults/professionals. Increased feelings of control, self understanding and self worth were also noted. Many young people also explained that involvement with Connexions had given them hope that there was a possibility of recovery, creativity and emotional well-being. Similar findings were reported from interviews with young people at Belong’s Haven. Quantitative outcomes such as “improved mental health status” and “reduced homelessness” were reported as difficult to measure for the clients of Connexions because clients came to the program with their own individual life circumstances and had freedom in the issues they chose to work with. Case studies of eight clients demonstrated that some worked with accommodation issues, some with mental illness, some with substance misuse and some with offending issues.

Clinical outcomes for the six young people involved in Limelight Two (the second Limelight Program) were assessed using the Inventory of Suicide Orientation (ISO-30), a clinical interview and case managers reports. Measures were taken at the beginning of the project, upon completion and six months after completion. Five of these six participants showed improvements over the period of Limelight Two and these improvements were sustained or increased at the six month follow-up. These results were consistent across the ISO-30, clinical interview and case managers reports.

Feedback from young people participating in Limelight Two also suggests that young people experienced improvements in self esteem, confidence, self understanding and coping skills:

“I got to prove that I’m not hopeless, not worth shit.”

“I understand about how I feel and why it happens – this makes it more bearable.”

“I learnt to recognise feelings – previously my feelings were unnoticed by myself. I have learnt ways to avoid the shithole.”

“My self confidence has improved.”

“I felt I completed something – usually I don’t stick at things. “

► **Holistic service provision**

All of the projects in this group have noted the fact that the young people they are trying to work with experience problems in multiple domains of life. Many experience mental health problems as well as problems in their relationships and living situation. Many are disconnected from family and peers and are struggling to complete their education and develop a satisfying vocation.

Most of these projects have emphasised the importance of providing services in a holistic manner that deals with all of the issues that the young person is confronting. The holistic approach advocated in these projects appears to be characterised by two main principles. The first is philosophical or theoretical and involves acknowledging the young person as a whole person with a unique view of the world, instead of typifying a particular kind of problem such as homelessness or sexual abuse. This theoretical dimension of holism provides a conceptual framework that supports key clinical practices such as respect that are critical to the process of engagement. Several projects, particularly ConneXions, the Young Women’s Project, High Street and Cellblock have provided important insights into ways in which workers can develop attitudes, values and skills that are consistent with this philosophical or metaphysical dimension of holism.

The second dimension of holism is concerned with the need to apply specific interventions across the range of domains in which the young person is experiencing difficulties. Achievement of holistic practice has not been as substantial in this second dimension as in the first. Specific projects have generally demonstrated attempts to intervene in only a limited range of life domains or systems. The strongest focus has been on the dimensions of intra-psychoic wellbeing, peer relationships and independent living. Considerably less activity appears to have been directed to the domains of family, education and employment.

► **Long term therapy**

The Project staff and evaluators, as well as other respondents in these projects were overwhelmingly unanimous in their support for the view that long term therapy is necessary to achieve sustained positive mental health outcomes for this client group.

Unfortunately, the evidence cited in support of this claim is not strong, according to the standards recommended as underlying evidence-based practice

(see, for example, NH&MRC 1997). The current evidence consists mainly of a correlation between the length of time that clients spend engaged with the relevant program and improvements as observed by staff or reported by clients. All these evaluations are methodologically compromised because of the lack of control groups and the biasing of samples in favour of clients who have stayed with the service. This sampling bias would generate a sample that is more likely to express satisfaction with the service and more likely to generate data that supports the hypothesis that engagement in long term therapy is a predictor of positive outcomes.

There is also a variety of confounding factors that could explain the correlation between length of contact with a service and perceived improvements. Clients who happen to stay engaged for longer may be more stable, more mature and more ready to change than clients who drop out. No control or consideration was given to the influence of these possible confounding factors in the current set of projects. Without a control group, it is not possible to say whether or not the effectiveness of a service is the critical factor behind changes in behaviour or mental health.



What works to enhance the capacity of services to support marginalised and disaffected young people?

Work on building the capacity of services to provide treatment and support for young people who are marginalised and disaffected was mostly limited to one project. This project, based at Centacare in Adelaide focused on three strategies:

- a mobile assessment consultancy service;
- training in suicide risk assessment for workers in non-government agencies; and
- collaboration between non-government agencies and government mental health services.

While other projects did not focus specifically on capacity building in the wider service system, they did provide some important insights regarding building capacity within organisations.

► *Caring for staff*

The importance of providing adequate support to staff is emphasised repeatedly by evaluators of a number of projects. Staff working with marginalised young people experience high levels of stress. Staff are exposed to emotional breakdowns, aggression, psychotic episodes, depression, self harm and suicide attempts on a regular basis. The commitment to genuine listening and validation of young

people's experience means that staff "really hear" stories of long term abuse and violence and identify closely with the emotions of the client. This means risking vicarious traumatisation: "With constant exposure to such high levels of psychic trauma, all participants are at risk of suffering vicarious traumatisation" (Ridge, Hee and Aroni 1999).

Evaluators identified a range of strategies that are critical to managing stress and supporting staff working in these services. These strategies were generally based on an acknowledgment of the reality of staff emotions and the importance of open discussion of emotional issues. Professional supervision from experienced clinicians outside the organisation was identified as essential. Frequent team meetings, up to three per week, also facilitate communication and ensure adequate time is given to working through emotional issues that come up.

Another major aspect of managing stress for staff is placing limits on caseloads. Flexibility in response to crises and prolonged periods of high workload is also important. This includes flexibility in working hours, use of rostered days off and holiday planning.

Kelk (2000, personal communication) and Howard (2000, personal communication) note the importance of workers maintaining boundaries. Kelk notes that High Street Youth Health Service strongly maintained boundaries between the staff and the young people, and extended this to insisting that staff not work much overtime. This was associated with a healthier environment and higher morale for staff at High Street compared to Cellblock where less emphasis was placed on maintenance of boundaries. Howard notes that some youth workers can over-identify with clients and take excessive amounts of responsibility. This can encourage overdependency and inhibit links with other professionals.

Information from all evaluations in this group suggests that for professionals who are passionate and strongly committed to their work, and for agencies where teamwork is required, individual wellbeing is strongly related to the wellbeing of the team as a whole. Shared values and philosophies were identified as a key quality of a healthy team. Shared values facilitate the ability of staff to provide support to each other. They also provide a sense of common purpose and camaraderie.

Skilful and sensitive management is also identified as critical to team wellbeing.

► ***Mobile assessment consultancy***

Evaluation of the Centacare CYSIP mobile assessment consultancy service suggests that the service was of value to staff in non-government agencies and that it is a service that is not available from other sources. Mental health services are generally unavailable to provide prompt assessment and assistance with case planning for non-government agency clients who have mental health problems or are at risk of suicide.

Criticisms of the mobile assessment consultancy service centred around a failure of the CYSIP Program to provide follow-up of any sort after the provision of the assessment. Provision of assertive follow-up is considered to be a critical element of good clinical practice to enhance engagement of clients. It might be hypothesised that assertive follow-up would also be effective when practitioners are working to change the behaviour and develop the skills of other practitioners to whom they have provided consultancy services. It is also clearly important for quality assurance and evaluation purposes.

The evaluation of the Centacare Project neglected to examine performance indicators such as program reach and accessibility across the full range of providers who might benefit from such a service. It is noted that in 1998 the number of primary and secondary consultations declined compared to 1997. Primary consultations took place at a frequency of one every three weeks and secondary consultations took place once per week. This appears to be a surprisingly low level of service use compared to the level of perceived need which provided the rationale for the program. Information would be useful about the average frequency with which staff in a representative sample of non-government agencies would have need for assistance in conducting an assessment on a young at-risk client, and to compare this with actual use of the Centacare CYSIP service.

More systematic assessment of the level of need among providers in non-government agencies and youth services for other types of assistance from mental health services would also be of value. At present, level of need is frequently perceived and argued to be high, but hard data that can be used to adequately inform funding decisions is lacking.

► ***Training***

Training in suicide risk assessment provided by the Centacare Project to staff in non-government agencies was extremely well received and there was strong demand. Participant satisfaction was high and a large majority of participants reported increased understanding of suicide risk factors. Follow-up evaluation conducted three months after conclusion of the workshop indicated that for a substantial minority of participants, training had not impacted on their work practices. Feedback from training participants indicated widespread perception of a need for training beyond narrowly focused suicide risk assessment and referral – extending into ongoing management of mental disorders such as depression and personality disorders.

► ***Interagency collaboration***

The evaluators of the Centacare Project (Martin, Roeger, Marks and Allison 1999) identified only limited achievements in the area of building links between non-government agencies and government mental health services. This relationship

was identified as highly problematic. Staff in Supported Accommodation Assistance Program (SAAP) services were strongly consistent in their opinion that Child and Adolescent Mental Health Services are inadequate and inappropriate for SAAP clients with mental health problems.

Specifically, CAMHS services are seen as lacking flexibility and having too strong a focus on short term intervention and on children living in families. SAAP staff stated that their clients generally require long term intervention. Waiting lists are also prohibitive. Staff in all but two agencies stated that after they are offered an initial consultation, they *often have to wait up to 12 months or longer for the next appointment*. Martin et al. (1999) also report a widespread perception on the part of SAAP staff that staff in mental health services needed to: understand adolescent development in a broader framework; develop a more positive and respectful attitude; offer something more than “endless assessments”; and receive education about the non-government sector and the Supported Accommodation Assistance Program in particular.

High staff turnover is likely to be a problem for building sustainable links if communication depends heavily on relationships between individual staff members, as seems to be the case. The evaluators of the Centacare Project noted that of the 26 staff from 18 SAAP agencies included in the original interviews, only 11 were still available one year later. Many of those not followed up had left the agency or were on maternity leave. Formal mechanisms at the service management level would appear essential for maintaining links that are robust to the transitions of individual staff.

Martin et al. (1999) suggest that the development of effective collaboration between SAAP agencies and mental health services is too formidable a task for locally based projects and that the relationship between the sectors needs to be tackled at a broader level.

General discussion

In considering the information that has come out of the current group of projects it is important to bear in mind that the group of young people considered here has been very poorly researched. Homeless people in particular are largely invisible and nearly impossible to include in studies based on samples drawn from the general population. Many of the methodological problems that have limited research into this population have also affected the ability of the current projects to explore critical issues in a rigorous manner. Against this context, the National Youth Suicide Prevention Strategy projects have generated some important insights and hypotheses that can inform program development and form the basis of a more comprehensive program of service development research.

Engagement

The most important theme that emerged from this group of projects is that of engagement. There were a number of points of strong consensus regarding the characteristics of services that are required to engage young people who are marginalised and alienated from society. The clearest of these is that engagement requires the service provider to take responsibility for building a relationship with the young person. This relationship is characterised and supported by a range of factors that form the basis of many other positive human relationships including long term commitment and non-judgmental respect. Provision of time and space, including a safe physical place, are also identified as very important to the development of a good relationship between vulnerable young people and service providers.

Holistic service provision has also been identified as critical to engagement and to longer term outcomes. Holistic service provision, by a single service, appears to enhance engagement because it provides young people with the space and time (that is, the flexibility), to make choices about how they become involved with the service. Young people learn that they can exercise control. This learning appears to be a foundation stone of the kind of relationship that is essential for ongoing engagement in therapy. Holistic service provision is also essential for long term outcomes because the problems experienced by these young people are multifaceted and multidetermined in nature.

A physical space

The ability of an agency to provide a holistic range of services and activities as well as time for young people to hang out and build up a relationship with the workers appears to be greatly facilitated when the agency is able to provide a physical place in which these processes can unfold. This makes practical as well as symbolic sense. In practical terms, many of the activities that young people enjoy and can gain skills from such as art and group work require a reasonable space. Time to hang out and chat to workers requires a shared physical space where young people can relax. At a symbolic level, it is not surprising that a safe and welcoming physical place would be highly valued by young people who have experienced neglect, abuse or homelessness, which is essentially about lacking a safe physical place where they can feel a sense of belonging and attachment.

The importance of a physical space for engaging marginalised young people and those with multiple problems has also been noted by several other projects described elsewhere (Here For Life Youth Sexuality Project, Chapter 3, Volume 2, and YPPI-IA, Chapter 2 this volume).

Assertive outreach has long been recognised in the literature as critical for engaging individuals who are highly marginalised and reluctant or unable to access services on their own. The outreach provided by Benelong's Haven was

functional as well as physical. Staff went out to the physical places of the justice system and provided young Aboriginal people with practical assistance in accessing the service.

The physical dimension of outreach is relatively well recognised among service providers working with marginalised young people. For example services are frequently provided in the physical places preferred by the young person. Functional outreach is perhaps less well recognised. People whose lives are complicated by multiple problems have difficulties with daily living that often make it hard to find the time or practical means to attend services for therapy. Outreach in the form of limited assistance in meeting practical needs can facilitate engagement by demonstrating understanding and caring about the client's practical circumstances. This begins the process of developing a relationship.

Holistic service provision, can function as a form of outreach in the sense that these services are often directed at meeting the immediate practical needs of clients who have difficulties with daily living. Again, the practical assistance needs to be provided, to a large extent, by the service wishing to engage the client in longer term therapy if the relationship and the engagement process is to benefit.

Holistic or multi-systemic intervention

The importance of a holistic approach to service provision in achieving positive outcomes for young people with complex problems is well supported in the literature. Decades of research has shown that complex problems are multi-determined. There is also a substantial and growing body of well controlled research involving this target group which demonstrates the effectiveness of therapies that intervene in multiple systems. Multisystemic Therapy (MST) for example, was developed primarily as an intervention for young people at risk of repeated offending behaviour and or substance misuse, but is highly relevant for young people with a range of other complex problems.

A series of studies including randomised controlled trials has demonstrated the effectiveness of MST in reducing recidivism among juvenile offenders (Santos, Henggeler, Burns, Arana and Meisler 1995). Multisystemic Therapy is grounded on a social-ecological model of developmental psychology (Bronfenbrenner 1979) and intervenes in a variety of systems and processes known to be related to the psychosocial problems of the adolescent, including family, peer groups, educational and vocational settings, as well as the individual (Henggeler, Melton and Smith 1992; Santos et al. 1995).

Multisystemic Therapy places strong emphasis on self determination, with young people (and their families) setting the goals and objectives that they wish to achieve. Respect and non-judgmentalism are also emphasised. The ability of the

therapist to avoid negative responses to behaviours that many people might find distasteful is seen as important and the identification and development of strengths is critical to the instillation of hope that positive change can occur.

Most importantly, the relationship between the therapist and the young person and family is central. In contrast to the passive approach to relationship adopted by most service providers, MST emphasises that it is the therapist's responsibility to take whatever steps are necessary to build the relationship with the client. This includes the responsibility to monitor the quality of engagement and implement strategies that address problems as they arise. Cunningham and Henggeler (1999) provide a detailed overview of the processes that MST uses to "diagnose" and address barriers to engagement.

Future funding of suicide prevention interventions targeting young people affected by multiple risk factors for suicide should aim to encourage interventions that address the full range of systems that have been implicated in the problems of the target population including the family system.

The family system

Several project reports identified family conflict and disruption as one of the major factors contributing to the problems experienced by their clients. Family conflict has also been identified repeatedly as a risk factor for suicide (Beautrais 1999). However, the current group of projects appear to have directed little attention towards intervening with the family system.

Among the multiple systems targeted in multisystemic therapy, the family system is identified as most central. A fundamental assumption of MST is that regardless of the specific goals of treatment, the young person's family or caregiver is the key to favourable long term outcomes. MST also recognises that the family or caregiver may present significant clinical challenges (Cunningham and Henggeler 1999).

Future service development activity should pay greater attention to the full range of systems in which young people are living their lives and in particular the family system. Recent developments in social policy directed towards youth homelessness have emphasised the importance of considering solutions that involve families (Prime Ministerial Youth Homelessness Taskforce 1998). This report acknowledges that while reconciliation with families is not always possible for young people who have been forced to leave the family home, reconciliation is often desired by both young people and families and can in many cases provide the basis for improvements in other areas of the young person's life.

Service development research aimed at clarifying the situations in which family involvement is desirable and appropriate, and identifying structural barriers to family involvement would be valuable.

The stage of development of the problems affecting young people and their families is likely to be important in determining the effectiveness of family intervention. Four stages of homelessness have been identified: (1) dropping out of school; (2) occasionally leaving home; (3) leaving home for longer periods, and (4) living on the streets. It is likely that family interventions will be more effective at the earlier stages.

There also appear to be some structural and philosophical barriers to family interventions within youth services. In Multisystemic Therapy the family or caregiver is seen being a client alongside the young person. This position appears to be at odds with the philosophy of many youth services in Australia which explicitly identify the young person as the only client to which the service is committed, irrespective of the nature of problems being experienced. One might hypothesise that primary commitment to the young person to the exclusion of the family might cause problems of divided loyalties for young people who remain strongly identified with and committed to their families, in spite of serious difficulties in this relationship. This is likely to be an issue for many young people from non-English speaking and indigenous backgrounds. It is notable that Multisystemic Therapy has demonstrated effectiveness with young people and families from a variety of ethnic backgrounds.

Mental health care and non-specialist mental health services

One of the major issues arising from this group of projects concerns the relationship between non-government agencies, youth health services and mental health services in providing treatment and support to young people who are marginalised and disaffected and who are experiencing multiple risk factors for suicide including mental health problems. Considerable uncertainty surrounds the relationship between these three types of services and the demarcation between them.

Information from the projects in this group suggests that there is a high prevalence of serious mental health problems among young people who are using youth health services and various non-government services. Staff in non-government agencies participating in the Centacare Project training program identified the need for further training, particularly in the area of long term management of mental health problems in their young clients. This perceived need could be accepted on face value but it also raises questions about the broader service context and the role of non-government services within this.

Is it appropriate for workers in non-government agencies who may not have formal qualifications in mental health to be providing services to young people suffering from serious mental health problems on a long term basis? If so, what type of services should they be providing? What sort of services are best provided by specialist mental health services? Conversely, is it appropriate for mental health workers to be providing services to young people without special training in youth health?

The ongoing confusion about the roles of mental health services, youth health services and non-government agencies in providing long term care for young people with mental health problems as well as other complex issues highlights the fact that there is a major gap in the service system as far as the needs of this client group are concerned. In combination with the current findings regarding the importance of a strong relationship between a young person and an individual service provider, the role of holistic service provision, the need for time and commitment as well as a safe physical place in facilitating this, these findings point to the need for a shift towards development of services for young people that are more holistic “within themselves”.

Providing a “comprehensive range” of services by referring young people to the various different services that each focus on the various specific problems they experience does not appear to be the same as “holistic service provision” of the kind that facilitates strong engagement. Services that focus mostly on one area of need find it difficult to provide a comprehensive and holistic service to individual young people. Yet this narrow singular focus is how services are generally structured. Within this fragmented structure, young people who are experiencing multiple problems may (in theory) receive comprehensive attention regarding their full range of problems, but are not treated as whole human beings. Opportunities to develop a strong relationship with a trusted service provider appear to be reduced.

The “youth health model” of service provided by youth health services such as High Street, Cellblock and the Bridge, as well as the holistic youth mental health model provided by ConneXions, represent models of service provision that appear to come closest to the “holistic” ideal. These models warrant further consideration with a view to possible expansion.

Based on an ethnographic study of High Street and Cellblock Youth Health Services in Sydney, Wyder and Kelk (1997) also conclude that the “youth health model” has strong advantages as a model of suicide prevention for young people who are marginalised and disaffected and at high risk of suicide. Youth Health Services in NSW were established and expanded in response to recommendations of the Burdekin Report into youth homelessness (HREOC 1989) that health services accessible and appropriate to the needs homeless young people needed to be developed.

A total of 14 services were operating in NSW in 1997. Services are free of charge, confidential and accessible without a Medicare card. A broad range of services is provided, including medical, counselling/therapy, assistance with accommodation and basic needs, as well as advocacy. Arts programs, health promotion and community development also feature strongly in some services. Strong emphasis is placed on commitment to the young person, empowerment, giving young people control over their own care and involving

young people in service development and evaluation. Young people can engage with the service on their own terms, without having to define themselves as a “problem” or a “diagnosis”. The young people are not defined by their issues but as individuals (Wyder and Kelk 1997). The concept of a controlled safe physical place is essential. Youth health services could not provide the type of service they do without it, and it is also critical for engaging young homeless people.

Some similar holistic youth health services also exist in other states, particularly Victoria and Queensland, but their availability is less extensive. The Commonwealth provides limited support for small programs and projects across Australia that seek to develop aspects of service provision consistent with the youth health model under the Innovative Health Services for Homeless Youth (IHSY) Program.

In conclusion, further policy and service development work should be directed at exploring the wider capacity of the youth health service system to provide a comprehensive health service to young people affected by multiple risk factors for suicide. Governments need to work in partnership with Area/Regional Health Services, youth health services, mental health services and young people in this task (*Recommendation 1.1*).

An important question concerns whether or not youth health services should be supported to take on a stronger role in the provision of mental health services to youth and what the relationship with specialist mental health services would be. Relative under-resourcing as well as professional marginalisation of the youth health service sector compared to other parts of the health system is a major problem to be overcome. Wyder and Kelk (1997) found that there was a poor understanding in the wider health system about the functions and capacities of High Street and Cellblock Youth Health Services and recommend that these services need to increase the level of networking, collaboration, consultancy and co-work with related agencies.

Wyder and Kelk (1997) also express concern that youth health services are not as widely accessible to the full range of young people who might benefit from such services, especially those from non-English speaking backgrounds and same sex attracted young people. Better understanding of the roles of youth health services and closer collaboration with other government and community agencies might enhance referral of a greater number and wider range of young people to such services.

Results of the Wyder and Kelk study also suggest that levels of professional support provided to staff, the strength of decision-making processes and capacities for quality assurance and evaluation are likely to be variable across different youth health services. Policy development and service planning should prioritise the setting of standards and building of capacities in these areas.

Long term intervention

Project staff and evaluators expressed consistent and strong opinion that long term therapy is essential for improving the health and wellbeing of young people in this client group. This is consistent with the major rationale underlying these projects, which is that enhancing engagement will increase length of exposure to interventions and hence improve outcomes. The current finding is also consistent with the finding of the report of the National Inquiry into Homeless Children (HREOC 1989) which highlighted the need for some long term approaches to address the “crisis merry go round” that many homeless young people experience.

The Young Women’s Project evaluation report raised concerns that recent SAAP funding guideline amendments constrain service provision to six months. Recent developments in mental health service delivery are also moving towards briefer and briefer interventions. SAAP staff interviewed for the evaluation of the Centacare Project expressed the view that Child and Adolescent Mental Health Services were inappropriate for their clients, largely because of their focus on brief intervention.

The question of precisely how long it takes to achieve clinically significant change in any given situation, and under what circumstances brief interventions may be as effective as long term interventions is a vexed question in relation to many mental health problems. It is clear that further evaluation research is required in this area. In the meantime there may be a need for service planners in state and territory governments as well as service managers at the local level to ensure that policies and protocols guiding service provision are sensitive to the possibility that brief intervention may not be effective for all clients, and that longer term intervention is available if needed for clients with complex problems at high risk of suicide (*Suggestion 1.1a*).

Issues for service development research

There are several key research questions that need to be addressed before we can be confident in initiating major service development for marginalised young people with complex problems. There is a need for a comprehensive, coordinated program of service development research (*Recommendation 1.2*).

Priority issues for exploration in youth health service development research include:

- models of service provision targeting young people with mental health problems including personality disorders and other complex problems;
- the involvement of families and care givers;
- staff turnover, the mental health and wellbeing of staff, and strategies for ensuring adequate professional support of staff;

- collaboration between primary health care services, specialist mental health services and other government and non-government agencies;
- strategies for enhancing quality assurance and evaluation; and
- improving access and engagement of young males, young people from culturally and linguistically diverse backgrounds, young people involved in the justice system and same-sex attracted young people.

It is suggested that suicide prevention funds be provided by the Commonwealth and State and Territory Health Departments to establish a number of demonstration projects based in youth health services with the aim of further refining potential models of service provision targeting young people with mental health problems and other complex problems who are marginalised and disaffected (*Suggestion 1.2a*). It is essential that relevant service managers in Area and Regional Health Services such as Area Directors of Mental Health and Community Health be involved in the development of any demonstration projects based in their Areas to ensure that developments in youth health services are linked with local area planning processes.

Needs assessment and service planning

Planning for enhanced collaboration between relevant services and evaluation of alternative models of service provision will require more comprehensive data about needs of client populations, patterns of service use and the ways in which services are currently being provided.

The high prevalence of mental health problems among young people using non-government support agencies is generally known to be the case by workers in these services, however, acknowledgment of this by professionals in mental health services and at a policy level remains inconsistent. In some states, particularly Victoria, there has been a concerted policy decision to encourage the development of specialist mental health programs targeting young people within non-government agencies. In other states the apparently heavy reliance of young people with mental health problems on non-government agencies is less well planned.

Reliable quantitative data about the actual prevalence of mental health problems in the population of young people using non-government services and youth health services is currently scarce and may be useful in stimulating greater commitment from mental health services to respond to referrals and requests for assistance from providers. If such data collection were to identify a significant prevalence of depression and other mental health problems among this population, this would raise questions about the appropriateness of the current division of labour between specialist mental health services and non-government services. It is possible that there is significant overlap in the nature of mental health problems experienced by the client populations served by these two groups of

services. However, comorbidity, the presence of a range of psychosocial problems, as well as eligibility criteria imposed by many specialist mental health services, may work to direct some individuals away from specialist mental health services and towards non-government services.

The extent to which this scenario is true throughout different regions and whether or not this is appropriate is currently unclear. It would be valuable for Area and Regional Health Services to conduct research aimed at developing a comprehensive profile of young people with mental health problems who are using specialist mental health services compared to non-government services and youth health services (*Suggestion 1.2b*).

This information needs to be compared to policies regarding the types of clients that particular services are intended to serve with a view to examining the appropriateness of existing services and arrangements. Such information would be very valuable for informing the design of rational “systems” of local services rather than the largely irrational collection of agencies that operate in an uncoordinated fashion in most locations. Such research would also provide a basis for systematically identifying areas of unmet need and prioritising service development. It is suggested that State and Territory Mental Health Branches conduct systematic reviews exploring the relationships between mental health services, non-government agencies and youth services with a view to developing recommendations for policy making and service planning at the local level (*Suggestion 1.2c*).

Many Area and Regional Health Services currently lack sufficient resources to conduct area/regional level needs assessment and service development research in a systematic fashion. Clinical information systems in mental health services, youth health services and non-government services are likely to be inadequate in most areas. Staff skilled in designing needs assessment research and analysing such data area also scarce. Area and Regional Health Services would need to redirect resources to this work.

Priority populations

Several groups of young people have been identified in the literature as experiencing additional barriers to service access or as particularly difficult to engage in services. These include males; young people involved in the justice system; indigenous young people and young people from non-English speaking backgrounds. The National Youth Suicide Prevention Strategy projects did not direct sufficient attention to these subpopulations. Future service development planning and research will need to give high priority to these groups (*Recommendation 1.2, sixth dot point*).

While rates of completed suicide are consistently higher among young males than young females, young males are widely acknowledged as much harder to engage

in services than females. This gender imbalance was also observed in several of the current set of projects, but concerted effort to address this problem was not a feature of these projects. Of the staff participating in the evaluation of the training delivered by the Centacare Project, only 25 per cent were male. Further examination of the effects of staff gender ratios on engagement may be fruitful.

Only one of the current group of projects provided focused discussion on the issues around enhancing the engagement of young people who have been involved with the justice system. This was in the context of substance misuse among Aboriginal young people. A broader view of the issues affecting this population is required. The First National Stocktake of Youth Suicide Prevention Activities also detected very low levels of suicide prevention activity targeting young people in the justice and juvenile justice systems (Mitchell 1998).

While not a great deal of epidemiological attention has been directed to this issue there is nevertheless some evidence that rates of suicide and suicide attempt are high amongst people who have had contact with the justice system (Beautrais 1999). Most public attention has been directed towards deaths in custody, particularly of Aboriginal people. However, there is also evidence of inflated risk for those not currently incarcerated, as well as evidence that access to appropriate services is particularly problematic (Mitchell 1998).

It will be important for future suicide prevention initiatives, particularly those based in youth services to increase attention to the needs of young people involved in the justice system. It is notable that Multisystemic Therapy (MST) has demonstrated impressive effectiveness in enhancing retention of juvenile offenders and their families in treatment aimed at reducing recidivism (Santos et al. 1995). Future service development research could examine the capacity of MST in enhancing engagement and outcomes for this target group with a view to improving mental health outcomes and preventing suicide and self harming behaviours.

At a philosophical level, providing a holistic service is largely to do with recognising that clients are individuals with unique and diverse needs and qualities. Marginalisation from the general community due to negative community attitudes is exacerbated for young people from indigenous and non-English speaking backgrounds and for same-sex-attracted young people. It is particularly important for services to be sensitive to the presence of this diversity among their client group. However, with minor exceptions, the issue of diversity was not explored in depth in the current group of projects.

The need for holistic approaches to health and wellbeing have been noted as crucial when working with Aboriginal people (Swan and Raphael 1995) and people from many non-English speaking background communities. With respect to cultural diversity, a holistic approach needs to include attention to the place of the individual within the community and therefore requires sensitivity to community issues as well as strategies that target whole communities (Mitchell, Malak and Small 1998).

Employment of staff from minority communities is widely regarded as greatly enhancing the ability of services to be sensitive to cultural diversity (Mitchell, Malak and Small 1998). Consistent with this, the Young Women's Project reported that employment of staff from a mix of cultural backgrounds allowed staff to teach each other things that can not be learned through training. Analysis of client profile data demonstrated that the proportion of Young Women's Project service users from a non-English speaking background increased to more than a third following employment of staff from culturally diverse backgrounds. It is important that future research and service development focused on holistic service provision for marginalised young people gives much greater prominence to cultural diversity among the issues addressed.

Training

Training is a key strategy that has been identified for enhancing collaboration between the various agencies that provide services to young people at risk of suicide (see Technical Report Volume 1, Chapter 3). There are specific issues that may need to be addressed in training for providers working with marginalised young people. Relationships between relevant providers in this field have been identified as particularly problematic. Considerable mistrust has developed between staff working in youth services and staff working in mental health services. Training programs in youth suicide prevention usually include a focus on attitudes towards suicide and young people. Training programs may also need to include a focus on the attitudes that professionals hold about themselves and other groups of professionals.

It would be useful to conduct further research and evaluation in the area of training provided to staff in non-government services working with young people with mental health problems. Future evaluation should include formative and outcome evaluation in addition to the usual process evaluation. Formative evaluation should focus on clarifying the appropriate goals and objectives of training. Outcome evaluation is needed to determine whether indicators of process, such as satisfaction of participants and their perception of the amount of learning obtained, actually translate into objectively measured changes in practice and improved outcomes for clients. Data from the evaluation of the Centacare Project training suggested that some participants perceived little change in their work practice. With regard to those who did perceive some changes, little information is available about the nature and extent of change actually achieved.

Kirkpatrick (1994) in his seminal work on the evaluation of training programs has pointed out that barriers often stand in the way of learners who want to apply new learning. Training programs that are effective in instilling new knowledge and skills cannot be effective in achieving "results" unless environmental factors are conducive to the effective application of new learning. Outcome-focused evaluation of training will require greater clarity in regard to the broader goals and objectives. These need to extend beyond immediate impacts on

learners' skills and knowledge, and to define a vision of how services should be delivered. Clear and measurable performance indicators for individual services and service systems would provide valuable guidance to the design of training programs and relevant evaluation that is cognisant of the broader service, community and policy context (see Technical Report Volume 1, Chapter 3 for further discussion).

Other service delivery issues

Flexibility in the length of intervention provided to marginalised young people at risk of suicide suggested above (see Suggestion 1.1a) should be accompanied by rigorous evaluation. Specifically it would be desirable to conduct routine monitoring of outcomes over time across a range of different programs and client groups in order to generate data that can be used to make comparisons across interventions and client groups, while controlling for confounding factors using statistical techniques. It will generally not be possible or appropriate for individual service agencies to conduct such controlled evaluation research. This work would require collaboration across multiple agencies in multiple states for sufficient numbers of observations to be generated (*Suggestion 1.2d*). Data is also currently lacking as to the effectiveness of briefer interventions with this population. It may be possible that certain, discrete, brief interventions may be effective for addressing particular problem areas, when integrated into a holistic long term management plan.

Further close study is required of the factors that mediate drop-out from service. Such research could be conducted within individual agencies using routine detailed documentation of all clinical contacts from initial inquiries and appointments, through to later appointments. Research based on this information would be consistent with the clinical priorities of staff who want to conduct comprehensive case planning and monitor the progress of their clients. Routine, *prospective*, documentation of a range of potentially relevant data about all clients (or a representative sample) is essential if research is to identify the factors that differentiate drop-outs from clients who engage successfully. An alternative approach is to compare the extent of engagement achieved across different agencies, by documenting and contrasting agency practices and relating this to retention rates. This design would avoid the need to collect detailed information from a representative sample of clients within each agency, but would not provide information that is useful to service providers in their daily work.

The finding regarding the importance of the relationship between a young person and an individual worker raises a number of questions for research. One of these concerns the issue of staff turnover. High rates of staff turnover have been noted as a problem in many mental health services as well as non-government service agencies, and may act as a barrier to maintaining engagement with young

people at high risk of suicide. This issue was not explored systematically in the current set of projects, but a number of observations suggest that this is likely to be a problem.

It would be useful for future studies of engagement to collect information about rates of staff turnover and the rates at which clients terminate prematurely when workers leave. Such studies might also collect information about the reasons why clients decide to leave, any arrangements that are made for alternative care, as well as outcomes for clients. Such information would be valuable for estimating the impacts of high staff turnover on the cost-effectiveness of services. If high staff turnover is found to have negative impacts on client engagement, it may be worth conducting further research aimed at identifying factors that contribute to staff maintaining a longer term commitment to particular agencies.

It is plausible that the level of support provided to staff is an important factor. The evaluations of ConneXions and the Young Women's Project emphasised the importance of providing staff with adequate support, including professional supervision, a genuine teamwork approach, team meetings that encourage exploration of emotions as well as flexibility in working hours and leave arrangements. Other experts have raised concerns about the mental health and wellbeing of staff working with this group of young people. Kelk (1999c) wondered if the psychoemotional health of workers in the area of homeless and alienated youth was poorer than that of workers in more mainstream youth health and also whether this area may attract people with personal, social, and physical and mental health problems. Kelk (2000, personal communication) reports that one of the people who was on the Cellblock/High Street Steering Committee who is a very experienced youth worker believes this is a major issue in the field, which needs constant attention in the work place, and requires research.

Building capacity for service development research and evaluation

Measurement issues

Research on the needs of marginalised young people at high risk of suicide will benefit from clarification of the meaning of engagement and the development of generally agreed indicators of such. While definitions of engagement should be generally applicable across a range of service settings, specific indicators of engagement may vary according to the particular aims of a service and the nature of interventions used. For example in some settings, engagement may not necessarily imply high and consistent levels of service use over a long period of time. It may be equally present if clients feel comfortable to approach the service whenever the need arises. Considerable flexibility would be required to accommodate this type of engagement. Several services in this group provided "multiple entry and exit points" so that young people can access the service when they need to.

Data collection

The question of the collection of quantitative data for evaluation and service planning purposes was a major issue in the current set of projects. Evaluators expressed divergent opinions concerning the appropriateness and usefulness of formal questionnaires and standardised instruments. Some argued passionately that it is inappropriate to ask young people experiencing complex problems to complete formal questionnaires. In these cases qualitative evaluation methods were preferred. Other evaluators found that, when they are asked, young people are willing and able to complete such questionnaires, that they are well received and that few young people experience any negative reactions. Moreover, the standardised instruments used in the High Street, Cellblock and Limelight Productions Projects demonstrated sensitivity to change and convergent validity with clinical interviews (Kelk 1999c).

On balance it is clear that the difficulties of collecting quantitative data from marginalised young people at high risk of suicide are very real. The major barrier appears to be the reluctance of clinicians to approach their clients to act as participants in evaluation, rather than widespread rejection of structured questionnaires by young people themselves.

Further work is required to clarify and address the concerns of clinicians regarding the use of structured instruments in the evaluation of services. A major barrier affecting clinical programs appears to lie in the negotiation of appropriate definitions of the desired impacts or performance indicators by clinical staff and evaluators. A close correspondence between the information needs of clinicians and evaluators is desirable and is likely to enhance clinicians' engagement in the evaluation process. If clinicians do not see the information as relevant to their needs, it is not surprising if they will be reluctant to dedicate scarce time to this work.

A major source of contention between clinicians and evaluators revolves around the perception that collection of quantitative data necessarily involves an intrusion into and a threat to the clinical relationship. This danger does not extend to evaluation of the process of service provision, but appears to have contributed to a generalised reluctance on the part of evaluators, as well as clinicians, to collect data about any aspect of clinical service provision, whether or not it necessitates collecting data from clients directly.

If monitoring of clinical outcomes is not possible or appropriate, then monitoring of practices judged to be related to these outcomes is the next best option. For example if the program wants the target services to develop more appropriate referral practices, then "appropriate referral practice" needs to be clearly defined in terms that can be measured reasonably effectively. One important aspect of good referral practice, especially when greater interagency collaboration is a concurrent aim, is follow-up by the referrer to determine whether or not

the client presented, whether or not the referral was appropriate to the provider referred to, and whether or not the client has engaged with the new agency. Collection of this basic information is intrinsic to good clinical practice as well as being useful for continuous quality enhancement and other evaluation purposes.

However, there is a need for more rigorous research aimed at ascertaining the effectiveness of interventions directed at young people affected by complex problems and at high risk of suicide. Most controlled treatment evaluation research excludes subjects with complex problems and measures outcomes in single clinical domains. Some project managers and evaluators in this group noted that it is difficult to measure outcomes for the young people in their service using standardised instruments, because the outcomes of interest are so varied.

This concern has some validity but is also open to challenge. It is possible to argue that there is a set of outcomes that have very broad applicability across a wide range, and a large proportion, of individuals when we adopt a public health or population-based approach to addressing the underlying issues. For example, for the group of young people with which we are concerned, there is a group of risk factors to which many have been exposed (physical and sexual abuse, neglect, violence) and a group of outcomes or problems that many experience as a result of exposure to these risk factors (depression, self harm, substance misuse, homelessness).

While each individual experiences these risk factors and outcomes to varying degrees and in a unique pattern, we cannot plan service systems or understand and address underlying causes such as social factors if we only look at the individual level. Some understanding of the aggregate experience is necessary for this. This is perhaps where the major value of standardised instruments lies but may be beyond the interest and experience of most clinicians or youth workers. However, also at the individual level, standardised instruments that measure the most common risk factors, protective factors and outcomes, will in most cases be highly relevant in planning the care and treatment of individual clients. These can help clinicians see the problems of their clients from the broader perspective of how they compare with others who have experienced similar problems. It is possible that many clinicians have not been exposed to much discussion of the uses and value of standardised instruments. Formal education about the uses of standardised instruments is provided routinely to some professional groups but not others.

However, there is also a strong argument that many standardised instruments fail to provide a clear picture of the concerns and goals of individual clients and that these factors are not yet given adequate consideration in systems of outcome measurement that have been proposed. One tool that might be worthy of exploration or further development in future research with this population is Goal Attainment Scaling (GAS). GAS is also a useful clinical case planning tool (Kiresuk and Sherman 1968).

Research ethics

Based on his experience evaluating a number of projects targeting “alienated and marginalised” young people attending youth health services Kelk (1999c) observes that there are some additional external barriers to research and evaluation with this population that need to be addressed. Kelk notes that it is generally very difficult to secure approval from research ethics committees to conduct research and evaluation on “marginalised” young people but that many of the activities that would take place in such research projects proceed without question when the activity is initiated by clinical workers. By simply adding on the requirement of evaluation, such activities become subject to research ethics committee approval and are often blocked. Kelk suggests that few people on research ethics committees have an intimate knowledge of alienated, marginalised and homeless youth and as a consequence, committees tend to overestimate the extent to which researchers or clinicians can exploit such young people for research purposes.

In the interests of enhancing evidence-based practice within youth health services (and mental health services), it may be appropriate for service managers and staff as well as research ethics committees to clarify the distinction between clinical innovation, evaluation and research (*Suggestion 1.2e*).

Need for intersectoral action

Progress in the development of services that are appropriate to the needs of young people with complex problems will require intersectoral collaboration in policy development and service planning at the Commonwealth and state/territory government levels. There are a number of intersectoral developments led by the community services sector that could provide important opportunities for the health and mental health sectors to promote better collaboration for youth suicide prevention.

Based on the recommendations of the Prime Minister’s Youth Homelessness Taskforce Report *Putting Families in the Picture*, the Commonwealth Government has recently initiated development of a National Youth Pathways Action Plan, a National Homelessness Strategy as well as renewed funding for a youth homelessness early intervention program (Newman and Kemp 1999). A primary focus of these initiatives will be to link strategies targeting homelessness more closely with programs targeting related problems such as unemployment, substance abuse, criminal behaviour, mental health problems and physical, sexual and psychological abuse. Key aims are to enhance early detection and early intervention with young people at risk of homelessness as well as to provide a more holistic service response to their complex needs.

Centrelink, with its comprehensive reach into communities of greatest need, as well as its new single point of service model will act as a key first point of

contact for the planned early detection system. It is also noteworthy that the Prime Ministerial Taskforce on Youth Homelessness and the Government's response emphasise the critical importance of services providing opportunities for families to be involved in interventions and that efforts are made to support and maintain the family structure wherever possible.

These developments provide unique opportunities for those service planners interested in youth suicide prevention to raise issues of relevance to this aim with key potential partners. It is recommended that the National Advisory Council on Suicide Prevention and the Commonwealth Mental Health Branch work closely with the Youth Homelessness Taskforce and the National Youth Pathways Action Plan Drafting Committee to ensure appropriate attention is given to issues of relevance to suicide prevention and young people with mental health problems and to identify opportunities for collaboration (*Recommendation 1.3*).

Recommendations

It is recommended that:

- 1.1 Governments should work in partnership with Area/Regional Health Services, youth health services, mental health services and young people to identify strategies for expanding the capacity of youth health services to provide a comprehensive health service to young people affected by multiple risk factors for suicide.

(This is Recommendation 17 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

- 1.1a Service planners in state and territory governments as well as managers at the local level should ensure that policies and protocols guiding service provision are sensitive to the possibility that brief intervention may not be effective for all clients and that longer term intervention is available if needed for clients with complex problems at high risk of suicide.

It is recommended that:

- 1.2 Funding should be provided to support a program of service development research aimed at identifying strategies for engaging marginalised and alienated young people with services. Key topics for further exploration should include:
 - models of service provision targeting young people with mental health problems including personality disorders and other complex problems;

- the involvement of families and care givers;
- staff turnover, the mental health and wellbeing of staff, and strategies for ensuring adequate professional support of staff;
- collaboration between primary health care services, specialist mental health services and other government and non-government agencies; and
- strategies for enhancing quality assurance and evaluation;
- improving access and engagement of young males, young people from culturally and linguistically diverse backgrounds, young people involved in the justice system and same-sex attracted young people.

(This is Recommendation 18 in the evaluation overview, “Valuing Young Lives”.)

It is further suggested that:

- 1.2a Funds be provided by the Commonwealth and State and Territory Health Departments to establish a number of demonstration projects based in youth health services with the aim of further refining potential models of service provision targeting young people with mental health problems and other complex problems who are marginalised and disaffected.
- 1.2b Area and Regional Health Services should conduct reviews aimed at developing a comprehensive profile of young people with mental health problems who are using specialist mental health services compared to youth health services and non-government services.
- 1.2c State and Territory Health Departments and Area/Regional Health Services should conduct reviews exploring the relationship between mental health services, non-government agencies and youth health services with a view to developing recommendations for policy making and service planning at the local level.
- 1.2d Flexibility in the length of intervention provided should be accompanied by rigorous evaluation. Specifically it would be desirable to conduct routine monitoring of outcomes over time across a range of different programs and client groups in order to generate data that can be used to make comparisons across interventions and client groups while controlling for confounding factors using statistical techniques. Such evaluation research would require collaboration across multiple agencies in multiple states for sufficient numbers of observations to be generated.
- 1.2e In the interests of enhancing evidence based practice within youth health services (and mental health services) it may be appropriate for service managers and staff as well as research ethics committees to clarify the distinction between clinical innovation, evaluation and research.

It is recommended that:

- 1.3 The National Advisory Council on Suicide Prevention and the Commonwealth Mental Health Branch should work closely with the Youth Homelessness Taskforce and the National Youth Pathways Action Plan Drafting Committee to ensure that appropriate attention is given to issues of relevance to suicide prevention and young people with mental health problems, and to identify opportunities for collaboration.

(This is Recommendation 19 in the evaluation overview, “Valuing Young Lives”.)

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Map of program logic: support for young people who are marginalised and disaffected

Goals/outcomes

- Reduce the incidence of suicide and suicide related behaviour among young people exposed to multiple risk factors for suicide and who are marginalised and disaffected.

Objectives/impacts

- Minimise the length of time that young people are exposed to problems such as homelessness and mental disorders that could place them at risk of suicide.
- Minimise the harm, distress and disadvantage suffered by young people exposed to problems such as homelessness, substance misuse, mental health problems, contact with the justice system and sexual identity issues.
- Maximise the life skills and quality of life of young people living with problems that could place them at risk of suicide.

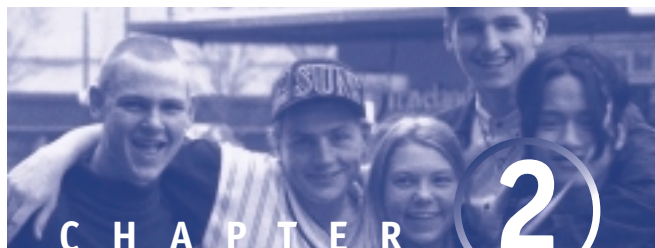
Aims/processes

- Enhance service delivery to young people who are marginalised and disaffected by virtue of exposure to risk factors such as homelessness, substance misuse, contact with the justice system, sexual identity issues as well as mental health problems, self harming behaviour, and previous suicide attempts.
- Enhance engagement of marginalised young people in services especially people belonging to the following special needs groups: young males, Aboriginal and Torres Strait Islander young people; young people from non-English speaking backgrounds; same sex attracted young people.

Performance indicators

- Holistic youth oriented services are available in all geographic regions.
- Area and Regional Health Services have comprehensive service plans detailing the roles and relationships between youth health services, specialist mental health services and non-government agencies with respect to service provision to young people.
- Staff in relevant services have the skills, knowledge and information necessary to provide care for marginalised young people.

- Young people from all identified subpopulations and special needs groups have equitable access to services.
- Service evaluation provides evidence that services are effective in engaging young people from all identified subpopulations.
- Service evaluation demonstrates that young people from all identified subpopulations and special needs groups are satisfied with services.
- Service evaluation demonstrates positive mental health and wellbeing outcomes for young people from all identified subpopulations and special needs groups.



CHAPTER 2

Mental health services

This chapter presents and analyses information about the projects funded under the National Youth Suicide Prevention Strategy that were based in mental health services.

The goal of this group of projects was to reduce the incidence of suicide and suicide related behaviour among young people with established mental health problems and mental disorders.

Projects sought to enhance the quality of care provided to young people affected by mental health problems and disorders and who require assessment, treatment and support from mental health services. This aim has been addressed strategically by seeking to develop information, knowledge and skills pertinent to good practice in the assessment, treatment and management of mental health problems and disorders, particularly depression, psychosis and dual diagnosis involving substance misuse. Specific aims and objectives common across the projects included: (i) enhancing access and engagement of young people with mental health services; and (ii) improving mental health outcomes.

Issues for mental health services and young people with mental health problems are also discussed at considerable length in other volumes of the Technical Report series. Early intervention in mental health problems is discussed further in Chapter 3 of Technical Report Volume 2. The role of mental health services in providing assessments and ongoing care for people who present to hospital accident and emergency departments following a suicide attempt is discussed in Chapter 1 of Technical Report Volume 3. Issues surrounding the role of primary health care services in caring for young people with mental health problems are discussed in more detail in Chapter 2 of Technical Report Volume 3, and Chapter 1 of this volume. Building capacity for research and evaluation into provision of mental health services for young people is discussed further in Chapter 1 of Technical Report Volume 1.

Projects based in mental health services

As shown in Table 2.1, there were three projects in this group: *Young People & Psychiatric Illness – Intervention and Assessment (YPPI-IA)*, based at the Central Coast Health Service, Mental Health Service in NSW; *Out of the Blues*, based at the Southern Child and Adolescent Mental Health Service in Adelaide; and *LifeSPAN*, based at Mental Health Services for Kids and Youth (MH-SKY) in Melbourne.

YPPI-IA

Located on the New South Wales Central Coast Area, and based in the YPPI (Young People, Prevention and Early Intervention) Centre, the Young People and Psychiatric Illness – Intervention and Assessment Project (YPPI-IA) was grafted on to the existing service.

A youth-oriented and community-based mental health program, YPPI-IA sought to: promote access to, and participation in, services by young people with a history of severe mental illness and or deliberate self-harm; provide optimal treatment and care to young people; develop strategic alliances within the community in order to integrate the project within existing mainstream services; and bring about a reduction in the symptoms and disability caused by mental illness.

The project also sought to increase the collaboration between referral agencies and community service providers working with young people with serious psychiatric illnesses by increasing the awareness of these agencies about suicide intervention strategies and options. Information about awareness levels were then compared to levels prior to implementation of the project.

Strategies implemented in meeting these aims were: to provide a specialist mental health service; to educate referring agencies about the best ways to help young people with early psychosis access services; and to develop an assessment package, intervention protocols and manuals for circulation in mainstream services.

Program name	Organisation	Main intervention	Evaluation design
Young People & Psychiatric Illness – Intervention and Assessment (YPPI-IA)	Central Coast Health Service, Mental Health Service	Early psychosis and substance misuse	Single group, repeated measurement of outcomes
Out of the Blues	Southern Child and Adolescent Mental Health Service	Depression	Single group, repeated measurement of outcomes
LifeSPAN	Mental Health Services for Kids and Youth (MH-SKY)	High suicide risk	Randomised controlled trial

Other products of the project included a video entitled *Catch us if you can*, fact-sheets on a range of topics related to psychosis and support services, client information pamphlets entitled *Grief and loss* and *Feeling good*, a computer disc with YPPI-IA protocols, measures, guidelines and checklists, and various stickers, postcards and posters.

Out of the Blues

Out of the Blues was a Mood Disorders Unit based at Southern Child and Adolescent Mental Health Service in Adelaide. The objective of the project was to improve recognition and treatment of depression in an attempt to reduce the incidence of suicidal behaviours and suicide in young people. By targeting young people aged 15–24 years, Out of the Blues sought to overcome or avoid the gaps and disruptions in service provision that often arise for older adolescents and young adults, due to the usual separation of child and adolescent and adult mental health services.

The Out of the Blues Unit aimed to promote young people's access to, and engagement with the service, and provide them with optimal care and treatment. It also aimed to promote strategic alliances within the community, achieve recognition of the Unit's work on a wider scale, and evaluate the project.

In addition, the project sought to: develop, promote and disseminate best practice locally and nationally; actively explore issues of mental health promotion, early detection, intervention, treatment and management, as well as relapse prevention; promote a national focus on these issues through professional publications, national bulletins, media discussion and all electronic means; and promote education in best practice for affective disorders in young people through national conferences, seminars and workshops focused on affective disorders. Training workshops aimed at non-health sector workers provided education in risk assessment, initial management, and appropriate referral to the mental health sector. Training was also provided to health professionals and students.

Evaluation was both quantitative and qualitative. A range of different quantitative measures including client questionnaires and clinician questionnaires was administered at three stages. Qualitative feedback was obtained through a telephone interview with clients which aimed to discover "What makes counselling services useful for clients?", and to evaluate the client's experience of the therapeutic relationship and the effectiveness of treatment for depression in the Out of the Blues program.

LifeSPAN

The LifeSPAN Project operated from the Mental Health Services for Kids and Youth (MH-SKY) (Youth Program) at Parkville in Melbourne. MH-SKY (Youth Program) is a comprehensive integrated mental health service for young people aged 14–25 years with serious mental illness living in the Western Region of Melbourne.

MH-SKY (Youth Program) developed throughout the 1990s from a basic inpatient first episode psychosis service to a comprehensive community based early intervention and prevention service for youth. It incorporates the Early Psychosis Prevention and Intervention Centre (EPPIC), an Older Adolescent Service and several other services. Research, evaluation, and training are well developed within MH-SKY and the service plays a role in the wider dissemination of good practice.

The LifeSPAN Project trialed the efficacy of a specific cognitive therapy program in preventing suicide and reducing suicidality. This represents the first ever attempt to develop such an intervention for patients with psychotic illnesses such as schizophrenia and major affective disorders. The therapy was designed to complement and augment standard clinical care.

The LifeSPAN Therapy was developed by the project team after consultation with a range of experts in the field of suicide prevention. It is an individual cognitive therapy program of ten weeks duration designed to: (i) better engage high risk patients in treatment and (ii) address cognitive risk factors for suicide such as hopelessness, poor problem solving, misconceptions about mental illness, low self-esteem and cognitive rigidity.

Therapy was delivered by two clinical psychologists who were extensively trained and provided with weekly supervision by two senior clinicians. It involves four phases: engagement; assessment and formulation; cognitive intervention; and closure and handover.

Trial participants were recruited from EPPIC and the Older Adolescent Program at MH-SKY over a 15-month period from October 1997 to December 1998. Recruitment depended upon referral from service clinicians of patients identified through screening as being at particularly high risk of suicide. Eligible patients referred were randomly allocated to usual treatment and care (n=28) or usual treatment and care plus the specific suicide prevention intervention (n=30). A little over half (57.1 per cent) suffered from an affective psychosis.

A major component of the LifeSPAN Project involved facilitating awareness among clinical staff of the importance of early detection of suicide risk among their patients. The project used two simple measures of suicide risk, one to be used on initial assessment when the patient was first referred to the service and one to be used at regular intervals upon follow-up. The Suicide Risk Factor Checklist was developed by the project for the first function and the Brief Psychiatric Rating Scale (BPRS) suicide subscore was eventually selected for the ongoing monitoring function. This rating system acted as a prompt for clinicians to refer high risk patients to the LifeSPAN therapy described below.

Although MH-SKY was not the subject of the Strategy funded project or the evaluation, it nevertheless constitutes a fundamentally important context for the LifeSPAN project. Many of the service characteristics identified by YPPI-IA and

Out of the Blues as enhancing service effectiveness are shared by MH-SKY. MH-SKY itself is more relevant and consistent with the aims of YPPI-IA and Out of the Blues than the LifeSPAN project. The Evaluation has therefore included information about MH-SKY in this content analysis wherever appropriate. Reference is also made to the Centre for Young People’s Mental Health (the former name of MH-SKY) and the Early Psychosis Prevention and Intervention Centre (EPPIC) which is part of MH-SKY.

Results of the evaluation

Information from the qualitative meta-analysis fell into four main categories:

- increasing young people’s access to mental health services;
- engaging young people with mental health services;
- improving mental health outcomes and reducing suicide and self-harm; and
- reorienting and building capacity of mental health services to meet the needs of young people.



What works to increase young people’s access to mental health services?

Thirty-nine per cent of respondents in the survey of Strategy key stakeholders believed that the extent to which young people with chronic problems (including mental health problems) have access to effective treatment and support got “a little better” since 1995. Thirty-six per cent believed there had been no change, and 9 per cent believed it had got a little worse. The majority of respondents (77 per cent) believed that the Strategy had at least some role in the progress that had been made in the area of treatment and support (including service accessibility), with 31 per cent saying it had a moderate role and 9 per cent saying it had a strong role.

Increasing the access of young people to mental health services was a major aim of both YPPI-IA and Out of the Blues, and both these projects were able to incorporate a number of service design features that proved effective in particular ways. However, both YPPI-IA and Out of the Blues were operating under general conditions that limited the ability of the programs to make themselves as widely accessible as they might have been to young people who could have benefited from the services provided. Specifically, resource constraints meant that fairly strict eligibility criteria had to be applied.

As with most indicators of service performance, accessibility is a relative concept and is only really meaningful when it can be contrasted with the accessibility of other, alternative services. Unfortunately, neither of these projects aimed to

determine whether or not these programs were any more accessible than other mental health services. This was not identified as one of the requirements of evaluation.

One key indication that these programs were accessible to the target group is the fact that at least 50 per cent of initial referrals were for young males. The evaluators of Out of the Blues note that only one third of referrals to generic Child and Adolescent Mental Health Services are for males (Martin and Wright 1999). Males are also usually much less likely to use mental health services for mood disorders than females. Martin and Wright also note that the high number of self referrals and referrals from parents suggests high community acceptability. Unfortunately, a large proportion (around half) of the referrals that were declined came from parents.

The projects have generated valuable insights into strategies that could be effective in increasing the access of young people to mental health services. The following factors were identified as important:

- a dedicated youth mental health service;
- thorough assessment;
- sufficiently wide eligibility criteria;
- acceptance of primary, secondary and tertiary referral;
- flexibility, outreach and assistance to attend appointments;
- after hours access;
- strong links with a youth oriented health service; and
- public relations, outreach, networking and promotion.

► ***A dedicated youth mental health service***

One of the clearest findings emphasised in the evaluations of both YPPI-IA and Out of the Blues was that having a dedicated youth mental health service provides enhanced access for young people. The LifeSPAN project was based at a service which, while constantly evolving in structure and name has included a specific youth focus (ages 14–25) via EPPIC and the Centre for Youth People’s Mental Health for several years. EPPIC has become an important model for the development of youth specific early psychosis services in other areas.

Defining features of a dedicated youth mental health service include having a team of clinicians that are clearly and exclusively focused on working with young people and a physical building or space that belongs to that dedicated service.

A dedicated team of clinicians is important to service accessibility for several reasons. Having a dedicated team or organisational structure appears to promote access by allowing the development of an organisational profile. Having an

organisational profile promotes awareness of the existence and role of the service among consumers, the community and professionals, thereby encouraging primary, secondary and tertiary referrals.

Having a physical building or space that belongs to the service promotes access for young people because it facilitates the creation of an environment that is youth friendly and which reflects aspects of youth culture.

Having a dedicated service unit is a very different model than placing individual workers focused on a particular target group in generic services. The authors of the Out of the Blues evaluation report (Martin and Wright 1999) note that providers in other services sometimes felt confused about the work of Out of the Blues because they believed that they were already doing things in the way that Out of the Blues clinicians were advocating. This suggests that the way in which an organisation works is more than the sum of its parts (ie staff members and their clinical activities). Organisations have a culture and create environments that cannot be reproduced by individual professionals unless they are working with others according to the same set of principles.

► ***Thorough assessment***

An innovative feature of the YPPI-IA program that appears to be important for enhancing access to services is the provision of an extended (six -week) assessment period that is offered to young people when it is felt that “something’s not right”, but it is unclear what the problem might be.

The “six-weekers” were young people who presented to YPPI-IA with very unclear clinical issues. Typically they reported phenomena that may have been prodromal (early signs of the onset) of psychosis but which could have been explained by other events (such as trauma). The phenomena were not of sufficient severity, frequency or duration to indicate acute psychosis or treatment. The six-week assessment period provided by the YPPI-IA Project allowed thorough exploration of the presenting problems and facilitated engagement through the development of trust. If phenomena developed into a more typical psychotic disturbance appropriate treatment could be initiated promptly. Alternatively other options for managing the problem could be explored.

The finding regarding the advantage of a thorough assessment process is consistent in certain key respects with the finding of projects targeting marginalised young people with complex problems, that young people generally need to be given time and space. For a variety of reasons it can be difficult to identify and clarify the issues that might need to be addressed. Exclusion of young people from services based on an overly hasty assessment might act as an inappropriate barrier to service access.

► *Sufficiently wide selection criteria*

Age restrictions governing Child and Adolescent Mental Health Services (usually up to 17 or 18) and Adult Mental Health Services (18 and older) have been identified as creating access problems for adolescents and young adults. Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) have been identified as inappropriate to the needs of large numbers of adolescents and young adults. Several key mental health problems have their onset in adolescence and early adulthood, most usually between the mid teens and mid 20s. Thus the “divide” between Child and Adolescent Mental Health Services and Adult Mental Health Services, with its dangers for continuity of care, has its greatest impact on clients at this most critical and vulnerable age.

Diagnostic selection criteria have also been identified as creating barriers to service access for young people because young people often present with problems which do not fit clearly into usual “child” or “adult” diagnostic criteria.

All three of the services in this group sought to address age and diagnostic barriers. Since its inception, the MH-SKY Youth Program has targeted its services at the youth to young adult age group (14–25 years) and some services extend to young adults up to 30 years of age. The LifeSPAN Project addressed the same youth to young adult age bracket. The Out of the Blues project moved away from the usual divide between the Child and Adolescent and Adult Mental Health Service that characterises the wider mental health service in that area, and targeted young people aged 15–24 years. YPPI-IA focused on the 14–19 year age bracket but only because resources were insufficient to allow the service to extend to young people over 19 years. In interviews with staff from the YPPI Program and other services, many expressed a strong desire for the YPPI-IA Program to be extended to young people aged 20–24 as well as those aged 14–19.

EPPIC, based at MH-SKY, which was the source of most LifeSPAN clients has consistently emphasised the importance of relaxing criteria for inclusion in the service. EPPIC is inclusive of clients experiencing a variety of psychotic phenomena as well as phenomena that may be early signs of the onset of psychosis. The MH-SKY Youth Program evolved alongside EPPIC with the addition of generalist adolescent mental health services, an Older Adolescent Service and various other specialist programs. The intention was to create a fully comprehensive youth mental health service for the population of western Melbourne.

The YPPI-IA service focused primarily on psychosis. This was defined broadly in the sense that young people who may have been experiencing prodromal were not excluded from the service. Usual diagnostic exclusion criteria were also addressed through the conscious decision to focus on dual diagnosis involving substance misuse. Out of the Blues was intended to focus on the treatment of depression.

The focus on particular diagnostic categories was identified as a source of concern regarding the accessibility of these programs. Some stakeholders interviewed in the evaluation of YPPI-IA made the criticism that YPPI-IA was not accessible for young people experiencing crises that may place them at risk of suicide, unless they were also experiencing psychosis. As a worker from the Gosford Mental Health Assessment Crisis Team, said: “You talked about the one thing they didn’t do. The one thing I would have liked them to have done is to expand it further to taking youth in crisis more than just psychotic youth because that wasn’t dealt with . . . Your teenagers who are suicidal for relationship reasons . . . that sort of fell back on us still . . .” (Howe et al. 1999).

While this comment is intended to identify the limitations of YPPI-IA, it also implies that YPPI-IA was the only youth focused mental health service that was providing a crisis response to young people with acute mental health problems in this area. It raises the question as to the roles and responsibilities of the broader child and adolescent mental health services in providing all young people with access to a comprehensive range of mental health services. These issues did not arise in the LifeSPAN Project which was based in a comprehensive youth mental health service.

► *Acceptance of primary, secondary and tertiary referrals*

Related to the issue of selection criteria is the question of from where services will accept and encourage referrals. It would appear to be important for specialist mental health services to be able and willing to accept primary referrals, including people who spontaneously walk in to the service. At present it is unclear to what extent this is the case. Many specialist mental health services operate mostly as secondary referral services (accepting referrals from primary health care services such as general practitioners and other community-based workers) and tertiary referral services (accepting referrals from other mental health services such as Crisis Assessment Teams or inpatient units or hospital services such as Emergency Departments).

It has been noted that services that do accept primary referrals tend to be those in rural and regional towns, in outer urban areas, and where services are located in the main shopping areas of the town or suburb. Child and Adolescent Mental Health Services located in the grounds of psychiatric hospitals have been identified as particularly inaccessible to young people (Hearn 1993).

Out of the Blues and YPPI-IA operated as primary, secondary and tertiary referral agencies, actively seeking and encouraging self referral from young people and from parents and other carers. This strategy appeared to be effective in enhancing access. Nineteen per cent of referrals to Out of the Blues (that actually received a full assessment) were from parents and 10.6 per cent were self referrals. When YPPI-IA operated a 24-hour “Y” Page service, 49 per cent of

referrals were directly from young people themselves. Approximately 85 per cent of these young people were within the target age group (14–19 years) and 54 per cent were young males. However, a majority were either current or past YPPI-IA clients.

It is likely that a significant number of the young people accessing Out of the Blues and YPPI-IA directly would be unlikely to gain access to services that do not encourage primary referrals and are less well known to the public. However, data showing the referral source profile of comparison services is necessary before we can make firm conclusions.

► ***Flexibility, outreach and assistance to attend appointments***

Both Out of the Blues and YPPI-IA placed strong emphasis on being flexible regarding appointment times and location. Appointments were provided at locations most accessible to the young person including home or other agencies. Some young people find it difficult to talk in a formal, enclosed office and prefer to talk in a coffee shop or walking along the beach. After hours appointments can be important for some young people to ensure that therapy does not cause excessive disruption to school and extra-curricula activities. Reception staff can also work extended hours on some days to ensure a normal safe environment for both clients and staff.

Transport can be a major barrier to young people attending appointments at service centres. Out of the Blues provided Cab Charge vouchers if necessary and occasional lifts home. It was found that young people are very grateful for any assistance given in this regard and generally tried to overcome difficulties for themselves at subsequent appointments (Wright and Martin 1998a).

Wright and Martin (1998b) note that with the increasing emphasis on early intervention, symptoms experienced by young people may not be severe enough to force young people to accept or maintain treatment. Providing assistance and making attendance at appointments as easy as possible demonstrates to young people that the team cares about their treatment, and this, in turn, encourages them to commit to the necessary involvement.

► ***After hours access***

The YPPI-IA Team recommends that 24-hour access to mental health services, particularly acute care services is important for ensuring maximum accessibility. Providing 24-hour access or even limited extended hours access was found to be difficult for both YPPI-IA and Out of the Blues because they were small services with limited staff numbers. Both projects addressed this problem by working in partnership with mainstream mental health teams that already provided 24-hour access for adult clients.

For the first year of the project YPPI-IA staff were available on call if young people were identified as requiring specialised assistance after triage by the

24-hour acute care team. Due to staffing limitations YPPI-IA could not maintain this 24-hour on-call service indefinitely and reduced its availability to normal business hours, but stakeholders from other services indicated it would be desirable for the on-call service to be available seven days per week.

► ***Strong links with other youth oriented services***

The MH-SKY Youth Program has well developed working relationships with agencies in a range of sectors (youth, educational, vocational, accommodation, correctional, community health and general practice) that have regular contact with youth people. MH-SKY clinicians provide primary and secondary consultation and collaborative case-management.

While the YPPI-IA “Project” was based within the Children and Young People’s Mental Health Program of the Central Coast Mental Health Service, the original YPPI “Program” evolved out of the Youth Health Service and maintains strong practical and philosophical links with this service.

At a philosophical level, YPPI-IA has retained and further developed key aspects of the Youth Health Model that is espoused by youth health services. The Youth Health Model, which is not yet well defined in the published literature, basically involves a more holistic approach to health and has a focus on accessibility and participation in service development by young people. The YPPI Program and YPPI-IA Project have sought to develop a Youth Mental Health Model, which combines the youth focused philosophy of the youth health model with the scientific or evidence-based approach to treatment that has gained strength in mental health in recent years, particularly in the area of early psychosis.

YPPI-IA recommends that support should be provided to continue researching specific components of the Youth Mental Health Model.

Out of the Blues and YPPI-IA have interacted with youth health services in different ways. While YPPI-IA received a substantial proportion of referrals from the youth health service and participated in their intake system, Out of the Blues developed a co-work intervention aimed at linking clients in with community agencies that could provide ongoing services such as general health care or programs targeting specific issues such as sexual abuse.

The concept of the youth mental health model is closely related to the concept of a “dedicated youth mental health service” identified earlier as perhaps one of the most important factors facilitating access to mental health services for young people.

YPPI-IA and Out of the Blues argue that for youth mental health services to develop an environment and focus that is sensitive to young people’s culture they need a certain degree of separation from other mental health services such as child and adult services. On the other hand a close relationship with other

mental health services is clearly important for resource sharing purposes such as ensuring access to after hours services. The positioning of youth mental health services in relation to mental health services on the one hand and youth health services on the other is an important question facing the development of the youth mental health model. It may also be beneficial to consider the relationship with generalist youth services.

► *Public relations, outreach, networking and promotion*

Both YPPI-IA and Out of the Blues placed a strong emphasis on public relations, networking and other activities which assisted in raising the public profile of the programs among professionals and the general community.

Program staff participated in a range of activities which involved getting out in to the community to talk about mental health issues and increase the skills of community members and gatekeepers in recognising mental health problems and assisting young people to access services. This included participation in mental health promotion programs, interviews on local and national radio and television, and presentations to local professional and community groups.

It is unclear how effective liaison with community agencies was in generating referrals.



What works to engage young people with mental health problems in treatment?

The Early Psychosis Prevention and Intervention Centre (EPPIC) has a previously documented established track record in the effective engagement of young people with early psychosis. Data on retention in treatment, rates of participation in outcome assessment and satisfaction with services suggests that both YPPI-IA and Out of the Blues were highly successful in engaging the young people who were initially accepted into the programs.

Of the 79 young people who formally entered the YPPI-IA treatment program none “dropped-out” of treatment. Only a very small number of the young people refused to participate in the outcome evaluation which used standardised instruments. The young people were experiencing severe levels of psychiatric disability and were highly depressed and suicidal. Use of drugs and alcohol was also very high. It was concluded that the YPPI-IA team was successful in engaging a very disabled group of individuals. Focus groups conducted with clients and carers, as well as the Verona Service Satisfaction Scale Questionnaires indicated a high level of satisfaction with the YPPI-IA service.

A Telephone Evaluation Survey conducted by Out of the Blues revealed a strong sense of engagement with the service (liking, appreciation, connection with)

expressed by young people. Data from a formal Client Satisfaction Questionnaire indicated that the percentage of the group who were either “delighted” or “satisfied” with the various aspects of the service was uniformly high. Very few reported dissatisfaction with any aspect of their experience.

Forty-seven per cent of the young people who entered therapy at Out of the Blues were males. Martin and Wright (1999) interpret this as indicating that Out of the Blues was generally very effective in engaging young males with depression because this group has been identified as usually very difficult to engage. However, Martin and Wright (1999) acknowledge that through the initial triage process and the first assessment interview, the service “lost” more young men than young women. The authors note that depressed young males tend not to present with typical depression, rather the clinical picture is complicated by the presence of externalising conditions such as conduct disorder and substance abuse which tend to disguise the signs and symptoms of depression. The presence of these externalising conditions also make it more difficult to engage young males in assessment and therapy.

Many of the strategies identified earlier as facilitating access are also important to engagement and vice versa. The engagement process usually begins with the first interview. If early engagement is not successful the client may not return and access is effectively denied. A number of other factors were also identified as particularly important to the ongoing engagement process:

- therapeutic alliance;
- open communication with the young person and carers;
- a youth friendly environment;
- a philosophical youth orientation; and
- assertive outreach.

► *Therapeutic alliance*

Out of the Blues emphasised the concept of alliance as a key part of the engagement process (Wright and Martin 1998a). Alliance is the bond that develops between therapist and client that enables the tasks of therapy to continue toward set goals. Wright and Martin point out that many young people will be resentful at being brought to a mental health service or will be struggling to understand that there is a problem that needs to be addressed. This makes engagement with young people particularly difficult. However, Wright and Martin (1998b) argue that when severe depression and suicide risk are present, it is critical that clinicians do not give up and let communication break down.

Developing a therapeutic alliance involves the therapist and the young person developing a common understanding of the issues so that they can set goals and agree on strategies. Respect and trust are key ingredients.

Wright and Martin (1998a) note that developing a therapeutic alliance is important from the first phone call but may take up a major part of the initial sessions.

► *Open communication with the young person and carers*

During initial contact and assessment and in the first few days and weeks of a young person's involvement with a mental health service, good communication is essential for establishing engagement.

Wright and Martin (1998a) identify good communication as the key to development of a therapeutic alliance, especially in the early sessions. An ability to listen actively and to communicate empathy and caring are particularly important. The good listening skills of Out of the Blues clinicians was one of the major themes identified in the Telephone Evaluation survey.

While conducting assessments and organising immediate interventions (such as medication), YPPI-IA workers ensure that they explain as much as they can to the young person about the Program and seek the young person's permission to continue their involvement. In the next few days or weeks the worker may spend many hours at the young person's home developing a management plan in consultation with the young person and carers and providing education about psychosis, the YPPI-IA role, medication and management strategies. Family members are encouraged to ask questions and voice their anxieties and space is provided to work through these issues.

Home based care and involving carers at this level provides the worker with more detailed understanding of the concurrent issues facing the young person and is an integral part of the holistic, multisystemic model of care.

► *A youth friendly environment*

Both YPPI-IA and Out of the Blues placed strong emphasis on creating a youth friendly environment. Interviews with young people indicated that friendly environments were achieved and that this was very important for promoting ease and comfort for young people visiting the service.

After moving several times, the YPPI Program and YPPI-IA Project located themselves in a specific building known as the YPPI Centre. This is a cottage attached to, but located outside of the Gosford Hospital Campus, and painted yellow, purple and green.

The YPPI Centre aims to provide an environment in which young people and workers have equal rights and space. The committed staff space is two rooms at the front of the cottage and the rest of the house is "shared space". Young people can use the house to drop in, "chill out", see their worker, sleep or rest. The house also provides an "art space" for the creative arts component of the YPPI Program.

Although the staff are cramped at times, the young people report satisfaction with the arrangement and readily come to the YPPI Centre. The house seems to facilitate engagement by “reinforcing the place young people hold in the service” or providing young people with a sense of ownership and belonging to the Program.

While Out of the Blues did not have access to a separate building, staff attempted to help clients feel at home by providing a kitchen area with easy access to coffee and biscuits, appropriate music (JJJ) as well as a designated smoking area outside overlooking a grassy lawn. Staff also made an effort to be available to chat with clients casually while they waited. In the Telephone Evaluation Survey, young people expressed a strong appreciation of the relaxed, youth friendly environment at Out of the Blues.

► *A philosophical youth orientation*

An orientation to young people is not just about the physical attributes of the agency, but is fundamental to the philosophy of the service. This philosophical youth orientation is the core feature of the Youth Health Model described above. In practice this philosophy is manifested by responsiveness - “structuring the service to meet the young people’s needs, not making the young people fit the service” (Howe, Temple, Mackson and Teesson 1999).

Closely related to this commitment to responsiveness is an emphasis on being non-judgmental, providing acceptance, and validating young people’s own experiences. According to one YPPI-IA Worker: “It’s as much about acceptance as . . . it is about knowledge about an illness, and language can be a bit different. So a person can have a pretty good explanation of what they are experiencing but it doesn’t fit with the . . . language . . . a mental health worker will use. But that explanation is sort of validated, and we work with that explanation rather than try and say, ‘well this is what’s wrong with you’. It is like, ‘this is what you think and we are really interested and curious about what you think and how it impacts on your life’, rather than having been able to quote out of a text book as to what is psychotic or what their diagnosis is” (Howe et al. 1999).

Wright and Martin (1998a: 13) indicate that “an ability to appreciate youth culture without trying to join it” will help develop the therapeutic alliance. Sensitivity to youth culture includes an awareness of the fact that many young people experience adults as having a dismissive attitude to their interests and pastimes and that their concerns are often passed off with the statement that, “you’ll understand when you get older”. It is suggested that therapists need to find a language and approach which minimise the effects of this in therapy.

Wright and Martin (1998b) emphasise the importance of a youth orientation as critical to the development of a therapeutic alliance, especially with so called “difficult” cases. This is operationalised by adopting a customer service focus

in which the young person is seen as the primary “customer” and a “contract” established with them. Wright and Martin note that, when young people are brought unwillingly to therapy by their parents or other adults, clinicians can tend to give greater attention to the views of the adults or those in authority.

It is important for the clinician to meet privately with the young person, hear their version of the story, and identify what they want. A lack of willingness to cooperate can be turned around by skilful negotiation. “Of course the young person may want nothing but to be ‘left alone’. This then can become the subject of what you as the therapist sells them, the ‘problem’ agreed between the therapist and the young person. The core of the contract becomes ‘How could I be of help in getting everyone to leave you alone?’” (Wright and Martin 1998b).

The genuine respect demonstrated by Out of the Blues staff was reported strongly by young people responding to the Telephone Evaluation Survey.

► *Flexible and assertive outreach*

Several of the strategies used to enhance access, such as provision of flexible appointment times and clinicians’ willingness to meet with clients at home or community-based locations, are also critical to enhancing engagement.

These strategies, which demonstrate that the service provider has a strong interest in the wellbeing of the clients, make it easier for them to attend appointments and facilitate their engagement. Another aspect of this approach to engagement is assertive outreach or active follow-up when clients fail to attend appointments. The policy of Out of the Blues was for the therapist to contact the client within two days following non-attendance. A barrier to implementation was that time constraints sometimes prevented prompt follow-up.



What works to reduce suicidality and improve mental health and wellbeing among young people with mental health problems?

All three projects in this group used a range of standardised quantitative instruments to measure mental health outcomes for clients. YPPI-IA and Out of the Blues used a single cohort design involving repeated measures - with YPPI-IA collecting data at baseline, six months, twelve months, eighteen months and two years, and Out of the Blues collecting data on three occasions. The study samples were drawn from the entire client population of those services. The LifeSPAN Project evaluation included a randomised controlled trial of a specific suicide prevention intervention compared to usual treatment and care which focused only on clients who were identified as being at high risk of suicide, as well as a retrospective examination of completed suicide data over the life of the service.

Key instruments used by one or more of the projects include: the Health of the Nation Outcomes Scale (HoNOS) and the Brief Psychiatric Rating Scale (BPRS) as measures of psychiatric disability; the Adolescent Suicide Questionnaire – Revised (ASQ-R) as a measure of suicidality; the Centre for Epidemiological Studies – Depression scale (CES-D) and the Beck Depression Inventory (BDI) as measures of depression; and the Adolescent Drug Abuse Diagnosis (ADAD) as a measure of drug and alcohol use. Others are: the Hamilton Rating Scale for Depression (Ham-D); the Hospital Anxiety and Depression Scale – Anxiety Form (HAD-A); and the Family Assessment Device General Functioning Scale (FAD-GFS). Out of the Blues also trialed the use of Visual Analogue Scales reflecting key concepts from the more formal questionnaires in order to address the reported (or assumed) reticence of young people to answer lengthy questionnaires.

Analysis of the retrospective suicide data at MH-SKY showed that the suicide rate dropped from 4 per cent in 1991 to less than 0.4 per cent in each of the last five years. These changes have been mirrored by a reduction in the level of secondary morbidity associated with psychosis.

A substantial proportion of the young people involved in all projects completed the quantitative outcome measures at baseline and at follow-up. Young people who completed baseline measures had high levels of psychiatric disability, were severely depressed and were highly suicidal.

The young people who completed repeat measures were found to experience a substantial and generally statistically significant reduction in their level of psychiatric disability, depression and suicidality over the time period.

The Out of the Blues data showed only slight improvements in family functioning, and improvements in anxiety were only significant in the Visual Analogue Scales. Anxiety was identified as a continuing problem for this group of young people with depression, even when depression and other indicators of mental health improved. The YPPI-IA clients were found to have high levels of substance use at baseline and mean scores on the ADAD did not change significantly over time. However, there was a decrease in the number of clients using various substances. An additional finding was that use of marijuana may impede the recovery of young people with psychosis.

Even though not all young people completed the self report measures at both the baseline and repeat measures, further analysis of the data revealed that the positive findings were not due to less severe baseline morbidity among those individuals who completed repeat assessments. The YPPI-IA evaluator also argues that the findings are unlikely to be artifactual because the young people belonged to a severely disabled group who were unlikely to spontaneously remit and the areas of improvement were evident in the clinician completed and self-report measures.

At the end of the Out of the Blues project, there were eight young people who continued to attend on a regular basis and who remained severely depressed. These

young people also remained highly anxious. Several characteristics distinguished this group from clients who did improve. Seven of the eight were young women, who were significantly more depressed than others at Time 1 and at Time 2. Five of the eight with a secondary diagnosis of “anxiety”, had significantly greater problems with relationships according to the HoNOS and there was less improvement in this area. Perhaps most importantly, the young people who remained severely unwell reported higher levels of family dysfunction and reported no improvement in their perception of family functioning over the course of treatment. Six of the eight had been sexually abused and some were subject to ongoing abuse or threats of abuse.

Because the treatment programs explored here were multifaceted, it is difficult to identify with confidence which, if any, particular elements were most responsible for the positive mental health outcomes observed. It is likely that the comprehensive nature of care was fundamentally important. The YPPI-IA evaluation report (Howe et al. 1999) presents detailed information from interviews with staff and focus groups with clients carers focusing on the process of service provision. These data highlighted a number of attributes of the program that appeared most critical in helping young people to get well. As the Out of the Blues evaluation did not provide detailed coverage of this topic, the following discussion is based mainly on the YPPI-IA data. However, the data that were available suggest strong consensus of opinion about the components of care most critical to positive outcomes.

The focus of the material presented below is on aspects of care critical to the service model used at MH-SKY, YPPI-IA and Out of the Blues, but which may not have universal recognition and tend not to be implemented consistently in other mental health services:

- comprehensive community-based mental health care with a focus on early intervention;
- case management;
- acute care;
- a focus on recovery;
- ongoing support;
- after hours contact;
- holistic approach/continuity of care;
- medication; and
- psychological therapies.

➤ ***Comprehensive community-based mental health care with a focus on early intervention***

Reductions in the suicide rate among clients of MH-SKY since 1991 have followed the change in the service model from an inpatient first episode psychosis

service to a comprehensive community-based early intervention and prevention service for psychotic disorders in youth. These changes have been accompanied by improvements in service delivery, quality and effectiveness, including reduced delays in the assessment and engagement of first-episode psychosis patients in treatment, reduced rates of admission to hospital and reduced levels of medications used to treat psychosis.

The cognitive therapy program trialed by the LifeSPAN Project was found to be no more effective in preventing suicide and reducing suicidality than the usual high quality care provided at MH-SKY (Power, Bell, Mills and Hermann-Doig 1999).

► *Case management*

The core service model used by YPPI-IA and MH-SKY is case-management. YPPI-IA label their model “intensive case management” (ICM). The aim of case management is to provide a structure for treatment that ensures the provision of adequate care during crises or acute episodes of illness as well as continuity of care between illness episodes.

Critical elements of the case management model used by both MH-SKY and YPPI-IA are intensive outreach and pro-active or assertive follow-up. At YPPI-IA contact is made with clients as often as is deemed necessary, which may be as often as twice a day during acute illness and not less than once a week during the recovery phase. Follow-up may involve many phone calls and visits. YPPI-IA workers will travel to wherever the young person wishes to see them – home, school, the beach or a café. EPPIC provides follow-up for 18 months and the Older Adolescent Service provides follow-up until the young person is 19 years of age. Intensive outreach and assertive follow-up are necessary to ensure young people remain engaged with treatment for as long as is necessary to secure recovery and stabilisation over the long term.

The “youth” case management model used at YPPI-IA and MH-SKY also ensures a holistic approach to the treatment and recovery process. Young people are addressed in the entirety of their life and experience. In addition to specific treatments such as medication and cognitive therapies, attention is directed to building and maintaining young peoples’ social networks and family connections. Families are involved in discussions about, and actively involved in, treatment planning and both EPPIC and YPPI-IA provide family interventions.

A team work approach is important to ensuring continuity of case management over the long term as well as to maintain high standards of care. At YPPI-IA, work practices are transparent with weekly team clinical meetings to discuss all clients and their management plans. If a client’s case manager is away, other team members can provide an appropriate and immediate response. Similarly, other agencies can discuss issues with another team member rather than having to wait until the young person’s case manager is available.

Good supervision and accountability structures are emphasised by MH-SKY and YPPI-IA and YPPI-IA notes the use of small case loads of not more than 15 young people.

The value of the assertive, mobile case management model emerged quite strongly from the focus groups held by YPPI-IA with young people and their carers. There was consensus among the young people that case managers were helpful with various aspects of their daily life and that this was something that was good about the Program. Home visits by their case managers were regarded by the young people as being one of the most helpful and important aspects of the YPPI-IA Program. Carers also identified the support provided by case managers to the whole family as very important in helping them cope with the illness of their family member.

► *Acute care*

Major management tasks during the acute phase of psychotic disturbance are finding the right medication and minimising side effects. Close monitoring is required to identify the types of management strategies that work best for each individual. These should be documented in the management plan. Liaison with a range of professionals, especially doctors and 24-hour support services, is a major part of the task at this stage.

► *A focus on recovery*

Recovery is given strong emphasis in the YPPI-IA and EPPIC programs. When symptoms begin to subside after an acute episode of psychosis, case managers focus on developing strategies to prevent relapse. These include minimising the impact of the experience on the young person's life, removing the concept of handicap and disability and reducing stigma. A plan is created for the future and optimism instilled while maintaining a balance with ongoing medical needs.

The YPPI-IA treatment program includes a Recovery Group which is held once a week and involves a range of activities. Young people identified it as an important part of the Program, and expressed a desire for the group meet more frequently and for more varied activities. Carers also reported the Recovery Program as being one of the most valuable aspects of the program, especially in providing their son or daughter with some structured activity.

► *Ongoing support*

The YPPI-IA Program provides ongoing case management for a small number of young people who require ongoing support. If support is required past the age of 20, young people are linked in to the Adult Mental Health Team. If another service is to become involved, it is critical to ensure a smooth seamless handover. EPPIC provides follow-up for 18 months.

The YPPI-IA Project team argues that it is essential to create a happy and positive termination of contact with young people and their families. This should leave the young people with a sense of confidence and completion, not an overwhelming sense of loss or regret. It is important to reassure them about the possibility of recontact while at the same time reaffirming knowledge of the completion of this phase of their lives.

During the development of the LifeSPAN therapy (see below), expert consultants pointed out that disengagement after brief intensive interventions may be experienced as a significant loss by patients and is associated with suicide. In order to address this possibility, the LifeSPAN therapy was designed to include preparation for handover to another ongoing therapist. In fact, in key respects the LifeSPAN therapy worked to promote engagement with ongoing therapy among patients at risk of premature disengagement.

► ***Holistic approach/continuity of care***

Based on the results of a literature review, the YPPI-IA project team recommend that there should be an integrated approach to treatment when a young person is affected by both mental health and substance misuse problems. Following the observations of Enter and Richards (1998) it is noted that drug and alcohol misuse and mental health problems are integrally connected to each other and cannot be treated effectively in isolation.

The YPPI-IA team argue further that other issues also need to be taken into account to achieve a reduction in suicidality among young people with mental health and substance misuse problems. Other major issues include sexual assault, trauma, and eating disorders. It is suggested that all presenting issues need to be treated concurrently.

A holistic approach is observed to provide greater continuity of care because clients do not need to move around between different services to get their various needs met. As one YPPI-IA Project Worker said: “You don’t have to move from one group of workers to another to get service, so it’s not like acute, then case management and then recovery and then rehab and accommodation. There is a certain seamlessness about it all that makes it easy for young people and their families.”

The teamwork model used by the YPPI Program was also identified as a major facilitator of continuity of care.

Interviews with YPPI-IA Project staff revealed some concern that the program had not been able to achieve the ideal level of continuity of care. The reason for this is the inevitable fact that workers sometimes leave or go away for extended periods of time and this occasionally happens when clients are at a particularly vulnerable time and find it difficult to adjust to the loss of the relationship with their case manager. People may fall through gaps when this happens and become unwell.

It is noteworthy here that average levels of drug and alcohol use did not decline for YPPI-IA clients. Although some young people ceased their use, a number increased their use. Staff from YPPI-IA identified a lack of adequate support for ceasing drug use as one of the gaps in the program. While YPPI-IA did address drug and alcohol use and did not partition it off from other issues affecting young people, the program did not include development of a specific intervention for drug and alcohol use. The YPPI-IA team recommend that a specific intervention, with a focus on marijuana use, is developed and evaluated in a randomised controlled trial.

YPPI-IA staff identified that young people who are misusing substances require support in making lifestyle changes. This reinforces the importance of providing a holistic range of services. While drug rehabilitation programs generally offer this form of support, many such programs do not accept people with mental health problems in addition to substance abuse problems.

► *After hours contact*

Young people identified the ability to access the YPPI team out of hours as important to the recovery process. Having someone to talk to who was not as emotionally involved as family and friends was reported as important in helping young people get through emotional crises: “I just punched everything in sight and I was that angry and crying and so confused, I just needed someone to talk to or I would have blown my head off” (Young person, YPPI-IA Project).

► *Medication*

The authors of the Out of the Blues evaluation report (Martin and Wright 1999) conducted a comprehensive review of recent research (since 1994) that has examined the use of antidepressant medication with children and adolescents. They find that although few well designed studies have yet been conducted, certain selective serotonin reuptake inhibitors (SSRIs) have been found to be effective in the treatment of adolescent depression. SSRIs have also been found to be safer, have fewer side effects and are better tolerated by adolescents than other antidepressants.

It was found that 43 per cent of Out of the Blues clients had been prescribed some sort of medication prior to their first assessment at Out of the Blues, either currently or in the past. Although none had been prescribed tricyclics (consistent with good prescribing practice), dosages of antidepressant medication were considered to be very low. During therapy 63 per cent of patients had medication begun, changed or ceased by the Out of the Blues team. Antidepressant medication was prescribed to the majority (n=61, 80 per cent) of Out of the Blues 76 clients. The most commonly used medications were sertraline (31 clients), fluoxetine (7 clients) and venlafaxine (6 clients). Thirty-four (45 per cent) of the total therapy group remained on medication at closure.

A reduction in the dosage of anti-psychotic medications used has been a central component of the practice changes that have been accompanied by reductions in suicide rates and secondary morbidity at EPPIC.

► *Psychological therapies*

Cognitive behavioural therapy (CBT) has been recommended as the treatment of first choice for depression among young people (NH&MRC 1997). The literature review conducted by Martin and Wright (1999) shows that cognitive behaviour therapy continues to be the most well studied psychological therapy and still has strong research support. However, the recent data indicates that while CBT is effective for depression of mild to moderate severity it is not effective in the treatment of severe depression. The recent literature also provides additional support for the value of CBT when co-morbid anxiety is present.

Most other forms of psychological therapy have not been well studied. Martin and Wright (1999) particularly note the lack of published research that has examined interventions into the family environment of depressed adolescents. Sanford et al. (1995; cited in Martin and Wright 1999) recommend that treatments aiming to enhance parent-adolescent relationships, and which specifically target co-existing disorders show promise in the treatment of persistent and recurrent depression and require further investigation.

The majority of Out of the Blues clients (69 clients or 90.8 per cent) took part in some form of individual psychotherapy. The most commonly used style of therapy was “supportive therapy”, which was provided to 34 clients (44.7 per cent), followed by cognitive behavioural therapy, provided to 15 clients (19.7 per cent), and individual psychodynamic therapy, provided to eight clients (10.5 per cent). Other individual therapies used included narrative therapy, crisis intervention and relaxation therapy. Six young people accepted brief family therapy. In most cases a second mode of therapy was provided to address particular symptoms. Thus, for example, even when CBT was not the primary therapy, elements of it were frequently used where relevant. No particular style of therapy was associated with any particular diagnosis, nor the eight hardest (“residual”) cases.

It is notable here that while significant improvements were found for most clinical outcome measures for Out of the Blues, anxiety continued to be a problem for a majority of the sample. It is possible that greater impacts on anxiety could have been obtained if cognitive behavioural therapy had been used more widely.

Martin and Wright (1999) report that Out of the Blues originally intended to implement CBT much more systematically but was not able to achieve this. They note that the research literature advises that the best results are obtained when using clinicians that are expert at CBT. Out of the Blues was not able to secure employment of anyone with extensive experience in CBT. As an alternative, training in CBT was sought for all staff.

It is possible that an ability to implement CBT effectively may require more than brief training of staff. The NH&MRC Clinical Practice Guidelines on Depression in Young People indicate that ongoing supervision is required in addition to training in most psychological interventions such as CBT (NH&MRC 1997: 86).

Too small numbers of Out of the Blues clients were provided with family therapy to ascertain whether or not this particular intervention was effective. However, it is notable that the young people who did not experience any improvement in their depression and anxiety reported having severely dysfunctional families and that no improvement in the family situation occurred over the course of their treatment.

Standard treatment for early psychosis at EPPIC includes a range of psychological interventions in addition to low dose pharmacotherapy. Previous evaluation research has shown these interventions to provide additional benefits in psychosocial functioning and outcome (Jackson et al. 1999 and Edwards et al. 1998, cited in Power, Bell, Mills and Hermann-Doig 1999).

► *Monitoring of suicide risk*

A major component of the LifeSPAN Project was facilitating awareness among clinical staff of the importance of early detection of suicide risk among their patients. The project used two simple measures of suicide risk, one to be used on initial assessment when the patient is first referred to the service and one to be used at regular intervals upon follow-up. The Suicide Risk Factor Checklist was developed by the project for the first function and the Brief Psychiatric Rating Scale (BPRS) suicide subscore was eventually selected for the ongoing monitoring function. This rating system acted as a prompt for clinicians to refer high risk patients to the LifeSPAN therapy described below.

The Suicide Risk Factor Checklist was administered to 148 of the approximately 700 patients who entered the MH-SKY Youth Program during the survey. Over one tenth of these patients reported thinking of suicide most or all of the time.

The LifeSPAN Project Team reported that despite attempts to make the Suicide Risk Checklist user friendly, clinician compliance with the use of the form was less than 50 per cent. This problem was successfully addressed by incorporating the content of the form into a new comprehensive clinical assessment form (Power et al. 1999).

Evaluation over a longer term would be required to determine whether regular monitoring of suicide risk is associated with further reductions in rates of completed and attempted suicide at MH-SKY.

Another issue raised in the concept mapping exercise held by the LifeSPAN Project was that information about suicide risk was poorly recorded and communicated between different levels of the service. Patient tracking and database systems were inadequate to this task.

An important observation of YPPI-IA staff was that despite having a good relationship with the young people they were often surprised by the extreme levels of suicidality they were experiencing. This often only became apparent when the self report measures (ASQ-R) were completed. Thus even with very competent case management the severity and frequency of suicidal thoughts may never be disclosed unless concerted efforts are made to address this issue.

► *Cognitive-therapy based suicide prevention intervention*

A concept mapping exercise conducted by the LifeSPAN project found that clinicians perceived themselves as well able to diagnose and describe the mental state of patients, particularly in relation to suicide risk. However, they perceived themselves as less able to address the psychological factors involved.

The LifeSPAN Project included the development and evaluation of a specific cognitive therapy based suicide prevention intervention. This represents the first ever attempt to develop such an intervention for patients with psychotic illnesses such as schizophrenia and major affective disorders. The therapy is designed to complement and augment standard clinical care.

The LifeSPAN Therapy was developed by the project team after consultation with a range of experts in the field of suicide prevention. It is an individual cognitive therapy program of ten weeks duration designed to: (i) better engage high risk patients in treatment and (ii) address cognitive risk factors for suicide such as hopelessness, poor problem solving, misconceptions about mental illness, low self-esteem and cognitive rigidity.

Therapy was delivered by two clinical psychologists who were extensively trained and provided with weekly supervision by two senior clinicians. It involves four phases: engagement; assessment and formulation; cognitive intervention; and closure and handover.

Trial participants were recruited from EPPIC and the Older Adolescent Program at MH-SKY over a 15-month period from October 1997 to December 1998. Recruitment depended upon referral from service clinicians of patients identified through screening as being at particularly high risk of suicide. Eligible patients referred were randomly allocated to usual treatment and care (n=28) or usual treatment and care plus the specific suicide prevention intervention (n=30). A little over half (57.1 per cent) suffered from an affective psychosis.

Patients in both the LifeSPAN group and the control group experienced significant and similar improvements in numbers of suicide attempts, frequency of self harm and measures of suicidal ideation (SIQ) and psychiatric symptoms (BPRS) over the three observation points (baseline, ten weeks and six months follow-up). One patient from each of the study and control groups died by suicide shortly before the six month follow-up. This is consistent with current rates of suicide at EPPIC (Power et al. 1999).

However, patients in the treatment group showed significantly better improvements on a number of cognitive measures of risk for suicide including Quality of Life Score, Reasons for Living subscales, and Beck Hopelessness Scale at either ten weeks or six months follow-up.

The results suggest that the LifeSPAN Therapy as implemented in this trial had little, if any, meaningful added effect over and above standard clinical care provided at MH-SKY Youth Program. The project team speculate that this may be due to the fact that standard care at MH-SKY already includes a strong component of cognitive therapies and that regular clinicians were very likely to have picked up considerable knowledge of LifeSPAN components during the course of the project and introduced these into their usual practice, thereby diluting any effects for the study group.

The LifeSPAN Project team recommend that the therapy be refined for incorporation into standard clinical counselling rather than continued as an additional specialist intervention.



What works to reorient and the build capacity of mental health services to meet the needs of young people?

Fifty-two per cent of respondents in the survey of Strategy key stakeholders believed that the availability of skills, information and resources necessary to work towards good practice in the treatment and management of mental disorders in young people has got “a little better” since 1995. Thirteen per cent believed this availability is “a lot better” and 23 per cent believed there has been no change. The majority of respondents (77 per cent) believed that the National Youth Suicide Prevention Strategy had at least some role in this progress with 31 per cent saying it had a moderate role and 9 per cent saying it had a strong role.

One of the aims of the YPPI-IA project was to re-orient the Adult Mental Health Services and other community agencies to better meet the needs of young people with mental health problems. Evaluation of this component of the project included focus group discussions with staff of two Adult Mental Health Services and a Youth Health Service. Staff in one of the Adult Mental Health Services and the Youth Health Service indicated that there was an increased awareness and knowledge regarding YPPI-IA and the needs of young people with early psychosis. Many staff also reported increases in their skills in working with young people with psychosis.

Aims of the LifeSPAN Project included increasing awareness of suicide risk among clinicians already working in a youth-focused mental health service.

► *Consultancy and information provision*

Staff in services who perceived changes in their service indicated that the YPPI-IA Project had made an impact by educating staff about issues for young people with early psychosis. A worker from the Gosford Mental Health Acute Care Team (MHACT), commented: “I reckon it made dealing with youth easier because we had an expert to discuss them with, an expert to deal with” (Howe et al. 1999). A worker from Youth Health, said: “I suppose that it improved my skills in assessment of young people who might have a psychiatric disorder, and it increased my confidence, and it was good to have that back up of knowing that Y Page [paging service] would come and help.”

YPPI-IA staff also identified the consultancy role as important in helping services develop confidence in their ability to provide a service for young people with psychotic illness: “Accommodation services gave feedback that they were much more prepared to maintain young people with psychotic illness in their accommodation service with the knowledge that somebody from YPPI would be available if there was a crisis, but also available for education and consultation with staff (YPPI-IA Worker, Howe et al. 1999).

Staff from the Youth Health Service noted that the youth focus of the YPPI-IA Program was particularly important to the value of the consultancy role of YPPI-IA. Sharing a youth-focused philosophy helped ensure that joint assessment between the Youth Health Worker and the Mental Health Worker (YPPI-IA) came across as coherent for the client.

► *A clear philosophical base/transparent work practices*

During the early development of the YPPI-IA Project, it became clear that it was important for the team members to have a united philosophical base. This was difficult at first as project workers came from different occupational backgrounds and varying levels of experience. To work towards the development of this philosophical base, many discussions were held between staff members around a team approach. To ensure adherence to the good practice model, the importance of transparent work practices and open analysis of treatment were stressed. Team supervision was also vital. Having an independent person available to discuss relevant issues was integral to the success of developing a united philosophical base.

A clear philosophical base appears to be critical to the success of a team approach to service provision. The process of establishing agreement on key philosophies is conducive to maintaining high quality practice.

Establishment of innovation within a single service or program is to some extent a microcosm of the challenge of reorientation at the wider system level. The experience of YPPI-IA is that reorientation of services involves developing an

awareness of why changes are needed and a vision of how things can be done differently. Change leaders need to be able to articulate their vision to those they wish to influence. Having a clear philosophy to communicate would appear to be the first requirement of any type of service reorientation.

► ***Consult with young people with mental health problems***

The initial phase of the YPPI-IA project involved researching the needs of young people experiencing severe mental health problems. The input of young people was obtained via direct consultation, participation on the Project Steering Committee and in focus groups. The input of young people into service development continued throughout the project and the evaluation.

► ***Dissemination of project results and information***

YPPI-IA was one of the most widely known projects funded under the National Youth Suicide Prevention Strategy. The high profile of the YPPI-IA Project is associated with a very comprehensive dissemination strategy that has been implemented from the very beginning of the project. By the time the final report was completed, aspects of the project had been presented at a total of 36 conferences, workshops and seminars across Australia. These included several national and international conferences. The project staff also spoke about the project or aspects of the practice model at a large number of local meetings and in-services.

The YPPI-IA Project also participated in a substantial number of local meetings and ongoing working parties concerned with related issues.

Public relations were managed by the Project Coordinator. The project was the subject of ten newspaper articles and the Project Coordinator also participated in a radio interview, a documentary program and two video projects.

The YPPI-IA Report notes that media coverage and other public relations work not only increases exposure for the project itself but also promotes knowledge of good practice more generally.

► ***A driving mechanism with a positive focus***

The LifeSPAN Project emerged out of the interest and initiative of a group of senior clinicians at MH-SKY. These clinicians formed a Suicide Reference Group which was identified as a useful mechanism for formulating and driving initiatives. When the LifeSPAN Project ended, the group no longer had a core focus and disbanded. Since then suicide prevention policy developments have continued in an ad-hoc and reactive manner rather than a pro-active manner.

► ***Build on functional quality enhancement systems***

A notable achievement of the LifeSPAN Project was the incorporation of a suicide risk assessment and risk management plan into the standard clinical

assessment form. Less successful was the attempt to introduce routine monthly assessments by case managers. In an effort to facilitate regular data recording and use, the project developed a new database and provided clinicians with training in its use. However, the new system was not used. It was concluded that, while desirable, such regular monitoring systems would not be sustainable without further coordination and resource support from both the administrative (including medical records and quality assurance structures) as well as senior clinical structures of a service.

More generally, the LifeSPAN Project team conclude that new policies and initiatives for suicide prevention can only be successful if they are embedded within existing functional structures and systems. It is further noted that the more functional services are perhaps not the ones that most require new policies and procedures.

One solution recommended by the LifeSPAN team is that mental health services appoint a suicide prevention coordinator whose role would include regular monitoring and provision of feedback regarding suicide related issues in the service. This position would be closely linked to regular auditing and quality assurance systems. The Clozapine Prescribing Monitoring System is cited as one example of a “clinician friendly” auditing system that could be used as a model.

The YPPI-IA “Project” as funded by the Strategy developed out of a number of quality enhancement initiatives within the Mental Health Division of the Central Coast Health Service. The initial YPPI (Young People and early Psychosis Intervention) “Program” was initiated in 1994, prior to the Strategy, in response to increasing evidence in the mental health literature that traditional services were failing to meet the needs of young people experiencing significant mental health problems. The initial establishment phase involved researching the needs of young people experiencing severe mental health problems through a literature review and by providing young people with an opportunity to communicate with service providers about their experiences. The early research also identified various best practice models that were in place in Australia and overseas. After considering these models and relevant data the YPPI Program developed a service model that took the most important elements of the Youth Health Model and married these with the evidence-based elements of community mental health practice.

A Quality Management Project was established in July 1996 by the Mental Health Division of the Central Coast Area Health Service. This Project aimed to explore issues of service delivery for young people with psychosis who were using mental health services, youth health services and other alcohol and drug services, to document what was actually occurring within those services and to develop recommendations for quality improvement. The recommendations coming from the Project focused on strategic planning, improving access and education of staff on current treatment and best practice models.

The Central Coast Area Health Service has adopted a pro-active stance on suicide prevention since 1995. Activities included the establishment of a Suicide Outcomes Group as part of the Area's Outcome Council and a two-day consumer phone-in.

The YPPI-IA Final Report notes the strong culture of quality enhancement within the Central Coast Area Health Service as critical to the success of the YPPI Program and the YPPI-IA Project.

General discussion

Enhancing the quality of mental health services for young people should be made a priority for the immediate future as well as the longer term. Informal consultations with stakeholders conducted by the evaluator, as well as information presented in a number of project evaluations discussed in other volumes of the Technical Report series, indicate that perhaps the most substantial and remediable barrier to full implementation of the youth suicide prevention initiatives advanced by the National Youth Suicide Prevention Strategy is the lack of appropriate and accessible mental health services for young people.

Apart from treatment of the mental disorders that constitute the major risk factors for suicide, other strategies for suicide prevention have placed increased demands on mental health services. For example, the need to conduct mental health assessments on all young people presenting to accident and emergency departments with self harm and suicide attempts, and the education and training of general practitioners and other community gatekeepers has been reported by such gatekeepers, as well as staff of Child and Adolescent Mental Health Services, as leading to an increase in demand for specialist mental health treatment and care. Resources to meet this increased demand are generally unavailable and waiting lists continue to expand. Early intervention programs also tend to increase demands on mental health services by requiring the input of mental health expertise in their implementation, and identifying individuals with mental health problems who would otherwise remain unrecognised.

The survey conducted for the evaluation suggests that stakeholders perceive that less progress has been made in the treatment and support of young people with mental disorders and other complex problems than in other areas targeted by the Strategy. The majority of respondents to the survey felt that over the past five years the situation has got "a little better" (52 per cent) or "a lot better" (13 per cent) with respect to the level of skills, information and resources available with which to improve the quality of treatment and care provided to young people with mental health problems. However, the majority of respondents perceived that the harm and disadvantage suffered and the quality of life enjoyed by young people with mental health problems has not changed (over 50 per cent) or has become worse (over 15 per cent). Views on changes in service accessibility were divided with

39 per cent of respondents perceiving that accessibility was a little better, 36 per cent perceiving no change and 12 per cent perceiving it had become worse.

Only three projects funded under the Strategy focused on the treatment and support of young people with mental health problems by specialist mental health services. Despite the low numbers of projects that have addressed this topic they have between them provided a rich source of information about the key issues and have identified some exciting possibilities for progress in the development of mental health services for young people.

The most important and overarching issues of concern are: (i) how to enhance the accessibility of services for young people; and (ii) how to increase their engagement with treatment.

A number of other, mostly clinical issues were also identified. These include: how best to address dual diagnosis involving substance misuse; the use of medication in the treatment of depression in young people; use of psychological therapies, particularly in cases of severe depression; and how services can best respond to young people with mental health problems who are at particularly high risk of suicide.

The issues of access and engagement as well as the clinical issues highlight some important questions about the ways in which mental health services are currently organised and what sorts of arrangements may be most appropriate for facilitating the delivery of effective mental health services to young people.

Models of mental health service delivery for young people

The projects in this group were based on models of service provision that are different from what is generally available in most areas of Australia at present. They differed on two key dimensions. Firstly the models of service provision used by the current projects were youth specific. In contrast most mental health services target either adults, or children and adolescents. Youth specific services or programs are rare. A second key feature of the service models examined in the current group of projects was a focus on specific diagnostic groups. Two of the projects in the current group focused on particular diagnostic groups.

Youth specific versus generic mental health services

All three projects in the current group involved a youth specific model of service provision, targeting ages 14–25 (or 30 years), encompassing the period from mid-adolescence to young adulthood.

Following the tradition of its predecessors (EPPIC and the Centre for Young People's Mental Health), MH-SKY (Youth Program) is a pioneer of the youth specific model of mental health service provision in Australia. YPPI was also formed previous to receiving funding from the Strategy in an effort to develop an alternative model of care to those currently available. Out of the Blues was a

special project funded by the Strategy to trial a youth specific model of service provision for young people with depression. In contrast, publicly funded mental health services for young people are generally only available from generic child and adolescent (or child and youth) mental health services (up to age 17 or 18) and generic Adult Mental Health Services (18 years and over). Very few youth specific services (targeting ages 14–25 years) are currently available.

The results of all three of the current projects converge to identify a set of conditions, practices or service characteristics that are likely to be important in improving access, engagement and outcomes for young people. There is a strong suggestion that the youth specific model of service provision is fundamentally important to ensuring that these conditions and practices are in place. Having a team of clinicians that are all dedicated to working with adolescents and young adults appears to facilitate adoption of these practices by encouraging the development of an organisational philosophy or culture that is sensitive to the social and developmental issues affecting young people. The youth specific team model appears to provide a structure that ensures a strong focus on professional development, professional supervision and peer support structures that continually reinforce staff members' commitment to the work practices required.

The results of the current studies are sufficiently positive to justify policy makers and service planners giving serious consideration to expanding the availability of youth specific mental health services. This process of consideration will need to include a program of service development research aimed at systematically testing the effectiveness of youth specific versus existing models of mental health service provision to adolescents and young adults (see Key issues for further research below).

Diagnosis specific versus generic services

Two of the projects in the current group focused on particular diagnostic groups. While the information from the project evaluations is consistent in its support for the youth specific service model, the issues surrounding the value of diagnostic specificity are much more complex.

Recent years have seen a substantial increase in resources allocated to early intervention in psychosis. A number of services (program units or teams) with aims and objectives similar to those of YPPI have been established in most states and territories.

The advantages to be gained by focusing program teams on particular diagnostic groups are similar to those that accrue to other types of specialisation. Expertise can be concentrated and developed to a high level. Team work and professional support is also enhanced when a group of colleagues is working on the same issues. Specialist teams can also act as a valuable resource for generalist workers requiring advice and assistance in working with particular groups of clients.

A key issue for mental health policy development concerns whether the process of service development that has occurred in the area of early psychosis should be replicated for early intervention in depression and other high prevalence disorders.

The South Australian Government has proposed to “replicate” the Out of the Blues model by placing individual workers focusing on depression in young people within Child and Adolescent Mental Health Services. This approach does not actually include the essence of the Out of the Blues model, which revolves around the identity, philosophy and sense of place created by a team of professionals working on similar issues. There is doubt as to whether such specialist expertise can be adequately developed, used and supported without a specialist team.

Models of service delivery for early intervention in psychosis have included the placement of individual workers focusing on early psychosis in generic Child and Adolescent and Adult Community Mental Health Services as well as the creation of specialist services and teams such as EPPIC and YPPI. However, as yet there has been no systematic evaluation of the *youth specific team model* compared to the *individual worker within a generic team model*. The latter model has been trialed in Western Sydney Area Health Service and can be judged a failure. There was very high staff turnover and poor morale from almost the beginning of this exercise. Early intervention staff were placed on their own in Adult Mental Health Services and experienced major difficulties initiating the kinds of activities that have been identified as necessary in enhancing access for young people. Yet these staff were expected to actually stimulate cultural change in Adult Mental Health Services. This model has now been abandoned in favour of a specialist early intervention team that is based together in its own building.

It must also be borne in mind that there is currently only a very small pool of staff with specialist mental health early intervention skills. Models of service delivery and development need to be sensitive to this fact and include mechanisms for nurturing and growing the skill base. There is evidence that a specialist team model that includes professional and peer supervision is effective in this regard.

It is important that there be a process of mental health service enhancement aimed at building the capacity of services to identify and treat depression in young people. Any such process of service development needs to be preceded by further rigorous evaluation of the various models and approaches to service development. Evaluation should also aim to identify which approaches are best suited to effective management of co-morbidity involving depression, anxiety disorders and substance misuse. Early psychosis services also need to increase their focus on treatment of co-morbid substance misuse.

Evaluation should compare indicators of mental health outcomes, engagement and accessibility as well as cost effectiveness of different service models.

Processes of service development and implementation, impacts, outcomes and costs should be monitored for at least five years.

The role of generic Community Mental Health Services

The suggestion that generic Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) might need a special worker to focus on depression in young people raises the question about the proper roles of generic CAMHS and AMHS in relation to treatment of mental health problems in adolescents and young adults. After all what could be more generic than treatment of depression in young people? (Hazell, P., personal communication). Why are the other CAMHS and AMHS staff not already including this work among their other priorities?

Further, the suggestion that generic CAMHS and AMHS need specialist youth staff contributes to a growing body of evidence that these services are failing to meet the needs of adolescents and young adults. One possible explanation is that CAMHS and AMHS are more accessible to children and adults than to youth and that the demands of treating clients who actually present limit the ability of these services to take the steps necessary to make themselves more accessible to young people. Similar processes are likely to be operating in relation to other populations whose utilisation of services is relatively low, such as people from non-English speaking and indigenous backgrounds.

The NSW Youth Health Policy – *Young People’s Health Our Future* (NSW Health 1999b: 1) states: “Young people have not enjoyed the same improvement in health status when compared to other sections of the community . . . Young people have specific health problems, needs and concerns. These problems and needs differ from the needs of adults or children. Another reason why young people’s health has not improved is because it is often assumed that the health needs of young people can be adequately catered for within adult or child health services.”

The response of the National Youth Suicide Prevention Strategy was in large part based on recognition of this fact and the results of the project evaluations provide further evidence to this effect.

The evaluation of YPPI-IA in particular revealed tensions regarding the accessibility of services for young people with mental health problems other than psychosis. The suggestion was made by stakeholders that YPPI-IA should expand to incorporate a wider set of issues. It is remarkable that a specialist service focusing on psychosis should be identified as in need of expansion to meet this broader need of young people. The criticism that YPPI-IA was too narrowly focused raises the question about the roles and responsibilities of generic Child and Adolescent Mental Health Services (and Adult Mental Health Services) in providing access to mental health services for all young people with mental health problems. It adds to the evidence that generic services frequently fail to meet the needs of young people adequately and that changes in the way services operate are

required. (Note that EPPIC operates as a specialist unit within a comprehensive youth specific model.)

Further work is required to clarify the proper roles and responsibilities of specialist services and generic Child and Adolescent Mental Health Services as well as Adult Mental Health Services. Specialist youth programs focusing on particular diagnostic groups or particular types of mental health problems may become the focus of unrealistic and inappropriate expectations if youth mental health is not receiving adequate attention by other parts of the mental health system who should share this responsibility.

Principles and directions for policy and service development

The tension between the strategy of disorder-focused specialisation versus youth-focused specialisation is highlighted even further when we consider the view expressed by YPPI-IA staff that a holistic approach to service provision is needed in order to provide appropriate care to young people with dual diagnosis and other complications.

The New South Wales youth health policy (NSW Health 1999b: 3) also recognises the importance of a holistic approach to health service provision for young people: “Programs and approaches which reflect [a] holistic view and which focus on mental health issues, lifestyle and environmental/social issues present the greatest opportunity to make positive health improvements and maintain health outcomes for young people.”

The conclusion that a holistic approach to service provision is important when caring for young people with mental health problems and substance misuse issues is also consistent with the findings of the projects discussed in Chapter 1 of this Technical Report. It was observed in the discussion of these projects that there appears to be considerable overlap in the client populations of specialist mental health services and non-government agencies and youth health services working with marginalised young people at high risk of suicide.

Can a specialist mental health service focusing mainly on one particular type of disorder such as psychosis or depression provide holistic care? The YPPI-IA team have drawn attention to the concept of a “youth mental health model” (which combines elements of the holistic oriented “youth health model” with the evidence-based practice approach to service development which is gaining strength in the mental health sector) and suggested the need to conduct further research in this area. The concept of the “youth mental health model” could provide a useful framework for organising the range of service development research activities required (see below). Because it acknowledges its conceptual roots in the development of youth health services (and generalist youth services) the model also provides a framework for exploring issues surrounding the creation of partnerships across sectors.

It has been suggested previously that resources be allocated to demonstration projects capable of exploring the roles of agencies in different sectors in providing services to young people with mental health problems as well as other complex problems (see Chapter 1). The convergence of thinking regarding the need for a holistic approach emerging from the projects based in youth health services, non-government agencies, and mental health services is reassuring as well as challenging. There is clearly a need to invest resources in the development of *identifiable places* that can provide, in the one location, a comprehensive range of services to young people with complex problems including mental health problems, drug and alcohol problems, family conflict, homelessness, exposure to abuse and neglect. A holistic service that provides a physical space may also be more successful in encouraging and supporting young people's involvement in service development and evaluation activities.

One of the most critical questions emerging from the issues identified above and in Chapter 1 of this volume is where such services would be best located, professionally and administratively. Youth health services are more advanced along the path of holistic service provision than most mental health services. The New South Wales youth health policy (NSW Health 1999b) describes a number of youth health services in that state, most of which are funded under the *Innovative Health Services for Homeless Youth (IHSY) Program*, which currently provide a wide range of services for disadvantaged young people. It is noted that an evaluation of the IHSY Program conducted in 1996–1997 found these services to be “highly effective in providing a range of health care services to disadvantaged young people” (p. 5). Physical co-location of a number of service providers on one site is noted as providing enhanced access for young people (p. 6).

“Significant findings of this evaluation were that young people regularly accessed a youth friendly, youth appropriate service for a diverse range of health needs including drug and alcohol, counselling, clinical services such as treatment of injury, immunisation services, accommodation assistance and referrals to specialist services. As part of the Evaluation young people reported that often they sought help for a number of health related issues while visiting the youth health service and considered the youth health service to be friendly, safe, and confidential placed to seek help. The accessibility of IHSY services and the numbers of young people who access the services who would otherwise leave health problems untreated reaffirms the importance of providing and promoting youth appropriate services.” (NSW Health (1999b: 23).

New South Wales youth health policy also notes that these programs and services are not available to all young people throughout the state, particularly young people in rural areas. The policy recommends that all Area Health Services identify at least one Community Health Centre and develop this Centre to be “youth friendly”. “In order to increase access to services, existing successful models

should be further developed and where appropriate, replicated or modified to suit local circumstances” (NSW Health 1999b: 25).

Since youth health services have been identified as generally being highly accessible for young people and effectively addressing a range of health issues it is surprising that there has been so little consideration of the potential role of youth health services in providing mental health care for young people. Such services are likely to be viewed as more acceptable and less stigmatising by young people (Kurtz 1996). It might be expected that IHSY programs might be particularly well suited to providing primary mental health care for young people with complex needs.

The holistic Primary Health Care model, on which these services are based has been identified as particularly important in improving the emotional wellbeing of Aboriginal and Torres Strait Islander people (Swan and Raphael 1995a and b). Enhancing the mental health service provision capacity of primary health care services forms the central thrust of the *Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan* (Commonwealth Department of Health and Family Services 1996).

Existing reviews of youth health services and IHSY programs do not include detailed discussion of mental health issues. It has been noted that young people with mental disorders do not currently gain equitable access to IHSY programs (Howe, D., personal communication, March 2000). Conversely, staff of the Supported Accommodation Assistance Program (SAAP) have argued that mental health services are not appropriate to the needs of young people who are homeless or at risk of homelessness and that specialist mental health staff are not available to provide them with consultation support when it is needed (see Chapter 1 this volume).

In many parts of Australia youth health services and youth focused non-government agencies are often already providing the only form of mental health care that many young people are willing or able to access (see Chapter 1 of this volume). A number of non-government youth services such as the Connexions Program of Jesuit Social Services in Victoria (see Chapter 1) have developed considerable expertise in providing treatment for mental disorders as well as a range of other services to young people with highly complex issues. There are currently very few such services available.

Clearly there is a need for policy and service development planning and research work focused on building and refining effective models of mental health service delivery for young people (*Recommendation 2.1*). This work needs to be led by the Commonwealth and state and territory governments. Policy frameworks and strategic plans are required to inform and guide the development of mental health services for young people in areas and regions. Key aims for strategic plans should be: (i) to ensure that service models are available which address the specific needs

of young people in addition to adults and children, as well as young people with complex mental health problems and those exposed to multiple risk factors for suicide (*Recommendation 2.1, first dot point*); and (ii) to achieve an appropriate balance between generic mental health services and specialist units such as those focusing on youth or psychosis, depression, and dual diagnosis (*Recommendation 2.1, second dot point*).

The project of identifying and further developing effective models of service delivery for young people with complex problems who are currently not accessing other services, as well as delivery of primary mental health care for young people more generally will require partnerships between youth health services, youth focused non-government agencies and mental health services.

There is room for the development and trial of a range of different models including: consultation-liaison; Shared Care; employment of specialist mental health professionals or teams within youth health services; expansion of the specialist youth mental health model (for example, YPPI) to address a wider range of mental health related issues; and co-location of specialist youth mental health services with youth health and other youth focused services.

As an initial stage of an ongoing reform process, demonstration programs should be established and be located in a number of different service environments including specialist mental health services, youth health services and non-government agencies (*Suggestion 2.1a*). Evaluation of these projects should be coordinated to ensure a design that is capable of testing for the effects service environment. For example, there needs to be use of uniform impact and outcome measures. A variety of potential new service models and their relationship to existing services is shown in Table 2.2.

The nature of mental health services provided by such services would be somewhat more extensive than that traditionally allocated to the primary health care tier. Close collaboration with other specialist mental health services, particularly inpatient services and after hours crisis assessment services would also be required.

It seems likely that each type of model will have advantages and disadvantages depending on the particular needs of the populations they serve and the availability of other related services. It must also be acknowledged that in most locations, particularly rural and remote areas, no single agency or sector will have the capacity to provide a sufficiently holistic service that is adequately tailored to the particular needs of adolescents and young adults. In order to meet the requirements of genuine holistic service provision within an identifiable youth friendly space, creative solutions will be required.

An alternative model worthy of exploration is physical co-location of the “youth arms” of a variety of relevant services. For example, a specialist mental health

service, a youth health service, a drug and alcohol service, an accommodation service and a welfare agency could pool resources and co-locate workers that are dedicated to working with youth in a “multiservice setting” or a “multi purpose youth service”.

This concept is similar to the Multi Purpose Service (MPS) which has been developed as a response to problems of providing a comprehensive range of services to small populations in rural and remote areas. The MPS involves pooling Commonwealth and state/territory funds from a variety of sectors. Variations of the MPS model have been trialed with considerable success in numerous sites in various states (Andrews et al. 1995; Fitzgerald and Medley 1999). Models that place emphasis on community involvement in prioritising the various purposes or functions that could be included in a particular MPS are preferred. The major recommendation made by Andrews et al. (1995: 4) is that “the MPS concept and related strategies . . . be extended to appropriate new sites”.

While originally developed for rural and remote communities, the MPS model is also suitable for addressing problems of cost effective service delivery to small populations with special needs such as young people with mental disorders and other complex problems. Multiservice settings or Multi Purpose Youth Services with strong administrative and professional links across a range of sectors would also be in a position to overcome many of the barriers that currently hinder wider implementation and institutionalisation of early intervention, primary prevention and mental health promotion.

Growing awareness of the potential of this approach is demonstrated by the recent initiative of the Victorian Government to establish *school focused youth services*, whose brief includes mental health promotion and early intervention in mental health problems. Capacity of school focused youth services to include a strong focus on mental health and be adequately linked and supported by specialist mental health services is enhanced by the Mental Health Promotion Officer scheme which has placed a worker dedicated to mental health promotion in every Child and Adolescent Mental Health Service (CAMHS) service in Victoria.

It is suggested that three or more “multiservice settings” targeting youth (or Multi Purpose Youth Services) be developed as demonstration projects and evaluated along with other demonstration projects based within traditional service settings via a multi-site trial (*Suggestion 2.1b*).

It would be preferable for Multi Purpose Youth Service (MPYS) demonstration projects to be based in Areas that have already established structures to support intersectoral collaboration between state government services. For example, several Areas in New South Wales, such as the Hunter and the North Coast, are relatively advanced in their implementation of the Regional Coordination Program which is administered by the New South Wales Premier’s Department (see Chapter 4 Technical Report Volume 1 for more detail). Regional and rural centres that

TABLE 2.2 Levels of expanded mental health service provision for youth

	General Practice and Community Health Services	Youth Health and Multi Purpose Youth Services (MPYS)	Mainstream AMHS and CAMHS	Super specialist youth mental health teams
Level	Primary	Primary and secondary	Primary and secondary.	Tertiary
Location	Accessible community based, close to public transport	Accessible community based, close to public transport, schools and youth venues	Current variety (some are based in community settings and some are located in the grounds of hospitals)	Co-located with main-stream AMHS and CAMHS
Target population	All adults, youth and children	Adolescents and young adults (no specific age limits) with a focus on marginalised young people at high risk.	All adults, youth and children affected by mental health problems	Young people with severe and complex mental illness
Roles	General primary health care services	Range of services relevant to youth including: <ul style="list-style-type: none"> • Primary health care • Health promotion • Primary prevention • Treatment of mental disorders • Drug and alcohol services • Sexual health care • Basic care facilities (for example, showers, cooking) • Welfare and advocacy Mix to be determined by community based needs assessment including consultation with young people	Provision of general specialist mental health care Provision of specialist mental health support to Youth Health and MPYS and other primary health care services	Provision of specialist treatment for: <ul style="list-style-type: none"> • early psychosis • depression and related disorders (including anxiety disorders and substance misuse) Provision of specialist support to main-stream AMHS, CAMHS, Youth Health and MPYS and other primary health care services
Staffing	GPs Multidisciplinary health care professionals	Multidisciplinary (including GPs, Community Health Nurses, youth workers and specialist mental health professionals with training in adolescent health)	Specialist mental health professionals	Specialist mental health professionals with additional training in adolescent mental health

have established Multi Purpose Services would also be well placed to support such demonstration projects if local communities have identified young people's mental health as a priority and if the additional resources required were made available.

Dual diagnosis

Policy development and planning needs to give high priority to the development of service models appropriate to the needs of young people with dual diagnosis involving mental health and drug use problems. There needs to be formal discussion between mental health professionals and drug and alcohol professionals about ways of working together more effectively. While the need to work in partnership is widely recognised, there has been a failure to identify concrete models that services could use as a foundation or guide for the development of collaborative working relationships. It may be productive for mental health services and drug and alcohol services to work collaboratively to develop and trial models of collaboration (*Recommendation 2.1, third dot point*). Over recent years Divisions of General Practice across Australia have developed and trialed a variety of models of shared care between general practitioners and mental health services. A number of these models might be adaptable to partnerships between mental health services and a range of other services including drug and alcohol services, youth services, sexual assault and child protection services.

Enhancing engagement of young males

Even though Out of the Blues appeared to be more accessible to males with depression than usual services, Martin and Wright (1999) report that young males with comorbid externalising problems such as conduct disorder and substance misuse remained difficult to engage and that a number of depressed young males with these problems were "lost" to the service through drop-out. Further work is clearly required to develop strategies that are more effective in engaging young males in the treatment of mental health problems, particularly complex problems involving depression, conduct disorder and substance misuse (*Recommendation 2.1, fourth dot point*).

There is a dearth of evaluation research literature that has examined what is effective in enhancing the engagement of young males with mental health services. However, as noted in Chapter 1 of this volume, rigorous evaluation research in the United States has demonstrated the effectiveness of Multisystemic Therapy in engaging young males presenting with antisocial behaviour and substance misuse. Henggeler et al. (1996) compared Multisystemic Therapy (MST) and a "usual services" condition in the treatment of substance misuse among juvenile offenders and found that 98 per cent of the families in the Multisystemic Therapy condition completed the full course of treatment. In contrast, only 22 per cent of families in the usual services condition attended any service at all.

Multisystemic Therapy as practiced in the studies by Henggeler and colleagues is delivered by Community Mental Health Centres and focuses on promoting

functioning and enhancing positive connections of young people within a variety of systems including family, school, positive peers and community. A particularly strong emphasis is placed on the family system. Several of the key features of Multisystemic Therapy that Henggeler and colleagues identify as critical to its effectiveness in engaging disturbed young males are highly consistent with the factors identified by Out of the Blues and YPPI-IA. Most significantly, Multisystemic Therapy emphasises the responsibility of the therapist to actively implement strategies to engage clients and their families. Multisystemic Therapy is focused on the young person and the family, with treatment goals and intervention strategies tailored to the needs, strengths and goals of the youth and family. Services are provided in the home and community-based locations rather than in traditional office and institution based settings. Therapists are available to see clients after hours. Treatment is holistic in that it seeks to address all the key issues affecting the young person (Henggeler et al. 1994).

Suicide specific interventions

Results of the LifeSPAN Project evaluation suggest that an additional cognitive behavioural intervention targeting young people with psychotic illness identified at particularly high risk of suicide did not produce further improvements in outcomes above and beyond those achieved by the comprehensive community-based youth specific treatment and care provided at MH-SKY (Youth Program).

Nevertheless, the LifeSPAN Project Team believe that more systematic monitoring of suicide risk by clinicians is likely to increase their capacity to respond more effectively when necessary. Power et al. (1999) recommend that mental health services appoint a suicide prevention coordinator whose role would include regular monitoring and provision of feedback regarding suicide related issues in the service. This position would be closely linked to regular auditing and quality assurance systems. This recommendation is supported (*Suggestion 2.1c*). Another key role for such a position would be to coordinate the regular collection and analysis of a range of data items that have been identified as possibly related to increased risk of suicide among clients of mental health services.

Another critical role for mental health services in suicide prevention is providing mental health assessments for people who present to accident and emergency departments following deliberate self harm and suicide attempts, and providing follow-up care and treatment as needed. This appears to be a particularly problematic area of work for mental health services and these issues are discussed in detail in Chapter 1 of Technical Report Volume 3.

Key issues for further research

As noted above, the results of the current studies are sufficiently positive to justify policy makers and service planners giving serious consideration to expanding the availability of youth specific mental health services. This process

of consideration should include a program of service development research aimed at systematically testing the effectiveness of youth specific versus existing models of mental health service provision to adolescents and young adults (*Recommendation 2.2, first dot point*).

A major limitation of the projects funded under the National Youth Suicide Prevention Strategy is that while they provide evidence that these services are accessible, and are capable of engaging young people and achieving positive mental health outcomes, we cannot conclude with certainty that the model proposed, is more effective than most services that are currently in place. As a first step it would be valuable to have information about the extent to which the practices identified here as facilitating access, engagement and outcomes are implemented by Child and Adolescent (Child and Youth) Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) more widely and what potential there is for wider adoption of these practices within current models of service delivery (*Suggestion 2.2a*).

For example, do CAMHS and AMHS generally have a conscious orientation towards maximising access or do most operate only as secondary and tertiary referral services? What proportion also accept secondary and primary referrals? How many provide a physical youth friendly space where young people are free to spend time and engage with services when they feel comfortable? How many actively network with youth health services? How flexible are appointment systems? What proportion provide assertive outreach to young people in community-based locations and provide after hours services? How many services support the input of young people into service development and service delivery? More detailed information about the current operating procedures of CAMHS and AMHS and the variations in these across services in different areas is required to further our understanding and to inform policy development in this area.

Data on child and adolescent mental health services have not been readily available and were collected by the National Survey of Mental Health Services for the first time in 1996/1997. The New South Wales Strategy, *Making Mental Health Better for Children and Adolescents* (NSW Health 1999) notes that data from the National Survey of Mental Health Services will be used to monitor implementation of that Strategy until 2001. It is strongly suggested that the National Survey of Mental Health Services continue to collect data appropriate to monitoring the operation of child and adolescent mental health services as well as data on the extent to which CAMHS and AMHS are meeting the needs of adolescents and young adults (*Suggestion 2.2b*).

Measuring access

Measurement of service accessibility is complex and very little rigorous service evaluation research has been done in this area in Australia. Yet access is a fundamental dimension of overall service quality and effectiveness that cannot remain

neglected if we are to be confident that services are being provided equitably to all members of the population that require them.

Developmental evaluation work is required in order to identify valid indicators of accessibility that can be used with reasonable ease by service managers (*Recommendation 2.2, second dot point*). Total numbers of referrals, assessments and ongoing clients are not sufficiently sensitive indicators of service accessibility. Several potentially useful indicators are suggested from the efforts of YPPI-IA and Out of the Blues to address this question.

Source of referral, in particular the number and proportion of referrals received from community agencies, parents and young people themselves, appears to be an important indicator of the extent to which the agency is known and well regarded in the public domain and the relative ease with which community members can identify and make contact with the service.

Changes in referral source profiles could be used to assess whether changes to services have increased their accessibility or not. Comparison of referral source profiles could provide an indication of the relative accessibility of different services. Most community mental health services gain a large proportion of their referrals through hospitals. Referrals to community-based mental health services from community gatekeepers, parents and young people themselves are likely to occur before the individual in question has become sick enough to require hospitalisation and would indicate a higher degree of client willingness and ability to access services. Thus an important indicator of a service's accessibility may be a decrease in the proportion of hospital referrals and an increase in the proportion of referrals from community gatekeepers and self referrals. Ratios of hospital to community referrals could be used to compare the accessibility of different services and to evaluate the effectiveness of measures that aim to increase accessibility.

The next question that arises here is whether referrals from the community are likely to make it through the various processes that most services are forced to use to ensure that the limited resources available are directed to those individuals most in need. Martin and Wright (1999) reported that a high proportion of referrals to Out of the Blues from parents were declined after an initial telephone interview. Only 18 out of 59 referrals from parents (31 per cent) progressed to a face-to-face assessment. In contrast 10 out of 12 (83 per cent) self referrals from young people went on to assessment.

The accessibility of any particular service also needs to be considered in the context of the total need for services among the population being served and whether alternative services are available to meet these needs. Thus access is best evaluated by considering the total availability and utilisation of relevant services in a specified geographic area and comparing this with the prevalence of mental health problems from population-based surveys. The number of young people with psychosis or depression actually presenting or gaining access to a particular

service within a particular period of time could be compared to the estimated incidence of these conditions at a population level. By including a number of different services in such a study the relative accessibility of different services and the importance of certain service attributes to accessibility could be explored.

Most mental health services currently lack the resources to conduct such sophisticated monitoring of service access. Service data systems generally remain inadequate to the task of providing reliable data about service utilisation across different population groups and data about the prevalence of mental health problems in different population subgroups are not available at local area health service levels. However, the National Survey of Mental Health and Wellbeing of Children and Adolescents, conducted for the first time in 1997 (and released in November 2000), has recently made relevant data available (Sawyer et al. 2000). These data could be used as a guide to the prevalence of mental health problems in most areas. The National Survey of Mental Health and Wellbeing of Children and Adolescents would need to be repeated at 5 or 10 year intervals if it is to be of value in monitoring any changes in the prevalence of mental health problems and patterns of service utilisation (*Suggestion 2.2c*).

At a day-to-day management level it may be more feasible to evaluate accessibility by monitoring the numbers of referrals that are declined by particular services as well as the issues presented by these referrals and the reasons why they are declined. It would also be valuable to have information about whether these declined referrals are referred to other services, where they are referred to and if these referrals are accepted by the alternative services. Even though certain referrals might not be appropriate for a particular service as it is currently constituted, might a need exist that is not being met? In the case of young people who are not accepted to a service because their disturbance is not severe enough to warrant diagnosis of a particular mental disorder, such information may be particularly valuable for assessing need for early intervention aimed at preventing the onset of a mental disorders in the future.

Another important dimension of accessibility is the amount of time it takes clients to access the service after the problem begins (duration of untreated illness) and the “smoothness” of the pathway they travel in coming to the service. A growing body of research has examined the “pathways to care” for adults with mental health problems (Commander et al. 1997; Gater et al. 1991; Moodley and Perkins 1991), and recent research has also focused on pathways for young people with early psychosis (Larson et al. 1998; Lincoln and McGorry 1995). However, very little is known about the range of pathways through which adolescents and young adults with other mental health problems gain access to mental health services. Pathways research involving a representative sample of young people accessing any particular service would provide useful information in the evaluation of service accessibility as well as informing service development work aimed at enhancing accessibility (*Recommendation 2.2, third dot point*).

Measuring engagement

Effective engagement of young people who are seriously affected by mental health problems and at high risk of suicide is a clearly evident achievement of the three mental health services in this group. Measurement and documentation of engagement were more rigorous and more thorough than measurement and documentation of access. This is probably because it is easier to measure engagement than access. Engagement is a process that unfolds after the client has made contact with the service, whereas many (but not all) of the factors determining access exert their influence before the client contacts the service.

Engagement of young people should be considered a central indicator of mental health service quality and effectiveness and data relevant to this indicator can and should be collected and reported routinely by all mental health services as an integral part of quality assurance (*Suggestion 2.2d*).

Simple data items that could be included on electronic data systems include: if the client has ceased contact with the service prematurely (in contra-indication of key worker/case manager/team advice); client agreement/refusal to participate in service evaluation activities; and proportion of appointments attended.

It would also be desirable for services to collect data on client satisfaction with service routinely with a view to monitoring their effectiveness in engaging with individual clients and different groups of clients and informing the ongoing design of strategies to improve engagement. Data on satisfaction with particular aspects of service in the current projects were very useful for identifying the characteristics of service provision that are most effective for engaging young people.

Efficacy of treatment for depression, anxiety and substance misuse

Further work is clearly required to develop and evaluate models of treatment for young people with depression and anxiety as well as for young people with substance misuse and mental health problems (*Recommendation 2.2, fourth dot point*).

One of the key issues raised by Martin and Wright (1999) in the development and evaluation of Out of the Blues concerns the use of medication in the treatment of depression in young people. Effective use of medication with young people suffering from depression is an area where further research is urgently required.

While there is widespread consensus regarding best practice in the use of medication in the management of early psychosis, that is, the lowest possible dosage of neuroleptic medication (National Early Psychosis Project 1998), knowledge about appropriate use of medication in the management of depression in young people is less well developed.

The current National Health and Medical Research Council guidelines on the management of depression in young people (NH&MRC 1997) identify cognitive behavioural therapy (CBT) as the treatment of choice for unipolar depression in

young people and specify that antidepressant medication should only be used when first line treatments have been unsuccessful. This recommendation is based on the fact that controlled trials have demonstrated the efficacy of CBT in the treatment of depression in young people while no such data were available to support the use of antidepressant medications. This is not due to the failure of trials to demonstrate efficacy but because of a lack of appropriate studies.

Martin and Wright (1999) review the literature published since the NH&MRC guidelines were developed and find evidence to support the use of selective serotonin reuptake inhibitors (SSRIs) in the treatment of depression in adolescents. Patton and Burns (1999) also cite positive evidence to this effect from a double blind, randomised, placebo-controlled trial (Emslie, Rush, Weinberg et al. 1997). The young people in this study were aged 7–17 years. Patton and Burns (1999) note that the lack of adequately designed pharmacological studies examining the treatment of depression in young people is striking. Recent research with adults indicates that antidepressant medication is under-used in the treatment of patients with major depression and with a history of suicide attempt (Oquendo et al. 1999).

It is important that evaluation research be conducted that can be used to monitor the appropriateness, and guide the updating, of the NH&MRC Clinical Guidelines as necessary. Specifically, it would be valuable to have information about the characteristics of young people who respond positively to Cognitive Behaviour Therapy as well as those who do not respond to Cognitive Behaviour Therapy, and who instead improve when prescribed particular antidepressant medications. Evaluation research also needs to monitor long term outcomes (*Suggestion 2.2e*).

At this point in time the NH&MRC Clinical Practice Guidelines on Depression in young people (NH&MRC 1997) remain the only initiative of national significance aimed at enhancing the treatment and prevention of depression in young people. Distribution of practice guidelines on their own, in the absence of enabling and reinforcing strategies has been found to be ineffective in generating improved performance or health outcomes (Davis et al. 1992). Andrews (1999) has identified a set of strategies that appear to be necessary for implementing clinical practice guidelines. These include ensuring that organisational processes in work environments facilitate the practices recommended and evaluation. It is important that evaluation be conducted to determine the extent to which the NH&MRC Clinical Practice Guidelines on Depression are being used and whether use of the guidelines is associated with improved outcomes for young people (*Suggestion 2.2f*).

The YPPI-IA team have recommended that a randomised controlled trial of specific substance misuse interventions for young people with mental disorders should be funded, particularly focusing on marijuana use. This recommendation is strongly endorsed (*Suggestion 2.2g*).

It would also be useful to conduct formative research aimed at better defining the key issues and clarifying the critical dimensions of service provision that need to be tested in an ongoing program of dual diagnosis intervention research. For example, it would be valuable for research to examine the issue of which setting (mental health services or drug and alcohol services or elsewhere) may be the most appropriate base for programs targeting dual diagnosis and what factors determine the most appropriate setting for particular clients.

Staff of YPPI-IA observed that programs that support lifestyle changes are required and that drug rehabilitation programs are oriented towards this. On the other hand, the literature review conducted by the YPPI-IA Project suggests that drug rehabilitation services often use techniques and apply restrictions that are not appropriate to people with mental health problems and that “rehabilitation” programs may not be appropriate for young people who have been using substances since childhood (see Howe et al. 1999 for a review). The First and Second National Stocktakes of Youth Suicide Prevention Programs and Activities have identified a number of different models being used to address the needs of young people with mental health and substance misuse issues. A number of these are located in non-government agencies and youth health services and several target young people of Aboriginal descent. A review of the programs identified in the Stocktakes would be valuable in informing the development of further evaluation research (*Suggestion 2.2h*).

Termination of mental health care

Another area of clinical practice worthy of focused research with respect to suicide prevention is termination or reduction of mental health care. Termination of a course of intensive treatment was identified by expert consultants to the LifeSPAN project as an area requiring special care. The YPPI-IA team also identified the critical importance of ensuring that termination of care is a positive experience for the client. Recent published research has found that reductions in care are strongly associated with suicide by people with mental illness (Appleby et al. 1999). These authors interpret these findings as suggesting that maintaining care beyond the point of clinical recovery is important in protecting high risk individuals. Research into the attributes of an effective termination process in the eyes of young consumers of mental health services as well as clinicians is warranted (*Recommendation 2.2, fifth dot point*). This research should also examine the relationships between satisfaction with care, satisfaction with termination and longer term clinical outcomes including self harm and suicide attempt.

Risk factors for suicide among clients of mental health services

Suicide prevention research should also continue the search for clinical and psychosocial risk factors for suicide among clients of mental health services. The reliability and fruitfulness of such research might be improved if mental health services collect and document relevant information proactively and routinely.

At the end of the Out of the Blues project eight young people continued to attend on a regular basis and remained severely depressed. These young people also remained highly anxious. One of the factors that distinguished this group of young people who remained severely unwell from those who did improve was their reporting of significantly higher levels of family dysfunction and the lack of improvement in their perception of family function over the course of treatment. Six of the eight had been sexually abused and some were subject to ongoing abuse or threats of abuse. At least one of the two young people in the LifeSPAN study who took their own lives had a history of severe psychological trauma.

Martin and Wright (1999) report that no particular set of therapies distinguished the group of young people who consistently failed to show a response to standard treatment. It will be important for future service development and evaluation activity to include a stronger focus on the needs of young people who show indications of a lack of response to therapy. Identification of psychosocial risk factors may provide a guide to the design of more effective treatment strategies for these individuals. For example, the presence of severe family dysfunction and a history of abuse in particular may indicate the need for interventions that specifically address these problems.

Epidemiological and preventative research focusing on clients of mental health services could also benefit from increased attention to risk factors associated with the treatment process such as premature dropout and other indicators of poor engagement. Surprisingly little research has explored these factors, but one recent study found premature drop out and reduced attendance at appointments to be significantly more prevalent among mental health service clients who completed suicide compared to matched controls (Dahlsgaard et al. 1998).

As noted earlier in the discussion of engagement, Multisystemic Therapy has been found to be effective in significantly enhancing engagement in treatment as well as outcomes among young people historically considered to be intractable including serious juvenile offenders and young people with substance misuse issues (Henggeler et al. 1992, 1994, 1996; Cunningham and Henggeler 1999). Severe family dysfunction and abuse is highly prevalent among such populations and addressing family dysfunction appears to be critical to the effectiveness of Multisystemic Therapy in enhancing both engagement and outcomes for these young people.

The LifeSPAN Project team recommend that further evaluation research needs to be conducted to determine whether models of early intervention in mental illness reduce suicide rates. This question could be addressed within the service development evaluation framework proposed above by ensuring that *duration of untreated illness* of clients is included among the measures of program *impact* and determining whether this factor makes an independent contribution to rates of suicide, attempted suicide and self harm among client populations of different services.

Sustaining service reform

An important problem in any service reform process is sustaining the positive changes that are achieved. It is possible that many new services may be more effective than old ones largely because of the increased enthusiasm and optimism of the staff of new services rather than any fundamental characteristics of the service model (Hazell, P., personal communication). This is a particular problem for mental health services where there is a strong tendency for staff to become pessimistic and “burnt-out” as they gradually accumulate chronic and dependent clients. Services tend to become less and less responsive to new and high intensity work as this process unfolds.

Some suggestions for avoiding these problems and maintaining service responsiveness were provided by several Strategy projects. The YPPI-IA team spoke about the importance of a clear philosophical base and transparent work practices in building a new service. This is also likely to be critical for maintaining high practice standards over the long term. Similarly, other Project Managers and evaluators noted that creating an organisational culture of critical reflectiveness is important. The role of management was noted as particularly vital. Managers need to be willing to acknowledge the fact that emotional and interpersonal problems do arise for professional staff working in human service agencies and need to create structures for addressing these problems openly.

Key structures and processes include clinical supervision and regular team meetings in which staff are encouraged to continually review their practice and discuss problems in a supportive environment. Mechanisms for ensuring that staff contribute actively to ongoing service development also appear to help sustain the vitality and enthusiasm of services.

Recommendations and suggestions

“The root of the difficulty in applying research findings to improve services is that the services are mostly not conceived as a system of care. If mental health is the desired outcome, we can only hope to achieve it if services are planned and enabled to work together as a system with this common aim.” (Kurtz 1996: 51).

“Research should be planned to cover the working of mental health services as a system of care as well as to increase what we know about treatment efficacy and effective clinical practice.” (Kurtz 1996: 56).

It is recommended that:

- 2.1 Commonwealth and state and territory governments should develop policy frameworks and strategic plans to guide the development of mental health services for young people. These should give particular consideration to:

- ensuring that service models are available which address the specific needs of young people in addition to adults and children, as well as young people with complex mental health problems and those exposed to multiple risk factors for suicide;
- achieving an appropriate balance between generic mental health services and specialist units (such as those focusing on youth, psychosis, depression, and dual diagnosis);
- methods of treatment of dual diagnosis (substance misuse and mental disorders) and models of collaboration between mental health services and drug and alcohol services;
- the engagement of young males with mental health services;
- building the capacity of mental health services in early intervention, primary prevention and mental health promotion; and
- building the capacity of mental health services to evaluate service provision.

(This is Recommendation 20 in the evaluation overview, “Valuing Young Lives”.)

It is further suggested that:

2.1a. Commonwealth and State and Territory governments collaborate to establish a number of demonstration programs aimed at developing holistic models of service provision appropriate for young people with complex mental health problems. Projects should be based in a number of different settings including mental health services, youth health services and youth focused non-government agencies and a range of different models should be compared including:

- consultation-liaison;
- Shared Care;
- employment of specialist mental health professionals or teams within youth health services and other youth focused agencies;
- expansion of the specialist youth mental health model (for example, YPPI) to address a wider range of mental health related issues; and
- co-location of specialist youth mental health services with youth health and other youth focused services.

Evaluation of these projects should be coordinated in a multi-site trial to ensure a design that is capable of testing for the effects service environment.

2.1b. Three or more “multiservice settings” targeting youth (or Multi Purpose Youth Services) be developed as demonstration programs and evaluated along with other demonstration programs based within traditional service settings via a multi-site trial. It would be preferable for Multi Purpose Youth

Service demonstration programs to be based in Areas that have already established structures to support intersectoral collaboration between state government services.

- 2.1c Mental health services should appoint a suicide prevention quality consultant whose role would include regular monitoring and provision of feedback regarding suicide related issues in the service.

It is recommended that:

- 2.2 Funding should be provided to support a research program focusing on:
- evaluation of the effectiveness of youth specific service models versus existing models of mental health service provision for adolescents and young adults;
 - development of valid indicators of service accessibility and engagement that can be used with reasonable ease by service managers;
 - pathways to mental health care;
 - efficacy and effectiveness of treatments for depression, anxiety and substance misuse in young people: evaluation research should monitor long-term outcomes;
 - the attributes of a safe and effective termination process from the perspective of young consumers of mental health services as well as clinicians.

(This is Recommendation 21 in the evaluation overview, “Valuing Young Lives”.)

It is further suggested that:

- 2.2a State/Territory Mental Health Branches and Area/Regional Mental Health Services should collaborate to conduct systematic reviews of Child and Adolescent (Child and Youth) Mental Health Services and Adult Mental Health Services to identify the extent to which the practices identified here as facilitating access, engagement and outcomes for young people are being implemented throughout the mental health system and what potential there is for wider adoption of these practices within existing models of service delivery.
- 2.2b Questions capable of generating improved information about the current operating procedures of Child and Adolescent Mental Health Services and Adult Mental Health Services with respect to servicing adolescents and young adults should be included in the National Survey of Mental Health Services.
- 2.2c The National Survey of Mental Health and Wellbeing of Children and Adolescents should be repeated at 5 or 10 year intervals to enable monitoring of any changes in the prevalence of mental health problems and patterns of service utilisation.
- 2.2d Engagement of young people should be considered a central indicator of mental health service quality and effectiveness and data relevant to this

indicator should be collected and reported routinely by all mental health services as an integral part of quality assurance. Simple data items that could be included on electronic data systems include:

- whether the client has ceased contact with the service unilaterally (in contra-indication of key worker/case manager/team advice);
- client agreement/refusal to participate in service evaluation activities;
- proportion of appointments attended.

- 2.2e Funding should be provided to conduct research to identify the characteristics of young people who respond positively to Cognitive Behaviour Therapy as well as those who do not respond to Cognitive Behaviour Therapy and who instead improve when prescribed particular antidepressant medications. Evaluation research should monitor long term outcomes.
- 2.2f Evaluation should be conducted to determine the extent to which the NH&MRC Clinical Practice Guidelines on Depression in young people are being used and whether use of the guidelines is associated with improved outcomes for young people.
- 2.2g Funding should be provided to conduct a randomised controlled trial of an intervention aimed at reducing marijuana use among young people with mental health problems.
- 2.2h A review of programs targeting dual diagnosis identified in the First and Second National Stocktakes of Youth Suicide Prevention Activities should be conducted to identify the dimensions of service provision that should be tested in an ongoing program of dual diagnosis intervention research.

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Map of program logic: Mental health services

Goals/outcomes

- Reduce the incidence of suicide and suicide related behaviour among young people with mental health problems.
- Enhance mental health outcomes for young people with mental health problems.
- Reduce the incidence and prevalence of mental health problems among young people.

Objectives/impacts

- Minimise the severity and duration of symptoms experienced by young people who develop mental health problems.
- Maximise the life skills and quality of life of young people living with mental health problems.
- Minimise the harm, distress and disadvantage experienced by young people with mental health problems.
- Minimise exposure to risk factors for mental disorders.
- Maximise exposure to mental health protective factors.

Aims/processes

- Enhance the access of young people to appropriate mental health services, especially young males, young people with substance misuse and other complex problems and young people living in rural and remote areas.
- Enhance engagement of young people with mental health services, especially young males and those with substance misuse and other complex problems.
- Improve the quality and availability of mental health promotion, primary prevention, early intervention and treatment programs targeting young people at risk of mental health problems.

Performance indicators

- Mental health services and programs which address the specific needs of young people, in addition to adults and children, are available in all geographic regions.
- Mental health services in all regions have evidence-based programs appropriate to mental health promotion, primary prevention, early intervention and treatment of the major mental disorders affecting young people including psychosis, depression, anxiety and substance misuse problems.
- Staff in specialist mental health services, primary care services and other relevant agencies have the skills, knowledge and information necessary to provide appropriate mental health care for young people.
- Commonwealth and state/territory governments have policy frameworks and strategic plans to guide the development of mental health services for young people.

Index of projects referred to in this volume

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- Benelong's Haven Ltd
See Alternative to Gaol Program for Young Aboriginal People
- Bridge Youth Service
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List of contact details for projects referred to in this volume

- Alternative to Gaol Program for Young Aboriginal People
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Phone: 03 9415 8700
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- Here for Life youth sexuality project
Western Australia AIDS Council
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Contact person: Mr Joe Bontempo

High Street Youth Health Service
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Youth suicide prevention initiative for
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