Building the Foundations for Mental Health and Wellbeing

A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania

June 2009

Statewide & Mental Health Services
Department of Health and Human Services

Tasmania
Explore the possibilities

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Executive Summary

Building the Foundations for Mental Health and Wellbeing is a landmark policy for Tasmania in guiding investment in PPEI, and reflects the commitment by Tasmanian Mental Health Services to enhancing positive mental health for Tasmanians, as well as reducing the prevalence of mental disorders.

Building the Foundations for Mental Health and Wellbeing provides a Strategic Framework and Action Plan for implementing mental health promotion, prevention of mental ill-health and early intervention (PPEI) approaches in Tasmania. The Framework is informed by the companion document, *Review of Australian and International Mental Health Promotion, Prevention of Mental Ill-health and Early Intervention Policy* undertaken as part of the development of this policy.

One of the unique features of the Framework is the articulation of roles and responsibilities of Department of Health and Human Services (DHHS) funded Mental Health Services and Community Sector Organisations in the implementation of the strategies and actions. This reflects the involvement of government and community sectors as well as clinical and non-clinical services. Mental health promotion, prevention of mental ill-health and early intervention has been a priority in mental health policy in Australia since the late 1990s. However, the mental health services sector has struggled for the last decade in translating that priority into meaningful roles and responsibilities for the workforce which provides services to people with acute and chronic mental illness. Clear articulation of such roles provided in this Framework is a groundbreaking policy development which will be of interest across Australia and internationally.

In addition, the Framework is founded on the understanding that 'mental health is everybody's business' and that the impact of a broad range of policies and practices on mental health must be identified and considered across whole of government and whole of community. To embed promotion, prevention and early intervention approaches to mental health throughout government and community initiatives, a range of policy, communication and infrastructure supports are required. This necessitates 'building the foundations' for supporting mental health and wellbeing at a number of different levels (including government, community, families, service provision and society) and development of a supportive policy environment and system of coordination.

It is recommended that the implementation and evaluation of this Strategic Framework be coordinated by a Promotion, Prevention and Early Intervention Unit within the Statewide & Mental Health Services (SMHS) State Office. This task would be supported by a Strategic Framework Monitoring Committee, comprised of government, agency and community representatives. Implementation of the Strategic Framework will be driven by Mental Health Services with leadership from SMHS State Office, in collaboration with other government agencies and current initiatives, and under the general direction of the Strategic Framework Monitoring Committee. A first step, therefore, is formation of the Strategic Framework

Monitoring Committee. This Committee will develop an implementation action plan and timeline, and accompanying evaluation plan.

Conceptual framework

The Strategic Framework and Action Plan needs to be understood within the context of several key concepts, principles and frameworks, consistent with contemporary directions in promotion and prevention policy internationally. These include:

- **Positive concept of mental health**

Fundamental to a positive concept of mental health is the distinction between 'mental health' and 'mental illness', and the place of mental health as an overall component of health. Traditionally, policies and services concerned with 'improving mental health' have in reality focused on mental ill-health, particularly on provision of access to services and stigma related issues. This has resulted in conceptual confusion for policy makers, service systems and communities broadly about how mental health and mental health promotion are defined, and how a positive concept of mental health fits within the full range of promotion, prevention and early intervention activity. A positive concept of mental health embraces the notion that mental health is a desirable quality in its own right and is more than the absence of the symptoms of mental illness. It moves beyond a medical view of mental health and supports the concept of 'mental health and wellbeing'. It encompasses notions such as resilience in the face of adversity, purpose in life, self-acceptance, social contribution and personal growth. Furthermore, it is based on the principle that mental health is relevant for the entire population, irrespective of the presence or otherwise of mental illness. Services and the community need to be supported to better understand and embrace a positive concept of mental health.

- **Spectrum of Interventions**

The 'Spectrum of Interventions' as originally defined by Mrazek and Haggerty in 1994[1] (and subsequently revised by others) (refer Figure 1) is widely recognised and adopted as a population framework for defining the entire range of mental health interventions encompassing mental health promotion, prevention of mental ill-health, early intervention, treatment and recovery approaches (including relapse prevention). The spectrum reflects a population health approach which recognises the status and mental health needs of the entire population – that is, people who are currently well; those at risk of mental health problems on the basis of their individual, social and/or environmental circumstances; and those who are currently, or have previously, experienced mental ill-health. The elements of the spectrum are summarised as follows.

Mental health promotion is relevant for all people, regardless of whether they are currently well or ill. It is about optimising people's mental health by developing supportive environments. Much of the work in mental health promotion has been conducted within the

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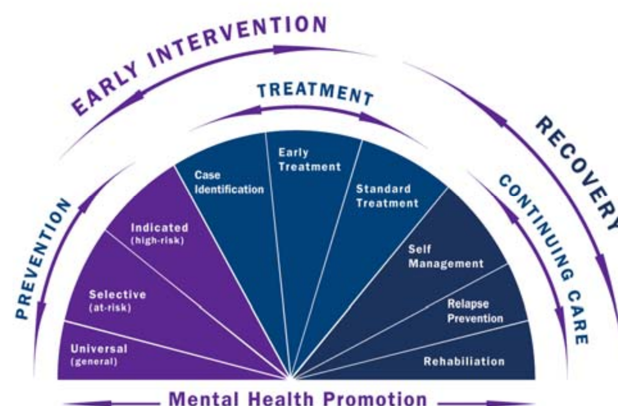
[1] Mrazek, P. & Haggerty, R. (1994). *Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington D.C.: National Academy Press.

framework of the Ottawa Charter for Health Promotion. The concept of **Recovery** for people with mental illness is closely aligned with mental health promotion. Wellbeing, quality of life, a sense of control over one's health, and the ability to bounce back from adversity are key components of recovery approaches and consistent with mental health promotion.

Prevention interventions focus on reducing risk factors and enhancing protective factors associated with mental ill-health. There are three major types of prevention. *Primary prevention* interventions are targeted to population groups according to the level of risk. *Secondary prevention* targets those who are showing early signs or symptoms of mental illness or disorder and seeks to lower the prevalence of the illness through early detection and treatment. *Tertiary prevention* seeks to reduce the negative impact and associated disability of existing mental illness. Tertiary prevention interventions have similarities with **Relapse prevention**. Relapse prevention involves supporting people with mental illness to recognise early warning signs or relapse and develop appropriate response plans. There are two types of **Early intervention** – *prevention* focused for individuals beginning to show the early signs and symptoms of a mental health problem; and *treatment* focused for individuals experiencing a first episode of mental illness.

Figure 1: Spectrum of interventions (adaptation by Rickwood, 2006)



Evidence to support investment in mental health and wellbeing

There is a substantial body of evidence to support current directions and priorities in mental health promotion, prevention and early intervention policy and practice. It is widely recognised that the economic and social impacts of mental ill-health for individuals, families, communities and countries are enormous and that treatment approaches alone will not reverse current trends towards increasing rates of mental ill-health. At an international level key organisations such as the World Health Organization (WHO), the World Federation for Mental Health, and the International Union for Health Promotion and Education (IUHPE) have led the way in advocating for greater research and activity in promotion, prevention and early intervention approaches to mental health.

Evidence exists for the effectiveness of a wide range of exemplary mental health promotion and prevention programs and initiatives in improving quality of life and/or reducing risk for mental illness. Some examples include:

- Improving housing
- Promoting a healthy start to life
- Parenting programs
- School based interventions
- Support for children of parents with a mental illness
- Workplace interventions
- Recovery oriented approaches
- Interventions for older people.

Given that mental health is influenced by the settings of everyday life, a range of sectors have the potential to contribute to mental health outcomes - the degree to which will vary depending on the objective of the program/policy and the populations being targeted. Key strategic sectors may include health, education, welfare, housing, community, childcare, arts/sports/recreation, employment, corrections, financial, media, government and the home.

Strategic Framework and Action Plan

The five Priorities encompassing a range of strategies and actions defined in the Strategic Framework and Action Plan align with 'building the foundations' to support mental health and wellbeing for Tasmanians at a range of different levels:

Priority 1: Promote mental health and wellbeing across whole of government and whole of community.

> *This priority addresses an important foundation of* ***'building support for mental health and wellbeing at the government level'*** *through developing a coordinated policy framework, effective intra and intersectoral partnerships and investing in research. The responsibility for promotion, prevention and early intervention approaches is not limited to one sector or one discipline and requires collective action across a range of government departments.*

Priority 2: Build capacity across sectors and in the community to implement programs and initiatives to support mental health and wellbeing.

> *This priority addresses the foundation of* ***'building support for mental health and wellbeing in the community'*** *through education, training and the implementation of evidence-based programs and intervention strategies. The goal of this priority is to develop a shared understanding of positive mental health and improved mental health literacy across different workforces, embedding this knowledge in service provision, and creating community settings - such as schools and workplaces - that support mental health and wellbeing.*

Priority 3: Invest in the early years and families.

> *This priority addresses the foundation of* ***'building support for mental health and wellbeing in families'*** *through strengthening family relationships, enhancing parenting skills and establishing strong parent/child attachment in the early years. The evidence is*

clear that investment as early as possible in the developmental cycle will have the most significant impact on mental health and wellbeing.

Priority 4: Consolidate and further strengthen reorientation of Mental Health Services and Community Sector Organisations to support mental health and wellbeing.

This priority addresses the foundation of ***'building support for mental health and wellbeing in the mental health service system'*** *through ensuring Mental Health Services and Community Sector Organisations enhance mental health and wellbeing for people with mental illness or 'at risk' of mental illness, and empower consumers and carers to achieve a better quality of life. Mental Health Services need to be seen as a key driver of promotion, prevention and early intervention approaches that support mental health and wellbeing.*

Priority 5: Reduce mental health inequalities.

This priority addresses the foundation of ***'building support for mental health and wellbeing in society for people disadvantaged or disempowered in the community'*** *through identifying the key social and environmental determinants that impact on the mental health and wellbeing of these population groups and exploring ways to ameliorate their impact. The goal of this priority is to enhance social inclusion, reduce discrimination and stigma, and increase economic participation in society.*

Mental Health Services and Community Sector Organisations funded by DHHS have a critical role to play in relation to positive mental health, mental health promotion, prevention of mental ill-health, and early intervention. Mental Health Services and Community Sector Organisations[2] must embrace positive mental health and wellbeing for everyone, understand the factors influencing the mental health of their clients, support the workforce to understand the difference between mental health and mental ill-health, and provide education to organisations within and external to DHHS to increase understanding of mental health, mental health promotion, prevention of mental ill-health and early intervention.

The key role for Mental Health Services and Community Sector Organisations in mental health promotion is to enhance mental health and wellbeing for people experiencing mental ill-health. Reorienting services to a recovery focus is essential in developing mental health promoting services for people experiencing mental ill-health. Effective and empowering consumer and carer participation strategies and infrastructure are paramount to a recovery oriented service model.

Mental Health Services is not responsible for all prevention interventions across the spectrum from illness to wellness. Inter and intra sectoral partnerships and collaborations are essential in implementing prevention interventions. The key role of Mental Health Services and Community Sector Organisations in prevention is in the domains of secondary

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[2] It is acknowledged that clinical services are provided by Mental Health Services and the majority of non-clinical services (such as supported accommodation, social participation, vocational rehabilitation) are provided by Community Sector Organisations.

and tertiary prevention (ie., downstream interventions). Relapse prevention is an important tertiary prevention intervention to be implemented in recovery oriented services.

The objective of this Framework is to guide investment in PPEI, and to support mental health and wellbeing to become an overarching consideration in all State government policies, and across relevant portfolio areas. Central to building the foundations for mental health and wellbeing in Tasmania is the need for policy coordination at different levels of government. This includes the Australian Federal Government (including the Council of Australian Governments [COAG]), State Government of Tasmania, and the local government level.

Policies and initiatives at all three levels of government operation need to be coordinated to maximise potential and ensure sustainability, reduce waste and duplication, and identify and eliminate gaps. The wide range of government portfolios and agencies that are relevant to mental health and wellbeing makes this a complex task. With leadership from SMHS State Office, strong whole of government coordination is required to clearly link and effectively communicate relevant policy initiatives, and to provide improved mental health and wellbeing outcomes for all Tasmanians.

Summary of recommended strategies and actions

Priority 1: Promote mental health and wellbeing across whole of government and whole of community

Strategy 1. Establish Tasmania's Mental Health Services as a key driver of PPEI

Actions:

- Establish a mechanism to enable Mental Health and Statewide Services (SMHS) State Office to provide leadership and be a key driver for PPEI.
- Consolidate resources, through the leadership of the coordinating unit in SMHS State Office, to establish a single focus for PPEI activities, incorporating initiatives related to mental health, alcohol and other drug use, and suicide prevention.
- Enable the coordinating unit within SMHS State Office to lead change within Mental Health Services and Community Sector Organisations, as well as the broader mental health sector, to progress PPEI initiatives across government and community.
- Strengthen the partnership with Public Health, DHHS.

Strategy 2. Build and make accessible the evidence base for PPEI

Actions:

- Develop a coordinated and systematic approach to building the evidence base for PPEI and evaluating local PPEI initiatives, including enabling access to the required research skills and methodologies.
- Undertake a review of evidence-based interventions in priority areas to be addressed in this Strategic Framework (such as positive parenting programs, school based initiatives, social marketing) that may be appropriate to adopt/adapt in Tasmania.
- Enable access in Tasmania to relevant PPEI information and evidence.
- Collaborate with Public Health to build the evidence base, in particular to develop indicators of positive mental health and wellbeing to evaluate initiatives and demonstrate progress.

Strategy 3. Ensure that mental health and wellbeing outcomes are considered in all government policies and that initiatives at all levels of government are coordinated

Actions:

- Establish a whole of government coordination mechanism that has, as a priority, the role of identifying the mental health and wellbeing outcomes/impacts in all government policies and linked initiatives. The coordination function needs to consider the impact of government policies on mental health and wellbeing across

portfolios and at all three levels of government (local, State and Federal).

- Undertake an audit or policy map of linked initiatives under the auspices of the whole of government coordination mechanism. Identify the mental health and wellbeing components of strategic policies and plans that are currently in progress and investigate their overlap, synergies, potential conflicts and possible gaps.

Strategy 4. Ensure critical collaborative intersectoral relationships are developed and sustained

Actions:

- Further develop and implement the proposed 'Framework for Intersectoral Collaboration', to establish a multi-faceted approach to coordination and collaboration through the formation of four Working Groups:
  - *Inter Agency Mental Health Working Group* (including a range of sectors such as health, education, Premier and Cabinet, justice, police, community services);
  - *Intra Agency Working Group* (reflecting the interface between health and human services and includes population health, mental health, alcohol and other drugs, disability, housing, children and families, oral health, hospitals);
  - *Community and Consumer/Carer Working Group* (representing the not-for-profit sector bringing together consumer and carer groups and member organisations of the Mental Health Council of Tasmania); and
  - *Clinical Network* (reflecting the interface between mental health and primary care including general practice and primary health care services).
- Ensure sustainability and further development of effective collaborations such as the Inter Agency Support Teams, Drought Network Tasmania, Inter Agency Working Group on Drugs, Tasmanian Suicide Prevention Steering Committee (TSPSC), and Tasmanian Transcultural Mental Health Network.
- Determine a mechanism for the identification and recognition of shared clients, particularly for Mental Health Services, Alcohol and other Drug Services, Child Protection, Youth Justice and Corrections.
- Establish a mechanism for more formal collaboration between the mental health and education sectors.
- Develop strong links with public health. There is considerable synergy to be achieved by working with public health on initiatives to reduce the risk factors for physical illness and chronic disease, acknowledging the interrelationship between physical and mental health and wellbeing.

Strategy 5. Develop a Suicide Prevention Strategy for Tasmania that reflects a whole of government and whole of community approach to suicide prevention and a framework for action

Actions:

- Establish a collaborative mechanism to oversight the development of a Suicide Prevention Strategy for Tasmania as recommended by Tasmania's Parliamentary Joint Standing Committee on Community Development Report on Strategies for the Prevention of Suicide (2007).
- Ensure the development of the Suicide Prevention Strategy is aligned with the national strategic framework for preventing suicide and promoting mental health and resilience, Living is for Everyone (LIFE) – A Framework for Suicide Prevention in Australia (2007).
- Ensure the development of the Suicide Prevention Strategy is underpinned by the conceptual framework noted in *Building the Foundations for Mental Health and Wellbeing*.
- Consider recent Tasmanian research and reports from the Tasmanian Suicide Prevention Steering Committee to inform the development of the Strategy including 'Voices of Tasmanians on Suicide Prevention' 2009 and the TSPSC Report 2006/2008.
- Ensure suicide prevention and self harm minimisation programs are evidence-based, safe and effective interventions.
- Increase the support for the work of Community Sector Organisations in suicide prevention activity such as the 'Rural Alive and Well' project.
- Establish strategic partnerships with other agencies to increase individual, family and community awareness and understanding of suicide and suicide prevention including risk and protective factors.

Strategy 6. Establish a strong and supportive relationship with the media

Actions:

- Progress mechanisms to ensure accurate and appropriate media reporting of issues and incidents related to mental illness and suicide, including supporting the Tasmania Media Awards and working with SANE Australia.
- Partner with both public health and the media to disseminate messages that promote health, mental health and wellbeing, including contributing to the Community Broadcasting Association's Suicide Prevention Project, which aims to provide help-seeking and wellbeing messages to a wide and diverse network of communities.
- Investigate opportunities to adopt and adapt social marketing campaigns for Tasmania that improve understanding of positive mental health and reduce stigma, similar to VicHealth's 'Together We Do Better', Queensland Government's 'Be Kind To Your Mind' and Mentally Healthy WA's 'Act-Belong-Commit'.

Priority 2: Build capacity across sectors and in the community to implement programs and initiatives that support mental health and wellbeing

Strategy 1. Enhance understanding of mental health and wellbeing and mental ill-health amongst service providers

Actions:

- Identify relevant service sectors that require development for better understanding of mental health and wellbeing and mental ill-health.
- Develop a plan for implementing mental health and wellbeing training across service sectors in Tasmania.
- Develop a plan for implementing 'Mental Health First Aid', or similar, in community and non-clinical service sectors in Tasmania, especially the Department of Police and Emergency Management and the Department of Education.
- Implement stigma-reduction initiatives amongst service providers. These can include such initiatives as mental illness education delivered by consumers and carers, and other effective consumer participation activities (such as paid consumer consultants in relevant services).

Strategy 2. Support school-based interventions to promote mental health and wellbeing

Actions:

- Build a stronger partnership between Mental Health Services and the Department of Education through development of a process and mechanisms for coordination. In particular, support the Wellbeing Curriculum in Schools and enable Education and Mental Health to work together to identify and implement current evidence-based school-based interventions, such as MindMatters, KidsMatter, the Resourceful Adolescent Program (RAP), anti-bullying and school connectedness programs.
- Support the role of CAMHS' workers in providing mental health education and early intervention in schools through stronger coordination between mental health and education.
- Implement programs that focus on building skills to support positive mental health, such as those that focus on resilience and problem solving, during the primary school years.
- Continue to implement interventions that build resilience in the secondary school years, but add components that improve mental health literacy, reduce the stigma of mental illness, and—most importantly—encourage effective early help-seeking for mental health problems and related issues such as suicidal thoughts, alcohol and other drug use, and relationship problems.

Strategy 3. Promote positive mental health messages and improve mental health and wellbeing through the workplace

Actions:

- Facilitate opportunities to work with various workforces (such as apprentices, hospitality, industry) to improve understanding of ways to protect and improve mental health and wellbeing, effective actions to take to prevent the development of illness, and how to identify early signs and symptoms of mental health problems and take appropriate action.
- Identify opportunities to work with key business representatives and peak bodies to develop mental health promoting workplaces, including programs to reduce workplace bullying and increase social inclusion.

Strategy 4. Promote positive mental health messages and improve mental health and wellbeing through community settings

Actions:

- Develop a plan to work with the Neighbourhood House initiative for communities to identify their mental health promotion needs and ways to implement activities that promote positive mental health.
- Use opportunities such as Agfest, Rural Health Week and Mental Health Week to promote messages that support mental health and wellbeing.
- Promote arts and recreation-based initiatives that engage community members, particularly those who are socially isolated or disadvantaged, to connect with the community and take part in meaningful activities.

Priority 3: Invest in the early years and families

Strategy 1. Strengthen mental health support within child and maternal health and family centres

Actions:

- Ensure that nurses working in infant, child and perinatal health care services and family centres have skills in promoting mental health and wellbeing, particularly in relation to building parent/child attachment.
- Coordinate implementation of the National beyondblue Perinatal Mental Health Program.
- Support the role of CAMHS' workers in providing specialist support and knowledge to infant, child and perinatal health care services and family centres.
- Enable early identification of risk factors (such as family breakdown) and promote engagement in relevant intervention opportunities through infant, child and perinatal health care services and family centres.

Strategy 2. Support development of positive parenting skills

Actions:

- Identify opportunities to support all new parents to develop positive parenting skills, though the implementation of evidence-based programs such as Triple-P[3].
- Provide a high level of support to parents of children at risk, particularly parents identified through child protection agencies, corrective services, alcohol and other drug agencies, and parents with mental illness.

Strategy 3. Investigate opportunities for mental health promotion in early childhood settings

Actions:

- Bring together key stakeholders from the childcare and early childhood education sectors to identify priorities and develop an action plan for improving children's mental health and wellbeing in these settings.

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[3] See: http://www.triplep.net/

Priority 4. Consolidate and further strengthen the reorientation of Mental Health Services and Community Sector Organisations to support mental health and wellbeing

Strategy 1. Engage Mental Health Services as a key driver of PPEI

Actions:

- Review current funding and service models in Mental Health Services and Community Sector Organisations to determine the changes that are required to embed reorientation toward recovery and PPEI.
- Quarantine or otherwise allocate part of the Mental Health budget for PPEI activities.
- Implement workforce development programs to ensure that the workforce in Mental Health Services and Community Sector Organisations have the skills to implement PPEI.
- Build PPEI activities into the job descriptions of Mental Health Services' clinicians and align Key Performance Indicators (KPIs) to this part of their role.
- Fund specialist roles in Mental Health Services and Community Sector Organisations to acknowledge the need for specially trained mental health promotion officers who can build collaborative partnerships and undertake education and evaluation.
- Develop a reporting mechanism to provide feedback to the Mental Health Services and Community Sector Organisations on progress in PPEI.

Strategy 2. Improve access to early intervention

Actions:

- Consider ways to work toward redefining Mental Health Services to provide four service streams—for children, adolescents and youth (12-25 years), adults, and older adults. This approach is consistent with evidence regarding the developmental pathways of mental health problems, and highlighting the importance of focusing on adolescence and youth for early intervention as these are the life stages when the vast majority of mental disorders first emerge4.
- Develop a mechanism for the early identification of emerging risks affecting mental health. This mechanism will ensure timely service access for shared clients of mental health, alcohol and other drug services, child protection and corrections, as well as for family members who might also be at increased risk. This is particularly important for people with co-occurring conditions.

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[4] McGorry, P.D., Purcell, R., Hickie, I.B. & Jorm, A.F. (2007). Investing in youth mental health is a best buy. *The Medical Journal of Australia,* 187(7), S5-S7.

- Improve linkages between Mental Health Services and Community Sector Organisations and primary care and general practice, particularly in rural areas. This might include the development of better clinical networks, and the development and implementation of innovative ways to overcome issues of distance through use of new technologies and/or transport options.

Strategy 3. Embed a recovery orientation within Mental Health Services and Community Sector Organisations

Actions:

- Determine the training and professional development needs of the workforces in Mental Health Services and Community Sector Organisations to ensure the skills to work within a recovery orientation.
- Develop recovery-oriented KPIs for the mental health workforce and recovery standards for Mental Health Services and Community Sector Organisations.
- Ensure that clinical and non-clinical workers in Mental Health Services and Community Sector Organisations work effectively together to provide holistic recovery-oriented mental health care through implementation of the proposed 'Framework for Intersectoral Collaboration'.

Strategy 4. Ensure effective consumer and carer participation in Mental Health Services and Community Sector Organisations

Actions:

- Implement the recommendations of the Tasmanian Mental Health Services Consumer and Carer Participation Review, including development of a sustainable mechanism for State-wide consumer support.
- Develop and implement an effective consumer and carer participation framework for Mental Health Services and Community Sector Organisations.

Priority 5. Reduce mental health inequalities

Strategy 1. Consider the mental health and wellbeing needs of people living in rural and remote areas in all initiatives

Actions:

- Support the work of the University of Tasmania and the Centre for Rural and Remote Health to ensure the needs of rural and remote Tasmanians are identified and addressed.
- Increase support for the development of innovations in technology and other approaches that can overcome issues of distance to ensure that people living in rural and remote areas can access health services based in more urban settings.
- Identify ways that people in rural and remote areas can be involved in consumer and carer participation initiatives.

Strategy 2. Build on initiatives for drought-affected farmers, producers and communities

Actions:

- Increase the capacity and sustainability of current initiatives for drought affected farmers and communities, such as Drought Network Tasmania.
- Build on initiatives to reduce the stigma of asking for help to encourage early help-seeking for farmers, particularly those experiencing depression, suicidal thoughts, harmful alcohol and other drug use.
- Enhance initiatives to help prepare farmers for a life after farming, including other modes of economic support and possible transitions to living in more urban areas, in collaboration with the Tasmanian Farmers and Graziers Association and Tasmanian Women in Agriculture.

Strategy 3. Work with relevant policy makers, health organisations and communities to ensure the unique PPEI needs of Tasmanian Aboriginal people are identified and met

Actions:

- Liaise with key stakeholders to determine how this PPEI Strategic Framework aligns with strategies specifically developed with Tasmanian Aboriginal people as well as with national initiatives.

Strategy 4. Support the children of parents with mental illness

Actions:

- Support implementation of the Kids in Mind initiative across Tasmania.

- Develop a mechanism to identify and implement emerging initiatives relevant to Tasmania from the Children of Parents with Mental Illness national initiative.

Strategy 5. Build on health promotion initiatives in justice and correctional settings

Actions:

- Facilitate and enhance the work of Inter Agency Support Teams to identify and support young people at risk.
- Establish a mechanism for the development and sustainability of strong partnerships between Corrections, Mental Health Services, Alcohol and other Drug Services, Youth Justice and Child Protection. This mechanism should facilitate identification of shared clients and ways to provide them with improved support and service access.
- Support mental health promotion initiatives in correctional and justice settings through the PPEI Coordination Unit.

Strategy 6. Address the needs of Tasmania's culturally and linguistically diverse communities

Actions:

- Maintain the Tasmanian Transcultural Mental Health Network.
- Provide access to mental health promotion information in all languages. Importantly, include information acknowledging the strengths and resilience acquired through migration.
- Enable Mental Health Services and Community Sector Organisations to work in partnership with other community groups to identify and reduce barriers to service access for specific culturally and linguistically diverse communities, especially around reducing the stigma of seeking help and ensuring knowledge of how to access services.
- Support initiatives to provide increased support for former refugees and recently arrived migrants, noting their very high level of risk of mental health problems due to exposure to torture, trauma, grief and loss.

Strategy 7. Ensure that changes in risk and protective factors across the lifespan are recognised and appropriately targeted

Actions:

- Ensure workers in Mental Health Services and Community Sector Organisations are aware of key risk factors as they apply across the lifespan, including the life transitions that signify increased risk, such as: school leaving; family breakdown; and significant life events, particularly those involving loss.
- Recognise emerging sexual orientation as a period of increased risk, particularly for same-sex attracted youth. Facilitate implementation of appropriate supports for

same-sex attracted youth.

- Acknowledge older adulthood as an important life stage that deserves special recognition in relation to mental health and wellbeing, as this is a generally neglected area in the PPEI field since the focus is often earlier in the lifespan. There are unique risk and protective factors for mental health in older adulthood, such as loss and grief as common risks. Consequently, all services working with older adults need to identify such risks and refer to appropriate support services when necessary. Furthermore, a stronger focus on positive mental health and wellbeing in older age should be encouraged, particularly within aged care services.

1. Introduction

About 450 million people suffer from mental and behavioural disorders worldwide. One in four Tasmanians will develop one or more of these disorders in their lifetime. According to Saraceno, *'Mental disorders are inextricably linked to human rights issues. The stigma, discrimination and human rights violations that individuals and families affected by mental disorders suffer are intense and pervasive'*[5]. There is now compelling evidence that treatment approaches alone are not sufficient to reduce the prevalence of mental illness and that attention needs to be given to implementing effective prevention and promotion approaches[6,7].

In addition, the 'presence' of positive mental health or wellbeing also influences outcomes such as healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life[8,9,10].

Building the Foundations for Mental Health and Wellbeing provides a Strategic Framework and Action Plan for implementing promotion, prevention and early intervention (PPEI) approaches in Tasmania. It reflects the recognition and commitment by Mental Health Services in Tasmania of the benefits of promotion, prevention and early intervention approaches for the Tasmanian population in enhancing positive mental health, as well as reducing the prevalence of mental disorders.

The Strategic Framework and Action Plan has been developed in collaboration with the Tasmanian PPEI Steering Committee and through stakeholder interviews and focus groups held in three regions of Tasmania: North, North West and South. It has also been informed by the companion document, *Review of Australian and International Mental Health Promotion, Prevention of Mental Ill-health and Early Intervention Policy* undertaken as part of the development of this Framework.

One of the unique features of this Framework has been the articulation of roles and responsibilities of Department of Health and Human Services (DHHS) funded Mental Health Services and Community Sector Organisations in the implementation of the strategies and actions. This reflects the involvement of government and community sectors as well as

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[5] World Health Organization (WHO) (2004a). *Prevention of Mental Disorders: Effective interventions and policy options*. Geneva: WHO, p. 3.
[6] World Health Organization (WHO) (2004b). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.
[7] World Health Organization (2004a). op. cit.
[8] Barry, M. & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier.
[9] World Health Organization (2004b). op. cit.
[10] Jané-Llopis, E., Barry, M., Hosman, C. & Patel, V. (2005). Mental health promotion works: A review. *Promotion and Education*, IUHPE Special Issue 2, 9-25.

clinical and non-clinical services. A comprehensive description of DHHS funded Mental Health Services can be found in Section 2.

Underpinning the Strategic Framework and Action Plan is a conceptual framework articulating a positive construct of mental health and wellbeing, and the factors that influence it. It also provides an overview of the concepts and principles of mental health promotion, prevention of mental ill-health and early intervention. This can be found in Section 4.

Building the Foundations for Mental Health and Wellbeing will provide an overarching framework for all activity in the area of mental health promotion, prevention of mental ill-health and early intervention and will link to a number of other related policies including the development of the Tasmanian Suicide Prevention Strategy. Section 5 provides an outline of the policy context at the international, national and local level in which this Strategy is positioned and emphasises the importance of linkage, consistency and coordination of policy.

The Framework outlines five key priority areas for investment which are linked to five foundations that build support for mental health and wellbeing at a range of different levels.

- **Government**: where the focus will be on enhanced co-ordination and collaborations both within DHHS and with other government departments and the community sector.
- **Community**: where the focus will be on raising awareness of positive mental health and supporting schools, workplaces and community settings to enhance mental health and wellbeing.
- **Families**: where the focus will be on developing strong parent/child attachment and secure, stable family relationships in the early years of life.
- **Service provision**: where the focus will be on creating a mental health service system which enhances and optimises wellbeing for people with mental illness or 'at risk' of mental illness, and empowers consumers and carers to achieve an enhanced quality of life.
- **Society**: where the focus will be to address the factors impacting on the mental health and wellbeing of those disadvantaged, disempowered or 'at risk' of mental health problems and which enhance social inclusion, reduce stigma and discrimination and increase productivity.

Finally, implementation and ongoing evaluation and monitoring of the actions and outcomes are essential in measuring improvement in mental health. These are discussed in Section 8.

Building the Foundations for Mental Health and Wellbeing is a landmark policy for Tasmania in guiding investment in mental health promotion, prevention of ill-health and early intervention. The articulation of the roles and responsibilities of the Tasmanian Mental Health Services and Community Sector Organisations in implementing such approaches will be of world-wide interest.

2. Background

Over the past decade in Australia, promoting mental health and preventing mental ill-health has been a key priority of national mental health policy and reform. This has necessitated changes in the mental health sector to embrace a social view of health and recognise the broader determinants of health. Integrating these concepts in the mental health service system has been challenging. In line with national and international directions, Tasmania is committed to ensuring that mental health services focus on promoting the mental health of the community, preventing, where possible, the development of mental ill-health and reducing the impact of mental disorders on individuals, families and the community as well as providing high quality treatment and rehabilitation services.

The objective of this Strategy is to provide a Strategic Framework and Action Plan for implementing promotion, prevention and early intervention strategies which support mental health and wellbeing in Tasmania and is evidence-based. The Strategy and its implementation will be the responsibility of Tasmania's Mental Health Services and will be implemented across their four service units in mental health promotion, suicide prevention, early intervention, and recovery and relapse prevention. Although the Framework has been developed in the context of the Mental Health Services sector, it also provides direction for the development and further strengthening of inter and intra sectoral partnerships that are essential to achieving the desired outcomes.

Development of the Strategic Framework and Action Plan

The Strategic Framework and Action Plan has been developed in collaboration with the Tasmanian PPEI Steering Committee.

The methodology used to develop the Framework included:

- A national and international review of mental health policy.
- Focus groups with key stakeholders.
- Structured interviews with key informants.
- Planning workshop with key stakeholders.

The review of mental health policy has been an important component of the development of the Strategy because it positions Tasmania in the context of the national and international arena. The conceptual frameworks and principles underpinning this framework are current and reflect the developments occurring globally. However, in reviewing the policy, it is also clear that there is a gap in policy in articulating the roles and responsibilities of mental health services in relation to promotion, prevention and early intervention. One of the unique features of this Strategy is its articulation of the role of mental health services in promoting mental health and preventing mental ill-health.

Seven focus groups and 26 interviews were conducted in three locations: Hobart, Ulverstone and Launceston. 84 stakeholders participated in the consultation process. 40 participants

from the interviews and focus groups were subsequently invited to participate in a planning workshop to develop the priority areas for the Strategy. Focus group and interview participants were selected from within DHHS such as mental health, population health, alcohol and other drugs, housing, social inclusion, corrections as well as external to DHHS including education, police, justice, and local government and community organisations. Mental health stakeholders included government and community sector organisations, clinical and non-clinical service providers and consumer and carer representation.

Overview of Mental Health Services in Tasmania

The mental health services sector in Tasmania consists of both government and community sector, clinical and non-clinical services providing a range of clinical, rehabilitation and support services to children, young people, adults and older people who have a mental illness or mental disorder or 'at risk' of experiencing mental illness and mental disorder.

As outlined in Tasmania's Mental Health Services Strategic Plan 2006 - 2011, Mental Health Services are delivered through three regions: the North, North West and the South. The key service components funded by Mental Health Services are reflected in the following diagram:

Figure 1: Tasmanian Mental Health Services major service components

The key service components funded by Mental Health Services include:

Child and Adolescent Mental Health Services for consumers aged from birth to 17 years. Most services are delivered as community based services.

Adult Mental Health Services which are divided into Community and Inpatient/Extended Care Services. Acute inpatient services are provided in the three general hospitals: Royal Hobart, Launceston General and North West Regional as well as a State-wide psychiatric intensive care unit at the Royal Hobart Hospital and additional extended care facilities in Hobart and New Norfolk.

There are a number of adult community centres across the state delivering a range of mental health services to urban and rural communities. In Launceston and Hobart there are also specialist community based teams delivering crisis, intensive support and rehabilitation services.

Mental Health Services for Older People consist of acute inpatient assessment and treatment services, day centre and community services as well as a Dementia Support Unit which is part of the Commonwealth Government Psychogeriatric Unit Program.

Community Sector Services such as supported accommodation, rehabilitation, peer support and carer support which are provided by community sector organisations such as Aspire and Richmond Fellowship.

3. About Tasmania

In developing the Strategic Framework it has become clear that there are some important contextual issues that need to be acknowledged. These include:

- Rurality of Tasmania featuring a small regionally dispersed population.
- Sustainability of agriculture and primary industry in the context of climate change and drought.
- Growing ageing population.
- Unique features of Tasmanian Aboriginal people and culturally and linguistically diverse populations.
- Broader health and social issues impacting on mental health and wellbeing.

Geography and environment

The island State of Tasmania, including the smaller islands, comprises 68,102 km^2 or approximately 0.9 per cent of the total area of Australia. At its greatest length, Tasmania spans 296 kilometres from north to south; and its greatest width, is 315 kilometres from east to west.[11]

The major population centres in Tasmania are Hobart in the South, Launceston in the North and Burnie and Devonport in the North West. For the purposes of DHHS planning and service delivery, the State's 29 Local Government Areas (LGAs) are categorised into seven Primary Health coordination areas within three catchment populations (North, North West and South).

The issue of rurality is highly relevant in Tasmania. Based on the Remoteness Structure classification employed by the Australian Bureau of Statistics (ABS), 64.7 per cent of the population live in Inner Regional locations, 33.2 per cent in Outer Regional, 1.5 per cent in Remote and 0.5 per cent in Very Remote. There is considered to be no Major City location in Tasmania.

In addition 27 per cent of the Tasmanian population live in a Major Urban (population of 100,000 or more) section of the State; 45.6 per cent in Other Urban (population of 1,000 to 99,999); 6.9 per cent in Bounded Locality (population of 200 to 999); and 20.4 per cent in Rural Balance (the remainder of the State)[12]. This contrasts with other jurisdictions in which, with the exception of the Northern Territory, between 64 to 99 per cent live in a Major Urban section of the state/territory and between 73 to 99 per cent reside in a Major City.

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[11] Australian Bureau of Statistics (2008). *Tasmania at a Glance*, *2008*, Catalogue no. 1305.6.
[12] Australian Bureau of Statistics (2008). *National Regional Profile: Tasmania.*

According to the Garnaut Climate Change Review[13], as a result of climate change Tasmania will begin to experience small changes in climate resulting in warmer weather, increasing storm events and decreased livestock capacity. In 2007 Tasmania experienced its warmest year on record and below average rainfalls, particularly along the east coast and southern midlands. A CSIRO evaluation of 13 climate change models (where Tasmania and Victoria are considered one region) predicted that the extent and frequency of extremely hot and dry years will increase in the future. It is expected that between 2010-2040, extremely hot years will be experienced by approximately 75 per cent of the region every 1.3 years on average, 10 per cent will experience years of extremely low rainfall approximately every 12 years, and that by 2030, 11 per cent of the region will experience extremely low soil moisture every nine years[14]. These changes in climate have considerable implications for Tasmania's rural and farming populations, already struggling under the impact of the drought, in relation to agricultural and community sustainability.

Population

As of June 2007, Tasmania's population was 493,300 people[15], and is now estimated to have reached 500,000[16] people, marking an overall population increase of approximately 3.3 per cent since the year 2001. Tasmania's population is projected to increase slowly before leveling out by around 2040 and then decreasing marginally from 2051 onwards (571,000 people in 2056)[17].

Tasmania's small population is one of the most regionally dispersed of any Australian jurisdiction. More than half the State's population lives outside the capital city. At 30 June 2007, 42.1 per cent of the Tasmanian population lived in the Greater Hobart capital city region, with 22.3 per cent in the North West and 28.3 per cent in the North, and 7.4 per cent in the Southern region outside Greater Hobart. Most of Tasmania's 29 LGAs experienced population growth in the year to June 2008. Three of the five fastest growing LGAs were within commuting distance of inner-city Hobart[18]. Across the 29 LGAs, five account for approximately 50 per cent of Tasmania's population. These include:

- Launceston (64,620)
- Clarence (50,808)
- Hobart (49,556)
- Glenorchy (44,179)

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[13] Garnaut, R. (2008). *Garnaut Climate Change Review: Final report*. Cambridge University Press.
[14] Australian Bureau of Statistics (March, 2009). *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[15] Australian Bureau of Statistics (March, 2009). *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[16] Tasmanian Government media release, 18 March 2009: www.media.tas.gov.au/release.php?id=26241 (last accessed 3 April, 2009).
[17] Australian Bureau of Statistics. *Population Projections, Australia, 2006-2101*, Catalogue no. 3222.0.
[18] Australian Bureau of Statistics. *Regional Population Growth, Australia, 2006-07*, Catalogue no. 3218.0.

- Kingborough (31,706)[19]

Tasmania's regions have different age structures. For example the Greater Hobart Statistical Division (SD) has a relatively higher proportion of 15 to 29 year olds, while the Southern SD has a relatively higher proportion of 45 to 59 year olds[20]. This has implications for planning and delivery of services and programs relevant to the needs of local populations. Overall, the median age of the population is approximately 39.1 years compared to the Australian average of 36.9 years.

The Tasmanian population is ageing at a faster rate than all other Australian states and territories. The proportion of the population aged 65 and over increased from 12.8 per cent of the population in 1996 (12.1 per cent Australia) to 14.9 per cent in 2006 (13.3 per cent Australia), and is estimated to be 23 per cent by the year 2021. The proportion of persons aged 85 years and over increased from 1.2 per cent in 1996 to 1.8 per cent in 2006[21,22].

Declining fertility and increased life expectancy are the main reasons for Tasmania's ageing population. Migration driven losses have also resulted in a 16.4 per cent rise in the number of residents aged 45 years and over, and an 8.2 per cent decline in the number of residents aged under 45 years[23]. Tasmania's population is therefore ageing both numerically (an increase in the number of people aged 65 years and over) and structurally (an increase in the proportion of a population aged 65 years and over).

Tasmanian Aboriginal people

In 2006, 455,028 people in Australia identified as Aboriginal and Torres Strait Islander in the Australian Bureau of Statistics (ABS) Census count. This represents an 11 per cent increase between the 2001 and 2006 Censuses, and an approximate 100 per cent increase over the past twenty years[24].

In 2006, 3.5 per cent of the Tasmanian population identified as Aboriginal and Torres Strait Islander (16,900 people)[25]. Of this total number, approximately 88 per cent identified as Aboriginal, 7 per cent identified as Torres Strait Islander, and 3 per cent identified as both

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[19] Demographic Change Advisory Council (2008). *Tasmania's Population 1996-2006: What's changed? Information Paper No. 3*. Hobart: Government of Tasmania.

[20] Australian Bureau of Statistics (March, 2009). *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

[21] Australian Bureau of Statistics. *Population Projections, Australia, 2006-2101*, Catalogue no. 3222.0.

[22] Australian Bureau of Statistics (April, 2008). Feature Article: 'Ageing in Tasmania 2006 (selected indicators)' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

[23] Demographic Change Advisory Council (2008). *Tasmania's Population 1996-2006: What's changed? Information Paper No. 3*. Hobart: Government of Tasmania.

[24] Australian Bureau of Statistics (2006). *Population Distribution, Aboriginal and Torres Strait Islander Australian*s, Catalogue no. 4705.0.

[25] Australian Bureau of Statistics (2006). *Population Characteristics, Aboriginal and Torres Strait Islander Australians, Tasmania*, Catalogue no. 4713.6.55.001.

Aboriginal and Torres Strait Islander[26]. In this Strategy, the term **'Tasmanian Aboriginal people'** is used to refer to all Aboriginal and Torres Strait Islander populations in Tasmania.

The majority of Tasmanian Aboriginal people are located in the South (47.9 per cent), followed by the North West (31.9 per cent) and the North (20.1 per cent). The Aboriginal population has a younger age structure than the general population. Among Tasmanian Aboriginal people in 2006:

- Children (aged 0 to 14 years) accounted for 36.3 per cent of the population, nearly double the proportion of children in the general Tasmanian population (19.7 per cent).
- More than half (57 per cent) of Tasmanian Aboriginal people are under the age of 25 years.
- The working age population (aged 15 to 64 years) accounted for 60.4 per cent compared with 65.3 per cent for the general Tasmanian population.
- Older persons (aged 65 years and over) accounted for 3.4 per cent compared with 14.9 per cent for the general Tasmanian population.
- The median age of Tasmanian Aboriginal people was 20 years compared with 40 years for the general Tasmanian population[27].

Aboriginal and Torres Strait Islander Australians have the lowest health status of any identifiable population group in Australia. Life expectancy for Aboriginal and Torres Strait Islander peoples is 15 to 20 years less than the general community and prevalence of disease is up to 12 times higher than the Australian average. In a 1998 survey, Tasmanian Aboriginal people reported that:

- 46 per cent did not drink or only rarely drank alcohol (compared with 40 per cent of the general Tasmanian population).
- 31 per cent drank at least once a week (compared with 43 per cent of the general Tasmanian population).
- 42 per cent were smokers (compared with 25 per cent of the general Tasmanian population).
- 12 per cent had excellent health (compared with 13 per cent of the general Tasmanian population).
- 24 per cent had fair or poor health (compared with 18 per cent of the general Tasmanian population).
- 24 per cent had experienced depression.
- 8 per cent had seriously contemplated taking their own life[28].

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[26] Australian Bureau of Statistics (2006). *Population Distribution, Aboriginal and Torres Strait Islander Australians,* Catalogue no. 4705.0.

[27] Australian Bureau of Statistics (April, 2008). Feature Article: 'Ageing in Tasmania 2006 (selected indicators)' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

[28] Australian Bureau of Statistics (2006). *Statistics, Tasmania*, Catalogue no. 1384.6.

Tasmania's culturally and linguistically diverse populations

The World Health Organization estimates that more than 50 per cent of migrants worldwide have a mental health problem. These range from severe mental illness to trauma and distress. This is more prominent in those who have fled persecution[29].

The Australian Government Department of Immigration and Citizenship recognises that Humanitarian Program refugee arrivals generally have the highest settlement needs due to their pre-arrival experiences[30].

'The fact that most refugees have survived horrific experiences, and yet have re-established their lives in Australia, is evidence of their enormous survival strengths. Nevertheless they suffer a higher incidence of physical and mental health problems than migrants and people born in Australia'[31].

Furthermore, refugees who are ageing face additional risks to their health and wellbeing including mental health vulnerability, family stress, social and emotional isolation and more barriers to accessing services[32].

In 2006, 10.6 per cent of Tasmania's population was born overseas. This compares with 22.2 per cent of Australia's total population. In 2007-08 the top five countries of origin of permanent additions to Tasmania were the United Kingdom (263 persons), New Zealand (131 persons), the Peoples Republic of China (130 persons), India (102 persons), and South Africa (80 persons). In addition, of the 244 Humanitarian Program permanent additions, 15.6 per cent were born in Sudan, 14.3 per cent in the Democratic Republic of Congo and 13.9 per cent in Burma (Myanmar). Of all immigration categories, Tasmania accepts the highest proportion of Humanitarian Program settlers of all jurisdictions[33]. The health issues of refugee arrivals to Tasmania have been identified as 'a critical concern', especially in relation to accessing services such as appropriate counseling in relation to their pre-arrival experiences of torture and trauma[34].

Adults and young people in custodial settings

Adult prison and juvenile detention centre populations are widely recognised as one of the most disadvantaged and stigmatised populations in society. Individuals from disadvantaged backgrounds, low educational achievement, histories of unemployment, and high rates of

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[29] Multicultural Mental Health Australia (MMHA) (2007). *Mental Health in a Changing World: The impact of culture and diversity.* MMHA.

[30] Department of Immigration and Citizenship (DIAC) (2007). *Tasmania: Settlement trends and needs of new arrivals 2007*. Canberra: DIAC.

[31] Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) (2006). *Out of the Abyss: Australia's program of assistance to survivors of torture and trauma.* Brunswick: FASSTT, p.3.

[32] Atwell, R.S., Correa-Velez, I. & Gifford, S.M. (2007). Ageing Out of Place: Health and well-being needs and access to home and aged care services for recently arrived older refugees in Melbourne, Australia. *International Journal of Migration, Health and Social Care,* 3(1), 4-14.

[33] Department of Immigration and Citizenship (DIAC) (2009). *Population Flows: Immigration Aspects 2007-08.* Canberra: Economic Analysis Unit, Migration and Visa Policy Division, DIAC.

[34] Ibid.

substance use are over-represented among these populations in Australia[35]. Furthermore, Aboriginal and Torres Strait Islander adults are 13 times more likely to be imprisoned relative to the general Australian population[36]. More than half of young people aged 10 to 17 years in juvenile corrective institutions in Australia in 2006 were Aboriginal and Torres Strait Islander[37].

International research has found that people with a mental illness are over-represented in adult prisons. A meta-analysis of sixty-two prison mental health surveys found that prisoners were substantially more likely to have psychotic illness, major depression, and a personality disorder than the general population[38]. Suicide has consistently been the leading cause of death in Australian adult custodial settings over the past two decades (36 per cent for females and 44 per cent for males)[39]. Furthermore 43 per cent of detainees in Australia (across selected sites) are considered dependent on illicit drugs, and 32 per cent are considered dependent on alcohol. Among adult detainees who self-reported using alcohol or an illicit drug in a previous 12 month period, 16 per cent said they were currently in a treatment program. One third of detainees attributed at least some of their offending to their drug use (excluding alcohol)[40]. In one Australian jurisdiction approximately 60 per cent of females and 50 per cent of males in custody with a substance use disorder also have a mental illness[41].

The Drug Use Monitoring in Australia (DUMA) program reported that for most detainees who self-reported regular use of a drug, first use usually begins with alcohol or cannabis at around the age of 14 years. For drugs other than cannabis or alcohol, the average age of first arrest reported by both male and female detainees was younger than the average age at which they began regular drug use.

Since 2005 (in selected sites only), there has been an increase in the percentage of juvenile detainees who self-reported being in a juvenile detention centre in the past year (3 per cent in 2005, 14 per cent in 2006, and 22 per cent in 2007)[42].

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[35] Butler, T. & Allnutt, S. (2003). *Mental Illness Among New South Wales' Prisoners.* NSW Corrections Health Service.

[36] National Indigenous Drug and Alcohol Committee (2009). *Bridges and Barriers: Addressing Indigenous incarceration and health*. Canberra: Australian National Council on Drugs.

[37] Australian Institute of Criminology (AIC) (2008). *Australian Crime Facts and Figures 2007*. Canberra: AIC.

[38] Fazel, S. & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359,* (9306), p. 545-550.

[39] Collins, L. & Mouzos, J. (2002). Deaths in Custody: A gender-specific analysis. *Trends and Issues in Crime and Criminal Justice No. 238*. Canberra: Australian Institute of Criminology.

[40] Adams, K., Sandy, L., Smith, L. & Triglone, B. (2008). Drug use monitoring in Australia: 2007 annual report on drug use among police detainees. *Research and Public Policy Series, No. 93*. Canberra: Australian Institute of Criminology.

[41] Australian Government National Drug Strategy (2008). National Corrections Drug Strategy 2006-2009. Canberra: Australian National Council on Drugs.

[42] Ibid.

In Tasmania:

- The average daily adult prison population (2008-09) (inclusive of all Tasmanian prisons including Risdon Prison, Hobart Reception Prison, Launceston Reception Prison, Hayes Prison Farm, and the Women's Prison) was 490 males and 40 females.
- Of the total 530 prisoners, 85 per cent were identified as non-Indigenous, and 15 per cent Aboriginal and Torres Strait Islander[43].
- The average age of adult prisoners was 34 years and the average sentence was 4.7 years.
- Among a ten per cent sample of men who presented at prison health services in March - April 2008, 25 per cent exhibited suicide and self-harm behaviour, 13 per cent exhibited major mental illness (psychosis and bipolar disorder), up to 56 per cent reported illicit drug use (of various types), and 82 per cent reported alcohol use. Only 1.5 per cent of this sample did not exhibit suicide and self-harm behaviour, mental illness, or drug and alcohol use[44].
- In a study which examined one year of data (2004-2005) on young people remanded in custody in Tasmania, it was reported that juveniles placed in detention on remand were predominantly male and three quarters of them were aged between 15 and 17 years (however the age range was between 11 to 18 years). 19 per cent of juveniles identified as being of Aboriginal and Torres Strait Islander origin. Just under one half (45 per cent) of the juveniles were placed on remand more than once during the one year period.
- Between July 2004 to June 2005, there was an average of 33.4 juveniles per day being held in the Ashley Detention Centre, and a total of 113 juveniles on detention at least once during the 12 month period. This included 96 boys and 17 girls[45].

Gay, lesbian, bisexual, transgender and intersex populations

There is a growing awareness in Australian and international literature of sexual orientation and gender identity as key social determinants of health and mental health. Gay, lesbian, bisexual, transgender and intersex (GLBTI) populations experience high rates of social exclusion and discrimination as a result of their sexual orientation or gender identity. Social determinants such as socio-economic status, geographic location, racial background, and physical and intellectual disability interact with sexual orientation and gender identity to produce health concerns specific to GLBTI communities. In addition critical life stages such as adolescence to early adulthood, entering the workforce, child-rearing, and loss of a partner, pose additional stressors for GLBTI individuals.

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[43] Tasmanian Department of Justice, Annual Statistics, www.justice.tas.gov.au/__data/assets/pdf_file/0009/87957/Prison_Statistics_ROGS.pdf#Annual%20Statistics

[44] Wake, C.J. (2008). *Risdon Prison: Are we up to speed?* Presented at: First Annual ATDC Conference: ATOD Practice, Integration and Development. 28-30 April, 2008. Hobart, Tasmania: http://www.atdc.org.au/uploaded_pdf/ATDCConferenceCWake.pdf

[45] Tresidder, J. & Putt, J. (2005). *Review of Data on Juvenile Remandees in Tasmania: Final report*. Canberra: Australian Institute of Criminology.

It has been found that there are no significant differences in happiness, overall adjustment or psychiatric status between GLBTI and heterosexual populations. However, it is clear that exposure to discrimination is linked to psychological distress and mental disorders. This suggests that same-sex attraction and transgenderism are not in themselves risk factors for mental illness. Rather, it is the impact of homophobia, transphobia and a range of other social prejudices which marginalise and isolate certain sections of GLBTI communities (including HIV positive people), resulting in poor mental health outcomes. In the research literature internationally it has been reported that[46]:

- Mental health issues were the third most common subject raised in submissions from GLBTI individuals and organisations to a Victorian hearing. They included concerns about depression, anxiety, suicide, isolation, marginalisation, homelessness, and the lack of appropriate counseling services for GLBTI people.
- An Australian study of 403 gay men reported that 27 per cent of respondents were suffering major depression.
- In a study of 200 lesbians, 60 per cent reported feelings of depression related to their sexual orientation, while 63 per cent had contemplated suicide, and 30 per cent had attempted suicide.
- Studies suggest that the suicide rate among gay men and lesbians is two to seven times higher than among heterosexuals. Same-sex attracted youth are reported to be six times more likely to attempt suicide than the general population.
- Same-sex attracted people living in rural areas are particularly at risk of suicide.
- Depression has been identified as a major mental health issue for bisexual men, and rates of depression among transgender people are reported to be even higher than among gay men and lesbians.
- The use of alcohol and other drugs has been found to be higher across all age groups in GLBTI populations.

A Tasmanian study focusing on the experiences of GLBT populations in Tasmania, found similar levels of stigma, discrimination and social exclusion as reported in the international literature. However, given the small, decentralised and rural nature of Tasmania's population, GLBT individuals expressed an increased sense of isolation. Key health and wellbeing issues for GLBT populations identified in the study included, lack of support networks and a sense of 'community', the need for access to support services during the critical 'coming out' life stage for individuals, the impact of homophobia/transphobia ranging

[46] All studies reported here are referenced in: Ministerial Advisory Committee on Gay and Lesbian Health (2002). *What's the Difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians: Research paper*. Melbourne: Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services.

from underlying apprehension to violence and bullying, and discrimination and ignorance by health workers resulting in reduced access to health services by GLBT populations[47].

Health and mental health

The Australian Institute of Health and Welfare has reported that, compared to those living in Major Cities, people in Inner Regional, Outer Regional and Remote/Very Remote areas have 20 per cent higher reported rates of fair or poor health[48]. Life expectancy at birth for males in Tasmania is 77.4 years (79.0 years Australia) and for females is 82.3 years (83.7 years Australia)[49]. The standardised death rates for most causes of death have fallen in the last 10 years with the exception of:

- Mental and behavioural disorders - up from 15.9 deaths per 100,000 population to 27.7 deaths per 100,000.
- Intentional self-harm - up from 11.2 deaths per 100,000 to 14.7 deaths per 100,000.
- Diabetes mellitus and transport accidents[50].

It is widely recognised that mental illness is a substantial burden for individuals and communities in Australia. In brief:

- At any one point in time, 2-3 per cent of the Australian adult population will be affected by severe mental illness, 4-5 per cent by moderate to severe mental illness, and 9-10 per cent by moderate mental illness[51].
- Mental illness ranks fourth as the major cause of life-years lost (after heart attacks, stroke and cancer).
- Mental illness typically affects people at important developmental stages such as late adolescence and early adulthood.
- Up to 14 per cent of children and adolescents experience mental health problems each year, with the potential for long term disability.
- One in five adults, or approximately 60,000 Tasmanians per year experience mental ill-health including depression or anxiety, with contributing issues such as alcohol or substance use.

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[47] Blanch Consulting Pty Ltd. (2003). *Gay, Lesbian, Bisexual and Transgender Health and Wellbeing Needs Assessment*. Tasmanian Department of Health and Human Services' Gay, Lesbian, Bisexual and Transgender Reference Group.

[48] Australian Institute of Health and Welfare (2008). *Rural, Regional and Remote Health: Indicators of health status and determinants of health*. Rural Health Series no. 9. Catalogue no. PHE 97.

[49] Australian Bureau of Statistics (2008). *Tasmania at a Glance*, *2008*, Catalogue no. 1305.6.

[50] Australian Bureau of Statistics (March, 2009). 'Health' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

[51] Mental Health Standing Committee (2008). *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*. Canberra: Australian Health Ministers Advisory Council.

- In the years 2001-2005, Tasmania had rates of suicide 39 per cent above the national rate[52].
- The 2004-05 National Health Survey found that over two-thirds of Tasmanians experienced low levels of psychological distress, 20.1 per cent reported moderate levels of stress, and 8.8 per cent reported high levels of stress[53].

Alcohol and other drugs

The use of drugs in Australia contributes to significant illness and disease, injuries, workplace concerns, violence, crime, breakdowns in relationships and families, and other social problems within communities. Prevention and early intervention activities seek to improve social, health and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs[54].

In 2004, 15 per cent of Tasmanians reported illicit drug use in the previous 12 months. This is a higher percentage than reported in NSW and Victoria. Among Tasmanian males (14 years or older) in 2007, more than 12 per cent were at risk of alcohol-related harm in the long-term. After the Northern Territory, this was the highest proportion of all Australian states and territories. For females, more than 11 per cent were at risk of alcohol-related harm in the long-term. The proportion of Tasmanian males and females at risk of alcohol-related harm in the short-term, was also higher than the Australian average[55].

Among Alcohol and Drug Services clients, symptoms of mental ill-health are common. Whilst psychosis, whether drug induced or as a dual diagnosis can have a large impact on services, the majority of clients exhibit symptoms of one of the high prevalence disorders: depression or anxiety. According to the Australian Institute of Health and Welfare, about one in four persons with an anxiety, affective or substance use disorder also had at least one other mental illness[56]. Among those with psychotic disorders, 30 per cent had a medical history of alcohol abuse or dependence, 25 per cent of cannabis abuse and 13 per cent of other substance abuse or dependence[57].

Among people with a mental illness, abuse of certain types of substances, particularly alcohol and cannabis, appears to be most common, and where drug abuse occurs, it often

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[52] Australian Bureau of Statistics (2007). *Suicides Australia 2005*, Catalogue no. 3309.0.

[53] Australian Bureau of Statistics (March, 2009). 'Health' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

[54] Ministerial Council on Drug Strategy (2004). *The National Drug Strategy: Australia's integrated framework: 2004-2009*. Canberra: Australian Government.

[55] Australian Institute of Health and Welfare (AIHW) (2008). *2007 National Drug Strategy Household Survey: State and territory supplement*. Drug Statistics Series no. 21. Catalogue no. PHE 102.

[56] Hall, W., Lynskey, M. & Teesson, M. (2001). What is comorbidity and why does it matter? In M. Teesson & L. Burns (Eds.), *National Comorbidity Project*. Canberra: Commonwealth Department of Health and Aged Care, 11-17.

[57] Jablensky, A., McGrath, J., Herrman, H., Castle, C., Gureje, O., Morgan, V. & Korten, A. (1999). *People Living with Psychotic Illness: An Australian Study 1997-98. National Survey of Mental Health and Wellbeing - Report 4.* Canberra: Mental Health Branch, Australian Commonwealth Department of Health and Aged Care.

co-exists with alcohol abuse[58]. Studies have shown that moderate to heavy alcohol use has been associated with exacerbation of depressive symptoms in major depression; increased frequency of admissions and more rapid cycling in those with bipolar disorder, and increased readmissions in those with psychotic disorders. Cannabis use has been associated with increased positive symptoms (hallucinations, delusions and thought disorder), increased rates of rehospitalisation and shorter relapse time in people with schizophrenia[59].

Dual diagnosis is associated with a host of social, behavioural, psychological and physical problems, including:

- Increased symptom severity and suicidal behaviour[60]
- Greater non-compliance with treatment[61]
- More hostile and aggressive behaviours[62]
- Increased risk of violence to others[63]
- Higher rates of offending, imprisonment and homelessness[64].

Education and literacy

In August 2007, there were 81,859 full-time primary and high-school students in Tasmania. The age participation rates for full-time students in August 2007 were 99.6 per cent for 14 year olds, 100.0 per cent for 15 year olds and 84.7 per cent for 16 year olds. The participation rate for 17 year olds in Tasmania (63.3 per cent) was higher than for Western Australia (40.2 per cent), the Northern Territory (44.9 per cent) and Queensland (47.8 per cent). The apparent retention rate of full-time Tasmanian students from Year 7/8 to Year 12 was 65.4 per cent. This varied significantly by gender with 73.9 per cent for females in 2007, and 57.4 per cent for males.

Results of testing conducted in 2006 to identify the achievement of students in each of the Years 3, 5 and 7 as measured against national benchmarks show that the large majority of

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[58] Rassool, G.H. (2002). Substance misuse and mental health: An overview. *Nursing Standard*, 16(50), 47-53.

[59] Todd, F.C., Sellman, D. & Robertson, P.J. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. *Australian and New Zealand Journal of Psychiatry*, 36(6), 792-799.

[60] Wright S., Gournay K., Glorney E. & Thornicroft, G. (2000). Dual diagnosis in the suburbs: Prevalence, need, and in-patient service use. *Social Psychiatry Psychiatric Epidemiology*, 35(7), 297-304.

[61] Ibid.

[62] Gafoor, M. & Rassool, G.H. (1998). The co-existence of psychiatric disorders and substance misuse: Working with dual diagnosis patients. *Journal of Advanced Nursing*, 27(3), 497-502.

[63] Wright et al., op. cit.

[64] Wright et al., op. cit.

primary school students in these Years are achieving at the benchmark level or better in reading, writing and numeracy[65].

The 2006 Adult Literacy and Life Skills Survey found that the literacy skills of Tasmanians aged 15 to 74 years were consistently below the national average across all domains. Less than half of Tasmanians were assessed as having adequate numeracy skills to effectively manage and respond to the mathematical demands of diverse situations. Around one-third were assessed as having sufficient health literacy skills to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, first aid and staying healthy. Only approximately one-quarter of Tasmanians were assessed as having sufficient problem solving skills to meet the complex demands of everyday life and work[66].

Social issues

In 2005-06 more Tasmanians were living below the poverty line than in any other jurisdiction. 13 per cent of Tasmanians were living in households earning less than 50 per cent of the median equivalised disposable income, and 24 per cent were living below the 60 per cent median poverty line[67].

The rate of homelessness in Tasmania has remained fairly consistent between 2001 and 2006 Census counts. In 2006 there were 2,507 homeless people in Tasmania. This represents a rate of 53 per 10,000 which is consistent with the Australian rate[68]. The number of homeless young people aged 12 to 18 years in Tasmania decreased between 2001 and 2006 from 1,008 to 770 individuals. It has been suggested that this decline is mainly due to an increase in early intervention services targeting homeless and at risk young people since 2001. In 2006, the homeless youth rate in Tasmania was 16 per 1,000. This is higher than the Australian rate of 11 per 1,000[69].

In 2005-06, Tasmania had the highest proportion of households dependent on welfare as their main source of income (31.5 per cent)[70]. Low-income households are experiencing additional hardship with the rising cost of essentials (food, electricity, housing, transport and health). For an unemployed couple with two children it is estimated that this would take up

[65] Australian Bureau of Statistics (March, 2009). 'Education' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[66] Australian Bureau of Statistics (2008). Feature Article: 'Adult literacy in Tasmania' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[67] Saunders, P., Hill, T. & Bradbury, B. (March, 2008). *Poverty in Australia: Sensitivity Analysis and Recent Trends*. SPRC Report 4/08, Social Policy Research Centre, Table 23, p.44.
[68] Chamberlain, C. & MacKenzie, D. (2008). *Counting the Homeless, Australia, 2006.* Australian Bureau of Statistics, Catalogue no. 2050.0.
[69] MacKenzie, D. & Chamberlain, C. (2008). Youth homelessness 2006. *Youth Studies Australia,* 27(1), 17-25.
[70] Australian Bureau of Statistics (2008). *Australian Social Trends*, Catalogue no. 4102.0.

93.5 per cent of their welfare entitlement, leaving little room for emergency expenses or savings[71].

Tasmania had one of the highest average Deprivation Index scores of all states and territories in a 2006 study. The study analysed the extent to which people are unable to access essentials such as medical treatment if needed, warm clothes and bedding, a substantial meal at least once a day, and a reasonable quality and secure home[72].

Tasmania had the second-highest proportion of people living in disadvantaged communities of all states and territories in 2006, after the Northern Territory. 38,600 people (or 8.2 per cent of the Tasmanian population) lived in the most disadvantaged 5 per cent of Census Collection Districts in Australia[73].

Summary

The information provided in this Section provides a contextual basis for the priorities, strategies and actions defined in Section 7.1 (Priorities for Strategic Actions). Underpinning the Strategic Framework as a whole are several key factors of relevance to Tasmania. These include the issue of rurality and the distribution of a relatively small population across a number of population centres and rural areas; the impact of climate change and drought on the productivity, health and wellbeing of individuals and communities; the growing ageing population; unique features of the Tasmanian Aboriginal and culturally and linguistically diverse populations; and a range of significant social issues including poverty, homelessness, substance use, isolation and disadvantage.

The issues and population groups identified in this Section are, in particular, reflected in the strategies and actions identified in Priority 5 of Section 7.1. Priority 5 focuses on reducing mental health inequalities. On the basis of available information and data outlined in this Section, several populations have been prioritised for action in recognition of increased disadvantage and risk factors for mental ill-health. While overall the Strategic Framework applies to all Tasmanians, and the populations highlighted in Priority 5 are not the only population groups of importance in Tasmania, they are of particular significance from an equity perspective. The focus of strategies and associated actions identified in Priority 5 has been to promote the best possible mental health and wellbeing outcomes for identified populations (including age groups across the lifespan) by enhancing social inclusion, community and economic participation, mental health and mental illness literacy, and access to appropriate supports and services.

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[71] Tasmania Together 2020, Benchmark Reports, Indicator 1.1.1 www.tasmaniatogether.tas.gov.au/obr/benchmark_reports

[72] Saunders, P., Naidoo, Y. & Griffiths, M. (November, 2007). *Towards New Indicators of Disadvantage: Deprivation and social exclusion in Australia*, Social Policy Research Centre, University of New South Wales, Table 7, p.58.

[73] Australian Bureau of Statistics (2006). *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia - Data only*, Catalogue no. 2033.0.55.001.

4. Conceptual Framework and Evidence Base

The Strategic Framework and Action Plan has been developed consistent with key concepts and principles, and contemporary directions, in promotion and prevention policy internationally. These include:

Population health approach

A population health approach recognises that health and illness (including mental health and mental illness) are influenced by the settings and events of everyday life and result from a complex interplay of biological, psychological, social, environmental, economic and political factors. This approach is closely aligned with the concept 'social determinants of health' in which the association between social environment and health outcomes throughout the life course independent of individual risk factors is critical.

A population health model focuses on the status and health needs of whole populations and implements interventions to promote health and reduce ill-health across whole population groups. It acknowledges the full range of protective and risk factors that influence health at all levels (such as for individuals, communities and societies). Protective factors are those which enhance and protect positive health and mental health and reduce the likelihood that a problem or disorder will develop. Risk factors increase the likelihood that a problem or disorder will develop and may exacerbate the burden of existing ill-health. Risk factors may include genetic, biological, behavioural, socio-cultural and demographic conditions and characteristics.

The majority of protective and risk factors for mental health reside outside the sphere of health and mental health services such as in workplaces, families, schools, correctional facilities, recreational and cultural settings. Therefore in order to make changes to the conditions which impact on mental health, a population health approach emphasises the need for long-term and sustained participation and commitment across levels of government, multiple sectors, and the community.

Positive concept of mental health

Growing support for the concept of positive mental health is reflected in emerging conceptual frameworks such as quality of life, positive psychology, wellbeing and happiness. Fundamental to a positive concept of mental health is the distinction between 'mental health' and 'mental illness', and the place of mental health as an overall component of health. Traditionally, policies and services concerned with 'improving mental health' have in reality focused on mental ill-health, particularly on provision of access to services and stigma related issues. This has resulted in conceptual confusion for policy makers, service systems and communities broadly about how mental health and mental health promotion are defined, and how a positive concept of mental health fits within the full range of promotion,

prevention and early intervention activity. A positive concept of mental health embraces the notion that mental health is a desirable quality in its own right and is more than the absence of the symptoms of mental illness. It moves beyond a medical view of mental health and supports the concept of 'mental health and wellbeing'. Mental health and wellbeing is impacted on by a range of circumstances for individuals and communities such as quality of housing, economic stability, family relationships, and employment opportunities. It encompasses notions such as resilience in the face of adversity, purpose in life, self-acceptance, social contribution and personal growth. Furthermore, it is based on the principle that mental health is relevant for the entire population, irrespective of the presence or otherwise of mental illness.

According to Antonovsky, 'promoting mental health as a positive concept belongs to the family of salutogenic concepts, that is, concepts that explore the origin of health not disease'[74]. The salutogenic approach which focuses on the causes of health rather than the causes of disease (pathogenesis) is synergistic with a positive construct of mental health.

The Dual Continua Model of Mental Health[75] provides a useful framework for understanding the relationship between mental health and mental ill-health. It challenges the assumptions that the absence of mental illness equates to the presence of mental health and that measures of mental health belong to a single 'two-headed' continuum. A 'flourishing' approach to promoting and protecting mental health supports the theory that mental health and mental illness belong to two separate, but interconnected continua in which optimal mental wellbeing is considered 'flourishing' and minimal wellbeing 'languishing'. According to this view a person can experience signs and symptoms of mental illness and still have good or flourishing mental wellbeing. Similarly, a person may have significant mental health problems, but not have a clinically identifiable mental illness. This approach is being adopted in leading international promotion and prevention policy particularly in Scotland, Wales, England and Canada. Organisations in Australia such as the Australian Centre on Quality of Life at Deakin University, the Australia Institute, VicHealth and the McCaughey Centre are taking a lead around wellbeing and quality of life research.

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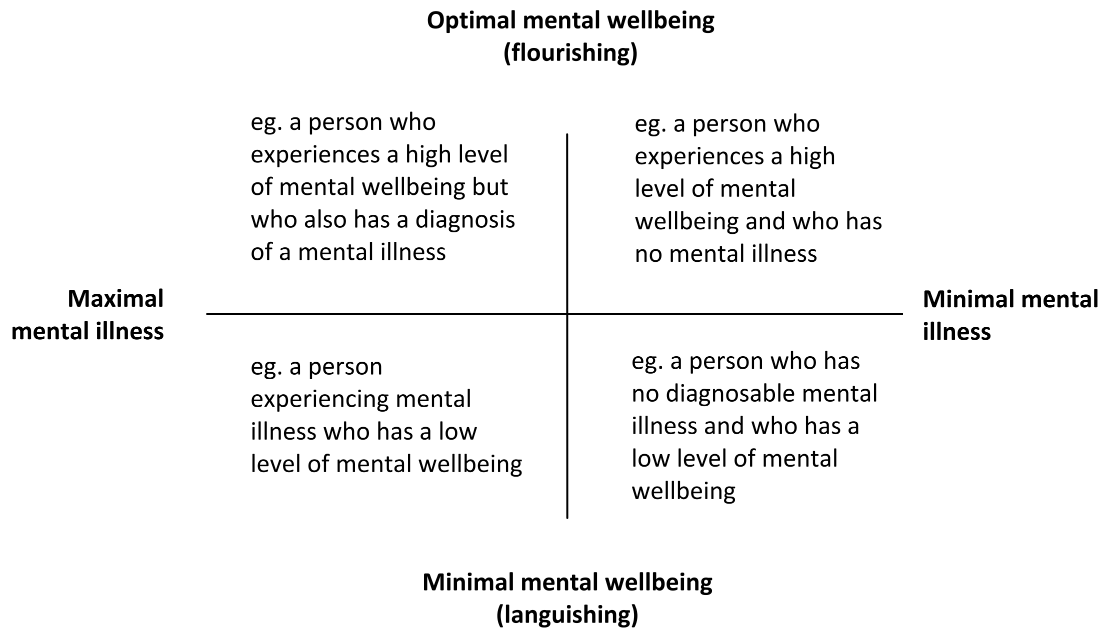
[74] Antonovsky, A. (1979). *Health, Stress and Coping*. San Francisco: Jossey-Bass.
[75] Tudor, K. (1996). *Mental Health Promotion: Paradigms and Practice*. London: Routledge.

Figure 2: Dual Continua Model of Mental Health (Tudor, 1996).



Social determinants of mental health

There is considerable support for the association between the social environment and health outcomes throughout the life course, independent of individual risk factors[76,77]. A number of factors which have been identified as increasing the sensitivity of health to the social environment include: the social gradient, stress, early life, social exclusion and social support, addiction, work and unemployment. For each of these factors behavioural issues such as parenting, nutrition, exercise and substance abuse may play a role; as well as structural issues including employment factors and poverty (among many others)[78,79]. For Aboriginal and Torres Strait Islander populations, issues such as cultural connectedness, colonisation, and racism have also been identified as having a unique influence on mental health and social and emotional wellbeing. Similarly for people from culturally and

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[76] Henderson, G., Robson, C., Cox, L., Dukes, C., Tsey, K. & Haswell, M. (2007). Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People within the Broader Context of the Social Determinants of Health. In I. Anderson, F. Baum and M. Bentley (Eds.). *Beyond Bandaids: Exploring the underlying social determinants of Aboriginal health*. Northern Territory: Cooperative Research Centre for Aboriginal Health.

[77] South Australian Council of Social Service (SACOSS) (2008). *The Social Determinants of Health: SACOSS Information Paper*. Adelaide.

[78] World Health Organization (WHO) (2004). Promoting Mental Health: Concepts, emerging evidence, practice: Summary report. Geneva: WHO.

[79] Wilkinson, R. & Marmot, M. (Eds.) (2003). *Social Determinants of Health: The Solid Facts (2nd edition)*. Geneva: World Health Organization.

linguistically diverse (CALD) backgrounds the process of immigration, connection with culture and discrimination play a significant role on health and mental health outcomes.

The Commission on the Social Determinants of Health established by WHO reflects the international scale of interest in addressing the social factors that lead to ill-health and health inequalities. The relevance of a comprehensive understanding of the impact of social determinants is essential for effective mental health promotion which seeks to foster positive individual, social and environmental qualities. Some examples of evidence which support the influence of social determinants on mental health include the following:

- Unemployed people experience higher levels of depression, anxiety and distress as well as lower self esteem and confidence than employed people.
- Young people who do not have confiding relationships are between 2 and 3 times more likely to experience depressive symptoms than peers who report confiding relationships.
- People with low education levels, low-status occupations and low incomes have relatively poorer mental health than their higher status and more affluent counterparts.
- People who suffer physical violence as children are more likely to experience a number of problems as adults including a lower sense of personal control, less emotional support and more negative interactions with family and friends. These factors in turn are associated with depressive symptoms in adulthood.
- Racial discrimination has been found to be associated with a poorer sense of wellbeing, lower self esteem and sense of control or mastery, psychological distress, major depression, anxiety disorder and other mental disorders.
- Common mental disorders are significantly more frequent in socially disadvantaged populations.
- Alcohol dependence, illicit drug use and cigarette smoking are all closely associated with markers of social and economic disadvantage and drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health.[80]
- People with mental health problems are at particular risk of experiencing problems relating to alcohol.
- Less education (leaving school before the age of 16) is associated with higher prevalence of common mental disorders[81,82].

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[80] World Health Organization (WHO) (2003). *The Social Determinants of Health: The Solid Facts*, 2nd Edition: Geneva: WHO

[81] Barry, M. & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier.

[82] Victorian Health Promotion Foundation (VicHealth) (2005). *A Plan for Action 2005-2007: Promoting mental health and wellbeing*. Carlton South: VicHealth.

Mental health and wellbeing encompasses a positive view of mental health and is relevant for everyone, irrespective of the presence or absence of mental illness. Mental health and wellbeing is a positive sense of emotional, social, intellectual and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity. It enables individuals to feel, think and act in ways that enhance the ability to enjoy life, to contribute to the world around them and to deal with adversity and change. It is the foundation of effective functioning for individuals, families, communities and societies[83].

Mental illness

For the purpose of this Strategic Framework, mental illness (or mental ill-health) refers to the spectrum of mental health problems and mental disorders that interfere with an individual's cognitive, emotional or social abilities. Mental illnesses are of different types and degrees of severity and range from problems which emerge in response to temporary life stressors, to disorders which have substantial and lasting impacts on individuals and communities. Some of the major mental illnesses perceived to be public health issues are depression, anxiety, psychosis and dementia. Substance use disorders are also included in the concept of mental illness adopted in this Strategic Framework.

Spectrum of Interventions

The 'Spectrum of Interventions' as originally defined by Mrazek and Haggerty in 1994[84] (and subsequently revised by others) is widely recognised and adopted as a population framework for defining the entire range of mental health interventions encompassing promotion, prevention, early intervention, treatment and recovery approaches. The Second National Mental Health Plan was the first instance of Australian national policy to adopt the framework and, with some revisions, this continued with the development of the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Action Plan 2000[85]) which has formed the basis of ongoing national and state and territory promotion and prevention implementation and practice.

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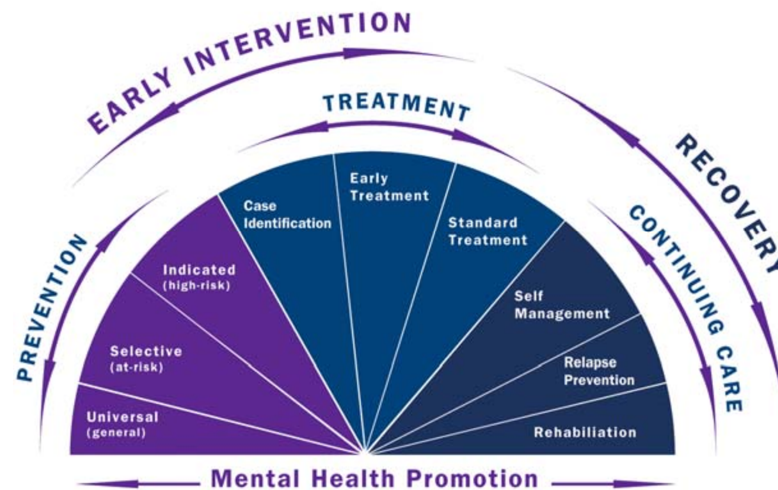
[83] Adapted from: GermAnn, K. & Ardiles, P. (2008). *Toward Flourishing for All: Mental health promotion and mental illness prevention policy background paper*. Commissioned by the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention.

[84] Mrazek, P. & Haggerty, R. (1994). *Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington D.C.: National Academy Press.

[85] Commonwealth Department of Health and Aged Care (2000a). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*. Mental Health and Special Programs Branch. Canberra: Commonwealth Department of Health and Aged Care.

Figure 3: Spectrum of Interventions (adaptation by Rickwood, 2006).



Various adaptations of the spectrum (such as by Rickwood (2006), Figure 3) have reflected increasing understanding of the interrelationship between the components of the spectrum and to encompass the role and scope of mental health promotion and concepts such as recovery. Irrespective of revisions, there are some important general principles:

- The spectrum reflects a population health approach which recognises the status and mental health needs of the entire population – that is, people who are currently well; those at risk of mental health problems on the basis of their individual, social and/or environmental circumstances; and those who are currently, or have previously, experienced mental ill-health.
- The delineation between the various components of the spectrum has more cross-over than the visual representation may imply. For example, mental health promotion strategies may overlap in some instances with primary prevention. Secondary prevention has commonalities with early intervention (early identification and early treatment). 'Real-life' interventions may reflect more than one aspect of the model.
- Despite the original Mrazek and Haggerty model having been essentially developed as a prevention framework, all revisions have sought to demonstrate that mental health promotion can be applied across the spectrum, regardless of the status of a person's mental health.

Mental health promotion

Mental health promotion is about improving wellbeing for all people, regardless of whether they are currently well or ill. It is about optimising people's mental health by developing environments that are good for everyone. Mental health is affected by the events that happen in ordinary day-to-day lives, as well as by significant stressful events that occur such as loss and grief, physical ill-health, etc.

Mental health can be promoted by making sure that public policies support the social and emotional wellbeing of individuals and groups. All environments - social, physical, economic, and cultural - need to be supportive of mental health. Community life is important and communities need to be empowered to take the actions required to build their capacity to support their members. All people should be supported to develop skills to understand, enhance and respond to their mental health needs.

Much of the work in mental health promotion has been conducted within the framework of the **Ottawa Charter for Health Promotion**[86] and the Jakarta Declaration[87]. The five platforms of the Ottawa Charter are:

1. *Building healthy public policy*: development of policies that support the mental health and wellbeing of individuals, families and community groups.
2. *Creating supportive environments that support mental health and wellbeing*: this includes social, economic, cultural and physical environments.
3. *Strengthening community action*: collective action that assists communities take control over the factors that influence mental health and wellbeing.
4. *Developing personal skills*: enhancement of skills at a range of levels that enable people to have greater control over their lives.
5. *Reorienting services toward promotion, prevention and early intervention*: enabling services to promote mental health, prevent mental ill-health as well as provide treatment and rehabilitation.

Some examples of effective interventions include:

- Public housing policies to ensure that all people have access to safe secure and affordable housing.
- 'Whole school' approaches to support mental health and wellbeing.
- Promoting positive messages about mental health in the workplace.
- Community development programs.
- Programs to support vulnerable and disadvantaged groups.
- Community action groups which determine goals for a community and influence local planning and policy.
- Provision of information in a range of languages which help people understand ways to look after their mental health and wellbeing.
- Skills in self management of illness.

[86] World Health Organization (WHO) (1986). *Ottawa Charter for Health Promotion*. Geneva: WHO.
[87] World Health Organization (WHO) (1997). *Jakarta Declaration on Leading Health Promotion into the 21st Century*. Geneva: WHO.

Recovery

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability[88].

Mental health services have a responsibility for promoting the wellbeing of individuals and communities, as much as they do for treating illness. For each of the platforms of the Ottawa Charter, there are related strategies which are specifically relevant to people with existing mental illness. For example stigma reduction initiatives, an example of platform two (creating supportive environments), aim to reduce negative stereotypes resulting in greater participation by people with mental illness in all aspects of community life including work, integrated housing, social and recreation groups. Platform three (strengthening community action) may involve various models of consumer-led initiatives such as mutual support and advocacy groups, and business enterprises.

The concept of recovery for people with mental illness is closely aligned with mental health promotion. In essence, mental health promotion is about maximising wellbeing, quality of life, a sense of control over one's health, and the ability to bounce back (resiliency) from the challenges of life[89]. These factors are as relevant for people affected by mental illness as they are for the entire population. An understanding of the principles of mental health promotion is essential in relation to development of recovery oriented mental health service systems.

While 'definitions' of recovery vary to some extent, it is commonly understood to encompass a process more than an end state, and to involve 'gaining control over one's life and the illness' (rather than the illness having control over the individual)[90]. Recovery has been defined as the product of a dynamic interaction among individual characteristics (including hope, and a sense of meaning and self), environmental factors (including opportunities for satisfying basic material needs, social relationships, meaningful activities and peer support), and features of the service delivery system (including choice and empowerment, independence and interdependence)[91].

Prevention

Prevention interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental ill-health.

[88] Adapted from: Anthony, W.A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159-168.
[89] Pape, B. & Galipeault, J. (2002). *Mental Health Promotion for People with Mental Illness: A discussion paper*. Canada: Mental Health Promotion Unit, Health Canada.
[90] Pape, B. & Galipeault, J. ibid. p.12.
[91] Onken, S., Dumont, J., Ridgway, P., Dornan, D. & Ralph, R. (2002). *Mental Health Recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators*. Virginia USA: National Technical Assistance Center for State Mental Health Planning, National Association for State Mental Health Program Directors.

Risk and protective factors

Inherent within a population health approach is the concept of risk and protective factors. This approach recognises that a combination of factors at the individual, social, environmental and structural levels, which interact with individuals in the ordinary spaces of life such as family, work, school and community, have the potential to influence mental health. *Risk factors* are associated with greater likelihood of developing a mental health problem or mental illness, and of increasing the severity and duration of the mental health problem. Overall, risk factors increase vulnerability and the ability of a person to respond effectively to the challenges of life. Risk factors are understood to have a cumulative effect. Exposure to multiple risk factors over time may combine to have a strong interactive effect[92,93].

Protective factors ameliorate or 'protect' against the impact of risk factors and therefore have the potential to reduce the likelihood that a mental health problem or illness will develop. Protective factors increase resiliency, and for people with existing mental ill-health, can reduce the severity and overall impact of the illness. In this context enhancing the influence of protective factors is integral to recovery oriented approaches to mental health.

Specific risk and protective factors have been identified as particularly influential for some population groups (such as cultural identity for minority ethnic groups and long-term parental unemployment for children), and at various life transition stages (such as from primary to high school and loss of life partner) It is important to understand these factors and the available evidence when planning and implementing programs and services targeting specific population groups. The World Health Organization[94], Commonwealth Department of Health and Aged Care[95], and Bayer and Sanson[96] are several key sources for more information about specific risk and protective factors which have the potential to influence mental health outcomes.

The following are some areas of broad agreement in relation to risk and protective factors:

- A range of generic risk and protective factors are common to several mental health problems and disorders. These include such issues as low self-esteem and poor coping skills; and strong attachment to family and cultural identity.
- Other risk and protective factors are associated with specific disorders. These include parental depression (risk factor for depression), and cannabis use (risk factor for psychosis). While the evidence suggests there is an association between such factors and

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[92] Commonwealth Department of Health and Aged Care (2000). *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.
[93] Kazdin, A.E. & Kagan, J. (1994). Models of dysfunction in developmental psychopathology. *Clinical Psychology: Science and Practice*, 1, 35-52.
[94] World Health Organization (WHO) (2004). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.
[95] Commonwealth Department of Health and Aged Care, op. cit.
[96] Bayer, J. & Sanson, A. (2003). Preventing the development of emotional mental health problems from early childhood: Recent advances in the field. *International Journal of Mental Health Promotion*, 5(3), 4-16.

some disorders, this should not be confused with causality. The impact of a range of factors varies for individuals.

- Risk and protective factors may be specific to life stages (such as school achievement) or may have an impact across all stages of the lifespan (such as poverty). Other factors may be so influential that the impact carries on well beyond the specific time and circumstance (such as childhood neglect, incarceration).
- Interventions need to target 'malleable' risk and protective factors (such as social isolation and parenting). Some risk and protective factors cannot be modified (such as age and genetic inheritance) although it is important to understand the interrelationship between all risk and protective factors and potential cumulative effects.
- Risk and protective factors can be usefully categorised across three major spheres. These include influences at the individual, social and structural levels. Plans and frameworks have been developed on the strength of evidence to support the influence of specific determinants. In addition the Health Education Authority in the UK (now known as the National Institute for Health and Clinical Excellence (NICE)) has identified three key social and environmental factors which influence mental health. These are:
  - Healthy social support, economic and cultural structures.
  - Strong social networks and social inclusion.
  - Emotional resilience[97].
- Evidence exists for the links between mental and physical health. For example chronic pain can be a risk factor for mental ill-health. Cardiovascular disease has been linked with depression.
- Identification of risk and protective factors makes it clear that many determinants of mental health reside outside the health and mental health spheres. It makes a strong case for intersectoral ownership and collaboration.

According to WHO *'Sufficient evidence-based knowledge is already available on risk and protective factors to warrant governmental and non governmental investments in the development, dissemination and implementation of evidence-based programs and policies'*[98]. Also required is more comprehensive understanding about the causal pathways between generic and disorder-specific risk factors leading to mental ill-health, and on the relationship between mental disorders and mental and physical health.

Types of prevention

There are three major types of prevention:

1. **Primary prevention** seeks to prevent the onset or development of a disorder or illness. Primary prevention interventions can be targeted to population groups identified according to the level of risk. There are three different levels of risk applied:

[97] Health Education Authority (HEA) (1997). *Mental Health Promotion: A quality framework*. London: HEA.
[98] World Health Organization (WHO) (2004). *Prevention of Mental Disorders: Effective interventions and policy options*. Geneva: WHO, p. 20.

i. ***General or universal*** – These are interventions that are targeted at the general public or a whole population group. No specific risk factors have been identified and the intervention is aimed at preventing mental health problems for everyone. This level of intervention has many commonalities with **mental health promotion** – the main difference being a shift of emphasis from a positive concept of mental health to prevention of mental ill-health. Interventions are designed to reduce risk factors and/or increase protective factors that are likely to be relevant to the whole population:

   Some examples include:

   - Parenting programs provided for all parents.
   - Pre-school education provided for all pre-school children.
   - Exercise programs for all age and fitness levels.
   - Anti-bullying programs in schools and workplaces.
   - Pre-natal support programs.

ii. ***At risk or selective*** – These are interventions aimed at individuals or population groups whose risk of developing a mental health problem or mental illness is higher than for the general population. Interventions are designed to reduce risk factors and/or increase protective factors for a population group identified as being at higher risk:

   Some examples include:

   - Ongoing support for children of parents with a mental illness.
   - Support groups for people who have recently been bereaved.
   - Provision of mental health-related information for people with physical illnesses.
   - Postnatal support programs.

iii. ***High risk or indicated*** – These interventions are for people who are at very high risk of developing a mental health problem or mental illness. They are designed to reduce risk factors and/or increase protective factors for people at imminent risk of mental ill-health:

   Some examples include:

   - Support for refugees.
   - Counselling and support for victims of violence.
   - Support programs for people recently released from prison.
   - Suicide postvention programs for people bereaved by suicide.
   - Support programs for people with chronic pain and chronic illness.
   - Postnatal support for mothers with birth complications.

2. **Secondary prevention** targets those who are showing early signs or symptoms of mental illness or disorder and seeks to lower the prevalence of illness through early detection and treatment. Secondary prevention interventions have similarities with **early intervention:**

Some examples include:

- Early identification and treatment of psychosis programs for young people.

3. **Tertiary prevention** seeks to reduce the negative impact and associated disability of existing mental illness. Tertiary prevention interventions have similarities with **relapse prevention.**

Some examples include:

- Mental health literacy education programs for people with mental illness.
- Programs to assist people with mental illness and their carers understand and identify early warning signs, risk and protective factors, and ways of mediating these to prevent relapse.

Relapse prevention

Relapse prevention is a specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs or relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors...relapse prevention is an essential, but not sufficient, component of the recovery process for people with mental illness[99].

Relapse prevention strategies therefore have much in common with tertiary prevention given that a major objective is to reduce the negative impact of illness. It can be considered an adjunct to standard treatment where there is a deliberate focus on ongoing illness management aimed at reducing the likelihood and impact of future episodes of the illness. The term rehabilitation, also frequently referred to in the context of recovery approaches for people with mental illness, refers to services and resources that are made available to people with mental illness to assist them to acquire and use the skills and supports necessary for successful living. The spectrum of interventions revised by Rickwood (refer Figure 3), locates relapse prevention and rehabilitation under the arc of recovery which comprises treatment and continuing care.

[99] Rickwood, D. (2006). *Pathways of Recovery: Preventing Further Episodes of Mental Illness (Monograph).* Canberra: Commonwealth of Australia, p. 4.

Early intervention

Early intervention comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem; and people developing or experiencing a first episode of mental disorder.

Early intervention refers to two main types:

1. **Prevention focused** for individuals beginning to show the early signs and symptoms of a mental health problem (early recognition/identification). Prevention oriented early intervention often takes place early in the developmental cycle. Interventions of this type aim to prevent progression to a diagnosable illness:

   Some examples of effective interventions include:

   - Effective treatment of conduct disorder in children.
   - Early identification of anxiety in children.
   - Education about drug and alcohol misuse in young people.

2. **Treatment focused** for individuals experiencing a first episode of mental illness (early assessment and treatment). Interventions of this type aim to reduce the impact of the illness in terms of its duration and the damage it may cause to the person's life, and also to foster hope for future wellbeing:

   Some examples of effective interventions include:

   - Early intervention for psychosis.
   - Early identification and treatment of postnatal depression.
   - Hospital at home services.

5. Policy Context and Linked Initiatives

This Strategy needs to be considered in the light of a broader policy context which includes international, national and local state based policy. The international policy context is important in influencing the conceptual frameworks on which this Strategy is based and ensuring consistency with international developments. The Strategy needs to be consistent with national priorities and directions and add value to the local policy context in Tasmania.

A comprehensive review of Australian and international mental health promotion and prevention policy can be found in the companion document, *Review of Australian and International Mental Health Promotion, Prevention of Mental Ill-health, and Early Intervention Policy*.

International

There is considerable activity at the international level regarding policy development, program implementation, and research and evidence relevant to promotion, prevention and early intervention approaches to mental health. Widespread support exists for the notion that mental health is integral to overall health and wellbeing and that improving mental health and wellbeing must be a part of a comprehensive public mental health policy approach[100].

The World Health Organization (WHO) has been particularly active and influential in progressing the promotion and prevention agenda over the past decade. The World Health Organization report, *New Understanding, New Hope*[101] spearheaded discussion about the complex interaction between biological, psychological and social factors on mental health, and the policy and service development required to reduce the burden of mental and behavioural disorders worldwide. In 2002, two reports further defined the concepts of promotion and prevention in mental health[102,103], and several years later the publication of two influential reports provided more detailed discussion of evidence-based risk and protective factors; social, environmental and economic determinants; effective interventions; and policy options[104,105]. Work undertaken by WHO in collaboration with

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[100] Health Scotland (2008). *A Review of Scotland's National Programme for Improving Mental Health and Wellbeing 2003-2006*. Scotland: NHS Health.

[101] World Health Organization (WHO) (2001). *Mental Health: New understanding, new hope*. Geneva: WHO.

[102] World Health Organization (WHO) (2002). *Prevention and Promotion in Mental Health: Evidence and research*. Department of Mental Health and Substance Dependence. Geneva: WHO.

[103] World Health Organization (WHO) (2002). *Prevention and Promotion in Mental Health*. Geneva: WHO.

[104] World Health Organization (WHO) (2004). *Prevention of Mental Disorders: Effective interventions and policy options*. Geneva: WHO.

international experts in this area has provided significant leadership towards the development of policy and implementation in a variety of countries around the world.

Other key policy developments in countries outside Australia include:

- National Program for Improving Mental Health and Wellbeing: Action Plan 2003-2006 (Scotland).
- Making it Possible: Improving mental health and wellbeing in England.
- Building on Strengths: A new approach to promoting mental health in New Zealand/Aorearoa.
- Toward Recovery and Wellbeing: A framework for a mental health strategy for Canada.

Some of the common themes in these policies include:

- Increased recognition that positive outcomes for mental health are influenced by policies and programs residing within and outside traditional health care boundaries – 'mental health is everybody's business'.
- Leadership and advocacy of the promotion and prevention agenda by influential international bodies such as WHO.
- Benefits of national or central leadership for advocacy and coordination of promotion and prevention activity.
- Widespread acknowledgment that treatment approaches alone will not reverse the trend towards increasing rates of mental illness.
- Positive construct of mental health and the concept of 'wellbeing'.
- Improved understanding of overarching determinants of mental health including concepts such as social inclusion, and stigma and discrimination.
- Improved understanding of specific determinants of mental health for culturally and linguistically diverse populations and population groups across the lifespan.
- Recovery approaches to mental health for people affected by mental illness.
- Meaningful consumer participation in planning and delivery of policy, programs and services.
- The role of social marketing as a tool for promoting mental health including anti-stigma campaigns.

The drivers of mental health promotion and prevention of mental ill-health policy currently include both mental health and public health. It is clear that maintaining a social view of health and emphasis on the social determinants requires the ongoing collaboration of mental health and public health in policy development and implementation. Increasingly, countries are considering more integrated policies or moving towards 'whole of government' approaches.

Scotland is the best example of an integrated mental health policy framework integrating treatment, recovery, suicide prevention, promotion, and prevention in the one mental

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[105] World Health Organization (WHO) (2004). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.

health policy. Given that many of the drivers of mental health promotion and prevention activity lie outside the health sector, broader inclusive cross-government approaches are regarded as desirable in the future. This will lead to greater investment by other government departments in supporting the mental health and wellbeing agenda.

Another significant development at the international level is the work being undertaken to develop indicators of positive mental health and wellbeing. As the move in policy development is toward positive mental health and wellbeing, it is no longer satisfactory to use indicators of illness and prevalence as indicators of wellbeing. Scotland has undertaken a comprehensive project over the last few years to establish a core set of national, sustainable mental health indicators to support the Scottish Executive in measuring mental health improvement in the Scottish population. The project has developed a set of indicators that cover both positive mental health and mental health problems which enables monitoring of changes in Scotland's mental health. A mixed approach (taking into account current data, policy, evidence, expert opinion and theory) was used to obtain measurable, meaningful indicators relevant to the policy making process[106,107]. The focus in the first instance was adults and work is currently underway to develop indicators for children and young people's mental health. To obtain an assessment of the overall positive mental health of the adult population a new scale was developed in the course of the mental health indicators program. This 14 item scale is the *Warwick-Edinburgh Mental Wellbeing Scale* (WEMWBS)[108].

National

The key national policy documents this Strategic Framework needs to align with are:

- National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000).
- COAG National Action Mental Health Plan 2006-2011.
- National Mental Health Policy 2008.
- 4th National Mental Health Plan (draft).

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Action Plan 2000) has provided a comprehensive guiding framework for action using a population approach. Few policies at the jurisdictional level focus specifically on promotion, prevention and early intervention approaches and to date, no such policy exists to specifically guide the work of mental health services in this area. In this respect this Strategy will make a unique contribution to the field with its emphasis on articulating the roles and responsibilities of the mental health services sector.

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[106] Parkinson, J. (2007). *Establishing a Core Set of National, Sustainable Mental Health Indicators for Adults in Scotland: Rationale paper*. Health Scotland, www.healthscotland.com/documents/2160.aspx

[107] Parkinson, J. (2007). *Establishing a Core Set of National, Sustainable Mental Health Indicators for Adults in Scotland: Final report*. Health Scotland, www.healthscotland.com/documents/2349.aspx

[108] See: www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx

On the other hand, there is considerable activity in policy development across a diversity of settings and sectors with the potential to intersect with and support positive mental health outcomes across populations. From a social health perspective, policies concerned with such issues as access to good quality housing, child protection, disaster relief, and social planning provide opportunities for supporting positive mental health and preventing mental ill-health.

While commonly the role of mental health services is understood to operate exclusively at the early intervention and treatment ends of the spectrum, it can be demonstrated that tertiary mental health services also have a significant role to play in promoting mental health for people with mental illness, preventing the onset and reducing the impact of mental ill-health[109].

Within Australia

Most jurisdictions in Australia are in the process of developing or have developed policy in mental health promotion, prevention of mental ill-health and early intervention. However, only two jurisdictions have comprehensive published policies specific to mental health promotion and /or prevention. These are:

- Victorian Health Promotion Foundation: A plan for action 2005-2007: Promoting mental health and wellbeing.
- ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006-2008.

This Strategic Framework companion document, *Review of Australian and International Mental Health Promotion, Prevention of Mental Ill-health, and Early Intervention Policy,* provides a comprehensive overview of the policy context in each of the jurisdictions. The key drivers of policy development in this area in the jurisdictions fluctuate between mental health, health promotion and social inclusion. In South Australia, the key driver is Health Promotion SA, Department of Health; in Victoria, VicHealth (Victorian Health Promotion Foundation) and in all other states the policy driver is Mental Health. Queensland Health has recently committed funds to establish a Centre for Mental Health Promotion, the Australian Capital Territory has recently developed an extension plan to their current strategy, and New South Wales is exploring the development of a State-wide framework for PPEI.

The significant contribution that this Strategic Framework and Action Plan will make to the Australian and international context is its articulation of priorities, actions, roles and responsibilities for organisations providing specialist mental health clinical and non-clinical services.

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[109] Pape, B. & Galipeault, J. (2002). *Mental Health Promotion for People with Mental Illness: A discussion paper*. Canada: Mental Health Promotion Unit, Health Canada.

Tasmania

In the local context, there are a number of key policies and frameworks that have already been developed or currently in development that will be important for this Strategy to link with.

- ***Tasmania's Health Plan (DHHS*)**

  This Plan provides a blueprint for health services reform in Tasmania and highlights the need to focus on preventive and early intervention services and to introduce new models of care.

- **Department of Health and Human Services Strategic Directions 2009-2012**

  Strategic Directions sets out the vision, mission and values of the Department's services and identifies five key strategic objectives *including promoting health and wellbeing and intervening early when needed*.

- ***Mental Health Services Strategic Plan: 2006-2011 (MHS, DHHS)***

  The Mental Health Services Strategic Plan provides a framework for the reform of Mental Health Services in Tasmania.

- ***Tasmania Together 2020***

  This is a Plan developed by the Tasmania Together Progress Board. It sets benchmarks and goals for a community that is healthier, better educated, environmentally sustainable and more equitable.

- ***Strengthening the Prevention and Management of Chronic Conditions: Policy Framework 2005***

  This Framework addresses the social determinants of health and wellbeing and their influence on the prevention of illness. Mental illness is identified as a chronic condition.

- ***Alcohol, Tobacco and other Drug Services: Future Service Directions - A Five Year Plan 2008/09-2012/13 (DHHS)***

  The Future Service Directions Plan provides guidance for the investment of funding and for the development of alcohol, tobacco and other drugs services in Tasmania for a five year period.

- ***Tasmanian Drug Strategy 2005-2009***

  This Strategy outlines the Tasmanian Government's response to alcohol and drug misuse.

- ***Youth Health Service Framework 2008-2011 (Primary Health Services and Population Health, DHHS)***

  This Framework outlines directions for DHHS's Youth Health Service to focus on health and wellbeing promotion, ill-health prevention and early intervention.

Other key policies currently under development which relate to this Strategy are:

- ***A Strategic Framework for Health Promotion 2009-2011 (Population Health, DHHS*)**

This sets the Strategic Framework for health promotion and includes mental health and wellbeing as one of its 7 priority action areas.

- ***Social Inclusion Strategy / Social inclusion Unit (DPAC)***

  The Social Inclusion Unit which has been established for approximately one year is currently working on the Social Inclusion Strategy due for release in 2009.

The following interagency networks are important to strengthen and consolidate as part of this Strategy.

- ***Drought Network Tasmania / Tasmania's Drought Task Force (DPAC)***

  Drought Network Tasmania has been established to provide assistance and support to people in drought affected areas of Tasmania. Organisations involved in the networks include County Women's Association, Red Cross, Centrelink, Anglicare, Relationships Australia, Rural Alive and Well, Tasmanian Farmers and Graziers Association, Tasmanian Women in Agriculture, Aussie Helpers, Salvation Army, Department of Primary Industries and Water, and St. Vincent de Paul. Tasmania's Drought Task Force consisting of representation from a range of sectors has been established to provide a coordinated response to Tasmania's drought issues.

- ***Tasmanian Suicide Prevention Steering Committee***

  An intersectoral network has been established with representation from a range of sectors to guide and influence work in suicide prevention.

- ***Inter Agency Support Teams***

  Inter Agency Support Teams have been established under the Kids in Mind Tasmania initiative. The teams are located in most Local Government Areas across Tasmania and are led by the Department of Police and Emergency Management. They have been established to provide a coordinated and early intervention approach for at risk young people.

- ***Inter Agency Working Group on Drugs***

  The Inter Agency Working Group on Drugs has been established to address a whole of government approach to the drug strategy. It includes representation from DHHS, Police, Justice, Education, Premier and Cabinet, AOD Council, LGA and Liquor Licensing Council.

- ***Tasmanian Transcultural Mental Health Network***

  Multicultural Mental Health Australia and the Tasmanian Government provided seed funding to develop a State-wide network to address transcultural related mental health issues. The Migrant Resource Centre (Southern Tasmania Inc.) has responsibility for hosting and supporting the Network.

Linkages with the Alcohol, Tobacco and Other Drug Sector

The focus of this Strategic Framework is primarily on mental health. However, there are clearly inextricable linkages with the Alcohol, Tobacco and Other Drug (ATOD) sector and as

such, a number of strategies identified within the Framework will have resonance and applicability to the broader ATOD sector.

The World Health Organization published a report in 2005 which notes that knowledge of the determinants of mental health is growing.[110] There is also some consensus that some of the major determinants of mental health are located within social and economic domains and include:

- Social inclusion and access to supportive social networks.
- Stable and supportive family, social and community environments.
- Access to a variety of activities.
- Having a valued social position.
- Physical and psychological security.
- Opportunity for self-determination and control of one's life.
- Access to meaningful employment, education, income and housing.

The evidence also suggests that these determinants are also common to alcohol and drug use.[111] It is therefore reasonable to assume that the development of strategies designed to address the socio-economic determinants of mental health could also have a positive impact in other domains.[112]

The Victorian Department of Human Services in its recently released Blueprint for Alcohol and Other Drug Treatment Services 2009-2013, notes that *'prevention is multidimensional, operating across the continuum of prevention, early intervention, harm reduction, treatment, relapse prevention and recovery.'* It also notes that opportunities to prevent and address harmful substance use can be taken up in other health and education systems and earlier intervention can be achieved through improved linkages and raise awareness within these other systems.[113]

In 2008, the Tasmanian Government released Future Service Directions: A Five Year Plan 2008/09 – 2012/13. This is a plan that provides a strategic focus for the ATOD service sector in Tasmania for the next five years.[114]The plan outlines a *'service framework and establishes*

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[110] World Health Organization (WHO) (2004b). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.

[111] Resnick, M., Bearman, P., Blum, R., Bauman, K., Harris, K., Jones, J., Tabor, J., Beuhring, T., Sieving, R., Shew, M., Ireland, M., Bearinger, L. & Udry, J. (1997). Protecting adolescents from harm: Findings from the longitudinal study on adolescent health. *Journal of the American Medical Association*, 278(10), 823-832.

[112] WHO, op. cit.

[113] Victorian Government Department of Human Services (2009). *A New Blueprint for Alcohol and Other Drug Treatment Services 2009-2013.* Melbourne: Victorian Government Department of Human Services.

[114] Tasmanian Government Department of Health and Human Services (2008). *Future Service Directions: A Five Year Plan 2008/09-2012/13*. Hobart: Tasmanian Government Department of Health and Human Services.

building blocks from which a contemporary service system can be constructed.'[115] One of the key features of the plan is the identification of opportunities for increased collaboration, partnerships, linkages and support between ATOD services and mainstream health and community services. It is anticipated that the ATOD sector, in line with the National Drug Strategy's commitment to prevention and strengthening partnerships, will identify opportunities to develop synergies with other service systems, most notably the mental health services system, to achieve the best outcome for consumers of both services.

This Framework and Action Plan is also supported by the work of the National Preventative Health Taskforce.

The discussion paper *Australia: the healthiest country by 2020* notes that 'our health is not only determined by our physical and psychological make-up and health behaviours, but also by our education, income and employment; our access to services; the place in which we live in and its culture; the advertising we are exposed to; and the laws and other regulations in place in our society.

'Treat preventative health care as a first order economic challenge because failure to do so results in a long term negative impact on workforce participation, productivity growth and the impact on the overall health budget'.

The Taskforce, established in April 2008, has been tasked with the production of the National Preventative Health Strategy focusing on the primary prevention of obesity, tobacco and harmful consumption of alcohol. The next phase of the Taskforce's work in 2009 will be focused on other areas of preventative health which is likely to include mental health. To achieve this end, the Taskforce is working closely with other groups involved in health reform, including the National Primary Health Care Strategy, the Indigenous Health Equity Council and the National Advisory Council on Mental Health.

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[115] Ibid, p. 6.

6. Investing in Mental Health and Wellbeing

This Section provides an overview of the importance of investing in mental health and wellbeing and the evidence base that supports it.

Why invest in mental health and wellbeing

The evidence is clear that underpinning mental health promotion and illness prevention approaches is a positive concept of mental health, which is independent of the presence or absence of illness. Following are nine evidence-based reasons for investing in initiatives that support and enhance mental health and wellbeing.

Table 1: Nine reasons to invest in mental health promotion and mental illness prevention[116]

- Positive mental health is a basic human right. It is 'fundamental to all human and social progress and is a prerequisite to a happy and fulfilled life for individual citizens, for effectively functioning families and for social cohesion'[1]. It is the foundation of a healthy society and a healthy economy[2].
- The significant and growing global and national burden of mental illness cannot be stemmed by treating one individual at a time. A proactive population-based approach that promotes positive mental health and stops people from becoming mentally ill is required.
- Statistically, one in every four people will experience a mental health problem or illness at some point in their lives[3], taking an enormous human toll that cannot be measured exclusively in economic terms. The human burden of mental illness includes psychic pain, feelings of guilt, helplessness, hopelessness, and exacerbated anxiety and depression both for the persons suffering the illness and for the people who love and care for them[4]. Financial difficulties, discrimination and marginalisation impose additional burdens on these people.
- Poor mental health disproportionately affects those who are socially and economically disadvantaged while also contributing directly to poverty[5,6].
- Mental health promotion and mental illness prevention, and their focus on the structural determinants of mental health, can foster safer and healthier families, workplaces and communities; higher educational achievement; improved interpersonal relationships; and personal dignity[7,8].
- Research has demonstrated that anything less than flourishing is associated with increased impairment and burden to self and society[9]. People who are flourishing have been found to miss fewer days at work, have fewer chronic physical diseases, have the

[116] Adapted from: GermAnn, K. & Ardiles, P. (2008). *Toward Flourishing for All: Mental health promotion and mental illness prevention policy background paper*. Commissioned by the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention, p. 19.

lowest rates of healthcare utilisation and have the highest levels of psychosocial functioning[10]. In contrast, the absence of positive mental health is correlated with the presence of mental illness and physical disease[11].

- Not only does mental health promotion promote positive health, but also it helps reduce the risk behaviours (eg., tobacco, alcohol and drug misuse; unsafe sex); social and economic problems (eg., school dropout rates, crime, absenteeism from work, intimate partner violence); and the rates and severity of, and mortality from, physical and mental illness[12].
- Positive mental health is essential for school success[13,14]. School studies show the importance of mental health for learning – anxious and depressed children perform less well academically[15]. Mental health problems lead to early school-leaving[16].
- Positive mental health is an essential ingredient in quality of life from birth to death.

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1. Jané-Llopis, E. & Braddick, F. (Eds.) (2008). *Mental Health in Youth and Education: Consensus paper*. Luxembourg: European Communities, p. 3.
2. Moodie, R. & Jenkins, R. (2005). I'm from the government and you want me to invest in mental health promotion. Why should I? *Promotion and Education, Supplement 2: The Evidence of Mental Health Promotion Effectiveness: Strategies for action*: 37-41.
3. World Health Organization (WHO) (2001). *The World Health Report 2001: Mental health: New understanding, new hope*. Geneva: WHO.
4. Lehtinen, V., Riikonen, E. & Lahtinen, E. (1996). *Promotion of Mental Health on the European Agenda*. Finland: National Research and Development Centre for Welfare and Health.
5. Jané-Llopis, E. & Braddick, F. op. cit.
6. Moodie, R. & Jenkins, R. op.cit.
7. World Health Organization (WHO) (2005). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.
8. Moodie, R. & Jenkins, R. op.cit.
9. Keyes, C. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist*, February-March, 95-108.
10. Keyes, C. op. cit.
11. Keyes, C. op. cit.
12. Moodie, R. & Jenkins, R. op.cit. p. 37.
13. Jané-Llopis, E. & Braddick, F. op. cit.
14. Keyes, personal communication, June 2008.
15. Moodie, R. & Jenkins, R. op.cit.
16. Jané-Llopis, E. & Braddick, F. op. cit.

What to invest in to improve mental health and wellbeing

Evidence exists for the effectiveness of a wide range of exemplary mental health promotion and prevention programs and initiatives. Following is a summary of some of the key interventions that have been proven effective in enhancing quality of life and reducing the risk factors for mental ill-health.

Effective interventions

A number of strategies have been found to be effective in improving quality of life and/or reducing risk for mental illness. These include:

- **Improving housing**

  Quality of housing is a key determinant of both physical and mental health and improvements in housing have been shown to have significant benefits for the health and wellbeing of individuals as well as for community safety and increased social participation[117].

- **Promoting a healthy start in life**

  During the early stages of life there is more development in mental, social and physical functioning than in any other period across the lifespan[118]. What happens from birth to age three influences how the rest of childhood and adolescence unfolds[119].

  The major dimensions of a healthy start to life are physical and psychological wellbeing. The quality of the early years in building resilience influence the likelihood of later behavioural problems including oppositional defiant disorder, aggression and conduct problems, attention deficit and hyperactivity and readiness for school.

  The most successful programs addressing risk and protective factors early in life are targeted at child populations at risk, especially from families with low income and education levels[120]. They include home-based interventions during pregnancy and infancy, parenting programs and preschool programs.

- **Parenting programs**

  Parenting programs have also shown significant preventative effects. Two examples of evidence-based parenting programs include: 'Incredible Years Program' and 'Triple-P Positive Parenting Program'. The Incredible Years Program provides a behaviourally based intervention that increases positive interactions, improves problem-solving and social functioning and reduces conduct problems at home and school[121]. Triple-P is a multilevel parenting program which includes universal, selective and indicated strategies. Triple-P has shown significant reduction in disruptive behaviours and an

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[117] Thomson, H., Petticrew, M. & Morrison, D. (2001). Housing interventions and health: A systematic review. *British Medical Journal*, 323, 187-190.

[118] World Health Organization (WHO) (2004). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.

[119] UNICEF (2002). *UNICEF Annual Report 2002*. New York: UNICEF.

[120] Brown, H. & Sturgeon, S. (2005). Promoting a healthy start to life and reducing early risks. In: C. Hosman, E. Jané-Llopis, & S. Saxena (Eds.). *Prevention of Mental Disorders: Effective interventions and policy options*. Oxford: Oxford University Press.

[121] Webster-Stratton, C. & Reid, M.J. (2003). The incredible years parents, teachers and children training series: A multifaceted treatment approach for young children with conduct problems. In: A.E. Kazdin (Ed). *Evidence-based Psychotherapies for Children and Adolescents*. New York: Guilford Press.

increase in parenting confidence[122]. Triple-P has been developed in Australia by Professor Matt Sanders, University of Queensland.

- **School based interventions**

  The role that schooling plays in the lives of children and young people and the school setting has been identified as a critical environment for influencing positive mental health and reducing risk factors. A range of interventions have been developed for implementation in the school environment and they range from 'whole of school' approaches, to specific classroom programs targeting certain age groups or children at greater risk of poor educational and mental health outcomes.

  Examples of evidence-based school interventions in Australia include MindMatters, KidsMatter, FRIENDS, and RAP (Resourceful Adolescent Program)[123].

  Mindmatters and KidsMatter are whole school approaches for secondary and primary schools respectively and are funded by the Australian Government and implemented nationally. FRIENDS and RAP are classroom based interventions for children and young people.

  Programs that focus simultaneously on different levels, such as changing the school ecology as well as improving individual skills, are more effective than those that intervene on solely one level[124].

- **Support for children of parents with a mental illness**

  Children of parents with a mental illness or substance use disorder represent one of the populations at highest risk of mental illness. For instance, children of depressed parents have about a 50 per cent risk of developing a depressive disorder before age 20[125]. Over the last decade researchers and practitioners from the United States of America, Australia and Europe have developed a range of interventions aimed to prevent transgenerational transfer by addressing risk and protective factors in the children and their families. In Australia, the Australian Government funds the national Children of Parents with a Mental Illness (COPMI) program[126].

- **Workplace interventions**

  There is evidence to suggest that work and workplaces can contribute to mental health problems (eg., burnout, anxiety disorders, depression, sleeplessness) and produces

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[122] Sanders, M.R., Montgomery, D. & Brechman-Toussaint, M. (2000). Mass media and the prevention of child behaviour problems. *Journal of Child Psychology and Psychiatry*, 42, 939-948.

[123] See:
MindMatters http://www.mindmatters.edu.au/
KidsMatter http://www.kidsmatter.edu.au/
FRIENDS http://www.friendsinfo.net/friendsinschools.html
Resourceful Adolescent Program http://www.hlth.qut.edu.au/psyc/rap/

[124] World Health Organization (WHO) (2004). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.

[125] Beardslee, W., Keller, M., Lavori, P., Klerman, G., Dorer, D. & Samuelson, H. (1988). Psychiatric disorder in adolescent offspring of parents with affective disorder in a non-referred sample. *Journal of Affective Disorders*, 15(3), 313-322.

[126] See: http://www.copmi.net.au

social and economic burdens to health and human services[127]. Stress management training, stress inoculation techniques, relaxation training, and social skills and fitness training can increase coping capacity[128]. Several meta studies show that such methods are preventing adverse mental health outcomes in work environments[129,130].

- **Recovery oriented approaches**

  The concept of positive mental health can be helpful to people with a mental illness and their carers. Positive health and protective health resources can coexist with sometimes severe psychopathological symptoms (eg., person living with schizophrenia). This suggests the value of developing more comprehensive clinical approaches with an additional focus on the person's positive health, strengths, capabilities and personal effort towards recovery in prevention, diagnosis, treatment and rehabilitation[131]. The recovery model empowers consumers and those involved with them with its emphasis on strengths, hope and positive health and wellbeing.

- **Interventions for older people**

  In the year 2000, more than 600 million people across the world were aged over 60 years. This rapid increase in the ageing population brings an increase of age related physical and mental health problems. Different types of universal, selective and indicated interventions have been successful in improving the mental health of older people[132]. Examples of universal strategies include exercise interventions, social support and befriending programs. Promising preventative interventions for selective and indicated elder populations include the use of patient education methods, early screening, interventions in primary care and programs using life review techniques.

In summary, these interventions although not exhaustive identify some key areas where investment will make a difference. The most successful programs that enhance mental health and reduce risk factors for mental ill-health have the following characteristics:

- Are **strategic**, often multi-level programs and initiatives. Generally, one off interventions are not as successful.
- Are **well resourced** with both financial and human resources.
- Are **evidence-based.**

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[127] Price, R. & Kompier, M. (2005). Work, stress and unemployment. In: C. Hosman, E. Jané-Llopis & S. Saxena (Eds.). *Prevention of Mental Disorders: Effective interventions and policy options*. Oxford: Oxford University Press.

[128] World Health Organization (WHO) (2004). *Promoting Mental Health: Concepts, emerging evidence, practice: Summary report*. Geneva: WHO.

[129] Murphy, L.R. (1996). Stress management in work settings: A critical review of the health effects. *American Journal of Health Promotion*, 11, 112-135.

[130] Van der Klink, J., Blonk, R., Schene, A., & van Dijk, F. (2001). The benefits of interventions for work-related stress. *American Journal of Public Health*, 91(2), 270-276.

[131] World Health Organization (2004). op. cit.

[132] Jané-Llopis, E. et al. (2005). Ageing mentally healthy. In: C. Hosman, E. Jané-Llopis, & S. Saxena (Eds.). *Prevention of Mental Disorders: Effective interventions and policy options*. Oxford: Oxford University Press.

- Address **key determinants** or **evidence based risk and protective factors.**
- Usually involve **strong collaborations and partnerships.**
- Are often **medium to long-term interventions** (3-5 years).
- Are **well evaluated.**

How to invest to enable improvement in mental health and wellbeing

Knowing what to invest in is important but without investment in the necessary infrastructure to support implementation of interventions (as identified in Table 2), the translation of evidence or policy into practice is less successful.

Table 2: Developing the infrastructure for promoting mental health[133]

- Establish a policy framework that provides a mandate for action.
- Develop a strategic action plan which identifies priorities, key goals and objectives for action.
- Coordinate an intersectoral and partnership approach to policy implementation at governmental, regional and local levels.
- Invest in research to guide evidence-based mental health promotion policy and practice.
- Invest in human, technical, financial and organisational resources to achieve priority actions and outcomes.
- Support capacity building and training of the mental health promotion workforce to ensure effective practice and program delivery.
- Identify models of best practice and support the adoption and adaptation of high quality, effective and sustainable programs, particularly those meeting the needs of disadvantaged groups.
- Engage the participation of the wider community.
- Put in place a system of monitoring policy implementation and impact.
- Systematically evaluate program process, impact, outcome and cost.

Effective outcomes in mental health promotion, prevention of mental ill-health and early intervention can only be achieved with strong intersectoral partnerships, highly skilled workforces, access to the evidence base and ongoing evaluation and monitoring that will enable improvements in mental health and wellbeing. To achieve these outcomes, there is a need for investing in building the necessary infrastructure and providing strategic leadership and capacity building for the workforce.

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[133] Barry, M. & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier, Box 1.6, p. 34

7. Strategic Framework and Action Plan

The priorities, strategies and actions outlined in the following Section align with building the foundations or infrastructure to support mental health and wellbeing for all Tasmanians.

Developing the foundations or infrastructure for supporting mental health and wellbeing is the first significant step in investing and embedding mental health promotion and illness prevention approaches in sustainable government structures. Increasing attention in the literature is being given to the importance of governments developing the infrastructure for promoting mental health as an important step in building sustainability and long-term investment[134].

Underpinning all the strategies and actions is a positive construct of mental health and wellbeing, as defined in Section 4.

Section 7.1 provides an overview of the key priority areas and strategic actions, while Section 7.2 specifically focuses on articulating the roles, responsibilities and outcomes for Mental Health Services and Community Sector Organisations that emanate from 7.1.

There are five key priority areas in the Strategic Framework. Each of these priorities is linked to five foundations for building support for mental health and wellbeing at a number of different levels: government, community, families, service provision and society. These are:

Priority 1: Promote mental health and wellbeing across whole of government and whole of community.

> *This priority addresses an important foundation of '**building support for mental health and wellbeing at the government level**' through developing a coordinated policy framework, effective intra and intersectoral partnerships and investing in research. The responsibility for promotion, prevention and early intervention approaches is not limited to one sector or one discipline and requires collective action across a range of government departments.*

Priority 2: Build capacity across sectors and in the community to implement programs and initiatives to support mental health and wellbeing.

> *This priority addresses the foundation of '**building support for mental health and wellbeing in the community**' through education, training and the implementation of evidence-based programs and intervention strategies.*
>
> *The goal of this priority is to develop a shared understanding of positive mental health and improved mental health literacy across different workforces, embedding this*

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[134] Barry, M. & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier.

knowledge in service provision, and creating community settings—such as schools and workplaces—that support mental health and wellbeing.

Priority 3: Invest in the early years and families.

*This priority addresses the foundation of '**building support for mental health and wellbeing in families'** through strengthening family relationships, enhancing parenting skills and establishing strong parent/child attachment in the early years.*

The evidence is clear that investment as early as possible in the developmental cycle will have the most significant impact on mental health and wellbeing.

Priority 4: Consolidate and further strengthen reorientation of Mental Health Services and Community Sector Organisations to support mental health and wellbeing.

*This priority addresses the foundation of '**building support for mental health and wellbeing in the mental health service system'** through ensuring Mental Health Services and Community Sector Organisations enhance mental health and wellbeing for people with mental illness or 'at risk' of mental illness, and empower consumers and carers to achieve a better quality of life.*

Mental Health Services need to be seen as a key driver of promotion, prevention and early intervention approaches that support mental health and wellbeing.

Priority 5: Reduce mental health inequalities.

*This priority addresses the foundation of '**building support for mental health and wellbeing in society for people disadvantaged or disempowered in the community'** through identifying the key social and environmental determinants that impact on the mental health and wellbeing of these population groups and exploring ways to ameliorate their impact. These include cultural dislocation, discrimination, poverty, homelessness, isolation, trauma, climate change and drought. The goal of this priority is to enhance social inclusion, reduce discrimination and stigma, and increase economic participation in society.*

7.1 Priorities for Strategic Actions

Priority 1: Promote mental health and wellbeing across whole of government and whole of community

The first priority area in this Strategic Framework acknowledges the need to promote mental health and wellbeing across the whole of government and whole of community. This acknowledges that 'mental health is everybody's business' and that the events and settings of everyday life affect mental health and wellbeing. Consequently, mental health is relevant across the entire portfolio of government and community agencies. The impact of policies and practices on mental health must be identified and considered, and this needs to happen at all levels of government as well as all levels of the community. To embed promotion, prevention and early intervention approaches to mental health throughout government and community initiatives requires a range of policy, communication and infrastructure supports. Changes need to be made to fundamental approaches, processes and practices and this necessitates development of a supportive policy environment and system of coordination.

Strategy 1. Establish Tasmania's Mental Health Services as a key driver of PPEI

It is essential that Mental Health Services take a leadership role in driving reform for PPEI. Both policy and service provision in mental health have a major investment in promoting mental health and preventing mental ill-health, as well as their more traditional orientation of treating mental illness. This commitment to PPEI needs to be acknowledged and used to drive reform and investment. It is important to use the specialist knowledge of Mental Health Services to guide practice in PPEI and ensure strong and effective collaboration across the wide range of services and sectors that need to work together to promote mental health and prevent and respond early to mental illness. Without strong leadership from within Mental Health Services, progress toward PPEI is unlikely to occur.

Actions:

- Establish a mechanism to enable Statewide & Mental Health Services (SMHS) State Office to provide leadership and be a key driver for PPEI. This could include setting up and supporting a coordinating unit within SMHS State Office to provide a State-wide focus.
- Consolidate resources, through the leadership of the coordinating unit in SMHS State Office, to establish a single focus for PPEI activities, incorporating initiatives related to mental health, alcohol and other drug use, and suicide prevention.
- Enable the coordinating unit within SMHS State Office to lead change within Mental Health Services and Community Sector Organisations, as well as the broader mental health sector, to progress PPEI initiatives across government and community.
- Strengthen the partnership with Public Health, DHHS.

Strategy 2. Build and make accessible the evidence base for PPEI

A critical strategy required to embed PPEI within government and community initiatives is building a strong and convincing evidence base supporting the value of investing in PPEI approaches, initiatives and interventions. As PPEI is an innovation in practice and emerging area of research in mental health[135], solid infrastructure support is required to continue to build the evidence base. Moreover, investing in PPEI comprises a long-term commitment to the mental health and wellbeing of Tasmanians, and the outcomes of many initiatives will not be evident for some considerable time. This means that initiatives can be at risk due to short-term outlooks, and concerted effort is required to build the argument for sustainability and continued investment. A great deal of activity is occurring nationally and internationally in this field[136], and a small State like Tasmania needs to be able to adopt, adapt and build upon the evidence being accumulated in places where there is more research and evaluation capacity, as well as develop the capacity to undertake its own research and evaluation where necessary.

Actions:

- Develop a coordinated and systematic approach to building the evidence base for PPEI and evaluating local PPEI initiatives, including enabling access to the required research skills and methodologies.
- Undertake a review of evidence-based interventions in priority areas to be addressed in this Strategic Framework (such as positive parenting programs, school based initiatives, social marketing) that may be appropriate to adopt/adapt in Tasmania.
- Enable access in Tasmania to relevant PPEI information and evidence. Ensure that this information is provided in formats that are easily accessible for government agencies, service providers, and community groups.
- Collaborate with Public Health to build the evidence base, in particular to develop indicators of positive mental health and wellbeing to evaluate initiatives and demonstrate progress.

Strategy 3. Ensure that mental health and wellbeing outcomes are considered in all government policies and that initiatives at all levels of government are coordinated

Mental health and wellbeing must become an overarching consideration in all State government policies, and relevant outcomes need to be identified, considered and communicated across relevant portfolio areas. This is consistent with the first action area of the Ottawa Charter for Health Promotion—*Building healthy public policy,* which *'puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health'*[137].

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[135] Commonwealth Department of Health and Aged Care (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.
[136] World Health Organization (WHO) (2005). *Promoting Mental Health: Concepts, Emerging Evidence, Practice: Summary Report*. Geneva: WHO.
[137] WHO (1986). http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

Furthermore, to maximise opportunities and work towards sustainability, policies need to be coordinated at different levels of government. In Australia this means between the Australian Federal Government (including the Council of Australian Governments [COAG]), State Government of Tasmania, and the local government level. Policies and initiatives at all three levels of government operation need to be coordinated to maximise potential and ensure sustainability, reduce waste and duplication, and identify and eliminate gaps.

The wide range of government portfolios and agencies that are relevant to mental health and wellbeing makes this a complex task; consequently, strong whole of government coordination is required to clearly link and effectively communicate relevant policy initiatives.

Actions:

- Establish a whole of government coordination mechanism that has, as a priority, the role of identifying the mental health and wellbeing outcomes/impacts in all government policies and linked initiatives. The coordination function needs to consider the impact of government policies on mental health and wellbeing across portfolios and at all three levels of government (local, State and Federal). Further roles would be to facilitate priority setting for Tasmania through effective consultation, coordinate appropriate responses, and provide a monitoring and reporting function. An ongoing long-term workplan to identify and report relevant policy and practice initiatives, and to coordinate responses, would need to be developed.
- Undertake an audit or policy map of linked initiatives under the auspices of the whole of government coordination mechanism. Identify the mental health and wellbeing components of the following policies and plans that are currently in progress, and investigate their overlap, synergies, potential conflicts and possible gaps:
    - Strategic Framework for Health Promotion 2009-2011
    - Social Inclusion Strategy
    - Tasmania's Health Plan
    - Mental Health Services Strategic Plan: 2006-2011
    - Tasmania Together 2020
    - Strengthening the Prevention and Management of Chronic Conditions: Policy Framework 2005
    - Alcohol, Tobacco and other Drug Services: Future Service Directions - A Five Year Plan 2008/09-2012/13
    - Tasmanian Drug Strategy 2005-2009
    - Youth Health Service Framework 2008-2011

Strategy 4. Ensure critical collaborative intersectoral relationships are developed and sustained

Effective PPEI is predicated on the development and sustainability of key partnerships and collaborations. Strong action is required to support collaborations that are already in place, or emerging in Tasmania, and ensure that these are maintained and strengthened. Areas where critical collaborations are missing need to be identified and these gaps addressed.

Importantly, key collaborations that are vital for mental health and wellbeing have been identified through the Mental Health Services 'Framework for Intersectoral Collaboration', which outlines the development of four key Working Groups to enhance coordination and collaboration across key activities both within and between sectors.

Actions:

- Further develop and implement the proposed 'Framework for Intersectoral Collaboration', to establish a multi-faceted approach to coordination and collaboration through the formation of four Working Groups:
    - *Inter Agency Mental Health Working Group* (including a range of sectors such as health, education, Premier and Cabinet, justice, police, community services);
    - *Intra Agency Working Group* (reflecting the interface between health and human services and includes population health, mental health, alcohol and other drugs, disability, housing, children and families, oral health, hospitals);
    - *Community and Consumer/Carer Working Group* (representing the not-for-profit sector bringing together consumer and carer groups and member organisations of the Mental Health Council of Tasmania); and
    - *Clinical Network* (reflecting the interface between mental health and primary care including general practice and primary health care services).
- Ensure sustainability and further development of effective collaborations such as the Inter Agency Support Teams, Drought Network Tasmania, Inter Agency Working Group on Drugs, Tasmanian Suicide Prevention Steering Committee, and Tasmanian Transcultural Mental Health Network.
- Determine a mechanism for the identification and recognition of shared clients, particularly for Mental Health Services, Alcohol and other Drug Services, Child Protection, and Corrections.
- Establish a mechanism for more formal collaboration between the mental health and education sectors.
- Develop strong links with public health. There is considerable synergy to be achieved by working with public health on initiatives to reduce the risk factors for physical illness and chronic disease, acknowledging the interrelationship between physical and mental health and wellbeing.

Strategy 5. Develop a Suicide Prevention Strategy for Tasmania that reflects a whole of government and whole of community approach to suicide prevention and a framework for action

Suicide is one of the most complex human tragedies and while it is a relatively uncommon event in Australia, it remains a major public health and community issue that impacts greatly upon the lives of those affected as well as relatives, friends and work colleagues.

The Tasmanian suicide rate for 2006, including unconfirmed cases, was 14.7 per 100,000.[138] This is of concern to the Tasmanian Government and provides further evidence of the need for the development of a suicide prevention strategy for Tasmania.

It is known that the risk factors for suicide vary with age, gender and ethnicity. However it is generally agreed that individuals are at higher risk if they experience depression and/or other mental disorders, or substance use disorders; have a family history of suicide; or have made a previous suicide attempt.

Actions:

- Establish a collaborative mechanism to oversight the development of a Suicide Prevention Strategy for Tasmania as recommended by Tasmania's Parliamentary Joint Standing Committee on Community Development Report on Strategies for the Prevention of Suicide (2007).
- Ensure the development of the Suicide Prevention Strategy is aligned with the national strategic framework for preventing suicide and promoting mental health and resilience, Living is for Everyone (LIFE) – A Framework for Suicide Prevention in Australia (2007).
- Ensure the development of the Suicide Prevention Strategy is underpinned by the conceptual framework noted in *Building the Foundations for Mental Health and Wellbeing.*
- Consider recent Tasmanian research and reports from the Tasmanian Suicide Prevention Steering Committee (TSPSC) to inform the development of the Strategy including Voices of Tasmanians on Suicide Prevention 2009 and the TSPSC Report 2006/2008.
- Ensure suicide prevention and self harm minimisation programs are evidence-based, safe and effective interventions.
- Increase the support for the work of Community Sector Organisations in suicide prevention activity such as the 'Rural Alive and Well' project.
- Establish strategic partnerships with other agencies to increase individual, family and community awareness and understanding of suicide and suicide prevention including risk and protective factors.

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[138] Tasmanian Suicide Prevention Steering Committee Report 2006/2008, (2009). Department of Health & Human Services, p. 16.

Strategy 6. Establish a strong and supportive relationship with the media

A key partnership of special significance is with the media. It is well-established that the media has a profound effect on people's attitudes and behaviours, and this is particularly evident in relation to mental health[139]. The media have an impact on understanding of positive mental health, mental health literacy, as well as being a major influence on the stigma experienced by people with mental illness.

The evidence for the role of the media in stigma reduction and improving mental health literacy is becoming well-established[140]. The media need to be engaged in a range of ways, including the responsible reporting of mental illness and suicide.

An important development in this regard was the inaugural Excellence in Mental Health Reporting category of the Tasmania Media Awards instituted in 2008 to recognise positive journalistic practice. Multi-modal approaches are required to effectively convey messages to the community in general, as well as specifically targeting relevant population groups (such as young people), to improve understanding of mental health and wellbeing, increase mental health literacy, reduce stigma, as well as influence the risk and protective factors for mental health, such as social exclusion/inclusion.

Actions:

- Progress mechanisms to ensure accurate and appropriate media reporting of issues and incidents related to mental illness and suicide, including supporting the Tasmania Media Awards and working with SANE Australia.
- Partner with both public health and the media to disseminate messages that promote health, mental health and wellbeing, including contributing to the Community Broadcasting Association's Suicide Prevention Project, which aims to provide help-seeking and wellbeing messages to a wide and diverse network of communities.
- Investigate opportunities to adopt and adapt social marketing campaigns for Tasmania that improve understanding of positive mental health and reduce stigma, similar to VicHealth's 'Together We Do Better', Queensland Government's 'Be Kind To Your Mind' and Mentally Healthy WA's 'Act-Belong-Commit'.

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[139] Francis, C., Pirkis, J., Blood, W., Dunt, D., Burgess, P., Morley, B., Stewart, A. & Putnis, P. (2004). The portrayal of mental health and illness in Australian non-fiction media. *Australian and New Zealand Journal of Psychiatry*, 38(7), 541- 546.

[140] Sartorius, N. & Schulze, H. (2005). *Reducing the Stigma of Mental Illness. A Report from a Global Programme of the World Psychiatric Association*. Cambridge: Cambridge University Press.

Priority 2:
Build capacity across sectors and in the community to implement programs and initiatives that support mental health and wellbeing

It is vital to educate service providers and the community to have a better understanding of mental health and wellbeing, and the factors that affect this. Education needs to occur in a range of settings and at different levels to be able to target diverse population groups. Importantly, mental health education needs to encompass understanding of a positive view of mental health, as well as understanding risk and protective factors, and the signs and symptoms of mental ill-health and when and where to seek help. The main aims of education and increased awareness are to ensure that people know how to protect their own and their family's mental health, and when and how to take appropriate action and seek help. A further vital outcome of improved awareness and understanding should be greater inclusiveness and less stigmatisation of people who have experienced mental illness, and other social marginalised and disadvantaged groups.

Strategy 1: Enhance understanding of mental health and wellbeing and mental ill-health amongst service providers

Understanding the difference between mental health and mental ill-health and the factors that influence each are fundamental to determining different roles and responsibilities in relation to promoting mental health and preventing mental ill-health in different service sectors.

Actions:

- Identify relevant service sectors that require development for better understanding of mental health and wellbeing and mental ill-health.
- Develop a plan for implementing the Auseinet 'Understanding Mental Health and Wellbeing', or similar module across service sectors in Tasmania.
- Develop a plan for implementing 'Mental Health First Aid', or similar, in community and non-clinical service sectors in Tasmania, especially the Department of Police and Emergency Management and the Department of Education.
- Implement stigma-reduction initiatives amongst service providers. These can include such initiatives as mental illness education delivered by consumers and carers, and other effective consumer participation activities (such as paid consumer consultants in relevant services).

Strategy 2. Support school-based interventions to promote mental health and wellbeing

Understanding of mental health needs to be developed early in life, and a critical setting within which to educate young people is school. Australia has developed some world-first school-based interventions to increase resilience and improve understanding of mental

health and mental illness[141] and these need to be widely adopted across Tasmania. Whole of school approaches should be supported, so that the entire school environment promotes mental health and wellbeing. Programs that encourage connectedness to schools and that address bullying need to be prioritised. Importantly, school-based interventions must be age-appropriate; a focus on positive mental health skills is appropriate during the primary school years, with an increasing (but not exclusive) focus on understanding the factors that affect mental ill-health and encourage seeking help for mental health problems in the later school years. Mental health education programs should contain information about positive mental health as well as mental ill-health.

Actions:

- Build a stronger partnership between Mental Health Services and the Department of Education through development of a process and mechanisms for coordination. In particular, support the Wellbeing Curriculum in Schools and enable Education and Mental Health to work together to identify and implement current evidence-based school-based interventions, such as MindMatters, KidsMatter, the Resourceful Adolescent Program (RAP), anti-bullying and school connectedness programs.
- Support the role of CAMHS' workers in providing mental health education and early intervention in schools through stronger coordination between mental health and education.
- Implement programs that focus on building skills to support positive mental health, such as those that focus on resilience and problem solving, during the primary school years.
- Continue to implement interventions that build resilience in the secondary school years, but add components that improve mental health literacy, reduce the stigma of mental illness, and—most importantly—encourage effective early help-seeking for mental health problems and related issues such as suicidal thoughts, alcohol and other drug use, and relationship problems.

Strategy 3. Promote positive mental health messages and improve mental health and wellbeing through the workplace

The workplace is another key setting within which to promote mental health and educate people about the factors that affect it and how to recognise and respond to signs and symptoms of mental ill-health. Different types of workforces provide different opportunities, but fundamentally there are two main ways to engage with the workforce: improve the skills of individuals in understanding their personal mental health and wellbeing; and improve the capacity of service providers in the workforce to understand and influence the factors that affect mental health and wellbeing on a broader scale.

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[141] See:
MindMatters http://www.mindmatters.edu.au/
KidsMatter http://www.kidsmatter.edu.au/
Resourceful Adolescent Program http://www.hlth.qut.edu.au/psyc/rap/

Actions:

- Facilitate opportunities to work with various workforces (such as apprentices, hospitality, industry) to improve understanding of ways to protect and improve mental health and wellbeing, effective actions to take to prevent the development of illness, and how to identify early signs and symptoms of mental health problems and take appropriate action.
- Identify opportunities to work with key business representatives and peak bodies to develop mental health promoting workplaces, including programs to reduce workplace bullying and increase social inclusion.

Strategy 4. Promote positive mental health messages and improve mental health and wellbeing through community settings

Another key setting for improving understanding of mental health is the communities within which people live. Reaching people within their own communities is often the best way to widely educate the public. It is also the way that local communities can be empowered to take actions to identify and address their own needs, which improves community engagement and the local relevance of initiatives.

Actions:

- Develop a plan to work with the Neighbourhood House initiative for communities to identify their mental health promotion needs and ways to implement activities that promote positive mental health.
- Utilise opportunities such as Agfest, Rural Health Week and Mental Health Week to promote messages that support mental health and wellbeing.
- Promote arts and recreation-based initiatives that engage community members, particularly those who are socially isolated or disadvantaged, to connect with the community and take part in meaningful activities.

Priority 3:
Invest in the early years and families

The evidence strongly supports investment in the early years as pivotal to achieving the best outcomes for improving mental health and wellbeing[142]. Investment in the early years includes prenatal, perinatal and the early years of life where attachment, positive parenting and stable and secure families are all vital protective factors for mental health. In this priority area it is important to build on a whole of government policy framework for the early years.

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[142] Stanley, F., Richardson, S. & Prior, M. (2005). *Children of the Lucky Country? How Australian Society has Turned its Back on Children and Why Children Matter.* Sydney: Pan Macmillan Australia Pty Ltd.

Strategy 1. Strengthen mental health support within child and maternal health and family centres

Infant, child and perinatal health care services and family centres are settings that provide opportunities to access young families, and these need to be utilised as a key opportunity for supporting families and ensuring that Tasmanians have the best start to life.

Actions:

- Ensure that nurses working in infant, child and perinatal health care services and family centres have skills in promoting mental health and wellbeing, particularly in relation to building parent/child attachment.
- Coordinate implementation of the National *beyondblue* Perinatal Mental Health Program.
- Support the role of CAMHS' workers in providing specialist support and knowledge to infant, child and perinatal health care services and family centres.
- Enable early identification of risk factors (such as family breakdown) and promote engagement in relevant intervention opportunities through infant, child and perinatal health care services and family centres.

Strategy 2. Support development of positive parenting skills

Parenting skills are the foundation of positive child development. Parents need to understand the importance of quality attachment with their children as well as ways to increase the protective factors available to their family and reduce risks. New parents require opportunities for developing parenting skills that facilitate attachment and build resilience within the child and the family unit.

Actions:

- Identify opportunities to support all new parents to develop positive parenting skills, though the implementation of evidence-based programs such as Triple-P[143].
- Provide a high level of support to parents of children at risk, particularly parents identified through child protection agencies, corrective services, alcohol and other drug agencies, and parents with mental illness.

Strategy 3. Investigate opportunities for mental health promotion in early childhood settings

Early childhood settings, including child care and preschool, provide critical opportunities for intervening early in life. Ways to work with these services and service providers to improve mental health and wellbeing need to be explored.

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[143] See: http://www.triplep.net/

Actions:

- Bring together key stakeholders from the childcare and early childhood education sectors to identify priorities and develop an action plan for improving children's mental health and wellbeing in these settings.

Priority 4: Consolidate and further strengthen the reorientation of Mental Health Services and Community Sector Organisations to support mental health and wellbeing

Change needs to continue to occur in Mental Health Services and Community Sector Organisations to strengthen reorientation towards a system that supports mental health and wellbeing for clients, the mental health workforce and the broader community. A widely accepted and embedded reorientation toward recovery is required, focusing on improved early access to services, more holistic continuing care, and genuine consumer and carer participation. Importantly, it is essential that the geographically dispersed and mostly rural nature of Tasmania's population is acknowledged and issues related to service accessibility addressed.

Strategy 1. Engage Mental Health Services as a key driver of PPEI

To reorient Mental Health Services and Community Sector Organisations, as well as engage the broader mental health sector, it is essential that Mental Health Services is a key champion and driver of PPEI. The relevant workforces will then be motivated to engage fully with this Strategic Framework and implement the actions needed for change to occur. Importantly, Mental Health Services and Community Sector Organisations need to be convinced of the need for reorientation, and formally acknowledge the long-term and fundamental nature of the changes required and the extended timeframes it will take to see tangible benefits from PPEI initiatives.

Actions:

- Review current funding and service models in Mental Health Services and Community Sector Organisations to determine the changes that are required to embed reorientation toward recovery and PPEI.
- Quarantine or otherwise allocate part of the Mental Health budget for PPEI activities.
- Implement workforce development programs to ensure that the workforce in Mental Health Services and Community Sector Organisations have the skills to implement PPEI.
- Build PPEI activities into the job descriptions of Mental Health Services' clinicians and align Key Performance Indicators (KPIs) to this part of their role.
- Fund specialist roles in Mental Health Services and Community Sector Organisations to acknowledge the need for specially trained mental health promotion officers who can build collaborative partnerships and undertake education and evaluation.

- Develop a reporting mechanism to provide feedback to the Mental Health Services and Community Sector Organisations on progress in PPEI.

Strategy 2. Improve access to early intervention

It is vital that a shift occurs in mental health service delivery from treatment services, which can be crisis driven, to services that provide effective early intervention. This requires a fundamental restructure of some of the access points and entry criteria to mental health care.

Actions:

- Consider ways to work toward redefining Mental Health Services to provide four service streams—for children, adolescents and youth (12-25 years), adults, and older adults. This approach is consistent with evidence regarding the developmental pathways of mental health problems, and highlighting the importance of focusing on adolescence and youth for early intervention as these are the life stages when the vast majority of mental disorders first emerge[144].
- Develop a mechanism for the early identification of emerging risks affecting mental health. This mechanism will ensure timely service access for shared clients of mental health, alcohol and other drug services, child protection and corrections, as well as for family members who might also be at increased risk. This is particularly important for people with co-occurring conditions.
- Improve linkages between Mental Health Services and Community Sector Organisations and primary care and general practice, particularly in rural areas. This might include the development of better clinical networks, and the development and implementation of innovative ways to overcome issues of distance through use of new technologies and/or transport options.

Strategy 3. Embed a recovery orientation within Mental Health Services and Community Sector Organisations

Working within a recovery orientation is recognised nationally and internationally as the most appropriate and effective service delivery approach for people with mental illness. While it requires a major change in practice and training of many mental health service providers, it is an approach required to improve mental health and wellbeing for consumers and carers, through ensuring an holistic approach to mental health care and one that helps to destigmatise mental illness.

Actions:

- Determine the training and professional development needs of the workforces in Mental Health Services and Community Sector Organisations to ensure the skills to work within a recovery orientation.

[144] McGorry, P.D., Purcell, R., Hickie, I.B. & Jorm, A.F. (2007). Investing in youth mental health is a best buy. *The Medical Journal of Australia,* 187(7), S5-S7.

- Develop recovery-oriented KPIs for the mental health workforce, and recovery standards for Mental Health Services and Community Sector Organisations.
- Ensure that clinical and non-clinical workers in Mental Health Services and Community Sector Organisations work effectively together to provide holistic recovery-oriented mental health care through implementation of the proposed 'Framework for Intersectoral Collaboration'.

Strategy 4. Ensure effective consumer and carer participation in Mental Health Services and Community Sector Organisations

Authentic participation of consumers and carers is fundamental to mental health services working within a recovery orientation. Participation must occur at all levels, which means that consumers, supported by their families and carers, should be actively involved not only in the planning, delivery and evaluation of services, but also in the planning of their own treatment and continuing care. Active participation is necessary to support the mental health and wellbeing of consumers and carers involved in treatment, but also plays a vital role in destigmatising mental illness—within services and more broadly across the community.

Actions:

- Implement the recommendations of the Tasmanian Mental Health Services Consumer and Carer Participation Review, including development of a sustainable mechanism for State-wide consumer support.
- Develop and implement an effective consumer and carer participation framework for Mental Health Services and Community Sector Organisations.

Priority 5: Reduce mental health inequalities

The priorities, strategies and actions identified in this Strategic Framework aim to support all Tasmanians to achieve the best possible mental health and wellbeing. However, there are some population groups that have a higher level of risk than others of developing mental illness, and there are also unique features of some population groups that need to be specifically acknowledged and addressed in order to work towards health equity.

Some of the population groups for Tasmania that need to be prioritised to reduce mental health inequalities are: people living in remote and isolated areas; drought-affected farmers, communities and producers; Tasmanian Aborigines; people from culturally and linguistically diverse backgrounds; and those involved with the justice, corrections, child welfare, and alcohol and other drug services. There are also unique needs that emerge at different stages of the life cycle. While it is not possible to consider all possible higher risk population groups, this final priority area highlights some distinctive needs and unique applications of the Strategic Framework that need to be emphasised for higher risk population groups.

Strategy 1. Consider the mental health and wellbeing needs of people living in rural and remote areas in all initiatives

Although Tasmanians living in rural and remote areas are identified as a priority population group, it must be acknowledged that this group comprises the majority of Tasmanians. Consequently, all strategies in this Strategic Framework should ensure that the actions implemented effectively encompass and reach those in rural and remote areas. A focus on this population group is re-stated here to reinforce some key actions specifically aimed at reducing health inequalities for those in rural and remote areas.

Actions:

- Support the work of the University of Tasmania and the Centre for Rural and Remote Health to ensure the needs of rural and remote Tasmanians are identified and addressed.
- Increase support for the development of innovations in technology and other approaches that can overcome issues of distance to ensure that people living in rural and remote areas can access health services based in more urban settings.
- Identify ways that people in rural and remote areas can be involved in consumer and carer participation initiatives.

Strategy 2. Build on initiatives for drought-affected farmers, producers and communities

A large proportion of Tasmania's community live in farming areas, most of which are severely affected by drought and many also by disadvantaged socio-economic conditions. Farmers and their communities must, therefore, be recognised as a high-risk group for mental health problems, including suicide. A number of key initiatives are currently underway and these need to be supported, enhanced and sustained.

Actions:

- Increase the capacity and sustainability of current initiatives for drought affected farmers and communities, such as Drought Network Tasmania.
- Build on initiatives to reduce the stigma of asking for help to encourage early help-seeking for farmers, particularly those experiencing depression, suicidal thoughts, harmful alcohol and other drug use.
- Enhance initiatives to help prepare farmers for a life after farming, including other modes of economic support and possible transitions to living in more urban areas, in collaboration with the Tasmanian Farmers and Graziers Association and Tasmanian Women in Agriculture.

Strategy 3. Work with relevant policy makers, health organisations and communities to ensure the unique PPEI needs of Tasmanian Aboriginal people are identified and met

Aboriginal and Torres Strait Islander Australians have unique needs regarding mental health and wellbeing. Understanding mental health from their perspective requires incorporating an holistic concept of social, emotional, spiritual and cultural wellbeing. There are several relevant national and Tasmanian strategies, including:

- *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009*
- *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*
- COAG initiative *Overcoming Indigenous Disadvantage*
- *National Drug Strategy Aboriginal and Torres Strait Islander Complementary Action Plan 2003-2009*
- *The Needs of the Tasmanian Aboriginal Community in Response to Alcohol, Tobacco and Other Drugs Use Issues Report 2008: DHHS Alcohol & Drug Service Responses 2009/10 - 2012/13*

It is essential that Tasmanian initiatives are aligned with the national agendas, and that both mainstream and Aboriginal-specific policy makers and service providers work together to address mental health inequalities for Tasmanian Aboriginal people. Importantly, the unique demographic characteristics of Tasmanian Aboriginal people need to be acknowledged, as they are a particularly young population group, which means that there are many opportunities for early intervention and for intervening early in the lifespan.

Actions:

- Liaise with key stakeholders to determine how this PPEI Strategic Framework aligns with strategies specifically developed with Tasmanian Aboriginal people as well as with national initiatives.

Strategy 4. Support the children of parents with mental illness

The children of parents with mental illness are a high-risk group for developing mental health problems and need to be prioritised for prevention and early intervention. These children require support in ways that ensure that their unique risk factors are attended to, which means coordinated effort across a number of sectors and services. Their priority group status needs to be recognised in both policy and service provision.

Actions:

- Support implementation of the Kids in Mind initiative across Tasmania.
- Develop a mechanism to identify and implement emerging initiatives relevant to Tasmania from the Children of Parents with Mental Illness national initiative (COPMI)[145].

Strategy 5. Build on health promotion initiatives in justice and correctional settings

Justice and correctional settings provide a wide range of opportunities for supporting mental health and wellbeing, for both the offender and his/her family. Consequently, these are important settings for PPEI, and engaging the justice and corrections sectors in this Strategic Framework is essential.

[145] See: http://www.copmi.net.au/

Actions:

- Facilitate and enhance the work of Inter Agency Support Teams to identify and support young people at risk.
- Establish a mechanism for the development and sustainability of strong partnerships between Corrections, Mental Health Services, Alcohol and other Drug Services, and Child Protection. This mechanism should facilitate identification of shared clients and ways to provide them with improved support and service access.
- Support mental health promotion initiatives in correctional and justice settings through the PPEI Coordination Unit.

Strategy 6. Address the needs of Tasmania's culturally and linguistically diverse communities

Tasmania is comprised of a wide range of culturally and linguistically diverse groups. Many of these people have high levels of positive mental health; the experience of migration can be one that builds resilience and these strengths need to be recognised and promoted. However, there are also unique needs and increased risks for some groups, such as former refugees, that need to be acknowledged and addressed.

Actions:

- Maintain the Tasmanian Transcultural Mental Health Network.
- Provide access to mental health promotion information in all languages. Importantly, include information acknowledging the strengths and resilience acquired through migration.
- Enable Mental Health Services and Community Sector Organisations to work in partnership with other community groups to identify and reduce barriers to service access for specific culturally and linguistically diverse communities, especially around reducing the stigma of seeking help and ensuring knowledge of how to access services.
- Support initiatives to provide increased support for former refugees and recently arrived migrants, noting their very high level of risk of mental health problems due to exposure to torture, trauma, grief and loss.

Strategy 7. Ensure that changes in risk and protective factors across the lifespan are recognised and appropriately targeted

Risk and protective factors for mental health vary markedly across the lifespan. To engage in effective PPEI, changing needs across the lifespan need to be recognised and addressed. This requires targeting interventions to particular ages and settings. There needs to be widespread understanding of changing mental health needs across the lifespan within the mental health workforce.

Actions:

- Ensure workers in Mental Health Services and Community Sector Organisations are aware of key risk factors as they apply across the lifespan, including the life transitions that signify increased risk, such as: school leaving; family breakdown; and significant life

events, particularly those involving loss. This awareness needs to extend to the availability of appropriate prevention and early intervention options to address these risks.

- Recognise emerging sexual orientation as a period of increased risk, particularly for same-sex attracted youth. Facilitate implementation of appropriate supports for same-sex attracted youth.
- Acknowledge older adulthood as an important life stage that deserves special recognition in relation to mental health and wellbeing, as this is a generally neglected area in the PPEI field since the focus is often earlier in the lifespan. There are unique risk and protective factors for mental health in older adulthood, such as loss and grief as common risks. Consequently, all services working with older adults need to identify such risks and refer to appropriate support services when necessary. Furthermore, a stronger focus on positive mental health and wellbeing in older age should be encouraged, particularly within aged care services.

7.2 PPEI and Mental Health Services / Community Sector Organisations

Mental health promotion, prevention of mental ill-health and early intervention has been a priority in mental health policy in Australia since the late 1990s. However, the mental health services sector has struggled for the last decade in translating that priority into meaningful roles and responsibilities for the workforce that is providing services to people with acute and chronic mental illness.

This Section articulates the roles and responsibilities of Mental Health Services and Community Sector Organisations funded by DHHS (as defined in Section 2) in relation to implementing the strategies and actions outlined in Section 7.1. It is acknowledged that clinical services are provided by Mental Health Services and the majority of non-clinical services (such as supported accommodation, social participation, vocational rehabilitation) are provided by Community Sector Organisations.

Although this Section specifically outlines roles and responsibilities for DHHS funded services, it can also be used to guide the broader mental health services sector.

Role of Mental Health Services and Community Sector Organisations in relation to positive mental health

Mental health and wellbeing as defined in Section 4 recognises mental health as a positive construct independent of the presence or absence of illness. This construct of positive mental health which is further supported by the Dual Continua Model of Mental Health[146] (see Figure 2, Section 4) is relevant to all people, regardless of a diagnosis of mental illness. This model demonstrates how one's mental health can be enhanced regardless of a diagnosis of mental illness, and is therefore fundamental to an understanding of how mental health promotion principles can be applied to people with mental illness.

Positive mental health is a basic human right and resource for quality of life that enables individuals, families, organisations and communities to navigate challenges and realise their aspirations[147]. Positive mental health is essential for school success and contributes fundamentally to the extent to which people feel able and motivated to exercise choice and control and to adopt a healthy lifestyle[148].

This positive view of mental health is synergistic with positive psychology where the focus is on the positive aspects of health and wellbeing.

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[146] Tudor, K. (1996). *Mental Health Promotion: Paradigms and Practice*. London: Routledge.

[147] Jané-Llopis, E. & Braddick, F. (Eds.) (2008). *Mental Health in Youth and Education: Consensus paper*. Luxembourg: European Communities.

[148] National Institute for Mental Health in England (NIMHE) (2005). *Making it Possible: Improving mental health and well-being in England*. Leeds, England: NIMHE.

Mental Health Services and Community Sector Organisations need to acknowledge that positive mental health and wellbeing is relevant to everyone and seek to understand the factors influencing the mental health of their clients. Stemming the tide of mental illness requires a shift in thinking about 'mental health' which is often erroneously interpreted in terms of mental illness.

Responsibilities of Mental Health Services and Community Sector Organisations include:

- ***Ensuring services embrace a positive construct of mental health.***
- ***Ensuring the workforce understands the difference between mental health and mental ill-health and the conceptual underpinnings of mental health promotion and prevention of ill-health.***
- ***Provision of education to organisations within and external to DHHS to enhance knowledge and understanding of mental health, mental health promotion and prevention of mental ill-health.***

Outcomes:

- ***A positive construct of mental health is visible in the mission statement of Mental Health Services and Community Sector Organisations.***
- ***Training in understanding mental health and wellbeing has been rolled out across Mental Health Services, Community Sector Organisations, and other key sectors.***
- ***'Mental Health First Aid' or a similar program has been implemented in the community and non clinical sectors in Tasmania.***

Role of Mental Health Services and Community Sector Organisations in relation to mental health promotion

Mental health promotion is about improving wellbeing for all people, regardless of whether they are currently well or ill. Many approaches are possible but the focus is on creating supportive environments conducive to good mental health, strengthening communities through empowerment and engagement and the development of skills to deal with life's challenges.

Recovery oriented services are what most mental health services in Australia and internationally are aspiring to. This is true for Tasmania where the development of a recovery focus in the delivery of mental health services is clearly articulated in Tasmania's Mental Health Services Strategic Plan 2006 - 2011.

Recovery has been defined as:

> *A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery*

involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability[149].

The concept of recovery for people with mental illness has synergy with the concept of mental health promotion. Mental health promotion is about maximising wellbeing, quality of life, a sense of control over one's health, and the ability to bounce back (resiliency) from the challenges of life[150]. These factors are as relevant for people affected by mental illness as they are for the entire population. Recovery takes a holistic approach to an individual where the experience of an illness is only one component. According to Keyes[151], a key to treatment of mental illness is reorienting the individual to the principles of flourishing - this is critical for recovery. This means that mental health promotion is essential even for those experiencing mental illness. In essence, recovery is mental health promotion for people with a mental illness and recovery-oriented services are mental health promoting services for people experiencing mental ill-health.

There is a range of services made available to people who have mental health problems which would be regarded as addressing the social and economic determinants of mental health. These include: supported accommodation, peer support programs, vocational rehabilitation and social participation programs. In addition, strategies being implemented to reduce stigma, enhance social inclusion and those addressing homelessness and poverty are also addressing the determinants of mental health.

Mental Health Services and Community Sector Organisations play a pivotal role in creating supportive environments for people who have a mental illness and their carers. Reorienting services to be recovery focused is vital to supporting and enhancing mental health and wellbeing for people experiencing mental illness.

Consumer and carer participation in the development of recovery oriented services is paramount as recovery involves partnership between consumers, their carers and health service providers. Recovery seeks to empower consumers in taking control of their lives and therefore calls for a different relationship with the clinician or treatment provider than traditional treatment services which embrace the clinician or provider as the 'expert'.

The purpose of mental health promotion for people with a mental illness is to ensure that individuals with mental illness have power, choice and control over their lives and mental health, and that their communities have the strength and capacity to support individual empowerment and recovery.

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[149] Adapted from: Anthony, W.A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159-168.

[150] Pape, B. & Galipeault, J. (2002). *Mental Health Promotion for People with Mental Illness: A Discussion Paper*. Canada: Mental Health Promotion Unit, Health Canada.

[151] Keyes, C. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist*, February-March, 95-108.

The key role for Mental Health Services and Community Sector Organisations in mental health promotion is to enhance mental health and wellbeing for people experiencing mental ill-health. Reorienting services to a recovery focus is essential in developing mental health promoting services for people experiencing mental ill-health. Effective and empowering consumer and carer participation strategies and infrastructure are paramount to a recovery oriented service model.

Responsibilities of Mental Health Services include:

- ***Ensuring Mental Health Services operate within a recovery orientation.***
- ***Ensure effective consumer and carer participation.***
- ***Support school based interventions and strengthen the partnership between mental health services and education.***
- ***Promote positive mental health messages and improve mental health and wellbeing through workplaces and community settings.***

Responsibilities of Community Sector Organisations include:

- ***Ensuring services operate within a recovery orientation.***
- ***Ensure effective consumer and carer participation.***
- ***Promote positive mental health messages and improve mental health and wellbeing in the community.***

Outcomes:

- ***Training and professional development has been provided for the Mental Health Services and Community Sector Organisation workforces that gives them the skills to work within a recovery orientation.***
- ***Recovery-oriented KPIs have been developed for staff employed in Mental Health Services and Community Sector Organisations and recovery standards are developed for service provision.***
- ***More improved collaborative working relationships through implementation of the proposed 'Framework for Intersectoral Collaboration'.***
- ***Consumer and carer participation is embedded in the recovery-focused Mental Health Services and Community Sector Organisations.***
- ***Strong partnerships have been developed between CAMHS and schools which enable CAMHS' workers to provide mental health education and early intervention in schools.***
- ***Improved collaboration with Neighbourhood House initiatives in promoting better understanding of mental health and wellbeing.***
- ***Events such as Agfest, Rural Health Week and Mental Health Week are utilised by Mental Health Services and Community Sector Organisations to promote messages that support mental health and wellbeing.***

Role of Mental Health Services and Community Sector Organisations in relation to prevention of mental ill-health

The issue of prevention is often a perplexing one for providers of predominantly treatment and rehabilitation services. Prevention interventions work by mediating risk and protective factors in reducing vulnerability to mental illness and mental disorder.

Prevention interventions can be differentiated into primary, secondary and tertiary as outlined in Section 4. It is clear that many of the actions that need to be undertaken to prevent the onset of illness lie outside the health sector. Generally, by the time people engage with the health sector, signs and symptoms of illness are already present.

Given the nature of Adult Mental Health Services, the focus of prevention interventions falls mainly in the secondary and tertiary prevention domains. However, some interventions such as support for children of parents with a mental illness are primary prevention interventions as they seek to prevent illness in a high risk group. Furthermore, treating mothers with postnatal depression as early as possible also protects the mental health of the newborn and as such is a primary prevention strategy for the child. Similarly, supporting and counseling people bereaved by suicide is also a primary prevention strategy as the evidence indicates they are high risk. All these types of interventions can be implemented by Mental Health Service providers.

Other universal primary prevention interventions such as social marketing campaigns and 'whole school' approaches are more appropriately led by organisations outside of the Mental Health Services sector. Partnerships are essential for ensuring collective action across the whole spectrum of interventions from illness to wellness.

Relapse prevention is an important tertiary prevention strategy in that the key objective is to prevent relapse and possible hospitalisation. While recovery can be regarded as a broader mental health promoting strategy, relapse prevention is a specific component within that.

> *Relapse prevention is a specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs or relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors...relapse prevention is an essential, but not sufficient, component of the recovery process for people with mental illness*[152].

Early intervention or secondary prevention falls within the remit of mental health services, particularly CAMHS' services. Early identification and help-seeking, coupled with effective delivery of responsive services, can assist in reducing the impact of the illness.

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[152] Rickwood, D. (2006). *Pathways of Recovery: Preventing Further Episodes of Mental Illness (Monograph).* Canberra: Commonwealth of Australia, p. 4.

Mental Health Services are not responsible for all prevention interventions across the spectrum from illness to wellness. Inter and intra sectoral partnerships and collaborations are essential in implementing prevention interventions. The key role of Mental Health Services and Community Sector Organisations in prevention is in the domains of secondary and tertiary prevention (ie., downstream interventions). Relapse prevention is an important tertiary prevention intervention to be implemented in a recovery oriented services.

Responsibilities of Mental Health Services include:

- ***Ensure critical collaborative relationships are developed and sustained.***
- ***Strengthen mental health support within child and maternal health and family centres.***
- ***Implement the National beyondblue Perinatal Mental Health Program.***
- ***Support development of positive parenting skills.***
- ***Ensure relapse prevention strategies are being implemented.***

Responsibilities of Community Sector Organisations include:

- ***Ensure critical collaborative relationships are developed and sustained.***
- ***Ensure effective referral pathways.***
- ***Ensure staff understanding of risk and protective factors and early warning signs for relapse.***
- ***Support relapse prevention programs.***

Outcomes:

- ***Improved coordination and collaboration both within and external to Mental Health Services and Community Sector Organisations.***
- ***Improved processes for working with shared clients across Mental Health, Alcohol and other Drugs, Child Protection and the Criminal Justice systems.***
- ***Nurses working in infant, child and perinatal health care services and family centres have skills in promoting mental health and wellbeing, particularly in relation to building parent/child attachment.***
- ***Implementation of the National beyondblue Perinatal Mental Health Program.***
- ***CAMHS' workers provide a greater level of specialist support and knowledge to infant, child and perinatal health care services and family centres.***
- ***Staff working in Community Sector Organisations and child, maternal and family centres are skilled in the recognition and early identification of risk factors and intervention opportunities.***
- ***Increased support to parents at risk, particularly parents identified through Child Protection agencies, Corrective Services and Alcohol and other Drugs agencies, and parents with mental illness.***
- ***Implementation of relapse prevention strategies.***

Role of Mental Health Services and Community Sector Organisations in early intervention

The role of Mental Health Services in early intervention is very clear. Effective evidence based early intervention is dependent on appropriate early identification and help-seeking and accessible, responsive services. Early intervention requires effective referral pathways and coordinated, streamlined services which make it easy for the client and other providers to navigate. Early intervention services are characterised by being responsive and flexible (do not have long waiting lists), use evidence based assessment and diagnostic tools, are culturally appropriate, are well known and accessible to the community and primary care services, and well resourced.

The specific role of Mental Health Services in early intervention is two-fold:

- To ensure the provision of education to service providers and the community on the signs and symptoms of mental illness and ways to enhance help-seeking.
- Provision of early intervention services that are either preventative or treatment oriented, especially in the case of first episode psychosis.

Mental Health Services are responsible for the provision of timely, accessible and appropriate evidence based services that seek to intervene early to prevent the onset of illness or to intervene as early as possible in the onset of signs and symptoms of mental illness. Mental Health Services play a key role in ensuring that providers outside the health sector and the community are educated about the signs and symptoms of mental illness and ways to respond that facilitate help-seeking. Development of effective referral pathways and screening tools are also a key role of Mental Health Services.

The specific role of Community Sector Organisations in relation to early intervention is two-fold:

- To ensure the community and staff of Community Sector Organisations have sufficient knowledge to identify the signs and symptoms of mental illness and facilitate help-seeking.
- Facilitate access to timely and responsive assessment and treatment services.

Community Sector Organisations are responsible for ensuring the capacity of their organisations and the community more broadly to be able to identify the early signs and symptoms of mental illness and to facilitate early help-seeking. Community Sector Organisations also have a key role in brokering access to early intervention assessment and treatment services.

Responsibilities of Mental Health Services include:

- ***Provision of timely, accessible and appropriate evidence-based early intervention services.***
- ***Ensuring providers outside the health sector and the community are educated about early identification, risk and protective factors and pathways to help-seeking.***

- ***Ensure effective referral pathways and co-ordination of services.***

Responsibilities of Community Sector Organisations include:

- ***Ensuring staff and the broader community are educated about early identification, risk and protective factors and pathways to help-seeking.***
- ***Ensuring effective referral pathways that facilitate access to timely and effective assessment and treatment services.***

Outcomes:

- ***Mental Health Services are responsive and flexible and can meet the needs of providers and clients needing timely assessment, diagnosis and treatment services.***
- ***Well coordinated referral pathways between Primary Care, General Practice, Mental Health Services and Community Sector Organisations.***

8. Governance, Implementation and Evaluation

Governance, implementation and evaluation of such a wide-reaching Strategic Framework and Action Plan as this are complex and pose considerable challenges. Consequently, significant investment in the oversight, implementation and monitoring of the Strategic Framework is essential.

Importantly, it must be understood that change of this nature takes time, and often occurs over three different stages[153]:

1. **Motivational** or educational interventions to prepare for change – reorienting toward PPEI approaches requires a fundamental attitude shift for many policy makers, service providers and community leaders. People need to be made ready for change by convincing and motivational arguments of the benefits of change. This is particularly challenging in the PPEI field, as it is an approach that comprises a long-term investment in mental health and wellbeing, many outcomes of which will not be evident if only a short-term outlook is adopted.

2. **Enabling** or skill building interventions to enact new practice – often PPEI approaches and interventions require learning new skills through training and professional development. This necessitates both the development of training resources and support as well as incentives for staff and service providers to take up the training and adopt new practice.

3. **Reinforcing**, structural or financing interventions to sustain change – without a high level of investment and resourcing that enables fundamental and sustainable system change, the implementation of PPEI for mental health and wellbeing will remain sporadic and piecemeal and not achieve the long-term benefits envisioned for Tasmania.

Governance and reporting

It is recommended that the implementation and evaluation of this Strategic Framework be coordinated by a Promotion, Prevention and Early Intervention Unit within the Statewide & Mental Health Services (SMHS) State Office. This task could be supported by a Strategic Framework Monitoring Committee, comprised of government, agency and community representatives. This Committee would meet regularly to consider and report on progress of the Framework to the CEO of Statewide & Mental Health Services (or Minister of Health

[153] Drake, R.E., Torrey, W.C. & McHugo, G.J. (2003). Strategies for implementing evidence-based practices in routine mental health settings. *Evidence-based Mental Health,* 6, 6-7.

Services). A report summarising progress of the Strategic Framework will be developed annually.

Implementation

Implementation of the Strategic Framework will be driven by Mental Health Services with leadership from SMHS State Office, in collaboration with other government agencies and current initiatives, and under the general direction of the Strategic Framework Monitoring Committee.

A first step, therefore, is formation of the Strategic Framework Monitoring Committee. This Committee will develop an implementation action plan and timeline, and accompanying evaluation plan.

Implementation requires the development of substantial infrastructure in terms of communication and collaboration mechanisms. This is likely to include the following major initiatives:

1. Establish a **PPEI Coordination Unit** in Statewide & Mental Health Services State Office. This Unit will be the operational unit within Mental Health Services to take responsibility for the governance of the implementation of this Framework and Action Plan. Relevant resources within Mental Health Services will need to be consolidated under the control of this Unit. The Unit will support the Strategic Framework Monitoring Committee comprising representatives from key government portfolios and relevant sectors and agencies. The Unit will liaise with other agencies and sectors to instigate and support collaborative initiatives. This Unit will also develop plans for implementing some targeted intervention programs such as Mental Health First Aid in relevant community organisations and stigma reduction programs in Mental Health Services and Community Sector Organisations.
2. Establish a **research, evaluation, monitoring** and dissemination mechanism, ensuring effective partnership and collaboration with current areas of relevant research strength, such as the University of Tasmania and Centre for Rural and Remote Health. This mechanism could be responsible for the evaluation of implementation of the Strategic Framework.
3. Establish a mechanism for **whole of government communication**. This might be an advisory group or steering committee of relevant agency representatives. The group will need to oversee an exercise to audit and map current linked initiatives, as well as the mental health and wellbeing impacts of current policies and plans at the local, State and Federal levels, and develop strategies to ensure a joined up government approach.
4. Establish a support infrastructure for the **Intersectoral Collaboration Working Groups**, particularly a mechanism to ensure their integration. This is likely to be a function of the PPEI Coordination Unit. In particular, there is a need to ensure a mechanism for the development and sustainability of strong partnerships between corrections, Mental Health Services, alcohol and other drug services, and child protection. Part of the role of these collaborative Working Groups will be to develop

a way to recognise shared clients to ensure early identification of emerging risks and timely service access for these clients and their at-risk family members.

5. Establish a **Working Group to review current funding and service models** in mental health to determine the changes that are required to embed reorientation toward a recovery focus and PPEI. This Working Group will need to consider the standards for Mental Health Services and Community Sector Organisations, and position descriptions and KPIs for all Mental Health Services workers to embed PPEI and a recovery orientation as standard practice.
6. Establish a mechanism, such as a key liaison position within the PPEI Coordination Unit, to develop better collaboration and **communication with the media** to promote mental health and wellbeing, improve mental health literacy, and reduce stigma across the community.
7. Establish a coordination and communication mechanism to progress implementation of mental health and wellbeing **initiatives in schools**. This needs to facilitate inclusion of CAMHS' workers to participate in school-based initiatives.
8. Determine a way to collaborate with **Public Health** to develop a mental health and wellbeing population education and monitoring strategy. This might include development of a social marketing plan that coordinates messages to improve physical and mental health and wellbeing for Tasmanians. It may also include the development of population indicators to monitor changes in health and wellbeing.
9. Establish a strong **consumer and carer support** network and ensure implementation of an effective participation strategy for consumers and carers at all levels of mental health service delivery.
10. Develop and implement a State-wide approach to educate **service providers across sectors** about positive mental health and wellbeing.
11. Develop a mechanism to identify and liaise with relevant **community and workforce** activities and initiatives. This might include such initiatives as the Neighbourhood Houses and Agfest, as well as initiatives in other workforce sectors (such as hospitality, apprentices, farm workers). The aim of this liaison will be to promote positive mental health messages wherever possible, as well as improve mental health literacy and encourage early help-seeking.
12. Identify a collaboration and communication mechanism to ensure that Mental Health Services are engaged with relevant initiatives in **infant, child and perinatal services**. This might include coordination of the National *beyondblue* Perinatal Mental Health Program as a focal point.
13. Instigate a forum for key stakeholders from the **childcare and early childhood education** sectors to identify priorities and develop an action plan for improving a focus on mental health and wellbeing and linkages with other relevant initiatives, such as parenting programs, in these settings.
14. Establish a strong communication and collaboration mechanism between Mental Health Services and **Primary Care Services**. In particular, this mechanism needs to prioritise the development and implementation of ways to improve access to primary care services through innovations that overcome barriers of distance and social disadvantage.

15. Develop a process to liaise with key stakeholders in **Aboriginal health** to determine how this Framework aligns with Aboriginal-specific plans and strategies in Tasmania and nationally.

Evaluation

It is essential to monitor and evaluate progress regarding implementation of this Strategic Framework. This will require development of a detailed evaluation plan to be undertaken concurrently with implementation of the Framework. Appropriate resources must be provided to enable an effective evaluation to be commenced along with implementation.

The evaluation plan will need to take four main steps to effectively evaluate progress of the Strategic Framework and Action Plan:

Evaluation Step 1 – document implementation decisions

A first step is to develop a process to determine and clearly document which strategies and actions were implemented and when they were initiated. It is unlikely that all the strategies and actions presented in this Framework will be able to be actioned, and of those that are, some will be put in place earlier than others. Decisions regarding the actions taken need to be clearly documented, so that it is evident which strategies and actions were fully implemented, partly implemented or not implemented. The timeframes for implementation must be also made clear. It would be valuable to provide justification for not undertaking those strategies and actions that are not implemented. There can be important practical or contextual considerations that impact on implementation, which help to understand the processes by which such a complex Strategic Framework is rolled out. Such transparent decision making and its documentation is often overlooked, yet essential for evaluation. Clearly, it is not possible to achieve outcomes in areas that were not actioned. The Strategic Framework Monitoring Committee will need to be involved in agreeing which strategies and actions were implemented and which were not.

Evaluation Step 2 – undertake a process evaluation

A vital intermediate step in evaluation research is determining whether the processes for implementation were put in place and how well this was done. This is generally termed a *process evaluation* and requires identification of performance indicators that demonstrate that the appropriate processes for implementation were enacted. It is not possible to achieve outcomes if the processes were not adequately implemented. Performance indicators need to be developed for each of the strategies and actions, and ways to measure whether the indicators were fully or partly met must be agreed. Both quantitative and qualitative information regarding performance will be of value to determine to what extent the necessary processes were enacted.

Many of the performance indicators will relate to the 15 major implementation initiatives specified in the Implementation Section (Section 8), and others will relate to the initiatives specific to Mental Health Services and Community Sector Organisations that have been outlined in Section 7.2.

Examples of relevant performance indicators are likely to include:

- PPEI Coordination Unit was established in a timely manner and appropriately resourced.
- Mechanism for whole of government communication was established and appropriately resourced.
- Working Group to review current funding and service models in mental health was established.
- Mechanism was developed to recognise shared clients for Corrections, Mental Health Services, Alcohol and other Drug Services, and Child Protection.

Of special note, one of the vital performance indicators that must be achieved is the development of processes for ongoing sustainability of relevant initiatives—this is something that should not be overlooked in the evaluation.

Evaluation Step 3 – undertake outcome evaluation

This step requires a clear understanding of the outcomes to be achieved by each of the strategies and actions. Outcomes are specification of the aims that are planned to be achieved by a particular action. Outcomes need to be clearly defined, measurable and have an appropriate timeframe. Importantly, in an area like mental health, outcomes can be both short and long-term. A short-term outcome might be 'increase understanding of positive mental health' in a defined population group, such as a group of high school students, whereas a much longer-term outcome will be 'reduce the incidence of depression in adolescents'. Realistic outcomes within the measurement timeframe must be identified.

Importantly, a limited set of outcomes needs to be agreed as the methodology to collect the relevant information can be onerous, complex and time consuming. Outcome evaluation is a multi-disciplinary research activity that involves considerable input from a wide range of stakeholders, including service providers. Effective outcome evaluation generally requires measurement and monitoring of change, which may require collecting baseline information from which change can be determined. Importantly, baseline data need to be collected prior to the implementation of an intervention. The research required to undertake an effective outcome evaluation requires considerable investment in time and research skill.

Examples of relevant outcome indicators are likely to include:

- Improved mental health literacy.
- Reduced stigma for people with mental illness.
- Improved attachment for infants of parents at risk.

Evaluation Step 4 – provide feedback and disseminate information

Dissemination of the results of evaluation research is an important driver of change, and is especially important in the relatively recent and growing area of PPEI. Consequently, a critical component of the evaluation strategy will be development of a way to inform relevant stakeholders of progress. Commitment to implementation is supported and reinforced if pertinent and timely feedback regarding progress can be provided to those who need to be engaged in the process. This is especially important when service providers are being asked to collect and record information and provide it for evaluation purposes. The quality of information provided to researchers will be improved if the information is fed back in a meaningful way to those who have been required to put in the effort to gather it. Good feedback has the dual benefits of facilitating better information and reinforcing implementation.

Glossary of Key Terms

Anxiety

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

Affective disorder

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

Bisexual

A person who is sexually and emotionally attracted to people of both sexes.

Community Sector Organisations / Services

Those organisations in the community funded by the Tasmanian Department of Health and Human Services to provide supported accommodation, rehabilitation, peer support and carer support.

Depression

There are five main types of depression involving a range of emotional, cognitive and somatic signs and symptoms including sustained sad mood or lack of pleasure. These include: Major depression, Psychotic depression, Dysthymia, Mixed depression and anxiety, and Bipolar disorder.

Dual diagnosis

Refers to individuals with co-occurring mental illness and substance use problems.

Early intervention

Early intervention comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem; and people developing or experiencing a first episode of mental disorder.

Gay

Refers to a person whose primary emotional and sexual attraction is toward people of the same sex. The term is most commonly applied to men.

Health inequalities

Refers to the unequal patterns or distribution of health and illness across various segments of the population on the basis of a range of determinants including socioeconomic status, cultural background, geographic location, age, sexual orientation and gender. Many of these inequalities are preventable and relate to aspects of life which support good health, including mental health and wellbeing. These include income, education, supportive living

and working conditions, social and cultural networks, freedom from discrimination and violence, and access to good quality health information and timely and appropriate services.

Homophobia

The fear, dislike or hatred of gay and lesbian people.

Illicit drugs

Illegal drugs, drugs and volatile substances used illicitly or inappropriately, and prescription or over-the-counter pharmaceuticals used for non-medical purposes.

Intersex

A biological condition where a person is born with reproductive organs and/or sex chromosomes that are not exclusively male or female.

Lesbian

A woman whose primary emotional and sexual attraction is towards other women.

Licit drugs

A drug whose production, sale or possession is not prohibited (such as alcohol). 'Legal drug' is an alternative term.

Mental health and wellbeing

Mental health and wellbeing encompasses a positive view of mental health and is relevant for everyone, irrespective of the presence or absence of mental illness. Mental health and wellbeing is a positive sense of emotional, social, intellectual and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity. It enables individuals to feel, think and act in ways that enhance the ability to enjoy life, to contribute to the world around them and to deal with adversity and change. It is the foundation of effective functioning for individuals, families, communities and societies.

Mental health promotion

Mental health promotion is about improving wellbeing for all people, regardless of whether they are currently well or ill. It is about optimising people's mental health by developing environments that are good for everyone. Mental health is affected by the events that happen in ordinary day-to-day lives, as well as by significant stressful events that occur such as loss and grief and physical ill-health.

Mental Health Services

Funded by DHHS to provide specialist mental health services. This includes Inpatient and Extended Care Mental Health Services, Mental Health Services for Older People, Child and Adolescent Mental Health Services (CAMHS), and Adult Community Mental Health Services.

Statewide and Mental Health Services (SMHS) State Office

This refers to the State-wide policy unit in the Department of Health and Human Services (DHHS).

Mental health services sector

This refers to government, community and private organisations and individuals providing mental health services and includes clinical and non-clinical services.

Mental illness

For the purpose of this Strategic Framework, mental illness (or mental ill-health) refers to the spectrum of mental health problems and mental disorders that interfere with an individual's cognitive, emotional or social abilities. Mental illnesses are of different types and degrees of severity and range from problems which emerge in response to temporary life stressors, to disorders which have substantial and lasting impacts on individuals and communities. Some of the major mental illnesses perceived to be public health issues are depression, anxiety, psychosis and dementia. Substance use disorders are also included in the concept of mental illness adopted in this Strategic Framework.

Perinatal

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

PPEI

An acronym referring to the spectrum of mental health promotion, prevention of mental ill-health and early intervention approaches and interventions.

Prenatal

Relating to the period before the birth of a baby.

Prevention

Prevention interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental ill-health. There are three levels of prevention:

1. **Primary prevention** seeks to prevent the onset or development of a disorder or illness. Primary prevention interventions can be targeted to population groups identified according to the level of risk. These are:

   - **General or universal** targeting the whole population.
   - **At risk or selective** aimed at individuals or population groups whose risk of developing a mental health problem or mental illness is higher than for the general population.
   - **High risk or indicated** for people who are at very high risk of developing a mental health problem or mental illness.

2. **Secondary prevention** targets those who are showing early signs or symptoms of mental illness or disorder and seeks to lower the prevalence of illness through early detection and treatment. Secondary prevention interventions have similarities with **early intervention.**

3. **Tertiary prevention** seeks to reduce the negative impact and associated disability of existing mental illness. Tertiary prevention interventions have similarities with **relapse prevention.**

Protective factors

Protective factors are characteristics or variables which enhance or protect positive mental health and reduce the likelihood that a mental illness will develop.

Psychosis

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

Recovery

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. The concept of recovery for people with mental illness is closely aligned with mental health promotion. In essence, mental health promotion is about maximising wellbeing, quality of life, a sense of control over one's health, and the ability to bounce back (resiliency) from the challenges of life. These factors are as relevant for people affected by mental illness as they are for the general population.

Relapse prevention

Relapse prevention is a specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs or relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors.

Resilience

Capacities within individuals and communities which promote positive outcomes; such as mental health and wellbeing, and community cohesion; and provide protection from factors that might otherwise place the person or community at risk of adverse health outcomes. It is commonly referred to as the 'ability to bounce back' from difficult events or circumstances.

Risk factors

Risk factors are characteristics or variables which increase the likelihood that mental health problems or mental illness will develop and may also increase the duration and severity of existing mental illness.

Schizophrenia

A constellation of signs and symptoms which may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions and a restriction in thought, speech and goal-directed behaviour.

Substance use disorders

Involves the dependence on, or abuse of, alcohol and/or drugs, including the nonmedical use of prescription drugs, to such an extent that behaviour becomes maladaptive and social and occupational functioning is impaired.

Suicide

A conscious or deliberate act that ends one's life.

Tasmanian Aboriginal people

For the purpose of this Strategic Framework, 'Tasmanian Aboriginal people' refers to Tasmanian individuals and communities who identify themselves as Aboriginal, Torres Strait Islander, or Aboriginal and Torres Strait Islander.

Transgender

Refers to individuals who do not identify with the gender assigned to them at birth. Sometimes the terms male-to-female or female-to-male are used to refer to individuals who are undergoing or have undergone a process of gender affirmation.

Transphobia

Fear, dislike or hatred of people who are transgender.