Promotion, Prevention and Early Intervention for Mental Health

A Monograph

2000
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2000
About this document


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 disorder, and to intervene as early as possible to minimize 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 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 3788
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National Mental Health Promotion and Prevention Working Party membership

The National Mental Health Promotion and Prevention Working Party operates under the auspices of the Australian Health Ministers’ Advisory Council National Mental Health Working Group and the National Public Health Partnership Group. The Promotion and Prevention Working Party comprises members or nominees of these auspicing groups as well as representatives of other key stakeholder groups.

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Executive summary


Chapter 1 introduces the promotion, prevention and early intervention approach to improving mental health for all Australians. It defines the terms ‘mental health’, ‘mental health problems’, ‘mental disorders’, ‘prevention’, ‘promotion’ and ‘early intervention’. It describes the burden of mental health problems and mental disorders, and considers the international and Australian context in which mental health reforms are taking place. It also highlights the importance that consumers place on taking a promotion, prevention and early intervention approach to mental health issues: an approach that does not wait until mental health problems and mental disorders have become ‘serious enough’ before action is taken.

Chapter 2 considers the influences on mental health and provides the rationale for a multisectoral approach to mental health that requires partnerships, input and commitment from all sectors of the community. It shows how the determinants of health and mental health occur at a population level and comprise a range of psychosocial and environmental factors including income, employment, poverty, education and access to community resources, as well as demographic factors. These determinants translate into risk and protective factors for population groups and individuals. Risk factors increase the likelihood that a mental health problem or mental disorder will develop, whereas protective factors reduce this likelihood.
Chapter 3 describes the population health approach, which is the conceptual framework for promotion, prevention and early intervention. It presents the basic tenets of a population health approach, which focus on the importance and relevance of scientific evidence, research and evaluation, and monitoring and surveillance. A model of the spectrum of interventions for mental health, comprising promotion, prevention, early intervention, treatment and continuing care, is also described in detail.

Chapter 4 shows the sectors that are strategically important for promotion, prevention and early intervention initiatives. It also covers separately the main principles and strategic approaches of promotion, prevention and early intervention.

Chapter 5 provides a whole-of-lifespan account of mental health and mental illness. It describes what is known about the development of mental health across the lifespan, as well as the development of mental health problems and mental disorders from infancy through to older adulthood.

Chapter 6 recognizes that particular population groups within Australia require separate consideration due to their special circumstances. Specifically, Aboriginal peoples, Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and people who live in rural and remote regions experience high levels of risk and a unique combination of risk factors that require separate attention.
Chapter 7 considers promotion, prevention and early intervention issues related to some of the mental disorders that are of concern to Australians: behavioural disorders, depressive and anxiety disorders, eating disorders, postnatal depression, psychotic disorders, substance use disorders and dementias, along with the related issues of comorbidity and suicide prevention.

Chapter 8 summarises the main elements of promotion, prevention and early intervention for mental health that will provide the basis of good practice in this area. It also gives a brief overview of the purpose, structure and ongoing monitoring of Action Plan 2000.

Overall, the monograph aims to present the rationale for adopting a promotion, prevention and early intervention approach to mental health. It argues that accumulating evidence shows the widespread and long-term benefits that this approach will have on the social and emotional wellbeing of Australians. Through multi-sectoral partnerships and activity, and with due consideration of the issues presented in this monograph, commitment to a promotion, prevention and early intervention approach will enable Australia to reduce the burden of mental health problems and mental disorders and enhance the mental health of all Australians.
CHAPTER 1: Introduction

For most Australians, the remarkable progress that has been made in physical and material wellbeing over the twentieth century has not been matched in terms of social and emotional wellbeing (Mathers, Vos & Stevenson 1999). As part of a coordinated national approach to redress this imbalance, the Mental Health Promotion and Prevention Working Party has developed two publications that focus on the promotion of mental health and prevention and early intervention activities that aim to reduce the prevalence and burden of mental health problems and mental disorders:

• The Action Plan provides the policy framework, outlines strategies for action across the lifespan and for special population groups, and incorporates the best available scientific evidence. The first Action Plan 1999, entitled Mental Health Promotion and Prevention National Action Plan, was released in February 1999. It focused on promotion and prevention activities to improve mental health. The second Action Plan 2000, entitled National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, incorporates feedback from users of the first plan and has been expanded to include early intervention concepts and strategies.

• This companion document is entitled Promotion, Prevention and Early Intervention for Mental Health—A Monograph, and presents the theoretical and conceptual foundation and background for Action Plan 2000.
Growing evidence indicates that an approach to mental health that incorporates promotion, prevention and early intervention activities can have far-reaching benefits by improving mental health across the Australian population as well as reducing the prevalence and burden of mental health problems and mental disorders. This approach comprises a long-term investment in the social and emotional wellbeing of Australian communities, in addition to its potential to achieve long-term cost savings.

The focus on promotion of mental health and prevention and early intervention for mental health problems and mental disorders represents a major and exciting direction for mental health activities in Australia, complementing and expanding the traditional focus on treatment.

A wide range of factors influence mental health, mental health problems and mental disorders. This expanded focus therefore requires partnerships that reach well beyond specialist 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 as such requires a whole-of-community response.

Many of the factors that influence mental health and mental illness also influence outcomes in other sectors, for example education and criminal justice. Promotion, prevention and early intervention for mental health have the capacity to deliver benefits well beyond the traditional health services sector—to individuals, families and our communities.

This monograph and Action Plan 2000, therefore, address 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 those who are generally interested in the broad concept of mental health. Activities to promote mental health and to prevent and intervene early for mental health problems and mental disorders need to be carried out across whole populations, both within and beyond the mental health sector. These activities will result in corresponding gains across our whole society.
Mental health, mental health problems and mental disorders

Mental health is not simply the absence of mental illness but describes the capacity of individuals and groups to interact with one another and their environment 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 is a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community (WHO 1999).

Mental health problems and mental disorders refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. 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. 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 mental disorders. 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.
Promotion, prevention and early intervention

This document presents an approach to mental health, mental health problems and mental disorders that focuses on promoting mental health and preventing and intervening early in mental health problems and mental disorders.

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals.

Prevention refers to interventions that occur before the initial onset of a disorder to prevent the development of the disorder.

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.

The burden of mental health problems and mental disorders

More than one million Australians are estimated to have a mental disorder; with almost half of those people affected long term. 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, Yin & Stevenson 1999). It is estimated that close to one in five people in Australia will be affected by a mental health problem at some stage in their lives (Commonwealth Department of Health and Aged Care & AIHW 1999), including 14–20 per cent of children and adolescents (Hubrich et al. 1995, Sanyet et al. 2005).

Worldwide, the burden of mental health problems and mental disorders has been seriously underestimated, according to the Global Burden of Disease Study (Murray & Lopez 1996). While mental health problems are responsible for little more than one per cent of deaths, they account for almost 11 per cent of the disease burden worldwide. Of the ten leading causes of disability in 1990 (measured in years lived with a disability), five were psychiatric conditions. Importantly, predictions suggest that by 2020 the disease burden of mental health conditions may increase to almost 15 per cent.

The public health burden of mental health problems and mental disorders has been defined by Nations for Mental Health, a World Health Organization (WHO) initiative, at four different levels (WHO 1997). The defined burden is that which affects people with mental health problems and mental disorders and is measured in terms of indicators such as prevalence of disorders. The analytical model relates to the impact of mental health problems and mental disorders on individuals, communities and society in general.
disorders on people other than the individuals directly affected. This burden is borne by families and communities in terms of both human and economic costs. Mental health problems and mental disorders tend to affect the psychosocial and cognitive functioning of the individual, diminishing his or her social role and productivity in society and increasing the need for assistance. The hidden burden is associated with stigma and human rights violations. The stigma associated with mental disorders is pervasive and leads to negative consequences for the person with a mental disorder, their family and the wider community. The future burden is the ongoing legacy of the existing burden, as a consequence of the ageing population and increasing social problems.

International context

There is a growing body of interest internationally in promotion, prevention and early intervention for mental health. The United States Institute of Medicine produced a definitive review of the evidence for prevention in mental health (Maas & 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). There have also been major initiatives in Europe, including the formation of the European Network on Mental Health Promotion, created to identify and disseminate good practice in mental health promotion and prevention. The WHO 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, the International Journal of Mental Health Promotion.

Internationally, much of the mental health promotion work has been conducted within the framework of the Ottawa Charter for Health Promotion (WHO 1986). Key components of the Charter are building healthy public policy and emphasizing the role of all sectors in health outcomes, creating supportive environments in all settings, strengthening community action, developing personal skills including mental health literacy, and increasing the focus on prevention and early intervention. This has recently been endorsed in a report of the US Surgeon General, which emphasizes 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

Promotion, prevention and early intervention activities in Australia are taking place in the context of a major expansion of activity in the area of mental health. In 1992, all health ministers agreed on a National Mental Health Strategy to take forward a nationally agreed agenda for mental health reforms in Australia. There had previously been little national coordination and leadership in the area of mental health. At that time the National Mental Health Strategy was made up of three related documents:

- Mental Health Statement of Rights and Responsibilities (Australian Health Ministers 1991);
- National Mental Health Policy (Australian Health Ministers 1992); and

The period covered by the National Mental Health Plan (1992) ended in June 1998 and a second plan was signed by Australian health ministers for the period 1998 to 2003. It provides a five-year framework to progress mental health reform to June 2003, identifying three priority areas for future activity: promotion and prevention; partnerships in service reform; and quality and effectiveness of service delivery. A total of $300 million (indexed) was allocated by the Federal Government for mental health service activity throughout the five years of this second plan. Promotion, prevention and early intervention comprise a major platform in the Second National Mental Health Plan, and outcomes identified include:

- improved public health strategies to promote mental health;
- reduced incidence and prevalence of mental illness 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.

The promotion and prevention components of the first National Mental Health Plan were focused primarily on increasing public awareness of the extent of mental disorders and on reducing stigma. In the Second National Mental Health Plan, these activities were expanded to include decreasing stigmatising attitudes within the helping services and increasing mental health literacy in key settings and among key groups in the community.
The Evaluation of the National Mental Health Strategy (National Mental Health Strategy Evaluation Steering Committee 1997) identified national direction in promotion and prevention as a major need, in order to provide leadership, clarify responsibilities, stimulate development of specific programs for populations at higher risk of developing mental health problems and mental disorders, and support primary care providers. The National Mental Health Working Group of the Australian Health Ministers’ Advisory Council and the National Public Health Partnership Group agreed to auspice the National Mental Health Promotion and Prevention Working Party to develop a plan of action that would provide this national direction. Action Plan 2000 describes the current directions of that plan.

Consumers’ perspective

Consumers’ voices are central in arguing for a strong focus on promoting mental health and preventing and intervening early for mental health problems and mental disorders. People who have had a mental disorder are keen to spare their children from a similar experience. Personal narratives provide a critical view of pathways to care, and individuals who have experienced a mental disorder, along with their family and carers, have unique stories to share.

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 condemn the notion that a mental disorder must be ‘serious enough’ before action is taken. Reflecting on the time that they were experiencing early signs and symptoms of first or recurrent disorder, some consumers recall that ‘nobody would help because it wasn’t serious enough’. Carers and clinicians echo the concern that treatment often is not initiated until symptoms are well advanced. The quote ‘I came upon the scene too late; most of the damage was already done’ (McGlashan 1996, p. 198) describes the experience of many clinicians.

Other consumers are reluctant to seek professional help. Mental health services, and inpatient services in particular, are seen as a last resort. Lincoln and McGorry (1999) examined a topography of pathways to psychiatric care and describe situations where ‘becoming a patient can be a threatening and disempowering event’ (p. 73) with, on the one hand, barriers and inefficiencies to obtaining psychiatric care and, on the other hand, reluctance and resistance to seek care.
The pathways to effective care are often unclear and extremely difficult to negotiate, especially for young people and their families, and for people from backgrounds that are not part of the dominant mainstream culture. Pathways to professional care require identifying the existence of a mental health problem or mental disorder, recognizing the need for professional assistance and knowing how to access this assistance. There may be a prolonged waiting period for services and some financial cost. Stigma may be attached to admitting to having a mental health problem and attending a mental health service (Crisp et al. 2000), and there may also be a requirement to repeatedly disclose personal information to strangers. While there are many ways that people with mental health problems and mental disorders seek help—and these do not necessarily include mental health services (Zubrick et al. 1995)—this scenario illustrates the gap that can exist between people’s mental health needs and access to services (Waxman, Weist & Benson 1999).

Increasing the focus on promotion, prevention and early intervention may empower consumers by, for example, reducing the likelihood of crisis situations, such as sudden hospitalization. A mental disorder can be a serious ‘life event’ that threatens self and identity, valued goals and roles, and social status. People of all ages, and young people in particular, place high value on their independence, autonomy and plans for the future. Traditional forms of treatment for mental disorders can exclude people from these important values, whereas promotion, prevention and early intervention can help keep them intact (Birchwood, McGorry & Jackson 1997).
CHAPTER 2: The influences on mental health

Historically, advances in health and medicine have been dominated by a belief in ‘single sufficient causes’. This is the belief that illnesses have one specific cause and if this were interrupted or eliminated the illness could be prevented or cured. Many diseases have been successfully eradicated or treated through this approach and it persists in such terms as ‘miracle cures’ and ‘magic bullets’ (Zubrick et al. 2000a). In practice, however, it is rarely as simple as this; for many conditions the pathway to disease is complex and involves a range of factors with varying levels of ‘causality’. For example, many bacterial infections that cause diseases are now known and can be targeted directly by specific antibiotics. However, the incidence of bacterial infection caused by these agents started to fall before antibiotics were introduced. This fall was in response to changes in other factors on the causal pathway to the disease, such as a clean water supply, better housing and nutrition, and improved literacy and education (McKeown 1979; Harper, Holman & Dawes 1994).

It is now recognised that most of the diseases and disorders that represent a significant burden to human populations have multifactorial causes, determinants, risk and protective factors that interact in complex ways with each other. Mental health problems and mental disorders develop through such complex causal interactions, and it is seldom possible to identify a single principal cause. Moreover, the exact nature of the causal interactions affecting mental health problems and mental disorders are often unknown.

Traditionally, several distinctions have been made among the factors that influence health and mental health according to the type of causal relationship they have with health outcomes.
A cause can be defined as an external agent (such as a microbe, chemical substance or physical trauma) that results in a condition or disease in a person who is susceptible. For example, an autosomal dominant genetic abnormality causes Huntington's Disease, and long-term alcohol abuse with nutritional deficiencies will cause severe memory impairment and loss.

A determinant is a factor that operates at the system, social or community level to affect the likelihood that people will be exposed to a disease or condition or, when exposed, the likelihood of their developing the condition. Typically, determinants are best understood in terms of whole populations. Population-attributable risk is the percentage of morbidity in a population that can be attributed to a particular determinant.

Of prime importance for promotion, prevention and early intervention are those determinants that actually modify the risk of disease in populations (termed aetiological determinants) (Susser & Susser 1989). For example, exposure to economic and social inequality is a powerful determinant of health and wellbeing in populations (Keating & Hertzman 1999). Modifying these determinants should result in changes in population health and wellbeing.

There is considerable overlap between determinants and risk and protective factors, which translate the determinants of disease to the level of individuals or identifiable groups. Risk factors increase the likelihood that a particular individual or identifiable group of people will develop a disorder, while protective factors reduce that likelihood. For example, child abuse and violence in the home are significant risk factors for conduct disorder, whereas the availability of a positive peer group is a protective factor that can reduce this risk.
Psychosocial determinants of health and mental health

The determinants of physical and mental health status, at the population level, comprise a range of psychosocial and environmental factors including income, employment, poverty, education and access to community resources (Yen & Syme 1999; Kawachi & Marmot 1998; Baum 1998), as well as demographic factors, most notably gender, age and ethnicity. Physical and mental health are interdependent (Commonwealth Department of Health and Aged Care & AIHW 1999), and the contribution of physical health to mental wellbeing and the effect of mental health on physical health must both be considered (Mishizaka & Haggerty 1994).

The benchmark Whitehall studies of British civil servants (Marmot, Shipley & Rose 1984) demonstrated the relationship between exposure to psychosocial factors and subsequent general health status. The factors that were associated with ill health were low socioeconomic status, high stress levels, hardship or risk exposure in early life, social exclusion, high stress in the workplace, job insecurity, low social support, addictive behaviours, unhealthy food choices and unhealthy transport practices. These factors are not mutually exclusive and are generally related to widening income inequalities and a sense of lack of personal control over the environment. The way in which the societal distribution of income affects an individual's health may have more to do with position in society than with absolute living standards (Kawachi, Kennedy & Wilkinson 1999).

The results of the Whitehall studies are supported by Australian research showing a relationship between lower socioeconomic status and ill health (McLennan 1998). Social disadvantage is associated with a number of other factors that have a negative impact on health and the ability to access appropriate health care. For example, poverty reduces financial access to health services and may also be associated with lower educational attainment, lower literacy levels and less knowledge about positive health practices compared with more socially advantaged groups.

It has been suggested that the importance of poverty in contributing to mental health problems and mental disorders is related to the many stressors that stem from a lack of resources. Children living in poverty are more likely to be exposed, for example, to physical illnesses, family stress, inadequate social support and parental depression (Parker, Gair & Zuckerman 1998). Poverty is associated with unsupportive, antistimulating and chaotic home environments, psychological distress in the parents and poor family management practices (Hart & Risley 1995; Duncan 1991; Larner & Collins 1996). The effects of these stressors accumulate over time, as poverty is a condition that tends changes quickly (Garmezy 1993).
Ethnicity is an important demographic determinant of health status, and for some groups is closely associated with other factors related to disadvantage. In particular, Aboriginal peoples and Torres Strait Islanders remain the least healthy identifiable population groups in Australia (Commonwealth Dept of Human Services and Health 1994), disadvantaged through level of education, employment status, economic status and housing, and also through lack of appropriate infrastructure within their communities to maintain health (for example poor sanitation) (Dean & Raphael 1995). This is compounded by social marginalisation, isolation and identity issues. All these factors contribute to lower health status and a vicious circle of disadvantage in many Aboriginal and Torres Strait Islander communities.

For Aboriginal peoples, Torres Strait Islanders and people from culturally and linguistically diverse backgrounds, racism and discrimination also affect health status. foremost, they translate into differential opportunities for employment and education. However, they also expose individuals to the psychosocial effects of having to deal with discriminatory behaviour. Repeated rejection and hostility and feelings of shame can undermine self-worth and self-efficacy and contribute to psychological distress (Kirby & Fraser 1997). Other marginalised groups within communities, such as people who are gay or lesbian and older adults, can also be exposed to the multiple negative consequences of stereotyping and discrimination.

Gender is another important demographic factor that differentiates health status in the population. Health statistics regularly reveal greater morbidity and health service use for women, but higher mortality rates for men (AIHW 1998; Verbrugge 1989). Paradoxically, although women are more likely to be living in poverty than their male counterparts, their life expectancy is longer (Kaplan, Anderson & Wingard 1991). The reasons for these gender differences are unclear, but some authors suggest that they may be related to gender differences in acquired risk. For example, men are more likely to be involved in hazardous jobs and engage in unhealthy behaviours such as harmful alcohol use, while women are more likely to seek treatment for illness and are more aware of preventive health behaviours (Verbrugge 1989). Research reveals gender differences in the performance of a range of self-care and prevention behaviours (Duaa 1989; Leonam, Weins & Laron 1992).

Gender also affects responses to a variety of stressors, including family discord, divorce and childcare, and boys can show more severe and prolonged disturbances than girls to these stressors (Luthar & Zigler 1991). While gender differences are associated with some mental health conditions, it is not clear to what extent gender itself is a determinant. As social expectations and opportunities for males and females have changed over the past century, so have the comparative rates of mental health problems. It may be that different patterns of risk impact on the mental health of men and women (Kirby & Fraser 1997).
The level of social integration within a community is an often-underestimated determinant of health status. This includes poor access to social support, marginalisation, isolation and a concomitant increase in physical and emotional vulnerability (Royal Australasian College of Physicians 1999). Lack of social support is also associated with social disadvantage, as factors such as poverty and unemployment contribute to social isolation. Social capital is a term that has come to refer to the strength of personal support networks and ability to access such support within a community, along with levels of trust, mutual responsibility and effective collaboration (Putnam 2000; Berry & Rickwood 2000). Research has found that these elements are very important to a community's level of health and social and emotional wellbeing, and protect against the negative impacts of economic deprivation and other trauma (Health Education Authority 1998).

**Risk and protective factors**

Determinants of health, operating at a population or community level, translate into risk and protective factors that influence the physical and mental health of individuals and identifiable population groups. In the context of mental health, risk factors increase the likelihood that a disorder will develop and can exacerbate the burden of existing disorder, while protective factors give people resilience in the face of adversity and moderate the impact of stress and transient symptoms on social and emotional wellbeing, thereby reducing the likelihood of disorders. Protective factors reduce the likelihood that a disorder will develop. They can be truly protective, reducing the exposure to risk, or they may be compensatory, reducing the effect of risk factors (Barlow 1985). A protective factor that can reduce exposure to risk is parenting behaviour where parents responsibly monitor the whereabouts and behaviour of their child(ren), thereby reducing the likelihood of exposure to physical or psychological harm. A protective factor that can reduce the effect of risk factors is parenting behaviour that is caring and supportive, whereby the child has access to social support and is also likely to have higher self-esteem. The presence of more protective factors, regardless of the number of risk factors, has been shown to lower the level of risk (Rutter et al. 1997). However, people who have high resilience (that is, have the capacity to bounce back after adversity) are still vulnerable to adverse events and circumstances. Resilience changes over time and is specific to particular domains and stages of development. It cannot be assumed that protective factors will always override the effect of risk factors, and resilience can be put under extreme pressure in some environments. For example, only 1.5 per cent of children who experienced sexual abuse and neglect showed normative functioning three years later (Fraser 1997).
Risk factors are vulnerability factors that increase the likelihood and burden of disorder. They include genetic, biological, behavioral, psychological, sociocultural, economic, environmental and demographic conditions and characteristics. Single risk factors often have only a minimal effect on their own but may combine to have a strong interactive effect, and exposure to multiple risk factors over time has a cumulative effect (Kazdin & Kagan 1994).

Fraser (1997) describes ‘risk chains’ as risk factors operating over time to influence vulnerability. Some, such as poverty, are more distant in time from the emergence of a mental health problem, while factors such as early parental neglect or rejection by the peer group may be more immediately important in precipitating a problem. Events such as the death of both parents or arrest on criminal charges may, in some individuals, have an effect so profound that they change the developmental course from that moment.

Tables 1 and 2 present the factors generally accepted by practitioners and researchers as important to consider as potential contributors to the development of mental health problems and mental disorders. Many of these factors are specific to particular stages of the lifespan, particularly childhood; others have an impact across the lifespan, for example, socioeconomic disadvantage. The level of evidence that supports these factors varies, although vigorous research activity in this field is constantly producing new evidence.

Table 1 presents protective factors that can affect the development of mental health problems and mental disorders. These are factors that can reduce the likelihood of mental health problems and mental disorders and mitigate the potentially negative effects of the risk factors presented in Table 2. However, it is important to note that while the available evidence shows that these factors are associated with positive mental health outcomes, the strength of association and level of evidence for causation varies. Consequently, no causal relationship can be assumed for these factors; for some individuals there will be no impact of any particular factor or combination of factors, while for other people a particular factor or combination of factors may be very protective of their mental health.
Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Family factors</th>
<th>School context</th>
<th>Life events and situations</th>
<th>Community and cultural factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• easy temperament</td>
<td>• supportive caring parents</td>
<td>• sense of belonging</td>
<td>• involvement with significant other person (partner or adult)</td>
<td>• sense of connectedness</td>
</tr>
<tr>
<td>• adequate nutrition</td>
<td>• family harmony</td>
<td>• positive school climate</td>
<td>• availability of opportunities for critical turning points or major life transitions</td>
<td>• attachment to and networks within the community</td>
</tr>
<tr>
<td>• attachment to family</td>
<td>• secure and stable family</td>
<td>• prosocial peer group</td>
<td>• economic security</td>
<td>• participation in church or other community group</td>
</tr>
<tr>
<td>• above-average intelligence</td>
<td>• small family size</td>
<td>• required responsibility and helpfulness</td>
<td>• good physical health</td>
<td>• strong cultural identity and ethnic pride</td>
</tr>
<tr>
<td>• school achievement</td>
<td>• more than two years between siblings</td>
<td>• opportunities for some success and recognition of achievement</td>
<td></td>
<td>• access to support services</td>
</tr>
<tr>
<td>• problem-solving skills</td>
<td>• responsibility within the family (for child or adult)</td>
<td>• school norms against violence</td>
<td></td>
<td>• community/cultural norms against violence</td>
</tr>
<tr>
<td>• internal locus of control</td>
<td>• supportive relationship with other adult (for a child or adult)</td>
<td>• sense of belonging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• social competence</td>
<td>• strong family norms and morality</td>
<td>• positive school climate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• social skills</td>
<td>• supportive relationship with other adult (for a child or adult)</td>
<td>• prosocial peer group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• good coping style</td>
<td>• strong family norms and morality</td>
<td>• required responsibility and helpfulness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• optimism</td>
<td>• involvement with significant other person (partner or adult)</td>
<td>• economic security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• moral beliefs</td>
<td>• availability of opportunities for critical turning points or major life transitions</td>
<td>• good physical health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• values</td>
<td>• economic security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• positive self-related cognitions</td>
<td>• strong cultural identity and ethnic pride</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 presents risk factors that potentially influence the development of mental health problems and mental disorders. These are factors that increase the likelihood that mental health problems and mental disorders will develop. Again, it is important to note that while the available evidence shows that these factors are associated with negative mental health outcomes, the strength of association and level of evidence for causation varies. Consequently, no causal relationship can be assumed for these factors; for some individuals there will be no impact of any particular factor or combination of factors, while for other people a particular factor or combination of factors may be very detrimental to their mental health.
Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Family/social factors</th>
<th>School context</th>
<th>Life events and situations</th>
<th>Community and cultural factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>prenatal brain damage</td>
<td>having a single parent</td>
<td>bullying</td>
<td>physical, sexual and emotional abuse</td>
<td>socioeconomic disadvantage</td>
</tr>
<tr>
<td>prematurity</td>
<td>having a teenaged mother</td>
<td>peer rejection</td>
<td>school failure</td>
<td>social or cultural discrimination</td>
</tr>
<tr>
<td>birth injury</td>
<td>antisocial role models in childhood</td>
<td>poor attachment to school</td>
<td>family violence and disharmony</td>
<td>neighbourhood conflict and crime</td>
</tr>
<tr>
<td>low birth weight, birth complications</td>
<td>marital discord</td>
<td>poor supervision and monitoring of child</td>
<td>physical, sexual and emotional abuse</td>
<td>population density and housing</td>
</tr>
<tr>
<td>physical and intellectual disability</td>
<td>neglect in childhood</td>
<td>low parental involvement in child's activities</td>
<td>employment, homelessness, incarceration</td>
<td>lack of support services</td>
</tr>
<tr>
<td>poor health in infancy</td>
<td>long-term parental unemployment</td>
<td>social isolation</td>
<td>poverty and economic insecurity</td>
<td>including transport, shopping, recreational facilities</td>
</tr>
<tr>
<td>insecure attachment in infant/childhood</td>
<td>caring for someone with an illness/disability</td>
<td>lack of support services</td>
<td>work or natural disasters</td>
<td></td>
</tr>
<tr>
<td>low intelligence</td>
<td>living in nursing home or aged care facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difficult temperament</td>
<td>war or natural disasters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chronic illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>poor social skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low self-esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>alienation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>impulsivity</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Of major significance for the development of interventions to improve mental health is the realisation that most of the protective and risk factors for mental health lie outside the main ambit of mental health services, in socioeconomic and sociocultural conditions. Of equal importance is recognition that effective interventions related to these risk and protective factors have positive outcomes beyond the mental health domain. There are ‘common causal pathways’ from these factors to outcomes in the mental health, health, educational, correctional and community sectors (Department of Human Services 2000).

Changes to these factors generally require long-term sustained effort across multiple sectors of the community and government; these changes cannot be achieved by the mental health, or even the health, sector alone, and the benefits of such changes are not restricted to the mental health sector. The nature of risk and protective factors highlights the critical importance of intersectoral and whole-community partnerships to improve mental health.

The importance of focusing on determinants and risk and protective factors

An understanding of the complex interaction of causes, determinants and risk and protective factors affecting mental health is important for the following reasons.

1. It demonstrates the need for collaborative intersectoral partnerships to promote social and emotional wellbeing. The epidemiological understanding of the causes, determinants, risk and protective factors for mental health problems and mental disorders, particularly in children, is much clearer now than it was 20 years ago. It is evident that many of these influences lie outside the mental health service sector and they are psychosocial and environmental in nature (for example poverty). There is, therefore, a critical need to apply knowledge about the prevention of mental health problems and mental disorders and the promotion of mental health in sectors outside mental health services. This knowledge needs to be available to those services and sectors that can impact on the factors that influence mental health, across all lifespan groups and particularly for children and young people. These service sectors are looking to the mental health field because of their need to develop mental health expertise and leadership.
It highlights the cost-effectiveness and significance of shifting efforts in population health, and maximizing health gain in populations, as opposed to focusing on individual health gains. Most of the risk factors for mental disorders, in and of themselves, have a very low likelihood of actually causing a disorder (that is, they are weak in strength). However, if a large population of individuals is exposed to a weak risk factor, then preventing or interrupting exposure to this factor can result in valuable reductions in the burden of associated disorder (Doll 1996). This is because a large number of individuals exposed to a small risk may generate many more cases of disorder than a small number of individuals exposed to high risk. Prevention efforts that secure a large benefit for a population group may bring relatively little benefit to each individual. Consequently, the benefits of prevention in the mental health field are most evident in, and best understood in relation to, the effects on whole populations rather than specific individuals.

Accordingly, an approach is required that recognizes the complex and multifactorial nature of the causal pathways to mental health problems and mental disorders. The contribution of diverse psychosocial, demographic and environmental factors that derive from the unique circumstances of individuals and also from fundamental structural social and economic inequities within societies and communities must be incorporated. The understanding is that mental health will be maximized by a comprehensive approach that is integrated across all sectors of care and all levels of society. While this is an ambitious enterprise, the potential benefits to the population as a whole, and thereby to individuals, are considerable.

Such an approach requires a model encompassing the full range of influences on health, including factors at the individual, family, community, sector/system and society level (Hamilton & Bhui 1996). Factors at these levels impact on individuals and communities through income and social status, social support networks, education and educational settings, working conditions, physical environments, families, biology and genetics, personal health practices and coping skills, child development and health services. All these factors are incorporated within the population health approach, discussed in the next chapter.
CHAPTER 3:

Conceptual framework for promotion, prevention and early intervention activities

The population health approach acknowledges the complex and multifactorial nature of the causal pathways to health problems. It thereby provides a conceptual framework for the promotion of mental health and prevention and early intervention for mental health problems and mental disorders (Raphael 2000a).

A population health approach

While the 1980s marked the emergence globally of the ‘new public health’ philosophy, more recently this term has been replaced by ‘population health’. This change in terminology attempts to allay the confusion in the use of the terms ‘public health’ and ‘new public health’, which have been incorrectly understood by some to be synonymous with publicly funded health structures (that is, public hospital systems).
The Mental Health Promotion and Prevention Working Party has conceptualised population health as follows:

Population health attends to the health status and health needs of whole populations. It encompasses population needs assessment, developing and implementing interventions to promote health and reduce illness across the whole population and in particular population groups, along with monitoring trends and evaluating outcomes. Population health recognises that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at personal, local and global levels.

Support for a population approach to mental health emerged with the Global Strategy for Health for All by the Year 2000 (WHO 1981) document, which linked health improvements to overall social and economic development. Key elements of this document were an emphasis on global cooperation and peace as important aspects of primary health care, along with the need to adapt primary health care practices to the unique circumstances of a country and its local community. Primary health care was upheld as the necessary foundation of a nation's health strategy, with a need to emphasise health promotion and disease prevention. The achievement of equity in health status was a paramount goal, along with the involvement of all sectors as participants in the planning, organisation, operation and control of primary health care, and supported by appropriate education.

This emphasis was expanded with publication of the Ottawa Charter for Health Promotion (WHO 1986), which resulted from the First International Conference on Health Promotion. The Ottawa Charter has been instrumental in shifting the focus away from an individual, disease prevention approach toward the more fundamental, underlying influences on health. The population as a whole, in the context of everyday life, provides the focus, rather than individuals at risk of specific diseases.

The key elements of the Ottawa Charter are to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services. There is a strong emphasis on active community participation, along with acknowledgment of the major role intersectoral partnerships play in enabling positive health outcomes.

The Jakarta Declaration (WHO 1997) grew out of the 4th International Conference on Health Promotion. It aimed to promote social responsibility for health and increase investment for health development through a truly multisectoral approach. The consolidation and expansion of partnerships for health were emphasised, along with increasing community capacity and empowering both communities and individuals. The need for a secure infrastructure for health promotion was recognised, and the consequent need for new funding mechanisms.
A monograph

A population approach to mental health, therefore, promotes health and prevents and intervenes early in the pathways to mental illness through strategies involving individuals, communities and whole population groups. It aims to provide a comprehensive range of high-quality, integrated health-promoting and illness care services, while striving to achieve equity of health status, health-resource allocation, and health service access and utilization across the population. It recognizes, however, that resources are limited and that choices must be made about which services can be offered to whom, and that decisions on allocating resources must be based on evidence and explicit values rather than anecdote, custom or prejudice.

A major national initiative that has occurred through the population health approach in Australia is the development of the National Public Health Partnership Group. This initiative seeks to provide a more systematic and strategic approach to dealing with public health priorities and a way for major initiatives, new directions and best practice to occur. It examines ways in which coordination and collaboration across national strategies can be improved, including a supportive context in which to advance mental health promotion. In doing so, it presents opportunities for collaboration between the mental health and public health systems across policy, administration, service delivery and community settings.

Scientific evidence base

A population health approach must be based on strong scientific evidence. This evidence base needs firstly to contribute to our understanding of the determinants of mental health. However, it should be noted that for effective action it is not necessary to understand the causes of mental health problems and mental disorders; it is still possible to reduce the incidence and duration of disorders without such an understanding (Mrazek & Haggerty 1994).

Marmot (1999) draws attention to the different types of evidence obtainable through a population health approach. Promotion and prevention activities that target the broader socioeconomic determinants of health and mental health, such as community development, are unlikely to be supported by randomised controlled trial evidence—the ‘gold standard’ of scientific evidence—as such trials are simply not possible at this level. Other types of evidence must be sought, including epidemiological evidence. It is important that research focusing on more ‘upstream’ determinants is supported and valued, despite its inherent difficulties (Lindholm & Rosén 2000). The further downstream from the broad social and environmental determinants of health and towards the treatment end of the intervention spectrum, the greater the likelihood of finding evidence at the level of a randomised controlled trial.
The evidence base needs to provide ways to reliably and validly identify the factors that are protective of mental health and promote resilience in both individuals and communities, as well as the factors that place individuals and communities at increased risk of mental health problems and mental disorders. Again, this will enable better targeting of promotion and prevention interventions. Similarly, the early signs and symptoms of mental health problems and mental disorders need to be reliably identified to inform early intervention activities.

Of fundamental importance is evidence supporting a range of effective intervention strategies to promote, prevent and intervene early for mental health. Early detection of problems or potential problems ‘is of value only if effective intervention strategies are available’ (Falloon et al. 1996, p. 272). It is important to determine a variety of effective intervention strategies that are appropriate for the many diverse aspects of promotion, prevention and early intervention, encompassing the different communities, populations and individuals, and developmental stages of life that need to be targeted.

Finally, the evidence base needs to be widely disseminated to all those with an interest in mental health, particularly consumers, carers and relevant workforces, in order to improve their mental health literacy. Workforces also need to be appropriately trained and supported to incorporate advances in the evidence base as part of their practice and service. This requires a number of support strategies including the dissemination of information and ongoing training in new techniques. The availability of guidelines, including clinical practice guidelines, is an important strategy to support the uptake of evidence-based interventions, but needs to be carefully implemented and supported with complimentary activities in order to be effective (NHMRC 1998).

The evidence base for mental health promotion currently confirms 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 & Jans-Lopis 1999; Tilford, Delaney & 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 behavioral 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 & 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 (Mushak & Haggerty 1994; Health Education Authority 1997a, 1997b). There is also evidence from a randomised controlled trial to show that exercise can decrease stress levels in older adults (King, Taylor & Haskell 1993). A number of extensive randomised controlled prevention trials are under way and the United States National Institute of Mental Health is establishing a clearinghouse of such trials at http://www.nimh.nih.gov. Economic data, although limited and derived from US studies, provide evidence of cost-savings. The evidence for early intervention is accumulating, and is particularly promising in the area of early psychosis (Wyatt & Henter 1997; McGorry et al. 1996). A meta-analysis revealed that indicated prevention programs were effective for children and adolescents (Durlak & Wells 1998). There is also some evidence related to the effectiveness of opportunistic early interventions for hazardous and harmful alcohol use (Saunders & Lee 1999). A literature review of early intervention has recently been published (see http://Auseinet.flinders.edu.au/).

Research and evaluation
Research and evaluation are vital contributors to the scientific evidence base. Specifically, two types of research contribute to determining the outcomes of interventions: efficacy and effectiveness studies (Ruggeri & Tansella 1995).

- **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).

- **Effectiveness** studies test the ‘real world’ impact of interventions that have been shown to be efficacious. 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.
Effectiveness studies can easily be confounded by uncontrollable real world factors. These factors include the difficulty in describing, measuring, and maintaining the content and quality of multimodal interventions and in distinguishing between specific and non-specific, and effective and ineffective, intervention elements (Lindholm & Rosén 2000). Effectiveness studies ideally are comprehensive and measure effectiveness along several dimensions, including psychopathology, social functioning and quality of life (McGorry et al. 1996).

The potential confounds of effectiveness studies may be magnified in some communities. For example, in Aboriginal and Torres Strait Islander communities, the complex interplay of social, environmental and psychological factors may extend the timeframes in which the responses to interventions may be evident. Furthermore, the powerful impact of other factors beyond the control of the intervention (such as historical factors) may mitigate the effects of an intervention. These difficulties can result in innovative interventions for disadvantaged and minority groups being omitted from programs considered to have ‘best evidence’ for effectiveness (Hawe et al. cited in Hunter & Garvey 1998). In some instances, selecting programs according to those with the strongest evidence of effectiveness may propagate further health inequities because it is more difficult to attain positive program evaluations in more complex sociocultural settings.

In the evaluation of interventions, not only must their possible beneficial effects be examined, but their potential harmful outcomes must also be explicitly ascertained. It is particularly important to understand the safety and efficacy of prevention and early intervention programs because these interventions will often be applied during benign states; many of the participants targeted in these interventions were not going to develop a disorder anyway, so it is imperative that they are not exposed to any additional risk.

Other key issues for determining the effectiveness of promotion, prevention and early intervention activities are sustainability and integration. It is inappropriate to initiate a one-off intervention program that benefits one small cohort of people. It is similarly inappropriate to identify a group of people with previously unmet need and pass them on to services who have not been integrated into the process and who may not be able to cope with the increased demand. In particular, if screening is undertaken there must be the resources for all those who have been identified as requiring follow-up to receive an effective evidence-based follow-up intervention (NHMRC Australian Health Ethics Committee 1993).
These issues are particularly pertinent given the proliferation of prevention and early intervention pilot programs that are being evaluated in schools. If a program is shown to be effective and appropriate, there is an ethical obligation to have the resources in place to continue to provide the intervention in an ongoing way once the pilot program is complete.

Research and evaluation are required to help formulate and improve intervention programs, to ensure that interventions are effective, and to measure both the short- and long-term consequences. This information needs to be widely disseminated to the broadest possible audience, including service providers and potential consumers. Such dissemination will improve mental health literacy and the support for prevention, promotion and early intervention at all levels across the community. This requires an effective dissemination strategy that crosses service and sector barriers. The uptake of effective techniques and their sustained implementation also requires policy and funding commitment, along with supportive education and training of all the relevant workforces.

**Monitoring and surveillance**

Monitoring and surveillance of the indicators of mental health within populations informs the development of mental health interventions at all levels. At present, better measures of mental illness are available than measures of mental health. However, many researchers are currently concentrating on developing measures of mental health and quality of life (Zubrick et al. 2000c; The WHOQOL Group 1998). Monitoring will be greatly improved when we can identify health outcomes in terms of improvements in mental health along with reductions in mental illness.

Health outcomes are a change in the health of an individual, a group of people or a population group that is attributable to an intervention or series of interventions (Australian Health Ministers’ Advisory Council 1993). Within a population health approach, outcomes are not restricted to measuring disease or illness incidence, but also include social and environmental factors such as changes in employment status, level of education and social capital. There is often a considerable time lapse before changes in health outcomes are apparent, and consequently there is a need for indicators of more proximal measures to assess the outcomes of mental health interventions. Indicators relevant to monitoring the outcomes for promotion, prevention and early intervention for mental health need to focus on the incidence and prevalence of risk and protective factors related to mental health and mental illness, as well as levels of morbidity and mortality within communities and specific population groups.
Indicators need to be specific, measurable, reliable, valid, realistic, practical, cost-effective, evidence-based and ethical (Health Education Authority 1997a). Accurate monitoring and surveillance require information systems that can track the performance indicators for promotion, prevention and early intervention. Performance indicators are operationally defined measures of selected aspects of a system that give some indication of how far it conforms with its intended purpose (Glover & Kamis-Gould 1996). For mental health interventions, the intended purpose should be linked to the needs of the community and consistent with the stated aims of the intervention. Well-defined performance indicators are an important element of successful monitoring activities.

Six key performance indicators fundamental to evaluating the outcomes of the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Action Plan 2000) have been identified. These indicators reflect mental health outcomes that are relevant across all 15 priority groups indicated in the plan (Spence et al. 2000). Data collected will show progress towards the achievement of the primary objectives of Action Plan 2000 at a national level across 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 (see criteria on page 76) relevant to the promotion of mental health and the prevention and reduction of mental health problems and mental disorders by governments and non-government agencies.
Use of these indicators to monitor progress in mental health and mental health interventions will greatly improve the evidence base for promotion, prevention and early intervention and provide vital information regarding the progress of Action Plan 2000. However, as there is often a considerable time lapse before changes in health outcomes are apparent, it is also important to have performance indicators showing that the processes have been put in place that are expected to deliver these outcomes. The following are process indicators that will show that the necessary actions are taking place to implement Action Plan 2000 for all the 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.
The mental health intervention spectrum

A coherent framework for action related to mental health from a population health approach needs to be able to encompass a wide range of activities, describing how they relate to each other, clarifying roles and identifying target groups for specific strategies. The mental health intervention spectrum, put forward by the Institute of Medicine in the United States (Mrazek & Haggerty 1994), provides such a model. It extends earlier models and has been widely adopted in the Australian mental health field as best portraying the continuum of mental health interventions within a population health framework.

Figure 1 presents an adaptation of Mrazek and Haggerty’s original model, revised to incorporate early intervention and reflect the Australian context. The spectrum comprises promotion, prevention, early intervention, treatment and continuing care. The Second National Mental Health Plan recognises that efforts across the entire spectrum of mental health interventions are required to maximise mental health outcomes.

It should be noted that the model presents an idealised conceptualisation. In reality, the boundaries between the various sectors of the model are blurred. Furthermore, 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.

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

Source: adapted from Mrazek & Haggerty (1994).
Mental health promotion

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals.

It aims to protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health. Mental health promotion is relevant across the continuum of care and entire spectrum of interventions—before, during and after the onset of mental health problems and mental disorders. It focuses on the promotion of wellbeing for the entire population—people who are currently well, at risk and experiencing illness.

The term ‘promotion of emotional and social wellbeing’ may be preferred to the term ‘mental health promotion’, due to the strong historical association between the terms ‘mental health’ and ‘mental illness’. The concept of emotional and social wellbeing is compatible with holistic concepts of mental health held by Aboriginal peoples, Torres Strait Islanders and some other cultural groups.

Mental health promotion aims to optimise mental health and wellbeing in communities and thereby in individuals (Neuhauser et al. 1998). It focuses on improving environments (social, physical and economic) that affect mental health and enhancing the coping capacity of communities as well as individuals (Wood & Wise 1997). Examples of mental health promotion are interventions designed to increase the sense of belonging and connectedness within a school or workplace community, programs that support and strengthen family functioning, and programs that promote awareness and acceptance of cultural diversity.

Mental health promotion is applicable across the entire spectrum of mental health interventions and is focused on the promotion of wellbeing rather than illness prevention or treatment. It is based on the premise that the emotional and social wellbeing of everyone in a community can be enhanced through promotion activities that build the community’s capacity to support mental health.
Prevention

Prevention is defined as ‘interventions that occur before the initial onset of a disorder’ to prevent the development of disorder (Mrazek & Haggerty 1994, p. 23).

Although the defined goals of promotion and prevention differ in that promotion activities aim to improve mental health and prevention activities aim to prevent the development of mental health problems and mental disorders, these interventions often adopt similar approaches and produce similar outcomes. Thus, a mental health promotion intervention aimed at increasing wellbeing in a community may also have the effect of decreasing the incidence of mental health problems and mental disorders in that community.

The prevention of mental health problems and mental disorders relies on reducing the risk factors for mental disorder, as well as enhancing the protective factors that promote mental health. The level of risk of an individual developing a mental health problem or mental disorder can be determined by their exposure and vulnerability to risk factors and the presence and strength of protective factors associated with the development of mental health problems and mental disorders.

As indicated in Figure 1, prevention interventions can be targeted universally at the general population, selectively at population subgroups or individuals whose risk of developing mental disorder is significantly higher than average, or as indicated by the needs of high-risk individuals, such as those with the early signs and symptoms of mental health problems and mental disorders. Distinctions between the types of prevention interventions are summarised in Table 3.

Universal prevention interventions are directed towards whole populations that have not been identified on the basis of risk, and are aimed at improving the overall mental health of a population. An example is building connectedness and a sense of belonging, coping skills and hope for the future in school students. Working with a community to reduce risk factors associated with mental disorders, such as low control and high stress levels in a workplace community, is also a universal intervention.

Selective prevention interventions focus on population groups and individuals at higher risk of mental health problems or mental disorders. The level of risk is identified as being significantly higher than average, and may be an imminent or a lifetime risk. Selective prevention interventions aim to reduce the risks to the targeted population. Examples are positive parenting programs in disadvantaged populations, school-based programs specifically targeting young people at risk of depression, and programs for people exposed and at risk following adverse life experiences, such as divorce or bereavement.
Indicated prevention interventions are aimed at population groups and individuals at high risk of the onset of a disorder, who have the early signs and symptoms foreshadowing mental health problems and mental disorders but who do not meet the diagnostic criteria for diagnosis of a disorder. Examples of indicated prevention interventions include programs for children displaying the early warning signs for conduct disorder of aggression and noncompliance, and programs to intervene during the early warning signs for psychosis.

Table 3: Definitions of prevention interventions for mental health

<table>
<thead>
<tr>
<th>Type of prevention intervention</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>Targeted to the general public or a whole population group that has not been identified on the basis of individual risk (Mrazek &amp; Haggerty, p. 24)</td>
<td>Good prenatal care Programs to prevent bullying in schools</td>
</tr>
<tr>
<td>Selective</td>
<td>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 disorders (Mrazek &amp; Haggerty, p. 25)</td>
<td>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</td>
</tr>
<tr>
<td>Indicated</td>
<td>Targeted to 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 (Mrazek &amp; Haggerty, p. 25)</td>
<td>Parenting programs for parents of preschool children who display aggression and noncompliance Programs for children identified at school with some signs of behaviour problems</td>
</tr>
</tbody>
</table>

Source: Adapted from Mrazek & Haggerty (1994).
Early intervention refers to interventions targeting 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.

Early intervention encomasses the "indicated prevention", "case identification" and "early treatment" sectors of the model presented in Figure 1 (Commonwealth Department of Health and Aged Care 1999). It is the early identification of people with emerging signs and symptoms of mental health problems and mental disorders to enable timely, effective and appropriate treatment in order to prevent diagnosable illness and reduce the disability associated with symptoms.

Programs oriented toward early intervention aim to prevent the development of mental health problems or a diagnosable mental disorder by enhancing a person’s protective factors and reducing their risk factors (or the impact of their risk factors), as well as helping them to deal effectively with their current level of symptoms. These interventions occur shortly after a need has arisen, aiming to reduce distress, shorten the episode of care and minimise the level of intervention required. By doing so, early intervention aims to reduce dependency and the disabilities that are often associated with symptoms of mental health problems and mental disorders, as well as enhance hope for future wellbeing (Gardner 1996).

The definition of early intervention includes indicated prevention interventions, whereas universal and selective prevention interventions are defined solely as prevention. This conceptually distinguishes prevention approaches depending on the presence or absence of signs and symptoms of disorder. Universal and selective prevention interventions take place in the absence of any current signs and symptoms of mental health problems or mental disorders, whereas indicated prevention takes place when minimal but detectable signs and symptoms of disorder are present.
Often, however, like the distinction between promotion and prevention, the distinction between prevention and early intervention is not clear-cut, particularly given the near-impossibility in most cases of pinpointing the start of the early signs and symptoms of mental health problems and mental disorders. Early intervention may occur at any stage of life, from childhood to old age; its distinguishing feature is that it occurs early in the developmental pathway to mental disorder. Early intervention does not, in this context, refer specifically to interventions early in childhood. Early intervention aims to prevent the progression into diagnosable disorder of emerging signs and symptoms; for people developing or experiencing a first episode of mental disorder, it aims to reduce the impact of the disorder, in both its duration and the damage it may cause to a person’s life.

**Treatment**

Treatment is made up of early intervention, in the form of proactive case identification for first episodes of disorder and case identification more generally, along with standard treatment for diagnosed disorders. Case identification refers to individuals identified and diagnosed in clinical settings or clinical outreach. Early and reliable recognition of disorder is the primary goal. Standard treatment involves the application of effective, evidence-based treatments for individuals with diagnosed disorders. The aim is to provide the most effective treatment to achieve the fullest possible recovery.

**Continuing care**

Continuing care comprises interventions for individuals whose disorders continue or recur. The aim is to provide optimal clinical treatment and the necessary rehabilitation and support services in order to prevent relapse or the recurrence of symptoms, and to maintain optimal functioning to promote recovery. Rehabilitation may focus on vocational, educational, social and cognitive functioning. Ongoing mental health promotion, the reduction of risk factors and the enhancement of protective factors are still relevant at this end of the spectrum, to facilitate and support recovery and ongoing wellbeing.

**Relapse prevention**

Relapse prevention refers to interventions in response to the early signs of recurring mental disorder for people who have already experienced a mental disorder. Relapse prevention is a critical issue for this group of people, their families, mental health services and the wider community. Recognition of the early signs of recurrent disorder and the appropriate treatment responses comprise a unique area of investigation.
In this paper, the term ‘early intervention’ is not applied to relapse prevention. While many of the issues related to early intervention are also relevant to relapse prevention, there are many issues unique to relapse prevention that are not covered in this document.

Some of the issues that distinguish relapse prevention from early intervention include the possibility that quite different factors may influence the relapse and recurrence of a disorder than those that influence its onset (Zubrick et al. 2000a). For example, a determinant of the onset of conduct disorder in children may be poor foetal growth (Zubrick et al. 2000b; Breslau 1995) while determinants of the persistence of this disorder at the time a clinician sees the child may be poor parental monitoring and a deviant peer group (National Crime Prevention 1999). These latter determinants from part of the prognosis for treatment while the former determinant, now no longer amenable to treatment, is an early risk factor and target for prevention.

Factors related to the early detection of recurrent disorder can be quite different to those related to the early detection of first episodes of disorder (McGorry et al. 1996; Yaglou 1996). Fundamentally, relapse prevention involves people who have already experienced a mental disorder and generally have been in contact with services. Ongoing engagement with services and longer term monitoring become important issues. Once a diagnosis has been made and accepted, improvements to mental health literacy can be targeted to the specific disorder, and appropriate consumer and support groups can be accessed.

Furthermore, standard treatments for recurrent disorders may differ from preferred treatments for the early signs and symptoms of mental health problems and mental disorders and first episodes of disorder. Specifically, pharmacological therapies are not the preferred treatment for most mental health problems and first episodes of disorder, particularly if, as is likely, the mental health problem or first episode of disorder takes place early in the lifespan. The safety and efficacy of many pharmacological interventions have not been established for children and young people.

In summary, many of the issues for promotion, prevention and early intervention for mental health raised in this document have relevance for relapse prevention. However, there are sufficient distinctions to warrant a separate consideration of relapse prevention. The focus in this document is on interventions early in the pathway to mental health problems and mental disorders. As an equally high priority, relapse prevention requires separate treatment that deals with the issues later in the pathways of mental disorders.
CHAPTER 4:
Promotion, prevention and early intervention for mental health

Mental health and mental illness result from the complex combinations of events and conditions that occur in everyday life across all of life’s domains—biological, individual-psychological, social-psychological and structural. It is the interplay between the individual and the environment that is critical, and effective promotion, prevention and early intervention activities are based on this premise.

Some of the most important environmental influences on mental health are opportunities that enable people to exercise control over their lives, to use their skills and to engage in supportive social interactions. It is also important for individuals, groups and communities to be able to set goals and experience a variety of opportunities. Having a valued social position, an adequate income and physical security are also fundamental to mental health (Lehtinen, Rihonen & Lahtinen 1997). High levels of these influences promote emotional and social wellbeing, while low levels may be harmful.

These influences on mental health and mental illness occur in the events and settings of everyday life and, as a consequence, promotion, prevention and early intervention for mental health need to take place beyond the traditional mental health, or even health, sectors, that is, in all the sectors that are part of and impact on people’s daily lives.
Strategic sectors for promotion, prevention and early intervention

To impact effectively on the determinants of mental health it is necessary to identify the sectors, settings and people that have relevant roles. Table 4 (page 38–39) presents the many and diverse areas of life that have major influences on mental health determinants. It should be noted, however, that many of the settings and people categorised in this table fit within more than one sector; although this is not shown in the table. For example, drug and alcohol services could be classified as being within the health, mental health, education, welfare and correctional sectors. The difficulty in clearly placing settings and people within specific sectors reflects the fundamentally multifactorial nature of the life issues that such services deal with.

Identifying the key strategic sectors, settings and people that contribute to particular mental health outcomes is a critical first step for successful promotion, prevention and early intervention. The sectors, settings and people that are identified need to be engaged as partners in any mental health interventions. The range of intersectoral and intrasectoral partners participating in an intervention, and their relative importance, will depend on the focus of the intervention and the target population groups involved. In all instances, however, a broadly based, cumulative and community-driven process is critical. Partnerships for effective promotion, prevention and early intervention need to extend across all relevant sectors to encompass all those people, groups, services, organisations, policies and practices that impact on the everyday life events that influence mental health.

Mental health promotion—principles and strategic approaches

Mental health promotion is concerned with enabling people to maximise their wellbeing through influencing the environmental determinants of mental health. These determinants are broadly based in all aspects of life and, as a consequence, the gains from mental health promotion activities generalise to improvements in physical health as well as productivity in the school, home and workplace. It is important to recognise that health promotion is a process: a process aimed at giving power, knowledge, skills and necessary resources to individuals, families, the community and whole populations (European Commission 1999).

Traditionally, health promotion interventions have been targeted either within defined settings (such as schools, workplaces or cities) or with identified population groups (such as older adults or young people); inevitably, programs and strategies cross boundaries. Some are setting-based, others are population-based, while others straddle both.
Effective mental health promotion leads to changes in the determinants of mental health, both those within the control of individuals, such as health behaviours and the use of health services, and those outside their direct control, such as social, economic and environmental conditions (European Commission 1999). The five main strategies of action for mental health promotion are building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and expanding the orientation of health services (WHO 1986). Comprehensive approaches that use combinations of these five strategies are more effective than single-strategy approaches.

Public policy that promotes mental health

Actions that affect mental health occur at all levels: international, national, regional, local, community, family and individual. They also occur in all sectors of life: home, childcare, education, health, welfare, housing, community, employment, financial, corrections and the media. Public policies at all these levels and in all these sectors impact on mental health.

There are two major principles for developing public policy that promotes mental health. The first recognizes that policies at all levels and in all sectors need to consider their impact on mental health. The influences on mental health are so pervasive that most public policies will have some impact on mental health. It is important that the mental health consequences of policies are explicitly considered and that policy makers at all levels accept responsibility for the consequences of their decisions.

Often policies have unintended negative impacts on mental health. For example, a policy in the education sector aimed at saving money by reducing administration costs in schools may result in larger schools. Larger schools may make it more difficult for students to develop a sense of belonging to their school and this is a risk factor for mental health problems. Larger schools may also make it more difficult to identify early students at risk and effectively intervene with them to prevent the development of mental disorders.

Accordingly, the potential mental health consequences of policies need to be identified and clarified. Alternative policies that achieve the same outcomes, but without the negative mental health consequences, may need to be considered. If no suitable alternative policy is identified, additional procedures or services may be put in place, alongside the new policy, to ameliorate the negative mental health consequences.
### Table 4: Key strategic sectors, settings and people for mental health partnerships

<table>
<thead>
<tr>
<th>Sector</th>
<th>Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>homes, family daycare, childcare centres</td>
</tr>
<tr>
<td>Childcare</td>
<td>Homes, family daycare, childcare centres</td>
</tr>
<tr>
<td>Education</td>
<td>preschools, schools, tertiary institutions, adult education, University of the Third Age, Open Learning</td>
</tr>
<tr>
<td>Health</td>
<td>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</td>
</tr>
<tr>
<td>Welfare</td>
<td>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</td>
</tr>
<tr>
<td>Housing</td>
<td>housing services (including Supported Accommodation Assistance Program), refuges and shelter, residential aged and disability care settings, retirement villages</td>
</tr>
<tr>
<td>Community</td>
<td>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</td>
</tr>
<tr>
<td>Arts, sport and recreation</td>
<td>arts, sport and recreational settings</td>
</tr>
<tr>
<td>Employment</td>
<td>public and private sector workplaces (especially identified high-risk occupation workplaces), occupational rehabilitation settings</td>
</tr>
<tr>
<td>Financial</td>
<td>financial services, insurance services</td>
</tr>
<tr>
<td>Corrections</td>
<td>courts, juvenile and adult correctional services, juvenile and adult correctional institutions</td>
</tr>
<tr>
<td>Media</td>
<td>radio, television, print and newspaper offices, advertising and production agencies, computerised services such as the Internet</td>
</tr>
<tr>
<td>Government</td>
<td>local, state and territory, national</td>
</tr>
</tbody>
</table>
People—individuals and groups

- children, parents, families, carers, support groups
- carers and their families, management and administration, policy makers, professional organisations, researchers
- students, teachers, academics, counsellors, curriculum developers, support staff, management, administration, policy makers, professional organisations, researchers
- clients/patients, 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, 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, administration, policy makers, shareholders, professional organisations
- offenders, parole, youth workers, parole and probation officers, correctional officers, legal profession, policy makers, professional organisations
- politicians, editors, cartoonists, photographers, policy makers, employers, professional organisations
- policy makers, administrators, local members, ministers, lobbyists
The second major principle for the development of public policy that promotes mental health is that the impact of policy made in one sector must be considered within other sectors. All aspects of life are inextricably interlinked, and policies made in one sector can have far-reaching implications. For example, the previously mentioned hypothetical education sector policy aimed at saving money by reducing administration costs in schools may result in fewer schools. Fewer schools may mean that fewer communities have a local, neighbourhood school, and consequently the community sector may be adversely affected. Local schools provide an important focal point for a community in many ways. Children, parents and citizens interact within the school environment and develop community links. School teams represent the local community and provide a source of identification and sense of belonging. On a more practical level, local school facilities are used by other community groups. The loss of the local school takes away an important link to the local community and may adversely affect the community’s sense of connectedness, which is important to the mental health of the community and its individual members.

It is especially important for those concerned with promoting mental health to consistently monitor the impact of decisions and actions falling outside the mental health sector. Of particular concern are decisions in the mainstream health, welfare, education and justice sectors. Policy and funding decisions can be cross-checked to ensure that these sectors are not pursuing goals that may actively work against each other. Specific examples of just a few of the policy areas that have mental health implications include the provision of daycare subsidies for low-income families, flexibility in work schedules to accommodate family needs, paid maternity leave, parental leave, provision of high-quality early childhood education for disadvantaged families, universal antenatal screening, and follow-up of mothers at risk of postnatal depression.

Effectively implementing the two principles of healthy public policy requires communication and partnerships between sectors. Policy-making processes need to ensure consultation with all potentially related sectors to create seamless intersectoral approaches to public policy. Rigid funding models and policy developments that are sector-specific need to be discouraged, as these are counterproductive to producing public policy that promotes mental health.
Creating supportive environments

Supportive social, economic, cultural and physical environments provide a basic framework for developing and maintaining mental health. This includes providing for the physical needs of a community as well as creating a sense of belonging and the ability to participate in the social world. Environments that recognise and accept diversity and encourage mutual responsibility also contribute to social and emotional wellbeing.

At the most basic level is the need to create peaceful and safe communities in which to live. The absence of war and conflict are fundamental to emotional and social wellbeing. Yet even in peaceful communities there are opportunities to create safer environments by reducing the rates of crime, violence and vandalism. At the more micro level of schools and workplaces it is important to implement strategies, such as anti-bullying schemes, to reduce the rate of physical and verbal abuse. Enhancing the safety of environments not only increases people’s feelings of safety but also encourages the use of these environments (such as public space, parks and streets). This may increase participation in community activities, enhancing a sense of belonging and supporting mental health.

Improving the physical environment through infrastructure promotes mental health. Good public transport, affordable and accessible leisure activities, availability of adequate housing, the provision of work and workplaces, schools, libraries, local shops, health care services, and businesses forging close ties with the community all contribute to the emotional and social wellbeing of a community. Supportive physical environments are those that service the social, emotional, physical and economic needs of a community. They are also environments that are attractive, encourage meaningful participation, and are free from vandalism and danger.

The social environment can also be enhanced to promote mental health. Social support, strong social networks and a sense of integration and inclusion are key predictors of mental health. Loneliness and isolation reduce people’s ability to cope with stressful life events and increase the risk of mental illness and suicide. To encourage participation, social environments need to be inclusive. To do this they need to be non-discriminatory: to not stigmatise or alienate any groups or individuals and, instead, enable and encourage access by all members of the community (Mind 1999).

It is especially important for environments to be supportive of parents and families, as early childhood experiences within the family form a platform for later mental health. Mental health-promoting workplaces can create supportive environments in which individuals and families can actively participate in a meaningful way. Family-friendly work practices enable parents to participate in the workforce while also providing for their family’s needs. Affordable, accessible
and high-quality childcare also enables families to participate fully in their communities. Community structures can support families, through providing safe communities within which to live and grow and the support services and infrastructure that families need to function optimally.

Strengthening community action

A healthy community is one where people feel empowered to take control over their daily lives and where people feel involved, included and able to influence the decisions that affect them (Health Education Authority 1998). A growing body of research demonstrates that the strength of community life, or ‘social capital’ within a community, is profoundly important to people’s overall sense of emotional and social wellbeing (Wilkinson 1996).

Communities with high levels of social capital are characterised by trust, tolerance and reciprocity (Kawachi, Kennedy & Lochner 1997). They offer a wide range of diverse networks that provide many opportunities for mutual support and participation at all levels, along with the exchange of skills and information. Empowered communities work with government and all other sectors to attain the goals that the community itself has set.

Community action is strengthened by enabling all sectors within the community—individuals, groups and organisations—to participate in community decisions. It is particularly important to incorporate those groups that may otherwise be disenfranchised, as there are barriers to community participation for many people. Language can be a major barrier. Groups and individuals that are not members of the dominant mainstream culture are also more likely to be excluded from community action. Age, gender, disability and illness, social status, cultural background and level of education can also exclude people from community participation.

Effective community participation requires knowledge, skills and resources, along with the absence of discrimination and stigma. Strategies need to be developed to ensure that all members of the community have the necessary knowledge, skills and resources to support active participation. More than this, there needs to be a culture of acceptance and tolerance, of welcoming difference, and a willingness to work together to find acceptable solutions to community issues.

Community education is an important strategy to strengthen community action. The goals of community education are to raise awareness, increase knowledge and provide information and skills training. Community education aims to change values, attitudes, beliefs, skills and behaviours and empower members of the community to take action for themselves.

Community education is a tool that can be used to strengthen social capital.
Improved mental health literacy is a potential positive outcome of community education. Mental health literacy includes knowledge of ways to seek mental health information, factors that are protective of and risks to mental health, the availability and efficacy of self-treatments and professional help as well as the ability to recognise specific disorders. It involves attitudes and beliefs that promote recognition of mental health status and appropriate help-seeking behaviour (Jorm et al. 1997). Good mental health literacy means having accurate, non-stereotyped information related to mental health and mental illness. Improving mental health literacy within a community can empower and enhance community-based action supporting mental health.

Role of the media

The media has a major role to play in community education regarding mental health. The media forms an integral part of our society by being a major source of information and a powerful influence on public opinion (Commonwealth Department of Health and Aged Care 1999). Media coverage and reporting is critical to mental health literacy, particularly through forming community attitudes to mental health and mental illness, and to people affected by mental illness.

The critical role of the media in forming attitudes related to mental health is evident in the growing body of evidence showing that media accounts of mental illness that instil fear have a greater influence on public opinion than direct contact with people who have mental illness (Bhui et al. 1997). Electronic and print media coverage often reflects and perpetuates the myths and misunderstandings associated with mental illness (Hyde, Gabbard & Schneider 1991). Dramatic effects, comical buffoon-like portrayals, sensational story lines and headlines, and a focus on dangerousness and unpredictability all serve to contribute to the pervasive negative perceptions of people with mental illness (Williams & Taylor 1995).

Consequently, the media can be encouraged to promote the accurate reporting and portrayal of people with mental illness and thereby potentially reduce the stigma and discrimination that substantially adds to the burden of mental illness. A major initiative in this direction put out under the Mental Health Promoting Media Strategy is Achieving the Balance—a Resource Kit for Australian Media Professionals for the Reporting and Portrayal of Suicide and Mental Illnesses. Importantly, this kit specifically acknowledges the effect that media publicity has on suicidal behaviour in the community (Martin 1998a; Gould & Schaffer 1986).

The Mental Health Promoting Media Strategy aims to promote mental health literacy in the community, reduce stigma and discrimination to promote recovery and understanding of mental illnesses, and incite appropriate early help-seeking behaviour for mental health problems and mental disorders.
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 racism and discrimination. The media has a major role in promoting the acceptance and valuing of diversity within our communities, reducing the stigmatised portrayals of particular groups of people and encouraging a social climate that is inclusive and supports the mental health of all people.

**Developing personal skills**

Mental health is a resource that enables individuals to manage their lives successfully. It is underpinned by emotional and social skills. Increasing the emotional resilience of individuals benefits the mental health of the entire community. Mental health promotion acknowledges the importance of psychological processes: how people think, feel, interpret the world and communicate affects interactions and experiences at all levels. Mental health promotion, therefore, incorporates the development of personal skills to enhance emotional and social wellbeing (Health Education Authority 1998).

Personal skills include the ability to manage change, and to recognise, acknowledge and communicate thoughts and feelings, both positive and negative. Also vital is the ability to make and maintain relationships. Resources and skills are needed to cope with stress and adversity, to modify the environments or relationships that cause stress, and to overcome mental health problems. Individuals need to have feelings of self-worth and empowerment, the belief that they can control and influence their life experiences. However, it is also important to accept that mental health problems and mental disorders do occur, in both ourselves and other people, and that the associated burdens can be overcome.

The personal skills that support mental health can be developed through mental health promotion interventions at a number of levels. Fundamentally, major achievements in mental health can be attained by improving the environments that affect the development of resilience in children. Examples of such strategies include parenting skills programs (particularly for the parents of at-risk children), quality childcare, family-friendly work practices, and life-skills training in learning to solve problems and have an optimistic outlook.
Incorporating promotion, prevention and early intervention within health services

Although it is clear that much of the activity in mental health promotion needs to be undertaken outside the health sector in the other sectors that impact on the daily lives of individuals and communities, there is still much that the health sector itself can achieve. This requires health services to focus on promoting health along with treating illness. However, a major shift is needed in philosophy and resource allocation to enable health agencies to embrace mental health promotion.

Hunter (1997) notes that the limited resources allocated to mental health have historically been used for ‘treating victims’ and it is not surprising that there has been little left over for initiatives earlier in the intervention spectrum. Mental health promotion represents a different focus from traditional approaches to mental illness. Agencies planning to incorporate such new directions inevitably face problems in prioritising and allocating sufficient funds ahead of other options. It is imperative that a balance is achieved in allocating resources across the entire spectrum of mental health interventions (Mrazek & Haggerty 1994).

Health services can incorporate mental health promotion with the support of three main strategies. The first of these is the developing evidence base showing that mental health promotion works (Health Education Authority 1997b, 1999; Davies & Macdonald 1998). This evidence base needs to be further developed through research, evaluation, monitoring and surveillance. The best possible evidence needs to be obtained and then widely disseminated throughout the community, not only to health researchers but to all sectors of the community. When all sectors are aware of the benefits of mental health promotion, there will be greater support at all levels for prioritising mental health promotion activities.

A second strategy involves encouraging a longer term and whole-of-lifespan perspective on outcomes related to mental health and mental illness. The positive effects of mental health promotion take some time to be evident, particularly at the community level but also at the individual level. Furthermore, the positive effects of living in communities that promote mental health are evident in different ways across the lifespan; for example, for children they may be evident in better attachment patterns while for older adults they may be shown through greater community participation. When it is widely recognised that mental health promotion is a long-term investment in the future health of the whole community, it is more likely to be supported. This requires sustained efforts by individuals, groups, organisations, communities and governments at all levels and in all sectors.
Education and training

Mental health promotion requires different skills and approaches from those traditionally available in the health sector, where the focus has been primarily on treatment. Without the development of these skills, it will be difficult to inaugurate and sustain mental health promotion interventions. The third important strategy is therefore educating and training the workforce to engage in mental health promotion.

Mental health promotion requires skills to work with populations and communities as well as individuals, using strategies outside the mainstream mental health sector, such as policy development, community development and empowerment, and interventions focusing on improving physical and social environments. It requires high-level liaison and communication skills to engage and facilitate the participation of diverse sectors.

While much of the impetus for mental health promotion 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. For example, the health, education and corrections sectors have acknowledged interest in the mental health of communities and individuals. The skills for mental health promotion may, therefore, also be available or developed within these and other sectors outside the health sector.

Research and evaluation

Research and evaluation are critical to the advancement of mental health promotion. However, there are some major challenges in this regard. Mental health promotion focuses on actions and processes and does not necessarily directly address mental health outcomes (Lehtinen, Riihonen & Lahtinen 1997). The health outcomes achieved by mental health promotion initiatives may not be evident until several years after their implementation. Evaluations of mental health promotion initiatives targeting whole population groups may not always include mental health or mental ill health outcome measures, and may instead focus on measures of the hypothesised risk and protective factors and processes. 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 projects across communities are required to build a solid evidence base for mental health promotion.

Especially relevant to advancing knowledge regarding mental health promotion 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). To fully assess the wide range of activities that comprise mental health promotion, there is a need not only for quantitative evaluative approaches common in epidemiology, but also the use of qualitative approaches drawn from other fields of inquiry such as policy analysis and organizational change (Health Education Authority 1997b).

**Prevention—principles and strategic approaches**

The prevention of mental health problems and mental disorders depends on identifying and modifying the determinants of mental health and mental illness. Effective prevention requires an understanding of the risk and protective factors for mental health, identification of the groups and individuals who can potentially benefit from interventions, and the development, dissemination and implementation of effective interventions.

**The nature of risk**

During the past thirty years a growing body of research has revealed some of the risk factors that predispose children and adults to mental health problems and mental disorders. Tables 1 and 2 present the risk and protective factors generally accepted, although with varying degrees of supportive evidence, as contributing to the development of mental health problems and mental disorders.

Risk factors are variables or characteristics associated with an individual that make it more likely that she or he, as opposed to another person selected randomly from the population, will develop a problem (Mrazek & Haggerty 1994). Risk factors:

- exist before a mental health problem or mental disorder;
- may be time-limited or continuous over time;
- can derive from the individual, the family, the community, institutions or the general environment and wider society; and
- can play a causal role or be a marker for a problem.

Risk factors can reside within the individual or within the family, social network, community or institutions that surround the individual. They can be biological or psychosocial in nature. They occur within the context of everyday life: they are found in perinatal influences; in family relationships and the home; in schools and workplace; in interpersonal relationships of all types; in sport, 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.
The notion of risk reduction as a prevention strategy comes from a medical, epidemiological and public health perspective. Such a perspective seeks to identify internal (heredity, biological, behavioural) and external (environmental, socioeconomic, demographic) risk factors and minimize their impact on the individual, family and community (Health Canada 1997).

Some risk factors play a causal role in mental illness. For example, being raped or being in active combat have a causal role in the development of post-traumatic stress disorder. If causal risk factors can be targeted in an intervention and are able to be modified, the risk of onset of the disorder can be reduced. However, the underlying causal processes are not always known before undertaking an intervention study.

Other risk factors are markers that an individual is at increased risk of a mental health problem or mental disorder, but are not of themselves causal. For example, women in the perinatal period are at increased risk of mental health problems because of the many changes they are experiencing, physically, emotionally and socially. Such risk factors are not necessarily causal, but can identify populations and individuals where prevention interventions can be targeted.

The identification of risk factors and an understanding of their nature set the parameters for intervention programs. Some risk factors, like age, gender and inherited conditions, cannot be modified. Other risk factors can be modified; some of these are under the control of the individual, for example behavioural factors such as diet and exercise, while others are at a more macro level and are not under the control of the individual, although they may be under the control of other agents (such as governments), for example socioeconomic conditions affected by welfare policy.
Risks across the lifespan

Variables that are risk factors at one life stage are not necessarily so at another. For example, the effect of gender as a risk factor varies across the lifespan. In childhood, although boys are not exposed to more risks than girls are, they appear to be more vulnerable to the negative effects of physical and psychosocial stressors. In adolescence, girls appear to be more vulnerable to the negative effects of psychosocial stressors, and males are again more vulnerable in early adulthood. Developmental processes contribute significantly to the mechanisms by which risk factors are translated into mental health problems and mental disorders. Research into the developmental nature of risk factors provides an essential tool for unravelling the ways that risk factors evolve and contribute to the establishment of behavioural and emotional disorders.

Early in life, children exposed to many of the risk factors presented in Table 2 are in particular need of prevention interventions. Specifically, low birthweight and prematurity, adverse prenatal variables (such as drug or alcohol use during pregnancy), difficult temperament, low intelligence, chronic physical illness or neurophysiological deficits, early language difficulties, and gender have been identified as markers of vulnerability in childhood (Health Canada 1997). Emotional and physical neglect and abuse in childhood greatly increase vulnerability to mental health problems and mental disorders both in childhood and later in life, and inhibit the development of emotional resilience in children.

Many children who are at increased risk of developing mental health problems and mental disorders can be identified by the services to which either they or their parents are connected. This includes children whose parents have a mental illness (Cowling, McGorry & Hay 1995), whose parents are incarcerated (Standing Committee on Social Issues 1997), whose parents have drug or alcohol problems, who are in care settings (Cashmore & Pannin 1996) and who are experiencing major life events (especially religious) and family disruption.

Although the life stages of adolescence and young adulthood are periods of particular vulnerability to mental health problems and mental disorder, within these age groups there are some young people who are at even greater risk as a consequence of their exposure to risk factors. Young people involved with the criminal justice system, especially if they are incarcerated, are at very high risk (National Crime Prevention 1999). Young people from Aboriginal or Torres Strait Islander backgrounds who are incarcerated are at an even greater level of risk (Royal Commission into Aboriginal Deaths in Custody 1991).

1. Note that Auseinet has recently described clinical approaches for the psychological adjustment of children with chronic conditions (Swanson, Williams & Naun 2000).
In adulthood, women in the perinatal period are at much increased risk of mental health problems and mental disorders, specifically postnatal depressive disorder. Adults, in general, tend to be most at risk through exposure to life events. Losses and psychological trauma contribute to the development of disorders in adulthood, along with physical illness. For older adults, losses and bereavement become more prevalent, as do physical disorders and disabilities, all of which are risk factors for mental health problems and mental disorders. Of particular significance for older adults is moving to a nursing home or aged care hostel, which is a marker for increased risk of mental health problems and mental disorders (Amer 1993).

A common theme running through many of these risk factors is the importance of life transitions. Periods of major life change appear to be sensitive periods when vulnerability to mental illness is heightened. Some major life changes are unexpected, such as natural disaster, unemployment, bereavement and family disruption. These cannot be planned for, but procedures can be put in place to enable rapid response when they do occur. Many transitions are, however, predictable in their timing, like starting school, moving from primary to high school, starting a career, childbirth and retirement, these can be identified and targeted for prevention interventions. Such transitions are generally specific to particular stages of the lifespan, so knowledge of how, where and when resilience and risk factors emerge is critical. Selective prevention interventions can be targeted to the population groups and individuals exposed to known risk factors at particular stages of the lifespan.

Due to the nature of human developmental processes, prevention interventions at one stage of the lifespan can have multigenerational effects. For example, prevention interventions for new mothers can improve the mental health of both the mother and child. Effective prevention earlier in the lifespan—targeting children, young people and young adults—can also have multiple ongoing positive benefits. Firstly, it can affect the lives of the young people themselves and enable them to develop into more effective and productive adult members of their communities. Secondly, it can break the generational cycle of mental health problems and mental disorders by enabling people to become more effective parents, thereby reducing the risks for the next generation of children.
Potential problems in a risk approach

It should be noted, however, that risk factors have limitations as predictive tools (Jonah 1996). Firstly, the extent to which any particular risk factor contributes to the development of a mental health problem or mental disorder is not always certain, as risk is based on probability. Not everyone who is exposed to a risk factor will have an adverse outcome. Risk factors tend to be ‘associated with’ negative outcomes. In most cases it is inaccurate to assume a cause and effect relationship. Risk is a relative concept; some risk factors are markers to minimally harmful situations while others mark life-threatening situations (Health Canada 1997).

Furthermore, for some risks there is an element of choice, while for others there is none. The Canadian Association of Gerontology (see Health Canada 1997, p. 8) identifies personal risks on a continuum as follows:

| risk pursued as opportunity | freely accepted risk | reluctantly assumed risk | with little or no choice |

Thirdly, the process of identifying risk can be biased. Risk is not a neutral concept; decisions regarding what are acceptable or unacceptable levels of risk are subjective. Those decisions include deciding what is a ‘normal’ level of risk for a particular factor and what is an unacceptable level. This bias can extend to assigning higher levels of risk to particular communities or subgroups of the population because they are different from the ‘mainstream’. The level of exposure of different groups in the population to particular risk factors is often unknown, yet assumed.

The generalized use of the ‘at risk’ label is highly problematic and implicitly racist, classist, sexist and a 1990s version of the cultural deficit model which locates problems or ‘pathologies’ in individuals, families, and communities rather than in institutions and structures that create and maintain inequality. (Oeaden & Labch 1995, p. 3)

The process of ascribing risk can be disempowering for consumers, as the assessment of risk factors is often carried out by services. Asking people themselves what is important with regards to their mental health can generate factors very different from those determined by a service provider. Interventions can be paternalistic or beneficent and at odds with the concepts of consumer empowerment or participation. A risk focus concentrates on weaknesses rather than strengths, and can encourage an approach akin to ‘rescuing’ those in need. Alternatively, there is a danger that enforced intervention will be seen as desirable or even necessary; for example, there are advocates of the enforced treatment of pregnant women whose unborn children are at high risk of fetal alcohol syndrome.
Risk factors interact, and multiple and persistent risk factors predict more strongly than any individual risk factor (Mrazek & Flaggerty 1994; Fraser 1997). Addressing a single risk factor or having a short-term orientation to prevention is likely to be ineffective. These types of simplistic approaches are all too common and derive from and underlie the fragmented, sector-specific nature of many services. Structural barriers can hinder intersectoral approaches and impede more multifocused, holistic and intersectoral prevention interventions.

If risks are improperly identified, interventions can be targeted at the wrong factors. At best such interventions may be ineffective and a waste of scarce resources; at worst they may exacerbate other risk factors. An example of an intervention that may increase risk is the premature removal of children from their families in response to perceived risk and placing them in foster care or institutions. The stolen generation of Aboriginal children resulted from a biased, misguided, paternalistic and racist decision to remove part-Aboriginal children from the ‘risks’ associated with growing up within Aboriginal culture and provide them with the ‘benefits’ of being assimilated into the ‘dominant’ culture. The disastrous and multigenerational outcomes of this intervention are now evident.

It is also important to understand that interventions grouping together people at risk of developing a particular disorder can be problematic. For example, grouping children or young people identified as being at risk of developing conduct disorders or drug misuse can exacerbate the very behaviours that the interventions are designed to reduce (Spence 1996a). Bringing together groups of high-risk individuals for prolonged periods of time can enable the group to establish its own subculture and norms that increase the likelihood of the problem behaviours developing.

Finally and importantly, a risk approach focuses on the negative. While reducing risk factors where possible, and enabling people to better cope with the risk factors that they cannot modify, is integral to prevention interventions, a concomitant focus on improving protective factors greatly enhances the effectiveness of interventions.
Protective factors

While traditionally there has been a focus on risk factors, protective factors are increasingly being emphasised for prevention interventions. Like risk factors, protective factors derive from all domains of life, from the individual, family, community and wider environment. Many of the commonly accepted protective factors are presented in Table 1. Some protective factors are internal, such as a person’s temperament and level of intelligence, while others are external, related to social, economic and environmental supports. Protective factors enable individuals to maintain their emotional and social wellbeing and cope with life experiences and adversity. They can provide a buffer against stress as well as a set of resources to draw upon to deal with stress.

Although there are many different kinds of protective factors, four distinct protective ‘processes’ are consistently cited in the literature (Rutter 1987). The first includes processes that alter exposure to a risk condition. For example, consistent parental supervision can reduce children's exposure to risky situations (Hawkins, Catalano & Miller 1992). Second is the reduction of risk impact (harm minimisation), reducing the negative chain reactions that can occur after exposure to risks. An example is enabling children whose parents are going through a divorce to remain at their current school and keep their social relationships intact. Third is the development of resilience through promoting self-esteem and self-efficacy. Self-efficacy is a belief or confidence in one’s effectiveness, and high self-efficacy enhances adaptive behaviour (Bandura 1977). Secure relationships, a sense of belonging to family and school success contribute to self-efficacy in children. Finally, the availability of opportunities is a protective process. People who have a wide variety of options in life are able to make choices to suit their particular needs at any given time. Opportunities that enable educational attainment and employment success have a major protective effect on mental health.

The relationship between risk and protective factors is complex. It is not simply the presence of risk and protective factors, but their interaction and the accumulation of factors over time that affects the development of mental health problems and mental disorders. Resilience to mental health problems and mental disorders is not a static characteristic, but rather a process of coping. It consists of the balance between stress and adversity on one hand and the ability to cope and availability of support on the other: a complex and changing balance between risk and protective factors. When stressors exceed the individual’s protective factors, even individuals who have previously been resilient may be overwhelmed (Mangham et al. 1995). Nevertheless, individuals high on protective factors are better able to cope with adversity.
Types of prevention interventions

As described in Table 3, prevention interventions can be targeted according to different levels of ascribed risk within populations. Indicated prevention interventions are targeted to people at the highest level of ascribed risk: those who are already above the threshold for disorder because they are showing the early signs of mental health problems and mental disorders. Selective interventions are targeted to population groups at higher than average risk of developing mental health problems and mental disorders, while universal prevention strategies are targeted to whole population groups regardless of their level of risk. Both selective and universal prevention strategies aim to reduce the population risk to reduce the number of people who are above the threshold for mental health problems and mental disorders (Hart 1999).

Universal prevention interventions target the general public or a whole population group that has not been identified on the basis of individual risk. They are based on the premise that it is not necessary to be able to identify the specific individuals at risk within the population in order to help them; rather, interventions aim to shift the distribution of risk so that at any time fewer people are over the threshold for mental health problems and mental disorder (Hart 1999; Rosenman 1998). Universal interventions are deemed to be desirable and risk-free for everyone within the population group (Mrazek & Haggerty 1994). Due to their wide scope, universal interventions generally have low cost per individual and are acceptable to the members of the population within which they are being implemented.

Selective prevention interventions target population subgroups whose risk of becoming ill is above average. Population subgroups at higher risk can be distinguished by characteristics such as age, gender, occupation, or exposure to known risk factors (like divorce or living in a disadvantaged community). Individual pathways to mental health problems and mental disorders are not predicted very well by these types of risk factors, but the probability that any individual exposed to them will develop a mental health problem or mental disorder is above average; consequently they can be a guide for more targeted interventions. Selective interventions generally do not exceed a moderate level of cost and the potential negative effects are minimal or nonexistent (Mrazek & Haggerty 1994).

Indicated prevention interventions target individuals who have risk factors or early warning signs that identify them as being at very high risk for developing a mental health problem or mental disorder. Indicated prevention is distinguished from both universal and selective prevention interventions by its focus on individuals, rather than population groups. It is concerned with people who are above the threshold for disorder, showing the early signs of mental health problems and mental disorders, rather than people who are currently non-symptomatic and below the threshold. For this reason, indicated prevention is incorporated within early intervention in this document.
The importance of the prevention–intervention research cycle

The uptake of a prevention approach to mental health problems and mental disorders relies upon knowledge of effective interventions. A major worldwide initiative in this regard is the development of the International Classification and Registry of Preventive Trials to disseminate through the Internet. This Registry contains standard descriptions of prevention interventions, their implementation history, study design and short- and long-term outcomes (Brown, Mrazek & Homan 1999, see http://www.oslc.org/spr/registry.html).

The process of determining effective interventions is cyclic and iterative. Prevention trials are based upon an evolving understanding of the processes that support and harm mental health. The causal nature of these processes is not yet clear, and the outcomes of prevention trials not only determine the efficacy of the intervention in preventing mental health problems and mental disorders but also inform further development of the underlying causal models of mental health and mental illness.

A prevention trial is conceptualised on the basis of current understanding of the risk and protective factors within a particular population. It is then initially tested under tightly controlled conditions in order to determine the efficacy of the intervention itself. Efficacy refers to the extent to which a specific intervention, procedure, regimen or service produces a beneficial result under ideal conditions. Once a prevention intervention has been shown to be efficacious in trials, its efficacy and effectiveness in community settings need to be determined. Effectiveness is the extent to which a specific intervention, procedure, regimen or service, when deployed in the field, does what it is intended to do for a defined population. Effectiveness trials rigorously test the ‘fit’ of an efficacious prevention intervention in a defined population within a particular community setting. This is especially important, as prevention interventions that are successful in one cultural setting or for one particular population group may need to be adapted for use in other settings or population groups.
Model programs are those that have established efficacy, but which may need to be reinvented, or adapted, in order to be effective in different settings and population groups. Generalizing model programs from one setting or population group to others provides important insights into the predictors, mediators and moderators of prevention programs. These need to be understood before large-scale implementation can be undertaken (Hosman & Engels 1999).

The process of adapting model programs to diverse settings and population groups raises the ‘fidelity versus reinvention’ dilemma. The absolute implementation, without modification, of an efficacious prevention program can conflict with community ownership and empowerment, and community participation is essential to effective and enduring interventions. Yet reinventing programs, through modifications made to suit a particular community’s needs, can undermine the efficacy of the original program.

The notion of ‘fidelity to principles’ was developed to deal with this dilemma (Bauman, Stin & boys 1991): if the underlying principles on which a prevention intervention is based are made explicit, fidelity to these mechanisms of operation can be achieved. This can be done within the context of adapting the program to the local community’s needs and unique characteristics. Reinvention can be successfully undertaken with the preservation of key principles and attention to causal mechanisms, together with ongoing program evaluation to ensure maintenance of and adherence to program integrity.

A critical component of the large-scale implementation of programs found to be efficacious and effective is determining the cost-benefit or cost-effectiveness of the prevention intervention. In a cost-benefit analysis, costs and benefits for all measures are expressed in dollar amounts. In a cost-effectiveness analysis, two categories of outcome measures are used, dollar amounts and health (for example years of healthy life gained). Often too little attention is focused on conducting cost-benefit or cost-effectiveness analyses that can reliably demonstrate whether prevention interventions actually improve health and save money. Such information is of great importance to policy makers. Both short-term and long-term benefits need to be assessed, since the effects of some interventions may not be immediately evident.

In summary, prevention interventions need to be developed according to a multistage strategic prevention-intervention research cycle. Initially, a trial is developed and evaluated. Efficacy studies determine whether the program achieves targeted outcomes under ideal conditions. Effectiveness studies are then undertaken to determine whether the outcomes hold under normal practice conditions. Evaluations of reinvented model programs reveal the mediators and moderators of the intervention. Finally, there needs to be widespread dissemination and implementation of the intervention and ongoing monitoring. This information feeds back into the development of innovative prevention programs, thus completing the intervention cycle.
Infrastructure to incorporate prevention

The infrastructure required for the widespread implementation of effective prevention interventions is informed by the population health approach, and comprises prevention research, prevention practice, education and training, policy and organisation (Hosman & Engels 1999). All these functions are required to complete the prevention intervention cycle, and the roles are mutual and reciprocal.

Prevention research is required to develop and evaluate programs, monitor mental health and mental illness, and improve our understanding of the determinants of mental health. Education and training are required to disseminate knowledge related to mental health and effective intervention programs, provide professional training and consultation, and enhance the quality of practice, policy and research. Training and research facilities need to be able to produce the types of expertise needed. Organisations and services are required to carry out the practice of prevention by implementing and reinventing programs. Policy and organisation is required to translate research outcomes into recommendations, ensure quality control, set priorities, provide budgets and develop organisations to deliver and improve prevention interventions.

All these functions are essential and need to be undertaken through intra-, inter- and multisectoral partnerships; they are not restricted to the mental health sector. Funding structures need to recognise and support the necessary collaboration between organisations with similar tasks and encourage mutual support between organisations that are performing complementary tasks (Hosman & Engels 1999). Communication and a flow of information between these organisations are essential.
Early intervention—principles and strategic approaches

Early intervention takes place when people are displaying the early signs and symptoms of a mental health problem or mental disorder, or developing or experiencing a first episode of mental illness. Its focus is primarily on the individual who is experiencing problems, although the ongoing contribution of promotion and prevention interventions are fundamental to its effectiveness.

Early intervention relies upon strategies for identifying the early signs and symptoms of mental health problems and mental disorders. It also requires immediate access to treatment strategies that are effective and appropriate for people experiencing an at-risk mental state or the early stages of disorder. It is essential that interventions do not, in themselves, exacerbate the course or burden of mental health problems or a mental disorder. Strategies for early intervention become more disorder-specific as the signs and symptoms of specific mental disorders become evident and in instances of first episodes of mental disorder. Partnerships with consumers and carers are vital for determining what comprises good practice in early intervention.

Identifying early signs and symptoms

Early intervention is fundamentally about enhancing the capacity for early recognition of mental health problems and mental disorders by services across the health, education and community support sectors. It requires identifying and providing appropriate responses for people with the early signs and symptoms of disorder and who have not recognised their emerging symptoms or not sought appropriate help. It depends upon the identification of a developing disorder that has not reached the stage of clinical diagnosis, and this in turn rests on an understanding of what comprises the early signs and symptoms of a developing disorder.

Early signs and symptoms of a developing disorder are:

- fewer than those required to diagnose a disorder;
- present for a shorter period of time than is required to diagnose a disorder; and
- less intense and disruptive than those of a diagnosable disorder.

The early signs and symptoms of mental disorders may, nonetheless, markedly disrupt an individual's social interactions and produce a diminished state of mental health.
There are many diagnostic instruments for first episode of mental disorder, based on the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (APA 1994) and the International Classification of Diseases, tenth edition (ICD-10) (WHO 1992), that aim to detect different types of fully developed disorder. Diagnosis using these instruments is possible only once there is a fully developed disorder, entailing the presence of specified symptoms for a designated length of time and at a particular intensity. These instruments are designed for clinical assessment.

Major considerations in evaluating such diagnostic tools are their applicability within a particular setting and their cultural appropriateness, as well as their sensitivity and specificity. Sensitivity refers to the ability of the instrument to detect whatever it is designed to detect. Specificity refers to its accuracy in categorising people as either ‘well’ or ‘unwell’. False positive occur when a screening instrument indicates that an individual meets the threshold for disorder, although the individual does not have the disorder. False negative occur when the instrument indicates that an individual does not meet the threshold for disorder, although the individual has the disorder. Consequently, even the diagnosis of fully developed mental disorder is not always precise, particularly when used outside the culture or language within which the diagnostic instrument was developed.

More sensitive and flexible tools are needed to recognise signs and symptoms earlier in the development of mental health problems and mental disorders, when an at-risk mental state is evident but there is no diagnosable disorder. The current diagnostic systems need to be adapted for such applications, as the established thresholds for the diagnosis of disorder do not apply. This raises the issue of what is ‘normal’ and what is ‘not normal’ in terms of mental health. Mental health has been defined as a multidimensional construct; there is no simple dichotomy with some people being ‘mentally healthy’ and others being ‘mentally unhealthy’. Nor is there a continuum from good mental health to poor mental health, with degrees of mental health in between. The dimensions that comprise mental health change across the lifespan and vary between individuals and population groups.

As noted by Kosky (1998), even the notion of symptoms is complex. Traditionally, symptoms have been derived from clinical experiences. This is how the two main diagnostic taxonomies, DSM and ICD, were developed. Yet symptoms evident in clinical samples and detected by current diagnostic systems have progressed well beyond those that are the signs of an at-risk mental state.
Early intervention relies on identifying signs and symptoms at their earliest onset and manifestation, as an indication that something may be going wrong or about to go wrong for a specific individual. Table 5 presents some of the potential early signs and symptoms that are particularly relevant for young people and that relate most strongly to the development of disorders such as depression, anxiety and psychosis.

Table 5: Potential early signs and symptoms for some mental health problems and mental disorders, particularly for young people

| Source: Adapted from NSW Health (1999) p. 7. |

It is evident from Table 5 that the problems and disturbances that people may show before the onset of major categories of mental disorder are non-specific and are experienced by many people who never develop a mental disorder. The probability of whether or not a particular group of signs and symptoms indicates the development of a disorder is unknown, yet critical. If the probability is low, interventions may be undertaken unnecessarily; conversely, if the probability is high, intervention is clearly warranted.

The search for the early warning signs of mental disorders has been frustrating (Kosky 1998), but there are currently major developments in this area. Work in the early psychosis field reveals that the vast majority of people who develop psychosis can be seen, in retrospect, to have experienced a period of pre-psychotic symptomatology and behavioural change. This period

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<td>Appetite changes</td>
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<td>Loss of energy or motivation</td>
<td>Emerging unusual beliefs</td>
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<td>Loss of energy or motivation</td>
<td>Emerging unusual beliefs</td>
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<td>Perception that things around</td>
<td>Belief that thoughts have speeded up</td>
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<td>have changed</td>
<td>or slowed down</td>
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A monograph has been termed the ‘prodrome’—a period when ‘something is not quite right’, when a person shows evidence of an at-risk mental state (McGorry & Singh 1993; Eaton, Badawi & Molan 1995). This can be considered the earliest form of disorder, and it markedly increases the probability of a subsequent episode of mental disorder (Yung & McGorry 1996), although not all people with such an at-risk mental state will go on to develop a disorder.

The signs and symptoms for psychosis may or may not be relevant as early indicators for other disorders or for different age groups. This is an area of pressing research need—to determine the early warning signs and symptoms for specific disorders. It may be that there are generic precursor signs and symptoms for all mental disorders and also disorder-specific indicators. Reliable ways to identify an at-risk mental state are needed, including the signs and symptoms that are generic to the development of any type of mental disorder as well as the signs and symptoms that are related to the development of specific types of mental disorders. The development of appropriate early intervention approaches will be greatly facilitated through increased knowledge about the early signs and symptoms of disorders (Yung & McGorry 1996).

Through the National Mental Health Strategy the Commonwealth government has developed a set of ‘clinical approaches’ for the identification, early intervention and prevention of several mental disorders for children and young people (see http://austinet.flinders.edu.au/). These clinical approaches will be of considerable use, not only to mental health workers but also to other professionals who are likely to come into contact with people experiencing an at-risk mental state. They set out how to identify the signs and symptoms of an at-risk mental state for various mental disorders, and also how to provide an early intervention service approach that is effective, appropriate, sensitive and ethical.
Settings for action

Effective early intervention requires outreach services, whereby services actively seek out people in need. Services need to reach out to people where they live, work, learn and play rather than waiting for them to seek help from traditional centre-based services. A number of Australian studies have shown that adolescents, in particular, generally avoid professional help services and that outreach services are preferred (Rickwood & Braithwaite 1994; Fallon & Bowles 1999).

Strategic settings for early intervention are those where people at increased risk of developing mental health problems and mental disorders naturally are. Mental health and other health services are just one of the strategic settings for action. Others are the home, school, workplace and community, which are all outside the mental health service sector. Working through these settings recognises the aetiology and epidemiology of mental health problems and mental disorders but, even more importantly, can avoid the stigma generally associated with attending mental health services.

Schools are an obvious and potentially ideal location for early identification of the signs and symptoms of emerging mental health problems and mental disorders. School-aged children and adolescents are in a life stage of major significance for early intervention. Many high-risk adolescents, however, will have left the school environment as early as possible and need to be identified through the services that they might access (for example, homeless shelters, street outreach, housing, employment, drug and alcohol, and corrections services).

General practice is another setting where people of all ages showing the early signs and symptoms of mental health problems and mental disorders are likely to attend. It is critical, therefore, that general practitioners be able to recognise heightened risk and the early signs and symptoms as they manifest across the lifespan. Studies suggest, however, that primary care physicians vary considerably in their ability to detect some mental disorders. For example, accuracy rates for detecting depression vary between 25–75 per cent (Brown & Schulberg 1998). A survey of general practitioners revealed that most of the respondents reported their undergraduate training in adolescent mental health issues to be inadequate and 64 per cent said that they found it difficult to obtain advice on complex mental health problems (Vaet et al. 1996).

In contrast, Goldberg and Huxley (1998) note that, despite the brevity of contact in most presentations, general practitioners are able to detect two-thirds of all mental disorders and a higher proportion of psychotic disorders. Even without formal training in screening, most general practitioners provide reasonably good screening for mental disorders (Prince & Phelan 1994).
Primary care physicians need to be aware that when people seek help for a mental health problem, they often do so in an indirect manner; for example, by presenting with a physiological symptom such as trouble sleeping, tiredness or pain. Consequently, it is necessary to probe beyond the presenting issue to uncover the mental health problems. Many people are not able to articulate their mental state, and others are uncomfortable about coming forward with their mental health issues. Young people, older adults and people from culturally and linguistically diverse backgrounds are especially likely to present indirectly with their mental health problems.

Recent clinical practice guidelines developed by the National Health and Medical Research Council (NHMRC) recommend, in regard to detecting depressive symptoms in young people, that general practitioners ask young people how life is going in general and pay special attention to emotional issues in young people who present frequently to general practice with what appear to be minor complaints. Screening for mental health issues is encouraged, and the presence of certain disorders and conditions which are comorbid with depression should raise concern regarding the possibility of depressive disorder (anxiety, eating, or attention deficit/hyperactivity disorders, viral illnesses such as infectious mononucleosis or hepatitis; chronic illnesses such as diabetes mellitus, schizophrenia and cancer; abuse—sexual, physical and emotional) (NHMRC 1997b, p. 5). These guidelines may apply equally well to other population groups who are not likely to be forthcoming about their mental health problems.

Early treatment
Within an early intervention approach, early treatment has a somewhat different focus from standard mental health treatment for diagnosed disorders. While there may be a concern with symptoms and the alleviation of symptoms, there is also consideration of the broader determinants of the individual's mental health status. This entails identification of the risk and protective factors that are contributing to the person's mental health problems, and an appropriate level of ongoing monitoring for individuals who are experiencing a period of things being 'not quite right'.

An early intervention treatment approach is holistic and considers the person within their social and cultural environment. Additional screening may be used to identify the risk factors that are affecting the person's mental health. Interventions can then be put in place related to these risk factors. Where possible, interventions will attempt to eliminate or reduce the risks to a person's mental health. Potential risks to consider are those presented in Table 2. These might include inadequate or unsafe housing, relationship problems, and legal or financial difficulties. When it is not possible to modify the risk factors themselves, interventions may focus on helping the
individual to develop better ways to cope to reduce the impact of the risk factors on their mental health.

The protective factors presented in Table 1 also need to be considered. If people can be supported to improve their resilience and build upon their current strengths, this may enhance their ability to cope with the stresses they inevitably encounter in their daily lives. Improving access to social support and a sense of connectedness within the community are particularly important protective factors to enhance.

Improving mental health literacy of a person showing the early signs and symptoms of mental health problems and mental disorders is an important strategy for early intervention. Increasing a person’s knowledge of the determinants of mental health enables them to make choices and changes within their own life to better support their mental health. An understanding of the symptoms of different mental health problems and mental disorder enables them to seek help at the earliest signs of problems and thereby prevent the damage that can occur to their life by waiting for symptoms to become more serious. Experiences and information that de-stigmatise mental illness and help-seeking behaviour also encourage early help-seeking, preventing the problems that can be caused by prolonged symptoms. Providing information about the nature and effectiveness of diverse help-seeking avenues and treatment options enables people to be informed consumers of mental health services and to seek the help that they believe is appropriate for them at that particular time. Such mental health literacy is equally important for families and carers.

Effective early intervention is unlikely to occur as a result of a one-off short-term intervention. Mental health problems and mental disorder develop over time, may be episodic, and are likely to recur. Consequently, intervention services need to have a longer term perspective and be able to follow up over time people who have been identified as being at increased risk of a mental health problem or mental disorder. This requires strategies to provide continued care and ongoing monitoring.

Fundamentally, services need to be integrated across time and therefore across age groups. Early interventions may need to be ‘staged’ to mirror the developing or episodic nature of a mental disorder. It is especially important to overcome artificial barriers between adolescent and adult services, as the median age of disorder onset, between 15 and 25 years, cuts across the child–adult distinction (McGorry 1998).
Ongoing coordination and monitoring of care may need to be provided (Rosen 1999). Some people may be unable to negotiate access to needed services due to their age, level of disability or lack of family and friends able to take on this role. The alternative could be someone with whom the person has developed a trusting relationship, and need not be a mental health specialist.

If early intervention is early enough, the focus will be on reducing risk factors and enhancing protective factors rather than providing treatment. The early intervention services required need not necessarily be mental health services but might relate to environmental stressors such as housing, income, education or family and interpersonal issues. General health, employment, housing and other community support services are increasingly including a care coordination or case management approach for those recognized as needing additional help to negotiate the services they need. Equally, clinical staff of specialist mental health services are now more likely to recognize the importance of a range of psychosocial factors on the development, continuation or recurrence of mental health problems and mental disorders and to plan their interventions accordingly.

An illustration of the importance of planning early interventions around psychosocial risk and protective factors comes from the long-lasting detrimental effects of reduced educational attainment for young people with a mental health problem or mental disorder. Professionals and others already involved in supporting or caring for the young person can negotiate with education authorities a more flexible educational approach that takes into account the specific nature of the mental health problem (NCAGMH 1994). This may enable the young person to attain their qualifications, which will have an ongoing protective and risk reduction effect throughout their life. Working outside the mental health sector in this way can profoundly reduce the impact of a mental health problem or mental disorder on a person's life.
Education and training

The expanded treatment focus of early intervention requires training and education for relevant workforces. Outreach services in all sectors need to be able to recognise the early signs and symptoms of mental health problems and mental disorders and know when, how and where to refer people for help. Training needs to focus on sharing information and creating a common dialogue. There is a need for a common language that includes all the different disciplines involved. Terms need to be identified that are familiar to partnership services, and with which non-health workers are comfortable. This has been clearly demonstrated in the early intervention initiatives for psychotic disorders (McGorry et al. 1996). Confidence and core knowledge need to be developed across the diverse range of services that are likely to come into contact with people experiencing the early signs of mental health problems and mental disorders.

At present there is little available literature about the training of personnel and broadening the focus of services to include early intervention (Davies et al. 2000). Much of the existing information is concerned with training in the areas of child development, child psychotherapy, children with disabilities, special education, home-based family services and family day care. Another body of information relates to the training needs of those involved in the early identification of psychosis.

A common theme emerging from the literature and consultation with service providers is the need to equip workers with practical knowledge and skills— that is, to move from the rhetoric to the reality. The clinical approaches for children and young people developed through Auseinet, and training in the implementation of these, are especially important in providing necessary skills. Such publications pull together the collective wisdom of acknowledged experts in the domains of particular mental disorders and put it into a form that is accessible by a wider audience.

It is critical to develop strategies to widely promote and disseminate training and education material that supports good practice in early intervention. Technology is critical to facilitating such information sharing, for example, through websites and list servers (such as Auseinet). However, ways to foster intersectoral access to such information need to be pursued. Cross-postings to all relevant sectors requires the identification of and collaboration with a wide range of diverse sectors and services, as well as consumers and carers.
Avoiding potential negative outcomes of early identification

Identifying people early in the pathways to developing a mental disorder is not without potential pitfalls. It is essential to implement early intervention in a sensitive and ethical manner to avoid any of the negative outcomes that may result from identifying and labelling people as being at risk.

Stigma is a serious issue related to identifying an individual as being in the early stages of a mental disorder. Stigma refers to the linking of undesirable characteristics with mental illness and the adverse cognitive and behavioral consequences (Link et al. 1997). The stigma attached to mental illness has marked effects on the psychological wellbeing and life satisfaction of people with mental illness (Markowitz 1998). People with mental illness may both expect and experience rejection because they think less of themselves, because they have limited social opportunities and resources and because of the severity of their illness. Stigma affects social outcomes, in part through its negative effect on the self-concept, and in part through prejudice and discrimination (Rosenfield 1997).

The potential for stigma could be a major argument against early intervention. However, Falloon maintains that screening for the early signs of disorder can enable people to be better informed about mental disorder, and this is a major benefit. There were few adverse effects of early intervention, specifically related to schizophrenia, in his study. ‘Early intervention is the very antithesis of the “labelling” concept that has been so justifiably criticized’ (Falloon et al. 1996, p. 280). Moreover, if screening can identify people before the onset of diagnosable disorder, individuals need not be labelled with a particular mental illness, as their current level of symptoms does not warrant such a label. Then, if early intervention is effective, these people will not develop a diagnosable disorder, and will benefit further by improving their mental health literacy.

Nevertheless, fear of the stigma attached to mental health problems and mental disorders is a powerful disincentive to early treatment and a major factor in treatment delay. This problem was clearly demonstrated in the Griffith Early Intervention Program. Originally the program was based on indicated prevention—identifying and intervening with students who were at identified risk of mental disorder. However, when it was realised that singling out these students within a school system was to their detriment, a universal prevention approach was adopted instead (Shochet et al. submitted). This removed the possibility of stigma being attached to the young people who were identified as being in need of a mental health intervention.
To prevent potential negative consequences for people identified for early intervention, one strategy is to provide mental health assessments in 'low-stigma' settings. Home-based assessments are of particular value in this regard. People experiencing the early signs of mental health problems and mental disorders and their families are more likely to accept assessment and treatment if it is provided at home or in some other 'low-stigma' setting (Birchwood, McGorry & Jackson 1997; EPPIC 1997). Within the limits of safety, settings chosen by the consumer or their family are preferred.

Telling people that they have the early signs and symptoms of a developing mental disorder can, in itself, cause problems such as anxiety. In the pilot study conducted by Falloon et al. (1996) this fear was not, however, realised. Yet it is imperative that the process of identification does not generate increased stress and concern on the part of the targeted individual (Spence 1996a). This is especially important for people who are showing the signs of developing disorders that can be exacerbated by stress, such as schizophrenia. People need to be informed of their mental health status in a sensitive and supportive way that does not exacerbate their symptoms.

With a focus on early intervention, some people may unnecessarily receive an intervention due to our inability to predict perfectly who will develop disorder. Depending on the nature of the intervention, this may or may not pose a problem. Receiving stress management or educational information about a disorder is unlikely to have major negative consequences (Falloon et al. 1996). However, the safety and efficacy of more invasive interventions is paramount because interventions will often be applied during benign states. An important principle to adopt is to ‘do no harm’.

Due to the potential for harm, particularly in relation to possible side-effects, the place of medication in early intervention needs to be carefully considered. The Australian Clinical Guidelines for Early Psychosis (EPPIC 1997) note that medication should be avoided during the period when there is only evidence of an at-risk mental state. The NIMH/CDC’s Depression in Young People—Clinical Practice Guidelines (NIMH 1997b) also emphasises that medication is not the preferred treatment for young people with depression, and that psychological and social interventions are preferred in the first instance. There is need for a greater understanding of the effects of medication for young people (Commonwealth Department of Health and Aged Care & AIHW 1999) as well as early in the course of a mental disorder. Evidence is accumulating, however, to suggest that treatment via low-dose anti-psychotic medication is effective for first-episode of early psychosis (Bennett et al. 1998).
The potential negative outcomes of early intervention must always be carefully considered. However, these problems are surmountable with carefully designed early interventions, and the potential advantages for the individual, their family, the community, and health and other services far outweigh these manageable risks.

**Participation of consumers and carers**

Of particular importance for the development and implementation of effective, sensitive and ethical early intervention strategies are strong partnerships with consumers and carers. When consumers and carers are actively involved in consultations around the development and implementation of interventions, the potential negative outcomes of stigma, stress and increased prevalence of mental health problems may be more likely to be avoided.

In the context of early intervention, consumer and carer participation needs to be broadly defined. Early intervention, in terms of indicated prevention interventions, occurs before the onset of a diagnosable mental disorder. Consequently, representation and advocacy will not be based around disorder-specific diagnoses.

There are many ways to encourage consumer and carer participation at all points of the intervention spectrum that need to be put in place to break down barriers to effective participation (Australian Psychiatric Disability Coalition 1999; Lconomico et al. 1997). Providing funding can help to establish and maintain consumer and carer advisory groups. Adequate resources enable fuller participation and assist groups to stay together and function optimally. Appropriate support for and remuneration of consumers and carers on advisory bodies also validate their contribution.
Promotion, Prevention and Early Intervention for Mental Health

The supportiveness of wider organisational environments determines whether consumer and carer participation flourish. Appropriate informal and formal structures can facilitate more effective consumer/carer participation. Consumers and carers need certain skills and knowledge in order to participate equitably and effectively in partnerships. Training is therefore required to enable consumers, carers and service staff to work together.

The diverse backgrounds of consumers and carers can also affect their participation and level of influence. In particular, people from culturally and linguistically diverse backgrounds are often discouraged from participation due to issues such as fear of stigma related to identifying themselves as either a consumer or a carer. Language and cultural barriers further inhibit participation. For some cultural groups, challenging authority in any way is especially difficult.

Successful partnerships between consumers, carers and mental health services have been shown to be possible when there are appropriate supports, the organisations involved are flexible, and diverse views are valued and accommodated. A formal acknowledgment of the barriers is required, along with a commitment to fully involve and support consumer and carer participation.
CHAPTER 5:

A whole-of-lifespan approach to mental health and mental illness

Our understanding of the development of mental health across the lifespan is based largely on our knowledge of the development of mental illness; unfortunately we know much less about the aetiology of mental health. However, the recent, and growing, emphasis on mental health promotion and the consequent development and evaluation of mental health programs and indicators will facilitate advancing knowledge in this area.

In contrast, our understanding of mental health problems and mental disorders is increasingly well developed. Most mental health problems and mental disorders develop along a pathway, or trajectory, with gradually increasing frequency and severity of symptoms, and there are often no clear-cut stages when a disorder is not present at one moment and present at the next (Coie et al. 1993). Some disorders develop slowly over time, such as some drug use disorders, while others can be episodic in nature, such as schizophrenia and depression. Other disorders may develop very quickly following a major trigger event. A severely traumatic event may trigger anxiety, depression or post-traumatic stress reactions in people who would otherwise not experience a mental health problem.
A whole-of-lifespan approach informs our understanding of the development of mental health problems and mental disorders and thereby informs our understanding of appropriate interventions. The earliest signs and symptoms of a disorder may occur at any time throughout the lifespan, but these are periods when the occurrence of particular mental health problems or mental disorder is more likely. The nature and timing of prevention and early intervention depends not just on the individual’s age, but on the identified pathways to mental health problems and mental disorders, and the risk factors and critical transition points that characterise those pathways.

An optimal mix of interventions across the spectrum is needed to improve the social and emotional wellbeing of all Australians, and the nature of the combination of interventions will change as knowledge accumulates (Offord et al. 1993). While mental health promotion is always relevant, regardless of current or future health status, prevention must occur before the onset of disorder, and early intervention must occur at the point where there are signs and symptoms suggesting an at-risk mental state or indicating a first episode of mental illness.

Mental health across the lifespan

While the factors that support mental health are not as well understood as those that influence mental illness, Figure 2 presents the developmental tasks that are generally considered to be important to wellbeing across the lifespan for people in western cultures. Successful negotiation of these life changes and developmental tasks enhances mental health for many people, however, it is important to understand that many individuals do not follow this life course and, provided they live within a community that supports diversity of life choices and opportunities, their mental health is not adversely affected. Conversely, unsuccessful negotiation of these developmental tasks can indicate higher risk for mental illness for many people.
Figure 2: Developmental tasks across the lifespan

<table>
<thead>
<tr>
<th>Life stages</th>
<th>Major life changes and developmental tasks</th>
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<tr>
<td>Infancy and toddlerhood</td>
<td>Developing playmate control</td>
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<tr>
<td>Childhood</td>
<td>Learning to read and write</td>
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<tr>
<td>Adolescence</td>
<td>Dating</td>
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<tr>
<td>Early adulthood</td>
<td>Leaving home</td>
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<td>Adulthood</td>
<td>Pursuing higher education</td>
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<td>Older adulthood</td>
<td>Choosing a vocation</td>
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<td>Finding a partner</td>
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<td>Parenting a young child</td>
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<td>Parenting a primary-school child</td>
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<td>Parenting an adolescent</td>
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<td></td>
<td>Achieving vocational success</td>
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<td></td>
<td>Parenting a child who is leaving home</td>
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<td></td>
<td>Parenting adult children</td>
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<td></td>
<td>Providing care for an ill parent</td>
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<td></td>
<td>Becoming a grandparent</td>
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<td></td>
<td>Retiring from a job</td>
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<tr>
<td></td>
<td>Coping with illness or disability</td>
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<tr>
<td></td>
<td>Providing care for an ill spouse</td>
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<td></td>
<td>Coping with the death of a spouse</td>
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<td></td>
<td>Coping with the death of peers</td>
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<tr>
<td></td>
<td>Dying</td>
</tr>
</tbody>
</table>

Source: Adapted from Mrazek & Haggerty (1994) p. 224, which was adapted from Kellam SG, Branch JD, Agrawal KC, Ensminger ME 1975, Mental Health and Going to School, University of Chicago Press, Chicago.
Mental health promotion is relevant across the entire lifespan, regardless of current health status. Effective mental health promotion enhances the structures and supports that enable people of all ages to live safe, productive and fulfilling lives and to effectively negotiate their life course. It is fundamental to the mental health of whole communities as well as their individual members, and optimises opportunities for effective prevention and early intervention. A mentally healthy community supports and nurtures individuals and families through empowering people to develop the environments that promote subjective wellbeing, optimal development, the use of skills, and the achievement of individual and collective goals.

Mental health problems and mental disorders across the lifespan

Infancy and childhood

There is now evidence showing that the quality of nourishment and nurturing in the early years has far-reaching effects (Katering & Flottman 1999). Major influences on an infant's well-being that help to prevent mental health problems and mental disorders later in life include sound maternal and perinatal health, adequate nutrition, secure attachment between infant and caregiver, and knowledgeable, skilled and competent caregivers who have access to support services and networks.

Possible risk factors for adverse mental health outcomes include low infant birthweight and birth complications; poor infant health; insecure attachment; inadequate cognitive stimulation; abuse and neglect; mental or physical health problems in the mother; parental substance misuse; mental disorder and criminality; and poverty. Developmental disorders, intellectual disability and genetic factors may also contribute. Children with developmental disabilities are particularly vulnerable to adverse mental health outcomes when they experience further risk factors through their family and social environments, and are protected from adverse outcomes by supportive family and social environments (Centre for Community Child Health 2000).

Experiences in childhood lay the foundation for mental health later in life. There is very clear evidence showing the continuity of disorders between childhood, adolescence and into the adult years (Heijmens Visser et al. 2000; Barber & Smith 1995). Many prevention activities for mental health problems are therefore ideally placed in childhood. This can have the most effective impact on the developmental trajectory of mental disorders and other psychosocial outcomes, the possible cumulative effect of risk factors and the development of resilience (Department of Human Services 2000).
Prevention interventions for children are not necessarily targeted directly at the child. Interventions need to improve the environment experienced by the child so that the range of factors that can enhance resilience is supported; interventions need to increase the protective factors and reduce the risk factors within the environment. Consequently, interventions that improve the parenting skills, mental health and socioeconomic status of parents can prevent the development of mental health problems in children.

Signs and symptoms of mental health problems can be evident very early in life, although, before the ages of 3 or 4 years, risk factors for mental health problems and mental disorders, rather than actual manifestations of disorder, are more likely to be evident. Mental disorders account for 16 per cent of the disease burden in children aged 0-14 years (Mathers, Vos & Stevenson 1999), and mental health problems become increasingly prevalent during childhood. According to the 1993 Western Australian Child Health survey, nearly one in six 4–11-year-olds have had a mental health problem compared with more than one in five 12–16-year-olds, within a 6-month period (Zubrick et al. 1995). In the recent child and adolescent component of the National Survey of Mental Health and Wellbeing, 14 per cent of children aged 4–17 years had a mental health problem in a 12-month period (Sayer et al. 2000). This overall prevalence rate is somewhat lower than other surveys, due to methodological differences. Specifically, in the national survey, the data for children were collected from parents only, while the data for young people were collected from both the young people themselves and their parents, yet these two sources of information are not reported in combination (Raphael 2000b). Generally the earliest signs of mental disorder to emerge in childhood are those related to attention-deficit hyperactivity disorder (ADHD), conduct disorders, anxiety disorders and depressive disorders.
A child showing behavioural problems lacks or has insufficient control over behaviour that is expected in a given setting and is appropriate to the child’s age. Two general categories of behavioural problems are frequently differentiated: ADHD and conduct disorders. When evident in childhood, these are generic risk factors for later mental health problems and are therefore vital for prevention and early intervention.

ADHD generally emerges earlier in childhood than conduct disorders. Australian studies have shown prevalence rates for ADHD ranging between 2.3 per cent and 11.2 per cent (Glow 1980 cited in NHMRC 1997a; Sawyer et al. 2000). In the recent child and adolescent component of the National Survey of Mental Health and Wellbeing, 19.3 per cent of boys and 8.8 per cent of girls aged 6–12 years, and 10 per cent of boys and 3.8 per cent of girls aged 13–17 years were identified with ADHD through parent reports, in a 12-month period (Sayer et al. 2000). In the United States, the prevalence of ADHD has been estimated to be as low as 3–5 per cent (APA 1994, Barlow & Durand 1995) and as high as 15–20 per cent at the elementary (primary) school level (Gordon & Fished 1994). Children are most likely to present for assessment and treatment for ADHD around 8–9 years of age (Handel 1998). Parental retrospective report, however, that specific symptoms of ADHD have been present for about three years (Hazell, McDowell & Walton 1996) and many can describe around problems dating back to infancy. ADHD is one of the main reasons that children are seen in mental health services, comprising up to 40 per cent of child referrals (Barlow & Durand 1995; DuPaul & Stoner 1994). Boys outnumber girls 6 to 1 in clinical settings and 3 to 1 in the community generally (Barlow & Durand 1995). While care must be taken in interpreting the figures, as diagnostic criteria have changed considerably over time, it appears that over half of all children with ADHD will continue to have some manifestation of the disorder in adulthood (Barkley 1995).

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 & Harrington 1994). There is evidence that preschoolers who show high levels of noncompliance and aggression at age 4 are at increased risk for conduct disorder (Conduct Problems Research Group 1992). Conduct disorder includes delinquent behaviour and is defined as a ‘repetitive and persistent pattern of behaviour in which the basic rights of others or the major age-appropriate society norms or rules are violated’ (APA 1994, p. 85). The child and adolescent component of the National Survey of Mental Health and Wellbeing revealed 4.8 per cent of boys and 1.9 per cent of girls aged 6–12 years, and 3.8 per cent of boys and 1.0 per cent of girls aged 13–17 years with conduct disorder through parent reports, in a 12-month period (Sayer et al. 2000). Other prevalence rates for conduct disorder in general child and adolescent populations are between 6 and 16 per cent for boys and between 2 and 9 per cent for girls (APA 1994).
Strong support for interventions targeted early in the lifespan comes from research on conduct disorders. As conduct disorders begin to become evident in childhood, prevention and early intervention must occur very early in life, before the full emergence of the disorder. It is especially important to prevent conduct disorder because they are potential markers for long-term mental health problems and are a considerable burden to both the individual and the community. Conduct disorders have been shown to be extremely difficult to treat effectively, although this may be because families only seek assistance when their child’s problem has become severe and is of long standing (Kazdin 1987, 1991). Evidence is accumulating that programs identifying children earlier in their pathway toward conduct disorder can be effective in both the short and long term (Sanders & Markie-Dadds 1996).

Internalising disorders such as depression and anxiety often have their earliest signs in childhood (Jaycox et al. 1994). Anxiety disorders are the most common mental health problems in childhood (Kashani & Orvaschel 1990) and if left untreated, they tend to persist: many adult psychological disorders can be traced back to anxiety disorders in childhood (Mattson 1992). Epidemiological studies have found prevalence rates of around 8 per cent for clinically significant anxiety problems in children (Rommers & Cochrane 1991, cited in Cotton & Jackson 1996). Surveys of children using self-report questionnaires show rates of childhood anxiety disorders in the general population range from 17 to 21 per cent (Anderson et al. 1987; Kashani & Orvaschel 1988, 1990), and around 8 per cent of children will require treatment (Spence & Dadds 1996).

Rates of depression increase with age until early adulthood (Commonwealth Department of Health and Aged Care & AIHW 1999). Depressive disorder is rare in children of preschool age, with studies reporting a very low 0.9 per cent in a clinic sample (Kashani & Caribou 1987) and 0.3 per cent in a community sample (Kaplan, Sadock & Goff 1994). Between 2 and 11 per cent of 6-15-year-olds are reported to have experienced major depressive disorder (Cohen et al. 1993). The child and adolescent component of the National Survey of Mental Health and Wellbeing reported 3.7 per cent of boys and 2.1 per cent of girls aged 6-12 years, and 4.8 per cent of boys and 4.9 per cent of girls aged 13-17 years with depressive disorder through parent reports, in a 12-month period (Sayer et al. 2000). Childhood depression can be the antecedent of depression in adolescence (Evans et al. 1984).
Adolescence and young adulthood

Many first episodes of mental disorder occur in mid- to late adolescence and young adulthood (Rutter & Smith 1995). Most mental disorders—depression, substance use, anxiety disorders (Commonwealth Department of Health and Aged Care & AIHW 1999) and psychoses (HTPC 1997)—have their peak period of incidence at this stage of the lifespan. Only behavioural disorders have their onset earlier in life and the dementias later in life. Mental disorders account for a substantial 55 per cent of disease burden in young people aged 15-24 years (Mathers, Vos & Stevenson 1999).

Anxiety disorders are the most common mental health problem in adolescence (Kashani et al. 1989). Such disorders are also very likely to be comorbid with depression, substance misuse and disruptive behaviour disorder in young people (Schutteberg et al. 1998; Anderson et al. 1987).

Around 20 per cent of young people in the community suffer from depressed mood, with up to 43 per cent reporting that they felt sad for at least two weeks in the past year (Carlisle 1994). Five per cent of young people suffer from a depressive disorder and the prevalence of current major depressive disorder was found to be 7.7 per cent (NHMRC 1997b). In around two-thirds of cases of major depressive disorder, anxiety tended to precede the onset of the depressive disorder and persist after the depression (Kovacs et al. 1989).

Substance misuse disorders emerge in adolescence and peak in late adolescence and early adulthood, before gradually declining throughout adulthood (Andrews et al. 1999).

A similar pattern is evident for psychotic disorders (EPTC 1997). Psychotic disorders generally occur after puberty, with peak age of onset in the early to mid-twenties for males and mid- to late twenties for females (Lezine 1998). These disorders affect about one per cent of the population.

Eating disorders are strongly related to age and gender, with young women being most affected (Stanke & Oseran-Wozni 1998). They tend to have a chronic, fluctuating course and can persist for years (Collinge & King 1994). The most commonly reported eating disorders are anorexia nervosa and bulimia nervosa, which affect around 1.8 per cent and 0.4 per cent of women, respectively (Strak et al. 1997). Around one per cent of adolescents experience eating disorders (Kerr, Thomes & Woldind 1996). These disorders are very rare in males.

Suicidal behaviours are rare in childhood, emerge in early adolescence and increase until the mid-teens (Farron et al. 1997; Zubrick et al. 1995, 1997). Between 5 and 10 per cent of young people from early teens to mid-twenties report making a suicide attempt in any one year (Martin 1995; Zubrick et al. 1995, 1997). Suicide is at one of its highest levels in early adulthood (Cantor, 78
Neulinger & De Leo 1999; Cantor et al. 1998). Suicide is a leading cause of death in Australia, with Australian Bureau of Statistics figures showing that in 1998, 2,683 deaths (2,150 males, 533 females) were attributed to suicide (Commonwealth Department of Health and Aged Care 2000).

The disruptive and disabling effects of mental health problems and mental disorders are exacerbated by the mid- to late adolescence and early adulthood developmental period in which most mental disorders first occur (Kosky & Hardy 1992). This is a critical developmental period in the lifespan, particularly in terms of social and emotional wellbeing. In all developmental domains—social, emotional, physical and cognitive—major changes are occurring that determine outcomes in adulthood. For example, the process of separation from parents and the establishment of an independent individual identity occurs, critical educational and vocational decisions are made, and peer group affiliations and intimate relationships are formed. All these processes have major long-term influences on the individual.

The onset of even a relatively mild mental health problem at this time can have profound effects through crucial psychosocial changes. For example, mental health problems can reduce educational and vocational attainments, which can have ongoing consequences in adulthood (Kessler et al. 1995). Having a major mental disorder at this time can cause serious immediate and ongoing problems, with substantial disruptive effects on identity formation and the establishment of adult roles (Ragland 1996). Both the family and the individual affected can experience considerable trauma and multiple losses. Evidence shows that major damage can occur to the social and family environments and vocational prospects of a young person with psychosis for whom effective treatment is delayed (Moscarelli, Capri & Neri 1991). Similarly, for depressive disorders, the associated social withdrawal can have a major impact on adult life through reduced social and vocational opportunities (Brown & Harris 1978, Crerahan 1985).

Furthermore, it is during this period that health-related behaviours are formed that are carried into adulthood. With growing independence from parents, young people become increasingly responsible for their own health actions and help-seeking behaviours. Young people monitor their own health status and take the health actions that they themselves choose and initiate. They may not, at times, be able to recognize accurately their mental status and generally do not define symptoms as requiring professional or external help. Only a very small proportion seek help from professional services; young people tend to seek help from friends or family, or try to deal with problems themselves. For example, in the Western Australian Child Health Survey, only 2 per cent of the 4–16-year-olds with mental health problems had been in contact with mental health services in a 6-month period (Jilactiv et al. 1995). The child and adolescent component of the National
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Survey of Mental Health and Wellbeing revealed that only 29 per cent of children and adolescents with a mental health problem had been in contact with a professional service of any type in a 12-month period, which included health, mental health and educational services (Sawyer et al. 2000). Despite the importance of adolescence and early adulthood in the aetiology of mental health problems and mental disorders, young people tend to be poorly informed, and improving the mental health literacy of young people is of vital importance for mental health.

Adulthood and older adulthood

After peaking in late adolescence and early adulthood, the prevalence of most mental disorders decreases with age (Commonwealth Department of Health and Aged Care & AIHW 1999). The incidence of new mental disorders also declines, and many disorders in adulthood are a recurrence of earlier mental health problems. Mental disorders account for 17 per cent of the disease burden in adults aged 25–64 years (Mathers, Vos & Stevenson 1999).

The 1997 National Survey of Mental Health and Wellbeing revealed that when considering the most common mental disorders of anxiety, affective and substance use disorders, anxiety disorders were the most prevalent (Andrews et al. 1999). They had affected just under one in ten adults in the past 12 months, followed by substance use disorders and then affective disorders. However, men were more likely than women to have a substance use disorder and women were more likely than men to have an anxiety or affective disorder.

For adults, stressful life events are strongly associated with the onset of mental health problems and mental disorder. 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 (e.g. Raphael 1977). Periods of involuntary unemployment can also be an adverse life event that contributes markedly to mental health problems and mental disorders. Imprisonment is another adverse life event that can have a negative effect on mental health. Of special concern, suicide is the leading cause of death in Australian prisons, and this risk is greater for younger people, Aboriginal peoples and Torres Strait Islanders (Dalton 1999).
Postnatal depression is a disorder of major concern to women of childbearing years. The ‘blues’, or brief episodes of depressed mood and tearfulness, occur in 50–70 per cent of women within one to ten days of childbirth (NSW Health 1994). The presence of the ‘blues’ is related to subsequent development of postnatal depression (Cooper & Murray 1998). Ten to 15 per cent of women will suffer a major depressive episode within the first 3–6 months of childbirth (Östlind 1987). Postpartum psychosis is a rare but potentially very damaging disorder to both mother and child, and affects about two women per thousand deliveries (Boyle & Stubbs 1994).

There is also substantial evidence that the rates of mental disorders are higher among those who have physical impairments, cancer, chronic conditions such as arthritis, or are experiencing the effects of a stroke (Jorm 1995). Studies in primary care settings confirm the link between physical illness and mental disorders, particularly depression (Coulehan et al. 1990). People with severe physical illnesses are more likely to develop a mental disorder, and when physical illness is present, symptoms of mental disorders are more severe (Kiseley & Goldberg 1996).

Mental disorders account for very little of the disease burden in adults aged over 65 years, although severe dementia accounts for 7.2 per cent (Matthew, Von & Stevenson 1999). The 1997 Survey of Mental Health and Wellbeing estimated the total prevalence of common mental disorders to be about 6 per cent among those aged 65 years and over. An additional 6 per cent are estimated to have dementia. Dementia is recognised as a major contributor to the mental health problems of older adults.

The prevalence of mental health problems and mental disorders varies considerably, depending on the living arrangements of older adults. Older people who live in the community experience the best mental health across the adult lifespan in Australia. However, in hostels and nursing homes, over 28 per cent and 60 per cent of residents, respectively, have some form of dementia (Hawkesworth 1997). Depressive symptoms and disorders are also more common in these settings (Pahules, Katz & Lawton 1988). This does not mean that living arrangements determine mental health for older people, but rather that there are complex interrelationships whereby older people in residential care settings are more likely to have complex health problems and experience a range of risk factors, such as disability and social isolation, that increase the likelihood of mental health problems.
CHAPTER 6: Special population groups

Due to the unique nature of their special circumstances, some population groups within Australia deserve special consideration with regard to promotion, prevention and early intervention for their mental health. Specifically, Aboriginal peoples, Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and people who live in rural and remote regions experience high levels of risk and a unique combination of risk factors that require separate attention.

Aboriginal peoples and Torres Strait Islanders

Promotion

The National Aboriginal Health Strategy (1999) defines health as 'not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.' Health is a holistic concept, and mental health is part of full health. Mental health promotion must incorporate all aspects of wellbeing—physical, social, cultural, emotional and spiritual.

Aboriginal essence lies at the heart of cultural well-being. It is shaped and expressed in the web of physical, spiritual, political, environmental, economic and ideological inter-relations. Cultural well-being is the outcome of the integrity and harmony of these inter-relations. These inter-relations operate at the individual, family, community and societal levels. (Collins 1994 cited in NSW Health 1997, p. 7)
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The Ways Forward report (Swan & Raphael 1995) did much to recognise the socially constructed concept of Aboriginal and Torres Strait Islander mental health, with its priorities of wellness, holistic health and culturally informed approaches to healing. This report provided a common language, which enabled some progress to begin to be made in the area of Aboriginal and Torres Strait Islander mental health.

Cultural well-being is affected by the degree and nature of disruption to these inter-relations which in practical terms come in the form of acts and processes of dispossession, physical genocide, attempted cultural genocide, violence, violation and denial of our rights, assimilation, forced separation and incarceration in reserves and prisons, sexual abuse, theft, destruction of our material and economic base, and governments and their departments telling us what's good for us and what we can and can't have or do. (Collins 1994 cited in NSW Health 1997, p. 7)

Mental health interventions must recognise the past for its role in the current health problems of Aboriginal and Torres Strait Islander communities. Interventions need to focus on addressing the influences of the past. When past influences and their associated stressors are resolved, mental health in Aboriginal and Torres Strait Islander communities will improve.

These acts and processes in turn bring much sick and sorry business to Aborigines and our communities through things like loss of independence, malnutrition, extremely high levels of illness and death rates, shorter life spans, adoption of corrupting values including disrespect which leads to hostile acts like violation of women and children, alcohol and drug abuse, violence between Aboriginal men, poor living conditions, endless frustration, and which means the loss of the prerequisites to our cultural well-being. (Collins 1994 cited in NSW Health 1997, p. 7)

Mental health promotion is fundamental for Aboriginal peoples and Torres Strait Islanders. Mental health interventions cannot take place without the strengthening of communities and enhanced cultural awareness and affirmation.

People within the community itself are a vital resource to the process of establishing and implementing mental health intervention programs in Aboriginal and Torres Strait Islander communities. These are the people who will best understand their community's needs and have first-hand knowledge of those members of their community who are in most need of the services being offered. Community members who can see the benefits of intervention
programs and who want to see positive changes in terms of mental health within their community will provide the necessary impetus for change. Through their own community processes of consultation they will be able to persuade others of the advantages of a particular intervention program. Priorities need to be self-determined and community-controlled.

Aboriginal and Torres Strait Islander communities tend to be holistic-looking at the whole, not only the individual parts (Merritt 1999). Consequently, whole-person and whole-community services are imperative. Strategies for dealing with problems involve family and community participation; they are based on the old ways of maintaining culture and Aboriginal ways of being, and have strong family values as their basis. These processes need to be honoured and harnessed when introducing change to Aboriginal and Torres Strait Islander communities (Harnett, Clarke & Shochet 1998). Mainstream services therefore need to be adapted to provide a culturally sensitive approach. Aboriginal Community Controlled Health Services are central for the provision of culturally appropriate holistic services that integrate culture, and social, emotional and physical health for individuals as well as the whole community.

In an innovative and culturally appropriate medium, HEATworks (Health Education and Theatre Works) uses live theatre to deliver health promotion messages.

Visual and oral methods give people a more holistic look at issues that affect their lives. Theatre is our main focus; here a dramatic story looks at a specific issue and the related problems surrounding that issue. This gives people a far wider understanding, enabling solutions to be found. Placing an issue in a ‘real life’ context, with an emotional base, helps people identify with characters and their problems. (HEATworks program flyer, quoted in Hunter & Garvey 1998, p. 10)

Playback theatre and cultural action have also been widely used in a range of settings to assist Aboriginal and Torres Strait Islander communities in remote areas to deal with community-defined issues (VicHealth 1999).
Prevention

The effective development of prevention interventions in Aboriginal and Torres Strait Islander communities is impeded by several factors identified by Hunter (1998). Foremost is the issue of identifying individuals and groups at risk. In many Aboriginal and Torres Strait Islander communities the risk factors are experienced universally. For example, high levels of premature and early death mean that lives are structured around loss and grief. It is therefore difficult to identify risk factors selectively because the level of risk pervades.

Of special significance for Aboriginal peoples is the issue of the stolen generation. The Bringing Them Home report (HREOC 1997) lists reduced parenting skills among the effects of removal of Aboriginal children from their families. Forced removal prevented these children from having the opportunity to experience a normal family life, often instead experiencing institutionalised living and physical, sexual and emotional abuse. To some extent, Aboriginal people may have internalised the major premise of the official policies of the period: that Aboriginal parents could not provide adequately for their children and that they were not good enough parents. This, combined with other well-documented injustices, has contributed to the high rates of social problems in Aboriginal communities. There is therefore a great need for interventions designed to enhance parenting practices (Harnett, Clarke & Shochet 1998).

The high level of risk experienced universally in Aboriginal and Torres Strait Islander communities is not, however, at the expense of protective factors. In the face of overwhelming adversity, Aboriginal and Torres Strait Islander communities have shown tremendous resilience. The extensive extended family and community systems that have survived through the period of colonisation are testimony to this (Harnett, Clarke & Shochet 1998). It is important to recognise and build upon these strengths.

There is a special need for Aboriginal and Torres Strait Islander parents to recognise their vast collective and personal parenting resources, inherited from family and community across the generations. These resources are all-inclusive and non-discriminatory in their practice, and these are particular strengths upon which to build. Parenting programs in Aboriginal and Torres Strait Islander communities must also, however, consider high-risk parents who may not normally engage in programs or who require other interventions targeting grief, trauma, domestic violence and substance misuse.
Early intervention

Early intervention is hampered in Aboriginal and Torres Strait Islander communities by two main issues. Firstly, it may be difficult to distinguish the normal reactions to grief and adversity from indicators of developing disorder in Aboriginal peoples and Torres Strait Islanders. There are currently no valid and reliable early diagnostic tools. Secondly, even if early signs and symptoms of disorder could be reliably identified, this presumes that services are in place to support and sustain intervention responses. In Aboriginal and Torres Strait Islander communities the provision of functional clinical services of any type may be a basic first step. Early intervention is not possible in the absence of functional basic health care services.

The mental health system, and psychiatry specifically, received considerable criticism from the Royal Commission into Aboriginal Deaths in Custody (1991). Similarly, analyses under the National Aboriginal Health Strategy revealed pervasive indifference and disadvantage experienced by Aboriginal peoples and Torres Strait Islanders within the mental health system (Hunter & Garvey 1998). At the same time, much of the work being done, and proposed, by Aboriginal and Torres Strait Islander communities is not seen to ‘fit’ the categories recognised by mainstream mental health service providers.

The adaptation of narrative therapy to the needs of Aboriginal peoples and Torres Strait Islanders and the development of Aboriginal and Torres Strait Islander therapies are examples of progress in this area. Traditional healers are integral to providing culturally sensitive services.

Mental health services in Aboriginal and Torres Strait Islander communities need to be culturally sensitive and take an holistic approach by addressing the close association between physical health and mental health, and social, spiritual, cultural, historical, economic and political factors (NSW Health 1997). There are many barriers to Aboriginal peoples and Torres Strait Islanders accessing mental health services. These barriers will begin to be broken down with the empowerment of the community-controlled sector to enhance its capacity to be self-determining. For Aboriginal and Torres Strait Islander communities, this requires that there are appropriately trained and supported workers of Aboriginal or Torres Strait Islander backgrounds who can provide health and mental health services. The role of Aboriginal health worker is important in this regard, but it is also critical to promote the training of Aboriginal peoples and Torres Strait Islanders to take up positions in both mainstream and community-controlled services as qualified mental health professionals and Aboriginal mental health workers. This needs to be supported by mainstream services working in close partnership with Aboriginal Community Controlled Health Services, and training in Aboriginal culture and history for non-Aboriginal health workers.
In summary, mental health promotion is a priority for improving the social and emotional wellbeing of Aboriginal peoples and Torres Strait Islanders. When their communities are empowered, Aboriginal peoples and Torres Strait Islanders will be able to determine their own needs in the areas of promotion, prevention and early intervention.

People from culturally and linguistically diverse backgrounds

The 1997 Survey of Mental Health and Wellbeing revealed that migrants from non-English-speaking countries had a lower rate of common mental disorders (14 per cent) compared with migrants from English-speaking countries (16 per cent), who in turn had a rate lower than that for the Australian-born population (19 per cent) (Commonwealth Department of Health and Aged Care & AIHW 1999). While most new arrivals to Australia ultimately settle successfully, the process of adjustment can, nevertheless, be very stressful initially.

Promotion

People from culturally and linguistically diverse backgrounds require access to the resources of mainstream society, while at the same time being able to maintain their cultural and religious integrity (Ferguson & Browne 1991). This means that systems and resources need to be easily accessible and negotiable by all members of the community, regardless of language and cultural differences.

Within most Australian communities, however, the ability to speak English supports many of the activities that promote mental health. Consequently, programs to teach English to migrants and refugees are vital to promoting mental health.

People from culturally and linguistically diverse backgrounds are vulnerable to racism and discrimination at individual, community and institutional levels. The experience of racism and discrimination impacts on self-esteem, feelings of belonging and personal safety, and can also act as a barrier to accessing services (HREOC 1991). Schools, workplaces and local services are important sectors where acceptance and valuing of cultural, religious and ethnic diversity can be promoted.

The active participation of all groups in Australian communities needs to be encouraged, with special care taken to enable people with language and cultural barriers to fully participate in community life. This requires equal access to all resources and the provision of safe and accepting environments within which to live. Equity in opportunities for recreation, social support, education, employment and housing is essential to the promotion of mental health.
Prevention

The practical demands of adjusting to a new country produce unique risk factors that can have an adverse influence on mental health (Lin 1986). Principally, limited proficiency in English can be a major daily difficulty; it can also contribute to social isolation and act as a barrier to attaining employment and accessing mental health and other services (Westermeyer 1986). There is also grief associated with the loss of the country, culture, friends and family left behind (Lerner, Mirsky & Barasch 1994). In the host country, migrants may have limited access to social support from friends, family and community support services (Westermeyer 1986). Conflicting cultural values are also an issue, and can be a particular problem for women and young people (Lin 1986).

Culturally appropriate prevention interventions 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 (Artsch & Hartgenik 1998). It is equally important to enhance protective factors for people from culturally diverse communities. Of special importance is having a sense of pride in your cultural origin. The ability to accept and include an ethnic identity within your sense of self is vital, particularly for young people.

Early Intervention

In providing intervention services it is important that services are culturally sensitive and ensure equal access to all members of the community, particularly those with language barriers. Mainstream service providers need to acquire a pervasive awareness of the issues relevant for people from culturally and linguistically diverse backgrounds. A multicultural approach is favoured, which involves changing work practices to ensure that all staff are able to work well with people from all cultures, rather than an ethno-specific approach, which involves employing bicultural staff to focus on specific communities (Sozomenou et al. 1997; VicHealth 1999).

The types of interventions offered also need to be culturally aware and sensitive. It is particularly important to recognize that people from small migrant communities may be especially concerned about the stigma of accessing mental health services; consequently, service reorientation to prevent such stigma requires special emphasis.

There is a pressing need to develop culturally specific and appropriate screening and diagnostic tools. The limitations of current screening tools are amplified for people from culturally and linguistically diverse backgrounds, due to a lack of valid and reliable culturally specific instruments. Especially lacking are appropriate diagnostic tools designed specifically for the unique
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circumstances experienced by refugees. For this group of people, it is important not to pathologise what is a normal response to a grossly abnormal experience (Pittaway & Breen 1999).

Refugees are a particularly important target group for early intervention, as they experience all the risks of other migrants and many more. People from refugee-like situations experience rates of certain mental illnesses, such as post-traumatic stress disorder and anxiety and depressive disorders, that well exceed the rates for the general population (Silove 1995). The effects of such disorders can be both long-term (Creamer 1996) and transgenerational (Harkness 1993). The experiences that led refugees to flee their country automatically target them for selective and, more probably, indicated prevention interventions (VFST 1998). The experience of torture is particularly likely to be related to psychological problems (Sud et al. 1999).

The re-establishment of safety, autonomy and control is a necessary first step for traumatised refugees and extreme care must be taken to not further traumatise these groups of people (VFST 1998). Nevertheless, it is important to understand that, with support, many refugees are able to adjust to their past experiences and current circumstances (Silove 1995).

Refugee children are particularly at risk, not only as a consequence of their own experiences in their home country but also because their traumatised parents often cannot provide necessary family support when in the host country. Other services may need to step in to fill this gap. Schools, refugee support groups and migrant resource centres are settings that can be used to reach out to refugee children to identify and meet their special needs.

School-based services are reported to have major advantages for culturally diverse groups, according to Garston, Roy and Aran (1999). They describe the advantages of school-based services for Latino children in the United States and indicate how this model might be applied to other culturally diverse groups. Appropriately designed school-based mental health programs can overcome barriers to care, such as limited finances, lack of private health insurance and language differences. They can also facilitate a holistic approach to the child's mental health by coordinating learning and school activities as well as involving the family in the therapeutic process.
Rural and remote communities

Rural and remote communities require specific strategies to address their needs. Demographic, epidemiological and social indicator data provide evidence that individuals in these communities are at greater risk of health (including mental health) problems than those living in cities. The disadvantages experienced by people living in rural Australia require further research, however, as indicated by the Human Rights and Equal Opportunity Commission (1998).

Promotion

Social capital is central to the maintenance of mental health in rural communities and has been significantly eroded by recent changes to rural life. A sense of safety, connection and belonging to the community and the environment need to be supported, along with strong emotional support networks among family and community. Adequate income, meaningful work and a sense of control over decision making are of vital importance. Also essential is access to services that support not only health and mental health but also socioeconomic, educational and justice conditions. Interventions to promote mental health need to focus on improving social capital in rural communities.

The National Rural Health Alliance (1997) identified a range of criteria to assist the survival of rural communities. These are interpreted by the Rural Communities Taskgroup to involve:

- Local ownership and development of programs;
- Collaborative work between funding bodies and rural communities;
- Communication in a language and medium that the community understands;
- Goals developed with genuine consultation with the community;
- Programs based on fostering the capacity of the community to promote their own mental health;
- Supporting rural communities to enhance their sense of control; and
- Reducing inequities in income, unemployment and access to essential services (VicHealth 1999).
Prevention

Rural communities are not homogeneous and each has a unique set of factors contributing to the social and emotional wellbeing of its members. Rural communities are often, however, poorer, with more unemployed people, higher suicide rates and higher domestic violence rates than urban areas (Shell 1997). The general health of people living in rural and remote communities is poorer than that of their city counterparts (Mathers 1994).

People living in these communities have particular mental health needs due to isolation, the impact of economic restructuring, and exposure to environmental hazards such as drought, flood and fire. The impact of drought alone has been found to lead to anxiety, depression, family breakdown, grief and anger (Walker 1996).

The Western Australia Child Health Survey has highlighted the high incidence of mental health problems among children in some rural areas (Zubrick et al. 1995). Pervasive issues for young people in rural communities are the lack of employment and educational opportunities, substance misuse, increased suicide rates and discrimination experienced by young people who are gay or lesbian (Hillier et al. 1998). Issues salient for rural women include isolation, postnatal depression, sexuality and sex-role stereotyping (National Rural Health Alliance 1997). For males, a culture of poor interpersonal communication and violence contributes to lack of personal safety, social isolation and mental health problems (Allen 1997).

These problems are compounded by closures of services (both public and private sector), the economic viability of small communities, industrial and agricultural change, and social polarisation (HREOC 1998). Many rural people feel powerless and angry in the face of such upheaval. This often leads to increased rates of depression.
Early intervention

Lack of appropriate services and service providers, distance from services, transport problems and fear of stigma associated with using mental health services are frequently part of rural and remote life and need to be addressed to enable early access to mental health services. Important elements in early intervention programs are the need to include a strong community focus in defining problems and exploring solutions, the involvement of mental health professionals in a community rather than a clinical setting, and the facilitation of access to services (Giant, Land & Cox 1998). Advances in telemedicine and use of the internet as a help-seeking source are potential avenues that need to be more fully explored to facilitate access to services in rural and remote regions.

In terms of current interventions for rural and remote communities, a parenting program involving information-based strategies and targeting parents of children with behaviour problems living in rural and remote communities has been shown to reduce disruptive child behaviour and improve parenting skills and parental adjustment (Connell, Sanders & Markie-Dadds 1997). In contrast, there is currently no strong evidence for the efficacy of crisis intervention and telephone counselling for high-risk groups with suicidal ideation and suicidal behaviour, particularly young males (Patton & Burn 1998), although these services are widely accessed in Australia, and these types of interventions require further research.
Disorder-specific issues are relevant when the early signs and symptoms are pointing toward a specific type of mental disorder and for first episodes of diagnosable mental illness. Consequently, disorder-specific issues are generally most applicable to early intervention. Once a mental health problem has developed into symptoms that are associated with an identified mental disorder, the treatment interventions that are available for that disorder can be used as the framework for early intervention. For some disorders, such as conduct disorders and postnatal depression, specific early warning signs and risk factors have been identified and as a result prevention interventions can be specifically targeted at these disorders. For many disorders, however, the risk factors are generic and it is not possible to determine which risk factors will lead to a particular mental disorder. Effective prevention programs tend to target a range of risk factors such as those identified in Table 2. These programs are likely to have a preventive effect for all mental health problems and mental disorders. Yet many risk factors are associated with particular stages of the lifespan and consequently the preventive effect may be most evident for the disorders that are also associated with that stage of the lifespan. Nevertheless, due to the continuity of disorders between childhood and later life, the preventive effect can be cumulative and long-lasting.

The uptake of promotion, prevention and early intervention in relation to mental health has been hampered by pessimism regarding the effectiveness of interventions for mental health problems and mental disorders. Many effective interventions are now available, including both pharmacological and psychosocial approaches. Evidence is accumulating that the earlier mental health problems are effectively dealt with, the less likely they are to develop into diagnosable disorders. Furthermore, the earlier diagnosable
disorders are effectively treated, the less severe they are, the shorter their
duration and the less likely they are to recur. Without timely and effective
intervention, mental health problems and mental disorders can recur
throughout the lifespan and cause increasing disability.

Mental health promotion and mental disorders

Mental health promotion is relevant across the entire spectrum of mental
health interventions and applies regardless of whether people are mentally
healthy or experiencing a particular type of mental disorder. Mental health
promotion is focused on enabling the mental health capacity of all members
of the community, regardless of health status.

In the context of specific disorders, mental health promotion is particularly
important in terms of creating supportive communities: communities where
all people can participate to the fullest. People with mental disorders can be
severely marginalised within the community if the community itself is not
‘mentally healthy’ enough to support and sustain its members with mental
health problems and mental disorder. This means that the community needs
to have ‘mental health literacy’ and be non-discriminatory in its practices
towards people with mental health problems and mental disorders. The
elimination of stigma attached to having a mental health problem or mental
disorder and to accessing mental health services is essential in this regard.

Furthermore, communities require the infrastructure that supports the social
and emotional wellbeing of people with mental disorders. This means that
adequate and appropriate housing and other services need to be provided for
people with mental disorders. Safety is an especially important issue for some
people with mental disorder who, without adequate support, can become
victims of violence, crime and abuse.

Enhancing protective factors for both individuals and their communities is
essential to the effectiveness of early intervention for people with mental
health problems and mental disorder. Such support can reduce the duration
and burden of disorders. Building on an individual’s resilience through their
social support, sense of belonging, physical health, coping skills and mental
health literacy is integral to effective early intervention for people with
mental disorders.

Importantly, there is a great deal that mental health promotion can do to
support families. Childhood experiences within the family are associated with
all mental disorders. Communities need to actively value families and
provide the infrastructure necessary for optimal family life. This can include
public policies that support and value families; workplace practices that
support family life; programs that support the children of parents with
problems, including parents who are engaging in criminal behaviour;
substance misuse or who are experiencing a mental disorder; providing adequately for the material needs of families through adequate and appropriate income, housing, medical care, education, clothing, food and entertainment; and the inclusion and acceptance within the community of all types of families regardless of culture, religion, ethnicity or language. Foremost, all parents, particularly those likely to be at higher risk, need to be supported to develop good parenting skills.

**Behavioural disorders**

The reduction of behavioural disorders is a major challenge for mental health. The costs of these disorders, particularly conduct disorder, is substantial and felt in many diverse domains of life, including schools, homes and public safety.

**Prevention**

The effective prevention of conduct disorder would have a flow-on effect of enormous magnitude. Conduct disorder appears to be related to the adverse perinatal factors of prematurity, low birthweight and birth trauma (McGee, Silva & Williams 1984). These perinatal influences interact with family factors, such as large family size, low socioeconomic status, marital discord, and criminality, substance misuse and mental disorder in parents (McGeorge 1997). Protective factors seem to be being female, high intelligence, a resilient temperament and positive social orientation.

The quality of parenting and attachment appears to be a major determining factor, and many of the risk factors for conduct disorder are associated with the provision of poor-quality parenting. Consequently, programs that focus on improving parenting skills in at-risk families have been found to be effective. There is accumulating evidence for the efficacy of parenting skills programs for preschool-aged and primary school-aged children with disruptive behaviour problems (Connell, Sanders & Markie-Dadds 1997; Sanders, 1995). Parent training techniques are based on social learning principles and target family interaction patterns known to contribute to the development and maintenance of behavioural problems. The treatment gains of these programs tend to be maintained over time and the skills learned have been shown to generalize to other situations (Dadds, Sanders & James 1987; Sanders & James 1983).
Early Intervention

The precursors of conduct disorder can be evident in the preschool years, with children at risk showing aggressiveness toward peers, severe noncompliance, social isolation and destructive behavior. Screening for the early signs and risk factors related to ADHD at school entry can enable schools to plan the allocation of special resources. Children with behavioral disorders are likely to have classroom behavior and academic problems. The predictive validity of the ADHD diagnosis in preschool children is unclear, however, and only about one-half of preschoolers identified as hyperactive will meet criteria for ADHD in middle childhood (Beitchman, Wekerle & Hood 1987). Nevertheless, screening can help to target indicated preventions, if the resources for appropriate and sustainable prevention interventions and follow-up are put in place.

An important issue, in terms of preventing children with ADHD from developing a conduct disorder, is for schools to manage children with ADHD effectively and sensitively within their mainstream programs, when possible. Establishing separate educational or prevention programs that bring together high-risk children for prolonged periods of time has the potential hazard that the group will develop a subculture that actually increases disruptive behavior and the chance of developing conduct disorder (Spence 1996a).

Auseinet has recently described clinical approaches for early intervention for ADHD (Randall 2000) and conduct disorder (Danden, Gosley & Nicholson 2000). The NHMRC has also released a report for health professionals and teachers about the diagnosis and management of ADHD (NHMRC 1997a). The report states that children suspected of having the disorder should undergo a thorough assessment before diagnosis is made. The assessment should include medical, developmental, behavioral and educational components. An individualized management plan should be developed that involves consideration of simultaneous medication use, behavior therapy, educational management and family counseling and support. Management plans should be reviewed regularly, and children with ADHD need to be sensitively monitored over time to ensure that they do not develop a conduct disorder. There is particular need for collaboration between the education, justice and welfare systems, given that the costs of untreated and undertreated ADHD are borne by these sectors.

In terms of early intervention, the pharmacological treatment of very young children is a contentious issue, and is viewed ambivalently by many clinicians. Published practice guidelines consider the very young a special population, and advise caution in treating with drugs. Consequently, many clinics actively discourage the referral of preschool children suspected of having ADHD. However, research evidence shows that the earlier a child presents for treatment, the more favorable the short- or medium-term
response to psychostimulant treatment (Taylor et al. 1987). It is unclear whether this is truly an age effect or an effect of briefer duration of symptoms. Unpublished data suggest the latter (Hazell 1998), and shorter symptom duration is one of the major benefits of early intervention.

Yet early intervention may mean that many children receive unnecessary treatment, due to imperfect prediction of those at-risk children who will go on to exhibit ADHD and, later, develop a conduct disorder. This poses a problem for pharmacological treatments: once a child has been prescribed psychostimulant medication, it can be a very difficult decision to reverse, as both parents and teachers are reluctant to risk recurrence of the child's problems.

Psychosocial prevention interventions do not suffer this potential harm. These programs can be safely applied in situations where a child is not actually going to progress to develop ADHD or conduct disorder. By being applied universally they also avoid stigma.

Depressive and anxiety disorders

Prevention

Established risk factors for anxiety disorders include being female and familial predisposition (although this varies for different anxiety disorders). Parental disorder is a significant risk factor for the development of anxiety disorders in children (Haasdijk & Eikes 1992). Disturbed parenting, in terms of both low parental care and overprotection, has also been associated with children's anxiety disorders (Parker 1986).

Some of the risk factors for depression are being female (Wells et al. 1989), marital difficulties (Weissman 1987), stressful life events (Kendler et al. 1993) and depressive symptoms (Normathi et al. 1992). A family history of depression has also been found to be a consistent risk factor (Weissman 1987).

While many of these risk factors are not amenable to modification, developments in prevention interventions for depressive and anxiety disorders are promising, with rigorous scientific trials showing that depression may be preventable in some cases (Murri et al. 1987; Clarke et al. 1995).

School-based programs designed to promote resilience and optimism have been effective in preventing anxiety and depression in children. Resilience can be improved through encouraging an optimistic outlook and teaching better coping skills. Effective programs include the Coping Koala Programme and Friends Programme (Barrett, Dadds & Eikes 1996; Dadds et al. 1997; Dadds et al. 1999) and the Penn Prevention Program (Jaycox et al. 1994). The parenting skills of parents with anxiety and depression disorders can also be targeted and improved through parenting programs in order to provide a better environment for children (Sanders 1995; Sanders & Markie-Dadds 1998; Cornell, Sanders & Markie-Dadds 1997).
Anxiety and depressive symptoms are very common in adolescence. Due to this high prevalence, there is strong support for selectively providing interventions to all young people. The Resourceful Adolescent Project being undertaken at Griffith University provides both early intervention and prevention programs for depression and anxiety disorders. It is targeted at both adolescents (RAP-A) and their parents (RAP-P) (Clarke et al. 1995). The adolescent component represents an experiential, resilience-building program designed to promote positive coping abilities in the face of stressful and difficult life circumstances. The parent intervention promotes parental self-esteem and methods for dealing with parent-adolescent conflict. Preliminary findings from this project showed reduced levels of depressive symptoms at post-intervention and 10-month follow-up, particularly for those adolescents who initially showed high or moderate levels of depressive symptoms (Shochet & Osgarby 1999; Shochet et al. submitted). The Gatehouse Project is another intervention showing positive outcomes for adolescents (Fattah et al. 2000).

For adults, stressful life events often precede an episode of depression or anxiety. Divorce and bereavement are particularly significant events around which prevention interventions can be built (e.g. Raphael 1997). For women, hormonal levels may be implicated in some depressive disorders and oestrogen has been shown to lift mood in perimenopausal women experiencing depression (Schmidt et al. 2000).

For older adults, bereavement is even more salient. Social isolation, physical illness and dependency also contribute to mental ill health in older age. When these events occur, extra resource need to be put in place to support the social and emotional wellbeing of an older person. Increasing social networks, preventing institutionalization and supporting family caregivers are important prevention approaches for older adults (Rommet, Gat & Hertoghom 1999). Resilience in older adults can be facilitated by programs that promote independence, whenever possible, within all domains of mental, social and physical functioning.
A monograph

Early intervention

A recent description of clinical approaches for early intervention for anxiety disorders in children and adolescents (Dadds et al. 2000). Recognition of the main issues for both anxiety and depressive disorders. Although these disorders often have their first signs in middle childhood, children showing early signs can be overlooked because they are generally not disruptive, particularly when compared with children showing signs of behavioral disorder. Behavioral inhibition is a common feature (Spence 1996b), and it is this very characteristic that, with careful observation, can identify those children who are particularly at risk (Kagan & Snidman 1991).

Another indicator of high risk is the presence of parental affective disorder. When parents are being treated for such disorders, their children should be recognized as being at higher risk and also be considered. Aspects of parenting behaviour can also play a strong role in the development of childhood anxiety disorders, and parenting skills programs are an important component of treatment (Spence 1996b).

For adolescents, recognition and acknowledgment of depression and anxiety symptoms and willingness to seek help are important. There is often an expectation that adolescence will be a time of emotional turmoil, and consequently young people and their families put up with distressing symptoms for too long before seeking help. Appropriate types of professional help that are acceptable to and are able to engage young people need to be more widely available. The development of suitable service models for young men is particularly critical, given their high suicide rate and lack of help-seeking behaviour and service use.

In older adults, recognition of affective disorder is also a critical issue. Depression often goes unrecognized in older age, yet it has been suggested that it may be twice as common as dementia (Snowdon 1987). Depression in older people can present as dementia. It can also be passed off as a ‘normal’ response to the accumulating losses and physical disability that may be experienced in older age. It is important that workers dealing with older adults understand that depression can be treated and that it is not an expected accompaniment to old age.

Screening for depression needs to be encouraged in all aged care settings and when physical illness and dementia-like symptoms are present in older adults presenting to general practice. The Psychogeriatric Assessment Scale, developed by Jorm & 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.
Eating disorders

Eating disorders are an important area for development and research, as onset is often insidious and the disorder is usually well established with significant disability before it is recognised (NSW Health 1999).

Prevention

Risk factors for eating disorders have focused on developmental, familial, biological and sociocultural factors. While there is considerable research related to these factors, most of it is methodologically flawed and inconclusive. The only clearly identified risk factors are being young and female. The lack of evidence for risk factors for eating disorders highlights a need for research in this area.

Prevention interventions have focused on school-based programs aimed at modifying knowledge in relation to eating and dieting. O’Shea and Abraham (1999) report on a large, randomised controlled trial of an interactive, school-based education program (Everybody’s Different), and demonstrate that promoting young people’s self-esteem can improve their body satisfaction and eating behaviours. Other programs have targeted high-risk groups of young women such as gymnasts, athletes and ballet dancers, with mixed effects (Moriarty & Moriarty 1986). Generally, while some short-term attitude changes have been noted, there is little evidence for the long-term impact of many eating disorder prevention programs (Russell & Beumont 1995).

Early intervention

Effective early intervention in response to the early signs of eating disorders is essential, given their potentially fatal outcome (Crimp et al. 1992). To do this there needs to be widespread recognition of eating disorders along with the development of appropriate treatment services.

Important partnerships for early intervention are with the staff of gymnast, modelling agencies, ballet schools and sports clubs. Staff in these agencies can be encouraged to project a more healthy message to young women using their services and can also be recruited to facilitate recognition and self-referral in the presence of eating disorders.
Postnatal depression

Prevention and early intervention for postnatal depression have valuable multigenerational effects. This disorder has negative effects not only on the woman herself, but also on the development of the child, relationships with other children and the marital relationship (Boyce & Stubbs 1994; Boyce 1995). Postnatal depression is also likely to recur and may become chronic. Effective prevention of postnatal depression has pronounced, ongoing positive consequences for the whole community.

Prevention

All women require a positive birth and perinatal experience, but identified risk factors that increase the likelihood of postnatal depression include marital conflict, the absence of a supportive partner, lack of social support, difficulties with the infant, stressful life events and previous psychiatric history, particularly depression (Commonwealth Department of Health and Aged Care & AIHW 1999). These risk factors point to selective and indicated populations within which to target specific interventions.

A culturally sensitive understanding of birth practices for Aboriginal, Torres Strait Islander, migrant and refugee women is also important. A culturally traumatic birth experience can be a risk factor for postnatal depression. Awareness of the special circumstances and ability to recognise unique indicators that something might be wrong for women from diverse cultural groups is an important skill for perinatal workers. Outreach programs in different cultural settings are essential to addressing unmet need for prevention and early intervention services (NSW Health 1996).

Early intervention

Auseinet has recently described clinical approaches for the perinatal period (Kowalenko et al. 2000). Attempts to predict which mothers will become depressed or anxious have used measures such as the Edinburgh Post Natal Depression Scale (Boyce 1995; Cooper et al. 1996). Screening can also be relatively simple, and asking a woman how she is feeling generally is of enormous benefit for both the woman and her family (Matthey 1999). Such screening serves the dual purposes of predicting women who are more likely to develop problems and, at the same time, providing good clinical care. Mothers identified through screening can be provided with psychosocial support services during the pregnancy and extra support in the early postpartum weeks. Referral pathways to appropriate clinical care also need to be in place for those women identified as at risk by the screening process.
Psychotic disorders

Prevention and early intervention

While there is presently no known prevention for psychotic disorders, such as schizophrenia and bipolar disorder, research shows the positive effects of early intervention (McGorry 1999). Arguments for early intervention were a response to recognition that there were often major delays in the provision of treatment for psychotic disorders, with an average of one year between the time of first presentation with psychotic symptoms and treatment (Birchwood, McGorry & Jackson 1997). The length of time to first presentation for treatment was associated with increasing complications, including severe behavioural disturbances and family difficulty (Johnstone et al. 1986). Taking more than one year to access services was associated with a tenfold increase in relapse rates over the following two years. Loebel et al. (1992) also reported that the time to remission and level of remission was related to duration of untreated psychosis.

It has been demonstrated that early detection of psychotic symptoms and effective treatment may lead to a dramatic reduction in further symptoms and prevent the development of diagnosable disorder. Wyatt and Henter (1997) discuss four types of studies that provide evidence that early intervention with anti-psychotic medications affects the long-term course of schizophrenia, although the authors note that these studies must be interpreted cautiously and, at present, provide only ‘tantalizing clues’. Wyatt (1995) suggests that untreated psychosis causes negative biological changes and is responsible for long-term illness. Other research supports the notion that there may be physiological changes in certain parts of the brain as a result of diagnosable psychotic disorder (Lieberman et al. 1993a, 1993b; Chatterjee & Lieberman 1999). It is possible that the active psychotic phase of the illness may signal an underlying pathological process that injures the brain and that, if not treated in time, can be irreversible (Lieberman 1997). The potential for irreversible biological damage to the brain provides strong support for the importance of early intervention.

The Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne commenced in October 1992 and provides a comprehensive model of care for people aged 16–25 years. Its focus is the early detection and intensive early treatment of emergent psychosis so as to limit the damage to personal identity, social networks and role functioning that can be caused by underlying illness (McGorry et al. 1996).

Out of this project has emerged the Australian Clinical Guidelines for Early Psychosis (EPPIC 1997). These recommend assessment and careful monitoring of the precursor symptoms during a potential prodromal phase,
as well as looking for other risk factors for early psychosis, such as family history. During the prodromal phase, psychosocial interventions are preferred and the use of neuroleptic or other medication should be avoided unless there is a very rapid deterioration or risk of harm to self or others. Should this occur, a time-limited trial of low-dose neuroleptics is suggested. The model promotes the use of anti-psychotic medication in low doses, which has been found to be effective in first episodes of psychosis. A strategy of low-dose medication is particularly effective in encouraging adherence to the medication regime.

Cognitively oriented psychotherapy is also offered to help prevent depression, anxiety, demoralisation and the lowered self-esteem that is often associated with a psychotic episode, and to address the issues that young people confront. The program has a mobile assessment team that provides information and support through each stage of assessment. Assessments are often undertaken in the home, to reduce the fear of stigma and encourage early help-seeking, and continuity of care is provided for the young person throughout their contact with the service.

The guidelines also recommend the promotion of awareness and education about risk factors and signs and symptoms associated with the prodromal phase to inform parents, teachers, school counsellors, general practitioners, health professionals and other relevant groups.

Substance use disorders

Within the harm reduction framework adopted by the Commonwealth Government’s National Drug Strategic Framework (Ministerial Council on Drug Strategy 1998), there is a focus on both preventing the uptake of drug use and reducing the harm associated with drug use. Prevention and early intervention activities need to identify people at risk of drug use and those beginning to experiment with drugs. The aim is to divert people from progressing to harmful drug use. The challenge for prevention and early intervention in drug misuse is considerable, particularly when, as is often the case, drug misuse is comorbid with a mental disorder. Abstinence is one possible goal, but other goals relate to enabling people to use drugs in ways that do not lead to dependence, disease or criminal sanctions. Diversion from the criminal justice system is especially important, and partnerships between health services and corrective services are vital.
Prevention
The extent to which genetic, environmental and learned behaviours interact to determine substance misuse is the subject of considerable research (Butterworth 1993). Familial drug or alcohol abuse is established as a major risk factor (Board of Trustees 1991). Emotional and behavioral problems along with peer and family influences are also associated with substance misuse (Miller & Wens 1980; Ferguson et al. 1994).

Prevention programs have focused largely on controlling access to substances and educating people as to their harmful effects. The success of these many and varied measures is widely debated, particularly in terms of the high cost of supply-reduction strategies. There is also disturbing evidence that some well-intentioned drug education programs implemented in schools to prevent the uptake of harmful drug use actually increase drug use behaviour (Wallace & Staiger 1998; Hartshorne, Garrard & Dunt 1995; Stiles & et al. 1971). This emphasises the importance of program evaluations for prevention interventions.

Early Intervention
Programs designed for people with more established drug use are generally inappropriate for people early in the pathway to drug use. Specifically, adolescents in drug-treatment programs are not just younger versions of adults in drug treatment. Their issues and needs differ qualitatively and quantitatively and youth-specific services are best able to meet those needs (Spooner, Mattick & Howard 1996). Currently, few drug-harm intervention programs are oriented toward adolescents, and a model of early intervention for substance use in young people is needed. Especially inappropriate are programs that facilitate interaction between young people experimenting with drugs and young people with established drug problems, as such interaction may socialise young people further into drug-using and criminal subcultures.

Primary care is ideally situated to intervene early in substance misuse, particularly of licit substances. For example, the term ‘opportunistic brief interventions’ refers to a range of brief therapeutic strategies that may be delivered at the primary care level to people who do not present primarily with an alcohol problem. A screening technique can identify patterns of alcohol use that are harmful or hazardous, and this can be followed by brief advice, which takes only a few minutes to deliver. Studies have shown that just a few minutes of structured advice is an effective and efficient intervention for harmful or hazardous drinking (Saunders & Lee 1999, 2000). For illicit substance misuse, the opportunities for early intervention in primary care may be more limited, as people are less likely to admit to engaging in an illicit activity than they are to admit to their use of licit substances.
Dementias

Dementia is a syndrome characterized by a major decline in cognition (Hening, Adams & Peterson 1995). There are different forms of dementia; many have an insidious onset and almost all are progressive. Dementia is a major contributor to poor social and emotional wellbeing in later life. Prevention and early intervention for dementia is a concern for the entire health system (Jorm 2000). Carers and doctors of people with dementia seek help from mental health services when complex problems associated with psychiatric symptoms and challenging behaviour emerge. Mental health services contribute an expert understanding of some of the complex conditions that can arise. Through the provision of consultation to the general health system, service responsiveness can be enhanced to ensure people with dementia and their carers receive the help they need when they need it.

Prevention

Some dementias are clearly related to specific modifiable risk factors. These risk factors relate to brain injury and disease processes or infection, which in the end lead to dementia. For example, about 10 per cent of dementias are caused by alcohol abuse and preventing the alcohol abuse would prevent these disorders (Allen 1994). Vascular dementia is responsible for another 10-15 per cent of dementias. This dementia is related to cerebrovascular disease, cardiovascular disease and diabetes. As the risk factors for these diseases are well known and amenable to treatment, there is considerable potential for prevention (Jorm 1994). Strategies that reduce the risk of HIV infection and provide appropriate treatment will reduce AIDS-related dementia. Modifiable risk factors are currently subject to public health campaigns targeted at reducing the prevalence of the underlying injury, disease or infection rather than the resulting dementia. In time, secondary benefits in reduced prevalence of these dementias will be seen. However, many public health programs are currently targeted to the younger population and need to be modified to be relevant to the older population (Department of Human Services 1997).

The most common dementia is of the Alzheimer’s type (DAT), representing about 60 per cent of diagnosed dementias. The confirmed risk factors are not modifiable—old age, family history, presence of a particular genotype and Down syndrome (Rebeck et al. 1994). Some possible protective factors 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).
Promotion, Prevention and Early Intervention for Mental Health

Early Intervention

Recognition and appropriate diagnosis and treatment early in the course of the disorder are important to treat reversible causes of dementia, prevent excess disability and reduce the impact of the illness and the associated care on the health of the caretaker.

Active, early treatment of cerebrovascular illness can minimise the harm of vascular dementia. The education of general practitioners about the management and benefits of active, early treatment is important (Department of Human Services 1997). Psychosocial educational interventions with carers can reduce stress and mental health problems for carers and delay institutionalisation (Bosley & Peters 1991).

Early recognition enables supports to be put in place to reduce future burden related to the disorder. People with the early signs of dementia can be directed to appropriate services and risk factors that are modifiable can be addressed. For example, the risk of falls and injury is greatly increased for people with dementia (Sekska et al. 1995). If this risk is recognised and acknowledged, prevention interventions can be put in place to reduce the injuries that can occur as a consequence of dementia.

Plans can be made for future care if there is early warning. Notably, people can make their own decisions about their future care, rather than having these decisions taken out of their hands later on, when their impairment is too great to be able to make decisions. However, care must be taken that screening does not lead to premature entry into residential care, as older people and their carers may anticipate the inevitable decline and future burden of caregiving (O’Connor et al. 1991).
Comorbidity

The co-occurrence of more than one mental disorder is termed comorbidity. Comorbidity of mental disorders is common. In the 1997 Survey of Mental Health and Wellbeing, around one in four people with an anxiety, affective or substance use disorder also had at least one other mental disorder (Andrews et al. 1999). Similarly, in the more recent child and adolescent component of that survey, 23 per cent of all children with an identified disorder had symptoms that met the criteria for another disorder (Leyser et al. 2000).

Adults with comorbid mental disorders had more days out of role and used more health services than those with only one mental disorder. Comorbidity further exacerbates the negative outcomes of mental illness and may lead to even greater damage to the person’s quality of life.

The development of one mental disorder increases the likelihood of developing a range of other mental health problems. Of special significance is the likelihood of substance use being comorbid with other mental health problems. People become more vulnerable to substance use through attempts to self-medicate their symptoms with licit and illicit drugs, as well as through lifestyle changes related to their mental disorder (Dixon et al. 1991).

Consequently, substance use problems are more common among those diagnosed with mental disorders than among the general population (McLennan 1998; Jablonsky et al. 1999; Hambrecht & Hafner 1996). While approximately 15 per cent of the general population have a substance use disorder, at least half of all people with a psychotic disorder may use alcohol or other drugs in ways that put them at risk of physical or psychological harm (Fowler et al. 1998). There is also a high prevalence of problematic substance use among people with bipolar disorders and mood disorders, such as anxiety and depression (Regier et al. 1990).

The effects of substance use on mental health are many. Although people with a mental disorder may use substances for the immediate benefits of relief from emotional discomfort and loneliness or to reduce the side-effects of prescribed medication, in the longer term substance use often has harmful consequences (Jenner forthcoming; Ritson 1999; Jenner et al. 1998). Some of the possible harmful consequences of comorbid substance misuse in the treatment of mental disorders are masking of symptoms of mental disorder; making diagnosis more difficult; exacerbation of psychotic, depressive and anxiety symptoms; increased suicide attempts; reduced compliance with treatment regimes; reduction in the effectiveness of prescribed medication; poorer treatment outcome; and increased psychosocial problems, including financial problems, legal difficulties, housing problems and family disruption.
Substance misuse, therefore, poses a particular challenge when it is part of a dual diagnosis with another mental disorder. The high prevalence of dual diagnosis necessitates routine assessment for substance use problems among those accessing mental health services, as well as routine assessment for mental health problems among those in treatment for substance use disorders, along with close partnerships between mental health and drug and alcohol services.

Suicide prevention

Individuals with mental health problems and mental disorders (particularly depression, psychotic disorder and drug/alcohol misuse) are at markedly increased risk of suicide (Patten et al. 1997). Consequently, all services (both within and beyond the health sector) that come into contact with people at risk of or experiencing mental health problems or a mental disorder need to be aware of the potential risk for suicide (Mitchell 1998).

Children and adolescents with more emotional and behavioural problems report substantially more suicidal ideation and behaviour. For example, in the child and adolescent component of the National Survey of Mental Health and Wellbeing, of the adolescents with a very high level of mental health problems, 42 per cent reported that they had seriously considered suicide and 25 per cent that they had made an attempt in the past 12 months. This compared with rates for adolescents with a low level of mental health problems of only 2 per cent who reported that they had seriously considered suicide and less than one per cent that they had made an attempt in the past 12 months (Sawyer et al. 2000).

Westermeyer, Harrow and Marango (1991) reported a prospective follow-up of 586 psychiatric patients and found that the first six years after the first hospitalisation was a critical period for suicide risk. During this period, over 60 per cent and 40 per cent of suicides had taken place for people diagnosed with schizophrenic and psychotic disorders and people with non-psychotic disorders, respectively. A study of mental health clients in New South Wales found that, at around the time of discharge from inpatient care, clients had a suicide risk about 100 times greater than that of the general population (Chipps, Stewart & Sayer 1995). Other studies have found that about 90 per cent of older adults who attempt or die by suicide in Australia have a mental disorder, usually depression, which has often been inadequately treated (Drapor 1995), and it has been estimated that one in 10 people with schizophrenia die by suicide (Tobar & Murray 1996).
The mental disorder most commonly associated with suicide is depression (Martin et al. 1997), although harmful drug use and psychotic disorder are prominently associated with suicides among younger adults (Correll et al. 1996). Suicide rates are higher for people who are not receiving treatment or whose current treatment is not effective (Chapple et al. 1995), and there is strong evidence that appropriate pharmacological treatment can dramatically reduce the risk of suicide in depression, schizophrenia and bipolar disorder for adults (Goldney 1998). Early intervention for mental health problems and mental disorders therefore clearly has the potential to reduce the incidence of associated suicides.

Suicide is the final outcome of what is usually a complex, cumulative and interacting set of risk factors. The trajectory is different for each individual and it is not possible to predict individual suicide with any certainty (APS 1999), although there are a number of personal and environmental factors that place people at increased risk (Bourmain 1998). Indicators of heightened risk of suicide include depressive symptoms, hopelessness, recent loss, a previous attempt and active suicide ideation (APS 1999). A series of negative events over time appear to escalate a person along the trajectory. At some point there occurs a ‘last straw’ that results in the suicidal behaviour.

While suicidal behaviour and thinking are strong risk factors for suicide at all ages, risk factors vary across the lifespan and differ, for example, between older males and young adult males, the two groups at highest risk of suicide (Commonwealth Department of Health and Aged Care 2000b). Older adults who die by suicide are less likely than younger people to have a history of suicidal behaviour and thinking. Suicide in older adults is less impulsive, methods tend to be violent, and there is less opportunity for intervention. These different risks suggest that preventive strategies need to be differently targeted across the lifespan (De Leo et al. 2000).
While transient suicidal ideation appears to be quite common, it provides one potential identifier for indicated suicide prevention (Diekstra & Garnefski 1995). It is important to note that asking about suicidal ideation does not increase suicide risk (APS 1999). When suicidal ideation is evident, it must be taken seriously, and this should include determining whether a person has a suicide plan and whether he or she has access to the preferred means of suicide. This can indicate the level of suicide risk. A previous suicide attempt is an important predictor of suicide, and the nature of the previous attempt can be significant. ‘Termination behaviour’, such as making a will and giving away possessions, are also predictive.

Often suicide prevention is best approached indirectly; many intervention programs do not address the issue of suicide itself, and instead address risk or protective factors, such as depression, school failure, delinquency, family conflict, gun control and resilience (NSW Health 1999). Suicide prevention programs may also target younger children, many years before they are likely to attempt suicide, when the risk factors for suicide and mental health problems are beginning to develop.

The national suicide prevention strategy, Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia, is an initiative that will provide updated evidence about where along the trajectory it is best to place available resources in order to prevent suicide. Currently, there is still a need to clarify the pathways to suicide and determine the ‘best buys’ for intervention (Martin 1998b). Some evidence is emerging, however. For example, suicide prevention programs in schools are no longer supported because of increased risk to young people who may be vulnerable. Similarly, it has been recognised that media reporting of suicide can affect suicidal behaviour in the community (Martin 1998a; Gould & Schaffer 1986), and the Resource Kit for Australian Media Professionals for the Reporting and Portrayal of Suicide and Mental Illnesses has been developed as a response.
CHAPTER 8:  
TOWARDS GOOD PRACTICE IN PROMOTION, PREVENTION AND EARLY INTERVENTION

An increasing body of evidence shows that activities aimed at the promotion of mental health and prevention and early intervention for mental health problems and mental disorders will substantially improve the social and emotional wellbeing of all Australians. The benefits of promoting mental health are many and include improved psychosocial functioning in all of life's domains, better physical health and increased productivity, as well as reduced health problems, mental disorders and associated burdens. The factors that influence mental health and mental illness occur in the events and settings of everyday life. Thus, while effective promotion, prevention and early intervention for mental health require support from and partnerships with all sectors of the community, the benefits of this plan of action will also be felt in these sectors.

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 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 the 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 for the intervention strategy to be sustained and generalised to other areas, and
• the capacity of the intervention to redress inequalities.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Action Plan 2000) presents priority groups for mental health interventions. The priority groups are:

• Whole of community: Groups across the lifespan; 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;
• Other priority populations: 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; and
• Key strategic priority groups: Consumers and carers, Media, Health professionals and clinicians.
It takes the issues that have been raised in this monograph and develops a framework for mental health interventions. For each of the 15 priority groups identified, it sets out:

- outcomes: the anticipated benefits of promotion, prevention and early intervention activities for the identified priority group;
- rationale: an outline of why this group is a priority and the conceptual basis supporting the choice of actions;
- evidence base for action: a summary of the research that informs current understanding of possible directions for promotion, prevention and early intervention initiatives. The section also presents important research questions to address significant gaps in the evidence base;
- who will be involved: identifies those individuals, groups and agencies that need to be involved as partners, custodians, stakeholders or agents of change;
- where self will happen: identifies the places or environments where interventions can occur;
- national action: presents major national policy or program initiatives that may contribute to the achievement of outcomes specific to each priority group;
- process indicators: lists measures of progress that are specific to each priority group in order to achieve desired outcomes; and
- outcome indicators: lists indicators of changes in health status specific to each priority group.

The success of Action Plan 2000 depends on planning and building capacity. This requires political commitment at all levels—local, State/Territory and national—along with 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. Of utmost importance in developing interventions is community participation at all stages, as well as effective partnerships with all those individuals, services and sectors identified as being relevant to the aims of the intervention. Special consideration needs to be given to the engagement of consumers and carers.
Mental health promotion is especially relevant to the whole community. It is applicable regardless of current mental health status and across the entire mental health intervention spectrum. Mental health promotion is the framework within which effective prevention and early intervention can be accomplished. Prevention interventions targeted at both the proximal and more distant risk and protective factors for mental health problems and mental disorders have the potential to greatly reduce the development of many mental health problems and mental disorders and their associated burdens. Early intervention provides the bridge between prevention and treatment, as it spans indicated prevention, case identification and treatment of first episodes of disorder. The challenge for early intervention is to provide a strong link between traditional mental health services and the growing body of promotion and prevention approaches.

Mental health promotion is able to improve the social and emotional wellbeing of all people, regardless of their current mental health status, through:

- improving the capacity of communities to support the social and emotional wellbeing of their members;
- improving the capacity of communities to support the social and emotional wellbeing of their members;

Prevention of mental health problems and mental disorders occurs through:

- widespread understanding of the contributing risk and protective factors;
- support for the prevention-intervention cycle;
- the development and uptake of universal, selective and indicated interventions;
- emphasis on the reduction of risk factors across all domains—personal, social, cultural and economic; and
- emphasis on improving protective factors to better enable individuals and communities to cope with adversity.
For early intervention the critical elements are:

- awareness of the early signs and symptoms of mental health problems and mental disorders among the entire community, and particularly among workers in settings likely to come across people experiencing early signs and symptoms;
- an increased emphasis on outreach through indicated and opportunistic screening;
- use of non-stigmatising assessment procedures, including home-based assessments;
- for people with an at-risk mental state, emphasis on reducing risks and enhancing protective factors;
- for first episodes of diagnosable disorder, the provision of best practice for that disorder (which may differ from standard practice); and
- an emphasis on ongoing monitoring that, if necessary, can sensitively and non-intrusively follow a person across stages of the lifespan.

For all these interventions there is a need for:

- integration of, consultation with and advocacy for consumers and carers;
- the provision of ongoing training and support for the workforce in promotion, prevention and early intervention;
- widespread dissemination of up-to-date and evidence-based information related to promotion, prevention and early intervention;
- an emphasis on research, evaluation and monitoring to determine the effectiveness of interventions and areas of current need; and, most importantly,
- ongoing intersectoral and intrasectoral partnerships and linkages among mental health, health, education, family, community, employment, housing, correctional and welfare services, and other relevant agencies.

Figure 2 gives an example of how the framework for promotion, prevention and early intervention described in this document might be implemented in middle childhood. Practical applications to other lifespan groups are presented in Action Plan 2000.
<table>
<thead>
<tr>
<th>Protective factors to enhance</th>
<th>Risk factors to reduce</th>
<th>Possible early signs and symptoms to recognize</th>
<th>Possible interventions</th>
<th>Settings for interventions</th>
<th>Workforce to engage and train</th>
<th>Ongoing partnerships to form</th>
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<tr>
<td>Family harmony</td>
<td>Family discord and reconcile</td>
<td>Disruptive and social behavior</td>
<td>Program to reduce social and economic disadvantage for families</td>
<td>Family School, Childcare services, Parent support services</td>
<td>General practice practitioners, Childcare workers, Child health clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Positive school achievement</td>
<td>Low family income</td>
<td>Behavioral inhibition</td>
<td>Programs to promote competence of children and families</td>
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<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<tr>
<td>School achievement</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Self-worth</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
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<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Self-efficacy</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
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<tr>
<td>Coping skills</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Personal confidante</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<tr>
<td>Positive peer group</td>
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<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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<td>Active lifestyle</td>
<td>Parental substance misuse and mental health problems</td>
<td>School failure</td>
<td>Programs to support family functioning and supervision</td>
<td>General practice Child Health Services, Childcare workers, Child Health Clinic workers, Welfare workers, Volunteer workers and volunteers, Aboriginal health workers, Family School</td>
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</table>

**Figure 2:** Promotion, prevention and early intervention during middle childhood
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
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<td>AGPS</td>
<td>Australian Government Publishing Service</td>
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<td>AIPW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>APA</td>
<td>American Psychiatric Association</td>
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<tr>
<td>APS</td>
<td>Australian Psychological Society</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<tr>
<td>EPPIC</td>
<td>Early Psychosis Prevention and Intervention Centre</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>HREOC</td>
<td>Human Rights and Equal Opportunity Commission</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NCAGMH</td>
<td>National Community Advisory Group on Mental Health</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<tr>
<td>RIMA</td>
<td>Rural, remote and metropolitan areas (classification)</td>
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<tr>
<td>VFST</td>
<td>Victorian Foundation for the Survivors of Torture</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
Glossary

**Aboriginal concepts**

**Health**

"Not just the physical wellbeing of an individual, but... the social, emotional and cultural wellbeing 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) diagnostic; (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, address, 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 behaviour. 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 judgment.

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—newspaper, magazine)" (Commonwealth Department of Health and Family Services, 1998, p. 236).
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. 238).

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
Meta-analysis  
'A systematic review that employs statistical methods to combine and summarize 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 Morose, 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).

Parents  
The person or people who are a child’s primary carers. 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 composition, 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 disorder 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:

<table>
<thead>
<tr>
<th>Zone</th>
<th>Category</th>
<th>Metropolitan</th>
<th>Other metropolitan centres</th>
<th>Rural</th>
<th>Large rural centres</th>
<th>Small rural centres</th>
<th>Other rural areas (urban centres population &lt; 10,000)</th>
<th>Remote</th>
<th>Remote centres (urban centres population &lt; 5,000)</th>
<th>Other remote areas (urban centres population &lt; 5,000)</th>
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<tbody>
<tr>
<td>Metropolitan</td>
<td>Capital cities</td>
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<td></td>
<td>Rural</td>
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<td>Rural</td>
<td>Large rural centres</td>
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<td>Other rural areas (urban centres population &lt; 10,000)</td>
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<td>Remote centres (urban centres population &lt; 5,000)</td>
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</table>
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 obligations 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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A Monograph

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