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Under the Second National Health Plan: 1998-2003.
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MENTAL HEALTH PROMOTION AND PREVENTION

NATIONAL ACTION PLAN

UNDER THE SECOND NATIONAL MENTAL HEALTH PLAN: 1998-2003

A JOINT COMMONWEALTH, STATE AND TERRITORY INITIATIVE

January 1999

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Request for feedback

The Mental Health Promotion and Prevention National Action Plan is a working document that will be updated regularly in response to emerging priorities, to the outcomes of research and other projects, to identified best practice and to user feedback.

Feedback on the Action Plan is welcomed from individuals and organisations with an interest in mental health promotion and illness prevention. In particular, comments are sought on the usefulness of the Plan and how it may be strengthened.

Feedback on the current Plan should be provided by **31 August 1999** and may be forwarded to:

Promotion and Prevention Section
Mental Health Branch
MDP 37

Commonwealth Department of Health and Aged Care
GPO Box 9848

CANBERRA ACT 2601

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Foreword

The *NationalAction Plan* for mental health promotion and prevention represents a major and exciting initiative that will take forward new directions for improving the mental health outcomes of the Australian population.

The *Action Plan* provides the policy framework for promotion and prevention, one of the three key themes of the *Second National Mental Health* Plon.The strategies proposed in the *Action Plan* offer the opportunity for both a national coordinated approach and State leadership; emp hasise the importance of forming partnerships at many levels; and recognise the potential for contributions from all groups in the community.

The *Action Plan* has been developed in a partnership between the National Mental Health Working Group and the National Public Health Partnership and is thus based on expertise from both the mental health and the public health fields.

It incorporates the best available scientific evidence about effective prevention programs and suggests directions for research and development where further evidence is needed.The plan will be complemented by other reports, including a conceptually-based report and detailed documentation for particular priority areas and strategies.

The *Action Plan* is a working document suggesting both opportunities and challenges, and has been developed in consultation with representatives from a range of sectors and, from consumers, carers and community groups. It will continue to be responsive to new information as it becomes available, as well as to feedback as it is used.

This *Action Plan* represents a major and important new direction for mental health in Australia as an agreed component of the Second National Mental Health Plan. Its progressive implementation will place Australia at the forefront of the mental health promotion and prevention field internationally and will contribute significantly to lessening the adverse impact of mental health problems and mental disorders, now and in the future.

Professor Beverley Raphael,
National Mental Health Working Group

Dr Diana Lange,
National Public Health Partnership Group

National Mental Health Promotion and Prevention Working Party Membership

The Promotion and Prevention Working Party (PPWP) is auspiced by the National Mental Health Working Group and the National Public Health Partnership Group.The PPWP is comprised of members or nominees of these auspicing groups.

Professor Beverley Raphael (Chair)	Centre for Mental Health NSW Health Department Member, National Mental Health Working Group
Dr Diana Lange	Queensland Health Department Member, National Public Health Partnership Group
Mr Paris Aristotle	Victorian Foundation of Survivors of Torture
Ms Louise Cooke	National Aboriginal Community Controlled Health Organisation
Ms Karen Dini-Paul	National Aboriginal Community Controlled Health Organisation
Ms Trisha Goddard	Consumer representative (until September 1998)
Mr Clive Skene	Department of Public Health, Flinders University, SA
Ms KerryWebber	Promotion and Prevention Section Mental Health Branch Commonwealth Department of Health and Aged Care
Ms Anwen Williams	Division for Psychosocial Research TVW Telethon Institute for Child Health Research, WA
Associate Professor Steve Zubrick	Division for Psychosocial Research TVW Telethon Institute for Child Health Research, WA
Sr Pat Swan	National Aboriginal Community Controlled Health Organisation

Secretariat

Ms Linda Pettigrove
Promotion and Prevention Section
Mental Health Branch
Department of Health and Aged Care

Executive Editor/Consultant

Dr Kathleen Griffiths (from October 1998)

Ms Nada Martinek (until September 1998)

Background

Introduction

The burden of mental health problems and disorders is high and rising. **It** has been estimated that depression alone will constitute one of the greatest health problems worldwide by the year 2020 (Murray & Lopez **1996).**

These findings pose immediate and serious concerns and challenges for government, policy makers, researchers, health and other essential service providers, individuals, families and communities. It is becoming increasingly clear that the enormous personal, social and financial costs associated with mental health problems and disorders will not be reduced significantly by treatment interventions alone and that interventions which impact earlier in the developmental trajectory of mental health problems are required. There is now a critical need to prioritise mental health promotion and prevention in global, national and regional policy and to develop a clear plan for progressing mental health promotion and prevention activities.This *Action Plan* provides a framework for a coordinated national approach to the promotion of mental health and the prevention of mental illness in Australia.

There ;Is convincing evidence that preventive interventions can be effective (see Effectiveness of *prevention* a*nd promotion,* p4). Moreover, the scientific evidence base is expanding. It is now time to use this knowledge base to improve mental health outcomes for Australians.

The way forward is for everyone, within and across all sectors, to work together to provide quality services, programs and initiatives that involve a spectrum of interventions to reduce mental disorders and problems and to improve well-being. Mental health promotion and prevention must take its place alongside treatment and maintenance in Australian mental health service delivery. A focus on prevention does not detract from a commitment to and further research into the causes and treatment of mental disorder. Rather, it takes forward opportunities for impacting on the many factors that are known to contribute to mental disorders.

Concepts and terminology

A number of terms such as **prevention, promotion, mental disorder, mental health problems, mental health, early intervention, and mental health literacy** are used throughout this document. There has been considerable inconsistency in the use and definitions of a number of these terms in the literature and elsewhere (see Freedman 1995).This section therefore attempts to clarify the meanings of key terms as they are used in the current Action Plan. It is acknowledged that the terms may have been used differently in other contexts and that some of the conceptual difficulties inherent in the field may still at times be reflected in the present document.

Definitions of other terms used in this document appear in the glossary.

Prevention, mental disorders, mental health problems

In keeping with a framework developed by the United States Institute of Medicine (IOM), **prevention** is defined in this Action Plan as 'interventions that occur before the initial onset of a disorder' (Mrazek & Haggerty 1994, p23).The goal of these preventive interventions is to reduce the incidence of mental health problems and mental disorders and to thereby reduce their prevalence and associated disabilities.

In this context, a **mental disorder** is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. There are different types and varying degrees of severity of mental disorder. Examples of mental disorders include depression, anxiety, substance abuse, bipolar disorder and schizophrenia. A **mental health problem** interferes with a person's cognitive, emotional or social abilities but not to the extent that it meets the criteria for a disorder.

The *Action Plan* has also adopted the IOM system for subcategorising preventive interventions for mental disorder (see figure 1).This system classifies preventive interventions as either universal, selective or indicated. Universal programs are provided to whole populations, selective interventions are targeted at those at increased risk of developing a disorder and indicated interventions are targeted at those who are showing minimal signs and symptoms of a disorder (see table 1).Together, the universal, selective and indicated categories of intervention correspond to the concept of primary prevention in the Capian (1964) model of prevention.

Early Intervention

In this plan, **early intervention** refers to interventions targeting people displaying the prodromal signs and symptoms of an illness and to the early identification of people suffering from a disorder. It thus encompasses the indicated intervention and case identification sectors of the IOM

Mental health literacy

The term **mental health literacy** was introduced by Jorm et al (1 997) who defined it as 'Knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (p 182).They noted that mental literacy includes:

- the ability to recognise specific disorders;
- knowing how to seek mental health information;
- knowledge of risk factors and causes, of self-treatments and of professional help available; and
- attitudes that promote recognition and appropriate help-seeking (p182).

Table 1 - The Institute of Medicine definitions of preventive interventions (Mrazek & Naggerty 1994)

Type of intervention	Definition	Examples
Universal	targeted to the general public or a whole population group that has not been identified on the basis of individual risk' (Mrazek & Haggerty, p24)	Pre-natal care, parenting programs
Selective	targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average….. The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological or social risk factors that are known to be associated with the onset of mental disorder' (Mrazek & Haggerty, p25)	Home visitation and day care for low-birth weight infants Educational preschool programs for children from disadvantaged communities
Indicated	'targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms fore-shadowing mental disorder, or biological markers indicating predisposition for mental disorder, but who do not meet DSM-IV diagnostic levels at the current time' (Mrazek & Haggerty, p25)	Training program for children with some signs of behaviour problems

Table 1 reprinted with permission from Reduced *Risks for Mental Disorders*, National Academy Press 1994, by the National Academy of Sciences, courtesy of the National Academy Press,Washington, DC.

Mental health promotion, mental health

Whereas preventive approaches are typically focused on avoiding illness, mental health promotion aims to optimise mental health and well-being in individuals and communities. In the health promotion context, mental health is not viewed simply as the absence of mental disorder but rather as:

The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, 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)

However, as indicated in the Second National Mental Health Plan (1 998), the term'promotion of emotional and social well-being' 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 and Torres Strait Islander communities and some other cultural groups.

Mental health promotion focuses on improving environments (social, physical, economic) which affect mental health and enhancing the 'coping' capacity of communities as well as individuals (Wood &Wise 1997, p42). Examples of mental health promotion include action designed to increase the connectedness and supportiveness of school or workplace communities.

In contrast to prevention, which is concerned with individuals prior to the onset of a disorder, mental health promotion is applicable across the continuum of care and is focused on the promotion of well-being rather than illness prevention.

Although the goals of prevention and promotion differ, the two intervention frameworks may sometimes use similar approaches and produce similar outcomes. Thus, a mental health promotion intervention aimed at increasing well-being in a community may also at times have the effect of decreasing the incidence of mental disorder.

The need for a National Action Plan

The development of the *Action Plan* has been motivated by the high prevalence and personal and economic burden of mental disorders together with evidence that preventive interventions can be effective. In addition, mental health promotion has the potential to improve the quality of life and well-being of all Australians.

Prevalence of mental health disorder

Almost 20 per cent of all children and adolescents in Australia are affected by mental health problems and at least half of these show impaired schooling and social development (Zubrick, Silburn & Garton et al 1995).There is now ample evidence that mental health problems in childhood and adolescence are associated with greatly heightened risk of mental disorder in adult life, as well as other risk factors and vulnerabilities in the developmental years.

Eighteen per cent of adults in the Australian community suffer from a mental disorder (McLennan 1998) and the prevalence of anxiety, depressive and substance use disorders among adults is 9.7 per cent, 5.8 per cent and 7.7 per cent respectively. The highest level of mental disorder occurs in young adulthood, with more than one-quarter of all young adult Australians aged 18 to 24 years suffering from at least one mental disorder (McLennan, 1998).

Finally, only 38 per cent of adult Australians with mental disorders receive help for their problems (McLennan 1998).This finding is consistent with the results of overseas studies.

Burden of mental health disorders

It has been reported that the burden of mental disorders has been significantly underestimated and that psychiatric disorders account for almost 11 percent of all disease burden worldwide (Murray & Lopez 1996). Moreover, five of the ten leading causes of disability worldwide in 1990 were psychiatric conditions.

The direct cost of mental disorders and- problems in Australia was estimated to be $2 billion in 1989-90 (Australian Institute of Health &Welfare 1996). Such estimates do not include community costs, family impact, the need for welfare response and coronial work in the case of suicides. The health costs and loss of earnings due to all suicides and suicide attempts over a one year period was estimated to be $920 million for the financial year 1989-90 (see Raphael & Martinek 1994).

The effectiveness of prevention and promotion

Although prevention and promotion activities have been accepted as legitimate interventions in the area of physical health for many years, there has been a resistance to introducing these approaches in the mental health services area. Today this status is changing and the scientific basis for prevention and promotion in mental health is expanding. Extensive randomised controlled prevention trials exist and the US National Institute of Mental Health is currently establishing a clearing-house of such trials. Reports such as: OSAP *Prevention Monograph-2* (Schaffer, Phillips & Enzer 1989); Scope *for Prevention in Mental Health* (Raphael 1993); *Reducing Risks for Mental Disorders* (Mrazek & Haggerty 1994); Healthy *Families: Strategies for Promoting Family Health in Australia* (Sanders 1995); *Prevention in Psychiatry* (Paykel & jenkins 1994); *Handbook of Studies on Preventive Psychiatry* (Raphael & Burrows 1995); and *Early Intervention and Prevention in Mental Health* (Cotton & Jackson 1996) provide comprehensive and soundly based reviews of the prevention and promotion fields. Economic data, although limited and derived from US studies, provides evidence of cost savings.

Evidence for prevention programs is strongest in the area of child and adolescent mental health. A metaanalysis of such programs showed that they were at least as effective as many established treatment interventions in medicine and the social sciences (the average outcome for the intervention group surpassing that achieved by between 59% to 82% of control group participants) (Duriak &Wells 1997).

However, there is also evidence, based on randomised controlled trials, of efficacious interventions for adults affected by adverse life events such as bereavement, physical illness, divorce and separation, trauma and violence and unemployment (eg, see Mrazek & Haggerty 1994; see Health Education Authority 1997). In addition, exercise has been shown in a randomised controlled trial to decrease stress levels in older adults (King, Taylor & Haskell 1993). In the area of mental health promotion, a controlled trial has demonstrated that media campaigns in conjunction with appropriate community activities can positively influence attitudes and knowledge (Hersey, Kiinamoff, Lam & Tayfor 1984, cited by Health Education Authority 1997).

There is nevertheless a need to conduct further research on mental health promotion and the prevention of mental health problems and disorders to increase the evidence base for a range of lifespan, population and other key groups. For example, there is little evidence concerning interventions for young adults, people in the workplace, people living in rural and remote areas, people from diverse cultural and linguistic backgrounds and Aboriginal peoples and Torres Strait Islanders.

In addition, there is a lack of evidence concerning the effectiveness of mental health promotion (as opposed to preventive) interventions. It is essential that mental health promotion programs are subjected to rigorous scientific evaluation.To this end, there is a need to develop appropriate indicators of well-being and mental health promotion benchmarks and to ensure that mental health promotion interventions incorporate an evaluation component,

Finally, all preventive interventions rely on an understanding of the complex biological, psychological and social factors that contribute to the aetiology of mental health problems and disorders. Further research to extend our knowledge of these risk factors is essential. Such understandings will form a stronger basis for preventive interventions.

The policy context

International context

The current *Action Plan* has been developed in the context of an international movement to prevent mental health problems and disorders and to lessen the global burden of these conditions.

In a definitive report, the US Institute of Medicine published a systematic review of the evidence for prevention in mental health (Mrazek & Haggerty 1994). Specific prevention programs have now been established in the United States by government mandate. There have also been important 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 World Health Organization (WHO) has also contributed to the field, producing in 1993-94, the *Guidelines on the Primary Prevention of Mental, Neurological and Psychosocial Disorders* (see Bertolote 1998).

Much of the mental health promotion work internationally has been conducted within the framework of the Ottawa Charter for Health Promotion (WHO & Canadian Public Health Association 1986) which includes as key components: building healthy public policy (emphasising the role of all sectors in health outcomes); creating supportive environments in all settings; strengthening community action, developing personal skills (knowledge and attitude to health) and increasing the focus on prevention and early intervention.

Australian context

Australia's National Mental Health Strategy, comprising the *Mental Health Statement of Rights and Responsibilities, the National Mental Health Policy* and the *National Mental Health Plan,* was set in place in 1992. It has a principle aim of promoting mental health and, where possible, preventing mental health problems and disorders.

In July 1998, the Australian Health Ministers endorsed the *Second National Mental Health Plan (2nd NMHP)* to provide a five-year framework to progress further mental health reform to June 2003.The 2nd NMHP, to which all States are co-signatories, identifies further priority areas for reform within the three areas of. promotion and prevention; partnerships in service reform; and quality and effectiveness of service delivery. The Commonwealth has allocated to the States and Territories a total of $250 million over five years for the implementation of the 2nd NMHP An additional $28 million over three years is also available for Commonwealth initiatives in these areas.

Outcomes identified in the 2nd NMHP in relation to promotion and prevention include:

- improved public health strategies to promote mental health;
- 0reduced 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.

Whereas the promotion and prevention components of the first *National Mental Health* Plan were focused primarily on increasing public awareness of the extent of mental illness and on promoting destigmatisation, prevention and promotion activities in the 2nd NMHP 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 (1997) identified that national direction in the area of promotion and prevention was needed in order to provide leadership, clarify responsibilities, stimulate development of specific programs for populations at higher risk and support primary care providers.

The Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group (NMHWG) and the National Public Health Partnership (NPHP) Management Group agreed to auspice the National Mental Health Promotion and Prevention Working Party (PPWP) to develop an Action Plan which would provide this national direction. This document represents the resulting *Action Plan*.

The National Action Plan

Purpose of the plan

The *Mental Health Promotion and Prevention National Action Plan* outlines a 5 year strategic framework and a plan for action to meet the prevention and promotion priorities and outcomes outlined in the second National Mental Health Plan from 1998 to 2003.The *Action Plan* provides a framework to lessen morbidity through diminishing risk and enhancing protective influences that contribute to the disorder process. It also contains strategies for promoting mental health.

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

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

The *Action Plan* outlines the agreed initiatives that will be undertaken at a national level, provides a rationale for the selection of the priority areas and refers to the evidence base to support the suggested activities.The framework enables the detail of specific activities to be developed individually by the States and Territories as they progress the plan within their own environments. Current initiatives can also be integrated into the template. In this context, the *Action Plan* is a tool that will provide direction, prompt action, assist consistency, avoid duplication of effort, and standardise information collection and reporting. While providing joint leadership via this national focus and facilitating full autonomy to each area to develop and deliver individual plans, it will ensure the opportunity for a collaborative partnership is maintained.

Scope of the plan

The *Action Plan* is concerned with:

- mental health promotion; and
- the prevention of mental health problems and mental disorders.

The prevention strategies are restricted to universal, selective and indicated interventions and case identification on the Institute of Medicine spectrum (see figure 1). In particular, the *Action Plan* does not encompass treatment and maintenance interventions that are the responsibility of mental health treatment services. The field of early intervention, while closely related to the current plan, will be considered in a separate report and is thus not addressed here. In addition, since youth suicide prevention and depression strategies are the subject of the *National Youth Suicide Prevention* Strategy and the *Depression Action Plan* respectively, these areas are not addressed in detail here.

However, it is intended that there will be close links with these two highly relevant initiatives throughout the implementation of the *Action Plan*.

The literature reviewed in this document focuses more on preventive than promotion approaches due to the greater strength and quality of evidence concerning the effectiveness of preventive interventions. In addition, although biological factors and, in many instances, genetic influences, may contribute to the prevention of mental health problems and disorders, evidence-based opportunities for prevention currently lie primarily in the field of psychosocial interventions. Accordingly, there is an emphasis on psychosocial rather than biological preventive interventions in the *Action Plan*. Nevertheless, the framework of the plan is responsive to emerging evidence, and new findings, including those relating to biological factors and promotional interventions, can be incorporated as data becomes available.

Principles and general strategies

The *Action Plan* outlines opportunities for prevention that have the **strongest scientific basis** with the potential for short and long term savings in both human and economic terms. **Multicomponent** programs across settings are emphasised due to their effectiveness. In areas where there is little empirical evidence concerning the effectiveness **of** interventions, the plan provides for **developing, piloting** and **evaluating innovative approaches** to prevention and promotion and for **commissioning research** aimed **at** improving the evidence base.

Particular emphasis is placed on the development of **partnerships** within and outside the mental health and health sectors.The burden of mental health problems and mental disorders transcends sectors and borders and requires links between a range of groups/organisations (eg, mental health, health, public health, police, paramedic, accident and emergency, midwife, school, housing, welfare, justice, consumer, carer, general practitioner, lawyer, psychologist, psychiatrist, researcher, lifespan, Indigenous, diverse cultural and linguistic).The plan also recognises that it is essential that priority be placed on a **consultative, community driven** process when implementing programs for specific target groups in any of the priority mental health areas.

The use of **screening** and **early detection** programs is an important strategy in the *Action* Plan. The plan **also** calls for the introduction of **health promoting environments. Community education** and **professional development** programs are key strategies across a number of target areas as is the development of effective methods for **disseminating** and **exchanging** information to facilitate the introduction of **best practice interventions.**

Evaluation, implementation and responsibility for the plan

The *Action Plan* is a working document that will be updated regularly over the five year period of the 2nd NMHP, as the outcomes of research and other projects become available, as best practice is identified and as new priorities emerge. It is one of several documents proposed by the Promotion and Prevention Working Party (PPWP), which together will provide a strategic framework and plan of action for the years 1998-2003, to meet the priorities and outcomes outlined in the 2nd NMHR

The National Mental Health Working Group (NMHWG) is responsible for the overall implementation, monitoring and evaluation of priority areas and strategies of the 2nd NMHP and thus will provide regular

progress reports on the *Action Plan* to the Commonwealth, State, and Territory Health Ministers.The National Public Health Partnership (NPHP) will continue to provide advice and coordination, particularly with respect to population strategies and research, and will maintain representation on the PPWPThe PPWP will assume responsibility for national implementation and monitoring aspects of the plan and will continue to provide advice to the NMHWG and liaise with the NPHP

The PPWP recognises that the implementation of the *Action Plan* will require substantial workforce and infrastructure development including significant education and training. These issues will be addressed during the implementation process for the plan.

A formal evaluation strategy and appropriate indicator set for the plan and its individual components is also required and will be developed by an expert consultant/consultant group.

Structure of the plan

The *National Action Plan* summarises opportunities for promotion, prevention and early intervention initiatives across lifespan groups, population groups 'and key strategic groups. A total of 15 priority mental health areas are identified (see table 2).

Table 2 - Priority target groups and areas

Priority target groups across the lifespan	Priority population groups	Key strategic priority groups
• 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 in the workplace • Older people and the elderly	• Individuals, families and communities experiencing adverse life events • Rural and remote communities • Aboriginal and Torres Strait Islander communities • People from diverse cultural and linguistic backgrounds	• Consumers, carers and communit organisations • Whole of community • Media • Health professionals and clinicia

It should be noted that the identified priority areas are not mutually exclusive. Thus, Aboriginal peoples and Torres Strait Islanders, people from diverse cultural and linguistic backgrounds and people living in rural and remote areas have specific needs in all **of** the other priority mental health areas.

For each **of** the 1 5 priority areas, the plan sets out priority mental health targets, the underlying rationale **for selection** of the area, the evidence base for intervention (including research questions) and national **strategies to** progress the area. Process and long term outcomes are also identified, together with the **settings** for intervention, the relevant communities of interest and any major linked initiatives. These are described below:

- **priority mental health targets -** the desired broad benefits of promotion, prevention and early intervention activity for the identified mental health area;
- **rationale** - an outline of the reason why this area has been targeted and the context in which the strategies have been developed;

- **evidence base -** research which informs current understanding of possible directions for promotion and prevention initiatives. In this section, an asterix (*) signifies those areas where evidence is based on randomised controlled trials.The section also contains a list of important areas for future research **(Research questions);**
- **communities of interest-** those who need to be strategically involved as either partners. custodians. stakeholders or agents of change;

- **settings -** the place or environment where the intervention will occur;

- **linked initiatives -** any major policy or program initiative that may influence the achievement of outcomes.The Second National Mental Health Plan is linked to all target areas and has thus not been listed separately for each target area;

- **national strategies -** agreed national activity to be undertaken in order to achieve the outcomes. This activity could include implementation of known effective interventions. research, pilot projects, training and infrastructure initiatives, networking etc;

- **process outcomes -** achievements and understandings arising from the national strategies;

- **longer term outcomes -** those outcomes which are linked to the priority mental health targets, and which national, State and Territory initiatives are expected to significantly contribute towards achieving over the longer term; and

- **indicators -** indicators measuring progress towards achieving outcomes, to be incorporated at a later date.

The initial sections of the Action Plan are concerned with prevention and promotion for priority target groups across the lifespan, beginning with the youngest age groups. The middle sections of the plan list the prevention and promotion opportunities for priority population groups. The final sections of the Action Plan are concerned with key strategic priority groups who may impact on the priority lifespan and population target groups.

Perinatal and infants
0-2 years

Priority mental health targets

- Promote mental health and enhance protective factors/reduce risk factors for mental health problems and disorders among parents and infants as follows:
- .reduce the incidence of infant low birthweight;
- promote cognitive and language development in the infant;
- reduce the incidence and prevalence of maternal depression and anxiety disorders; and
- enhance parenting **skills,** child **development** and family functioning.

Rationale

The major mechanisms known to be instrumental in promoting and enhancing mental health and in preventing emergent mental health disorders include: sound maternal and perinatal health; and secure attachments with caregivers who have skills and access to resources capable of stimulating infant cognitive, intellectual and emotional development.

Possible risk factors for adverse mental health outcomes include: low birthweight and birth complications; poor infant health; inadequate cognitive stimulation; abuse and neglect; maternal mental health and physical health problems; and poverty (Mrazek & Haggerty 1994). Possible protective factors include: adequate parenting; good quality care in safe environments; and adequate nutrition (Mrazek & Haggerty 1994).

Therefore, programs aimed at providing quality pre- and post- natal care, enhancing parenting skills/parent-infant attachment, providing a stimulating environment and improving parental mental and physical health have long term mental health benefits.

Evidence base

Effective universal perinatal screening tests for maternal and infant health are available and include screening for maternal mental health problems such as postnatal depression and effective intervention strategies to reduce this major risk factor for adverse mental health outcomes in the infant (eg, Hoiden, Sagovsky & Cox 1989). Other interventions that have been effective in reducing parental mental health problems include those aimed at treating anxiety (Barnett & Parker 1985; Barnett et al 199 1) and loss (Murray 1998).

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

*evidence is based on randomised controlled trials

Communities of interest

- parents and infants;
- maternal and child health services;
- general practitioner and other primary health care services (including Aboriginal Health and Medical Services);
- family planning services;
- women's health clinics and information and referral services;
- drug and alcohol services (including Aboriginal Substance Misuse Organisations);
- health professionals and clinicians;
- community agencies;
- welfare services; and
- local government.

Settings

- pre- and post- natal health care settings;
- home-based settings;
- daycare and other infant care settings; and
- general practitioner and other primary care settings.

Linked initiatives

- Audit of Home Visitor Programs 1996a; and
- National Health and Medical Research Council Surveillance and Screening Guidelines for Child Health.

These programs include: the Prenatal/Early Infancy Project (Olds et al 1986, 1988, 1997; Olds, Henderson & Kitzman 1994),@ the Early Intervention for Preterm Infants (Field et al 1980)4@ the Tactile/Kinesthetic Stimulation study (Field et al 1986)*; the Infant Health and Development Program (IHDP 1990; McCormick et al 1991, 1993; Ramey et al 1992; Brooks-Gunn et al 1994a, b; McCarton et al 1997)*; and the Carolina Abecedarian Project (Horacek et a] 1987)*. Barnett (1 995) has also reviewed interventions that enhance the transition to parenthood. These include: STEEP (Steps

Towards Effective Enjoyable Parenting, Erickson et al 1992); programs such as Home Start and Newpin (Mills & Pound 1986) and interventions for those vulnerable to child abuse (eg. Kempe 1976; Gray et al 1979a,b).

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

Research question

- What are the components critical to the efficacy and effectiveness of a home visiting intervention or service in terms of improved mental health outcomes?

National strategies

Screening

Develop national initiatives for coordinating and implementing screening programs for infant health and parental mental health problems (including maternal depression) and implement relevant selective, indicated and treatment interventions. Possible high risk vulnerable groups include infants of mothers with post-natal depression, infants in socio-economically disadvantaged communities, infants from Aboriginal and Torres Strait Islander communities, low birthweight infants, infants with congenital abnormalities and parents and families when an infant dies.

Home visiting

- Identify core effective mental health components of home visiting and pilot programs targeted to high-risk groups (see risk groups above).

Early educational infant daycare

- Develop and evaluate demonstration programs to deliver selective educational infant daycare to improve mental health outcomes (see risk groups above).

Antenatal education

- Investigate partnerships and develop initiatives in the area of antenatal education to increase parent mental health literacy (including knowledge about post-natal depression).

Process outcomes

- increased education, screening and management programs aimed at improving mothers' mental health in the perinatal period;
- increased home visiting or related parentlinfant support programs with essential mental health components; and
- increased early educational infant daycare programs.

Longer term outcomes

- improved maternal and infant mental health;
- increased community awareness and skills in maintaining and enhancing maternal and infant mental health and well-being.,
- improved parent-infant attachment, monitoring and care;
- increased self-efficacy in parenting for mothers, fathers and other carers;
- increased early identification and management of families at risk of mental health problems in the pre- and post- natal period;
- decreased maternal depression, anxiety and distress;
- decreased rates of abuse for babies and infants; and
- increased rates of maternal education completion and employment, particularly in disadvantaged areas.

Toddlers and preschoolers 2-4 years ,

Priority mental health targets

Promote mental health and enhance protective factors/reduce risk factors for mental health problems and disorders among parents and infants, **as follows:**

- promote strong positive attachment between parent and child;
- promote cognitive development and social competency in the child;
- promote positive parenting skills and increase parental self-efficacy in parenting,
- reduce risk factors for disruptive behaviour disorders and associated mental health morbidities;
- reduce maternal depression, anxiety and stress; and
- .reduce marital conflict.

Rationale

The period of early childhood to the commencement of formal schooling is a time of rapid developmental growth, particularly in speech and language and the formation of social relationships. The acquisition of good language skills to prepare the child to read and write and the development of impulse control are critical developmental tasks associated with lower risks for adverse mental health outcomes, particularly disruptive behaviour disorders (Hawkins & Catalano 1992).

Risk factors for disruptive behaviour disorders include: absence of warm responsive attachment; coercive parenting practices; inconsistent management; parental depression; anxiety and stress; marital discord; low social resources and support; economic deprivation; parent criminality; and parent psychopathology. Protective factors that promote good communication and pro-social skills include: warm responsive attachment between parent and child; consistent and fair behaviour management practices; a close positive and stable relationship with a caregiver; and low family stress (Mrazek & Haggerty 1994).

Therefore, the following prevention approaches have been shown to be effective: enhancing social competence and cognitive development; providing a variety of support and educational services; teaching skills in caregiving and effective behaviour management; providing survival-focused support; and addressing issues of health, education, and child safety (Mrazek & Haggerty 1994).

Communities of interest

- parents and caregivers;
- daycare and preschool staff,
- family, child and maternal health services (including Aboriginal child care agencies);
- general practitioner and other primary health care providers;
- child and adolescent and adult mental health services;
- community groups and agencies;
- drug and alcohol services; rehabilitation services; women's refuges; and child protective agencies

Settings

- daycare settings
- preschools;
- home-based settings;
- general practitioner and other primary health care and clinic settings;
- women's refuges;
- welfare settings; and
- community centres.

Linked initiatives

- mental health promoting schools.

Evidence base

Many programs effective at the perinatal to age 2 period have evidenced-based* extensions into this developmental epoch (see Karoly et al, 1998).These include: the Houston Parent-Child Development Centre Program Oohnson 1990, 199 I)*; the Mother-Child Home Program of Verbal Interaction Project (Levenstein 1992. Madden, O'Hara & Levenstein 1984)*; the Parent-Child Interaction Training Program (Strayhorn & Weidman 199 I)*; the High/Scope Preschool Curriculum Comparison Program (Weikart, Schweinhart & Larner 1986; Schweinhart & Weikart 1992)*, the Perry Preschool Program (Berrueta-Clement et a] 1984)*; and the ICPS (1 Can Problem Solve) Interpersonal Cognitive Problem-Solving Program (Shure & Spivak 1982)*.The'Triple P' Positive Parenting for Preschoolers program is one such preventive initiative in this field in Australia (Sanders 1995; Sanders & Markie-Dadds 1996;Williams, Silburn & Zubrick 1996; Williams, Zubrick, Silburn & Sanders 1997, Connell, Sanders & Markie-Dadds 1997*).

The effects of these programs are measurable not only in terms of positive mental health outcomes for the participating children but also in improved maternal health and well-being, education and employment.

Research questions

- What is the minimum **level** of intervention required to prevent the developmental trajectory to conduct disorder?

- For which families are the current interventions ineffective and why?

National strategies

Parenting programs

- Monitor progress of current parenting projects and trials and determine scale and scope of program replication in light of the evidence base.

- Determine and establish relevant partnerships to support cost effective program delivery and maintenance of program integrity.

- Research the applicability of efficacious interventions to target the following priority populations: rural and remote communities; Indigenous peoples; people from diverse cultural and linguistic backgrounds; and populations with special needs such as children of parents with a mental illness, people who have a serious chronic physical illness, have a substance use problem, or who have experienced domestic violence or sexual abuse.

Daycare and preschool programs

- Inform the development of healthy public policy across sectors. Examine the cost benefit ratio of regulations to address,the affordability, accessibility and availability of quality daycare for disadvantaged groups in the community.

- Support the establishment of mental health promoting learning environments, including healthy public policy and practice (implementing universal programs and supporting early case identification, selective and indicated interventions where appropriate, for speech and language problems, social and behaviour problems).

- Establish partnerships with relevant agencies and *Communities of interest*.

Process outcomes

- increased participation in effective parenting education programs by parents most at risk;

- improved policy and program links between mental health services, early childhood, public and community health services, drug and alcohol services and child welfare services to support families at risk, and

- improved policy and practice to promote positive supportive learning environments and links between home, daycare and preschool settings.

Longer term outcomes

- improved positive nurturing learning environments;
- increased early identification and treatment of families at risk; and
- decreased disruptive behaviour disorders and associated morbidities.

Children **5-11** years

Priority mental health targets

- Promote mental health and enhance protective factors/reduce risk factors for mental health problems and disorders among parents and children, as follows:
- promote self-worth (including a healthy body image) and self-efficacy and social competency in the child;
- promote family and child sense of connectedness to the school;
- promote positive peer relationships;
- promote child and family participation in school and community activities;
- promote mental health literacy in school communities; and
- reduce risk factors for conduct, anxiety, depression and eating disorders.

Rationale

The commencement of formal schooling marks a major transition point and a significant opportunity for mental health promotion and prevention intervention. In this developmental epoch risk factors for poor mental health outcomes increasingly reflect the social and physical environments available for education and socialisation.These risk factors include: less than year 1 0 parental education; parental unemployment; low family income; violence and family discord; absence of love and affection; coercive parenting style; poor monitoring and supervision in home and school settings; low teacher/student attachment; harsh punitive and or inconsistent behaviour management in school setting; poor peer relations; and alienation from school. Protective factors include: a cohesive and non-violent school environment; student sense of self-worth; self-efficacy in problem solving, coping skills and social skills; a sense of social connectedness; a positive valuing and affectionate family environment; having a personal confidante, role model or mentor; belonging to a positive peer group; an active lifestyle; and an internal focus of control. Therefore, prevention approaches that enhance and promote structures to support the school community in achieving academic outcomes, that promote social and emotional well-being and lifeskills for students and staff, and identify and manage, at an early age, young people at risk of mental health problems, are of demonstrated efficacy in preventing poor mental health outcomes.

Evidence base

A diverse range of interventions, involving both home and school settings, have been effective in preventing mental health problems in this age group. These include:

- universal, selective, and indicated positive parenting programs;

- mental health promoting school-based interventions that strengthen life skills and resilience, foster a supportive school environment and develop a school culture which encourages partnerships between school. home and community services;

- specific programs that promote optimistic thinking styles which may reduce levels of anxiety and depressive symptoms;

- social problem solving and self efficacy building which may enhance social skills and anti-bullying and aggression programs which reduce levels of aggressive behaviours;

- identification of, and universal screening for, factors that impede learning and reduce mental health outcomes; and

- selective and indicated school interventions that reduce student behaviour problems, anxiety and depression.

Programs which can enhance social competency*, academic achievement,* parenting skills*, or a combination of these include: Assertiveness Training Program 1 (universal) and 2 (indicated), (Rotheram 1982)*; Social Skills Training (selective), (Bierman 1986)*, Montreal Longitudinal Experiment Study (indicated), (Tremblay et al 1991, 1992)*; Seattle Social Development Project (universal) (Hawkins et al 1992)*.

School-based programs aimed at altering school organisation and changing school systems have led to decreased bullying (the Campaign Against Bully-Victim Problems (universal), (Olweus 199 1) and improved academic achievement (The Yale-New Haven Primary Prevention Project, Comer 1985).

School-based programs designed to promote resilience and optimism have been effective in preventing anxiety* and depression in children.These include the Coping Koala Programme and Friends Programme (indicated) (Barrett, Lowrey & Holmes 1997; Barrett, Dadds & Rapee 1994; Dadds et al 1997; Dadds et al, in press)* and the Penn Prevention Program Jaycox et a] 1994).

Communities of interest

- parents and primary school aged children;
- primary school teachers, support and management staff,
- health and education professionals;
- community groups and agencies;
- parent training and support groups;
- local government; and
- parent associations.

Settings

- primary schools;
- home-based settings;
- community sport and recreation settings;
- general practitioner and other primary health care settings; and
- State and Territory child and adolescent health and mental health services.

Linked initiatives

- National Youth Suicide Prevention Strategy;
- mental health promoting schools; and
- National Drug Strategy.

Research question

- Which interventions interrupt the developmental trajectories of conduct disorder, anti-social and depressive/anxiety behaviours, and eating disorders and enhance resiliency?

National strategies

Partnerships with schools and relevant systems

- Establish a national coordinated approach for primary school-based programs including integration of mental health issues into schooling.
- Establish partnerships with key stakeholders to implement and support the mental health promoting school strategy.

Prevention programs

- Implement multi-component primary school-based prevention programs in each State with universal, selective and indicated programs to promote life-skills and to reduce: anxiety; depression; conduct, aggressive and antisocial behaviours; eating disorders and racism.

Promotion programs

- Develop and evaluate programs for enhancing school environments using a mental health promoting schools framework and incorporating cultural needs.

- Promote mental health literacy in school communities.

- Promote awareness and acceptance of cultural diversity through the development and distribution of cultural awareness packages. In partnership with Aboriginal community controlled services, incorporate Aboriginal history into core curriculum.

Process outcomes

- increased numbers of mental health promoting schools and increased mental health components in health promoting schools;

- increased universal schoolbased interventions to promote life skills and resiliency;

- increased recognition of students requiring indicated intervention for behavioural, emotional, attention, speech and language problems and increased numbers receiving appropriate indicated intervention at an early age;

- strengthened partnerships and links between school, home, health and other community settings;

- increased students' understanding of cultural diversity and Indigenous history and the impact of history in relation to emotional and social wellbeing issues; and

- increased Aboriginal and Torres Strait]slander students' participation in schools.

Longer term outcomes

- improved positive learning environments at home and school;

- increased early identification and treatment of families and students at risk.,

- decreased mental health problems in children in this age group including conduct/disruptive and anxiety/depressive problems; and

- mental health promotion addressed and incorporated into school policy and practice.

Young people 12-17 years

Priority mental health targets

- Promote mental health and enhance protective factors/reduce risk factors for mental health problems and disorders among young people, as follows:
- promote self-worth (including health body image) and self-efficacy in problem solving, social competency and coping skills;
- promote a sense of connectedness to school and community;
- promote positive peer relationships;promote participation in school and community activities;
- promote mental health literacy in school communities;
- promote an acceptance and valuing of cultural diversity; and
- reduce the incidence and prevalence of depressive, anxiety, substance abuse and eating disorders, suicidal behaviours and self-harm, anti-social behaviours and associated morbidities.

Rationale

Entry into secondary school, the increasing need for autonomy, the onset of puberty and the influence of peers are critical influences in the developmental pathways of young people. This developmental period is marked by increased risk exposures predisposing young people to poor mental health outcomes.These risk exposures include: violence and family discord; absence of love and affection; coercive parenting style; poor monitoring and supervision in home and school settings; low teacher/student attachment; harsh punitive and or inconsistent behaviour management in the school setting; poor peer relations; alienation from school; and poor body image.

During this period, some young people experience the first onset of mental health problems or mental disorders such as anxiety, depression and related disorders, eating disorders, substance abuse, and deliberate self-harm. Protective factors include: a positive relationship with at least one parent, a cohesive and non-violent school environment; sense of self-worth; self-efficacy in problem solving, coping skills and social skills; experiences of achievement; a sense of social connectedness; having a personal confidante, a role model or mentor; belonging to a positive peer group; an active lifestyle; and an internal locus of control. Therefore, prevention efforts that enhance and promote structures to support the school community in achieving academic outcomes, that promote social and emotional well-being and lifeskills for young people, and identify and manage, at an early age, young people at risk of mental or emotional health problems, are effective in reducing poor mental health outcomes.

Evidence base

There is evidence that appropriate interventions can reduce risk factors associated with depression, anxiety, substance abuse, antisocial behaviours and eating disorders in young people.

A number of programs targeting hazardous substance misuse have been effective.* These programs, which are aimed at providing social influence and promoting norms against drug use, include: Positive Youth Development Program (Caplan et al 1992)*; Adolescent Alcohol Prevention Trial (Hansen & Graham, 199 l)*;ALERT Drug Prevention (Ellickson & Bell, 1990)* and Alcohol Education Project (Perry et al, 1989)*.

Communities of interest,

- parents and young people;
- education professionals (including school principals, teachers and counsellors);
- general practitioner and other primary health care providers;
- adolescent mental health services;
- media and communication technologies (print, radio, television, internet - including movie, tv, music and sporting stars and role models).,
- training and educational agencies (including schools and Aboriginal education organisations);
- police;
- juvenile justice services; and
- youth agencies.

Settings

- schools;
- sport and recreational settings;
- club and social settings;
- community agencies and youth centres;
- families and local communities;
- child and adolescent mental health settings;
- general practitioner and other primary health care settings;
- State welfare agencies; and
- juvenile justice settings.

Linked initiatives

- youth policy;
- National Youth Suicide Prevention Strategy;
- National Drug Strategy;
- AusEinet Project;
- homeless youth programs; and
- national school-based programs.'

Effective prevention programs targeting depression* and/or anxiety* include: The Coping Koala Programme and Friends Programme (indicated) (Barrett, Lowrey & Holmes 1997; Barrett, Dadds & Rapee 1994; Dadds et al, 1997; Dadds et al, in press)*; Resourceful Adolescent Program (RAP) (universal) (Shochet et al submitted); Penn Prevention Program (Jaycox et al 1994); and the Coping with Stress Course (indicated) (Clarke et al 1995)*.

Effective programs for preventing antisocial behaviours include: Campaign Against Bully-Victim Problems (universal) (Olweus 1991) and a behavioural prevention intervention (indicated, Bry 1982)*.

A program aimed at improving self-esteem has been reported effective in reducing body dissatisfaction in young people and in altering weight control behaviour in young females (O'Dea 1997: Everybody's Different Program (universal)).

Specific programs are needed for homeless or other high risk populations, such as those from rural and remote areas, Aboriginal peoples and Torres Strait Islanders, people from diverse cultural and linguistic backgrounds and young people in juvenile justice settings.

Research questions

- What are key predictors of poor educational and mental health outcomes that can inform the development of healthy policy and school practices?

- What are the key elements of effective program implementation that will ensure efficacious replication?

- What programs are effective in preventing eating disorders?

National strategies

Partnerships

- Establish a national coordinated approach for mental health promoting schools initiatives. Develop partnerships with *Communities of interest* outside school settings (eg, juvenile justice, youth services, welfare services) and identify gaps and opportunities for prevention and promotion.

Promotion programs

- Further develop, implement and evaluate programs for enhancing school environments, and increasing mental health literacy in school communities.

- Promote awareness and acceptance of cultural diversity through the development and distribution of cultural awareness packages. In partnership with Aboriginal community controlled services, incorporate Aboriginal history into core curriculum.

Prevention programs

- Further progress implementation of efficacious prevention programs targeting depression, anxiety and substance abuse, antisociallaggressive behaviours and eating disorders in schools. Progress the implementation of the NHMRC's clinical practice guidelines: Depression *in Young* People (1 997). Consolidate links between mental health services, general practitioners and other primary care providers and schools.

- Build on evaluation of suicide prevention initiatives.

Process outcomes

- increased universal, selective and indicated prevention programs in secondary schools;

- increased recognition and management of students requiring selected and indicated intervention for depressive and anxiety symptoms and eating problems;

- increased mental health promotion programs to reach young people outside school settings;

- increased students' understanding of cultural diversity and Indigenous history and the impact of history in relation to emotional and social wellbeing issues; and

- increased Aboriginal and Torres Strait]slander students' participation in schools through increased self-worth.

Longer term outcomes

- increased retention in schools, entry to tertiary education and employment;

- decreased incidence and prevalence of depression; anxiety symptoms/disorders; and eating disorders;

- decreased incidence and prevalence of comorbid substance use disorders;

- decreased incidence and prevalence of antisocial/aggressive spectrum behaviours and adverse legal consequences; and

- decreased rate of selfharming behaviours, suicidal ideation and attempts.

Young adults **18-25** years

Priority mental health targets

- Promote emotional resilience, enhance protective factors and reduce risk factors for mental health problems and disorders among young adults.
- Promote emotional and social well-being among young adults.
- Reduce the incidence and prevalence of mental health problems and disorders including depression, suicide, self-harm, anxiety disorders, eating disorders, substance abuse, and early psychosis among young adults.
- Promote mental health literacy among young adults.

Rationale

Young adulthood is a key transition period marked by reduced dependence on parents and peers, and the commencement of long term relationships, careers and families. Mental disorders are more common in young adults than at any other age with more than one in every four young adults from the Australian community suffering from a mental disorder (McLennan 1998). Comorbidity is common and mental disorders are often accompanied by other social or emotional problems including problems with the law and unemployment.

Rates of depression and anxiety are high, especially among young women. Women of this age are also more likely to engage in self-harm, attempt suicide and develop a range of eating disorders. Harmful drug use and substance disorders are high among young men. The latter also have the highest rates of suicide and imprisonment of any age group. Psychoses, such as schizophrenia, may first become obvious in young adulthood.

Young men are particularly difficult to engage in health promotion and prevention activities and in traditional treatment systems, possibly as a result of gender-based social, developmental and cultural expectations.

Some groups are at particular risk of developing mental health problems or problems with social and emotional well-being.These groups include young adults who are: socially alienated or disadvantaged; unemployed; early school leavers; from Aboriginal or Torres Strait Islander backgrounds; or rural residents. These young people are unlikely to seek help from formal mental health services but may come into contact with correctional, drug treatment, youth or community services. It is critical to engage at-risk young adults within the service systems they use, to understand relevant youth sub-cultures, and to establish links with services that can provide practical support. In young men involved with the criminal justice system, avoiding incarceration and maintaining connectedness with family and community may reduce suicide and self-harming behaviours.

Communities of interest

- young adults;
- families and local communities.'
- general practitioner and other primary care providers;
- youth services and venues;
- youth support services;
- local government;
- employment and social service agencies;
- education and training authorities;
- gay and lesbian community,
- business agencies and organisations;
- Aboriginal community controlled services;
- music and entertainment industry;
- correctional service system;
- drug and alcohol service system;
- HIV/AIDS and other sexual health services; and
- sexuality-based services.

Settings

- families and communities;
- workplace and vocational training settings;
- tertiary education settings;
- rural and remote settings;
- clubs and social settings; and
- sport and recreation settings.

Linked initiatives

- National Youth Suicide
- Prevention Strategy.,
- National Drug Strategy;
- Child and Youth Health Policy;
- National campaign against violence and crime; and
- Commonwealth Disability
- Strategy.

Evidence base

Preventive cognitive behavioural programs involving preparation for marriage or long term relationships can diminish the risk of marital disorder and associated mental health problems (see Halford 1995).

Some interventions that are known to be effective for late adolescence may also be useful for this group. In particular, effective preventive programs for depression and anxiety disorder in adolescence* may be relevant to young adults (see *Young People 12-17 years)* and should be evaluated for this age group. Indicated programs (eg, Clarke et al 1995) could be applied to tertiary education settings such as universities and the vocational education and training sector. A promising model for brief interventions

for substance use disorders through general practitioners, community health centres and other primary care settings (Saunders, Conigrave & Gomel 1998) also warrants evaluation.

Research questions

- What are the risk factors for the onset of depression and anxiety disorders in this age group?
- What are effective preventive interventions for this age group?
- What are the reasons for the low mental health service use (particularly
- among males) in this age group and how can this be resolved?
- What is the impact of comorbidity on the development of mental health problems in this age group?

National strategies

Conduct research

- Collect data on risk and protective factors and identify the range of relevant programs available across relevant service sectors.
- Identify which programs and services reach, attract, engage and retain young adults and determine which of these are effective.
- Consult with young adults, particularly those from high-risk groups, to identify effective health promotion and prevention messages and programs and model and test programs in partnership with them.

Pilot initiatives in different settings

- Pilot and evaluate prevention initiatives based on the above evidence and tailored to setting and group. This could involve: counselling or emergency services; workplaces; youth services; entertainment venues appropriate to this age group; sports clubs; universities, colleges and vocational education settings; and services relating to marriage, the establishment of relationships, and early parenting.

Implement programs for young adults with life crises or problems

- Introduce initiatives designed to reduce the emotional and social impact of adverse events, such as unemployment, relationship break-up, or imprisonment, which place young people at high risk for mental health problems.
- Develop models of intervention which can be implemented in partnership with young people and other services and which recognise and respect the reluctance of young people at high risk to access psychiatric care.

- Develop a strategy to encourage implementation of these models within relevant service systems.

Process outcomes

- increased understanding and uptake of mental health promotion, prevention and early intervention for young adults;
- increased knowledge and understanding of young adults' mental health issues among the general community;
- increased access to, and use of. young adult-focussed and generic mental health-related services;
- client satisfaction with mental health services and related youth support services;
- practice guidelines and protocols for a range of relevant service types across a range of sectors developed, available and supported by training and policy
- development within relevant organisations; and
- increased effective mental health promotion and prevention programs.

Longer term outcomes

- increased mental health literacy in young adults;
- reduced mental health problems and disorders and related injury, disability or death in the young adult population; and
- enhanced mental health and well-being.

Adults in the workplace

Priority mental health targets

- Increase mental health promoting workplaces, work practice and policy.
- Promote mental health literacy.
- Enhance workers' social and emotional well-being and productivity in the workplace.
- Increase pathways for response to workers' identified mental health needs.
- Reduce stigma, discrimination, sexual harassment, victimisation and bullying in the workplace.
- Reduce the incidence, prevalence and severity of stress and the health burden associated with work places and organisational settings.

Rationale

After the home, the workplace is the primary location of adult life for the majority of people and plays a highly influential role in individual health and wellbeing. There is evidence of significant increase over recent years in the level of reported workplace stress and an associated increase in stress-related mental health problems and mental health costs (eg, cost associated with stress-related compensation claims; days lost to stress-related conditions; individual distress). In addition, it is well documented that stress associated with the workplace may affect family and home environments, creating a reduction in mental health and functioning of families.

Possible risk factors for workplace related stress and/or mental health problems include:

- unfavourable organisational factors (eg, rapid change, poor communication, inadequate consultation, lack of participation in the decision making processes);
- unsatisfactory work relationships (eg, supervisors with perceived inadequate management skills; inadequate social support at work);
- role conflict;
- career development problems;
- unfavourable working environment (eg, shift work; poor physical working conditions); and

- workforce accidents and injuries, particularly psychological injuries and trauma. (Cooper 1993; Cotton 1996,Turner, Meldrum & Raphael 1995)

Job insecurity and increased management drive for efficiency and workplace downsizing may also contribute to stress. In addition, certain personality characteristics and coping styles may be associated with increased risk of mental health problems in the work place (Cotton 1996).

Possible protective factors are social support (Mrazek & Haggerty 1994) and positive coping styles (Cotton 1996).

Communities of interest

- workforce;
- management structures and workplace policy makers;
- national, State, Territory and local government;
- employers;
- unions;
- business associations;
- workplace support and rehabilitation services;
- insurance companies;
- Comcare and related agencies;
- legal services;
- Human Rights and Equal Opportunity Commission; and
- health promotion foundations.

Settings

- workplace settings across the public and private sectors;
- management and administration systems;
- occupational health and safety systems;
- occupational rehabilitation settings;
- professional and vocational training settings; and
- identified high risk occupation worksites and workplaces.

Linked initiatives

- Commonwealth Rehabilitation Service, including manual for Commonwealth employers on employing people with psychiatric disability;
- Commonwealth Disability Strategy;
- Disability Discrimination Act 1992 (Disability *Action Plan);*
- Department of Education, Training and Youth Affairs programs;
- Worksafe; and
- occupational health and safety programs.

Evidence base

Mental health promotion and prevention activities in the workplace have primarily focussed on stress prevention and management and developing positive ways of coping with difficult workplace situations

and workplace pressures. More recently, there ha!r also been interest in altering organisational structures and developing mental health promoting workplaces in order to prevent stress and promote well-being (Cotton 1996). However, there is little evidence concerning the effectiveness of any of these interventions.

Mrazek and Haggerty (1994) have described one selective intervention which was effective in modifying risk factors and decreasing depressive symptoms in people working in a stressful environment (Heaney 1992:The Caregiver Support Program).* This program targeted house managers and caregivers working in group houses for people with a mental illness or a development disability.The protocol focused on enhancing social support and relationships within the workplace and resulted in improved support and positive feedback from supervisors and reduced mental health problems among employees.

There is a need for additional trials of the effectiveness of interventions which increase social support in the workplace. Further research is also required to identify potentially effective interventions relating to the following areas: workplace policy; work systems (including management structures and styles); stress management and education; prevention of traumatic stress and post trauma psychological morbidity including post-traumatic stress disorder (PTSD); interventions aimed at individual workers and work groups (eg, addressing violence and bullying in the workplace); and interventions for the prevention of suicide in high risk professions.

Research questions

- What interventions are effective in reducing workpiace stress and associated morbidity including PTSD?

- At what point in the development of workplace-related mental health problems, and in what workplace contexts, do interventions have optimal impact in (i) preventing mental health problems/mental disorders and promoting mental health in the workplace; and (ii) encouraging appropriate help-seeking behaviours?

- What barriers exist to the uptake of identified interventions?

- What other factors are significant in workplace mental health (eg, conflict between work and home roles, social environment)?

National strategies

Clearing house and research

- Identify data, initiatives, needs and partnerships (such as unions, management, Occupational Health and Safety) to develop a clearinghouse on mental health promoting workplaces, policies, and practices and specifically explore prevention of workplace stress and associated morbidity.

Pilot programs

Pilot and evaluate models of mental health promotion and prevention
in the workplace in partnership with relevant groups.

Process outcomes

- increased successful Return To Work programs for stress related injuries;

- increased availability at workplaces of appropriate assistance and early intervention for mental health problems (eg, employee assistance programs, occupational health and safety officers); and

- increased awareness, particularly at management level, of the role of the workplace in influencing mental health, of legislative responsibilities, and of the economic cost of workrelated mental health problems.

Longer term outcomes

- reduced workplace stress, related days lost, and disability claims;

- reduced burden of mental health problems associated with workplaces.,

- improved mental health literacy in workplaces and organisations;

- improved organisational effectiveness through the creation of satisfying, safe and effective work environmen

- mental health promotion, prevention and early intervention targets embedded in workplace policy and practice; and

- reduced reporting of workplace sexual harassrr discrimination, victimisatic and bullying.

Older people

Priority mental health targets

- Promote community awareness and understanding of positive mental health and ageing.
- Reduce the incidence and, prevalence of depression and mental health morbidity associated with ageing and caring for the aged.
- Promote awareness and skills that enhance well-being in older people,

Rationale

According to the National Survey of Mental Health and Wellbeing (McLennan 1998), the prevalence of mental disorders among older people in the Australian community is 6. 1 %. However, this figure excludes cases of dementia, a mental disorder reported by jorm et al (1 987) to rise in prevalence from 1.6% in 65-70 year olds to 39% in 90-94 year olds. In addition, there is substantial evidence that rates of mental disorders are higher amongst the 10% of older people who are in institutional care, and among those who have physical impairments; suffer from chronic conditions such as arthritis; have cancer; or have had a stroke. Mental health problems are also high among those who carry the burden of care for people with significant behavioural disturbance, particularly where there is little support or respite.

Older people who are bereaved may be at higher risk in certain circumstances, as may be those who are isolated and lack social networks and support. Protective factors include good physical health, supportive relationships, and protection from the extremes of poverty. Head trauma is a possible risk factor for Aizheimer's dementia and better education or higher intelligence may be a protective factor for the disorder gorm 1997). Potentially modifiable risk factors for vascular dementia include hypertension, diabetes, cholesterol and smoking gorm 1995).

Evidence base

Selective intervention involving a multimodal program of counselling and support for carers of spouses with dementia can be effective in reducing depressive symptoms (Mittelman et al 1995)* as can self help programs for widows involving support and resource information (Vachon et al 1980)*.

There is some evidence that the intellectual decline associated with normal ageing can be slowed through the use of training programs (see Birren & Schaie 1996).There is also suggestive evidence (longitudinal prospective study) that social or leisure activities might delay the onset of dementia but further research is required (see Katzman 1995). Similarly, there is a need for further investigation of the possible effectiveness of oestrogen replacement therapy in protecting against cognitive problems andlor dementia Oorm 1997; Rice et al, 1997).The efficacy of anticoagulant therapy in preventing (as opposed to

treating) vascular dementia in the elderly has not been examined, although it is known that the therapy is ineffective in preventing strokes in younger people* Oorm 1995).

Communities of interest

- older people;
- families and communities;
- public and private health services;
- general practitioner and other primary health care providers;
- nursing home and other residential services for the aged;
- community groups and agencies for the aged;
- police;
- media;
- legal sector;
- superannuation and retirement investment sector; and
- carer groups.

Settings

- local communities. including local council services, eg, transport, libraries, sporting and recreation settings, senior citizens' clubs;
- residential care settings; retirement village settings; and
- education and information settings eg, University of the Third Age.

Linked initiatives

- national, State and Territory aged care and aged health care policies;
- disability and ageing initiatives (eg, International Year of Ageing 1999);
- National Dementia *Action Plan* and State dementia plans;
- Department of Veterans' Affairs Dementia and Aged Veterans Program; and
- developing an Active Australia campaign.

Other areas requiring further investigation are:

- mental health education for positive mental health;

- the role of physical fitness in mental health; protective programs for those with physical disability or at high risk through other adversities;

- counselling for life stresses;

- early recognition of depression (screening in high risk settings, particularly isolation, stroke, physical illness, cancer. disability); and

- preventive interventions for dementia (including lifest)de modification to reduce hypertension) and associated psychological morbidity.

Research questions

- What are the most effective preventive approaches and networks?
- What roles can general practitioners (GPs) and other aged care services contribute to prevention and promotion?
- What are effective interventions to prevent depression and cognitive declineldementia in this age group?
- What are public and clinician (GP) attitudes tolstereotypes of old age and how can negative perceptions be altered?
- How can older people and their families be prepared for inevitable losses?
- What are the resilience indicators in this age group?

National strategies

Research and partnerships

- Collect and analyse data, and identify needs, initiatives, partnerships and potential good practice relevant to mental health promotion and prevention for this age group. Consider older people's focus groups and undertake qualitative research.

Depression

- Introduce State-based initiatives in focal areas targeting depression prevention and early intervention as it relates to prevention.

Pilots

- Pilot and evaluate potential projects for specific high-risk populations (including bereavement and carer support programs).

Process outcomes

- increased number of prevention and promotion programs for high risk groups including bereavement and carer support; and
- increased number of partnerships between health and interlintrasectoral settings aimed at prevention.

Longer term outcomes

- improved quality of life for older people;
- decreased incidence and prevalence of depressive and anxiety symptoms and disorders for older people in high risk settings;
- reduced 'burden' of illness;
- decreased mental health problems and disorders in carers; and
- increased focus on psychosocial factors in aged care.

Individuals, families and communities experiencing adverse life events

Priority mental health targets

Reduce the incidence and prevalence of psychosocial morbidity associated with adverse life events. including:

- events associated with life or personal threat, illness or accident such as assault, violence, disaster, war, motor vehicle accidents or cancer;
- child abuse and **neglect (physical, sexual** and emotional);
- **loss, grief** and **bereavement;**
- divorce, separation and family breakdown;
- imprisonment and major legal problems;
- unemployment, social adversity, **poverty;**
- separation from families, alienation; and
- racism, stigma, or labelling.

Rationale

Adverse life events occur across the life span in various contexts and settings, are frequent, and may be associated with adverse mental health outcomes (posttraumatic stress disorder, adjustment disorder, depression, anxiety, substance use disorder and precipitating other adverse effects such as family breakdown and impaired mental health functioning). Some adversity is chronic. Genetic factors may contribute to the way a person responds to life stressors, indicating vulnerability and an opportunity for intervention. People may respond to adverse life experience as a challenge rather than a stressor, and show personal growth.

Risk factors associated with life stressors include: degree of threat, particularly life threat; closeness of the attachment in relationship loss; perception, availability and adequacy of social support; degree of suddenness, unpredictability and uncontrollability; multiple stressors occurring simultaneously or in close time frames; persisting vulnerabilities such as stressor response and past experiences unsuccessfully dealt with; and social adversity.

Protective factors include: personal characteristics of 'hardiness' and 'fighting spirit'; past successful-coping; preparation or anticipatory preparedness; sense of control; supportive social networks; and rituals.

Trauma and grief across the lifespan are one of the most significant and frequent problems identified by Aboriginal peoples and Torres Strait lslanders.Their impact relates to the history of invasion, ongoing impact of colonisation, loss of land and culture and high rates of premature mortality, incarceration and family separations, particularly forced separation of children and parents, and Aboriginal deaths in custody. Domestic violence, sexual and physical abuse, and other traumas also contribute (Swan & Raphael 1995).These multiple adverse life experiences greatly increase the risk of negative physical and emotional health outcomes.

Communities of interest ·

- families;
- local communities;
- public and private health services;
- local government;
- general practitioner and other primary health care providers
- loss and grief centres, organisations and groups;
- Aboriginal and Torres Strait Islander communities;
- church and welfare agencies;
- police, ambulance and emergency services;
- military and disaster relief services;
- finance and business organisations;
- insurance companies; and
- family court and related settings.

Settings

- communities, families and
- individuals experiencing life stressors;
- home-based settings;
- health care settings;
- Aboriginal Community Controlled Services;
- workplaces;
- sexual assault services;
- child abuse services; and
- employment and social service settings.

Linked initiatives

- Nil

Evidence **base**

Generic counselling by itself does not achieve prevention outcomes for those experiencing adverse life events such as child abuse (Tebutt et al 1997) and trauma (Wesseley, Rose & Bisson 1998). However, there are a substantial number of effective specialised counselling, educational and support interventions for those at high risk.

Effective programs for loss and bereavement include preventive counselling for: children who have lost a parent (Black &Young 1995); widows (Raphael 1977*; Parkes 1990*;Vachon et al 1980*); aged bereaved people (Gerber et al 1975); parents after child death (Forrest, Standish & Baum 1982; Lowman 1979; Lieberman & Videka-Sherman 1986*; Murray 1998*); and families when a family member dies (Kissane et al 1998).

There is no evidence that debriefing prevents psychological morbidity after trauma. Some suggest it may increase the likelihood of adverse outcomes (Wessely et al 1998). Effective targeted interventions focussing on a traumatic experience are available for: sexually abused children (Deblinger, McLeer & Henry 1990); children following disaster (Pynoos & Nader 1990; Storm 1997); and motor vehicle accidents (Bordow & Porritt 1979*). Effective prevention programs for marital couples and stepfamilies include those for stepfamily members (Nicholson 1996) and couples before marriage (Markman et al 1993; Halford 1995). Effective divorce intervention programs include programs for school children (Pedro-Carroll & Cowen 1985)* and divorced parents (Bloom, Hodges & Caldwell 1982; Bloom et al 1985)*. Effective programs are available for unemployed people (Proudfoot et a] 1997). Enrichment programs with other multicomponent interventions for high risk children can also achieve positive outcomes. Cross cultural programs include narrative therapy and theatre.

Research questions

- What factors can prevent adverse outcomes associated with trauma and violence, including systems of violence?
- What educational and other interventions can operate to lessen risk associated with life stressors and enhance positive outcomes?
- What health interventions can decrease psychosocial morbidity associated with illness and accidents?

National strategies

Identify and develop partnerships and initiatives

- Develop partnerships to promote policies and practice that promote resilience, positive models such as mastering life challenges and supportiveness, and the use of effective short term programs for those at high risk.

Develop and implement guidelines

- Develop and implement best practice guidelines and manuals for specific groups at high risk in association with adverse circumstances.

- Work with stakeholders for training, education, dissemination and implementation of best practice guidelines, and develop a clearinghouse for these.

Implement and evaluate programs

- Develop, implement and evaluate national pilot projects for unemployment using mental health outcomes.

- Develop and pilot a comprehensive, evidence-based, prevention program to improve mental health for children and families following family breakdown and divorce.

Process outcomes

- increased individual, family and community access to evidence-based programs for high risk adverse life experience eg, effective:
- targeted short term trauma counselling for acute situations;
- bereavement support, education and counselling;
- programs for divorce and famfly breakdown; and
- programs for people experiencing mental health vulnerability in association with unemployment;
- increased self-help initiatives advocating support, recovery and evidence-based care;
- development of evidencebased best practice guidelines for interventions for those at high risk from disorders associated with adverse life experiences; and
- accreditation and training in evidence-based practice of those involved through health, non-government organisations and private sectors in providing interventions in association with adverse life experiences.

Longer term outcomes

- decreased morbidity associated with adverse life events eg, decreased posttraumatic stress disorder and depression;
- improved whole of community response to individuals', families and communities experiencing adverse life events;
- increased cultural and social recognition that stressful life events can provide an opportunity for growth and adaptation;
- improved awareness, knowledge, education and training curricula and programs in responding to adverse life experience with respect to mental health outcomes in *Communities of* interest; and
- greater access to effective interventions, rams and initiatives for families and communities who are at high risk following adverse life events.

Rural and remote communities

Priority mental health targets

- Promote family and community cohesion.
- Promote protective factors that impact on the effects of unemployment and environmental hazards.
- Reduce the incidence and prevalence of risk factors for depression, anxiety, stress and suicide.
- Promote capacity building of infrastructure and communication.
- Develop and support culturally appropriate initiatives as determined by local communities.
- **Increase access to** mental health promotion and prevention services.

Rationale

People living in rural and remote communities (RRCS) in Australia have particular mental health needs due to isolation, the impact of economic restructuring, and exposure to environmental hazards such as drought, flood, and fire. Lack of appropriate services and service providers, distance from services, and transport problems are frequently part of rural and remote life. Moreover, the general health of people living in RRCs is poorer than that of their city counterparts (Mathers 1994). Aboriginal peoples and Torres Strait Islanders who live in rural and remote areas are even further disadvantaged since the health and socioeconomic status of people from Indigenous backgrounds is markedly lower than that of other Australians. Added to this are the compounding effects of loss, grief and trauma over generations.

Adverse mental health outcomes in the general population are correlated with broader psychosocial problems including poverty, unemployment, substance misuse, child abuse and domestic violence. However, the added problems associated with rural and remote life place additional strains on people from RRCs.The pressures on young people are reflected in the extremely high suicide rate among rural youth (twice that of their city counterparts). The Western Australia Child Health Survey has also highlighted the high incidence of mental health problems among children in some rural areas (Zubrick et al 1995). It is likely that Indigenous peoples in rural and remote areas are at even greater risk of poor emotional and social well-being.The limited data available suggests that the suicide rate in young people from Indigenous communities is an alarming 40% higher than amongst the general population (Commonwealth Department of Health and Family Services 1997).

It is essential that prevention and promotion initiatives are community driven and owned and culturally appropriate to community needs. '

Evidence base

An indicated intervention (Triple P) involving information-based strategies and targeting parents of children with behaviour problems living in RRCS, reduced disruptive child behaviour and improved parenting skills and parental adjustment (Connell, Sanders, and Markie-Dadds 1997)*.There is no strong evidence to support the efficacy of crisis intervention and telephone counselling for high risk groups with suicidal ideation and suicidal behaviour, particularly young males (Patton & Burn 1998).Additional evaluation and alternative **strategies** are needed in this area.

Communities of interest

- rural and remote families and communities;
- Aboriginal and Torres Strait]slander communities;
- community agencies, groups and associations;
- consumer and carer groups;

- people from diverse cultural and linguistic backgrounds;
- general practitioner and other primary health care providers;
- rural and remote mental health services and networks; and
- local government;

Settings

- clubs and social settings;
- education and training centres, including. schools; vocational education and training., and universities;
- hospital and community health settings;
- rural and public health training units;
- Aboriginal community controlled services; and
- sport and recreation settings.

Linked initiatives

- Mental Health Information for Rural and Remote Australia (MHIRRA);
- Commonwealth initiatives including Rural Health policy and Department of Primary Industry and Energy Rural Communities programs; and
- National Drug **Strategy.**

Relevant programs, currently under evaluation, include: optimism programs in schools; a demonstration project for promoting positive mental health in country schools; and a community-driven life promotion program aimed at preventing suicide in RRCS. Promising techniques requiring further evaluation include playback theatre and cultural action.These programs have been widely used in a range of settings to assist Indigenous communities in remote areas to deal with community defined issues. Important elements 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 (Grant, Laird & Cox 1998).

Research questions

- What are best practice indicators for RRC mental health promotion and prevention, reduced impact of stress, and depression, anxiety and suicide prevention?
- What are the causes of family breakdown specific to RRCS?
- What is the impact of rural unemployment on the mental health of RRC families and individuals?
- What is the availability, limitations and effectiveness of internet/telehealth/telemedicine interventions for mental health promotion and prevention in remote and rural areas?
- What evidence-based methodologies need to be developed for and by Aboriginal and Torres Strait Islander communities?

National strategies

Identity opportunities

Identify data, initiatives, needs and partnerships to examine opportunities for mental health promotion and prevention, including the effectiveness of conduct disorder prevention, programs promoting optimism. health promotion theatre and suicide prevention programs. Consider the role of rural and remote mental health information services and telemedicine and the internet.

Pilot programs

- Pilot program models based on current knowledge for implementation in response to local needs and in partnership with local communities but using core measures to ensure national database development.

- Develop culturally sensitive prevention and promotion programs, including local community driven programs.

Pilot community development initiatives

- Pilot community development approaches and evaluate mental health outcomes.

Develop education programs

- Determine health workforce education and training needs, including the role of telemedicine. Develop programs.

Systems for integration across priority areas

- Support and promote systems for integrating issues relating to people from RRCs into the planning, monitoring, and evaluation of initiatives in all relevant priority areas in the *Action Plan*.

Process outcomes

- increased availability of distance-mode mental health education and training and of rural mental health components in mainstream health and social science courses;

- increased employment of mental health, public health and primary health care workers with knowledge and promotion and prevention skills appropriate to RRCS;

- increased professional development in the use of telemedicine and other technologies and increased delivery of prevention and promotion services using these technologies; and

- increased availability and community participation in prevention and promotion/community development programs in RRCS;

Longer term outcomes

• increased mental health literacy;

• reduced risk factors for mental health problems and mental disorders;

• decreased levels of depression, anxiety, substance abuse disorder and other mental disorders and mental health problems; and • improved mental health and well-being.

Aboriginal and Torres Strait Islander communities

Priority mental health targets

- Improve the emotional and social well-being of Aboriginal and Torres Strait Islander communities within a holistic framework.

- Increase links between mainstream and Aboriginal community controlled services.

- Decrease the incidence and prevalence of, and risk factors for, mental health morbidity, especially depression, anxiety and substance abuse symptomatology and issues around loss, grief and trauma.

- Increase mental health literacy.

- Decrease social disadvantage, racism and oppression.

Rationale

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

Although data is incomplete, it is clear that Indigenous peoples experience high rates of mental health problems and disorder. Studies by McKendrick (1 992, 1993) have revealed high rates of psychological distress and depression in clients presenting to Aboriginal medical services. A review of Aboriginal Community Controlled Health concluded that in urban areas, mental health was the leading issue to be managed by the service (VVronski et al 1994).

However, emotional and social well-being issues and mental health problems have not been identified as priority issues by Aboriginal peoples and Torres Strait Islanders until recently. Stigma, incarceration and lack of cultural understanding has inhibited Indigenous peoples from acknowledging mental health problems. In addition, historically, mental health systems have not been attuned to the needs of Aboriginal peoples and Torres Strait Islanders (Swan, Mayers & Raphael 1994). Misdiagnosis in mainstream mental health services has been common due to a failure to recognise and understand the Indigenous social and emotional context of presenting problems.

The mental health and well-being issues of Aboriginal and Torres Strait Islanders can only be understood within the context of the Aboriginal concept of health which has been defined as: not just the physical well being of an individual, but... the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well being of their community. It is a whole of life view and includes the cyclical concept of life-death-life (NACCHO 1997).

It is not possible to understand the mental health outcomes for Aboriginal peoples and Torres Strait Islanders without recognising the impact of historical events, the ongoing trauma and loss and the high levels of disadvantage in

Communities of interest

- Aboriginal and Torres Strait Islander communities;
- Aboriginal Community Controlled services;
- Aboriginal and Torres Strait Islander Commission;
- Commonwealth Department of Health andaged Care;
- Department of Education, Training and Youth Affairs;
- public and private health services;
- general practitioners and other mainstream health providers;
- Corrective Services;
- Department of Housing., and
- Aboriginal sections of **State** Departments of Education.

Settings

- Aboriginal and Torres Strait Islander communities;
- education settings;
- criminal justice settings;
- health settings; and
- local government.

Linked initiatives

- National Aboriginal Health Strategy 1989;
- Royal Commission into Aboriginal Deaths in Custody 1991;
- NACCHO manifesto on Aboriginal MentaiWell-being 1993;
- NSWAboriginal Mental Health Report 1993;
- TheWays Forward Report 1995;
- Commonwealth Aboriginal and Torres Strait]slander Social and Emotional Action Plan 1996;
- National Drug Strategy 1996;
- The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families 1997;
- NSW Aboriginal Mental Health Policy 1997;
- State andterritory Framework Agreements 1997-98; and
- Accredited Youth Suicide Prevention Training for Indigenous Community Workers 1998.
- indigenous cornmunities.The current levels of loss, trauma, premature death, family breakdown and separation of children from their families, racism, and social disadvantage are among the effects of colonisation that have contributed to the present high levels of stress, grief, depression and suicide in Aboriginal and Torres Strait Islander communities (Swan & Raphael 1995; Raphael & Swan 1997).

Community control is central to developing suitable promotion and prevention strategies for Aboriginal peoples and Torres Strait Islanders. Community control is'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community' (NACCHO 1997). Some Aboriginal Community Controlled Health Services have been funded to expand their social health programs. It is essential that such programs are developed and evaluated within local communities. If this principle is not followed, community participation is unlikely and benefits will be minimal (Swan & Raphael 1995; National Aboriginal Health Strategy 1989).

Evidence base

The National Aboriginal Health Strategy (1 989), the Royal Commission into Aboriginal Deaths in Custody (1 99 1), the Burdekin Report (1 993) and the Ways Forward Report (Swan & Raphael 1995), contain highly relevant evidence which is essential to the development of any prevention and promotion programs in Aboriginal and Torres Strait Islander communities. Furthermore, there is an urgent need to develop and evaluate the effectiveness of culturally valid holistic models of mental health promotion and prevention. Models such as narrative therapy. psychosocial drama and other appropriate therapies for trauma and loss should be further developed and evaluated. Programs incorporating health promotion and education, screening, parenting skills, prevention of child abuse and neglect and post-natal depression are also key interventions requiring evaluation. In addition, prisoner rehabilitation and outreach support services are a priority for development and evaluation.

Research questions

- What are the most appropriate interventions for reducing mental health problems and disorders and increasing social and emotional well-being in different Indigenous communities?

- What evidence-based methodologies need to be developed for and by Indigenous communities?

National strategies

Establish partnerships and programs

- In full consultation with Aboriginal controlled services, further develop and enhance State-based partnerships and strategies, particularly to address loss and trauma. Develop and maintain a reference group across sectors to progress Aboriginal peoples' and Torres Strait Islanders' mental health and social and emotional well-being.

- Continue to implement the strategies outlined in the Ways Forward report (Swan & Raphael 1995).

Systems for integration across priority areas

- Support and promote systems for integrating issues relating to Aboriginal peoples and Torres Strait Islanders into the planning, monitoring, and evaluation of initiatives in all relevant priority areas in the *Action Plan.*

Process outcomes

increased culturally appropriate mental health promotion, prevention and early intervention programs and initiatives;

- Indigenous community ownership of programs;
- improved partnerships with other sectors;
- joint planning between Aboriginal community controlled services and mainstream organisations; and
- increased number of Aboriginal professionals employed in health and education settings.

Longer term outcomes

- improved social and emotional well-being in Indigenous communities;
- decreased level of risk factors for mental health disorders and problems; and
- improved and increased level of understanding of the impact of history in relation to emotional and social well-, being issues.

People from diverse cultural and linguistic backgrounds

Priority mental health targets

- Promote resilience and enhance protective factors for mental health problems and disorders among individuals and families from diverse cultural and linguistic backgrounds.
- Reduce risk factors for mental health problems and disorders among individuals and families from diverse cultural and linguistic backgrounds.
- Increase access to culturally relevant promotion and prevention initiatives and services.
- Promote mental health literacy and reduce stigma related to mental illness amongst people from diverse backgrounds.
- Promote culturally sensitive responses and mental health prevention interventions among health care providers.
- Promote community capacity building to address mental health promotion and prevention for people from diverse backgrounds.

Rationale

Australians from non-English speaking backgrounds comprise approximately 20 per cent of the national population (Sozemenou et a] 1998).They represent a diverse range of cultures and are characterised by different needs, problems, and understandings of mental health and mental disorders. In addition, the specific requirements and problems of groups and individuals within a community may vary markedly.

It has been suggested that certain factors associated with the migration process may increase the risk of mental health problems.These have been summarised by Mihalopoulos & Pirkis (1 998) as follows:

> low socioeconomic status, or a drop in socioeconomic status following migration; inability to speak the language of the host country; separation from family; prejudice and discrimination in the host society; lack of recognition of professional qualifications; isolation from others of a similar cultural background; traumatic experiences or prolonged stress before or during immigration (as in the case of refugees); being adolescent or elderly during the time of migration; and extent of acculturation (p. 34).

Thus, high risk groups may include the elderly, adolescents, refugees (including asylum seekers) and those of low socioeconomic status.

Potential barriers to effective prevention and promotion activities within culturally and linguistically diverse communities include: language and cultural factors; culturally specific beliefs and understanding

of mental health problems and their causes; and stigmatising attitudes to mental health problems within the families and culturally diverse communities (Long et al 1998; Mihalopoulos & Pirkis 1998).

Good practice in promotion and prevention service delivery to culturally diverse communities may include: providing information that will increase mental health literacy with respect to prevention and early detection; liaising with community leaders to facilitate promotion of mental health and prevention initiatives; promoting culturally appropriate ways of destigmatising mental illness; providing

Communities of interest

- community, consumer and carer organisations;
- the ethnic media;
- State and Territory transcultural mental health centres and networks;
- torture and trauma rehabilitation services;
- drug and alcohol agencies;
- relevant university mental health services and training programs;
- community and mental health professionals;
- Divisions of General Practice;
- Primary, secondary and tertiary education systems;
- Department of Immigration and Multicultural Affairs Settlement Services; and
- Department of Education,
- Training and Youth Affairs.

Settings

- general practitioner and other primary care settings and community mental health settings;
- adult migrant education
- centres and language centres;
- primary and secondary schools;
- ethnic community organisations;
- youth and other community specific associations and clubs;
- forums for torture and trauma survivors and asylum seekers.

Linked Initiatives

- Transcultural mental health centres and networks;
- Program of Assistance to Survivors of Torture and Trauma (DHAC);
- Department of Immigration and Multicultural Affairs Integrated Humanitarian Settlement Strategy; and
- national initiatives (eg, National Illicit Drugs Strategy, GP Strategy, National Rural Health Strategy, National Mental Health Strategy Education and Training activity and labour market programs.

information and education to the community; increasing cultural awareness through staff development; and liaising with communities to ensure cultural sensitivity in the delivery of programs (Australian Transcultural Mental Health Network. Long et al 1998).

Evidence Base

There is a need to develop an evidence base for effective mental health promotion and prevention for different cultural groups. taking into account various risk, protective, language and cultural issues.

Research questions

- What programs are effective in preventing mental disorders in various cultural groups?
- What mental health promotion and prevention information resources and skills are required within the mental health care system to better meet the needs of various cultural groups?
- What are the benefits of promotion and prevention programs for newly arrived refugees?
- What interventions are most effective in reducing the secondary and trans-generational effects of refugee trauma on children and adolescents?

National Strategies

Develop partnerships and evidence base

- Review the existing evidence base for prevention and promotion activities in diverse cultural and linguistic communities.
- Review mechanisms for translating prevention programs of established effectiveness into appropriate programs for culturally and linguistically diverse communities while retaining program integrity.
- On the basis of the above reviews, develop a strategy for promotion and prevention activities in partnership with transcultural mental health services and the community sector.
- Identify initiatives, needs and partnerships and support research relating to prevention and promotion, particularly for high risk groups (eg, children, adolescents, older people and refugees, including asylum seekers).
- In collaboration with relevant agencies, support appropriate work force development initiatives and community capacity building activities.

Develop programs

· Develop and evaluate specific culturally sensitive and relevant interventions to address promotion and prevention, service access knowledge and options, and early identification and response by health services.
· Support the widespread implementation of effective promotion and prevention programs for people from diverse backgrounds.

· Support the national implementation of Cultural Awareness Standard 7 of the National Standards for Mental Health Services (1 996).

Systems for integration across priority areas

- Support and promote systems for integrating issues relating to people from diverse backgrounds into the planning, monitoring, and evaluation of initiatives in all relevant priority areas in the *Action Plan.*

Process Outcomes

- increased mental health promotion and prevention activities relating to people and communities of culturally and linguistically diverse backgrounds;
- effective partnerships between mental health services and relevant national and local organisations to address promotion and prevention needs of people from diverse backgrounds;
- increased use and adherence to the Cultural Awareness standard of the National Mental Health Standards; and
- increased research activity in the area of mental health promotion and prevention for people from diverse backgrounds.

Longer term outcomes

- reduced incidence and prevalence of depressive, anxiety, substance abuse and other disorders;
- improved mental health literacy amongst people from diverse cultural and linguistic backgrounds;
- reduced stigma associated with mental illness within diverse communities;
- improved access to effective promotion and prevention programs;
- reduced transmission of secondary effects of parental and family trauma on the development of children and adolescents; and
- improved health and mental health service provider appreciation of cultural issues and capacity to provide appropriate prevention and promotion information to diverse communities.

Consumers, carers and community organisations

Priority mental health targets

- Promote mental health literacy.
- Build partnerships with consumers, carers and their families and engage in mental health promotion and prevention programs and initiatives.
- Promote optimism, resilience, social and emotional well-being for people with mental problems and disorders.
- Enhance protective factors to lessen morbidity associated with mental health problems and disorders.

- Reduce risk factors known to impact on mental health problems and illnesses including social disadvantage, unemployment, homelessness, stigma and discrimination.

Rationale

In Australia, the consumer and carer movement has grown in size and influence over the past two decades.The drive for reform under Australia's National Mental Health Strategy is largely a result of the convergent desire of mental health professionals, consumers and carers for a better mental health service system (Behan, Killick & Whiteford 1994).

The benefits and opportunities for consumers, carers and community organisations of mental health promotion and prevention approaches are not yet well defined. However, there is no doubt that as a result of their unique experiential knowledge base, consumers and carers can play a key role in facilitating the effective development and implementation of the strategies proposed in all key areas of the *Action Plan.*

Many consumers, carers and community support and advocacy agencies have been actively engaged in activities relevant to the *Action Plan*, including: community education to increase mental health literacy and reduce discrimination and stigma; training programs for volunteers and mental health professionals; and the development of educational curricula. Many groups have expert knowledge in the field of mental health and have initiated prevention and promotion strategies and community development programs. Continued ownership and development by these groups is essential and their participation is seen as a priority.

Experiencing a mental disorder may in itself be distressing and traumatic. Consumers and carers have identified the importance of preventing further psychological problems and stress associated with the primary illnesses and their treatment.The process of developing and delivering meaningful promotion and prevention activities might promote improved self esteem among consumer participants, which in turn could protect against secondary mental health problems and promote emotional and social well-being,

Communities of interest

- consumer and carer groups and organisations;
- local government;
- private and public health services;
- primary practitioner and other primary health care providers;
- Human Rights and Equal Opportunity Commission; and
- media.

Settings

- home;
- . health care settings;
- local communities;
- schools;
- community agencies;
- education and training sectors; and
- relevant national, State and Territory conferences, meetings and forums.

Linked initiatives

- The Consumer Advocacy Kit;
- Mental Health Council of Australia and Australian Mental Health Consumers Network; and
- Department of Health and Aged Care carer policies and initiatives.

Evidence base

The evidence base in this priority mental health area requires developing with further research and evaluation.

Research questions

- What effective contributions do consumers and carers make to mental health promotion and prevention?
- What are the consumer and carers issues in mental health promotion and prevention?
- What are effective community-based interventions for children of parents with a mental illness.

National strategies

Develop partnerships

- Develop partnerships with consumers, carers and community organisations and explore and implement strategies to increase their participation in mental health promotion and prevention.

Pilot programs

- Pilot and evaluate consumer and carer mental health promotion and prevention initiatives,
- Pilot and evaluate programs to enhance protective factors and lessen the risk of secondary psychosocial morbidity (eg, depression) associated with mental health problems and disorders.

Carer programs

- Establish links with existing carer initiatives and develop partnerships. Investigate issues such as access to support, respite, education and best practice.

Consumer programs

- Implement the Consumer Advocacy Kit (Commonwealth Department of Health and Family Services 1998). Investigate the prevention and promotion roles of peer support and self-help groups.

Programs for children of people with a mental illness

- Investigate the availability of prevention and support programs and make recommendations for future action.

Process outcomes

- increased quality mental health education, training and support materials for consumers and carers in mental health promotion, prevention and early intervention;
- increased paid representation of consumers and carers on management committees;
- increased participation and advocacy in media and public presentations by a range of mental health consumers and carers reflecting their experiences with different W% and severides of mental disorders and representing youth, rural, aged, Indigenous and other specffic needs groups;
- increased numbers of nongovernment mental health agencies involved in the delivery of mental health promotion and prevention and community mental illness education; and
- evaluation of the effectiveness and sustainability of prevention initiatives for consumers, carers and children with parents with a mental illness.

Longer term outcomes

- increased mental health promotion/prevention activities by peak and national carer and consumer groups;
- increased mental health literacy for consumers and carers;
- increased availability of carers' prevention and respite programs;
- for children who have a mentally ill parent:
- improved support;
- improved mental health and fewer mental health problems/mental disorders;
- better knowledge and understanding of parental illness; and
- improved parenting by parents; and
- improved access, care, outcomes, functioning and capacity for full participation in family and community life for people with mental health problems across all age groups.

Whole of community

Priority mental health targets

- Promote mental health literacy in the community.
- Reduce stigma and discrimination to promote recovery and understanding about mental illnesses. '
- Increase appropriate early help-seeking behaviour for mental health problems and illnesses.

Rationale

There is a high level of misunderstanding about mental health problems and mental illnesses in the Australian community (Reark Research 1993; jorm et at 1997) including inadequate recognition of the significant symptoms of mental disorders and a lack of awareness of the effectiveness of common methods of treatment.The topic of mental illness arouses deep-seated fears and constant denial at all levels of society (Reark Research 1993).

Poor mental health literacy contributes to the stigma and discrimination experienced by people with mental illness, discourages people from seeking early and appropriate help for mental health problems and illnesses and may perpetuate behaviours and environments which are risk factors for mental health problems and disorders.There is a need to increase mental health literacy in the community to address these problems.

Some initiatives have been directed at changing community attitudes to mental health problems and disorders in Australia. However, there has been minimal coordination of national, State and Territory and local activities and a notable lack of community mental health promotion by mental health services.The initiatives have also been identified as not appropriate for a range of groups, including people from diverse cultural and linguistic backgrounds and Aboriginal peoples and Torres Strait Islanders (Evaluation of the National Mental Health Strategy 1997).

Evidence base

There is evidence from the US that media campaigns in conjunction with appropriate community activities can positively influence community attitudes and knowledge (Hersey, Kiinamoff, Lam & Taylor 1984 (controlled trial) cited by Health Education Authority 1997).

In Australia, the Community Awareness Program (CAP) - comprising a series of media advertisements and educational materials and initiated as part of the National Mental Health Strategy - was followed by some increase in awareness and improved attitudes to mental health disorders suggesting that overall the campaign had been effective in reinforcing non-discrimatory attitudes. However, effects were small and the evaluation was based on a benchmark survey and prelpost tracking design. Moreover, improved attitudes do not necessarily imply changed behaviour and awareness may reflect media weight and exposure rather than changes in individuals' beliefs or intentions (Elliott & Shanahan Research 1998). In fact. there was overwhelming qualitative feedback that the CAP had no practical impact on community attitudes or behaviour towards people with mental illness, with consumers reporting that stigma and discrimination remained at the high level that existed prior to the Strategy (Evaluation of the National Mental Health Strategy 1997).

Communities of interest

- whole of community,
- local government;
- community agencies;
- consumer and carer groups;
- employers;
- unions;
- health professionals and clinicians;
- education and training agencies; and
- media organisations.

Settings

- **local** communities;
- **workplaces;**
- **schools;**
- media **worksites;**
- **education and** training **settings;** and
- sport/recreation/social/club settings.

Linked initiatives

- National Drug Strategy,
- Attitudes of Health Professionals Project;
- Life Promoting Media Strategy (proposed);
- National Transcultural Mental Health Network Project; and
- Australian Rotary Health Research Fund Mental Health Initiative.

Nevertheless, at a process level, evaluations revealed strong support for the campaign and a high level of demand for the written educational materials that were developed for the campaign (Eureka Strategic Research 1996).There was also feedback that the campaign increased the self-esteem of consumers.

Given the relative lack of an evidence base, an evaluation of previous healthrelated campaigns may help identify effective communication strategies. In addition, all future campaigns should be evaluated using the best available methodologies. Finally, there is a need to develop campaigns which will enhance community knowledge concerning risk and protective factors and preventive opportunities in mental health.

Research questions

- Which community target groups can impact on mental health literacy, attitude and behaviour change?

- What messages and strategies are effective in engaging the target group? (it may be appropriate to focus on a specific mental disorder, such as depression.)

- What are effective community-wide prevention and promotion activities?

National strategies

Identify best practice principles and partnerships for improving mental health literacy and attitudes

- Identify data, initiatives and partnerships relevant to changing community attitudes and increasing knowledge by reviewing public health campaigns and defining key effective elements.

Mental health messages

- Develop and evaluate whole of community mental health promotion initiatives based on the above research.

- Pilot integration of key mental health messages, including prevention and promotion, into future media campaigns and evaluate effectiveness with respect to targeted goals.

Coordinate national, State and Territory and local mental health promotion activities

- . Support national coordination that will enhance and maximise the effect of mental health promotion.

Process outcomes

- mental health **messages** and materials for **selected target** audiences **developed** and delivered;
- State, Territory and local initiatives reinforcing campaign messages implemented; and
- strategic linkages established between national and State activities, Mental Health Week, and other initiatives.

Longer term outcomes

- improved attitudes towards mental health/mental disorder and decreased stigmatization of mental disorder;
- improved mental health literacy. Recognition that:
- mental health (as well as physical health) can be protected and promoted;
- ordinary people' can experience mental health problems;
- many mental health problems are curable;
- preventive measures can be undertaken to reduce potential mental health problems; and
- help services are available for those experiencing possible mental health problems; and
- increased appropriate early help-seeking behaviour for mental health problems and illnesses.

Media

Priority mental health targets

· Promote mental health literacy throughout media settings and media workforce.

· Improve the reporting and portrayal of mental health issues and people with mental disorders.

Rationale

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

At present, media coverage often reflects the widespread misunderstanding of mental health problems and mental disorders that exists in the broader community (egwilliams & Taylor 1995). Education and raising awareness within the media about these issues may improve accuracy and balance in reporting and assist in promoting mental health literacy in the general Australian community. In addition, collaboration between media representatives and mental health professionals may help identify means by which the media can discourage rather than affirm suicidal behaviour without creating negative attitudes to mental illness (Martin 1998).

Communities of interest

- media workforce, including journalists. editors, radio and television presenters, administration, management and production staff,
- communication and broadcasting censorship; and ,,
- press council.

Settings

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

Linked initiatives

Mental Health Media **Resource** Kit and media **strategy.**

Evidence base

The evidence base in this priority mental health area requires further analysis and development.

Research questions

- To what extent, and in what ways, does the media influence community attitudes to mental health and mental disorders? What components of media reporting and presentations promote positive attitudes to people with mental health problems and illnesses?

- How balanced and accurate is media portrayal of mental health problems and mental health issues?

- Does the media impact upon mental health andlor the development of mental health problems (eg, the effect of violence in the media on children and adults)?

- What strategies are effective in influencing media portrayal of mental illness and mental health issues and prevention?

National strategies

Research

- Review the evidence concerning the content, balance, accuracy and impact of the media as it relates to mental health promotion and prevention. Review evidence concerning strategies for influencing media portrayal of mental health/mental illness issues.

Promote accurate and positive media reporting

- Develop initiatives and partnerships to progress and ensure accurate and appropriate media reporting and portrayal of mental health and mental disorder.This includes distributing the Mental Health Media Resource Kit and developing cross cultural awareness packages for the media.

- Develop a media strategy to promote positive messages about Aboriginal peoples and Torres Strait Islanders.

Identify and support mental health spokespeople

- Form a group of experts and eminent spokespeople for mental health issues across the media (print, television and radio).

Process outcomes

- strategic linkages established between mental health and media;
- increased media coverage by community spokespeople on mental health-related issues;
- increased positive media coverage regarding Aboriginal peoples and Torres Strait Islanders.

Longer term outcomes

- increased media mental health literacy; and
- increased media coverage of mental health and mental illness that is accurate in content and appropriate in presentation, together with decreased negative reporting.

Health professionals and clinicians

Priority mental health targets

- Promote sustained mental health promotion and prevention initiatives in primary, secondary and tertiary health settings.
- Reorient mental health services to include appropriate commitment of resources to mental promotion, prevention and early intervention work.
- Reorient clinicians towards a public health approach which equips them to provide a spectrum of interventions (promotion, prevention, and early intervention as well as treatment services) in order to maximise population and individual mental health outcomes.
- Promote links and partnerships intersectorally and intrasectorally to maximise opportunities in mental health promotion and prevention at the national, State and Territory levels.
- Promote capacity building of workplace structures.

Rationale

Current mental health services are focused primarily on interventions at the treatment and maintenance end of the mental health intervention spectrum (Evaluation of the National Mental Health Strategy 1997). However, it is becoming increasingly clear that if mental health outcomes are to be improved, mental health professionals must expand their focus beyond treatment to encompass public health issues such as the promotion of mental health literacy, education and advocacy for mentally healthy lifestyles and the identification and early response to mental health problems and disorders.

Currently, many primary health care providers play a proactive role in preventing physical illness (eg, lifestyle advice for physical fitness. cancer and heart disease prevention, early identification and response to early signs and symptoms).There is considerable scope for all primary health care providers to play a similar role in mental health promotion and illness prevention.

Factors which may promote sustained promotion and prevention work among health and mental health workers include :'strong support from a robust health promotion infrastructure' (Wood &Wise 1997); staff commitment, professional development and education; and systems which identify and disseminate good practice (eg, internet). Factors which may inhibit promotion and prevention work include the attitudes of health professionals (see Attitudes of Health Professionals Project Survey 1998) and failure to understand lay perspectives of mental disorder. For example, lay perceptions of the usefulness of treatments for mental disorder differ from those of professionals gorm et a] 1997) and a growing number of people are attracted to wider models of health-maintenance and less medical style interventions (eg, see Eisenberg et al 1998).An awareness of such perspective may be important in formulating activities and encouraging prevention and early help-seeking. Finally, the term 'serious mental health illness' in the National Mental Health Strategy has inhibited effective prevention and early intervention activities (Evaluation of the National Mental Health Strategy 1997).

Communities of interest

- State and Territory health systems and GPs and other primary care service provide
- mental health professionals;
- policy and project managers;
- public health professionals;
- Aboriginal andtorres Strait Islander Emotional and Social Well Being regional centres;
- Recruitment managers/ workforce project officers based with NACCHO peak State/Territory affiliates;
- ethnic liaison health ~ers; an
- health promotion and health education officers.

Settings

- public and private hospitals, community mental health centres, shared care in primary health care settings, and government settings; and

- education and training settings including health and mental health professional development systems in universities, vocational education and training sector. Open LearningAustralia.

Linked initiatives

- National Public Health Partnership;
- Attitudes of Health Professionals Project;
- Professional Competency Development Project;
- Community Development Project;
- health workers forums;
- GP Training Centres Project;
- AusEinet Project;
- protocol development by the College of Emergency Medicine and the College of Psychiatry for working with young people who may be suicidal;
- NACCHO Recruitment Services Program;
- Commonwealth Aborizinal and Torres Str-ait Islander Emotional and Social Well Being *Action* Plan.

Evidence base

As described throughout this document and in summaries of the literature (eg, Mrazek & Haggerty 1994), preventive interventions can be efficacious in reducing risk factors andlor preventing mental health problems. However, the effectiveness of many of these programs in different health care settings (as opposed to their efficacy in ideal conditions) is yet to be established.There is a need to implement and evaluate programs in different settings.There is also a need to identify the rneans by which mental health and general practitioner and other primary care professionals can participate in effective prevention and promotion activities and to identify the barriers to this participation.

Research questions

- How may mental health professionals best inform current health promotion activities to allow the effective incorporation of mental health issues?
- What points in the mental health service cycle present opportunities to communicate effective health promotion/prevention messages?
- How may health professionals be best encouraged and assisted to widen their role in mental health promotion and illness prevention?
- How may mental health professionals develop a fuller understanding of lay perceptions of mental health and well-being and factors that contribute to mental health maintenance and help-seeking?
- How may'alternative' models of health maintenance and prevention (with high public acceptance) inform professionals of lay perceptions of mental health and illness and effective strategies?

National strategies

Identity relevant mechanisms

- Identify data, initiatives and partnerships relevant to mental health promotion and prevention, and mechanisms to encourage and support these approaches across the health system, in close liaison with consumers.

Pilot prevention and promotion programs across health services

- .Develop a series of pilot prevention and promotion programs in mental health provided by a range of health services including interventions to enhance positive attitudes and mental health promoting health care environments.

Improve job satisfaction and reduce burnout

- Identify and implement core mental health elements of workplace prevention and promotion programs that contribute to improved job satisfaction and reduce staff burnout.

Develop cultural awareness

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

Process outcomes

- increased focus on mental health promotion, prevention and early intervention including; reorientation of services; realignment of structures; inclusion in contracts, service agreements, business plans and outcome statements at all levels; recognition of work undertaken; and appropriate record keeping-,
- inclusion of promotion and prevention in specialist mental health education curricula;
- acceptance of promotion and prevention as a legitimate part of service delivery;
- inclusion of culturally appropriate education and training curricula and distance education programs in Indigenous mental health

issues in mainstream health and social science courses in States and Territories;

- cross cultural awareness incorporated into health services.

Longer term outcomes

- increased mental health promotion and prevention (mhp&p) activity across health settings and in mental health service settings;
- .increased focus by mental health professionals on mhp&p;
- increased mhp&p literacy and competency among health professionals and clinicians;
- increase in positive attitudes among health professionals and clinicians to people with mental health problems or disorders;
- increase in mental health promoting service environments for workers and consumers;
- increased evidence base for mental health promotion and prevention in health settings; and
- increased awareness, knowledge and work practice in Indigenous mental health issues for mental health workers and public and primary health care workers.

Abbreviations

2nd NMHP	Second National Mental Health Plan
AHMAC	Australian Health Ministers'Advisory Council
CAP	Community Awareness Program
DHAC	Department of Health and Aged Care
GP	general practitioner
HIVIAIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
]OM	United States Institute of Medicine
NSW	New South Wales
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
NMHWG	National Mental Health Working Group
NPHP	National Public Health Partnership
PPWP	National Mental Health Promotion and Prevention Working Party
PTSD	Post-traumatic stress disorder
QLD	Queensland
RRC	rural and remote communities
SA	South Australia
WA	Western Australia
WHO	World Health Organization

Glossary

Aboriginal concepts

Health

'Not just the physical well being of an individual, but... the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well being 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.

Anxiety disorder

'A condition in which worry, anxiety or fear is a prominent symptom. Defined according to standard psychiatric
criteria' (NHMRC 1997, p 154).

Carer

'A person whose life is affected by virtue of a close relationship and a caring role with a consumer' (2nd National
Mental Health Plan 1998, p25).

Clearinghouse

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

Comorbidity

'The co-occurrence of two or more disorders such as depressive disorder with anxiety disorder. or depressive disorder with anorexia' (NHMRC 1997, p 1 54).

Community education

An organised campaign designed to increase awareness of an issue.

Conduct disorder

'Condition characterised by aggressive, destructive, deceitful and rule breaking behaviours. Defined according to standard psychiatric criteria' (NHMRC 1997, p 1 54).

Consumer

'A person utilising, or who has utilised, a mental health service' (2nd National Mental Health Plan 1998, p25).

Debriefing

'The act of discussing or talking through a recent experience, such as a crisis' (Commonwealth Department of Health and Family Services, p257).

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 1993, p45).

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 (after Henderson & Jorm 1998, p6).

Depression

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.

Early Intervention

Interventions targeting people displaying the prodromal signs and symptoms of an illness. Early intervention **also** encompasses the early identification of people suffering from **a** disorder.

Eating disorder

'A syndrome that negatively affects body-image, self-confidence and personality' (Seizner, Bonomo & Patton, 1995, p2032).Anorexia nervosa is characterised by excessive and self-induced weight loss and Bulimia Nervosa involves eating binges alternated with self-induced vomiting and laxative abuse.

Incidence

The percentage of the population suffering from a disorder for the first time (during a given period).

Media

'Channel for Mass communication of information to general andlor specific audiences (electronic media - radio, television, **film;** print media - newspapers, magazines)' (Commonwealth Department of Health and Family Services 1998, p258).

Mental **disorder**

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

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' Oorm et al 1997, p 1 82).

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.' (The Kit, Commonwealth Department of Health & Family Services 1998, p258).

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 & Centre for Social Health 1996, p 1 0).

Mental health **promotion**

'Action **to** maximise mental health and well-being among populations and individuals' (2nd National Mental Health
Plan **1998,** p 1 2).

Mental health

'The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.' (Australian Health Ministers 199 1)

Meta analysis

'A systematic review that employs statistical methods to combine and summarise the results of several studies' (Cook & Guyatt 1994, p 1 327).

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 (2nd National Mental Health Plan 1998, p27).

Partnership

An association intended to achieve a common aim.

Perinatal

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

Post-natal depression

Maternal depression occurring after the birth of a baby

Prevalence

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

Prevention

'Interventions that occur before the initial onset of a disorder' (Mrazek & Haggerty 1994, p23).

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 & Haggerty 1994, p24).

Selective intervention

A preventive intervention'targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average' (Mrazek & Haggemy 1994, p25).

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 & Haggerty 1994, p25).

Protective factors

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

Randonlised controlled trial

Trial in which individuals are randomly assigned to the intervention/control conditions under investigation.

Risk factor

'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 & Haggerty 1994, p 1 27).

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 (after American Psychiatric Association 1994, pp274-275).

Stakeholders

'The different groups that are affected by decisions, consultations and policies.' (The Kit, Commonwealth Department of Health and Family Services 1998, p259).

Substance abuse

'A rnaladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances' (American Psychiatric Association 1994, p 1 82).

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