Model projects for early intervention in the mental health of young people

Reorientation of services

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A PROJECT OF AUSEINET

The Australian Early Intervention Network for Mental Health in Young People

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The AusEinet project is managed jointly by Associate Professor Graham Martin MD and Professor Robert Kosky MD. Ms Anne O'Hanlon is the senior project officer for the reorientation of services and the promotion of good practice streams of the project and Ms Pauline Dundas was a consultant during the initial phase of the reorientation process. Ms Cathy Davis is the senior project officer for the networking stream.

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Chapter 1

Introduction

The background

In 1992, the Health Ministers of the Commonwealth of Australia and the State and Territory governments recognised the need to improve conditions and services for people with mental illnesses. Together, they set up a collaborative framework for the reform of Australia's mental health services. This was known as the National Mental Health Strategy. The strategy had as its objective improvements in a number of areas. These included recognition of consumer rights, the relationship between mental health and general health sectors, the mix between hospital and community services and between preventive and curative services, the roles of primary care and non-government organisations, and the monitoring of the quality of the help provided to those in need.

The changes which occurred under the National Mental Health Strategy have been documented in a series of reports (Commonwealth Department of Health and Family Services, 1997). Several large-scale projects have been developed out of the strategy, including the National Survey of the Mental Health and Well Being of Australians. The reports describing the prevalence of mental disorders among the Australian population and their relation to services are now becoming available (e.g. Andrews, Hall, Teeson & Henderson, 1999).

One aspect of reform to claim the attention of the health ministers was the potential benefits that might come from intervening in the natural history of mental disorders as early as possible. They had noted that all too often the story of those affected by mental disorders was that help came too late - sometimes years too late. Disability and stigma set in before the true plight of the person had been recognised. For some authorities, an early intervention approach seemed to be a realistic way to reduce the tragic disablement so often associated with mental disorders and yet to utilise precious resources effectively (Kosky & Hardy, 1992; McGorry, Edwards, Mihalopolous et al., 1996).

However, few mental health services across Australia were geared to early intervention. In 1995-6, the Mental Health Branch, on advice from the Early Intervention Working Party of the National Strategy, established three major national projects in early intervention. These projects were: early intervention in psychotic illnesses (Early Psychosis Prevention and Intervention Centre - EPPIC), early intervention in anxiety disorders (Griffith Early Intervention Project - GEIP), and early intervention for the mental health of young people (AusEinet). These projects are not entirely separate, but overlap in various areas. This is an aspect that has been addressed by AusEinet in its journals (AusEinet, 1997-2000) and in the national seminars held under its auspices.

As soon as an early intervention approach is adopted, it becomes apparent that more than just traditional mental health services need to be involved. General health providers, education, welfare, justice, pastoral care services and so on, are in early contact with people who are becoming unwell. These services also involve workers from many fields and professions, not just doctors and nurses. Most importantly, early intervention means a realistic and open exchange with those who are becoming ill and their carers. To develop ways to link these diverse groups and agencies was one of the challenges for AusEinet.

This book deals with one aspect of the AusEinet project, but it is one that we consider to be a key to any national or state approach to early intervention. The issue that it addresses is how to reorient services away from traditional curative and rehabilitation modes of care, to interventions which identify the first intimations of mental disorder and that seek to preserve the best functioning capacity of the affected individual.

AusEinet

The Australian Early Intervention Network for Mental Health in Young People (AusEinet) was established to coordinate a national approach to early intervention for mental health in young people. AusEinet was jointly developed by Flinders University of South Australia and the University of Adelaide and funded by the

Commonwealth Department of Health and Aged Care under the National Mental Health Strategy and the National Youth Suicide Prevention Strategy. The project had three streams:

- the development and maintenance of a national early intervention network for mental health in young people;
- the identification and promotion of good practice in early intervention;
- the reorientation of service delivery towards early intervention.

The separation of the project into 'streams' was somewhat artificial, as all the activities of the project were interrelated. For example, the team prepared the way for the AusEinet project by presenting information on early intervention at seminars and workshops in every state and territory in Australia. Information that emerged from the networking activities of the first stream helped to guide the work being done in the other two streams. Similarly, the progress made in the reorientation process and the promotion of good practice was fed back to the network. In this way, AusEinet contributed to, and benefited from, the enthusiasm of the consumers, carers, administrators, mental health professionals, researchers and others who became members of the network.

In this book, we want to focus on the reorientation stream of the AusEinet project by presenting some practical models for the reorientation of service delivery to early intervention. In order to place the reorientation process within the context of the larger AusEinet project, the activities and outcomes of the other two streams are described briefly here.

The national network for mental health in young people

The establishment of the national early intervention network began in July 1997 and by July 1999 included more than 2800 individuals, agencies and organisations. The network comprises carer and consumer groups, child and adolescent mental health workers and primary health providers, as well as education, juvenile justice, family and youth services. A variety of strategies was used to develop and expand the network. Workshops were conducted in Australian states and the northern territory in order

to inform people about early intervention in mental health, promote the AusEinet project and showcase local early intervention programs. Information about early intervention was also disseminated at other meetings and conferences and via media interviews.

The network was further extended by liaising with other early intervention projects and working groups and through AusEinet's function as a national clearinghouse on early intervention. Information, discussion and debate about early intervention were maintained through the AusEinet website http://auseinet.flinders.edu.au, a quarterly newsletter (AusEinetter) and an email discussion group einet@flinders.edu.au. Other outputs of the network were two national stocktakes of prevention and early intervention programs and a review of the literature on early intervention. These are available from the AusEinet website.

Promotion of good practice in early intervention

AusEinet funded a range of projects which had the potential to make a significant contribution to early intervention for the mental health problems of young people. Three of the project teams evaluated the efficacy of early interventions with specific groups of young people. One of the teams investigated the management of disruptive behaviours in young children with developmental disability, another explored early intervention with physically abused children and their caregivers, and the third evaluated a brief intervention for substance abuse in early psychosis.

Two other project teams prepared practical early intervention materials. One team produced a set of materials for refugee children and young people who had experienced torture and trauma, and developed companion sets for their teachers and school counsellors. Another team developed a handbook for working with Indigenous Australians, which was devised primarily for psychologists, but has relevance for a broader range of professionals. The project teams have been encouraged to publish their outcomes in the appropriate scientific journals. Summaries of the projects and extracts from the handbook for working with Indigenous Australians were placed on the AusEinet website.

AusEinet commissioned several other clinical research groups to look at clinical approaches to early intervention in specific mental health problems or disorders

which affect children and young people. They examined the world literature, assessed the evidence base for the effectiveness of the approaches and summarised the appropriate interventions. The problems or disorders were attention deficit hyperactivity disorder, anxiety disorders, conduct problems, perinatal mental health, and psychological adjustment to chronic conditions. These were developed into a series of AusEinet publications which can be downloaded from the AusEinet website. We are also developing a guide to early intervention in delinquency.

In summary, as well as this book on model projects for early intervention in the mental health of young people, AusEinet has produced a range of other books:

- National stocktake of early intervention programs (Davis, Martin, Kosky & O'Hanlon, 1998)
- National stocktake of prevention and early intervention programs (Davis, Martin, Kosky & O'Hanlon, 1999)
- Early intervention in the mental health of young people: A literature review (Davis, Martin, Kosky & O'Hanlon, 2000).

and has edited a series entitled '*Clinical approaches to early intervention in child and adolescent mental health*' which so far includes:

- Attention deficit hyperactivity disorder in preschool aged children (Hazell, 2000)
- Early intervention for anxiety disorders in children and adolescents (Dadds, Seinen, Roth& Harnett, 2000)
- Early intervention in conduct problems in children (Sanders, Gooley & Nicholson, 2000)
- The perinatal period: Early interventions for mental health (Kowalenko, Barnett, Fowler & Matthey, 2000)
- The psychological adjustment of children with chronic conditions (Swanston, Williams & Nunn, 2000).

Purpose of this book

This book focuses on the reorientation of services to early intervention. It has two main purposes. It is primarily intended as a ***guide for professionals and health administrators considering reorienting their own service*** to early intervention. We anticipate that many readers will be particularly interested in the reorientation experience of agencies similar to their own. To assist them, we have included descriptions of the reorientation strategies developed in each of the projects. We have also provided contact information so that readers can contact the agencies for further details. Overall, we hope to show how reorientation was achieved in different types of agencies, working with a range of clients and with varying levels of resources.

It is also intended as a complete ***record of the reorientation process*** and therefore documents all aspects of the process, from selection of agencies, to training and support of the reorientation officers, through to outcomes and analysis. We anticipate that some readers will be interested in the more global aspects of the reorientation process, such as the approach used to coordinate the process at a national level and the analysis of the strategies which were developed to build capacity within the agencies.

There is currently a lack of practical material on which to build an early intervention approach. This was an obstacle for us during the AusEinet project, particularly in its early stages. This book, the two national stocktakes of prevention and early intervention programs, the literature review and the clinical approaches series, give some idea of the range of programs currently operating in Australia and of the depth of interest in early intervention approaches to mental health. They are our attempt to provide some practical assistance to professionals and administrators wishing to adopt an early intervention approach to improve the mental health of children and young people.

In Chapter Two we discuss the need for early intervention and present an overview of the groups and individuals for whom early intervention may be most beneficial. The chapter concludes with a discussion of some of the challenges in adopting an early intervention approach.

In Chapter Three we focus our attention on the reorientation of services. First, in order to outline some possible strategies for reorientation, we draw upon the literature on building the capacity of organisations to achieve health gains. Then, we describe how AusEinet put the process of reorientation into motion by selecting eight agencies to run the model projects, training the reorientation officers and supporting them throughout the process.

The model projects are presented in Chapters Four to Twelve. This is the part of the book that we hope will guide other agencies considering reorienting their services to an early intervention approach. For each project, we present background information on the agency in order to give a sense of its geographical location and the services it provides. This is followed by a description of the reorientation strategies used in the project, the opportunities and barriers which were encountered and the likely ways that the strategies will be sustained.

In Chapter Thirteen we draw the projects together to discuss their commonalities and differences, opportunities for and barriers to reorientation, and the strategies used to achieve immediate gains as well as those used to lay the groundwork for longer term, potentially sustainable change. We conclude by outlining some of the lessons we have learned from the reorientation process.

Terminology

For the purposes of the AusEinet project, ***children and young people*** ranged in age from birth to 24 years. We considered ***early interventions*** to be those aimed at individuals and groups of people who have a higher than average risk of developing a mental health disorder, and those who have early signs or symptoms of a disorder. They are also aimed at individuals who are in the early stages of a disorder. These equate with selective interventions, indicated interventions, case identification and treatment for known disorders, as described by Mrazek and Haggerty (1994) in their mental health intervention spectrum. This is discussed further in Chapter Two.

During the timeframe of the AusEinet project, the definition of early intervention used by the Commonwealth Mental Health Branch and some other groups was

subsequently redefined to include only indicated interventions, case identification and treatment for known disorders.

Capacity building is central to the process of reorientation. It refers to the implementation of integrated sets of strategies to enhance an organisation's capacity to achieve health gains. It is most often used to refer to gains in health promotion, but we believe it can also be applied to early intervention. Ideally, capacity will be potentially sustainable in the longer term. AusEinet funding for the model projects ceased at the end of May, 1999. In our description of the projects, ***sustainability*** refers to the likelihood that the strategies for reorientation can be sustained without any further funding from us.

The ***agencies*** described in this book include small support groups, community projects, non-government organisations and government departments of education, health and community services. The agencies were not necessarily primarily mental health focused, but they all provided services to a significant number of children or young people who had, or were at risk of developing, mental health problems.

Chapter 2

Early intervention

The need for early intervention

Each year in Australia, about 100,000 children and young people aged 5 to 25 years develop crippling emotional disorders. About a million more young people are seriously affected by emotional problems (Zubrick, Silburn, Garton et al., 1995). In many cases, the symptoms persist and progress, causing huge burdens of suffering and caring. The futures of the young people affected by such conditions are placed in jeopardy, their families are stressed and there are ramifications at every level of society (Kosky & Hardy, 1992). These disturbances are often the precursor to life-long difficulties in mental health and social wellbeing. Most serious chronic psychiatric illnesses have their onset in the teenage and early adult years of life (Rey, 1992).

Over $2 billion is spent each year in Australia for mental health services (Commonwealth Department of Health and Aged Care, 1997). However, most of our current services are orientated to mature adults where, in many cases, disability secondary to emotional problems has well and truly set in.

One obvious way to reduce the impact of these emotional problems is to identify young people who are at risk of developing a disorder, or are in the early stages of the disorder. Then, effective interventions and treatments can be initiated in order to prevent or ameliorate the progression of symptoms. This is what is meant by early intervention. The challenge is how to do this.

Many people want to help identify young people who are developing a mental disorder, and many are in a position to do so. General medical practitioners, paediatricians, nurses, psychologists, social workers, youth workers, teachers, lawyers and many other service providers have contact with young people when

their problems are just starting to develop. Families, especially parents, may be the first to notice when things go wrong, but often do not know what to do.

AusEinet sought to raise awareness of early intervention in a broad audience of consumers, carers and service providers and to develop and promote methods for putting early intervention principles into practice. This meant reorienting some services so that they developed a deeper awareness of the natural history of symptoms over the life span and of the early onset of many emotional problems. A challenge for AusEinet was to identify the most effective methods for early intervention. We wanted to demonstrate how reorientation to early intervention can prevent long term disability and ease the burdens of suffering for children, adolescents and their families.

The meaning of early intervention

AusEinet promoted early intervention for a range of target groups and individuals and sought to assist in the clarification of which interventions provide clearly improved outcomes. In Figure 1, we have shaded Mrazek and Haggerty's (1994) mental health intervention spectrum for mental disorders to indicate our focus.

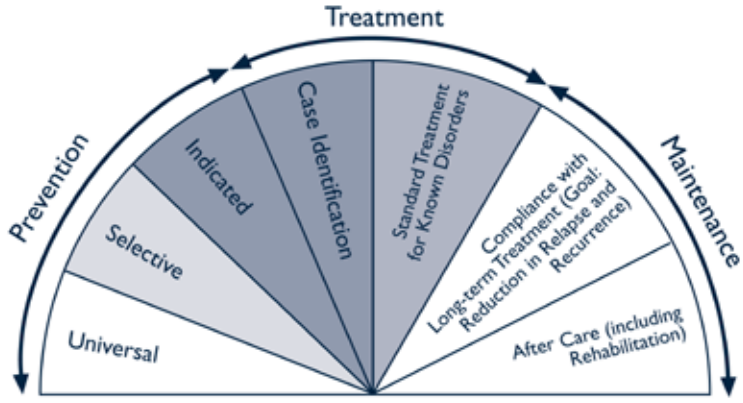

Figure 1. The mental health intervention spectrum for mental disorders (adapted from Mrazek & Haggerty, 1994)

We were interested in interventions for individuals or subgroups in the population known to be at higher than average risk of developing a mental disorder, that is, ***selective interventions*** (Mrazek & Haggerty, 1994). Examples include children of parents with a mental illness or a problem with substance abuse, children with certain medical illnesses, or young people who have been abused. They may not show signs of problems, symptoms or illnesses at the point of intervention, but are considered to be at risk.

We were also interested in ***indicated interventions*** (Mrazek & Haggerty, 1994). These are aimed at individuals known to be at high risk because they have early signs of illness, a high number of risk factors for a given illness, or biological markers known to predispose to mental illness. A number of current programs in Australia (for example, Griffith University's early intervention program for anxiety disorders, the Melbourne based early psychosis prevention and intervention program, and the early detection of emotional disorders program in Adelaide) actively seek to intervene with young people with early signs of illness.

Finally, a major focus was ***case identification*** (Mrazek & Haggerty, 1994). This is probably the area that makes most sense to clinicians. It seems obvious to state that we should be able to identify illness at the earliest possible time. We should know what the best treatment and support programs are, and we should be clear about how to reach out and maintain access for those experiencing a first clearly defined episode of illness. We know in practice, however, that the whole area is much more complex.

We reiterate that during the timeframe of the AusEinet project, the definition of early intervention used by the Commonwealth Mental Health Branch and some other groups was subsequently redefined to include only indicated interventions, case identification and treatment for known disorders.

For some disorders, it may seem impossible to intervene until the illness is obvious. An example might be a young man with increasing school difficulties in early high school, who has escalating conflict with his parents, has tried marijuana to excess and only after six months of increasing difficulty acknowledges some of his paranoid delusions. Here the problem is to provide early intervention in the form

of rapid response, safe care, accurate treatment and careful, thorough and active follow-up. But what conditions might have helped his teachers, the school counsellor, the general practitioner or his parents recognise and deal with the problem earlier?

For other disorders, like conduct disorder, as a society we cannot afford to wait until the problem is obvious. The best early interventions are probably parental education, educational assistance as soon as problems arise at school, and a range of other (usually school-based) programs targeted at the errant conduct. Without early intervention, the behaviours may become more and more entrenched. There is also increasing evidence that programs which address multiple issues in a comprehensive way are superior to those which focus on only one of the problems. We need to understand all of this better. The series of clinical approaches to early intervention in child and adolescent mental health, which was commissioned by AusEinet and is described in Chapter One, represents an attempt to move towards such an understanding.

Challenges in early intervention

One can't work in the field of early intervention or deal with general theories about early intervention in mental health without at some time coming face-to-face with the issue of what is normal in human conduct and emotions and what is something we should worry about. In most of mental health work this question can be pushed into the background because we are usually dealing with clear-cut, long-established patterns of illness, disorders or behaviours, which almost everyone agrees constitutes a problem.

The interpretations of the results of surveys to establish the prevalence of mental illness, mental disorders or mental health problems in the community are often conflicting however and the line between what is and what isn't considered normal is then not so clear cut. The first issue to address is the question of symptoms. What are symptoms, how are they recognised and what relationship do they bear to mental health disorders? It is the task of early intervention to identify symptoms at their earliest onset and in their earliest manifestation so that an intervention can be made.

Roughly, the manifestations of symptoms may occur in two different ways. Most obviously, symptoms may occur as a rupture in the course of ordinary development. In these cases, a person who is previously well becomes unwell over a short space of time. The second pattern of onset of symptoms is where they manifest slowly over time. Gradually someone who was once well becomes unwell, although it is not always easy to identify the point at which this change occurred. In this case, the symptoms may really represent a transition from one state to another. It is generally regarded that the sudden, more explosive types of symptom manifestation are more a consequence of some biological problem, while the slower transitional forms are more under the control of the environment. However this is to simplify matters too greatly and there are many combinations of intrinsic and extrinsic factors involved in the production of symptoms.

Are there symptoms and signs which, together, do not necessarily make up a mental disorder, but nevertheless indicate the incipient onset of mental disorder? If so, these prodromal symptoms would be a point for intervention in order to prevent the development of the mental disorder. The search for prodromal symptoms has proved frustrating. In general, the sorts of problems or disturbances people show before the onset of the major categories of mental illness are very non-specific and are shared by many people who never develop the disorders. Thus, the issue gets down to one of probability measurements of whether or not a particular group of prodromal symptoms indicates the development of a disorder. Should the probability be low, it is likely that interventions would be made with many people where it is quite unnecessary and may be harmful. If the probability is high, then there may be a case for early intervention in individuals who show this non-specific symptomatology. However, if the probability is high, it may be that the prodromal symptoms are in fact the symptoms of the disorder.

Most surveys of the mental health of populations indicate that about 20 percent of people, that is one in five, have some form of mental health problem (Zubrick et al., 1995). Mostly these problems, while curtailing some aspects of function, are minimal or moderate in severity. It is reasonable to regard these problems as difficulties in coping with life events, without necessarily saying that their causes are limited to the biological, psychological or social realm. They mostly represent poor adaptations to some aspects of field or context, that is, the family or community.

In some ways, the manifestations of these mental health problems are as variable as the individuals who have them, but in another way the symptoms usually fit into one or other of the two great classes of mental health problems derived from statistical surveys. These are, on the one hand, internalising problems where individuals themselves suffer, and on the other, externalising problems where individuals cause suffering to others around them.

One way of approaching these 'life difficulties' on a community scale would be through risk management. This approach would require an understanding of the relative risks of certain types of situations and the potential mental health outcomes. We have some of this knowledge, but it is far from complete and what knowledge we have has been haphazardly acquired and lacks overall synthesis. It may be that one of the tasks of early intervention is to bring some order to the knowledge about human development that resides across many disciplines at the moment.

A second approach to these mental health problems is through the enhancement of individual resilience by improving the capacity of the family or community to facilitate maturation for the child. Again the knowledge in this area is reposed in various disciplines and it seems that there is a lack of a general theory of human development which takes into account the knowledge that is currently scattered among various disciplines. Synthesising this again represents a major task for early interventionists.

The other main group of mental health problems are much less frequent. They are much more severe in their effect. They seem to affect about two percent of the population, that is one in fifty (Zubrick et al., 1995). They represent mental states which are non-productive, persistent and ultimately harmful (Laing, 1971). They include biological brain disturbances for which we are only now at the threshold of understanding their causes and mechanisms and of providing specific treatments. In these severe cases of mental disorders, early intervention approaches are, in our current state of knowledge, probably best directed towards the individual rather than at a group. This form of intervention requires the early identification of the symptoms of the condition in the individual and their early treatment.

If certain conditions can be tied in with prodromal symptoms that indicate a high probability of developing the disorder, then these too can be the targets of individualised early intervention. As well, this opens the possibility for identifying

those who are likely to become seriously ill, without falsely identifying others who would not go on to develop any particular problems. At the moment we are not in this stage for many illnesses, except the most clearly biologically based disturbances associated with some forms of mental retardation and possibly some forms of depressive illness.

Conclusion

Problems of mental health in young people are a considerable burden on the community, both in terms of lost potential and the need for care. Early intervention provides an approach that is aimed at reducing the distress and disability of mental health problems. For the purposes of our projects, we used early intervention to include selective and indicated interventions and case identification, as proposed by Mrazek and Haggerty (1994). In practice, it can be difficult to separate these approaches from approaches that are more universal.

One of the problems facing any early intervention approach is the definition of what constitutes a problem. On the whole, we have recognised that there are mental health problems that affect 20% of young people in the course of a year, but far from all of these are severe and enduring. Nevertheless, they are of concern to the community and contribute to distress and disability.

Our targets for early intervention have therefore gone beyond the low prevalence severe problems to include the more common problems of emotional and behavioural disturbances in young people. This approach means considering children and young people who are at risk of developing mental health problems. Most of the eight model projects described in this book address the issue of children at risk as well as those who are showing signs of a disorder. As will be seen in the following chapters, we have encouraged imaginative approaches to these problems.

In supporting these projects, AusEinet took the view that people currently working in the field would be best placed to manage the projects. We saw our role as changing the culture of the agencies that had declared an interest in early intervention, to better reflect early intervention practice. We were particularly interested in the opportunities that arose from the reorientation process and the barriers to it at the practical level in the field.

Chapter 3

Reorientation

In this chapter, we set the scene for the model projects described in Chapters Four to Twelve. First, we discuss why it is important to build the capacity of an organisation to achieve health gains, outline some strategies which can be used to enhance capacity and address some of the challenges in measuring the extent to which capacity has been built and sustained. Then, we describe how AusEinet prepared the way for reorientation by selecting the host agencies, training the reorientation officers in early intervention and supporting them through the reorientation process.

Building capacity

The concept of 'capacity building' is central to the process of reorientation. While most of the work on 'capacity building' is found in the health promotion literature, the general principles can be applied to early intervention.

The reorientation of services is essentially a process of organisational change (Gray & Casey, 1995). To bring about change, an organisation can build its capacity to achieve clearly specified health gains. Capacity can be built by planning and implementing integrated sets of strategies which span several levels of the organisation (NSW Department of Health, 1998).

The development of 'capacity building' dimensions and indicators is a new and still relatively crude area of research and the term itself is used in different ways in the literature (Hawe, Noort, King & Jordens, 1997). It is sometimes used simply to refer to the capacity of an organisation to build an infrastructure to support particular programs, and other times to the capacity for a program to be sustained after an initial demonstration phase. It can also be used more broadly to refer to enhancing the problem solving capability of individuals, organisations and communities (Hawe, King, Noort et al., 1998). It would seem that all are points on a continuum of capacity building. The first is mostly limited to immediate gains, the second

relates to longer-term maintenance and sustainability, while the third is a higher order outcome in which a community develops generalised skills to tackle a range of health issues.

Given that health organisations often have scarce resources, it makes sense to build mechanisms that have the potential to be sustained in the longer-term (Hawe et al., 1997). Health gains are more likely to be sustained if capacity building strategies involve a range of individuals and groups. These can include key staff within the organisation who are responsible for keeping the health issue on the agenda, as well as senior managers, middle managers and service providers. The strategies should also involve key individuals and groups in other organisations and in the community (Lefebvre, 1992; Gray & Casey, 1995).

Sustainability is also more likely to be achieved if individuals and organisations are encouraged to take responsibility for identifying, planning and implementing their own initiatives. This may involve giving people information, training them to work differently and supporting new practices at the organisational level. In this way, the initiatives can be maintained after the removal of dedicated funding and personnel (Radoslovich & Barnett, 1998). A variety of other strategies have been identified and are outlined in the next section.

Strategies for building and sustaining capacity

The NSW Department of Health (1998) developed a strategic framework for building capacity within an organisation. It was intended to guide health promotion activities, but we believe that it can also be applied to early intervention. The framework delineates three key components for effective capacity building and proposes strategies for each. Capacity can best be sustained by developing integrated sets of strategies across the three components.

Workforce development focuses on improving the skills and knowledge of the staff within the organisation. Strategies can include continuing education, professional development and training opportunities for staff, as well as professional support and supervision. While workforce development is a vital component for building capacity, on its own it is unlikely to bring about sustainable change.

Organisational development focuses on strengthening organisational support for building capacity. Strategies include developing strategic plans and policies, ensuring management support and commitment (e.g. by involving senior managers in steering committees) and developing recognition and reward systems.

Resource allocation is listed as a separate component to organisational development in order to emphasise its importance. The organisation's chances of building capacity are likely to be increased if sufficient financial and human resources and administrative support are made available and if staff have access to information and specialist advice when required.

This framework is useful for planning and assessing capacity building *within a*n organisation. However, it is also important to develop strategies for building capacity *across o*rganisations and within the broader community (Hawe et al., 1998). It would seem fruitful to expand each of the three components to encourage cooperation and collaboration with other organisations e.g. by combining resources to train staff, developing interagency plans and policies and pooling resources to support these endeavours.

The development of ***partnerships and networks***, sometimes called 'healthy alliances', are vital for building and sustaining capacity (Kickbusch, 1997; Nutbeam, 1997; Radoslovich & Barnett, 1998; Hawe et al., 1997; Scriven, 1998). Healthy alliances are driven by the needs of the health agenda and a belief that these are better achieved through joint agency activity (Douglas, 1998). There is ample evidence in the health promotion literature that partnerships between agencies, and with the community, are effective in bringing about health gains (Gillies, 1998).

Partnerships can be informal or formal. Strategies for developing informal partnerships include networking with other organisations, sharing information and working together to develop training programs. Partnerships can be formalised through strategies such as the development of shared plans, agreements and policies. A successful collaboration does not necessarily require that the parties share the same paradigm; they must, however, have a clearly defined common purpose and a shared language (Seaburn, 1996). There are particular challenges for collaborations between community health and mental health services as they may have different

cultures and negative assumptions about each other. It is important to have a commitment between the leaders in both services as well as liaison individuals in each setting to provide a conduit for information and ideas (Seaburn, 1996).

Measuring capacity

Measuring the extent to which capacity has been built and sustained is particularly challenging. Reorientation is a lengthy process and many positive outcomes may not be apparent in the short term. Some modest immediate gains may have great potential to be sustained, while other promising immediate gains may not be sustained in the longer term (Hawe et al., 1997). A long-term commitment of resources is needed to allow changes and results to become evident (Guldan, 1996). In reality, many programs are judged on their immediate outcomes rather than allowed time for their strengths to emerge.

It is important to differentiate between 'output indicators' which can be assessed in the short-term and 'outcomes' which may only be apparent in the much longer term (Hawe et al., 1997). In a relatively short reorientation phase such as ours, it is more realistic to focus on output indicators.

Gray and Casey (1995) identified a range of interrelated measures to determine the success of capacity building strategies within an organisation. These include the commitment of senior management, the allocation of resources, coordination to ensure a solid infrastructure to support initiatives, increased skills across the whole organisation and working with other sectors to achieve sustainable health gains. Funnell and Oldfield (1998) identified output indicators to determine the success of alliances. These include knowledge and attitude change, skill development, policy change and service and environment change.

There are two broad indicators of sustainability (Hawe et al., 1997). The first is the extent to which initiatives and programs have been absorbed into the everyday practice of the organisation, after dedicated funding has ceased. The second indicator is the extent to which initiatives and programs have been adopted by other organisations. Both of these indicators are difficult to measure in the short term. We can make an objective judgement of the potential of the different strategies to be sustained, but longer term outcomes need to be evaluated at follow up.

Developing the reorientation projects

AusEinet funded a variety of model projects in the reorientation of service delivery towards early intervention for the mental health of children and young people. Open tender was considered the most equitable way to award the projects. This was achieved by inviting tenders from agencies that wished to reorient their service but needed assistance to do so. Two hundred and thirty three agencies requested information.

Seventy-nine tenders were received from a diverse range of agencies from around Australia. They included mental health services, family and community services, primary health services, aboriginal services, education departments and support groups. A full description of the tender and selection process is contained in Appendix 1. We aimed to select a range of agencies that reflected the cultural, geographic and functional diversity of service providers across Australia. The agencies had to provide services to a significant number of children or young people in distress, but did not have to be primarily mental health focused.

There were several specific selection criteria. The agencies had to demonstrate an understanding of early intervention in mental health issues and be able to show how it related to their work. It was also important that the staff of the agencies were receptive to the early intervention approach and that the agencies intended to continue to use the approach after the conclusion of the project. At a more practical level, the agencies had to demonstrate that the objectives of the project would be an effective and efficient use of resources and that they had set realistic and achievable timelines to undertake the work.

Model projects were implemented in eight agencies:

- Barrington Support Service, Devonport, Tasmania;
- Lower Great Southern Primary Health Service and Albany District Education Office, Albany, Western Australia;
- Hunter Mental Health Services and Department of Community Services, Newcastle, New South Wales;

- Child and Family Services, Launceston, Tasmania;
- Children of Prisoners' Support Group, Sydney, New South Wales;
- Mildura Aboriginal Corporation, Mildura, Victoria;
- Karawara Community Project, Perth, Western Australia;
- Anglicare CQ, Rockhampton, Central Queensland.

AusEinet provided funds to each agency to employ a part-time reorientation officer from late July 1998 to the end of May 1999. We wanted the reorientation officers to be an integral part of the agency so, rather than assigning officers to them, left the recruitment and appointment to the agencies. In all but three cases, the reorientation officer had previously worked with the agency. The first three of the agencies listed above contributed their own funds to employ the reorientation officer full time, and therefore the projects tended to have broader objectives.

While respecting the diversity of the projects, we were keen to foster a coordinated, team approach with the reorientation officers. The reorientation officers were all experienced in mental health work but varied in their professional backgrounds (e.g. psychology, social work, mental health nursing, education, counselling). For most of them, early intervention and reorientation were new concepts, so it was essential to provide support and guidance as needed. We also wanted to promote a sense of cohesion and common purpose in order to encourage the sharing of ideas and experiences, to provide support against difficulties and to counter the potential problem of geographical distance.

The reorientation officers' task was to implement and evaluate reorientation to early intervention in their agency. We put considerable energy into overseeing, supporting and guiding the reorientation process but did not want to be overly prescriptive about the methods used to achieve objectives. It was important that management and staff saw the objectives of the project as relevant to their own needs and, ultimately, the needs of their clients. Therefore, we adopted a principle throughout of collaboration and cooperation. We believed that reorientation had to be largely self-directed if it was to succeed in the short term and be sustained beyond the timeframe of our funding.

In order to guide reorientation, we outlined some broad objectives that we wanted the reorientation officers to achieve. These objectives were implemented in a variety of ways. The overarching goal of the projects was to implement reorientation strategies that could be maintained after the AusEinet project was completed. The reorientation officers were to work with agency staff to maximise opportunities for and overcome barriers to reorientation and implement a tailored training program to help staff develop knowledge and skills in early intervention. They were to suggest modifications to existing policies and procedures where necessary and promote a collaborative approach to early intervention by establishing and strengthening links with other agencies. A final requirement was to evaluate the outcomes of the project in terms of staff satisfaction and increased knowledge about the mental health of the young people involved with the agency.

We preferred that the reorientation officers did not implement early intervention strategies directly with clients. We wanted them to focus their energies on skilling staff, influencing policy and strengthening links with other agencies, that is, putting the mechanisms for sustainable reorientation firmly in place. Many of the agency staff began applying their new skills immediately. We believe that the next step in reorientation could be a dedicated phase in which the trained staff implement early intervention strategies with their clients, evaluate their usefulness and revise them as appropriate.

Preparing reorientation officers for their early intervention tasks

The reorientation officers met for the first time in Sydney in July 1998. The reorientation training session was scheduled to coincide with an AusEinet workshop/seminar and the Third National Child and Adolescent Mental Health Services Conference. This allowed the reorientation officers to meet with each other and AusEinet staff over a period of several days, use the environment of the conference to consolidate and expand their understanding of early intervention and make contact with others working in the field of young people's mental health. They all met again at the end of the projects to present their outcomes at the AusEinet International Conference on Early Intervention in Adelaide in June 1999. This gave a good sense of closure to the process.

The training session was an essential first step in providing the reorientation officers with the skills to begin the reorientation process in their agencies. The overall objective of the session was to clarify the role of the reorientation officer and to place the reorientation projects within the context of the AusEinet project as a whole. A considerable amount of time was devoted to personal introductions so that the reorientation officers could establish a good rapport and develop a sense of cohesion and common purpose.

Prior to the training session, the reorientation officers received a handbook. It contained an overview of the AusEinet project, a summary of the goals of each of the reorientation projects and a program for the Child and Adolescent Mental Health Services conference, marked to indicate sessions that were relevant to early intervention. It also contained a set of preliminary readings on early intervention, including articles by Kosky and Hardy (1992), Coie, Watt, West et al. (1993), Silverman (1995), and Pless and Stein (1996). Mrazek and Haggerty's (1994) mental health intervention spectrum was included as a key reading in the handbook. The theoretical basis of the spectrum was reviewed during the training session and its practical applications were discussed in relation to AusEinet, other early intervention projects and examples from the workplace. The spectrum was also discussed by several speakers at the AusEinet workshop.

It was important to clarify the role of the reorientation officers in their own projects and in the AusEinet project as a whole. A large part of the session focused on the objectives which the reorientation officers were asked to achieve during their project. As outlined above, they included identifying opportunities for, and barriers to early intervention, implementing strategies for reorientation, assisting staff to develop new skills, establishing or strengthening links with other agencies and evaluating the reorientation process.

Considerable emphasis was placed on documenting the process and outcomes of the project. Documentation was essential for evaluating the viability of the reorientation process and providing information about barriers and opportunities for other agencies wishing to reorient their services. The reorientation officers requested further guidance in evaluating their projects and preparing the progress

report and final report. This was subsequently provided on an individual basis over the telephone and during site visits and on a group basis via teleconferences and the distribution of written materials.

Supporting the projects

Given the number and diversity of the projects, it was imperative to monitor their progress closely. The key objectives in supporting the projects were sharing information on mental health issues, maintaining a sense of cohesion and common purpose, providing information on the formal requirements of the project and developing mechanisms for dealing with problems. Several strategies were implemented to realise these objectives.

The reorientation officers completed informal monthly reports which outlined their objectives for the period, opportunities and barriers to reorientation, evaluation activities, new contacts, significant achievements, information on meetings with steering committees and reference groups and plans for the next period. Several of the reorientation officers commented that the informal reports were valuable as a method of recording the successes and difficulties of the reorientation process that might have been forgotten in hindsight.

AusEinet maintained regular, individual contact with the reorientation officers. The most intensive periods of contact occurred at the beginning of the project, during the development of evaluation questionnaires and prior to the submission dates for the progress and final reports. The reorientation officers reported that they discussed issues and ideas informally amongst themselves. Teleconferences were held at regular intervals throughout the project. These proved to be a valuable means of sharing information, identifying problems and clarifying formal reporting requirements. Given the geographical distances between the reorientation officers, the teleconferences were particularly valuable for maintaining a sense of cohesion.

Site visits were conducted half way through the projects, just before the progress report was due. The senior project officer from AusEinet met with the reorientation officer, the agency supervisor and, where possible, members of the Steering

Committee and Reference Group. The visits were a valuable opportunity to see the process of reorientation in action and to discuss the progress being made towards putting sustainable strategies into place.

The reorientation process took nearly a year to complete. One of the biggest challenges was coping with the vast geographical spread of the projects. Training and support for the reorientation officers required innovative use of modern electronic communications. This aspect adds a new dimension for possibilities for training people across vast areas. With the advent of email, the internet and telepsychiatry, the distances that once hindered communications between professionals and worker in the field no longer present the same difficulties. This has implications not only for national strategies, but also for international communications about project developments in mental health.

Chapter 4

The model projects

Model projects were established in four government agencies and four non-government agencies across Australia. They represented a range of service types and cultures in urban and rural locations. The agencies included a mental health service, two educational services, a primary health unit, an Aboriginal service, several community-based services and state government departments providing family and children's services.

Two of the projects were collaborations between two state government departments. Six of the agencies were regional centres, with either a rural catchment area or a rural-remote catchment area. Only two agencies were located in a capital city; one providing a statewide service and the other providing services to a small, disadvantaged community. The preponderance of rural/regional locations was largely the result of these agencies being able to demonstrate significant unmet mental health needs.

The tendering and selection processes are described in detail in Appendix 1. Some of the agencies that applied to us for funding were already doing good work in early intervention. This applied especially to a number of projects in South Australia, including some assisting mothers and babies, and some innovative work in partnership with young people. Figure 2 shows the locations of the agencies. Table 1 shows a summary of the eight model projects, indicating the location of the agency, the target age groups and mental health issues addressed by the agency and the broad outcomes which each project hoped to achieve.

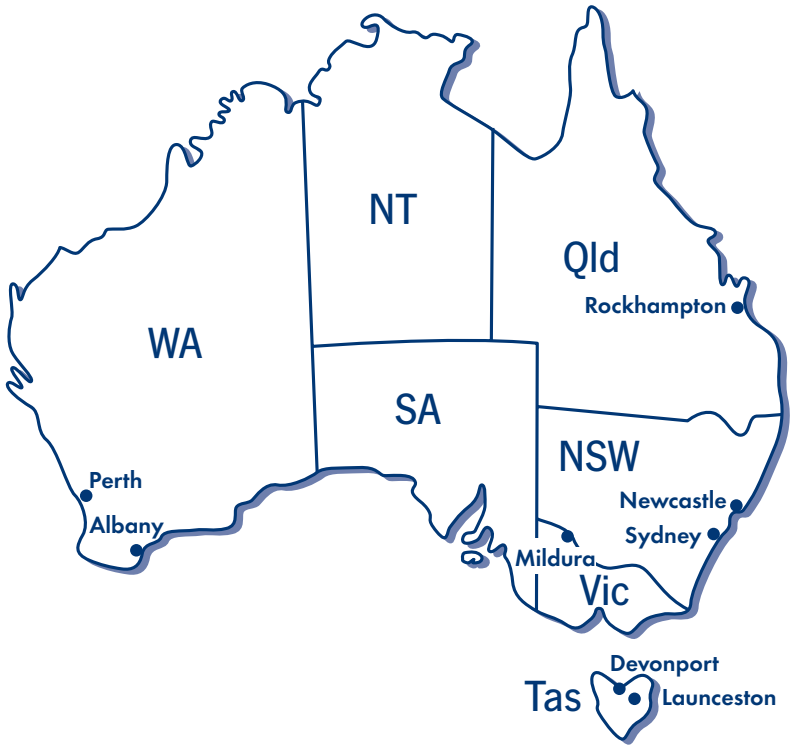

Figure 2. Map of Australia showing the location of the agencies

In the following chapters, we have provided background information about the agencies to help provide a context for the reorientation process. The reorientation strategies used in the projects, and the opportunities for and barriers to reorientation, are described. We have also summarised the strategies which were used to build capacity in the agency (i.e. workforce development, organisational development and resource allocation) and indicated those which are likely to be sustained in the long term without any further funding from AusEinet.

We emphasise that the projects presented in this book have not yet been fully evaluated for their effectiveness. The reorientation officers evaluated staff attitudes and knowledge about early intervention and mental health issues, as well as the process and content of the training sessions. The summaries shown in Appendix 2 are intended to convey the essence of these evaluations. In all cases, there were encouraging signs of effectively achieving their objectives. External evaluators,

Table 1. Summary of the model projects for reorientation to early intervention

Agency name and location	Target age range	Mental health issues addressed by agency	Desired outcomes
Government agencies			
Barrington Support Service Devonport, Tasmania	5 to 18 years	Suicide, attempted suicide and severe psychiatric disorders	More effective ways for teachers and support staff to respond to serious mental health issues
Lower Great Southern Primary Health Service & Albany District Education Office Albany, Western Australia	5 to 18 years	Depression, anxiety and conduct problems	Early intervention training for staff and development of a district wide interagency policy
Hunter Mental Health Services & Department of Community Services Newcastle and the Lake Macquarie area, New South Wales	0 to 10 years	Children at risk because their primary care giver has a mental illness	An effective early intervention approach for maintaining positive family environments and better outcomes for young children at risk
Child and Family Services Launceston and northern area of Tasmania	10 to 18 years	Challenging behaviour among state wards and repeat offenders	Use of early intervention to avoid admission to juvenile detention centres
Non-government agencies			
Children of Prisoners' Support Group Sydney, New South Wales (statewide service)	0 to 18 years	Anxiety, depression, disruptive behaviour in children who have a caregiver in custody	Achievement of a positive impact on the mental health of a specific 'at risk' group
Mildura Aboriginal Corporation Mildura and Sunraysia district, Victoria.	13 to 24 years	Antisocial behaviour, violence, drug and alcohol use and teenage pregnancy among at risk indigenous youth	'From Shame to Pride' used as a culturally acceptable program to address indigenous mental health issues
Karawara Community Project Perth, Western Australia	0 to 18 years	Serious conduct disorders, drug use and emotional problems	Application of early intervention within a small community organisation dealing with a multicultural and socially disadvantaged population
Anglicare CQ Rockhampton, Central Queensland (Regional centres servicing rural and remote areas)	0 to 24 years	Grief, loss and, suicidal behaviour	Application of early intervention to diverse programs across a vast geographical area of Australia

who spoke with the reorientation officers and their agency supervisors on several occasions during the project, also evaluated the projects, again with promising results. Their report is available from the AusEinet website.

Neither of these forms of evaluation conforms to the level of evidence that would result from comparative studies with control groups. The models presented here are case series with pre-test and post-test evaluations. We have recommended to the Early Intervention Working Group that these projects be followed up to assess their long term efficacy. This will require a substantial research effort.

Chapter 5

Early intervention in a school setting

Barrington Support Service - Devonport, Tasmania

About the agency

The Barrington District is located on the north west coast of Tasmania. It covers an area of 3,000 square kilometres and has a population of approximately 56,000 people. Devonport is the largest urban centre and schools are located in the coastal towns and rural hinterland. In 1998 in the Barrington District there were 19 primary schools, 5 high schools, a rural district high school, a secondary college, a special school and an early special education centre, with a total of approximately 9,000 students.

The Barrington Support Service is responsible for coordinating the services of a multi-disciplinary team which is based in the schools. It supports the inclusion of students in their local school, provides resource, teaching and learning support to the schools, as well as professional development programs which address the needs of school communities. It manages the allocation of special education resources, collaborates with the schools to manage specific programs (e.g. behaviour management) and liaises with early special education, government and community agencies.

Support for the project

Funding from AusEinet: $36,300
Funding from other sources: Barrington Support Service contributed additional salary and administration costs.
Project support: A reference group was established, consisting of the Support Services Manager, Senior Guidance Officer and a School Principal.

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Reorientation strategies

The Barrington District is characterised by social disadvantage that can to lead to early vulnerability to mental health problems, yet in north-west Tasmania there are very few mental health practitioners and no child psychiatrists. This project was chosen to see what could be achieved in a school setting in an area where mental health services were meagre. Four primary schools and two secondary schools were involved in the reorientation process. The overall objective of the project was to help teachers and school support staff to develop the skills they needed to identify and address serious mental health issues in students. The main strategies used to achieve this were training the teaching and specialist support staff in mental health and early intervention issues, implementing early intervention programs in the schools and strengthening links with other agencies.

The teaching staff from the four primary schools and two secondary schools attended two training sessions. The first session was an introduction to early intervention in the mental health of young people, with a particular focus on anxiety for the primary school staff and depression for the secondary school staff. The second session focused on strategies which can be used to reduce anxiety, such as relaxation and problem solving.

The specialist support staff participated in several training sessions. In an introductory session, guidance officers and social workers were given an overview of early intervention, an outline of the aims and objectives of the AusEinet project and informed of the specific objectives of the Barrington Support Service project. Further sessions were conducted by a Child and Adolescent Mental Health Services psychiatrist and focused on anxiety, depression and early psychosis. Several of the support staff also attended sessions on obsessive compulsive disorder, trauma and depression, which were conducted by other groups.

In addition to the training sessions, Barrington Support Service and Burnie Child and Adolescent Mental Health Services presented a full day seminar entitled 'Emotional and Behavioural Disorders in Children and Adolescents'. More than 120 teachers, senior staff and support staff from the north and north west Tasmanian education districts attended the seminar. The response was overwhelming and indicated the concern of the professionals in the region for the mental health of the young people in their schools.

The Barrington Support Service team wanted the project to have practical benefits for the young people in their schools. Therefore, they supervised the screening of children in the pilot schools for anxiety and depression. The Reynolds Adolescent Depression Scale was administered in the two secondary schools and the Spence Children's Anxiety Scale was administered in the four primary schools. Students above the respective cut-off points were identified and confirmed by re-testing. Informed parental consent was obtained and interventions were initiated. The FRIENDS program for anxiety (Barrett, Lowry-Webster & Holmes, 1998) was run in three primary schools and the Resourceful Adolescent Program (RAP; Schochet, Whitefield & Holland, 1998) was run in the two secondary schools.

Strengthening links with other agencies in the region was an important part of this project. Barrington Support Service and the Child and Adolescent Mental Health Services held a combined forum to examine effective work practices between the two agencies. The forum resulted in nine recommendations, including organisational and policy changes and the Child and Adolescent Mental Health Services team made a commitment to provide ongoing access and training for Barrington Support Service personnel. A Consultative Committee, which included students with mental health problems and their parents, was also established to assist with the development of the project. The committee met several times over the period of the project and compiled a list of recommendations and strategies for dealing with the mental health problems faced by school children.

Opportunities and barriers

Several opportunities for reorientation were identified. There was a strong commitment to early intervention amongst the Barrington Support Service staff as well as the teachers and specialist support staff in the region. In the absence of formal mental health services, schools were considered a logical place for early intervention. There was ready access to children for observation and intervention and there was potential for mental health issues to be incorporated into the curriculum. All schools in the district were already involved in interagency activities and provided information on mental health to the community via newsletters, parents and friends groups and school councils. Therefore, the foundations for strengthening liaisons were firmly in place. At a broader level, there was an emerging climate

of acceptance of early intervention within the Tasmanian Education Department (for example, the 5th National Health Promoting Schools Conference was held in Tasmania in July 1999).

The main barriers to reorientation were the size of the project and the limited amount of time in which to achieve the objectives. Six pilot schools were too many for one reorientation officer to manage in a one-year period, especially when larger than expected numbers of students were identified in the screening process. Considerably more time than had been planned was devoted to response and intervention. The teachers in the pilot schools showed a strong level of commitment to the project but were already working under considerable pressures; ideally, they needed some form of relief from other duties. Many of the specialist staff were initially reluctant to be involved in the project, but after the training sessions they felt more skilled and confident to take part. The reorientation officer felt at the start of the project that stigma around mental health problems may have been a barrier. However, careful planning and communication seemed to be effective as parents and students were positive about the project.

Building capacity

The strategies developed by the Barrington Support Service to build capacity are summarised in Table 2. Most of the strategies have potential to be sustained without further funding from AusEinet.

Table 2. Reorientation strategies developed by Barrington Support Service

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Training teachers	✔	✔	✔
Training specialist support staff	✔	✔	✔
FRIENDS program in schools	✔	✔	✔
RAP program in schools	✔	✔	✔
Consultative Committee	✔	✔	✔
Position continuing		✔	✔
Curriculum change			✔

There were significant indications of change within the Barrington Support Service and the broader educational district. Workforce development was achieved through training the teaching and specialist support staff to enhance their mental health literacy. There was also clear evidence of organisational development. Senior managers, teaching staff and specialist support staff demonstrated a high level of commitment to the process of reorientation and a readiness to adopt an early intervention principles to enhance the mental health of the young people in their schools.

Informal and formal partnerships were established. The Barrington Support Service involved six pilot schools in the project and several other schools expressed an interest in becoming involved in the future. The Burnie Child and Adolescent Mental Health Service worked with Barrington Support Service staff to provide training during the project and have made a commitment to continue the training in the future.

The foundations were laid for future policy change, as the project prompted an examination of the role of schools in providing services for mental health in young people. For example, one of the high schools will introduce a whole-school approach to the emotional well being of students and discussions are under way to relocate a Child and Adolescent Mental Health Services clinic to a local secondary school. The possibilities for a comprehensive, coordinated early intervention approach to mental health for children and adolescents are being explored at an interdepartmental committee level.

Ongoing resources were allocated to the project. The agency contributed additional funds to employ the reorientation officer on a full basis. The position will continue, the project will be expanded to include other schools within the district and the FRIENDS and RAP programs will continue in the schools. The Consultative Committee will continue and the reorientation officer will be re-employed part time to continue working towards a model of early intervention, with an emphasis on sustaining the strategies developed in the project.

Several additional initiatives will be instigated. Formal transition procedures (eg from primary to secondary school) for students at risk or showing signs of mental health problems will be developed. The viability of incorporating mental

health issues into the school curriculum will be explored and the use of telepsychiatry for supervision and training will be investigated in conjunction with Child and Adolescent Mental Health Services and several local schools and colleges.

Early intervention approaches in the education sector have great potential. We consider that this project provides a useful model for applying early interventions in a school setting. It focused on training staff to be alert for signs of mental health problems and also implemented a screening program for anxiety and depression (two of the problems most commonly seen in young people). It was achieved at low cost and was an effective use of resources. The project has potential to be developed within the pilot schools and applied in other schools.

Chapter 6

A collaboration between health and education departments

Lower Great Southern Primary Health Service and Albany District Education Office - Albany, Western Australia

About the agencies

During 1998/99 the Lower Great Southern Primary Health Service provided public health programs in the South West and Great Southern Regions of Western Australia. These regions have a population of approximately 230,000 people and cover an area half the size of Victoria. The majority of public health staff is based in Albany or Bunbury but provide services throughout the two regions. Public Health Services are delivered in close cooperation with regional health services, Divisions of General Practice, individual general practitioners and local government and non-government agencies. They aim to ensure that regional responses to public health issues are coordinated and collaborative where appropriate, adopt a health outcome approach and are evaluated.

Albany Education District is located in the Great Southern region of Western Australia, with the City of Albany at its southern-most point. The district extends to Walpole in the west, Wellstead in the east and Kojonup to the north. The District Office is located in Albany and provides support to the 27 Education Department schools in the district. The Student Services team is a district shared resource which provides specialist support to government schools within the Albany Education District.

Support for the project

Funding from AusEinet: $36,300
Funding from other sources: The host agencies provided additional salary and administration costs.
Project support: A Planning and Advisory Group and a Steering Committee were established to develop and guide the project.

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Reorientation strategies

This project was chosen because it brought together two influential government departments which were capable of having a substantial positive impact on the mental health of children and young people. While the immediate aim was to develop an interagency policy to enhance service delivery in the Albany district, the project also showed potential for effecting policy change across the entire Great Southern region of Western Australia. The main objective of the project was to realign policies and practices in order to deliver early intervention programs for school-aged children and adolescents. The project was carried out in two phases: policy formation and staff training.

A series of Interagency Managers' Forums was convened, during which a district wide interagency policy and an implementation plan were formulated. Fourteen agencies made a commitment to the policy. All were located within the Lower Great Southern region of Western Australia and several extended across the whole of the Great Southern region. The agencies were:

Aboriginal Affairs Department
Albany Consumers Team
Albany Drug Services Team
Albany Women's Centre
City of Albany
Disability Services Commission
Education Department of Western Australia
Family and Children's Service
Great Southern Division of General Practice
Health Department of Western Australia
Ministry of Justice
Police Department
Southern Aboriginal Corporation
Young House

The Western Australian Minister for Health officially launched the interagency policy in June 1999. Representatives from AusEinet and management and staff from all the agencies attended the launch. The occasion was also used to showcase some of the early intervention initiatives being undertaken in the region.

The agencies agreed to make early intervention a priority in planning within their own organisations and to work in a coordinated manner to reduce the likelihood of overlap or gaps in services. Each will develop a plan to outline their commitment to early intervention for the mental health of young people. The plans will highlight how each agency will link with others to provide the most comprehensive early intervention service possible. Training programs will be jointly funded and protocols for ongoing communication will be developed. The plans will ensure that early intervention becomes, and remains, part of the ongoing planning cycle for each agency.

The project will be replicated in the Central and Upper Great Southern regions, culminating in a policy which will incorporate early intervention as a priority in all major agencies across the entire Great Southern region. The project was brought to the attention of the Director General, Executive Director and Director of Student Services in the Education Department of Western Australia. They are looking towards providing additional funds to determine how such a program could be implemented across the state.

The project brought about a positive shift in the way the agencies thought about the services they provided to the young people of the Albany district and helped them to identify areas where they could enhance or create services. The process of collaboration highlighted that many of the agencies, although not primarily mental health focused, dealt with mental health issues on a regular basis.

The purpose of the staff training was to provide staff with an overview of early intervention as well as specific skills to be able to deal with a variety of mental health issues. Evidence based early intervention strategies were used where available. The training phase expanded considerably to include sessions for all staff of the participating agencies, as well as parallel information sessions for teachers, parents and community members. Staff from the lead agencies and a range of guest speakers conducted the training sessions. Topics included an introduction to early intervention in mental health, youth suicide prevention, depression, anxiety, early psychosis, eating disorders, attention deficit hyperactivity disorder, post natal depression and bereavement. The training sessions will be replicated with the Central Great Southern and the Upper Great Southern Health Services.

The project created a great deal of local interest. The Parents and Citizens Association, the Aboriginal Education Council, local youth workers and school staff asked to have the training sessions repeated in different settings. The local newspaper ran a story about the project and the local radio station interviewed the reorientation officer and several of the guest trainers. The reorientation officer spoke about the project at several conferences, including the 1999 Youth Affairs Conference, the Australian Guidance Counsellors' Association National Conference and The Australian Psychological Society National Conference.

Opportunities and barriers

The reorientation officer and the supervisors from the lead agencies had a strong level of commitment to the project. This was essential, as the task required consistent, ongoing contact with the managers of all the participating agencies. There were many other projects being developed in the Albany region at the same time as the AusEinet project. This created a fertile and stimulating environment and agencies in the region were highly motivated to be involved. Conversely, this caused confusion at times as several of the projects overlapped in their focus.

The main barriers identified by the reorientation officer related to the scope of the project. The project expanded quite considerably as more agencies became involved. While the reorientation officer strongly encouraged the interest in the project, it was difficult to find enough time to complete the expanding list of tasks. It also proved difficult to find suitable times to work with groups of people from the many agencies which were central to the process.

Building capacity

The strategies which were used by the host agencies to build capacity are summarised in Table 3. A key feature of this project was its flexibility to expand to meet the needs of different groups, both in the policy development and the training phases. All of the strategies have potential to be sustained without further funding from AusEinet.

Table 3 Reorientation strategies developed by Lower Great Southern Primary Health Service and Albany District Education Office

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Interagency Managers' Forum	✔	✔	✔
Interagency Working Group	✔	✔	✔
Interagency policy	✔	✔	✔
Individual agency plans	✔	✔	✔
Steering committee	✔	✔	✔
Training sessions	✔	✔	✔

There were many indicators of change in the host agencies and in the other agencies which were involved in the project. Widespread workforce development was achieved through training the staff in all the participating agencies as well as teachers, parents and community members, to enhance their mental health literacy.

There was also evidence of organisational development. Management commitment, policy development and formal partnerships were demonstrated by attendance at the managers' forum and the development of the interagency policy. The interagency working group made a commitment to implement the policy, review and rewrite it annually and seek other opportunities for early intervention activities. Informal networking was also achieved by inviting guest speakers to participate in the training program and through local media coverage of the project.

Ongoing resources were allocated to the project. The agency contributed additional funds and other resources to support the reorientation officer on a full basis. Additional funds were secured from other sources to allow the training program to continue through to the end of 1999 and the current position to continue into 2000.

The agencies will consider a coordinated approach to delivering best practice programs. While the ongoing project will be primarily responsible for highlighting these programs, it will also identify ways to facilitate an interagency approach to training. The reorientation officer also hopes to establish an interagency referral system to better cater for clients with multi-agency input.

Several of the initiatives developed in the project will be adopted by other organisations. Several sources of funding were secured to allow the replication of the project in the Upper Great and the Central Great Southern regions of Western Australia. The interagency policy will be redeveloped, with a greater school orientation, for possible implementation across all education districts in Western Australia.

We found this to be a successful model of interagency collaboration. It brought together a broad range of services, each of which had a commitment to enhancing the mental health of young people, but in which there was previously little intercommunication. The project generated a great deal of interest not only in the Albany district but also across a large region of south Western Australia.

Chapter 7

A collaboration between mental health and community services

Hunter Mental Health Services and NSW Department of Community Services - Newcastle, New South Wales

About the agencies

Two groups of welfare and health care professionals were involved in the reorientation process; child protection workers from the Department of Community Services and community mental health workers from the Lake Macquarie Mental Health Service. The Lake Macquarie City Council local government area has a population of 185,000. The district incorporates the southern suburbs of the city of Newcastle as well as high growth suburbs on the eastern and western shores of Lake Macquarie.

The Lake Macquarie Mental Health Service is part of Hunter Mental Health Service and provides community mental health services in the local government area. It delivers a comprehensive array of in-patient, community and specialist programs and is staffed by a clinical director who is a psychiatrist, a service manager, a psychologist, a psychiatric registrar and sixteen caseworkers who are either registered nurses, psychologists, social workers or occupational therapists.

Department of Community Services child protection services in the district are provided by Charlestown and Toronto Community Service Centres which together have a staff of twenty district officers, two child protection casework specialists, a clinical psychologist, four supervising assistant managers and a manager for each centre.

Support for the project

Funding from AusEinet: $36,300
Funding from other sources: Department of Community Services provided additional salary and training costs and Hunter Child and Youth Mental Health Service provided supervision and administration costs
Project support: The project was jointly sponsored and supported by the two departments

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Reorientation strategies

This project was chosen because it presented an opportunity for two agencies to work together towards the common goal of providing better services for children whose primary carer has a mental illness. A systematic interagency approach had been lacking because the two agencies have different cultures, histories, professional backgrounds and a limited understanding of each other's legislative base, policies and programs. The pilot project sought to reorient child protection casework and community mental health clinical intervention into a collaborative program in which knowledge, skills and resources were shared between agencies. This was achieved by training staff, developing interdepartmental protocols and implementing conjoint field placements.

A major objective of the project was to train staff in a broad range of early intervention issues. These included an overview of adult and paediatric mental illnesses, the effects of parental mental illness on parenting capacity and family functioning, methods for enhancing resilience in children in affected families, recognising child maltreatment and intervening to protect children and principles of child protection casework using a risk assessment model.

Sixteen staff from Lake Macquarie Mental Health Service attended a one hour introductory session on early intervention. This was followed by a full day workshop entitled "Playing Your Part: A Child Protection Training Package for Health Workers" (developed by Education Centre Against Violence for the NSW Department of Health). The content of the workshop included definitions of child maltreatment, indicators of abuse and neglect and the nature of abuse (including offender tactics, parenting issues and the family milieu). In a second three hour training session, mental health staff joined with their Department of Community Services and Family Support Service counterparts for input on child and family mental health issues.

Twenty eight Child Protection Officers and ten Family Support Services staff attended an introductory session on early intervention. This was followed by a three hour session on the spectrum of schizophrenic disorders and related personality disorders. A final three hour session focused on the structure of the Lake Macquarie Mental Health Service, aspects of the laws governing mental health and an overview of the symptoms of major depressive disorders in children and young people.

On completion of the training, the Community Services Centres, the Family Support Service Centres and Lake Macquarie Mental Health Service were each provided with a tailored resource folder containing articles, policy statements and chapters from monographs relevant to the needs of the respective agencies.

Another reorientation strategy was the development of interdepartmental protocols. Formal protocols were developed to facilitate collaborative casework between the Department of Community Services and the Hunter Mental Health Service through a Memorandum of Understanding. The protocols delineated the basis on which case coordination between the agencies would occur, criteria for the referral of clients to the program and the respective casework responsibilities of the two agencies.

The implementation of conjoint field placements was a major achievement of the project. Child Protection Officers each spent two days on placement with the Lakes Mental Health Team and the Lakes Mental Health workers spent two days on placement in Toronto and Charlestown Community Services Centres. The reorientation officer outlined the host agency's organisational structure, policies and clinical casework programs. Each participant was then 'buddied up' with a worker to accompany them on home visits to observe casework with clients.

The placements allowed staff from Department of Community Services and the Lake Macquarie Mental Health Service to establish rapport and working relationships, observe everyday procedures in each other's agency and gain insight into the need for interagency collaboration. Throughout the three months of the placement process, there were numerous instances of conjoint assessments and cooperative case planning. The foundation was laid for ongoing collaboration between the Department of Community Services' Charlestown and Toronto child protection teams and Lake Macquarie Mental Health Service.

Opportunities and barriers

There were several opportunities for reorientation. The reorientation officer had an extensive knowledge of the policies and procedures of both of the agencies and was therefore able to facilitate the training program, the field placements and the formal agreement. Staff from both of the agencies were enthusiastic about the project and

keen to participate in the conjoint field placement program. At a broader level, the Hunter Mental Health Service already had a reputation for innovative services and programs (e.g. a Court Liaison Service, an Adolescent Services Team and a Centralised Intake System). The Department of Community Services had instituted a "Change and Reform Program" which incorporated new policies, systems and procedures, and several statewide initiatives based on a whole of government approach to child protection were starting to produce better client outcomes.

The main barriers to reorientation arose from misunderstandings about the role of the other agency. The Hunter Mental Health Service staff devoted considerable effort and skill to engage adult clients in a trusting therapeutic relationship, so tended to be very protective of them. Some of them notified abuse and neglect reluctantly, as they perceived it to be a betrayal of trust. The Department of Community Services staff were initially sceptical about developing working relationships with other services and felt that another set of policies and procedures would have to be incorporated into an already overloaded system.

Building capacity

The strategies which were used to build capacity in the agencies are summarised in Table 4. The key achievement of this project was the success of the interagency collaboration, as evidenced by the formal partnership agreement and the conjoint field placements. All of the strategies have potential to be sustained without further funding from AusEinet.

Table 4. Reorientation strategies developed by Hunter Mental Health Services and New South Wales Department of Community Services

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Staff training	✔	✔	✔
Resource folders	✔	✔	✔
Protocols	✔	✔	✔
Conjoint field placements	✔	✔	✔
Formal partnership agreement	✔	✔	✔
Pilot program		✔	✔

Workforce development was achieved by providing tailored resource folders and conducting intensive training sessions for the staff in both of the agencies. Presenting information about the other agency's policies and practices was an effective strategy for correcting misconceptions and preparing the way for the subsequent conjoint field placements.

The supervised field placements contributed to both workforce development and organisational development. They provided the opportunity to acquire new skills and at the same time to develop informal partnerships with staff in the other agency. Management from the lead agencies demonstrated a high level of commitment to the project by providing additional resources to employ the reorientation on a full time basis, allowing staff to take part in the field placements and by formalising the collaboration through a memorandum of understanding.

The project will be sustained with funding from other sources. A pilot program to be conducted in the Lake Macquarie local government area will be fully funded for a period of six months by the Department of Community Services. A district mental health officer will be the primary caseworker for approximately twenty families in which children are affected by parental mental illness. A conjoint casework approach will be used to identify at risk children and a family casework approach will be used to promote medium to long-term involvement with the families.

The collaboration between the Department of Community Services and the Hunter Mental Health Service will continue through the formal memorandum of understanding and the protocols for the conjoint casework. The program will be articulated to a wide range of health, welfare and education agencies in order to provide families with individualised, comprehensive services. If successful, the program may be expanded to include the inner suburbs of Newcastle, which are considered to be areas of high need.

We consider that this is a good model for aligning the work practices of two services with formal, traditional structures, in which there are different philosophical bases. The conjoint placement scheme is a good model for informing staff of the workings of other agencies. It requires commitment from managers and staff and a substantial coordination effort, but is likely to yield benefits. The initiatives have a high probability of being sustained.

Chapter 8

Early intervention for children with challenging behaviours

Child and Family Services - Launceston, Tasmania

About the agency

Child and Family Services provides protection services to children and young people who have been or are at risk of harm and maltreatment or neglect. In 1996-97, approximately 800 notifications were received. Of these 650 were classified as being 'child and family concern' and a further 150 cases were classified as 'child harm and maltreatment'. In the same period, Child and Family Services worked with 800 women and approximately 1500 children who were victims of domestic violence. While many of these children needed help to address the problems they were facing, there were no mental health services in the Northern Tasmanian region specifically to assist them.

Child and Family Services currently provides case management services to over 100 wards of the State, most of who have been subjected to neglect or physical abuse or sexual abuse. The department estimates that approximately one third of these children have significant mental health problems including suicidal tendencies, anorexia and bulimia, self-mutilation, and extreme antisocial behaviour including violence towards self and others. In 1996-97, the Youth Justice Services in the area worked with over 150 young people charged with offending. Many of these offenders had been subjected to maltreatment or neglect. A significant number had mental health related problems.

Support for the project

Funding from AusEinet: $33,053
Funding from other sources: None
Project support: A Reference Group was established to support the project.

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Reorientation strategies

This project was chosen because it provided an opportunity to intervene in antisocial behaviours developing on a trajectory to detention and to therefore avoid a lengthy, more costly and frequently less successful rehabilitation after the offending behaviours became established. The overall objective of the project was to assist staff to address the needs of children and young people with challenging behaviours. This was achieved by training staff in mental health and early intervention issues, compiling information on early intervention resources and mapping local services for young people and their families.

In the first training session, staff were given an overview of issues in mental health and early intervention. In three subsequent sessions, they received information on anger management, anxiety and depression. These were identified in a pre-project survey to be the issues about which the staff most wanted information. Information packages were developed as an ongoing resource. They contained materials from the training sessions, resources for parents and information on good practice in early intervention.

The main product of the project was the preparation of a map of services for young people in the Launceston area. These included aboriginal, migrant, health, drug and alcohol, sexual assault and student support services. The services were grouped to indicate those most relevant for problems faced by children, adolescents and parents.

Service providers were consulted throughout the process of compiling the map and were given progress updates via feedback sheets, newsletters and information sharing forums. The map was initially compiled for Child and Family Services staff but was subsequently made available to all service providers in the community sector in the region. The staff from Child and Family Services and other local agencies reported that the map was an invaluable resource.

A Reference Group with representatives from Child and Family Services, Department of Education, Community and Cultural Development, Oakrise Child and Adolescent Mental Health Service, and Family, Child and Youth Health was

formed to support the project. An Umbrella Group was subsequently formed to sustain the momentum of the project and to further develop strategies for early intervention in mental health. It had representation from several agencies in Launceston, including Oakrise Child and Adolescent Mental Health Service, Anglicare, Centrelink, Family Resource Centre and Child and Family Health. Members of the Umbrella Group made a commitment to continue promoting early intervention by involving senior management, creating protocols for early intervention referrals and providing ongoing training opportunities.

Opportunities and barriers

The staff at Child and Family Services were eager to gain new skills and staff from several other agencies in the area were keen to be involved in the reorientation process. Members of the Reference Group made a commitment to establish an Umbrella Group to continue promoting early intervention for the mental health of young people. The reorientation officer was new to the agency but had extensive contacts in other local mental health services. This local knowledge helped when developing informal partnerships and compiling the Service Map.

There were also barriers to reorientation. The staff had very heavy workloads, which left little time to attend workshops, forums and meetings. In order to involve as many staff as possible, it was necessary to repeat the training sessions three times. Communication difficulties were sometimes encountered, as service providers from different agencies used diverse language in their everyday work.

Building capacity

The strategies developed by Child and Family Services to build capacity are summarised in Table 5. The main focus of the project was to enhance the mental health literacy of the staff and identify appropriate avenues for referral. Most of the strategies have potential to be sustained without further funding from AusEinet.

Table 5. Reorientation strategies developed by Child and Family Services

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Training sessions	✔	✔	✔
Information packages	✔	✔	✔
Networking	✔	✔	✔
Service Map	✔	✔	✔
Umbrella Group	✔	✔	✔
Reference Group	✔		

There was evidence of workforce development through the training of staff in early intervention approaches to the mental health, the compilation of the Service Map and the development of information packages. The first two of these strategies also helped to strengthen informal partnerships as they involved staff from other agencies.

Organisational development was achieved through the multiagency membership of the Reference Group and the Umbrella Group. Oakrise Child and Adolescent Mental Health Service has undertaken to provide six monthly training sessions for Child and Family Services staff. The Service Map will continue to be a valuable reference for the staff and management of all agencies in the area. The position will not continue in the immediate future, but the umbrella group will sustain the momentum and develop reorientation strategies further.

This project aimed to provide staff with the skills to recognise the complex set of mental health problems in young people with challenging behaviours. We consider that the strategy of enhancing the mental health literacy of staff, rather than focusing directly on clients, was realistic in this setting.

Chapter 9

Children with a parent in prison

Children of Prisoners' Support Group - Sydney, New South Wales

About the agency

Children of Prisoners' Support Group is a state-wide, non-government organisation located outside the gates of the Silverwater Correctional Complex. It provides a range of support services and advocacy for children and young people with imprisoned parents. It works to promote a whole-of-community understanding of the shared responsibility of ensuring that the rights of the children are upheld. The organisation is committed in its efforts to work in a supportive and collaborative manner with other government and non-government agencies and to focus on the best interests of children and young people (birth to 18 years of age) at all times.

The organisation assists children from approximately five hundred families per year. It provides a range of direct services to children of prisoners, outside carers and imprisoned parents. These include support groups for children, young people and carers, casework for children of imprisoned parents and their families, pre and post release service for families, transport to take children to visit an imprisoned parent, and the 'Maintaining the Family Unit' project.

Support for the project

Funding from AusEinet: $26,472
Funding from other sources: None
Project support: The project was supported by the Executive Officer and the Management Committee.

Contact information

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Reorientation strategies

For children and young people with a parent in prison, the emotional effects of separation alone can include anger, depression, grief, confusion and fear. Changes in practical circumstances can result in sudden changes in parenting arrangements, financial hardship, new schools and homes and separation from siblings. Children and young people can experience aggression and behaviour problems, lack of trust, defiance of authority and low self-esteem. This agency was chosen to be part of the AusEinet project because it was a grassroots self-help organisation whose staff were in a position to identify young people at risk of developing mental health problems, but did not have any formal training in mental health issues. The overall objective of the project was to inform staff and volunteers about the mental health issues often experienced by children who have a caregiver on remand or in custody. This was achieved by training staff, networking with other services, formulating an early intervention policy and developing a referral list.

Training sessions were attended by staff, volunteers and transport workers from Children of Prisoners' Support Group, as well as staff from Department of Community Services, Barnardos, Anglicare, CRC Justice Support and Prison Welfare. Guest speakers were invited to speak on a broad range of topics which were relevant to the needs of the children who used the service. The topics included an overview of early intervention, attention deficit hyperactivity disorder, anxiety, marijuana use, depression, sexual abuse, psychosis and postnatal depression.

Extensive networking with other services, in particular mental health services, provided an opportunity to develop referral links and resulted in greater community awareness about children of imprisoned parents and the Children of Prisoners' Support Group itself. The reorientation officer achieved further networking by attending and presenting at meetings and conferences. A great deal of informal networking took place between the people who attended the training sessions.

A Steering Committee was formed with representation from Children of Prisoners' Support Group, Mulawa Welfare, Life After Prison Ministries (Anglicare), CRC Justice Support, Department of Community Services, Corrections Health Service and Department of Corrective Services.

A 'Mental Health Early Intervention Policy' was designed specifically to minimise the psychological and emotional impacts of having a parent in prison. The focus of the policy was the identification of early signs of mental health problems and strategies for effective referral and support. The objectives of the policy were linked with the objectives of NSW Health. Strategies were outlined for applying an early intervention approach at Children of Prisoners' Support Group. The policy has the potential to guide the agency in considering mental health issues in all areas of its service delivery.

A resource manual was compiled from information sheets from NSW Health, NSW Mental Health Information Service and from guest speakers and also included the mental health intervention policy. A referral list was compiled to provide details of appropriate referral services, particularly within the Western Sydney Area Health Service.

Opportunities and barriers

There were opportunities for the reorientation officer to make use of extensive contacts in the mental health field to improve links with other services and develop referral strategies. Several support groups and programs were already in place within the agency, so the reorientation officer was able to work with these groups to increase their knowledge and skills in early intervention.

Several barriers were identified. Ongoing funding constraints within the organisation made it difficult to employ staff with appropriate levels of skill or experience. Positions tended to be limited term or part-time, making it difficult to make long-term plans. Volunteers played an important role in the organisation, but relying too much on their services was problematic. The reorientation officer felt that staff needed to be clearer about their own roles within the agency and about the function of the other organisations with which they collaborated. A more general barrier was that access to mental health services can be difficult for the client population, as they tend to be diverse, transient, stigmatised and poorly educated.

Building capacity

The strategies developed by Children of Prisoners' Support Group to build capacity are summarised in Table 6. Most of the strategies have potential to be sustained without further funding from AusEinet.

Table 6. Reorientation strategies developed by Children of Prisoners' Support Group

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Staff training	✔	✔	
Links with other agencies	✔	✔	✔
Manual and referral list	✔	✔	✔
Mental health policy	✔	✔	✔
Steering Committee	✔	✔	✔
Creation of new position			✔

Workforce development was achieved by developing a training program for staff and volunteers, to enhance their mental health literacy and assist them to identify young people in need. There were also indicators of organisational development. Management was supportive of the project and a Steering Committee was established to oversee continued training and partnership development.

Informal partnerships were developed throughout the project. As well as agency staff and volunteers, staff from other agencies and a range of guest speakers were invited to participate in the training program. This was an important strategy for extending networks and developing referral mechanisms. Early intervention principles were incorporated into Children of Prisoners' Support Group procedures via the mental health early intervention policy.

An outline for a future reorientation officer position was developed and, if funding can be secured, it will focus on promotion and prevention, fostering partnerships with other services, and direct services to the client population. The work towards reorientation will be sustained by the Steering Committee. Further training sessions will be arranged every three months in order to maintain the networks developed during the project. The committee will also consider the impact of physical health

issues on the mental health of the children and young people who use their service, with a view to providing information services to inmates and their families.

We consider that this project was a realistic approach to early intervention for a special group of children who are at risk of developing mental health problems. The agency itself does not have the resources to provide mental health services directly to the children. Instead, staff and volunteers of the agency have been skilled to identify potential problems and to refer to other services where appropriate.

Chapter 10

A culturally determined training program

Mildura Aboriginal Corporation - Mildura, Victoria

About the agency

Mildura Aboriginal Corporation is a non-government agency that was established in Mildura, Victoria approximately twelve years ago. It provides services to the Aboriginal Community in the Sunraysia District, and transient Aboriginal people from other areas. The immediate service area of Mildura Aboriginal Corporation has a population of approximately 3000 people (in New South Wales and Victoria) which increases by up to 800 people during periods of seasonal work in the district.

The local service area covers the Victorian population centres of Mildura, Red Cliffs, Irymple, Merbein, and the New South Wales centres of Dareton, Gol Gol, and Wentworth. The corporation is also part of a larger service area provider as a member of the Murray River Corporations who are incorporated under the North West Cultural Heritage Aboriginal Incorporation Committee. Its service area includes the population centres of Robinvale, Swan Hill, and Echuca in Victoria.

The corporation provides a range of services to Aboriginal families, sole parents, elderly and young people. They include Health Services, Welfare Service, Family Group Home, 'Warrakoo' Life Skills Rehabilitation Program, Women's Program, Cultural Heritage Awareness Program, Supported Accommodation Assistance Program and Community Justice Program.

Support for the project

Funding from AusEinet: $10,500
Funding from other sources: Additional funds were provided by the Koori Women's and Children's Health Unit of the Department of Health and Human Services.
Project support: The North Mallee Mental Health Network and the local Welfare Reference Group already existed to support local initiatives and liaise between programs.

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Reorientation strategies

The most enduring problems experienced by the indigenous community are 'mental health' related, yet non-indigenous mental health workers typically have a very limited understanding of indigenous cultural issues. People in the local Aboriginal community have believed for some time that the criteria used to diagnose mental disorders, particularly those that fall short of the major psychotic illnesses, are not sufficiently sensitive to the local indigenous culture. People who would be regarded by the community as stressed or distressed are classified in clinics as mentally disordered and this often results in inappropriate treatment and social ostracism. Mildura Aboriginal Corporation believed it was time to reframe the issue of distress among the community in terms of 'mental wellbeing'. The objective of the project was to develop a training program which would enhance the skills of staff and ultimately empower children and young people to cope with the social problems they face every day.

Mildura Aboriginal Corporation contracted Commonground Training Resources to conduct a series of workshops, originally called 'Spiritual Healing' but subsequently changed to 'From Shame to Pride'. Commonground had already delivered culturally appropriate programs to other indigenous communities in Bendigo, Echuca and Shepparton in Victoria.

Eight participants completed four intensive workshops, each of three days duration over a ten month period. Seven of the participants were from the local indigenous community (including staff from Mildura Aboriginal Corporation, Murray Valley Aboriginal Co-operative in Robinvale and Swan Hill Aboriginal Co-operative). There was one non-indigenous participant from the Juvenile Justice Unit of Human Services Victoria.

The content of the workshops was determined by the needs of the community and the participants. The most pressing needs identified by the community were anger management, conflict resolution, family counselling and family mediation. The participants requested training in the assessment and support of young people and skills to deal with young people presenting with violent or challenging behaviours. Grief, suicide, racism and drug and alcohol issues were also explored during the course of the program.

A key feature of the program was its flexibility to allow other issues to be addressed as they arose. The content and process remained relevant throughout the entire program because they were always group directed. The workshops were a blend of structured presentation and open discussion. Issues were explored through a range of techniques such as role play, meditation, sharing of stories, and the discussion of real life scenarios. The participants immediately used their new skills in their everyday work. All were very enthusiastic about the workshops and indicated that they would like further training using this model.

The participants felt very strongly that any future training programs should be 'owned' by them as an indigenous group. They wanted training programs to be tailored to the needs of the group, to be 'hands on' and practical (with a minimal emphasis on academic performance) and conducted in small groups over a number of short training periods (preferably a maximum of two days per session). One of the participants believed the training should include indigenous people only.

The group demonstrated a high level of commitment to the program right through to the final session. Previous training programs undertaken by the Mildura Aboriginal Corporation (and many other indigenous organisations) had an anticipated attendance of 40% for the first day, and 10% for the second day. Very few programs would be attempted over a three day period. The 'From Shame to Pride' program appears to have overcome the problem of attrition by providing an interesting and culturally appropriate program which allowed the participants to develop skills, confidence and self esteem.

The Mildura Aboriginal Corporation wanted other service providers in the district to know that they were developing an alternative training program that would enhance the range of service available to the Community and fill a gap in service provision. Promotion of the program is ongoing through the Northern Mallee Mental Health Network and Mildura Aboriginal Corporation hopes to develop a culturally relevant and appropriate training method for their community using a 'train the trainer' model.

Opportunities and barriers

The participants and the broader community were positive about the program from its inception. The participants were fully committed to the program throughout (whereas previous training programs at Mildura Aboriginal Corporation had very high attrition rates). The program provided staff with invaluable skills and confidence and gave Mildura Aboriginal Corporation a successful model for future training programs.

Only two barriers were identified. Funding for the program was limited and the workshops required a commitment of three days on three occasions and therefore the participants had to take considerable time out from work and family.

Building capacity

The strategies developed by Mildura Aboriginal Corporation to build capacity are summarised in Table 7. The strategies were driven by a concern to make a positive impact on the young people in the community and most have potential to be sustained without further funding from AusEinet.

Table 7. Reorientation strategies developed by Mildura Aboriginal Corporation

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Increased staff skills	✔	✔	✔
Workshops	✔	✔	✔
Networking	✔	✔	✔
Effective training model	✔	✔	✔
Further funding			✔

Workforce development in the form of staff training was the key feature of the project. In conjunction with the workshop presenters to identify the needs of the community. The intensive training program seems to have been successful in enhancing the skills of the staff in the participating agencies to identify and respond to young people in need.

There were also indicators of organisational development. Management commitment was demonstrated by the allocation of resources to the project and the willingness to release staff from other duties to attend the intensive workshop program. Informal partnerships were strengthened through inviting indigenous and non-indigenous staff from other sectors to participate in the training program and through networking to promote the program to other agencies. There was significant uptake of the training program within the organisation and signs of interest from other groups.

The project was an effective use of resources and achieved impressive results within a short timeframe and with limited funds. The agency has made a commitment to run one more workshop for staff and community members who were unable to participate in the initial sessions. Additional funding has been sought to develop the program further. Mildura Aboriginal Corporation has identified the needs of its community and is negotiating further funding to implement alternative methods of caring for young indigenous people. It believes it has found a culturally appropriate model of care.

We consider that this project can be viewed as a culturally appropriate, alternative model for this specific community. The strength of the project was the consultation with the community to find an appropriate training program and the flexibility to respond to the ongoing needs of the participants. It is an example of what can be achieved within an indigenous community but, given their heterogeneity, should not be viewed as a model which can necessarily be replicated in other communities.

Chapter 11

A multicultural community project

Karawara Community Project - Perth, Western Australia

About the agency

Karawara Community Project is a non-government community agency situated in the last large housing development in Perth. This community has a large indigenous population and a transient population of migrant people, many of whom have recently arrived from places where they have experienced war or privation. The Karawara district has a high level of poverty and many families and individuals who struggle against disadvantage. Many of the young people who make use of Karawara Community Project facilities are reluctant to use the public system because of previous bad experiences, cultural and language barriers and suspicion of authority.

Karawara Community Project is run by a committee of community representatives and has a staff of about 16 people, many of whom are part time or volunteer. It provides services such as The Fun Factory (a supervised adventure construction playground, mainly for children of primary school age), a drop-in youth counselling service, a variety of clubs (e.g. Young Women's Club and Young Boy's Club), a drug counselling service and a family liaison worker.

Other agencies and groups make use of Karawara Community Project facilities when working with their consumer groups. For example, various Aboriginal organisations work with Karawara Community Project to improve service delivery. Karawara Community Project also has links with the Disability Services Commission, Family and Children's Services, Aboriginal Medical Service, Clontarf Aboriginal College, Marmooditj Aboriginal Service and Lady Gowrie Community Centre for mothers and infants.

Support for the project

Funding from AusEinet: $36,235
Funding from other sources: None
Project support: A sub-committee was established to support the project.

Contact information

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Reorientation strategies

Karawara Community Project was chosen because it was a community-based organisation working in an area of severe disadvantage with a multicultural population. Karawara Community Project had developed a safe haven in which children and families could develop better interpersonal and social skills. Through this project, Karawara Community Project hoped to enrich their work by concentrating on mental health issues. They sought to raising awareness of early intervention, extend networks and provide training in early intervention to staff and volunteers.

Raising awareness of early intervention was achieved through presentations to the staff at the Karawara Community Project, the Rotary Club and the Western Australian Welfare Association and site visits to other agencies. Informal partnerships were strengthened with Disability Services Commission, Family and Children's Services, Aboriginal Medical Service, Clontarf Aboriginal College, Marmooditj Aboriginal Service and Lady Gowrie Community Centre and a new link was established with a local high school.

A Steering Committee was formed to support the project and facilitate the spread of information through the network. It had representatives from Juvenile Justice, Community Health (including the Bentley Mental Health Unit) Education Department, Family and Children's Services, Southcare, Lady Gowrie Community House, Uniting Church, Youth Affairs Council and Karawara Community Project.

Education on early intervention was targeted at managers of other agencies via a 'Policy and Management Seminar'. Guest speakers presented information about mental health and early intervention with young people as well as practical networking skills. This was followed by a discussion of current practice, early intervention programs and strategies for accessing funds and developing special interest groups. The seminar was instrumental in expanding the network.

A training kit entitled 'Early Intervention Assessment Schedule for Young People' (EiASY-P) was developed for staff and volunteers with no formal mental health training. It was designed to guide the recognition of young people who might be at risk of developing, or already displayed signs of, mental health problems. It was not a diagnostic tool.

The kit was presented to staff and volunteers through a two and a half hour training session. The kit contained background information on early intervention in mental health and an assessment proforma covering normal development, psychosocial problems, internalising/externalising disorders and psychotic disorders. It also contained information on what to do after assessment (e.g. monitoring, referral and emergency response). The Western Australian Minister for Health launched the kit in June 1999.

Opportunities and barriers

There were several opportunities for reorientation. Management and staff at the Karawara Community Project were enthusiastic about the project and had a firm belief in the benefits of early intervention for the young people who used their service. The reorientation officer was able to build on existing links with other agencies in the area, particularly when interest in the EiASY-P kit began to develop.

The lack of resources in this small community organisation was the main barrier. A great deal of time was needed to organise meetings and events and this was difficult for a part-time worker with little administrative support. The time frame of the project proved to be limiting as most of the time was spent raising awareness and building the momentum of the project. The staff's knowledge of mental health and early intervention increased, but there were limited avenues for referral. The response from other agencies and organisations was initially disappointing, probably due to already heavy workloads. As a backdrop to these difficulties, the suburb of Karawara is to be redeveloped, so Karawara Community Project will need to be re-established in a new location.

Building capacity

The strategies developed by Karawara Community Project to build capacity are summarised in Table 8. Changes made during the project were incorporated into the daily structure of the agency and most of the strategies have potential to be sustained without further funding from AusEinet.

Table 8. Reorientation strategies developed by Karawara Community Project

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Increased awareness	✔	✔	✔
Networking	✔	✔	✔
Staff training (EiASY-P)	✔	✔	✔
Management seminar	✔	✔	
Position continuing		✔	✔

Workforce development was achieved by training staff and volunteers in the use of the EiASY-P kit and by educating managers from other agencies. Raising awareness of early intervention and mental health was a challenge for the project. Awareness was slow at the beginning of the project but there was a high level of interest from other agencies once the EiASY-P kit had been launched and promoted.

There were indicators of organisational development in Karawara Community Project, and in other agencies, through the involvement of the managers in the policy and management seminar. Informal partnerships were strengthened with other agencies through the training sessions and have potential to develop further as the training in the EiASY-P kit continues.

The project was conducted under challenging circumstances. There were limited financial resources and other administrative supports for the project. Karawara Community Project will be allocating more funds to allow the reorientation officer to continue the reorientation process by incorporating early intervention into a clinical role and other funds have been secured to develop the EiASY-P kit.

We consider that this project has a valuable lesson for what can be achieved in a small community setting with limited resources, i.e. that reorientation needs time to develop. Interest in the project, outside the host agency, was initially slow but gathered momentum and credibility when the EiASY-P kit was developed.

Chapter 12

A rural and remote welfare organisation

Anglicare CQ - Rockhampton, Central Queensland

About the agency

Anglicare (formerly Careforce) was established in 1983 as a non-government family welfare agency auspiced under the Anglican Church. The agency provides individual and group support and intervention services for families at risk of social disintegration and family breakdown. Since 1989, Anglicare has established a network of centres and services in Central Queensland, covering a geographical region of 600,000 square kilometres with approximately 250,000 residents. Anglicare has centres in Rockhampton, Mt Morgan, Capricorn Coast, Gladstone, Biloela, Moura, Blackwater, Emerald, Barcaldine, Longreach and Winton.

In 1998, approximately 55 Anglicare staff provided a range of services across Central Queensland. These included rural and isolated accommodation services, family and adolescent counselling and support services, foster care provider services, childcare services, youth information and referral services, mental health information and referral services, Aboriginal welfare and mental health community development.

Support for the project

Funding from AusEinet: $32,873
Funding from other sources: None
Project support: A small Reference Group was established.

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Reorientation strategies

This agency was chosen because it was part of a large, stable non-government organisation with a rural and remote focus. It afforded an opportunity to determine whether reorientation to early intervention could be achieved across a vast geographical area. The overall objective of the project was to reorient Anglicare staff and key personnel in other agencies to an early intervention approach to mental health. This was achieved by training staff and developing training manuals and an information kit.

A two stage training program was developed through consultation with the Child and Youth Mental Health Service, Rockhampton District Mental Health Service, Central Queensland University and the Rural Health Training Unit. Gladstone, Biloela, Rockhampton, Longreach and Emerald were selected for the first stage of training.

The participants were assisted to develop an awareness of their role in mental health and to develop an understanding of early intervention. The session covered information on mental illness, early intervention and the identification of early warning signs in young people. The participants identified depression, anxiety and suicide as the most pressing issues for further training and these became the key focus for the next stage of training.

The second stage of training was presented in two regional locations (Gladstone and Rockhampton). The aim was to build upon the skills and knowledge developed in the first stage, with particular emphasis on responding to depression, anxiety and suicide. Techniques used in the training session included intensive small group discussions of each of these mental health issues, large group discussion to clarify facts and in-depth analysis using case scenarios.

Training manuals were developed for both stages of the training program and provided a detailed record for future use. An information kit was designed to assist workers to understand and respond to young people with mental health problems. The kit contained information sheets on a range of disorders, service brochures and a list of resources and internet sites.

Opportunities and barriers

The main opportunity for reorientation was the enthusiasm of staff to be involved in the reorientation process. There was also a high level of support from management and the Reference Group.

There were several barriers. Staff initially perceived that mental health issues were not directly connected to their work, but this perception changed after they had completed the training course. Some remote workers were unable to attend training sessions because of the distance involved in travelling to the regional centres. As the reorientation officer was employed only half time and resources were limited, appropriate training for foster care and disability care providers could not be developed.

Building capacity

The strategies developed by Anglicare CQ to build capacity are summarised in Table 9. The project had a clear focus on improving mental health literacy of the many staff who have contact with young people. Most of the strategies developed in the project have potential to be sustained without further funding from AusEinet.

Table 9. Reorientation strategies developed by Anglicare CQ

Strategies	Immediate gains	Continuing outcomes	Sustainability beyond AusEinet
Staff training	✔	✔	✔
Training manuals	✔	✔	✔
Information kit	✔	✔	✔
Networking	✔	✔	✔
Reference group	✔	✔	✔
Ongoing position	✔	✔	✔

Workforce development was achieved across a large geographical region through the training sessions and the subsequent development of the manuals and information kit. It may be possible to offer training in the future to foster care providers, disability care providers and generic service providers across Central Queensland. Management

commitment was indicated by the formation of the reference group to guide the project, the ongoing efforts of the working groups to review policies and procedures and the allocation of resources towards the ongoing position.

We consider that this was an appropriate model for reorienting services in a large organisation spanning a vast geographical area. The project was realistically limited to improving the mental health literacy of staff who have contact with young people.

Chapter 13

Discussion

It has been difficult to convey the enthusiasm and energy of the reorientation officers, the agency managers, staff and volunteers who participated in the reorientation process as well as others who have become part of the early intervention network. This was the first time that this type of project had been attempted in the area of early intervention. Some very rich information has been gathered from the reorientation projects and from the other parts of the AusEinet project, especially the early intervention seminars, the national stocktakes and the good practice projects.

Over the course of two years, we have had contact with thousands of people in Australia who are concerned about the mental health of young people. Early intervention seemed to make sense to a lot of people. It provided a shared language for people from different disciplines and with different interests. We were struck by their enthusiasm and overwhelmed by the demand for information on how to put early intervention into practice.

Seventy-nine agencies submitted tenders for the reorientation process. Their projects covered a wide range of innovative strategies in early intervention. The eight projects we have described here cover a broad range of mental health issues, but represent just a sample of possible early intervention approaches. We are conscious that we have not included projects that address issues in homelessness, drug and alcohol problems, gender-based difficulties, children in residential care and many other contemporary issues impinging on the mental health of young people.

The tender brief suggested that mental health services, primary health care providers, service providers with a non-mental health focus (e.g. education, juvenile justice, family and community services) and community based, non-government organisations (e.g. family and youth services) dealing with children and young people in distress, might apply. Our two national stocktakes of prevention and early

intervention programs (Davis et al., 1998, 1999) indicate that many attempts are being made across Australia to address wide ranging concerns about the mental health of young people. We refer the reader to the AusEinet publications listed in Chapter One to get an overview of the extent of the burgeoning possibilities of early intervention in Australia.

Commonalities

We consider that the projects we have described have certain elements in common. They shared a sense of being at the edge of the developments in the provision of mental health services to young people. There was an excitement generated by this knowledge which transcended the different styles and objectives of the agencies and which brought the reorientation workers together. We think the projects can be replicated and, in doing so, more considered evaluations of their effectiveness could be developed. The projects have been well documented by the groups involved and they have been highly accountable to their parent organisations and to AusEinet.

The projects all took an ecological view of mental health, that is, they all considered the real life circumstances of the young person. All have attempted to link with other human services in the public and private sector and thereby to diminish the barriers to access that are sometimes encountered by people in the early stages of mental health problems. All of the projects are multidisciplinary in approach and expertise, and they have involved close collaborations between the mental health disciplines. Clear targets and objectives have helped this collaboration.

This overall approach seems to us to contrast with most traditional styles of mental health service delivery, which often seem to be developed in isolation. We think that the way forward in mental health service delivery may be through the development of exciting partnerships with the many people who are concerned about children and young people. We do recognise that curative, personal treatment approaches and rehabilitation would continue to play an important role.

There were also differences between the agencies that participated in the reorientation process. The larger agencies, supported by government departments (e.g. the Hunter Mental Health and Department of Community Services collaboration), or non-

government organisations (e.g. Anglicare CQ), were able to provide more infrastructure support for the reorientation officer, and most of them contributed additional funds to employ the reorientation officer on a full time basis. The smaller agencies (e.g Children of Prisoners' Support Group) typically could not provide this extra support and the reorientation officer was usually employed just over half time.

The projects which were conducted in the larger, government agencies typically had a broader range of objectives than did those in the smaller, non-government agencies. This is not to denigrate the achievements of the smaller projects; we believe that the scope of each project represented a realistic appraisal of what could be achieved with the resources available to the agency. It is worth noting, however, that most of the projects achieved more than was originally envisaged.

Opportunities and barriers

The most commonly identified opportunity for reorientation was the positive commitment of the managers and staff of the agencies. Some of the reorientation officers in the non-government agencies saw the opportunity to increase the skill levels of staff as an essential component of the reorientation process. Several of the reorientation officers in the government agencies felt that they were able to capitalise upon a burgeoning climate of acceptance of early intervention in their region. Overall, the reorientation officers in the government agencies identified more opportunities than those in the non-government agencies.

We consider that there were many other opportunities for reorientation to an early intervention approach. The early intervention approach may give professionals who are enthusiastic and knowledgable about the mental health of young people the opportunity to be innovative in their approach to clinical work. The early intervention approach also has the potential to involve consumers and carers in the development, running and evaluation of projects. In doing so, some practical matters relating to access could be addressed (e.g. transportation and childcare, cultural sensitivity and language barriers).

The early intervention approach tends to include people who are sometimes overlooked, for example the families of people who have a mental illness or children who have a parent in prison. The approach may present an opportunity to define

more clearly what target areas are important in the public health approach to mental health. The early intervention approach may also play a role in destigmatising mental health problems. This could be achieved by incorporating mental health issues into ordinary community services (e.g., Karawara Community Project has early intervention programs housed together with childcare and playgroup facilities).

There were opportunities to strengthen links with other agencies and groups, for example by departments working together to achieve commonly agreed objectives and to develop protocols with wide acceptance. There were indications of public support for the projects and some of the models (e.g. the Primary Health and Education Department collaboration in Albany) have already been taken up by other groups.

There is potential to replicate and extend the projects, and to develop better forms of evaluation which could, for example, more fully address the needs of consumers and carers. Evaluations of this type have the potential to produce accountable programs which, in turn, could give administrators flexibility in their service delivery, (e.g. by moving scarce resources to programs in which effectiveness can be demonstrated).

The biggest barrier to reorientation was the heavy workloads of mental health professionals in the host agency and in the other collaborating agencies. Despite these being discreet projects, it seemed that it was often impossible to prevent the demands on the staff's time and attention coming from many other sources. Several of the reorientation officers found that some staff were initially reluctant to be involved in the reorientation projects because of their already heavy workloads. Generally, the reluctance was short-lived; as staff became involved in the training they tended to become enthusiastic about the project and prioritised their time to enable greater involvement in the project.

The reorientation officers also commented on the demands of their own workloads. Most felt that they had insufficient time in which to achieve the objectives of the project. Several of the reorientation officers in the non-government agencies especially found their workload demanding because they were generally employed on a part-time basis. Most commented that they thought that the resources devoted to the project by the organisation were insufficient. Some of those in the government agencies felt

that as the projects became more widely known in the community, there was a strong tendency for greater demands to be put on the project staff.

Not all these demands could be met, which sometimes was a source of frustration to the agency staff and irritation to consumers and carers who felt their particular needs might be overlooked. One of the difficulties that we faced was that our central aim was to train staff and not to provide direct clinical services. However, when knowledge of the early intervention objectives of the projects became known throughout the community, often through newspaper, radio and television, unrealistic expectations were inadvertently developed. For instance, the early intervention approach was given national publicity following AusEinet's international conference on early intervention in Adelaide in June 1999, at which all the reorientation officers presented their projects. There were media reports, including a feature article in a popular national weekly magazine (Bagnall, 1999).

To the extent that this type of positive publicity helped our aims, it was welcome. But, it was also somewhat unexpected and we had not made allowance for the fact that the early intervention approach would be so widely seen as timely and appropriate. We acknowledge that in the context of the interest that developed, our selection of a small number of projects as demonstration models seems limited. At the beginning of the AusEinet project, however, it seemed that we were being adventurous.

Building capacity

The time frame for bringing about reorientation was limited to less than one year. We had to be realistic about the amount of change that could be achieved in that time. Hence, we asked the reorientation officers to focus on the important first steps in reorientation. These included changing attitudes and developing skills, incorporating early intervention principles into agency plans and policies, and developing informal and formal partnerships with other agencies.

An overview of the model projects, including a summary of the strategies used by each of the agencies to build capacity, is shown in Table 10. The summary of strategies follows the framework developed by the NSW Department of Health (1998) which was outlined in Chapter Three.

Table 10. Summary of the strategies used by each agency to build capacity

Agency name and location	Mental health issues addressed by agency (target age range)	Desired outcomes	Reorientation strategies		
			Workforce development	Organisational development	Resource allocation
Government agencies					
Barrington Support Service Devonport, Tasmania	Suicide, attempted suicide and severe psychiatric disorders (5 to 18 years)	More effective ways for teachers and support staff to respond to serious mental health issues	Staff training	Policy development Formal partnerships	Position to continue (in modified form)
Lower Great Southern Primary Health Service & Albany District Education Office Albany, Western Australia	Depression, anxiety and conduct problems (5 to 18 years)	EI training for staff and development of a district wide interagency policy	Staff training	Policy development Formal partnerships Agency plans	Position to continue
Hunter Mental Health Services & Department of Community Services Newcastle and the Lake Macquarie area, New South Wales	Children at risk because their primary care giver has a mental illness (0 to 10 years)	An effective EI approach for maintaining positive family environments and better outcomes for young children at risk	Staff training Resource folder Conjoint placements	Policy development Formal partnerships	Position to continue (in modified form)
Child and Family Services Launceston and northern area of Tasmania	Challenging behaviour among state wards and repeat offenders (10 to 18 years)	Use of EI to avoid admission to juvenile detention centres	Staff training Service map	Informal partnerships developed through Umbrella Group	Position will not continue in immediate future

Table 10 (continued)

Non-government agencies

Children of Prisoners' Support Group Sydney, New South Wales (statewide service)	Anxiety, depression, disruptive behaviour in children who have a caregiver in custody (0 to 18 years)	Achievement of a positive impact on the mental health of a specific 'at risk' group	Staff training Training manual Referral list	Policy development Informal partnerships developed through Steering Committee	Funding sought for position to continue
Mildura Aboriginal Corporation Mildura and Sunraysia district, Victoria	Antisocial behaviour, violence, drug and alcohol use, teenage pregnancy among at risk indigenous youth (13 to 24 years)	'From Shame to Pride' workshop developed as a culturally acceptable program to address indigenous mental health issues	Staff training Training manual	Informal partnerships through networking Commitment to further training	Funding sought for further training sessions
Karawara Community Project Perth, Western Australia	Serious conduct disorders, drug use and emotional problems (0 to 18 years)	Application of EI within a small community organisation dealing with a multicultural and socially disadvantaged population	Staff training Management seminar Training kit	Informal partnerships developed through policy and management seminar	Position to continue (in modified form)
Anglicare CQ Rockhampton, Central Queensland (Regional centres servicing rural and remote areas)	Grief, loss and, suicidal behaviour (0 to 24 years)	Application of EI to diverse programs across a vast geographical area of Australia	Staff training Training manual	Informal partnerships Potential policy development	Position to continue

All agencies made ***workforce development***, in the form of staff training and development, the foundation of their reorientation process. As most of the agencies were not primarily mental health focused, enhancing the mental health literacy of staff was a vital first step in reorientation. The smaller agencies in particular were less likely to have staff with the qualifications needed to conduct early interventions directly with young people. These projects more realistically aimed to inform staff about the mental health issues faced by the young people who used their service, gave them the skills to recognise risk factors and early warning signs and established procedures for appropriate referral.

For most of the projects, a record of the training program and a resource package were prepared. These should be valuable reference sources for staff and a useful guide for future training programs. Several of the projects also prepared practical documents for future use in the agency, including referral procedures (e.g. Children of Prisoners' Support Group and Karawara Community Project) and a map of local services for young people (Child and Family Services).

All of the projects showed evidence of ***organisational development*** in the form of management commitment, informal partnerships, formal partnerships and policy development. Management support was demonstrated by the formation of steering committees (e.g. Children of Prisoners' Support Group) and reference groups (e.g. Anglicare CQ) to guide the progress of the projects and the formation of an umbrella group to continue the work in early intervention (Child and Family Services).

The development of partnerships was one of the most successful aspects of the projects. All of the agencies successfully established ***informal partnerships*** with others in the local area. The training sessions were an important strategy for developing informal partnerships and networks (aside from their primary function of skilling staff). Most of the agencies included guest speakers and staff from other agencies in their training programs, thereby establishing new networks or strengthening existing ones. Some of the smaller agencies (e.g. Children of Prisoners' Support Group and Karawara Community Project) found this had the added benefit of raising their profile in the community. Some of the agencies (e.g. Mildura Aboriginal Corporation and

the Primary Health and Education Department collaboration) actively sought to promote their projects by informing the broader community about the initiatives they were developing.

Several of the projects developed successful ***formal partnerships***. Two of the larger projects were collaborations between influential agencies. Both had the resources to allow the projects to expand beyond their original scope. For example, the Primary Health and Education Department collaboration in Albany expanded to include more agencies in the interagency agreement than had originally been planned and several other groups were included in the training program. The Hunter Mental Health and Department of Community Services project was able to cement its collaboration by developing the conjoint field placement program. This was an unplanned initiative, but became one of most significant achievements of the project. Barrington Support Service also developed partnerships with its six pilot schools and was flexible enough to be able to respond to the unexpected number of young people identified in the screenings for anxiety or depression.

Policy development occurred within individual agencies as well as between agencies. The two collaborative projects (Primary Health and Education Department; Hunter Mental Health and Department of Community Services) formalised their working relationships and future directions by developing interagency agreements and policies. Children of Prisoners' Support Group developed an early intervention policy outlining referral and support mechanisms and two other agencies developed recommendations for incorporating early intervention into new policies (Barrington Support Service and Anglicare).

All of the agencies ***allocated resources*** to the projects and several of the larger agencies contributed additional funds to employ the reorientation officer full time. After our funding phase had finished, most of the agencies had allocated funds to maintain the reorientation position. Several of the agencies will continue the position in much the same form so that training programs can be completed or replicated (e.g. Barrington Support Service and the Primary Health and Education Department collaboration). Others will modify the position to take the reorientation process in a new direction, such as combining staff training with direct intervention work with

young people (e.g. the Hunter Mental Health and Department of Community Services collaboration and Karawara Community Project).

In summary, there were many indicators of change within the agencies, including the commitment of management and staff, the allocation of resources and the skilling of staff in early intervention approaches to mental health. There were also indicators of successful alliances, including informal networking, formal partnerships and policy development. Follow up measurement will be required to see if these strategies for reorientation can be sustained.

Lessons learned from the reorientation process

A key lesson we learned from the reorientation process was that there was a great deal of interest in early intervention from the staff, managers and volunteers in the agencies. All of the projects expanded beyond their original objectives and the larger projects, in particular, grew in response to the enthusiasm of all those involved. It was important to allow room for expansion to capture the enthusiasm.

A number of people working in the host agencies had already developed initiatives to address mental health problems in a pragmatic way. During the training sessions, some realised that they already were unwittingly using early intervention approaches. They found the confirmation of their work reassuring and the location of the initiatives within an early intervention framework helped to provide a theoretical basis for what they were doing.

It was important to assign dedicated personnel for the reorientation process. In all cases, one key person (the reorientation officer) was assigned to implement the reorientation strategies. Though they were busy on this project, the reorientation officers had few other competing demands on their time. For interagency collaborations to succeed, it was also necessary to identify key contact people in the other agencies who were committed to the reorientation process.

In several cases, the reorientation officers were new to the agency, so it was important to allow them time to become familiar with policies and procedures and to meet

with managers and staff. For all the reorientation officers, it was necessary to allow time to develop their own knowledge of and skills in early intervention. While all had backgrounds in mental health, they had to develop their knowledge of early intervention as the project developed.

Training the reorientation officers was a vital first step in the reorientation process. When the projects first began, there were limited sources of information available about early intervention. It was necessary for us to provide a starting point for the reorientation officers and to keep them informed at various intervals along the way. The reorientation officers also contributed to this process by sharing information sources they had located themselves.

Staff training was the foundation of all the projects. In all cases, the reorientation officers worked with the agency managers and supervisors to identify the training needs of the staff. They did not impose their own ideas about what training was needed. In this way, the training was appropriately tailored to suit the needs of the staff and ultimately the needs of the young people who used the service. It was also necessary to cater for the different skill levels of staff and volunteers in the agencies. Some of the projects opted to run separate training sessions for different groups (e.g. volunteers, teachers and parents).

Scheduling the training sessions to promote maximum attendance proved to be difficult in some cases. In some of the agencies it was necessary to run repeat sessions, as competing commitments made it difficult for all of the staff to attend at the same time. Where limited time could be spared for training, it was vital to give priority to the mental health issues which were most often seen in the agency. Most of the agencies secured funding to continue the reorientation process. Their training programs will be developed by either focusing on other mental health issues or looking at the issues covered in the pilot phase in greater depth.

Most of the reorientation officers chose not to conduct all of the training session themselves. By inviting guest speakers to the sessions, some of the smaller agencies were able to raise their own profile in the community. By inviting staff from other agencies to attend the training sessions, the reorientation officers were able to

promote the project and at the same establish new informal partnerships or strengthen existing ones.

One of the common features of the projects was their aim to involve consumers and carers in the development of their models and in the evaluations. Two of the projects (Children of Prisoners' Support Group and Karawara Community Project) already had an established consumer involvement through their volunteer networks. Other projects needed to develop this aspect. This was hard to do. First of all, there were constraints on the capacity of consumers and carers to participate. Many had busy and demanding lives on a day-to-day basis and found consistent attendance at meetings to be difficult. They were mostly expected to participate in an unpaid capacity and rarely were they even offered transport costs. Most agencies did not provide childcare facilities or means of supervising a family if a parent wanted to participate.

These are issues which we should have considered in the early stages of supporting the projects and for which we should have provided within the project budgets. They are also issues which the agencies themselves should have considered in their applications to AusEinet. We have learned that we cannot assume that issues of time, childcare and transport for consumers and carers have been adequately addressed in developing early intervention programs. This inadequacy is a reflection of a broader recognition of the problems for consumers and carers in participating in mental health service policy and strategies. This matter is currently being addressed in the National Mental Health Strategy and forms one of the most important planks in the platform of mental health reform in Australia (Australian Health Ministers, 1998).

It was also found that even when consumers and carers could find the time to participate, they often felt that they did not have the skills to work effectively in the committee forum, in order to influence the policy-making. They needed skills in the rules and protocols of committees, in framing agenda items and speaking to them, and in learning how to extract from other views those issues which they think are relevant to their own. Although there are guidelines to help the consumers and carers through the committee experience (e.g., National Community Advisory

Group, 1995a; Consumer Health Forum of Australia, 1999), we consider that these are probably insufficient in themselves. Probably most consumers need practice models of learning. There might be an important role for higher education centres such as universities and TAFE to collaborate with consumers and carers to develop this training (National Community Advisory Group, 1995b; Deakin Human Services, 1999).

Evaluating process and output indicators was a challenge for some of the projects. Most of the agencies and reorientation officers had limited experience in evaluation. It may have been beneficial for us to have identified a key person within the agency to advise on evaluation, or to have allowed funds to employ the services of an evaluation consultant. Evaluation needs to be considered from the outset, as it is vital for determining the success of the process, setting future directions and securing funding. It is necessary to identify the types of outcomes to be measured and put in place mechanisms for conducting follow up measurement.

Strategies for sustaining the achievements of the model projects were discussed with the reorientation officers at the initial training session and reinforced throughout the management phase of the project. Most of the reorientation officers left detailed records of the strategies developed throughout the process (e.g. final reports, training manuals, resource folders and referral lists). Strategies used to enhance sustainability included establishing umbrella groups, developing new or modifying existing early intervention policies and replicating the project in other regions. Securing additional funding was a key sustainability strategy and it was important to seek the additional funds well before the pilot phase was completed to ensure continuity of the process. We agree with Roberts (1996, p.19), in his book which identified model programs in child and family mental health in the United States, that the documentation of utility and efficacy will be the key to sustaining program initiatives; in our case, the reorientation of services for children and young people to an early intervention approach.

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Appendix 1

Selection of agencies

Call for tenders

Open tender was considered to be the most equitable way to award the reorientation projects. Therefore, a tender brief was prepared to provide the necessary information and selection criteria. To ensure that the process was widely accessible, a number of strategies were implemented including a mailout to all members of the AusEinet network, specific targeting of likely agencies by phone and mail and an advertisement in the national press. AusEinet received 233 requests for tender briefs.

Tenders received

Seventy-nine tenders were received. The tenders represented a broad range of agencies from every Australian state and territory, as shown in the tables below.

Table A1. Tenders received by type of organisation

Type of agency	Number
Child and Adolescent Mental Health Services	8
Other Mental Health Services	18
Family, Community or Youth Services	24
Primary Health Services	11
Aboriginal Services	4
State Education Departments/Schools	6
University Departments	3
Support Groups	2
Juvenile Justice	2
Other (AIDS Council)	1
Total	**79**

Table A2. Tenders received by each Australian state and territory

Location*	n	Location*	n
VIC Capital city	15	NSW Capital city	12
VIC Rural/remote	3	NSW Rural/remote	4
VIC Regional Centre	5	NSW Regional Centre	1
VIC Total	**23**	**NSW Total**	**17**
QLD Capital city	6	SA Capital city	8
QLD Rural/remote	1	SA Rural/remote	3
QLD Regional Centre	5	SA Regional Centre	1
QLD Total	**12**	**SA Total**	**12**
WA Capital city	4	TAS Capital city	1
WA Rural/remote	0	TAS Rural/remote	1
WA Regional Centre	5	TAS Regional Centre	1
WA Total	**9**	**TAS Total**	**3**
ACT Total	**2**	**NT Total**	**1**
		TOTAL	**79**

* Several services located in regional centres also covered rural and remote areas and several of the capital city services were statewide services.

Selection criteria

Specific criteria

The selection criteria were listed in the tender brief and required that the agency was able to demonstrate:

- a basic understanding of the concept of early intervention in mental health issues and be able to show how that would relate to the work of the agency;
- that they provided services to a significant number of children and/or young people in distress;
- that staff of the agency would be receptive to trying a new approach (ie, developing an early intervention approach);
- that the agency intended to continue to use early intervention approaches after the conclusion of the project;

- realistic and achievable timelines to undertake the work; and
- that, within the context of the agency, the project would be an effective and efficient use of resources.

General criteria

Further to these criteria, AusEinet desired to select the types of agencies that reflected the cultural, geographic and functional diversity of service providers across Australia, namely:

- an indigenous-orientated service;
- a traditional CAMHS or community mental health service;
- a NGO family/youth service or juvenile justice service;
- a consumer or carer organisation;
- a traditional hospital based service or University service; and
- an educational service.

In addition the team sought:

- a fair rural/urban distribution and no more than one service in each State and Territory if possible;
- services selected to be representative of gender; and
- services selected to be sensitive to cultural aspects.

Selection process

There were several steps in the selection process:

- The project consultant summarised each tender and assigned a rating of A (high), B or C (low) against the selection criteria outlined in the tender brief.
- The AusEinet team (Professor Robert Kosky, Associate Professor Graham Martin, Ms Anne O'Hanlon, Ms Cathy Davis and Ms Pauline Dundas) considered all tenders which were rated A or B. Each tender in the A group was then independently rated by each person in three categories:

- meets selection criteria
- originality
- practicality.

- These scores were then averaged and ranked to arrive at the eight top tenders.
- The shortlisted tenders were also checked against the general selection criteria to ensure diversity in terms of the types of agencies, target groups and issues to be addressed and that there was a balance between urban, rural and remote locations.
- A 'reserve list' of six agencies was formed in case any of the first eight did not proceed to the contractual stage.

The Early Intervention Working Group and the AusEinet National Reference Group were sent information about selection process. The information package included the tender brief, a full list of the agencies which applied for funding and information about the shortlisted and the reserve list agencies. The shortlisted agencies were approved.

Confirmation of suitability

The eight shortlisted agencies were advised of their success and negotiations commenced with each one to clarify aspects of their proposal, including the key tasks, budget, timeline and evaluation plan. This necessitated a revision of tenders.

In order to be successful in obtaining funds, the shortlisted agencies had to then meet the following criteria (confirmed by a site visit):

- the selected service should be a bona fide incorporated body able to properly account for the project funding;
- where possible community organisations should be linked or affiliated with established government, non government, hospital or higher education services/ institutions;
- the selected service should be able to demonstrate quality assurance mechanisms, evaluation mechanisms and the capacity to report progress and outcomes;

- the selected service should have an appropriate industrial relations policy and the capacity to meet industrial requirements;
- the selected service should be able to demonstrate the capacity to evaluate outcomes of the project;
- the selected service should have a commitment to early intervention and the tenets of AusEinet.

All shortlisted agencies met the above requirements and subsequently signed a Memorandum of Agreement specifying the obligations of both parties.

Appendix 2
Evaluations

The reorientation officers evaluated staff attitudes and knowledge about early intervention in the mental health issues seen in their everyday work. They also asked staff to evaluate the process and content of the training sessions. Summaries are shown here to convey the essence of the results of the evaluations.

Barrington Support Services, Devonport, Tasmania

Pre and post project questionnaire

A competence and confidence questionnaire was administered to all teaching staff. They were asked to rate their understanding of mental health issues and early intervention, attitudes to students with metal health problems and knowledge of depression or anxiety. There was a positive pre to post shift on all items.

Competence and confidence for support staff was evaluated by a questionnaire addressing current skills and experience, perceived training needs, knowledge, competence and confidence in a range of mental health problems. There appeared to be a positive shift in knowledge of anxiety, depression and psychosis from pre to post evaluation.

Training sessions

The training sessions for teachers were well received in all schools. Following the five initial sessions, teachers requested more training, and following the second session in two schools, requested still further training. Most teachers and support staff found the sessions relevant and well presented and reported they had acquired new knowledge or skills.

"Emotional and Behavioural Disorders in Children and Adolescents" seminar

All participants wished to be involved in further seminars on mental health. Most thought the session was well presented and relevant to their work context and reported that they had acquired new knowledge and skills.

FRIENDS and Resourceful Adolescents Program (RAP) evaluations

Extensive evaluations of the FRIENDS (Barrett et al., 1998) program were conducted with participants, parents and school personnel, and further evaluations are in process. The results were too extensive to report here, but the program was clearly well received by all involved. There was preliminary evidence of decreases in anxiety for almost all participants. Evaluation of RAP (Schochet et al., 1998) is incomplete, however participants so far rated the program as both enjoyable and useful.

Lower Great Southern Primary Health Service and Albany District Education Office, Albany, Western Australia

Pre project evaluation

Knowledge, skills and understanding of the mental health issues covered in the training sessions were assessed by questionnaire at the start of the project. Post project data to assess changes in knowledge and skills will be collected on completion of the training program. Pretest results across all the agencies indicated relatively low scores for skills, knowledge and confidence in the mental health issues. This was expected given that most of the respondents were not mental health workers and had no formal training in the area. However, individual scores varied dramatically. This possibly reflected the likelihood of some individuals needing to know the information as part of their work.

Training sessions

Evaluations were available for two staff training sessions (overview of early intervention and anxiety). Other evaluations will be available on completion of the training program. For each of the sessions, participants identified the opportunity to network as a particular strength. For the introductory early intervention session,

the most useful aspects were identified as information about the AusEinet project and the agencies involved in the interagency policy. Participants also appreciated the overview of programs being used by other agencies. For the anxiety session, participants identified the most interesting and useful aspects as information on definition, incidence, risk factors and treatment as well as practical information on preventive strategies.

Interagency Managers' Forum

Agency managers rated the content and presentation of the first forum very positively and considered it essential that forums continue in the future. They felt that such a forum could be an invaluable tool in better coordinating the services provided in this district as well as planning together to look at ways of providing new services. The forum was video taped for future evaluation purposes.

Hunter Mental Health Services and NSW Department of Community Services, Newcastle, New South Wales

Training needs

In order to determine the training needs of staff from the participating agencies a needs analysis was conducted through a comprehensive pre-project survey questionnaire (based upon a questionnaire produced by the Queensland Institute for Schizophrenia Research, and used with their permission). The instrument sought to access attitudes and beliefs concerning early intervention, the origins of mental illness, the causes of child maltreatment, what measures would best assist children and their parents and how collaborative programs can work to the best advantage.

Staff from the agencies knew little about each other's substantive knowledge base. Child Protection Officers had a poor understanding of mental health clinical practice or the legislative, policy and program framework that defined how Lake Macquarie Mental Health Service operated. Similarly, mental health workers had a patchy understanding of child protection theory and the Department of Community Services' legislative base, policies and child protection program.

There was a congruence of attitudes across the agencies on many of the questions dealing with early intervention, the potential effects of parental mental illness on children in affected families, as well as the therapeutic and casework approaches that would enhance parenting capacity, family functioning and resilience in children. For example, respondents generally agreed on the specific factors in the family environment that render children vulnerable to emotional and behavioural disturbance, as well as the sorts of interventions that can be introduced to enhance parenting and build resilience in children.

The overall conclusion was that staff across the agencies had attitudes conducive to good practice in the areas of concern of the project and the task therefore was to enable them to put these attitudes to work through policies and programs that supported proactive collaboration of services.

Training sessions

Mental health staff evaluated the training session very positively overall and commented that a great deal of new information was conveyed and many issues were clarified. Staff were optimistic that there was scope for interventions to have a positive impact, and that the knowledge imparted would enhance clinical work with affected families. Department of Community Services staff found the sessions intrinsically interesting and responses showed that Child Protection Officers and Family Support Services workers found information on mental health very valuable as a significant proportion of their clients are affected by mental illness.

Conjoint field placements

At the conclusion of their conjoint field placement each participant was asked to complete an evaluation. The feedback was positive and respondents commented that they were surprised that the two agencies faced similar challenges in carrying out their work. Most respondents indicated that they would welcome the opportunity to undertake a longer placement (eg. one month) in each other's workplace.

Child and Family Services, Launceston, Tasmania

Pre project evaluation

An extensive pre project evaluation was conducted in order to identify staff's knowledge of mental health issues, existing early intervention practices, barriers to early intervention and strategies for improving interagency links. Respondents identified a variety of early intervention approaches they either used in their own work place or accessed via other services. They felt, however, that there were significant barriers to access, (for example, waiting lists, lack of resources, lack of experienced staff, lack of follow-up care and lack of assistance for parents). They identified several strategies for improving links with related agencies, for example, regular interagency meetings, information about services provided by other agencies, education about the importance of mental health issues, agreement on goals, open communication and sharing of knowledge.

Post project evaluation

Staff opinions were sought on new information and skills acquired during the period of the project as well as the most useful tools for their service delivery. At the conclusion of the project period, responses were still being received. Preliminary results indicated that staff appreciated the opportunity to attend training sessions and access information packages, felt that there had been more interaction between teams. They considered the Service Map to be an invaluable resource.

Training sessions

The training evaluation consisted of four questions on the content of the session and four open-ended questions on knowledge, skills, confidence and interest in further training. Most considered that the training sessions introduced new, relevant and useful material, and that concepts were explained clearly. In response to the open ended questions, most participants indicated that they had acquired new knowledge and skills, and felt more confident in dealing with mental health issues. Ninety five percent were interested in further personal development sessions.

Children of Prisoners' Support Group, Sydney, New South Wales

Pre and post project questionnaire

At the beginning of the project, a mental health knowledge questionnaire was completed by staff and volunteers to assess their knowledge of range of disorders. They were also asked to list the benefits of early intervention, any barriers and opportunities for promoting early intervention within the organisation, and problems they most often saw in children who attend their centre.

At the end of the project, the same staff and volunteers were asked to rate themselves again to ascertain if their new knowledge had been maintained. For each disorder there was an increase in knowledge, particularly in the areas of anxiety, bipolar disorder, conduct disorder, post traumatic stress and psychosis.

Overall project evaluation

The most significant benefits people gained from this project were the opportunities to network with each other and have access to up-to-date information. These benefits assisted with increasing awareness, understanding and knowledge. The most significant change to work practice was the increase in awareness that potentially will impact on the decisions and actions taken by individuals. As mental health issues were rarely addressed prior to the project, increased awareness alone was a significant positive change. Other changes included improved referral procedures and policy revision.

Most of the participants were eager to increase their knowledge and skills by attending further training courses. A suggested improvement for the project was for the position to be full time to allow more time to be spent with staff. This would have been beneficial towards the end of the project, as once staff began to adopt an early intervention approach they sought more assistance.

Mildura Aboriginal Corporation, Mildura, Victoria

Workshops

Video taped interviews were conducted at the conclusion of each of the workshops. The facilitators and supervisor felt that written evaluations were not appropriate. At the conclusion of the first workshop, participants were positive about the content, but gave brief answers. In sharp comparison, at the end of workshop two, they readily identified activities and skills which would be useful in their work. All were very enthusiastic about the program and indicated that they had already used skills from the first workshop in their everyday work. The 'role play' component of the program appears to have been one of the most enduring and successful aspects of the training. All said they would like further training using this model.

Final evaluation

Final evaluation interviews were conducted by a Welfare Studies student from Sunraysia TAFE College in Mildura. Participants were asked about the value of the project in their work and home environment, the degree to which the project covered new and relevant skills, their level of comfort in using the new skills and their desire for further training.

Participants were overwhelmingly positive about the program and all stated that they would attend further training. All the participants reported that they were able to immediately put new skills into practice and this was confirmed by observation. After the first workshop participants renamed the program 'From Shame to Pride' and began to take ownership of it. At this point there was a noticeable positive change in staff work practice and confidence. It is too soon to assess change in the target groups (youth, children and families). However, there has been a marked difference in the way the program participants relate to their client groups and other agencies, and in the relationship between participants and some individuals in the youth target group.

All participants reported that the training gave them a better understanding of how others feel and react and further reported that they used these skills in their work to empower young people to cope with everyday problems. All reported that they

were better able to make assessments of situations both at work and with their family groups. Some staff members have successfully taken control of their own work areas and used their initiative to expand and develop programs. There was also a noticeable confidence in the participants when dealing with allied agency workers and this was shown most dramatically in the request by two participants to undertake work experience placements in another agency. Prior to the training many participants were reluctant to have any relationship with non-indigenous workers in other agencies or attend interagency training and networking sessions.

All the participants felt that the training affirmed that what they had already been doing was 'right'. This has increased their confidence levels and encouraged them to pursue further training in specific skills. Although all the participants agreed that they would like further training, they were reluctant to seek this from formal educational institutions. The consensus within the group was that training programs need to be tailored to their specific needs, to be 'hands on' and practical (with low emphasis on academic performance) and conducted in small groups over a number of short training periods (two day maximum was preferred). One of the participants believed the training should include indigenous people only. All participants felt very strongly that any future training program should be 'owned' by them as an indigenous group.

Karawara Community Project, Perth, Western Australia

EiASY-P kit and training

The training program and the EiASY-P kit evolved over the life of the project and interest in the kit peaked after the launch and management seminar. Consequently training was incomplete at the conclusion of the project. Preliminary results only were available. Karawara Community Project staff considered that the project and kit were useful, had helped Karawara Community Project to be seen as more professional and had improved networking with other agencies.

High school staff evaluations were very positive both in terms of their own learning and its possible use within schools. The community agency staff indicated verbally

that they were positive about the training. The Welfare Workers Association participants all found the training useful for their work and felt that their knowledge of early intervention had increased significantly. All were satisfied with the content and presentation of the training.

Policy and management seminar

The majority of participants rated their prior knowledge as average to high, all felt that their knowledge had increased either slightly or significantly after the session, and all rated the seminar as useful to their work. Most were satisfied with the content and presentation of the seminar. The most positive aspects of the day were identified as the opportunity to network and hear about AusEinet and the practical applications of early intervention.

Anglicare CQ, Rockhampton, Central Queensland

Training sessions

The participants in stage one training rated the process, content and organisation positively. They reported perceived changes in understanding of mental illness and early intervention. They identified future training needs as the development of fact sheets, more information on specific illnesses and skill development in crisis management and counselling.

The stage two training participants rated the process and organisation of the workshop positively and rated the content as relevant to their work. The major strengths of the workshop were identified as its interactive approach, use of role play and the clarity of information well suited to the needs of participants. The majority of participants perceived that there had been some change in their understanding of and skills in dealing with anxiety, depression and suicide.

Pre and post training

Assessment of staff knowledge of mental illness was conducted prior to and on completion of the first stage of training and on completion of the second stage. Staff knowledge increased across the three assessment stages. Before stage one training,

75% of respondents rated their knowledge of mental illness as minimal. On completion of training only 26% rated knowledge as "minimal", and 71% as "average". The increase was maintained on completion of stage two training.

Participants were asked to list three risk factors for the development of a range of mental illnesses. Correct responses increased from pre (53%) to post stage one training (78%). The increase was maintained after stage two training. Participants were also asked to list three indicators of each of three mental health issues: anxiety, depression and suicidal ideation. Correct responses increased for each issue pre stage one training to post stage two training (anxiety 43% to 94%; depression 50% to 76%; suicidal ideation 81% to 94%). Knowledge of suicidal ideation was high to begin with, as staff had received training in suicide awareness and prevention from other sources.


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