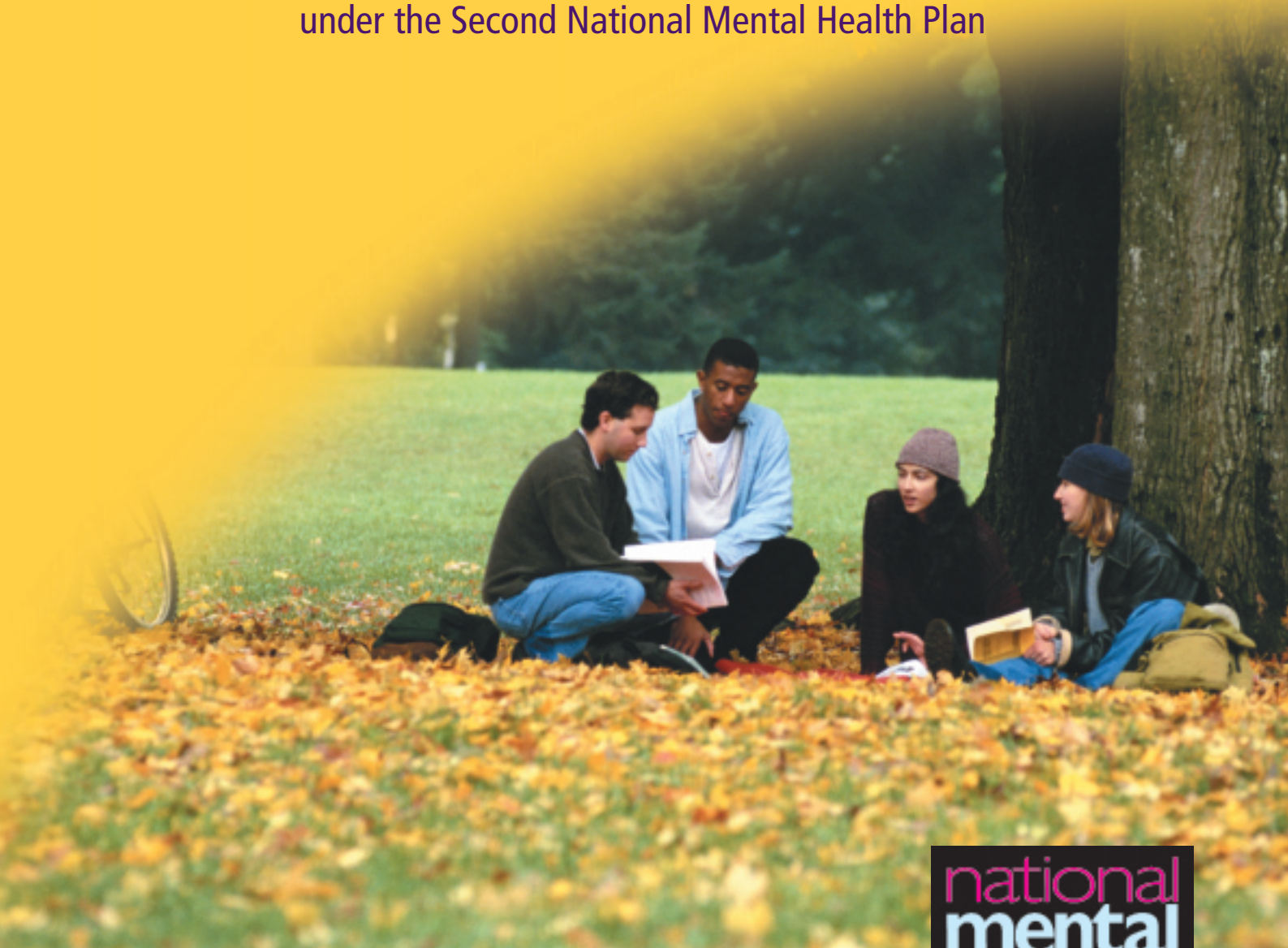


# National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000

A Joint Commonwealth, State and Territory Initiative  
under the Second National Mental Health Plan



national  
mental  
health  
strategy

# **National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000**

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under the Second National Mental Health Plan

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## About this document

This *Action Plan 2000* is a companion document to the *Promotion, Prevention and Early Intervention for Mental Health—A Monograph 2000* (Monograph 2000). The two documents are distributed as a set.

Monograph 2000 provides the theoretical and conceptual framework and background for *Action Plan 2000*.

*Action Plan 2000* outlines a strategic framework and plan for action to address the promotion, prevention and early intervention priorities and outcomes outlined in the *Second National Mental Health Plan*. It contains strategies to promote mental health, to reduce mental health problems and mental disorders through enhancing protective factors and reducing risk factors for mental disorders, and to intervene as early as possible to minimise the impact of the symptoms of mental health problems and mental disorders.

# Request for feedback

These two companion documents will be updated in response to emerging priorities, to the outcomes of research and other projects, to identified best practice and to user feedback. Feedback on the first *Action Plan 1999* was collected and considered by the National Mental Health Promotion and Prevention Working Party and included in the *Action Plan 2000*. Ongoing feedback on *Action Plan 2000* and *Monograph 2000* is welcomed from individuals and organisations with an interest in promotion, prevention and early intervention for mental health. In particular, comments are sought on the usefulness of the documents and how they may be strengthened.

A feedback form is included at the back of this document and can also be accessed on the Auseinet Website <http://auseinet.flinders.edu.au>

You are invited to contribute your feedback in the following ways:

1. Send feedback form by mail (form has address incorporated). If the form has been removed, please send your written feedback, including your name, organisation and contact details to:

Auseinet  
Southern CAMHS  
Flinders Medical Centre  
BEDFORD PARK SA 5042

*If preferred, you can fax the feedback form to: (08) 8357 5484*

2. Lodge your feedback through the website at <http://auseinet.flinders.edu.au>
3. Take part in a discussion forum in your state/territory.

Forums will be organised within each state/territory during early to mid 2001 at which all relevant stakeholders and interested parties will be invited to express their views. For more information on the dates and venues for these forums please visit the website at: <http://auseinet.flinders.edu.au> or phone (08) 8357 5788



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# Mental Health Promotion and Prevention Working Party Membership

The National Mental Health Promotion and Prevention Working Party (PPWP) exists under the auspices of the Australian Health Ministers' Advisory Council National Mental Health Working Group and the National Public Health Partnership Group. The PPWP is made up of members or nominees of these groups as well as representatives of other key stakeholder groups.

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# Foreword

This *Action Plan 2000* and the companion document *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*, represent a major and exciting initiative to improve the mental health outcomes of the Australian population. They provide the policy and conceptual framework for promotion, prevention and early intervention for mental health—key themes of the *Second National Mental Health Plan*. The strategies proposed in *Action Plan 2000* offer opportunities for a nationally coordinated approach and for state and territory leadership. They emphasise the importance of forming partnerships at many levels and recognise the potential for contributions from all groups and sectors within the community.

Many of the factors that influence mental health and mental ill health also influence outcomes in these other sectors, such as the education and the criminal justice systems. Promotion, prevention and early intervention for mental health have the capacity to deliver benefits well beyond the traditional health services sector—to individuals, to families, to our communities, and to our society as a whole.

An effective response therefore requires partnerships that reach well beyond mental health services, encompassing not only broader health services but also family and community services, educational institutions, workplaces, correctional services, emergency services, and the sports, arts and business sectors, as well as carers and consumer groups. Indeed, mental health is an issue for the entire community and requires a whole of community response.

With this in mind, these documents have been developed for the widest possible audience—all those people who may come into contact with people at risk of developing a mental health problem or mental disorder, and all those who are generally interested in the broad concept of mental health.

Developed under the auspices of the National Mental Health Working Group and the National Public Health Partnership Group, these documents draw on expertise from both these fields, as well as consultation with representatives from a range of sectors, and consumers, carers and community groups.

We would like to take this opportunity to thank all those people who contributed to the development of these documents. This major effort has resulted in a resource that incorporates the best scientific evidence available. Importantly, it places Australia at the international forefront of mental health promotion, prevention and early intervention for mental health.



Emeritus Professor Beverley Raphael  
National Mental Health Working Group



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# Background

This document presents the revised national action plan for promotion, prevention and early intervention for mental health. The first action plan, entitled *Mental Health Promotion and Prevention National Action Plan (Action Plan 1999)* (Commonwealth Department of Health and Aged Care, 1999), was released in January 1999. *Action Plan 1999* was a working document to be updated regularly in response to emerging priorities, to the outcomes of research and other projects, to identified best practice and to user feedback. Comments on the usefulness of *Action Plan 1999* and how it could be strengthened were encouraged from individuals and organisations with an interest in mental health promotion and illness prevention.

*Action Plan 2000* is an update of *Action Plan 1999* in response to user feedback and recent developments in mental health. Of particular note is the addition of early intervention along with promotion and prevention. *Action Plan 2000* is entitled *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*. Like the first plan, it is also a working document that will be updated in response to future developments and user feedback.

## The need for an Action Plan

It is now well known that the burden of mental health problems and mental disorders is high and rising. It is estimated that depression alone will constitute one of the greatest health problems worldwide by 2020 (Murray and Lopez, 1996).

These findings pose immediate and serious challenges for governments and policy makers, researchers, service providers, communities, families, and individuals. It is becoming increasingly clear that treatment interventions alone cannot significantly reduce the enormous personal, social and financial burdens associated with mental health problems and mental disorders, and that interventions are required earlier in the development of these conditions. There is a compelling need to make promotion, prevention and early intervention priorities in global, national and regional policy, and to develop a clear plan for progressing activities in these areas.

*Action Plan 2000* provides a framework for a coordinated national approach to the promotion of mental health and prevention and early intervention for mental health problems and mental disorders. It builds on the convincing and growing body of evidence that these approaches can be effective, and recognises that such initiatives comprise a long-term investment in the personal, social and economic wellbeing of Australian communities.

Mental health is influenced by risk and protective factors that occur in the many different domains of everyday life. Consequently, effective action to promote mental health, prevent the development of mental health problems, and intervene early in mental disorders requires cooperation, commitment and partnerships that reach well beyond mental health services. Effective action needs to encompass, not only the broader health sector, but family and community services, educational institutions, workplaces, correctional services, emergency services, and the sports, arts and business sectors, as well as carers and consumer groups. Indeed, mental health is an issue for the entire community, requires a whole of community response, and delivers benefits for the whole community. *Action Plan 2000* therefore addresses the widest possible audience: not only agencies, organisations and governments, but all people, both professional and non-professional, who have the potential to promote mental health

across population groups or who may come into contact with people at risk of developing or showing the early signs and symptoms of a mental health problem or mental disorder, as well as all those who are generally interested in the broad concept of mental health.

Effective action in this area means people working together within and across sectors and communities to provide quality services, programs and initiatives that involve a wide spectrum of interventions to improve social and emotional wellbeing and reduce mental health problems and mental disorders. This focus does not detract from a commitment to further the understanding and treatment of mental disorders, but complements it by working to alleviate the many factors known to contribute to these disorders, along with strengthening the factors that support mental health.

## **The burden of mental disorders in Australia**

Close to one-in-five people in Australia were affected by a mental health problem within a 12-month period, according to the National Survey of Mental Health and Wellbeing (McLennan, 1998). Young adults were particularly affected, with more than one-quarter of Australians aged 18 to 24 years suffering from at least one mental disorder over a 12-month period. Among adults, some 18 per cent suffer from a mental disorder and the prevalence of anxiety, depression and substance use disorders is 9.7 per cent, 5.8 per cent and 7.7 per cent, respectively. For older adults the prevalence of mental disorders drops to 6 per cent among those aged 65 years and over, although an additional 6.1 per cent are estimated to have dementia. Dementia is strongly related to age, affecting 1.6 per cent of 65 to 70 year-olds and 39 per cent of 90 to 94 year-olds (Henderson and Jorm, 1998; Jorm et al, 1987).

There is ample evidence that risk factors and vulnerabilities in infancy and early childhood are associated with mental health problems in childhood and adolescence, and these in turn are associated with greatly heightened risk of mental disorders in adult life (Keating and Hertzman, 1999). For children and adolescents, between 14 per cent and 20 per cent were shown to be affected by a mental health problem in a six to 12-month period (Zubrick et al, 1995; Sawyer et al, 2000) and, for the majority of these, schooling and social development were impaired (Zubrick et al, 1995, 1997; Sawyer et al, 2000).

The co-occurrence of more than one mental disorder is common at all ages and considerably adds to the burden of disorder (McLennan, 1998; Mathers, Vos and Stevenson, 1999; Sawyer et al, 2000). Co-morbidity of mental disorder and substance misuse is especially problematic, particularly for young people (Moon, Meyer and Grau, 1999), and increased risk of suicide and self-harm also add substantially to the burden of mental health problems and mental disorders.

Despite these figures, only 38 per cent of adult Australians with a mental disorder receive help for their problem (McLennan, 1998), a figure that is consistent with findings overseas. Similarly, only 29 per cent of children and adolescents with a mental health problem had been in contact with a professional service, which included health, mental health and educational services, in a 12-month period (Sawyer et al, 2000).

It has been reported that the burden of mental disorders has been significantly underestimated in terms of its personal, social and economic impact. Worldwide, psychiatric disorders account for almost 11 per cent of all disease burden (Murray and Lopez, 1996) and in 1990 they made up five of the ten leading causes of disability. In Australia, mental disorders accounted for nearly 30 per cent of the non-fatal disease burden in 1996. While not a major direct cause of death, accounting for only 1.4 per cent of years of life lost, mental disorders are a major cause of chronic disability, accounting for 27 per cent of years lost due to disability (Mathers, Vos and Stevenson, 1999). The direct cost of mental disorders and problems in 1989–90 was estimated to be \$2 billion (AIHW, 1996). This estimate does not take into account indirect costs such as the impact on families and communities, the need for welfare response, and coronial work in the case of suicides. The health costs and loss of earnings due to suicides and suicide attempts during 1989–90, for example, was estimated to be \$920 million (Raphael and Martinek, 1994).

## The policy context

### *International context*

*Action Plan 2000* has been developed in the context of an international movement to promote mental health, prevent mental health problems and mental disorders, and lessen the global burden of mental ill health.

The US Institute of Medicine, in a definitive report, published a systematic review of the evidence for prevention in mental health (Mrazek and Haggerty, 1994) and specific prevention programs have now been established in the United States by government mandate (US Department of Health and Human Services, 1999). The European Network on Mental Health Promotion has been set up to identify and disseminate good practice in mental health promotion and prevention. The World Health Organization has also contributed to the field, producing *Primary Prevention of Mental, Neurological and Psychosocial Disorders* (WHO, 1998). There is now an international journal specifically focused on mental health promotion (*International Journal of Mental Health Promotion*).

Much of the mental health promotion work internationally has been conducted within the framework of the Ottawa Charter for Health Promotion (WHO, 1986) and the Jakarta Declaration (WHO, 1997). Key components of these are:

- building healthy public policy (emphasising the role of all sectors in health outcomes);
- creating supportive environments in all settings;
- strengthening community action;
- developing personal skills; and
- reorienting services toward promotion, prevention and early intervention.

This has recently been endorsed in a report of the US Surgeon General, which emphasises the role of promotion and prevention, particularly in relation to a growing understanding of the factors that are risks to, or protective of, mental health (US Department of Health and Human Services, 1999).

### ***Australian context***

Australia's National Mental Health Strategy, comprising the *Mental Health Statement of Rights and Responsibilities*, the *National Mental Health Policy* and the *National Mental Health Plan* (Australian Health Ministers, 1991, 1992a and b respectively), was set in place in 1992. One of its principle aims was to promote mental health and, where possible, prevent or reduce the burden of mental health problems and mental disorders.

In July 1998, all Australian Health Ministers endorsed the *Second National Mental Health Plan*. This provides a five-year framework to progress mental health reform to June 2003, identifying three priorities for future activity: promotion and prevention; partnerships in service reform; and quality and effectiveness of service delivery. A total of \$300 million (indexed) for mental health service activity throughout the five years of this second plan.

Outcomes identified in the *Second National Mental Health Plan* in relation to promotion, prevention and early intervention include:

- improved public health strategies to promote mental health;
- reduced incidence and prevalence of mental disorders and associated disability (including depression);
- reduced numbers of suicides;
- increased consumer and carer satisfaction with clinicians' responses to early warning signs of mental disorders; and
- improved mental health literacy at all levels.

Whereas the promotion and prevention components of the *First National Mental Health Plan* focused on increasing public awareness of the extent of mental disorders and reducing stigma, activities in the *Second National Mental Health Plan* added reducing stigmatising attitudes within the helping services and increasing mental health literacy in key settings and among strategic groups.

An evaluation of the National Mental Health Strategy identified the need for national direction in promotion and prevention, leadership, clarification of responsibilities, development of programs for populations at higher risk and provision of support for primary care providers (National Mental Health Strategy Evaluation Steering Committee, 1997).

The National Mental Health Working Group of the Australian Health Ministers' Advisory Council and the National Public Health Partnership Group agreed to auspice the Mental Health Promotion and Prevention Working Party to develop a plan of action to provide this national direction: *Action Plan 2000* presents the current directions of that plan.

## Concepts and terminology

A number of the terms, central to *Action Plan 2000*, are used in many other contexts, with a degree of inconsistency (Freedman, 1995). This section defines key terms as they are used here. Definitions of other terms used can be found in the glossary.

**Mental health** is not simply the absence of mental disorders but describes: 'The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice'. (Australian Health Ministers, 1991)

A **mental disorder** is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and some of the major mental disorders perceived to be public health issues are depression, anxiety, substance use disorders, psychosis and dementia. Mental disorders are diagnosed by standardised criteria, such as those contained in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) (American Psychiatric Association, 1994) and the *International Classification of Diseases*, 10th Edition (ICD-10) (WHO, 1992). The term **mental illness** is synonymous with mental disorder.

A **mental health problem** also interferes with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common mental complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into a mental disorder. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration of the symptoms.

**Mental health literacy** comprises 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention', and includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm et al, 1997, p182).

**Mental health interventions** can be classified according to a system originally developed by the US Institute of Medicine (Mrazek and Haggerty, 1994) and presented in a revised version in Figure 1. This model has been widely adopted in the Australian mental health field as best portraying the continuum of mental health interventions within a population health framework.

**Mental health promotion** is any action taken to maximise mental health and wellbeing among populations and individuals. It is concerned with enabling people to maximise their health potential through influencing environmental conditions. It is a process aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the ‘coping’ capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources to individuals, families, communities and whole population groups (Wood and Wise, 1997). Examples include action designed to increase the connectedness and supportiveness of school or workplace communities.

Mental health promotion is applicable across the whole spectrum of interventions (as shown in Figure 1), and is concerned with promoting wellbeing across entire population groups, for people who are currently well, for those at-risk, and for those experiencing illness. As indicated in the *Second National Mental Health Plan*, the strong historical association between the terms ‘mental health’ and ‘mental illness’ may lead some to prefer the term ‘promotion of emotional and social wellbeing’, which also accords with holistic concepts of mental health held by Aboriginal and Torres Strait Islander communities and some other cultural groups.

**Prevention** refers to ‘interventions that occur before the initial onset of a disorder’ to prevent the development of disorder (Mrazek and Haggerty, 1994, p23). The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental disorders. Prevention interventions may be classified according to their target group, as: **universal**, provided to whole populations; **selective**, targeting those population groups at increased risk of developing a disorder; and **indicated**, targeting people showing minimal signs and symptoms of a disorder (see Table 1). Together, the universal, selective and indicated categories of intervention correspond to the concept of ‘primary prevention’ in the model of prevention applied to mental health by Caplan (1964).

Prevention of mental health problems and mental disorders requires identification and modification of factors that determine mental ill health. The risk and protective factors to mental health occur within the context of everyday life: they are found in perinatal influences; in family relationships and the home; in schools and workplaces; in interpersonal relationships of all types; in sports, art and recreation activities; in media influences; in social and cultural activities; in the physical health of individuals; and in the physical, social and economic ‘health’ of communities. Effective prevention requires partnerships, consultation and community involvement to support the necessary multi-faceted approach. Wide ownership and commitment are needed to modify the events and settings of everyday life that determine mental health and mental illness, for individuals, communities and population groups.

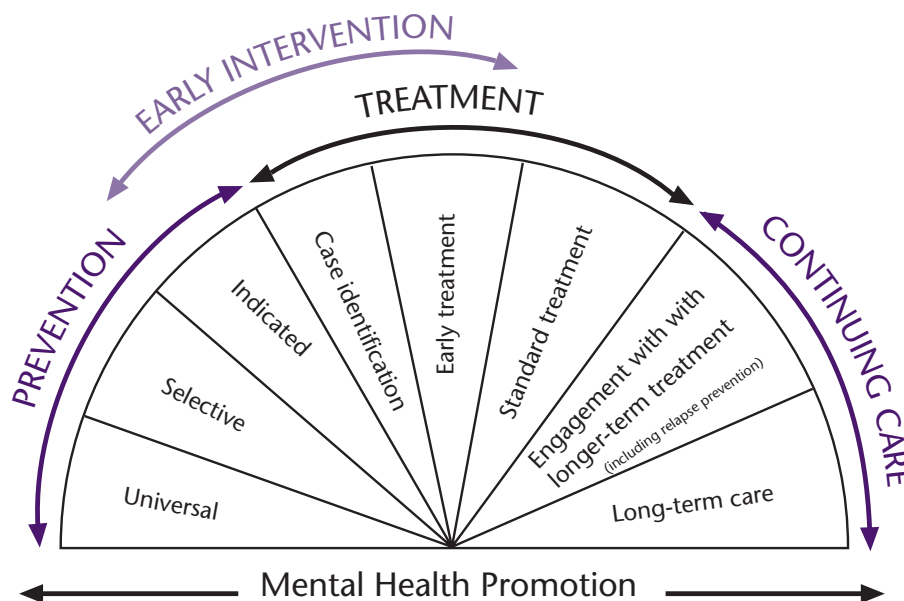
Throughout the document symbols have been used to discriminate promotion [ ● ], prevention [ ▲ ] and early intervention [ ■ ] initiatives. However, in practice it may be difficult to classify an intervention as purely promotion, prevention or early intervention as many interventions combine elements of all of these.

**Early intervention** comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder. It encompasses the indicated intervention, case identification and early treatment sectors of the spectrum shown in Figure 1. Early intervention aims to prevent the progression to a diagnosable disorder for people experiencing early signs and symptoms of mental health problems. For people experiencing a first episode of mental disorder, early intervention aims to reduce the impact of the mental disorder in terms of its duration and the damage it may cause to the person's life, and also to foster hope for future wellbeing.

Early intervention has a more individual focus, although the ongoing legacy of promotion and prevention interventions provides essential support. It requires the early identification of signs and symptoms of mental health problems and mental disorders, and intervening in supportive and sensitive ways that do not cause any negative outcomes, such as increased stress and stigma. This requires ongoing training and support for the diverse workforces that may be in positions to identify, refer and/or treat individuals showing the early signs and symptoms of mental disorders, as well as strong partnerships with consumers and carers.

Note: Although the goals of promotion, prevention and early intervention differ, there is often considerable overlap. An intervention aimed at increasing wellbeing in a community (promotion) for instance, may also have the effect of decreasing the incidence of mental health problems (prevention). Intervening early for mental health problems (early intervention) may prevent the development of diagnosable disorder (prevention).

**Figure 1: The spectrum of interventions for mental health problems and mental disorders**



Source: adapted from Mrazek and Haggerty (1994)

**Table 1: Definitions of prevention interventions for mental health**

Type of prevention intervention	Definition	Examples
Universal	Targeted to the general public or a whole population group that has not been identified on the basis of individual risk	Good prenatal care Programs to prevent bullying in schools
Selective	Targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average... The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of mental disorder	Support for children of parents with a mental disorder Bereavement support groups Psychosocial support for people experiencing physical illness Social support programs to prevent depression for older people in residential care
Indicated	Targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms foreshadowing mental disorder, or biological markers indicating predisposition for mental disorder, but who do not meet DSM-IV diagnostic levels at the current time	Parenting programs for parents of preschool children who display aggression and noncompliance Programs for children identified at school with some signs of behaviour problems

Source: adapted from Mrazek and Haggerty (1994 pp 24–25)

## A population health approach

*Action Plan 2000* adopts a population health approach to mental health. The term ‘population health’ avoids the confusion sometimes associated with the terms ‘public health’ and ‘new public health’. The Mental Health Promotion and Prevention Working Party has described population health as ‘attending to the health status and health needs of whole populations’. It is based on the premise that health and illness at personal, local, national and global levels result from a complex interplay of biological, psychological, social, environmental, economic and political factors. It is an approach that assesses needs at the population level, and develops and implements interventions to promote health and reduce ill health across whole population groups, supported by appropriate monitoring and evaluation (Raphael, 2000). It recognises the value of activities that secure a benefit for whole population groups, although they may bring relatively little benefit to specific individuals.

The population health approach is based on an understanding that the influences on mental health occur in the events and settings of everyday life (Marmot, 1999). Mental health and mental ill health result from a complex combination of events and conditions that take place in biological, individual-psychological, social-psychological and structural domains. The interplay between the individual and the environment is critical. The population health model encompasses the full range of risk and protective factors that determine health ( at the individual, family, community, sector/system and society level. **Protective factors** are those that give people resilience in the face of adversity and moderate the impact of stress and transient symptoms on the person’s social and emotional wellbeing. Protective factors reduce the likelihood that a disorder will develop. **Risk factors** increase the likelihood that a disorder will develop, and exacerbate the burden of existing disorder. Risk factors indicate a person’s vulnerability, and may include genetic, biological, behavioural, socio-cultural and demographic conditions and characteristics.

Most risk and protective factors for mental health lie outside the domain of mental health and health services—they derive from conditions in the everyday lives of individuals and communities. Risk and protective factors occur through income and social status, physical environments, education and educational settings, working conditions, social environments, families, biology and genetics, personal health practices and coping skills, sport and recreation, the availability of opportunities, as well as through access to health services.

Making changes to the conditions that affect mental health therefore generally requires long-term sustained effort across multiple sectors of the community. Effective promotion, prevention and early intervention activities are not confined to traditional mental health, or even health, services and domains. Interventions in all sectors of the community and at all levels can enhance mental health. This requires widespread recognition of the interrelatedness of the domains of life and an understanding that the responsibility for mental health, along with the benefits, reside in all sectors of the community. These benefits will become increasingly evident over time, as they comprise a long-term investment in better mental health for all Australians.

## Evidence for promotion, prevention and early intervention

Although promotion, prevention and early intervention activities have been accepted as legitimate in the area of physical health for many years, there has been some resistance to these approaches in the mental health field. The situation is changing, however, as the scientific basis for promotion, prevention and early intervention for mental health continues to expand and strengthen.

Comprehensive reviews of the field now exist. These include:

- *OSAP Prevention Monograph-2* (Schaffer, Phillips and Enzer, 1989);
- *Scope for Prevention in Mental Health* (Raphael, 1993);
- *Reducing Risks for Mental Disorders* (Mrazek and Haggerty, 1994);
- *Prevention in Psychiatry* (Paykel and Jenkins, 1994);
- *Healthy Families Healthy Nation: Strategies for Promoting Family Mental Health in Australia* (Sanders, 1995);
- *Handbook of Studies on Preventive Psychiatry* (Raphael and Burrows, 1995);
- *Early Intervention and Prevention in Mental Health* (Cotton and Jackson, 1996);
- *Effectiveness of Mental Health Promotion Interventions: A Review* (Health Education Authority, 1997a); and
- *Pathways to Prevention: Developmental and Early Intervention Approaches to Crime in Australia* (National Crime Prevention, 1999).



Considerable evidence exists regarding a number of factors known to influence mental health and mental ill health. There is also an emerging body of knowledge that links programs and policies with the factors that influence mental health. Due to the complex nature of mental health, programs targeting multiple risk factors and using multiple strategies have better outcomes than those targeting only one risk factor or using only one strategy.

Despite this growing evidence, further research is needed to extend our understanding, and we are unlikely to prove all the steps in the 'causal chains' for mental health problems and mental disorders. Many of the important influences on mental health and mental ill health occur early in life, and a wide range of intervening factors affect the outcomes for individuals. The further away in time, or the greater the number of intervening variables between an influence and its outcome, the less likely it is that randomised controlled trial evidence—the 'gold standard' of scientific evidence—will be available or feasible. Yet it is possible to achieve favourable mental health outcomes even without a clear understanding of causation (Mrazek and Haggerty, 1994), and there is a need to look for other types of evidence regarding the broad social influences on mental health (Marmot, 1999).

The evidence base needs building, particularly for some age and population groups. There is little evidence, for example, on interventions specifically for young adults, people in the workplace, people in rural and remote areas, people from diverse cultural and linguistic backgrounds, Aboriginal peoples and Torres Strait Islanders.



For **mental health promotion**, there is currently evidence that parenting programs and school-based and work-related programs can achieve positive mental health outcomes, in terms of reduced risks and increased functioning (Hosman and Jané-Lopis, 1999; Tilford, Delaney and Vogels, 1997). A controlled trial has demonstrated that media campaigns, in conjunction with appropriate community activities, can improve mental health literacy (Hersey et al, 1984). However, further studies are needed on the effectiveness of mental health promotion. The rigorous scientific evaluation of all mental health promotion programs will contribute to this emerging evidence base. Appropriate indicators of wellbeing and mental health promotion benchmarks need to be developed.

There is strong evidence for the effectiveness of **prevention** programs related to child and adolescent mental health, and for early intervention for behavioural disorders in children and in response to early warning signs for psychotic disorders in late adolescence and early adulthood. A meta-analysis of universal prevention programs for children and adolescents revealed that they were at least as effective as many established treatment interventions in medicine and the social sciences (Durlak and Wells, 1997). Randomised controlled trials provide evidence of efficacy for interventions for adults affected by adverse life events such as bereavement, physical illness, unemployment, divorce and separation, trauma and violence (Mrazek and Haggerty, 1994, Health Education Authority, 1997a and b). There is also evidence from a randomised controlled trial to show that exercise can decrease stress levels in older adults (King, Taylor and Haskell, 1993).

A number of extensive randomised controlled prevention trials are underway and the United States National Institute of Mental Health is establishing a clearing-house of such trials at <http://www.nimh.nih.gov>. Economic data, although limited and derived from United States studies, provide evidence of cost-savings.

The evidence for **early intervention** is accumulating, and is particularly promising in the area of early psychosis (Wyatt and Henter, 1997; McGorry et al, 1996). A meta-analysis revealed that indicated prevention programs were effective for children and adolescents (Durlak and Wells, 1998). There is also some evidence related to the effectiveness of opportunistic early interventions for hazardous and harmful alcohol use (Saunders and Lee, 2000). A literature review of early intervention has recently been published (see <http://Auseinet.flinders.edu.au/>).



# The Action Plan

## Purpose

*Action Plan 2000* outlines a strategic framework and plan for action to address the promotion, prevention and early intervention priorities and outcomes outlined in the *Second National Mental Health Plan*. It refines, expands and updates *Action Plan 1999*. It contains strategies to promote mental health, to reduce mental health problems and mental disorders through enhancing protective factors and reducing risk factors for mental disorders, and to intervene as early as possible to minimise the impact of the symptoms of mental health problems and mental disorders.

## Objectives

The primary objectives of *Action Plan 2000* are to:

- enhance social and emotional wellbeing among populations and individuals;
- reduce the incidence, prevalence and effects of mental health problems and mental disorders; and
- improve the range, quality and effectiveness of population health strategies to promote mental health and prevent and reduce the impact of mental health problems and mental disorders among the Australian population.

*Action Plan 2000* outlines agreed initiatives that will be undertaken at a national level, provides a rationale for the selection of priority groups, and refers to the evidence base that supports the suggested activities. It will enable each state and territory to develop the detail of specific activities in their own environments and to integrate existing initiatives within a national framework. *Action Plan 2000* will provide direction, prompt action, assist consistency, avoid duplication of effort, and standardise information collection and reporting. While supporting autonomy to develop and deliver local plans, it provides national leadership and facilitates and fosters collaborative partnerships.

## Scope

*Action Plan 2000* is concerned with:

- mental health promotion;
- prevention of mental health problems and mental disorders; and
- early intervention for emerging signs and symptoms of mental health problems and first episodes of mental disorder.

The prevention and early intervention strategies fall within the universal, selective and indicated prevention, case identification, and early treatment segments of the revised spectrum of interventions (see Figure 1). *Action Plan 2000* does not cover standard treatment or continuing care, which are the responsibility of mental health treatment services. Nor does it address in detail depression or suicide prevention strategies, which are the focus of the *Depression Action Plan and Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia*, respectively (Commonwealth Department of Health and Aged Care, 2000a and b). There is, however, considerable overlap with these initiatives, which will be acknowledged throughout the implementation of *Action Plan 2000*.

The literature reviewed in this document focuses more on prevention and early intervention than on promotion approaches due to the greater strength and quality of evidence in the former areas. Furthermore, the emphasis is on psychosocial rather than biological interventions as this is where evidence-based opportunities for prevention currently lie. *Action Plan 2000* will continue to be responsive to emerging evidence, including evidence relating to promotion interventions, and opportunities to influence biological and genetic factors that may also contribute to mental health problems and mental disorders.

## Structure

*Action Plan 2000* summarises opportunities for promotion, prevention and early intervention for the 15 priority groups listed in Table 2. These priority groups and their needs are not mutually exclusive, and there are many areas of cross-reference. For example, the needs of Aboriginal peoples, Torres Strait Islanders, people from diverse cultural and linguistic backgrounds and people living in rural and remote areas are also concerns within each of the other priority groups. Similarly, across the lifespan, the needs of parents and other family members are integrally linked with those of children.

**Table 2: Priority groups**

<b>Whole of community</b>	
<b>Groups across the lifespan</b>	Perinatal and infants 0–2 years Toddlers and preschoolers 2–4 years Children 5–11 years Young people 12–17 years Young adults 18–25 years Adults Older adults
<b>Other priority populations</b>	Individuals, families and communities experiencing adverse life events Rural and remote communities Aboriginal peoples and Torres Strait Islanders People from diverse cultural and linguistic backgrounds
<b>Key strategic priority groups</b>	Consumers and carers Media Health professionals and clinicians

For each of the 15 priority groups, *Action Plan 2000* sets out:

**Outcomes** — the anticipated benefits of promotion, prevention and early intervention activities for the identified priority group. ❶

**Rationale** — an outline of why this group is a priority and the conceptual basis supporting the choice of actions. ❷

**Evidence base for action** — a summary of the research that informs current understanding of possible directions for promotion, prevention and early intervention initiatives. An asterisk (\*) signifies those areas where evidence is based on randomised controlled trials. The section also presents important **research questions** to address significant gaps in the evidence base. ❸

**Who will be involved?** — identifies those individuals, groups and agencies that need to be involved as partners, custodians, stakeholders or agents of change. ❹

**Where will it happen?** — identifies the places or environments where interventions can occur. ❺

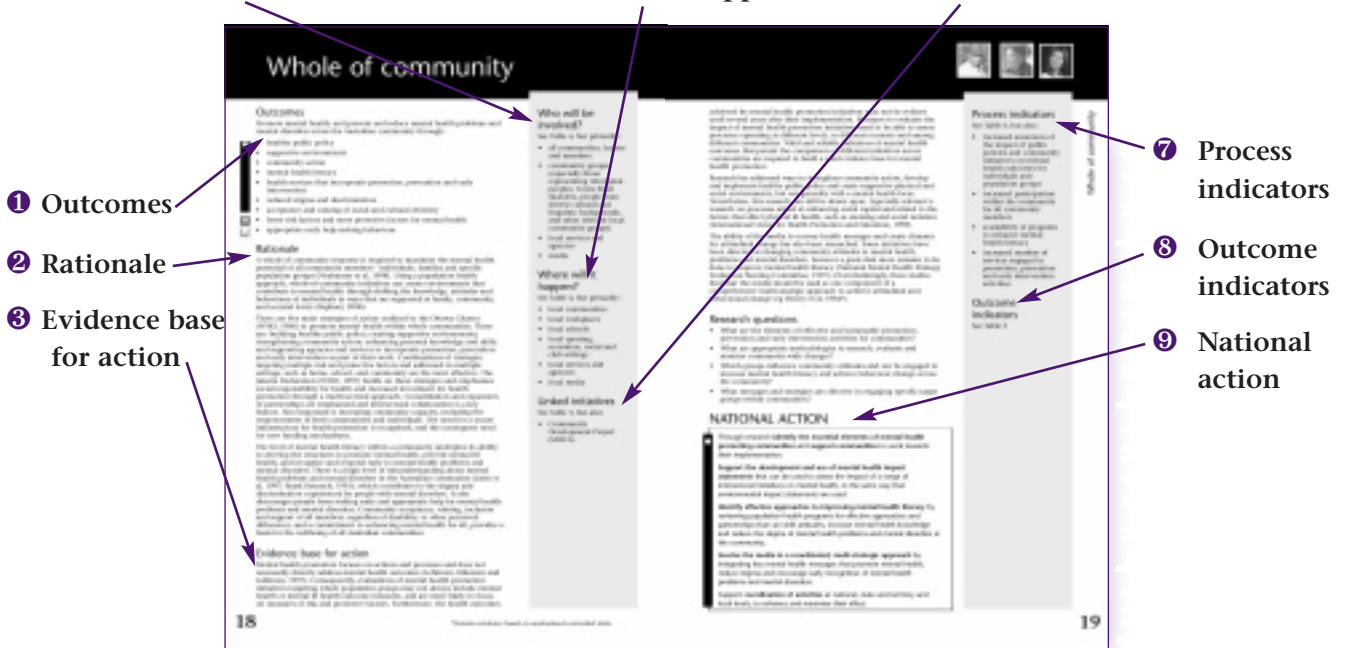
**Linked initiatives** — presents major national policy or program initiatives that may contribute to achieving outcomes specific to each priority group. There are, however, many current initiatives that are linked to **all** the priority groups, such as the *Second National Mental Health Plan*. These are presented in Table 3 and are not repeated for each priority group. ❻

**Process indicators** — lists measures of progress that are specific to each priority group in order to attain desired outcomes. The process indicators listed in Table 6 apply to all priority groups and are not repeated for each. ❼

**Outcome indicators** — lists indicators of changes in health status specific to each priority group. The outcome indicators listed in Table 5 apply to **all** priority groups and are not repeated for each. ❽

**National action** — presents agreed national activities to be undertaken in order to achieve the desired outcomes specific to each priority group. ❾

- ❹ Who will be involved?    ❺ Where will it happen?    ❻ Linked initiatives



**Table 3: Linked initiatives across all priority groups**

National Mental Health Strategy	National Strategy for Palliative Care in Australia
National Public Health Partnership Group	Active Australia Strategy
National Suicide Prevention Strategy	Supported Accommodation Assistance Program
National Action Plan for Depression	Commonwealth Disability Strategy
Life Promoting Media Strategy	National Injury Prevention Action Plan
Mental Health Promoting Media Strategy	National Aboriginal Health Strategy, 1989
Auseinet—the national network for promotion, prevention and early intervention for mental health	NACCHO Manifesto on Aboriginal Mental Wellbeing, 1993
Australian Transcultural Mental Health Network	National Strategy on Indigenous Family Violence
Stronger Families and Communities Strategy	National Aboriginal and Torres Strait Islander Nutrition Strategy
National Crime Prevention Strategy: Towards a Safer Australia	Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan 1996–2000
National Drug Strategy	Enhanced Primary Care Medicare Benefits Schedule items for care planning and case conferencing for people with chronic and multi-disciplinary care needs
<ul style="list-style-type: none"> <li>• National Alcohol Action Plan</li> <li>• National Action Plan on Illicit Drugs</li> <li>• National Tobacco Strategy</li> </ul>	
Primary Mental Health Care Initiative	

### Adopting a promotion, prevention or early intervention approach

To adopt a promotion, prevention or early intervention approach, services and organisations need to know how to select an appropriate intervention. Initially, consideration must be given to criteria that guide the identification and selection of the health conditions to be targeted and the strategies that most appropriately address them. In planning intervention strategies the following criteria serve to guide the selection of focus and intervention strategy, and typically include:

- the extent of burden (incidence/prevalence/social and economic cost to the community);
- the empirical evidence demonstrating definite health gain and/or evidence of capacity of the intervention to address known multiple risk and protective factors;
- the availability, and cultural appropriateness of the intervention;
- the cost-benefit effectiveness of the intervention (including timing of the intervention to maximise outcomes);
- the capacity of the intervention to adopt a population health approach (recall that a large number of people exposed to a small risk may generate many more ‘cases’ than a small number of people exposed to a high risk);
- the amenability of the intervention to evaluation;
- the capacity to engage intersectoral collaborative partnerships and/or strategic alliances;
- the capacity to engage stakeholder and consumer support;
- the potential sustainability and ability to generalise the intervention strategy to other areas; and
- the capacity of the intervention to address inequalities.

## Who will be involved and where will it happen

The success of *Action Plan 2000* depends on careful planning and capacity building to implement the planned strategies and activities. This requires political commitment at all levels—local, state and territory and national—along with appropriate intersectoral partnerships and commitment across all sectors of the community.

While much of the impetus may come from within the mental health sector, it needs to be recognised that other sectors also have a major and explicit interest in improving the emotional and social wellbeing of communities and individuals. A consultative, community-driven process is crucial in implementing promotion, prevention and early intervention programs. Partnerships need to extend across all sectors of the community including: consumers; carers; local communities and community groups; mental health services; public health services; maternal and child health services; education; housing; welfare; justice; police; accident and emergency; general practitioners; paramedics; lawyers; psychologists; psychiatrists; researchers; Aboriginal and Torres Strait Islander communities; diverse cultural and linguistic communities; and many more—all those people, groups and services that impact on the events of everyday life for all Australians.

Identifying the key strategic sectors, settings and people that contribute to particular mental health outcomes is a critical early consideration for successful promotion, prevention and early intervention. The range of intersectoral and intrasectoral partners that need to be engaged in an intervention, and their relative importance, will depend on the focus of the intervention and the target population groups involved. Table 4 presents the many and diverse areas of life that have major influences on the determinants of mental health: they are relevant for **all** the priority groups considered in *Action Plan 2000* but are not repeated for each.



**Table 4: Key strategic sectors, settings and people for mental health partnerships**

Sector	Settings
Home	homes
Childcare	homes, family daycare, childcare centres
Education	preschools, schools, tertiary institutions, vocational institutions, adult education, University of the Third Age, Open Learning
Health	prenatal and postnatal health care settings, child health clinics, general practice and other primary health care settings, adolescent health and mental health services, specialist mental health services, specialist aged care health services, Aboriginal Community Controlled Health Services, community health and mental health settings, public and private hospitals, accident and emergency services, rehabilitation services
Welfare	child and family welfare services, counselling services (relationship, financial, gambling, drug and alcohol, bereavement), sexual assault services, child protection services, employment services, home and community care, disability services
Housing	housing services (including Supported Accommodation Assistance Program), refuges and shelters, residential aged and disability care settings, retirement villages
Community	communities, social and recreational settings (including youth and other community-specific associations and clubs), local businesses, local community services (including local council services such as transport, libraries, sporting and recreation settings, senior citizens' clubs), Aboriginal Community Controlled Health Services, ethnic community organisations
Arts, sport and recreation	arts, sport and recreational settings
Employment	public and private sector workplaces (especially identified high-risk occupation workplaces), occupational rehabilitation settings
Financial	financial services, insurance services
Corrections	courts, juvenile and adult correctional services, juvenile and adult correctional institutions
Media	radio, television, print and newspaper offices, advertising and production agencies, computerised services such as the Internet
Government	local, state and territory, national

<b>People—individuals and groups</b>
children, parents, families, carers, support groups
children, carers and their families, management and administration, policy makers, professional organisations, researchers
students, teachers, academics, counsellors, curriculum developers, support staff, management, administrators, policy makers, professional organisations, researchers
clients/patients, carers, nurses (general and mental health), general practitioners, primary care workers, specialists, psychiatrists, psychologists, social workers, occupational therapists, support workers, administration, management, professional organisations, policy makers, professional development providers, researchers
clients, carers, counsellors, clergy, youth and outreach workers, foster carers, managers, administrators, policy makers, professional organisations, consumer organisations, researchers
clients, staff, management and administration, policy makers, professional organisations, consumer organisations, researchers
patrons, volunteers, committees, community and business organisations, consumer groups, local councils, local government services
patrons, volunteers, committees, profit and non-profit organisations, professional and amateur associations, management, sponsors
employees, employers, management, administrators, occupational health and safety officers, rehabilitation officers, policy makers, professional organisations, employee assistance programs, shareholders
workers, management, administrators, policy makers, shareholders, professional organisations
offenders, police, youth workers, parole and probation officers, correctional officers, legal profession, policy makers, professional organisations
journalists, writers, editors, cartoonists, photographers, policy makers, employers, professional organisations
policy makers, administrators, local members, ministers, lobbyists

## Key strategic indicators

Underpinning all interventions aimed at promotion, prevention and early intervention is the need for a strong evidence base identifying the factors that impact on mental health across the lifespan and effective ways to intervene. This means that, along with research to monitor population trends in mental health, all interventions need to be evaluated. This requires a common set of indicators, which can then be used to monitor the progress of activities undertaken in response to *Action Plan 2000*.

Six key **outcome indicators** that link to objectives of *Action Plan 2000* are presented in Table 5 (Spence et al, 2000). These indicators reflect mental health outcomes that are relevant across all 15 priority groups. Data collected will show progress towards achieving the objectives of *Action Plan 2000* at a national level across all the priority groups.

**Table 5: Outcome indicators for all priority groups**

Outcome indicator 1	Reduction of mental health problems and symptoms as these relate to a range of symptomatic presentations and disorders, including anxiety, depression, postnatal depression, substance misuse, conduct disorder and behavioural disorders, suicide and self-harming behaviours, eating disorders, psychosis, and dementia.
Outcome indicator 2	Increased mental health, wellbeing, quality of life and resilience.
Outcome indicator 3	Increased mental health literacy.
Outcome indicator 4	Improved family functioning and parenting skills.
Outcome indicator 5	Enhanced social support and community connectedness.
Outcome indicator 6	Increased investment in evidence-based programs relevant to promoting mental health and preventing and reducing mental health problems and mental disorders by governments and non-government agencies.

There is often a considerable time lapse before changes in health outcomes are apparent, so it is also important to have indicators showing that the processes that are expected to deliver the anticipated outcomes have been put in place. Table 6 presents **process indicators** that will show that the necessary actions are taking place to effectively implement *Action Plan 2000* for all the priority groups.

**Table 6: Process indicators for all priority groups**

Process indicator 1	Increased monitoring and surveillance of mental health problems, mental disorders, and risk and protective factors, including social and family functioning.
Process indicator 2	The presence of evidence-based programs related to promotion, prevention and early intervention for all priority groups.
Process indicator 3	Increased early identification of mental health problems and mental disorders and appropriate referral.
Process indicator 4	Increased community education related to mental health.
Process indicator 5	Increase in public policy and practices that promote mental health in all relevant settings (including family, education, workplace, recreation, and community).
Process indicator 6	Increased professional education and training.
Process indicator 7	Increased inter, intra, and multisectoral collaboration and partnerships.
Process indicator 8	Increased mental health research and evaluation activities.

Widespread dissemination of the evidence gathered related to both the process and outcome indicators will improve mental health literacy across the community, increase the uptake of effective interventions, and consolidate promotion, prevention and early intervention as standard practice in a wide range of services and sectors. Auseinet, the national network for promotion, prevention and early intervention for mental health, will operate as a national network and clearinghouse to disseminate information and raise awareness about promotion, prevention and early intervention for mental health to a variety of stakeholders and sectors.

On-going supportive education and training is required to keep policy-makers, researchers, practitioners, related workforces, consumers and carers up-to-date and committed to implementing promotion, prevention and early intervention. Appropriate funding structures and policy commitments are essential to sustain effective mental health interventions across the entire spectrum.

## **Evaluation, implementation and responsibility for the plan**

The National Mental Health Working Group is responsible for the overall implementation, monitoring and evaluation of priorities and strategies of the *Second National Mental Health Plan*, and it will continue to provide regular progress reports on *Action Plan 2000* to the Commonwealth, State, and Territory Health Ministers. The National Public Health Partnership Group will continue to provide advice and coordination, particularly with respect to population strategies and research, and will maintain representation on the Mental Health Promotion and Prevention Working Party. The Mental Health Promotion and Prevention Working Party will assume responsibility for national implementation and monitoring aspects of the plan and will continue to provide advice to the National Mental Health Working Group and liaise with the National Public Health Partnership Group.

The Mental Health Promotion and Prevention Working Party recognises that the implementation of *Action Plan 2000* requires substantial workforce and infrastructure development including significant education and training. These issues are being addressed during the implementation process for the plan.

# Whole of community

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders across the Australian community through:

- healthy public policy
- supportive environments
- community action
- mental health literacy
- health services that incorporate promotion, prevention and early intervention
- reduced stigma and discrimination
- acceptance and valuing of social and cultural diversity
- fewer risk factors and more protective factors for mental health
- appropriate early help-seeking behaviour

## Rationale

A whole of community response is required to maximise the mental health potential of all community members—individuals, families and specific population groups (Neuhauser et al, 1998). Using a population health approach, whole-of-community initiatives can create environments that contribute to mental health through shifting the knowledge, attitudes and behaviours of individuals in ways that are supported at family, community, and societal levels (Raphael, 2000).

There are five main strategies of action outlined in the *Ottawa Charter* (WHO, 1986) to promote mental health within whole communities. These are: building healthy public policy; creating supportive environments; strengthening community action; enhancing personal knowledge and skills; and supporting agencies and services to incorporate promotion, prevention and early intervention as part of their work. Combinations of strategies targeting multiple risk and protective factors and addressed in multiple settings, such as home, school, and community are the most effective. The *Jakarta Declaration* (WHO, 1997) builds on these strategies and emphasises social responsibility for health and increased investment for health promotion through a multi-sectoral approach. Consolidation and expansion of partnerships are emphasised and intersectoral collaboration is a key feature. Also important is increasing community capacity, including the empowerment of both communities and individuals. The need for a secure infrastructure for health promotion is recognised, and the consequent need for new funding mechanisms.

The level of mental health literacy within a community underpins its ability to develop the structures to promote mental health, prevent mental ill health, and recognise and respond early to mental health problems and mental disorders. There is a high level of misunderstanding about mental health problems and mental disorders in the Australian community (Jorm et al, 1997; Reark Research, 1993), which contributes to the stigma and discrimination experienced by people with mental disorders. It also discourages people from seeking early and appropriate help for mental health problems and mental disorders. Community acceptance, valuing, inclusion and support of all members, regardless of disability, or other perceived differences, and a commitment to enhancing mental health for all, provides a basis for the wellbeing of all Australian communities.

## Evidence base for action

Mental health promotion focuses on actions and processes and does not necessarily directly address mental health outcomes (Lehtinen, Riikonen and Lahtinen, 1997). Consequently, evaluations of mental health promotion initiatives targeting whole population groups may not always include mental health or mental ill health outcome measures, and are more likely to focus

## Who will be involved?

See Table 4, but primarily:

- all communities, leaders and members
- community groups (especially those representing Aboriginal peoples, Torres Strait Islanders, people from diverse cultural and linguistic backgrounds, and other relevant local community groups)
- local services and agencies
- media

## Where will it happen?

See Table 4, but primarily:

- local communities
- local workplaces
- local schools
- local sporting, recreation, social and club settings
- local services and agencies
- local media

## Linked initiatives

See Table 3, but also:

- Community Development Project (Mental Health Council of Australia)



on measures of risk and protective factors. Furthermore, the health outcomes achieved by mental health promotion initiatives may not be evident until several years after their implementation. Measures to evaluate the impact of mental health promotion initiatives need to be able to assess processes operating at different levels, in different contexts and among different communities. Valid and reliable indicators of mental health outcomes that permit the comparison of different initiatives across communities are required to build a solid evidence base for mental health promotion.

Research has addressed ways to strengthen community action, develop and implement healthy public policy and create supportive physical and social environments, but not generally with a mental health focus. Nevertheless, this research can still be drawn upon. Especially relevant is research on processes aimed at enhancing social capital and related to the factors that affect physical ill health, such as smoking and social isolation (International Union for Health Promotion and Education, 1999).

The ability of the media to convey health messages and create climates for attitudinal change has also been researched. Some initiatives have been directed at changing community attitudes to mental health problems and mental disorders, however a great deal more remains to be done to improve mental health literacy (National Mental Health Strategy Evaluation Steering Committee, 1997). Overwhelmingly, these studies find that the media should be used as one component of a comprehensive multi-strategic approach to achieve attitudinal and behavioural change (eg Hersey et al, 1984\*).

#### Research questions

- What are the elements of effective and sustainable promotion, prevention and early intervention activities for communities?
- What are appropriate methodologies to research, evaluate and monitor community-wide changes?
- Which groups influence community attitudes and can be engaged to increase mental health literacy and achieve behaviour change across the community?
- What messages and strategies are effective in engaging specific target groups within communities?

## NATIONAL ACTION

Through research **identify the essential elements of mental health promoting communities** and **support communities** to work towards their implementation.

**Support the development and use of mental health impact statements** that can be used to assess the impact of a range of intersectoral initiatives on mental health, in the same way that environmental impact statements are used.

**Identify effective approaches to improving mental health literacy** by reviewing population health programs for effective approaches and partnerships that can shift attitudes, increase mental health knowledge and reduce the stigma of mental health problems and mental disorders in the community.

**Involve the media in a coordinated, multi-strategic approach** by integrating key mental health messages that promote mental health, reduce stigma and encourage early recognition of mental health problems and mental disorders.

Support **coordination of activities** at national, state and territory and local levels, to enhance and maximise their effect.

### Process indicators

See Table 6, but also:

- increased awareness of the impact of public policies and community initiatives on mental health outcomes for individuals and population groups
- increased participation within the community for all community members
- availability of programs to enhance mental health literacy
- increased number of services engaged in promotion, prevention and early intervention activities

### Outcome indicators

See Table 5

# Perinatal and infants 0–2 years

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among parents and infants through:

- environments and infrastructure that support infant health, maternal health and wellbeing
- family-friendly workplace policies and practices
- infrastructure that supports family functioning
- ▲ parenting skills and optimal family functioning
- safe, nurturing and consistent quality care for infants
- reduced incidence of low infant birth weight
- reduced maternal depression and anxiety and parental substance misuse
- reduced child abuse and neglect
- early identification and appropriate follow-up of parents and infants at risk of or suffering from perinatal physical and mental health problems

## Rationale

There is now evidence showing that the quality of nourishment and nurturing in the early years has far-reaching effects (Keating and Hertzman, 1999). Major influences on an infant's wellbeing that help to prevent mental disorders later in life include: sound maternal and perinatal health; secure attachment between infant and care giver; adequate parenting; good quality care in safe environments; and adequate nutrition.

Possible risk factors for adverse mental health outcomes include: low infant birth weight and birth complications; poor infant health; insecure attachment; inadequate cognitive stimulation; abuse and neglect; mental or physical health problems in a parent, particularly the mother; and poverty. Developmental disorders, intellectual disability and genetic factors may also contribute.

There is, therefore, the potential to achieve long-term mental health benefits from programs that: provide quality prenatal and postnatal care; enhance parenting skills; promote attachment and provision of positive, safe, engaging learning environments for infants; and improve the mental and physical health of parents. Workplace policies and practices and local community services are especially important in supporting optimal family health and functioning.

## Evidence base for action

Auseinet has recently described clinical approaches for the perinatal period (Kowalenko et al, 2000). A number of effective perinatal screening tests for maternal and infant health problems are available and routinely used. Screening for maternal mental health problems, such as postnatal depression, anxiety and stress, combined with effective intervention strategies, has the potential to reduce this major risk factor for adverse mental health outcomes in the infant (eg Holden, Sagovsky and Cox, 1989; Barnett and Parker, 1985; Barnett et al, 1991).

Selective interventions involving home visits and educational childcare programs, often in combination, have been effective in promoting positive outcomes and modifying a range of risk factors for mental health problems, particularly in the short term\*. These interventions have targeted vulnerabilities associated with pregnancy, the period after birth, and the earliest years. In particular, interventions have been aimed at improving outcomes for premature or low birth weight infants, infants of teenage mothers and infants with socioeconomically disadvantaged parents. There is evidence that such programs can enhance development and cognitive competence\*, reduce child abuse\*, improve parenting\*, and reduce behavioural problems. They have also been shown to result in early return to work and higher rates of employment for women who participate\*.

## Who will be involved?

See Table 4, but primarily:

- infants, parents and families
- parent support groups
- childcare providers
- maternal and child health services
- child and family welfare agencies

## Where will it happen?

See Table 4, but primarily:

- homes
- childcare settings
- perinatal health care settings
- primary health care settings
- child health clinics
- child and family welfare services

## Linked initiatives

See Table 3, but also:

- Audit of Home Visitor Programs (Commonwealth Department of Health and Family Services, 1996a)
- NHMRC Surveillance and Screening Guidelines for Child Health (National Health and Medical Research Council, 1993)
- Quality Improvement and Accreditation System for Long Daycare Centres
- NIFTEY National Initiative for the Early Years
- National Child Nutrition Program
- National Breastfeeding Strategy
- Eat Well Australia / National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
- National Health Plan for Young Australians
- Child and Youth Health Policy



Selective programs that reduce the impact of risk factors for infants include:

- Prenatal/Early Infancy Project (Olds et al, 1986, 1988, 1997; Olds, Henderson and Kitzman, 1994\*)
- Early Intervention for Preterm Infants (Field et al, 1980\*)
- Tactile/Kinesthetic Stimulation Study (Field et al, 1986\*)
- Infant Health and Development Program (Infant Health and Development Program, 1990; McCormick et al, 1991, 1993; Ramey et al, 1992; Brooks-Gunn et al, 1994a, b; McCarton et al, 1997\*)
- Carolina Abecedarian Project (Horacek et al, 1987\*)

Barnett (1995) has reviewed interventions that enhance the transition to parenthood. These include:

- STEEP (Steps Towards Effective Enjoyable Parenting) (Erickson, Korfmacher and Egeland, 1992)
- Home Start and Newpin (Mills and Pound, 1986)
- interventions for those vulnerable to child abuse (eg Kempe, 1976; Gray et al, 1979a, b)

A multi-component program (visits and childcare) results in better cognitive development than home visits alone (Ramey et al, 1985\*). Mental health outcomes of home visiting programs are also improved when linked to specialist mental health expertise and when provider roles and supports are identified.

#### Research questions

- What are the components critical to the efficacy and effectiveness of a home visiting intervention in terms of improved mental health outcomes for mother and child?
- How can mothers from culturally and linguistically diverse backgrounds best be supported during the perinatal period?
- How are at-risk families best identified and effectively and sensitively supported?

## NATIONAL ACTION

- **Provide workplace support for parents** through family-friendly workplace policies and practices.
- ▲ Promote antenatal education initiatives to **improve mental health literacy for parents** (including knowledge about postnatal depression) as well as knowledge regarding infant nutrition.
- Identify core effective mental health components of home visiting that will enhance parenting skills and promote attachment. **Provide home visiting and parent support programs** for those families at risk of mental health problems.
- Develop and evaluate demonstration programs that **deliver quality infant childcare** promoting social and emotional wellbeing, particularly for infants at high risk of mental health problems.
- Develop initiatives to **implement and coordinate screening programs for infant health and parental mental health problems** (particularly maternal depression); improve workforce skills in screening processes; and implement effective indicated and treatment interventions.

### Process indicators

See Table 6, but also:

- increase in education, screening and management programs to improve mothers' mental health in the perinatal period
- increased home visiting and parent/infant support programs with mental health components
- increase in parenting skills programs, particularly for families identified as at-risk
- increased availability of quality infant childcare programs

### Outcome indicators

See Table 5, but also:

- decreased incidence of low birth weight in infants
- decrease in maternal depression, anxiety and distress and parental substance misuse
- decreased rates of infant abuse
- improved infant/care giver attachment

# Toddlers & preschoolers 2–4 years

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among parents and toddlers and preschooler children through:

- environments and infrastructure that support family wellbeing
- family-friendly workplace policies and practices
- ▲ positive parenting skills and optimal family functioning
- safe, nurturing and consistent quality care for children
- safe, engaging and positive learning environments for children
- reduced maternal depression and anxiety and parental substance misuse
- reduced marital conflict
- reduced child abuse and neglect
- early identification and appropriate follow-up for children showing the early signs of disruptive behaviour

## Rationale

The period of early childhood to the start of formal schooling is a time of rapid development, particularly in speech and language and the formation of social relationships. The acquisition of good language skills is critical to prepare the child for success at school. The development of impulse control is also associated with lower risk for adverse mental health outcomes, particularly disruptive behaviour disorders (Hawkins et al, 1992).

Risk factors for disruptive behaviour disorders include: insecure attachment; coercive parenting practices; inconsistent management; parental depression, anxiety and stress; marital discord; low social resources and support; economic deprivation; and parental drug and alcohol misuse, criminality or mental disorder. In the child, developmental disorders, intellectual disability and genetic factors may also contribute.

Disruptive behaviour in early childhood increases the risk of conduct disorder, substance misuse and criminality later in life (Satterfield et al, 1994; Moffitt, 1990; Moffitt and Harrington, 1994). Children at-risk can be identified as early as four years of age by high levels of noncompliance and aggression (Conduct Problems Research Group, 1992). Evidence is accumulating that the earlier problems are identified and family interventions put in place, the better the mental health outcomes for the child (Sanders and Markie-Dadds, 1996). Auseinet has recently produced guidelines related to behaviour disorders in preschool aged children (Hazell, 2000).

Protective factors include: secure attachment between parent and child; consistent and fair behaviour management practices; a close positive and stable relationship with a care giver; low family stress; and good social and language skills in the child (Mrazek and Haggerty, 1994). Workplace policies and practices play an important role in family health and functioning by supporting family environments that are optimal for child development.

## Evidence base for action

Prevention approaches that have been shown to be effective include: enhancing social competence and cognitive development in the child; providing a variety of support and educational services; teaching care givers skills in effective behaviour management; and addressing issues of health, education and child safety.

## Who will be involved?

See Table 4, but primarily:

- children, parents and families
- parent support groups
- childcare and preschool staff
- child health services
- general practitioners and primary health care providers
- child and family welfare agencies

## Where will it happen?

See Table 4, but primarily:

- homes
- childcare settings
- preschools
- primary health care settings
- child health clinics
- child and family welfare services

## Linked initiatives

See Table 3, but also:

- NHMRC Surveillance and Screening Guidelines for Child Health (NHMRC, 1993)
- Quality Improvement and Accreditation System for Long Daycare Centres
- National Child Nutrition program
- Eat Well Australia: National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
- National Health Plan for Young Australians
- Child and Youth Health Policy



Effective early childhood programs include:

- Houston Parent–Child Development Centre Program (Johnson, 1990, 1991\*)
- Mother–Child Home Program of Verbal Interaction Project (Levenstein, 1992; Madden, O’Hara and Levenstein, 1984\*)
- Parent–Child Interaction Training Program (Strayhorn and Weidman, 1991\*)
- High/Scope Preschool Curriculum Comparison Program (Weikart, Schweinhart and Larner, 1986; Schweinhart and Weikart, 1992\*)
- Perry Preschool Program (Berrueta-Clement et al, 1984\*)
- ICPS (I Can Problem Solve) Interpersonal Cognitive Problem-Solving Program (Shure and Spivak, 1982, 1988\*)
- ‘Triple P’ Positive Parenting Program—an initiative developed in Australia (Sanders, 1995; Sanders and Markie-Dadds, 1996; Williams, Silburn and Zubrick, 1996; Williams et al, 1997; Connell, Sanders and Markie-Dadds, 1997\*)

The effects of these programs are measurable not only in terms of positive mental health outcomes for the participating children but also in improved maternal health and wellbeing, education and employment. Many programs targeted at the perinatal and infancy age group (0–2 years) also have effective extensions into this developmental period of early childhood\* (Karoly et al, 1998).

#### Research questions

- What is the minimum level of intervention required to prevent development of behavioural disorders?
- For which families are the current interventions ineffective and why?
- How can good parenting skills be developed across the community, particularly within at-risk families?

## NATIONAL ACTION

- **Promote workplace support for parents** through workplace policies and practices that support family relationships and reduce parental stress.
- **Promote parenting skills** as an important social value.
- **Provide quality childcare and preschool programs** accessible to all families, particularly those who are disadvantaged. Develop mental health promoting learning environments in early childhood settings.
- ▲ **Monitor progress and implement successful parenting programs** as widely as possible, with a focus on populations of parents with heightened risk, and ensuring adherence to program integrity. Establish partnerships to coordinate delivery of parenting programs to ensure appropriate follow-up and access to assistance when needed.
- **Provide parenting support for families at-risk and with special needs** by investigating the applicability of programs for rural and remote communities, Aboriginal communities, Torres Strait Islander communities, people from diverse cultural and linguistic backgrounds, and other population groups with special needs (eg parents with a mental disorder, serious chronic physical illness, substance use problem, or who have experienced domestic violence or sexual abuse).
- **Identify early the children** with signs of speech, language, social and behaviour problems and intervene appropriately.

### Process indicators

See Table 6, but also:

- increased availability and uptake of effective parenting education programs
- improved policy and program links between key service providers to support families at-risk
- increased availability of quality preschool and childcare programs
- increase in programs for early identification and appropriate treatment of children with cognitive, speech, language, social and behavioural difficulties

### Outcome indicators

See Table 5, but also:

- decreased child abuse and neglect
- decreased marital conflict
- decreased incidence and prevalence of cognitive, speech, language, social and behavioural difficulties for preschool children
- increased social, language and cognitive skills for preschool children

# Children 5–11 years

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among parents and children through:

- environments and infrastructure that support family wellbeing
- family-friendly workplace policies and practices
- acceptance and valuing of social and cultural diversity
- school environments that enhance mental health and mental health literacy
- ▲ positive parenting skills and optimal family functioning
- ▲ reduced marital conflict
- ▲ reduced child abuse and neglect
- ▲ increased self-worth, social competency, coping skills and resilience in children
- positive peer relationships
- sense of connectedness to family, school and community
- early intervention for children showing the early signs and symptoms of conduct, anxiety, depression and eating disorders

## Rationale

The start of formal schooling marks a major transition point and a significant opportunity for promotion of mental health and prevention and early intervention for mental health problems. Increasingly, through this developmental period, risk factors for poor mental health outcomes derive from the social and physical environments that provide education and socialisation experiences for children, as well as ongoing family factors.

Risk factors include: level of education of parents (ie below year 10); parental unemployment; low family income; discord and violence in the family; absence of love and affection; coercive parenting style; poor monitoring and supervision at home and school; low teacher–student attachment; poor peer relations; harsh, punitive or inconsistent behaviour management in the home and/or school setting; alienation from school; and parental criminality, substance misuse or mental disorder.

Protective factors include: a family environment that is valuing and affectionate; a cohesive and non-violent school environment; a sense of self-worth and social connectedness; self-efficacy in problem solving, coping skills and social skills; an internal locus of control; belonging to a positive peer group; leading an active lifestyle; and having a personal confidante, role model or mentor.

## Evidence base for action

In middle childhood effective interventions are those that promote structures to support the family and the school community in developing social, emotional and problem-solving life skills for children as well as achieving academic success. Programs that identify and manage, at an early age, children showing the early signs of mental health problems can also be effective. Auseinet has recently described clinical approaches for conduct problems (Sanders, Gooley and Nicholson, 2000) and anxiety disorders (Dadds et al, 2000) in children.

Interventions in both home and school settings that have been effective in preventing mental health problems in this age group include:

- universal, selective, and indicated positive parenting programs, such as ‘Triple P’ Positive Parenting Program (Sanders, 1995; Sanders and Markie-Dadds, 1996; Williams, Silburn and Zubrick, 1996; Williams et al, 1997; Connell, Sanders and Markie-Dadds, 1997\*)
- mental health promoting schools that strengthen life skills and resilience, foster a supportive school environment, and develop partnerships between school, home and community

## Who will be involved?

See Table 4, but primarily:

- children, parents and families
- school leaders, teachers and counsellors
- general practitioners and primary health carers
- specialist child health and mental health services
- child and family welfare agencies

## Where will it happen?

See Table 4, but primarily:

- homes
- primary schools
- primary health care settings
- child health and mental health services
- community, sport and recreation settings
- child and family welfare services

## Linked initiatives

See Table 3, but also:

- National Child Nutrition Program
- Eat Well Australia: National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
- National School Drug Education Strategy
- National Literacy and Numeracy Plan
- Indigenous Education Strategic Initiatives Program
- National Asian Languages and Studies in Australian Schools Strategy
- CESCO Working Groups on bullying and racism
- National Health Plan for Young Australians
- Child and Youth Health Policy



- school-based programs designed to promote resilience and optimism have been effective in preventing anxiety and depression in children and include: Coping Koala Programme and Friends Programme (indicated) (Barrett, Dadds and Rapee, 1996; Dadds et al, 1997; Dadds et al, 1999\*); and Penn Prevention Program (Jaycox et al, 1994)
- interventions that increase social problem solving, build self-efficacy and enhance social competency and academic achievement, improve parenting skills, or a combination of these include: Assertiveness Training Program 1 (universal) and 2 (indicated) (Rotheram, 1982\*); Social Skills Training (selective) (Bierman, 1986\*); Montreal Longitudinal Experiment Study (indicated) (Tremblay et al, 1991, 1992\*); and Seattle Social Development Project (universal) (Hawkins et al, 1992\*)
- school-based programs aimed at altering school organisation and changing school systems have led to decreased bullying, reduced school violence, and improved academic achievement through: Campaign Against Bully-Victim Problems (universal) (Olweus, 1991); The Second Step: a violence prevention curriculum (Grossman et al, 1997\*); and The Yale-New Haven Primary Prevention Project (Comer, 1985), respectively.

Early identification and effective intervention with children experiencing conduct, eating, anxiety and depressive disorders is also important. Generally, psychosocial interventions are preferred as the first mode of treatment for children, although pharmacological treatments may be appropriate in the case of identified and specific disorders that have been diagnosed (see NHMRC, 1997a, b).

#### Research questions

- Which interventions enhance resilience in children?
- What screening tools identify risk and protective factors for children?
- What screening tools validly and reliably identify the early signs and symptoms of emerging mental health problems in children?
- Which interventions interrupt the developmental trajectories of conduct disorder, antisocial and depressive/anxiety behaviours, and eating disorders?

## NATIONAL ACTION

**Promote awareness and acceptance of cultural diversity** through developing and distributing cultural awareness packages. It is of particular importance to incorporate Aboriginal history into core curriculum, in partnership with Aboriginal Community Controlled Health Services.

**Promote mental health literacy** in school communities.

Develop and evaluate programs to **enhance school environments** using a mental health promoting schools framework and incorporating cultural needs.

Establish a **nationally coordinated approach for primary school programs** aimed at integrating mental health issues into policy and curriculum.

**Implement multi-component primary school-based prevention programs** to promote self-efficacy, resilience and optimistic thinking and to reduce racism, sexism and bullying as well as anxiety, depression, aggressive and antisocial behaviours, and eating disorders.

**Support teachers and other school staff** to identify and appropriately refer children showing early symptoms of emerging mental health problems.

**Intervene early with children showing early signs and symptoms** of anxiety, depression, behavioural disorders and eating disorders.

**Establish links with services** to provide timely and effective treatment and monitoring of children identified with mental health problems.

### Process indicators

See Table 6, but also:

- increase in schools adopting a mental health promoting schools approach
- increase in programs promoting cultural awareness and acceptance of social and cultural diversity
- increase in programs to enhance self-efficacy, resilience and optimistic thinking and to reduce bullying
- increased school participation by Aboriginal and Torres Strait Islander students
- increased early recognition and early intervention for students with behavioural, emotional, attention, speech and language problems

### Outcome indicators

See Table 5, but also:

- decreased child abuse and neglect
- decreased marital conflict
- increased cultural awareness and acceptance of cultural diversity
- decreased incidence, prevalence and burden associated with conduct/disruptive and anxiety/depressive problems
- increased social, coping and academic skills

# Young people 12–17 years

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among young people through:

- environments and infrastructure that support family and social functioning
- family-friendly workplace policies and practices
- acceptance and valuing of social and cultural diversity
- school environments that enhance mental health and mental health literacy
- opportunities for personal development and exploration
- ▲ positive parenting skills and optimal family functioning
- increased self-worth, social competency, coping skills and resilience
- sense of connectedness to family, school and community
- positive peer relationships
- reduced marital conflict
- reduced child abuse and neglect
- early intervention for young people showing the signs and symptoms of anxiety, depression, eating disorders, antisocial behaviour, substance misuse, self-harm, and psychosis

## Rationale

Entering secondary school, puberty, an increasing need for independence, peer relationships, and identity and sexual orientation issues influence the development of young people. This period is marked by increased exposure to risks that may predispose young people to poor mental health outcomes, including the first onset of anxiety, depression, eating disorders, substance misuse, psychosis and deliberate self-harm.

Risk factors include: discord and violence in the family; absence of love and affection; coercive parenting style; poor monitoring and supervision at home and school; poor peer relations; behaviour management in the school setting that is harsh, punitive or inconsistent; low teacher–student attachment; alienation from school and early school leaving; experience of abuse or violence; parental mental disorder, substance misuse and criminality; and poor body image.

Protective factors include: connectedness to family and school; a cohesive and non-violent school environment; having a positive relationship with at least one parent; having a personal confidante, role model or mentor; a sense of self-worth and social connectedness; self-efficacy in problem solving; coping and social skills; an internal locus of control; experiences of achievement; belonging to a positive peer group; and leading an active lifestyle.

## Evidence base for action

Mental health problems may be reduced by activities that enable school communities to develop a sense of belonging and life skills for young people as well as academic success (Resnick et al, 1997).

Effective prevention programs targeting depression and/or anxiety include: Resourceful Adolescent Program (RAP) (universal) (Shochet and Osgarby, 1999; Shochet, Harnett and Osgarby, submitted); Penn Prevention Program (indicated) (Jaycox et al, 1994); Coping with Stress Course (indicated) (Clarke et al, 1995); Adolescents Coping with Emotions (ACE) (indicated) (Hannan, Rapee and Hudson, in press; Kowalenko, Starling and Simmons, 2000); and Gatehouse Project (Patton et al, 2000). Auseinet has recently described clinical approaches for anxiety disorders in adolescents (Dadds et al, 2000).

Effective programs for preventing antisocial behaviours include: Campaign Against Bully–Victim Problems (universal) (Olweus, 1991) and A Behavioural Prevention Intervention (indicated) (Bry, 1982\*). Australian resources addressing bullying include a book and video called *Bullying in Schools* (Rigby and Slee, 1993, Rigby, 1996).

## Who will be involved?

See Table 4, but primarily:

- young people, parents and families
- school leaders, teachers, counsellors and advisers
- general practitioners and primary health carers
- health professionals
- youth, child and family welfare agencies
- police and corrections officers

## Where will it happen?

See Table 4, but primarily:

- homes
- schools
- primary health care settings
- health services, including mental health services
- community, sport and recreation settings
- youth refuges
- child and family welfare services
- juvenile justice settings

## Linked initiatives

See Table 3, but also:

- MindMatters
- National School Drug Education Strategy
- Indigenous Education Strategic Initiatives Program
- CESCO Working Groups on bullying and racism
- Acting on Australia's Weight
- National Homelessness Strategy
- Youth Pathways Action Plan
- Jobs Pathways Programme
- National Health Plan for Young Australians
- Child and Youth Health Policy



The universal Everybody's Different Program aiming to improve self-esteem was effective in reducing body dissatisfaction in young people and in altering weight control behaviour in girls (O'Dea and Abraham, 1999\*; O'Dea, 1997).

A number of programs effectively target hazardous substance use through providing social influence and promoting norms against drug misuse, including: Positive Youth Development Program (Caplan et al, 1992\*); Adolescent Alcohol Prevention Trial (Hansen and Graham, 1991\*); ALERT Drug Prevention (Ellickson and Bell, 1990\*); Alcohol Education Project (Perry et al, 1989\*); and Communities That Care (Hawkins and Catalano, 1992).

Early intervention can also improve mental health outcomes for young people experiencing mental health problems and mental disorders (Helgason, 1990; Loebel et al, 1992; Johstone et al, 1986; Clarke et al, 1995; Jaycox et al, 1994).

Specific programs are needed for high-risk populations, including young people who are: homeless; not in school; adolescent parents; living in rural and remote areas, of Aboriginal or Torres Strait Islander background, from diverse cultural and linguistic backgrounds, and in juvenile justice settings.

A program for the parents of adolescents—PACE (Parenting Adolescents a Creative Experience) reported increased confidence and decreased depression in parents and reduced parent–adolescent conflict after completion of the program (Jenkins and Bretherton, 1994; Jenkins and McGennis, 2000).

#### Research questions

- How can an at-risk mental state be reliably identified in young people?
- What prevention and early intervention programs are effective for eating disorders and substance misuse in young people?
- What are the effects and side-effects of using medication for early intervention with young people, particularly for psychosis and depression?
- What are the most effective strategies for young people no longer at school?

## NATIONAL ACTION

**Nationally coordinate** development and evaluation of programs using a mental health promoting schools framework.

**Promote awareness and acceptance of cultural diversity** through developing and distributing cultural awareness packages.

**Implement effective school-based prevention programs** targeting depression, anxiety, substance misuse, conduct disorder, eating disorders, racism, sexism and bullying.

Support development and evaluation of **adolescent parenting programs**.

**Develop partnerships with communities of interest outside school settings** (eg juvenile justice, youth services, welfare services) and identify intervention opportunities, particularly for young people no longer at school.

**Progress uptake of the** *Depression in Young People. Clinical Practice Guidelines* (1997b). **Consolidate links** between mental health services, primary health care providers and schools.

**Support teachers and other school staff** to identify and appropriately refer young people showing early symptoms of emerging mental health problems.

**Establish links with services to intervene early** with young people showing signs and symptoms of anxiety, depression, behavioural disorders, psychosis, substance misuse and eating disorders.

## Process indicators

See Table 6, but also:

- increase in schools adopting a mental health promoting schools approach
- increase in programs promoting cultural awareness and acceptance of social and cultural diversity
- increase in programs to prevent and intervene early for young people with depression and anxiety, antisocial behaviours, drug and alcohol misuse, eating disorders and early psychosis
- availability of programs for young people at-risk outside the school system, particularly unemployed and homeless young people

## Outcome indicators

See Table 5, but also:

- increased level of coping, social and problem-solving skills among young people, both in and out of school
- increased acceptance and valuing of social and cultural diversity among young people
- increased school retention rates
- increased participation by young people in educational, vocational and community activities
- decreased incidence, prevalence and burden associated with depression, anxiety, conduct, substance misuse, eating disorders and psychosis
- reduced suicide and self-harm

# Young adults 18–25 years

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among young adults through:

- environments and infrastructure that support family and social functioning
- family-friendly workplace policies and practices
- acceptance and valuing of social and cultural diversity
- mental health literacy
- opportunities for personal development and exploration and for meaningful participation in the workplace and community
- ▲ emotional resilience and a sense of connectedness to family, community and workplace
- positive intimate and other social relationships
- reduced risk factors for early psychosis, anxiety, depression, and eating disorders as well as substance misuse, self-harm and suicidal behaviours
- early intervention for young adults showing the signs and symptoms of early psychosis, anxiety, depression, eating disorders and substance misuse

## Rationale

Young adulthood is a time for identifying as an adult with personal and social responsibilities by developing intimate relationships and embarking on career and vocational pathways. In this age group, however, the prevalence of mental health problems and mental disorders peaks. Rates of depression and anxiety are high, especially among young women, who are also more likely at this age to engage in self-harm, attempt suicide, or develop an eating disorder. Among young men, harmful drug use is prevalent and rates of suicide and imprisonment are at a peak. Psychoses, such as schizophrenia, often first become obvious in young adulthood (EPPIC, 1997).

Young adults at greater risk of developing mental health problems include those who are socially alienated or disadvantaged, unemployed, early school leavers, from Aboriginal or Torres Strait Islander backgrounds, or residents in rural and remote areas. Students often have high levels of psychological distress and young workers may also be at increased risk due to greater workplace stress compared with older workers, partly because they are more likely to be in subordinate positions (Dean, 1998).

Young adults are reluctant to seek help from formal mental health services, but may come into contact with correctional, drug treatment, youth or community services. It is critical to engage at-risk young adults with appropriate services, by understanding relevant youth sub-cultures and establishing links with services that can provide practical support. For young men involved with the criminal justice system, avoiding incarceration and maintaining connectedness with family and community may be especially important to reduce suicide and self-harming behaviours. Young men are particularly difficult to engage in positive health behaviours, possibly as a result of gender-based social, developmental and cultural expectations.

Many young adults are parents, so the needs related to their children that are covered in previous sections are also highly relevant.

## Evidence base for action

Some interventions that are known to be effective for late adolescence may also be useful for this age group. In particular, effective prevention programs for depression and anxiety disorders in young people may be relevant to young adults and should be evaluated for this age group. Indicated programs (eg Clarke et al, 1995) could be applied to tertiary education settings such as universities and the vocational education and training sector. Brief interventions for substance use disorders through general practitioners, community health centres and other primary health care settings (Saunders,

## Who will be involved?

See Table 4, but primarily:

- young adults and families
- general practitioners and primary health carers
- specialist mental health workers
- higher education providers
- workplaces
- youth workers
- drug and alcohol workers
- HIV/AIDS and other sexual health services workers
- support groups
- police and correctional officers
- education, employment and social service workers
- business agencies and organisations

## Where will it happen?

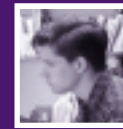
See Table 4, but primarily:

- homes
- primary health care settings
- mental health settings
- workplace and vocational training settings
- tertiary education settings
- community, sport and recreation settings
- welfare settings
- correctional settings

## Linked initiatives

See Table 3, but also:

- National HIV/AIDS Strategy
- National Hepatitis C Strategy
- Jobs Pathways Programme
- National Homelessness Strategy
- National Health Plan for Young Australians
- Child and Youth Health Policy



Conigrave and Gomel, 1998; Saunders and Lee, 2000) are a promising model that also warrants evaluation.

Cognitive behavioural programs involving preparation for marriage and long-term relationships can reduce the risk of marital difficulties and associated mental health problems (Halford, 1995).

The *Australian Clinical Guidelines for Early Psychosis* (EPPIC, 1997) focus on the early detection and intensive early treatment of emerging psychosis, to lessen the adverse impact on personal identity, social networks and role functioning (McGorry et al, 1996). More recent papers show the benefits of this program (McGorry and Jackson, 1999).

### Research questions

- How do risk factors in earlier adolescence relate to the emergence of signs and symptoms of mental health problems and mental disorders in later adolescence and young adulthood, and how can the effect of these be ameliorated?
- How can an at-risk mental state be reliably identified in young adults, including generic signs and symptoms and those that are related to specific disorders?
- What are the reasons for the low mental health service use by young adults (particularly males) and how can this be resolved?
- What factors protect the mental health of well-adjusted gay and lesbian young adults and other well-adjusted high-risk groups?

## NATIONAL ACTION

- **Consult with young adults** to develop and identify effective promotion, prevention and early intervention programs, settings and messages.
- ▲ **Collect data on risk and protective factors and identify effective approaches and settings** across relevant service sectors that **reach, attract, engage and retain young adults**, particularly from high-risk groups, in relevant programs.
- Introduce initiatives designed to **reduce the impact of adverse events** (eg unemployment, relationship break-up, imprisonment) that place young adults at high risk for mental health problems and suicide.
- Increase in programs that **enhance education, work and career development** opportunities for young adults.
- Increase in evidence-based programs to develop **responsible and rewarding interpersonal relationships**.
- ◻ Increase awareness and skills across sectors to **recognise early signs and symptoms** of mental health problems and mental disorders.
- Develop models of early intervention** that can be implemented in partnership with young adults that respect the reluctance of young adults at high risk to access mental health care. Develop a strategy to encourage implementation of these models within relevant service systems and diverse settings.

### Process indicators

See Table 6, but also:

- increased availability and uptake of effective relationship and parenting programs
- increased availability and uptake of effective educational and vocational programs
- availability of best-practice guidelines and protocols relating to prevention and early intervention with young adults, for a range of services and types of problems

### Outcome indicators

See Table 5, but also:

- increased acceptance and valuing of social and cultural diversity
- increased participation by young adults in educational, vocational and community activities
- decreased incidence, prevalence and burden associated with depression, anxiety, substance misuse, eating disorders and psychosis
- reduced suicide and self-harm

# Adults

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among adults through:

- mentally healthy workplaces, work policies and practices
- mental health literacy
- meaningful community participation for all adults
- improved family and social functioning
- acceptance and valuing of social and cultural diversity
- ▲ social support and connectedness
- reduced stigma, discrimination, sexual harassment, victimisation and bullying in the workplace
- reduced incidence, prevalence and severity of stress and other health burdens associated with workplaces and organisational settings
- reduced risk factors for mental health problems and mental disorders, particularly related to family violence and loss events
- early intervention for adults with signs and symptoms of anxiety, depression, substance misuse and psychosis

## Rationale

Important issues during adulthood are family life and relationships, social engagement, financial security, and opportunities for involvement and achievement. The workplace is where most people spend the larger part of their adult life; it can be internal or external to the home and work can be paid or unpaid. Meaningful work is important for mental health, as it provides not only financial security, but also contributes to feelings of self-worth and control through opportunities for social interaction and achievement.

Over recent years, the level of reported workplace stress has increased along with associated stress-related mental health problems and costs (eg cost associated with stress-related compensation claims, days lost to stress-related conditions) (Mayhew and Peterson, 1999). The risk of work-related stress, accidents and injury is heightened in some occupational groups, including ambulance officers, police, and health workers (Cooper, 1993; Cotton, 1996; Turner, Meldrum and Raphael, 1995). Work-related stress can affect home environments and the wellbeing and functioning of families.

Key factors for stress control have been identified as: workload/workpace, work schedule/flexibility, positive relationships at work, equity, job design/degree of autonomy, employee's role/status in the organisation, decision making and planning, and general management and culture (Health and Safety Executive, 1995, 1998). Restructuring, involuntary redundancies, organisational/technological change, widespread downsizing and job insecurity are currently particularly salient causes of stress (ACTU, 1998).

Possible protective factors for adults working both within and outside the home are social support and positive coping styles (Cotton, 1996). There are many ways workplaces can promote mental health that are, as yet, untapped.

People who do not have meaningful work can be missing an important support for mental health. Within any community there will always be some members who do not work, either temporarily or long-term. Healthy communities provide other avenues for meaningful community participation for their non-working members.

For adults, stressful life events are also strongly associated with mental health problems and mental disorders. In half the cases of depressive disorder, an external stressor was found to precede the depression (Judd, 1997). Divorce and bereavement are particularly significant events around which prevention interventions can be built (eg Raphael, 1977). A period of involuntary unemployment or underemployment can be a major stressor. The section on individuals, families and communities experiencing adverse life events considers promotion, prevention and early intervention around stressful life events.

## Who will be involved?

See Table 4, but primarily:

- adults, working adults
- employers
- unions
- workplace policy makers
- workplace support and rehabilitation services
- general practitioners and primary care workers
- business associations
- insurance companies
- Human Rights and Equal Opportunity Commission
- culturally-specific work-related organisations

## Where will it happen?

See Table 4, but primarily:

- public and private sector workplaces
- workplace management and administration
- workplace occupational health and safety
- occupational rehabilitation settings
- professional and vocational training settings
- identified high-risk occupation worksites and workplaces
- general practice and primary care

## Linked initiatives

See Table 3, but also:

- CRS Australia
- Job Network
- National Occupational Health and Safety Commission
- Australian Chamber of Commerce and Industry Awards for Family-Friendly Workplaces
- Workplace English Language and Literacy
- Non-Communicable Diseases Strategy



Many adults are parents, so the needs related to their children, covered in previous sections, are also highly relevant.

### Evidence base for action

The evidence for successful workplace interventions is fragmentary, and usually limited to a single occupational group facing specific stressors, such as teachers or correctional service officers (Mayhew, 1999). The literature does, however, provide an indication of the most at-risk groups, likely health impacts, and costs from stress-related ill health. Subjective opinions about the causes of stress vary considerably, and objective evidence is scant.

Mental health promotion and prevention activities in the workplace have focused primarily on stress management and developing positive ways of coping with difficult workplace situations and pressures. More recently, there has been interest in altering organisational structures and developing mental health promoting workplaces to prevent stress and promote wellbeing (Danna and Griffin, 1999; Cotton, 1996) but there is little evidence, as yet, of effectiveness.

A selective intervention effective for people working in a stressful environment (care givers in group houses for people with a mental disorder or a developmental disability) is The Caregiver Support Program (Heaney, 1992\*). Enhancing social support within the workplace resulted in improved support and positive feedback from supervisors and reduced mental health problems among employees.

Further trials are needed regarding the effectiveness of interventions to increase social support in the workplace. Research is also required to identify potentially effective interventions relating to: workplace policy; work systems (including management structures and styles); stress management and education; prevention of traumatic stress (including post-traumatic stress disorder); prevention of suicide in high-risk professions; and interventions addressing violence and bullying in the workplace.

#### Research questions

- What are the factors that contribute to workplace mental health?
- What interventions are effective in reducing workplace stress and reducing associated morbidity, including post-traumatic stress disorder?
- How can meaningful community participation be enhanced for adults not in the paid workforce?
- How do changes in the labour market affect the mental health of communities and individuals?

## NATIONAL ACTION

- **Provide workplace support for parents** through family-friendly work policies and practices and positive work environments.
- ▲ **Pilot and evaluate workplace models** of promotion, prevention and early intervention in partnership with relevant groups.  
Identify data, initiatives, needs and partnerships (eg unions, management, occupational health and safety) to **develop a clearing-house** on mental health promoting workplaces, policies, and practices.  
Explore intervention initiatives that reduce workplace stress.
- Increase capacity for **primary care providers**, including general practitioners, to detect the early signs and symptoms of mental health problems and mental disorders in adults and to intervene effectively.

### Process indicators

See Table 6, but also:

- increased community awareness of the impact on mental health of social and economic inequality, poor social connectedness, low status, low sense of control and autonomy
- increased availability and uptake of programs to prevent workplace discrimination, victimisation, bullying and sexual harassment
- increase in programs to prevent mental health problems and mental disorders
- increased availability at workplaces of appropriate assistance and early intervention for mental health problems

### Outcome indicators

See Table 5, but also:

- increased sense of equity, status, autonomy and control for all adults
- increased sense of support and connectedness for workers, both working in the home and at the workplace
- reduced workplace discrimination, victimisation, bullying and sexual harassment
- reduced workplace stress, related days lost, and disability claims
- decreased incidence, prevalence and burden associated with depression, anxiety, substance misuse, and psychosis

# Older adults

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among older adults through:

- community awareness and understanding of positive ageing
- policies and practices that encourage community participation of older adults
- mental health literacy among older adults
- ▲ social support and social connectedness
- improved mental health for carers of all ages
- reduced abuse of older adults
- reduced risk factors for mental health problems and suicide
- early intervention for depression, anxiety and dementia

## Rationale

Older adulthood can be a period of considerable change; some changes are positive—like having more time to engage in leisure activities or travel—while others are negative—including loss of work-related identity, bereavement, reduced social opportunities, poorer health and reduced income. Older adulthood is a positive experience for most people, and much can be done to improve the wellbeing of older adults who are not as fortunate.

Older adults who live in the community experience the best mental health across the lifespan in Australia. However, in residential aged care settings, depressive symptoms and disorders are more common (Parmalee, Katz and Lawton, 1989; DeLeo et al, 2000), and over 28 per cent of hostel residents and 60 per cent of nursing home residents have some form of dementia (Rosewarne, 1997).

Risk factors for older adults include physical impairments that derive from cancer, cardio vascular conditions, chronic conditions such as arthritis, or the effects of a stroke (Jorm, 1995a). Older people who are isolated and lack social networks and support, who are bereaved, and who are socially disadvantaged are at higher risk of depressive disorders. Head trauma is a possible risk factor for Alzheimer's dementia, and potentially modifiable risk factors for vascular dementia include hypertension, diabetes, high cholesterol and smoking (Jorm, 1997; Jorm, 1995b).

Protective factors include good physical health, supportive relationships and social interactions, and protection from the extremes of poverty. Better education or higher intelligence may be a protective factor for Alzheimer's dementia (Jorm, 1997).

## Evidence base for action

Screening for depression and dementia needs to be encouraged in all aged care settings and when physical illness, dementia-like symptoms, and social isolation or other stressors are evident in older adults presenting to general practice. The Psychogeriatric Assessment Scale (Jorm and MacKinnon, 1995, 1997) is brief but effective in identifying older people who may have depression or dementia, and can be used by lay interviewers after training.

Selective interventions can reduce depressive symptoms for carers of spouses with dementia using a multi-modal program of counselling and support (Mittelman et al, 1995\*), and for widows through self-help programs involving support and resource information (Vachon et al, 1980\*). Estrogen has been shown to lift mood in perimenopausal women experiencing depression (Schmidt et al, 2000\*).

There is some evidence that the intellectual decline associated with normal ageing can be slowed through the use of training programs (Birren and Schaie, 1996).

## Who will be involved?

See Table 4, but primarily:

- older adults and their families
- carers of all ages (Carers Association of Australia)
- local services (eg shopkeepers, transport, libraries, clubs)
- Aged Care Assessment Teams
- general practitioners and primary health carers
- public and private residential services for the aged
- community agencies (eg home and community care)
- superannuation and retirement investment sector

## Where will it happen?

See Table 4, but primarily:

- retirement homes and villages
- residential care settings
- local community services (eg transport, libraries, clubs)
- education settings (eg University of the Third Age)
- health care settings
- aged care services

## Linked initiatives

See Table 3, but also:

- National Strategy for an Ageing Australia
- Department of Veterans Affairs Dementia and Aged Veterans Program
- Healthy Seniors Initiative
- Acting on Australia's Weight Strategy
- Aged Care Standards and Accreditation Agency
- Non-Communicable Diseases Strategy



There are promising leads in prevention of dementia (Jorm, 2000). Some dementias are clearly related to specific modifiable risk factors that, in the end, lead to dementia, such as brain injury and disease processes or infection. For example, preventing alcohol abuse would reduce the 10 per cent of dementias caused by this (Allen, 1994). There is considerable potential for prevention of vascular dementia, as it is related to cerebrovascular disease, cardio vascular disease and diabetes; these risk factors are well known and amenable to treatment (Jorm, 1994; NHMRC, 1996). There is also suggestive evidence (longitudinal prospective study) that social or leisure activities might delay the onset of dementia, but further research is required (Katzman, 1995).

Some possibly protective factors for Alzheimer's dementia are anti-inflammatory drugs, oestrogen replacement therapy, and level of education and premorbid intelligence. More research is required to understand these associations before prevention strategies can be developed (Jorm, 1997).

#### Research questions

- What are the most effective approaches to promote positive mental health and resilience for older adults?
- How can older adults and their families be enabled to adjust positively and constructively to the losses that accompany ageing?
- What roles can general practitioners and aged care services contribute to promotion, prevention and early intervention for older adults?
- What are effective interventions to prevent suicide, depression and anxiety and prevent or minimise cognitive decline and dementia and associated burdens?

## NATIONAL ACTION

- **Include mental health** considerations in programs promoting healthy ageing.

Develop programs to enable older adults to **participate fully in their communities** and to develop and maintain social networks.

- ▲ **Identify needs, initiatives, partnerships and potential good practice** relevant to promotion, prevention and early intervention for older adults.

Pilot and evaluate projects that **address high-risk populations**, such as older adults with chronic physical illness or disability, living in residential care settings, who are recently bereaved, and carers of all ages.

- Introduce state and territory prevention and early intervention initiatives that **focus on depression and suicide prevention** for older adults.

### Process indicators

See Table 6, but also:

- increased availability and uptake of programs to support the participation of older adults within the community
- increased availability and uptake of programs to encourage appropriate physical exercise by older adults
- increased programs to support carers, particularly respite care
- improved training for general practitioners, community nurses and other professionals related to screening and detection of suicidal ideation, depression, anxiety and other mental health problems in older adults

### Outcome indicators

See Table 5, but also:

- more positive representation of ageing within the community
- increased community participation of older adults
- increased social support for older adults, particularly those in residential care settings
- reduced abuse of older adults
- decreased incidence, prevalence and burden associated with depression, anxiety and dementia for older adults
- reduced suicide

# Individuals, families & communities experiencing

## Outcomes

Reduce the incidence and prevalence of mental health problems and mental disorders associated with adverse life events affecting individuals, families and communities, through:

- mental health literacy acknowledging the potential impact of adverse events
- community capacity to support members experiencing adverse life events
- reduced stigma associated with experiencing an adverse life event
- communities and individuals with the resilience and resources to cope effectively with adverse life experiences
- communities with the capacity to reduce exposure to adverse life events
- appropriate access to support services and effective early intervention in response to adverse life events

## Rationale

Adverse life events that impact on the mental health of individuals and communities include: threats to life or person, including illness (particularly chronic illness), disability, accident, assault, violence, disaster and war; child abuse (physical, sexual, emotional) and neglect; loss, grief and bereavement; divorce, separation and family breakdown; imprisonment and/or major legal problems; unemployment, social adversity, poverty, and homelessness; separation from family; alienation; and the experience of racism and discrimination.

Life stressors are an inevitable part of life, and they can occur at any stage of life and in various contexts and settings. Some forms of adversity are transitory (eg acute illness) while others can become chronic (eg poverty). Adverse life events may be associated with mental health problems like post traumatic stress disorder, adjustment disorder, depression, anxiety, or substance misuse, and they may precipitate other adverse effects such as family breakdown. They may also increase the risk of suicide. Suicide is the leading cause of death in Australian prisons (Dalton, 1999). A mental disorder, itself, can be an adverse life event, increasing the risk of further mental health problems and stigma.

The degree of risk associated with life stressors is related to: the degree of threat; the closeness of attachment (in relationship loss); the perception, availability and adequacy of social support; personal coping style; and the suddenness, unpredictability and uncontrollability of the stressor. Stress is cumulative and is related to the number of stressors (occurring simultaneously or close together), along with any persisting vulnerability from previous adverse experiences.

For the majority of people who experience an adverse life event there are no long-term problems. Some events can be responded to as a challenge and personal growth experienced as an outcome of coping effectively. Protective factors include personal characteristics such as resilience, an optimistic outlook on life and a sense of humour. Successful coping in the past, preparedness for future events, a sense of control, supportive social networks, and personal and community rituals that acknowledge the adverse experience, also appear to enhance resilience in the face of adversity.

Multiple adverse life experiences are major and ongoing stressors across the lifespan for some population groups, including Aboriginal peoples, Torres Strait Islanders, and refugees. These greatly increase the risks to social and emotional wellbeing for these individuals and communities and are considered in the sections on Aboriginal peoples and Torres Strait Islanders and people from diverse cultural and linguistic backgrounds.

## Evidence base for action

While generic counselling alone has not been shown to prevent adverse mental health outcomes for those experiencing adverse life events, such as child abuse (Tebutt et al, 1997) and trauma (Wesseley, Rose and Bisson, 1998), there are a number of effective specialised counselling, educational and support interventions for those at high-risk. There is, however, no evidence that critical incident debriefing prevents mental health problems after

## Who will be involved?

See Table 4, but primarily:

- local communities
- health services
- general practitioners
- loss and grief services
- welfare agencies
- police, ambulance and emergency workers
- military and disaster relief workers
- finance, insurance and business organisations
- disability support services
- family court

## Where will it happen?

See Table 4, but primarily:

- local community settings
- emergency services
- health care settings, including general practice
- Aboriginal Community Controlled Health Services
- workplaces
- disaster assistance services
- housing services
- disability services
- counselling services
- sexual assault services
- child protection services
- criminal and juvenile justice and correctional settings
- armed forces and veterans affairs settings

## Linked initiatives

See Table 3, but also:

- National Homelessness Strategy
- Program of Assistance for the Survivors of Torture and Trauma
- Department of Veterans Affairs mental health policy

# adverse life events



trauma, with suggestions that it may actually increase the likelihood of adverse outcomes (Wesseley, Rose and Bisson, 1998).

Effective interventions include:

- preventive counselling following loss and bereavement for children who have lost a parent (Black and Young, 1995), for widows (Raphael, 1977\*; Parkes, 1990\*; Vachon et al, 1980\*), for older adults who are bereaved (Gerber et al, 1975), for parents after the death of a child (Forrest, Standish and Baum, 1982; Lowman, 1979; Lieberman and Videka-Sherman, 1986\*; Murray, 1998\*), and for families when a family member dies (Kissane et al, 1998)
- targeted interventions focusing on motor vehicle accidents (Bordow and Porritt, 1979\*), the trauma experienced by sexually abused children (Deblinger, McLeer and Henry, 1990), children following disaster (Pynoos and Nader, 1990; Storm, 1997) and specialised counselling interventions for those at high risk of post traumatic stress disorder (Bryant and Harvey, 2000)
- divorce intervention programs including programs for school children (Pedro-Carroll and Cowen, 1985\*) and divorced parents (Bloom, Hodges and Caldwell, 1982; Bloom et al, 1985\*)
- prevention programs for stepfamily members (Nicholson, 1996) and couples before marriage (Markman et al, 1993; Halford, 1995)
- interventions for unemployed people (Proudfoot et al, 1997)

Auseinet has recently described clinical approaches for the psychological adjustment of children with chronic illness (Swanston, Williams and Nunn, 2000). Enrichment programs, with multi-component interventions for high-risk children, can also achieve positive outcomes. Narrative therapy and drama therapy may be useful in multicultural programs.

## Research questions

- What factors can prevent adverse outcomes associated with trauma, violence, and systems of violence?
- What educational and other interventions can operate to lessen risk and enhance positive outcomes associated with life stressors?
- What interventions can decrease mental health problems associated with illness and accidents?
- How are risk and resilience interrelated?

## NATIONAL ACTION

- Develop policies and programs to **enhance the capacity of communities** to provide support during adverse life events.
- ▲ Develop, implement and evaluate pilot projects, using mental health outcomes, to **reduce the risks associated with unemployment**.  
Develop and pilot a comprehensive, evidence-based, prevention program to **reduce the risks associated with family breakdown** for children and families.  
Develop, implement and evaluate programs to **prevent violence and abuse** and their adverse mental health consequences.  
Develop, implement and evaluate projects to **reduce the mental health burden of disability and chronic illnesses**, focusing on reducing stigma and discrimination and supporting carers.
- **Develop, implement and disseminate good practice guidelines** for prevention and early intervention programs for groups who are at high risk of mental ill health due to adverse circumstances.  
**Develop partnerships** with relevant sectors and services to support the integration of good practice guidelines, and develop a clearing-house for these.

## Process indicators

See Table 6, but also:

- increased availability and uptake of best practice guidelines developed for a range of services and dealing with a range of adverse life events
- increased curricula content in mental health professional education and training programs relating to prevention and early intervention for individuals who have experienced adverse life experiences
- better access and use of evidence-based prevention and early interventions for high-risk individuals who have experienced adverse life circumstances

## Outcome indicators

See Table 5, but also:

- increased support from the whole community for individuals, families and communities experiencing adverse life events
- increased recognition that stressful life events can provide an opportunity for growth and adaptation
- reduced incidence, prevalence and burden associated with post traumatic stress disorder and other mental health problems and mental disorders related to experiencing adverse life events

# Rural and remote communities

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders in rural and remote communities through:

- family and community connectedness and functioning
- culturally-appropriate initiatives determined by local communities
- community capacity to be resilient to adversity
- acceptance and valuing of social and cultural diversity
- ▲ protective factors for the effects of unemployment and environmental conditions
- reduced incidence and prevalence of risk factors for depression, anxiety, substance misuse, stress and suicide
- improved access to mental health-related services

## Rationale

The effects of broader psychosocial problems such as poverty, unemployment, substance misuse, child abuse and domestic violence are magnified for people living in rural and remote communities in Australia, partly through exposure to additional stressors related to isolation, the impact of economic restructuring, and environmental conditions such as drought, flood, and fire (VicHealth, 1999). The general health of people living in rural and remote communities is poorer than that of their city counterparts (Mathers, 1994). Aboriginal peoples and Torres Strait Islanders who live in rural and remote areas are further disadvantaged since their health and socioeconomic status is markedly lower than that of other Australians, and exacerbated by the effects of loss, grief and trauma over generations.

The extra strains associated with rural and remote life are reflected in the disproportionately high suicide rates among young men in rural areas. The Western Australia Child Health Survey has also highlighted the high incidence of mental health problems among children in some rural areas (Zubrick et al, 1995; Silburn et al, 1996).

Heightened risks for mental health problems and mental disorders in rural and remote communities are compounded by lack of appropriate services, distance from services, transport problems, and fear of stigma associated with using mental health services.

It is important to recognise that rural communities are extremely diverse and different localities have differing needs. It is, therefore, essential that promotion, prevention and early intervention initiatives are community-driven and owned in order to address community needs. Enhancing the capacity of communities to identify and respond to their own needs is fundamental to strengthening the capacity of rural and remote communities to be resilient to adversity.

## Evidence base for action

Promotion programs currently being evaluated include a demonstration project for promoting positive mental health in country schools and a community-driven life promotion program aimed at preventing suicide in rural and remote communities. Promising techniques requiring further evaluation include playback theatre and cultural action, which have been widely used in a range of settings to help remote Aboriginal and Torres Strait Islander communities deal with community-defined issues. Important elements are a strong community focus to define problems and explore solutions, involvement of mental health professionals in a community rather than a clinical setting and improved service access (Grant, Laird and Cox, 1998).

There is currently no strong evidence for the efficacy of crisis intervention and telephone counselling for high-risk groups with suicidal ideation and behaviour, particularly young males (Patton and Burn, 1998), although these services are widely used in Australia, and enhance access for rural and remote communities. Additional evaluation and alternative strategies are needed in this area.

## Who will be involved?

See Table 4, but primarily:

- local community members, groups and leaders
- community health and mental health providers (including general practitioners and community nurses)
- school leaders, teachers
- counselling services
- financial and insurance services
- disaster assistance services
- police and emergency workers

## Where will it happen?

See Table 4, but primarily:

- local community settings
- health care settings
- Aboriginal Community Controlled Health Services
- workplaces
- education and training centres
- counselling services
- correctional settings
- accident and emergency services
- rural and public health training
- local clubs, social, sport and recreational settings

## Linked initiatives

See Table 3, but also:

- Healthy Horizons Framework
- Regional Health Strategy: More Doctors, Better Services
- Rural Communities program
- Rural Partnerships program
- Regional Assistance Program



An indicated intervention, the 'Triple P' Positive Parenting Program, involving information-based strategies and targeting parents of children with behaviour problems living in rural and remote communities, reduced disruptive child behaviour and improved parenting skills adjustment (Connell, Sanders and Markie-Dadds, 1997\*). Telephone contact was an important component of this program for rural and remote communities.

**Research questions**

- What are protective factors unique for mental health in rural and remote communities?
- What promotion, prevention and early intervention strategies are effective in rural and remote communities to reduce the impact of stress, environmental conditions and rural unemployment; reduce depression, anxiety and substance misuse; and prevent self-harm, suicide and violence?
- What factors contribute to family breakdown in rural and remote communities?
- What is the potential for Internet/telehealth/telemedicine/telecounselling in rural and remote communities?

## NATIONAL ACTION

- Pilot and evaluate ways to **develop community capacity**, particularly through enhanced infrastructure and communication technologies.
  - Highlight rural and remote issues** in planning, monitoring and evaluating initiatives across all priority groups in *Action Plan 2000*.
  - Pilot **culturally sensitive programs** developed in partnership with the local community to **respond to local needs**.
  - Improve mental health literacy** in rural and remote communities, particularly by considering the role of mental health information services, telemedicine, telecounselling and the Internet.
  - Identify effective prevention approaches** for rural and remote communities to enhance resilience, particularly in relation to adversities like unemployment and environmental conditions. Focus on reducing depression, anxiety, behavioural problems, substance misuse, violence and suicide.
  - Identify data, needs and partnerships for **effective early intervention approaches**, particularly for early signs of depression, anxiety, psychosis and substance misuse. Partnerships between education and health services are critical to explore, as well as an enhanced role for general practitioners and primary care providers.
  - Improve access to mental health services** in rural and remote communities by reducing barriers, particularly through using telemedicine, telecounselling, the Internet and partnerships with metropolitan services.
  - Support workforce training** in health-related communication technologies.

### Process indicators

See Table 6, but also:

- increased community development and ownership of promotion, prevention and early intervention programs in rural and remote communities
- increased employment of mental health, public health and primary health care workers with knowledge and skills in promotion, prevention and early intervention for mental health appropriate to rural and remote communities
- improved access to mental health services, partly through development of telemedicine and other technologies, and training of service providers in use of these technologies

### Outcome indicators

See Table 5, but also:

- reduced risk factors for mental health problems and mental disorders, particularly improved socioeconomic conditions and community infrastructure
- decreased incidence, prevalence and burden associated with depression, anxiety and substance misuse
- reduced suicide and self-harm

# Aboriginal peoples and Torres Strait

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among Aboriginal peoples and Torres Strait Islanders through:

- reduced social disadvantage, racism and oppression
- mental health literacy
- culturally appropriate initiatives determined by local communities
- community capacity to be resilient to adversity
- ▲ enhanced protective factors for mental health problems and mental disorders
- reduced risk factors for mental health problems and mental disorders, especially around issues of loss, trauma, incarceration, violence and substance misuse
- awareness in mainstream services of the impact of cultural issues on the mental health of Aboriginal peoples
- awareness in mainstream services of the impact of cultural issues on the mental health of Torres Strait Islander people
- links between mainstream and Aboriginal Community Controlled Health Services

## Rationale

Aboriginal peoples and Torres Strait Islanders are seriously disadvantaged in comparison with the general Australian population, experiencing markedly poorer health (ABS and AIHW, 1997), poorer nutrition, greater poverty, poorer housing and facilities, lower levels of education, and higher levels of unemployment, imprisonment, racism and discrimination (Raphael and Swan, 1997).

Although data are limited, it is clear that people from both Aboriginal and Torres Strait Islander communities experience high rates of mental health problems. A review of Aboriginal Community Controlled Health Services concluded that in urban areas, mental health was the leading issue to be managed (Wronski et al, 1994). In clients presenting to Aboriginal medical services psychological distress and depression were prevalent (McKendrick et al, 1992; McKendrick, 1993). The limited data available suggest that the suicide rate for young Aboriginal and Torres Strait Islander men is about 40 per cent higher than among the general population, with rates much higher in some communities (Harrison and Moller, 1994).

Historically, mainstream mental health systems have not been attuned to the needs of Aboriginal peoples and Torres Strait Islanders, and have been slow to address social and emotional distress in Aboriginal and Torres Strait Islander communities (Swan, Mayers and Raphael, 1994). Misdiagnosis has been common due to a failure by mainstream services to recognise and understand the social and emotional context of presenting problems for Aboriginal peoples and Torres Strait Islanders. Stigma and lack of cultural understanding have inhibited acknowledgment of mental health problems.

The mental health of Aboriginal peoples and Torres Strait Islanders can only be understood within the context of the Aboriginal concept of health, defined as:

not just the physical well being of an individual, but ... the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life–death–life (National Aboriginal Community Controlled Health Organisation [NACCHO], 1997).

It is fundamental to recognise the impact on mental health of historical events related to invasion and colonisation including trauma and loss,

## Who will be involved?

See Table 4, but primarily:

- Aboriginal communities
- Torres Strait Islander communities
- Aboriginal Community Controlled Health Services
- Aboriginal and Torres Strait Islander Commission
- health services
- education services
- police and correctional services

## Where will it happen?

See Table 4, but primarily:

- Aboriginal communities
- Torres Strait Islander communities
- Aboriginal Community Controlled Health Services
- workplaces
- education and training settings
- correctional settings

## Linked initiatives

See Table 3, but also:

- Royal Commission into Aboriginal Deaths in Custody, 1991
- The Ways Forward Report, 1995
- National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, 1997
- Accredited Youth Suicide Prevention Training for Indigenous Community Workers
- Indigenous Education Strategic Initiatives Program
- Indigenous Employment Policy

# Islanders



premature death, racism, social disadvantage, family breakdown and separation of children from their families. The ongoing consequences of colonisation are evident in the high levels of stress, grief, depression, suicide and substance misuse in many Aboriginal and Torres Strait Islander communities (Swan and Raphael, 1995; Raphael and Swan, 1997).

## Evidence base

It is essential that programs are developed, owned and evaluated by local communities. Unless this occurs, community participation is unlikely and benefits will be minimal (Swan and Raphael, 1995; National Aboriginal Health Strategy, 1989). Aboriginal community control is 'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community' (NACCHO, 1997).

The National Aboriginal Health Strategy (1989), the Royal Commission into Aboriginal Deaths in Custody (1991), the Burdekin Report (1993) and the Ways Forward Report (Swan and Raphael, 1995), document considerations that are essential to the development of any promotion, prevention and early intervention programs in Aboriginal and Torres Strait Islander communities. There is an urgent need to develop and evaluate the effectiveness of strategies that are holistic and culturally valid. It is essential that policy, planning and broad resource allocation support the strategies and programs determined by Aboriginal and Torres Strait Islander communities. Research and evaluation must occur within the ethical guidelines of the community in which it takes place.

## Research questions

- What methodologies are appropriate for use by Aboriginal and Torres Strait Islander communities to acquire an evidence base for interventions?
- What are appropriate promotion, prevention and early intervention activities for diverse Aboriginal and Torres Strait Islander communities?
- What are culturally appropriate measures of the early signs and symptoms of mental health problems and mental disorders for Aboriginal peoples and Torres Strait Islanders?
- How can mental health services be accessible and culturally appropriate for Aboriginal and Torres Strait Islander communities?

## NATIONAL ACTION

Across all sectors and settings **promote understanding, acceptance and valuing of Aboriginal and Torres Strait Islander cultures, facilitate participation and inclusion** of Aboriginal peoples and Torres Strait Islanders, and **reduce racism and discrimination**.

**Highlight issues relevant to Aboriginal peoples** in planning, monitoring, and evaluating initiatives across all priority groups in *Action Plan 2000*.

**Highlight issues relevant to Torres Strait Islanders** in planning, monitoring, and evaluating initiatives across all priority groups in *Action Plan 2000*.

In **full consultation with** Aboriginal Community Controlled Health Services, further develop and enhance state- and territory-based partnerships and prevention strategies, particularly to address loss and trauma.

Support Aboriginal and Torres Strait Islander communities to **develop and evaluate culturally appropriate interventions** within mainstream and specialised services to identify early signs and symptoms, improve access, and effectively treat mental health problems and mental disorders.

Continue to **implement the strategies** outlined in the Ways Forward report.

## Process indicators

See Table 6, but also:

- Aboriginal community ownership of programs
- Torres Strait Islander community ownership of programs
- increase in culturally appropriate mental health promotion, prevention and early intervention initiatives
- joint planning between Aboriginal Community Controlled Health Services and mainstream organisations
- increase in Aboriginal peoples and Torres Strait Islanders professionally trained and employed in health and education settings

## Outcome indicators

See Table 5 and also:

- reduced racism and discrimination for Aboriginal peoples and Torres Strait Islanders
- improved capacity for Aboriginal and Torres Strait Islander communities to be self-determining and resilient
- reduced socioeconomic disadvantage, violence, incarceration, family separation, substance misuse, depression and anxiety for Aboriginal and Torres Strait Islander communities
- reduced suicide and self-harm for Aboriginal peoples and Torres Strait Islanders who are incarcerated

# People from diverse cultural and

## Outcomes

Promote mental health, and prevent and reduce mental health problems and mental disorders among people from diverse cultural and linguistic backgrounds through:

- acceptance and valuing of social and cultural diversity
- reduced racism and discrimination
- enhanced community capacity to ensure meaningful participation for people from diverse cultural and linguistic backgrounds
- mental health literacy
- reduced stigma associated with mental health problems and mental disorders
- enhanced resilience and protective factors for mental health problems and mental disorders
- reduced risk factors for mental health problems and mental disorders
- cultural sensitivity among health care providers
- increased access to culturally appropriate early intervention initiatives and services

## Rationale

Australians from non-English-speaking backgrounds comprise approximately 20 per cent of the national population (Sozemenou et al, 1998). While immigrants to Australia have, overall, a lower rate of mental disorders compared to the Australian-born population (Commonwealth Department of Health and Aged Care and AIHW, 1999), and most new arrivals to this country ultimately settle successfully, the process of adjustment can be very stressful. Australian migrants represent a diverse range of cultures and are characterised by different needs, problems, and understandings of mental health and mental health problems.

The risk of mental health problems may be increased by some of the factors associated with the immigration process, including: low socioeconomic status or a drop in socioeconomic status following immigration; inability to speak the language of the host country; separation from family and friends; prejudice and discrimination in the host society; lack of recognition of professional qualifications; isolation from others of a similar cultural background; grief associated with these losses; traumatic experiences or prolonged stress before or during immigration, especially for refugees; being adolescent or elderly at the time of immigration; and extent of acculturation (Lerner, Mirsky and Barasch, 1994; Mihalopoulos and Pirkis, 1998; VicHealth, 1999). Higher-risk groups are older migrants, adolescents, refugees (including asylum seekers) and those of low socioeconomic status.

Potential barriers to effective promotion, prevention and early intervention activities are language and cultural factors, culturally specific beliefs and understanding of mental health problems and their causes, and stigmatising attitudes to mental health problems within families and communities (Long et al, 1998; Mihalopoulos and Pirkis, 1998).

Culturally appropriate prevention and early intervention activities are necessary to identify and address existing difficulties to ensure they do not become enduring barriers to successful settlement and the attainment of social and emotional wellbeing (Aroche and Hartgerink, 1998). Good practice in promotion, prevention and early intervention for culturally diverse communities may include: increasing mental health literacy by providing information and education in appropriate formats and languages; liaising with community leaders to facilitate promotion, prevention and early intervention initiatives, and with communities to ensure cultural sensitivity in the delivery of programs; promoting culturally appropriate ways of destigmatising mental disorder; and increasing cultural awareness in mainstream services through staff development (Long et al, 1998).

## Who will be involved?

See Table 4, but primarily:

- community organisations
- transcultural mental health centres and networks
- community and mental health professionals
- general practitioners and primary health care
- education systems
- torture and trauma rehabilitation services

## Where will it happen?

See Table 4, but primarily:

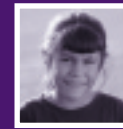
- local community settings
- primary health care
- adult migrant education centres and language centres
- primary and secondary schools
- forums for torture and trauma survivors and asylum seekers
- workplaces
- housing services
- counselling services
- employment and social services

## Linked initiatives

See Table 3, but also:

- Program of Assistance for the Survivors of Torture and Trauma
- Department of Immigration and Multicultural Affairs Integrated Humanitarian Settlement Strategy
- National Asian Languages and Studies in Australian Schools Strategy
- National Rural Health Strategy

# linguistic backgrounds



## Evidence base for action

An evidence base for effective promotion, prevention and early intervention activities for different cultural groups needs to be expanded, taking into account various risk, protective, language and cultural issues.

### Research questions

- What is the potential for mental health promotion activities in English language classes?
- How can the early signs and symptoms of mental disorders be detected effectively in primary care and other appropriate settings for people from diverse cultural and linguistic backgrounds?
- What are effective strategies to reduce racism and discrimination in all communities?
- How can people from culturally and linguistically diverse backgrounds, especially those who are refugees, be supported to participate fully in community life?

## NATIONAL ACTION

Across all communities and in all sectors and settings **promote understanding, acceptance and valuing of cultural diversity**, facilitate **participation and inclusion** of diverse cultural groups, and **reduce racism and discrimination**.

**Integrate issues related to cultural background and language** into the planning, monitoring and evaluation of initiatives across all priority groups in *Action Plan 2000*.

**Develop and evaluate effective approaches** to promote mental health and prevent and intervene early for mental health problems and mental disorders for people from culturally and linguistically diverse backgrounds. In particular, determine to what extent established programs can be applied within other cultural groups and communities.

**Support partnerships in action** with transcultural mental health services and the community sector to develop strategies for promotion, prevention and early intervention. Identify initiatives, needs and partnerships and support research, particularly related to high-risk groups (eg children, adolescents, older people and refugees, including asylum seekers). In collaboration with relevant agencies, support appropriate workforce development initiatives and community capacity building activities.

**Develop and evaluate culturally sensitive and relevant interventions** within mainstream and specialised services to identify early signs and symptoms, improve access to services, and effectively treat mental health problems and mental disorders.

**Nationally implement** the Cultural Awareness Standard 7 of the *National Standards for Mental Health Services* (DHFS, 1996b).

## Process indicators

See Table 6, but also:

- cultural awareness included in curricula of mental health, primary health and public health professional education and training programs
- increased use of and adherence to the Cultural Awareness standard 7 of the National Mental Health Standards
- improved access to culturally appropriate and effective promotion, prevention and early intervention programs

## Outcome indicators

See Table 5, and also:

- communities that accept and value cultural diversity and actively disown racism and discrimination
- reduced transmission of secondary effects of parental and family trauma on the development of children and adolescents
- reduced incidence and prevalence of trauma, post traumatic stress disorder, depression, anxiety, and substance misuse

# Consumers and Carers

## Outcomes

Enable consumers and carers to work effectively as agents of change through:

- mental health literacy
- effective partnerships
- community ownership of mental health issues
- ▲ increased protective factors that can lessen the burden of mental health problems and mental disorders, such as optimism and resilience
- reduced risk factors that can exacerbate the burden of mental health problems and mental disorders, such as social disadvantage, unemployment, homelessness, stigma and discrimination
- consumer and carer participation in developing and evaluating services, including promotion, prevention and early intervention programs

## Rationale

Considerable growth in the consumer and carer movement in Australia over the past two decades has increasingly brought consumer and carer perspectives to the forefront in the consideration of health and mental health issues. Consumers and carers have been established as positive and proactive contributors to development of policy and services. The drive for reform under Australia's *National Mental Health Strategy* is largely a result of the convergent desire of mental health professionals, consumers and carers for a better mental health service system (Behan, Killick and Whiteford, 1994). Consumers place a high priority on promotion, prevention and early intervention, and have been concerned that the *National Mental Health Strategy* be implemented in a way that strongly supports such activities (NCAGMH, 1994). Consumers and carers strongly condemn the notion that mental disorders must be 'serious enough' before action is taken.

Many consumers, carers and community support and advocacy agencies were actively engaged in activities relevant to *Action Plan 1999*, including community education to increase mental health literacy and reduce discrimination and stigma, training programs for volunteers and mental health professionals, and development of educational curricula. Many groups have expert knowledge in the field of mental health and have initiated promotion, prevention and early intervention programs. Continued ownership and development of programs by consumers and carers is essential and their participation a priority. Consumers and carers have a unique experiential knowledge base that equips them to play a key role in effective development and implementation of the strategies proposed in all key areas of *Action Plan 2000*.

Along with intervening early in the development of mental health problems and mental disorders, consumers and carers have identified the importance of preventing further psychological problems and stress associated with experiencing a mental disorder and its treatment. Mental health promotion is highly relevant in this context and there is a great deal that can be done to improve the social and emotional wellbeing of individuals experiencing mental ill health. Involvement in developing and delivering meaningful promotion, prevention and early intervention activities may improve self-esteem among consumer participants, which in turn may protect against secondary mental health problems and promote wellbeing. Furthermore, activities that reduce stigma and discrimination reduce the burden of illness by enabling consumers and carers to participate more fully within their communities through work and other activities.

Consumer involvement needs to be widely defined for promotion, prevention and early intervention activities, as all people are potential consumers and many relevant groups will not identify as consumers. Importantly, young people need to be specifically engaged in the development and evaluation of early intervention services as these interventions will often be targeted at people in the adolescent and young adult life stages due to increased morbidity at these times.

## Who will be involved?

See Table 4, but primarily:

- consumer and carer groups and organisations, particularly Mental Health Council of Australia, Carers Association of Australia, and Australian Mental Health Consumer Network
- private and public health services
- Human Rights and Equal Opportunity Commission

## Where will it happen?

See Table 4, but primarily:

- health care settings
- local communities
- schools
- community agencies
- education and training sectors
- relevant national, state and territory conferences, meetings and forums

## Linked initiatives

See Table 3, but also:

- Community Development Project (MHCA)
- National Mental Health Education and Training Advisory Group
- Carers of People with a Mental Illness Project



Relapse prevention and early intervention for recurrent disorders are not specifically covered in *Action Plan 2000*, although their importance to consumers and carers is recognised. This is an area identified for future action. It should be noted, however, that many of the issues related to promotion, prevention and early intervention addressed in this document also apply to relapse prevention.

## Evidence base for action

The evidence base related to this priority group requires development through further research and evaluation.

### Research questions

- How can consumers and carers be supported to most effectively contribute to promotion, prevention and early intervention activities?
- How can participation of consumers and carers from diverse cultural and linguistic backgrounds be supported?
- What are the issues of greatest concern to consumers and carers related to promotion, prevention and early intervention?

## NATIONAL ACTION

**Develop partnerships with consumers and carers** to explore and implement strategies to increase their participation in and contribution to promotion, prevention and early intervention.

**Implement the Community Development Project** and investigate the promotion, prevention and early intervention roles of peer support and self-help groups.

**Enhance understanding** of promotion, prevention and early intervention for consumers and carers.

Pilot and evaluate initiatives that **promote the mental health of consumers and carers**, by enhancing protective factors, improving mental health literacy, and reducing the burdens associated with mental health problems and mental disorders. Establish links and partnerships with existing consumer and carer initiatives and organisations. Investigate issues such as access to support, respite and information.

Development of **mental health promoting mental health services**.

**Support children of parents with a mental disorder** through implementing promotion, prevention and early intervention programs.

## Process indicators

See Table 6, but also:

- improved training and support materials for consumers and carers in mental health promotion, prevention and early intervention
- increased paid representation of consumers and carers
- increased media involvement of consumers and carers promoting positive and diverse images of people with a mental disorder
- increased availability of programs to support children who have a parent with a mental disorder
- increased availability of programs to support and provide respite for carers
- reduced risk factors that exacerbate mental health problems and mental disorders, especially unemployment, homelessness, stigma, and discrimination

## Outcome indicators

See Table 5, and also:

- increased participation by consumers and carers in mental health promotion, prevention and early intervention activities
- increased participation in family and community life for people with mental health problems and mental disorders
- reduced incidence, prevalence and burden of mental health problems and mental disorders for consumers and carers

# Media

## Outcomes

Engage the media to promote mental health through:

- mental health literacy throughout the media workforce
- responsible and accurate reporting and portrayal of mental health issues and people with mental disorders
- media contributions to promotion, prevention and early intervention activities

## Rationale

The media is an integral part of our society, conveying information and influencing community attitudes and perceptions of social norms. Media coverage and reporting is, therefore, critical to forming and influencing community attitudes to mental health and mental disorders and to people affected by mental ill health. Media publicity also influences suicidal behaviour in the community (Martin, 1998; Gould and Schaffer, 1986).

Each section of the broadcasting industry has developed codes of practice which govern the presentation of program material. All codes prohibit broadcast of material likely to incite or perpetuate hatred against a person or group of persons on the basis of, amongst other things, disability. However, media coverage still often reflects the widespread misunderstanding in the community of mental health problems and mental disorders (Williams and Taylor, 1995). Educating and raising awareness within the media about these issues may improve accuracy and balance in reporting and help promote mental health literacy. Collaboration between media representatives and mental health professionals may also help identify ways in which the media can discourage rather than affirm suicidal behaviour without creating negative attitudes to mental disorders (Martin, 1998).

More broadly, the media also influence attitudes on a range of everyday life issues that affect mental health. The portrayal of various community groups, such as young people, older adults, Aboriginal peoples, Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds, affects community attitudes in relation to prejudice and discrimination. The media have a major role in promoting the acceptance and valuing of diversity within our communities, reducing the stereotyped portrayals of particular groups of people, and encouraging a social climate that is inclusive and supports the mental health of all Australians.

## Who will be involved?

See Table 4, but primarily:

- media workforce, including journalists, photographers, editors, radio and television presenters, administration, management and production staff
- Office of Film and Literature Classification
- Press Council
- consumers and carers
- mental health spokespersons
- media researchers

## Where will it happen?

See Table 4, but primarily:

- media settings, including film, radio, television, print and newspaper offices
- public and private communication organisations, including advertising and production agencies
- computerised services such as the Internet
- media education and training settings

## Linked initiatives

See Table 3, but also:

- Life Promoting Media Strategy
- Mental Health Promoting Media Strategy
- Mental health media resource kit



## Evidence base for action

The evidence base related to this priority group requires further analysis and development. A controlled trial has demonstrated that media campaigns in conjunction with appropriate community activities can improve mental health literacy (Hersey et al, 1984).

### Research questions

- To what extent, and in what ways, do the media influence community attitudes to mental health and mental ill health?
- How balanced and accurate is media portrayal of mental health problems and mental health issues?
- Do the media impact upon mental health and/or development of mental health problems (eg the effect of violence in the media on children and adults)?
- What strategies are effective in influencing media portrayal of mental health issues?

## NATIONAL ACTION

- Through partnerships and information sharing, engage the **media to promote mental health**, particularly through support for local communities.

**Review the evidence** concerning the content, balance, accuracy and impact of the media as it relates to mental health, mental health problems and mental disorders.

Develop initiatives and partnerships to **support accurate and appropriate media reporting and portrayal** of mental health, mental health problems and mental disorders, including distribution of *Achieving the Balance: A Resource Kit for Australian Media Professionals for the Reporting and Portrayal of Suicide and Mental Illnesses*.

Develop a media strategy to **promote positive messages around social and cultural diversity**, especially related to Aboriginal peoples, Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds, to reduce prejudice and discrimination.

Form a group of experts and **spokespersons for mental health issues** and facilitate their consultation across the media.

## Process indicators

See Table 6, but also:

- strategic links established between mental health and media
- increased media coverage by informed spokespersons on mental health-related issues
- increased positive media coverage of people with mental disorders
- increased positive media coverage of Aboriginal peoples, Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and other potentially marginalised social groups

## Outcome indicators

See Table 5 and also:

- reduced stigma, stereotyping and negative reporting portrayed through the media
- increased media coverage of mental health and mental ill health that is accurate in content, appropriate in presentation, positive and hopeful

# Health professionals and clinicians

## Outcomes

Maximise the support of health professionals and clinicians in promoting mental health and preventing and intervening early for mental health problems and mental disorders through:

- adoption of a population health approach
- holistic concepts of health that recognise the interrelatedness of mental and physical health
- commitment of resources to sustained evidence-based promotion, prevention and early intervention initiatives in all health settings
- links and partnerships within and across sectors
- capacity building in the workplace for promotion, prevention and early intervention for mental health

## Rationale

Prior to implementing *Action Plan 1999* it was noted that mental health services were focused primarily on interventions at the treatment and continuing care end of the intervention spectrum. Use of the term 'serious mental illness' in the National Mental Health Strategy reinforced this focus and has inhibited the progress of effective promotion, prevention and early intervention activities (National Mental Health Strategy Evaluation Steering Committee, 1997).

It is increasingly apparent that to improve mental health outcomes, mental health professionals need to adopt a population health approach (Raphael, 2000). This means including promotion, prevention and early intervention initiatives appropriate for a service's entire population, alongside current clinical interventions. Effective implementation of promotion, prevention and early intervention initiatives requires an understanding of the demographic characteristics of the population served by the agency or service along with building to capacity of staff in relation to a population health approach.

Placing mental health services within a population health approach benefits the mental health of the whole community targeted by that particular service, not just individual clients. Many initiatives undertaken by mental health services will occur in collaboration with partners across other agencies and sectors, and the consequent benefits will be widely experienced across the community. Establishing initiatives to enhance the community's understanding of mental health is fundamental.

There is considerable scope for primary health care providers to play a proactive role in relation to mental health, as they do in preventing physical illness (ie lifestyle advice for physical fitness, cancer and heart disease prevention). This might include promoting evidence-based practices that support mental health, such as exercise, social support and stress reduction. It can also include attempts to reduce practices that pose risks to mental health, such as substance misuse and relationship problems. The interdependence of mental and physical health support such an holistic approach.

Structural and funding barriers need to be addressed at all levels to ensure promotion, prevention and early intervention strategies are adopted by health services. For example, the high likelihood of comorbid mental disorder and substance misuse, necessitates effective partnerships between mental health and drug and alcohol services. Opportunities for a more proactive approach to mental health need to be developed and implemented within all services.

Health services also need to attend to the needs of their own staff, by setting up initiatives to prevent staff burnout and stress, which can result in reduced mental health for the staff member involved, loss of productivity for the workplace, and can ultimately lead to a reduction in the quality of service provision.

## Who will be involved?

See Table 4, but primarily:

- general practitioners and primary health carers
- mental health services, leaders and managers
- public health professionals
- policy and project managers
- recruitment managers/workforce project officers based with NACCHO
- ethnic liaison health workers
- RRC mental health workers

## Where will it happen?

See Table 4, but primarily:

- public and private hospitals
- community health centres
- general health services
- emergency departments
- all mental health services
- Divisions of General Practice
- Aboriginal Controlled Community Health Services
- Aboriginal and Torres Strait Islander Emotional and Social Well Being regional centres
- education and training settings

## Linked initiatives

See Table 3, but also:

- National Mental Health Education and Training Advisory Group
- Professional Competency Development Project
- Population Health Education and Research Program
- National Comorbidity Project



## Evidence base for action

While the effectiveness of many initiatives early in the intervention spectrum has been established under ideal conditions and in some settings, there is a need to evaluate programs in different settings, and to identify the factors that affect their uptake and implementation (Hosman and Jané-Lopis, 1999). This includes not only how mental health professionals, general practitioners and other primary health care professionals can participate in effective promotion, prevention and early intervention activities, but also the barriers to such participation.

Factors that may support sustained promotion, prevention and early intervention activities among health and mental health services include 'strong support from a robust health promotion infrastructure' (Wood and Wise, 1997), together with staff commitment, professional development and education, and systems that identify and disseminate good practice. Potentially inhibitory factors include the attitudes of health professionals (Frank Small and Associates, 1998) and failure to understand lay perspectives of mental disorder. For example, lay perceptions of the usefulness of treatments for mental disorders differ from those of professionals (Jorm et al, 1997) and a growing number of people are attracted to wider models of health maintenance and less medical style interventions (Eisenberg et al, 1998). An awareness of such perspectives may be important in developing prevention strategies and encouraging early treatment.

### Research questions

- How can health professionals, including mental health professionals, be encouraged, assisted and skilled to widen their role in promotion, prevention and early intervention and to evaluate their efforts?
- How can mental health professionals best contribute to improving the mental health literacy of population groups and individual clients?
- What aspects of mental health service provision present opportunities to implement evidence-based promotion, prevention and early intervention initiatives?
- What are effective service models to contribute to promotion, prevention and early intervention with respect to comorbidity?

## NATIONAL ACTION

Identify data, initiatives and partnerships relevant to promotion, prevention and early intervention, and mechanisms to **encourage and sustain approaches** across the health system, in close liaison with consumers, carers and local communities.

**Provide education and training within a population health context** by establishing programs to enhance the knowledge and skills of health professionals, including mental health professionals, about promotion, prevention and early intervention.

Develop and **implement cultural awareness packages** for all health services and establish cultural awareness programs in tertiary curricula.

**Provide easy access to the latest evidence, guidelines and model programs** related to promotion, prevention and early intervention for mental health.

**Support the mental health of health professionals** by developing and implementing workplace promotion, prevention and early intervention programs that contribute to improved job satisfaction, reduced burnout, improved mental health, and reduced sick leave.

**Support the concept of mental health promoting health services** by developing and evaluating mental health promoting service models.

## Process indicators

See Table 6, but also:

- inclusion of population health approaches in undergraduate health and specialist mental health education curricula
- increased awareness and training in culturally appropriate mental health service provision
- increased percentage of work time of health professionals spent on promotion, prevention and early intervention activities

## Outcome indicators

See Table 5 and also:

- increased adoption of population health approaches in all health settings
- increased evidence base for promotion, prevention and early intervention in mental health settings
- more positive attitudes among health professionals toward people with mental health problems and mental disorders
- increased availability of culturally appropriate mental health services
- decreased incidence and prevalence of depression, anxiety and substance misuse in health professionals





# Abbreviations

ABS	Australian Bureau of Statistics
ACTU	Australian Council of Trade Unions
ADHD	attention deficit hyperactivity disorder
AGPS	Australian Government Publishing Service
APA	American Psychiatric Association
AIHW	Australian Institute of Health and Welfare
CESCO	Conference of Education Systems Chief Executive Officers
DHFS	Commonwealth Department of Health and Family Services
DVA	Department of Veterans Affairs
MHCA	Mental Health Council of Australia
NCAGMH	National Community Advisory Group on Mental Health
NMHS	National Mental Health Strategy
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
OSAP	Office of Substance Abuse Prevention (United States)
WHO	World Health Organization



# Glossary



## ***Aboriginal concepts***

### **Health**

'Not just the physical wellbeing of an individual, but ... the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life–death–life' (NACCHO, 1997).

### **Community control**

'A process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community' (NACCHO, 1997).

## ***Acculturation***

Adaptation to a different culture.

## ***Aetiology***

All the factors that contribute to development of an illness or disorder.

## ***Affective disorders (mood disorders)***

This is a term that can be used to describe all those disorders that are characterised by mood disturbance. Disturbances can be in the direction of elevated expansive emotional state or, in the opposite direction, a depressed emotional state.

## ***Anxiety***

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal.

## ***Anxiety disorder***

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal defined according to clinically derived standard psychiatric diagnostic criteria.

## ***Assessment***

Ongoing process beginning with first client contact and continuing throughout the intervention and maintenance phases to termination of contact. The major goals of assessment are (a) identification of vulnerable or likely cases; (b) diagnosis; (c) choice of optimal treatment; and (d) evaluation of the effectiveness of the treatment.

### ***Attention deficit hyperactivity disorder (ADHD)***

Children with ADHD are persistently inattentive, hyperactive and/or impulsive in almost all settings. They make careless mistakes with schoolwork, find it hard to persist with tasks and are easily distracted. They often fidget, talk excessively, interrupt others, and are constantly 'on the go'.

### ***Auseinet***

The national network for promotion, prevention and early intervention for mental health. Auseinet will operate as a national network and clearinghouse to disseminate information and raise awareness about promotion, prevention and early intervention for mental health to a variety of stakeholders and sectors. <http://Auseinet.flinders.edu.au/>

### ***Bipolar disorder***

A mood disorder characterised by the presence of history of manic (or hypomanic) episodes usually, but not necessarily, alternated with depressive episodes.

### ***Carer***

'A person whose life is affected by virtue of a close relationship and a caring role with a consumer' (Australian Health Ministers, 1998, p. 25).

### ***Chronic***

Of lengthy duration or recurring frequently, often with progression seriousness.

### ***Clearinghouse***

A centralised repository of information, such as research papers and guidelines, on a particular topic which can be accessed by interested stakeholders.

### ***Cognitive behavioural programs or cognitive behaviour therapy (CBT)***

A short-term goal-oriented psychological treatment. The two guiding principles are that: how we behave (including how we feel) is learned through experience, and therefore may often be changed or unlearned; and thought processes directly impact on the person. The person is encouraged to examine their negative perceptions and interpretations of their experiences. They are also taught problem-solving techniques.

### ***Comorbidity***

'The co-occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia' (NHMRC, 1997b, p. 154).

### ***Community capacity***

The characteristics of communities that affect their ability to identify, mobilise, and address social and health problems and the cultivation and use of transferable knowledge, skills, systems and resources that affect community and individual level changes consistent with population health-related goals and objectives (Goodman et al, 1998).

### ***Community development***

Refers to the process of facilitating the community's awareness of the factors and forces that affect its health and quality of life, and ultimately helping to empower the community with the skills needed to take control over and improve those conditions. It involves helping communities to identify issues of concern and facilitating their efforts to bring about change in these areas (Hawe, Degeling and Hall, 1990).

### ***Community education***

An organised campaign designed to increase awareness of an issue.

### ***Conduct disorder***

'Condition characterised by aggressive, destructive, deceitful and rule breaking behaviours. Defined according to standard psychiatric criteria' (NHMRC, 1997a, p. 154).

### ***Connectedness***

A person's sense of belonging with others. A sense of connectedness can be with family, school or community.

### ***Consumer***

'A person utilising, or who has utilised, a mental health service' (Australian Health Ministers, 1998, p. 25).

### ***Counsellor***

At present, anyone in Australia can call himself or herself a counsellor, therapist or psychotherapist. There are, however, credentialling bodies for counsellors, such as the Australian Body of Certified Counsellors and a range of professional organisations that offer standards, codes of practice, ethical guidelines and continuing education such as the Australian Psychological Society, the Psychotherapy and Counselling Federation of Australia and the Australian National Network of Counsellors.

### ***Debriefing***

'The act of discussing or talking through a recent experience, such as a crisis' (Commonwealth Department of Health and Family Services, 1998, p. 257).

## ***Dementia***

A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement (WHO, 1992).

### **Alzheimer's Disease**

A degenerative form of dementia of unknown aetiology characterised by a reduction in neurons and the appearance of neurofibrillary tangles. The most common form of dementia.

### **Vascular dementia**

A group of dementias caused by multiple small strokes, or a single infarct or ischaemia in the brain (Henderson and Jorm, 1998).

## ***Depressed mood***

A sad or unhappy mood state.

## ***Depressive disorder***

A constellation of emotional, cognitive and somatic signs and symptoms including sustained sad mood or lack of pleasure and defined according to standard diagnostic criteria.

## ***Diagnosis***

A decision based on the recognition of clinically relevant symptomatology, the consideration of causes that may exclude a diagnosis of another condition, and the application of clinical judgement.

## ***Early intervention***

Interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder. Early intervention also encompasses the early identification of people suffering from a first episode of disorder.

## ***Eating disorder***

'A syndrome that negatively affects body-image, self-confidence and personality' (Selzner, Bonomo and Patton, 1995, p. 2032). Anorexia nervosa is characterised by excessive and self-induced weight loss and bulimia nervosa involves eating binges alternated with self-induced vomiting and laxative misuse.

## ***Effectiveness***

Effectiveness studies test the 'real world' impact of interventions that have been shown to be efficacious under controlled conditions. These studies are imperative to determine the generalisability of controlled studies in the real world, because interventions conducted under highly controlled conditions may not translate well into the uncontrolled environment that is the real world.

### ***Efficacy***

Efficacy studies, usually randomised controlled trials, are undertaken under experimental or 'controlled' conditions to develop and refine strategies. They provide important, but limited, information regarding the outcomes of interventions under ideal circumstances. They do not, however, yield information related to all the outcomes of interest (Aveline, 1997). (see randomised controlled trials)

### ***Epidemiology***

The study of statistics and trends in health as applied to the whole community.

### ***Evaluation***

The process used to describe the process of measuring the value or worth of a program or service.

### ***Evidence-based practice***

A process through which professionals use the best available evidence integrated with professional expertise to make decisions regarding the care of an individual. It is a concept which is now widely promoted in the medical and allied health fields and requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

### ***Externalising problems***

Externalising problems are associated with aggressive, disobedient and destructive behaviours.

### ***Follow-up study***

A research procedure whereby individuals observed in an earlier investigation are contacted at a later time for further study.

### ***Good practice guidelines***

Good practice is the benchmark against which programs can be evaluated. Good practice guidelines are statements based on the careful identification and synthesis of the best available evidence in a particular field. They are intended to help people in that field, including both practitioners and consumers, make the best use of available evidence.

### ***Incidence***

In community studies of a particular disorder, the rate at which new cases occur in a given place at a given time.

### ***Internalising problems***

Anxiety, depression, somatic and mood disorders are the most common types of internalising problems.

### ***Media***

‘Channel for mass communication of information to general and/or specific audiences (electronic media—radio, television, film; print media—newspapers, magazines)’ (Commonwealth Department of Health and Family Services, 1998, p. 258).

### ***Mental disorder***

A diagnosable illness that significantly interferes with an individual’s cognitive, emotional or social abilities.

### ***Mental health***

‘The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.’ (Australian Health Ministers, 1991)

### ***Mental health literacy***

‘The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking’ (Jorm et al, 1997, p. 182).

### ***Mental health problems***

Diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a mental disorder are met.

### ***Mental health professionals***

‘Professionally trained people working specifically in mental health, such as social workers, occupational therapists, psychiatrists, psychologists and psychiatric nurses’ (Commonwealth Department of Health and Family Services, 1998, p. 258).

### ***Mental health promoting school***

‘Where all members of the school community work together to provide students with integrated and positive experiences and structures which promote and protect their [mental] health (Youth Research Centre and Centre for Social Health, 1996, p. 10).

### ***Mental health promotion***

‘Action to maximise mental health and wellbeing among populations and individuals’ (Australian Health Ministers, 1998, p. 12).

### ***Meta-analysis***

‘A systematic review that employs statistical methods to combine and summarise the results of several studies’ (Cook and Guyatt, 1994, p. 1327).

### ***Monitoring***

The ongoing evaluation of a control or management process (Noah, 1997). The continuous measurement and observation of the performance of a service or program to see that it is proceeding according to the proposed plans and objectives (Vaughan and Morrow, 1989).

### ***Morbidity***

The relative frequency of illness or disorder, or illness rate, in a community or population.

### ***Mortality***

The relative frequency of death, or death rate, in a community or population.

### ***Outcome***

A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions (Australian Health Ministers, 1998, p. 27).

### ***Parent/s***

The person or people who are a child's primary care givers. There is wide variation in the composition of Australian families and parenting can include combinations of mother, father, stepmother, stepfather, other family members, and non-related carers. Regardless of the combination, parents (both male and female) have a profound influence on child development and mental health.

### ***Partnership***

An association intended to achieve a common aim.

### ***Perinatal***

Relating to the periods shortly before, and shortly after, the birth of a baby.

### ***Population-based interventions***

Population-based interventions are targeted at populations, rather than individuals. These interventions include whole population activities as well as those activities deliberately targeted to population subgroups, such as rural communities.

### ***Postnatal depression***

An episode of major depressive disorder occurring in the first 12 months after childbirth.

### ***Prevalence***

The percentage of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).

## ***Prevention***

'Interventions that occur before the initial onset of a disorder' (Mrazek and Haggerty, 1994, p. 23).

### **Universal intervention**

A preventive intervention 'targeted to the general public or a whole population group that has not been identified on the basis of individual risk' (Mrazek and Haggerty, 1994, p. 24).

### **Selective intervention**

A preventive intervention 'targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average' (Mrazek and Haggerty, 1994, p. 25).

### **Indicated intervention**

A preventive intervention 'targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms foreshadowing mental disorder ... but who do not meet DSM-IV diagnostic levels at the current time' (Mrazek and Haggerty, 1994, p. 25).

## ***Primary care***

In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention. For example, general practitioners, Aboriginal health workers, pharmacists and community health workers provide primary health care. Specialist care, or tertiary services, may be provided by accident and emergency services, hospital wards, youth health or mental health services.

## ***Protective factors***

Those factors that 'produce a resilience to the development of psychological difficulties in the face of adverse risk factors' (Spence, 1996, p. 5).

## ***Psychiatrist***

Medical practitioner with specialist training in psychiatry.

## ***Psychologist***

While there are various governing laws throughout the States and Territories of Australia, a practitioner is not allowed to call him or herself a 'psychologist' unless the required training has been undertaken and they are registered with the relevant state registration body. This is generally four years of full-time university study, followed by two years of supervised practice.

## ***Psychosis***

Psychosis 'refers to a group of disorders in which there is misinterpretation and misapprehension of the nature of reality reflected in certain symptoms, particularly disturbances in perception (hallucinations), disturbances of belief and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder) (EPPIC, 1997, p. 11).

### **Randomised controlled trial (RCT)**

Trial of an intervention under experimental conditions, where individuals are randomly assigned to either the intervention condition(s) under investigation or a control condition (where participants do not receive an intervention). This research design produces the strongest scientific evidence that an intervention causes the demonstrated outcomes. (*see also* efficacy and effectiveness)

### **Reliability**

The extent to which a test, measurement or classification system produces the same scientific observation each time it is applied.

### **Resilience**

Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.

### **Risk factors**

‘Those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder’ (Mrazek and Haggerty, 1994, p. 127).

### **Risk-taking behaviours**

Risk taking behaviours are behaviours in which there is some risk of immediate or later self-harm. Risk-taking behaviours might include activities such as dangerous driving, train surfing, and self-harming substance use.

### **Rural and remote communities**

The rural, remote and metropolitan areas (RRMA) classification was developed in 1994 by the then Commonwealth Department of Primary Industries and Energy and Commonwealth Department of Human Services and Health, based primarily on population numbers and an index of remoteness. The RRMA categories show a natural hierarchy, providing a model for incremental health disadvantage with rurality and remoteness as risk factors. Based on population density, the following three zones and seven area categories are recognised:

#### **Structure of the rural, remote and metropolitan areas (RRMA) classification**

<b>Zone</b>	<b>Category</b>
Metropolitan	Capital cities Other metropolitan centres (urban centres population $\geq$ 100,000)
Rural (index of remoteness $<$ 10.5)	Large rural centres (urban centres population 25,000–99,000) Small rural centres (urban centres population 10,000–24,999) Other rural areas (urban centres population $<$ 10,000)
Remote (index of remoteness $>$ 10.5)	Remote centres (urban centres population $\geq$ 5,000) Other remote areas (urban centres population $<$ 5,000)

### ***Schizophrenia***

A constellation of signs and symptoms which may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions and a restriction in thought, speech and goal-directed behaviour (American Psychiatric Association, 1994, pp. 274–75).

### ***Self-harm***

This includes the various methods by which young people may harm themselves, such as self-laceration, self-battering, taking overdoses, or deliberate recklessness. Recent research suggests that self-harm is more common than attempted suicide and is itself a serious youth health problem.

### ***Social and cultural diversity***

Refers to the wide range of social and cultural groups that make up the Australian population and Australian communities. It includes groups and individuals who differ according to gender, age, disability and illness, social status, level of education, religion, race, ethnicity, and sexual orientation.

### ***Socioeconomic status***

A relative position in the community as determined by occupation, income and amount of education.

### ***Somatic complaints***

Chronic physical complaints without known cause or medically verified basis.

### ***Stakeholders***

‘The different groups that are affected by decisions, consultations and policies.’  
(Commonwealth Department of Health and Family Services, 1998, p. 259).

### ***Stressor***

An event that occasions a stress response in a person.

### ***Substance dependence***

The misuse of a drug accompanied by a physiological dependence, made evident by tolerance and withdrawal symptoms.

### ***Substance misuse***

'A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances' (American Psychiatric Association, 1994, p. 182). Use may be to such an extent that the person is often intoxicated throughout the day and fails in important obligation and in attempts to abstain, but where there is not necessarily physical dependence.

### ***Substance use disorders***

Disorders in which drugs are used to such an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological, as in substance misuse, or physiological, as in substance dependence.

### ***Suicide***

Suicide is a conscious act to end one's life. By conscious act, it is meant that the act undertaken was done in order to end the person's life.

### ***Suicidal behaviour***

Suicidal behaviour includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

### ***Symptom***

An observable physiological or psychological manifestation of a disorder or disease, often occurring in a pattern group to constitute a syndrome.

### ***Surveillance***

Close monitoring of selected health conditions in the population. The term has been expanded to include not only information on diseases, injuries and other conditions, but also information such as the prevalence of risk factors, both personal and environmental. Surveillance means continuous watchfulness over the distribution and trends of incidence through the systematic collection, consolidation, and evaluation of morbidity and mortality reports and other relevant data, together with timely and regular dissemination to those who need to know (Berkelman, Stroup and Buehler, 1997).

### ***Withdrawn behaviour***

Shyness, social withdrawal and isolation.





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