Editorial

On quality of mental health care: Is Australia getting it wrong?

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In being Clinical Director of a large Child and Youth Mental Health Service, there are constant nagging questions to be considered about the quality of care we provide every day. Are the right clients being seen? How many potential clients are there out in the community with similar problems to those that are brought to us, who just cannot get to care? Perhaps no-one has recognised there is a problem, the professionals concerned (if there are any) never thought to seek further consultation or referral, everyone was put off by the waiting lists, the distances to be covered are just too long. Are there groups of clients who do not get to see us and really should? Are there groups of clients for whom we do not have the skills? Are the clinical assessments accurately telling us what needs to be done to change situations to the client family’s satisfaction? Do clinicians accurately diagnose the collection of problems? Does the right therapy exist in our service for the specific set of problems presented to us? Are we training the right set of therapeutic skills? Are clinicians able to utilise the skills we are training? What actually does go on in the clinical consulting room?

We do try to address many of these issues. In our service we have had the good fortune to gain specific funding, for instance, to set up community outreach services for young people involved in the juvenile justice system (CYFOS), we have a clinical team working in the local Youth Detention Centre, we have a collaborative program with the Drug and Alcohol service (MHATODS). We provide good orientation programs for new staff, and regular staff update sessions – often with responsibility for organising the presentation sessions being taken by community teams themselves (‘in teaching we learn’). We have ongoing focused therapy training for various groups, and are planning update training courses in specific modalities such as Interpersonal Therapy. But I still have nagging questions about what actually does go on in the clinical consulting room?

Of course we have clinical accountability. Regular supervision occurs with senior practitioners in the service, and some form of supervision is available in an ongoing manner for all staff. Even with new consultant psychiatrists, who theoretically have ‘jumped through all the hoops to become good safe practitioners, I provide 12-18 months of what we call ‘transition to consultanthood’ – which allows us to talk about clinical, interpersonal and administrative issues, and gives me both insight into the consultant, and some security in their ability to manage. In addition to supervision, we have an electronic record keeping system (which does occasionally provide feedback), and we have written notes, we have regular team discussions about both new and follow-up cases, and of course we have the Health of the Nation Outcome Scales for Children and Adolescents and the Strengths and Difficulties Questionnaires, and other scales to tell us about our outcomes. But I still have nagging questions about what actually does go on in the clinical consulting room?
Do we provide enough time, and in particular thinking time, for our clinicians? Are they accurate enough in the response to the sequence of minute issues brought up in sessions, voice inflections, body language, and other indicators of therapeutic alliance? In applying sometimes formulaic therapeutic interventions are they still able to assist the young client, and/or their family, to gain a sense of meaning? When we apply evidence-based practice to the consulting room and the individual case do we really get to the essence of solving clinical problems? What is the evidence for that? Are we really being effective and efficient if certain clients keep on coming back? This is a real question based on a real case. Recently I did an internal review of a long-term case with a young person with a mix of intellectual, speech and conduct problems in the context of a separated mother with bipolar disorder, and a dysfunctional extended family. Several therapists had spent about two years each on the set of problems not to mention the inpatient admissions, the case review sessions, and the ongoing angst about the emerging diagnosis. The therapists had been caring and supportive to the family, and certainly responded to all the crises in an appropriate manner. But the case had been part of our service for 11 years. Is that an efficient use of time and very scarce resources? Had we actually achieved any change? By what yardstick do we measure these things?

As a service we have adopted the complexities of promotion, prevention and early intervention (PPEI) - we are ‘early adopters’ -, and allocated considerable resources to training clinicians in somewhat new ways of thinking, as well as setting up specific programs. As examples, we now have a very active (and prize winning) program for children of parents with mental illness (KOPING), a superb collaborative program for the families of young children with multiple problems (Future Families), and a wide range of regular education programs for professionals in the community (which attract large crowds). Like all clinicians, ours moaned about the new national direction in the Second Mental Health Strategy (Oh no, not something else we have no time to do! On top of everything else...!). Now there is an integration of some of the ideas about mental health promotion not just being a Public Health program, but able to be utilised in the consulting room. But then is it? There I go again with that hard question about what actually does go on in the clinical consulting room?

The question is not just academic, or the foible of an ageing child psychiatrist. We have two circumstances where new money is being supplied to develop new teams. In response to the very adverse report of the CMC enquiry, recurrent funding has been supplied to the Department of Child Safety to buy in clinical services for the (often very troubled) young people under their care. Across Queensland (and based on equity of access) there will be nine new teams of about ten staff, with a strong focus on clinicians, a half-time psychiatrist position for each team, an a half-time evaluation position for each team. Such riches! Leaving aside the question of where we suddenly get 90 staff from, the central question is how do you respond to a challenge like this? How do we ensure that we have the skilled staff to do what may be very complex clinical work with the particular socio-economically deprived group represented? How do you develop a system of access and care to ensure that we not only do a good job for the young people and their families or foster families, but are also seen to be responsive and doing a good job for the Department of Community Services (DoCS). Funnily enough we began back to front looking at the demands of outcomes at the clinical level, the service level, the interagency level and the Ministerial level. Evaluation has driven the clinical and administrative process! This led us to provide clear parameters of functioning at all of the levels. But I am still pondering that essential question, and it has seemed to me through all of the meetings we have had, all of those clinical questions are brought into sharp relief. Well, of course, we could just supply a group of trained clinicians and sort of do ‘more of the same’, but we have felt this to be a fantastic opportunity to apply our best consensus knowledge, draw on evidence-based practice, and try to do the very best we can. It could, of course end up over time with us all just doing ‘more of the same’, but that would be a great shame.

Another fantastic opportunity, and one more relevant to this journal, and the processes that Auseinet has tried to drive in Australia, is that
provided by North Lakes, a new comprehensive suburb 35 minutes north of Brisbane. Again with new recurrent money to build a Child and Youth Mental Health Service from the ground up (alongside community health and adult mental health), we are being challenged to think through what we need to consider to build the very best service we can. We are using the PPEI framework and, in a series of workshops with broad representation from services and the community, looking at the kinds of collaboration we will need to ensure we can both manage the preventive frame (from Universal through Selective to Indicated approaches) as well as the pressure of clinical work in what will become a catchment of 150,000 people with a wide range of socio-economic backgrounds. And of course we must make it sustainable. I am not yet sure what we will end up with, but even with my long-term commitment to PPEI, I will have to ask all of those difficult clinical questions.

An emerging answer to both the DoCS and the North Lakes situations seems to relate to the quality of the clinicians we are able to employ. If we are looking for effectiveness and efficiency, with commitment to the clinical outcomes as well as provision of a sense of meaning for the young people and the families we see, then there is no substitute for highly trained, well qualified, experienced, and well supervised clinicians who have an ongoing fascination for the clinical process. One of the conundrums here is that if the clinicians are genuinely effective and efficient, then they will have time for reflection, and time to consider the wider range of programs necessary in a new suburb. If we are only able to employ young clinicians, or those who left a previous service because they were disaffected with the apparent daily clinical overload, we may well be in trouble.

So this brings me to the issue of quality and some of the pitfalls that may be emerging in Australia. There are more than rumours that nurse training may be reduced in universities to increase the numbers of available nurses and replenish the obvious need in our hospitals and the community. At one level you can see the logic, but does shorter training by implication mean that these people will come with fewer skills, and less experience? There is also more than just talk that the current graduate medical degree may be shortened to a two year graduate degree. Again you can see the logic given Australia is currently so short of primary care and specialist doctors. But does less training, and less time to reflect on a professional career, less time to weed out those who perhaps should not be practicing in one of the helping professions, mean that we get professionals who are less effective, less efficient, and more prone to give up under the sometimes intense pressures with which we all at times have to struggle. Leaving aside some of the current debates about professional incompetence (as if we can leave them aside with all the international media coverage) what is it about training that might protect professionals from burnout? Personally, I believe it is something to do with quality of training, the building of commitment and a passion for what it is that we do, a thorough knowledge of what it means to be ethical, and learning how to be both effective and efficient. Sometimes surviving a lengthy and somewhat arduous training is important to the quality of the end result.

Which brings me to the final area I want to discuss. I have recently had the privilege to bring together a Consortium to complete an application for the proposed National Youth Mental Health Foundation (I am sure we are one of many groups to tender). Again this is a fantastic opportunity to address issues to do with literacy in young people and access for those young people with mental health problems. It is also a fantastic opportunity to provide training to general practitioners, and allied health professionals who may have the opportunity to work in primary care with GPs. It is also an opportunity to consider carefully the models that can be promoted, improved, or developed as initiatives to improve service access for young people. And the stated framework is one of PPEI! Hurrah!

But there are some questions emerging for me about the program. It is three and a half years of funding, and therefore whoever gains the large grant will have the enormous task of building in some sort of sustainability to the Foundation and its programs. Another issue is that there are already many groups – State and Territory based as well as national – whose work already impinges on the area. Somehow all of these
groups will have to be drawn together – a ‘joining of the dots’ I have heard it called. But the question in mind is about quality. The pointy end of this whole process is that young people deserve the very best of care that can be made available, which includes the quality of engagement, the optimum development of a therapeutic alliance, and the ability to do effective, efficient and meaningful therapy to solve the problems presented by the young person. I have been a general practitioner, and we have recently been working with general practitioners to provide an audit of their ability to recognise mental health problems. What emerged from this process was the tremendous pressure that GPs are under to provide a rapid throughput of casework. We are asking a lot of GPs, even those committed to mental health issues who have trained through the Better Outcomes in Mental Health Care program, to expect that they will be able to make time to do a quality job. And coming back to my repeated question, how will we be able to assess just what occurs in the consulting room? I wish the successful tenderers every success in developing this massive venture. At the pointy end, the challenge may be to develop the quality of general practice mental health care and allied health care in primary care, or the quality of care in some innovative youth access programs. But we still must continue to improve access to care in dedicated mental health services and ensure that the professionals there are able to deal with the most serious of mental health issues in a timely, effective and efficient way because they are experienced, well trained and well supervised. The focus of the exercise really is the whole system and its quality.

Which brings me finally to this issue of AeJAMH, where it will be abundantly clear that we do have some very good quality articles. We have two thoughtful guest editorials which record the changes occurring in our mental health system. Lynne Fréidli reflects on the launch of the UK National Framework for Improving Mental Health and Well-being. She notes that ‘tackling discrimination and social exclusion have received a stronger focus than promoting mental health’ thus far in England, and that this fine focus may have stopped the wider lens view of what factors in a society may be toxic to mental health and well-being. There are high hopes that there will be a refocusing on ‘how we live’, and its impact on ‘care of children, care of the self and social relationships’. Jennie Parham reflects on the recent Dublin conference ‘Mental Health Promotion: Going from Strength to Strength’, and her discussions with colleagues in the UK, who believe that Australia may be 10 years ahead in the development of preventive activity in mental health. Jennie rightly asks why we in Australia may not feel that this is so. After reviewing the current status in Europe, and then in Australia, she examines the ‘report card’ for Australia against a recent WHO framework document, noting that the complexity of our federation makes for difficulty in the translation of national policy into practice, concluding that considerable effort is still necessary to maintain the momentum we have with regard to mental health and its promotion against the pressure of the need for clinical service.

Two articles (Reid et al. and Maybery et al.) address the two sides of the care coin. Darryl Maybery and colleagues’ research on children of parents with a mental illness, reminds us of the need to develop and improve support and coping mechanisms such as ‘problem focused coping, developing adaptive cognitive styles, fostering social skills with peers and siblings’. However the children in the research also provide us with a challenge - to enhance the natural supports of the child, that is the peer group, especially in times of crisis when a parent is newly ill.

Joanne Reid and colleagues report on ‘the other side of the coin’ in a timely, challenging article based on phenomenological research on the needs of parents of adult children with mental illness. In recent years, we have heard so much about the children of parents with mental illness, that this is a refreshing reminder of a contrasting area of need. In focusing on psychoeducation, they address educational needs, barriers to accessing information and support, and other unmet carer needs, including the need for managing stress and emotional needs. My own experience is of being bailed up after Rotary forums where desperate parents frequently bewail the system which attempts to lock them out of the information system while expecting them to provide ongoing support and care. This paper is a timely reminder to think again.
Janice Chesters and colleagues explore the perspectives of fifteen residents about a supported housing program for people recovering from low prevalence mental health disorders, and address the importance of such accommodation in the community. The semi-structured interviews provide a sometimes poignant richness of comment. Overall, supported accommodation provides a treatment and living place, but more than that a venue in which to put together the right ingredients to help facilitate recovery.

Phillippa Farrell and Trish Travers report on Healthy Start, a program designed to build the capacity of the childcare workforce to promote the mental health of children. The research demonstrated increased awareness of risk and protective factors and referral sources, as well as levels of confidence in discussing mental health issues with parents, immediately after the training, but this was sadly not sustained over time. The crucial role of childcare workers, the needs they have for education, and the lessons learned from the program are explored.

Sarah Stewart provides a welcome exploration of how culture may mediate the inter-relationship between interpersonal trauma and suicide. In this very thorough review of the literature, she explores abuse, domestic violence and culture, considers these across a number of specific cultures, and notes there are gaps in our understandings of how culture mediates the inter-relationship between interpersonal violence and suicide. Sarah rightly challenges our current understandings about suicide and takes policy to task on the issue of domestic violence.

Finally, in a supplement to this issue of AeJAMH, Geoff Waghorn and Chris Lloyd provide an in-depth exploration of employment and mental illness, looking at education and employment opportunities as human rights, the disease burden of mental illness, and the inter-relationship of specific illness and employment. This comprehensive study goes on to look at the implications for the psychiatric disability support sector, and the development of policy. They comment: ‘although a range of promising vocational services and programs are available in Australia, the forms in which these are provided are the result of service systems evolving over time’. They then recommend six priorities for policy makers and funding providers which emerge from the study.
Guest Editorial
Promoting mental health in the United Kingdom: a case study in many parts

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… for Mack, who excels at the art of connecting.

Keywords
mental health promotion, public mental health, well-being

For while the tired waves vainly breaking,  
Seem here no painful inch to gain,  
Far back, through creeks and inlets making,  
Comes silent, flooding in, the main.  
Say not the struggle nought availeth. Arthur Clough

As this journal goes to press, England will be launching its first National Framework for Improving Mental Health and Well-being. The reasons why we haven’t had a strategy in England until now are, of course, primarily a matter for English colleagues to reflect on, along with a number of uncomfortable trends that we share with many other Western countries: the declining mental health of our children, the escalation in prescribing rates for antidepressants and the steady rise in stress related sickness absence. More broadly, however, the presence or absence of national strategies in the United Kingdom and elsewhere raises some interesting questions about what needs to be in place to achieve improved public mental health.

Public mental health takes a population wide approach to understanding and addressing risk and protective factors for mental health and well-being and has been defined as the art, science and politics of creating a mentally healthy society (Friedli, 2004; Scottish Executive, 2004).

In the UK, the term public mental health is beginning to take precedence over mental health promotion:

public mental health (of which mental health promotion is one element), provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population. (Friedli, 2004)

This may be a tactical, rather than a conceptual shift, as public health is enjoying a renaissance, stimulated by a series of Treasury reports on the economic benefits of prevention (Wanless, 2002; 2003) and the recent launch of Choosing Health, the English public health White Paper (Department of Health, 2004).

Over the past decade or so, mental health promotion has inspired strong commitment, gained an impressive range of advocates and is beginning to lose its marginal status, hence the title of an international conference held in Dublin earlier this year: Mental Health Promotion: Going from Strength to Strength (http://www.charity.demon.co.uk/dublin/). What might be called the mental health promotion movement has contributed to a marked shift in the debates about mental health, from a

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predominant focus on mental illness to an analysis of the importance of mental health and well-being (Jané-Llopis & Anderson, 2005). This shift is evident in UK and European policy, notably the WHO Europe Helsinki Declaration’, and has been informed by a number of significant developments:

- the shift from treatment to recovery - what people need in order to hold on to or regain a life that has meaning for them;
- evidence for the impact of mental health on physical health;
- interest in the relationship between social capital and health; and
- critiques of the use of economic development (GDP) as a sufficient indicator of national prosperity.

Although the reform of mental illness services and addressing the stigma, discrimination and denial of human rights and civil liberties experienced by people with mental health problems remain central, these goals are now also being considered in the context of public mental health.

Campaigns and other initiatives to achieve a society in which people with mental health problems are valued, accepted and included are more likely to be effective if they form part of a population based strategy to promote mental well-being. (Mental Health Foundation, 2005; Gale et al., 2004).

The WHO Europe Action Plan (WHO, 2005a), which sets out the commitments and responsibilities of both the WHO and national governments, stresses the need for:

- mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems.

It has 12 priority areas, with a strong public mental health focus, including:

- promotion of mental well-being;
- incorporation of mental health as a vital part of public health policy;
- reduction of stigma and discrimination;
- prevention of mental ill health and suicide; and
- access to good primary health care.

The extent to which public mental health will achieve better outcomes for people with severe and enduring mental health problems is an open question. In England, tackling discrimination and social exclusion have received a stronger focus than promoting mental health for all, notably with the publication of Mental Health and Social Exclusion by the Office of the Deputy Prime Minister and From Here to Equality, the National Institute for Mental Health’s (NIMHE) strategy for tackling stigma and discrimination on mental health grounds (NIMHE 2004; Social Exclusion Unit, 2004). Reasons for this include:

- the pressing need to address barriers to inclusion for people with mental health problems;
- lack of awareness of the relevance of mental health promotion to improved health and quality of life outcomes for people with mental health problems; and
- most stakeholders work within or use mental health services.

The launch of the national mental health promotion framework can be seen as an effort to provide greater leadership and support for a population wide approach to improving mental health.

Notwithstanding these developments, public mental health could hardly be described as mainstream. What is needed then, to support the mental health promotion community and perhaps more critically, what do those of us committed to public mental health need to do to strengthen both the quality and status of mental health promotion theory and practice? This was subject of a plenary at the Dublin conference, where the differences between the UK and Australia provided a basis for reflecting on these issues (see Jennie Parham’s guest editorial in this issue: Parham, 2005).

Based on what is happening in the UK and Europe, it seems to me that developing the art of connecting is a key strategy (see Figure 1), and that this needs to focus on three areas:

- public debate and engagement;
- policy and emerging ideas; and
- the values underpinning our practice.
Public debate and engagement

The focus on stigma and discrimination has tended to preclude a wider debate about factors that are toxic to mental health, whether or not one has a diagnosis. We have a wealth of data on public attitudes to mental illness, but very little on public knowledge of what harms and hinders mental well-being: the mental health equivalents of smoking and car exhaust fumes.

The extent of control that individuals have over factors that potentially damage their mental well-being varies considerably and in many cases will be very limited. But greater public awareness and understanding of mental health as a resource to be protected and promoted could contribute significantly to reducing structural barriers. For example, prior to the widespread introduction of smoke free workplaces, many people had no choice but to work where they were exposed to second hand smoke. As awareness of the dangers of passive smoking increased, demand from unions and employees contributed to the adoption of workplace smoking policies. Rather than perpetual hand wringing about the public’s stigmatising attitudes, perhaps we should focus on building the same public demand for mental health and well-being as has been achieved for smoke free public spaces.

Emerging ideas

Many different disciplines and intellectual traditions can (and should) contribute more centrally to our thinking: we need to form alliances with colleagues concerned about the environment, violence and political conflict, the rise of fundamentalism, human rights, civil liberties and the implications of bio-science. Three areas of very specific relevance to mental health promotion also merit attention – the economics of well-being, health assets and ongoing debates about evidence.

The economics of well-being challenges the equation of economic growth with life satisfaction and reminds us of the cost of economic growth, notably the psychosocial impact of inequality and materialism (Layard, 2005; Marks & Shah, 2004; New Economics Foundation, 2004). It draws on robust evidence that the structure and quality of social relations are fundamental to well-being and provides a context for analysing how the drivers of economic growth undermine individual and community efforts to remain or become connected. The focus is less on individual psychological and cognitive attributes and more on the relationship between the organisation of society and how we feel. In the UK, a cross government Whitehall Wellbeing Working
Group has been established to explore how policies might change with an explicit well-being focus (DEFRA, 2005). This is an interesting development in the current political climate, where the rhetoric of civic engagement, participation and inclusion coincides with a simultaneous discourse of suspicion, intolerance and vilification of more and more sectors of the population. A contradiction that will not be unfamiliar to Australian readers.

Health assets or salutogenesis is an approach to public health that focuses on assets and resilience, rather than solely on deficit and vulnerability. It aims to maximise assets within a community, not just to reduce need. In mental health terms, it is the equivalent of measuring positive mental well-being, as opposed to surveys of psychiatric morbidity. This is important because strategies that focus on need may (inadvertently) reduce health assets, for example through fostering high levels of dependence on professional input; conversely, an intervention that enhances health assets, for example social networks, may have no impact on disease. In other words, interventions to improve health may be entirely independent of interventions to prevent disease:

*Salutogenesis asks, “What are the causes and distribution of health and well-being in this group, community or country population”. Epidemiology asks “what are the causes and distribution of disease and early death in this group, community or population”. (WHO Europe, 2005)*

Emerging research on health assets can help in making a robust case for the importance of mental health and well-being, both in ethical and in public health terms. It can also contribute to current debates about evidence and effectiveness: who is defining success and what measures are they using? The demand for evidence-based practice is likely to remain fundamental, but questions about what counts as evidence are growing louder. Factors informing these questions include a growing emphasis on:

- the impact of psychosocial factors on health, for example social capital, social inclusion and quality of life;
- public/patient involvement and the need to take account of consumer views in deciding what success looks like; and
- user led research, drawing on people’s own expertise in living and coping with mental health problems.

Mental health promotion can contribute centrally to the development of measures and methodologies that can capture a wider range of domains than symptoms, and a wider range of stakeholder perspectives.

**Values**

Faced with the relentless pressure to ‘do and deliver’, it is never easy to reflect on the values underpinning our practice. This is particularly true in an environment unsympathetic to intellectual work: we look longingly across the Channel in that respect. But a robust debate about first principles has never been more pressing: one of which might be that neither prevention nor cure necessarily result in health. For mental health promotion, this means considering whether mental health problems are like polio. Are the characteristics, attributes, insights and experiences associated with, for example, what we call schizophrenia or depression, to be eradicated?

This question is central in considering some of the potential problems with ‘raising awareness’ campaigns. At root, these invite the public to adopt a medical explanation for their problems and to seek medical help, while also, usually through case studies or first person accounts, highlighting the consequences of the disorder: stigma and exclusion. They do not invite reflection on economic and environmental causes. Public health warnings rarely include ‘inequality and injustice seriously damage your mental health’ or ‘fear of foreigners really screws you up’. The reinterpretation of problems as medical suggests that we’re not well, but always, already, potentially (medically) sick. The data used to support our case for the importance of mental health: one in four (lifetime prevalence), one in seven (point prevalence), every family in the land etc., reinforce the myth that mental health problems are a random misfortune, as opposed to a consequence of risk factors that are well understood and strongly associated with social and material deprivation (Melzer, Fryers & Jenkins, 2004; Rogers & Pilgrim, 2003).
Conclusion

It’s been said that the mental health equivalents of drains and clean water are respect and justice. For our own mental health we need to be heard, believed, understood and respected. Justice is about the distribution of the good and bad things in life in a way that is felt to be fair. There is overwhelming evidence that inequality – a key indicator of injustice – erodes mental well-being and that this is one of the key pathways through which deprivation impacts on overall health.

In the UK, we are still recovering from an eighteen year period in which community resources and infrastructures for challenging inequality were systematically dismantled. In this period of potential recovery, mental health promotion needs to build alliances with those communities who are already critical of ‘how we live’ and its impact on care of children, care of the self and social relationships. Of course public mental health needs resources and strategic influence, but it also needs a grass roots movement, one which mobilises against global and local trends that are toxic to the mental health and well-being of all of us. A National Framework for Improving Mental Health and Well-being in England that can contribute to this would be well worth waiting for.

Notes

1. To date, Northern Ireland (DHSSPS, 2003; Friedli, 2004) and Scotland (the National Programme to Improve Mental Health and Well-being http://www.wellontheweb.org/well/well_MainTemplate.jsp?pContentID=77&p_applic=CCC&pMenuID=157&p_service=Content.show&) are the only countries in the UK that have a mental health promotion strategy.

2. The WHO European ministerial conference on mental health, in Helsinki in January 2005, brought together all 52 countries in the European region of the WHO. Organised in partnership with the European Union and the Council of Europe, the conference’s declaration and action plan will drive the policy agenda on mental health for the coming years (WHO, 2005a, 2005b).

References


Guest Editorial
Promotion and prevention ‘report card’: Is Australia getting it right?

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Keywords
mental health promotion, prevention of mental disorders, international mental health policy

The last decade has witnessed an increasing international momentum in addressing mental health promotion and prevention of mental disorders. Positive mental health ‘is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ (WHO, 2001). Mental disorders are found in people of all ages, regions, countries and societies, and are present at any point in time in 10% of the adult population. Furthermore, ‘the social and economic costs of mental ill health for societies are wide-ranging, long-lasting and enormous. Mental health promotion and prevention of mental disorder can be effective in leading to health, social and economic gains’ (WHO, 2004a).

It is widely recognised and understood that treatment interventions alone cannot significantly reduce the burden of mental illness and mental disorder. Positive mental health cannot be achieved by treatment alone because mental health is not about the absence of illness. Several international agencies and organisations acknowledge mental health promotion and prevention of mental disorders as a key priority. These include World Federation for Mental Health, Clifford Beers Foundation, World Health Organisation (WHO) and the International Union of Health Promotion and Health Education (IUHPHE). Mental health promotion and prevention has become the focus of an international conference World Conference on Mental Health Promotion and Prevention of Mental and Behavioural Disorders which began in 2000 and is held every second year. WHO (2004a, 2004b) has recently released two international policy documents on mental health promotion and prevention of mental disorder.

Australia is part of this worldwide movement. Recently, I had the privilege of attending and giving a keynote presentation at a conference in Dublin called Mental Health Promotion: Going from Strength to Strength (as mentioned by Lynne Friedli in her editorial in this issue: Friedli, 2005) which brought together people from the five nations of the United Kingdom and Ireland, along with several international colleagues. Before and after the conference, I met with some of these colleagues in their respective countries. One of the most consistent remarks made to me on my travels was how far ahead Australia was in comparison to the United Kingdom and Europe. ‘At least 10 years’ was the most common response. Since returning to Australia, I have spent time reflecting on Australia’s progress in addressing mental health promotion and prevention in the context of the international arena. Back in Australia, why doesn’t it feel like we’re 10 years ahead? Are we getting it right?
International developments

Before providing a somewhat subjective assessment of Australia’s progress so far, I will give a brief snapshot of some of the developments happening in various parts of the world including the United Kingdom, Europe and Australia.

The UK experience

Lynne Friedli has provided insights into the UK experience in her guest editorial in this issue (Friedli, 2005) highlighting the development of England’s first National Framework for Improving Mental Health and Wellbeing. As Friedli (2005) notes, ‘the only countries in the UK that have a mental health promotion strategy are Northern Ireland and Scotland’.

What is notable about the UK experience is that there is a broad policy landscape for mental health promotion which traverses a range of different sectors. Policies include National Service Framework: Mental Health (Department of Health, 2004a); Action on Mental Health: A Guide to Promoting Social Inclusion (Social Exclusion Unit, 2004); Choosing Health: Making Healthy Choices Easier (Public Health White Paper: Department of Health, 2004b); and Social Care Green Paper, Independence, Wellbeing and Choice: Our Vision for the Future Social Care of Adults (Department of Health, 2004c). It is interesting to note that although there is a separate National Suicide Prevention Strategy for England, it is also integrated into the Service Framework for Mental Health.

The National Institute for Mental Health (England) was established to support the implementation of the National Service Framework and assist in service improvement. It has eight development centres, aligned to the eight health authorities in England. Each development centre has responsibility for supporting implementation of the National Standards, of which Standard One is Mental Health Promotion and Standard Eight is Suicide Prevention. However, implementation and investment in mental health promotion fluctuates across the country.

Colleagues in England commented that the lack of country wide strategic coordination of activities had stalled progress in England. Perhaps the launch of the new Strategic Framework may alleviate this problem.

Scotland, on the other hand, has developed a very comprehensive approach to mental health promotion. A significant investment has been made by the Scottish Executive (2003) in establishing the National Program for Improving Mental Health and Wellbeing in Scotland. The National Program has four main aims: raising public awareness of mental health and mental illness and promoting positive mental health and emotional wellbeing; eliminating stigma and discrimination; preventing suicide; and promoting and supporting recovery. There are six priority areas covering population groups and settings. The policy is supported by a national program of support activities including collecting and disseminating the evidence base, research and evaluation, establishment of learning networks, and communication strategies.

In the process of developing their national program, Scotland undertook an international review of mental health policy and their conclusions were that Australia was leading the way in policy development. Scotland is also looking to Australia for implementation models and a number of colleagues from Scotland will be visiting Australia in the near future to examine and explore some of our initiatives.

The European experience

By far the most significant development in Europe is the Implementing Mental Health Promotion Action (IMHPA) network. With the participation of 28 countries and co-financed by the European Commission, the Ministry of Health, Welfare and Sport (The Netherlands) and the National Research and Development Centre for Welfare and Health (STAKES) of Finland, the IMHPA network provides a European platform that combines support for policy priority setting and the dissemination of evidence-based knowledge on prevention and promotion in mental health. The IMHPA network has been engaged in three main activities since April 2003: the development of a European Action Plan for mental health promotion and prevention of mental disorder, (Jané-Llopis & Anderson, 2005); the compilation of a web-based registry of evidence-
based interventions for promotion and prevention in mental health across Europe; and the development of a set of training initiatives, including a training manual for primary health care professionals.

The Netherlands has an extended system for mental health promotion and prevention within health services, clinics and NGOs. Many of these services have specialised promotion and prevention teams targeting mental health, financed by municipalities or the national health insurance system. Emphasis has been given to building the capacity of the workforce in the Netherlands: workforce development programs addressing mental health promotion and prevention have been developed and implemented.

Finland has been implementing the European Early Promotion Project since 1997. The national project has trained more than 2,000 primary health care nurses in half the country’s municipalities between 1997 and 2002. The training program included a manual on the identification of risk factors and focussed interventions to be used in primary care and with those working in day care and social services.

These are just some examples of developments in Europe and are by no means comprehensive, but they provide a flavour of the activity.

The Australian experience

At a policy level, Australia has developed national policy in mental health promotion and prevention: The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000a). This complements the National Mental Health Plan: 2003-2008 (Australian Health Ministers, 2003). Other national policies which have a direct impact on mental health promotion and prevention in Australia include:

- LiFe: The National Framework for Preventing Suicide and Self-Harm;
- The National Strategy for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing 2004-2009;
- Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia;
- National Drug Strategy; and
- National Crime Prevention Strategy.

These strategies link the mental health sector with Aboriginal and Torres Strait Islanders, general practice and primary care, multicultural health services, drug and alcohol services, and local government.

The Australian Government has also invested in a number of national initiatives which support the implementation of mental health promotion and prevention strategies in a range of different sectors. These include, but are not limited to:

- Auseinet;
- MindMatters;
- Mindframe National Media and Mental Health Initiative;
- beyondblue: the national depression initiative;
- Better Outcomes in Mental Health Care Initiative;
- COPMI National Project;
- ResponseAbility; and
- CommunityMindEd.

These national projects and initiatives support the implementation of promotion and prevention in a range of sectors including health, media, journalism, education, and community services.

At the state and territory level in Australia, there is also a range of initiatives in place. Most jurisdictions have developed policy or an action plan to guide the implementation of promotion and prevention, funding commitments, and coordination mechanisms. Most have also made significant investments in initiatives and programs to implement evidence-based PPEI approaches.

Australia’s ‘report card’ - the current status of progress

In a briefing paper, produced for the WHO European Ministerial Conference on Mental Health in Helsinki, (WHO, 2004c), a number of challenges were identified in addressing the future implementation of mental health promotion and prevention activities. These challenges provide a framework I think is useful for assessing progress in this area. The key components for effective implementation of mental health promotion and prevention include:

1. Development of a comprehensive strategy for mental health promotion and prevention of mental disorder.
2. Establishment of infrastructure to support implementation. This includes organisational infrastructure, policies at the local level, capacity building, and workforce development.

3. Inter-sectoral linkages and collaborations. Mental health is a shared responsibility. It is not only an issue of mental health or public health, but also one of public policy. There is a need to engage support from other sectors such as social welfare, employment, housing, education, and criminal justice sectors.

4. An environment which facilitates a climate of respect for and protection of basic civil, political, economic, cultural, and social rights.

How well does Australia fare using this framework as a guide? Clearly, the perception of countries outside Australia is one of admiration. Is that consistent with the perception of Australians themselves? Do we see our progress the same way as the rest of the world sees us? Following is a subjective analysis of Australia’s progress so far, based upon my experience of leading Auseinet (Australian Network for Promotion, Prevention and Early Intervention for Mental Health: www.auseinet.com) for the past four years, and upon dialogue and interactions with many colleagues working in the area.

**Comprehensive strategy**

Australia does have a strong national policy framework in place. The National Action Plan for Promotion, Prevention and Early Intervention 2000 and its accompanying monograph Promotion, Prevention and Early Intervention: A Monograph, were released by the Australian Government in 2000 (Commonwealth Department of Health and Aged Care, 2000a, 2000b). At the time, it was a landmark policy on mental health promotion and prevention. In a national consultation conducted by myself and Debra Rickwood in 2001 (Parham & Rickwood, 2003), it was evident that there was strong support for the national policy from a range of different sectors and settings. Scotland released its policy in 2003 (Social Exclusion Unit, 2003), WHO in 2004 (WHO 2004a, 2004b), and the European Action Plan was released in 2005 (Jané-Llopis & Anderson, 2005). Many of these action plans and policies have been influenced by the Australian policy. More recently, Australia has added to this area in the development of policy for relapse prevention and recovery. This soon to be released policy Pathways to Recovery: A Framework for Preventing Further Episodes of Mental Illness will provide a platform for the development of recovery oriented services in Australia.

However, Australia, unlike the UK and Europe, has a federated system of government which includes three levels of government. At the national level, the policy platform is strong and is complemented by other national strategies and action plans. By contrast, at the state/territory level, policy development is less consistent. Most of the jurisdictions have developed policy and/or action plans for mental health promotion and prevention but not all are operational.

Overall, the progress in this area is substantial and significant but could be strengthened further, particularly at the state/territory level.

**Establishment of infrastructure to support implementation**

Australia may be regarded as having the best policy in the world, but what about implementation? Again, some of the challenges for implementation derive from having a number of levels of government and others from the tensions within the health system between ‘treatment’ and ‘prevention’. The consultation on the National Action Plan for PPEI identified implementation as one of the key issues to be addressed (Parham & Rickwood, 2003).

The Australian Government has made a significant investment and commitment to the promotion and prevention agenda in mental health. This is demonstrated by promotion and prevention being a key platform in the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003), the establishment of the National Mental Health Promotion and Prevention Working Party to guide policy development, and funding a range of national initiatives which either provide models for implementation or support implementation in a range of sectors and settings. Furthermore, the Australian Government has taken risks in investing in initiatives and projects that build capacity and address structural/systemic issues
(i.e. MindMatters, Better Outcomes in Mental Health Care, Auseinet, beyondblue) or that build partnerships with other sectors (i.e. MindMatters, Mindframe Media and Mental Health Initiative, ResponseAbility, CommunityMindEd). Most of these initiatives are developing international reputations and putting Australia on the global map.

At the state/territory level, the picture is a little different. The key drivers of this agenda (i.e. those with the funds to invest) are largely Departments of Health and/or Human Services and their respective Mental Health and Public Health Units.

There is acknowledgement at the jurisdictional level of the importance of investment in promotion and prevention. The big question is ‘Who is responsible?’ The answer quite often is ‘mental health is everybody’s business’, that is, it’s a shared responsibility. Sometimes, that can mean no responsibility. It would appear that despite good intentions and goodwill, progress seems slow at the state/territory level.

There are a number of reasons for this. From mental health’s perspective, there are a number of significant challenges. These include an under funded and under resourced mental health service system; a workforce that is predominantly trained in the medical model; and service models that are oriented to treatment rather than early intervention.

At a recent hearing of the Senate Select Committee on Mental Health in Australia, Auseinet presented to the hearing that other countries (particularly in the UK) were commenting that Australia is leading the way in mental health policy development. In the midst of all the ‘doom and gloom’ they were hearing, there was a good news story. However, good policy alone does not lead to effective implementation. Infrastructure does need to be put in place to support it, which includes organisational support, funding, workforce development and capacity building.

Implementing a promotion and prevention approach in mental health services requires a multi pronged approach that needs to include:

- Service reorientation;
- Workforce development;
- Attitudinal and cultural change; and
- Provision of a range of service levels to enable appropriate referral pathways.

Some of these strategies require additional funds in an already under funded environment.

From a public health perspective, there is a need to make more effective linkages between physical health and mental health. In Australia, mental health has, largely, taken the responsibility to lead the promotion and prevention agenda, despite the national policy being signed off by both mental health and public health. Clearly, in England now with the release of the White Paper and the launch of the Framework, public health is rising to the challenge of providing leadership in this area.

The level of collaboration and partnership between mental health and public health fluctuates, but there is enormous potential for the expertise of those working in public health to be utilised to progress the mental health promotion and prevention work.

Implementation of PPEI at the jurisdictional level is largely determined by the level of infrastructure in place and in some cases, the energy and commitment of 'champions' or 'advocates.'

Overall, evidence of infrastructure to support implementation in Australia is progressing but patchy and based on champions. It needs to be embedded more in sustainable structures and systems.

**Inter-sectoral collaboration and partnership**

Achieving positive mental health requires the contribution of a range of sectors and settings. As Jané-Llopis states ‘many of these potential partners are not aware of the benefits they can gain from investing in mental health promotion’ (WHO, 2004c). She further states that ‘the health sector can provide leadership by engaging in active promotion and advocacy for mental health and by encouraging other sectors to join in multi-sectoral activities, sharing goals and resources’ (WHO, 2004c).

There is a real need for mechanisms to be put in place that facilitate the participation of other sectors in a meaningful way (i.e. memorandums of understanding, joint planning groups, collaborative partnerships).
Some of the best examples of inter-sectoral partnership in Australia are demonstrated in the area of suicide prevention. There are many projects that have multi-sector input and many of the state/territory plans for suicide prevention are whole of government.

VicHealth, the Victorian Mental Health Promotion Foundation, has a strong track record in working with many of the sectors outside of health, which they identify as some of the ‘key drivers of mental health’ as well as developing resources and workforce development programs that support the development of collaborative partnerships.

In general, this is the area that needs the most strengthening. There is a lot of energy for and commitment to addressing mental health issues from sectors outside health that needs to be harnessed and utilised. Non government organisations, in particular, are essential partners in ensuring accountability in mental health. Strengthening the NGO sector will be an important factor in the development of recovery oriented services as they are the primary vehicle for the provision of housing, rehabilitation, employment and support services.

Overall in this area, progress has begun but there needs to be greater investment and strengthening.

Respect and protection of civil rights

Creating a mentally healthy society involves eliminating stigma and discrimination. In Australia, the most frequently discriminated against include people with mental illness and mental disorder, Aboriginal and Torres Strait Islanders, refugees and detainees. They are the subject of a number of Royal Commissions occurring in Australia at this time. beyondblue: the national depression initiative, has certainly had an impact in Australia on reducing the stigma of depression and raising public awareness. There are a number of models of mental health literacy being implemented in Australia and the Rotary seminars have certainly assisted in that process. VicHealth has developed and implemented a major mental health promotion campaign ‘Together we do Better’, aimed at addressing one of the important social determinants, social connectedness.

Overall, Australia has not done very well on this dimension it would seem. There is a need for a more coordinated, strategic national approach.

Summary

In summary, there is a growing worldwide movement to address mental health promotion and prevention of mental disorder. Australia has led the way in the development of policy and in innovative initiatives and projects. In these areas, we are getting it right. However, in the area of sustainable implementation of evidence-based practice, engaging stakeholders from other sectors outside health and reducing discrimination, Australia has still a long way to go.

Despite the ‘pressures’ in the health system in Australia, there is a sense of urgency about ensuring that mental health promotion and prevention remains on the agenda, that progress increases and we do not lose the distinct advantages we currently have with an innovative, cutting edge policy platform. Otherwise, the rest of the world will catch up and benefit more from the investment Australia has made so far.

References


http://www.imhpa.net


http://www.euro.who.int/document/mnh/ebrief08.pdf
The psychoeducation needs of parents who have an adult son or daughter with a mental illness

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Abstract
Since deinstitutionalisation, parents of adults with mental disorders are increasingly utilised as a resource for their relatives’ care. This study used a general phenomenological perspective to capture people’s experiences. Semi-structured in-depth interviews were conducted with eight parents who were members of the Schizophrenia Fellowship of Southern Queensland to explore their perceptions of their psychoeducation needs. The themes that emerged included the usefulness of past experiences with psychoeducation, educational needs, barriers to accessing information and support, and other unmet carer needs, including the need for managing stress and emotional needs, recognition and inclusion of family members in decision-making, and negotiating the best care for their family member within the health care system. This study adds to an increasing body of knowledge that advocates for the greater inclusion and involvement of families in the care and treatment of their relatives. Further research into the needs of families, in particular barriers and supports in accessing information and services, is recommended.

Keywords
carers, psychoeducation, mental illness, supports, barriers

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Children of a parent with a mental illness: perspectives on need

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Abstract

Being a child of a parent who has a mental illness involves considerable risk to the child’s secure attachment and long-term mental health. Parental mental health concerns place children at a significantly greater risk of lower social, psychological and physical health than children in families not affected by mental illness. In this paper, previous research is extended by examining the needs of these children from the perspectives of children, parents and mental health and welfare professionals. The study involved qualitative and quantitative data collection from focus groups with children and parents, and a comparison of quantitative findings with mental health professionals. Similar responses from the children and parents included problems with major episodes (e.g. parent hospitalisation), issues regarding coping and the importance of sibling support. Parents also identified a number of different issues (e.g. external support) compared with children (e.g. the importance of friendships). A final component of the research undertook a quantitative comparison of seven core ‘things that might help’ children in the circumstance of their parent being hospitalised. The findings showed differences between parents and mental professionals but most significantly with children. The findings overall are discussed in relation to the needs of children whose parent has a mental illness and recommendations are made regarding policy and service provision.

Keywords

attachment, mental illness, children whose parents have a mental illness, connectedness, focus groups, resilience

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Mental illness recovery and place

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Abstract

This paper explores fifteen residents’ perspectives on a supported housing program for people recovering from low prevalence mental health disorders in rural Gippsland, Victoria, Australia. It moves beyond the often unproductive institutional versus community care dichotomy to present a more complex consideration of the residents’ perceptions of supported housing as a site for recovery. This paper contributes to the literature on consumers’ experiences of mental health care in particular places. The residents’ narratives highlight the importance of supported accommodation as an integral part of a recovery focused service system delivered predominantly, but not exclusively, in the community.

Keywords
recovery, rural mental health, place, mental health promotion, community care

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A Healthy Start: Mental health promotion in early childhood settings

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Abstract

Childcare services are an important part of life for many families. Childcare workers have a vital role in the development of a child’s mental health, and yet are often under-trained in this area. This paper describes the implementation, evaluation and sustainability of the Healthy Start program in regional Western Australia, with particular attention to outcomes for childcare workers. Healthy Start aimed to build the capacity of the childcare workforce to promote the mental health of children attending childcare, their families and those working in the childcare sector. A range of strategies was developed and implemented, including mental health literacy training and communication skills training which were delivered to over thirty-five childcare workers. Pre and post-training questionnaires showed that awareness of risk factors, protective factors and referral sources, as well as levels of confidence in discussing mental health issues with parents, increased immediately after training. Baseline and follow-up telephone surveys showed however that the childcare workers’ awareness of risk and protective factors was not sustained over a twelve month period. The findings suggested that messages need to be reinforced post-training to retain new knowledge and confidence. As a result, agency partnerships have grown to include a range of early childhood professionals and provide annual training.

Keywords

child care, settings approach, mental health literacy, mental health promotion, evaluation

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Suicidality, interpersonal trauma and cultural diversity: 
a review of the literature
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Abstract
There are substantial bodies of literature focusing on suicide and interpersonal trauma, and on suicide across cultures. There is also a growing body of knowledge relating to interpersonal trauma across cultures. However, there is a marked gap in the literature that brings these three areas together. Studies that specifically investigate the prevalence of suicidality in relation to experiences of domestic violence, sexual assault and childhood abuse in a cross-cultural context are indeed scant. Moreover, inconsistencies in data collection and reporting and considerable variability in results among the few existing studies highlight substantial methodological limitations and definitional differences in the research. The identification of at-risk groups is thus hampered, as is an examination of possible risk and protective factors. What is clear is that interpersonal trauma and suicide are linked in significant and complex ways. What is less evident is how culture mediates this inter-relationship. It is suggested that gender and cultural biases in suicide research may well account for our limited understandings in this area. Implications for practice include the need for alternative research perspectives and more inclusive frameworks that promote greater cross-discipline dialogue and intersectoral collaboration. There is thus ample scope for further research in this area so as to elucidate the implications for suicide prevention, intervention and postvention work with culturally and linguistically diverse communities.

Keywords
suicide, suicidality, culture, interpersonal trauma, domestic violence, sexual assault, childhood abuse, mental health
The employment of people with mental illness
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Abstract
People with a mental illness are among the most socially and economically marginalised members of the community. They experience high levels of unemployment and non-participation in the labour force. Unemployment has a number of negative effects including the loss of purpose, structure, roles and status and a sense of identity which employment brings. Employment enables social inclusion in the wider community and is an important way that people with a mental illness can meaningfully participate in the wider community. Australia has a mental health strategy, which guides the ongoing reform of mental health services. However, specific strategies to address the social and economic marginalisation of people with a mental illness have not been addressed. A recovery-oriented approach is recommended, which integrates the key sectors involved. To date there has been little inter-sectoral collaboration between the various sectors such as mental health services, housing, and vocational services. People require more role-specific assistance to enable them to participate in socially valued roles implicit with citizenship. There is a need to formulate improved pathways to assistance and more evidence-based forms of assistance to re-establish career pathways. This report aims to: 1) collect relevant overseas and Australian evidence about the employment of people with mental illness; 2) identify the potential benefits of employment; 3) describe patterns of labour force participation in Australia among people with mental illness; 4) identify how mental illness can cause barriers to employment; 5) outline the type of employment restrictions reported by people with mental illness; 6) identify the evidence-based ingredients of employment assistance; 7) identify relevant policy implications; and 8) suggest strategies to improve employment outcomes and career prospects for people with mental illness.

Keywords
mental illness, work, policy development, vocational interventions, supported employment, evidence-based components