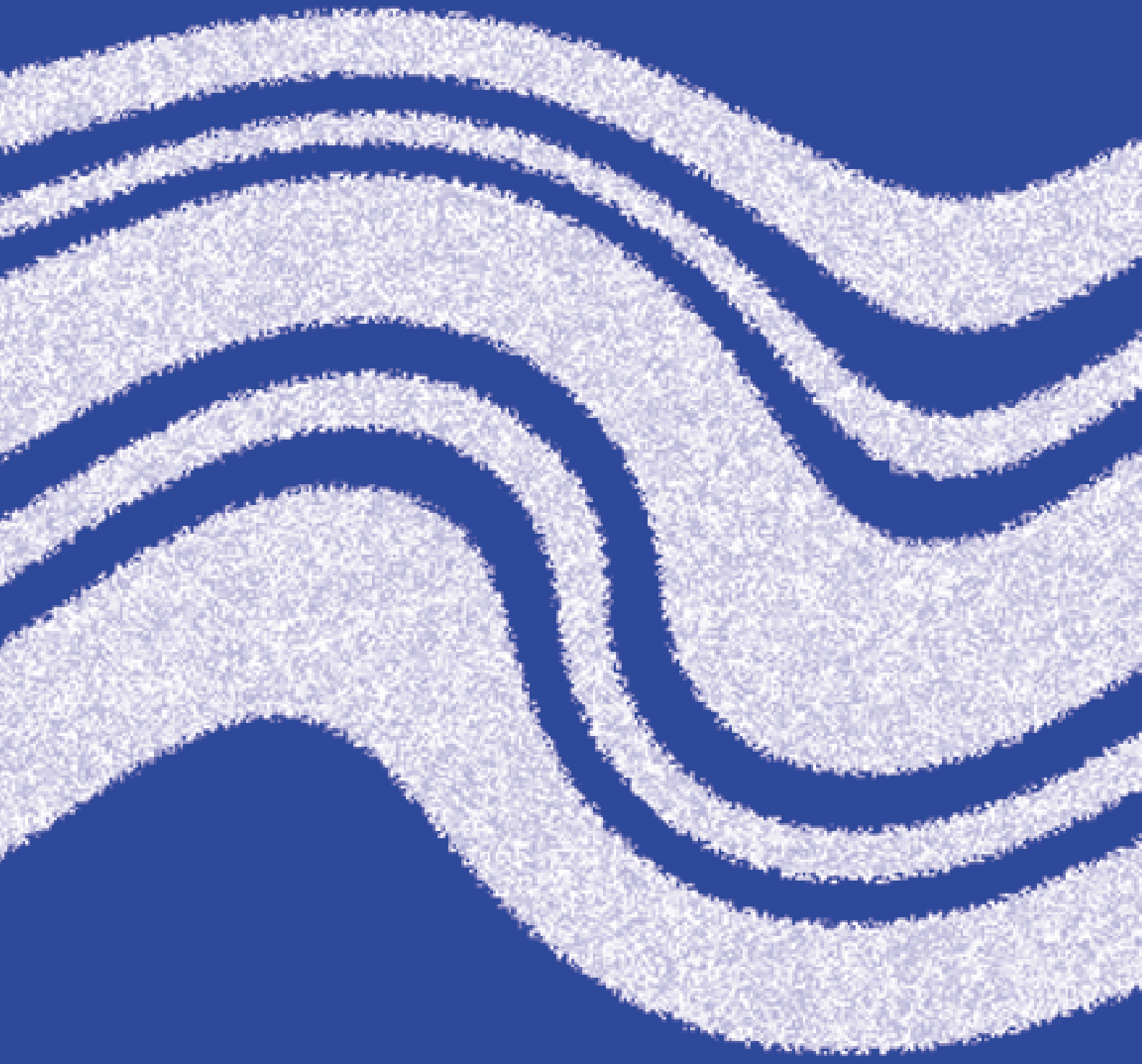
Getting in Early

A framework for early intervention and prevention
in mental health for young people in New South Wales



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Getting in Early - A framework for early intervention and prevention in mental health for young people in NSW

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Foreword

A substantial number of adolescents and young adults have significant mental health problems. Up to 24% of adolescents experience depression by the time they are 18 years old. Young people aged 15-24 years are the group most frequently affected by a first episode of psychosis. Mental health problems in young people have been poorly recognised, identified and managed and there has often been a considerable delay in young people receiving appropriate care.

Getting In Early – A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW was first released as a draft discussion paper in May 1999. The document provides an innovative framework for mental health service delivery for young people from a whole of lifespan approach.

There are many different settings in which young people with mental health problems may present, such as schools, general practice and youth, community health and juvenile justice services. Collaboration between mental health services and these other services is critical to ensure that mental health problems in young people are prevented, identified early and that appropriate mental health care is provided.

The Australian clinical practice guidelines for depression and for early psychosis in young people have highlighted the importance of these mental health problems and have provided a foundation for their effective identification and management. Recognising the importance of this, the NSW Government has committed considerable funding for mental health programs and services for young people.

First onset psychosis programs have been established in Area Health Services. These programs are spearheading mental health service reform and change in the culture of mental health service delivery in NSW. Evaluation of these services and monitoring outcomes for young people are a core component of service delivery.

A significant vehicle for progressing programs for depression in adolescents is the NSW School-Link initiative. The statewide School-Link Training Program for school and TAFE counsellors and mental health workers focuses on depression and related disorders, particularly anxiety, in adolescents. The program models many of the principles in the framework – using evidence in practice, improving pathways to care and learning more about how to prevent, recognise and intervene early, effectively and collaboratively in young people's mental health problems.

Naturally there are still a number of issues that need to be explored. Mental health workers have been keen to embrace these new directions in mental health service delivery. The evidence for effective early intervention continues to build; however, evaluation of progress in real world settings is essential for the further development of this field. The level of problematic substance misuse and its high comorbidity with mental health problems are critical and growing issues. This emphasises the importance of collaboration between mental health services and alcohol and other drug services.

The progress which has already been made in depression and early psychosis services augurs well for a range of other disorders affecting young people that also need attention – anxiety disorders, eating disorders, anti-social personality disorders and conduct disorders. The comprehensive structure and strategies outlined in *Getting in Early* will be an invaluable resource to support collaboration and to progress prevention and early intervention programs and services in mental health for young people across NSW.

Professor Beverley Raphael
Director, Centre for Mental Health

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Executive summary

Improving young people's mental health is a priority of the NSW Government. Mental illnesses such as depression and related disorders, first onset psychosis and anxiety disorders pose a significant problem for young people and their families. In the National Survey of Mental Health and Wellbeing conducted in 1997, young people aged 18-24 years had the highest prevalence of mental disorders of any adult age group. Increased suicide risk, increased risk of hazardous substance use, disruption to psychological, educational and social development, strain on relationships and increasing costs to mental health services and society are all serious consequences of mental health problems and disorders. Such disorders, unless adequately recognised and treated, continue into adult life, with potential chronic impairment and disability.

It is estimated that up to 62,000 young people in NSW will experience an episode of major depression in any six-month period. Despite this the detection of depression and related disorders in young people is extremely poor. The National Health and Medical Research Council's Depression in young people: Clinical Practice Guidelines provide evidence-based recommendations for prevention, detection, treatment and management of depression in young people. Although there has been progress in implementing these guidelines in parts of NSW, much work is still needed to ensure that prevention, detection, treatment and management programs are available in all Areas and accessible for young people with and at risk of developing depression and related disorders.

About 800 young people will experience a first episode of psychosis each year. There is often a 1-2 year delay between the first symptoms of psychosis and receiving effective treatment. NSW has been part of the National Early Psychosis Project which has developed best practice guidelines and other resources for the early detection, management and treatment for first onset psychosis. All Areas in NSW are setting up services or programs for early intervention in first onset psychosis. Many are in the early phases of development and much assistance is required to ensure appropriate and skilled implementation.

Although young people experience distress related to the symptoms of depression and related disorders, first onset psychosis and other mental disorders, they may be unaware of the cause or may find it difficult to seek help.

Young people may also experiment with alcohol and other drugs or engage in risk-taking behaviours. These problems may complicate the young person's presentation for care and their treatment or add complexity to the developing illnesses. Programs oriented to young people's needs and culture and to potential comorbidity need to be developed to provide a basis for early intervention strategies.

Increasing evidence shows that preventing and intervening early for young people with mental health problems can dramatically improve outcomes. State, national and local initiatives are fostering a climate for the further development of these services and programs. Since 1996/97, the NSW Government allocated an additional $2.38 million recurrent funding to Area Health Services for depression and first onset psychosis programs across NSW and a further $9.2 million from 1999/2000, over five years for School-Link, early psychosis programs and community depression programs. The Government is now providing a further guaranteed $107.5 million increase in recurrent funding for mental health services over the next three years and early intervention services will continue as key effective components of the reform agenda.

Early intervention and prevention are developing fields in mental health. Statewide and Area coordination is essential in continuing to forge these new directions in NSW. Mental health services also have a key role to play in educating others about these illnesses, their prevention, early detection and management, as well as facilitating the setting up of local services and programs.

Five broad strategies are outlined for progressing prevention and early intervention in mental health for young people:

1. Developing and coordinating comprehensive programs and services
2. Engaging young people and their families and providing comprehensive assessment and management
3. Developing and implementing prevention programs
4. Educating the community, particularly on depression and related disorders and first onset psychosis in young people
5. Monitoring quality and effectiveness

Introduction

Young people and mental health issues

The mental health of young people is a priority for the NSW Government and community. In this paper, the term 'young people' refers to 15 to 24-year-olds. Major mental illnesses such as depression, anxiety, psychosis and substance abuse frequently have their onset during mid-late adolescence and early adulthood.

Young people's mental health is as important to their development as their physical health. Mental disorders, such as depression and psychosis, impact greatly on the young person, their family and social networks[1, 2]. These disorders affect the young person's capacity to mature and accomplish developmental tasks, especially those relating to social development and independence. They impact upon thinking processes, emotions, perceptions, motivation and confidence, resulting in difficulties in learning, problem solving and achieving vocational goals. Mental disorders impact on schooling and other education, employment, the ability to cope with life situations and transitions, relationships and the capacity to enjoy normal activity.

Many young people have more than one mental health problem, for example young people with first onset psychosis often also experience depression and anxiety. Young people with eating disorders often experience depression. Antisocial problems may reflect aspects of depression in some young men. Hazardous use of alcohol and other drugs is strongly linked to the prevalence of mental disorders, including depression and psychosis, in young people. Suicide and self-harming behaviour are also linked to mental disorders.

Adolescence and young adulthood are periods of significant change and development that present opportunities and challenges. Stress is commonly experienced by young people during this time. Stress is associated with family problems and breakup, study, finding a job, relationships, sexuality and with developing a sense of identity and individuality. Young people from culturally diverse backgrounds, or Aboriginal and Torres Strait Islander populations and other special needs groups can often experience additional stressors related to cultural issues. Same sex attracted young people may be at greater risk of depression and suicide. Mental disorders, such as depression or psychosis, can exacerbate these feelings of stress in young people.

There are family, school and individual factors that assist young people to negotiate the challenges associated with this period, for example feeling close to and cared for by their families and having a sense of belonging at school.

Young people may also be disturbed by recent or past experiences of trauma and this increases the likelihood of their developing a range of problems that may continue into adulthood. Physical, emotional or sexual abuse may contribute to major problems for the young person. Some young people may have been traumatised by community violence or experiences as refugees. Post-traumatic stress symptoms may also complicate the assessment and management of young people's mental health[3].

There are gender differences in the main types of problems that young people report having experienced. For example, males are more likely to engage in risky behaviours, whereas females are more likely to have experienced or witnessed physical abuse or witnessed sexual abuse[4].

Use of mental health services by young people – barriers and opportunities

Young people tend to be poorly informed about mental illness, including depression, anxiety and psychosis. When they have a mental health problem they seek assistance from family and friends or try to sort things out themselves[5]. Australian studies suggest that only a very small proportion of young people will seek professional help from mental health services[6].

There are many reasons why young people do not access mental health services. Discrimination against people with mental illness is high, preventing help seeking behaviour. Many young people find mental health services are not culturally or youth friendly, and may not see them as relevant to their needs. Young people seeking help may be turned away from a mental health service as their problem may not be considered serious enough. Mental health staff may have difficulty in distinguishing emerging mental health problems from normal adolescent difficulties. The pathways to effective care may not be clear for the young people and their families and multiple contacts with the health system may be experienced prior to their receiving appropriate care.

Young people may be in contact with other health services, for example general practitioners, community health or youth health. Australian studies suggest that children and adolescents with mental health problems were more likely to present to non-mental health agencies, with 65% of children and adolescents with a mental health problem seeing a general practitioner in the previous six months prior to being surveyed[7].

This provides opportunities for early recognition, intervention and referral. Collaborative links between mental health services and other services which young people access need to be strengthened to improve access to mental health services.

Mental health policy in NSW

In February 1999, the NSW Government released *NSW Strategy: Making Mental Health Better for Children and Adolescents*[8], which defines and strengthens the structure for child and adolescent mental health. It includes five strategic directions:

- Strengthening the structure and working together for child and adolescent mental health;
- Mental health promotion, prevention and early intervention;
- Better mental health care for children, adolescents and their families;
- Crisis and emergency mental health response for children, adolescents and their families; and
- Quality and effectiveness in mental health care.

These strategic directions are underpinned by the need to strengthen collaborative partnerships to provide good quality mental health care for children, adolescents and their families covering promotion and prevention, primary care, secondary mental health care and tertiary services and programs.

The child and adolescent mental health strategy supports and develops strategic directions described in *Caring for Mental Health. A Framework for Mental Health Care in NSW* (October 1998)[9]. Key themes in *Caring for Mental Health* are the provision of comprehensive, integrated mental health services across the lifespan, with an emphasis on promotion of good mental health, prevention and early intervention and the provision of the full spectrum of interventions, including mental health treatment and maintenance care.

Mental health is a key focus in *Strategic Directions for Health 1998-2003*[10] which was released in August 1998. The document outlines the purpose, goals and broad strategies for NSW Health to 2003.

Young People's Health: Our Future (1999) is a policy document which deals more broadly with many important health issues that can impact on the mental health of young people.

The policy is one of a range of strategies under the NSW Government's *Focus on Young People* (1998), the whole of government youth policy aimed at upholding the social justice principles of coordination, access, equity, participation, rights and responsibilities and early intervention.

NSW initiatives to progress early intervention and prevention

Early intervention and prevention are developing fields in mental health. Evidence increasingly shows that preventing and intervening early for young people with mental health problems, particularly depression and first onset psychosis, can dramatically improve immediate and long term outcomes.

Achieving new directions in local mental health services requires time and cultural change. In the past, mental health services have tended to be oriented towards acute and long term care of seriously and chronically ill adults. The focus is being broadened to cover the full range of ages, from childhood to old age and, the full spectrum of intervention opportunities, where there is evidence for their effectiveness, from prevention to long term care. Collaborative partnerships are a critical component in providing this extended range of services.

Careful consideration of how to provide accessible, high quality, appropriate services for adolescents and young adults is required. This age group spans the usual focus for child and adolescent services and adult services with the potential for 'falling through the gap'. Information from Area Youth Mental Health Forums held across NSW have highlighted many ways in which mental health services can link with and build on existing youth services to meet young people's mental health needs such as strengthening partnerships between mental health and other youth services, strengthening the structure of mental health services for young people, improving crisis and emergency services for young people and enhancing promotion, prevention and early intervention[11].

This reorientation of mental health services will require extensive consultation and the provision of resources directed towards supporting these new directions. Continued Statewide coordination is critical to facilitate and progress the implementation of depression and related disorders and first onset psychosis initiatives across NSW. Statewide coordination enhances links and partnerships between Area Health Services and the cross fertilisation and dissemination of knowledge and information. It facilitates the provision of education and training and equitable resource distribution while offering support and monitoring of service development.

The framework presented in this paper is intended to have general application to the development of services for young people who have or may be developing mental health problems. It focuses on first onset psychosis, and depression and related disorders, as priority areas in implementing the framework.

Depression has been identified as one of the major public health problems of the 21st century. Up to one in four young people will experience one or more episodes of major depression by the time they reach 18 years[12]. First onset psychosis affects more than one per cent of young people. Most of these young people do not receive treatment for up to 2.5 years. The longer the delay to treatment for young people who are affected, the worse the outcome[13].

Depression and first onset psychosis:

- commonly have their first onset during the late adolescence or early adulthood years;
- are often preceded by identifiable 'warning signs' (prodrome, less serious signs and indicators);
- can recur throughout adult life;
- can have a significant impact on the young person's social, educational, emotional and vocational development;
- can have a major impact on the young person's family functioning;
- are commonly associated with serious risk factors;
- are linked with hazardous substance use and increased risk of suicide.

There is emerging clinical and scientific evidence that[14, 15, 16]:

- there are effective treatment and management strategies for depression and related disorders and first onset psychosis;
- there are effective prevention strategies for depression and related disorders;
- early intervention can provide the opportunity to decrease the severity of symptoms, prevent the progression of the illness and minimise the effect on the young person's development;
- effective management can reduce the frequency or severity of recurrent episodes.

NSW initiatives for depression and first onset psychosis

Statewide coordination and the allocation of funding targeting programs and services for first onset psychosis and depression in young people have contributed significantly to the establishment and progression of several initiatives across NSW.

The School-Link initiative is becoming well-established in Area Health Services throughout NSW. Area Health Services have appointed School-Link Coordinators to implement the initiative locally, including: enhancing formal links and pathways to care between schools and child and adolescent mental health services; facilitating implementation of prevention and mental health promotion programs in schools; and facilitating continuing education for school counsellors and other relevant groups of workers regarding mental health issues. A key component is the School-Link Training Program, a shared training program for all school counsellors, TAFE counsellors and mental health workers in NSW. The School-Link Training Program focuses on adolescent depression and related disorders and is aimed at enhancing the collaboration between schools, TAFE and mental health services to support young people with mental health problems.

Area Health Services now offer first onset psychosis programs or services. These programs or services offer evidence based care for young people with first onset psychosis. Several models of first onset psychosis service delivery are emerging. These range from specialist first onset psychosis teams or sites through to an integrated model in which all staff are trained to work with young people with first onset psychosis. The evaluation of these services and the monitoring of outcomes for young people are core components of service delivery.

National initiatives for depression in young people and first onset psychosis

Five major national programs have been set up to support the development of services and programs for first onset psychosis and depression and related disorders in young people (refer to Appendix 2 for further details):

- *Depression in young people: Clinical Practice Guidelines* were published by the National Health and Medical Research Council in March 1997. They are evidence based guidelines to assist health professionals in making decisions about appropriate and effective care of depressed young people and prevention of depression in young people (13 to 20-year-olds).
- *The Australian Clinical Guidelines for Early Psychosis* were developed through the National Early Psychosis Project funded by the Commonwealth under the National Mental Health Strategy. The guidelines have provided an opportunity for systematic collaboration, information sharing and the development of a nationally agreed range of interventions in first onset psychosis.

- The *Griffith Early Intervention Program* has developed a national strategy for promoting, evaluating and implementing early intervention programs targeting anxiety in late childhood (the FRIENDS program) and depression in early adolescence (Resourceful Adolescent Programs). A FRIENDS program for young adolescents has also been piloted.
- AusEinet has established a National Early Intervention Network to promote evidence-based early intervention in mental health problems specifically for children and young people.
- The National Youth Suicide Prevention Strategy has funded several projects with an emphasis on early intervention, particularly for depression.

The National Health Priority Areas Report on depression[17] profiles depression in Australia, discusses prevention and management of depression, describes Australian initiatives related to depression and outlines potential opportunities and future directions to impact on depression in Australia.

The Second National Mental Health Plan (1998-2003)[18] provides a framework for furthering the achievements of the National Mental Health Strategy through prevention and promotion, quality and effectiveness of service delivery and partnerships in service reform. The Mental Health Promotion and Prevention National Action Plan[19] develops the policy framework for prevention and promotion in the field of mental health. This has been a joint initiative of the National Mental Health Working Group and the National Public Health Partnership. Depression has been targeted as a primary focus under the National Health Priority Areas Initiative and the National Public Health Partnerships.

Size and scope of the problem

Prevalence of mental health problems among young people

Note: for the purposes of this paper, 'young people' refers to 15 to 24-year-olds. This is the age range during which major mental health disorders, particularly depression and psychosis, often have their first onset. Several different data sources have been accessed to provide epidemiological information about mental health and young people. The data sources are not congruous in the age groups that they include; thus, there are small variations in age groups that are reported in different parts of the paper.

In the 1996 Australian census, there were 885,227 young people (15-24 years) in NSW (14% of the total NSW population)[20]. Many Australians are from diverse cultures, with 27% of the NSW population born overseas and from a non English speaking background (NESB)[21]. There were 69,999 Aboriginal and Torres Strait Islander people living in NSW (1.2% of the total NSW population) with between 41% and 54% of the Aboriginal and Torres Strait Islander population aged 20 years or less[22].

A series of international prevalence studies has reported that a substantial proportion (18-22%) of young people has significant mental health problems[23, 24, 25, 26]. Two studies indicate similar prevalence in Australia. In the Western Australian Child Health Survey (WACHS), 21% of 12 to 16-year -olds were identified as having mental health problems in the six months prior to being surveyed[27]. More than half of these problems were 'serious'; that is, they caused distress or impairment, or required professional help.

In the Australian National Survey of Mental Health and Wellbeing (NSMHW) 1997, which surveyed people 18 years and older, 27% of young people aged 18-24 years had mental disorders in the twelve months prior to being surveyed[28]. This was the highest prevalence of any age group in the survey. In the NSMHW, 'mental disorders' includes anxiety, affective disorders (mainly depression), alcohol use and drug use disorders.

Around 229,000 young people in NSW (15 to 24 year-olds) will experience mental health problems during a six to twelve-month period.
(Estimates based on the Western Australian Child Health Survey, 1993 and the National Survey of Mental Health and Wellbeing, 1997)

Mental health problems and disorders among young people include substance misuse, conduct disorders, eating disorders, phobias, attention-deficit/hyperactivity disorder, thought problems (psychosis), anxiety disorders and depression and related disorders.

In the NSMHW, 11% of young people aged 18-24 years had anxiety disorders, 7% had affective disorders and 16% had substance use disorders during the previous twelve months prior to being surveyed. In the NSMHW, 'anxiety disorders' includes panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder; 'substance use disorders' include harmful use and dependence on alcohol and other drugs.

Certain communities are exposed to higher risk factors for mental health problems such as rural and remote communities, Aboriginal and Torres Strait Islander communities, culturally and linguistically, diverse (CALD) communities, homeless young people, young people in custody and young people with issues relating to gender and sexuality. These groups may need particular attention with regard to access to and the provision of appropriate early intervention and prevention services.

Comorbidity among young people is high Australian studies indicate that between 25% and 60% of young people with mental health problems have more than one mental health problem.

Substance misuse is of particular concern and has a high level of comorbidity with other problems. Over half of the young people (18-24 years) in the NSMHW who had substance use disorders in the twelve months prior to being surveyed also had other mental health or physical problems. For young people who have substance use problems, there are additional health and social consequences[29]. These include overdose, psychosis, school failure, family dislocation, unemployment, homelessness, imprisonment and the greater likelihood of other risky behaviours.

Despite the high level of mental health problems among young people, most do not have either general or specialist mental health treatment, and the problems tend to persist. For example, of those with mental health problems identified in the WACHS, one in three had received some kind of non-specialist attention (mainly from teachers) but only one in 50 had consulted specialist mental health services[30].

The NSMHW reported health service use among 18 to 34-year-olds with mental disorders. Twelve per cent had used a health service for mental health problems in the previous twelve months prior to being surveyed. For less than one-third of those using a health service, this had been a mental health professional.

Even among those whose disability was classed as 'severe' in the previous four months (12% of those with a mental disorder), less than one-third (28%) had used a health service for mental health problems.

The reasons for non-use of services vary, but include stigma of mental health services, the lack of mental health services for young people and the difficulty of accessing the services that do exist. These difficulties are often exacerbated by language barriers and lack of cultural sensitivity in service delivery for young people from Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse populations. These groups are known to have lower rates of mental health service utilisation than young people in general[31, 32].

For Aboriginal and Torres Strait Islander communities, particular issues need to be considered. Aboriginal and Torres Strait Islander communities have a view of health that is holistic. In their view, health including mental health is seen as encompassing all aspects of life (social, spiritual, cultural, psychological and physical) and is not just the well being
of the individual but of the entire community and the land they inhabit[33].

Several broad mental health issues are common to most Aboriginal and Torres Strait Islander groups including: high rates of mental disorder combined with poor general health and socioeconomic deprivation; lack of good quality data about the extent and nature of mental disorders; underuse of mainstream mental health services, especially by Aboriginal and Torres Strait Islander males; lack of culturally appropriate, high quality, accessible mental health services[34] and often high levels of grief and loss as Aboriginal people are confronted with death and serious illness within their extended family networks more often than non-Aboriginal people and at a younger age[35].

Risk factors experienced universally in Aboriginal and Torres Strait Islander communities include high levels of premature death, disproportionate representation in custodial care (for example, alternative care of children, juvenile detention, correctional facilities, psychiatric hospitals), high suicide rates (especially for young males, who are four times more at risk for suicide than non-Aboriginal young males[36]), racism and discrimination, poverty, incomplete education, unemployment and high rates of alcohol and other substance misuse.

Several past governments' policies and practices have had a significant impact on the lives of Aboriginal communities, families and individuals[37]. The nature of these policies and practices, such as the stolen generation, continues to impact on Aboriginal and Torres Strait Islander people today and needs to be considered in attempts to address the mental health needs of young Aboriginal and Torres Strait Islander populations.

Young people from culturally and linguistically diverse backgrounds experience several unique social circumstances, some that are protective and some that may increase the risk of developing mental health problems. These include: migration or refugee experiences; issues arising from living in 'two cultures'; intergenerational conflict[38] and altered family functioning[39, 40]; grief and loss from separation from extended family; post-traumatic stress from experiences prior to resettlement, differing views of mental illness[41, 42] and possible experiences of racism and discrimination after resettlement[43].

The migration experience has a direct relationship to the psychosocial adjustment of young people. Adjusting to living in Australia where the history, culture, religion and political, legal and educational systems can differ from the country of origin, requires time and energy. Social isolation undermines resilience and, after migration, re-creating a social network is often required. Some immigrants may have been exposed to traumatic circumstances such as famine, economic crises, war, trauma, concentration camps and other kinds of persecution before arriving in Australia[44]. Research suggests that there are higher rates of mental disorder in refugees, than in the general population,[45] and young refugee women, in particular, have been highlighted as vulnerable[46]. Even though young people who have been exposed to the traumatic experiences of war show high levels of adaptive behaviour initially after resettlement[47], this may, in the short term, mask symptoms of post traumatic stress disorder and depression.

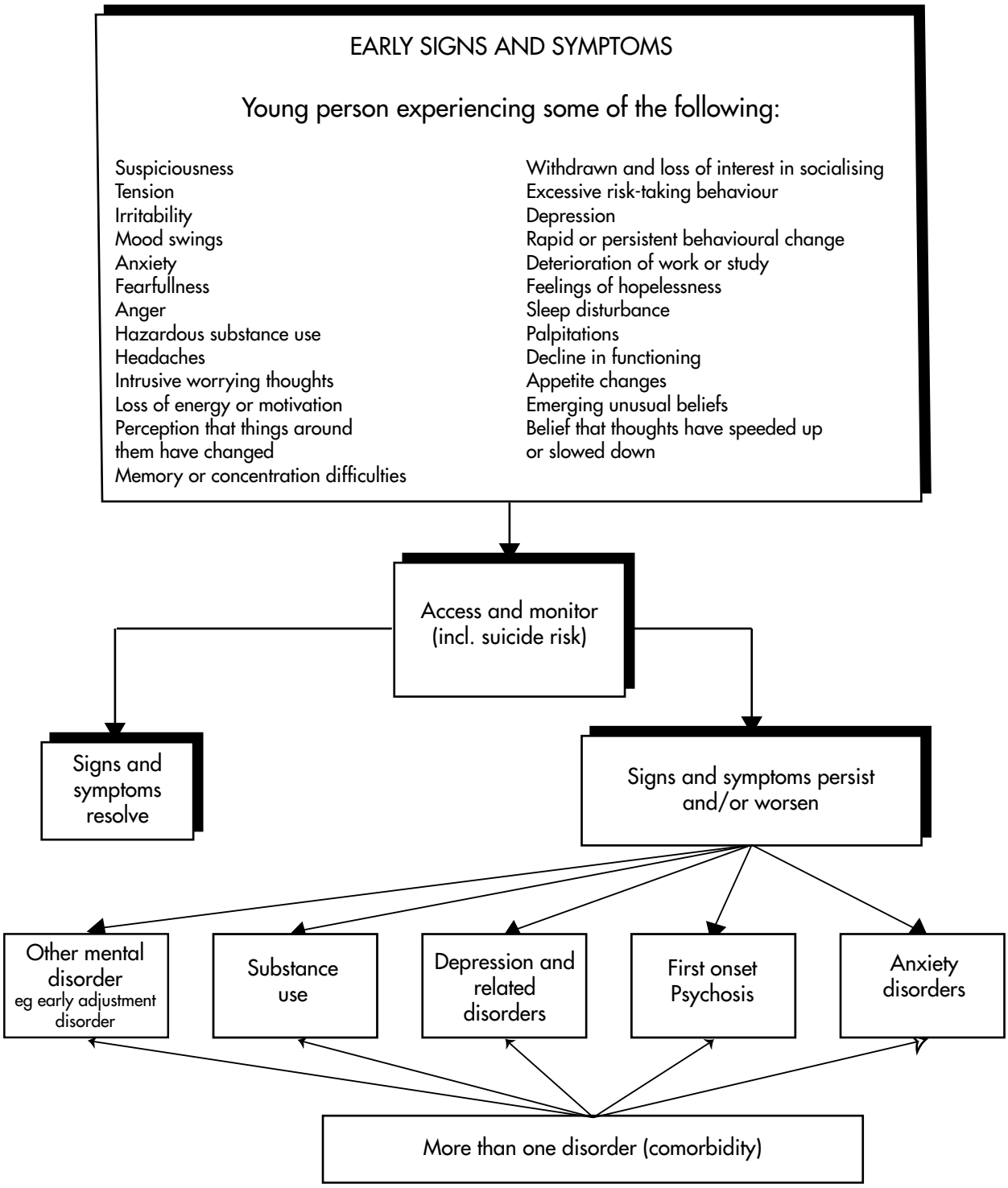
Development of mental health problems in young people before a mental health disorder develops, young people may experience several signs and non-specific symptoms, for example: mood swings, social withdrawal, difficulties in concentrating, that may indicate 'something is not quite right' (Figure 1). The signs and symptoms are not specific to a particular mental health disorder[48]. The changes in mental state could progress to several different problems, for example depression, psychosis, bipolar disorder, anxiety or other transient or longer term disturbance. It may also be symptomatic of a substance use problem.

Young people experiencing these symptoms may not necessarily go on to develop a mental disorder.

It may be difficult at this early stage to ascertain whether the signs and symptoms are part of normal adolescent development or whether they are the beginning of an illness. Since the symptoms evolve over time, it is important to engage these young people early, to provide support and access according to their changing needs and to be seen as a source of help. Families and peers can be important in this process, for example in providing information about changes in behaviour and encouraging the young person to seek help.

The development of a mental health disorder may become clearer as symptoms persist or worsen or become more evident. However, there can still be a considerable overlap between symptoms of different disorders, and the strong likelihood of comorbid problems and hazardous substance use further complicate the picture.

Figure 1: Development of mental health disorders among young people



First onset psychosis

Description of first onset psychosis

Psychosis is a term used to describe a mental state in which a person experiences a loss of contact with reality. The term comes from two Greek words - *psyche* (mind) and osis (a state of illness). First onset refers to the first time the young person experiences a psychotic episode. First onset psychosis has been conceptualised as occurring in three distinct phases: the prodrome ('something is not quite right'), the acute phase and the recovery phase.

The length of the *prodrome* varies for each individual. For some people, there is no identifiable prodromal phase. For people with psychosis, which can develop into schizophrenia, this period can last on average about two years[49]. Symptoms of psychosis are not yet apparent during the prodrome and no sign or symptom specifically indicates that psychosis will definitely develop, therefore diagnosis is often difficult. However, recognising and monitoring the signs and symptoms can assist in early intervention. As the prodrome is retrospectively identified after the diagnosis of psychosis, the term 'something is not quite right' has been used in the literature to better understand and identify potential warning signs and symptoms[50].

In the *acute phase* psychotic features are present. The main diagnostic symptoms (referred to as positive symptoms) are hallucinations (perceptual disturbances), thought disorder (confused thinking) and delusions (false beliefs) (Figure 2). Negative symptoms can be a feature of psychotic disorders and can cause significant impairment for the young person. Negative symptoms include restrictions in the range of emotion and expression, in the fluency and productivity of thought and speech and in the initiation of goal-directed behaviour.

There may be significant affective disturbances (changes in mood) or a syndrome of social withdrawal. There may also be comorbid symptoms of depression, obsessive compulsive disorder, posttraumatic stress disorder, anxiety disorder or substance abuse. Drug induced psychosis may have the same presentation as the acute phase of psychotic disorders but the duration of symptoms is shorter. Clinical observation and systematic scientific research indicates that substance use, for instance marijuana, may precipitate first onset psychosis. Other drugs such as amphetamines can cause an organic brain syndrome with psychotic features.

During the *early recovery phase*, the symptoms begin to remit with pharmacological treatment. Providing information to the young person and their family is vital during this phase. For most young people, the symptoms will remit within six months with continuing medication. A focus on rebuilding biopsychosocial functioning is important with continued support, monitoring and management of comorbid problems, in particular those associated with alcohol and other drugs. For some young people, symptoms may continue for longer periods. This is referred to as the *late recovery phase*.

The three phases of first onset psychosis

Prodrome ('something not quite right') phase
Period prior to the psychotic disturbance. The time between the first deviation from normal thinking, feeling or behaviour and the onset of psychosis. The prodrome is identified retrospectively.

Acute phase
Period when psychotic features are present, such as delusions, hallucinations and formal thought disorder.

Recovery phase
Period when psychotic symptoms begin to remit and rebuilding of biopsychosocial functioning occurs. Includes the early recovery phase and the late recovery phase.

(Based on the Australian Clinical Guidelines for Early Psychosis. 1998. Melbourne, Victoria: National Early Psychosis Project (NEPP), pp 13-14.)

In NSW, it is estimated that there will be 800 young people aged 15-24 years experiencing first onset psychosis each year.

(Estimates based on information provided by the Early Psychosis Prevention and Intervention Centre, Melbourne)

Incidence of first onset psychosis

The incidence of first onset psychosis is relatively low but the overall numbers and associated costs of the illness are high. Young people are the group most frequently affected by a first episode of psychosis. It has been estimated that every year there will be approximately nine young people per 10,000 population (aged 15 to 24 years) affected by first onset psychosis[51]. However, because of the one-to two-year delay in treatment, the prevalence of untreated first onset psychosis would be expected to be considerably higher.

Relapse rates after the first episode of psychosis vary, but a one-year figure of 15% to 35% and a two-year figure of 30% to 60% are suggested[52]. Early intervention with a comprehensive treatment plan, including careful use of low-dose medication, may help reduce the relapse rate.

Psychosis can have a significant, long-term impact on a person's functioning. The degree of impairment caused by psychosis is related to: the number and severity of the psychotic symptoms; the length of delay in getting treatment; the degree of withdrawal; the presence of changes in mood; the level of intelligence; social responsiveness; the loss of competence and the level of resilience. Therefore, it is important to implement appropriate and effective management to mitigate potential negative consequences.

Figure 2: Description of the diagnostic symptoms of psychosis

Hallucinations

Sensory perceptions are distorted and lead to a person hearing, seeing, feeling, tasting or smelling things which are not there. Auditory hallucinations (hearing voices) are most common, for example, a young person may hear voices telling them what to do and making derogatory remarks about them.

Delusions

Disturbance of beliefs and mis-interpretation of the environment, for example, a young person may believe they are a famous historical figure or a celebrity and act as if this is real. Some young people may believe that they are being followed by a foreign power.

Thought disorder

Jumbled, disorganised, vague or confused pattern of thought or speech that may lead a person's conversation to jump from one topic to the other or be so disjointed that it is extremely difficult to follow. The person may be 'stuck' on one topic or idea and not able to give straight answers.

Disturbance or changes of mood

Disturbance or changes of mood may occur without apparent cause. Such changes could include: mood swings, lack of emotional response, inappropriate emotional response, or a strange feeling of 'unreality', or of being cut off from the rest of the world.

Depression and related disorders

Description of depression and related disorders in young people

Depressive disorders are either unipolar, involving depression only, or bipolar, in which manic episodes also occur. Bipolar disorder often presents in adolescence as an initial episode of depression. Mixed anxiety and depressive symptoms are common, particularly with presentations in primary care settings, as are general depressive symptoms or depressive and anxiety symptoms during adverse life experiences.

There are two main types of unipolar depression:

- *major depressive disorder*, which involves five or more depressive symptoms for at least two weeks; and
- *dysthymia*, which involves at least three depressive symptoms throughout most of a year.

Apart from depressive disorders (clinical depression) as described above, other milder or earlier stages of depression also exist. These have been called depressed mood and depressive syndrome[53, 54]. They are important because they are related to the development of depression and to long term social problems.

Depressed mood refers to the presence of sadness, unhappiness, or blue feelings for an unspecified period and depressive syndrome refers to a set of co-occurring depressive and other emotional symptoms such as anxiety, loneliness or feelings of worthlessness.

Incidence and prevalence of depression and related disorders in young people

Up to 24% of young people may suffer one or more episodes of depression by the time they are 18 years old[55]. In international prevalence studies, 2% to 6% of young people have been identified as having depression/dysthymia[56, 57, 58].

In Australian studies, similar prevalences have been found for depression and related disorders in young people. In the Australian National Survey of Mental Health and Wellbeing 1997, the 12-month prevalence of affective disorders (mainly depression and dysthymia) among young people aged 18-24 years was 7%[59]. In the WACHS, during the six months before the survey, 4% of 12 to 16-year-olds were anxious or depressed, and 3% were withdrawn.

Around 62,000 young people in NSW (15 to 24-year-olds) will experience depression during a six-to twelve-month period.

(Estimates based on the Western Australian Child Health Survey, 1993 and the National Survey of Mental Health and Wellbeing, 1997)[60]

Definition of major depression

- *One or more of the following signs or symptoms are present most of the day, nearly every day:*
  - ✓ *depressed or irritable mood*
  - ✓ *markedly diminished interest or pleasure in most activities*
  - ✓ *significant change in weight or appetite*
  - ✓ *insufficient or excessive sleep*
  - ✓ *psychomotor agitation or retardation*
  - ✓ *fatigue or loss of energy*
  - ✓ *feelings of worthlessness or guilt*
  - ✓ *impaired thinking, concentration or decision making*
  - ✓ *recurrent thoughts of death or suicide.*
- *Five of these must be present for at least two weeks and must include depressed or irritable mood or diminished interest or pleasure in activities.*
- *The symptoms must cause significant impairment/distress.*
- *For young people, more common presenting problems may be irritability, decreased sociability, abdominal pain, headache, tiredness, family conflict, poor school performance or attempted suicide.*

Definition of dysthymia

- *Depressed (or irritable) mood, most of the day, more days than not, for at least one year (adolescents) or two years (adults).*
- *Two or more of the following present while depressed:*
  - ✓ *poor appetite or overeating*
  - ✓ *insomnia or sleeping too much*
  - ✓ *low energy or fatigue*
  - ✓ *low self-esteem*
  - ✓ *poor concentration or difficulty making decisions*
  - ✓ *feelings of hopelessness.*
- *During the one-or two-year period, the person has never been without the symptoms for more than two consecutive months.*
- *No major depressive episode during the first one or two years of the disturbance.*
- *The symptoms must cause significant impairment/ distress.*

In community studies, more females than males have been found to be depressed. Mid-to-late adolescence is one of the two main age groups for the first onset of major depressive disorder[61].

It is also estimated that in any six-month period, up to 40% of adolescents suffer periods of sadness or unhappiness which may affect their ability to cope[62, 63].

Depression frequently occurs in combination with other mental health problems, such as anxiety disorders, substance use related disorders, conduct and antisocial disorders, eating disorders and attention-deficit/hyperactivity disorder, as well as psychosis. Anxiety disorders have also been reported as antecedents to the development of depression[64].

Comorbidity with depression/dysthymia is not reported separately for 18 to 24-year-olds in the Australian National Survey of Mental Health and Wellbeing. However, 61% of the total population surveyed (18 years and older) had at least one other mental disorder in addition to depression or dysthymia[65]. In clinically referred populations of young people, the prevalence of depression may be as high as 1 in 2 because of the association between depression and many other mental disorders.

Depression can also be associated with substance use and with medical conditions in young people, such as glandular fever, hepatitis and diabetes. In the National Survey of Mental Health and Wellbeing, 29% of 18 to 24-year-olds who were depressed/dysthymic also had physical disorders[66].

Depression may also be higher in some cultural groups, for example Aboriginal males are four times more at risk of suicide than non-Aboriginal males, which suggests a probable higher incidence of depression in this group[67].

Depression causes significant morbidity and is a major risk factor for suicide[68]. Depressive disorders pose a substantial cost to society. They are responsible for more missed days of work than most other health problems[69]. The impact of effective interventions for depression and related disorders can be illustrated by the savings generated by the widespread use of lithium since 1970 to reduce recurrent episodes of bipolar disorder in the US. It has been estimated that by the early 1990s, over (US)$40 billion had been saved[70].

Anxiety disorders

The main characteristic of anxiety disorders is excessive worry or fear[71]. Fear and anxiety are normal human emotions and moderate levels of anxiety can enhance performance. In anxiety disorders, however, the fear or anxiety significantly interferes with the performance of everyday activities or is so intense or persistent that it causes great distress. Anxiety disorders can be severely disabling, can interfere with relationships and are frequently comorbid with depression. Anxiety disorders were the most prevalent disorder in the National Survey of Mental Health and Wellbeing, in line with international prevalence studies[72].

Anxiety disorders include (see Figure 3):

- panic disorders
- phobias, such as agoraphobia, social phobia
- generalized anxiety disorder
- obsessive-compulsive disorders
- post-traumatic stress disorder

The physical symptoms associated with anxiety disorders, such as dizziness, rapid heartbeat or breathing, can also cause significant impairment and people may present for help with these symptoms in the first instance. People may misuse and/or become dependent on medication such as diazepam or oxazepam, or misuse alcohol or drugs in an attempt to relieve symptoms.

Figure 3: Anxiety disorders

Panic Disorder: Recurrent, unexpected episodes of intense anxiety (panic attacks). They include bodily symptoms such as sweating, trembling and dizziness.

Social Phobia: Excessive fear of social or performance situations and the negative evaluation by others. This leads to avoidance of or extreme anxiety in social situations such as public speaking and meeting new people. This can lead to poor social and peer networks, limited recreational activities and poor development of social skills.

Specific Phobias: Excessive fear of a particular object or situation, for example fear of germs, fear of parental illness or death and agoraphobia. Agoraphobia is anxiety about places or situations in which escape might be difficult or help unavailable in the event of a panic attack. Avoidance of situations impairs the individual's ability to carry out daily duties.

Generalized Anxiety Disorder: Pervasive and persistent worry over several months, often associated with avoidance behaviour and somatic complaints.

Obsessive-Compulsive Disorder: Obsessions are recurrent thoughts, images or urges that are intrusive and distressing, for example concerns about contamination, harming others or themselves. Compulsions are repetitive behaviours performed in response to obsessions in an attempt to prevent a feared outcome, for example repeating rituals, washing or cleaning.

Post-traumatic Stress Disorder: Direct development of characteristic symptoms following exposure to a severely threatening event. This includes witnessing or hearing about an event that involves death, injury or threat to the physical integrity of another person.

Sources:

Rapee RM, Wignall A, Hudson JL, Schniering CA. 2000. Treating Anxious Children and Adolescents. An Evidence-Based Approach. California: New Harbinger Publications Inc.

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Why prevent and intervene early?

Depression and related disorders and first onset psychosis have their onset in adolescence, making it a critical period to focus prevention and early intervention efforts. For young people with mental health problems, several associated problems are likely to exist, such as hazardous substance use, poorer physical health, deteriorating school performance and increased likelihood of self-harm.

There can be serious consequences for the individual, their families and the community when mental health problems are not prevented, identified or treated early in these younger years. Since mental health problems in young people tend to be continuous with those of adult life[73], the effects of not intervening early are also significant for the adult population.

Prevention in mental health

Prevention literally means 'to keep something from happening'. In mental health it refers to interventions that occur before the onset of a mental disorder[74]. The focus is on targeting relevant population groups and reducing the incidence of a mental illness or disorder by interventions that reduce and modify risk factors associated with the illness and enhancing protective factors. Similar interventions can also occur throughout the various stages of illness to modify or ameliorate further illness or disability[75]. Strategies for prevention in mental health can be classified into universal, selective or indicated[76].

Prevention strategies in mental health

Universal interventions target the general public or whole population groups, such as adolescents 15-19 years, pregnant women or parents.

Selective interventions target population groups whose risk of developing a particular disorder is significantly higher than average, for example, adolescents with hazardous substance use or young people whose parents have a mental illness.

Indicated interventions focus on high risk individuals who have been identified as having minimal but detectable signs or symptoms foreshadowing a mental disorder, or biological markers showing predisposition for mental disorder, but who do not meet diagnostic levels at the current time. Examples of high risk individuals include young people with early signs and non-specific symptoms (in the 'something is not quite right' phase for first onset psychosis), or with depressive or anxiety symptoms, but not to the level of a disorder.

Preventing mental health problems is linked to the broader strategy of mental health promotion, that is, 'enabling people, communities and populations to increase control over and improve and/or maintain their subjective wellbeing, optimal development and use of mental abilities[77].

Prevention and promotion can share common approaches and goals, reducing risk factors and enhancing protective factors.

Early intervention in mental health

Early intervention refers to intervening at the earliest possible phase of an illness. Early intervention is recommended where there is evidence to show that[78]:

- intervening early will have a positive impact on health outcomes;
- there is an effective and available 'mechanism' to detect an illness at an early phase. The 'mechanism' can include screening or assessment tools and should minimise the risk of identifying people as having the illness who do not actually have it (known as 'false positives') as well as the risk of not identifying people who do have the illness (known as 'false negatives');
- effective treatment for the illness is available; and
- the effective treatment can be accessed early by those who need it.

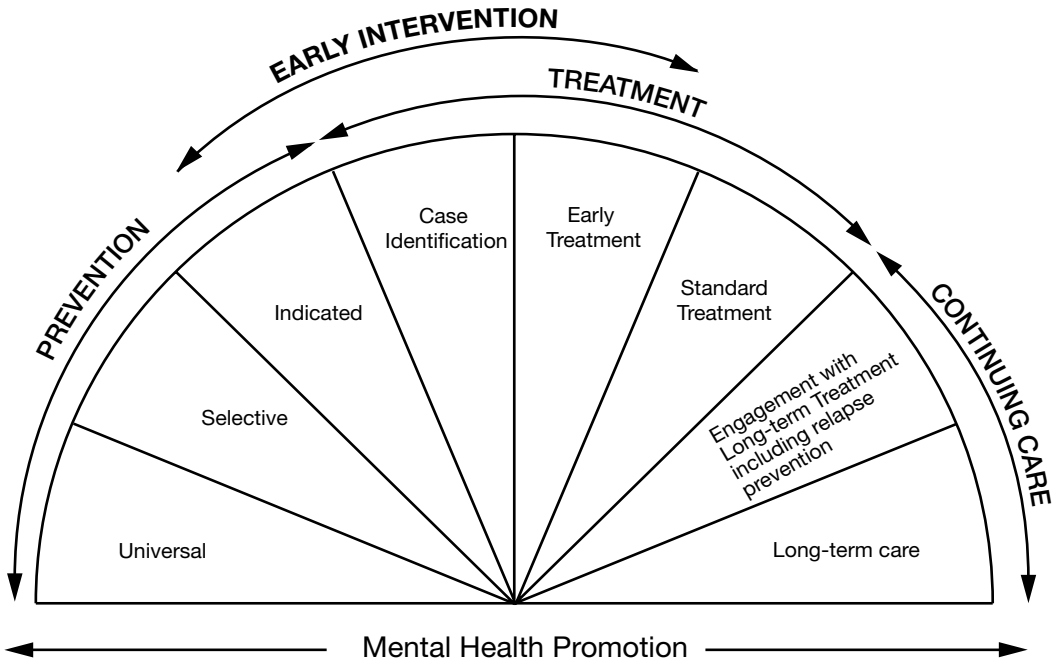
Early intervention should occur when warning signs or early symptoms begin to manifest. For individuals at high risk, early intervention may occur as an indicated prevention strategy before the onset of any signs or symptoms that reach clinical significance. Interventions that occur later in the process of illness onset, when symptoms have reached an acute stage, are classified as case identification and treatment.

The Mental Health Intervention Spectrum

In 1994, the US Institute of Medicine Committee on the Prevention of Mental Disorders introduced a classification system that recognises the importance of the whole spectrum of interventions for mental disorders, from prevention through treatment to maintenance (continuing care)[79].

In this classification model, prevention is distinguished from treatment as being an intervention that occurs before the initial onset of the disorder (Figure 4). The model can be further adapted to include early intervention and mental health promotion. Early intervention is seen as beginning in the indicated level (for individuals with signs and symptoms) and continuing through into case identification. Promotion of mental health is applicable across the whole spectrum of interventions.

Figure 4: The mental health intervention spectrum for mental disorders



Modified from Mrazek PJ and Haggerty RJ. (Eds.) 1994. Reducing Risks for Mental Disorders. Frontiers for Preventive Intervention Research. Washington, D.C., National Academy Press, p.23

Effective early intervention for first onset psychosis

In first onset psychosis, early intervention should ideally and, where possible, commence during the 'something is not quite right' phase where pre-psychotic symptoms and potential warning signs, such as social withdrawal and changes in behaviour, occur. This is distinct from the commonly held notion that early intervention for psychosis means first intervening when the young person is psychotic, which misses critical and important opportunities for prevention and intervention. Intervening at this earlier stage is relatively new for mental health. Although there are difficulties in identifying, accessing and treating young people in this phase, it is critical for improved outcomes.

As first onset psychosis mainly affects adolescents and young people, delayed access to effective treatment disrupts the normal processes of development and can have a profound effect on the individual and their family. During this period families and health professionals can often experience difficulty in identifying the difference between normal adolescent problems and symptoms of psychosis. Increasing evidence shows that early, effective, comprehensive treatment and management of young people with first onset psychosis has a significant impact on medium and long term outcomes for the individual and their family.

Early intervention, decreasing the lengthy delays to treatment can result in:

- less frequent admissions to hospital[80];
- shorter periods of inpatient care[81];
- more rapid and complete recovery[82];
- decreased risk of relapse over the following two years[83];
- less treatment resistance for psychosis[84].

There is often a significant period (up to 2.5 years) between the time of onset of psychotic symptoms and receiving appropriate treatment[85, 86]. During this time, the young person and their family often experience multiple contacts with health services before appropriate effective treatment is provided[87]. Not only does this impact upon the young person's chances of recovery, but also causes significant distress for the young person and their family.

There is a growing body of evidence about what is best practice for effective treatment and management of first onset psychosis[88] which is reflected in *The Australian Clinical Guidelines for Early Psychosis*. Treatment and management need to be tailored to the phases of first onset psychosis (prodrome, acute and recovery). Recommended practice involves engaging the young person and their family and regular monitoring and treatment of symptoms to reduce the stress and trauma associated with this disorder. This form of intervention does not prematurely identify young people as having a psychotic illness but rather engages the young person and their family in a supportive manner, provides a supportive engagement which enables an early response to any developing illness, lessens the effect of stressors and builds competence and strengths.

Effective and early intervention for depression and related disorders

There is now an agreed Australian guideline for good practice for the identification, treatment and management of depression in young people, the *NHMRC Depression in young people: Clinical Practice Guidelines*[89]. These guidelines, with accompanying modules for general practitioners and mental health workers, clearly articulate how best to prevent, intervene early, detect and manage depression in young people. There are also booklets for young people and their families.

Young people who suffer a depressive episode face a considerable risk of recurrence and of developing adult depressive disorder[90, 91, 92, 93]. Prevention and effective treatment of adolescent depression and related disorders could significantly reduce the incidence of adult depression and related disorders in years to come. Early intervention with young people who are at high risk of developing depression (for example, who are in a high risk group or have subclinical symptoms) or who have dysthymia, can decrease symptomatology, prevent continued dysthymia or decrease the likelihood of a depressive episode[94, 95, 96]. It has been shown that earlier intervention using effective treatments can lessen the length of depressive episodes and reduce relapse rates in adults and it is likely that similar effects can be achieved for adolescents[97]. Preventing relapse is also likely to improve psychosocial outcomes[98].

Although further evaluation of effective depression prevention programs is required, research to date has suggested that effective prevention programs should be comprehensive, multi-component programs and address protective as well as risk factors[99, 100]. Issues to target include: modifying poor self esteem, negative thinking, and poor social competence; enhancing good peer and parental relationships; encouraging employment; and strengthening individual resilience including positive and optimistic thinking styles[101, 102]. There is also emerging evidence that universal depression prevention programs for adolescents can reduce depression in young people who are at risk of developing depressive disorder (selective or indicated groups).

The NHMRC Guidelines describe risk factors for depression in young people. Those who work with or are in contact with young people can be trained to identify young people at risk of developing depression through early signs and/or by recognising risk factors and risk groups. Among the definite at-risk groups identified in the NHMRC Guidelines are young people with coexisting anxiety, conduct disorder or substance abuse, a depressed parent, a history of clinical depression or a previous suicide attempt.

Despite the potentially serious impact of depressive disorders, most young people with a depressive disorder do not receive treatment for their problem[103, 104, 105, 106]. One of the major problems is the failure to detect depression in young people. For example, none of the adolescents identified as suffering from major depressive disorder was known to health services in a recent UK study[107]. Undertreatment of depression in young people has also been reported in Australia[108].

The Guidelines indicate that management of depression in young people should begin with a comprehensive assessment of depressive and other symptoms. It should include engagement of the young person, intervention where necessary using appropriate and effective treatments and continuing counselling and support. Treatments are identified which have been found to be effective for 12 to 20-year-olds in well-conducted studies. The key treatment intervention recommended is cognitive behavioural therapy for both depressive disorder and elevated depressive symptomatology. Other interventions are also suggested which may be effective for treatment of adolescent depression. These are relaxation therapy, therapeutic support groups, social skills training, interpersonal therapy, family therapy and exercise (in decreasing order of evidence for their effectiveness).

Antidepressant medication is not recommended as a first line treatment for young people aged under 18 years and should only be considered for those young people who do not respond to other treatments or whose depression is very severe. The effectiveness of antidepressant medication for young people, particularly younger adolescents, is not well established, and there is concern about the potential for side-effects and the risk of overdose. For older adolescents and young adults, selective serotonin re-uptake inhibitors are likely to be found to be the most efficacious medication and are of lower toxicity[109].

Anxiety disorders are the most prevalent mental health disorders and have a high rate of comorbidity with other mental health disorders[110]. Guidelines have been published for early intervention for anxiety in children and adolescents but their focus is primarily on children[111]. At present there are no national guidelines addressing effective interventions for anxiety disorders in young people. Intervention strategies which have been shown to be effective in managing anxiety disorders include: cognitive restructuring, exposure, relaxation, and social skills and assertiveness training[112].

Anxiety disorder in childhood is a significant risk factor for the development of depression in adolescence[113, 114]. Effective prevention and early intervention for anxiety disorders in children has the potential to reduce the development of depression in adolescents. There is increasing evidence for effective prevention and early intervention programs for anxiety disorders in children and young adolescents[115, 116].

Several indicated anxiety prevention programs have been developed in Australia. These include Aussie Optimism (10 to 13-year-olds), Friends (7 to 12-years-olds) and the *Early Intervention and Prevention of Anxiety Project*. Parenting programs and initiatives also provide valuable interventions likely to prevent the development and maintenance of anxiety disorders.

The Management of People with a Co-existing Mental Health and Substance Use Disorder Service Delivery Guidelines and Discussion Paper provides a valuable framework for the care and treatment of people with coexisting disorders. Substance use disorders are significant problems in young adults and early intervention and treatment of mental health and substance use disorders in young people can reduce the long term negative effects of these disorders. Further research and development is needed to clarify the most effective treatment strategies.

The Department of Psychological Medicine at the New Children's Hospital is developing an early intervention model for eating disorders in children and young people.

Strategies for progressing prevention and early intervention in mental health for young people

In this section, five strategies are outlined which provide a framework for coordinating and progressing programs to deal with depression and related disorders, anxiety disorders, substance abuse, co-morbidity and first onset psychosis across NSW. They support NSW Health's strategic directions in mental health and encompass the roles of the Centre for Mental Health, Area Health Services and clinicians. The strategies will also link with the broader development of young people's mental health programs, initiatives for young people with a dual diagnosis and suicide prevention strategies and the development of mental health services for children, adolescents and young people.

Evidence-based practice has been used to define essential aspects of the NSW framework to prevent, intervene early and manage first onset psychosis and depression and related disorders in young people.

Initiatives in depression and first onset psychosis are occurring at an increasing rate at State, local and national levels. As with all new fields, time and leadership are needed to shift attitudes towards new ways of working, to develop an informed and skilled workforce and community, to plan and set up new services and programs and to monitor and evaluate the effectiveness of the new services and programs.

Strategies for progressing prevention and early intervention in mental health for young people

1. Developing and coordinating comprehensive programs and services.
2. Engaging young people and their families and providing comprehensive assessment and management.
3. Developing and implementing prevention programs.
4. Educating the community, particularly on depression and related disorders and first onset psychosis in young people.
5. Monitoring quality and effectiveness.

1. Developing and coordinating comprehensive programs and services

Prevention and early intervention and the implementation of evidence-based guidelines are new directions in mental health. Leadership, coordination and education are critical to set in motion cultural change to embrace these new directions.

At the Area level, leadership and consultation are important to ensure that: services are youth friendly and culturally relevant; appropriate assessment, referral and effective treatment are occurring; and gaps between services are addressed, including between adolescent and adult mental health services. There is a need to ensure that services available for young people cover the spectrum from prevention through to management and that practice is based on the best available evidence. It is also important that the providers of care are aware of, and skilled in, the assessment and management of the range of mental health problems and disorders that may occur at this time because of the undifferentiated nature of some problems that present and the high levels of comorbidity. It is important to work together with other organisations and services, such as youth health and community health, and young people and their families to build expertise, develop effective collaborative partnerships with specialist mental health services and make sure that pathways to care are developed and understood.

Local service planning should consider the differing needs of young people in rural and urban populations, and other special populations, such as young people from non-English speaking backgrounds and Aboriginal and Torres Strait Islander communities.

Programs for Aboriginal and Torres Strait Islander young people, for example, need to take into account the holistic view of health held by Aboriginal and Torres Strait Islander communities. Early intervention cannot take place without strengthening and supporting the community, culture, social issues and self esteem. Programs should utilise the extensive extended family and community systems that have survived through the years and recognise the tremendous resilience and adaptability shown by Aboriginal and Torres Strait Islander communities. Aboriginal community-controlled health services are a vital resource to the process of establishing and implementing mental health programs in Aboriginal communities and a number of programs in rural NSW have built on effective partnerships with good outcomes. It is crucial that the planning and development of early intervention and prevention in mental health services also takes into account historical issues for Aboriginal and Torres Strait Islander people and the role of the past in current health problems and risk factors.

Programs should be responsive to local community needs and issues, and the availability of resources while maintaining the integrity of the effective, evidence-based elements.

Education of management and staff will help to establish an environment conducive to embracing these new directions, progressing initiatives and enhancing the skills of mental health professionals.

Emphasis needs to be placed on:

- the prevalence and impact of mental health problems in young people, particularly for depression and related disorders, first onset psychosis, anxiety disorders, substance abuse and comorbidity
- the rationale for and importance of early intervention and prevention
- understanding of how these translate into the service context and link to treatment services
- educating and supporting staff to reorient service delivery to incorporate early intervention and prevention
- identifying and improving pathways to care
- using information about other programs and services across the State
- using evidence-based practice and developing strategies for implementing evidence-based programs/services
- developing skills in engagement, assessment and management of young people, considering diversity in culture and life experience.

The role of the Centre for Mental Health

`Promote Statewide and local leadership and coordination`

- Support the NSW Early Psychosis Advisory Committee and NSW Early Psychosis Program Working Group. This includes implementing the Australian Clinical Guidelines for Early Psychosis, promoting and conducting education and training, making recommendations for research and evaluation in first onset psychosis and disseminating information and resources.
- In collaboration with the Northern Sydney Area Health Service, coordinate the NSW Depression Interest Group.
- Consult with Area Directors of Mental Health and other relevant staff to provide information on the rationale and evidence for new directions in depression and related disorders and first onset psychosis for young people.
- Assist in developing plans for first onset psychosis and depression and related disorders programs in Area Health Services, including evidence based components as outlined in this framework.

- Participate in local Working Groups or Steering Committees as needed to guide local initiatives.
- Support the implementation of the School-Link initiative in local Area health services as a vehicle for progressing early intervention and prevention of depression and anxiety disorders in young people.
- Support Area School-Link Coordinators, particularly the implementation of the School-Link training program which focuses on depression and related disorders in adolescence.

School-Link

School-Link is a comprehensive initiative developed collaboratively by NSW Health and the Department of Education and Training. It will link schools and TAFE colleges with their local adolescent mental health services and is aimed at improving the understanding, recognition, management, support and prevention of mental health problems in young people. The initial focus will be on depression and related disorders, including anxiety. Components include:

- appointment of a School-Link Coordinator in each Area Health Service
- a statewide training program on depression and related disorders in young people for school and TAFE counsellors, adolescent mental health workers and other appropriate health workers
- introduction of depression prevention and resilience-building programs in schools.

Promote the development of collaborative partnerships

- Assist in promoting the development of collaborative partnerships with consumers and carers, with other agencies (youth services, schools, youth health, drug and alcohol services, juvenile justice and community services, cross cultural organisations, Aboriginal community-controlled health services, police, vocational rehabilitation services, and non-government organisations) and with general practice bodies.
- Coordinate the School-Link initiative in collaboration with the NSW Department of Education and Training and other educational bodies.
- Coordinate the School-Link Steering Committee, the School-Link Reference Group and the School-Link Curriculum Development Advisory Working Group.
- Collaborate with the education bodies to implement prevention and resilience building programs in secondary schools.

Promote evidence based practice

- Progress implementation of best practice guidelines across NSW, including consultations with Area Health Services, other government departments, non-government organisations, culturally specific services, young people, consumers, carers and other relevant agencies.
- Disseminate information on evidence based practice, programs, outcomes and monitoring.
- Produce and disseminate directories of first onset psychosis services in NSW.
- Develop education and training resources for management and staff about depression and related disorders and first onset psychosis in young people.
- Coordinate the School-Link program.
- Participate in planning and presenting relevant training programs for Area staff and management.
- Develop modules for first onset psychosis and depression and related disorders for incorporation in the curricula of relevant courses.
- Disseminate and encourage the use of Sally's Story, a training video on first onset psychosis for mental health workers.
- Encourage the development of relevant material and modules on issues for CALD, Aboriginal and Torres Strait Islander and other groups of young people with special needs for relevant training programs, such as the School-Link Training Program.

The role of Area Mental Health Services

- Prepare Area or sector plans to progress initiatives for first onset psychosis and depression and related disorders (see Figure 5).
- Set up local steering committees or working parties to guide the development, implementation, review and evaluation of depression and first onset psychosis services for young people.
- Build effective local collaborations with relevant services and organisations. Examples include schools, youth services, Departments of Juvenile Justice and Community Services, general practitioners, local police services, non-government organisations, Aboriginal and Torres Strait Islander health and medical services and communities, culturally and linguistically diverse services and workers, including the Transcultural Mental Health Centre (TMHC), consumers and carers, alcohol and other drugs services, child and family services, sexual assault services, programs for children whose parents have a mental illness.
- Appoint an Area School-Link Coordinator.

- Participate in the School-Link Training Program including local coordination.
- Coordinate links with schools and participate in depression education and prevention programs in local secondary schools.
- Participate in Area School-Link Coordinators network and forums.
- Facilitate and organise presentations to senior staff in Area Health Services to inform them of new directions and gain their endorsement to progress.
- Facilitate and organise workshops with Area Health Service staff and relevant staff from other organisations to inform them of new directions consistent with depression and first onset psychosis guidelines.
- Facilitate and assist in planning and developing Statewide education initiatives.
- Ensure that prevention and early intervention services are culturally appropriate through partnerships with cross cultural organisations and TMHC, the use of bilingual/ bicultural workers, partnerships with Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal and Torres Strait Islander staff and communities. Ensure that staff are aware of, and trained in, issues relevant to these and other groups with special needs.

Figure 5: Developing a plan for setting up services for young people for depression and related disorders and first onset psychosis

1. Estimate the potential size of the client group (this example is for 15 to 24-year-olds)

   • First onset psychosis: the potential number of young people with first onset psychoses in a one-year period (incidence estimated at around 9 per 10,000 15 to 24 year-old population – see Size and Scope of the Problem).

   • Depression: the potential number of young people with depression and dysthymia (prevalence estimated at 2-7% of the 15 to 24-year-old population – see Size and Scope of the Problem).

For example, in an Area Health Service with a population of around 112,000 15 to 24-year-olds, there would be approximately 100 young people each year with first onset psychosis and around 2,200-8,000 young people with depression or dysthymia in a six-month period.

Note: These disorders seldom exist on their own. Depression is frequently comorbid with first onset psychosis and anxiety disorders; psychosis and depression are both associated with hazardous drug and alcohol use.

2. Develop a profile of local youth-oriented services and organisations

- Identify services and organisations working with young people with, and at risk of, first onset psychosis or depression and related disorders.
- Assess the scope and nature of services available and of local referral networks.
- Identify gaps in service delivery based on optimal interventions.
- Develop strategies for effective partnerships to provide the full range of services for early identification, referral, management and prevention.
- Develop strategies for educating and skilling mental health workers, local services and organisations involved with young people, consumers and their families, and the wider community.

3. Develop a comprehensive plan for coordinated services

- Include all of the strategies outlined in this framework.
- Cover the full spectrum to include prevention, early intervention, engagement, assessment, treatment, management and monitoring of effectiveness, quality and outcomes.
- Include recognition and management of other comorbid disorders that may be present with these conditions particularly anxiety disorders, hazardous alcohol and drug use and risk-taking behaviours.
- Ensure that pathways to care include other services for young people with which specialist mental health services will work closely, such as drug and alcohol, youth and community services
- Set up structures and systems to ensure that young people access the other important services that they need.
- Include a sensitive and culturally appropriate appraisal of suicide risk.

4. Identify the service configuration appropriate to local needs and resources

- For first onset psychosis services in NSW four models have emerged:
  – specialist dedicated services focusing on young people with, or at risk of, first onset psychosis, operating from a specialist site;
  – specialist service or team operating from within an Adult Mental Health or in partnership with Youth Health service;
  – the designation of individual workers within existing teams who specialise in early psychosis but may also have other duties; and
  – generalist education and training of all workers in a mental health service.
- For depression in young people, several different approaches are being developed by Area Health Services. A considerable amount of work still needs to be done to ensure that young people in all parts of NSW have access to coordinated programs covering the full range from prevention through to management.

2. Engaging young people and their families and providing comprehensive assessment and management

Engagement is an ongoing process that begins with the first contact with the young person or their family and continues to be worked on throughout the therapeutic relationship. It involves: developing a therapeutic relationship with the young person and their family; establishing rapport; conveying interest and respect; promoting confidence and hopefulness; providing information; and building trust. Engagement of the young person and their family should occur at all stages, including the early or prodromal stages of an illness and throughout the continuing contact with the young person. It will often be necessary to be creative in finding effective ways of engaging and maintaining contact with the young person. Early contact with young people at risk of developing depression, for example those in high risk groups, can open up communication and increase the likelihood of those young people, their families and friends contacting appropriate services if they become ill.

Characteristics that young people prefer in a mental health service include: helpful and knowledgeable staff; confidentiality; discretion or anonymity; easy access; acceptability to family members; and staff who understand their problem[117].

Engaging young people can be difficult for many reasons. Young people and their families may not know about, or may have negative attitudes about, mental health services and about mental health professionals. There may be cultural barriers and they may have negotiated complex pathways to care before they reach the mental health service. During that time the illness may have worsened and the young person's and their family's confidence may have decreased.

It is also important to be mindful of the developmental phase, age, gender and cultural considerations of the young person and their family. These factors will be significant in developing engagement and intervention strategies.

There are problems related to the nature of the illness itself; the difficulty in recognising and assessing non-specific or early symptoms; and the lack of specificity in determining which of the young people at risk will develop an illness. For example, it can be difficult to engage with a young person who is experiencing psychotic symptoms, which could include disorganisation, social withdrawal, suspiciousness and hearing voices. When a young person is clearly psychotic, their thinking may be so distorted that they are unable to participate in the process of engagement. These problems can create further barriers to effective treatment and require even more rigorous efforts to engage the young person.

A depressed young person may be identified as being angry, irritable or having behaviour problems at school, without depression being considered as a possible cause (particularly for young males). The sense of hopelessness associated with depression requires clinicians to be very active and skilled in engaging the young person and maintaining a future-oriented focus.

Formulating an accurate diagnosis can be difficult, especially in the early phase of illness when symptoms and signs are non-specific. It is important to listen carefully to the young person's account of their experiences, bearing in mind possible cultural influences and help them make sense of what is happening. Over time, with continuing engagement and monitoring, the clinical picture becomes clearer and a trusting relationship should develop between the young person, their family and staff. Distinguishing between normal adolescent behaviour and the onset of symptoms may be difficult for young people, families and clinicians.

Involving and collaborating with families

Involving the young person's family has been shown to improve outcomes for young people with depression and first episode psychosis[118]. Families and carers should be involved in planning and, where appropriate, should be involved in the overall treatment. They should be able to access a range of interventions that fit with their long and short term needs and focus on their strengths. For most young people with depression and first onset psychosis, the family is the main provider of care and has a very important role to play in providing prevention and early intervention. The importance of the family, being broadly defined to include extended family and community members, is often heightened for CALD and Aboriginal and Torres Strait Islander populations. The unique role of families has often been overlooked in traditional mental health care.

Alcohol and other substance abuse

Alcohol and other substance use may complicate the clinical picture, treatment and management and it is important to develop collaborative partnerships between mental health and drug and alcohol services and provide integrated and comprehensive health care[119]. Symptoms may be caused or exacerbated by drug use. Young people may use substances in an attempt to relieve their symptoms. Substance use also raises issues such as whether specialist drug and alcohol services need to be involved, legal obligations relating to illegal drugs and the associated confidentiality issues, and whether any action should be taken specifically relating to the substance use.

A key component in assessing substance use is the context of the use, including the circumstances and environment in which the substances are used. It is important to find out if there are factors affecting how and when they use alcohol and other drugs, for example, whether the young person is alone or with friends, if it occurs at particular times of the day, or if it is a reaction to anxiety or boredom[120].

Suicide

Engaging young people who may be suicidal involves particular care and attention. Depression, disruption to psychological, educational and social development and strain on relationships can increase risk of suicide in young people[121]. Up to 75% of young people who die from suicide have a pre-existing depressive disorder[122] and young people experiencing first episode psychosis have been found to have differing levels of elevated suicide risk associated with the different phases of the illness[123]. Strategies that outreach to young people and include comprehensive suicide risk assessments are needed.

The role of the Centre for Mental Health

- Identify strategies to enhance services to become youth friendly and culturally sensitive, especially for young people at high risk.
- Disseminate clinical guidelines for first onset psychosis and depression in young people.
- Assist Area Health Services to identify local training needs and develop strategies to provide training in key areas identified to enhance knowledge and skills about youth mental health issues, particularly depression and related disorders, first onset psychosis, anxiety disorders, substance use and comorbidity.
- Disseminate information on the development of culturally appropriate services, for example the *NSW Aboriginal Mental Health Policy (1997) and Caring for Mental Health in a Multicultural Society: A strategy for the mental health care of people from culturally and linguistically diverse backgrounds* (1998).

The role of Area Mental Health Services

- Develop key strategies to encourage mental health services to provide 'youth-friendly' facilities with more flexible approaches to service delivery, for example outreach services, extended hours and convenient locations.
- Develop, provide and disseminate information about mental health, depression and related disorders and first onset psychosis for young people and their families.
- Ensure a network of youth focused services to facilitate effective pathways to mental health care.
- Build partnerships between child and adolescent services and adult services in mental health and between mental health and other generalist and specialist services for young people, particularly drug and alcohol services, general practitioners and CALD and Aboriginal and Torres Strait Islander services.

The Young People Prevention and Early Intervention Program (YPPI), Central Coast

The YPPI Program is a youth focussed, early psychosis and depression service providing comprehensive services through collaborative partnerships between youth health and mental health. The program is community based, situated in a cottage in Gosford; specific interventions are determined by the client group's needs.

The program has a particular emphasis on engaging young people. The program:

- provides community based assessment and crisis intervention for young people experiencing serious mental health problems and at risk of suicide;
- develops specific additional interventions for young people at extreme risk of suicide;
- acts as an advocate to assist young people to negotiate their service needs with relevant agencies;
- works within a holistic model, providing information for consumers and carers and assisting with the collaboration and integration of service provision between the adult mental health, youth health and alcohol and other drugs services;
- is developing an early intervention model of service delivery by incorporating the following components into the existing services: specialised and developmentally sensitive assessment; access to specialised crisis care during acute episodes either at home or in hospital; further development of the day program; linking young people into relevant work programs; collecting relevant outcome and process data throughout the course of the project; and
- has developed, with young people, a depression prevention initiative, Dumping Depression. It aims to: enhance resilience to depression in young people; enhance community perception of young people; and provide information and strategies for coping with depression.

- Build partnerships with general practitioners to enhance their skills in engaging young people, identifying mental health problems and intervening early and appropriately.
- Disseminate, workshop and implement locally the clinical guidelines for depression in young people and for first onset psychosis.
- Ensure all staff are skilled and knowledgeable about first onset psychosis and depression and related disorders in young people, including workers in mental health and other youth-oriented services.

The role of clinicians

- Develop and maintain collaborative partnerships with others, including youth health, community health, general practitioners, school counsellors, other primary health care, non-government organisations, cross cultural and Aboriginal and Torres Strait Islander services and communities, young people and their families/carers. This relationship involves providing specialist mental health expertise for skilling others to identify early signs and symptoms for mental health problems including depression and related disorders and first onset psychosis. It also involves collaborating with communities and key representatives on culturally appropriate ways to access and provide intervention for young people from Aboriginal and Torres Islander and NES backgrounds.
- Implement components as outlined in the guidelines for depression and first onset psychosis in young people (see Appendix 2). This should include: engaging young people and their families/carers; comprehensive assessment; monitoring; and evidence based treatment using a collaborative approach; and providing a range of appropriate interventions.

3. Developing and implementing prevention programs

There has been an increasing focus on prevention in mental health, particularly for depression and related disorders. This is a developing field and there is a need for continued research on how to deliver effective prevention, particularly at universal and selective population levels. At present, more is known about effective prevention of depression and related disorders in young people than for first onset psychosis.

The NHMRC Guidelines for depression in young people outline evidence from the literature to provide a framework for setting up prevention programs and suggest that programs should target young people in risk groups (selective prevention) (Figure 6).

Figure 6: Components of effective depression prevention programs (as outlined in NHMRC Depression in young people guidelines)

Identify young people who are at risk for developing depression:

- Known risk factors: young people with anxiety, substance abuse, or conduct disorders; personal or parental history of depression; close biological relative with depression; and, recent exposure to stressful events.
- Probable risk factors: family divorce, separation or marital distress; sexual or physical abuse; co-existing medical conditions; worsening school performance; poor peer relationships; homelessness; being in custody; and death of parent.

Identify population groups of young people that may be more exposed to risk factors associated with depression: living in rural areas; of low socio-economic status; Aboriginal and Torres Strait Islanders; from non-English speaking backgrounds; with intellectual disability.

Identify effective interventions that address the following: poor self-esteem, negative thinking, dysfunctional attitudes, poor social competence.

Identify modifiable protective factors, such as good peer and parenting relationships, employment, and individual resiliency including positive thinking styles.

Implement multi-component, comprehensive, integrated prevention programs (incorporating individual counselling, cognitive skills, modification of economic or social risk factors).

Adolescents Coping with Emotions (ACE) is an example of an indicated depression prevention program developed by Northern Sydney Area Health Service, Macquarie University and the Department of Education and Training. The program is being piloted in 1999 and 2000 in urban and rural NSW. Results of evaluations of ACE are expected to be available during 2000/2001.

Short and longer term follow-ups of the *Resourceful Adolescent Program* (see Appendix 1) suggests that universal programs conducted in schools can also be effective in decreasing depression in those with higher levels. Other programs, such as those promoting optimistic thinking in school children may lower vulnerability to depression. Ensuring programs are culturally relevant is also important.

The *Friends* program is a targeted, school-based prevention program for 7 to 12-year-olds, which was developed by the Griffith Early Intervention Program in Queensland. Friends is a local adaptation of the Coping Cat program developed by Philip Kendal in the USA. It is aimed at reducing anxiety symptoms and enhancing protective factors. Children and their parents participate in the program, which is currently being adapted and piloted as a universal prevention program for 12 to 16-year-olds.

For young people with non-specific signs and symptoms, it is important to provide early appropriate assessment, monitoring and treatment that will produce better outcomes for the young person and their families. Young people who are at greater risk of developing mental health problems, for example children of parents with a mental illness or refugees, should be given a high priority when prevention programs are being planned.

The role of the Centre for Mental Health

- Facilitate education and training for staff from Area Health Services, other government departments, non-government organisations, general practitioners, primary health care; and other organisations about first onset psychosis, and depression and anxiety prevention programs, identifying high risk groups and effective strategies that are culturally appropriate.
- Collaborate with the Department of Education and Training and other relevant bodies, to facilitate the implementation of depression and anxiety prevention programs in schools.
- Assist in setting up prevention programs in schools and other youth settings.

The role of Area Mental Health Services

- Identify young people at risk of depression, anxiety and first onset psychosis and plan for prevention and early intervention programs for these young people.
- Develop and implement special support, education and other relevant programs for children of parents with a mental illness.
- Set up prevention programs in collaboration with other youth-oriented organisations and services.
- Educate staff about universal, selective and indicated prevention and what is known about effective prevention programs (see Figure 6 for effective depression programs).
- Provide training for mental health and other appropriate staff in effective prevention techniques.
- Collaborate with local schools to implement depression and anxiety prevention programs and educational programs about depression and related disorders in young people. Informing the community about mental health problems,

4. Educating the community, particularly about depression and related disorders and first onset psychosis in young people

particularly depression and related disorders and first onset psychosis, affecting young people is important. This increases the awareness of risk signs for these potentially devastating illnesses, as well as helping to create a climate of help-seeking behaviour. Having an informed community also helps lessen the stigma associated with mental illness and seeking help about these problems. It is important that community education includes consumers and their families as partners in formulating the community education approaches.

Although there is confusion and a lack of knowledge about mental health issues among young people, they are interested in knowing more. They see the school system and the media as effective ways of communicating with them about mental health issues. Education for young people needs to include self-help and other information that is useful to them personally. The presentation has to be carefully designed to attract and maintain their interest (for example, having other young people to present some of the information and using videos and stories)[124]. Messages also need to be culturally appropriate and be available in local community languages.

Consultation and collaboration with young people and agencies working with young people will provide further information about young people's knowledge of and attitudes towards mental health and services and how and where education for young people should be directed. It is important that workers in these agencies be well trained and well informed about mental health problems in young people. Local directories of youth-oriented services will be an important part of the information provided to young people and their families.

The role of the Centre for Mental Health

- Assist and facilitate Area Health Services to set up community education programs to inform the community about mental illness, particularly depression and related disorders and first onset psychosis. The target audience includes parents, adolescents and young people, teachers, school counsellors, primary health care and other health workers. The content includes aetiology, recognition of the range of signs and symptoms, resources available for assessment, treatment, management and where to get help.
- Develop and disseminate information resources about depression and first onset psychosis for young people and their families such as the Family Help Kit, Dumping Depression resources (Central Coast Area Health Service) and CD Rom and NESB Family Help Kit and multilingual information brochures (TMHC).
- Liaise with State and national general practitioner bodies to facilitate general practitioner education about young people's mental health problems, particularly recognition, early intervention and prevention in first onset psychosis and depression and related disorders.

The role of Area Mental Health Services

- Educate the local community about mental health, depression and related disorders and first onset psychosis, warning signs and where to get help. The education would target adolescents, young people, parents, teachers, school and TAFE counsellors.
- Set up strategies to encourage young people to seek help with mental health problems.
- Liaise with local Divisions of General Practice to provide education for general practitioners, including recognition, assessment, referral and, where appropriate, treatment of young people with signs and symptoms of mental health problems.
- Provide and publicise Area phone numbers to provide easy access to appropriate services.
- Ensure that links are established between local mental health services for young people and Hotlines, such as Kids Helpline and Lifeline.
- Assist and facilitate the representation of young consumers in local consumer groups.

5. Monitoring quality and effectiveness

The Centre for Mental Health is developing strategies that include strategic directions for monitoring and evaluating mental health services and special mental health programs and projects, such as depression and related disorders and first onset psychosis. This includes the development of indicators to monitor process, performance and outcomes.

It is important to monitor and evaluate the new and developing prevention and early intervention programs and services across NSW to ensure that effective interventions are identified and evaluated for wider dissemination.
In addition, Area Health Services have an accountability to report on the use of enhancement funding allocated to them to progress depression and first onset psychosis programs and collaborative partnerships with a range of youth-oriented services and organisations.

The role of the Centre for Mental Health

- Provide a model for reporting progress in depression and first onset psychosis programs in NSW.
- Develop outcome indicators for programs for first onset psychosis (see Figure 7 for examples of indicators for first onset psychosis services) in collaboration with the NSW Early Psychosis Indicator Working Party.
- Develop outcome indicators for programs for depression in young people (see Figure 8 for examples of indicators for School-Link).
- Provide updates of directories of programs and services for first onset psychosis in NSW.
- Develop and disseminate *Evaluating Early Psychosis Interventions: A User's Guide* in collaboration with the NSW Early Psychosis Research and Evaluation Working Group.
- Conduct an audit of NSW Early Psychosis programs and initiatives in NSW.
- Develop criteria for an early psychosis flag on NSW information systems, in conjunction with the NSW Early Psychosis Indicator Working Group, to identify early psychosis clients.

The role of Area Mental Health Services

- Implement outcome indicators for programs for depression in young people and first onset psychosis.
- Provide regular updates on depression and first onset psychosis programs and services.
- Review and report on the quality and effectiveness of programs for first onset psychosis and depression in young people according to the framework developed.

Figure 7: Examples of indicators for an early psychosis service

Service model indicators

- How does the Area/sector provide services that meet the defined characteristics for an early psychosis program (characteristics in development)?
- Number of early psychosis workers in the Area mental health service.
- Number of staff who have participated in recent training in early psychosis.
- Knowledge and implementation of Australian Early Psychosis Guidelines.
- Have local early psychosis protocols been developed and implemented and a process for review established?
- Number of community agencies aware of and referring to early psychosis services.

Clinical indicators

- Number of early psychosis clients accessing service and numbers engaged in treatment.
- Number of clients entering service in prodromal, early onset and acute stages of psychosis.
- Average length of time between referral and action undertaken (for example, assessment).
- Proportion of families contacted in the first 24-48 hours after assessment and involved in treatment.
- Proportion of clients experiencing relapse in the first 12 months of treatment.
- Number of bed days per first episode during the first three months of treatment.
- Proportion of clients returning to productive activity, e.g. school or work in first 12-18 months.

Figure 8: Examples of indicators for School-Link

Centre for Mental Health Structural

Structural

- Formalise agreement with Department of Education and Training
- Monitor expenditure of the National Health and Mental Reform Incentive Funding for School-Link, and progress of Area School-Link initiatives.
- Statewide coordination of School-Link
- Coordinate NSW School-Link Steering Committee
- Coordinate NSW School-Link Reference Group
- Coordinate NSW School-Link Curriculum Advisory Group

Pathways to care

- Facilitate systematic approach to developing and documenting pathways to care for adolescents with depression and related disorders School-Link Training Program for school counsellors, TAFE counsellors and mental health workers.
- Develop the training program curriculum and materials.
- Coordinate and organise delivery of training program across NSW, including pilots and evaluation.

Ongoing systems

- Ensure training program is available on an ongoing basis.

Prevention programs

- Develop guidelines in collaboration with Department of Education and Training for implementation of prevention and promotion programs in schools.
- Facilitate training for specific prevention and promotion programs.
- Assist with providing resources for prevention programs including evaluation, research measures.

Educating school communities

- Assist in developing appropriate resources for education of teachers and other relevant school personnel.

Area Health Services

Structural

- Appoint an Area School-Link coordinator.
- Set up structures for local coordination, such as a steering committee or working group.
- Set up systems for formal links between schools (particularly school counsellors and district guidance officers) and local child and adolescent mental health services.
- Participate in the School-Link Coordinators Forums.
- Provide six-monthly progress reports to the Centre for Mental Health.

Pathways to care

- Provide documented pathways to care for adolescents with depression and related disorders, involving school and TAFE counsellors, relevant health workers and child and adolescent mental health workers, taking into consideration relevant Department of Education and Training (DET) policies and protocols.

Training program: Helping adolescents with depression and related disorders

- School-Link coordinator to coordinate local implementation of School-Link Program, including identifying and ensuring participation of appropriate health workers (as identified in pathways to care).
- School-Link coordinator to participate in all local School-Link Training Programs.
- Participate in evaluation of the School-Link Training Program.

Ongoing systems

- Implement ongoing systems for recognising, supporting and managing adolescents with depression and related disorders.

Prevention programs

- Participate in Activity Scans of schoolbased depression prevention and mental health promotion programs.
- Facilitate implementation of evidence-based promotion and prevention programs in schools, such as Resourceful Adolescent Program (RAP), Adolescents Coping with Emotions (ACE), Mind Matters.

Educating school communities

- Work with local schools and school counsellors to develop and deliver appropriate local education programs for teachers and other relevant school personnel.

Appendix 1:
National initiatives in early intervention for first onset psychosis and depression in young people

Depression in young people: Clinical Practice Guidelines
(National Health and Medical Research Council, March 1997). Available from the Australian Government Publishing Service, GPO Box 84, Canberra ACT 2601, Ph: 132 447 (Freecall).

These are comprehensive, evidence-based guidelines incorporating identification, assessment, diagnosis, management and prevention of depression in 13 to 20-year-olds. Each recommendation is evaluated according to the quality of evidence ratings recommended by the NHMRC.

There are five documents in the complete set:
- the full guideline which presents the epidemiology and scientific evidence and recommendations;
- a guide for mental health professionals;
- a guide for general practitioners;
- a comic book for young people; and
- a booklet for young people.

Griffith Early Intervention Program
c/o Resourceful Family Project, School of Applied Psychology, Griffith University, Nathan Qld 4111.
Ph: (07) 3875 3515
Website: http://www.gu.edu.au/school/psy/centres_rc.htm
Over a two-year period ending in July, 1998, the Griffith Early Intervention Project (GEIP) team were involved in a national strategy to promote and implement early intervention programs to prevent anxiety and depression in late childhood and early adolescence.

The aims of GEIP are to:
- increase awareness of the need for prevention programs targeting anxiety and depression in children and teenagers;
- encourage school and other agencies to set up prevention programs; and
- provide consultation and training for schools and other agencies implementing prevention programs.

This included the development of resource materials – group leader manuals, participant workbooks and videos.

Two prevention programs were developed. The *FRIENDS* program is designed to assist children and young people, at an appropriate developmental level, to learn important skills and techniques to cope with and manage anxiety.

The *Resourceful Family Project* is aimed at enhancing resilience to prevent depression and suicide for adolescents and includes two programs:
- The *Resourceful Adolescent Parent Program* (RAP-P), aimed at parents of adolescents, is designed to help parents make the transitions necessary for parenting adolescents, promote positive family relationships, decrease family conflict and connect with their adolescent children.
- The *Resourceful Adolescent Program* (RAP-A) is a universal depression prevention program for 12 to16-year -olds consisting of 10-11 one-hour sessions. The aims of the program are to:
  - assist young adolescents to develop life skills to increase resilience and prevent the onset of depression;
  - encourage young people to acknowledge their existing strengths as a basis to developing self-esteem; and
  - promote harmony in social situations, in particular peer and family settings.

An outcomes evaluation of the pilot programs indicates that RAP-A decreases depression among adolescents with elevated depression scores who participate in the sessions. Longitudinal information is also being collected to examine the maintenance of prevention effects.

National Early Psychosis Project (NEPP)
The *Australian Clinical Guidelines for Early Psychosis* are available from The Office Manager, EPPIC Statewide Services, Locked Bag 10, Parkville Vic 3052.
Web site: http://ariel.unimelb.edu.au/~nepp

This national project ran for 18 months from June 1996. It provided an opportunity for systematic collaboration, information sharing and the development of a nationally agreed range of interventions. Coordinators in all states and territories worked collaboratively on the project.

The aims of the NEPP were:
- to facilitate the development and promotion of best practice in the identification and optimal early intervention in psychosis;
- to progress mental health policy to ensure that services adopt and incorporate best practice principals in early psychosis service delivery;

- to enhance the capacity of mental health professionals around Australia to meet the needs of young people with emerging psychosis; and
- to develop a network through which mental health professionals, consumers, and other key stakeholders can share information and ideas about early psychosis.

The project provided tertiary consultation, ongoing support, advice, information and access to expertise for implementing best practice. It produced a range of professional development resources and training, educational and professional development activities tailored to local needs. Information was disseminated as broadly as possible using various different media, including a newsletter, resource centre, a training kit, best practice guidelines, the promotion of various resource and psychoeducational materials, a telepsychiatry network and the Internet. The `Australian Clinical Guidelines for Early Psychosis` have been published and are the major outcome of the project.

AusEin-et

(Australian Early Intervention Network)
c/o Flinders Medical Centre, Bedford Park SA 5042.
Ph: (08) 8357 5485 Fax: (08) 8357 5484
Website: http://auseinet.flinders.edu.au/

AusEinet, the Early Intervention Network for Mental Health in Young People, was established in May 1997 to promote early intervention in mental health problems specifically with children and young people.

The focus of the project has been the development of a national network involving key people such as consumers, carers, clinicians, researchers and policy makers and the development of resources to promote best practice in early intervention in mental disorders specifically with children and young people. The network has a Clearinghouse function, links people and gathers and disseminates information electronically and via other media. It promotes and enhances the development of early intervention services nationally through identifying and enhancing key service, structural and intersectoral issues and is further developing best practice in specific areas.

Appendix 2:
Summary of key recommendations from national guidelines for management of first onset psychosis and for depression in young people

Key elements of best practice for first onset psychosis

The National Clinical Guidelines for First Onset Psychosis outline 10 clinical practice guidelines for use by mental health professionals.

- Identifying, monitoring and providing needs-based care during a potential prodromal phase in early psychosis are optimal. Intervention during the prodromal phase may help to prevent the onset of psychosis.
- Mental health services are accessible and provide a timely assessment for people experiencing, or significantly at risk of, their first episode of psychosis and their families. Reducing delays into treatment through a clearly defined process of entry into specialist services can have positive outcomes, such as reducing the risk of relapse.
- Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress. Assessment procedures for clients experiencing first onset-episode psychosis should incorporate strategies to promote engagement.
- A case manager/mental health practitioner and treating psychiatrist should be allocated to each client upon entry to the service and provide a range of services to meet the needs of the client and their family and carers. The overarching goal of the case manager is the promotion of recovery and prevention of relapse and ongoing disability.
- Psychopharmacological interventions are to be provided during the acute phase and ongoing management of recovery for psychosis. The aim of psychopharmacology in first onset psychosis should be to maximise the therapeutic benefit for the client while minimising the side effects.
- Psychological interventions are provided as part of the acute and ongoing management of recovery from psychosis. The benefits of using psychological approaches to promote recovery are emerging.
- Family and carers are involved in the assessment, treatment and recovery process in episodes of acute psychosis. Families and carers play a vital role in supporting the client and facilitating engagement in treatment and thereby minimising long-term morbidity.
- Psychoeducation for clients and families is an essential component of the treatment process in early psychosis. Psychoeducation aims to develop a shared and increased understanding of the illness for both the client and their family.
- A comprehensive range of group programs specifically tailored to the needs of people with early psychosis should be available. Group work interventions for people experiencing early psychosis can be both efficient and effective in promoting recovery and involvement in community life, reducing the development of disability and facilitating the achievement of personal goals and vocational goals.
- Clients should receive treatment in the least restrictive manner wherever possible. Choice of treatment setting is a very important component in the overall management of people with first onset psychosis. While the decision regarding treatment setting should be based on the level of severity of presentation, and the assessed level of risk, the optimal treatment setting is considered to be the client's home.

Depression in young people: Clinical Practice Guidelines

(National Health and Medical Research Council, March 1997)
The guidelines make 83 statements about depression in young people, covering the following topics:

1. Overview of depression in young people
   - Definition of depression
   - Course and outcome of unipolar depression in young people
   - Epidemiology
   - Course and outcome of bipolar disorder in young people
   - Risk factors in the development of depression in young people
2. Special issues in managing depression in young people
   - Issues and obstacles
   - Overcoming the obstacles
3. Identification, assessment and diagnosis of depression in young people
4. The efficacy of treatments for depression in young people
   - Unipolar depression
   - Bipolar disorder

5. Practical guidelines for the care of the depressed young person
6. The prevention of depression in young people
   - Guidelines based on risk factor research and theoretical considerations
   - Guidelines based on outcomes of intervention studies
7. Requirements of specific groups

Summary of key recommendations

Assessment

Management of depression in young people begins with a comprehensive assessment of depressive and other symptoms. The purpose of assessment is to:

- identify depressive symptoms in 'at risk' adolescents;
- exclude other disorders to make diagnosis of depression;
- select appropriate treatment;
- evaluate treatment effectiveness.

Diagnosis

The clinical interview is essential for diagnosing a depressive disorder, covering:

- full range of current signs and symptoms (not just depression);
- level of functioning;
- previous history of relevant psychosocial and medical problems;
- recent stressors;
- use of medication and illegal drugs;
- sexual history;
- recent pregnancy;
- family situation and family history of depression;
- social support and other resources available;
- relevant cultural issues.

A non-standardised interview format is recommended as being more appropriate for young people because of its flexibility.

Management

The practitioner should:

- do no harm;
- engage the young person in an empathetic supportive relationship;
- conduct an appropriate assessment;
- decide whether intervention is needed;
- decide whether a referral, hospitalisation, or expert advice is required;
- arrange suitable support and backup services;
- select appropriate treatment;
- monitor treatment and provide counselling to support adherence to treatment;
- assess treatment effectiveness and modify the management program where necessary;
- provide or arrange support for family members;
- organise rehabilitation and reintegration in the community;
- arrange follow-up.

The aims of a depression treatment program are to:

- eliminate or minimise symptoms;
- minimise other negative outcomes, such as disruption of social, academic and work functioning;
- minimise the risk of self harm;
- avoid recurrences of depression.

Treatments should be selected on the basis of:

- known benefits and adverse effects of different options;
- 'clinical commonsense';
- the needs, problems, resources and preferences of the young person and their family;
- the availability and accessibility of trained personnel.

Effective treatments for unipolar depression

- Cognitive behavioural therapy is the treatment of first choice for depressive disorder and elevated depressive symptomatology.
- One or more of the following therapies may also be used: relaxation therapy; therapeutic support groups; social skills training; interpersonal therapy; family therapy; exercise.
- Pharmacological therapy may be considered where first line treatments have been unsuccessful. It may also be indicated in young people aged 18 or older. Selective serotonin reuptake inhibitors (SSRIs) are possibly more efficacious and have lower toxicity; however, it is possible that SSRIs may induce suicide in some young people. Monoamine oxidase inhibitors (MAOIs) are preferred to tricyclic antidepressants. Tricyclic antidepressants are not recommended for young people.
- Electroconvulsive therapy may be useful for severe depression where other treatments have not been effective.

Effective treatments for bipolar disorder

- Supportive counselling should always be part of the treatment program.
- Lithium is the treatment of choice.
- Carbamazepine or sodium valproate may be useful where other approaches have failed or where lithium is contraindicated.
- Electroconvulsive therapy may be useful where other treatments have not been effective.

Appendix 3:
NSW health publications and resources relevant to mental health in young people

Unless otherwise indicated, these resources are available from the Better Health Centre, Locked Mail Bag 5003, Gladesville, NSW 2111;
Ph: (02) 9816 0452 Fax: (02) 9816 0492.
Many are also available on the Internet at www.health.nsw.gov.au

The Management of People with a Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines and Discussion Paper. (May 2000)
State Health Publication No. (CMH) 000050

Prevention Initiati++es for Child and Adolescent Mental Health. NSW Resource Document. (March 2000).
State Health Publication No. (CMH) 980108

NSW Strategy: Making Mental Health Better for Children and Adolescents. (February 1999)
State Health Publication No. (CMH)980087

School-Link. Helping Adolescents with Depression and Related Disorders. (February 1999)
(leaflet) State Health Publication No. (CMH)990045

Young People's Health. Our Future. (January 1999)
State Health Publication No. (HP)980077

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