Conceptual and Empirical Underpinnings of Community-Based Early Intervention and Prevention in Youth Mental Health

(Includes Selected Bibliography of Relevant Research Literature)

The Evidence Base for:

Early Intervention & Systems Design in Youth Mental Health
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(Includes Annotated Bibliography of Research Literature, p. 17)

Relationship to Jigsaw

The Jigsaw model of service delivery is Headstrong’s response to the challenge of transforming how young people in Ireland access mental health support and attain positive developmental outcomes. Jigsaw brings services and supports together to insure that every young person has one good adult in their life to support them, whatever their level of need. Thus, Jigsaw seeks to: (1) ensure access to youth friendly integrated mental health supports when and where young people need them, (2) build the confidence and capacity of front line workers to directly support young people and to connect them to Jigsaw, and, (3) promote community awareness around youth mental health to enhance understanding of young people and the risk and protective factors that contribute to their mental health and well-being.

The Jigsaw model is aligned with the philosophy underlying the Health Service Executive’s (HSE) Primary Care Strategy, which is defined as “…an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing.” The Primary Care Strategy highlights many of the defining features of the Jigsaw model, including easy access, the need to span a spectrum of activities from mental health promotion to intervention, and the importance of being embedded within communities.

The Jigsaw model offers a service to young people that complements, strengthens, and integrates mental health services and supports currently available within the primary care system. Given that mental health problems are implicated in a great number of primary care consultations (depression is the third most common reason for GP consultation), and that 75% of mental health problems occur prior to age 25 (most emerging during adolescence and young adulthood), investment in youth mental health through a primary care approach makes considerable sense.

Moreover, Jigsaw is a multi-systemic early intervention and prevention model. In this context, it:

- Promotes positive mental health for young people by deploying strategies that target the whole population to enhance strengths, thereby reducing the risk of subsequent negative outcomes (e.g., community-level mental health awareness training);
- Utilizes universal prevention strategies designed to address risk factors in the whole population without attempting to discern which young people are at elevated risk (e.g., anti-stigma media campaigns and youth advocacy);
• Targets groups of young people at risk for developing mental health difficulties through *selective prevention strategies* (e.g., Youth Centred Practice training for front-line providers);
• Provides indicated early intervention/prevention supports and services for young people with mild / emerging mental health difficulties (e.g., brief interventions delivered through the *Jigsaw* Hub).

When fully operational, *Jigsaw* sites can occupy an important space in the community mental health services “landscape”. The programme is not intended to supplant other forms of mental health care and support, but rather to complement and help integrate them. A typical *Jigsaw* project is designed to have capacity to provide direct support for about 6% of a community’s youth population aged 12-25 years, but reaches a far greater number indirectly through capacity-building and outreach.

**Needs Analysis**

In the past one hundred years, Ireland has undergone unprecedented demographic, social and economic changes that have fundamentally transformed the pace of life, the places where people live, how communities function, and the lifestyles of its inhabitants. For example, life expectancy has increased from 45 and 49 for males and females in 1900 to 76.8 and 81.6 respectively in 2010. This represents over a thirty-year increase in life expectancy. Relative to other nations, Ireland’s birth rate has remained high, but this has been accompanied by dramatic reductions in maternal and infant mortality. Similar to other Western countries, there has been a dramatic shift in the “leading” and “actual” causes of death in Ireland, from diseases resulting from public health deficits (e.g., contaminated water and air, communicable diseases) to a preponderance of deaths caused by chronic diseases that are to some degree preventable (e.g., cardiovascular diseases, diabetes, lung cancer).

While the “traditional” nuclear family in Ireland is alive and well in the second decade of the 21st century, marriage patterns have changed and there is a dramatic increase in single parents. In addition to large changes in the agricultural and manufacturing sectors of society, the population in Ireland has become more urban than rural, and more mobile due to a dramatic rise in families with cars. Innovations in communications (radio, television, cinema, personal computers, GPS devices, the internet, search engines, mobile phones, social media) have transformed the lives of everyone in Ireland, especially young people.

From the early 1990s through 2007, Ireland experienced a period of unprecedented economic growth with the “good times” creating a pervasive sense of optimism for the future. The boom became bust in 2008 and the economic crisis continues to create turmoil in Ireland in 2012. The recession has had significant and far-reaching consequences for individuals, families, communities and the entire society, contrasting unemployment levels of less than 5% at the peak of the *Celtic Tiger* to current levels that hover around 15%. In certain ways, no population subgroup in Irish society has been affected to a greater extent by the economic downturn than young people.
To understand the impact of all of these changes on young people, Headstrong undertook (in 2007) a learning process with hundreds of young people, service providers in both statutory and voluntary service sectors, parents, community members, and government officials. Needs data were gathered through focus groups, key informant interviews, community meetings, and informal interviews. In 2008, Headstrong also conducted a survey (called My World) with a representative sample of about 1,000 adolescents (12-18) across the country. All of these data yielded an extensive empirical base for understanding what was happening with young people.

This work was occurring at a time when high rates of suicide and self-harm were driving Irish society’s sense of alarm about youth mental health. The national rate of suicide for young people had increased relentlessly, despite the economic boom unprecedented in Irish history. By 2008, Ireland’s National Office of Suicide Prevention reported that the rate of youth suicide was the 4th highest in Europe and by far the highest in Western Europe. Whilst for many countries the rate of youth suicide had stabilised and begun to decline, in Ireland the rate seemed only to level off. Suicide remained the leading cause of death among young people age 15-24 in Ireland. As study after study confirmed high rates of youth mental health problems among youth, an escalating drumbeat of media stories about suicide, anti-social behaviour, school failure, and substance abuse reinforced the perception of crisis.

The data gathered from all of these sources validated the overwhelming consensus across Irish society about the need for change. While several pockets of remarkable creativity and innovation were discovered (e.g., youth cafes, suicide prevention and mentoring programmes), the depth and complexity of the challenges for systems change were readily apparent. They included that: (1) pathways to care for young people were dysfunctional, (2) there was not a coherent continuum of services and supports, (3) providers tended to operate within silos and did not communicate or collaborate, (4) narrow funding streams and territoriality resulted in rigidity in the way people thought about young people, and (5) young people felt they had no voice.

Several cross-cutting themes emerged from the initial analysis. Perhaps strongest of these was the sense that young people were not connected to their communities. They frequently expressed frustration about being misjudged or mistrusted. One said, “Whenever people talk about youth, they talk about them as having problems or causing problems.” The high level of stress related to school performance was also striking. Young people were frank about the extent to which they experienced frustration, anxiety, and depression. At the same time, it was clear than many did not have a language to talk about their inner lives, and many cited the stigma attached to discussing mental health issues in Ireland. Help-seeking was seen as an expression of weakness, especially among young males. Young people’s lack of information about how and where to access mental health services and supports was also notable. Many said they were not comfortable accessing statutory services because they were not youth-friendly.

Headstrong concluded that the Ireland that young people were growing up in bore little resemblance to that of their parents’ generation. There is little doubt that young people in Ireland benefitted enormously from the prosperity brought by the Celtic Tiger, but young people have also been vulnerable to many effects of the severe economic downturn. They often seemed lost in their attempts to negotiate all of the challenges that growing up in Ireland entailed. Support systems that previous generations took for granted were less available, and while Ireland had
grown dramatically in terms of wealth, it had lost much of its social capital, the sense of
connectedness and belonging within communities. The strong influence of religious institutions
had weakened, family structures and supports had eroded, and quality family time was less
available. In an increasingly disconnected society, many young people felt isolated as they
sought to cope with emotional turmoil and the mounting pressures they faced. And all of this was
occurring at a time when community-based systems of mental health support were severely
under-developed or non-existent.

**Prevalence of Mental Ill-Health Among Young People**

The field of psychiatric epidemiology has made enormous contributions to our understanding of
the emergence, prevalence, risk, and lifetime course of a variety of mental disorders. Several
landmark studies in the United States, Europe, and Australia provide a useful backdrop within
which to understand youth mental health (and mental ill-health) in Ireland. Most of what is
known about the parameters of mental ill-health in young people comes from studies within the
“general” population (Merikangas et al. 2010, 2011). These studies utilize surveys of young
people and ask them to report symptoms of mental, emotional and behavioural disorders. Some
are conducted via diagnostic interviews in which it is possible to classify mental disorders
according to DSM-IV and/or ICD-10.

Anxiety disorders are the most common disorders in general population surveys (31.9%) followed
by behavioural disorders (19.1%) and mood disorders (14.3%) and substance use
disorders (11.4%). The prevalence of disorders classified as “severe impairment” and/or distress
is 22.2%, consisting of mood disorders (11.2%), 8.3% with anxiety disorders and 9.6% for
behavioral disorders. The median age at onset of anxiety is 6, age 11 for behavioural disorders,
age 13 for mood disorders and age 15 for substance use disorders (see Merikangas et al. 2010).
About one in five young people in the United States meet criteria for a mental disorder with
severe impairment across their life. Approximately one-half of young people with severe
impairment never receive services directed at their disorders. The rates of service utilization are
highest for ADHD and (59.8%) and behavioural disorders (45.4%). Fewer than one in five of
affected adolescents received services for anxiety, eating or substance use disorders (Merikangas
et al. 2011).

Kessler and colleagues (2005 a, b) reported on the National Co-morbidity Survey Replication
(NCS-R) study in the United States. This study administered the World Health Organization’s
Composite International Diagnostic Interview to 9,282 individuals in a nationally representative
sample of individuals to estimate the likelihood of anxiety, mood, impulse-control, and substance
use disorders to occur during the lifetime of an individual. It was found that about 26.2% of the
population was likely to have experienced a diagnosable mental disorder within their lifetime,
and that of these the most prevalent were major depressive disorder (16.6%), alcohol abuse
(13.2%), specific phobia (12.5%), and social phobia (12.1%). Anxiety disorders were found to be
the most prevalent class of lifetime disorders (28.8%), followed by impulse-control disorders
(24.8%), mood disorders (20.8%), and substance use disorders (14.6%).

Kessler et al. (2005) note that the onset patterns for mental ill-health are quite opposite from
most chronic physical health problems (which typically increase with age, peaking in middle or
old age). Psychiatric disorders are rooted in youth and risk gradually decreases as people mature into adulthood. The authors conclude:

“Given the enormous personal and societal burdens of mental disorders, these observations should lead us to direct a greater part of our thinking about public health interventions to the child and adolescent years and, with appropriately balanced considerations of potential risks and benefits, to focus on early interventions aimed at preventing the progression of primary disorders and the onset of comorbid disorders.”

(Kessler, et al, 2005, p.601)

Highly similar findings are found in the World Health Organization study of mental health disorders (Kessler, et al. 2007), which was based on face-to-face community surveys conducted with 85,052 individuals in seventeen countries in Africa, Asia, the Americas, Europe, and the Middle East. In sum, epidemiologic data confirm that the average age at onset for a variety of behavioural and emotional difficulties is within the teen and early adult year timeframe (12-25). In fact, it appears that approximately 75% of mental disorders emerge before the age of 25 (Kessler et al., 2005a).

The ability to negotiate the emotional, behavioural, and social challenges that occur during adolescence and young adulthood has a substantial impact on the trajectory and subsequent severity of these problems (McGorry & Purcell, 2009). It is therefore quite troubling that extensive research shows access to and utilisation of mental health services by young people is poor (Booth, Bernard, Quine, Kang, Usherwood, Alperstein, G., et al., 2004; Samargia, Saewyc, & Elliott, 2006). The system of mental health services and supports appears to be weakest at the exact point where research suggests it needs to be strongest (McGorry, 2007). To add fuel to the fire, research has also documented a significant rise over the past 25 years in emotional and behavioural difficulties among adolescents (Collishaw, Maughan, Goodman, & Pickles, 2004).

Mental health is not the absence of distress or mental illness, and general satisfaction with life does not necessarily connote well-being. Nonetheless, it should be first noted that on various measures of life satisfaction and well-being, the majority of Irish young people indicate their general satisfaction and happiness. On the most recent Health Behaviour Survey for Children (HBSC) (nic Gabhainn, Kelly, & Molcho, M. 2007), for example, within the 12-14 year age range, boys and girls reported similar levels of feeling very happy about their lives (54.3% & 53.1%, respectively), although these groups diverged at the 15-17 year range, when girls were much less likely (34.3%) than boys (43.6%) to indicate being “very happy”. Feeling happy appeared to occur at much higher rates when young people lived with both parents, found it easy to talk with parents and friends, had opportunities for socialisation, liked school, and did not feel pressured academically. Notably, social class did not appear to be have a moderating effect. In terms of overall life satisfaction Irish 15-year olds ranked 19th among 39 countries in Europe and North America with 70% reporting high life satisfaction (generally below most Scandinavian and western European countries, but above countries in central and eastern Europe).

A cross-national study showed that most Irish adolescents reported life satisfaction with family, friends, self and living environment as generally positive, at levels similar to cohorts in the United States, South Korea, and China, although less so with respect to school experiences
(Gilman, et al, 2004). More recently, McGrath, Brennan, Dolan, & Barnett (2009) compared Irish and American adolescents with regard to predictors of subjective well-being, finding that informal social support and school satisfaction were the strongest predictors across both locations, and peer and parental support were especially critical for a sense of well-being. Liking school and perceived school success appeared more important to school satisfaction in Ireland than Florida (in Florida, student camaraderie and bullying were stronger predictors of school satisfaction).

Some interesting health-related patterns were evident from the 2006 HBSC (nic Gabhainn, Kelly, & Molcho, 2007), which enabled examination of overall Irish rates as well as comparisons with other European and North American countries. While these patterns showed positive results for a substantial portion of the youth population, they also implied considerable need and risk. For example, Ireland experienced a significant decrease between 2002 and 2006 in the number of young people living with both parents, (although still ranking in the top third of European countries).

Whereas 74% of fifteen-year olds reported they found it easy to talk with their mothers (30th among 40 countries), only 59% reported they found it easy to talk with their father (13th among 40 countries). Only 50% of 15-year olds reported positive relationships with classmates (21st among 41 countries). When considered together, these data showed that a substantial portion of Irish adolescents did not find it easy to talk with either their parents or with peers. In terms of liking school, Irish 15-year olds ranked 29th among 41 countries, with 61% responding positively. 57.2% of Irish boys and 55.9% of Irish girls aged 15-17 years indicated that they had been drunk at some point in their lives (23rd among 39 countries), and Ireland ranked 21st among 39 countries in student reports of having been bullied (23% for age 15).

Despite these generally positive findings, there is extensive scientific evidence that Irish young people are experiencing high levels of mental ill-health. A rigorous population study of 1,589 adolescents in Clonmel (County Tipperary) found that 21.1% of 12–18 year olds met the criteria for at least one psychological disorder (Martin, Carr, et al., 2006). Of these, about one-fifth had problems associated with clinical risk (e.g., thoughts of death, being suspended or expelled from school). The majority of adolescents who were identified as either being at-risk or meeting the criteria for a psychiatric disorder were receiving no professional help, and fewer still had had contact with the child and adolescent mental health services.

Lynch, Mills, Daly, and Fitzpatrick (2004, 2006) assessed 723 12–15 year olds in eight Dublin schools and found that 19.4% were at-risk for developing a mental health disorder. Within this at-risk group, 12.1% expressed possible suicidal intent and 45.7% expressed suicidal ideation. Of the total sample, 15.6% met the criteria for a psychiatric diagnosis, including 4.5% for affective disorder, 3.7% for anxiety disorder, 3.7% ADHD, 1.9% with past suicidal ideation, and 1.5% with a history of parasuicide. Very few had come to the attention of the Child and Adolescent Mental Health Services (CAMHS).

The Lifestyle and Coping Survey (Sullivan et al., 2004), was administered to over 3,830 school students aged 15–17 in 39 randomly selected schools in Counties Cork and Kerry. Based on self-
report, it was discovered that serious personal, emotional, behavioural or mental health problems were experienced by 26.9% of those surveyed, but of these only 17.8% were able to access help. Within this sample, 12.2% reported having harmed themselves at some stage in their lives, and 21.6% indicated that they had thought of harming themselves in the past year.

The strongest, most recent, and most compelling evidence regarding the mental health of young people in Ireland comes from Headstrong’s My World Survey (MWS), administered to a stratified and representative sample of almost 14,500 young people across Ireland in 2011. The adolescent version of the scale was given to a representative sample of 6,085 individuals ages 12-19 and a non representative (skewed toward third-level) version was completed by 8,221 young adults. The samples included young people from all of the 26 counties in Ireland and all of the universities. A particular strength of the MWS is that it incorporates scales that measure both risk and resilience factors.

While the findings are far too extensive to fully describe here (and are available in National Study of Youth Mental Health, 2012), some of the more prominent findings were:

- About 8% of adolescents and 14% of young adults experience depressive symptoms classifiable as severe or very severe. An additional 22% of adolescents and 26% of young adults experience mild to moderate depression. At a population level, this equates to almost 270,000 young people experiencing depressive symptomatology.
- About 11% of adolescents and 14% of young adults experience anxiety symptoms classifiable as severe or very severe, and an additional 21% of adolescents and 23% of young adults experience mild to moderate anxiety. At a population level, this equates to around 240,000 young people experiencing difficulty with anxiety.
- 6% of adolescents and 20% of young adults are classifiable as hazardous or dependent drinkers, and an additional 15% of adolescents and a stunning 41% of young adults engage in occasional problem drinking. At a population level, this equates to around 325,000 young people experiencing difficulty with alcohol consumption.
- The population equivalent of about 225,000 young people report that they have used cannabis.
- About 4% of adolescents (the equivalent of 14,000 students) report that they have been suspended or expelled from their school at some point.
- About 21% of young adults (the population equivalent of 220,000) report that at some point in the last year they have deliberately hurt themselves without wanting to take their life (deliberate self-harm).
- A remarkable 7% of the young adult sample indicated that they had made an attempt to take their own life, 24% of which had been in the last year. For this age range alone, this equates to around 18,000. Even more sobering, 51% (population equivalent of 209,000) said that they had at some point thought about taking their life.
- Nearly 42% of adolescents (equivalent to 150,000 young people nationally) reported that they had been bullied at some point.
- Given the dominant research finding that having a trusted and caring adult is a strong predictor of outcomes, participants were asked about the support they had available to them. 16% (about 56,000 equivalent) of adolescents and 18% (about 75,000 equivalent) of young adults reported low or very low adult support.
When these findings are considered alongside similar information about hospitalisations, suicide and self-harm rates, school adjustment, early school leaving, antisocial behaviour, crime, and related indicators, there should be little doubt that mental ill-health among Irish young people has reached epidemic proportions.

Early Intervention and Systems Transformation

Throughout much of the 20th century, the Irish public’s understanding of mental ill-health was limited. “Mentally ill” people were consigned to mental hospitals or asylums, isolated from their family and community, “out-of-sight” of the general population, and treated by specialists. As recently as 1972, there were 15,856 “in-patients” in Irish psychiatric hospitals. The least prevalent “mental illnesses” (schizophrenia, bipolar disorders, mania) dominated the public’s perception of mental illness and mental disorders, and the perceived distance between “normal” and “abnormal” was vast.

In 2006, A Vision for Change described the “old” institution-based mental health system as broken and provided a blueprint for transformative systems change with a focus on community- and evidence-based care and support. A Vision for Change explicitly acknowledged the pressing need to change the way Ireland thinks about mental health and reduce the stigma associated with mental ill health. It envisioned a recovery-oriented system that was accessible, consumer-friendly, and more broad-based.

While vestiges of the old “attitudes” may remain, Irish knowledge and attitudes about mental health have changed steadily. Thus, in 2010, there were far less patients in Irish psychiatric units and hospitals (2,812), and the Mental Health Commission (2011) was recommending a public health approach that emphasizes building “mental capital” and improvement of well-being as a long-term investment approach.

Nonetheless, community-based mental health services that are specifically designed for young people are either non-existent or difficult to access (Vision for Change, 2006). While there are fine examples of best-practice interventions in communities around Ireland, they are sparse and tend to operate in isolation. Service delivery is, at best, fragmented, and even in very small communities, not integrated. As a result, young people often have negative experiences of help-seeking and services struggle to retain them.

Referral criteria for accessing services can serve to exclude young people in distress. For example, if a young person has a mild intellectual disability, a history of substance misuse, a diagnosis of a personality disorder, is homeless or between the ages of 16-18, they are prone to “fall between the cracks”. Moreover, the minority of young people who manage to engage with specialist services must enter the service by referral to either child or adult services. The settings and interventions offered within them can be inappropriate to a young person’s needs and desires because they are exclusively child or exclusively adult focused, there is a lack of choice regarding the types of interventions offered, and many perceive (or fear) an over-reliance on psychotropic medication and crisis intervention.
In light of these deficiencies, Ireland’s regulatory body, the Mental Health Commission (2008), stated:

“It is obvious that in Ireland there is a major discrepancy between the services provided and the identified needs of children and adolescents with mental health problems. The frustration of parents and staff is apparent, and children and adolescents who require assessment and interventions lose valuable time while waiting for essential services.”

Given that current mental health systems of services and supports are not attending to the unique needs of adolescents and young adults, systems change is required. The core solution requirement of change is that the transformed system must be comprised of an integrated array of youth-focused, community-based, and evidence-based prevention, early intervention, and treatment services. It must insure that young people can obtain more responsive support when they need it, where they need it, and at the level of support intensity required (Patel, Flisher, Hetrick, & McGorry, 2007).

It should be noted that some progress has been made in implementing the Vision for Change recommendations as they relate to young people, despite the serious economic limitations brought by austerity. For example, A Vision for Change stipulated the need for 99 12-person multidisciplinary child and adolescent mental health services (CAMHS) teams across Ireland to establish basic coverage for specialized mental health services (Health Service Executive, 2006). As of 2011, 61 of these teams had been established, 56 of which were community-based. Within these 61 teams (comprised of 464.74 FTEs), staffing was only at 63.8% of the recommended level, with considerable variability and disciplinary composition across teams and regions. While trending in a positive direction, there were still a significant number of young people on waiting lists to be seen (1,897 in September, 2011), and 10 teams had a waiting list of 50 to 99 (the remaining 2 community-based teams had waiting lists of 100-149 young people). The non-attendance (no-show) rate for CAMHS appointments had increased over prior years to 19.6% (12% for new cases). Fully implementing A Vision for Change is clearly a marathon, not a sprint.

Deployment and validation of a youth-focused model of early intervention and treatment is well underway in Australia (McGorry, 2007; McGorry, Parker, & Purcell, 2007; Patton, Hetrick, & McGorry, 2007). Much of Headstrong’s work has been modelled after the Australian system developed by Professor Patrick McGorry, an internationally acclaimed psychiatrist and acknowledged founder of the youth mental health movement. A native of Ireland, Dr. McGorry has been a member of Headstrong’s Board of Directors from its founding in 2007. (see bio below)

Due to the leadership of Professor McGorry and his colleagues, the Australian government has invested extensively in youth mental health services. The primary vehicle for the implementation of the Australian youth mental health system is community-based youth mental health centres operated by headspace, the National Youth Mental Health Foundation. As of 2012, there are 55 such centres operating across the country (with 5 more anticipated during the year). To date, more than 62,000 young people have been served through these programmes. According to the Australian government website:
“The 2011-12 Budget allocated $197.3 million over five years, on top of a current commitment of $133.3 million to 2013-14, to expand existing and establish new youth focused mental health services through the headspace program. Specifically, the 2011-12 Budget measure provides funding for 90 fully sustainable headspace sites across Australia by 2014-15. This will be achieved through boosting funding to the 30 current and 10 developing headspace sites and ensuring a robust funding base for the further 50 sites to be established by 2014-15. Once all 90 sites are fully established, headspace will help up to 72,000 young people each year.”


An independent evaluation of the initiative by the Social Policy Research Centre at the University of New South Wales (Muir, Powell, et al., 2009) found that it was highly successful in engaging young people with significant psychological distress, and that most service recipients reported reduced stress and were satisfied with the services they received.

![Suicide Rates, 15-19 Years, 1989-2009, by Sex](image)

Similar to the situation in Ireland, suicide and self-harm among young people were driving concerns for Australian young people. As can be seen in the graph below, coincident with the deployment of the youth mental health system around 2005/2006, suicide rates among young people began to drop. Currently, the 15-19 year old age group has the lowest rate of suicide for both males and females (compared to all other age ranges). The rate of suicide deaths in young males has fallen by 29% in the last decade and the rate for females has dropped by 46%.

A unique component of the Australian system of care is Orygen Youth Health, led by Professor McGorry. It is comprised of the world’s largest youth mental health research centre, a clinical service for young people with emerging serious mental health and substance disorders, and a
training and communication programme designed to share knowledge and enhance service system functioning.

To a significant extent, the Australian approach of integrating elements of service delivery with on-going research, training, and communication has informed the approach taken by Headstrong in developing areas of work such as community-based service development, My World (research), and national-level support activities (education & training, communication, service evaluation, & fund-raising). A powerful addition, unique to Headstrong, has been the systematic development of youth engagement, enablement, and leadership across all areas of work through activities such as local and national youth advisory panels (YAPs) and youth-led mental health promotion (Think Big).

Professor Patrick McGorry AO is a leading international researcher, clinician and advocate for mental health reform. Professor McGorry is Executive Director of Orygen Youth Health, a world-renowned mental health organisation for young people that has put Australia at the forefront of innovation in the prevention and treatment of mental illness. Orygen targets the needs of young people with emerging serious mental illness, including first-episode psychosis and has become the model upon which many other youth mental health services in the world are based. Professor McGorry is also a director of the National Youth Mental Health Foundation (headspace). He believes that early intervention offers the greatest hope for recovery and therefore takes every opportunity to educate the community to recognise the early signs of mental illness, without stigmatising or discriminating. Professor McGorry was named as Australian of the Year in January 2010 in recognition of "his extraordinary 27-year contribution to the improvement of the youth mental health sector [that] has transformed the lives of tens of thousands of young people the world over." Professor McGorry was made an Officer of the Order of Australia in June 2010.

In the United Kingdom, a tiered model of care was introduced in 1995 following several reports emphasising the need to better integrate primary and specialised mental health care within the Child and Adolescent Mental Health (CAMH) system. In this model, Tier 1 is defined as services provided by professionals who are not necessarily mental health specialists, such as GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. These individuals receive training and support from mental health professionals, and can refer children and young people to more specialist services. Tier 1 interventions can include early identification, general advice for mild-moderate problems, and mental health promotion and prevention provided by primary care and other front-line services. Tier 2 services are
provided by mental health specialists who work in community-based settings such as GP practices, paediatric clinics or schools. The development and implementation of a primary mental health care worker at the interface between Tier 1 and Tier 2 level in a particular catchment area is described by Gale and Vostanos (2006), with anecdotal evidence of the utility of this role (which is quite similar to *Headstrong*'s concept of a youth support worker). These components of the service array are similar to the role that *Headstrong* is intended to play within the Irish system of mental health care and support.

Research on the effectiveness of the Tier 1 component in the UK system of care has been limited, but what evidence is available seems to show that the system has not been fully implemented. Gowers, Thomas, and Deeley (2004) found in a survey of 291 schools that while teachers had great interest in mental health and improving the liaison with CAMH, little training had occurred, pathways to care had not been clarified, and communication was insufficient. These findings point to the importance of achieving full implementation and sustaining support in an early intervention approach such as this.

In Canada, England, Scotland, and Wales, considerable effort has recently gone into replicating a youth mental health first aid training program at community level similar to the validated Australian model (Kitchener & Jorm, 2006; Jorm, 2011). This training is targeted toward people who live with, work with or care for young people aged 11-18. It encompasses two days of work geared toward promoting mental and emotional wellbeing and supporting young people who experience mental and emotional distress. The specific goals for the course are to identify early signs of distress, enhance confidence about help-giving, provide help on a first aid basis, prevent self-harm, ameliorate the course of mental illness, facilitate recovery, guide young people toward the right support, and reduce stigma. These activities are highly consistent with a major component of the community training model being implemented through *Headstrong*, which is also aimed at a broad audience of care-givers, youth workers (e.g., coaches, hairdressers), parents, and other interested community members.

In the United States, extensive work over a two-decade period has gone into transforming child and adolescent mental health services for individuals with significant emotional and behavioural disorders. The majority of this work has been focused on children and families, but there are several “systems of care” initiatives focused on adolescents and young adults. One of the most prominent is the Transition to Independence Process (TIP) Model, an evidenced-based promising practice developed by the National Network on Youth Transition (NNYT). It emphasizes training for front-line and supervisory staff to enable young people with significant behavioural and emotional difficulties to transition into adulthood through an individualised process, engaging them in planning their own future and accessing developmentally appropriate services and supports. The core skills of the training include strength discovery, needs assessment, futures planning, rationales, in-vivo teaching, social problem solving, prevention planning related to high-risk behaviours and situations, and mediation (Clark, Belkin, et al. 2002). *Headstrong* engaged the programme’s originator (Prof. Hewitt Clark) to provide core training in these areas to site staff in 2011, and is examining the feasibility of incorporating the training model into its training sequence for front-line providers.
Canada is rapidly moving into systems development for youth mental health as a consequence of widely reported studies by the Kirby Commission (Kirby & Keon, 2006) and the Mental Health Commission of Canada, and a national report to the Minister of Health about child and youth mental health called *Reaching for the Top* (Leitch, 2007). All of these reports delineated extensive unmet need and called for both systemic reform and a significant infusion of new resources. Much of the effort to date has gone into advocacy for young people and training for mental health practitioners and other front-line staff who serve young people, as exemplified by the work of the Ontario Centre of Excellence for Child and Youth Mental Health. In Quebec, a major systems transformation of mental health from hospital care to primary care in communities has begun as a function of the *Plan d’action en santé mentale* (PASM) (Mental Health Action Plan). Changes to child and youth mental health (CYMH) are at the core of the work. A recent process evaluation (Nadeau, Jaimes, Rousseau et al., 2012) responded to several challenges, including establishing a common culture of care across hospital and community settings, despite strong progress toward partnership. Continuous communication was seen as key, and was fostered by numerous opportunities for clinical discussions, dialogue on models of care, harmonising administrative and clinical priorities, and involving key actors and structures.

References


For the past 3 decades adolescent healthcare providers have used HEADSS, which focuses on the psychological perspective, and hence, some modifications have been used by physicians thereof. This is a proposal to use “HI ADOLESCENTS”, an acronym that expands on the psychosocial areas to be more inclusive and to address physical and spiritual aspects as well. We believe this will be effective with a larger spectrum of adolescents.


An increasing number of countries are developing national strategies to reduce and prevent suicide. However, while the large volume of information from psychiatric, epidemiological, genetic, and biological research now gives a generally coherent and consistent picture about the risk factors and causal pathways for suicidal behavior, there is relatively little evidence-based information—at either a program level, or at the level of a national strategy—about the types of interventions that successfully reduce or prevent suicidal behavior. Against this background, it is timely to outline, albeit briefly, the small body of evidence about programs and strategies that show effectiveness, or promise of effectiveness, in reducing or preventing suicide.


International declarations that articulate core values, goals and standards have played an important role in enhancing the quality of care in a number of areas of medicine. This document attempts this task for early intervention in psychotic disorders. It was originally inspired by the St Vincent's declaration on the care of diabetes and carefully developed by David Shiers and Jo Smith with support from the Initiative to Reduce the Impact of Schizophrenia, National Institute for Mental Health in England and Rethink, resulting in the UK-focused Newcastle Declaration. The World Health Organization and the International Early Psychosis Association then collaborated to produce an international version of the declaration, which articulates the universal principles of early intervention and tries to blend these with local capacities and cultural diversity.


Early intervention services for psychosis aim to detect emergent symptoms, reduce the duration of untreated psychosis, and improve access to effective treatments. To evaluate the effectiveness of early intervention services, cognitive–behavioural therapy (CBT) and family intervention in early psychosis. Systematic review and meta-analysis of randomised controlled trials of early intervention services, CBT and family intervention for people with early psychosis. Early intervention services reduced hospital admission, relapse rates and symptom severity, and improved access to and engagement with treatment. Used alone, family intervention reduced relapse and hospital admission rates, whereas CBT reduced the severity of symptoms with little impact on relapse or hospital admission. For people with early psychosis, early intervention services appear to have clinically important benefits over standard care. Including CBT and family intervention within the service may contribute to improved outcomes in this critical
period. The longer-term benefits of this approach and its component treatments for people with early and established psychosis need further research.


In the last decade the use and abuse of substances has become recognised as a major national and international problem. The prevalence of substance use among young people has received considerable attention. While there is no shortage of anecdotal evidence regarding the use of substances among adolescents, it is only recently that research has been conducted in this area in Ireland. The present study aims to update information on trends and patterns of substance use among adolescents in Dublin and to gain information on the differences in rates and patterns of substance use between five European cities.


The prevalence of mental health problems, some of which seem to be occurring among younger cohorts, leads researchers and policy-makers to search for practical solutions to reduce the burden of suffering on children and their families, and the costs to society both immediate and long term. Numerous programs are in place to reduce or alleviate problem behaviour or disorders and/or assist positive youth development. Evaluated results are dispersed throughout the literature. To assess findings and determine common elements of effective children's services, a literature search was undertaken for evidence-based evaluations of non-clinical programs for school-age children. Prescriptive comments aim to inform service-providers, policy-makers and families about best practices for effective services such as: early, longterm intervention including reinforcement, follow-up and an ecological focus with family and community sector involvement; consistent adult staffing; and interactive, non-didactic programming adapted to gender, age and cultural needs. Gaps are identified in our understanding of efficiencies that result from effective programs. Policy implications include the need to developstrategies for intersectoral interventions, including: new financing arrangements to encourage (not penalize) interagency cooperation and, to ensure services reach appropriate segments of the population; replication of best practices; and publicizing information about benefits and cost savings. In many jurisdictions legislative changes could create incentives for services to collaborate on service delivery. Joint decision-making would require intersectoral governance, pooling of some funding, and policy changes to retain savings at the local level. Savings could finance expansion of services for additional youth.


Two comprehensive community-based interventions for youth with severe emotional disorders are contrasted and compared. The interventions are multisystemic therapy (MST)—a brief but intensive, clinician-provided, and home-based treatment; and wraparound—a long-term approach to planning and coordinating the provision of both formal and informal services in the community. Both approaches are spreading rapidly across the country. As this occurs, it is important for families, clinicians, and policymakers to have sufficient information to understand the requirements and the research base for each. This paper provides a description of both MST and wraparound across multiple dimensions (i.e., origin, theory, target population, principles, role of family, cultural competence, staffing, training, quality monitoring, costs, and the
The respective similarities and differences are discussed and options for utilizing both for selected youth and families who require intensive and long-term care are explored briefly.


The study assessed the impact of a school-based sexual risk reduction programme on adolescent's knowledge, need for information, problem-solving and communication skills, intention to talk about and to practise safer sex. The primary goal of working with adolescents in schools was successful, in that significant treatment effects occurred on knowledge, perception of skills and frequency of communication. The programme was not effective in improving intentions to use condoms. Evidence for the importance of social context aspects for safer sexual decisionmaking was found, since the impact of the programme differed for subjects differing in gender role attitudes.


Over the last century public health efforts, such as immunization, safer food practices, public health education and promotion, improved sanitation, and water purification have been very successful in eradicating and controlling a host of diseases. The result has been a dramatic improvement in health and life expectancy. However, the impact that mental illnesses have on individuals and society as a whole has largely been overlooked by the discipline. This pioneering volume examines the evidence-base for incorporating mental health into the public health agenda by linking the available research on population mental health with public mental health policy and practice. Issues covered in the book include the influence of health and mental health policies on the care and well-being of individuals with mental illness, the interconnectedness of physical and mental disorders, the obstacles to adopting a public health orientation to mental health/mental illness, and the potential application of public health models of intervention. Setting out a unique and innovative model for integrated public mental health care, Population Mental Health identifies the tools and strategies of public health practice, surveillance and screening, early identification, preventive interventions, health promotion and community action and their application to twenty-first century public mental health policy and practice.


A systematic review was conducted to identify and describe school-based prevention and early intervention programs for depression and to evaluate their effectiveness in reducing depressive symptoms. Forty-two randomised controlled trials, relating to 28 individual school-based programs, were identified through the Cochrane Library, PsycInfo and PubMed databases. A large proportion of the programs identified were based on cognitive behavioural therapy (CBT), and delivered by a mental health professional or graduate student over 8–12 sessions. Indicated programs, which targeted students exhibiting elevated levels of depression, were found to be the most effective, with effect sizes for all programs ranging from 0.21 to 1.40. Teacher program leaders and the employment of attention control conditions were associated with fewer significant effects. Further school-based research is required that involves the use of attention controls, long-term follow-ups and which focuses on the training and evaluation of sustainable program leaders, such as teachers.

Primary Mental Health Workers (PMHWs) have been deployed to address the mental health needs of young offenders referred to Youth Offending Teams (YOTs) in two UK areas. The mental health characteristics of 60 young people consecutively referred to these PMHWs, the assessment outcome and interventions offered, are described. In addition to the anticipated concerns about oppositional/aggressive behaviour, young people were referred for a range of mental health problems. There were high levels of emotional problems, self-harm, peer and family relationships difficulties, and school non-attendance. PMHWs offered a range of direct interventions, as well as consultation to YOT staff. The service findings indicate the usefulness of such an inter-agency model in strengthening the links between specialist CAMHS and YOTs, and providing an accessible, responsive and effective service to a needy group of young people.


Depression in adolescents and young people is associated with reduced social, occupational, and interpersonal functioning, increases in suicide and self-harm behaviours, and problematic substance use. Age-appropriate, evidence-based treatments are required to provide optimal care. Methods. "Evidence mapping" methodology was used to quantify the nature and distribution of the extant high-quality research into the prevention and treatment of depression in young people across psychological, medical, and other treatment domains. Results. Prevention research is dominated by cognitive-behavioral- (CBT-) based interventions. Treatment studies predominantly consist of CBT and SSRI medication trials, with few trials of other psychological interventions or complementary/alternative treatments. Quality studies on relapse prevention and treatment for persistent depression are distinctly lacking. Conclusions. This map demonstrates opportunities for future research to address the numerous evidence gaps for interventions to prevent or treat depression in young people, which are of interest to clinical researchers, policy makers, and funding bodies.


Early detection and prospective evaluation of individuals who will develop schizophrenia or other psychotic disorders are critical to efforts to isolate mechanisms underlying psychosis onset and to the testing of preventive interventions, but existing risk prediction approaches have achieved only modest predictive accuracy. To determine the risk of conversion to psychosis and to evaluate a set of prediction algorithms maximizing positive predictive power in a clinical high-risk sample. Design, Setting, and Participants: Longitudinal study with a 21/2-year follow-up of 291 prospectively identified treatment-seeking patients meeting Structured Interview for Prodromal Syndromes criteria. The patients were recruited and underwent evaluation across 8 clinical research centers as part of the North American Prodrome Longitudinal Study. Time to conversion to a fully psychotic form of mental illness. The risk of conversion to psychosis was 35%, with a decelerating rate of transition during the 2 1/2- year follow-up. Five features assessed at baseline contributed uniquely to the prediction of psychosis: a genetic risk for schizophrenia with recent deterioration in functioning, higher levels of unusual thought content, higher levels of suspicion/paranoia, greater social impairment, and a history of substance abuse. Prediction algorithms combining 2 or 3 of these variables resulted in dramatic increases in positive predictive power (ie, 68%- 80%) compared with the prodromal criteria alone. These findings demonstrate that prospective ascertainment of individuals at risk for psychosis is
feasible, with a level of predictive accuracy comparable to that in other areas of preventive medicine. They provide a benchmark for the rate and shape of the psychosis risk function against which standardized preventive intervention programs can be compared.


One in four young people will experience a mental health problem in any given 12 month period. If they receive support and help early, they are less likely to experience a recurrence of mental health problems in the future. Australian Red Cross is responding to these facts by working with young people in a peer-centered, early intervention framework across all our youth mental health initiatives and services. This presentation will examine the need for culturally appropriate, youth centred, peer education support programs, and the challenges and strengths in designing peer-led programs with a community development focus.


Drug prevention in schools is a top priority in most Western countries and several well-designed studies have shown that prevention programs have the potential of reducing drug use in adolescents. However, most prevention programs are not effective and there are no general criteria available for deciding which program is effective and which is not. In this systematic review of the literature, the current scientific knowledge about which characteristics determine the effectiveness of drug prevention programs is examined. Three types of studies are reviewed: meta-analyses (3 studies were included), studies examining mediating variables of interventions (6 studies), and studies directly comparing prevention programs with or without specific characteristics (4 studies on boosters, 12 on peer- versus adult-led programs, and 5 on adding community interventions to school programs). Seven evidence-based quality criteria were formulated: the effects of a program should have been proven; interactive delivery methods are superior; the “social influence model” is the best we have; focus on norms, commitment not to use, and intentions not to use; adding community interventions increases effects; the use of peer leaders is better; and adding life skills to programs may strengthen effects.


This study examined the effectiveness of a universal school-based prevention program that was designed to increase coping resources in preadolescents through the modeling and teaching of optimistic thinking skills. School psychologists, together with classroom teachers, implemented an eight-week program in eight Year 5 and 6 class groups as part of the regular school curricula. One hundred and sixty children who participated in the program were compared to 135 children in 8 control groups on pre- and post-test questionnaires. Post-test responses show that children who participated in the program reported significant improvements in coping efficacy, and reductions in depressive attributions and use of the non-productive coping strategies of worry, wishful thinking, not coping, and ignoring the problem when compared to controls. These results support the feasibility of implementing low-cost, non-intrusive programs in school settings that address the emotional health of all young people. Support is also provided for theories that suggest attributions for events and coping efficacy influence the selection of coping strategies.

The relationship between three different service coordinator models (dedicated and independent, dedicated but not independent, and blended) and the use of nine different service coordinator practices was examined in a study of families of infants and toddlers enrolled in the IDEA Part C early intervention program. Results showed that service coordinators provided children and families fewer services when using a dedicated and independent model and that the same service coordinators had less frequent contact with families and early intervention staff compared to service coordinators working in the context of the other two service coordination models. Strengths and limitations of the different service coordination models are discussed.


This article presents findings from a meta-analysis of 213 school-based, universal social and emotional learning (SEL) programs involving 270,034 kindergarten through high school students. Compared to controls, SEL participants demonstrated significantly improved social and emotional skills, attitudes, behavior, and academic performance that reflected an 11-percentile-point gain in achievement. School teaching staff successfully conducted SEL programs. The use of 4 recommended practices for developing skills and the presence of implementation problems moderated program outcomes. The findings add to the growing empirical evidence regarding the positive impact of SEL programs. Policy makers, educators, and the public can contribute to healthy development of children by supporting the incorporation of evidence-based SEL programming into standard educational practice.


To critically examine the orthodox view that young people's health and wellbeing are continuing to improve in line with historic trends. Transdisciplinary synthesis is used to analyse and integrate a wide range of evidence on young people's health and wellbeing. Synthesis seeks coherence in the overall conceptual picture rather than precision in the empirical detail. The orthodox view rests mainly on declining mortality among teenagers and young adults, and findings that most say they are healthy, happy and satisfied with life. With health improving for most, the focus of attention is on social inequalities in health. However, mortality rates underestimate the growing importance of non-fatal, chronic health problems, especially mental illness; self-reported health and happiness are flawed indicators of overall wellbeing. Evidence suggests that rates of mental illness in young people have increased over time, and are higher than in older age groups. Explanatory factors include quite fundamental features of modern societies, which go beyond inequality and disadvantage; trends in these factors predict a deterioration in health and wellbeing. Contrary to the dominant view that young people have never been healthier, their health and wellbeing may have declined over several generations. Which perspective is right has important implications for understanding and addressing youth mental health problems, implications that go well beyond medical interventions.


A study tested the efficacy of a school-based prevention program for reducing suicide potential among high-risk youth. Its potential efficacy was demonstrated for high school students.

Widespread implementation of effective programs is unlikely to affect the incidence of violent crime unless there is careful attention given to the quality of implementation, including identification of the problems associated with the process of implementation and strategies for overcoming these obstacles. Here we describe the results of a process evaluation focused on discovering common implementation obstacles faced by schools implementing the Life Skills Training (LST) drug prevention program.


This study examined points of entry into the mental health service system for children and adolescents as well as patterns of movement through five service sectors: specialty mental health services, education, general medicine, juvenile justice, and child welfare. The data were from the Great Smoky Mountains Study, a longitudinal epidemiologic study of mental health problems and service use among youths. The sample consisted of 1,420 youths who were nine, 11, or 13 years old at study entry. Each youth and a parent were interviewed at baseline and every year thereafter about the use of services for mental health problems over the three-year study period. Population estimates indicated that 54 percent of youths have used mental health services at some time during their lives. The education sector was the most common point of entry and provider of services across all age groups. The specialty mental health sector was the second most common point of entry for youths up to age 13 years, and juvenile justice was the second most common point of entry for youths between the ages of 14 and 16. Youths who entered the mental health system through the specialty mental health sector were the most likely to subsequently receive services from other sectors, and those who entered through the education sector were the least likely to do so. The education sector plays a central role as a point of entry into the mental health system. Interagency collaboration among three primary sectors—education, specialty mental health services, and general medicine—is critical to ensuring that youths who are in need of mental health care receive appropriate services.


Discusses key issues in developing and evaluating school-based violence prevention interventions. Schools provide a natural setting for implementing programs directed at teaching youth attitudes, knowledge, and skills to reduce their involvement in violence. Although multitudes of these programs exist, few have been rigorously evaluated. Developers of violence prevention programs need to pay particular attention to the type of violence being addressed, the target population, relevant risk and protective factors, and the target of the intervention. Conducting sound evaluations of such programs requires careful attention to the unit of randomization, treatment conditions, outcome measures, timing of data collection, and potential moderator variables. Efforts to develop effective prevention programs can be greatly facilitated by adopting an action–research strategy in which evaluation findings provide a basis for continual program refinement.

Evaluated Responding in Peaceful and Positive Ways (RIPP)—a 6th-grade universal violence prevention program. Classes of 6th graders at 3 urban middle schools serving predominantly African American youth were randomized to intervention (N = 321) and control groups (N = 305). Intervention effects were found on a knowledge test but not on other mediating variables. RIPP participants had fewer disciplinary violations for violent offenses and in-school suspensions at posttest compared with the control group. The reduction in suspensions was maintained at 12-month follow-up for boys but not for girls. RIPP participants also reported more frequent use of peer mediation and reductions in fight-related injuries at posttest. Intervention effects on several measures approached significance at 6-month and 12-month follow-up. The program’s impact on violent behavior was more evident among those with high pretest levels of problem behavior.


Adolescent resilience research differs from risk research by focusing on the assets and resources that enable some adolescents to overcome the negative effects of risk exposure. We discuss three models of resilience—the compensatory, protective, and challenge models—and describe how resilience differs from related concepts. We describe issues and limitations related to resilience and provide an overview of recent resilience research related to adolescent substance use, violent behavior, and sexual risk behavior. We then discuss implications that resilience research has for intervention and describe some resilience-based interventions.


To test whether frequent bullying victimisation in childhood increases the likelihood of self harming in early adolescence, and to identify which bullied children are at highest risk of self harm. The Environmental Risk (E-Risk) longitudinal study of a nationally representative UK cohort of 1116 twin pairs born in 1994-95 (2232 children). Setting England and Wales, United Kingdom. Participants Children assessed at 5, 7, 10, and 12 years of age. Main outcome measures Relative risks of children’s self harming behaviour in the six months before their 12th birthday. Results Self harm data were available for 2141 children. Among children aged 12 who had self harmed (2.9%; n=62), more than half were victims of frequent bullying (56%; n=35). Exposure to frequent bullying predicted higher rates of self harm even after children’s pre-morbid emotional and behavioural problems, low IQ, and family environmental risks were taken into account (bullying victimisation reported by mother: adjusted relative risk 1.92, 95% confidence interval 1.18 to 3.12; bullying victimisation reported by child: 2.44, 1.36 to 4.40). Victimised twins were more likely to self harm than were their non-victimised twin sibling (bullying victimisation reported by mother: 13/162 v 3/162, ratio=4.3, 95% confidence interval 1.3 to 14.0; bullying victimisation reported by child: 12/144 v 7/144, ratio=1.7, 0.71 to 4.1). Compared with bullied children who did not self harm, bullied children who self harmed were distinguished by a family history of attempted/completed suicide, concurrent mental health problems, and a history of physical maltreatment by an adult. Conclusions Prevention of non-suicidal self injury in young adolescents should focus on helping bullied children to cope more appropriately with their distress. Programmes should target children who have additional
mental health problems, have a family history of attempted/completed suicide, or have been maltreated by an adult

Using meta-analysis, we analyzed 32 outcome studies on the primary prevention of adolescent pregnancy and examined several moderator variables in relationship to the findings. Three outcome variables—sexual activity, contraceptive use, and pregnancy rates or childbirths—were analyzed as three separate and independent metaanalyses. Results indicate that the pregnancy prevention programs that we examined have no effect on the sexual activity of adolescents. We found sufficient evidence to support the efficacy of pregnancy prevention programs for increasing use of contraceptives. A smaller but significant amount of evidence supports program effectiveness in reducing pregnancy rates.

Fung, D. "Adolescent-Friendly Consultations."
An adolescent friendly consultation requires a doctor to negotiate the challenges of handling an intellectually and often socially adept individual who may regard doctors with suspicion or even as agent of parents seeking to interfere with or control their lives. The three pre-requisites for an adolescent friendly consultation are a) the right situation, b) the right person and c) the right questions. Useful techniques for communicating with adolescents are a) active listening, b) reflecting feelings and c) avoiding communication barriers. The HEADSS assessment is an interview instrument to obtain medical and psychosocial information of the adolescent. Risk assessment is a necessary skill to acquire when dealing with adolescents.

Previous studies suggest that school-based cognitive-behavioral interventions can reduce and prevent depressive symptoms in youth. This pilot study investigated the effectiveness of a cognitive-behavioral depression prevention program, the Penn Resiliency Program for Children and Adolescents (the PRP-CA), when combined with a parent intervention component. Forty-four middle school students and their parents were randomly assigned to the enhanced PRP (the PRP-CA plus parent program) or control conditions. Students completed measures of depression and anxiety symptoms at baseline and 2 weeks, 6 months, and 1 year after the intervention ended. The combined version of the PRP significantly reduced symptoms of depression and anxiety during the follow-up period. Children assigned to the intervention condition were less likely than controls to report clinical levels of anxiety symptoms. Findings suggest that school-based cognitive-behavioral interventions that include parents may prevent depression and anxiety symptoms in early adolescence. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

For teenagers, a psychosocial review of systems is at least as important as the physical exam. The popular and effective HEADSS method of interviewing has been expanded to HEEADSSS, focusing on assessment of the Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence.

Because of the almost complete absence of randomized controlled trials demonstrating the effectiveness of specific treatments, there is sometimes a degree of pessimism about our ability to prevent suicidal behaviors. However, the methodological challenges to produce such research are formidable and may never be overcome. Therefore, a pragmatic review of evidence-based methods of suicide prevention is required. This review of recent studies using a variety of research strategies, both nonpharmacological and pharmacological, particularly at the community level, provides persuasive data that suicide prevention is possible. This is achievable by the application of broad community and professional education programs, as well as by the optimum management of mental disorders.


Objective: To review critically the past 10 years of research on youth suicide. Method: Research literature on youth suicide was reviewed following a systematic search of PsycINFO and Medline. The search for school-based suicide prevention programs was expanded using two education databases: ERIC and Education Full Text. Finally, manual reviews of articles' reference lists identified additional studies. The review focuses on epidemiology, risk factors, prevention strategies, and treatment protocols. Results: There has been a dramatic decrease in the youth suicide rate during the past decade. Although a number of factors have been posited for the decline, one of the more plausible ones appears to be the increase in antidepressants being prescribed for adolescents during this period. Youth psychiatric disorder, a family history of suicide and psychopathology, stressful life events, and access to firearms are key risk factors for youth suicide. Exciting new findings have emerged on the biology of suicide in adults, but, while encouraging, these are yet to be replicated in youths. Promising prevention strategies, including school-based skills training for students, screening for at-risk youths, education of primary care physicians, media education, and lethal-means restriction, need continuing evaluation studies. Dialectical behavior therapy, cognitive-behavioral therapy, and treatment with antidepressants have been identified as promising treatments but have not yet been tested in a randomized clinical trial of youth suicide. Conclusions: While tremendous strides have been made in our understanding of who is at risk for suicide, it is incumbent upon future research efforts to focus on the development and evaluation of empirically based suicide prevention and treatment protocols.


The central goal of this report is to review and summarize the current state of knowledge on the effectiveness of preventive interventions intended to reduce the risk or effects of psychopathology in school-age children. In doing so, this report identifies critical issues and themes in prevention research with school-age children and families; identifies universal, selective and indicated programs that reduce symptoms of both externalizing and internalizing disorders; summarizes the state-of-the-art programs in the prevention of mental disorders in school-age children; identifies elements that contribute to program success, and provides suggestions to improve the quality of program development and evaluation. The current report is not intended to describe, in detail, preventive interventions that show effects only on
outcomes such as substance use, sexual behavior and contraception, or interventions that promote competence, but have not demonstrated effects on psychological symptomology.


The science and practice of prevention—whether related to physical disease or to behavioral health—have matured greatly. In the field of behavioral health today, a growing number of sophisticated models have been developed to describe how emotional and behavioral disorders develop over time. Preventive interventions based on these models have been tested empirically and shown to be effective in reducing behavioral disorders and promoting both emotional and physical health. The increased dissemination of these findings has encouraged communities to adopt and adapt preventive interventions that have been evaluated through high quality research and found effective. Policies set by both State and Federal funding agencies requiring grantees to use empirically based approaches have added further impetus to this growing community awareness and interest in implementing proven interventions. This report has been developed to help stimulate researchers and practitioners to place greater emphasis on how they conceptualize and measure implementation of evidence-based prevention programs. Without question, prevention practice will reach its full maturity only when known effective programs are implemented with integrity. Although the focus of this paper is on the implementation of school-based preventive interventions among children and youth, it has a broader application to other aspects of prevention research and practice by focusing squarely on the issue of how prevention models can be implemented with fidelity.


A comprehensive mission for schools is to educate students to be knowledgeable, responsible, socially skilled, healthy, caring, and contributing citizens. This mission is supported by the growing number of school-based prevention and youth development programs. Yet, the current impact of these programs is limited because of insufficient coordination with other components of school operations and in attention to implementation and evaluation factors necessary for strong program impact and sustainability. Widespread implementation of beneficial prevention programming requires further development of research-based, comprehensive school reform models that improve social, health, and academic outcomes; educational policies that demand accountability for fostering children’s full development; professional development that prepares and supports educators to implement programs effectively; and systematic monitoring and evaluation to guide school improvement.


Children and youth exhibiting serious emotional, behavioral, and interpersonal problems create substantial challenges for schools, teachers, their parents, and other students. Students having these characteristics are often underserved or unserved by educational and mental health systems in the United States. Recent prevalence rates for children served as emotionally disturbed (ED) under the Individuals With Disabilities Education Act is less than 1 percent although over 20 percent of the school population could qualify for a psychiatric diagnosis. A major reason for the underservice of children as ED lies in the federal definition of emotional disturbance which is nebulous, often illogical, and self-contradictory. An alternative approach to
ED identification based on a student's response to an evidence-based intervention is proposed in this article. Response to intervention is defined and described along with methods and procedures for quantifying whether or not a student shows an adequate or inadequate response to an evidence-based intervention implemented with integrity.


Traditionally, schools address students’ academic and behavioral difficulties in terms of a predictable three-stage process that can be described as a “refetest-place” approach. That is, students presenting academic and/or behavior problems are referred to a child study team that offers recommendations for an intervention to resolve the problem. Very often, however, these interventions are not evidence based and are often ineffective in solving the referral concern. These ineffective interventions then are followed by an official referral to a school psychologist or an assessment team to determine whether the student meets eligibility requirements for special education under a designated disability category (typically specific learning disabilities, emotional disturbance (ED), or mild mental retardation). Finally, if a team believes that the student is eligible for special education and related services, he or she is placed into special education and an individualized educational plan (IEP) is written (see Bocian, Beebe, MacMillan, and Gresham, 1999).


There is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic groups. Many previous authors have advocated that traditional mental health treatments be modified to better match clients’ cultural contexts. Numerous studies evaluating culturally adapted interventions have appeared, and the present study used metaanalytic methodology to summarize these data. Across 76 studies the resulting random effects weighted average effect size was d .45, indicating a moderately strong benefit of culturally adapted interventions. Interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. Interventions conducted in clients’ native language (if other than English) were twice as effective as interventions conducted in English. Recommendations are provided for improving the study of outcomes associated with mental health interventions adapted to the cultural context of the client.


By offering confidential consultation time to teenage patients, family doctors can uncover the real health issues and offer the appropriate management. The doctor should also try to help teenagers in their relationship to their parents and assist them in disclosure of the true situation to them. In many countries, teenagers have the legal right to consult and consent to treatment on their own [2, 3]. Yet, often, concerns about confidentiality are at the top of young people’s list of barriers in accessing health services [2, 4]. As family doctors, we have an important role to play in responding to young people’s health needs by providing adolescent-friendly services, ie, services that are accessible, affordable and developmentally appropriate [5]. Offering confidentiality is a priority step in responding to the needs of adolescents who come into our practices.

In this article, a distinct type of adult–youth relationship found in some youth programs and characterized as instrumental is discussed. Such relationships focus primarily on joint work on a task or project, or in a discipline, with the adult having expertise and a strong identity in the substantive domain involved, rather than in youth work per se. It is hypothesized that, by virtue of their matter-of-fact quality, their substantive focus, and their particular interactional patterns, instrumental relationships offer potential for some reworking of adolescents’ sense


This is a critical time for community foundations. More than 650 community foundations now operate throughout the country, and collectively they control over $30 billion in assets. Their contributions to community well-being are widely acknowledged and respected; local civic leaders and national foundations often turn to them to lead pivotal community improvement efforts. But community foundations also face two interrelated challenges that cut to the heart of their mission and effectiveness. First, the communities in which they work are becoming more complex and fragmented. In many cities and suburbs, populations are more ethnically and socioeconomically diverse. Commercial development, housing, and jobs are more regionally scattered than in the past. Mechanisms for raising public funds, providing public services, and making public decisions are more decentralized. Local civic leadership is being eroded by corporate consolidation and other factors. Meanwhile, the non-profit sector is growing in both size and diversity, often without the organizational infrastructure or funding required for optimal performance. Second, the fundraising environment for community foundations is becoming more competitive. Well-financed national corporations like Fidelity, as well as smaller, local financial service providers, have emerged as competitors for the same philanthropic dollars. Some large issue-specific charities and United Ways are creating their own endowments in addition to their annual fundraising efforts. Increasingly, individual donors want direct involvement with their giving and demand measures of impact and accountability. Compounding these pressures, a fluctuating stock market and a sluggish economy have reduced charitable assets and giving, while state and local budget constraints have decreased public sector support for meeting critical social needs. Community foundations are responding to these challenges by building on their distinctive position and history of community leadership. They are taking on more complex and demanding roles to convene, connect, inform, influence, and lead solutions to pressing problems. They are helping their communities take broader, bolder, and more comprehensive steps to build better futures. And they are connecting their donors to these efforts, expanding the influence, resources, and knowledge that are brought to bear. In short, they are becoming “community change makers.”


Effective implementation of service coordination in early intervention, as mandated by the Individuals with Disabilities Education Act, remains a challenge for most states. The present study provides a better understanding of the various aspects of the policy infrastructure that undergird service coordination across the United States. Data from a national survey of all state Part C coordinators contained critical variables that are used to describe three dimension of the policy infrastructure—responsibilities of the service coordinator, the document used to guide service coordination (Individualized Family Service Plan), and policies that facilitate a
comprehensive and interagency coordinated service system. The results indicated that in
general, most states do not have a sufficient policy infrastructure to support the
implementation of effective service coordination.

Hazell, P. (2003). "Establishment and evaluation of a clinical pathway for young suicide attempters and
Objective: To develop, implement and evaluate a pathway to care for young people presenting
with suicidal ideation or deliberate self-harm. Methods: A working party consisting of key
stakeholders was established to review existing practice, consider recommendations formulated
in other centres, formulate a pathway, identify training needs for clinical staff, identify gaps in
resources that would hinder the implementation of the pathway, and to evaluate effectiveness.
Results: No existing pathways were identified that could be applied to the local context. A
pathway was developed by consensus and disseminated to relevant clinical areas. A training
strategy involving clinical placements was implemented. Critical gateway points along the
pathway were identified and monitored. Compliance with gateway points was satisfactory, with
the exception of review by a mental health clinician in the emergency department. More than
75% of young people presenting on the pathway attended community follow up, which is higher
than the rate of compliance with follow up reported in most other studies. Conclusions:
Establishing a clinical pathway permitted the delineation of roles and responsibilities. Although
the pathway was developed for a local context, service planners may find it helpful to follow the
steps in the pathway development process that have been outlined.

Hickie, I. B. (2011). "Youth mental health: we know where we are and we can now say where we need to
go next." Early Intervention in Psychiatry 5(s1): 63-69.
Aim: To provide an overview of the state of knowledge relevant to the development of youth-
specific mental health initiatives. Methods: A selective review of data, particularly from
Australian community and health service studies, that are relevant to the decisions faced by
those who fund and organize health services internationally. Results: It is possible to reach
consensus on key issues such as the current state of evidence, myths that need to be
challenged, areas of genuine uncertainty, priorities for future reform, and five and ten year
goals and targets. Conclusions: There is considerable convergence of evidence from
epidemiology, clinical and basic neuroscience, population health and health service evaluation
that supports an urgent new investment in development and evaluation of youth mental health
initiatives.

Hickie, I. B. and P. D. McGorry (2007). "Increased access to evidence-based primary mental health care:
will the implementation match the rhetoric?" Medical Journal of Australia 187(2): 100.
There is clear evidence that coordinated systems of medical and psychological care
("collaborative care") are superior to single-provider-based treatment regimens. Although other
general practice-based mental health schemes promoted collaborative care, the new Medicare
Benefits Schedule payments revert largely to individual provider service systems and fee-for-
service rebates. Such systems have previously resulted in high out-of-pocket expenses, poor
geographical and socioeconomic distribution of specialist services, and proliferation of
individual-providerbased treatments rather than collaborative care. The new arrangements for
broad access to psychological therapies should provide the financial basis for major structural
reform. Unless this reform is closely monitored for equity of access, degree of out-of-pocket
expenses, extent of development of evidence-based collaborative care structures, and impact
on young people in the early phases of mental illness, we may waste this opportunity. The responsibility for achieving the best outcome does not lie only with governments. To date, the professions have not placed enough emphasis on systematically adopting evidence-based forms of collaborative care.


This study evaluated the effectiveness of augmenting a youth suicide-preventive intervention with a brief, home-based parent program. A total of 615 high school youth and their parents participated. Three suicide prevention protocols, a youth intervention, a parent intervention, and a combination of youth and parent intervention, were compared with an “intervention as usual” (IAU) group. All groups experienced a decline in risk factors and an increase in protective factors during the intervention period, and sustained these improvements over 15 months. Results reveal that the youth intervention and combined youth and parent intervention produced significantly greater reductions in suicide risk factors and increases in protective factors than IAU comparison group.


School-based violence prevention has become a growing concern for educators, parents, and researchers. This article describes the Piscataway Project—a school-based action research project focused on the development, implementation, and evaluation of violence-prevention instructional approaches—and discusses some of the challenges associated with school-based prevention efforts. Conceptual, delivery, training, and organizational variables that contribute to outcomes of school-based preventive interventions are described and their impact on the Piscataway Project is discussed. Lessons learned from the project are also presented as a guide for those interested in the development and implementation of school-based interventions.


Background: In the Swedish society, as in many other societies, many children and adolescents with mental health problems do not receive the help they need. As the Swedish society becomes increasingly multicultural, and as ethnic and economic residential segregation become more pronounced, this study utilises ethnicity and neighbourhood context to examine referral pathways to child and adolescent psychiatric (CAP) clinics. Methods: The analysis examines four different sources of referrals: family referrals, social/legal agency referrals, school referrals and health/mental health referrals. The referrals of 2054 children aged 11-19 from the Stockholm Child-Psychiatric Database were studied using multilevel logistic regression analyses. Results: Results indicate that ethnicity played an important role in how children and adolescents were referred to CAP-clinics. Family referrals were more common among children and adolescents with a Swedish background than among those with an immigrant background. Referrals by social/legal agencies were more common among children and adolescents with African and Asian backgrounds. Children with Asian or South American backgrounds were more likely to have been referred by schools or by the health/mental health care sector. A significant neighbourhood effect was found in relation to family referrals. Children and adolescents from neighbourhoods with low levels of socioeconomic deprivation were more likely to be referred to CAP-clinics by their families in comparison to children from other neighbourhoods. Such
differences were not found in relation to the other sources of referral. Conclusions: This article reports findings that can be an important first step toward increasing knowledge on reasons behind differential referral rates and uptake of psychiatric care in an ethnically diverse Swedish sample. These findings have implications for the design and evaluation of community mental health outreach programs and should be considered when developing measures and strategies intended to reach and help children with mental health problems. This might involve providing information about the availability and accessibility of health care for children and adolescents with mental health problems to families in certain neighbourhoods and with different ethnic backgrounds.


Psychotic illness is managed and treated with best results when it is recognized at the earliest stages of a person developing the disorder, or when that person is identified as being at high risk of doing so. Describing a stage-specific model highlighting the risk, the clinical and biological factors present during the development of the illness, and the best treatments available for each of these stages, this new edition will guide practitioners and researchers in the adoption of carefully planned management strategies fully integrating treatment with prevention. Issues such as resistance to drugs and vocational recovery are covered, with related topics such as service organization and community education. This will be essential reading for all those involved in the care of people with early psychotic illness, or those responsible for the organization of services.


Concern about violence in schools has been increasing, and, correspondingly, conflict resolution and peer mediation training programs have been proliferating. These programs have been developed by researchers in the field of conflict resolution, advocates of nonviolence, anti-nuclear-war activists, and members of the legal profession. It is unknown, however, whether the programs are needed and whether or not they are effective. While there are numerous methodological and conceptual problems with the research on conflict resolution and peer mediation programs, the current evidence indicates that (a) conflicts among students do occur frequently in schools (although the conflicts rarely result in serious injury); (b) untrained students by and large use conflict strategies that create destructive outcomes by ignoring the importance of their ongoing relationships; (c) conflict resolution and peer mediation programs do seem to be effective in teaching students integrative negotiation and mediation procedures; (d) after training, students tend to use these conflict strategies, which generally leads to constructive outcomes; and (e) students’ success in resolving their conflicts constructively tends to result in reducing the numbers of student-student conflicts referred to teachers and administrators, which, in turn, tends to reduce suspensions.


For major physical diseases, it is widely accepted that members of the public will benefit by knowing what actions they can take for prevention, early intervention, and treatment. However, this type of public knowledge about mental disorders (mental health literacy) has received much less attention. There is evidence from surveys in several countries for deficiencies in (a) the
public's knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others affected by mental health problems. Nevertheless, there is evidence that a range of interventions can improve mental health literacy, including whole-of-community campaigns, interventions in educational settings, Mental Health First Aid training, and information websites. There is also evidence for historical improvements in mental health literacy in some countries. Increasing the community's mental health literacy needs to be a focus for national policy and population monitoring so that the whole community is empowered to take action for better mental health.


The objective of the study was to find out whether the school-based prevention programme 'Initiated abstinence' is suitable to induce pupils to change their consumer behavior and attitudes. The participants of the prevention programme commit themselves 'per contract' to abstain from or considerably reduce their consumption of at least one of their currently used substances (e.g. sweets, cigarettes) or media (TV, computer games) for a period of 2 weeks. The main goal of the programme is to sharpen their problem and health consciousness concerning addiction and pleasure seeking. The programme was evaluated by a longitudinal study. At three given times, the 12- to 15-year-old pupils of the experimental classes were interviewed by standardized self-completion questionnaires (n = 2,267). The control classes were submitted to two surveys (n = 586). The study was carried out in the areas of Innsbruck (Austria), Schleswig-Holstein (Germany) and South Tyrol (Italy). Not all pupils were able to keep their intentions submitted in their contract, but 4 of 5 pupils had at least one positive experience with the renunciation (82%). There were 'overall effects': The actual renunciation of the pupils was much higher than stated in their agreement. The experimental group showed significant reduction effects for pupils, who had successfully reduced or stopped use of a substance or medium. In a further step, it should be explored whether the programme is suitable also for older groups, i.e. for pupils older than 15 years. Moreover, the long-term effects of the programmes should be tested.


Objective: To examine academic outcomes of a community-partnered school mental health intervention for students who have been exposed to community violence. Design: Randomized controlled trial. Setting and Participants: Sixth-grade students (n=123) from 2 middle schools in Los Angeles during the 2001–2002 academic year who had exposure to violence and posttraumatic stress symptoms in the clinical range. Intervention: Students were randomized to either receive a 10-session standardized school trauma intervention (Cognitive Behavioral Intervention for Trauma in Schools) soon after screening (Early Intervention) or after a delay following screening (Delayed Intervention), but within the same school year. Main Outcome Measures: 59 students in the Early Intervention group vs. 64 students in the Delayed Intervention group (screened in September or December) were compared on Spring Semester grades in math and language arts, controlling for the students' standardized state test scores from the previous academic year and other covariates. Results: Students in the Early
Intervention group had a significantly higher Spring Semester mean grade in math (2.0 vs. 1.6) but not language arts (2.2 vs. 1.9). Students in the Early Intervention group were more likely than students in the Delayed Intervention group to have a passing grade (“C” or higher) in language arts (80% vs. 61%; p<0.033) by Spring Semester but not in math. Conclusion: Through a collaborative partnership between school staff and researchers, preliminary evidence suggests that receiving a school trauma intervention soon after screening compared to delaying treatment can result in better school grades.


The Good Behavior Game (GBG), a universal classroom behavior management method, was tested in first- and second-grade classrooms in Baltimore beginning in the 1985–1986 school year. Followup at ages 19–21 found significantly lower rates of drug and alcohol use disorders, regular smoking, antisocial personality disorder, delinquency and incarceration for violent crimes, suicide ideation, and use of school-based services among students who had played the GBG. Several replications with shorter followup periods have provided similar early results. We discuss the role of the GBG and possibly other universal prevention programs in the design of more effective systems for promoting children’s development and problem prevention and treatment services.


This paper examines variations in suicide within the Republic of Ireland in order to determine if the services, as currently available, require redistribution. The rates of suicide and undetermined death in the four provinces, 26 counties and five cities of Ireland are examined for the years 1976 to 1994, with the age and gender distributions of local populations taken into consideration. Marked variations between areas are noted with a threefold difference between the counties with the highest and lowest rates. Counties tend to be similarly ranked for men and women but the male suicide rate, overall, was almost three times that for women. The male:female ratio was 2.3:1 for the first half of the study, but this increased to 3.4:1 for the second half; a reflection of increasing numbers of male suicides. Surprisingly, the male suicide rate in Dublin city has stayed steady at 12 per 100,000 over the entire study period, while the national male rate has more than doubled reaching approximately 18 per 100,000 in recent years. There is a need for improved services in rural Ireland. If the various available services are to help reduce the suicide rate, then a mechanism must be found to deliver these in areas of low population density where the need could well be greatest.


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Good mental health literacy in young people and their key helpers may lead to better outcomes for those with mental disorders, either by facilitating early help-seeking by young people themselves, or by helping adults to identify early signs of mental disorders and seek help on their behalf. Few interventions to improve mental health literacy of young people and their helpers have been evaluated, and even fewer have been well evaluated. There are four categories of interventions to improve mental health literacy: whole-of-community campaigns; community campaigns aimed at a youth audience; school-based interventions teaching help-seeking skills, mental health literacy, or resilience; and programs training individuals to better intervene in a mental health crisis. The effectiveness of future interventions could be enhanced by using specific health promotion models to guide their development.


BACKGROUND AND OBJECTIVES: The evidence base for the importance of the school environment for adolescent emotional health has never been systematically reviewed. We aimed to synthesize the evidence for the effect on adolescent emotional health of (1) interventions targeting the school environment and (2) the school environment in cohort studies. METHODS: Searches of Medline, Embase, PsychINFO, CINAHL, ERIC, the Social Citation Index, and the gray literature were conducted. Criteria for inclusion were (1) cohort or controlled trial designs, (2) participants aged 11 to 18 years, (3) emotional health outcomes, and (4) school environment exposure or intervention. Relevant studies were retrieved and data extracted by 2 independent reviewers. RESULTS: Nine papers reporting 5 controlled trials were reviewed, along with 30 cohort papers reporting 23 studies. Two nonrandomized trials found some evidence that a supportive school environment improved student emotional health, but 3 randomized controlled trials did not. Six (20%) cohort papers examined school-level factors but found no effect. There was some evidence that individual perceptions of school connectedness and teacher support predict future emotional health. Multilevel studies showed school effects were smaller than individual-level effects. Methodological shortcomings were common. CONCLUSIONS: There is limited evidence that the school environment has a major influence on adolescent mental health, although student perceptions of teacher support and school connectedness are associated with better emotional health. More studies measuring school-level factors are needed. Randomized controlled trials evaluating 1 or 2 environmental components may have more success in establishing effective and feasible interventions compared with complex whole-school programs.


Mental health problems affect 10–20% of children and adolescents worldwide. Despite their relevance as a leading cause of health-related disability in this age group and their longlasting
effects throughout life, the mental health needs of children and adolescents are neglected, especially in low-income and middle-income countries. In this report we review the evidence and the gaps in the published work in terms of prevalence, risk and protective factors, and interventions to prevent and treat childhood and adolescent mental health problems. We also discuss barriers to, and approaches for, the implementation of such strategies in low-resource settings. Action is imperative to reduce the burden of mental health problems in future generations and to allow for the full development of vulnerable children and adolescents worldwide.


During recovery, young people with psychosis need attention paid not only to their psychotic symptoms but also to the areas of functioning that restrict their capacity to live a fulfilled life in the community. Despite improvements in medications and psychological therapies, people with psychosis still have poor outcomes in functional domains such as vocation, physical health, housing, and imprisonment. This article reviews 2 of these areas: vocational functioning and physical health. It examines the extent of each of these issues, provides guidance as to what evidence there exists on which to base interventions, and describes such evidence.


Mental Health First Aid is a training program for members of the public in how to support someone in a mental health crisis situation or who is developing a mental disorder. The program has solid evidence for its effectiveness from randomized controlled trials and qualitative studies. It increases knowledge, reduces stigma and, most importantly, increases supportive actions. It even improves the mental health of first-aiders. Mental Health First Aid training can assist in early intervention and in the on-going community support of people with mental illnesses. It is useful for people employed in areas which involve increased contact with mental health issues and for carers of people with mental illnesses. It is recommended that Mental Health First Aid training becomes a prerequisite for practice in certain occupations which involved increased contact with people having mental health problems, such as teachers and police.


Behavior and psychological problems assessed prospectively by teachers and parents and by youths’ self-reports through late childhood and adolescence were examined as possible predictors of early adult depression. Data were from 765 participants in the Seattle Social Development Project, a multiethnic and gender-balanced urban sample. Analyses examined 7 waves of data from ages 10 to 21, and included measures from the Achenbach Child Behavior Checklist and assessments of past-year depressive episode based on the Diagnostic Interview Schedule. Self-reported conduct problems as early as age 10 (Mason et al. 2001) and throughout adolescence consistently predicted depression at age 21. Parent reports of conduct and other externalizing problems in adolescence also significantly predicted adult depression. None of the available teacher reports through age 14 were significant predictors. Results suggest that externalizing problems can be useful indicators of risk for adult depression. Prevention efforts that target externalizing problems in youth may hold promise for reducing later depression.

Effective parenting is the most powerful way to reduce adolescent problem behaviors. Dissemination of research-based family interventions has been slow, with most practitioners still implementing ineffective programs. This article reviews 2 federal studies that involved national searches for effective family interventions targeting prebirth to adolescence: Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches (Center for Substance Abuse Prevention, 1998) and Strengthening America's Families (R. Alvarado, K. L. Kumpfer, K. Kendall, S. Beesley, & C. Lee-Cavaness, 2000). Results identified 3 effective prevention approaches, 13 principles of effectiveness, and 35 programs. Recommendations include increased dissemination research on training and technical assistance systems, adoption with fidelity and quality, and gender-, age-, and culturally sensitive adaptations.


Early identification and proper diagnosis and treatment have been shown to be effective in addressing youth mental illnesses in both primary and specialty care settings. Appropriate interventions in youth can decrease disability, improve vocational success and enhance quality of life. Early intervention with effective therapies could thus greatly enhance population health while improving outcomes for the young people involved.


There has been a considerable increase in the need for psychiatric services for adolescents. Primary health care practitioners have a major role in detecting, screening and helping these adolescents. An intervention entitled SCREEN is described in this article. The SCREEN intervention was developed to help practitioners to detect and screen adolescent needs, to care for adolescents at the primary health care level and to facilitate the referral of adolescents to secondary care services in collaboration between primary and secondary health care. Secondly, the article presents the background and clinical characteristics of youths seeking help from the SCREEN services, and compares the background factors and clinical characteristics of those patients referred and not referred to secondary care services. The SCREEN intervention consisted of 1 to 5 sessions, including assessment by a semi-structured anamnesis interview, the structured Global Assessment Scale, and by a structured priority rating scale, as well as a brief intervention for each adolescent's chosen problem. Parents took part in the assessment in 39% of cases involving girls and 50% involving boys. During 34 months, 2071 adolescents (69% females) entered the intervention and 70% completed it. The mean age was 17.1 years for boys and 17.3 years for girls. For 69% of adolescents, this was the first contact with psychiatric services. The most common reasons for seeking services were depressive symptoms (31%). Self-harming behaviour had occurred in 25% of girls and 16% of boys. The intervention was sufficient for 37% of those who completed it. Psychosocial functioning improved during the intervention. Factors associated with referral for further treatment were female gender, anxiety as the main complaint, previous psychiatric treatment, self-harming behaviour, a previous need for child welfare services, poor psychosocial functioning and a high score in the priority rating scale. A brief intervention carried out by a team including professionals from both primary and secondary level services was sufficient for a considerable proportion of adolescents seeking help for their psychiatric problems. Referral practices and counselling in special level services can be
standardized. In the future, it will be important to develop and assess psychiatric services for adolescents using randomised controlled trials.


Aim A three and a half year follow up evaluation was conducted of eight government and non-government agencies who received seed funding from Auseinet to reorient an aspect of their service to an early intervention approach in mental health. The aim of the research was to determine key elements in sustainability of seed funded projects. Methods Face to face interviews were conducted with members of each agency involved in the reorientation project. This evaluation was situated in the theoretical base of capacity building and sustainability and focused on identifying barriers and opportunities that agencies faced in reorienting their services to an early intervention approach at agency and community levels. Findings Agencies had varied success in reorienting to an early intervention approach. This ranged from conceptual shifts in early intervention thinking to the expansion of early intervention services. Success was dependent on agency and community characteristics. Conclusions The findings confirm the Australian literature on capacity building which suggests several crucial predictors of success in changing the ways agencies run. These include the development of interagency links, management support and problem-solving abilities. This brief report is useful in identifying factors at a community level which impact on early intervention activity in mental health.


Examines the effectiveness of school-based suicide prevention programs for adolescents. Background information on suicidal adolescents; Goals of school-based suicide prevention programs; Theoretical orientation of suicide prevention programs; Targeted population of suicide prevention programs.


Few studies have examined risk factors of childhood and early adolescent depressive symptomatology trajectories. This study examined self-report depressive symptomatology across a 6-year time period from 2nd to 8th grade to identify latent groups of individuals with similar patterns of depressive phenomena in a sample of 951 children (440 girls, 511 boys). Analyses, using semiparametric group modeling (SGM), identified 5 trajectory groups for girls and boys: low depressed stables, low depressed risers, mildly depressed stables, moderately depressed changers, and moderately depressed risers. Individual risk factors, with the exception of shy/withdrawn behavior, were significantly different across trajectory group membership for boys and girls, as was low-income status for boys. Boys in the low depressed and mildly depressed stable trajectory groups had significantly higher levels of antisocial behavior, attention problems, and lower social competency compared to girls in similar groups. These results suggest that universal prevention programs implemented in early elementary school that target selected risk factors may be helpful in reducing future adolescent mental health problems, specifically depressive symptomatology.

One-year versus two-year outcomes were compared for a school-based prevention project for 82 children at risk for emotional disturbance. Matched pairs of children were assigned to either Parent Teacher Action Research (PTAR) teams or a control group. Significant differences favoring the PTAR group were found, especially following year two. Results support more long-term implementation of prevention programs.


It is well recognised that mental illness is a significant and enduring issue in Australia today. In order to address the growing concern, in July 2006 the Council of Australian Governments endorsed a National Action Plan on Mental Health which aimed: to reduce the incidence of mental illness in Australia with a particular focus on early intervention; to enhance the active citizenship of Australians with mental health issues; and to improve services for people with a mental illness, their families, and carers (Council of Australian Governments, 2006). As part of the Plan, a series of Mental Health Community Based Services initiatives were funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). This article will discuss one of those initiatives – the Family Life SHINE children’s mental health pilot project – which offered an early intervention and public health service strategy within a family support agency in the southern region of Melbourne. The findings of the two-year bi-phase evaluation will be presented, along with a selection of recommendations and key evaluation challenges that arose during the pilot period.


Among the noncommunicable diseases, mental ill-health represents the major threat to social and economic progress because it impacts so powerfully on the most critical decades of life. Consequently, mental health reform is increasingly recognized as an urgent priority worldwide. This brings into sharp focus the role of evidence, and more specifically the Cochrane paradigm, in influencing decisions about health system reform. Cochrane clearly still has great value, especially in evidence-based medicine, where the focus is the evaluation of individual treatments. However, it cannot be allowed to be a dominant influence in evidence-based health care (EBHC) policy decisions for health system reform, unless it is modernized or complemented. Health services reform should definitely be as evidence-based as possible; however, the jury should consider its verdict on key reform proposals based on the balance of probabilities and informed by the best “available” evidence from all sources, not only randomized clinical trials, which in many domains may be never be feasible. This is particularly the case when reform is urgent, and the status quo has manifestly failed. So on the one hand, the evidence-based paradigm must not be misused to stifle or paralyze urgent reform. Alternatively, there is a real risk that, if we do not improve the sophistication of EBHC, the whole paradigm will be sidelined and reform will remain reactive, impulsive, and desultory. The recent Cochrane review on early intervention in psychosis provides an opportunity to consider these issues and their wider significance.


Although the corrosive effect of mental ill health on human health and happiness has long been recognised, it is only relatively recently that mental illness has been acknowledged as one of the
major threats to economic productivity worldwide. This is because the major mental disorders most
commonly have their onset during adolescence and early adulthood, and therefore have a
disproportionate impact on the most productive decades of life. With the costs associated with
mental ill health estimated to double over the next two decades, a greater emphasis on
prevention and early intervention has become even more imperative. Although prevention
largely remains aspirational for many reasons, early intervention is well within our current reach
and offers the potential to significantly reduce the impact of mental ill health on our health,
happiness and prosperity in the immediate future.

McGorry, P., et al. (2013). "Designing youth mental health services for the 21st century: examples from
Australia, Ireland and the UK." The British Journal of Psychiatry 202(s54): s30-s35.
Despite the evidence showing that young people aged 12–25 years have the highest incidence
and prevalence of mental illness across the lifespan, and bear a disproportionate share of the
burden of disease associated with mental disorder, their access to mental health services is the
poorest of all age groups. A major factor contributing to this poor access is the current design of
our mental healthcare system, which is manifestly inadequate for the unique developmental
and cultural needs of our young people. If we are to reduce the impact of mental disorder on
this most vulnerable population group, transformational change and service redesign is
necessary. Here, we present three recent and rapidly evolving service structures from Australia,
Ireland and the UK that have each worked within their respective healthcare contexts to
reorient existing services to provide youth-specific, evidence-based mental healthcare that is
both accessible and acceptable to young people.

Diagnosis in psychiatry continues to struggle to fulfill its key purposes, namely to guide
treatment and to predict outcome. A clinical staging model, widely used in clinical medicine,
could improve the utility of diagnosis in psychiatry, especially in young people with emerging
disorders. Clinical staging has immediate potential to improve the logic and timing of
interventions in psychiatry, as it does in many complex and potentially serious medical
disorders. Interventions could be evaluated in terms of their ability to prevent or delay
progression from earlier to later stages of a disorder, and selected by consumers and clinicians
on the basis of clear-cut risk–benefit criteria. This would ensure that, as treatments are offered
earlier, they remain safe, acceptable and affordable, and potentially more effective. Biological
variables and a range of candidate risk and protective factors could be studied within and across
stages, and their role, specificity and centrality in risk, onset and progression of disorders
clarified. In this way, a clinicopathological framework could be progressively constructed.
Clinical staging, with restructuring across and within diagnostic boundaries and explicit
operational criteria for extent and progression of disorder, should be actively explored in
psychiatry as a heuristic strategy for developing and evaluating earlier, safer, and more effective
clinical interventions, and for clarifying the biological basis of psychiatric disorders. Young
people with emerging mental and substance use disorders could be the main beneficiaries.

This article focuses on an attempt to integrate evidence-based engagement interventions into
"real world" outpatient child mental health settings in order to increase access to care for urban
youth and their families. More specifically, empirical support for introducing engagement
interventions into child clinical settings will be reviewed. Then, specific engagement interventions that are delivered during the initial telephone contact with a child’s adult caregiver or during the first face-to-face contact with a child and family are described with attention paid to the training necessary to assist service providers in adopting this change in practice. Factors that serve to facilitate or impede adoption of evidence-based engagement interventions are also reviewed. Finally, preliminary evidence for the effectiveness of integrating such evidence-supported approaches is presented.


Communities, as well as society at large will: Work to positively shape and strengthen children’s physical, social, cultural, political, and economic environments in ways that promote optimal well-being and help prevent mental health problems. Provide a full continuum of services and supports, from promoting health and preventing problems to treating problems and reclaiming health, that help all children manage environmental, social, and emotional challenges, thrive, and be contributing members of society. The mission of this monograph is to: Present a conceptual framework for a public health approach to children’s mental health grounded in values and principles. Present a new intervention model for children’s mental health. Demonstrate the integration of a public health approach with the intervention model for children’s mental health. Show how the array of systems, agencies, and organization, as well as a variety of interventions that serve children are key to the implementation of a public health approach to children’s mental health. Offer terms and definitions for use in the monograph and language for the public health approach to children’s mental health and encourages their use. Provide examples of interventions and policies that have shown promise as components of the new framework. Suggest how partners, stakeholders and consumers might use this framework.


The purpose of this article is to provide a comprehensive review of school-based suicide prevention programs from a public health perspective. A literature review of empirical studies examining school-based suicide prevention programs was conducted.


Together, School Rampage Shootings and Other Youth Disturbances and its accompanying CD provide a complete toolkit for using early preventative interventions with elementary-school age children. In ten thoughtful, clearly written chapters, both new and experienced practitioners will find a wealth of research- and evidence-based techniques that link personal child and childhood environmental conditions to a number of symptoms, disturbances, and disorders in youth or adulthood, including the expression of rampage violence. In the second part of this indispensable collection – the accompanying CD – practitioners will find worksheets and handouts that translate useful techniques into reality and are sure to make any practice come alive.

Objective: To establish the nature and efficacy of Australian school-based prevention and early intervention programs for anxiety and depression. Data sources: Cochrane, PsychInfo and PubMed databases, and the Primary Mental Health Care Australian Resource Centre database, were searched in June 2006. Additional materials were obtained from program websites, reference lists and authors. Study selection: Programs that were developed in Australia or trialled in Australia and addressed anxiety, depression, or resilience were included. Data synthesis: 24 efficacy or effectiveness trials of 9 intervention programs were identified. Most were based on cognitive behaviour therapy, interpersonal therapy or psychoeducation. Six were universal interventions, two were indicated programs and one was a treatment program. Most were associated with short-term improvements or symptom reduction at follow-up. Conclusions: A number of schools programs produce positive outcomes. However, even well established programs require further evaluation to establish readiness for broad dissemination as outlined in the standards of the Society for Prevention Research.


A systematic review was conducted of school-based prevention and early intervention programs for anxiety. The aim of the review was to identify and describe the programs available, and to evaluate their effectiveness in reducing symptoms of anxiety. Twenty-seven outcome trials, describing 20 individual programs, were identified through the Cochrane Library, PsychInfo and PubMed databases. Results of the review indicated that most universal, selective and indicated prevention programs are effective in reducing symptoms of anxiety in children and adolescents, with effect sizes ranging from 0.11 to 1.37. Most programs targeted adolescents (59%), were aimed at reducing the symptoms of nonspecific anxiety (67%), and delivered cognitive behavioural therapy (CBT; 78%). Further quality school-based research is required that involves longer-term follow-up, the use of attention control conditions and evaluates teacher delivery.


Building resilience in young people is an important goal if we are to strengthen capacity and promote skills that help to reduce mental health problems. One way to foster resilience in young people is through meaningful youth participation; that is, decision-making by young people that involves meaning, control, and connectedness. Whilst youth participation may occur in recognition of young people’s rights to be involved in all decisions that affect them, meaningful participation can itself enhance a young person’s sense of connectedness, belonging and valued participation, and thereby impact on mental health and well being. Based on its extensive experience working collaboratively with young people, the Inspire Foundation, in partnership with young people, has developed a flexible and diverse approach to youth participation. This paper outlines the theoretical and conceptual underpinnings of the model, and discusses the operationalisation of program goals, atmosphere and activities that seek to build resilience through meaningful youth participation.


BACKGROUND: Approximately 21% of US children age 9 to 17 have a diagnosable mental illness with some degree of impairment. As early-onset mental illness may persist throughout the life span, effective primary mental health prevention programs are of paramount importance. METHODS: We conducted a literature review of various preventive programs targeting
childhood-onset psychopathology. We attempted to select those programs that present the strongest data on efficacy and those that are most commonly cited. RESULTS: Modifiable and nonmodifiable risk factors and different primary prevention strategies with positive outcomes have been identified for anxiety disorders, eating disorders, substance abuse, disruptive behavior disorders, and suicide in children. The reported results for attention-deficit/hyperactivity disorder (ADHD) and early-onset schizophrenia are neither uniform nor encouraging. CONCLUSIONS: Based on our review, there is ample evidence to conclude that primary preventive intervention has the potential to be effective for some mental health disorders, promoting positive development, particularly in children of all ages in high-risk environments. Additional research is needed to further investigate the validity and reliability of various preventive strategies.


Background After an epidemic rise in Australian young male suicide rates over the 1970s to 1990s, the period following the implementation of the original National Youth Suicide Prevention Strategy (NYSPS) in 1995 saw substantial declines in suicide in young men. Aims To investigate whether areas with locally targeted suicide prevention activity implemented after 1995 experienced lower rates of young adult suicide, compared with areas without such activity. Method Localities with or without identified suicide prevention activity were compared during the period of the NYSPS implementation (1995–1998) and a period subsequent to implementation (1999–2002) to establish whether annual average suicide rates were lower and declined more quickly in areas with suicide prevention activity over the period 1995–2002. Results Male suicide rates were lower in areas with targeted suicide prevention activity (and higher levels of funding) compared with areas receiving no activity both during (RR = 0.89, 95% CI 0.80–0.99, P = 0.030) and after (RR = 0.86, 95% CI 0.77–0.96, P = 0.009) implementation, with rates declining faster in areas with targeted activity than in those without (13% v. 10% decline). However, these differences were reduced and were no longer statistically significant following adjustment for sociodemographic variables. There was no difference in female suicide rates between areas with or without targeted suicide prevention activity. Conclusions There was little discernible impact on suicide rates in areas receiving locally targeted suicide prevention activities in the period following the NYSPS.


Background: The prevalence of mental illness in young people is the highest of any age group, with the onset of depression, anxiety and substance use peaking between 18 and 24 years. Effective treatments that target subthreshold or mild to moderate levels of disorder in young people are required to reduce the risk of persistence and recurrence. The aims of this study are to evaluate whether treatments that are less intensive than cognitivebehaviour therapy, such as problem solving therapy and exercise treatments, are acceptable and effective in managing depression and anxiety symptoms in young people and to identify possible attributes in those who are likely to respond to these treatments. Methods/design: This is a factorial randomised controlled trial conducted at a large, metropolitan youth mental health service. Participants are young help-seekers aged 15-25 years with sub-threshold or mild to moderate levels of depression and anxiety (with or without comorbid substance use). The interventions comprise 4 treatment combinations delivered by psychologists over 6 sessions on a weekly basis: a
psychological intervention (problem solving therapy versus supportive counselling) and an exercise intervention (behavioural exercise versus psychoeducation). Structured assessments occur at baseline, mid-point, end-point (6 weeks) and at a 6- and 12- month follow-up. The primary outcomes are depression and anxiety symptoms as measured by the Beck Depression and Anxiety Inventories. Secondary outcomes include remission (defined as no longer meeting the diagnostic criteria for a disorder if threshold level was reached at baseline, or no longer scoring in the clinical range on scale scores if sub-threshold at baseline), substance use, and functioning. Discussion: The effectiveness of less complex psychological and exercise interventions in young help-seekers with sub-threshold or mild to moderate presentations of high prevalence disorders is yet to be explored. This study has been designed to examine the effectiveness of these interventions delivered alone, or in combination, in a youthspecific service. If effective, the interventions have the potential to prevent the progression of early symptoms and distress to later and potentially more serious stages of mental disorder and reduce the likelihood of ongoing problems associated with the risk of persistence and recurrence.


Adolescents are a growing area in paediatric practice in both hospital and community settings. They make up around one quarter of the practice of many paediatricians. Yet until recently there has been little formal interest in young people’s health in the UK. The situation is now changing, particularly following the publication of the “National Service Framework for children, young people and maternity services”, which places a major emphasis on adolescent health. Given that this area is relatively new to many paediatricians, this article aims to provide an overview of the range of health problems that affect young people, to provide practical advice for working with this group in paediatric practice, and to outline current and future opportunities for training in adolescent health in the UK.


Suicide and associated mental health problems are a major issue for 18–25 year-olds in Australia, many of whom are studying at university. The Suicide Intervention Project (SIP) is a peer-based mental health promotion program, designed as a partnership between the University of Canberra and the YWCA of Canberra. In its first year, the SIP trained 56 participants to be better able to respond to the mental health problems of their university peers. The present study evaluated the SIP in terms of changes experienced by 42 of its first participants. Specifically, it was anticipated that there would be improvements in participants’ attitudes, norms, perceived behavioural control, self-efficacy and intentions toward talking to other university students about personal feelings and mental health problems. The social connectedness and mental health literacy of participants were also expected to improve. Results indicated the SIP did have a positive effect on participants, with almost all measures changing from pre- to post-test in the expected directions. Unexpectedly, however, none of these factors correlated with the actual behaviour of talking to other students about feelings, which was measured two weeks after program completion. Results are discussed in terms of the impact of the SIP program on the wider university community.

The concept of early intervention for psychosis has received much attention in recent years. The experience of pioneer services in the USA and Australia has convinced the UK Government to set aside millions of pounds to make dedicated early intervention teams an integral part of standard mental health services across the country. Other governments are set to follow suit. The rationale for early intervention is that there is a higher success rate if psychotic symptoms are treated early than if they are treated after they have been present for some time. It is also claimed that interventions early in the course of the illness can decrease the psychosocial impact of a psychotic illness that leads to secondary disability. But have these assertions been empirically demonstrated? Do such services simply take valuable resources, both in terms of funding and staff, from an already-overstretched mental health system, or do they change the trajectory of the disease process in a fundamental way?


Mental health difficulties are easily the key health issue faced by adolescents and young adults in the developed world today. Epidemiological studies have shown that the incidence and prevalence of the mental disorders, as well as their contribution to the overall burden of disease, is highest in those in the 15 to 24 year age group, and yet young people in this age range are the least likely to access services for mental health problems. This issue is particularly problematic given that untreated, or poorly treated, mental disorders are associated with ongoing disability, including impaired social functioning, poor educational achievement, unemployment, substance abuse, and violence that all too often leads to a cycle of dysfunction and disadvantage that is difficult to break. Young people tend to be reluctant to discuss emotional concerns with a general practitioner if indeed they have a regular doctor, and the traditional mental health services, which cater to the needs of children or older adults, are highly alienating to young people. A new approach to mental health services for young people is clearly needed—one that considers young people's unique developmental issues, their help-seeking needs and behaviors, and the complex and evolving patterns of symptoms and morbidity common in this age group. This article describes Australian innovation in the provision of youth mental health services, which has been informed by an evidence-based approach and dedicated advocacy, that seeks to contribute to this much needed reform process.


Parents of 468 children aged between 12 and 14 years in ten high schools in a city in regional north Queensland and metropolitan Melbourne participated in a survey of early adolescent behaviour. The major undesirable behaviours experienced by parents were fighting with siblings, talking back to adults, moodiness, and school difficulties. Frequently listed desirable behaviours that were experienced were related to housework and communication. Parents indicated a desire for education to help them assist their teenage children develop more appropriate behaviour, and in particular in regard to better managing their emotions. The findings are discussed in the context of the challenge of designing and delivering effective early intervention programs to large numbers of parents of early adolescents.

Background: The age at which most young people are in higher education is also the age of peak onset for mental and substance use disorders, with these having their first onset before age 24 in 75% of cases. In most developed countries, over 50% of young people are in higher education.

Aims: To review the evidence for prevention and early intervention in mental health problems in higher education students. The review was limited to interventions targeted to anxiety, depression and alcohol misuse.

Methods: Interventions to review were identified by searching PubMed, PsycINFO and the Cochrane Database of Systematic Reviews. Interventions were included if they were designed to specifically prevent or intervene early in the general (non-health professional) higher education student population, in one or more of the following areas: anxiety, depression or alcohol misuse symptoms, mental health literacy, stigma and one or more behavioural outcomes.

Results: For interventions to prevent or intervene early for alcohol misuse, evidence of effectiveness is strongest for brief motivational interventions and for personalized normative interventions delivered using computers or in individual face-to-face sessions. Few interventions to prevent or intervene early with depression or anxiety were identified. These were mostly face-to-face, cognitive–behavioural/skill-based interventions. One social marketing intervention to raise awareness of depression and treatments showed some evidence of effectiveness.

Conclusions: There is very limited evidence that interventions are effective in preventing or intervening early with depression and anxiety disorders in higher education students. Further studies, possibly involving interventions that have shown promise in other populations, are needed.


This paper summarises an ambitious research agenda aiming to uncover the factors that affect help-seeking among young people for mental health problems. The research set out to consider why young people, and particularly young males, do not seek help when they are in psychological distress or suicidal; how professional services be made more accessible and attractive to young people; the factors that inhibit and facilitate help-seeking; and how community gatekeepers can support young people to access services to help with personal and emotional problems. A range of studies was undertaken in New South Wales, Queensland and the ACT, using both qualitative and quantitative approaches. Data from a total of 2721 young people aged 14-24 years were gathered, as well as information from some of the community gatekeepers to young people's mental health care. Help-seeking was measured in all the studies using the General Help Seeking Questionnaire (Wilson, Deane, Ciarrochi & Rickwood, 2005), which measures future help-seeking intentions and, through supplementary questions, can also assess prior help-seeking experience. Many of the studies also measured recent help-seeking behaviour using the Actual Help Seeking Questionnaire. The types of mental health problems examined varied across the studies and included depressive symptoms, personal-emotional problems, and suicidal thoughts. The help-seeking process was conceptualised using a framework developed during the research program. This framework maintains that help-seeking is a process of translating the very personal domain of psychological distress to the interpersonal domain of seeking help. Factors that were expected to facilitate or inhibit this translation process were investigated. These included factors that determine awareness of the personal domain of psychological distress and that affect the ability to articulate or express this personal domain to others, as well as willingness to disclose mental health issues to other people. The results are reported in terms of: patterns of help-seeking across adolescence and young adulthood; the relationship of help-seeking intentions to behaviour; barriers to seeking help-lack of emotional competence, the help-negation effect related to suicidal thoughts,
negative attitudes and beliefs about help-seeking and fear of stigma; and facilitators of seeking help-emotional competence, positive past experience, mental health literacy, and supportive social influences. The paper considers the implications of the findings for the development of interventions to encourage young people to seek help for their mental health problems, and concludes by identifying gaps in the help-seeking research and literature and suggesting future directions.


The mental health and wellbeing of young people is at the forefront of mental health policy in Australia, with significant recent investment in initiatives for those aged 12-25 years. This is a welcome outcome from over 15 years of sustained advocacy. Mental health was recognised as a health priority area in 1996 and, since then, increasing awareness of the burden of mental disorder in adolescence and young adulthood has sharpened the focus on this stage of the lifespan. The most recent Australian data from the National Survey of Mental Health and Wellbeing revealed that one in four young people will experience an affective, anxiety or substance use disorder in a 12-month period. This parallels data from the large US comorbidity study, which showed that three-quarters of mental disorders emerge before the age of 25 years and half before the age of 14. The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health in 2000 emphasised the need to focus on the teenage and early adult years, and many of its directions were taken up and have significantly advanced. The Plan provided strong conceptual support to intervene early in the developmental trajectory of mental disorder, aiming to prevent the development of disorder where possible and, where this was not possible, to mitigate the impact of disorder on the individual, their family and the community. It is particularly important to reduce the impact of mental health problems on adolescents and young adults as they are in the process of accomplishing essential developmental tasks that if not achieved, interfere with their transition to adulthood and can have a lifelong negative impact. All young people need support to develop their identity and independence, belong and connect with relevant social groups including family, and to attain educational and vocational goals. Young people experiencing mental health problems need even greater support to achieve these outcomes.


Argues that the concept of help-seeking pathways, defined generically, oriented toward institutional structures and put at the forefront of research, can help integrate much of what is known about the use of mental health care and how to make such care more accessible and effective among underserved populations (e.g., Hispanics). By pathways, the authors mean the sequence of contacts with individuals and organizations prompted by the distressed person's efforts, and those of his or her significant others, to seek help; the pathways also include the help that is supplied in response to such efforts. The concept of help-seeking pathways is focused on current issues and research findings pertinent to the onset of psychological distress, the contacting of mental health care facilities, and the treatment in such facilities. The need for reliable procedures to retrospectively and prospectively assess pathways is discussed.

This paper examines factors associated with the adoption of evidence-based substance use prevention curricula (EBC) in a national sample of school districts. Substance abuse prevention coordinators in public school districts (n=1593), which were affiliated with a random sample of schools that served students in Grades 5–8, completed a written survey in 1999. Results indicated that 47.5% of districts used at least one EBC in their schools with middle school grades. Substance use prevention coordinators reported they had the greatest input in decisions about curricula. In a multivariate analysis of factors positively associated with district-level decisions to adopt evidence-based programs, significant factors included input from a state substance use prevention group, use of information disseminated by the National Institute on Drug Abuse or Center for Substance Abuse Prevention, use of local needs assessment data, consideration of research showing which curricula are effective and allocation of a greater proportion of the coordinator’s time to substance use prevention activities. State and federal agencies should increase their efforts to disseminate information about evidence-based programs, targeting in particular the district substance use prevention coordinator.


The role of help and hope as protective factors in prevention and early intervention with suicidal adolescents is examined. Hope is a forward-looking attitude serving as a buffer against suicide. Help reflects the belief and reality that there is a place to turn for support or assistance; it serves as a dynamic force against suicide. Help and hope can be powerful and mutually reinforcing components of any attempt to reach adolescents contemplating suicide. Implications for mental health counselors are presented, with an emphasis on the interrelatedness of help and hope.


There continues to be an increased interest in developing community-based services for children and adolescents as an alternative to inpatient care. However, there has been much more talk than action in creating such alternatives. This paper describes the success of a crisis stabilization program for children and adolescents in a community mental health center which historically over-utilized the State psychiatric facility for youth. The Crisis Stabilization Program consists of three components: (1) a two-person crisis team, (2) a four-person on-call team for after hours crises, and (3) funds which the crisis team utilized to broker for a wider array of community-based services.


To compare clinical practice and treatment effectiveness in patients managed by an early intervention (EI) team, and a general adult mental health team, and explore implications for service delivery. Methods A retrospective file audit was conducted comparing the treatment of two groups of 20 first-episode patients before and after the establishment of an early intervention team. Results EI patients had significantly higher levels of interaction with staff and were more likely to receive atypical antipsychotic medication, though at equivalent peak dosages. Both groups improved clinically with reduced symptoms and improved psychosocial functioning at the end of the six month follow-up period, however symptom improvement was
significantly greater for the EI group. Conclusions The findings suggest that stand-alone EI teams offer improved clinical effectiveness over standard care.


Although the need for early intervention for mental health difficulties is widely acknowledged, few studies have attempted to explicitly increase actual help seeking behavior for mental health difficulties. Students in intervention classrooms received two one-hour, in-class workshops on distress and help seeking and were compared to students in non-intervention classrooms in a 2-level hierarchical model. More frequent help seeking behavior and more mental health referrals were observed among students in the intervention group than among students in the comparison group. Effects were moderated by the level of distress experienced by students, but not by help seeking attitudes, and could not be accounted for by school staff referrals or website utilization. Results showed that help seeking behavior for mental health difficulties and mental health referrals can be increased with only a moderate investment in time, but that benefits of school-based intervention may be greatest among students with specific needs, such as high levels of distress.


Background Child and adolescent mental health problems are common in primary care. However, few parents of children with mental health problems express concerns about these problems during consultations. Aims To explore the factors influencing parental help-seeking for children with emotional or behavioural difficulties. Method Focus group discussions with 34 parents from non-specialist community settings who had concerns about their child’s mental health. All groups were followed by validation groups or semi-structured interviews. Results Most children had clinically significant mental health symptoms or associated impairment in function. Appointment systems were a key barrier, as many parents felt that short appointments did not allow sufficient time to address their child’s difficulties. Continuity of care and trusting relationships with general practitioners (GPs) who validated their concerns were perceived to facilitate help seeking. Parents valued GPs who showed an interest in their child and family situation. Barriers to seeking help included embarrassment, stigma of mental health problems, and concerns about being labelled or receiving a diagnosis. Some parents were concerned about being judged a poor parent and their child being removed from the family should they seek help. Conclusions Primary healthcare is a key resource for children and young people with emotional and behavioural difficulties and their families. Primary care services should be able to provide ready access to health professionals with an interest in children and families and appointments of sufficient length so that parents feel able to discuss their mental health concerns.


Evaluated whether a universal school-based program, designed to prevent depression in adolescents, could be effectively implemented within the constraints of the school environment. Participants were 260 Year 9 secondary school students. Students completed measures of depressive symptoms and hopelessness and were then assigned to 1 of 3 groups: (a) Resourceful Adolescent Program–Adolescents (RAP–A), an 11-session school-based resilience
building program, as part of the school curriculum; (b) Resourceful Adolescent Program–Family (RAP–F), the same program as in RAP–A, but in which each student’s parents were also invited to participate in a 3-session parent program; and (c) Adolescent Watch, a comparison group in which adolescents simply completed the measures. The program was implemented with a high recruitment (88%), low attrition rate (5.8%), and satisfactory adherence to program protocol. Adolescents in either of the RAP programs reported significantly lower levels of depressive symptomatology and hopelessness at post-intervention and 10-month follow-up, compared with those in the comparison group. Adolescents also reported high satisfaction with the program. The study provides evidence for the efficacy of a school-based universal program designed to prevent depression in adolescence.


This article reports on the lessons learned from a five-year, evidence-based substance abuse prevention initiative conducted in three school districts. Traditional outcome measures yielded no significant program effects, despite the use of an evidence-based curriculum. The failure to find significant statistical results is discussed in terms of four issues that are crucial for successful program implementation: (1) initial selection of an appropriate program, (2) adequate stakeholder involvement and school readiness, (3) attention to program fidelity, and (4) evaluation planning. Based on the literature and the authors’ experience, practice implications are offered to maximize the effectiveness of school-based prevention programs.


This study evaluated the effectiveness of the Problem Solving For Life program as a universal approach to the prevention of adolescent depression. Short-term results indicated that participants with initially elevated depressions scores (high risk) who received the intervention showed a significantly greater decrease in depressive symptoms and increase in life problem-solving scores from pre- to postintervention compared with a high-risk control group. Low-risk participants who received the intervention reported a small but significant decrease in depression scores over the intervention period, whereas the low-risk controls reported an increase in depression scores. The low-risk group reported a significantly greater increase in problem-solving scores over the intervention period compared with low-risk controls. These results were not maintained, however, at 12-month follow-up.


This study examined the impact of the Family Check-Up (FCU) and linked intervention services on reducing health-risk behaviors and promoting social adaptation among middle school youth. A total of 593 students and their families were randomly assigned to receive either the intervention or middle school services as usual. Forty-two percent of intervention families engaged in the service and received the FCU. Using complier average causal effect analyses, engagement in the intervention moderated intervention outcomes. Families who engaged in the intervention had youth who reported lower rates of antisocial behavior and substance use over time than did a matched control sample. Results extend previous research indicating that a family-centered approach to supporting youth in the public school setting reduced the growth
of antisocial behavior, alcohol use, tobacco use, and marijuana use throughout the middle school years.


Recently, the field of mental health has incorporated a growing interest in strengths, resilience, and growth, psychological phenomena that may be associated with healthy adjustment trajectories and profitably integrated into strategies for clinical assessment and practice. This movement constitutes a significant shift from traditional deficit-oriented approaches. Addressing clinical practitioners, this article (a) provides a broad overview of these constructs and phenomena, (b) discusses their relevance for clinical assessment and intervention, and (c) describes selected strategies and approaches for conducting assessments that can guide intervention.


Background There is controversy about whether mental health services should be provided in community or hospital settings. There is no worldwide consensus on which mental health service models are appropriate in low-,medium- and high- resource areas. Aims To provide an evidence base for this debate, and present a stepped care model. Method Cochrane systematic reviews and other reviews were summarised. Results The evidence supports a balanced approach, including both community and hospital services. Areas with low levels of resources may focus on improving primary care, with specialist back-up. Areas with medium resources may additionally provide out-patient clinics, community mental health teams (CMHTs), acute in-patient care, community residential care and forms of employment and occupation. High-resource areas may provide all the above, together with more specialised services such as specialised outpatient clinics and CMHTs, assertive community treatment teams, early intervention teams, alternatives to acute in-patient care, alternative types of community residential care and alternative occupation and rehabilitation. Conclusions Both community and hospital services are necessary in all areas regardless of their level of resources, according to the additive and sequential stepped care model described here.

Tylee, A., et al. (2007). "Youth-friendly primary-care services: how are we doing and what more needs to be done?" The Lancet 369(9572): 1565-1573.

For developmental as well as epidemiological reasons, young people need youth-friendly models of primary care. Over the past two decades, much has been written about barriers faced by young people in accessing health care. Worldwide, initiatives are emerging that attempt to remove these barriers and help reach young people with the health services they need. In this paper, we present key models of youth-friendly health provision and review the evidence for the effect of such models on young people’s health. Unfortunately, little evidence is available, since many of these initiatives have not been appropriately assessed. Appropriate controlled assessments of the effect of youth-friendly health-service models on young people’s health outcomes should be the focus of future research agendas. Enough is known to recommend that a priority for the future is to ensure that each country, state, and locality has a policy and support to encourage provision of innovative and well assessed youth-friendly services.

Background: Evidence-based best practices for incorporation into an optimal multilevel intervention for suicide prevention should be identifiable in the literature. Aims: To identify effective interventions for the prevention of suicidal behavior. Methods: Review of systematic reviews found in the Pubmed, Cochrane, and DARE databases. Steps include risk-of-bias assessment, data extraction, summarization of best practices, and identification of synergistic potentials of such practices in multilevel approaches. Results: Six relevant systematic reviews were found. Best practices identified as effective were as follows: training general practitioners (GPs) to recognize and treat depression and suicidality, improving accessibility of care for at-risk people, and restricting access to means of suicide. Although no outcomes were reported for multilevel interventions or for synergistic effects of multiple interventions applied together, indirect support was found for possible synergies in particular combinations of interventions within multilevel strategies. Conclusions: A number of evidence-based best practices for the prevention of suicide and suicide attempts were identified. Research is needed on the nature and extent of potential synergistic effects of various preventive activities within multilevel interventions. (PsycINFO Database Record (c) 2012 APA, all rights reserved)


Objective: To describe the work of the Hunter Institute of Mental Health, with special emphasis on its role in mental health promotion and prevention with adolescents. Method and Results: The Ottawa Charter for Health Promotion is used as a framework to describe the varied functions of this organisation. Four youth mental health promotion programs are given as examples of the Institute’s work. Results of preliminary evaluation of the Youth Suicide Prevention – National University Curriculum Project are provided. Conclusion: The Hunter Institute of Mental Health, a self-funding unit of the Hunter Area Health Service, provides innovative health promotion programs as part of its role as a provider of mental health education and training. The model may be particularly applicable to mental health services in regional Australia.


The widespread implementation of effective prevention programs for children and youth is a sound investment in society's future. The most beneficial preventive interventions for young people involve coordinated, systemic efforts to enhance their social-emotional competence and health. The articles in this special issue propose standards for empirically supported programming worthy of dissemination and steps to integrate prevention science with practice. They highlight key research findings and common principles for effective programming across family, school, community, health care, and policy interventions and discuss their implications for practice. Recent advances in prevention research and growing support for evidence-based practice are encouraging developments that will increase the number of children and youth who succeed and contribute in school and life.

For decades, empirically tested youth interventions have prevented dysfunction by addressing risk and ameliorated dysfunction through treatment. The authors propose linking prevention and treatment within an integrated model. The model suggests a research agenda: Identify effective programs for a broadened array of problems and disorders, examine ethnicity and culture in relation to intervention adoption and impact, clarify conditions under which programs do and do not work, identify change mechanisms that account for effects, test interventions in real-world contexts, and make tested interventions accessible and effective in community and practice settings. Connecting the science and practice of prevention and treatment will be good for science, for practice, and for children, adolescents, and their families.


Behaviour problems make up approximately 30–50% of all referrals to child and adolescent mental health services. Behavioural parent training is one of the most effective interventions for young children. However, those families most at risk of difficulties fail to access services. This paper outlines the Children And Parents Service (CAPS), a citywide multi-agency, early intervention service to young children and their families. The intervention includes parent training groups, multi-agency training and liaison in community settings. The model of service delivery is outlined and the obstacles to service implementation and the strategies used to overcome them are discussed. The service has adopted a well validated evidence-based model of parent training, monitoring of outcomes and user involvement, and is delivered in the wider context of multi-agency systems. A thorough evaluation of service delivery models, including CAPS, would be beneficial. Whilst research trials examine the efficacy of treatments, the effective delivery of treatments within clinical services requires clarity about the place of the intervention within wider systems. The CAPS model proposes a framework for delivering interventions within these systems.


Despite the high prevalence of mental health problems and disorders that develop in adolescence and early adulthood, young people tend to not seek professional help. Young men and young people from Indigenous and ethnic minority groups tend to be those most reluctant to seek help. Young people are more inclined to seek help for mental health problems if they: have some knowledge about mental health issues and sources of help; feel emotionally competent to express their feelings; and have established and trusted relationships with potential help providers. Young people are less likely to seek help if they: are experiencing suicidal thoughts and depressive symptoms; hold negative attitudes toward seeking help or have had negative past experiences with sources of help; or hold beliefs that they should be able to sort out their own mental health problems on their own. Young people may seek help through talking to their family and friends, with family being more important for younger adolescents, and friends and partners becoming more influential later on. The professionals most likely to act as gatekeepers to mental health services for young people are school counsellors, general practitioners, and youth workers. Increasingly, Internet-based information and interventions are being used to engage young people in the help-seeking process.

OBJECTIVE: To determine if brief standardized screening for suicide risk in pediatric primary care practices will increase detection rates of suicidal youth, maintain increased detection and referral rates, and be replicated in other practices. PATIENTS AND METHODS: Physicians in 3 primary care practices received brief training in suicide risk, and 2 standardized questions were inserted into their existing electronic medical chart psychosocial interview. The questions automatically populated for all adolescents aged 12.0 to 17.9 years. Deidentified data were extracted during both intervention trials and for the same dates of the previous year. Referral rates were extracted from social work records. RESULTS: The rates of inquiry about suicide risk increased 219% (clinic A odds ratio [OR]: 2.04 [95% confidence interval (CI): 1.56–2.51]; clinic B OR: 3.20 [95% CI: 2.69–3.71]; clinic C OR: 1.85 [95% CI: 1.38–2.31]). The rate of case detection increased in clinic A (OR: 4.99 [95% CI: 4.20–5.79]), was maintained over 6 months after the intervention began (OR: 4.38 [95% CI: 3.74–5.02]), and was replicated in both clinic B (OR: 5.46 [95% CI: 3.36–7.56]) and clinic C (OR: 3.42 [95% CI: 2.33–4.52]). The increase in case detection was 392% across all 3 clinics. Referral rates of suicidal youth to outpatient behavioral health care centers increased at a rate equal to that of the detection rates. CONCLUSIONS: Standardized screening for suicide risk in primary care can detect youth with suicidal ideation and prompt a referral to a behavioral health care center before a fatal or serious suicide attempt is made.


Objectives: To assess young people’s ability to recognise clinically defined depression and psychosis, the types of help they thought appropriate for these problems, their knowledge of appropriate treatments, and their perceptions regarding prognosis. Design: A cross-sectional telephone survey using structured interviews. Vignettes of a person with either depression or psychosis were presented, followed by questions related to recognition of the disorder, best forms of treatment and the prognosis. Participants: A randomly selected sample of 1207 young people aged 12–25 years. Setting: Melbourne, Victoria, and surrounding regional and rural areas. Outcome measures: Responses to a mental health literacy questionnaire. Results: Almost half the respondents were able to identify depression correctly, whereas only a quarter identified psychosis correctly. Counsellors and family or friends were the most commonly cited forms of best help, with family or friends preferred by the younger age group for depression. General practitioners were considered more helpful for depression, and psychiatrists and psychologists more helpful for psychosis. Most respondents considered counselling and psychotherapy to be helpful. However, more than half the respondents expressed negative or equivocal views regarding the helpfulness of recommended pharmacological treatments. Conclusions: The limitations we identified in youth mental health literacy may contribute to the low rates of treatment and the long duration of untreated illness reported in other studies. There is a need for initiatives to enhance mental health literacy among young people, and those close to them, if benefits of early treatment are to be realised.


Background: Early detection and treatment of mental disorders in adolescents and young adults can lead to better health outcomes. Mental health literacy is a key to early recognition and help seeking. Whilst a number of population health initiatives have attempted to improve mental health literacy, none to date have specifically targeted young people nor have they applied the rigorous standards of population health models now accepted as best practice in other health areas. This paper describes the outcomes from the application of a health promotion model to
the development, implementation and evaluation of a community awareness campaign designed to improve mental health literacy and early help seeking amongst young people. Method: The Compass Strategy was implemented in the western metropolitan Melbourne and Barwon regions of Victoria, Australia. The Precede-Proceed Model guided the population assessment, campaign strategy development and evaluation. The campaign included the use of multimedia, a website, and an information telephone service. Multiple levels of evaluation were conducted. This included a crosssectional telephone survey of mental health literacy undertaken before and after 14 months of the campaign using a quasi-experimental design. Randomly selected independent samples of 600 young people aged 12–25 years from the experimental region and another 600 from a comparison region were interviewed at each time point. A series of binary logistic regression analyses were used to measure the association between a range of campaign outcome variables and the predictor variables of region and time. Results: The program was judged to have an impact on the following variables, as indicated by significant region-by-time interaction effects (p < 0.05): awareness of mental health campaigns, self-identified depression, help for depression sought in the previous year, correct estimate of prevalence of mental health problems, increased awareness of suicide risk, and a reduction in perceived barriers to help seeking. These effects may be underestimated because media distribution error resulted in a small amount of print material "leaking" into the comparison region. Conclusion: We believe this is the first study to apply the rigorous standards of a health promotion model including the use of a control region to a mental health population intervention. The program achieved many of its aims despite the relatively short duration and moderate intensity of the campaign.


Objectives. We examined the effectiveness of the Sources of Strength suicide prevention program in enhancing protective factors among peer leaders trained to conduct schoolwide messaging and among the full population of high school students. Methods. Eighteen high schools—6 metropolitan and 12 rural—were randomly assigned to immediate intervention or the wait-list control. Surveys were administered at baseline and 4 months after program implementation to 453 peer leaders in all schools and to 2675 students selected as representative of the 12 rural schools. Results. Training improved the peer leaders' adaptive norms regarding suicide, their connectedness to adults, and their school engagement, with the largest gains for those entering with the least adaptive norms. Trained peer leaders in larger schools were 4 times as likely as were untrained peer leaders to refer a suicidal friend to an adult. Among students, the intervention increased perceptions of adult support for suicidal youths and the acceptability of seeking help. Perception of adult support increased most in students with a history of suicidal ideation. Conclusions. Sources of Strength is the first suicide prevention program involving peer leaders to enhance protective factors associated with reducing suicide at the school population level.


Following recent reviews of community- and practice-based mental health interventions, an assessment of Internet-based interventions is provided. Although relatively new, many Internet mental health interventions have reported early results that are promising. Both therapist-led as well as self-directed online therapies indicate significant alleviation of disorder-related
symptomatology. The number of studies addressing child disorders lags behind those of adults. More research is needed to address methodological issues of Internet-based treatments.


This article considers the implications for prevention science of recent advances in research on family poverty and children's mental, emotional, and behavioral health. First, we describe definitions of poverty and the conceptual and empirical challenges to estimating the causal effects of poverty on children's mental, emotional, and behavioral health. Second, we offer a conceptual framework that incorporates selection processes that affect who becomes poor as well as mechanisms through which poverty appears to influence child and youth mental health. Third, we use this conceptual framework to selectively review the growing literatures on the mechanisms through which family poverty influences the mental, emotional, and behavioral health of children. We illustrate how a better understanding of the mechanisms of effect by which poverty impacts children's mental, emotional, and behavioral health is valuable in designing effective preventive interventions for those in poverty. Fourth, we describe strategies to directly reduce poverty and the implications of these strategies for prevention. This article is one of three in a special section (see also Biglan, Flay, Embry, & Sandler, 2012; Muñoz, Beardslee, & Leykin, 2012) representing an elaboration on a theme for prevention science developed by the 2009 report of the National Research Council and Institute of Medicine.