The National Mental Health Strategy: Redefining Promotion and Prevention in Mental Health?

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This paper explores policy documents published as part of the National Mental Health Strategy for ideas about mental health promotion and prevention, to determine the extent to which these documents adopt a primary health care approach. Discourse analysis was undertaken of key policy documents to discover the manner in which they discuss mental health promotion and prevention. Three points of departure are identified. The first of these is a focus on social and biological risk factors that manifest at an individual rather than at a social level, effectively drawing attention away from social inequalities. These documents also primarily target a population that is viewed as being "at risk" due to exposure to risk factors, shifting attention from strategies aimed at improving the health of the population as a whole. A final difference is found in the understanding of primary health care. Recent policy documents equate primary health care with the first level of service delivery in the community, primarily by general practitioners, shifting the focus of care from mental health promotion with the community to early intervention with those experiencing mental health problems. This is supported by the incorporation of a biomedical understanding into mental health prevention. While recent mental health policy documents re-assert the need for early intervention and health prevention, the form of mental health prevention espoused in these documents differs from that which informed the Declaration of Alma Alta, Ottawa Charter for Health Promotion and World Health Organization's Health for All strategy.

Key words: *Mental health, Health promotion, Mental health preventions, Discourse analysis, Policy*

Mental health promotion and early intervention for those with mental disorders have received renewed attention in mental health policy documents since the release of the Second National Mental Health Plan in 1998, which made mental health promotion and prevention of mental disorders key goals for service delivery. This paper explores the manner in which mental health promotion and prevention are constructed in the policy documents constituting the National Mental Health Strategy. It posits that the manner in which promotion and prevention are presented in these documents departs from the goals of equity and social justice envisaged by the World Health Organization's (WHO) Health for All strategy and the Ottawa Charter for Health Promotion. This paper argues that this departure arises from the use of "risk factor" epidemiology. Risk factor epidemiology individualises the impact of the social environment through focusing on groups who are viewed as being at risk. This approach reduces concern with social causes of mental illness and contributes to promotion and prevention strategies targeting those viewed as being at risk. A waning interest in social causes of mental illness is reflected in primary care strategies which privilege medical intervention by general practitioners with those experiencing early signs of mental health problems.

New public health and health promotion

The new public health has its origins in the 1970s, initially in the report *A New Perspective on the Health of Canadians* (Landone, 1974) and then in WHO's Health for All strategy (McDonald & Bunton, 1992; Parish, 1995). This form of public health is concerned with the promotion of health rather than the prevention of ill health and with the impact of social and environmental factors on health.

The Health for All strategy originated from an International Conference on Primary Heath Care held at Alma Alta in the Soviet Union in 1977. This conference committed member countries to primary health care which was defined as:

> *[e]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination.* (Cited in McMurray, 2003, p.18)

The conference resulted in the Declaration of Alma-Ata. The declaration defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (cited in Wass, 2000, p.263). It focused on the impact of lifestyle on health; community participation; and intersectoral provision of health care; and redirected health policy towards the reduction of health inequalities through addressing social and economic inequalities (McDonald & Bunton, 1992; McMurray, 2003; Parish, 1995). These elements were evident in the WHO monograph *Health Promotion* released in 1984. The five key principles of this document were:

1. Health promotion involves the population as a whole and the context of their everyday life, rather than focusing on people at risk for specific diseases.
2. Health promotion is directed towards action on the determinants or causes of health.
3. Health promotion combines diverse, but complementary, methods or approaches.
4. Health promotion aims particularly at effective and concrete participation.
5. Health professionals, particularly primary health care, have an important role in nurturing and enabling health promotion (WHO, 1984).

The Alma Alta conference was followed by the first International Conference on Health Promotion in Ottawa, Canada, in 1986. This conference resulted in the Ottawa Charter for Heath Promotion. One of the central goals of the Ottawa Charter was an increased role for community participation in health care. It introduced three strategies for achieving this—advocacy; enablement through health education, lifestyle skills and opportunities to make healthy choices; and mediation through co-ordinated intersectoral delivery of health care (McDonald & Bunton, 1992; Wass, 2000). As such, it called for the sharing of responsibility for delivery of health care between governmental and private organisations across health and welfare sectors (McMurray, 2003). The Charter also sought to re-orientate health services away from curative services. McMurray views this as an attempt to de-medicalise control of health services.

A second International Conference on Health Promotion was held in Adelaide in 1988. This conference re-affirmed the goals of the Ottawa Charter for Health Promotion and identified women as a priority groups for health policy. The third International Conference on Health Promotion in Sandsvall, Sweden, in 1991 focused on health policy and sustainable development while the fourth International Conference on Health Promotion in Jakarta, Indonesia, in 1997 reflected on what constituted effective health promotion, re-examined determinants of health and identified health promotion priorities for the future. This conference resulted in the Jakarta Declaration on Leading Health Promotion into the 21st Century, which called for social responsibility for preventing individual and environmental harm; greater investment in health; the strengthening of existing health partnerships; increasing the community's capacity to manage their own health; and securing the infrastructure for health promotion through mobilising governmental and non-governmental resources for health promotion (McDonald & Bunton, 1992; McMurray, 2003; Wass, 2000).

A focus on social determinants of health is also evident in the WHO approach to mental health promotion. WHO distinguishes between mental health promotion and prevention of mental disorders. Mental health is understood as: "...a state of well-being in which the individual realizes his or her own capabilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (WHO, 2004b, p.12) .

The aim of mental health promotion is to create an optimal environment for mental and emotional wellbeing through management of determinants of health. The Jakarta Declaration on Leading Health Promotion into the 21st Century states that mental health promotion should focus upon "reduc[ing] inequalities and build[ing] social capital" (WHO, 2004a, p.16). Prevention of mental disorders, in contrast, involves the reduction of the risk factors and enhancement of the protective factors associated with mental health with the aim of reducing the symptoms and incidence of mental disorders (WHO, 2004a). In practice, the two overlap through mental health promotion strategies that protect against mental illness.

The principles that underpin the Health for All strategy were adopted by the Australian Government in 1986 and inform *Health for All Australians*, a report released by the Australian Health Ministers' Advisory Council in 1988. This report committed the

Australian federal government to a series of public health goals that targeted specific populations viewed as being at risk due to class, racial or age differences (Australian Health Ministers, 1988). The report was criticised for its biomedical focus, which is evident in the establishment of goals to manage major illness and to reduce identifiable risk factors for illness (McMurray, 2003). The mentally ill were identified as one of the target populations for further intervention in this report resulting in the release of the National Mental Health Strategy in 1992.

Critiquing new public health

Petersen and Lupton (1996) argued that while new public health philosophies focus upon the health status of the population as a whole, they make health the property and responsibility of the individual. This occurs through focusing on social and biological risk factors that manifest on an individual rather than a social level and through personal responsibility for management of lifestyle risks.

Public health strategies are informed by epidemiology. Tannahill (1992, p. 86) defines epidemiology as the "study of the distribution and determinants of disease in known populations." For Inhorn and Whittle (2001, p. 553), "[e]pidemiology as the 'basic science' of public health, has adopted a biomedical, clinical science model for the study of disease 'risk factors', which has taken epidemiology away from its fundamental roots in public health". They view this approach as encouraging public health policies that blame the individual for not managing health risks arising from poor lifestyle choices (Inhorn & Whittle, 2001). McMichael (1999) argues that contemporary epidemiology moves attention away from social factors towards the individual through research strategies that favour specific measurable exposures, circumstances and behaviours. This allows for the identification of groups who are viewed as having a higher risk of developing health disorders due to exposure to social and biological risk factors or through risky behaviours, and for the subjection of these groups to programs promoting healthy behaviours. Shim (2002, p. 132) views this approach as resulting in racial, class and gender inequalities being expressed as the *"individualised attributes of race, SES [socioeconomic status] and sex"* (italics in original).

For Bartley, Blane and Smith (1998) newer research methodologies contributed to a diminishing interest in a casual relationship between social conditions and health. Munater, Eaton, and Diala (2000) identified three stages in the development of psychiatric epidemiology. The first stage involved studies of the class of those within psychiatric hospitals. In the second stage, class was considered a major cause of vulnerability for mental illness while more recent studies explored the prevalence of specific mental disorders in the population. This focus removes social inequalities from the research agenda. Munater et al. associate this change with a "*rapprochement* with biology and a retreat from sociological questions" (2000, p.91, emphasis in original). Nettleton and Bunton (1995) viewed "risk factor epidemiology" as shifting attention away from structural aspects of inequality and establishing new societal divisions based upon health status. This form of epidemiology expresses social inequalities as lifestyle factors and behaviors of the individual. "The individual is viewed as the natural unit of epidemiology" (McMichael, 1999, p. 892).

Public health knowledges about the detrimental effects of lifestyle establish new norms for the presentation and management of the body. This arises from a preventative medicine concerned with pre-detection; that is, a form of medicine that seeks to prevent illness through early intervention in the lives of those deemed as being at risk due to exposure to social and biological risk factors (Castel, 1991, p.288). The dissemination of knowledges about lifestyle risks as part of health education creates an imperative for the individual to take an active role in monitoring and controlling these "lifestyle" factors.

These changes are understood as being indicative of a neo-liberal approach to health care, which is characterised by reduced governmental responsibility for service delivery and greater involvement of the individual in their own care. The relationship between the state and citizens is based upon the active participation of the public in the development of health policy and self-management of lifestyle risks (Hancock, 1999). Newer health knowledges produce "active citizens" though participation in the delivery of health care (Bunton, 1998, p.27). Public health advocates view community involvement in health care and the incorporation of lay knowledges as a means of reducing inequalities arising from the power

differentials between health professionals and the community. Petersen and Lupton (1996) argued, in contrast, that the incorporation of a consumer voice needs to be understood as compelling the individual to take responsibility for managing health problems that may arise in the future through managing health risks in the present. The good citizen is one who "manages their own relationship to risk through self-surveillance and self-help" (Petersen, 1996, p. 55).

Methodology

This paper examines Australian mental health policy documents published as part of the National Mental Health Strategy. The documents were identified and obtained through a search of the catalogue of the National Library of Australia and from the Department of Health and Ageing website, which publishes electronic copies of recent policy documents (http://www.mentalhealth.gov.au/).

The methodology adopted to analyse the data is discourse analysis. The underlying assumption of discourse analysis is that social reality is constituted in language (Tonkiss, 1998). Bacchi (2000) argued that a discourse approach to policy documents assumes that policy is not simply a response to existing social problems, but a means of identifying social problems and framing them in such a manner that the recommended interventions become self-evident. Policy creates the discursive framework for understanding a social problem through defining that problem in a certain manner, excluding alternate representations of the issue and limiting the range of possible interventions to those following from the framework. The goal of discourse analysis of policy documents is to examine the manner in which social issues are represented within policy; whose interests are represented and whose are excluded and the power evident in these representations (Bacchi, 2000; Silverman, 2000).

The policy documents in this study were explored for the way in which they construct mental health promotion and prevention of mental disorders and the range of interventions that follow from this representation. Documents were examined for the models used to describe promotion and prevention, and the manner in which they define primary health care, the role of the professions in the provision of care and the services recommended to promote mental wellbeing and prevent mental health disorders. These issues are explored in light of a biomedical understanding of risk and the delivery of mental health services.

Epidemiology, population health and risk

Mental health promotion and prevention are currently informed by epidemiology through a population health approach. This approach involves the detection of shared characteristics among those with mental disorders. The identification of the social and biological factors correlated with mental disorders allows for the expression of these factors as risk or protective factors. *Promotion, Prevention and Early Intervention for Mental Health*, a policy document released in 2000, states that a population health approach attends:

> *to the health status and health needs of whole populations. It encompasses population needs assessment, developing and implementing interventions to promote health and reduce illness across the whole population and/or particular population groups, along with monitoring trends and evaluating outcomes.* (Commonwealth Department of Health and Aged Care, 2000, p. 20)

The health status and needs of the population are determined through describing "the epidemiology of given mental illnesses" with a focus upon "the range of psychosocial and environmental factors... as well as demographic factors" that determine mental health status (Australian Health Ministers, 2003, p. 9).

A population health approach is underpinned by concerns with the determination of risk and risk reduction. *Promotion, Prevention and Early Intervention for Mental Health* identifies three aspects of the aetiology of mental illness: the cause that refers to conditions with an identifiable biological aetiology; the determinants of mental illness which are systemic or social factors that increase the likelihood of developing mental illness; and risk and protective factors which are understood as "determinants of health, operating at a population or community level" (2000, p. 13).

A risk reduction approach makes the determination of degree of risk posed to the individual one of the key mechanisms for the allocation of mental health prevention resources. Services are targeted towards the mentally ill or those identified as being at risk. Social and cultural

issues are expressed as risk factors and groups sharing these characteristics are identified as being at risk in this, and subsequent, policy documents. Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD) and rural and remote communities are routinely identified as being at risk. The Framework for the implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia adopts "a population health approach to mental health in CALD communities [which] acknowledges the importance of culture and migration experiences in determining the risk and protective factors that influence mental health" (2004 p. 7). This associates and reduces the experiences of CALD communities to the presence or absence of events that correlate with poor mental health. The Social and Emotional Well Being Framework developed for Aboriginal and Torres Strait Islander people, in contrast, promotes the view that poor mental health results from social dislocation arising from racism expressed in structural inequalities. The approach to mental health promotion in this document is holistic and collaborative, addressing a range of needs from housing, education and employment to crime protection and justice (2004, p. 3).

Targeting at-risk populations

A targeting of at-risk populations is enhanced by mental health prevention strategies that focus on the determination of the level of risk posed to the individual. The second National Mental Health Plan called for the adoption of universal, selected and indicated prevention strategies. Herman (2001, p. 712) argues that these strategies focus upon "levels of risk of illness or scope for health promotion, in various population groups". Universal strategies seek to improve the overall mental health of the population and "aim at building resilience and enhancing coping mechanisms for dealing with stress across the life span" (Australian Health Ministers, 1998, p. 12). Selected actions target sub-groups in the population with higher than average risk profiles who, due to exposure to a number of social factors, are viewed as being at risk (Australian Health Ministers, 1998; Herman, 2001). Indicated strategies target individuals who, by virtue of exposure to multiple risk factors, are seen as having a higher relative risk of developing a condition than the general population (Herman). They may also experience "minimal but detectable signs and symptoms foreshadowing mental disorder" (Commonwealth Department of Health and Aged Care, 2000, p. 31). An indicated preventative approach involves intervention with those identified as being "at risk of developing more severe disorders with the aim of taking appropriate action to lessen the risk" through early identification of potential problems and effective treatment at the first onset of mental illness (Australian Health Ministers, 1998, p. 14).

In practice, mental health policy has moved attention away from health promotion towards prevention activities undertaken through selected and indicated prevention strategies. The second National Mental Health Plan called for action to promote wellbeing in the population as a whole, through the integration of mental health promotion into mainstream health promotion activities (Australian Health Ministers, 1998). By the release of the third National Mental Health Plan in 2003, however, the focus shifted towards those who already experience mental heath problems or those viewed as being at risk. The outcomes for health promotion in this document centred on mental health literacy in the community and the development of a recovery orientation within mental health services (Australian Health Ministers, 2003). The emotional health and wellbeing of the population is largely associated with structural inequalities; however, these are viewed as being "*outside* the main ambit of mental health services", requiring a collaborative intersectoral approach (Commonwealth Department of Health and Aged Care, 2000, p. 17, emphasis in the original). Health promotion through universal prevention strategies are not, therefore, afforded high priority.

Understanding of primary health care

These ideas, taken together, inform the type of primary heath care services offered to those with early symptoms of mental illness. Wass (2000, p. 10) argued that primary health care has increasingly become associated with "the first point of contact with health services" rather than a philosophy of care that promotes equity, participation and social justice. This understanding of primary care is evident in policy documents from the National Mental Health Strategy, which associate primary care with "generalist providers [such as general practitioners, pharmacists and

community health workers] who are not specialists in the particular area of health" (Commonwealth of Australia, 2004, p. 16). These services are understood as being widely accessible to the community in contrast to secondary and tertiary mental health care, which involve specialist community or inpatient services (Raphael, 2000).

A primary care approach promotes the role of medicine in the delivery of preventative services. The National Mental Health Plan 2003–2008 notes that "[t]he role of primary care, which includes general practice, is acknowledged as a critical area complementing the specialist mental health workforce" (Australian Health Ministers, 2003). The role of general practitioners has been enhanced by government funding for shared care schemes. *Primary Care Psychiatry: The Last Frontier*, a report released by the Royal Australian College of General Practitioners and Royal Australian and New Zealand College of Psychiatrists in 1997, states that general practitioners are often the first point of contact with the mentally ill, but may not have the skills to manage mental illness. They recommend the use of collaborative services in which GPs work as case managers in conjunction with psychiatric consultants (Royal Australian College of General Practitioners, 1997). Greater use of general practitioners has been supported by the development of a *Manual of Mental Health Care in General Practice*, published in 2000, and the Enhanced Primary Care Items that allow GPs to claim Medicare rebates for time spent planning care and in case conferencing (Holmwood, 2001).

The role of medicine in providing primary health care has also been supported by the incorporation of biomedicine into primary health care. Raphael (2000, p. 17), in a policy paper called *A Population Health Model for the Provision of Mental Health Care*, argues that primary health care should bring together "the biomedical model, focusing on medical care for the individual in an encounter-base system and a broader biopsychosocial paradigm". This form of mental heath prevention supports individual, indicated prevention strategies with those displaying early symptoms of mental illness or common mental health disorders, rather than strategies that address the social impact of structural inequalities arising from race, class and gender.

Discussion

A number of authors (Inhorn & Whittle, 2001; McMichael, 1999; Munater et al., 2000; Shim, 2002) view the incorporation of epidemiology into public health as undermining the relationship between structural inequalities and health through individualising these inequities. This paper demonstrates that mental health promotion and prevention policies are informed by a population health approach. A population health approach involves the identification of social and biological factors that correlate with mental illness. This approach devalues the role of structural inequities through the reconstructing of this relationship as a statistical rather than a casual relationship. Further, the expression of social factors as risk factors individualises social inequalities through expressing them as properties of the individual. This is a departure from the principles touted in WHO policy documents.

Further, primary mental health care has become the domain of general practitioners who are often the first port of call for people experiencing distress. Government sponsorship of primary mental health service delivery by general practitioners' privileges indicated prevention strategies which target the individual, over universal strategies that promote the mental health of the population as a whole. These changes promote a form of mental health prevention concerned with management of symptoms rather than management of the impact of social circumstances, further individualising social inequalities and removing concerns with equity.

Finally, a risk reduction approach promotes the targeting of preventative services towards those deemed as being at risk due to exposure to multiple risk factors or those experiencing mental health disorders. As a consequence, mental health prevention is dominated by selected and indicated prevention strategies. Mental health promotion is also targeted towards this population, with the latest mental health plan calling for the development of a recovery orientation within mental health services. Structural inequalities are viewed as the domain of other agencies and services. While WHO supports intersectoral collaboration, managing the social determinants of mental health is central to health promotion. The approach to health promotion adopted in the latest mental health plan is, therefore, a further departure from WHO principles.

Conclusion

This paper has argued that the use of statistical techniques that allow for the identification of the level of risk posed to the individual by exposure to identified risk factors individualises the impact of social inequalities. The National Mental Health Strategy is informed by a population health approach. A population health approach uses epidemiological techniques to identify the social, biological and demographic risk factors statistically correlated with mental illness. This information is used to identify populations that can be viewed as having a greater risk of developing mental health disorders allowing for the targeting of services towards those viewed as being at risk. While the structural inequalities related to race, culture and gender are identified as risk factors they are largely seen as being managed outside of mental health services, leading to the fostering of prevention strategies that provide early intervention with those at risk. This approach is promoted through primary care by general practitioners who have a biomedical, individual approach to prevention. These circumstances as a whole ultimately distance current service delivery from the goals originally informing the Declaration of Alma Alta, Ottawa Charter for Health Promotion and World Health Organization's Health for All strategy.

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