CHAPTER 7

PROMOTION, PREVENTION AND EARLY INTERVENTION

Introduction

7.1   There is indisputable evidence that the bulk of mental health care resources are allocated to acute care and the treatment of mental illness through hospital-based services. Whilst the importance of treating mental illnesses and their symptoms should not be understated, the question remains as to how much pain – experienced by the consumer, the health care system and the community – could be avoided if preventative measures had been taken to reduce the potential for developing a mental illness, or there had been early intervention?

7.2   Mass media campaigns over the years have targeted community-wide issues, such as the prevention of AIDS, skin cancer and damage caused by smoking. Yet given the social impact and often devastating consequences of mental illness, there has been relatively little effort to raise awareness of a range of mental health issues on a national scale, and to break down the damaging stereotypes and misconceptions surrounding mental illness that create strong barriers to the seeking of help.

7.3   A number of community organisations are implementing valuable prevention, promotion and early intervention programs. However, the short term funding outlook of governments at the federal, state and territory levels in supporting the future development and continued delivery of such programs was criticised, as was the lack of back-up mental health care services to handle referrals and provide continuity of care, and the absence of a national effort to coordinate successful local programs or support their roll-out on a broader scale.

7.4   This chapter reviews: the stigma associated with mental illness and the need to realign the public's perception of mental illness; the prevention of mental illness by targeting the young and other high risk groups; the role of early intervention programs; and examines a number of community programs that are delivering positive results.

Setting the context of prevention, promotion and early intervention in mental health care

What are prevention, promotion and early intervention?

7.5   Promotion, prevention, and early intervention approaches are relevant across the entire spectrum of mental health problems and disorders, from behavioural disorders and depressive and anxiety disorders, through to psychotic disorders. Anxiety disorders in children, for example, can be prevented through school-based

programs designed to promote resilience.[1] Research also shows the positive effects of early intervention in reducing the impact of psychotic illness.[2]

7.6   Mental health **promotion** is any action taken to maximise mental health and wellbeing among populations and individuals. An example is programs that support and strengthen family functioning.[3]

7.7   **Prevention** is defined as 'interventions that occur before the initial onset of a disorder' to prevent the development of disorder. Prevention relies on reducing the risk factors for mental disorder, as well as enhancing the protective factors that promote mental health.[4] *Selective* prevention interventions target at-risk populations: an example is school-based programs specifically targeting young people at risk of depression. *Universal* prevention interventions are aimed at improving the overall mental health of a population: an example would be programs aimed at building connectedness and a sense of belonging in school students.

7.8   **Early intervention** refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or disorder, and people developing or experiencing a first episode of mental disorder. Early intervention aims to prevent progression into a diagnosable disorder, and for those experiencing a first episode of mental disorder, it aims to reduce the impact of the disorder.[5]

The national approach

7.9   The National Mental Health Strategy of 1992 and subsequent National Mental Health Plans recognised the importance of promotion, prevention, and early intervention. The Second National Mental Health Plan 1998-2003 identified promotion and prevention as one of three priorities for future activity. The current (third) National Mental Health Plan 2003-2008 identifies 'promoting mental health and preventing mental health problems' as one of four priority themes.

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1   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 99.

2   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 104.

3   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 29.

4   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 30.

5   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, pp. 32–33.

7.10   The need for national direction in promotion and prevention was identified in a 1997 evaluation of the National Mental Health Strategy. A Mental Health Promotion and Prevention Working Party was set up to develop a plan of action to provide this national direction.[6] Subsequently, a *National Action Plan for Promotion, Prevention, and Early Intervention for Mental Health 2000* (PPEI Action Plan) was published.[7] PPEI Action Plan is a joint initiative of federal and state governments. It is accompanied by a second document – a monograph providing the theoretical and conceptual framework and background (*Monograph 2000*).[8]

7.11   Working in parallel with PPEI Action Plan is the Australian Network for Promotion, Prevention, and Early Intervention (Auseinet), funded by the federal Department of Health and Ageing, which collects and disseminates information, and works collaboratively with government and non-government sectors.[9]

Why are prevention, promotion and early intervention important?

7.12   There is strong support for a prevention and early intervention approach, as it has the significant potential to reduce future adverse outcomes[10] and:

> It is widely recognised and understood that treatment interventions alone cannot significantly reduce the burden of mental disorder and that there is compelling evidence that implementation of promotion, prevention and early intervention approaches will significantly reduce the burden of mental illness and mental disorder. Given the current limitations in effectiveness of treatment interventions for decreasing disability due to mental disorders, the only sustainable method for reducing the burden caused by these disorders is prevention.[11]

7.13   The NSW Children's Commissioner similarly argued:

> The Commission supports the establishment and maintenance of prevention and early intervention programs rather than a single focus on the tertiary treatment of people with mental health issues. International research suggests that mental health outcomes are improved by effective prevention

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6   Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 4.

7   Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

8   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

9   Auseinet, *Submission 441*, pp. 3–4.

10   See for example, Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMA), *Submission 83*, p. 5.

11   Auseinet, *Submission 441*, p. 5.

programs and that early identification and treatment of problems is a priority for reducing the potentially disruptive influence of mental health problems on social engagement and functioning.[12]

7.14   The proportion of people with a mental disorder who access care is half that of comparable physical disorders. Almost all those with schizophrenia receive services but only 60 percent with depression, 35 percent with anxiety disorders and 11 percent with substance use disorders consult for their disorder.[13]

7.15   Savings can be made through prevention and early intervention:

> The emphasis on treatment is extremely costly. Planned and systematic prevention could save costs, time, suffering and much community and workplace dislocation.[14]

7.16   The need for prevention is not disputed by governments. The PPEI Action Plan states:

> treatment interventions alone cannot significantly reduce the enormous... burdens associated with mental health problems and...disorders…
>
> There is a compelling need to make promotion, prevention and early intervention priorities in global, national and regional policy, and to develop a clear plan for progressing activities in these areas.[15]

Promoting a healthier attitude to mental illness in the community

Stigma as a barrier to health care and services

7.17   Ignorance of and fear about mental illness exists in the general community, in organisations, and even in some cases amongst health care professionals. Stigma leads to discrimination, which compounds the disadvantage experienced by people already battling with difficult diseases. It results in low self-referral, under-reporting of illness and under-use of support services.

7.18   The stigma attached to mental illness is evident in many ways. It can be seen in the terminology often used relating to mental illness:

> …we are not "the Mentally Ill", we are "people with mental illness", we are not "beds", we are not "schizophrenics" we are people with Schizophrenia. Imagine what it would be like if a patient who had cancer was called "a cancer", what would that do to their self image and illness, to the attitudes of others to the patient called "the cancer".[16]

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12   NSW Commission for Children and Young People, *Submission 399*, p. 1.

13   Professor Gavin Andrews, *Submission 176,* pp. 8–9.

14   The Cairnmillar Institute, *Submission 204*, p. 1.

15   PPEI Action Plan, p. 1.

16   Ms Fay Jackson, *Submission 534,* p. [4].

7.19   The language used in mental health legislation, which conventionally refers to detainment and control, may underpin or promote the association of mental illness with criminality:

> The [NSW Mental Health] Act promotes social stigma. The words in the Act alone promote stigma: 'Control', 'detention', 'to apprehend', 'the court', 'the magistrate', 'police', 'forensic patients', the association of the Act with the Mental Health (Criminal Procedure) Act (NSW) 1990 that leads to a perception that people with mental illness are criminals or likely to be criminals. And if the Act were better known by the community (I am glad that it is not), it would promote the association with criminality by a community always sensitive to aberrant behaviour and ready to lay blame on that disadvantaged group.[17]

7.20   Lumping all mental illnesses together does not help people understand them, or help them understand that there are different issues associated with different illnesses:

> The current practice of using the generic term 'mental illness' rather than specifically addressing the issues contributing to stigma for different mental illnesses is a major barrier to destigmatisation of ANY mental illness. As such, current education programs are totally inappropriate and inadequate in de-stigmatising mental illness and disorders.[18]

7.21   DepressioNet suggested:

> The term 'mental health' should only be applied in the same situations that the term 'physical health' would also be used and deemed essential to differentiate from 'mental health' or 'spiritual health' etc. In fact if we use common practices in physical health as a guide when communicating about all health and specifically when referring to mental health, significant steps forward will be made.[19]

7.22   Ms Merinda Epstein reported:

> I have often been on the podium with Barbara Hocking from SANE. Usually I go first, which is one of the things about being a consumer—they ask you to speak first. We need to reclaim this language. We need to call ourselves 'batty'; Cath has a wonderful T-shirt about 'batty' and 'nut case'. We need to reclaim that language and make it not scary. Then Barbara gets on to speak and from a non-consumer perspective says, 'We need to get rid of all these horrible words like 'nut case'. Both of us are trying to do the same thing in totally opposite ways. That is where the consumer perspective is so vital. If we just rely on people who read it from a non-consumer perspective, I think that we will not make inroads into discrimination as

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17   Mr Peter Hutton, *Submission 185*, p. 11.

18   depressioNet, *Submission 475*, p. 11.

19   depressioNet, *Submission 475*, p. 7.

quickly as we will if consumers start to challenge it in unorthodox ways through such things as cartoons and language.[20]

7.23   Stigma associated with mental illness is also inhibiting people from seeking much-needed treatment. Submitters suggested that stigma is a major reason people attempt to 'self manage' their illnesses, with a consequent delay in treatment:

> My personal experience agrees with that, as my son took about 3 years to agree to assessment and treatment, despite support from university football colleagues and administrators including a doctor associated, and other friends. His fear was about future relationships, jobs etc., which was realistic. Alas lack of family unity due to ignorance did not help, and has taken some years to overcome, as we all learned how best to cope.[21]

7.24   If people are afraid to speak about their illness in their workplace, it can prevent them making use of support services that employers may have available. The committee was contacted by people who wanted to make submissions to its inquiry, but were not prepared to be identified in case their employers found out their identity. Employers are often ill informed about the nature of mental illnesses, and unsure how to make the best of employees affected. One consumer reported:

> I haven't disclosed anything about my illness to my employer, though I'm sure they know there is something going on. Initially, I had a shared office, which was really hard—I avoided going in to the office whenever I could (I work part time and have a fair bit of flexibility). We just didn't get on very well—but my employer was accommodating and found me another place where I could be by myself. But they have gone to the extreme—I have a whole level to myself and there is no one else around. I don't get to see anyone—it's weird but I get a sense that I'm there because they think I'm weird. Work is now very lonely.[22]

7.25   However, many consumers have no access to employment. The Catholic Welfare Australia Member Organisations reported that the negative perception attached to mental health problems and disorders is a significant factor inhibiting people's access to employment and other services within the community:

> Our Member Organisations report that owing to negative community attitudes, people with a mental health problem face difficulty finding private accommodation, achieving employment through accessing generic employment services, and other education and training programs. And it is often the case, that until these basic needs are met, further assistance for the client is ineffective.[23]

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20   Ms Merinda Epstein, *Committee Hansard*, 5 July 2005, p. 39.

21   Name withheld, *Submission 76*, p. 5.

22   Brotherhood of St Laurence, *Submission 97*, p. 8.

23   Catholic Welfare Australia, *Submission 302*, p. 17.

Damaging misconceptions of mental illness in the media

7.26   Negative stereotypes of people with mental illness are reinforced through representations of mental illness in the media:

> As a society, we are bombarded with negative images of people with mental illnesses. The media and entertainment industries overwhelmingly present people with mental illnesses as dangerous, violent and unpredictable individuals. These inaccurate and unfair portrayals shape the public's perception of people with mental illness as people to be feared and avoided.[24]

7.27   Sensational reportage of the most appalling outcomes, such as the recent case of child murder and sexual assault by a 23 year old with acute psychosis and substance abuse disorder,[25] draws attention to serious flaws in the health care system but also engenders the highest degree of misunderstanding and fear:

> stories of 'psycho killers' and 'feral psychotics' which are splashed in the tabloid press harm all people with mental illness and hamper the rehabilitation of offenders with mental illness.[26]

7.28   The Brotherhood of St Laurence commented:

> At a public level, the association of violence and aggression with mental illness must be challenged whenever it appears. The public must be made aware that such violence is an exception, and that people who do have a psychiatric illness are much more likely to be on the receiving end of it rather than to be the perpetrators. All people with a mental illness suffer at some level by them is the conception that is created by sensationalist media reporting.[27]

7.29   Consumers asked that, instead of the stigmatising portrayal of the mentally ill as 'crazy', the media should focus on educating the community about the experiences of people with mental illness.[28] A number of submitters commented on the 'silencing' of the real impacts of neglected mental health needs, especially in relation to the high number of suicides that are consequent to untreated depression:

> Anecdotal information given to NCOSS shows that not reporting on suicide marginalises and stigmatises mental illness even further, as it suggests that

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24   Richmond Fellowship of NSW, *Submission 266*, p. 7.

25   Probation and Community Corrections Officers (PACCOA), *Submission 503*, p. 4, and see 'NSW: Judge Criticises Health System for Releasing Schizophrenic', 24 March 2005; *Australian General News*; Story No. 9081.

26   Mental Health Legal Centre, *Submission 314*, p. 23.

27   Brotherhood of St Laurence, *Submission 97*, p. 6.

28   Name withheld, *Submission 20*, p. [1].

suicide is shameful and should not be publicly discussed – yet it is an issue that the whole of the community needs to consider.[29]

Damaging misconceptions of mental illness in the health care system

7.30   Experiences of discrimination and ignorance within health care services appear widespread, with potentially serious consequences. Some of this is specific to particular illnesses, a topic referred to again in Chapter 5.[30] A common complaint was that people with mental illness felt dehumanised by a system which took little account of their individuality. Consumers felt as they were seen through the lens of their illness, so that outside of their diagnosis they ceased to exist. A young consumer reported:

> I have been lucky I have not experienced stigma in the broader community. Everyone that I know and have met since my first episode has accepted and embraced my openness about it. Where I have felt like less of a person is within the adult mental health system…One thing that drives me to maintain my health is that I refuse to be part of a service that can't see me as a person, and believes that I am only a schizophrenic that speaks "schizophrenise". There are services out there that adopt a caring and responsive philosophy, if these places do it, why can't they all?[31]

7.31   A number of submitters maintained that mental health reform has exacerbated stigma by placing pressure on the mainstream health system to absorb care responsibilities for people with mental health problems when it is ill-prepared, and not sufficiently funded, to do so. The Public Advocate, South Australia, identified the following systemic features as drivers of this response:

- many non-mental health personnel still appear to be reluctant participants in service responses for the mentally ill and their families;

- the occupational health and safety issues and responses to protect staff seem to drive considerations of service responses (at times appropriately) which may serve to further traumatise and alienate already severely disturbed people (eg the use of security guards to guard detained patients in general hospitals); and

- there are conflicting beliefs from site to site about the nature, scope and service responsibilities and ethos that mental health services should be providing.[32]

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29   NCOSS, *Submission 274*, p. 9.

30   Dr Julie Johnson, *Submission* 4, Attachment 2, p. 14, and see Women and Mental Health Inc (WAMH), *Submission 310*, pp. 8–9.

31   Youth Mental Health Coalition, *Submission 284*, case study: JOLAN'S STORY, pp. 14–15.

32   Public Advocate South Australia, *Submission 268*, p. 13.

Promoting better mental health at the national level

7.32   The stigma described above creates a barrier to mental health promotion. Many submissions argued for a sustained national education campaign to inform Australians about the true nature and extent of mental illness. However, it was equally strenuously argued that such a campaign must be grounded in community-based education programs that promote good mental health and attack stigma in schools and in the workplace at the local level:

> AICAFMHA believes that the concept of mental health literacy should not be confined to a sole focus on mental health problems and disorders but should include knowledge and awareness of what constitutes positive mental health and strategies that promote good mental health. Multiple education and community awareness strategies that promote knowledge and skill development are required to improve mental health literacy and need to be specifically designed within a developmental framework for target populations and settings.[33]

7.33   A focus on reform of media commentary was just one aspect of this agenda:

> Currently there appears to be no standard to address the inaccurate statements that occur in many of the media reporting of mental health incidents. The complexity of the problems experienced by the mentally ill and the staff who provide support to them appear to exceed the capacity of the media to present a balanced report. This has implications if one is to encourage people to seek treatment. It is also a disincentive in recruiting people to the area. Considered, resourced educational programs for the press, for emergency services such as the police and the ambulance, and the public generally, are priorities. Resource allocation to the non-government sector and professional organisations could facilitate the development of de-stigmatising programs, which would then be able to offer education through effective targeted professional development strategies.[34]

7.34   A number of individual projects have been undertaken by non-government organisations to raise awareness of mental illnesses (discussed later in this chapter). However, Mr Jeff Kennett, Chairman of beyondblue, stated the importance of addressing mental health in the context of a government campaign on well being:

> …every day in the media we hear, see or read about deaths on our roads around the country. We do not hear about the injuries, only the deaths. But every day about eight or nine Australians take their life—suicide—as a result of depressive illnesses. The number of those who die by their own hand is almost more than double those who die in a motor vehicle accident, yet we hear nothing on our radio or see on our television screen or in the press nothing to try to prevent that. In other words, we get this media concentration on deaths and then we have governments responding to

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33   AICAFMHA, *Submission 83*, p. 6.

34   Association of Australian Rural Nurses Australian and New Zealand College of Nursing, *Submission 321*, p. 16.

deaths, but in the area of mental illness we do not have the same concentration on promoting good health and wellbeing as an ongoing program.[35]

7.35   However, for any such promotional activity or campaign to be truly effective, it must capture the authentic and diverse voices of consumers, and their images.[36] The effect of this empowerment would be profoundly remedial for both consumers and for the community in general. Insane australia wrote:

> The consumer-survivor movement is as culturally diverse as any, again, with parallels to the feminist and gay movements. *insane* welcomes, endorses and encourages this diversity of voices. One of the primary aims of *insane* is to promote the awareness of Mad Culture as a community with a culture and a unique voice of its own. We seek to promote this both among consumers and survivors as well as in the general community. With this awareness, we seek to encourage consumer-survivors to speak of their experience, in their own language, with pride rather than shame and for the general community to hear our voices with open minds and open hearts rather than with fear and judgement. We believe this will promote a much healthier dialogue and understanding of the many complex issues around mental health than is currently the situation in Australia.[37]

7.36   An enormous amount of evidence to the inquiry outlined how mental illness and the community in general suffer through an inadequate understanding of mental illness. It is the opinion of the committee that effective media campaigns are needed o raise community awareness. This will provide an important step in better managing mental health care in Australia, particularly given the community-based care focus that resulted from deinstitutionalisation.

Minimising the impact of mental illness through prevention and early intervention

7.37   The importance of prevention and early intervention was a particularly strong theme in evidence to the inquiry. The significance of applying prevention and early intervention approaches from an early age, and throughout childhood and youth are recognised to be of vital importance, while people of any age that are exposed to adverse environmental conditions (such as poverty or unemployment) also benefit from early intervention and prevention.

Early influences on the young

7.38   The literature on mental health refers to risk and protective factors as influences in the development of mental health problems. Experiences in infancy,

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35   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard,* 5 July 2005, pp. 3–4.

36   For comments on actors see Nicci Wall, *Submission 44*, p. 2.

37   insane australia, *Submission 2*, p. 2.

childhood and youth have an influence on the development of future mental health problems, and also there is a continuity of disorders between childhood, adolescence and into the adult years.[38]

7.39   Risk factors that increase the likelihood that a mental disorder will develop include insecure attachment in infancy, family disharmony, and harsh discipline style by a parent. Protective factors include a secure and stable family, a sense of belonging at school and adequate nutrition.[39]

7.40   A number of submissions argued that many risk and protective factors came into play even before birth, and that prevention and early intervention strategies need to begin in the antenatal and infancy periods.[40] Parental mental disorder has been identified as a risk factor for the development of mental health problems.[41]

7.41   The Australian Association for Infant Mental Health and NIFTeY referred to research indicating that infants as young as 3 months old can detect depression in their mothers.[42]

7.42   According to the Post and Antenatal Depression Association (PANDA):

[PND] can interfere with the behavioural and emotional interactions that are now recognised as being necessary for a successful mother-infant relationship. Mothers with depression tend to be less sensitive to the needs of their babies and can be less responsive to their communications

7.43   PANDA say:

Many women and their partners are not aware that mood changes are common after childbirth and can vary from mild to severe. In fact in the year after childbirth a woman is more likely to need psychiatric help than at any time in her life'.[43]

7.44   Studies show that 17 per cent of women giving birth in any year are likely to have postnatal depression, 10 per cent antenatal depression and 0.2 per cent postnatal psychosis and that 10 per cent of male partners of women giving birth may also have postnatal depression.[44] Children whose parents have untreated perinatal mental illness

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38   See,for example, Australian Divisions of General Practice, *Submission 308,* p. 29.

39   Monograph 2000, pp. 14–16.

40   Australian Association for Infant Mental Health and NIFTeY, *Submission 301*, p. 1; Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMA), *Submission 83*, p. 7.

41   Monograph 2000, p. 16.

42   *Submission 301*, p. 2.

43   PANDA, Mood changes, http://www.panda.org.au/aboutPndMoodChanges.html, (accessed March 2006).

44   PANDA, *Submission 544, Appendix A,* p. 9.

will demonstrate learning and developmental difficulties, hyperactivity disorders, mental illness and adult criminal behaviour.[45]

7.45   PANDA identified three mood disorders in the postnatal period:

- The 'baby blues', which affect most mothers between the third and tenth days after birth

- Postnatal depression (PND), affecting around 15 to 20 percent of mothers, and

- Postpartum psychosis, which affects about 1 in 500 mothers, usually in the first 3 to 4 weeks after delivery.[46]

7.46   PND is not always well understood or diagnosed. One mother recounted attempts to get help:

> I finally decided to tell my GP how I felt. He would help me, I thought. I tried to tell him how I felt, but it was too hard. Instead I complained that my baby was not feeding and sleeping well. I went back every week worried about my baby's health. Each week he reassured me that my baby was fine. Maybe, if he had asked about me, I would have told him that something was wrong and that I was scared, but he never did. I kept trying to tell him how I felt but the words just wouldn't come out. Each week I left his office and cried all the way home.[47]

7.47   Risk factors for PND include poor support from partner, family and or staff during labour, unplanned pregnancy, previous stillbirth, childhood sexual abuse, high trait anxiety, perceptions of not being in control, inadequate pain relief and fear for the wellbeing of the baby.[48]

7.48   Helpful in dealing with childbirth disorders were: early identification of the symptoms of PND; provision of accurate information and interventions; emotional support from family, friends and services; practical help with housework and childcare; psychological help with counselling and cognitive therapy; support groups; medical assessment and monitoring by GPs or psychiatrists; antidepressant medication; hospitalisation, ideally in a mother-baby unit and lifestyle changes – diet, exercise, rest.[49]

7.49   Beyondblue says there has been a lack of national focus and insufficient attention paid to improving women's mental health before they give birth:

> Left untreated, the impact on the mother and her child can be profound…

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45   PANDA, *Submission 544*, p. 2.

46   *Submission 544, Attachment 1*, p. 4.

47   *Submission 544, Attachment 1,* p. 3.

48   *Submission 544*, Attachment 1, p. 11.

49   *Submission 544*, Attachment 1, p. 9.

> If women at risk of postnatal depression are identified during pregnancy and effective psychological and social interventions are provided, then it is possible that postnatal depression may be reduced in severity or prevented altogether.[50]

7.50   Beyondblue conducted a four year National Postnatal Depression Program of research across six states to determine the scope for prevention through screening, information packages and psychological and social interventions. The findings show that new mothers were unlikely to identify their own depression and unlikely to seek treatment. Their beliefs about PND were often at odds with those of GPs over pharmacological treatment for depression. New mothers were also reluctant to use psychological or psychiatric therapies favoured by maternal and child health nurses.[51]

7.51   PANDA conducts a helpline in Victoria for PND but its limited state government funds allow it to operate only 4 days a week. The only two other states with PND help lines are WA and the ACT, neither of which receives public funds.

7.52   The organisation reported that many women calling their helpline admit to supplying deliberately false positive answers to a self-report scale used by health professionals working with mothers in the first postnatal year, for fear of being seen as bad mothers, insane, or that their child/ren will be placed in protective care.[52] This highlights both the stigma that can attach to mental illness and the need to ensure effective support is provided to women who feel they are experiencing, or at risk of, PND.

7.53   PANDA made a range of recommendations regarding perinatal mental health, including that there be a national strategy to support perinatal health services for 'the early identification, intervention, prevention and education of perinatal mental illness for men and women having children', arguing that it would be highly cost effective.[53]

7.54   The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) pointed to the negative effects of domestic violence:

> Of particular significance relating to infant mental health is the presence and effect of domestic violence - "a stressful life event" - experienced by women ante-natally and post-natally and her risk of developing post-natal depression. A mother's emotional availability and ability to respond sensitively to her infant are severely compromised and are influential in

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50   beyondblue, *About the PND Program: About PND,* http://www.beyondblue.org.au/postnataldepression/index.aspx?link_id=31.164, (accessed March 2006).

51   beyondBlue, *About the PND Program: PND Program Outcomes,* http://www.beyondblue.org.au/postnataldepression/index.aspx?link_id=31.168, (accessed March 2006).

52   PANDA, *Submission 544, Attachment 1,* p. 37.

53   *Submission 544,* p. 4.

limiting the infant's secure attachment leading to early development of poor mental health.[54]

7.55   Professor Jorm supported the use of information campaigns as part of a prevention and early intervention strategy, and suggested parenting was an area in which education for parents could be valuable:

> there is a lot of research showing that, if children grow up in an environment where there is a lot of conflict in the home from the parents, they are at greater risk of developing anxiety disorders and depressive disorders when they grow up. The critical thing seems to be that the children are involved in or witness the conflict. If all parents knew not to involve the children in arguments, not to argue in front of the children and not to involve them—it is a very simple thing—they could then take the personal action that is going to reduce risk. That is a preventive action.[55]

7.56   AICAFMHA also pointed to the consequences for a child when the parent has a mental illness, and the need for health professionals to recognise that families needed support. AICAFMHA advised the committee of its successful collaboration with psychiatrists:

> AICAFMHA, through its Children of Parents with a Mental Illness (COPMI) Project, has been successful in working with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in developing a Position Statement (Position Statement #56) which acknowledges the effects of parental mental illness on family and also recommends that any assessment of an adult psychiatric patient must take into account the impact of the parental mental illness on any children within the family and ensure that appropriate supports are available for the family.[56]

7.57   Suggested early intervention strategies for children included a specific Medicare item number for GPs for health checks for children and adolescents. The ADGP submitted a recommendation to:

> Develop, fund and implement an infant and early childhood promotion, prevention and early intervention program for primary care under the National Agenda for Early Childhood that includes... a child and adolescent health check item number into the Medicare Benefits Schedule.[57]

7.58   Strategies to identify children at risk were not well received by all. The Australian Mental Health Consumer Network recognised the benefits of a diagnosis for a young person in distress, but expressed concern at the negative consequences of the ensuing labelling:

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54   AICAFMHA, *Submission 83*, p. 19.

55   Professor Anthony Jorm, *Committee Hansard*, 1 February 2006, pp. 56–57.

56   *Submission 83*, p. 12.

57   ADGP, *Submission 308*, p. 4.

> The AMHCN is anxious about the attempts that have been made to intervene early in people's lives. We are not convinced that giving people medical diagnoses (labels) when they are young does anything to help their self esteem and generate the strengths that are necessary to deal with the ...real life issues...[58]

7.59   The identification of potentially unstable parents prior to birth of a child also was met with criticism. The Mental Health Legal Centre in Melbourne submitted that such identification was not backed up by practical initiatives such as support for those parents identified:

> A range of negative and discriminatory consequences can flow from labelling by government agencies which is not matched by appropriate service provision. In Victoria we have a push for antenatal notifications against parents the Department of Human Services perceive may have trouble parenting, there is nothing more offered, no parenting support or guidance, these parents continue with a pregnancy under surveillance, knowing that the child may be whipped away upon delivery.[59]

7.60   These circumstances seem likely to place additional stress in the parents, and this could potentially exacerbate the mental health risk factors for the child. There is an obvious need for antenatal identifications to be matched with support programs.

Adolescents and Young Adults

7.61   Mental disorders are most prevalent during adolescence and young adulthood, and account for 55 per cent of the total disease burden of those aged 15 to 24 years.[60]

7.62   According to ORYGEN Research Centre, over 75 per cent of all serious mental health and related substance use disorders commence before age 25 years and approximately 14 per cent of 12-17 year olds and 27 per cent of 18-27 year olds experience such problems in any given year. Effective, early intervention is necessary to reduce the burden of disease in this age group.[61]

7.63   Yet young people are particularly reluctant to get help. The ADGP advised on major barriers to young people:

> …14 percent of adolescents reported being worried about what other people would think of them if they sought help. 38 percent report that they preferred to manage their own problems, and other major barriers include thinking nothing would help (18 percent) and not knowing where to get help (17 percent).[62]

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58   AMHCN, *Submission 322*, p. 13

59   Mental Health Legal Centre, *Submission 314*, p. 8.

60   Australian Government, *Submission 476, Attachment 4,* p. 1.

61   ORYGEN Research Centre, *Submission 284*.

62   ADGP, *Submission 308*, p. 32.

7.64   Young males suffer the additional barrier conferred by the Australian stereotype of masculinity. Evidence suggested that rural males are even more affected, as the 'tougher than John Wayne' image supported the high incidence of suicide in the bush.[63] A submission stated:

> Unless they have lost a limb it is hard to get any young Australian male to a doctor. It is viewed as a sign of weakness to seek help and the fact that there are few physical symptoms with mental illness, the adage of 'It's all in your head', couldn't be any more relevant.[64]

7.65   The Victorian Task Force report on Suicide Prevention found that

> …young people living in family environments that display disharmony, inconsistent discipline, violence, neglect and abuse are at significantly increased risk of suicide and require particular support. Some young people living in such circumstances subsequently become homeless, and their risk of engaging in self-harming behaviours then may escalate.[65]

Targeting Australia's youth population through school-based programs

7.66   A number of submissions acknowledged the importance of GPs as a primary point of contact for families but many also acknowledged that young people do not necessarily seek help from GPs.[66] This was especially so for young people who are marginalised and disconnected from family and school.[67] A child and adolescent mental health service in Perth indicated that 35 percent of referrals came from schools.[68]

7.67   The Australian Guidance and Counselling Association (AGCA) representing school counsellors and school psychologists argued that schools are an obvious location in the community for mental health promotion, prevention and early intervention.[69] The AGCA pointed out that as young people were at school anyway, there was less of a problem associated with the stigma of seeking help, and less of a problem accessing transport when services were not locally available.[70]

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63   Mr Jeff Kennett, *Committee Hansard,* 5 July 2005, pp. 1, 9; and see NSW Farmers Association, *Submission 410*.

64   Mr Kieran Wicks, *Submission 104*, p. 8.

65   Victorian Suicide Prevention Task Force, *Report*, 1997, p. 56, http://www.health.vic.gov.au/mentalhealth/publications/suicide/report.htm, (accessed March 2006).

66   Professor Debra Rickard, *Committee Hansard*, 27 September 2005, p. 57.

67   ADGP, *Submission 308*, p. 32.

68   West Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24*, Section (c).

69   AGCA, *Submission 413*, p. 2.

70   *Submission 413*, p. 2.

7.68   Schools currently conduct a number of programs aimed at building students' healthy development and resilience. MindMatters is a mental health promotion initiative in secondary schools, funded by the Federal Department of Health and Ageing and discussed later in this chapter. The AGCA argued that although schools already conducted such programs, there was considerable room for improvement, and for mental health promotion and prevention to be built into the ongoing curriculum in the same way as subjects such as literacy and numeracy:

> Mental health promotion and illness prevention needs to be clearly built into the curriculum for teachers to afford it the same consistent attention they give to literacy and numeracy skills. Literacy and numeracy skills are reinforced year after year in school. All students need to develop resilience, social competence and coping skills. These abilities also need to be reinforced year after year in school.[71]

7.69   AGCA pointed to the importance of linkages between schools, health professionals, and community agencies to ensure effective early intervention. The ADGP argued that GP groups played an important role in bringing together schools, health professionals and family/community support groups for improved collaboration and referral pathways.[72]

Minimising the impact of adverse conditions or disadvantage

7.70   A number of submissions emphasised the importance of social connectedness as a protective factor against the development of mental health problems, and also stressed the importance of minimising risk factors, such as poverty, unemployment, and poor education. The AGCA indicated that children from impoverished backgrounds and disadvantaged population groups are at greater risk of adult mental health concerns.[73] The ADGP submitted that:

> Social connectedness, stable accommodation, employment and relationships are well documented factors that protect against the development of mental health problems and disorders.[74]

7.71   ACOSS argued that there was a strong link between poverty and disadvantage, and poor mental health:

> While there is a clear and strong association between poverty and mental illness, the causal links are more complex. Nevertheless, it is at least as likely that the stresses relating to poverty and disadvantage are as significant in contributing to mental illness as the presence of mental illness is to the likelihood of a person living in poverty. What is indisputable is that poverty and mental illness can combine in a vicious cycle in which the fact

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71   AGCA, *Submission 413*, pp. 2–3.

72   Australian Divisions of General Practice, *Submission 308*, p. 32.

73   *Submission 413*, p. 2.

74   *Submission 308*, p. 26.

of poverty contributes to the manifestation of mental illness, which in turn contributes to the risk of poverty.[75]

7.72   ACOSS argued for greater investment in supports and social services to not only reduce the poverty of people with mental illness, but to ensure that poverty did not contribute to the incidence of mental illness in the first place, or to its severity or persistence.[76]

7.73   In a similar vein, the AMHCN supported a focus on addressing social inequities that are risk factors in the development of mental health problems. Representing people living with mental illness, AMHCN submitted that

> Many of our members believe very strongly that their experiences of mental distress are closely linked to life experiences. Poverty, physical illness, immigration detention, racism, family violence, breakdown of adult relationships, losing substantial amounts of money, gambling etc. etc. lead to mental illness.

> Over the past decade it has been fashionable to attempt to understand mental illness as some sort of a biochemical abnormality acting in isolation from the rest of people's lives. This has meant that the focus has come off searching for ways of preventing the social and cultural inequities and traumas that many consumers believe precedes the development of signs of mental illness.[77]

7.74   Social disadvantage may also be vertically transmitted from one generation to the next in deprived communities, thus perpetuating emotional and behavioural and psychological problems.

Delivering promotion, prevention and early intervention programs to the community

7.75   A variety of community-based services are working to reduce the stigma of mental illness and raise awareness in the community. There is also a number of programs that are assisting to recognise the onset of mental illness and prevent the escalation of harm. Some concentrate on particular modes of service delivery; others concentrate on addressing specific issues. The following provides an overview of some of the services available in the areas of telephone counselling, online services, child and youth-focussed services, and other national initiatives.

Telephone counselling

7.76   A number of telephone counselling services exist that have an important place in the spectrum of prevention and early intervention strategies in Australia, providing

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75   ACOSS, *Submission 457*, p. 3.

76   *Submission 457*, p. 2.

77   AMHCN, *Submission 322*, p. 12.

a cost-effective and practical way of responding to the immediate needs of consumers.[78]

Lifeline

7.77   Lifeline Australia runs the longstanding free 24-hour telephone counselling service from 42 centres throughout Australia in around 59 different locations, half of which are in rural and remote areas.[79]   In addition, Lifeline provides information and referral services and has recently developed Just Ask, a mental health information telephone service with a particular focus on rural and regional areas and Just Look, a one-stop national service directory available through a web-based portal or CD-ROM.

7.78   Lifeline answered 489,406 calls in 2004-05, which gives an indication of the scope of assistance provided to the community.[80] The vast majority of Lifeline's workforce is volunteers (estimated at 10,000), providing telephone counselling and administrative support.

7.79   Telstra has committed around $1 million per annum for the next three years to Lifeline. Other sources of funding include corporate sponsors, partners and donors and contributions from community members.[81] Funding from the Australian Government (Department of Health and Ageing and Department of Family and Community Services) over the past year has enabled Lifeline to develop a range of new initiatives for improving access to care in the community.[82]   However, Lifeline has stated that it does not receive recurrent state government funding to manage the ever increasing demand for telephone counselling services, despite Commonwealth and State Government services advising clients to contact Lifeline for assistance.[83]

Kids Help Line

7.80   Kids Help Line is a free 24-hour national telephone and on-line counselling service for children and young people aged 5 to 18. The service is run by Boystown and adopts a child-centred early intervention approach towards the mental health issues of young people, employing 100 professionally trained, paid counsellors, and as well as 24-hour telephone counselling, provides crisis response, after-hours services, and ongoing support.[84] Many young people who contact Kids Help Line have experienced adverse life events and/or display early warning signs of mental health

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78   Illawarra Institute for Mental Health, *Improving NSW mental health care: evidence got the unique role of Lifeline's 24-hour telephone service,* February 2005, p. 1.

79   Lifeline, *Submission 328, Attachment 1,* p. 3.

80   Lifeline, *Annual Report 2004-05,* p. 10.

81   Lifeline, *Annual Report 2004-05,* p. 21.

82   Lifeline, *Annual Report 2004-05,* pp. 9, 14–15, 19–20.

83   *Submission 329, Attachment 6,* p.3.

84   Boystown, *Submission 107,* p. 4.

problems. In 2004, Kids Help Line answered 447,367 calls and more than half of these calls were from rural and remote areas.[85]

7.81   Kids Help Line is well-recognised by young people. A study conducted by the NSW Commissioner for Children found that it was the only formal service that most children and young people could identify.[86]

7.82   The key sources of revenue for Kids Help Line are Boystown lotteries and special community fund-raising activities, while funding from the Australian Government supports specific programs relating to suicide prevention, supported accommodation and employment assistance.[87] Revenue is also provided through donations from the public and corporate sponsors, with Optus being the major sponsor of Kids Help Line.[88]

Parentline

7.83   Kids Help Line has also developed the Parentline telephone counselling service, which assists parents and carers with behavioural management, parenting skills, and interpersonal relationships. Parentline is a Queensland and Northern Territory service, funded by the respective state governments.[89]

Online services

7.84   The Internet has been used effectively in recent times for various online counselling and therapy initiatives. These services deliver treatment in the form of computer-based therapy, facilitating care that may be otherwise unaffordable to the consumer or very difficult to access based on location.[90] This mode of delivery is also more cost effective than visiting a healthcare professional, yet effectiveness of treatment is reported to be on par.[91]

MoodGYM

7.85   MoodGYM is a free-of-charge interactive software program delivering therapy for depression. It leads the user through a number of modules that explore varying areas of their life, such as learned behaviours, coping skills and relationships,

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85   Kids Help Line, "Kids Help Line 2004", *Kids Help Line Infosheet 2, http://www.kidshelp.com.au/upload/12363.pdf* (accessed 10 March 2006).

86   NSW Commission for Children and Young People, *Submission 399*, p. 2.

87   Boystown, *Submission 107,* p. 1.

88   Boystown, *How you can support Kids Help Line, http://www.kidshelp.com.au/template/standard.aspx?s=122&p=119&r=2&b=1* (accessed March 2006).

89   Boystown, *Submission 107,* p. 5.

90   Centre for Mental Health Research, *Submission 186,* p. 15.

91   Inspire Foundation, *Submission 491,* p. 6.

and how to better manage some of the difficulties of everyday life. The site currently attracts around 18,000 visits per month, has 80,000 registered users and is accessed in 62 countries. [92] The site is fully funded through the Australian National University.

7.86   Research by the Centre for Mental Health Research has shown that MoodGYM is effective in reducing depression and anxiety symptoms, with the degree of improvement equivalent to that achievable through face-to-face psychotherapy.[93]

Kids Help Line online email and counselling

7.87   Boystown (through Kids Help Line) was funded by the Australian Government to establish real-time web counselling and email services.[94] Boystown reported these services as becoming increasingly popular, and the number of online contacts about mental health issues being 'three times higher than the rate of contacts to Kids Help Line via telephone counselling'. [95]   This is encouraging support for the further development of on-line services.

Reach Out!

7.88   Reach Out! is a web-based mental health service targeting late adolescent and early adults (18-24 year old age group). The service provides self-help information, illustrated by personal stories from people facing challenges, and is focussed on empowering individuals to work through difficulties themselves wherever possible, whilst also providing details of referral services for additional support.[96] Reach Out! is funded by the Inspire Foundation.[97]

depressioNet

7.89   DepressioNet is an on-line service providing information and resources on depression, including 24-hour peer based support. The service emphasises that it is operated by people who live with depression, providing encouragement and support that is tailored to the unique needs of people with depression, their families and

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92   The Australian National University, *The MoodGYM Training Program Mark II,* http://moodgym.anu.edu.au/ (accessed March 2006).

93   Centre for Mental Health Research, *Submission 186,* p. 17.

94   Boystown, *Submission 107,* p. 14.

95   *Submission 107,* p. 14.

96   Reach Out!, *Frequently Asked Questions,* http://www.reachout.com.au/default.asp?ti=926#q1 (accessed March 2006).

97   Inspire Foundation, *Submission 491,* p. 4.

carers.[98] DepressioNet is funded through grants, donations and corporate partnerships.[99]

Child and youth-focussed services

MindMatters

7.90   *MindMatters* supports the development of sound emotional and social development of pupils in Australian secondary schools through delivering education and resources for promotion of mental health, and prevention of and early intervention in mental illness.[100] An evaluation of the project by the Australian Principals Associations Professional Development Council reported very positive results, and this view is supported across other parts of the community.[101] A number of side projects have been created under the *MindMatters* banner, including *MindMatters Plus* (supporting students deemed to be at risk) and *MindMatters Plus GP* (establishing referral pathways between *MindMatters Plus* schools and primary mental health care practitioners).

7.91   *MindMatters* was funded from 2000-2005 through the National Mental Health Strategy, and the committee was informed that future funding requirements were to be sought through the Department of Health and Ageing.[102] The Australian Divisions of General Practice stated its support for federal Government funding to ensure the longevity of the project, as well as to expand *MindMatters Plus GP* initiative nation-wide.[103] Mr Don Zoellner, Chair of the *MindMatters* National Reference Committee, also informed the committee that the *MindMatters* program has not been taken up by all schools, possibly because they already have programs in place.[104] The Mental Health Council of Australia was supportive of *MindMatters*, but also stated that MindMatters is currently 'limited in its scope and application', and cannot be fully effective unless supported by broader community strategies.[105]

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98   depressioNet, *Submission 475,* p. 2.

99   depressioNet, *Partners in health,* http://www.depressionet.com.au/partners.html (accessed March 2006).

100   Mr Ian Webster, *Submission 458,* p. 10.

101   Australian Principals Associations Professional Development Council, *Submission 120,* p. 2; Mr Ian Webster, *Submission 458,* p. 10; *Submission 308,* p. 22.

102   Ms Susan Boucher, Chief Executive Officer, APAPDC, *Committee Hansard,* 27 September 2005, p. 21.

103   Australian Divisions of General Divisions, *Submission 308,* pp. 47, 33.

104   Mr Don Zoellner, Chair of the MindMatters National Reference Committee, *Committee Hansard,* pp. 21–22.

105   Mental Health Council of Australia, *Submission 262,* p. 32.

ORYGEN

7.92   ORYGEN is a youth-focussed (12-25 years old) mental health care and research organisation servicing the western and north-western regions of Melbourne, Victoria. Key services provided by the organisation include operating a youth clinical program, the ORYGEN Research Centre and managing the support and training service for early psychosis in Australia. ORYGEN is the 'only specialist youth mental health service of its type in Australia', and has received international recognition.[106]

7.93   The philosophy of ORYGEN is to acknowledge the special needs of youth and develop promotion, prevention and treatment strategies tailored to their specific requirements. ORYGEN advises:

> Treatments have never been better – if treated appropriately and early, a young person has excellent prospects for a happy and healthy life. Early case identification and intensive treatment of the emerging disorder has been shown to reduce the need for inpatient treatment and is associated with better outcomes and subsequent cost reductions for the health care system.[107]

7.94   Like many community-based organisations, ORYGEN has stated that it is unable to deliver services to all those in need due to a lack of resources. This results in a situation where 'a substantial number of very unwell young people have to be turned away' with longer-term impacts of untreated mental illness felt by both the consumer and society as a whole.[108]

7.95   In December 2005, the Prime Minister announced that a consortium, led by the ORYGEN Research Centre, will establish a Youth Mental Health Foundation.[109] The Foundation will have access to $54 million funding over four years from the Australian Government, and will bring together a number of organisations to improve coordination of mental health services for young people. This model of service delivery could be adopted across other areas of mental health care in Australia. ORYGEN recommended the creation:

> of youth-specific specialist mental health services for young people aged 12-25, which would complement existing state funded child and adolescent, adult and aged persons' services, and would provide access to integrated mental health, substance use, and vocational recovery supports and services.
>
> Such services would have a special focus on first episode and early stage psychotic disorders and major mood disorders — illnesses which eventually

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106   ORYGEN Research Centre, *Submission 284,* p. 2.

107   ORYGEN Research Centre, *Report 2004 & 2005*, p. 21.

108   *Submission 284,* p. 3.

109   Prime Minister of Australia, *Youth Mental Health Foundation,* http://www.pm.gov.au/news/media_Releases/media_Release1721.html (accessed March 2006).

make up the clientele of the State public mental health system. It is estimated that the roll-out of youth-specific, specialist mental health services across Australia would require a recurrent budget of $525M per annum, although a proportion of this cost may be offset by re-allocation of resources from existing CAMHS and adult public mental health services.[110]

7.96   Under this model, there would be at least three age brackets to which mental health care would be delivered: children; adolescents and/or youth; and adult. There is strong evidence that the onset of many mental health problems occurs during the teenage and early adult years, and that the special needs of this group deserve a targeted response.[111] Mental health amongst young people is also discussed further in Chapter 15.

Other Child and Youth Services

7.97   The committee heard about examples of other child and youth services, in addition to those above, and those discussed earlier such as PANDA. Mental Health Child Safety Support Teams, established by the Queensland Government, provide specialist identification, treatment and long-term therapy for children with severe psychological and behavioural problems. These teams are linked with primary health care providers, as well as non-government organisations to facilitate the continuity of care as the child matures.[112]

7.98   The Intensive Community Youth Service is under development by the Western Australian Government. It aims to strengthen the opportunities for early intervention in young people by linking a spectrum of both community-based and specific mental health services to young people to support them in life.[113]

7.99   The Perinatal and Infant Mental Health In the Community project, funded by the South Australian Government, is working to improve the diagnosis and management of perinatal and maternal health problems by primary health providers and community organisations.[114]

National initiatives

beyondblue

7.100   Beyondblue is a national organisation for raising awareness about depression, anxiety disorders and related substance abuse in Australia. It is a

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110   ORYGEN Research Centre, Submission 284B, pp. [3–4]

111   See AICAFMHA, *Submission 83*, pp. 7–9; beyondblue, *Submission 363*, p. 9; Inspire Foundation, *Submission 491*, pp. 3–4.

112   Queensland Government, *Submission 377A,* p. 10.

113   Department of Health – Government of Western Australia, *Submission 376,* p. 20.

114   Department of Health – South Australia Government, *Submission 506*, p. 4.

bipartisan project of the Commonwealth, State and Territory Governments, and the overwhelming focus to date has been raising awareness of mental illness as a health problem in Australia and reducing the associated stigma.[115] The organisation has conducted extensive research into people affected by depression, their carers and families, and is working to develop new initiatives for early intervention and prevention, destigmatisation of mental illness, and to improve access to training and support services for both the community and health care providers.

7.101   An example of recent work is beyondblue working with a range of health care bodies to ensure those with mental illness receive the same rights when dealing with insurance companies as are those with physical disabilities. This is in response to concerns from consumers that they are less able to access insurance products as compared to people with a physical disability, so are being discriminated against.[116]

Suicide prevention

7.102   Many important projects – at both the national and local level – have been funded through the 'Living is for Everyone' (LIFE) framework of the National Suicide Prevention Strategy.

7.103   The suicide rate is higher for mentally ill people than the general population, particularly for people with disorders such as depression, yet there is strong evidence that many individuals with this illness are not recognised or do not receive adequate treatment.[117] The indigenous population also has a much higher rate of suicide, compared with the general population.[118] A key outcome of the LIFE framework is to reduce known risk factors for suicide and self-harm.

7.104   Suicide Prevention Australia stated that for the 150 local projects funded through the LIFE framework, project areas include:[119]

- Aboriginal and Torres Strait Islander communities, ensuring that programs are culturally appropriate;

- suicide prevention in males, as they are more likely to commit suicide than females;

- families, carers and friends bereaved by an act of suicide;

- alcohol and substance abuse associated with self-harm and the increased risk of suicide;

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115   beyondblue, *Submission 363,* p. 5.

116   *Submission 363,* p. 19.

117   Suicide Prevention Australia, *Submission 425,* p. 3.

118   Auseinet, *Submission 441,* p. 14.

119   Suicide Prevention Australia, *Submission 425,* pp. 13, 15, 16, 17, 19, 20, 22, 27, 27.

- suicide prevention in older people, as international studies demonstrate that people over the age of 65 years have the highest rate of suicide;

- reduction in the impact of adverse social conditions associated with an increased suicide risk, such as a death in the family or domestic violence;

- support to people involved with, or that may potentially become involved with, the criminal justice or juvenile justice system;

- enhancement of community acceptance and support for marginalised groups, people with risk factors for suicide and those affected by suicide; and

- promotion of increased acceptability of help-seeking to respond to mental health problems.

7.105   However, the ORYGEN Research Centre argues that the LIFE suicide prevention strategy takes a public health oriented approach that is too broad to be effective:

> While such a broad population based approach is important if we are to reduce suicide at a population level, it is very hard to measure and implement. To make a measurable difference it is important to tackle populations we know to be at high-risk – the mentally ill (depression is present in 88 per cent of suicides), those in early stages of a mental illness or recently discharged from a mental health service and those with both mental health and substance abuse problems.[120]

The challenges of delivering promotion, prevention and early intervention programs

7.106   A number of key challenges is restricting the long term delivery of programs, or they are not available across the wider community. Challenges examined in this section are: resourcing, short-term funding approach and a lack of back-up services, and the need to embed a prevention approach within health bureaucracies. There is also a need to ensure that programs producing positive outcomes are recognised, funded appropriately, and strategies developed to roll them out on a national scale.

7.107   The effectiveness – and difficulties – of using on-line services as an alternative approach to reaching out to people in need is also examined in this section.

Resourcing

7.108   Despite consensus on the need to give priority to promotion, prevention and early intervention, a number of submissions argued that insufficient resources generally for mental health had the effect of tying up available resources in the treatment end:

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120   ORYGEN Research Centre, *Report 2004 & 2005*, p. 22.

> ... despite the policy directions and the evidence, the mental health service system appears to reflect a sense of competing priorities between treatment and promotion and prevention activities. Mental health expenditure needs to reflect commitment across the spectrum of services, not a focus on treatment services only.[121]

7.109   Whilst expressing praise for PPEI Action Plan, the Australian Health Promotion Association also lamented the competing resources that limited the implementation of the Plan:

> A significant barrier to progress in implementing [PPEI Action Plan] in jurisdictions is created by the need for 'prevention end' interventions to constantly compete with established clinical services for priority in funding.[122]

7.110   Submissions giving the perspective of medical and allied health professionals painted a picture of this competition for resources as it was felt at the coalface in hospitals and community mental health teams. Frustration was expressed at the lack of opportunity to provide prevention and early intervention services, because of the pressing need to deal with acute cases of mental disorder.[123] Auseinet argued strongly for increased expenditure on prevention and early intervention strategies:

> It is very clear that if we are going to stem the tide of increasing prevalence of mental disorders such as depression, anxiety and mood disorders, a greater proportion of the mental health budget needs to be expended on [promotion, prevention and early intervention] initiatives which intervene at a much earlier stage.[124]

Short-term funding approach and a lack of back-up services

7.111   Concerns were raised that many initiatives were funded on only a short-term basis, and did not result in lasting changes to the mental health system. The Mental Health Council of Australia commented that prevention and early intervention services were restricted to demonstration funding rather than ongoing funding.[125] The Australian Divisions of General Practice supported federal government initiatives to build capacity of general practitioners in the area of early intervention for children, but expressed concern at what was seen as 'ad hoc, uncoordinated funding of a series of projects by various levels of government'.[126]

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121   Auseinet, *Submission 441*, p. 5.

122   Australian Health Promotion Association, *Submission 187*, p. 3.

123   Victorian Section, Australian Psychological Society, *Submission 479*, p. 4; Australian College of Psychological Medicine (ACPM), *Submission 411*, p. 6.

124   *Submission 441*, p. 10.

125   Mental Health Council of Australia, *Submission 262*, p. 12.

126   Australian Divisions of General Practice, *Submission 308*, p. 29.

7.112   These comments reflect similar concerns expressed throughout the inquiry regarding the drawbacks of short-term funding and pilot project funding for many mental health initiatives, not just those associated with prevention and early intervention. These concerns are discussed in Chapter 4.

7.113   Suicide Prevention Australia argued that short-term funding of prevention and early intervention projects runs the risk of increasing demand for mental health services, without increasing services to meet that demand:

> The prevention 'push' often has encouraged the funding of short-term projects that risk increasing expectations without interventions being sustainable. Such funding enhancements generally have not generated ongoing new mental health services.[127]

7.114   The problem of creating demand without providing services to meet the demand can also apply to well-supported programs such as beyondblue, the depression awareness initiative, discussed earlier in this chapter. One medical practitioner (from regional NSW) told the committee of her concern that whilst the beyondblue initiative raised awareness of depression and encouraged people to seek help, it could result in frustration when services were not available:

> ... I would articulate the concern that, if we create more need, unless we have more services we can deliver to support these people we are going to have even more disappointed people. There is the difficulty of beyondblue coming to town and identifying and raising awareness but then the system does not have the capacity, or feels like it does not have the capacity, to respond to those needs being generated.[128]

7.115   Ms Jennie Parham of Auseinet echoed these concerns, telling the committee that a major problem in progressing the promotion and prevention agenda was under-funding of the treatment end of services that resulted in long waiting lists to access specialist mental health services. Ms Parham told the committee:

> ... if we are serious about wanting to identify mental illness early and get early intervention on the agenda, we really have to do something about the service system that supports it.[129]

Need to embed a prevention approach within health bureaucracies

7.116   A variable level of commitment to prevention and early intervention strategies across jurisdictions was raised as a concern with the committee. In particular, it was argued that there was a need within health bureaucracies to get past a short-term, project-funding outlook, and move towards firmly embedding a long-term prevention approach. Auseinet described its efforts in assisting jurisdictions to develop

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127   Suicide Prevention Australia, *Submission 425*, p. 5.

128   Dr Jennifer May, NRHAC, *Committee Hansard*, 4 July 2005, p. 80.

129   Ms Jennie Parham, Auseinet, *Committee Hansard*, 27 September 2005, p. 55.

infrastructure to support work in the prevention and early intervention area, and indicated that all jurisdictions now have some level of infrastructure in place to advance implementation. [130] Auseinet argued, however, that 'there is still a way to go in embedding [prevention and early intervention approaches] in sustainable systems and structures'.[131] Ms Jennie Parham of Auseinet told the committee:

> Unless you have things actually bedded down in what I would call bureaucratic capacity, then really they are not sustainable and we are just going to be back to square one. [132]

7.117   Auseinet also indicated that the level of prevention/early intervention infrastructure developed was in some cases determined by the energy and commitment of 'champions' or 'advocates', who made progress through developing collaborative relationships.[133] Unfortunately, as Professor Debra Rickwood told the committee, the collaborative relationships can break down when these key people move on, because the system supports are not there.[134]

7.118   At a more general level, the Australian Divisions of General Practice expressed concern at what it saw as a national lack of effort and commitment to prevention and early intervention:

> The problem is not a lack of evidence, availability of programs, or that these programs lack merit. The issue is quite the opposite. On a national scale, there has been insufficient effort and funding to promote awareness, and coordinated access and uptake of these vital mental health promotion, prevention and early intervention programs.[135]

7.119   To monitor progress of jurisdictions in implementing prevention and early intervention strategies, Auseinet suggested the development of a promotion and prevention scorecard.[136]

On-line services – a new way of targeting mental health problems?

7.120   A number of submissions pointed to the benefits of online resources for mental health. The anonymity of online services was seen as important in encouraging help-seeking by those who would otherwise not wish to reveal their concerns. As the

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130   Auseinet, *Submission 441*, p. 10.

131   *Submission 441*, p. 10.

132   Ms Jennifer Parham, Auseinet, *Committee Hansard*, 27 September 2005, p. 54.

133   *Submission 441*, p. 10.

134   Professor Debra Rickwood, Auseinet, *Committee Hansard*, 27 September 2005, p. 54.

135   Australian Divisions of General Practice, *Submission 308*, p. 30.

136   Professor Debra Rickwood, Auseinet, *Committee Hansard*, 27 September 2005, p. 52.

Australian Health Promotion Association pointed out, 'the advantage of anonymity in accessing online help is likely to prove life-saving in many cases'.[137]

7.121   The Australian Guidance and Counselling Association reported anonymity as being particularly important for young males who are more likely to seek anonymity and avoid closeness.[138] However, preliminary monitoring of gender and web counselling usage by Boystown revealed that males were not accessing this service at a higher rate than females, which was not the expected result.[139]

7.122   Online services also were seen as very positive for increasing access to services for people in rural and remote areas, especially in locations where professional help was not available locally.

7.123   Inspire Foundation, sponsor of the Reach Out! website, argued that online services were more appropriate than telephone services for the late adolescence and early adult group, which generally does not access Lifeline and Kids Help Line.[140] Inspire also argued that online services were much cheaper to provide than telephone services.

7.124   Although many submissions were very positive about the potential of online services in prevention and early intervention, some drawbacks were raised. The Australian Health Promotion Association (AHPA) put forward that online service provisions had further potential, and deserved continued support, but pointed to the problems of access for people on limited incomes.[141] One submitter, a parent of a person with a mental illness, echoed this concern, and suggested that mental health care using e-technology was primarily for benefit to people on middle and upper incomes.[142] The submitter argued that people with mental illness would make more use of such online services if they were more accessible and affordable:

> While people on low incomes and those below the poverty line may be able to obtain some access to the internet through social and other support services ... this access is not regular enough to be of any real help. Although my younger son rejects almost all support services, I believe he would access mental health care over the internet if he had free access to the internet in his home. He is very computer literate, very concerned about his privacy and would like to manage his life by himself (although he is not

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137   Australian Health Promotion Association, *Submission 187,* p. 10.

138   Australian Guidance and Counselling Association, *Submission 413*, p. 3.

139   Boystown, *Males and Help Seeking Behaviour,* *http://www.kidshelp.com.au/template/standard.aspx?s=164&p=162&r=156&b=109* (accessed March 2006).

140   Inspire Foundation, *Submission 491*, p. 4.

141   Australian Health Promotion Association, *Submission 187*, p. 10.

142   Name withheld, *Submission 251*, p. 6.

able to do so). Accessing mental health care by himself in the privacy of his own home would suit him very well.[143]

7.125   This parent suggested that 'people with a mental illness who are interested in accessing mental health care over the internet should be provided with a cheap second-hand computer and a certain amount of free internet access in their own home'.[144]

7.126   AICAFMA raised a further concern with online services provided to young people, suggesting that consideration needed to be given to the ethics of providing counselling to children without the consent of their parents.[145]

Concluding remarks

7.127   Whatever approach is taken to the labelling of mental illness, greater community awareness is widely regarded as an important part in the process of healing and acceptance. Raising community awareness will reduce fear and ignorance. This will allow people with mental illnesses to live and work more successfully in their communities.[146] But it is also a key part of enhancing mental health promotion, prevention and early intervention.

7.128   Prevention and early intervention clearly have a critical role in alleviating the impact of mental illness in the longer term, particularly when targeted at developing members of the community, such as the children, adolescents and young adults. The future benefits of proactive management of mental illness at an early stage and in minimising the social factors that may lead to the onset of mental illness are overwhelming.   This includes a reduction in the social burden associated with supporting people left untreated for so long that they are in very poor health and unable to function independently, lower clinical care costs, reducing the incidence of suicide, and a better quality of life for people with, or at risk of developing, a mental illness.

7.129   However, this is only part of the work that is needed. Much more still needs to be done at the national level to raise community awareness of other disorders with devastating effects, and in promoting the much-needed services that are available across communities, in every state and territory across Australia to deliver health care. Awareness raising is largely ineffective if the back-up services are not available. This

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143   Name withheld, *Submission 251*, p. 6.

144   *Submission 251*, p. 6.

145   AICAFMA, *Submission 83*, p. 6.

146   Other initiatives would be in expansion mental health first aid education programs, see Professor Anthony Jorm and Mrs Betty Kitchener, *Submission 47*, and introduction of work experience programs to improve both consumer and employer confidence. Ms Elizabeth Crowther, *Committee Hansard*, 5 July 2005, p. 97. See discussion of the Flat Bottle initiative, pp. 94, 97.

also extends to ensuring a steady and reliable funding stream to evolve promotion, prevention and early intervention initiatives and ensure their longer term success.